



Continuing Care Health Service Standards

Continuing Care Health Service Standards (2024)

Created by: Alberta Health, Continuing Care Branch

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Purpose

Alberta Health is committed to supporting the delivery of Quality Health Care to Albertans in the continuing care system through the application of the *Continuing Care Health Service Standards* (CCHSS). The CCHSS are a legislated requirement of Operators pursuant to the *Continuing Care Regulation* under the *Continuing Care Act*. The CCHSS set the minimum requirement that Operators in the continuing care system must comply with in the provision of publicly funded Health Care.

Scope and Terminology

In Alberta, publicly funded Health Care is provided by continuing care home operators and Home and Community Care providers as defined in the *Continuing Care Act*. Together, both operators and providers are called Operators within the CCHSS (see definitions).

The CCHSS direct requirements related to the provision of publicly funded Health Care in the continuing care system, applying to Operators providing Facility-Based Care in Continuing Care Homes as well as those providing Home and Community Care.

For clarity of terminology used throughout this document, regarding terms set out in the *Continuing Care Regulation* and *Continuing Care (Ministerial) Regulation*:

- Continuing care home refers to facilities that were previously known as publicly funded supportive living facilities and long-term care facilities. For the purposes of the CCHSS, only Type A and Type B Continuing Care Homes are in scope of application.
 - Type A Continuing Care Homes refer to facilities previously referred to as long-term care facilities.
 - Type B Continuing Care Homes refer to facilities previously referred to as publicly funded supportive living accommodations or designated supportive living accommodations.
- Home and Community Care refers to what was previously known as the Coordinated Home Care Program. For the purposes of the CCHSS, only type 1 and type 2 Home and Community Care are in scope of application.
 - Type 1 Home and Community Care is provided to an eligible individual by the Regional Health Authority.
 - Type 2 Home and Community Care is provided to an eligible individual by a Home and Community Care provider who has entered into agreement with Regional Health Authority for the provision of Home and Community Care.

Funding for Health Care is provided by Alberta Health to the Regional Health Authority. Health Care is delivered by Regional Health Authority or by an Operator contracted by the Regional Health Authority.

Contact Details

This document can be found on the Alberta Health website: www.health.alberta.ca. For general information, call Alberta Health's Licensing and Compliance Monitoring Branch at (780) 644-8428 for toll-free access within Alberta, first dial 310-0000 and your call will be directed to the appropriate personnel.

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Definitions

Advance Care Planning	A process undertaken by a Client, their family and Health Care Providers to communicate and document the Client's Health Care goals to be taken into consideration should there be a time in the future when the Client cannot express their wishes.
Assistive Equipment	Equipment that allows a Client to maintain mobility and social connectedness, and complete activities of daily living and instrumental activities of daily living. Examples of Assistive Equipment include but are not limited to the following: <ul style="list-style-type: none">a) walkers;b) wheelchairs;c) canes;d) scooters;e) motorized wheelchairs;f) grab bars;g) bath chairs; orh) mechanical lifts.
Care Plan	A written working document developed by the Interdisciplinary Team that includes a Client's assessed Unmet Health Care Needs, related Health Care goals and interventions.
Client	This term refers to both an eligible individual and eligible resident as defined in the <i>Continuing Care Act</i> .
End of Life Care	Care provided during the period of time when a resident of a continuing care home or an individual to whom Home and Community Care is provided is approaching death.
Enduring Power of Attorney	A legal document that appoints another person to make financial and legal decisions on behalf of a Client and meets the requirements of an enduring power of attorney under the <i>Powers of Attorney Act</i> .
Facility-Based Care	As defined in the <i>Continuing Care Act</i> , this refers to the group of goods and services that is provided on an ongoing basis to residents of a continuing care home and that is made up of the following: <ul style="list-style-type: none">a) prescribed accommodation goods and services;b) prescribed health goods and services; andc) prescribed other goods and services. <p>For the purposes of the CCHSS, only Type A and Type B Continuing Care Homes are in scope of application.</p>
Health Care	The Facility-Based Care and/or Home and Community Care provided to a Client by a Health Care Provider.

Health Care Aide	An Unregulated Health Care Provider responsible for providing direct care to assist in the activities of daily living, comfort and safety of the Client.
Health Care Provider	A Regulated Health Professional or Unregulated Health Care Provider employed or contracted by an Operator for the provision of Health Care to Clients.
Health Information	Information that is “health information” as defined in the <i>Health Information Act</i> .
Health Status	A description or measurement of the health of a Client at a particular point in time that may require intervention by a Regulated Health Professional.
Home and Community Care	As defined in the <i>Continuing Care Act</i> , this refers to the prescribed health goods and services and prescribed other goods and services that are provided by a Home and Community Care provider to an eligible individual in the individual’s home or community. Formerly, this program was referred to as the Co-ordinated Home Care Program and was also known as Alberta’s Home Care Program. For the purposes of the CCHSS, only type 1 and type 2 Home and Community Care are in scope of application.
Interdisciplinary Team	A group comprised of Health Care Providers, the Client or the Client’s legal representative, if applicable, and other individuals of the Client’s choosing, who meet for the purposes of planning, coordinating and delivering Health Care services to the Client. The Health Care Providers on the Interdisciplinary Team are determined by the Client’s assessed Health Care needs.
InterRAI Instruments	Comprehensive, standardized assessment instruments developed by InterRAI for evaluating a Client’s needs, preferences and strengths. The InterRAI Instruments have a number of outputs that highlight areas that require further investigation, evaluate current Health Status and facilitate the allocation of resources.
Life Enrichment Services	Services that support the mental, physical, emotional, social, intellectual or spiritual needs and goals of a Client.
Medical Care	Any diagnostic or screening procedure, treatment, drug, or therapeutic diet prescribed for or provided to a Client by a Physician or a Nurse Practitioner.
Medical Status	A description or measurement of the health of a Client at a particular point in time that may require intervention by a Physician or a Nurse Practitioner.

Medical/Surgical Supplies	Supplies used for medical or surgical treatments.
Medication Assistance	A service provided to a Client to facilitate the Client's ability to self-administer medication and to ensure medication is taken as intended by the prescriber. For example, handing a medication container to the Client or opening the packaging that holds medication(s).
Medication Management	The processes required to ensure safe and effective medication therapy for a Client, including prescribing, communication of medication orders, medication reconciliation, dispensing, delivery, storage, medication support, documentation and follow-up.
Medication Reminder	A service provided by a Health Care Provider to remind a Client to self-administer medication and ensure that medication is taken as intended by the prescriber.
Medication Review	A critical examination by the Interdisciplinary Team of a Client's medications for appropriateness, effectiveness, interactions, and adverse reactions for the purposes of optimizing the impact of medications and minimizing the number of medication related problems.
Non-Critical Medical Devices	A medical device that is intended to provide Health Care to more than one Client at different times. The Non-Critical Medical Device either touches only intact skin, but not mucous membranes, or does not directly touch the Client.
Nurse Practitioner	A registered nurse with advanced education, knowledge, skills and competencies who is licensed to practice as a Nurse Practitioner in Alberta and is regulated by the College of Registered Nurses of Alberta.
Operator	A legal entity that receives public funding for the provision of Health Care directly to Clients.
Palliative Care	Care provided to improve the quality of life and to prevent and relieve the suffering of a resident of a continuing care home or an individual to whom Home and Community Care is provided who has an illness that can be reasonably expected to cause the death of the resident or individual within the foreseeable future.
Person Centered Care	The following principles of Health Care delivery that inform a Client's experience: <ul style="list-style-type: none"> a) transparency; b) individualization; c) recognition; d) respect; e) dignity; and f) choice.

Personal Directive	A legal document which empowers a person to act as an agent on behalf of a Client with respect to personal matters and which meets the requirements of the <i>Personal Directives Act</i> .
Physician	A person qualified and licensed to practice medicine in Alberta and is a regulated member of the College of Physicians and Surgeons of Alberta.
Quality	The six dimensions of Quality according to the Health Quality Council of Alberta's Alberta Quality Matrix for Health: <ul style="list-style-type: none"> a) acceptability; b) accessibility; c) appropriateness; d) effectiveness; e) efficiency; and f) safety.
Regional Health Authority	The Regional Health Authority established under the <i>Regional Health Authorities Act</i> and is responsible for the delivery of publicly funded Health Care in Alberta.
Regulated Health Professional	A Health Care Provider who is a member of a regulated health profession in Alberta and is required to practice in accordance with the <i>Health Professions Act</i> .
Responsive Behaviour	A significant subset of the behavioural and psychological symptoms of dementia (BPSD) that are thought to be an expression of: <ul style="list-style-type: none"> a) an unmet need; b) a response to a stimulus in a Client's environment; c) a psychological need; or d) a response to the approach of Health Care Providers or other Clients.
Restraint	Any measure that is pharmacological, environmental, mechanical or physical that is used with the intention of protecting a Client from self-harm or preventing harm to another person. For clarity, a Restraint does not include a Secure Space.
Reusable Medical Device	A medical device that can be reprocessed and reused to diagnose and treat multiple Clients. The Reusable Medical Device is designed and labeled by its manufacturer for multiple uses and is reprocessed by thorough cleaning and high-level disinfection or sterilization between Clients.
Risk Management	The systematic identification, evaluation, and mitigation of potential risk to a Client's Health Care. Risk Management is a process that recognizes the Client's right to live at risk and respect for the Client's choice.
Secure Space	A secure unit within a facility, a secure facility or a technological measure that limits a Client's ability to exit a facility or unit that is used with the intention of protecting a Client from harm. For clarity, a technological measure includes, but is not limited to, a wander alert system.

Significant Change in Health Status	A consistent pattern of change in a Client's Health Status which is evidenced by at least two areas of decline or improvement according to the InterRAI Instrument or Standardized Assessment Tool used, and as determined by a Regulated Health Professional.
Staff	All employees of an Operator.
Standardized Assessment Tool	A formal tool that enables comprehensive standardized evaluation of the Health Care needs, strengths, and preferences of a Client.
Technology	<p>Technology which allows for automatic and continuous real- time monitoring for emergencies or Technology that supports Clients and their caregivers in completing activities of daily living and instrumental activities of daily living. Examples of Technology include but are not limited to:</p> <ul style="list-style-type: none"> a) assistive personal emergency response systems; b) fall detection and prevention systems; c) environmental monitoring and alarms; or d) appliance monitoring and control.
Type A Continuing Care Home	A facility that has a continuing care home licence type A as set out in the <i>Continuing Care Regulation</i> . These facilities were formerly referred to as long-term care facilities, which were inclusive of nursing homes and auxiliary hospitals.
Type B Continuing Care Home	A facility that has a continuing care home licence type B as set out in the <i>Continuing Care Regulation</i> . These facilities were formerly referred to as publicly funded supportive living accommodations or more commonly as designated supportive living.
Unmet Health Care Needs	The requirements for Health Care that remain after the abilities, existing supports and resources of the Client, the Client's family and their community have been considered upon completion of a standardized assessment.
Unregulated Health Care Provider	A Health Care Provider that is not registered or licensed by a regulatory body. An Unregulated Health Care Provider does not have a legally defined scope of practice and must work under the direct or indirect supervision of a Regulated Health Professional.

1.0 Standardized Assessment and Person-Centred Care Planning

- 1.1 An Operator must ensure that a Client's Health Care needs are assessed using the appropriate InterRAI Instrument upon the Client's commencement of Home and Community Care, or upon admission to a Type A Continuing Care Home or Type B Continuing Care Home and:
 - a) where an InterRAI Instrument is not appropriate, the Regional Health Authority must designate the Standardized Assessment Tool to be used;
 - b) the assessment is conducted by a Regulated Health Professional trained in the appropriate InterRAI Instrument or Standardized Assessment Tool;
 - c) Clients receiving services in a Type A Continuing Care Home must be reassessed:
 - i) quarterly; and
 - ii) upon a Significant Change in the Client's Health Status;
 - d) Clients receiving Home and Community Care or services in a Type B Continuing Care Home must be reassessed:
 - i) annually; and
 - ii) upon a Significant Change in the Client's Health Status.
- 1.2 An Operator must ensure that care planning begins upon the Client's commencement of Home and Community Care, or upon admission to a Type A Continuing Care Home or Type B Continuing Care Home and that the Care Plan:
 - a) reflects the findings of the assessment in 1.1;
 - b) is kept up to date and relevant to the Client's Health Status; and
 - c) is revised by a Regulated Health Professional based on any reassessments.
- 1.3 An Operator must ensure that the Care Plan addresses:
 - a) a Client's physical, mental, emotional, social, intellectual and spiritual Health Care needs and corresponding goals;
 - b) a description of the necessary interventions related to the assessment in 1.1 and which Interdisciplinary Team member is responsible for providing those interventions; and
 - c) where a Client has a legal representative:
 - i) identification of the Client's legal representative;
 - ii) identification of the source of their legal authority; and
 - iii) contact information for the legal representative.
- 1.4 An Operator of a Type A Continuing Care Home must have documented processes in place that ensure a Physician or a Nurse Practitioner conduct:
 - a) a Medical Status assessment of a Client upon admission; and
 - b) reassessments of a Client's Medical Status on an annual basis and when there is a significant change in the Client's Medical Status.
- 1.5 An Operator must ensure a Client or and the Client's legal representative, if applicable, have the opportunity to:

- a) participate in the development and review of the Client's Care Plan, including the determination of Health Care needs and service options;
 - b) invite individuals of their choosing to participate in the development and review of the Care Plan; and
 - c) access the Client's Care Plan upon request.
- 1.6 Where a Client or the Client's legal representative, if applicable, is unable or unwilling to participate in the development or review of the Client's Care Plan, the Operator must ensure this is documented in the Client's Care Plan.
- 1.7 An Operator must ensure that:
- a) an Interdisciplinary Team conference is held to create a Care Plan upon the Client's commencement of Home and Community Care or upon admission to a Type A Continuing Care Home or Type B Continuing Care Home; and
 - b) a Client has an Interdisciplinary Team conference to review and make necessary updates to the Client's Care Plan:
 - i) annually; and
 - ii) upon a Significant Change in the Client's Health Status.
- 1.8 An Operator must ensure that all Care Plan reviews address whether:
- a) the Care Plan addresses the Unmet Health Care Needs of the Client;
 - b) the Client's Health Care needs and goals are being met;
 - c) the interventions that have been implemented related to the Client's Health Care needs and goals have been effective; and
 - d) any revisions are required.
- 1.9 An Operator must ensure that any change to a Client's Care Plan is documented and communicated to the Client, the Interdisciplinary Team and the Client's Health Care Providers.
- 1.10 An Operator of a Type A Continuing Care Home must ensure that the Client's responsible Physician or Nurse Practitioner is contacted regarding the review of the Client's Care Plan for the purposes of providing input.



2.0 Case Management

- 2.1 Upon the Client's commencement of Home and Community Care or upon admission to a Type A Continuing Care Home or Type B Continuing Care Home, an Operator must ensure that each Client has an assigned Regulated Health Professional, qualified to provide case management, who is responsible for coordinating, integrating and facilitating Health Care services for the Client.
- 2.2 An Operator must ensure that each Client and the Client's legal representative, if applicable, is provided with information on who they should contact should they have questions or require assistance regarding the Client's Health Care or Care Plan.



3.0 On-Call Access to Physician or Nurse Practitioner Services

- 3.1 An Operator of a Type A Continuing Care Home must make a documented procedure available to all Regulated Health Professionals on how to access the on-call Physician or Nurse Practitioner outside of regular daytime or evening shifts.

4.0 Client Access to Information

- 4.1 Upon the Client's commencement of Home and Community Care, or upon admission to a Type A Continuing Care Home or Type B Continuing Care Home, an Operator must ensure that a Client or the Client's legal representative, if applicable, are provided written information:
 - a) about the Health Care or Medical Care available within the setting where the Client resides or where the Client's Health Care or Medical Care is provided;
 - b) summarizing the Health Care and Medical Care to be provided to the Client;
 - c) describing the funded and unfunded services and any costs assigned to the Client;
 - d) about the responsibilities of the Operator in the provision of Health Care and Medical Care to the Client; and
 - e) about the Client's responsibilities regarding their Health Care and Medical Care, if any.
- 4.2 An Operator must ensure that any updates to the information in 4.1 are provided and made readily available to a Client or the Client's legal representative.
- 4.3 Where an Operator has assessed a Client as requiring Health Care or Medical Care not provided by the Operator or not publicly funded, the Operator must ensure a Client or the Client's legal representative, if applicable, are provided with information on accessing the required Health Care or Medical Care.
- 4.4 Where an Operator has assessed a Client as requiring information on Personal Directives, Enduring Powers of Attorney, guardianship orders, trusteeship orders, or Advance Care Planning, the Operator must ensure that the relevant information is provided to the Client or the Client's legal representative, if applicable:
 - a) upon the Client's commencement of Home and Community Care, or upon admission to a Type A Continuing Care Home or Type B Continuing Care Home;
 - b) when the Client transfers between different publicly funded Operators;
 - c) when the Client transfers between different levels of care within the same Operator; and
 - d) following any Interdisciplinary Team conference.

5.0 Palliative Care and End-Of-Life Care

- 5.1 Where an Operator provides Palliative Care and/or End-of-Life Care, an Operator must:
 - a) establish, implement and maintain documented policies and procedures identifying what specific Palliative Care and/or End-of-Life Care it provides; and
 - b) make these policies and procedures available to the Client, the Client's legal representative, if applicable, and Staff.
- 5.2 An Operator must ensure that a Client or the Client's legal representative, if applicable, are provided with information on Palliative Care and/or End-of-Life Care based on the Client's Health Status and assessed Health Care needs.
- 5.3 An Operator must ensure the following are documented in a Client's Care Plan:
 - a) the Client's Palliative Care and/or End-of-Life Care goals; and
 - b) any relevant instructions pertaining to Palliative Care and/or End-of-Life Care listed in any legal documents made known to the Operator.
- 5.4 An Operator must ensure that all Health Care Providers providing Palliative Care and/or End-of-Life Care to a Client have access to the Client's necessary Health Information, including the Client's Palliative Care and/or End-of-Life Care goals, subject to 7.1.

6.0 Assistive Equipment, Technology And Medical/Surgical Supplies

- 6.1 An Operator must ensure that a Client is:
 - a) provided with any Assistive Equipment, Technology or Medical/Surgical Supplies that the Client has been assessed as requiring; or
 - b) referred to a service which can provide the Assistive Equipment, Technology or Medical/Surgical Supplies.
- 6.2 Where an Operator uses Assistive Equipment that it does not own for the purpose of providing Health Care to a Client, the Operator must establish, implement and maintain documented policies and procedures for Health Care Providers to identify and report unsafe Assistive Equipment being used.
- 6.3 Where an Operator owns and provides the Assistive Equipment, Technology, Reusable Medical Devices, or Non-Critical Medical Devices for the purpose of providing Health Care to a Client, the Operator must establish, implement and maintain documented policies and procedures for:
 - a) regular routine maintenance for the purposes of general upkeep against wear and tear;
 - b) regular preventative maintenance and repairs for the purposes of addressing wear and tear or sudden failure of equipment components;
 - c) documentation of the routine maintenance, preventative maintenance and repairs performed by the Operator; and
 - d) identification and reporting of any unsafe Assistive Equipment, Technology, Reusable Medical Devices or Non-Critical Medical Devices by the Staff using it.
- 6.4 An Operator must ensure that instruction on the appropriate and safe use of the Operator owned Assistive Equipment, Technology or Medical/Surgical Supplies is provided to each Staff, volunteer, Client, and the Client's designated caregivers required to use them.
- 6.5 For the purpose of 6.4, the Client's designated caregiver is an individual who consistently provides unpaid support, care and assistance in a variety of ways to the Client and is documented in the Care Plan.

7.0 Sharing of Client Information

- 7.1 To the extent allowed for by law, an Operator must ensure that the following is communicated to other Operators providing Health Care to a Client:
- a) the Client's necessary Health Information; and
 - b) the Client's Personal Directive, Enduring Power of Attorney, guardianship, trusteeship order, or Advance Care Planning document.

8.0 Health Care Providers

- 8.1 An Operator must establish, implement and maintain documented policies and procedures that require a criminal record check is obtained:
 - a) from each prospective employee as a condition of employment and prior to commencement of employment;
 - b) from each volunteer prior to commencement of volunteer service; and
 - c) within the six months prior to commencement of employment or volunteer service.
- 8.2 An Operator must provide the Health Care Providers it employs with access to current information on the required competencies, written job descriptions and guidelines for performing their roles.
- 8.3 An Operator must annually verify and document that all Regulated Health Care Professionals it employs are actively registered and in good standing with their professional colleges.
- 8.4 An Operator must ensure that all Health Care Aides it employs meet the competency requirements as defined by the Government of Alberta's Health Care Aide Competency Profile; and provide evidence to the Operator of their competency as follows:
 - a) Certified – certified as a Health Care Aide through a Government of Alberta licensed post-secondary institution using the Provincial Health Care Aide Curriculum (evidence required upon hire); or
 - b) Substantially Equivalent – an educational background deemed equivalent by the Operator as compared to the approved Provincial Health Care Aide Curriculum (evidence required upon hire); or
 - c) Deemed Competent – assessed as competent within 12 months of being hired by an Operator using the Provincial Competency Assessment Profile Tool.
- 8.5 An Operator must maintain evidence of competency status for all Health Care Aides it employs.
- 8.6 An Operator must ensure that all Unregulated Health Care Providers it employs work only within the defined competencies of their written job descriptions.
- 8.7 An Operator must ensure that all Unregulated Health Care Providers it employs are supervised by a Regulated Health Professional.

9.0 Staff Training

- 9.1 An Operator must ensure that training materials are current in relation to the legislation, regulations, standards, and guidelines listed in 9.2 and 9.3.
- 9.2 An Operator must establish, implement and maintain documented policies and procedures to ensure:
- a) training for all Staff in:
 - i) Person Centered Care;
 - ii) prevention, recognition and management of Responsive Behaviours;
 - iii) infection prevention and control practices; and
 - iv) emergency preparedness, pandemic preparedness and service continuity;
 - b) training for Health Care Aides involved in the provision of Medication Management are trained in Medication Reminders and Medication Assistance;
 - c) training for any Staff working with a Client with dementia are trained in care of Clients with dementia;
 - d) training for Health Care Providers in:
 - i) Risk Management;
 - ii) fall prevention and management;
 - iii) cardiopulmonary resuscitation (CPR) where their job description requires they must be trained in CPR;
 - iv) Palliative Care and End-of-Life Care where providing such care;
 - v) safe lifts and transfers where providing such care;
 - vi) restraint use and management where they may be required to implement or manage Restraints; and
 - vii) methods to ensure safe bath and shower water temperatures where involved in assisting Clients with bathing;
 - e) training in nutrition and hydration assistance techniques, including choking prevention and response, for any Unregulated Health Care Provider or volunteer involved in assisting a Client in meeting the Client's nutrition and hydration needs; and
 - f) the training in 9.2(a) through 9.2(e) occurs within six months from the date of hire, and every two years thereafter.
- 9.3 An Operator must establish, implement and maintain documented policies and procedures to ensure:
- a) training for all Health Care Providers in;
 - i) the CCHSS;
 - ii) Health Information management;
 - iii) the *Health Information Act* and the *Freedom of Information and Protection of Privacy Act*;
 - iv) the prevention and reporting of Client abuse; and
 - v) incident reporting pursuant to 20.2, 20.3 and 20.4;

- b) training for registered nurses, licensed practical nurses and Health Care Aides on Personal Directives, Enduring Powers of Attorney, guardianship and trusteeship in the provision of Health Care; and
- c) the training in 9.3(a) and 9.3(b) occurs within six months of the date of hire and within three months of any significant update or revisions to the related training materials.

9.4 An Operator must document compliance with the requirements in 9.1, 9.2, and 9.3.



10.0 Risk Management

- 10.1 Where a Client chooses to live at risk, the Operator must ensure:
- a) a managed risk agreement is initiated between the Operator and the Client or the Client's legal representative, if applicable that includes the Risk Management strategies to be implemented;
 - b) the managed risk agreement is dated and contains the Client's signature or the Client's legal representative's signature, if applicable;
 - c) documentation in the Care Plan of the inability or unwillingness of the Client or the Client's legal representative, if applicable, to sign the managed risk agreement;
 - d) the Client or the Client's legal representative, if applicable, are provided with a signed copy of the managed risk agreement;
 - e) a signed managed risk agreement is filed on the Client's chart and a copy placed in their Care Plan; and
 - f) the managed risk agreement is reviewed during the Interdisciplinary Team conference.
- 10.2 For the purpose of 10.1, "live at risk" means the Client or the Client's legal representative, if applicable, understands the facts pertaining to an activity or situation, the risks of their decision and accepts the possible negative Health Care outcomes.

11.0 Infection Prevention and Control (IPC)

- 11.1 An Operator shall establish, implement and maintain documented IPC policies and procedures which must address but are not limited to the following:
- a) performance of a point of care risk assessment to evaluate the risk factors related to the interaction between a Client and the Client's environment, which must include the Client's immunization and screening status, to determine their potential for exposure to infectious agents and identify risks for transmission;
 - b) hand hygiene programs for Staff, Clients, volunteers and visitors;
 - c) source control to contain infectious agents from an infectious source including signage, separate entrances, partitions, early recognition, diagnosis, treatment and respiratory hygiene;
 - d) aseptic technique;
 - e) immunizations and screening requirements for Staff;
 - f) use of personal protective equipment by Staff;
 - g) sharps safety program;
 - h) management of the Client care environment, including but not limited to, the following:
 - i) cleaning of the Client care environment;
 - ii) cleaning and disinfection of Non-Critical Medical Devices; and
 - iii) handling of waste and linen;
 - i) guidelines for the implementation of additional precautions;
 - j) outbreak prevention, identification, management and control for Staff, Clients, volunteers and visitors;
 - k) target surveillance and reporting of notifiable diseases in accordance with the Notifiable Disease Management Guidelines;
 - l) IPC management of Operator-owned, Client-owned, and pet-therapy pets and animals;
 - m) the cleaning, disinfection, and sterilization of single use medical devices, intended for use with a single Client; and
 - n) the cleaning, disinfection and sterilization of Reusable Medical Devices.
- 11.2 An Operator shall ensure information on IPC policies and procedures is made available to Staff, including contracted staff, Clients, the Clients' legal representatives, if applicable, volunteers, and visitors.
- 11.3 An Operator shall ensure that Staff has access to the necessary equipment and supplies to carry out the policies and procedures in 11.1.
- 11.4 An Operator must ensure that there is a documented procedure available to all Staff on how to contact the local IPC or Public Health resource.

12.0 Medication Management

- 12.1 Operators must establish, implement and maintain documented policies and procedures for Medication Management that must, at a minimum, include the following:
- a) pharmacy services;
 - b) quality improvement;
 - c) medication reconciliation to ensure complete and accurate transfer of medication information and reduce medication errors and adverse drug events:
 - i) upon the Client's commencement of Home and Community Care, or upon admission to a Type A Continuing Care Home or Type B Continuing Care Home;
 - ii) when the Client transfers between different publicly funded Operators; and
 - iii) as the Client transfers between different levels of care within the same Operator;
 - d) assessment of a Client's medication knowledge;
 - e) access to medication information by a Client or the Client's legal representative, if applicable;
 - f) assessment, ongoing monitoring and reassessment of a Client's physical ability and cognitive ability to competently self-administer medications;
 - g) Medication Review;
 - h) monitoring and reporting of adverse drug events;
 - i) management and documentation of willful or inadvertent non-adherence to the Medication Management program including:
 - i) failure to fill a prescription;
 - ii) failure to take a prescription;
 - iii) omitting doses or overdosing;
 - iv) improperly storing medication; or
 - v) improper use of medication administration devices;
 - j) medication labeling, packaging and storage;
 - k) safe disposal of medication;
 - l) the "8 Rights" of Medication Administration principles that Health Care Providers must adhere to when administering or assisting with medication:
 - i) right medication;
 - ii) right Client;
 - iii) right dose;
 - iv) right time;
 - v) right route;
 - vi) right reason;
 - vii) right documentation; and
 - viii) right to refuse a medication;
 - m) roles and responsibilities of Regulated Health Professionals; and
 - n) roles and responsibilities of Unregulated Health Care Providers.

- 12.2 An Operator must ensure that a Client is provided with the option of Medication Reminders or Medication Assistance to support and enable the Client to competently self-administer some or all of the Client's medications for as long as possible.
- 12.3 Where a Client is assessed as being unable to competently self-administer their medication, an Operator must ensure that the Client is provided with a plan for assistance in accordance with the Medication Management policies and procedures.
- 12.4 An Operator must ensure that a Client's plan for Medication Management will be reassessed at the Client's Interdisciplinary Team conference and updates documented in the Care Plan.



13.0 Life Enrichment Services

- 13.1 An Operator of a Type A Continuing Care Home or a Type B Continuing Care Home must provide Life Enrichment Services as indicated in the Care Plan.
- 13.2 An Operator must ensure that information about Life Enrichment Services is communicated to a Client and the Client's legal representative in an appropriate manner.
- 13.3 An Operator must ensure that Staff who are required to plan, develop, coordinate and deliver Life Enrichment Services have the necessary education and knowledge, or equivalent experience, to do so in a way that meets the needs of the Clients.



14.0 Nutrition and Hydration Management

- 14.1 Where concerns regarding a Client's nutrition and hydration needs are identified by Health Care Providers, an Operator must ensure that the Client is assessed by a Regulated Health Professional to determine if there is a need for nutrition and hydration intervention.
- 14.2 Where a Client has been assessed as having therapeutic nutrition and hydration needs, an Operator must ensure that a registered dietitian is included in the Client's assessment and identified as part of the Client's Interdisciplinary Team to provide direction for necessary nutrition and hydration care and interventions.
- 14.3 An Operator must ensure that the directions for nutrition and hydration interventions for a Client are reviewed by a Regulated Health Professional and documented in the Care Plan, including identifying which Interdisciplinary Team member is responsible for implementing the interventions.

15.0 Oral Care Assistance and Bathing Frequency in Continuing Care Homes

- 15.1 An Operator of a Type A Continuing Care Home or a Type B Continuing Care Home must establish, implement and maintain documented policies and procedures regarding:
 - a) the provision of oral care assistance to a Client; and
 - b) bathing frequency.
- 15.2 The policies and procedures in 15.1(a) must provide the Client with the opportunity for assistance with oral care twice a day and more frequently when required, as documented in the Client's Care Plan.
- 15.3 The policies and procedures in 15.1(b) must provide the Client with the opportunity for bathing at a minimum of twice a week by the method of the Client's preference, and more frequently based on the Client's Unmet Health Care Need.
- 15.4 A Client's preference for method and frequency of bathing must be documented in the Client's Care Plan.
- 15.5 For the purposes of 15, "bathing" means showers, tub baths, full body sponge baths and bed baths.



16.0 Safe Bath and Shower Water Temperature

- 16.1 An Operator must establish, implement and maintain documented policies and procedures regarding safe water temperatures where a Client is assisted by Health Care Providers with tub baths or showers. The policies and procedures must:
- a) require safe water temperatures between 38 and 43 degrees Celsius;
 - b) require monitoring and documentation of the water temperature of each assisted tub bath or shower;
 - c) require reporting of any variation from the established safe water temperatures; and
 - d) describe the competencies of a Health Care Provider assisting the Client with tub baths or showers.
- 16.2 An Operator of a Type A Continuing Care Home or Type B Continuing Care Home must establish, implement and maintain documented policies and procedures regarding:
- a) monitoring and maintenance of the water supply system; and
 - b) documentation of daily water temperature checks for each therapeutic tub prior to the first daily use.
- 16.3 For the purposes of 16.2, a “therapeutic tub” is a tub into which a Client is lifted or is fully accessible, for example by a side door.

17.0 Restraint Management and Secure Spaces

- 17.1 An Operator must establish, implement and maintain documented policies and procedures regarding Restraint use that require:
- a) where a Client has been assessed as exhibiting a behaviour or a Responsive Behaviour that puts the Client or others at risk of immediate harm, the Regulated Health Professional may initiate the process to utilize a Restraint;
 - b) supportive interventions must be considered prior to the utilization of a Restraint;
 - c) if supportive interventions are considered and deemed ineffective or inappropriate in the circumstance, the least restrictive Restraint may be utilized;
 - d) information on the use of Restraints must be provided to the Client or the Client's legal representative, if applicable, when possible prior to its use and at any Interdisciplinary Team conferences that occur during the time the Restraint is in use;
 - e) the method and frequency for monitoring the Client when the Restraint is in use;
 - f) criteria for the discontinuation of a Restraint; and
 - g) where an antipsychotic medication is used as a pharmacological Restraint:
 - i) a Medication Review by a Physician or Nurse Practitioner and the Interdisciplinary Team will occur at a minimum of once a month to ensure the appropriateness of the medications prescribed; and
 - ii) where the antipsychotic medication is no longer required, a Physician, Nurse Practitioner or pharmacist will document instructions regarding the process for gradual dose reduction and discontinuation.
- 17.2 An Operator must ensure that when a Restraint is used, it is reviewed by the Interdisciplinary Team on a frequency determined by the Interdisciplinary Team or upon significant change in the Client's behavioural symptoms.
- 17.3 When a Restraint is used, an Operator must ensure the following is documented in a Client's chart and Care Plan:
- a) the behaviour that put the Client or others at risk of harm;
 - b) the supportive interventions that have been considered and trialed;
 - c) indications for the initial use of the Restraint;
 - d) a Physician's order or Nurse Practitioner's order, within 72 hours of initiation of the Restraint, authorizing the use of the Restraint;
 - e) the method and frequency for monitoring the Client when the Restraint is in use; and
 - f) assessment of the Client while the Restraint is being used and review of the ongoing need for the Restraint.
- 17.4 An Operator must establish, implement and maintain documented policies and procedures regarding Secure Spaces that require:

- a) information on the Secure Space must be provided to the Client or the Client's legal representative, if applicable, prior to or on initiation of the Secure Space and upon request while the Client lives within or is subject to the Secure Space;
 - b) the method and frequency for monitoring the Client while the Client resides in, or is subject to, the Secure Space; and
 - c) criteria for the discontinuation of the use of a Secure Space.
- 17.5 An Operator must ensure that when a Secure Space is used that the appropriateness of the Secure Space is documented and reviewed by the Interdisciplinary Team:
- a) upon a client's admission to, or the initiation of, the Secure Space;
 - b) on a frequency determined by the Interdisciplinary Team; and
 - c) upon a significant change in the behaviour or Responsive Behaviour that led to the use of a Secure Space.
- 17.6 While a Client resides in, or is subject to, a Secure Space, an Operator must ensure the following is documented in a Client's chart and Care Plan:
- a) evidence of the reason for the use of the Secure Space for the Client;
 - b) the method and frequency for monitoring the Client; and
 - c) ongoing review of the appropriateness and effectiveness of the Secure Space in meeting the needs of the Client.
- 17.7 For the purposes of 17.1 and 17.3, "supportive interventions" are positive, non-restrictive and non-pharmacological interventions including, but not limited to:
- a) meaningful activity participation;
 - b) assessment and management of the Client's pain;
 - c) assisting the Client to the toilet;
 - d) assisting the Client with repositioning;
 - e) social interactions; or
 - f) environmental interventions.
- 17.8 For the purpose of 17.1(c), the "least restrictive Restraint" means only that degree of Restraint, used for the least amount of time, which is necessary for the avoidance of harm to the Client or harm to others.
- 17.9 For the purposes of 17.2 and 17.5 a "significant change" in the Client's behavioural symptoms is a pattern of change in the behaviour or Responsive Behaviour that led to the use of a Restraint or Secure Space. The assessment or determination that a significant change has occurred must be made by a Regulated Health Professional.

18.0 Continuity of Health Care

- 18.1 An Operator must establish, implement, and maintain documented emergency preparedness, pandemic, and contingency plans to provide for the continuity of Health Care to a Client in the event of a disruption to services and/or staffing.
- 18.2 An Operator must ensure the emergency preparedness plan, pandemic plan, and contingency plan:
- a) mitigate the risk and impact of the disruption of Health Care to a Client;
 - b) are reviewed and updated annually and after each implementation;
 - c) contain measures to ensure there are sufficient Staff to meet Clients' needs;
 - d) identify relevant agencies, partners, health service providers and funders, and resources that will be involved in responding to the disruption;
 - e) are developed, reviewed, and updated in collaboration with any relevant agencies, partners, health service providers and funders, and resources that will be involved in responding to the disruption;
 - f) include communications strategies to ensure that Clients, families, Staff, and other impacted parties are informed throughout the disruption;
 - g) are communicated and made available to the Client and the Client's legal representative, if applicable:
 - i) upon the Client's commencement of Home and Community Care, or upon admission to a Type A Continuing Care Home or Type B Continuing Care Home; and
 - ii) after any update;
 - h) are communicated and made available to any other impacted parties, including Staff, contractors, services providers, and volunteers;
 - i) are routinely practiced or simulated to the extent reasonably practicable, at frequencies stated in the plan, including with identified relevant agencies, partners, health service providers and funders, and resources that will be involved in responding to the disruption; and
 - j) identify the most responsible person during disruptions:
 - i) for the purposes of Type A and Type B Continuing Care Homes, this person must be on-site.

19.0 Concerns Resolution on Health Care

- 19.1 An Operator must establish, implement, and maintain a documented policy and procedure for responding to concerns about the Health Care provided. The policy and procedure must:
- a) be provided to the Client, the Client's legal representative, if applicable, and the Client's family:
 - i) upon the Client's commencement of Home and Community Care, or upon admission to a Type A Continuing Care Home or Type B Continuing Care Home and
 - ii) upon request;
 - b) identify the method and a timeframe in which the Operator will respond to concerns from a Client, the Client's legal representative, if applicable, or the Client's family;
 - c) include:
 - i) information on how the Client, the Client's legal representative, or the Client's family can make a concern known and to whom;
 - ii) the Operator's process for responding to a concern;
 - iii) record keeping by the Operator of any actions taken; and
 - d) be provided to Staff.
- 19.2 An Operator must provide the Client, the Client's legal representative, if applicable, or the Client's family with written information on relevant external complaints and concerns resolution processes:
- a) upon the Client's commencement of Home and Community Care, or upon admission to a Type A Continuing Care Home or Type B Continuing Care Home; and
 - b) upon request.

20.0 Quality Improvement Reporting

- 20.1 An Operator must establish, implement, and maintain documented Quality improvement policies and programs to evaluate and improve its delivery of Health Care.
- 20.2 An Operator must establish, implement, and maintain, documented policies and procedures for the documentation, tracking, and trending of:
- a) any incident that could pose an adverse risk to a Client; and
 - b) any near miss that could have resulted in negative consequences for a Client but did not because of chance or timely intervention.
- 20.3 An Operator must establish, implement and maintain documented policies and procedures for the prevention, reporting, review and follow-up of reportable incidents.
- 20.4 Reportable incidents must be reported in accordance with the process set out by the director designated under section 38 of the *Continuing Care Act*. The actions taken to address the incident must also be documented and reported to the director.
- 20.5 A reportable incident is an unexpected or normally avoidable outcome that negatively affects a Client's health or quality of life and occurs in the course of Health Care or has the potential to alter the Client's Health Status. Reportable incidents include:
- a) death or serious harm to a Client caused by:
 - i) error or omission in the provision of Health Care;
 - ii) error or omission in the provision of accommodation services;
 - iii) equipment malfunction or error in operation;
 - iv) accommodation grounds or equipment in disrepair or unsafe; or
 - v) assault/aggression;
 - b) Client being unaccounted for;
 - c) unplanned activation of a contingency plan caused by:
 - i) disruption of utilities;
 - ii) evacuation;
 - iii) Staff disruption;
 - iv) severe weather; or
 - v) loss of essential equipment.
 - d) extensive damage to the accommodation caused by:
 - i) fire or flood;
 - ii) disaster; or
 - iii) building or equipment failure.
- 20.6 An Operator must ensure that InterRAI assessment data is collected and submitted in accordance with the process and guidelines set out by Alberta Health once a month through the Alberta Continuing Care Information System (ACCIS).

Full versions of the *Continuing Care Act*, the Regulations and the standards can be accessed from King's Printer on-line at: <https://www.alberta.ca/alberta-kings-printer>.