ACCREDITATION CANADA

QMENTUM PROGRAM STANDARDS

# Long-Term Care Services

POWERED BY HSO

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# Preface

Health Standards Organization (HSO) develops evidence-based health and social services standards, assessment programs, and quality improvement solutions. Recognized as a Standards Development Organization by the Standards Council of Canada, we work with leading experts and people with lived experience from around the world, using a rigorous public engagement process, to co-design standards that are people-centered, integrated and promote safe and reliable care. For more information visit www.healthstandards.org

## HSO's People-Centred Care Philosophy and Approach

People-centered care (PCC) is an integral component of HSO's philosophy and approach. PCC is defined by the World Health Organization as: “An approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases” (World Health Organization, 2016). This definition is inclusive of all individuals – patients, residents, clients, families, caregivers, and diverse communities.

As such, PCC guides both what HSO does and how HSO does it. PCC calls for a renewed focus on the interaction and collaboration between people, leading to stronger teamwork, higher morale, and improved co-ordination of care (Frampton et al., 2017). This ensures people receive the appropriate type of care in the right care environment.

With a mission to inspire people, in Canada and around the world, to make positive change that improves the quality of health and social services for all, HSO has developed the following guiding PCC principles:

***1. Integrity and relevance:*** *Upholding the expertise of people in their lived experiences of care; Planning and delivering care through processes that make space for mutual understanding of needs /perspectives and allow for outcomes that have been influenced by the expertise of all.*
***2. Communication and trust:*** *Communicating and sharing complete and unbiased information in ways that are affirming and useful; Providing timely, complete, and accurate information to effectively participate in care and decision making.*
***3. Inclusion and preparation:*** *Ensuring that people from diverse backgrounds and contexts have fair access to care and opportunities to plan and evaluate services; Encouraging and supporting people to participate in care and decision making to the extent that they wish.*

***4. Humility and learning:*** *Encouraging people to share problems and concerns in order to promote continuous learning and quality improvement; Promoting a just culture and system improvement over blame and judgement.*

## About Our Standards

HSO standards are the foundation on which leading-edge accreditation programs and great public policy are built. Standards create a strong health care structure that the public, providers and policy makers can rely on, assuring high quality health services where it matters most.

HSO's standards are formatted using the following structure.

- **Subsection Title:** A section of the standard that relates to a specific topic.
- **Clause:** A thematic statement that introduces a set of criteria.
- **Criteria:** Requirements based on evidence, that describe what is needed by people to achieve a particular activity. Each criterion outlines the intent, action, and accountability.
- **Guidelines:** Provide additional information and evidence to support the implementation of each criterion.

This particular standard is intended to be used as part of a conformity assessment.

# Disclaimer

The intended application of this standard is stated below under Scope. Users of this standard are responsible for judging its suitability for their particular purposes.

HSO standards are not intended to replace clinical, management, or best practice guidelines or to contravene existing jurisdictional regulations.

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# Scope

### Purpose

This standard provides LTC home teams, leaders, and governing bodies with criteria and guidelines for delivering resident-centred, high-quality care, enabled by a healthy and competent workforce.

### Applicability

This standard applies to teams, leaders, and governing bodies of LTC homes. LTC homes, also referred to as continuing care, personal care, or nursing homes, are settings where people with complex health care needs live. LTC homes are formally recognized by jurisdictions with a licence or permit and are partially funded or subsidized to provide a range of health and support services, such as lodging, food, and personal care for their residents 24 hours a day, 7 days a week (Canadian Institute for Health Information, n.d.).

The defined resident population for this standard are adults who live in LTC homes.

In this standard, we use the term “resident” to refer to people who live in an LTC home. We recognize that this term might not be appropriate in all contexts. LTC home teams and leaders will respect the preference of those living in the LTC home as to what they would like to be called

# Terms and Definitions

## Standard Specific Definitions

**adverse drug reaction**. An unintended response to a medication that occurs at doses normally used for prophylaxis, diagnosis, or treatment that is not considered preventable. This differs from a resident safety incident, which is a preventable event that has the potential to cause or causes harm when an unintended medicine is prescribed, administered, or dispensed.

**care**. Actions taken in any setting to address a resident's social, physical, personal, emotional, psychological, cultural, spiritual, and medical needs to support their health and well-being (International Organization for Standardization, 2021). Care is relational and founded in relationships that emphasize and embrace the unique experiences, values, perspectives, and personhood of both the resident and the provider (Beach & Inui, 2006).

**communication**. “An interactive, two-way process that involves both understanding and being understood. Communication includes speech, gestures, body language, writing, drawing, pictures, symbol, and letter boards” (Communication Disabilities Access Canada, n.d.).

**competencies**. The total sum of knowledge, skills, abilities, attitudes, and behaviours required to be successful in a workplace role.

**cultural humility**. “A process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience” (First Nations Health Authority, 2016).

**cultural safety**. “An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health system. It results in an environment free of racism and discrimination, where people feel safe” when receiving and providing care and interacting with the health system (First Nations Health Authority, 2016). A culturally safe environment is one that is physically, socially, emotionally, and spiritually safe without challenge, ignorance, or denial of a person's identity (Turpel-Lafond, 2020). Practising cultural safety requires having knowledge of the colonial, sociopolitical, and historical events that trigger health disparities and perpetuate and maintain ongoing racism and unequal treatment (Allan & Smylie, 2015).

**decision-making**. A process taken by a resident, or if incapable, their substitute decision maker, and the team member providing care to determine the best option or course of action to meet the resident's goals, needs, and preferences. decision-making has three steps: introducing and describing the

choices to the resident; helping the resident explore how the options meet their goals, needs, and preferences; and giving the resident time to consider the information, understand it, and have their questions answered before being asked to make a decision.

**emergency**. Current or imminent situation that presents a significant danger capable of causing serious harm to people or damage to property. The situation may be caused by a force of nature, a disease or other health risk, or an accident or intentional or unintentional act and calls upon one or more first responders such as fire fighters, police, ambulance paramedics, and transportation or public works personnel. While an emergency situation requires rapid intervention, it does not surpass response capacity, such that, in contrast to disasters, the impact of an emergency is generally limited.

**equity, diversity, and inclusion approach**. An approach that strives to create an environment where everyone feels included, welcomed, valued, and respected. It aims to create fair access to resources and opportunities; improve communication and participation by diverse communities; and eliminate discrimination (Centre for Global Inclusions, n.d.).

**essential care partner**. A person or persons chosen by a resident, or if incapable, their substitute decision maker, to participate in the resident's ongoing care. An essential care partner can be a family member, close friend, private care provider, or other caregiver. A resident has the right to include or not include an essential care partner in any aspect of the resident's care. Depending on the jurisdiction, an essential care partner may be referred to by other terms, such as designated support person or essential family caregiver (Healthcare Excellence Canada, 2021).

**evidence-informed approach**. An approach to informing policies, procedures, and practices that integrates quantitative and qualitative knowledge from research, implementation science, and people with expertise and those with lived experiences. Combining research, expertise, and lived experience is an inclusive approach that ensures evidence reflects the person, the context, and the evolving nature of knowledge (Alla & Joss, 2021).

**evidence-informed practice**. Refers to the use of the best available and current evidence, along with clinical expertise and consideration of resident values and preferences, to guide healthcare decision-making and the delivery of resident care.

**family**. See essential care partner.

**health record**. The collection of confidential information about a person's health history and socio-demographic data. A health record includes information about the person's conditions and care activities. The information is documented by all health professionals providing care (Health Information Management, n.d.).

**individualized care plan**. A documented plan that outlines the integrated activities required to meet a resident's goals, needs, and preferences. An individualized care plan is developed collaboratively with the resident and informed by ongoing comprehensive assessments of basic, physical, mental, and

social needs. The individualized care plan is shared with appropriate team members. Individualized care plans support care that is seamless and safe.

**information and communication technology**. Any communication device and the various applications and services associated with them. Information and communication technology allows the transfer of information among people and systems (Huth, 2017). Examples include call systems, clinical information systems, staff scheduling systems, Wi-Fi, and tablets.

**integrated quality improvement plan**. Documented series of steps taken with teams to improve the quality of care. The plan includes objectives and measurement indicators as well as actions to be taken.

**jurisdiction**. A geographical area over which a government is responsible for the design, management, and delivery of services to a defined population (Jackman, 2000).

**long-term care (LTC) home**. A setting where people with complex health care needs live. Also referred to as continuing care, personal care, or nursing homes, LTC homes are formally recognized by jurisdictions with a licence or permit and are partially funded or subsidized to provide a range of health and support services, such as lodging, food, and personal care for their residents 24 hours a day, 7 days a week (Canadian Institute for Health Information, n.d.).

**LTC home leaders**. People in an LTC home who work in a formal or informal leadership capacity to support, manage, and recognize their teams and organizations. Leaders include executive and other senior leaders. For the purpose of this standard, an LTC home's governing body is not included in the term leaders or LTC home leaders.

**medication (or drug)**. Prescription and non-prescription pharmaceuticals; biologically derived products such as vaccines, serums, and blood derived products; tissues and organs; and radiopharmaceuticals.

**outbreak**. The occurrence of disease cases that is more than what would normally be expected in a defined community, geographical area, or season.

**partner**. An organization or person who works with others to address a specific issue by sharing information or resources. Partnership can occur at the organization level, team level, or through individual projects or programs.

**physical environment**. Refers to the various spaces within an organization such as public, administrative, team member and service delivery areas.

**policy**. The documented rules and regulations that guide an organization. A policy provides consistency, accountability, and clarity on how an organization operates. A policy needs to comply with jurisdictional requirements.

**polypharmacy**. The use of more medications than are medically necessary. These medications may not be indicated, may not be effective, or could be duplicative (Maher et al, 2014).

**procedure**. The documented steps for completing a task, often connected to a policy. Procedures are evidence informed and comply with jurisdictional requirements.

**process**. A series of steps for completing a task, which are not necessarily documented.

**public health**. An organized activity of society to promote, protect, improve, and, when necessary, restore the health of individuals, specified groups, or the entire population. The core functions of public health practice are population health assessment, surveillance, disease and injury prevention, health promotion, and health protection.

**quality improvement**. A systematic and structured team effort to achieve measurable improvements in care delivery, experiences, and outcomes.

**quality of life**. A person's sense of well-being and their experiences in life in the context of their culture and value systems and in relation to their goals, expectations, and concerns. Quality of life is a broad-ranging concept that is affected in a complex way by a person's physical health, psychological state, personal and spiritual beliefs, existential concerns, social relationships, and their relationship to salient features of their environment (Cohen et al., 2016; World Health Organization, n.d.-a).

**regularly**. Carried out in consistent time intervals. The organization defines appropriate time intervals for various activities based on best available knowledge and adheres to those schedules.

**resident**. A person who lives in an LTC home.

**resident-centred care**. An approach based on the philosophy of people-centred care that ensures that the resident is a partner and active participant in their care. The resident's goals, needs, and preferences drive decision-making for care.

**resources**. Human, financial, material, informational, and technological resources required to ensure safe, high-quality care.

**restraint**. A physical or chemical measure that controls or limits a resident's movement, behaviour, or mobility. The use and definitions of restraints may vary by jurisdiction and population type. Except in an emergency, the use of restraints requires the informed consent of a capable resident, or if incapable, their substitute decision maker.

**risk**. The probability of a hazard causing harm and the degree of severity of the harm (e.g., risks to health and safety or project completion). Risk involves uncertainty about the effects/implications of an activity with respect to something that people value (e.g., health, well-being, property, or the environment), often focusing on negative, undesirable consequences.

**safety incident**. An event or circumstance that could have harmed or did harm a client. Safety incidents experienced by clients (also referred to as patient safety incidents) may include medication errors, choking incidents, injuries, infections, mistakes during care, falls, or clients leaving the care environment without notice.

**service provider**. Health care professionals involved at any point, based on their scope of practice, in the medication management process.

**stakeholder**. An individual with an interest in or concern for the organization and its services. Stakeholders may include the workforce, clients, designated support persons, organizational leaders, and external partners. Stakeholders may be internal (e.g., staff) or external (e.g., community members).

**substitute decision maker**. A person or persons who have legal authority to make a care decision for a resident if the resident is incapable of making the decision for themself. Depending on the jurisdiction, a substitute decision maker may be referred to by other terms, such as health care representative, agent, proxy, personal guardian, committee of the person, temporary decision maker, or attorney for personal care.

**team**. People collaborating to meet the goals, needs, and preferences of the resident. The team includes the resident and, if incapable, their substitute decision maker; essential care partners with consent; and workforce members involved in the resident's care. Depending on the care provided, the team may also include LTC home leaders, volunteers, learners, external service providers, and visitors.

**team-based care**. A model of care in which a team collaborates to provide safe, effective, resident-centred, and accessible care, based on goals defined by the resident.

**timely**. Happening within a time limit that is acceptable, relevant, and appropriate.

**traditional or alternative remedies**. Remedies that are founded on knowledge, practices, theories, beliefs, and experiences originating from different cultures, that may or may not be explicable. Traditional medicine is used for the prevention, diagnosis, improvement, or treatment of physical and mental illness as well as for the maintenance of health (World Health Organization, 2013).

**trauma-informed care**. An approach to care that recognizes that many people have experienced psychological or emotional trauma, the lasting effects of which may influence their physical and mental health, behaviour, and engagement with health service providers and services. Trauma-informed care makes people feel safe and comfortable and avoids re- traumatizing them (Alberta Health Services, n. d.; Trauma Informed Oregon, n.d).

**virtual health**. Means of providing a service (not the service itself) that creates a virtual network to complement in-person care. Virtual health services occur at a distance, using information technology

and telecommunications, interaction between users, including clients, designated support persons and the care team, to facilitate or maximize the quality and efficiency of care provided to clients.

**visitor**. A person who enters an LTC home to interact with a resident or member of the workforce. A visitor could be, for example, a substitute decision maker, essential care partner, external health care professional, business adviser, friend, or family member.

**well-being**. A state of global life satisfaction that includes the presence of positive emotions and moods, the absence of negative emotions, satisfaction with life, fulfillment, and positive functioning. A state of well-being includes physical, economic, social, emotional, psychological, intellectual, and spiritual fulfillment (Centers for Disease Control and Prevention, 2018).

**workforce**. Everyone working in or on behalf of an organization on one or more teams. The workforce includes those who are salaried and paid hourly, in term or contract positions, clinical and non-clinical roles, regulated and non-regulated health care professionals, and all support personnel who are involved in delivering services in the organization.

## Abbreviations

HSO – Health Standards Organization

LTC – Long-term care

### HSO Quality Dimensions

HSO Standards are based on eight-quality dimensions. Each dimension highlights themes of safety and high quality care in all health and social services sectors. Each criterion within the standard is defined by one of the eight quality dimensions.

**Population Focus:** Work with my community to anticipate and meet our needs

**Accessibility:** Give me timely and equitable services

**Safety:** Keep me safe

**Worklife:** Take care of those who take care of me

**Client-centred Services:** Partner with me and my family in our care

**Continuity of Services:** Coordinate my care across the continuum

**Appropriateness:** Do the right thing to achieve the best results

**Efficiency:** Make the best use of resources

## Criteria Types

- **Required Organizational Practices:** Required Organizational Practices (ROPs) are essential practices that an organization must have in place to enhance client safety and minimize risk.
- **High Priority Criteria**: High priority criteria are criteria related to safety, ethics, risk management, and quality improvement.
- **Normal Priority Criteria:** Normal priority criteria are criteria that are not high priority or ROPs.

## Assessment Methods

- **Attestation:** A formal procedure where an organization attests their conformity against identified assessment criteria. The criteria tagged with “attestation” means that an organization will be expected to review the identified assessment criteria and attest their conformity against the identified assessment criteria.
- **On-Site:** A third-party review conducted to assess an organization's conformity against identified assessment criteria. The criteria tagged with “on-site” means that the criteria will be assessed on-site by a third-party reviewer.

## Levels

- **Gold:** Addresses basic structures and processes linked to the foundational elements of safety and quality improvement.
- **Platinum:** Builds on the elements of quality and safety, and emphasizes key elements of client centred care, creating consistency in the delivery of services through standardized processes, and involving clients and staff in decision-making.
- **Diamond:** Focuses on the achievement of quality by monitoring outcomes, using evidence and best practice to improve services, and benchmarking with peer organizations to drive system level improvements.

# 1 Upholding Resident-Centred Care

## 1.1 The LTC home leaders and teams respect residents' rights and responsibilities.

### 1.1.1 Teams follow the LTC home's procedure to inform residents about their rights and responsibilities.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Residents are entitled to know their rights, what is expected of them, and what they are accountable for while living in the LTC home.

Teams inform residents about their rights and responsibilities on admission and on an ongoing basis. The information is accessible and adapted to meet diverse needs such as language, culture, level of education, and cognitive abilities.

Residents are given time to consider the information about their rights and responsibilities, understand it, and have their questions answered. Teams note in residents' health records how and when information about residents' rights was provided.

### 1.1.2 Teams follow the LTC home's procedure to address claims that residents' rights have been violated.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Responding to claims that residents' rights have been violated contributes to a positive and trusting environment. It also ensures that residents can live securely and comfortably, experiencing daily life and care without fear of repercussion for speaking out.

Teams promote an environment where everyone feels comfortable raising concerns or issues. Any person, including residents, substitute decision makers, essential care partners, volunteers, visitors, and any other team member, can make a claim about a violation of residents' rights.

The LTC home's procedure establishes how to report a violation of residents' rights, such as poor, inadequate, or improper care or an incident of racism, discrimination, or abuse. The LTC home leaders ensure that the steps for filing a claim are clearly outlined and accessible to everyone. Teams share that information with residents on admission and on an ongoing basis.

The procedure is intended to protect those making a claim from negative consequences. It reassures the person that submitting a claim will not restrict or otherwise negatively affect the resident's care. The procedure ensures that the confidentiality, privacy, and security of the person submitting the claim and the contents of the claim itself are protected.

The procedure outlines the process for addressing the claim and communicating its outcomes. The LTC home makes every effort to address claims in a timely manner.

Residents are also provided with information about resources available to them outside the LTC home, such as advocates, ombudspersons, regulatory bodies, or privacy commissioners.

### 1.1.3 Teams use a risk management approach to balance residents' right to live with risk with the safety of others.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Residents may choose to engage in activities that could put others at physical, emotional, or psychological risk. A risk management approach helps teams balance residents' autonomy with the safety of others.

When a resident chooses a risk activity, the team uses a risk management approach. The resident, or if incapable, their substitute decision maker, and their essential care partners with consent are involved. Together, the team assesses the resident's chosen risk activity, the nature of the potential harm, who will be affected, and the probability and severity of the risk. Throughout the approach, the team reflects upon and avoids potential biases that may affect their involvement.

The team ensures the resident, or if incapable, their substitute decision maker, understands the proposed approach and accepts the risk or the options for managing an intolerable risk. The team supports the resident in making an informed decision without undue influence from others. The team communicates the risk mitigation plan to others to maintain the safety of all.

1.1.4 Teams follow the LTC home's procedure to determine residents' capacity to make their own care decisions.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Residents' capacity to understand information and make care decisions can change with time and circumstances. A resident's capacity to make care decisions is assessed with each decision before obtaining informed consent. The team collaborates with the resident to determine whether they understand and appreciate

- the reasons for and nature of the proposed care,
- the anticipated effect of the proposed care, and
- the immediate and long-term implications of their decision or not making a decision.

Disagreeing with a resident's decision is not a reason for determining that the resident lacks the capacity to make care decisions. When a resident is determined to be incapable, the team establishes what actions need to be taken in compliance with jurisdictional requirements.

Teams document all required information in residents' health records.

1.1.5 Teams follow the LTC home's procedure to obtain residents' informed consent to receive care.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Obtaining informed consent before beginning care protects residents' fundamental right to control what happens to their person.

Teams follow the LTC home's procedure for obtaining informed consent. The procedure complies with jurisdictional requirements. The most appropriate team members explain to residents the care options and the benefits, risks, side effects, alternative courses of care, anticipated outcomes, and likely consequences of not having the care. Residents are given time to consider the information, understand it, and have questions answered before being asked to provide consent.

Consent can be implied, usually by a resident's conduct or actions, such as rolling up a sleeve to have a blood pressure taken, or consent can be explicitly expressed, usually verbally or in writing. The LTC home's procedure defines which care activities require expressed consent. Teams respect residents' decisions.

If a resident is incapable of consenting, the resident's substitute decision maker will make decisions on the resident's behalf. The resident is still informed about and involved in making decisions about their care as much as possible. The team values the resident's questions and input and continues to respect the resident's rights. The team respects the principle of resident assent and communicates with the substitute decision maker when the resident refuses care.

In emergencies, obtaining informed consent may not be possible. If the resident has made a wish known that applies to the situation (which may, but is not required to, be in an advance care plan), the team must comply with that wish.

Teams document all required information in residents' health records.

### 1.1.6 Teams follow the LTC home's procedure to inquire whether residents have an appointed substitute decision maker.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

A substitute decision maker is someone who makes a care decision on behalf of a resident if the resident has been found incapable of making the decision for themself. Residents can appoint their substitute decision makers in a legal document, such as a power of attorney for personal care or a representation agreement. Substitute decision makers may also be appointed by a court or tribunal or identified through a hierarchy found in legislation.

Teams follow the LTC home's procedure and determine at admission whether a resident has an appointed substitute decision maker. Copies of documentation and contact information are obtained and the information is recorded in the resident's health record and individualized care plan. If the resident is capable of making decisions and has not appointed a substitute decision maker, the team provides the resident with information about appointing one and the consequences of not appointing one.

Teams also inform residents of their right to revoke an existing substitute decision maker appointment and, if they wish, to appoint another person, assuming the resident has the

capacity to make those decisions. If a resident is capable of making or revoking an appointment, the team reviews the choice of substitute decision maker with the resident at least annually. Should circumstances change during the year, such as the death or incapacity of the appointed substitute decision maker, procedures are followed in compliance with jurisdictional requirements to identify a new substitute decision maker.

If a resident is incapable and has not appointed a substitute decision maker, teams follow the LTC home's procedure for identifying who the substitute decision maker would be in compliance with jurisdictional requirements.

### 1.1.7 Teams follow the LTC home's procedure to communicate with residents' substitute decision makers.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Teams follow the LTC home's procedure to uphold the roles and responsibilities of substitute decision makers. The procedure complies with jurisdictional requirements and clearly outlines what and how to communicate with substitute decision makers who are making decisions on behalf of incapable residents, including

- what needs to be communicated,
- when it needs to be communicated,
- who on the team communicates with the substitute decision maker to obtain informed consent,
- who the substitute decision maker communicates with for information,
- how to proceed if substitute decision makers cannot be reached in a timely manner, and
- the process for communication regarding emergency care.

Teams ensure that substitute decision makers' contact information is recorded in residents' health record and individualized care plans and is reviewed regularly.

## 1.2 The LTC home leaders and teams enable resident-centred care.

### 1.2.1 The LTC home leaders implement a trauma-informed approach to care in the delivery of services.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

A trauma-informed approach to care recognizes that many residents have been exposed to experiences of trauma in their lives. These past experiences may be reactivated or new experiences of trauma initiated as a result of aging, dementia, or moving into an LTC home.

A trauma-informed approach to care ensures that

- the LTC home's commitment to trauma-informed care is reflected in its culture, strategy, policies, and procedures;
- universal trauma precautions are used;
- communication creates an environment of safety and well-being;
- residents and the workforce are educated to recognize trauma-induced symptoms and adopt strategies for prevention and management of symptoms;
- residents are assessed for past experiences of trauma and trauma-related symptoms;
- residents and the workforce have access to both recovery-oriented practices and mitigation and supportive practices depending on their expressed wishes and their capacities; and
- additional and responsive support is available to both residents and the workforce after a major incident.

A trauma-informed approach to care also embraces the needs of the workforce, some of whom may have experienced trauma that affects the work that they do.

Teams have access to appropriately trained professionals who can help with assessing residents for experiences with trauma, educate the workforce about trauma-informed approaches to care, and support the workforce and residents with appropriate psychosocial care and recovery-oriented practices when desired.

### 1.2.2 Teams enable residents' autonomy in their daily life and care activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Autonomy is to have control in one's life and be free to act on or make decisions based on individual choice or preference. Acknowledging and enabling residents' autonomy in managing their daily life and care activities enhances their well-being and quality of life. Teams support residents' autonomy by enabling residents to

- make their own decisions based on their goals, needs, and preferences, without controlling influences;
- engage independently in daily life and care activities;
- maintain and restore their mobility;
- maintain and restore their functional capacity; and
- socially engage with people they choose.

### 1.2.3 Teams ensure residents are actively engaged in their daily life and care activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Residents who are actively engaged partners in their care tend to be more empowered and have better care experiences and outcomes. They participate as team members to the best of their ability in planning, delivering, managing, and improving the quality of their own care.

Teams promote opportunities for residents' engagement in various ways. For example, they

- understand and respect residents' diversity and lived experiences,
- practise cultural safety and humility,
- include residents in designing their care and choosing their essential care partners if residents wish to have them,
- have ongoing conversations with residents about their experiences living in the LTC home, and
- communicate in a positive way to maintain residents' engagement.

### 1.2.4 Teams take time to build caring relationships with residents.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Caring relationships start with human connections that build trust, safety, security, belonging, and continuity. Relational care that is meaningful and purposeful is associated with better outcomes and safer care and promotes a resident-centred, team-based culture.

Building and sustaining relationships is an ongoing process that takes dedicated time and effort. Teams are flexible with routines and ways of living. They endeavour to be emotionally present to residents and aware of factors that can shape their responses.

Teams recognize that care involves more than required task-oriented activities. Working conditions support the teams' capacity to take the time needed to build caring relationships with residents.

## 1.3 The LTC home leaders and teams promote the role and presence of essential care partners.

### 1.3.1 Teams ensure residents have the opportunity to choose essential care partners to participate in their daily life and care activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Residents, or if incapable, their substitute decision makers, have the right to include, exclude, or redefine whom they choose as their essential care partners. They also have the right to choose when and how essential care partners participate in their daily life and ongoing care. Their right to designate a different essential care partner or change how an essential care partner is involved in their care is ongoing.

Teams respect residents' decisions about choosing their essential care partners and their roles. Teams document the information in residents' health records and individualized care plans and regularly review residents' essential care partner choices and roles.

Changes in a resident's individualized care plan may affect the essential care partner's role. Teams support essential care partners in assessing their ability to participate in residents' daily life and ongoing care. Residents who do not have an essential care partner and wish to have more support may be invited to appoint a volunteer or advocate as an essential care partner.

### 1.3.2 Teams provide essential care partners with information about their rights and responsibilities when participating in residents' daily life and care activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Essential care partners must understand their rights and responsibilities as partners in care and members of the team. Teams provide essential care partners with accessible information that addresses

- the role of essential care partners;
- their responsibilities, such as treating others with respect and reporting safety risks;
- how information is shared;
- how to access the LTC home and its facilities;
- emergency preparedness protocols; and
- infection prevention and control practices.

### 1.3.3 Teams ensure timely communication with essential care partners to support their participation in residents' daily life and care activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Ongoing and timely communication with essential care partners ensures relevant information about residents' needs is effectively and appropriately shared. Communication also supports essential care partners in voicing residents' needs and concerns.

Teams provide essential care partners with information about

- what to communicate with the team, who to contact, and how;
- the different roles that team members play and which team members should be contacted depending on the day of the week or time of day; and
- a resident's status and any changes in their needs or care in keeping with the role the resident has defined for their essential care partners.

When sharing information, teams follow the LTC home's procedures for protecting residents' privacy and confidentiality, in compliance with jurisdictional requirements. They communicate in plain language, considering the essential care partner's needs, level of understanding, and preferred language. Teams use communication methods that uphold the principles of equity, diversity, and inclusion; create cultural safety for the essential care partners; and facilitate a shared understanding of the information and concerns. For example, teams may ask essential care partners to restate directions in their own words or teams may restate essential care partners' concerns to ensure the shared information has been understood correctly.

Teams ensure a contact person at the LTC home is available to essential care partners 24 hours a day, 7 days a week.

1.3.4 The LTC home leaders provide teams with a visitor policy and procedures that promote the presence of essential care partners and other visitors.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

Visitors play a critical role in residents' lives. A policy and procedures that promote a visitor-friendly culture help to ensure residents' quality of life.

The policy and procedures identify and accommodate the different types of visits and visitors that residents value, including general visitors, essential care partners, and professional advisers. Different residents may value different visitors for different reasons.

The policy considers principles of residents' well-being and safety for all, equitable access, and flexibility. For example, the policy accommodates flexible visiting hours with minimal restrictions for essential care partners to respect caregiving relationships and minimize isolation and loneliness. If visits from essential care partners are restricted, LTC home leaders use an ethical decision-making approach to balance residents' well-being, preferences, and risk tolerance with other risks, such as safety.

General visitors may be subject to different limitations or restrictions, which are reflected in the LTC home's procedures. The procedures for all visitors consider everyone's safety and well-being. All visitors are expected to comply with safety practices such as infection and prevention control.

All visitors are supported with a public, visitor-friendly space where they may visit with residents. Visits are facilitated both indoors and outdoors.

## 1.4 The LTC home leaders and teams actively communicate with residents.

1.4.1 The LTC home leaders promote communication strategies that facilitate the engagement of all residents.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

The use of communication strategies that are engaging, relational, and enable team-based care is foundational to high-quality care.

LTC home leaders ensure residents' literacy levels, cultural norms, and ability to use technology are understood to optimize residents' participation in their daily life and care. Teams and the environment are set up to encourage verbal and non-verbal communication that matches residents' goals, needs, and preferences.

Communication methods such as information boards, non-verbal techniques, and call responder systems (call bells) are available to support verbal and written communication. Modifications to the physical environment, such as sound abatement, quiet spaces, wayfinding, and signage, promote effective communication and social interactions.

Teams and residents have access to community services and associations to support ongoing learning about communication techniques and interventions.

### 1.4.2 The LTC home leaders ensure timely translation and interpretation services are available to meet residents' needs.

Priority: **Normal Priority** | Quality Dimension: **Accessibility** | Assessment Method: **On-site**

Guidelines

Translation and interpretation services may be needed by a resident so they can participate fully in their daily life and care activities. These services are particularly important when making decisions for care and developing individualized care plans.

Teams ensure residents, substitute decision makers, and essential care partners are aware of available services, such as sign language for deaf residents and interveners for deafblind residents. Translation and interpretation services are provided by trained and qualified individuals. Alternative forms of communication such as visual or oral aids and technology such as translation apps may address some language barriers and be useful in urgent situations when interpretation services are not available in a timely way.

The LTC home leaders ensure that written materials provided by the LTC home are available in the languages commonly spoken by the residents.

### 1.4.3 Teams use active communication to engage residents in their daily life and care activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Respectful communication involves exchanging information in a positive, clear, complete, and timely way so that residents can participate in their daily life and care activities. This is key to maximizing residents' comprehension, ensuring their active participation in care, and reducing their social isolation.

Teams promote two-way communication and sharing of information that accommodates residents' individual needs and levels of understanding. Health literacy principles are used to ensure information shared with residents is written in plain language, in an accessible format, and at an appropriate literacy level. Special attention is paid to communicating with residents who have severe cognitive impairments, language or communication deficits, or are non-verbal.

Teams are responsive when residents share information, requests, or complaints. Timing of responses may vary depending on the urgency. For example, responding to a call bell would be considered urgent. Responding to a request to participate in a recreational activity could be considered important but not urgent. When responses are delayed or will require time, teams acknowledge receipt of the request and give an estimated time of when they will respond.

### 1.4.4 Teams address residents' complaints in a timely manner.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Acknowledging and acting on complaints that LTC home leaders and teams receive about residents' experiences fosters a safe environment and upholds continuous quality improvement practices. Complaints can come from residents, substitute decision makers, essential care partners, the workforce, volunteers, or others. Complaints can be communicated verbally or in writing, including electronically.

Teams are aware of how complaints can be made, what steps need to be taken to address a complaint, and how complaints will be resolved in a timely manner. They ensure residents, substitute decision makers, essential care partners, and other members of the teams know how to voice a concern or complaint. Allowing complaints to be made anonymously and treating all complaints confidentially helps to ensure that

those who make a complaint are protected from negative consequences. Responses to complaints are timely and documented according to the LTC home's procedures.

Information about how complaints are addressed is clear and accessible to all. Information about making complaints is shared through pamphlets, the LTC home's website, and regular conversations with residents.

# 2 Enabling a Meaningful Quality of Life for Residents

## 2.1 The LTC home leaders and teams enable residents' meaningful quality of life by providing a welcoming, home-like environment and purposeful daily activities.

### 2.1.1 The LTC home leaders ensure the home's physical environment meets residents' comprehensive needs to enhance their quality of life.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

A home-like and accommodating physical environment that meets the goals, needs, and preferences of residents is essential to providing resident-centred care and enhancing residents' quality of life. LTC leaders co-design the physical environment with residents to ensure that it is safe and welcoming, minimizes the risk of transmitting micro-organisms, and promotes physical safety.

The privacy and confidentiality of residents is respected. Residents are provided with spaces that offer privacy for basic needs such as bathing, hygiene, sleeping, care procedures, and intimacy with others. Private spaces are available when external services are provided.

The environment is universally accessible to enable resident autonomy. For example, adequate space is provided to promote safe mobility for all residents, including those who require assistive devices. Appropriate lighting, noise reduction, and clear wayfinding at entrances and hallways enhance accessibility for residents with communication, visual and sensory, or cognitive impairments.

Common areas offer space for eating, socializing, and participating in group activities that include creative activities, mobility programs, and exercise classes. Lounging and meeting areas allow residents to meet and dine with visitors, observe spiritual practices, and host committee meetings or small gatherings. A welcoming space for visitors is provided with clear signage, comfortable areas to visit, and places to walk or sit outside.

### 2.1.2 Teams follow the LTC home's procedures to ensure residents' safety.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Upholding physical and psychological safety within the LTC home prevents harm to residents. This is balanced with respecting residents' freedom of choice and mobility.

Teams follow the LTC home's procedures to promote physical safety and security. Resident rooms, staff areas, and the building itself have secured access. Controlled access points restrict who, when, and how a person can enter restricted areas, such as medication rooms and food service areas. Other access systems, such as wander control, can help ensure the safety of residents with cognitive impairment, returning wandering residents to a safe place.

Teams follow procedures to promote psychological health and safety throughout the LTC home. They act on identified risk factors and signs of harassment, abuse, neglect, and other threats to the psychological safety of residents. Teams encourage the emotional well-being of residents, promoting practices such as trauma-informed care and visitation to reduce the negative effects of social isolation. Residents report experiencing a healthy state of well-being living in the LTC home.

### 2.1.3 The LTC home leaders enable meaningful daily activities that foster residents' sense of purpose.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Meaningful daily activities contribute to residents' quality of life. They foster a sense of purpose, allow for social interactions, enhance physical and mental health, and alleviate loneliness, helplessness, and boredom.

The LTC home offers meaningful daily activities that contribute to satisfying residents' physical, spiritual, intellectual, social, intergenerational, cultural, and creative needs. LTC home leaders ensure that activities are co- designed and programmed with residents, substitute decision makers, and essential care partners. The activities reflect the diverse population of the LTC home. Recreation facilitators can help with coordinating and facilitating the LTC home's activities.

Activities may also include those offered through community organizations, volunteer programs, educational organizations, and other groups. LTC home leaders ensure that these activities respect the safety of all. This includes ensuring that infection prevention

and control practices are followed, that activities are offered in appropriate spaces, and that the visitor policy and procedures are followed.

Residents are informed of activity plans and schedules. Teams assist residents in accessing and participating in their selected activities. When desired activities cannot be provided by the LTC home, the LTC home leaders endeavour to support residents with access to broader community programming.

### 2.1.4 The LTC home leaders enable meaningful mealtime experiences that meet residents' needs and preferences.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Mealtimes support residents' nutritional, emotional, and social needs.

The LTC home leaders ensure mealtime experiences meet residents' needs and preferences. They ensure that food and beverage selections are current and include seasonal variation.

Teams engage residents in planning menus and choosing food and beverages for meals and snacks. Specific requests from residents, such as requests for culturally appropriate foods, are met whenever possible, and diets are modified as necessary. Food and beverages are served at the intended temperature. Residents who require assistance with eating and drinking are supported in a respectful and dignified manner.

A pleasant mealtime experience includes a clean, bright, and calm space. Dining is an activity that allows residents to socialize with their peers, substitute decision makers, essential care partners, the workforce, and volunteers. Meals are not rushed, giving residents sufficient time to enjoy their food and observe their cultural and spiritual practices.

All efforts are made to accommodate resident preferences around food and dining, allowing residents to dine in the manner they wish, despite possible risks.

### 2.1.5 Teams provide residents with flexible food and beverage options outside set mealtimes.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Flexible food and beverage options outside set mealtimes help to prevent residents' dehydration and malnutrition and ensure that residents have the energy, nutrients, and fluids they need to function optimally throughout the day.

Strategies to maintain normal hydration include regularly offering and encouraging residents to drink, offering smaller amounts to drink more frequently, and reducing obstacles to drinking. Similar strategies can maintain optimal nutrition.

Food and beverage options meet residents' goals, needs, and preferences. Flexible options could include a snack and beverage trolley service or a snack and beverage station stocked with healthy snacks and meal alternatives. Residents may need to be supported in accessing food and beverages beyond set mealtimes, for example by opening packages, pouring beverages, and assisting residents who require support with eating and drinking.

### 2.1.6 Teams promote access to nature and outdoor activities that meet residents' goals, needs, and preferences.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Access to nature and outdoor activities improves residents' well-being and quality of life, sleep, and memory attention and mood. Outdoor activities also increase residents' sense of belonging and social connection to neighbourhoods and communities. For residents living with dementia, outdoor activities can decrease agitation.

Teams promote access to nature and outdoor activities on an ongoing basis. Residents are assisted in accessing outdoor gardens, pathways, seating, shade, and open structures. Seasonal and environmental conditions are considered, and residents are appropriately dressed and protected during outdoor activities.

Residents benefit from indoor connections to the outdoors, created through the use of natural light, balancing open and closed spaces, and providing good air quality.

### 2.1.7 The LTC home leaders support the role of volunteers in enabling residents' meaningful quality of life.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

Volunteers play an important role in enhancing residents' quality of life. They provide relational care through social and cultural activities that can enhance residents' mental health and general well-being and reduce social isolation and loneliness.

Volunteers are unpaid and participate in activities such as friendly visiting and mealtime assistance. They organize and support special programming and events such as pet therapy and music, and they contribute to administrative duties and fundraising.

The LTC home leaders promote volunteer programming with teams. They ensure volunteer roles and responsibilities are clearly defined and procedures are in place for recruiting, screening, training, coordinating, and retaining volunteers.

### 2.1.8 The LTC home leaders promote residents' participation in community activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Community resources, events, and programs provide opportunities for social interactions, a sense of belonging, and intergenerational connections. Examples include resources such as libraries, recreational facilities, parks, and transportation; events such as art shows and concerts; special interest and faith organizations; and school and volunteer programs such as storytelling.

The LTC home leaders recognize the importance of the broader communities' roles and the resources they offer, and they include them when planning activities for residents. They strive to engage residents with community social groups and activities as much as possible by engaging with community stakeholders, inviting them to the LTC home, and promoting resident awareness of community services and events.

Teams support residents in accessing transportation so they may participate in community activities.

### 2.1.9 Teams use information and communication technology to promote social interactions that enhance residents' quality of life.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Information and communication technology can empower residents to be socially engaged, enhancing their quality of life.

Promoting social interaction through information and communication technology can include enabling access to phones, televisions, radios, tablets or computers, a Wi-Fi network, and information boards. Technologies are available to make devices accessible for residents with sensory or cognitive impairments. For example, telephones, computers, and video phones may be equipped with increased font size or assistive programming capabilities. While technology can enable social interactions, it is not meant to replace human interactions.

Teams support residents in accessing technologies by providing technical support based on residents' goals, needs, abilities, and preferences. For example, teams may assist residents with charging and turning on equipment or activating the technology's accessibility tools.

### 2.1.10 Teams facilitate access to appropriate transportation services that meet residents' needs, abilities, and preferences.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Residents of LTC homes depend on accessible transportation to access services, appointments, and events outside the home.

Residents are informed of the transportation options available to them for non-urgent medical needs and social needs, such as shopping, attending events or religious services, and keeping non-medical appointments such as hairstyling. Transportation for non-medical needs can include public transportation or private arrangements.

Teams consider whether residents should be accompanied based on residents' needs and abilities.

The LTC home supports residents' needs by coordinating with transportation providers, posting public transportation schedules, and ensuring that recommended or provided transportation services are safe and reliable.

### 2.1.11 The LTC home leaders communicate the results of annual quality-of-life surveys to teams.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

Quality of life is an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, needs, and preferences.

Quality-of-life surveys are based on self-reported methodologies and provide the LTC home with qualitative information on residents' perception of both their objective and subjective well-being.

Domains covered by quality-of-life surveys include physical capacity and function, psychological well-being, level of autonomy with decision-making, social relationships including those with staff, sense of purpose, and a subjective sense of lifestyle satisfaction.

Surveys should be easy to understand, easy to administer, and adapted for those residents who may have cognitive or communication barriers. For those residents unable to participate, reporting by proxy by substitute decision makers and essential care partners is encouraged. Workforce feedback is also considered.

As team members, residents, substitute decision makers, and essential care partners are engaged in planning, administrating, and communicating the outcomes of the quality-of-life survey. Data collection, analysis, and reporting is done by people who have the required competencies. A system is in place to ensure collected data are anonymized, and privacy measures protect resident confidentiality. The results of the quality-of-life survey are communicated to the workforce and residents in a timely manner and in a format that is clear and accessible for residents.

# 3 Ensuring High-Quality and Safe Care

## 3.1 The LTC home leaders and teams collaborate to develop, implement, and continuously update residents' individualized care plans based on comprehensive assessments of residents' needs.

### 3.1.1 The LTC home leaders provide teams with a validated template to conduct residents' comprehensive needs assessments.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

A comprehensive needs assessment provides the team with a holistic understanding of a resident's needs. The assessment gathers information about the resident's basic care, mental health, physical health, and social needs. The assessment template provides structure to assess the resident's needs and enables the team to develop an individualized care plan that promotes the resident's autonomy and functional capacity and enhances their quality of life.

LTC home leaders provide teams with a validated template to help them assess residents' needs consistently and reduce unintended variation. The selected template is evidence informed and supports resident-centred care. The template also embeds evidence-informed tools, such as a validated observational pain assessment checklist for residents with a limited ability to communicate.

### 3.1.2 The team conducts the resident's comprehensive needs assessment upon admission to the LTC home.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

The team uses evidence-informed, validated assessment tools to comprehensively assess a resident's needs and gather information about the resident's basic care, mental health, physical, and social needs. The team collects this information with the resident, or if incapable, their substitute decision maker, and essential care partners with consent.

Based on the information collected, the team may request a detailed assessment by other health care professionals within or outside the LTC home, such as a rehabilitation professional or physician. This team-based, interdisciplinary approach ensures a thorough assessment of the resident's needs.

Completing the assessment over a few encounters gives the team the chance to observe, engage with, and get to know the resident. The team establishes the resident's immediate needs first, then continually assesses the resident's evolving needs over time.

The assessment process provides the team with the information needed to develop and implement the resident's individualized care plan.

### 3.1.3 The team uses the validated needs assessment template to evaluate the resident's basic needs.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

Care provided in LTC homes includes assisting residents in meeting their basic needs and accomplishing their daily life activities.

The team assesses the resident's ability to meet their basic needs:

- **Eating and Hydrating**. The team assesses the resident's food and eating preferences (including cultural preferences), food allergies, ability to eat and swallow, and capacity for self-feeding and hydrating.
- **Dressing**. The team assesses the resident's ability to dress themself.
- **Sleep**. The team assesses the resident's sleep patterns and preferences.
- **Hygiene**. The team assesses the resident's bladder and bowel continence and ability to manage grooming, bathing, oral hygiene, and toileting.
- **Mobility and ambulation**. The team assesses the resident's ability to move, transfer, and walk and their risk of falls.

The team documents the results of the assessment in the resident's health record and individualized care plan and shares the information with appropriate team members.

### 3.1.4 The team uses the validated needs assessment template to evaluate the resident's mental health needs.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

LTC home residents are likely to experience significant life changes, increasing frailty and reduced capacity, and the effects of multiple chronic diseases. These factors put them at higher risk for experiencing mental health symptoms and mental illness.

The team uses a trauma-informed, culturally safe approach aligned with the principles of equity, diversity, and inclusion to gather information about the resident's mental health needs, cognition, past and present life experiences, and history of mental illnesses and addictions.

Team members take care to observe the resident when engaging with them for any interaction or care encounter. They observe the resident's reactions or behaviour and any changes or observable patterns. They note when these changes occur, what triggers them, and any actions that calm the resident.

When necessary, the team seeks mental health and addictions expertise within or outside the LTC home.

The team documents the resident's mental health needs in the resident's health record and individualized care plan and shares the information with appropriate team members.

### 3.1.5 The team uses the validated needs assessment template to evaluate the resident's physical health needs.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

A thorough understanding of the resident's physical health needs is essential to providing high-quality care. The team gathers information about the resident's physical health needs, including the following:

- **Nutritional status**. The team assesses the resident's intake of fluids and food, nutrient use by the body, food requirements or restrictions, and height and weight. Regular nutritional assessments help to prevent and identify dehydration and malnutrition.
- **Experience of pain**. The team uses verbal and non-verbal evidence-informed methods to assess the resident's experience of pain, taking particular care with residents with a limited ability to communicate and unable to tell others when they experience pain. Every attempt is made to minimize pain for the resident.
- **Sensory capacity**. The team assesses the resident's senses of sight, hearing, smell, touch, and spatial awareness. Sensory assessments may identify the need

for assistive devices, changes to the environment, or special consideration in delivering some types of care.

- **Oral health**. The team assesses the health of the resident's head and neck structures, gums, soft tissues, lips, tongue, and teeth, as well as the condition of any oral appliances (e.g., dentures, crowns, bridges). These assessments help to prevent tooth decay, gum disease, and oral lesions and enable healthy nutrition.
- **Skin integrity**. The team assesses the resident's skin colour, moisture, temperature, texture, and elasticity and inspects for skin lesions and tears. Regular skin assessments are essential to promote comfort and to prevent complications such as skin infections and wounds.
- **Medication profile**. The team generates a best possible medication history for the resident, including the names of the medications the resident is taking and their dosage, route of administration, and frequency. The medication profile includes prescription medications, over-the-counter medications, supplements, and any traditional or alternative remedies. Regular review of the resident's current and complete medication profile minimizes the risk of medication errors and adverse drug reactions.
- **Medical profile**. The team reviews the resident's relevant medical diagnoses (present and past), vital signs, medication and other allergies, adverse drug reactions, antibiotic-resistant colonization status, infection status, and immunization status. A complete medical profile provides the team with essential information about the resident's physical health.

When necessary, team members seek the expertise of other health care professionals within or outside the LTC home to assist with assessing the resident's physical needs.

The team documents the resident's physical needs in the resident's health record and individualized care plan and shares the information with appropriate team members.

### 3.1.6 The team uses the validated needs assessment template to evaluate the resident's social needs.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

Social isolation and loneliness contribute to an increased risk of disease, cognitive decline, and mental health challenges. LTC residents who are socially engaged and participate in meaningful daily activities experience better health outcomes, well-being, and quality of life.

The team uses a trauma-informed, culturally safe approach aligned with the principles of equity, diversity, and inclusion to understand the resident's social needs. The team gathers information on the resident's social needs, including

- preferred social experience and activities;
- preferred recreational activities, including those done alone or with others;
- experience with social and recreational activities, including any past trauma that could influence the resident's participation in some activities;
- mental and physical abilities and desire to interact with others;
- preferred spiritual practices;
- preferred cultural interests and activities; and
- gender identity, sexual expression, and opportunities to support the resident's sexual health and intimacy needs.

When necessary, team members seek the expertise of social care professionals within or outside the LTC home to assist with assessing the resident's social needs.

The team documents the resident's social needs in the resident's health record and individualized care plan and shares the information with appropriate team members.

### 3.1.7 The team conducts ongoing needs assessments according to the resident's changing health status and care needs.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

The resident's health status and care needs can change quickly and often. Delays or failures in identifying or reporting a change in health status can negatively affect the resident's overall safety, health, and well-being.

All team members take the time to observe and engage with the resident in every interaction and care encounter, wherever the encounter takes place. They pay close attention to the resident's health and well-being for any cues that something is different or not right, such as signs of new or worsened pain or changes in the resident's behaviour or mobility. The team continually learns about the resident's needs through regular conversations and check-ins and when they are providing one-on-one care activities with the resident.

The team documents the results of ongoing needs assessments in the resident's health record and individualized care plan and shares the information with appropriate team members.

Ongoing needs assessments comply with jurisdictional requirements.

### 3.1.8 The LTC home leaders provide teams with a validated template to develop individualized care plans.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

Individualized care plans provide a holistic roadmap of care that reflects residents' goals, needs, and preferences. The care plans use information from the comprehensive resident needs assessment to promote resident comfort, autonomy, and functional capacity.

The LTC home leaders provide a validated template to enable teams to use a consistent approach to develop and implement individualized care plans and reduce unintended variation. The selected template should be evidence informed and designed to support resident-centred care.

The LTC homes ensure teams use a trauma-informed, culturally safe approach aligned with the principles of equity, diversity, and inclusion to develop residents' individualized care plans. Individualized care plans are shared with appropriate team members.

### 3.1.9 The team engages with the resident to develop the resident's individualized care plan.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

The team uses a trauma-informed, culturally safe approach aligned with the principles of equity, diversity, and inclusion to develop the resident's individualized care plan. The team engages with the resident, or if incapable, their substitute decision maker, and essential care partners with consent to co-design the individualized care plan. Completing the care plan over a few encounters gives the team the chance to fully understand the resident's needs and ensure they are reflected in the care plan.

The individualized care plan includes

- pertinent information from the resident's needs assessments, any relevant documentation completed on evaluation prior to admission, and any new or updated documentation received from other health care professionals outside the LTC home;
- the resident's goals of care, needs, and preferences;
- the team members involved in the resident's care;
- the type of care, internal and external services, and meaningful daily activities to be provided to the resident;
- the assistive devices and technologies the resident requires to support mobility and sensory deficits; and
- the resident's safety plan.

The individualized care plan also includes the resident's advance care plan, should the resident choose to have one. An advance care plan may specify the resident's wishes for anticipated care, such as not to resuscitate in specified or all circumstances or not to have certain life-sustaining treatments, including hospital or intensive care. Advance care plans are not a form of consent. The team follows the appropriate steps to respect a resident's wishes in compliance with jurisdictional requirements.

The team documents and implements the individualized care plan, taking the time to provide care at the resident's pace. The individualized care plan is shared with appropriate team members. The appropriate information is documented in the resident's health record.

### 3.1.10 The team continually updates the resident's individualized care plan.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

Keeping the resident's individualized care plan current is essential to providing high-quality care.

The team collaborates with the resident, or if incapable, their substitute decision maker, and their essential care partners with consent to update the resident's individualized care plan to include

- changes in the resident's health or behaviour captured in the resident's ongoing needs assessments;
- changes in the resident's goals of care or wishes for care, including wishes for palliative or end-of-life care;

- changes in care or services prescribed by a health care professional, including those outside the LTC home, such as a physician, dentist, or registered dietitian; and
- any other relevant information or documentation from the resident, or if incapable, from their substitute decision maker.

The team documents the changes and shares the resident's updated individualized care plan with appropriate team members. The appropriate information is documented in the resident's health record.

3.1.11 The team follows the LTC home's procedure to share the resident's individualized care plan with appropriate team members.

Priority: **Normal Priority** | Quality Dimension: **Continuity of Services** | Assessment Method: **On-site**

Guidelines

Having access to the right information at the right time enables team members to understand all aspects of the resident's care, answer any questions the resident might have, and fully participate in the delivery of care.

The team follows the LTC home's procedure for sharing the resident's individualized care plan. The procedure complies with health privacy legislation for sharing of information and outlines who has full or limited access to the care plan. The procedure provides steps for securely sharing confidential information, including electronic documents and photos, by email, telephone, or other methods. All communication about the resident's care should be clear, timely, and aligned with the principles of health literacy.

The team is encouraged to share non-confidential elements of the resident's individualized care plan in creative ways. For example, special meals, activities, or events may be displayed on an information board or shared in an announcement or group message. Creating elements of fun contributes to a warm home environment for the resident.

## 3.2 The LTC home leaders and teams collaborate to design, deliver, and continuously evaluate the safety and effectiveness of care.

3.2.1 Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.

**ROP**

Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Using person-specific identifiers to confirm that clients receive the service or procedure intended for them can avoid harmful incidents such as privacy breaches, allergic reactions, discharge of clients to the wrong families, medication errors, and wrong-person procedures.

The person-specific identifiers used depends on the population served and client preferences. Examples of person-specific identifiers include the client's full name, home address (when confirmed by the client or family), date of birth, personal identification number, or an accurate photograph. In settings where there is long-term or continuing care and the team member is familiar with the client, one person-specific identifier can be facial recognition. The client's room or bed number, or using a home address without confirming it with the client or family, is not person-specific and should not be used as an identifier.

Client identification is done in partnership with clients and families by explaining the reason for this important safety practice and asking them for the identifiers (e.g., “What is your name?”). When clients and families are not able to provide this information, other sources of identifiers can include wristbands, health records, or government-issued identification. Two identifiers may be taken from the same source.

## Test(s) for Compliance

**3.2.1.1** At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.

Guidelines

Using person-specific identifiers to confirm that clients receive the service or procedure intended for them can avoid harmful incidents such as privacy breaches, allergic reactions, discharge of clients to the wrong families, medication errors, and wrong-person procedures.

The person-specific identifiers used depends on the population served and client preferences. Examples of person-specific identifiers include the client's full name, home address (when confirmed by the client or family), date of birth, personal identification number, or an accurate photograph.

In settings where there is long-term or continuing care and the team member is familiar with the client, one person-specific identifier can be facial recognition. The client's room or bed number, or using a home address without confirming it with the client or family, is not person-specific and should not be used as an identifier.

Client identification is done in partnership with clients and families by explaining the reason for this important safety practice and asking them for the identifiers (e.g., “What is your name?”). When clients and families are not able to provide this information, other sources of identifiers can include wristbands, health records, or government-issued identification.

Two identifiers may be taken from the same source.

### 3.2.2 The team follows the LTC home's procedure for nutrition and hydration management.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

LTC residents are vulnerable to malnutrition and dehydration, as well as unintentional weight loss. Proper nutrition and hydration are the foundation of residents' health and well-being and are an important element of effective pain and wound management.

Using a team-based approach, the team follows the LTC home's procedure to assess the resident's individual nutritional and hydration needs and prevent malnutrition and dehydration. The procedure is aligned with evidence- informed practices and includes steps to regularly observe and monitor the resident's food and fluid intake and weight, their ability to feed themself and swallow without choking, and any difficulties with food or fluid textures.

The team documents the resident's nutrition and hydration status in the resident's health record and individualized care plan. The information is shared with appropriate team members.

### 3.2.3 The team follows the LTC home's procedure for oral health management.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

LTC home residents are at greater risk of oral conditions such as dry mouth, bleeding gums, tooth decay, reduced sense of taste and smell, and lip and oral lesions.

Poor oral hygiene and care can result in worsened pain, increased risk of malnutrition, and communication problems, all affecting a resident's quality of life. Inadequate oral care can also result in a need for specialized care provided by a dentist or other health care professional.

Using a team-based approach, the team follows the LTC home's procedure to ensure ongoing oral care is provided. They regularly assess the resident's gums, lips, tongue, and oral cavity. Dental appliances are assessed for proper fit and damage. The team facilitates the resident's access to dental health care professionals for both preventive and acute care as needed.

The team documents all oral hygiene management activities in the resident's health record and individualized care plan. The information is shared with appropriate team members.

### 3.2.4 The team participates in the organization's evidence-informed program to optimize skin integrity.

**ROP**

Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

**Test(s) for Compliance**

**3.2.4.1** The team follows the organization's procedure to conduct screening for risk of impaired skin integrity.

Guidelines

Screening is a brief, evidence-informed process to proactively identify a client's health needs and risks that may require further assessment.

The organization's procedure identifies the selected screening tools to determine a client's risk of impaired skin integrity. The selected tools are evidence-informed and appropriate for the care setting and populations served. The organization's procedure also defines when screening is conducted and repeated, such as when care begins and when a client's health status changes.

In some care settings it may be appropriate to screen all clients for impaired skin integrity. Selective screening of clients, as defined in the organization's

procedure, may be more appropriate for other care settings. If appropriate, clients may use the tools to screen themselves.

The screening results are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

**3.2.4.2** The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of impaired skin integrity.

Guidelines

When screening results are positive, indicating that the client may be at risk of impaired skin integrity, a comprehensive assessment is conducted to determine appropriate interventions.

The assessment is timely and complete as defined in the organization's procedure. If the team does not have the required competencies to conduct the assessment, a referral may be made to a specialized health care professional outside of the organization or team.

The assessment is conducted using evidence-informed tools that reflect the services being provided, the care setting, and the populations served.

The selected assessment tools may include methods for assessing

- skin colour, moisture, temperature, texture, elasticity, and presence of lesions or tears;
- the client's sensory perception, degree of physical activity, mobility, and exposure to friction, shear, moisture, and environmental risk factors;
- the client's ability to manage their own skin integrity, including maintaining good hygiene, nutrition, and hydration; and
- associated risks from co-morbidities, such as diabetes, or planned interventions, such as surgery or cancer therapies.

The information collected during the assessment is documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

**3.2.4.3** The team implements intervenΘons to opΘmize skin integrity as part of the client's individualized care plan.

Guidelines

Interventions to optimize skin integrity are informed by the assessment results and the client's decisions about their care. Interventions may include

- implementing strategies to optimize skin integrity, such as movement, hydration, nutrition, and use of topical protectants;
- conducting safety checks and reassessments;
- reviewing medications that may impact skin integrity; and
- providing equipment or devices such as lifts, pressure-reduction cushions, or mattresses.

The selected interventions are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The interventions are regularly assessed. Client progress is measured and documented. The information is also shared during care transitions.

**3.2.4.4** The team follows the organization's procedure to report health care associated impaired skin integrity as a safety incident.

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents. Safety incidents are events or circumstances that could have harmed or did harm a client.

Health care associated impaired skin integrity is when a skin tear, infection, pressure, or other skin injury is caused by a care intervention or unintended variation in care.

The organization's procedure to report health care associated impaired skin integrity as a safety incident is aligned with evidence-informed practices and jurisdictional requirements. The procedure outlines what types of incidents need to be reported and how to report them. The procedure is simple, clear, and focused on system improvement.

Safety incidents are documented in the client's health record and the safety incident reporting system. The information is shared with the client and

other authorized team members in a clear and accessible format as required by the organization's procedure.

Safety incidents inform the organization's integrated quality improvement plan.

**3.2.4.5** The team participates in continuous learning activities about the program to optimize skin integrity.

Guidelines

Continuous learning helps the team implement safety practices to prevent harm and optimize skin integrity. As a member of the team, the client receives information and resources that enable them to play an active role in their care, make informed decisions, and manage their own health.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of optimizing skin integrity as a safety practice;
- identification of preventable and non-preventable risks to skin integrity;
- the importance of assessing surfaces and devices that are in contact with the skin;
- the importance of assessing devices that cross the skin barrier, such as intravenous lines; and
- reporting health care associated impaired skin integrity as a safety incident.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

The team is involved in the development and evaluation of continuous learning activities. The team is given time to participate in, reflect on, and share lessons and experiences. Learning activities are documented.

**3.2.4.6** The team participates in activities to improve the program to optimize skin integrity as part of the organization's integrated quality improvement plan.

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback. It also includes identifying and implementing actions that improve the organization's program to optimize skin integrity.

Aims, measures, and outcomes are documented in the organization's integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of documentation to assess the team's adherence to the organization's procedures to optimize skin integrity;
- assessing the impact of interventions to prevent injury and optimize skin integrity;
- root cause analysis of safety incidents related to health care associated impaired skin integrity;
- feedback from the team, including the client, on the organization's program to optimize skin integrity; and
- feedback from the team, including the client, on the continuous learning opportunities provided by the organization on optimizing skin integrity.

The team is given time to participate in, reflect on, and share quality improvement lessons and experiences.

### 3.2.5 The team follows the LTC home's procedure for pain management.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

Pain is an unpleasant sensory and emotional experience usually associated with actual or potential tissue or nerve damage. Pain includes acute pain, which usually lasts for short periods, and chronic pain, which persists or recurs for longer than three months. Many LTC residents experience some type of chronic pain. Preventing and minimizing all

types of pain reduces the resident's suffering and significantly improves their quality of life.

The team is attentive to and helps to mitigate the effects of pain on the resident's function and social, spiritual, and psychological well-being. Using a team-based approach, the team follows the LTC home's procedure to manage the resident's pain. The procedure is aligned with evidence-informed practices and takes a culturally safe approach to pain management. The procedure applies the principles of a multimodal approach that includes the following:

- **Physical strategies**. These interventions help improve the way the body functions physically. Examples include helping the resident with conditioning exercises, movement, and turning and repositioning in bed. Physical strategies also include mitigating pain with the use of specialized or adaptive equipment.
- **Psychosocial strategies**. These interventions address thoughts, emotions, and behaviours to help the resident influence their experience of pain. Examples include social and recreational activities and, in some cases, mindfulness meditation.
- **Pharmacological strategies**. These interventions involve the use of medication to relieve pain.

The team also considers the potential for experiencing pain when providing care, such as wound care. The team takes steps to prevent and minimize pain. The team documents all pain management interventions in the resident's health record and individualized care plan. The information is shared with appropriate team members.

### 3.2.6 The team participates in the organization's evidence-informed program to prevent falls and reduce injuries from falls.

**ROP**

Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

**Test(s) for Compliance**

**3.2.6.1** The team follows the organization's procedures for providing a safe physical environment to prevent falls and reduce injuries from falls.

Guidelines

A safe and barrier-free indoor and outdoor physical environment is essential to preventing falls and reducing injuries from falls.

The organization's procedures are current, informed by evidence, and aligned with jurisdictional requirements. The procedures identify how to provide a safe physical environment, such as

- keeping floors clean and dry and cleaning up spills promptly;
- providing mobility aids and furniture that are appropriate for the population served;
- ensuring structural features that enhance safety and accessibility are in place and in good working order, such as ramps, handrails, grab bars, non-slip flooring, and adequate lighting;
- minimizing overcrowding and reducing clutter; and
- conducting ongoing safety checks of the care setting and public spaces such as the cafeteria, entrance, and parking areas.

The client, as a member of the team, is encouraged to ask questions, share concerns, and participate in conversations about the safety of the physical environment.

**3.2.6.2** The team follows the organization's procedure to conduct screening for risk of falls and injuries from falls.

Guidelines

Screening is a brief, evidence-informed process to proactively identify a client's health needs and risks that may require further assessment.

The organization's procedure identifies the selected screening tools to determine a client's risk of falls and injuries from falls. The selected tools are evidence-informed and appropriate for the care setting and populations served. The organization's procedure also defines when screening is conducted and repeated, such as when care begins and when a client's health status changes.

In some care settings it may be appropriate to screen all clients for risk of falls and injuries from falls. Selective screening of clients, as defined in the organization's procedure, may be more appropriate for other care settings. If appropriate, clients may use the tools to screen themselves.

The screening results are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

**3.2.6.3** The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of falls or injuries from falls.

Guidelines

When screening results are positive, indicating that the client may be at risk of falls or injuries from falls, a comprehensive assessment is conducted to determine appropriate interventions.

The assessment is timely and complete as defined in the organization's procedure. If the team does not have the required competencies to conduct the assessment, a referral may be made to a specialized health care professional outside of the organization or team.

The assessment is conducted using evidence-informed tools that reflect the services being provided, the care setting, and the populations served. The selected tools may include methods for assessing gait, balance, mood, vision, cognition, medication history, co-morbidity, fall history, management of daily activities, and use of assistive devices.

The information collected during the assessment is documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

**3.2.6.4** The team implements interventions to prevent falls and reduce injuries from falls as part of the client's individualized care plan.

Guidelines

Interventions to prevent falls and reduce injuries from falls are informed by the assessment results and the client's decisions about their care. Interventions may include

- organizing the client's environment to minimize clutter and placing necessary items within reach;
- client self-management techniques to protect against falls such as improving strength and balance and learning to fall safely;
- reviewing medications that may increase risk of falls; and
- providing equipment or devices to improve the client's safety and mobility.

The selected interventions reflect the organization's procedure on the use of least restraint. The interventions are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The interventions are regularly assessed. Client progress is measured and documented. The information is also shared during care transitions.

**3.2.6.5** The team follows the organization's procedure to report falls and injuries from falls as safety incidents.

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents. Safety incidents are events or circumstances that could have harmed or did harm a client. Falls and injuries from falls that occur in the care setting or public space are reported as safety incidents.

The organization's procedure to report falls and injuries from falls as a safety incident is aligned with evidence-informed practices and jurisdictional requirements. The procedure outlines what types of incidents need to be reported and how to report them. The procedure is simple, clear, and focused on system improvement.

Safety incidents are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Safety incidents inform the organization's integrated quality improvement plan.

**3.2.6.6** The team participates in continuous learning activities about the program to prevent falls and reduce injuries from falls.

Guidelines

Continuous learning helps the team implement safety practices to prevent falls and reduce injuries from falls. As a member of the team, the client receives information and resources that enable them to play an active role in their care, make informed decisions, and manage their own health.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of fall prevention and injury reduction as a safety practice;
- prevention strategies that engage the interdisciplinary team, such as sharing the client's mobility status on the client's communication board;
- strategies for team members to reduce their risk of falls and injuries when supporting clients; and
- what to do when a fall or injury from a fall occurs in the care setting or public space, including reporting it as a safety incident.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives. The team is involved in the development and evaluation of continuous learning activities. The team is given time to participate in, reflect on, and share lessons and experiences. Learning activities are documented.

**3.2.6.7** The team participates in activities to improve the program to prevent falls and reduce injuries from falls as part of the organization's integrated quality improvement plan.

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning

practices, and providing feedback. It also includes identifying and implementing actions that improve the organization's program to prevent falls and reduce injuries from falls.

Aims, measures, and outcomes are documented in the organization's integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of documentation to assess the team's adherence to the organization's procedures to prevent falls and reduce injuries from falls;
- assessing the impact of interventions to prevent falls and reduce injuries from falls;
- root cause analysis of safety incidents related to falls and injuries from falls;
- feedback from the team, including the client, on the organization's program to prevent falls and reduce injuries from falls; and
- feedback from the team, including the client, on the continuous learning activities provided by the organization on preventing falls and reducing injuries from falls.

The team is given time to participate in, reflect on, and share quality improvement lessons and experiences.

### 3.2.7 The team follows the LTC home's procedure for the management of responsive behaviours.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Responsive behaviours are actions, words, or gestures presented by people with certain conditions related to cognitive impairment and intellectual disabilities. Experiences of past trauma and new or worsening pain may also contribute to a responsive behaviour.

Using a team-based approach, the team follows the LTC home's procedure to prevent, assess, and manage responsive behaviours. The procedure is aligned with evidence-informed practices and includes preventive approaches such as knowing the resident's history, preferences, and routines; maintaining a daily routine; assisting the resident with daily exercise; and planning simple activities and social time. Calming and soothing activities, such as music, pet visitations, weighted blankets, and lowered noise levels, can also help to prevent and manage responsive behaviours.

The team takes a trauma-informed, culturally safe approach to supporting the resident who is experiencing responsive behaviours. Antipsychotics and sedative medications should not be the first choice for treatment of responsive behaviours. The team collaborates to identify potential causes for the responsive behaviours and non- pharmacological approaches to address the behaviours. When possible, the team calms and redirects the resident and takes steps to address the cause of the behaviours.

The team facilitates access to appropriate health care professionals for assessment and support if a resident's responsive behaviours do not respond to strategies developed by the team.

The team documents the resident's responsive behaviours and the actions taken to address them in the resident's health record and individualized care plan. The information is shared with appropriate team members.

### 3.2.8 The team follows the LTC home's procedure on the use of least restraint.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

The use of restraints, whether physical or chemical, has significant adverse effects on the physical, mental, and emotional well-being of the resident. Physical restraints can cause loss of muscle mass, reduced mobility, skin breakdown, constipation, and incontinence. Chemical restraints, such as sedatives and antipsychotics, can lead to strokes, muscle contractions, involuntary movements, problems with balance, falls, and drowsiness. While these medications can be used to treat an illness, their risk of harm significantly outweighs any benefit when used to intentionally subdue, sedate, or restrain a resident. Restraints of all types can also lead to psychosocial effects such as shame, hopelessness, and agitation.

The use of restraints is rarely indicated. When restraints are indicated, they are only used as a short-term, temporary intervention. Except in an emergency to prevent risk of harm to self or others or to allow essential medical treatment to proceed, the use of restraints requires the informed consent of a capable resident, or if incapable, their substitute decision maker.

The LTC home's procedure promotes a team-based and trauma-informed approach to care. It identifies and addresses symptoms related to the use and appropriateness of restraints and provides alternative care approaches to limit their use. The procedure includes requirements for when restraints in use are reassessed, documentation, and consent for any use of restraints.

The team uses a least-restraint approach to care and provides safe, competent, and ethical care that upholds the resident's rights, dignity, and autonomy and complies with jurisdictional requirements. The team documents any use of restraints in the resident's health record and individualized care plan. The information is shared with appropriate team members.

3.2.9 The team follows the LTC home's procedure to review the resident's medication profile.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Regular reviews of the resident's medication profile are an important safety practice. Medication reviews should occur whenever there is a change in the resident's needs, goals of care, or diagnoses. If nothing has changed, medication reviews should occur every three months, or sooner if indicated. The resident, or if incapable, their substitute decision maker, may also request a medication review at any time.

Using a team-based approach, the team follows the LTC home's procedure to review the resident's medication profile. The procedure is aligned with evidence-informed practices and adheres to the following principles:

- **Prescribe appropriately**. When appropriate indicators exist, residents are offered the opportunity to be prescribed a medication that could improve their overall health and well-being. Residents are closely monitored for intended outcomes and side effects. Medications are reduced or stopped if they are not providing the intended outcome or are causing harm. Antibiotics, such as those used to treat urinary tract infections, are prescribed according to evidence-informed practices.
- **Use antipsychotics appropriately**. Antipsychotics are not used as a first choice to treat behavioural and psychological symptoms of dementia or sleep-related issues.
- **Reduce the use of multiple medications (polypharmacy)**. Using multiple medications can affect the resident's mobility, cognitive function, nutritional status, and quality of life and is avoided when possible.

The team documents any changes in medications in the resident's health record and individualized care plan. The information is shared with appropriate team members.

3.2.10 The team follows the organization's medication reconciliation procedure to maintain an accurate list of medications during care transitions.

**ROP**

Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

## Test(s) for Compliance

**3.2.10.1** The team follows the organization's procedure to obtain a best possible medication history during care transitions.

Guidelines

A best possible medication history is a complete and accurate list of medications the client is taking. Care transitions occur when a client moves from one care setting to another.

The organization's procedure defines how to obtain a best possible medication history during care transitions, including at least the following:

- Virtual or in-person conversations with the client or the person most responsible for medication management. These conversations are conducted in a way that encourages complete and accurate information about medication use, including prescription medications, over-the-counter medications, cannabis for medical purposes, supplements, and any traditional or alternative remedies.
- Verifying the client's list of medications with at least one other reliable source of information. Sources of information may include a community pharmacy record, health record, hospital discharge medication list, or medication administration record.

The organization's procedure is current and informed by evidence. The procedure identifies care transitions where a best possible medication history is completed. Examples include a client's transition to or from a hospital or long-term care home, an ambulatory care setting such as a cancer clinic, or a primary care setting where medication is being managed.

The best possible medication history is documented in the client's health record. The information is shared with the client and other authorized team members in a clear and accessible format.

**3.2.10.2** The team follows the organization's procedure to resolve medication discrepancies during care transitions in a timely way.

Guidelines

Unresolved medication discrepancies, both intentional and unintentional, can result in medication errors and cause harm to the client, unplanned clinical encounters, and related costs for the health system. Medication discrepancies include errors related to inappropriate prescribing, duplication of therapies, and omitted medications.

Medication discrepancies are identified and documented by a designated and trained member of the team. The best possible medication history is compared with what has been recently prescribed or is intended to be prescribed.

Identified discrepancies are documented and communicated to the client's most responsible prescriber. Discrepancies are resolved in a timely way as defined in the organization's procedure.

Resolution of discrepancies can occur prospectively or retrospectively. However, the risk of medication discrepancies is significantly reduced when a best possible medication history is completed before a prescription is written. The use of interoperable information technology helps to make medication reconciliation more reliable and effective.

Medication changes are discussed with the client to ensure the changes reflect the client's goals, abilities, and preferences. These conversations help the client understand which medications need to be stopped or changed; potential interactions with over-the-counter medications, cannabis for medical purposes, supplements, and any traditional or alternative remedies; and how to dispose of unnecessary medications.

The accurate list of medications is documented in the client's health record. This information is shared with the client and other authorized team members in a clear and accessible format.

**3.2.10.3** The team follows the organization's procedure to report incidents that could have harmed or did harm a client related to maintaining an accurate list of medications during care transitions as safety incidents.

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents. Safety incidents are events or circumstances that could have harmed or did harm a client.

Incidents related to maintaining an accurate list of medications during care transitions include when medication reconciliation is not completed, is done incorrectly, or is not completed in a timely manner and could have harmed or did harm a client.

The organization's procedure to report incidents related to maintaining an accurate list of medications during care transitions as safety incidents is aligned with evidence-informed practices and jurisdictional requirements. The procedure outlines what types of incidents need to be reported and how to report them. The procedure is simple, clear, and focused on system improvement.

Safety incidents are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Safety incidents inform the organization's integrated quality improvement plan.

**3.2.10.4** The team participates in continuous learning activities about the medication reconciliation procedure to maintain an accurate list of medications during care transitions.

Guidelines

Continuous learning helps the team implement safety practices to maintain an accurate list of medications during care transitions. As a member of the team, the client receives information and resources that enable them to play an active role in their care, make informed decisions, and manage their own health.

If the organization offers clinical practicums, students, residents, and fellows participate in required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of maintaining an accurate list of medications during care transitions as a safety practice;
- strategies to actively engage the client in maintaining an accurate list of medications during care transitions, including assessing the client's medication literacy;

- communicating medication changes during care transitions;
- training on the organization's medication reconciliation tools and interoperable technology; and
- reporting incidents related to maintaining an accurate list of medications during care transitions as safety incidents.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

The team is involved in the development and evaluation of continuous learning activities. The team is given time to participate in, reflect on, and share lessons and experiences. Learning activities are documented.

**3.2.10.5** The team participates in activities to improve the medication reconciliation procedure to maintain an accurate list of medications during care transitions as part of the organization's integrated quality improvement plan.

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges to delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback. It also includes identifying and implementing actions that improve the organization's medication reconciliation procedure to maintain an accurate list of medications during care transitions.

Aims, measures, and outcomes are documented in the organization's integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of documentation to assess the team's adherence to the organization's medication reconciliation procedure, including assessing the reliability and accuracy of best possible medication histories and assessing medication discrepancy resolution rates and timeliness;

- root cause analysis of safety incidents related to maintaining an accurate list of medications during care transitions;
- feedback from the team, including the client, on the applicability of the organization's medication reconciliation procedure to maintain an accurate list of medications during care transitions; and
- feedback from the team, including the client, on the continuous learning activities provided by the organization on the medication reconciliation procedure to maintain an accurate list of medications during care transitions.

The team is given time to participate in, reflect on, and share quality improvement lessons and experiences.

### 3.2.11 The LTC home leaders implement a program to ensure the appropriate use of antipsychotic medication.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Residents of LTC homes may be admitted with mental health conditions, such as major mood disorders or psychotic illnesses, that require the use of antipsychotic medications. Antipsychotic medications are second-line therapies for other conditions such as the management of complex responsive behaviours. The use of antipsychotic medications when not indicated can seriously harm residents.

As with any medication, informed consent from the resident, or if incapable, from their substitute decision maker, is required before giving an antipsychotic medication.

Teams are involved in educational initiatives to better understand the appropriate use of antipsychotic medication in treating medical conditions and their limited role in the treatment of responsive behaviours. Teams learn about the risks and benefits of antipsychotic medications, ways to replace inappropriate use with non-drug interventions when possible, approaches to reducing and possibly discontinuing antipsychotic medication when they are no longer needed, and when to seek support from mental health professionals.

Medication reviews include assessing how a given symptom or illness is responding to the prescribed antipsychotic and whether side effects are evident. A review includes feedback from the team, including the prescriber and, ideally, a consulting pharmacist.

Teams have an approach to taper residents off potentially inappropriate antipsychotic medication. The approach reduces the medication gradually and includes close monitoring.

### 3.2.12 The team uses validated order sets for the management of common infections.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Validated order sets are used to treat a resident based on evidence-informed criteria and practices for a specific condition. Common infections among residents include urinary tract infections, skin and soft tissue infections, gastroenteritis, and respiratory infections.

Using a team-based approach, the team consults validated order sets for evidence-informed details on appropriate assessment and testing, investigation for diagnosis, and criteria for the proper use of antimicrobial medication. For example, the team only uses antibiotics for urinary tract infections when the resident meets the criteria for treatment.

Many residents with serious or progressive illness want to avoid tests and interventions that may cause harm, particularly at the end of life. The team consults with the resident to understand the resident's goals, needs, and preferences before offering tests or interventions.

The team documents all orders in the resident's health record and shares this information with appropriate team members.

### 3.2.13 The LTC home leaders ensure immunization programs are provided to optimally protect people from infectious diseases.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **Attestation**

Guidelines

Group living settings and complex health conditions increase residents' risk of contracting infectious diseases. Immunization programs are an important part of care that protect residents' health and quality of life by reducing the incidence of infections. These programs also mitigate the risk of infectious disease outbreaks in the LTC home.

The LTC home leaders advocate immunization programs in the LTC home. They promote the implementation of evidence-informed immunization programs that

- inform residents of the vaccines available to them, including publicly funded vaccines and non-publicly funded vaccines, and any associated costs;
- obtain informed consent from the resident, or if incapable, their substitute decision maker, after providing information on the risks, benefits, and side effects of the vaccines;
- align with provincial and territorial vaccine schedules;
- coordinate with local public health services, other health care professionals, and community pharmacists for vaccine access, storage, and administration;
- report any adverse events; and
- document vaccine administration in residents' health record.

The LTC home leaders evaluate and update the immunization programs on a regular basis.

### 3.2.14 The team conducts regular simulations of the LTC home's emergency procedures.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Simulations of the LTC home's emergency procedures help the team prepare for emergencies or disasters. Given ongoing changes in resident populations and the workforce in LTC homes, these simulations must be conducted regularly.

Using a team-based approach, the team conducts simulations of the emergency procedures at the intervals and in the manner outlined in the procedures. The team conducts at least one physical, in-person simulation of one type of emergency or element of the procedures annually. Other simulation exercises may be conducted virtually. Jurisdictional requirements may dictate more frequent simulations, such as fire drills.

Once a simulation has been completed, the team conducts a debrief to evaluate the response and recommends improvements to the procedure to the LTC home leaders.

The emergency procedures are updated following simulation activities and any time there is a change in the LTC home environment that would affect the procedures, such as a loss of a common room or other space. Teams are informed of any changes in the procedures and provided with the updated versions.

3.2.15 The team participates in the organization's evidence-informed program to prevent venous thromboembolism.

**ROP**

Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

## Test(s) for Compliance

**3.2.15.1** The team follows the organization's procedure to conduct screening for risk of venous thromboembolism.

Guidelines

Screening is a brief, evidence-informed process to proactively identify a client's health needs and risks that may require further assessment.

The organization's procedure identifies the selected screening tools to determine a client's risk of venous thromboembolism. The selected tools are evidence-informed and appropriate for the care setting and populations served. The organization's procedure also defines when screening is conducted and repeated, such as when care begins and when a client's health status changes.

The selected screening tools identify risk factors for venous thromboembolism such as the client's history of venous thromboembolism, decreased mobility, advanced age, health conditions, and specified surgical and interventional procedures.

In some care settings, it may be appropriate to screen all clients receiving care for risk of venous thromboembolism. Selective screening of clients, as defined in the organization's procedure, may be more appropriate for other care settings. If appropriate, clients may use the tools to screen themselves.

The screening results are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

**3.2.15.2** The team follows the organization's procedure to use clinical decision support tools to determine appropriate interventions for a client who screens positive for risk of venous thromboembolism.

Guidelines

Clinical decision support tools provide the team, including the client, with evidence-informed information to support decision-making. Clinical decision support tools may be embedded in order sets.

When screening results are positive, indicating that the client may be at risk of venous thromboembolism, evidence-informed clinical decision support tools are used to determine appropriate interventions.

If the team does not have the required competencies to determine appropriate interventions, a referral may be made to a specialized health care professional outside of the organization or team.

The information collected from the use of the clinical decision support tools is documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

**3.2.15.3** The team implements interventions to prevent venous thromboembolism as part of the client's individualized care plan.

Guidelines

Interventions to prevent venous thromboembolism are informed by the clinical decision support tools and the client's decisions about their care. Interventions may include

- daily strategies such as hydration, mobilization, positioning, and wearing loose-fitting clothing;
- longer-term strategies such as maintaining a healthy weight and avoiding a sedentary lifestyle;
- pharmacological thromboprophylaxis; and
- mechanical thromboprophylaxis, such as using an intermittent pneumatic device.

The timing of initiation, duration, and monitoring requirements for thromboprophylaxis interventions are specified and tailored to the characteristics of the client. Client characteristics include risk of bleeding, weight, physiological functions, and risk factors such as falls and skin integrity.

The selected interventions are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The interventions are regularly assessed. Client progress is measured and documented. The information is also shared during care transitions.

**3.2.15.4** The team follows the organization's procedure to report health care associated venous thromboembolism as a safety incident.

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

Health care associated venous thromboembolism is when a blood clot in a vein or in the lungs is caused by a care intervention.

The organization's procedure to report health care associated venous thromboembolism as a safety incident is aligned with evidence-informed practices and jurisdictional requirements. The procedure outlines what types of incidents need to be reported and how to report them. The procedure is simple, clear, and focused on system improvement.

Safety incidents are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Safety incidents inform the organization's integrated quality improvement plan.

**3.2.15.5** The team participates in continuous learning activities about the program to prevent venous thromboembolism.

Guidelines

Continuous learning helps the team implement safety practices to prevent venous thromboembolism. As a member of the team, the client receives

information and resources that enable them to play an active role in their care, make informed decisions, and manage their own health.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of venous thromboembolism prevention as a safety practice;
- current guidance on identifying a client's risk of venous thromboembolism and appropriate preventive strategies including pharmacological and mechanical interventions; and
- reporting health care associated venous thromboembolism incidents as safety incidents.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

The team is involved in the development and evaluation of continuous learning activities. The team is given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

**3.2.15.6** The team participates in activities to improve the program to prevent venous thromboembolism as part of the organization's integrated quality improvement plan.

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback. It also includes identifying and implementing actions that improve the organization's program to prevent venous thromboembolism.

Aims, measures, and outcomes are documented in the organization's integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of documentation to assess the team's adherence to the organization's procedures to prevent venous thromboembolism;
- assessing the impact of interventions to prevent venous thromboembolism;
- root cause analysis of safety incidents related to health care associated venous thromboembolism;
- feedback from the team, including the client, on the organization's program to prevent venous thromboembolism; and
- feedback from the team, including the client, on the continuous learning opportunities provided by the organization on venous thromboembolism prevention.

The team is given time to participate in, reflect on, and share quality improvement learnings and experiences.

## 3.3 The LTC home leaders and teams coordinate to ensure residents receive appropriate care and services when, where, and how they need it.

### 3.3.1 The LTC home leaders provide teams with a policy and procedures for the appropriate delivery of virtual health services.

Priority: **Normal Priority** | Quality Dimension: **Accessibility** | Assessment Method: **Attestation**

Guidelines

Virtual health services can be provided through a variety of ways, such as voice, text, or video conferencing, and can extend to applications residents may have on their devices that promote self-management. When used appropriately, virtual health services can significantly relieve some of the challenges that residents experience with receiving in-person care, such as travelling to appointments.

The LTC home leaders ensure a policy and procedures that support virtual health services are part of the LTC home's strategy for delivering care. Virtual health services are offered when appropriate and are supported with adequate resources, including

- information to help residents and substitute decision makers understand whether and how to receive virtual health services and their related rights and responsibilities;
- equipment to support the delivery of virtual health services, such as communication devices;
- procedures to facilitate residents' access to virtual health services in the LTC home; and
- service agreements between the LTC home and providers delivering virtual health services where appropriate.

An appropriate team member accompanies the resident during a virtual care encounter when required.

When virtual care is offered, it is offered with the same standards of care as in-person care. Confidentiality is protected, continuity of care is ensured, and documentation requirements in the resident's health record are upheld.

### 3.3.2 The LTC home leaders facilitate residents' access to non-medical services.

Priority: **Normal Priority** | Quality Dimension: **Accessibility** | Assessment Method: **On-site**

Guidelines

Residents may need support in accessing non-medical services, such as banking or legal services. Facilitating residents' access to these services helps them accomplish their daily life activities and promotes their autonomy.

The LTC home leaders engage with residents and substitute decision makers to identify how best to support them in accessing the non-medical services residents need.

Access to non-medical services is coordinated in ways that are most helpful to residents, including access to in- person or virtual services. For example, some residents might require accessible transportation to an appointment, while others might need to be accompanied by a team member. Some residents who require legal services might benefit from referrals to local bar associations and law societies for additional information.

### 3.3.3 Information relevant to the care of the client is communicated effectively during care transitions.

**ROP**

Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Effective communication is the accurate and timely exchange of information that minimizes misunderstanding.

Information relevant to the care of the client will depend on the nature of the care transition. It usually includes, at minimum, the client's full name and other identifiers, contact information for responsible providers, reason for transition, safety concerns, and client goals. Depending on the setting, information about allergies, medications, diagnoses, test results, procedures, and advance directives may also be relevant.

Using documentation tools and communication strategies (such as SBAR [Situation, Background, Assessment, Recommendation], checklists, discharge teaching materials and follow-up instructions, read-back, and teach-back) support effective communication, as does standardizing relevant information, and tools and strategies across the organization. The degree of standardization will depend on organizational size and complexity. Electronic medical records are helpful but not a substitute for effective communication tools and strategies.

Effective communication reduces the need for clients and families to repeat information. Clients and families need information to prepare for and improve care transitions; this may include written information or instructions, action plans, goals, signs or symptoms of declining health status, and contact information for the team.

## Test(s) for Compliance

**3.3.3.1** The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.

**3.3.3.2** Documentation tools and communication strategies are used to standardize information transfer at care transitions.

**3.3.3.3** During care transitions, clients and families are given information that they need to make decisions and support their own care.

**3.3.3.4** Information shared at care transitions is documented.

**3.3.3.5** The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:

- Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer
- Asking clients, families, and service providers if they received the information they needed
- Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).

3.3.4 The team designates a team member to coordinate the resident's care before, during, and after a consultation with a health care professional outside the LTC home.

Priority: **Normal Priority** | Quality Dimension: **Continuity of Services** | Assessment Method: **On-site**

Guidelines

The resident will often have planned or unplanned appointments with health care professionals outside the LTC home, such as with a dentist, optometrist, or medical specialist. Coordination ensures the resident receives seamless care.

The team selects the team member responsible for planning the resident's consultation and coordinating their care. The designated team member considers the resident's transportation needs, such as a taxi or adapted transportation, and whether they recommend that the resident be accompanied to the consultation.

The designated team member also identifies the equipment, supplies, and information needed to support the resident and enable the external health professional to provide high-quality care, such as

- the resident's health record and individualized care plan or summary, including their medication profile and other relevant information, such as whether the resident has a nothing-by-mouth (NPO) order;
- the resident's required medications;
- the resident's mobility aids;
- the resident's assistive devices to enhance good communication; and
- a small amount of food or meal.

The selected team member ensures there is no lapse in care and that the resident is engaged throughout the process. The selected team member also clarifies any recommendations or orders made by the consulting health care professional.

3.3.5 The team follows the LTC home's procedure to facilitate medical transportation when required for the resident to access external care.

Priority: **Normal Priority** | Quality Dimension: **Continuity of Services** | Assessment Method: **On-site**

Guidelines

Residents may require emergency or non-emergency medical transportation to access external care.

The team follows the LTC home's procedure to arrange for medical transportation and ensures the resident is cared for throughout the process. The procedure includes discussions with the resident; the person managing their finances, if any, should there be a cost; and if the resident is incapable, their substitute decision maker to coordinate appropriate transportation for the resident depending on the external care required, the resident's status, and the location of the external service provider.

The procedure also involves gathering the medication, equipment, supplies, and any relevant information needed to enable the external service provider to provide high-quality care, such as

- the resident's health record and individualized care plan or summary, including their medication profile and other relevant information, such as whether the resident has a nothing-by-mouth order;
- the resident's required medications;
- the resident's mobility aids; and
- the resident's assistive devices to enhance good communication.

3.3.6 The team follows the LTC home's procedure for admitting, transferring, and discharging the resident.

Priority: **High Priority** | Quality Dimension: **Continuity of Services** | Assessment Method: **On-site**

Guidelines

An established procedure for admitting, transferring, and discharging residents helps to ensure a smooth and seamless experience for residents throughout these processes. The procedure also supports consistent data collection and continuous improvement in the LTC home.

The procedure includes steps to

- prepare the resident with the appropriate information for their admission to the LTC home;
- ensure the resident transfers from one care provider to another safely and seamlessly;
- prepare the resident for discharge and, in the event of death, communicate the death to the resident's substitute decision maker and essential care partners, offer condolences, and provide appropriate support to help them carry out their responsibilities; and
- document all socio-demographic information in the appropriate information system.

Data collected during admission, transfer, and discharge may be used to assess the LTC home's efficiencies and identify opportunities to improve productivity and access to care.

# 4 Promoting Quality Improvement

## 4.1 The LTC home leaders and teams demonstrate an ongoing commitment to quality improvement.

### 4.1.1 Teams have a quality improvement plan for improving residents' quality of life.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

The systematic, continuous collection of information and feedback from residents and teams can support LTC homes in improving residents' quality of life.

Teams are equipped by the LTC home leaders to use a quality improvement plan to set aims, measures, and actions for improving residents' quality of life that

- improve psychological and spiritual well-being,
- maintain and promote residents' autonomy and decision-making,
- strengthen social relationships including those with teams and the
- workforce, and
- enhance residents' engagement and sense of purpose through meaningful activities.

Teams are supported by LTC home leaders to collect a variety of quantitative and qualitative data on residents' quality of life. Data sources may include day-to-day interactions with residents and team members, annual quality- of-life surveys, committee activities, focused interviews, compliments, and complaints.

Aims, measures, actions, and outcomes to improve residents' quality of life are documented in the quality improvement plan and comply with jurisdictional requirements. Quality improvement actions that demonstrate positive change are implemented, sustained, and spread.

### 4.1.2 Teams have a quality improvement plan for improving residents' quality of care.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

The systematic collection of continuous information and feedback from residents and teams can support LTC homes in improving residents' quality of care.

Teams are equipped by the LTC home leaders to use a quality improvement plan to set aims, measures, and actions for improving residents' quality of care that

- demonstrate improved pain management,
- increase adherence to immunization recommendations,
- reduce the incidence of infections,
- reduce injuries related to falls,
- decrease the inappropriate use of antipsychotic medication,
- decrease the use of restraints, and
- optimize the use of antibiotics.

Teams are supported by LTC home leaders to collect quantitative and qualitative data on residents' quality of care in various ways. Data sources include residents' individualized care plans, day-to-day interactions with residents and teams, safety incident reports, surveillance, and routinely collected resident data.

Aims, measures, actions, and outcomes to improve residents' quality of care are documented in the quality improvement plan and comply with jurisdictional requirements.

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