Basic Service Standards for Continuing Care Centres

Alberta
HEALTH

BASIC SERVICE STANDARDS FOR CONTINUING CARE CENTRES

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PREFACE

The Basic Service Standards for Continuing Care Centres were prepared by the Continuing Care Centre Program Standards Task Force. The Task Force was composed of members working in continuing care settings and Alberta Health, and reported to the Continuing Care Outcome Measures Steering Committee.

This document consolidates current minimum program standards for basic services provided in continuing care centres, as defined in Alberta Health legislation (Hospitals Act and Regulations, Nursing Homes Act and Regulations) and policy documents. These standards are the minimum legal requirements expected of continuing care centre operators. The document does not replace current legislation, standards, guidelines, directives, or bulletins, and does not eliminate the responsibility of regional health authorities and individual operators to have a thorough understanding of the broad range of legislation which governs their operations. Regional health authorities may augment these standards as appropriate and are encouraged to utilize them in the monitoring of service delivery.

In addition to these minimum standards, program guideline expectations have been included, where available. Subsequent editions of this document will incorporate new models of delivering continuing care services.

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Abbreviations

AAPI:	Alberta Assessment and Placement Instrument
CCCRS:	Continuing Care Centres of Tomorrow: A Role Statement for Alberta's Long Term Care Facilities
CCDMFG:	Continuing Care Drug Management and Formulary Guidelines
CCHFA:	Canadian Council of Health Facilities Accreditation
CCPSR:	Continuing Care Pharmacy Service Requirements Manual
CSA:	Canadian Standards Association
DAA:	Dependent Adults Act
EPEA:	Environmental Protection and Enhancement Act
HA:	Hospitals Act, Revised Statutes of Alberta, consolidated October 9, 1992
HA-HBR:	Hospitals Act Hospitalization Benefits Regulation
HA-OHR:	Hospitals Act Operation of Approved Hospitals Regulation
LTCHSG:	Long Term Care Health and Safety Guidelines
NH Act:	Nursing Homes Act, Statutes of Alberta, consolidated March 23, 1988
NH-GR:	Nursing Homes General Regulation
NH-OR:	Nursing Homes Operation Regulation
OHSA:	Occupational Health and Safety Act
PHA:	Public Health Act
RHA:	Regional Health Authorities
SPE:	Single Point of Entry for Long Term Care Services in Alberta: Program Description
TBC:	Tuberculosis Control and Management Protocol for Long Term Care/Continuing Care Centres
TDGA:	Transportation of Dangerous Goods Act
WMGS:	Waste Management Guidelines and Standards for Hospitals and Long Term Care Facilities

Acknowledgements

The Continuing Care Centre Program Standards Task Force gratefully acknowledges the following sources for the valuable contribution they provided in the compilation of program standards and guidelines.

- Alberta Safety Council for Long Term Care Facilities. (1993). *Long term care health and safety guidelines*. Edmonton: Author.
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1.0 BASIC SERVICE STANDARDS FOR CONTINUING CARE CENTRES

1.1 INTRODUCTION

Continuing care centres (nursing homes and auxiliary hospitals) provide a range of services, including residential, personal, and health services to individuals with chronic disabilities and their families. Services provided in various settings ensure that Albertans will receive services according to their assessed needs.

In April 1995, the responsibility for managing and monitoring continuing care services (including the administration of current nursing home contracts) was transferred from Alberta Health to the newly created regional health authorities (RHAs). The RHAs are responsible for the planning and delivery of health services in the regions. One of the core services to be delivered in each region is residential continuing care (i.e., nursing homes and auxiliary hospitals) (RHA Act [1994]: S.22[c]).

The Minister of Health sets direction and priorities for the health system; defines core services; develops legislation, regulations, and standards; allocates funds; and monitors the performance of the health system. Alberta Health is responsible for setting program expectations and standards, assessing outcomes, and allocating resources to the RHAs. Alberta Health will work with the RHAs to develop the criteria, standards, and indicators by which the performance of the RHAs will be measured.

1.2 CONTEXT

The continuing care system has evolved through a tradition of consensus-based collaboration between care providers and Alberta Health. Primary benchmarks include the nursing homes legislation (developed as a result of recommendations of the Alberta Nursing Home Review Panel Report in 1982, and the Report of the Committee for Long Term Care for Senior Citizens in 1988), and the Continuing Care Centres of Tomorrow: A Role Statement for Alberta's Long Term Care Facilities, released in 1994.

Other documents outlining the broader health context include provincial policy documents, the Alberta Health Business Plan, the Regional Health Authorities Act, and other guidelines provided to regional health authorities, including the Core Services document. These documents outline the overall philosophy and direction within which health services and continuing care services will be offered and monitored. A key theme in these directional documents is that of accountability to Albertans.

1.3 BACKGROUND

There have traditionally been two types of continuing care centres in Alberta; specifically, nursing homes and auxiliary hospitals. Nursing homes are governed by the Nursing Homes Act, and the Nursing Homes Operations and General Regulations which outline the services to be provided and the required standards. Auxiliary hospitals are governed by the Hospitals Act, the Hospitals Act Operation of Approved Hospitals Regulation, and the Hospitals Act Hospitalization Benefits Regulation. Funding methodologies and policy directives have been used to integrate program and service differences between nursing homes and auxiliary hospitals. These acts, regulations, directives, and funding methodologies identify the present basic "core" services, and as such, form the minimum services every continuing care centre is now expected to offer.

1.4 A DEFINITION OF CORE SERVICES

Within the restructured health system, a core of services will be available or accessible to every individual who needs them. Specialized continuing care services that are funded as approved programs (i.e., programs for young individuals with disabilities) will be available only in certain locations, and not every service will be provided in every community. Core health services can be divided into two categories:

- available, which means that the service is provided within each region; and

- accessible, which means that if the service is not provided within a region, it will be available from another region or through a program that serves the whole province (Alberta Health, 1994(c), p. 2).

Basic services in continuing care centres are made up of core and supplementary services. Continuing care core services are those found in every centre and include essential services such as housing, meals, housekeeping, and laundry; personal services such as service/care coordination, personal care/assistance, life enrichment, and social supports; and health services such as pharmaceutical, nursing, and other therapeutic services provided by rehabilitation therapists, social workers, pharmacists, dieticians, and physicians (Alberta Health, 1994, p. 9). In addition, some continuing care centres may offer supplementary services.

Supplementary services are those that respond to particular community needs or reflect local or cultural characteristics. These services may include approaches such as culture-specific social programs, meals-on-wheels, or special care units for the cognitively impaired. They will be provided within the basic program budget for the centre.

Continuing care core services have been consolidated (for the purpose of this document) in the following five sections:

Residential Services/Supports

- housing services
- meal services
- laundry services
- housekeeping services

Personal Services/Supports

- service/care coordination
- life enrichment and social supports
- personal care/assistance
- technical services/aids
- respite services

Health Services/Supports

- physician services
- diagnostic support services
- health records
- nursing services
- inservice education
- resident safety
- therapeutic services
- nutritional services
- pharmacy services
- care for the dying/pronouncement of death
- ambulance/transportation

Administrative Services/Supports

- centre operations
- safety/security
- infection prevention and control
- trust accounts/banking
- resident property

Regional Services/Supports

- single point of entry
- existing services

1.5 PURPOSE/OBJECTIVES

The Basic Service Standards for Continuing Care Centres document consolidates current minimum program expectations for basic services provided in continuing care centres as defined in Alberta Health legislation (Hospitals Act and Regulations, Nursing Homes Act and Regulations) and policy documents. This document does not replace current legislation, standards, guidelines, directives, or bulletins, and does not eliminate the responsibility of individual operators to

have a thorough understanding of, and be compliant with, legislation which applies to their operations.

For the purpose of this document, a standard is that which is contained in legislation, directives, or other provincial policy documents. It is recognized that most organizations have developed their own program standards which exceed the minimum legal requirements. Regional health authorities may augment these standards as appropriate, and are encouraged to utilize them in the monitoring of service delivery.

In addition to these minimum standards, program guideline expectations are also included to assist continuing care centres to operationalize components of the role statement document. Subsequent versions of this document will be more comprehensive to incorporate a variety of continuing care delivery models (e.g., residential continuing care, family/companion care, group homes) and will apply to continuing care services offered in a variety of locations.

1.5.1 Purpose

This working document is intended to clarify and consolidate current minimum expectations as defined in legislation, directives, bulletins, and other policy documents for regional health authorities and continuing care centre operators.

1.5.2 Objectives

In April 1995, the responsibility for contracting or managing contracts for continuing care centre services was assigned by the Minister of Health to the newly created regional health authorities. As part of their new role, RHAs will ensure that available and accessible core services are being delivered in an integrated, effective, and efficient way; will maintain the quality of care and health delivery; and will provide a process for the evaluation of performance in meeting continuing care needs. RHAs have been assigned responsibility for managing nursing home contracts and delegated ministerial powers, duties, and responsibilities for the inspection of continuing care centres in their regions (Appendix III provides a listing

of the function, duties, and powers that have been delegated to RHAs). Program standards are critical to this new RHA role. The Minister of Health will retain the responsibility for setting the expectations and standards, assessing outcomes, and allocating resources to the RHAs (RHA Act [1994]: S.20).

It is intended that this initial program standards document will:

- assist the regional health authorities as they assume responsibility for continuing care services, facilitating a smooth delegation of responsibility, and a continuity of services in the transition;
- clarify minimum program expectations for continuing care centres so that access to continuing care services will continue to be available on an equitable basis to all Albertans; and
- provide operators and regional health authorities with a description of the current basic service expectations.

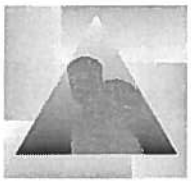
1.6 A DEFINITION OF CONTINUING CARE

A continuing care centre is a multifaceted centre which offers a range of continuing care services including **residential**, **personal**, and **health** services to persons with chronic disabilities and their families (Alberta Health, 1993a, p. 9).

The new vision for Alberta's continuing care centres is suggested in the following mission statement (Alberta Health, 1993a):

> To enable Albertans to maintain and improve health, quality of life, and personal independence by making the resources of a supportive residential setting and an array of health and personal support services available to meet the needs of individuals and their families for basic and specialized continuing care. (p. 6)

The fundamental goal of continuing care services is to assist each individual who resides in a continuing care centre in maintaining or improving his or her quality



of life and current abilities, and when necessary, in managing declining health and declining ability to do things for him/herself.

An increased emphasis on the quality of life by focusing on health promotion and well-being and the functional abilities of individuals rather than their limitations is required. This attitude of care delivery requires a holistic approach in which the physical, emotional, social, spiritual, intellectual, and cultural needs of continuing care residents are addressed through an interdisciplinary team approach. It requires the integration of significant beliefs and actions related to the ability of people to be self-directed in their care and to make their own decisions about care and service options on the basis of appropriate information (Alberta Health, 1993a, p. 12).

The average age of the typical resident living in Alberta's continuing care centres is 82 years, with the majority of residents between the ages of 75 and 94. The highest percentage of this population are female (67 percent). Forty-four percent of the continuing care centre population have the highest care requirements (i.e., F and G levels of care); 31 percent of these residents have a diagnosis of dementia; and an additional 15 percent have a diagnosis of Alzheimer's disease. Cognitively impaired residents have higher care requirements, and according to recent population projections, we can expect the proportion of cognitively impaired residents to increase in the future. Even though residents of continuing care centres will have more complex and diverse needs, their needs will still be provided for within a social model of care (Alberta Health, 1991).

While future populations may include individuals who have significant physical-care and cognitive needs, their emotional, social, spiritual, and intellectual needs cannot be overlooked. Optimizing the quality of life requires an effective, coordinated interdisciplinary approach to meeting residents' needs. Meeting residents' needs also requires an enabling approach where residents are assisted as much as possible to meet their own needs.

An interdisciplinary, enabling, holistic approach to resident care requires a thrust towards a social model, de-emphasizing the previous focus on a medical model (Exhibit 1). However, it is also recognized that future centre-based populations may have more physical and mental limitations that require medically oriented interventions or support. A social model that includes medical components, rather than vice versa, is necessary in all continuing care centres (Peat, Marwick, Stevenson, & Kellogg, 1992, p. 35).

The vision for continuing care centres of tomorrow is described in the companion document to these standards, "Continuing Care Centres of Tomorrow." This document was developed based on research and consultation on the needs and wishes of residents in Alberta's continuing care centres.

For the purpose of this document, *resident* includes the individual, family, and/or guardian, if appropriate, as determined by the resident's decision-making ability.

Exhibit 1
THE EVOLUTION OF CONTINUING CARE CENTRE SERVICES

	Moving From		Moving Towards
1.	Primary emphasis on physical and medical needs.	•	Emphasis on quality of life: social, intellectual, and spiritual needs, as well as physical/medical.
2.	Buildings and organizational structures which are based on hospital models.	•	Buildings and structures which are based on residential models. Flexibility in the actual location/setting for offering continuing care services.
3.	Centres often segregated from other parts of the community and the health system.	•	Continuing care centres provide a cluster of resources available to the community to support people staying in their own homes as long as possible, and part of collaborative service arrangements with public health, mental health, hospitals, and other community agencies to meet special needs.
4.	Caring for people meant doing many things for them, sometimes making them more dependent. Resident's role passive; people "placed" and then fit into available programs and services.	•	Greater emphasis on capability, maximizing abilities, opportunities, and the power to make decisions and take risks in daily living, leads to independence. Resident's role active; admission to a centre is the "best choice" for that person at that time.
5.	Group programming in many areas and prescribed schedules for many activities.	•	Increased choice, flexibility, and options through individualized service packages, and an enhanced case management function. People choose the programs and services they prefer; those services needed but not available in the centre are obtained.
6.	Focus on input measures: How much care is offered?	•	Focus on outcome measures: What is the result of services offered? Is this the result the resident wanted?

Alberta Health (1994a)

2.0 RESIDENTIAL SERVICES/SUPPORTS

This section of the document contains standards and guidelines as they pertain to housing and residential support services. Housing services refer to the shelter component such as the physical structure, and residential support services refer to meals, housekeeping, and laundry that are a normal part of operating a household. Safety/security and infection prevention and control standards and guidelines for residential services and supports are outlined in Section 5.0, Administrative Services/Supports.

2.1 HOUSING SERVICES

Philosophy

Residents want a home-like setting where they feel valued, safe, relaxed, comfortable, and free to entertain visitors. The design of the residents' rooms, dining and common areas, and service areas should promote privacy, autonomy, dignity, and security, as well as opportunities to socialize, in keeping with the established lifestyle and preferences of the resident and family.

Policy

The facilities, equipment, and grounds of the continuing care centre will be maintained and operated in a manner that respects the privacy, safety, and security of the residents, staff, and public.

2.1.1 Capital Codes/Standards/Permits

Required Standards

Safety Codes Act/NH-OR: s.23(a)/HA-OHR: s.7

- The owner/operator will ensure:
  - current operating certificates from an organization accredited by the Safety Codes Councils for:
    - boilers and pressure vessels, and
    - elevators and fixed conveyances.

- compliance with all applicable codes and standards:
  - buildings
  - fire protection and safety
  - gas
  - plumbing
  - electrical systems, and
  - boilers and pressure vessels.

HA-HBR: s.22, 23/HA-OHR: s.3,4, 5, 6/NH-GR: s.5, 7, 8

- Receipt of necessary approvals/ permits prior to undertaking buildings and grounds construction or improvement; or purchase, lease, or sale of any land, building, or equipment, as applicable.

It must be noted that legislative references represent provincial requirements and that municipalities may have local enhancements in place.

Recommended Guidelines

Space, equipment, and supplies will comply with applicable legislation, regulations, and codes of:

- Canadian Standards Association
- Provincial X-ray inspection services
- Bureau of Radiation Devices, Health Protection Branch, Health Canada
- Narcotic Control Act

Facility Design Issues for Continuing Care Centres, Alberta Health

- Construction standards established for long term care facilities were usually based on hospital models of care. The Facility Design Issues document is a resource to groups planning renovations to existing facilities or new residential continuing care buildings that offer basic long term care programs. The recommendations for new approaches to facility design are based

on literature and research findings, and integrate the needs of a frail elderly population with physical environments designed to support quality of life and independence.

2.1.2 Preventive Maintenance

Required Standards

NH-GR: s.2(b)/NH-OR: s.23(b)(i)

- Preventive maintenance is part of the basic program in a continuing care centre.

NH-OR: s.23(b)(i)

- The owner/operator will ensure that there is a preventive maintenance program to inspect, prevent, and/or minimize the breakdown of equipment and/or unnecessary deterioration of buildings, and repair and service as needed.

NH-OR: s.23(a)

- All fixed and moveable electric equipment will be approved as required under the Safety Codes Act.

Recommended Guidelines

- Programs should include a detailed inventory record, periodic inspections noting all maintenance, and completion of all indicated maintenance work.
- Preventive maintenance services should respond to urgent situations after regular business hours as necessary.
- Procedures should outline the use of tradespeople to service/repair centre equipment and to provide maintenance contracts.

- Back-up protocols should be readily available in the event of a breakdown in mechanical and/or electrical systems, or a failure of or inadequate supply of any utilities.

2.2 MEAL SERVICES

Philosophy

Part of a home-like environment for residents includes the opportunity for them to make choices about what, when, and where they eat. As much as possible, centres accommodate resident lifestyles and preferences at mealtime.

Policy

The continuing care centre will provide high-quality food and meal services.

Required Standards

NH-GR: s.2(a)(e)/NH-OR: s.23(b)(iv)

- Meal service is part of the basic care provided by a continuing care centre.

NH-OR: s.15(1-8)/D-263

- Meals will meet the Canada Food Guide recommendations as approved by the Canadian Council on Nutrition.
- Three meals per day shall be available to each resident.
- Nourishments, in addition to meals, shall be made available to residents at all times.
- Cyclic menus shall be prepared and approved by a Dietician.
- Each day, meal menus shall be posted in one or more public places before the first meal of the day.
- Records of menus (and changes) shall be retained and available for inspection (for three (3) months).

- A resident shall be provided meals in accordance with special requirements.
- Therapeutic diets for a resident shall be ordered in writing by a physician and be recorded in the resident's health record.

2.3 LAUNDRY SERVICES

Philosophy

Laundry services can affect the quality of residents' everyday life. Part of a safe and comfortable environment which encourages residents to feel at home in the centre includes the availability of clean, fresh linen and personal laundry.

Policy

The continuing care centre will provide laundry services.

Required Standards

NH-GR: s.2(b)/NH-OR: s.23(b)

- Laundry/linen services are part of basic facilities services provided in a continuing care centre.

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- Personal laundry services including pick-up, delivery, labelling, and minor repairs are the financial responsibility of the resident.

Recommended Guidelines

- The centre may offer a laundry service for resident personal laundry.
- If a centre does not offer a personal laundry service, it will coordinate access to these services.

2.4 HOUSEKEEPING SERVICES

Philosophy

A clean, safe, and comfortable environment encourages residents to feel at home, is fundamental to a good quality of life for residents, staff, and visitors, and is vital to quality of care.

Policy

The continuing care centre will provide housekeeping services.

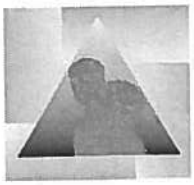
Required Standards

NH-GR: s.2(b)/NH-OR: s.23(b)

- Housekeeping is part of basic facilities services provided in a continuing care centre.

NH-OR: s.23(b)(ii)

- The centre will be maintained in a safe and hygienic manner.



3.0 PERSONAL SERVICES/SUPPORTS

Continuing care centres offer a package of services, including the planning process known as service/care coordination. The goal is to ensure the provision of individualized services, and to act as an advocate for the individual and family in obtaining the services required. In order to offer flexible and responsive services to meet client needs, centres offer a range of services, in full-time or part-time residency (e.g., respite care).

Standards and guidelines for service/care coordination, life enrichment and social supports, personal care/assistance, technical services/aids, and respite care are contained in this section.

3.1 SERVICE/CARE COORDINATION

Philosophy

Residents and their families expect to be partners in planning for their individualized care and services. Residents benefit from a comprehensive, coordinated, systematic, interdisciplinary approach to care/services which ensures their involvement in decisions regarding their own care. This is facilitated using a process called service coordination.

Policy

The continuing care centre will provide and/or arrange for health and support services required by residents to meet their health and personal care needs.

Definition

Service coordination is the process of ensuring appropriate access to, and provision of, services. The elements of service coordination include:

- **referral** for continuing care centre admission or services.
- interdisciplinary **assessment**, identification of needs, and the development of a comprehensive **care/service plan**.

- **monitoring** the well-being of the individual and the adequacy of the services being provided, which includes formal **reassessment** at regular intervals and/or at times of major changes in the health or social status of the individual, with an appropriate adjustment in the care plan and coordination of required services.
- **ongoing coordination** by a designated person who assumes the responsibility for locating, coordinating, and obtaining the required services (e.g., daily care planning, specialized services, discharge planning, etc.)(Alberta Health, 1994a, p. 55).

3.1.1 Referral for Centre Admission or Services

Required Standards

NH Act: s.16/NH-GR: s.3

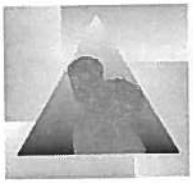
- To qualify for Nursing Home Benefits an individual
  - must be eligible for Alberta Health Care Insurance benefits,
  - must have resided in Alberta for one year prior to admission and have been a resident of Canada for ten years or more, *or*
  - must have lived in Alberta for three consecutive years sometime during his/her lifetime.

HA: s.54/HA-HBR: s.3

- To qualify for Auxiliary Hospital Benefits, an individual must be eligible for Alberta Health Care Insurance benefits. There is no residency requirement.

NH-OR: s.5, 6/HA-OHR: s.10(2)

- Admission to a continuing care centre is subject to the operator having an available bed, and according to the approved assessment procedures.



- No person shall be admitted to the continuing care centre
  - until the person has been assessed and approved for admission according to the approved assessment procedure.
  - unless the person has had a complete medical examination within three months prior to the application for admission, and the results have been reviewed by the committee responsible for approving admissions.

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- The provincially designated long term care assessment form (AAPI) is the approved form used to coordinate assessment and placement functions for continuing care services.

HA-OHR: s.9(5,6,7)

- All individuals seeking approval for centre admission (including respite admissions) will have their tuberculosis status assessed through a history and symptom inquiry and radiological assessment. Appropriate documentation, referral, and treatment must be provided prior to admission.
- Before a resident is accepted for admission to a continuing care centre, a report indicating a recent negative chest X-ray for tuberculosis is required.
- Residents who are candidates for admission to continuing care centres who are reported to have either inactive or active tuberculosis shall be referred to the Minister for assessment.

D-342

- Continuing care centres will admit applicants according to the established waitlist criteria, as described in the Single Point of Entry for Long Term Care Services Program Description.

NH-OR: s.5/D-291

- Prospective residents who have been assessed and approved for admission may have a bed held on their behalf for a maximum of five days.
  - Admissions from the community:
    - prospective residents are entitled to request that a bed be held on their behalf;
    - operators may hold a bed for up to a maximum of five days;
    - prospective residents may be levied the relevant accommodation charge for the type of room being held, provided that the resident has accepted the bed and will be admitted within the five-day period.
  - Admissions from another health care centre, including a continuing care centre:
    - the five-day holding period does not usually apply for residents currently awaiting transfer from another health care centre. In most cases the resident is transferred the day the bed is offered.

NH-OR: s.6(3)

- An individual may appeal a decision of the committee responsible for approving admissions to a continuing care centre.

Recommended Guidelines

CCCRS

- Residents who present a significant degree of danger to themselves, staff, or other residents of the centre will not be admitted to or remain in a continuing care centre.
- Persons who require acute care for an unstable physical or mental health condition will not be admitted until their condition has stabilized.

- Residents with active infectious pulmonary tuberculosis will not be admitted to a continuing care centre.
- Residents with infectious diseases other than active infectious pulmonary tuberculosis will be admitted providing that the centre can provide the appropriate precautions/care.
- Residents with an active infectious communicable disease who are not following the treatment required to control or eliminate the infection may be discharged because of the risk they pose to others who must share their environment.

3.1.2 Resident Assessment and Care Planning

Required Standards

NH-OR: s.11(2)

- The initial resident assessment ensures a comprehensive interdisciplinary review of the resident's status, capabilities, and needs, and the development of a preliminary plan outlining the care needs of the resident. The care planning process includes developing, implementing, and monitoring a plan of care to achieve intended outcomes.
- There is a process for ongoing review of and revision to the resident's care plan by the interdisciplinary team.

DAA: s.6

- The need for legal guardianship and/or trusteeship should be considered if an adult is repeatedly and continuously unable to care for him/herself and make reasonable judgements about personal matters.

Recommended Guidelines

- If in the opinion of the interdisciplinary team the resident's ability to comprehend his/her responsibility for his/her own health care is

in doubt, the family or legal guardian, if applicable, should be consulted and the appropriate action taken.

- The resident/legal guardian must provide consent for medical care/ treatment/diagnostic services. The resident must also provide consent for any activities affecting him/her directly. The resident has the right to refuse care. The resident should, however, be informed of the consequences of his/her action. If the resident has made an informed choice, the decision should be supported and the resident's right to refuse care assured.

3.1.3 Monitoring and Reassessment

Required Standards

NH-OR: s.11

- Regular reassessment of care needs is required to ensure that residents receive appropriate care and treatment.
- The current status of the resident shall be documented on the resident's health record on at least a monthly basis.
- Any incident of an unusual occurrence which affects the resident shall be noted.
- Interdisciplinary care plans shall be updated on a regular basis.

NH-OR: s.19

- The continuing care centre shall arrange for an examination of the resident by a physician during each 12-month stay in the centre, including a review of the resident's physical and mental status and the interdisciplinary care plan.

NH-OR: s.7/NH-GR: s.11

- The committee responsible for approving centre admissions may, on request, reassess a resident's need for continuation of care in the continuing care centre. If in the opinion of the committee the

resident no longer requires care in a continuing care centre, the resident may be eligible for discharge.

NH-OR: s.7/NH-GR: s.11

- The resident should be advised, in writing, of the decision to discharge from the centre.

NH-OR: s.6/NH-GR: s.11

- Discharge planning is an ongoing component of resident reassessment. When appropriate, discharge planning is part of the resident's plan of care. Discharge planning includes arranging for transfer to another continuing care centre.

Recommended Guidelines

TBC

- The continuing care centre will have tuberculosis control policies and procedures outlining the care and management of residents.
- All residents will have their tuberculosis status assessed through a tuberculosis history, a symptom inquiry, and a tuberculin skin test. The information will be recorded on the resident's health record prior to the initial interdisciplinary care conference or within six weeks of admission. Ongoing tuberculosis assessment will identify those persons who are symptomatic and at risk of developing active tuberculosis. Appropriate documentation, referral, and treatment should be initiated as required.

3.1.4 Ongoing Coordination

Required Standards

NH-OR: s.22/D-287

- Continuing care centre residents are entitled to a maximum of 50 days' hospital leave of absence per fiscal year. Hospital leave is counted on a cumulative basis per fiscal year, and includes leave taken due to admission to an acute care hospital, a mental health hospital, or a geriatric assessment unit. Residents exceeding 50 hospital leave days are to be discharged from the continuing care centre and referred for reassessment to the committee responsible for centre admissions.

NH-OR: s.22/D-287

- Continuing care residents are entitled to unlimited social leave. Social leave includes any overnight leave at the discretion of the resident, not counting hospital leave.

D-237, D-243, D-294

- Residents of continuing care centres will continue to use oxygen equipment and supplies from the centre when on leave from the centre. In cases where it is impractical for the resident to use the centre's equipment or supplies (such as a visit out of the general area of the continuing care centre), the resident/family should make arrangements with an appropriate supplier(s).

Recommended Guidelines

CCCRS

- Each resident should be assigned a case coordinator (or service coordinator) who would take responsibility for the overall care

plan for a particular resident. Case coordinators are responsible to ensure follow-up on all recommendations for care, including follow-up on discharge. The case coordinator is responsible for the overall quality of care received by the resident.

- Coordination between the continuing care centre, the committee responsible for approving admissions, and community care agencies is necessary to arrange for resident discharge to the community, or joint community/centre service arrangements.

3.2 LIFE ENRICHMENT AND SOCIAL SUPPORTS

Philosophy

Residents benefit from the opportunity to develop meaningful relationships with other residents, staff, and visitors, and to choose whether to participate in activities that they enjoy. Services are tailored to meet the individual and collective residents' physical, emotional, social, spiritual, intellectual, and cultural preferences and needs. Programs are designed with resident involvement to focus on existing and potential skills and abilities, and current interests of the residents. Residents also appreciate the wide variety of contributions to a caring environment that an organized volunteer service can bring.

Policy

The continuing care centre will provide life enrichment services.

Required Standards

NH-GR: s.2(h)/NH-OR: s.16(1-4)

- Life enrichment services are part of the basic care in a continuing care centre.

NH-OR: s.16(3)(a)

- Residents should be given the opportunity for personal visitation and spiritual guidance from the clergy of their choice, including religious services in an appropriate place in the centre.

NH-OR: s.12(e)/NH-OR: s.16(4)

- An individual staff person shall be responsible for the provision of life enrichment services.

NH-OR: s.16(3)(b)

- Where practical, the centre operator will encourage and assist residents to leave the centre to visit, shop, and attend religious services and community activities.

Recommended Guidelines

- Life enrichment services are designed to meet the preferences and lifestyles of residents.
- Individual and group program options should be available.
- Small-group programs for cognitively impaired residents should provide cognitive and sensory stimulation and focus on remaining strengths.
- A pastoral advisor may be appointed by the centre.

3.3 PERSONAL CARE/ASSISTANCE

Philosophy

Residents make everyday choices and decisions, and function with just the personal assistance needed to support those choices in as normal a setting as possible. Residents needing help with daily tasks that they cannot complete by themselves benefit from the opportunity to use their abilities to the fullest extent possible in every area of daily living. The nature and amount of personal care/ assistance offered is directed by the resident and is based on each resident's

personal preferences and values. If the resident is unable to choose, then staff collaborate with a substitute decision-maker.

Policy

Personal care/assistance will be provided to help individuals with tasks that they cannot perform independently.

Required Standards

NH-GR: s.2(d)

- Personal care/assistance is part of the basic care in a continuing care centre.

Recommended Guidelines

Alberta Patient Classification System for Long Term Care Facilities, 1988

- Personal care/assistance includes help with such tasks as eating, dressing, grooming, toileting, transferring, bathing, and mobility. In addition, occupational and physical therapy support programs may be part of the assistance required to enhance abilities to perform activities of daily living. Support is limited to those parts of the tasks that the resident cannot perform.

3.4 TECHNICAL SERVICES/AIDS

Philosophy

Technical services/aids assist individuals in maintaining or improving their quality of life by enhancing their ability to do things for themselves, thus preserving their identity, individuality, and self-esteem. Residents have the right to make decisions about their lives and accept certain risks in choosing where and how they will receive services. Services complement, rather than replace, residents' own abilities and strengths.

Policy

The continuing care centre will assist individual residents to obtain technical supports, certain basic mobility and communication aids, and medical supplies that are necessary to promote health, safety, and independence.

Required Standards

NH Act: s.1(c), 15/NH-GR, s.2/HA: Part 3/HA-HBR, s.4(1), D-317

- Continuing care centres are responsible for providing insured services at *no* cost to the resident. Insured personal care services include:
  - large bathroom equipment (e.g., commodes, shower chair)
  - large equipment (e.g., mechanical lifts)
  - wheelchairs and wheelchair accessories
  - bathing/toileting aids (e.g., grab bars)
  - mobility aids (e.g., crutches, canes)
  - all dressing and wound care supplies
  - incontinent products/system. The system may include disposable, reusable products, or a combination of either, and centres are responsible for providing incontinent supplies which meet the needs of residents.
  - oxygen services and supplies
  - ostomy supplies
  - bladder equipment, including catheters, irrigation equipment, and solutions
  - special care items such as side rails, sheepskin pads, elbow and ankle protectors, mattresses, side rail pads, and other similar items
  - medications and nutritional supplements prescribed by the attending physician (e.g., Ensure)

PHA: Alberta Aids to Daily Living, and Extended Health Benefits Regulation, s.2(4)

- Health and mobility aids may be available for specific residents under the Alberta Aids to Daily Living (AADL) Program Guidelines. The health

aid must be approved by an AADL authorizer who certifies that the health aid is for the sole use of an individual resident.

D-317

- Basic room furniture such as bed, mattress, chairs, and dresser are provided at no cost to the resident.

3.5 RESPITE SERVICES

Philosophy

Respite care supports a continuing care service system which is more responsive to individual needs. Respite care enhances the quality of life for both individuals and their social support systems. Individuals living in the community benefit from centre programs designed to offer flexible, short-term resident services, and respite care.

Policy

Respite services will be provided to allow periodic relief to caregivers through a planned short-term admission for individuals assessed as eligible for the program.

Required Standards

D-291/NH-OR: s.3(1-4)

- Standards of care and service for respite admissions are the same as for permanent admissions. This includes accommodation charge rates (room and board).

D-237

- It is expected that a client admitted for respite care will bring his/her own oxygen equipment and supplies to the continuing care centre. The Alberta

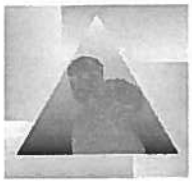
Aids to Daily Living Program will continue coverage for approved oxygen clients for up to a maximum of 30 days.

CCPSR/D-325

- Respite care residents may choose to bring their medications to the centre or may have the medications provided by the centre during their stay.
  - If residents bring their medications, the pharmacist should assess the medication regime, verify the contents of the medication vials, and provide reminder cards consistent with the controlled dosage system in place.
  - If the centre provides the medication, the pharmacist will assess the medication regime and supply the appropriate medications.

Recommended Guidelines

- The continuing care centre has an admission process for respite care admissions.
- An agreement for services will be established between the family and the centre and may specify:
  - length of stay
  - service charges/timing of payment
  - transportation arrangements
  - arrangements for medical care
  - rules of conduct
  - next-of-kin contacts
- A written care plan and a pre-admission discharge plan should be developed for each respite resident. The long term care assessment form as designated by Alberta Health may be used as the basis for this care plan if appropriate and current.
- The respite program should be evaluated annually in terms of meeting its goals and objectives.



4.0 HEALTH SERVICES/SUPPORTS

The Health Services/Supports section provides standards and guidelines for the care services components available in continuing care centres. These care services components include the professional and personal services received by residents in meeting their daily needs.

4.1 PHYSICIAN SERVICES

Philosophy

Part of a holistic and comprehensive response to the requirements of individual residents involves skilled professional services by physicians, according to the resident's assessed needs. Residents benefit from centre policies which ensure that appropriate medical assessment and treatment are offered to each resident.

Policy

The medical care of every resident will be supervised by a qualified physician. Medical administrative advice is available to staff to ensure the timely provision of appropriate and adequate medical services.

Required Standards

NH-OR: s.18, 19, 20/HA-OHR: s.31, 32/I-119

- Continuing care centres will appoint a physician as medical advisor.
- Each resident will be under the care of a physician.

NH-OR, s.19(4)

- The continuing care centre operator shall arrange for an examination of the resident by a physician during each twelve-month period of stay in the centre.

HA: s.32

- Auxiliary hospitals are required to prepare medical staff by-laws governing the organization and conduct of physicians practicing in the centre.

Recommended Guidelines

- Documented policies and procedures governing medical supervision of residents will be available in the centre.
- Written agreements will be established with each physician.
- There will be a documented arrangement to provide emergency or on-call medical supervision.
- Where there are a number of physicians attending to residents, the centre may wish to adopt medical staff by-laws.
- Responsibilities of the Medical Advisor will include:
  - reviewing resident care and records.
  - participation in the development of care policies and strategies.
  - reviewing centre medication policies and procedures.
  - being responsible for adjudication with attending physicians.
  - assuring adherence by medical staff to established medical policies and procedures.
  - assisting in developing related administrative committees; i.e., Interdisciplinary, Infection Prevention, Pharmacy and Therapeutics, Health Records, etc. The Medical Advisor may be a member of these committees.
  - assisting in inservice education programs.

4.2 DIAGNOSTIC SUPPORT SERVICES

Philosophy

Diagnostic support services provide relevant information to the interdisciplinary team which guides them in planning for appropriate individualized health services/ interventions for residents in a continuing care centre. Residents benefit from

centre policies that ensure the availability of appropriate diagnostic support services in accordance with each person's assessed need.

Policy

Continuing care centres will have arrangements in place to access laboratory, radiology, and other diagnostic services as required for residents.

Required Standards

RHA: s.28/HA-OHR: s.13/NH-OR: s.11(1)(g)

- Routine and emergency diagnostic support services will be available to meet the needs of residents.
- Records of test results will become part of the resident's health record.

Recommended Guidelines

- Service arrangements may be made with an appropriate community resource or, in some cases, provided in the centre.
- The results will be interpreted for the residents and family, as applicable.
- The results/reports should be available within a reasonable time to ensure appropriate and timely changes in the care provided to the resident.

4.3 HEALTH RECORDS

Philosophy

Residents benefit from clear, concise, and accurate health records which support a high quality of care. The health record reflects values and preferences and a comprehensive approach to the delivery of personal and health services based on that individual's assessed needs. The resident's information and person health record is maintained in a confidential manner.

Policy

Continuing care centres will have a system for maintaining a health records system and a health record for each resident.

Required Standards

NH Act: s.27(1)/HA-OR: s.11(1)/NH-OHR: s.13/HA: s.40(1)

- Continuing care centre operators will keep a health record for each resident.

NH-OR: s.11(1)(b)/HA-OHR: s.13(2)

- The health record should contain sufficient information to clearly identify the resident, the reasons for admission, diagnosis of disease, treatment, and results of treatment.

NH-OR: s.11(2)/HA-OHR: s.13(1)(2)

- Documentation of care needs and care provided should be evident.

NH Act: s.27(1-3)/HA: s.40(2)(3)(5(6)(7)(9)(10)/NH-GR: s.12

- The resident's health record is private and confidential, and except as prescribed by regulations shall not be presented, released, or disclosed in any detrimental manner.

NH-OR: s.11(3)/HA-OHR: s.15(1)

- Health records will be maintained for a minimum of five years after a resident has been discharged from a nursing home, and a minimum of ten years after discharge from an auxiliary hospital.

NH-OR: s.11(1a)/D-229

- The original long term care assessment form (AAPI) is part of the health record for the resident.

Recommended Guidelines

SPE

- The most recent original long term care assessment form (AAPI) is forwarded to the continuing care centre prior to admission of a resident.
- If the resident is discharged to another continuing care centre or to a home care program for community care, the most recent original long term care assessment form (AAPI) is forwarded to the receiving program and a copy is kept at the originating centre.

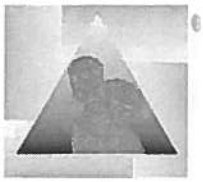
4.4 NURSING SERVICES

Philosophy

Nursing services coordinate the assessment, planning, and delivery of personal and health services in a spirit of partnership with the resident, family, and other staff. Individualized, holistic nursing care, based on the resident's assessed needs, respects the integrity, dignity, and uniqueness of each individual.

Policy

Nursing staff are available to provide health assessment, professional nursing care, and a variety of coordination and evaluation services related to residents' personal and health service needs.



Required Standards

NH-OR: s.1(g), 12(a), 13, 14

- There will be a full-time Director of Nursing (DON), and this person will be a Registered Nurse (RN) or a Certified Graduate Nurse (CGN).
- Unless the centre has fewer than 60 beds, paid hours for the DON will be used only for managing direct care services in the centre.
- There will be at least two staff on duty at all times, at least one of whom is an RN, CGN, or Registered Psychiatric Nurse (RPN) (if an RPN, then an RN or CGN must be on call).
- There will be at least 1.9 paid hours of nursing and personal services provided on average per resident day.
- At least 22 percent of the base 1.9 paid hours of combined nursing and personal services must be provided by nurses.

D-203, D-220, D-291, I-196

- Nursing staff are defined in legislation. Professional nursing practitioners bear primary responsibility and accountability for the nursing care that residents receive.

Recommended Guidelines

CCCRS

- Within the nursing services package, core services offered in the basic program in every continuing care centre will include (but not be limited to) the administration of medications by injection; the care of wounds or skin ulcers; foot care; provision of oxygen; suctioning or chest care; side stream nebulizers; the monitoring of vital signs; insertion and care of a urinary catheter; ostomy care; provision of fluids through hypodermoclysis; the administration of medication for pain by mouth, injection, or intravenous means; care for feeding/swallowing disorders; and bolus or continuous gastrostomy feedings.

4.5 INSERVICE EDUCATION

Philosophy

Quality and safe resident care is supported by a staff development program which is relevant to resident needs, and provides educational opportunities which enhance the potential of staff members. Residents will benefit from educated and competent staff.

Policy

Continuing care centres will provide ongoing inservice education and orientation programs to all staff.

Required Standards

NH-OR: s.17/D-091, D-291

- The continuing care centre will provide a formal inservice education program that includes (but is not limited to):
  - gerontology
  - fire prevention and safety
  - disaster preparedness
  - prevention and control of infections
- The type and length of inservice education programs will be reported annually, including number/type of participants and the instructor's time.

NH-OR: s.17(2)

- An inservice education program shall be provided by one full time equivalent staff in the case of a centre with a rated capacity of 100 beds or more.
- In the case of a centre with a rated capacity of less than 100 beds, an inservice education program shall be provided by the proportionate full-time staff equivalent of 1:100 beds.

Recommended Guidelines

- Education programs should be based on a continuous process of developing, monitoring, and reviewing competencies based on the position expectations and the developmental needs of the staff to provide safe and competent care to the residents of the centre.
- Staff should be given the opportunity to attend conferences and seminars that are specific to the needs of the staff member and the centre's residents.
- Orientation programs for new employees should be included in the inservice education program.

4.6 RESIDENT SAFETY

Philosophy

All staff in a continuing care centre have a role in assisting residents where safety is a concern. Residents will benefit from services designed to contribute to safe and effective care. Residents will be encouraged to use their abilities to the fullest extent possible, and to preserve their identity and individuality. They have the right to make decisions about their lives and to function with those choices in as normal a setting as possible. These choices and decisions include residents accepting an element of risk.

Policy

Continuing care centres are responsible for providing the appropriate equipment, environment, devices, and interventions that support resident safety. Competent care providers and appropriate resources are allocated and available to ensure resident safety.

Required Standards

NH-OR: s.23

- Safe continuing care services will be provided to residents.

I-387

- When electric beds are used in continuing care centres, the following will apply:
  - Continuing care centre staff are to determine those residents who are safe in an electric bed.
  - The electric bed must be CSA approved.
  - Recommended characteristics of the electric bed include:
    - an auxiliary crank
    - an easy-to-operate braking system
    - a control panel which includes a lock-out feature for each resident control
    - a button requiring continuous pressure to move the bed up or down; i.e., no walk-away feature.
  - There should be an adequate source of power to accommodate the bed and other electrical equipment requirements.

I-273

- The centre will take appropriate action following any Issue Alert circulated by Health Canada.

Correspondence - Minister of Hospitals and Medical Care, April 1981

- Continuing care centres shall have a written policy in place prior to using physical restraints. The policy shall address the circumstance in which physical restraints may or may not be used, who may order a restraint, the type of restraint to be used or not used, the period of use and release from use, the frequency of observation for safety and comfort, documentation on the resident's health record, and education for staff regarding the application of physical restraints.

Recommended Guidelines

- The centre protocol should define the term *restraint* to include anything which limits an individual's voluntary movement. This includes physical

(i.e., physical force), chemical (i.e., psychotropic drugs), mechanical (i.e., safety belts, wheelchair safety bars or lapboards, geriatric chairs, side rails), and environmental (i.e., locked doors) restraints.

- Restraining residents in any manner should be used only as a last resort, when there is an identified risk of injury to self and others, and other alternatives have proven ineffective.
- The restraint protocol should be discussed with the resident/family at the time of admission. If a restraint must be used, the resident or legal representative must consent to the use of the restraint. The resident/legal representative should be fully informed of the reasons for this decision, the nature of the restraint to be used, its potential risks and benefits, and alternate treatment options, if any.
- Staff and physicians should be fully aware of the centre's philosophy of restraint use and protocol. Regular reviews should be conducted if restraints are used.
- The use of geri-chairs as a restraint is not recommended.

4.7 THERAPEUTIC SERVICES

Philosophy

Residents have a strong desire to maintain physical, emotional, and social independence in all aspects of their lives. Therapeutic services may enable residents to function at their maximum level of independence. Residents benefit from therapeutic services which meet their specific individual needs and enhance their quality of life.

Policy

Continuing care centres will obtain the services of qualified therapeutic service staff whose responsibility includes the provision of services that are part of an approved program.

Required Standards

NH-OR: s.12(1)/NH-GR: s.2/D-090, D-154, D-263

- Therapeutic services will be provided by continuing care centres.
- Required therapeutic services include:
  - Professional physiotherapy and/or occupational therapy services and clinical dietician services (see 4.8) must be available for continuing care residents.
  - Other optional therapeutic services include speech language pathology, audiology, respiratory therapy, and volunteer coordination. Counselling includes social work, psychology, and pastoral services.
  - The following therapeutic services personnel must be graduates of a recognized university program and must be registered by their respective provincial college or association:
    - physiotherapist
    - occupational therapist
    - dietician
    - speech language pathologist
    - audiologist
    - respiratory therapist
    - social worker
    - psychologist
  - Recreation therapists must be graduates of a program at a community college or university (equivalencies in related program areas at a community college or university may be considered), and it is recommended that they be members of their provincial association.
  - Rehabilitation aides require appropriate supervision as defined by provincial legislation governing professions and occupations or professional associations. Guidelines for the duties and supervision of aides should be consulted.

Recommended Guidelines

- Centres will provide an appropriate mix of staff based on assessed resident need.
- Therapeutic programs must be delivered in each centre; however, the decision to employ or contract staff for therapeutic services is the responsibility of the operator/RHA.

4.8 NUTRITIONAL SERVICES

Philosophy

A resident's nutritional requirements are assessed and monitored to support their quality of life. Nutritional needs are provided for in keeping with the resident's preferences and lifestyle choices, and to maximize the therapeutic nutritional benefits to the resident.

Policy

Continuing care centres will obtain the services of a qualified registered dietician whose responsibility includes the nutritional care of residents.

Required Standard

NH-OR: s.12(1)(3)

- An operator may obtain the services of a registered dietician on a full- or part-time employment basis or on a consulting basis.

D-90/D-291

- The registered dietician must be a graduate of a recognized university program and be registered by the appropriate provincial college or association.

D-291

- Hours for the management of the food services department will not be included in the hours reported for clinical services provided by the registered dietician.

NH-OR: s.15(4b)

- The registered dietician will approve the cyclic menu planned for residents.

NH-GR: s.2(e)/NH-OR: s.12(3), s.15(7-8), s.23(b)(iv)

- Special dietary requirements will be provided.
- Therapeutic diets will be ordered in writing by a physician and recorded in the resident record.

D-317

- Nutritional supplements as prescribed by the attending physician will be provided.

I-143/D-364

- When the resident is at risk of choking or unable to maintain adequate nutritional intake, the following will be considered:
  - A full assessment by professionals specializing in pharyngeal/esophageal disorders may be necessary to determine the needs of the resident so that adequate nutritional intake is maintained.
  - Modifications to food consistency should be available in all centres.
  - Gastrostomy tubes may be considered for longer term use to ensure that adequate nutrition and comfort needs are met. The resident will be consulted and will consent to the insertion of the gastrostomy tube prior to the procedure.

- The use of syringe feeding is not recommended.
- All staff in the continuing care centre should be able to perform a Heimlich procedure.

4.9 PHARMACY SERVICES

Philosophy

The carefully considered and monitored use of medications contributes to the health and well-being of residents. Well-informed residents are partners in a safe and effective drug regimen, appropriate to the individual's unique health needs and situation.

Policy

Continuing care centres will provide/obtain pharmacy services for their residents.

Required Standards

NH-GR: s.2(f)/HA-HBR: s.4(1)(2)/D-317, D-462

- Continuing care centres will provide drugs/medicine specified by the Minister for routine/emergency needs of residents as prescribed by a physician. This will be part of the basic program.

NH-OR: s.20(4)/D-317

- When a physician prescribes a drug that is considered necessary for the treatment of a resident, it is the responsibility of the continuing care centre to provide the drug without charge.

NH-OR: s.20, 21/D-325, D-370, D-444, D-462/CCPSR

- The Pharmacy Services Requirements Document in the Continuing Care Pharmacy Services Manual outlines the standards for providing pharmacy services in continuing care centres.

- The 14 requirements address:
  - organization of service
  - pharmacy services and facility operators
  - equipment, forms, reference materials, space, and supplies
  - pharmacy and therapeutics committee
  - policies and procedures
  - after hours service and emergency drugs
  - procurement and distribution
  - storage and disposal
  - drug administration
  - LOA medications
  - respite care medications
  - consultation and education
  - drug utilization, and
  - quality assurance/risk management.

CCDMFG (Section X)

- Continuing care residents who are registered with the Alberta Cancer Board are eligible for drugs under the Alberta Cancer Board Outpatient Drug Benefit Program.

Recommended Guidelines

CCDMFG

- The Continuing Care Drug Management and Formulary Guidelines provide:
  - a drug list for residents in continuing care centres,
  - a list of those drugs considered to be most effective and safe for use in the elderly, and
  - drug-management information to assist physicians, pharmacists, and centre operators in establishing their own formularies (drug lists) and formulary systems (policies and procedures) which are pertinent and applicable to their continuing care centre.

- Continuing care centres are encouraged to develop and maintain a formulary system which meets the needs of residents and care staff.

4.10 CARE FOR THE DYING

Philosophy

Death and dying are a normal part of life. Residents living in a continuing care centre can expect to die according to their own values and preferences, surrounded by the family and friends most meaningful to them, and by caring and supportive staff.

Care for the dying incorporates palliative care principles which address the physical, psychosocial, and spiritual needs of terminally ill residents and their families, including the control of pain and other symptoms, to promote the quality of remaining life and a peaceful death. Palliative care services are recognized as an emerging area for future development in continuing care centres. Residents and families benefit from centre policies which incorporate palliative care principles and ensure the availability of a range of palliative care services.

Policy

Continuing care centres will provide care for dying residents and their families within the scope of the basic program. As resources become available, continuing care centres will provide enhanced palliative care services that would enable dying residents with extraordinary needs to remain in the centre.

Recommended Guidelines

CCCRS

- Continuing care centres have an essential role to play in the provision of palliative care services, including short-term admission for respite.
- Palliative care will be available to persons who have been living in the continuing care centre or who have been using the services of a continuing care centre on a part-time basis, before reaching the end stage of life.

- Palliative care services will also be offered to persons who have not previously received services from the continuing care centre, but are now in need of admission. Timely access to the continuing care centre for palliative care services will be coordinated with the waitlist process for admission to a centre and with the availability of other options such as the Home Care Palliative Program.
- Centres may wish to consider a private room for the dying resident as the end of life is reached. Provision for family members to stay overnight or have access to a private area should be considered.
- Specialized palliative care services in the region will be arranged for persons requiring complex technical and professional expertise not available in basic services.
- Detailed program guidelines for palliative care services are available in:
  - *Palliative Care: A Policy Framework,* Alberta Health, December 1993
  - *Palliative Care Services Guidelines,* Health and Welfare Canada, 1989

4.10.1 Pronouncement of Death

Policy

Continuing care centres are responsible for the requirements and actions specified in legislation when a resident dies in the centre.

Required Standards

HA-OHR, s.13(5)

- In auxiliary hospitals
  - a procedure for pronouncement of death occurring at night should be established, and
  - the pronouncement of the death of a resident who died during the night should be made by the first physician visiting the hospital.

HA-OHR: s.26(1)

- The body should not be released without signed documentation on the health record and a properly executed and signed death certificate, except when requested by a coroner.

HA-OHR: s.26(2)

- When the body of a deceased person is not claimed by the immediate relatives or their legal representatives, authorities shall take action in accordance with the Human Tissue Gift Act.

HA-OHR: s.26(3)

- If death was caused by a communicable disease, the centre must notify the funeral home of the cause of death on release of the body.

HA-OHR: s.25

- Autopsies shall be performed in all situations in which the cause of death is uncertain or in all post-operative deaths within 72 hours. Autopsies should be considered when it would enhance medical knowledge, if consent from next-of-kin or the estate executor has been received. An autopsy may also be requested by a medical examiner.

Recommended Guidelines

- When notified of the death of a resident in a continuing care centre, a physician should attend at the centre within a reasonable period of time in order to pronounce death and permit the release of the body. Ordinarily, this should be done within six hours. There may be exceptional circumstances in which this is not possible, in which event the time limit should not exceed 12 hours.

- Each centre should have an established policy identifying whose responsibility it is to notify the physician in the event of a death.
- The responsibility for notifying the next-of-kin may be delegated to the nurse-in-charge.
- The following sections of the Registration of Death form must be completed at the time of death by the physician or coroner:
  - name of deceased: full legal name, surname followed by given names
  - place of death
  - medical certificate of death, and
  - date of signature
- Since the Registration of Death is a permanent legal record, all entries must be legible and in black ink.
- The partially completed Registration of Death, including the Medical Certificate of Death, should be given to the funeral director who removes the body of the deceased resident. The funeral director completes the Registration of Death certificate and obtains a burial permit.

4.11 AMBULANCE/TRANSPORTATION

Philosophy

Residents' transportation to and from health centres in accordance with their assessed needs is part of a holistic and comprehensive response to continuing care requirements of individual residents.

Policy

Continuing care centres will provide ambulance/transportation services when assessed as being medically required.

Required Standards

HA-HBR: s.6, 4(1)/D-300, D-317, D-323/I-391

- Ambulance/transportation charges for prescribed services are the responsibility of the continuing care centre, including:
  - permanent transfer of a resident to an acute care hospital or approved centre where the resident is admitted for a period of diagnosis or treatment.
  - temporary transfer of a resident to outpatient or emergency services in an acute care hospital or approved centre for prescribing diagnostic or treatment services, with the immediate return of the resident to the originating continuing care centre.
  - outpatient transfer of an auxiliary hospital resident from one acute care hospital or approved centre to another for prescribed diagnostic or treatment services.
- Continuing care centres are not responsible for resident costs associated with:
  - outpatient transfer for nursing home residents from one acute care hospital or approved centre to another. The cost of the outpatient transfer is billed to Alberta Blue Cross for residents over age 65, or to third-party payers, or to the resident when under age 65.

5.0 ADMINISTRATIVE SERVICES/SUPPORTS

5.1 CENTRE OPERATIONS

Continuing care centres provide administrative direction for the day-to-day operation and management of its business affairs. This section of the program standards document contains standards and guidelines as they pertain to centre operations, safety and security, resident property (including trust accounts/ banking), and payment responsibilities. A variety of programs inherent in centre services protect and enhance the safety and security of the residents and their families, staff, and volunteers, including occupational health and safety, waste management, fire safety and prevention, disaster preparedness, and infection prevention /control.

Philosophy

Residents benefit from an administration which implements policies and procedures to support residents' values, preferences, and needs, and enhances the quality of life for, and safety and security of, residents, families, and staff.

Policy

Administration is responsible for the centre operations and its continuous improvement, and liaises with health professionals, the public, RHAs, and other health agencies in the community to provide coordinated services for its residents. Residents and their families will be informed of those services for which they are responsible for payment.

5.1.1 Quality Service

Required Standards

NH-OR: s.12(1)(2), 13(2)

- The operator of a continuing care centre shall obtain the services of a full time administrator for each centre operated. The

administrator may be employed on a part-time basis in a continuing care centre if employed at one or more centres owned and operated by the centre operator.

HA: s.38

- The administrator/operator is responsible for the day to day efficient operation of the centre.

NH-OR: s.23(b)(iv)

- The administrator/operator is responsible for preparing and complying with policies and procedures for the operation of the centre.

NH-OR: s.23(b)(vi)

- An integral component of service delivery will include an organization-wide process of quality monitoring and improvement, and each department/service in the continuing care centre will participate in the process on at least an annual basis.

HA-OHR: s.34(1)

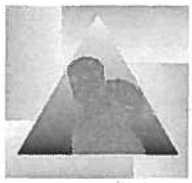
- Each continuing care centre shall strive to meet the standards for accreditation of centres established by the Canadian Council of Hospital Accreditation.

Recommended Guidelines

- Key management responsibilities should include processes to address:
  - resident rights/responsibilities
  - ethical issues and concerns
  - resident/staff abuse
  - integrating the centre with its community

- development and implementation of a strategic business plan
- allocation of human, financial, and physical resources to ensure the financial viability of the organization
- protection and control of resources including:
  - monitoring budgets
  - managing inventory
  - a staff identification system
  - providing adequate insurance coverage

- When an external company is providing a service (e.g., housekeeping, laundry, nutrition/food services, or pharmacy services), there will be a process for obtaining these contracted services for the centre. Formal contracts for services should specify:
  - services to be provided
  - qualifications of service providers
  - accountabilities of service providers
  - scheduling commitment/length of contract
  - description of the facilities or equipment required to provide the service
  - reporting relationships
  - requirement to comply with legislated standards, regulatory processes, and codes
  - financial arrangements
  - licence/registration status as applicable
  - mechanism for parties to cancel the contract
  - the parties to the contract
- The centre should establish a process for the coordination, review, and signature of all contracts.



5.1.2 Resident Payment Responsibilities

Required Standards

NH-OR: s.3

- An operator may charge a resident accommodation charges, up to the maximum amounts established by the Minister of Health.

HA-HBR: s.4(2), 5.1(d)/D-291, D-353, D-317

- Residents are responsible for the cost of non-insured services, including:
  - Room and board services: Residents are charged for their accommodation (room and board).

Setting Accommodation Charge Rates

Accommodation charges are established by the Minister of Health. Operators should refer to the most recent Alberta Health directive for current accommodation charge rates. Maximum rates in effect until March 31, 1996, are:

D-452

- standard: $24.75/day
- semi-private: $26.25/day
- private: $28.60/day

- *Exceptions to Accommodation Charge*:

Private Room Accommodation for Medical Reasons

Continuing care residents who require private accommodation for medical reasons are exempt from payment of the difference between private accommodation and their current accommodation charge.

Preferred Accommodation Not Available

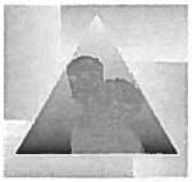
If a resident is required to take private accommodation because standard or semi-private accommodation is not

available, the maximum charge will be the semi-private rate. The resident will be placed on a priority list to be moved to the desired type of accommodation if and when it becomes available.

Semi-Private Accommodation Prior to February 1, 1988
If the continuing care centre does not have standard ward accommodation, a resident who moved into a semi-private accommodation prior to February 1, 1988, will be charged the standard room rate.

D-291

- Personal laundry services including pick-up, delivery, labelling, and minor repairs.
- Professional hair care services; e.g., shampoo and set, haircuts, colouring, etc.
- Personal goods and services requested by the resident; e.g.:
  - personal clothing and footwear
  - dry-cleaning services
  - confectioneries and other snack-bar purchases
  - toiletries, cosmetic supplies, and facial tissue
  - supplies for special recreation projects requested by the resident or the family
  - dental-hygiene products
  - personal telephone charges, cable TV, newspapers, magazines
  - tobacco and alcohol products
  - incontinent product/system other than that provided by the centre
- Transportation and related costs outside the centre for recreation programs, including admission costs to public places, events, and restaurants.
- Transportation costs of transfer between continuing care centres for nursing home residents only.



- Co-payment for some services is not fully covered by AHCIP or Blue Cross; e.g., dentistry, optometry, podiatry, chiropody, or equipment provided through the AADL Program.

Recommended Guidelines

- Residents experiencing financial hardship can be referred to the local offices of Health Canada, Alberta Family and Social Services, and/or Veterans Affairs Canada to determine eligibility for other income support programs.
- Centres should give residents a minimum of 30 days notice of a change in accommodation charges.

5.2 SAFETY/SECURITY

Philosophy

Residents, staff, and visitors benefit from an environment which protects the safety and security of all persons. Residents must be assured that their safety and security are a priority of the staff, programs, and centre which support their day-to-day activities.

Policy

Continuing care centres are responsible for developing appropriate policies and procedures which promote the safety and security of residents, staff, and visitors (assistance in the development and ongoing auditing of the health and safety program is available through Alberta Labor Health and Safety Programs and the Alberta Long Term Care Association's Health and Safety Advisory Committee).

5.2.1 Occupational Health and Safety

Required Standards

OHSA: Ch. 0-2

- Employers are responsible for ensuring the health and safety of their employees and contracted personnel by identifying, assessing, and controlling workplace hazards. Employees are responsible for their own health and safety and that of their co-workers.

HA-OHR: s.17/NH-OR: s.23(b)(iii)

- Continuing care centres will develop and maintain a program of health examinations for its staff based on the minimum considered necessary by its medical staff for the protection of both staff and residents.

OHSA: Chemical Hazard Regulation

- Identification of hazards and their control are outlined through the Workplace Hazardous Material Information System (WHMIS), which is both federally and provincially legislated. The three major components of the system are worksite labels, material safety data sheets (MSDS), and ongoing education and training.

Recommended Guidelines

WMGS/LTCHSG

- A person designated as being responsible for occupational health and safety should develop a comprehensive program. The basic elements of the program include:
  - policy statement(s)
  - hazard identification
  - hazard assessment and control

- education and training
- incident notification
- accident investigation, follow-up, and reporting
- emergency response
- administrative procedures

TBC

- All new employees and volunteers of continuing care centres will have their tuberculosis status assessed through a tuberculosis history, symptom inquiry, and tuberculin skin test.
- Employee and volunteer awareness and surveillance programs will be ongoing and tailored according to the incidence of tuberculosis in the community.
- Consult the Tuberculosis Control Manual (Alberta Health, 1993b) and refer any questions related to tuberculosis control and management to the local communicable disease control specialist in the region, or Alberta Health Tuberculosis Services.

5.2.2 Waste Management

Required Standards

OHSA: Chemical Hazard Regulation/EPEA/TDGA
PHA: Communicable Diseases Regulation, Waste Management Regulation, and General Sanitation and Nuisance Regulation

- The continuing care centre will have a comprehensive waste management program that effectively segregates and handles waste on-site and disposes of general, biomedical, and hazardous materials safely.

HA-OHR: s.33(3)

- Disposable needles and syringes shall be rendered useless prior to their disposal, and shall be disposed of in such a manner that their handling will not produce injury.

Recommended Guidelines

WMGS

- The program will include policies/procedures and codes of practice and be consistent with the *Waste Management Education Manual* (1992) published by Alberta Health.
- Workplace Hazardous Materials Information Systems (WHMIS) Labels and Material Safety Data Sheets (MSDS) will be kept on record for controlled products, chemicals, and hazardous substances used within continuing care centres. MSDS will be kept current and special attention given to ensure that disposal of chemicals and compounds meets regulatory requirements. Training in the safe use of controlled products is an employer's responsibility.

5.2.3 Fire Safety and Prevention

Required Standards

Safety Codes Act/HA-OHR: s.7

- The centre will have a comprehensive fire prevention and safety program and provide staff training in emergency response procedures.

NH-OR: S.17(1)(b)

- The centre operator will provide inservices to instruct staff in fire prevention and safety.

HA-OHR: s.16(g)

- The centre will post "No smoking" signs where oxygen is used.

It must be noted that legislative references represent provincial requirements and that municipalities may have local enhancements in place.

Recommended Guidelines

- There should be a written emergency response plan in place in the event of a fire which provides for the protection of residents, staff, and visitors and which includes evacuation procedures to an alternate location, if necessary.
- The fire plan should be practised on a regular basis by staff on all shifts.
- An appropriate fire detection system and appropriate, inspected fire extinguisher equipment should be in place.
- Fire inspections are undertaken regularly by the appropriate authorities to monitor fire hazards and to ensure the maintenance of equipment.
- A centre smoking policy should be in place to ensure the safety of residents and staff.

5.2.4 Disaster Preparedness

Required Standards

NH-OR: s.17,1(c)

- The centre operator will provide inservices to instruct staff in disaster preparedness.

Public Safety Services Act

- The centre's disaster plan should be developed in cooperation with the disaster plan prepared for the town/municipality in which the continuing care centre is located.

Recommended Guidelines

CCHFA

- There should be a written disaster plan in place which takes into account such events as failure of the water supply, loss of power, staff withdrawal of services, extreme weather conditions, chemical spills, and bomb threats.
- Staff should be trained in the emergency response procedures (i.e., evacuation, relocation, and isolation). A system should be in place for contacting and assigning personnel in the event of a real emergency. The plan should be updated regularly and reviewed with staff on a regular basis.
- Alternate shelter and resources should be arranged with local community agencies or organizations in the event of evacuation from the centre.
- Alternate sources of food, water, emergency power, fuel, and essential medical or other emergency supplies should be established.
- A process should be established to contact family members and communicate with the public.

5.3 INFECTION PREVENTION AND CONTROL

Philosophy

Infection prevention is the responsibility of all personnel in the continuing care centre. Residents and staff will benefit from a comprehensive program for the prevention and control of infection in the centre.

Policy

Continuing care centres will have an infection prevention and control program.

Required Standards

HA-OHR: s.16(i)

- Centres will establish an infection control committee, procedures for handling infections, and the methods of isolation.

NH-OR: s.23(b)/I-145, I-153, I-290, I-326

- Continuing care centres will be maintained in a hygienic and safe condition.

NH-OR: s.17(1)(d)

- Inservice education programs will include prevention and control of infections.

PHA: s.33, 34, Communicable Disease Regulations

- Any disease in an epidemic or unusual form shall be immediately reported to the Medical Officer of Health. The centre will establish procedures for notifying the Medical Officer of Health.

Recommended Guidelines

Infection Prevention and Control Standards for LTC Facilities

- The infection prevention program will include centre-specific policies/procedures outlined for:
  - administrative services
  - resident care services
  - meal services

- laundry services
- housekeeping services
- maintenance/engineering services
- central supply services

TBC

- The continuing care centre will have tuberculosis control policies and procedures pertaining to the residents, staff, and volunteers.

5.4 TRUST ACCOUNTS/BANKING

Philosophy

Control over one's own finances is important to continuing care residents in maintaining their personal independence, dignity, autonomy, and self-esteem. Residents' needs for assistance with varying levels of financial decision making is recognized. Residents benefit from centre policies designed to assist and protect their interests.

Policy

The continuing care centre will provide trust account services for residents.

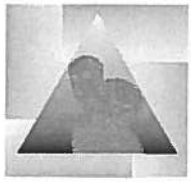
Required Standards

NH-OR: s.9(1-7)

- The centre operator will open and maintain a trust account in a banking facility (trust company, credit union, treasury branch, or bank) in the area where the centre is located.

NH-OR: s.9(5)

- The trust account will contain only money held for residents.



NH-OR: s.9(3)(4)

- Legal requirements pertaining to deposits and interest earned will be upheld by the operator, including but not limited to:
  - Maximum funds to be held in a thirty-day period are $500 per resident.
  - Excess funds shall be paid to the resident or legal representative.

NH-OR: s.9(7)

- Any money held for a resident shall be paid to the resident or his legal representative on written request.

NH-OR: s.9(6)(a)(b)

- In respect of interest earned on money deposited in the trust account:
  - subject to an agreement between an operator and a resident, the interest shall accrue to the resident in respect of whom the deposit was made but, if money deposited in the account is co-mingled for two or more residents in the nursing home, the interest shall be prorated on an equitable basis so that each resident receives as fair a distribution as is practicable of the aggregate interest, and
  - no part of the interest may accrue to the benefit of or be used by the operator.

Recommended Guidelines

- Monies retained for safekeeping will be maintained in a secure place.
- Residents will be able to access their money at times convenient to both the resident and the centre operator.

5.5 RESIDENT PROPERTY

Philosophy

Residents are encouraged to have personal belongings, such as their favourite chair and pictures, their own bureau, night table, and selected treasures. A room in a continuing care centre is considered a resident's home, and having some of his/her own possessions adds to a resident's quality of life.

Policy

Continuing care centre policies will respect and protect the residents' personal belongings and personal space.

Required Standards

NH-OR: s.8(1-6)

- On admission to the centre, an inventory of the resident's personal property, including money, will be prepared.

NH-OR: s.8(2)

- This inventory will be signed by representatives of the operator and resident.

NH-OR: s.8(3)

- A record of transactions pertaining to the resident's property will be maintained.

NH-OR: s.8(5)

- The operator will not withhold or withdraw or take money from the resident or trustee without authorization.

NH-OR: s.8(6)(a-d)

- The liabilities as specified in the legislation will be acknowledged by the operator.

D-317

- Residents are entitled to provide and maintain furnishings as outlined by centre policies.
- Residents' valuables retained for safekeeping will be maintained in a secure place.

6.0 REGIONAL SERVICES/SUPPORTS

Regional services/supports are services which serve more than one continuing care centre. Several programs have developed in the continuing care system to provide services which go beyond those available in the basic continuing care centre program. These programs are generally mandated to serve specific needs. It is expected that the regional health authorities will be interested in developing or ensuring continued access to these services.

6.1 SINGLE POINT OF ENTRY

Philosophy

Individuals and their families want simple and quick access to a variety of continuing care services which meet their specific assessed needs. Individuals benefit from a single point of entry approach which is consumer-centred, provides information about choices and options to support informed decision making, ensures ongoing comprehensive assessment, and coordinates the services available to the individual.

Policy

Individuals requesting continuing care services in either the community or centre settings will be referred through the approved process called Single Point of Entry (SPE).

Required Standards

NH-OR: s.5,6/HA-OHR: s10(2)

- Procedures for the review, approval, and reassessment of applications for admission to a continuing care centre will be established. These will be based on the approved assessment procedure.

D-342

- Continuing care centres will admit applicants according to the approved waitlist criteria as described in the Single Point of Entry to Long Term Care Services in Alberta: Program Description.

D-229

- The provincially designated long term care assessment form (AAPI) is the approved form used to document and coordinate assessment and placement functions for continuing care services.

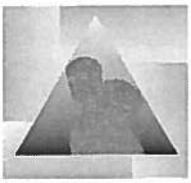
NH-QR: s.6(6)

- An individual may appeal a decision of the committee responsible for approving admissions to a continuing care centre.

Recommended Guidelines

SPE

- The approved admission process will include policies and procedures consistent with the Single Point of Entry for Long Term Care Services in Alberta: Program Description.
- The goal of SPE is to ensure that the individual requesting continuing care services is offered services appropriate for his/her needs.
- Community options are explored first before admission to a continuing care centre is approved.
- Single Point of Entry, at the regional level, provides a mechanism for planning and coordinating continuing care services.
- In cases of an urgent need for admission, individuals may be admitted temporarily to a centre other than the centre of choice until an opening is available in the continuing care centre of their preference.



6.2 EXISTING SERVICES/SUPPORTS AVAILABLE TO CLIENTS/ RESIDENTS

Single Point of Entry (SPE)

Single Point of Entry is the process developed to streamline and coordinate access to continuing care services in both community and centre settings. SPE provides individuals with a single access point through which their needs and the available services are matched appropriately and provided in a cost-effective and efficient manner. A regional approach is key to an effective SPE process. Standards and guidelines for Single Point of Entry are described in Section 6.1

Day Programs

Day programs include day support and day hospital programs. Adult day support programs are intended to provide health maintenance as well as social/recreational activities in a group setting to frail elderly or chronically disabled persons living in the community. An adult day hospital provides specialized medical and multidisciplinary assessment and treatment and intensive rehabilitation services as an alternative to acute care hospital admission. Clients are admitted to day hospitals from the community, acute care hospitals, and continuing care centres.

Regional Information, Support, and Referral Programs (RISARS)

The RISARS program was developed to assist continuing care centres with the assessment and management of individuals exhibiting mental health problems and/or behavioral symptoms. A combined community and continuing care focus is recommended so that the program can be a resource to staff and provide consultation for individuals with mental health problems in both settings.

Mentally Dysfunctioning Elderly Units (MDEU)

The purpose of these units is to provide short-term behavioral assessment and treatment for continuing care centre residents with moderate to severe dementia who also have severely dysfunctional behaviours. These are flow-through units.

Services for Younger Persons with Disabilities

Two specialized units in Edmonton and Calgary were developed to meet the unique needs of younger persons with disabilities who are unable to manage their care in a community setting. Similar services should be considered in other centres if there are sufficient clients. Alternatives to in-centre care should be actively explored.

Geriatric Centres

Two centres of excellence for geriatric care and research have been established in Alberta. The Northern Alberta Regional Geriatric Centre in Edmonton (NARGC) and the Southern Alberta Regional Geriatric Centre in Calgary (SARGC) provide coordinated and specialized geriatric assessment, rehabilitation, and consultation services on both an inpatient and an outreach basis. Education, research, and evaluation are important components of the geriatric centres. For example, NARGC and SARGC provide expertise and consultation to the Geriatric Assessment and Rehabilitation Units.

Geriatric Assessment and Rehabilitation Units in Acute Care Hospitals (GARU)

Specialized comprehensive geriatric assessment of acutely ill elderly persons is available in Edmonton and Calgary. The purpose of GARU is to improve or maximize an individual's functional ability and quality of life by providing medical, nutritional, pharmacological, psychiatric, and surgical services designed to eradicate, arrest, or reverse diagnosed organic disease or disability.

Inservice Training Program for Personal Care Aides

This is a self-directed, competency-based inservice training program delivered by the Alberta Vocational College through tutors in continuing care centres. It is focused on direct caregivers at the nursing aide level who work in continuing care centres and mental health facilities. The curriculum consists of over 90 modules in 14 major categories. All continuing care centre operators have access to this

program for their personal care aide staff. A similar program exists for home care/home support aides.

Alberta Long Term Care Inservice Resource Centre

The Inservice Resource Centre is a provincial resource providing cost-effective educational services to health agencies involved in the care of elderly persons. The Centre has a comprehensive collection of provincial, national, and international educational material including books, journals, and audiovisual materials pertaining to long term care. These are accessed through a request-based system.

A list of available documents describing programs which have developed to serve specific resident/client needs is included in the references.

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APPENDIX I

CONTINUING CARE CENTRES OF TOMORROW: A ROLE STATEMENT FOR ALBERTA'S LONG TERM CARE FACILITIES (CONDENSED VERSION)

Released by:
THE LONG TERM CARE FACILITIES SECTOR
ROLE STATEMENT WORKING GROUP

Fall 1993

Available from the

Community/Continuing Care Branch
8th Floor, 10025 Jasper Avenue
Edmonton, Alberta
T5J 2N3

Ph: (403) 427-7128
Fax: (403) 427-0767

APPENDIX II

FACILITY DESIGN ISSUES FOR CONTINUING CARE CENTRES

Discussion Paper Commissioned by:
The Long Term Care Facilities Sector Role Statement Working Group

1994

Available from the

Community/Continuing Care Branch
8th Floor, 10025 Jasper Avenue
Edmonton, Alberta
T5J 2N3

Ph: (403) 427-7128
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APPENDIX III

DELEGATED FUNCTIONS, DUTIES, AND POWERS FOR RHAS

DELEGATED FUNCTIONS, DUTIES, AND POWERS FOR RHAS

The Minister of Health assigned the administration of non-district nursing home contracts to regional health authorities effective April 1995. To provide each regional health authority with the authority necessary to administer these contracts, the following functions, duties, and powers under the Nursing Homes Act, the Nursing Homes General Regulation, and the Nursing Homes Operation Regulation have been delegated to regional health authorities.

(a) Nursing Homes Act

Section	
6	enter into contracts for nursing home care with operators;
11	grant approval for operators to enter into leases and management agreements;
14	enter into agreements with operators for the purposes of the Nursing Homes Act and regulations;
16(2)	pay benefits in respect of a resident who is eligible for services;
16(3)	refuse to pay benefits in respect of a resident who is ineligible for services;
17	make payment of benefits to an operator in the amounts and in the manner prescribed by the regulations;
18	make payment of operating grants as prescribed by the regulations;
19(1)	enter and inspect nursing homes; and require an operator to provide specified information;
20	require preparation of and approve correction plans;
25	remove residents upon cancellation of a contract;
26	require an operator to provide information.

(b) Nursing Homes General Regulations

Section	
9	enter into agreements with operators;
10(1)(a)	make grants to operators, based on agreements, in respect of operating costs that are not included in benefits paid for residents in the nursing homes;
10(3)	prescribe the purpose for which an operating grant will be used;
10(4)	require operators to repay any part of an operating grant not used for the purpose prescribed;
10(5)	enter into an agreement with an operator with respect to any matter relating to the payment of an operating grant;
10(6)	set terms and method of payment of an operating grant;
11(1)	declare a resident is no longer in need of service and may be discharged or transferred;
11(2)(b)	discharge a resident based on a physician report and nursing home records;
11(3)(a)	not pay benefits to the operator for a resident who refuses to leave;
12(2)	without the consent of residents, release information for the purpose of assessing standards of care, improving procedures, compiling statistics, conducting research, or any other purpose in the public interest;
12(3)	without the consent of residents, release information, to the Director of Medical Services under the Occupational Health and Safety Act, pertaining to an accident or disease related to the resident's occupation or former occupation; also divulge any diagnosis or record to the Workers' Compensation Board, Department of Veteran's Affairs, Department of National Defence, or the Indian and Northern Health Services of Health Canada;
12(4)	without the consent of residents, disclose information to or obtain information from the Director of Medical Services under the Occupational Health and Safety Act, Health Canada, or the government of a province of Canada, any records of nursing home services provided in respect of a resident.

(c) Nursing Homes Operation Regulations

Section	
2(2)(a)	pay an operator the applicable amount of basic benefit;
2(2)(b)(1)	pay an operator the amount of the applicable approved program benefit;
2(2.1)	pay an operator the basic benefit for non-use of a bed for a maximum of five days;
2(3)	deduct from the aggregate amount of a payment any amount due from the operator;
13(2)(b)	allow operators of a less than 60 bed nursing home to assign to the person employed as the director of nursing the duties and responsibilities of nursing services and personal services staff;
15(6)	order operators to maintain records of menus and changes to menus for 3 months;
17(3)	receive reports from operators no later than April 30 of every year showing the type and length of courses provided and number and type of participants in the program and the instructor's time;
23(b)(i)	approve preventative maintenance policies for maintenance of building and equipment in nursing homes.

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