Continuing Care Health Service Standards

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Alberta

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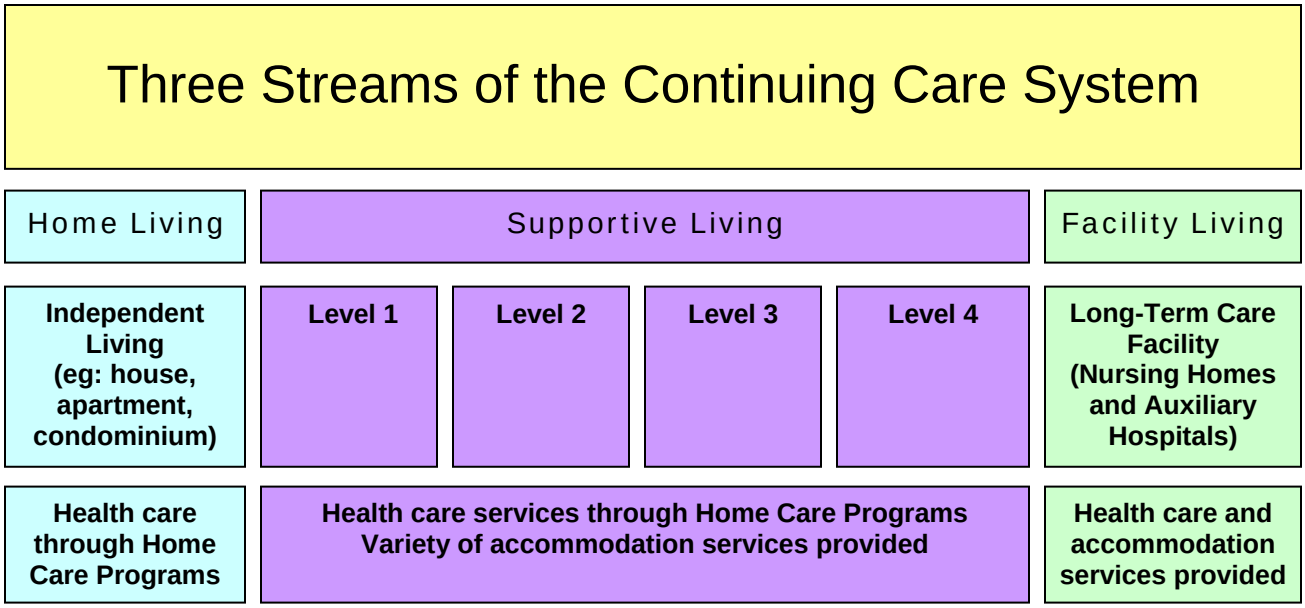
Continuing Care Health Service Standards

Introduction

In Alberta, the continuing care health system is made up of three streams of care: home living, supportive living, and facility living.



Alberta Health and Wellness is responsible for publicly funded continuing care health services and has developed the Continuing Care Health Service Standards. Alberta Seniors and Community Supports is responsible for overseeing the government's role in the provision of accommodation services and has developed accommodation standards for long-term care facilities and supportive living settings.

The Continuing Care Health Service Standards are intended to build on existing legislation, and include a number of standards not currently in legislation.

The original May 2006 version of the Continuing Care Health Service Standards was based on the input provided during a series of consultations undertaken by the MLA Task Force on Continuing Care Health Service and Accommodation Standards in 2005.

A regular process to review and update the standards has been implemented. In March, 2007 the standards were revised to address concerns expressed by stakeholders about the timeline for implementing the RAI tools as well as the timeline and clarity of the standard on Health Care Aide competencies.

This version of the standards is a result of consultations with the regional health authorities, continuing care operators/agencies, professional associations and other stakeholders in November, 2007 with the intent to clarify language and accountability.

Purpose

The intent of the Continuing Care Health Service Standards is to identify standards for the provision of quality continuing care health services that take into consideration the individual needs, preferences and abilities of each client. The standards are divided into two parts:

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

B. Quality Improvement and Quality Assurance

Principles

The Continuing Care Health Service Standards are based on the principles of:

- Client Centered Care - care planning, coordination and delivery of services are centered on the client and their unique needs and preferences. The client participates in decisions regarding their care and their decisions/choices are respected to the extent possible.

- Integrated Care Teams - all individuals who are providing care work together to develop and implement a care plan. Team members know their roles and responsibilities and work together and support one another in delivering the best possible care.

- Client and Family Involvement - clients/families are part of the integrated care team. They understand their roles/responsibilities and what is expected of them and are supported in making informed decisions about their care.

- Wellness and Safety - clients are provided with services designed to address their assessed health needs and promote and maintain their wellbeing in a safe manner.

- Quality Assurance – making sure a minimum quality of care is provided through compliance with the standards.

- Quality Improvement – improving the quality of care being provided through evidence based best practices, supporting innovation and creativity, and creating a culture of quality. This should incorporate the six dimensions of quality of the Alberta Quality Matrix for Health developed by the Health Quality Council of Alberta.

Scope

The Continuing Care Health Service Standards apply to all publicly-funded continuing care health services regardless of whether they are provided directly by, or under contract to, the regional health authority.

Responsibility and Accountability within the Continuing Care Health System

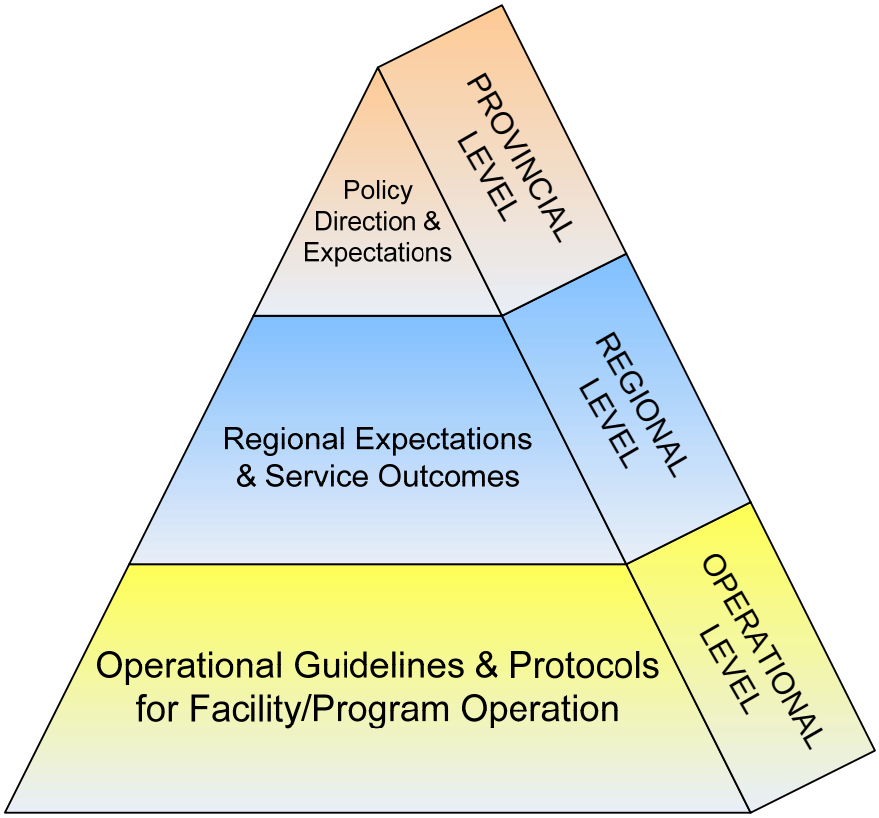
Responsibility and accountability within the continuing care health system can best be understood as being broken down into three levels – the provincial level, the regional level and the operational level. It is important to note that regional health authorities may work at both the regional and the operational level.

- Provincial Level – Alberta Health and Wellness sets strategic direction for the health system through policy, legislation and standards, the allocation of resources, and helping to develop and support the health system. Alberta Health and Wellness provides funding to the regional health authorities for the provision of health care services. Alberta Health and Wellness does not directly provide health care services, however, the department does set broad policies, standards and system expectations to promote the delivery of quality care and health services.

- Regional Level – Under the Regional Health Authorities Act, the regional health authorities are responsible for promoting and protecting the health of their population, assessing the health care needs of their population, determining priorities and allocating resources accordingly, ensuring reasonable access to quality services, and promoting the provision of health services that are responsive to the needs of their population. The regional health authorities deliver publicly-funded continuing care health services. They may provide the services directly or they may allocate funds for the provision of services through a contract. The regional health authorities may set more specific policies and processes to meet their obligations under the Regional Health Authorities Act and the expectations set out by Alberta Health and Wellness.

- Operational Level – Both regional health authorities and their contractors can be considered to be working at the operational level when they are providing continuing care health care services directly to the client. In some cases the regional health authority may work in conjunction with a contractor to provide services to a client. For example: the regional health authority's home care program may provide assessment, care coordination, and care planning services while a contractor such as a home care agency may provide the actual health care services to the client. In these situations both the regional health authority and the contractor are working at the operational level. At the operational level the regional health authority and/or the contractor may set specific policies and/or processes to direct or guide the provision of services.

Accountability follows the allocation of funding. The operational level is accountable to the regional level and the regional level is accountable to the provincial level.



Responsibility for Implementing the Continuing Care Health Service Standards

The Continuing Care Health Service Standards contain standards that address a wide variety of topics which impact both the regional and the operational level. Every effort has been made to identify which level would be most appropriate for implementing each standard. It is important to remember that when the regional health authority is providing services directly that they are working at the operational level. In some cases both levels have been identified. These are areas in which the regional and the operational level often work together.

It is recognized that the nine regional health authorities may operate differently. Therefore, the assignment of responsibility included in these standards is a guideline only. Regional health authorities and their contractors should work together to establish and clarify responsibility for implementing each standard. However, it is important to note that the regional health authority is accountable to Alberta Health and Wellness for ensuring that these standards are being implemented and adhered to at both the regional and the operational level.

Definitions

- Assessed health service needs are the unmet health service needs of clients, as assessed through the continuing care health service assessment and care plan processes as described within.

- Assistance in Accessing means when a regional health authority or a continuing health care services program does not provide a service that a client requests, or the client is not eligible to receive the service, the regional health authority or contractors providing the services shall facilitate the client in accessing said service. This may include the provision of contact information, a formal referral, or direction to an external provider as appropriate.

- Client(s) means individuals receiving publicly-funded continuing care health services through community and home care programs or in long-term care facilities, and where applicable, the clients' legal representatives.

- Care Coordination is a collaborative process to assist a client in accessing services within a stream of care. Care coordination includes assessing the needs of the client, planning for the client's care, coordinating the various services a client may require, and monitoring and evaluating the outcomes.

- Care Plan is a written working document which includes the assessed health needs of the client, the agreed upon health outcomes and target dates for achievement, the specific interventions/treatments that shall be provided and who provides them, and review and evaluation dates and information.

- Care Team includes all the individuals who are providing care to a client, as well as the client and/or their family. The members of the care team are determined by the client's assessed needs and the services outlined in their care plan. The care team works together to plan, coordinate and deliver quality care.

- Case Management is a collaborative process to assist a client in accessing appropriate services across the continuum of care. Case management includes assessing the needs of the client, planning for the client's care, assisting the client in navigating the health care system and accessing services, coordinating the various services a client may require, and monitoring and evaluating the options and outcomes.

- Community and home care programs means regional health authority programs which deliver publicly-funded continuing care health services in community or home settings such as supportive living, clients' homes, and community clinics.

- Continuing care health services means publicly-funded health care services and personal care services provided through community and home care programs or in long-term care facilities, where it is anticipated the client shall require health services for a period *exceeding three months*.

- Chemical Restraint is a medication that is used to inhibit a particular behaviour or restrict movement and that is not the standard treatment for a client's medical or psychiatric condition.

- Establish policies and/or processes means including the necessary procedures to develop, implement, evaluate and update written policies/processes on a regular basis, taking into consideration best practices and consistency with relevant legislation and professional standards of practice.

- Health Care Aides are non-regulated, direct client service providers who provide personal care, support and basic health care services for clients under the direct or indirect supervision of a regulated nurse or other regulated health care professional.

- Long-term care facilities are "nursing homes" under the *Nursing Homes Act* and "auxiliary hospitals" under the *Hospitals Act*.

- Medication has the same meaning as drug as defined in the *Pharmacy and Drug Act*.

- Operational Level refers to the organizations and agencies that deliver publicly-funded continuing care health services. This includes the regional health authority where the region is providing continuing care health services directly to the client and the region's contractors where the regional health authority has contracted for the provision of continuing care health services.

- Personal care services means services that assist clients with the activities of daily living, therapeutic regimes, and other aspects of general care. This may include but is not limited to assistance with bathing, personal hygiene, grooming, dressing, toileting, incontinence management, medication assistance and reminders, basic wound care, respiratory equipment management, ostomy care, mouth care, turning, and behaviour management.

- RAI stands for Resident Assessment Instrument and refers to the RAI/MDS 2.0 and RAI/HC tools, or the most current version thereof, which are comprehensive assessment and care-planning instruments used to assess long-term care facility and community and home care program clients.

- Regional Health Authorities includes all regional health authorities as defined by the *Regional Health Authorities Act*.

- Regional Level refers to the regional health authorities in terms of the activities they undertake to achieve their responsibilities under the *Regional Health Authorities Act* (promoting and protecting the health of their population, assessing the health care needs of their population, determining priorities and allocating resources accordingly, ensuring reasonable access to quality services, and promoting the provision of health services that are responsive to the needs of their population).

- Regulated health care provider means a health care provider regulated under the *Health Professions Act* or other provincial legislation.

- Reportable Incidents are defined as serious harm to a resident/client, staff member or visitor of a continuing care facility/program and/or incidents in which the regional health authority Emergency Response Code is activated.

- Serious Harm is defined as an unexpected or normally avoidable outcome that negatively affects the residents/clients health and/or quality of life, which occurs in the course of health care provision/treatment and/or has the potential to alter the clients/residents baseline health status. Serious harm includes, but is not limited to: death, prolonged hospital stays, medical intervention to sustain life, disability (temporary or permanent) or loss of limb or organ

- Staff includes employees of the regional health authority, or an employee of a contractor with the regional health authority for the provision of continuing care health services.

- Unregulated health care provider means a health care provider not regulated under the *Health Professions Act* or other provincial legislation (eg: health care aides, therapy aides).

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Continuing Care Health Service Standards

Putting Individuals First: Providing Quality Continuing Care Health Services

Continuing Care Health Service Standards

Publicly-funded continuing care health services are provided in accordance with the Continuing Care Health Service Standards.

STANDARD 1.1

Operational Level

1.1 (a) Regional health authorities shall comply with the continuing care health service standards.

Regional Level

1.1 (b) All long-term care facilities and community and home care programs shall comply with the continuing care health service standards.

1.1 (c) Regional health authorities shall monitor and enforce compliance with the Continuing Care Health Service Standards at both the regional level and the operational level.

Information on Continuing Care Health Services

Albertans have access to information on continuing care health services.

STANDARD 1.2

Regional Level

1.2 (a) Information shall be provided on continuing care health services available within the region through a single access toll-free phone line. This service shall be available seven days a week, and may be linked with other points of contact within the health system such as Health Link.

Regional Level

1.2 (b) Albertans shall have access to relevant and understandable information on the range of continuing care health services available within the region.

Regional Level

1.2 (c) Information on regional continuing care health services shall be provided to Albertans seeking information within 72 hours of the request.

Regional Level

1.2 (d) Where a specific continuing care health service is not provided within the region the Albertan shall be informed of known available options and shall be assisted in accessing these options.

Waitlist Management

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

STANDARD 1.3

Regional Level

1.3 (a) Waitlists for continuing care health services shall be prioritized based on the assessed needs of the client, while also considering the urgency of need, client preferences and available resources, where appropriate. Out of region clients shall be included in the same waitlist management system as regional clients.

Client Information and Feedback

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

STANDARD 1.4

Regional Level

1.4 (a) Clients shall have access to clearly written information that outlines:

- the continuing care health services that are provided or offered within the region,
- any associated charges to the client, and
- the responsibilities of the regional health authority and the client.

This document shall be readily available at all times and provided to all clients prior to placement or commencement of services.

Operational Level

1.4 (b) Clients shall have access to clearly written information that outlines:

- the continuing care health services provided or offered within a specific facility/program,
- any associated charges to the client, and
- the responsibilities of the facility/program and the client.

This document shall be readily available at all times and provided to all clients upon admission to the facility or program.

Regional and Operational Level

1.4 (c) Clients shall be provided with information on the importance of personal directives, enduring powers of attorney, guardianship, and trusteeship.

Operational Level

1.4 (d) Where clients or families express an interest in forming a "resident/family" council, they shall be provided with reasonable support, collaboration and cooperation.

Regional Level

1.4 (e) Regional health authorities shall develop a systematic process for client feedback and shall:

- conduct a survey of clients related to quality of care at least every two years,
- analyze the survey results,
- share the results with the operational level, their staff and clients, and
- respond in a clear, consistent way to quality concerns identified through client feedback.

Client Concerns

Clients have a process for raising concerns.

STANDARD 1.5

Regional and Operational Level

1.5 (a) In accordance with the Patient Concerns Resolution Process Regulation, there shall be a concerns resolution process to review concerns and complaints of clients. The process shall provide a fair process for managing concerns/complaints and attempt in good faith to resolve concerns/complaints within a reasonable time.

Regional and Operational Level

1.5 (b) Clients shall be provided with information on other complaints and concerns resolution processes, such as the Health Facilities Review Committee, Protection for Persons in Care, and the Provincial Ombudsman.

Promoting Wellness

Clients are supported, where appropriate, in maintaining and promoting a state of wellness and independence.

STANDARD 1.6

Regional and Operational Level

1.6 (a) Continuing care health services shall be planned for in a manner that supports clients in maintaining and promoting a state of wellness and independence, including mental health, physical health, and the prevention of disease and injury.

Operational Level

1.6 (b) Continuing care health services shall be provided in a manner that supports clients in maintaining and promoting a state of wellness and independence, including mental health, physical health, and the prevention of disease and injury.

Communicable Disease and Infection Prevention and Control

Clients receive services that are provided in a manner that reduces risk of transmission of infections and communicable diseases.

STANDARD 1.7

Operational Level

1.7 (a) Continuing care health services shall be provided in accordance with all communicable disease and infection prevention and control standards issued by Alberta Health and Wellness.

Regional and Operational Level

1.7 (b) There shall be policies and processes in place which shall address but are not limited to the following topics:

- Communicable disease reporting and infection surveillance
- Outbreak detection and response, including required reporting and control strategies;
- Disclosure of any known communicable diseases or infections when transferring a client to another setting based on a risk assessment;
- Health care provider and staff immunizations and screening;
- Client/resident immunizations and screening;
- Volunteer/visitor communicable disease prevention strategies;
- Monitoring of sub-contracted service providers, where services are provided in a long-term care facility where there is a risk of infectious diseases (e.g. massage, foot care, hair dressers);
- Monitoring of pet health where there are pets residing in a long-term care facility or visiting for pet therapy (e.g. immunizations, risk of infectious diseases and behaviour risks); and
- Mandatory and ongoing in-service training regarding communicable disease and infection prevention and control for all staff.

Standardized Assessment

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

STANDARD 1.8

For the Purpose of Determining Appropriate Service Options

Regional Level

1.8 (a) All clients entering the continuing care system shall have an initial assessment completed. This assessment shall be used to determine the health service needs of the client, the urgency of need, and appropriate options for the provision of services.

Regional Level

1.8 (b) Where it is determined that:

- The continuing care health services required to meet the client's assessed health service needs are not available locally; or
- The available continuing care health services are not ideally suitable to meet the client's assessed health service needs; or
- The client's preferred setting is either not available or is not ideally suitable to meet the client's assessed health service needs;

the client shall:

- be informed of why the assessed continuing care health services or preferred setting cannot be provided locally, or are not ideally suitable to meet the client's assessed health service needs;
- be provided with written notice outlining the associated risks with receiving the available continuing care health services or preferred setting; and
- be informed of available options for appropriate services or settings which meet the client's needs, and receive assistance in accessing those options should the client chose to do so.

Regional and Operational Level

1.8 (c) Where the client chooses the available services or setting, under the circumstances described in section 1.8(b),and where the regional health authority and the facility/program agrees to provide services:

- The regional health authority and the facility/program shall work with the client to identify any risks and collaborate on strategies to mitigate and manage those risks; and
- Thjs shall be acknowledged and documented through a managed risk agreement.

<u>For the Purpose of Individual Care Planning</u>

Operational Level

1.8 (d) Once admitted to a community and home care program or a long-term care facility, all clients shall have their needs assessed using a comprehensive assessment tool to identify individual health service needs.

Operational Level

1.8 (e) The needs of all long-term care facility clients shall be assessed using the RAI/2.0 assessment tool according to the timeline set out by Alberta Health and Wellness. As they become available newer versions of the RAI tools may be used.

Operational Level

1.8 (f) The needs of all community and home care program clients shall be assessed using the RAI/HC assessment tool according to the timeline set out by Alberta Health and Wellness. As they become available newer versions of the RAI tools may be used.

Operational Level

1.8 (g) These assessments and care planning shall commence upon admission to the facility/program and shall be completed within the timeframes set out in the appropriate RAI tool.

Operational Level

1.8 (h) Resident or Client Assessment Protocols (RAPS/CAPS) that are generated from the RAI assessments are to be reviewed and considered when preparing the client care plan.

Operational Level

1.8 (i) Where a RAI assessment triggers further detailed assessment, or where additional specialized assessments are required, appropriate health care professionals shall be consulted in the development of the client care plan.

Client/Family Involvement in Care Planning

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

STANDARD 1.9

Operational Level

1.9 (a) There shall be policies and processes in place which support, promote, and permit client involvement in the care planning process. These policies and processes shall also support and permit, with the client's permission, involvement of others in care planning (e.g. identified family members, supportive living operators).

Integrated Care Plan

Each client shall have one current, written, integrated care plan.

STANDARD 1.10

Operational Level

1.10 (a) All clients shall have one current, written, integrated care plan.

Operational Level

1.10 (b) The documented care plan shall include:

- The result of the assessment for the purpose of appropriate care planning as outlined in standards 1.8(d) to 1.8(i) (including where relevant, results of diagnostic testing);
- A description of the client's assessed health service needs;
- A description of the client's goals and expected results within a specific time frame;
- An outline of the interventions required to address the assessed health service needs and to assist clients in achieving identified goals and expected results;
    - A description of those interventions that are provided or funded as part of the region's continuing health services care program;
    - A description of those interventions that are not provided or funded as part of the region's continuing health care services program but that would be beneficial to the client;

- An outline of who is responsible for providing the different interventions outlined in the care plan. This should include health care providers, and where appropriate, other providers, such as supportive living operators, other organizations, clients, representatives and their families.

Evaluation and Revision of Care Plans

Operational Level

1.10 (c) Clients in long-term care facilities shall have their care plans reviewed and updated every three months, or more often as assessed health service needs change. This timeframe shall be in alignment with the RAI assessment guidelines.

Operational Level

1.10 (d) Clients in community and home care programs shall have their care plans reviewed and updated annually, or more often as assessed health service needs change. This timeframe shall be in alignment with the RAI assessment guidelines.

Operational Level

1.10 (e) Each continuing care client, at minimum, shall have an annual continuing care health service team conference to review, evaluate and if necessary, update the care plan.

Operational Level

1.10 (f) All care plan reviews shall include an evaluation of the overall effectiveness of the care plan to determine if the care plan addresses the assessed health needs and if the goals and expectations are being achieved. Care plans shall be updated accordingly.

Operational Level

1.10 (g) Any new intervention or change to the care plan shall be documented in the client's care plan, after consulting, where appropriate, with the client and relevant health care or service providers.

Case Management and Care Coordination

Case managers and care coordinators are available to assist clients in coordinating and managing their health needs.

STANDARD 1.11

System Wide Case Management

Regional and Operational Level

1.11 (a) Clients shall have access to system wide case management services as appropriate. Clients shall be informed about how to access these services and contact their case manager.

Regional and Operational Level

1.11 (b) System wide case management policies and processes shall be in place to:

- Coordinate and integrate health care services within and across the health care system;
- Facilitate access to and continuity of health services across the continuum of care (e.g. when a client is hospitalized or discharged from one continuing health care services program to another); and
- Assist clients in accessing appropriate services within the community.

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

Regional and Operational Level

1.11 (c) There shall be policies and processes in place to ensure that when required clients have access to emergency services. For long-term care facility clients this must include access to on-call medical services, acute care and ambulance services.

<u>Facility/Program Level Care Coordination</u>

Operational Level

1.11 (d) Each client shall have a regulated health care provider who is responsible for coordinating and integrating continuing care health services and facilitating continuity of health care services at the facility/program level.

Operational Level

1.11 (e) The roles and responsibilities of the care coordinator include, but are not limited to:

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

- Supporting the care team in working together and with the client to perform an interdisciplinary assessment, develop a comprehensive care plan, and deliver care.
- Supporting collaborative relationships between the care team, the client's physician and other relevant health care professionals;
- Communicating and sharing information with appropriate health care providers regarding the care of a client; and
- Documenting and communicating wishes for end-of-life care and care in the event of serious illness or a life-threatening condition when specified by the client.

Client Health Information

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

STANDARD 1.12

Regional and Operational Level

1.12 (a) To the extent permitted by law, there shall be policies and processes in place which support and permit the client and others, (such as supportive living operators and primary care physicians), in the appropriate sharing of client health information.

Continuing Care Health Service Providers

Continuing care health services are delivered by educated and qualified health care providers working within their scope of practice or competencies.

STANDARD 1.13

Operational Level

1.13 (a) Regulated health care providers shall work within their practice statement, competencies and conduct, as defined by the *Health Professions Act* or other relevant legislation, and governing professional organizations.

Regional and Operational Level

1.13 (b) Policies and processes shall be established that define the appropriate competencies and scope of work for unregulated health care providers. Unregulated health care providers shall work within those policies and processes.

Regional and Operational Level

1.13 (c) Unregulated health care providers shall work under the supervision of a regulated health care provider.

Regional and Operational Level

1.13 (d) Ongoing in-service training shall be provided for continuing care health service staff based on the changing needs of clients and current evidence based best practices.

Nurse Practitioners

STANDARD 1.14

Regional and Operational Level

1.14 (a) Where applicable, there shall be policies and processes related to continuing care health services provided by nurse practitioners.

Physician Services

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

STANDARD 1.15

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

Operational Level

1.15 (a) All long-term care clients shall be under the care of a physician.

Regional and Operational Level

1.15 (b) Any physician providing medical services to clients in a long-term care facility shall collaborate with the medical director of the facility in the provision of quality medical services.

Operational Level

1.15 (c) Long-term care facilities shall have a physician as a medical director. The medical director is responsible for overseeing the quality of client medical care services and providing clinical leadership in medical research and education.

Regional and Operational Level

1.15 (d) The medical director shall ensure that there are policies and processes governing the medical care of clients, including, but not limited to:

- Physician assessment, initial and on-going as needed;
- Medication review, every three months or more frequently based on the client's health needs;
- Reporting adverse drug reactions; and
- At minimum, an annual integrated care conference for each resident.

Regional and Operational Level

1.15 (e) Responsibilities of a medical director, shall include but are not limited to:

- Reviewing medication utilization;
- Investigating reportable incidents;
- Participating in the development of health service policies;
- Participating in program planning ;
- Reviewing and monitoring of physician services;
- Addressing concerns regarding medical practice; and
- Communicating relevant regional medical policies to physicians providing care to the clients.

Community and Home Care Program Clients

Regional and Operational Level

1.15 (f) Where a community and home care program client is assessed as having unmet medical needs, the client shall be assisted in accessing appropriate medical care.

Medication Management

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

STANDARD 1.16

Regional and Operational Level

1.16 (a) Policies and processes to ensure safe medication management for continuing care clients shall be established and put in place.

Regional and Operational Level

1.16 (b) An annual review shall be conducted to ensure that the following functions are being performed according to the established policies and processes for safe medication management for clients. The review shall include, but is not limited to a review of the following issues:

- Prescribing – ensuring the prescriber has supported each medication order with a clinical indication.
- Assessment of the order - ensuring appropriateness of the medication, with defined goals and targets of therapy, and that it is based on evidence and clinical indications.
- Implementing the order - ensuring transcribing and distribution of medications is timely and appropriate.

- Administering medications - ensuring roles and responsibilities for medication administration, medication assistance and medication reminders are clearly defined and followed, and that medications are administered following industry and professional practices. Ensuring un-regulated health care providers delivering medication assistance or reminders are appropriately trained and supervised.
- Monitoring - ensuring medication effectiveness is regularly monitored in compliance with professional standards and evidence-based best practices.
- Disposal - ensuring unused medications are disposed of appropriately and safely.

Operational Level

1.16 (c) The overall medication utilization of each long-term care facility shall be reviewed annually, or more often as may be required, to ensure appropriateness of the medications being used.

Regional Level

1.16 (d) Where there are continuing care specific formularies in use, there shall be policies and processes in place to ensure that these formularies are reviewed for evidence-based best practice and updated as necessary.

Regional Level

1.16 (e) There shall be policies and processes in place to ensure that where continuing care clients are transferred from one level of service to another, medication is reviewed and reconciled.

<u>Client Medications</u>

Regional and Operational Level

1.16 (f) Where the facility/program is responsible for medication management there shall be policies and processes established and put in place which clearly define the roles and responsibilities for medication management including medication administration, medication assistance and medication reminders.

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

- Simple and easy to understand information for clients about their medications (including the expected outcomes, potential adverse effects and drug interactions, the risks and consequences of non-compliance, and when medications may be discontinued to ensure the safe and proper use of medications).
- Health care providers administering medication adhere to current best practice and professional standards.

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

Therapeutic Nutrition and Hydration

Clients are assessed for nutrition and hydration needs.

STANDARD 1.17

Regional Level

1.17 (a) Clients shall be assessed for nutrition and hydration needs during the assessment for the purpose of determining appropriate services options as outlined in standard 1.8(a). Their assessed nutrition and hydration needs shall be considered when determining appropriate placement options.

Operational Level

1.17 (b) Clients shall be assessed for nutrition and hydration needs during the assessment for individual care planning as outlined in standards 1.8(d) to1.8(i).

Operational Level

1.17 (c) Where the assessment identifies a client with therapeutic nutrition or hydration needs, including but not limited to:

- Moderate to high nutrition or hydration risk;
- Feeding and swallowing difficulties;
- Therapuetic diet;

- Texture modified diet;
- Assistance with intake, including monitoring and adjusting assistance, as required; and
- Significant food allergies;

the client's needs shall be addressed in accordance with the care planning process.

Operational Level

1.17 (d) Where the assessment identifies a client with therapeutic nutrition or hydration needs, a registered dietitian or registered nutritionist shall be included in the care planning process, and shall provide services as appropriate, including approving texture modified diets to ensure they are of high quality and nutrient dense.

Therapeutic Services

Clients are assessed for therapeutic service needs, which may include but is not limited to physical therapy, occupational therapy, and recreation therapy.

STANDARD 1.18

Regional Level

1.18 (a) Clients shall be assessed for therapeutic service needs during the assessment for the purpose of determining appropriate service options as outlined in standard 1.8(a). Their assessed therapeutic service needs shall be considered when determining appropriate placement options.

Operational Level

1.18 (b) Clients shall be assessed for therapeutic service needs during the assessment for individual care planning as outlined in standards 1.8(d) to 1.8(i).

Operational Level

1.18 (c) Where the assessment identifies a client with therapeutic service needs they shall be addressed in accordance with the care planning process. Clients with assessed needs shall receive the therapeutic services that are provided or funded as part of the regional health authority's continuing care health services program. Clients shall be assisted in accessing therapeutic services that are not provided or funded as part of the regional health authority's continuing care health services program, but which may be beneficial to the client.

Oral Health, Dental, Podiatry, Hearing and Vision Services

Clients are assisted in accessing health services such as oral health, dental, podiatry, hearing and vision services.

Note: This standard refers to services that are not provided or funded by regional health authorities continuing health care services programs. Clients have the primary responsibility for accessing these services, and are entirely responsible for any fees or associated risks.

STANDARD 1.19

Regional and Operational Level

1.19 (a) Clients are assisted in accessing health services which are not provided or funded by the regional health authorities continuing health care services programs but which may be beneficial to the client. This shall be based on the assessed health service needs of the client and may include oral health, dental, podiatry, hearing and vision services.

Specialized Health Service Equipment and Medical-Surgical Supplies

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

STANDARD 1.20

Regional and Operational Level

1.20 (a) Where equipment and/or medical-surgical supplies are required, but not provided as part of the regional health authority's continuing care health services program the client shall be assisted in accessing them. This shall include referrals to other programs such as Alberta Aids to Daily Living as appropriate.

Regional and Operational Level

1.20 (b) There shall be policies and processes in place to ensure that health service equipment provided through the regional health authority's continuing care health services program is in safe working condition and in accordance with the manufacturers recommended use.

Regional and Operational Level

1.20 (c) There shall be policies and processes in place to ensure that all staff, clients, and family caregivers using equipment provided through the regional health authority's continuing care health services program are instructed in safe use of the equipment.

Operational Processes

There are operational policies and processes in place for the provision of continuing care health services.

STANDARD 1.21

Regional and Operational Level

1.21 (a) There shall be operational policies and processes in place for the provision of continuing care health services which reflect the changing characteristics of clients and current evidence based best practices.

Regional and Operational Level

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

- Client health information management
- Risk management and the use of managed risk agreements
- Client safety, including falls and injury prevention.
- Reportable incidents, including prevention, management and reporting.
- Client abuse, including prevention, management and reporting.
- Dealing with complications, crisis or emergencies, including basic life support.
- Prevention and management of aggressive or violent behaviour.
- Care of clients with dementia, cognitive impairment or mental health needs.
- Personal care of clients including oral care, continence management and safe bathing practices.
- Wound management.
- Restraints, including decision-making and review of physical, chemical and environmental restraints to manage client behavior.
- Pain assessment and management.
- Palliative care.
- End-of-Life care.
- Assessment of decision-making capacity.
- Biomedical/biohazardous waste management
- Emergency preparedness and pandemic planning.

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

Quality Improvement and Quality Assurance

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

Quality Improvement

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

STANDARD 1.22

Regional and Operational Level

1.22 (a) Quality improvement programs shall be established to regularly evaluate and improve continuing care health services. These programs shall include, but are not limited to the following:

- Monitoring overall quality of continuing care health services based on indicators such as resident, client, family and staff surveys;
- Reviewing factors and trends identified in client concerns resolution processes, reportable incident reports and quality improvement recommendations;
- Reviewing reportable incidents, near misses and other information to help prevent incidents from occurring in the future;
- Monitoring client outcomes and comparing them with evidence-based best practice;
- Utilizing quality indicators to improve services and achieve quality outcomes (benchmarking);
- Comparing performance with industry benchmarks;
- Developing and implementing quality improvement strategies or plans of action;
- Establishing a process to oversee quality improvement strategies or plans of action; and
- Establishing staff training strategies which respond to changing client needs and health care trends to improve quality of service provision.

Regional Level

1.22 (b) Regional health authorities shall obtain and maintain accreditation status from an appropriate accrediting organization as required by the Mandatory Accreditation in Alberta's Health System directive and the Minister.

Regional Level

1.22 (c) An annual report on accreditation status and quality improvement activities for continuing care health services shall be prepared and submitted in a manner and form to be determined by Alberta Health and Wellness.

Reporting

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

STANDARD 1.23

Regional Level

1.23 (a) RAI data and/or other quality indicator data as identified by Alberta Health and Wellness shall be collected and submitted in accordance with the guidelines set out by Alberta Health and Wellness.

Regional Level

1.23 (b) An annual report summarizing the regional health authority's compliance status with the Continuing Care Health Service Standards and relevant legislation, signed by the regional Chief Executive Officer, shall be submitted in a manner and form to be determined by Alberta Health and Wellness.

Regional and Operational Level

1.23(c) Reportable incidents shall be reported in accordance with the process and guidelines set out by Alberta Health and Wellness.

Alberta