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LONG-TERM CARE SERVICES

Accreditation Canada's sector- and service-based standards help organizations assess quality at the point of service delivery and embed a culture of quality, safety, and resident- and family-centred care into all aspects of service delivery. The standards are based on five key elements of service excellence: clinical leadership, people, process, information, and performance.

Accreditation is one of the most effective ways for organizations to regularly and consistently examine and improve the quality of their services. The standards provide a tool for organizations to embed accreditation and quality improvement activities into their daily operations with the primary focus being on including the resident and family as true partners in service delivery.

Resident- and family-centred care is an approach that guides all aspects of planning, delivering and evaluating services. The focus is always on creating and nurturing mutually beneficial partnerships among the organization's team members and the residents and families they serve. Providing resident- and family-centred care means working collaboratively with residents and their families to provide care that is respectful, compassionate, culturally safe, and competent, while being responsive to their needs, values, cultural backgrounds and beliefs, and preferences (adapted from the Institute for Patient- and Family-Centered Care (IPFCC) 2008 and Saskatchewan Ministry of Health 2011).

Accreditation Canada has adopted the four values that are fundamental to this approach, as outlined by the IPFCC, and integrated into the service excellence standards. The values are:

- 1. Dignity and respect:** Listening to and honouring resident and family perspectives and choices. Resident and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.
- 2. Information sharing:** Communicating and sharing complete and unbiased information with residents and families in ways that are affirming and useful. Residents and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- 3. Partnership and participation:** Encouraging and supporting residents and families to participate in care and decision making to the extent that they wish.
- 4. Collaboration:** Collaborating with residents and families in policy and program development, implementation and evaluation, facility design, professional education, and delivery of care.

Accreditation Canada's Long-Term Care Services standards are for organizations that provide high levels of care and nursing care that are available 24-hours a day to residents, and includes other services such as accommodations, social and recreational activities, housekeeping, and meals.

This set of standards contains the following sections:

- **Investing in quality services**
- **Building a prepared and competent team**
- **Providing safe and effective services**
- **Maintaining accessible and efficient information systems**
- **Monitoring quality and achieving positive outcomes**

All Accreditation Canada standards are developed through a rigorous process that includes a comprehensive literature review, consultation with a standards working group or advisory committee comprised of experts in the field, and evaluation by client organizations and other stakeholders.

If you would like to provide feedback on the standards, please complete the feedback form in this document.

Glossary

Care delivery model: A conceptual model that broadly outlines the way services are delivered. It is based on a thorough assessment of resident needs, involving a collaborative approach and stakeholder input, which considers the best use of resources and services that are culturally appropriate. The benefits of using a care delivery model include improving access to services, providing safe, quality care, promoting a resident-centred continuum of care, providing access to a balanced range of services, supporting a highly skilled and dedicated workforce, and reducing inequities in health status.

Care plan: May also be known as the service plan, plan of care, or treatment plan. It is developed in collaboration with the resident and family and provides details on the resident history as well as the plan for services including treatments, interventions, resident goals, and anticipated outcomes. The care plan provides a complete picture of the resident and their care and includes the clinical care path and information that is important to providing resident-centred care (e.g., resident wishes, ability/desire to partner in their care, the resident's family or support network). The care plan is accessible to the team and used when providing care.

Co-design: A process that involves the team and the resident and family working in collaboration to plan and

design services or improve the experience with services. Co-design recognizes that the experience of and input from the resident and family is as important as the expertise of the team in understanding and improving a system or process.

Electronic Health Record (EHR): An aggregate, computerized record of a resident's health information that is created and gathered cumulatively from all of the resident's health care providers. Information from multiple Electronic Medical Records is consolidated into the EHR.

Electronic Medical Record (EMR): A computerized record of a resident's health information that is created and managed by care providers in a single organization.

Family: Person or persons who are related in any way (biologically, legally, or emotionally), including immediate relatives and other individuals in the resident's support network. Family includes a resident's extended family, partners, friends, advocates, guardians, and other individuals. The resident defines the makeup of their family, and has the right to include or not include family members in their care, and redefine the makeup of their family over time.

Indicator: A single, standardized measure, expressed in quantitative terms, that captures a key dimension of individual or population health, or health service performance. An indicator may measure available resources, an aspect of a process, or a health or service outcome. Indicators need to have a definition, inclusion and exclusion criteria, and a time period. Indicators are typically expressed as a proportion, which has a numerator and denominator (e.g., percentage of injuries from falls, compliance with standard procedures, team satisfaction). Counts, which do not have a denominator, may also be used (e.g., number of complaints, number of residents harmed as a result of a preventable error, number of policies revised). Tracking indicator data over time identifies successful practices or areas requiring improvement; indicator data is used to inform the development of quality improvement activities. Types of indicators include structure measures, process measures, outcome measures, and balancing measures.

In partnership with the resident and family: The team collaborates directly with each individual resident and their family to deliver care services. Residents and families are as involved as they wish to be in care delivery.

Interoperable: The ability of two or more systems to exchange information and use the information that has been exchanged.

Medical devices and equipment: An article, instrument, apparatus or machine used for preventing, diagnosing, treating, or alleviating illness or disease; supporting or sustaining life; or disinfecting other medical devices. Examples include blood pressure cuffs, glucose meters, breathalyzers, thermometers, defibrillators, scales, foot care instruments, resident lifts, wheelchairs, syringes, and single-use items such as blood glucose test strips.

Medical equipment: A subset of medical devices, considered to be any medical device that requires calibration, maintenance, repair, and user training.

Partner: An organization or person who works with another team or organization to address a specific issue by

sharing information and/or resources. Partnership can occur at the organization level, team level, or through individual projects or programs.

Patient safety incident: An event or circumstance that could have resulted, or did result, in unnecessary harm to a resident. Types of patient safety incidents are:

- *Harmful incident:* A patient safety incident that resulted in harm to the resident. Replaces adverse event and sentinel event.
- *No harm incident:* A patient safety incident that reached a resident but no discernible harm resulted.
- *Near miss:* A patient safety incident that did not reach the resident.

Policy: A document outlining an organization's plan or course of action.

Population: Also known as community. A specific group of people, often living in a defined geographical area who may share common characteristics such as culture, values, and norms. A population may have some awareness of their identity as a group, and share common needs and a commitment to meeting them.

Procedure: A written series of steps for completing a task, often connected to a policy.

Process: A series of steps for completing a task, which are not necessarily documented.

Resident: The recipient of care. May also be called a patient, client or individual. Depending on the context, resident may also include the resident's family and/or support network when desired by the resident. Where the organization does not provide services directly to individuals, the resident refers to the community or population that is served by the organization.

Resident representative or resident advisor: Resident representatives work with the organization and often individual care teams. They may be involved in planning and service design, recruitment and orientation, working with residents directly, and gathering feedback from residents and team members. Integrating the resident perspective into the system enables the organization to adopt a resident- and family- centred approach.

Scope of practice: The procedures, actions, and processes that are permitted for a specific health care provider. In some professions and regions, scope of practice is defined by laws and/or regulations. In these cases, licensing bodies use the scope of practice to determine the education, experience, and competencies that are required for health care providers to receive a license to practice.

Self-efficacy: A person's estimate or judgment of his or her ability to cope with a given situation, or to succeed in completing tasks by attaining specific or general goals. An example of achieving a specific goal includes quitting smoking, whereas achieving a general goal includes continuing to remain at a prescribed weight level.

Team: The group of the care professionals who work together to meet the complex and varied needs of residents, families and the community. Teams are collaborative, with different types of health care professionals working together in service provision. The specific composition of a team depends on the type of service provided.

Team leader: - Person(s) responsible for the operational management of a team. Duties include identifying needs, staffing, and reporting to senior management. Team leaders may be formally appointed or take a role naturally within the team.

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

Transition in care: A set of actions designed to ensure the safe and effective coordination and continuity of care as residents experience a change in health status, care needs, health-care providers or location (within, between, or across settings (as defined by the Registered Nurses' Association of Ontario).

With input from residents and families: Input from residents and families is sought collectively through advisory committees or groups, formal surveys or focus groups, or informal day-to-day feedback. Input can be obtained in a number of ways and at various times and is utilized across the organization.

Legend

Dimensions



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



Accessibility: Give me timely and equitable services



Safety: Keep me safe



Worklife: Take care of those who take care of me



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



Continuity: Coordinate my care across the continuum



Appropriateness: Do the right thing to achieve the best results



Efficiency: Make the best use of resources

Criterion Types



High Priority High priority criteria are criteria related to safety, ethics, risk management, and quality improvement. They are identified in the standards.



Required Organizational Practices Required Organizational Practices (ROPs) are essential practices that an organization must have in place to enhance client safety and minimize risk.

Tests for Compliance

Minor Minor tests for compliance support safety culture and quality improvement, yet require more time to be implemented.

Major Major tests for compliance have an immediate impact on safety.



Performance Measures Performance measures are evidence-based instruments and indicators that are used to measure and evaluate the degree to which an organization has achieved its goals, objectives, and program activities.

INVESTING IN QUALITY SERVICES

1.0 Services are designed collaboratively to meet the needs of residents and the community.



Client-centred
Services



1.1 Services are co-designed with residents and families, partners, and the community.

Guidelines

Collaboration with residents, partners, and the community in service design is achieved through resident advocacy groups, community advisory committees, and resident experience surveys. Gaps in services are identified and addressed where possible.



Population
Focus

1.2 Information is collected from residents and families, partners, and the community to inform service design.

Guidelines

New information may be solicited from residents and families, partners, and the community, or existing information may be used when it is still relevant. If it is not within the team's mandate to collect information, the team knows how to access and use information that is available. Information can come from internal and external sources such as the Canadian Institute of Health Information (CIHI), census data, end-of-service planning reports, wait list data, and community needs assessments.

The information includes the expressed needs of residents served by the organization as well as trends that could have an impact on the community and its health service needs.

Health service needs are influenced by health status, capacities, risks, and determinants of health (i.e., income, social support networks, education and literacy, employment/working conditions, access to health services, gender, and culture).



Appropriateness

- 1.3 Service-specific goals and objectives are developed, with input from residents and families.

Guidelines

Residents and families, the team, and community partners are involved in developing team goals and objectives. Goals and objectives are aligned with the organization's strategic directions and are the foundation for delivering services. Objectives are clear, have measurable outcomes and success factors, and are realistic and time-specific.

Goals and objectives are meaningful to the team. They are reviewed annually or as needed and their achievement is evaluated.

Goals and objectives align with federal and provincial/territorial objectives as required.



Efficiency

- 1.4 Services are reviewed and monitored for appropriateness, with input from residents and families.

Guidelines

Monitoring and evaluating its services allows the team to examine what services are being offered to and used by residents, and identify areas for improvement. The type of information gathered about services is determined with input from residents and families.

Monitoring the use of services can make internal processes more efficient by identifying service gaps, either within the organization or in the community. Services are assessed to determine whether they are being offered and used as intended, are of appropriate quality, and whether there are opportunities to improve the service design and range of services.

This information is used to improve efficiency by minimizing duplication, evaluating cost-effectiveness of technologies and interventions, and increasing consistency across the organization.

Choosing Wisely Canada (<http://www.choosingwiselycanada.org>) provides information on services for various areas of service that may be unnecessary or inappropriate.



Continuity

1.5

Partnerships are formed and maintained with other services, programs, providers, and organizations to meet the needs of residents and the community.

Guidelines

Meeting the full range of needs of residents and a community is beyond the capabilities of one team or organization. Partnerships may be created to help residents navigate services across the continuum of care, or to fill service gaps.

Partnerships may be formed with primary care, acute care, community organizations, mental health services, education, housing, or social services. The organization may also partner or establish linkages with federal, provincial, or territorial organizations as well as non-governmental organizations.

Linkages and partnerships vary depending on the range of services provided by the organization and residents' needs.



Accessibility

- 1.6 Information on services is available to residents and families, partner organizations, and the community.

Guidelines

The information addresses, at minimum, the scope of the organization's services; costs to the resident, if any; how to access services; contact points; the effectiveness and outcomes of services; other services available to address the resident's needs; and any partner organizations.

Residents and families, partner organizations, and the community are engaged to determine what information is required or desired, and to evaluate whether the information provided meets their needs.



Accessibility

- 1.7 Barriers that may limit residents, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from residents and families.

Guidelines

There is a process to identify, report, and try to remove barriers to access.

Barriers to access may include the proximity and distribution of services, the physical environment, the cultural acceptability of services, wait times, the types of services available, language barriers, financial barriers, availability of transportation, and access to 24-hour emergency services.

Where barriers are beyond the control of the organization or team, they work with partners and/or the community to minimize them.

- 2.0 **Sufficient resources are available to provide safe, high-quality, and resident-centred services.**



Appropriateness

- 2.1 Resource requirements and gaps are identified and communicated to the organization's leaders.

Guidelines

The resources needed to provide safe, effective, and high quality care are determined by team members and the organization. Resources may be human, financial, structural, informational, or technological.

Identifying resource requirements is a collaborative process between the team and the organization's leaders. It includes criteria to determine where resources are required, potential risks to the team and residents, gaps in services, service bottlenecks, or barriers to service delivery or access.

The team and the organization's leaders work together to determine how to effectively use available resources or where additional resources are required.



Appropriateness

- 2.2 Technology and information systems requirements and gaps are identified and communicated to the organization's leaders.

Guidelines

Technology includes electronic medical/health records (EMR/EHR), decision tools, resident tracking systems, wait list management systems, resident self-assessment tools, or access to service-specific registries and/or databases. Depending on the organization, the need for systems could be complex (e.g., advanced software to increase interoperability) or support basic operation (e.g., newer computer systems).

As much as possible, innovative information technology is used to support the work of the service area.



Appropriateness

- 2.3 An appropriate mix of skill level and experience within the team is determined, with input from residents and families.

Guidelines

Ensuring an appropriate and optimal mix of skill level and experience supports safe, effective, resident-centred service delivery and creates learning opportunities for team members.

Optimal evidence-based ratios of skills and experience are determined. Team members have a broad range of knowledge, skills, and experience working with various resident groups.

Residents and families have a unique perspective on the skills level and experience available on their team. They may be able to point to services that were not available through their care team as well as individual skills and knowledge that could improve the resident experience. For example, residents and families may be well positioned to recognize a resource or knowledge gap on the team (e.g., knowledge of community resources; experience working with residents and families with certain conditions, barriers, levels of understanding, or languages) as well as areas to improve communication (e.g., between teams, between providers, when and how the team communicates with residents and families).



Safety

2.4

The physical space is designed with input from residents and families and is safe, comfortable, and reflects a home-like environment.

Guidelines

Elements of a safe and comfortable physical environment include appropriate washing facilities, toilets, sleeping space and common rooms, quiet areas, a dining room, green spaces, privacy, and indoor and outdoor walking areas.

The physical space is in compliance with any applicable legislation. The Canadian Standards Association provides best practice standards for Canadian health care facilities (Z8000-11).



Safety

2.5

The physical security of residents is protected.

Guidelines

Security issues in long-term care may include harm, abuse, responsive behaviours, elopement of residents, use of restraints, or accidents. The level of security required will vary depending on the nature of the organization and its residents. The level of risk within an organization is determined to decide what measures are necessary to protect the security of residents.



Appropriateness

- 2.6 The effectiveness of resources, space, and staffing is evaluated with input from residents and families, the team, and stakeholders.

Guidelines

Evaluating resources, space, and staffing helps determine the extent to which effective services are being provided and identifies opportunities for improvements. Input from residents and families, the team, and stakeholders is gathered through surveys, focus groups, advisory committees, and informal feedback.



Appropriateness

- 2.7 Team members and residents have access to information about community services, including palliative and end-of-life care.

Guidelines

Written and verbal information is provided as needed, and may include information about rehabilitation, community mental health, and primary care, depending on the population served and the resources available. The level of understanding, literacy, language, disability, and culture of the resident population are considered when developing and providing information.

Information on palliative and end-of-life care includes information for residents and families as well as resources for the team.



Accessibility

- 2.8 A universally-accessible environment is created with input from residents and families.

Guidelines

The service environment is kept clean and clutter-free to support physical accessibility for those who use mobility aids such as wheelchairs, crutches, or walkers. The environment is also accessible for those with language, communication, or other requirements, such as those who have auditory, visual, cognitive, or other impairments.

Where team members work outside the organization (e.g., delivering care in the community, home care) they work with partners, residents, and families to support accessibility.

BUILDING A PREPARED AND COMPETENT TEAM



Appropriateness



3.0 Team members are qualified and have relevant competencies.

3.1 Required training and education are defined for all team members with input from residents and families.

Guidelines

The required training and education varies by role. They may be defined by a professional regulating body, may be formal or informal, and may include lived experience or work experience.

Residents and families can provide valuable input regarding education and training that could benefit team members and enhance services. For example, residents and families may identify a need for training on working with residents with diverse cultural backgrounds, religious beliefs, and care needs. Residents and families can also provide valuable input into where knowledge gaps may exist.

Input from residents and families is sought collectively through advisory committees or groups, formal surveys or focus groups, or informal day-to-day feedback. Input can be obtained in a number of ways and at various times and is utilized across the organization.



Appropriateness



3.2 Credentials, qualifications, and competencies are verified, documented, and up-to-date.

Guidelines

Requirements vary for different roles in the organization, including for regulated or unregulated team members.

Designations, credentials, competency assessments, and training are monitored and maintained to ensure safe and effective delivery of services. Professional requirements are kept up-to-date in accordance with provincial and organizational policies.

Services are delivered within accepted scopes of practice. Team members have the appropriate training and capacities to provide resident-centred care and use equipment, devices, and supplies safely.



Appropriateness

3.3

A comprehensive orientation is provided to new team members and resident and family representatives.

Guidelines

The orientation program covers, at minimum, the organization's mission, vision, and values; the team's mandate, goals, and objectives; the philosophy of resident-centred care and how to apply its principles to practice; roles, responsibilities, and performance expectations; policies and procedures, including confidentiality; worklife balance initiatives; and the organization's approach to integrated quality management (e.g., quality improvement, risk management, utilization management, efficient use of resources).

Orientation processes and activities are documented.

Client-centred
Services

3.4

Education and training are provided to team members on how to work respectfully and effectively with residents and families with diverse cultural backgrounds, religious beliefs, and care needs.

Guidelines

Cultural education and training build the skills, knowledge, and attitudes that are required to safely and appropriately deliver interventions and services to culturally diverse populations. The training may cover topics such as disability, level of understanding, or mental health.

Cultural education and experience are part of the recruitment (including position advertisements) and selection processes.



Client-centred
Services

- 3.5 Education and training are provided on the organization's care delivery model.

Guidelines

The education and training program covers the philosophy of resident- and family-centred care adopted by the organization, the expected behaviours associated with a resident-centred approach, how to apply the principles to problem solve or address issues in the organization, residents' rights, the ways in which residents are involved in planning and delivering services in the organization, and the quality improvement initiatives that are being undertaken.



Appropriateness

- 3.6 Education and training are provided on the organization's ethical decision-making framework.

Guidelines

Training and support to handle ethical issues is provided to team members. Ethics-related issues include conflicts of interest, conflicting perspectives between residents and family and/or team members, a resident's decision to withdraw care or to live at risk, and varying beliefs or practices.



Safety



3.7

Education and training are provided on the safe use of equipment, devices, and supplies used in service delivery.

Guidelines

Information about the safe use of equipment is provided to all team members. They are trained on how to use existing and new equipment, devices, and supplies. Retraining may be requested or required if a team member does not feel prepared to use the equipment, device, or supplies, or has not used the equipment or device for a long time.

Training includes handling, storage, operation, and cleaning; preventive maintenance; and what to do in case of breakdown.



Safety



3.8

REQUIRED ORGANIZATIONAL PRACTICE: A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.

Guidelines

Infusion pumps, used to deliver fluids into a resident's body in a controlled manner, are used extensively in health care, including in the home environment, and are associated with significant safety issues and harm to residents.

This ROP focuses on parenteral delivery (i.e., routes other than the digestive tract or topical application) of fluids, medications, blood and blood products, and nutrients. It includes stationary and mobile intravenous infusion pumps, patient-controlled analgesia, epidural pumps, insulin pumps, and large-volume pumps. It excludes gastric feeding pumps.

Team members need training and education to maintain their competence in using infusion pumps safely, given the variety of pump types and manufacturers, the movement of team members between services, and the use of temporary staff. Safety is best achieved when organizations have a comprehensive approach that combines training and evaluation with the appropriate selection, procurement, and standardization of infusion pumps across an organization (see Accreditation Canada standards for medication management).

When evaluations reveal problems with infusion pump design, organizations can work with manufacturers to make improvements. Organizations are encouraged to report problems externally (e.g., to Health Canada or Global Patient Safety Alerts) so that other organizations can implement safety improvements.

Test(s) for Compliance

Major	3.8.1	Instructions and user guides for each type of infusion pump are easily accessible at all times.
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Major	3.8.2	<p>Initial and re-training on the safe use of infusion pumps is provided to team members:</p> <ul style="list-style-type: none"> • Who are new to the organization or temporary staff new to the service area • Who are returning after an extended leave • When a new type of infusion pump is introduced or when existing infusion pumps are upgraded • When evaluation of competence indicates that re-training is needed <p>When infusion pumps are used very infrequently, just-in-time training is provided.</p>
Major	3.8.3	<p>When residents are provided with resident-operated infusion pumps (e.g., patient-controlled analgesia, insulin pumps), training is provided, and documented, to residents and families on how to use them safely.</p>
Major	3.8.4	<p>The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.</p>
Minor	3.8.5	<p>The effectiveness of the approach is evaluated. Evaluation mechanisms may include:</p> <ul style="list-style-type: none"> • Investigating patient safety incidents related to infusion pump use • Reviewing data from smart pumps • Monitoring evaluations of competence • Seeking feedback from residents, families, and team members.
Minor	3.8.6	<p>When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.</p>
!	3.9	<p>Education and training on recognizing, preventing, and assessing risk of abuse are provided to the team.</p>



Safety

Guidelines

Abuse refers to all types of abuse, including physical, verbal, emotional, sexual, and financial or neglect. Incidents of abuse may occur between residents, between residents and family or residents and team members.

Education and training for team members is offered at orientation and at regular intervals. The training includes the organization's strategy for preventing abuse, how to assess residents' risk of abuse or abusing others, how to appropriately respond to abuse and the protocol for reporting alleged incidents of abuse.



Safety



3.10

Education and training on preventing and managing residents' responsive behaviours are provided to the team.

Guidelines

Responsive behaviours are behaviours that occur in response to something frustrating, or confusing in the resident's environment. They are often associated with dementia or mental health issues, physical changes and pain, and indicate a resident's needs may be going unmet. These behaviours include wandering, aggression or agitation, repetitive behaviours, and clinging.

Some examples of resident-centred training programs include Gentle Persuasive Approaches (GPA) for dementia care; P.I.E.C.E.S. training; and U-First!

Education is provided on the appropriate, evidence-informed use of pharmaceuticals, such that only those which are indicated for the resident's condition are administered.



Safety

3.11

Education and training on the safe and appropriate use of restraints are provided to the team.

Guidelines

The education and training includes an orientation to the organization's philosophy of least restrictive care, policies on the use of restraints, appropriate care of residents in restraint, and documentation of restraint use.



Safety

- 3.12 Education and training on safe techniques for moving and lifting residents are provided to the team.

Guidelines

The education and training focuses on ensuring safe practices when moving or lifting residents (e.g., the appropriate use of assistive devices such as lifts and transfer aids). The training includes how to ensure the appropriate preventative maintenance of lifts and other equipment has been performed, including documentation and inspections. All equipment and handling techniques that have the potential to cause injury or harm are included as topics in the training.



Appropriateness

- 3.13 Education and training are provided on information systems and other technology used in service delivery.

Guidelines

Education and training may cover topics such as knowledge of computer applications, word processing, software, time management tools, communication tools, research applications, cell phone use, and protecting the privacy of resident information.

Client-centred
Services

- 3.14 Education and training are provided on how to identify palliative and end-of-life care needs.

Guidelines

Training includes information on the organization's process to provide or facilitate access to palliative care and end-of-life services, communicating with families about end-of-life issues, and how and when to initiate discussions about palliative and end-of-life care.

Federal, provincial, and territorial legislation and regulations regarding consent and substitute decision making are followed.



Worklife



3.15

Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.

Guidelines

An established process to evaluate each team member's performance is followed. Resident and/or peer input is part of the evaluation process.

The evaluation may consider the team member's ability to carry out responsibilities, apply the principles of resident-centred care, and contribute to the values of the organization. It may also consider the individual's strengths; opportunities for growth; contributions toward patient safety, worklife, and respecting resident wishes; or specific competencies described in the position profile. The evaluation may identify issues that require follow up such as unprofessional or disruptive behaviour or challenges adopting resident-centred care practices.

A performance evaluation is usually done before the probationary period is completed and annually thereafter, or as defined by the organization. An evaluation may also be completed after retraining or when new technology, equipment, or skills are introduced.

Client-centred
Services

3.16

Resident and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.

Guidelines

Regular communication between team members/leaders and resident and family representatives ensures that the relationship is mutually beneficial. Discussions include opportunities for increased collaboration and role satisfaction.

Though an open and transparent dialogue is encouraged, team leaders recognize that resident and family representatives are to remain independent from the organization, to ensure their opinions and recommendations remain unbiased.



Worklife



3.17

Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.

Guidelines

Issues may be identified by the team member or the team leaders and are used to develop an action plan or professional development plan.



Worklife

3.18

Ongoing professional development, education, and training opportunities are available to each team member.

Guidelines

Team leaders encourage team members to participate in opportunities for professional or skills development on a regular basis. Additional training or education may be given based on the team member's performance evaluation or as identified through professional development plans.

4.0

Services are provided within a collaborative team environment.



Appropriateness



4.1

A collaborative approach is used to deliver services.

Guidelines

An interdisciplinary collaborative team needs to evolve and adapt to the changing needs of the resident. Depending on the needs and desires of the resident and family, the team may consist of specialized roles (e.g., care providers) and support roles (e.g., care planners, translators, security staff, or representatives from community partner organizations). Students, volunteers, and resident representatives or advisors may also be included as part of the team.

A team leader (or leaders) is defined and the role of each team member is made clear to the resident and family.

The collaborative team is established based on defined criteria such as accepted standards of practice; legal requirements; knowledge, experience, and other qualifications; volume or complexity of caseload; changes in workload; and resident safety and needs.



Appropriateness

- 4.2 The team works in collaboration with residents and families.

Guidelines

Residents and families are engaged in shared decision making and understand how care is provided. The resident defines the makeup of their family, and has the right to include or not include family members of their choice in their care, and the right to redefine the makeup of their family over time. Family includes an individual's extended family, their partners, friends, advocates, guardians, and other representatives.



Worklife

- 4.3 Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.

Guidelines

Position profiles include a position summary, qualifications and minimum requirements, the nature and scope of the work, and reporting relationships. They are developed for all team members including those who are not directly employed by the organization (e.g., contracted team members, partners, resident and family representatives).

Role clarity is essential in promoting resident and team safety as well as a positive work environment. Understanding roles and responsibilities and being able to work to one's full scope of practice helps create meaning and purpose for team members.



Safety



4.4

Standardized communication tools are used to share information about a resident's care within and between teams.

Guidelines

Standardized communication increases consistency, minimizes duplication, and improves teamwork while promoting patient safety. Tools may include protocols, technologies, or standardized processes such as SBAR (Situation Background Assessment Recommendation).

Team members are trained on organizational policies and practices regarding standardized communication tools.



Appropriateness

4.5

The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.

Guidelines

The process to evaluate team functioning and collaboration may include a review of its services, processes, and outcomes. This could be done by administering a team functioning questionnaire to team members, residents and families, and partners to stimulate discussion about areas for improvement.

The team evaluates its functioning when there has been a significant change to the structure of the team.

5.0 Well-being and worklife balance is promoted within the team.

- 5.1 The workload of each team member is assigned and reviewed in a way that ensures resident and team safety and well-being.

Guidelines

Appropriate criteria are used for determining workload depending on the environment and the unique demands of different services areas, including hours of work, caseload, role complexity, complexity of resident care, physical or emotional demands, repetitive nature of tasks, and level of responsibility. The preferences and availability of each team members are also considered.

In some cases teams may designate a maximum workload for team members. The process of assigning and reviewing workload includes monitoring and tracking hours and residents and when additional measures are needed (e.g., staffing transfers or team re-design).

An environment where team members are comfortable discussing demands and stress levels in the workplace is promoted by the organization and leaders. Measures are taken to alleviate these pressures as much as possible. These can include scheduling strategies, workload sharing, and scheduled time for documentation.

- 5.2 Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from residents and families where appropriate.



Worklife



Worklife

Guidelines

Job design refers to how a group of tasks, or an entire job, is organized. Job design addresses all factors that affect the work, including job rotation, work breaks, and working hours.

When developing and reviewing job design, roles, responsibilities, and assignments, team member and resident and family input and feedback is considered. They can all provide unique insight into areas of job design that directly impact them. The flexibility of job design, roles, responsibilities, and assignments will vary depending on the type of services being delivered, the residents being served, and the individual team members involved. Assignments include who each provider cares for, as well as other elements of the team members' roles (e.g., participation in quality improvement activities, training new staff members).



Worklife

5.3

Team members are recognized for their contributions.

Guidelines

Recognition activities may be individual, such as awards for years of service or special achievements, or they may involve team recognition or activities.

Recognition can be formal or informal and may be verbal, written, or focus on promoting an atmosphere where team members feel appreciated for their contributions.



Worklife

5.4

There is a policy that guides team members to bring forward complaints, concerns, and grievances.



Safety



5.5

Education and training on occupational health and safety regulations and organizational policies on workplace safety are provided to team members.



Safety



5.6

Education and training are provided on how to identify, reduce, and manage risks to resident and team safety.

Guidelines

Training may include physical hazards; challenges with equipment; handling spills, waste, or infectious materials; working with residents who may pose a risk to themselves or others; and challenges with handling, storing, or dispensing medications.

Common risks to the team may include lack of training on safety issues, performing improper lifts, improper use of equipment, or working alone.



Safety



5.7

Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.

Guidelines

Acts of violence include abuse, aggression, threats, and assaults. They may be committed by residents, their families, teams, or anyone else in the workplace.

Where possible, team members use de-escalation techniques as a preventive measure. De-escalation techniques are minimally intrusive and the least restrictive way to manage violence. Some training programs on how to safely work with residents who are at risk of or who exhibit aggressive or responsive behaviors include:

- CPI Training (Crisis Prevention and Intervention)
- GPA (Gentle Persuasive Approach)
- U-First!

Training and education include the use of a standardized risk assessment tool such as the Hamilton Anatomy of Risk Management (HARM) tool. Training may address:

- Identifying triggers
- Assessing and communicating a resident's potential for violence and recognizing signs of agitation and aggression
- Reducing harassment
- Responding to and managing violence (e.g., non-violent crisis intervention, emergency code response guidelines, conflict resolution and mediation, and self-defense)
- The trauma-informed approach
- Communication techniques

Training may also specify the team's alternate procedure for when de-escalation techniques are unsuccessful.



Safety



5.8

The organization's policy on reporting workplace violence is followed by team members.

Guidelines

Perceived, potential, or actual incidents of physical or verbal violence are reported to the appropriate authorities in accordance with applicable legislation, and may be reported in the resident medical record depending on the nature of the incident.

PROVIDING SAFE AND EFFECTIVE SERVICES

6.0 Access to services for current and potential residents, families, teams, and referring organizations is provided in a timely and coordinated manner.



Accessibility

6.1 Essential services can be accessed 24 hours a day, seven days a week.

Guidelines

Essential services are defined with input from residents and families, and are based on the types of services provided and the needs of the residents served. These services may include access to necessary medications, emergency pain interventions or emergency oxygen supplies, and other emergency services such as access to the on-call physician or pharmacist. Access may be in person, by telephone, or by e-mail, as appropriate.

Access to essential services is an indicator that can be tracked to measure overall access to services and responsiveness.



Accessibility

6.2 There is a process to respond to requests for services in a timely way.

Guidelines

Requests for service may come from residents, families, other teams, or referring organizations. There may be different processes to respond to a request based on who is requesting the services and what is being requested.

Requests for service, the process to respond to requests, and the definition of timely will vary by type of service being offered.

Responsiveness is monitored by setting and tracking times for responding to requests for services as well as through gathering feedback from residents and families, referring organizations, and other teams.



Appropriateness

- 6.3 Information about the resident is gathered as part of the intake process and as required.

Guidelines

This process may be called admission, intake, pre-admission, screening, start of service, or moving in. The information is validated and reviewed. It is used to determine if the organization's services fit with the resident's needs and preferences, identify the resident's immediate needs, and decide on service priorities.

The intake process is adjusted as needed for residents and families with diverse needs such as language, culture, level of education, lifestyle, and physical or mental disability.



Accessibility

- 6.4 Defined criteria are used to determine when to initiate services with residents.

Guidelines

The needs of potential residents are assessed in relation to the capacity of the team to meet those needs.



Accessibility

- 6.5 When the team is unable to meet the needs of a potential resident, access to other services is facilitated.

Guidelines

In the case where the organization is unable to meet the resident's needs, the rationale is explained and access to other services is facilitated. The information is documented for use in service planning.



Accessibility

- 6.6 Residents and families are made aware of the team member who is responsible for coordinating their service, and how to reach that person.

Guidelines

The assigned team member may be the collaborative team member with the most consistent contact with the resident, or the primary provider responsible for care.

Client-centred
Services

7.0 Residents and families are partners in service delivery.

- 7.1 There is an open, transparent, and respectful relationship with each resident.

Guidelines

The team supports a respectful and transparent relationship with residents by introducing themselves and explaining their role; asking permission before performing tasks; explaining what they are doing; using a respectful tone; expressing concern or reassurance; providing an opportunity for questions, input, and feedback; respecting cultural and religious beliefs or lifestyle; and respecting confidentiality and privacy.

Client-centred
Services

- 7.2 Residents and families are encouraged to be actively engaged in their care.

Guidelines

The environment encourages residents and families to be active participants in their care, ask questions, and provide input at all stages of the care process.

Client-centred
Services

- 7.3 The capacity of each resident to be involved in their care is determined in partnership with the resident and family.

Guidelines

Each resident will have differing levels of ability to be involved in their own care. At each stage, the appropriate team member works with the resident, family, or substitute decision maker to determine how much and what type of information the resident or family requires to be meaningfully involved in their care. This information is documented in the resident record.



Client-centred
Services

7.4

The resident's wishes regarding family involvement in their care are respected and followed.

Guidelines

The team finds ways to include members of the resident's support network in the resident's care.

Applicable legislation when a substitute decision maker or family is involved in decision-making is respected. There is a process to resolve conflicts regarding level of desired involvement between the resident and family.



Client-centred
Services

7.5

Complete and accurate information is shared with the resident and family in a timely way, in accordance with the resident's desire to be involved.

Guidelines

Sharing detailed and complete information is critical for informed choice and shared decision making between residents, families, and the team. Information is delivered according to individual needs and interests, as well as levels of understanding.

Residents and families are made aware of the risks and benefits of care; the resident's roles and responsibilities in service delivery; the benefits, limitations, and possible outcomes of proposed services or interventions; how to prepare for tests and treatments; the availability of counselling and support groups; and how to reach team members in an emergency or crisis.

Varying levels of information may be required at different points in the resident's care and are accommodated wherever possible. Similarly, different messages will require different delivery methods (e.g., serious topics require a more structured approach).



Client-centred
Services

7.6

The team verifies that the resident and family understand information provided about their care.

Guidelines

The level of understanding, literacy, language, disability, and culture are considered when providing information to residents and families.

Processes to verify residents' understanding include encouraging and allotting time for questions, having the resident repeat back information, ensuring a linguistic or cultural match wherever possible, using visuals or videos where possible, and creating an ongoing exchange where confirming understanding is a recurring event.

The Always Use Teach-back! Website (www.teachbacktraining.org/) provides useful tools to learn how to confirm resident understanding of information.



Client-centred
Services

7.7

Translation and interpretation services are available for residents and families as needed.

Guidelines

Written materials are available in the languages commonly spoken in the community, as required. Interpretation services are available when required by residents or families, wherever possible.



Client-centred
Services

7.8

The resident's capacity to provide informed consent is determined.

Guidelines

The process of evaluating a resident's capacity to consent is carried out on an ongoing basis. With respect to decision making for consent purposes, “capacity” means the ability to understand the information relevant to the decision, appreciate foreseeable consequences of a decision or failure to make a decision, and weigh the risks and benefits of that decision.

Federal, provincial, and territorial legislation are followed when working with children and youth. When dealing with the elderly, minors, or those deemed incapable of consenting, residents are involved to the greatest extent possible in making decisions about their services, and the team values their questions and input.



Client-centred
Services



7.9

The resident's informed consent is obtained and documented before providing services.

Guidelines

Informed consent consists of reviewing service information with the resident, family, or substitute decision maker; informing the resident about available options and providing time for reflection and questions before asking for consent; respecting the resident's rights, culture, and values including the right to refuse consent at any time; and recording the resident's decision in the resident record. The consent process is ongoing.

Implied consent occurs when providing services where written consent is not needed, such as when residents arrive for an appointment or class, have blood pressure taken, present their arm to have blood drawn, arrive for service through Emergency Medical Services (EMS), or present with life-threatening or emergent condition(s) and require immediate resuscitation.



Appropriateness



7.10

When residents are incapable of giving informed consent, consent is obtained from a substitute decision maker.

Guidelines

A substitute decision maker is consulted when residents are unable to make their own decisions, and an advance directive is used, where available, to ensure decisions are in line with the resident's wishes. In these cases, the substitute decision maker is provided with information about the roles and responsibilities involved in being a substitute decision maker, and given the opportunity to discuss questions, concerns, and options. Selecting the appropriate substitute decision maker is done in consideration of the applicable legislation and may be an advocate, family member, legal guardian, or caregiver.

If consent is given by a substitute decision maker, his or her name, relationship with the resident, and the decision made is documented in the resident record.

When working with children and youth, informed consent is received and documented from the child, youth, family or legal guardian before providing services. The consent process includes involving them as much as possible in the decisions about their service, intervention, or treatment, and valuing their questions and input.



Appropriateness

7.11

Residents and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.

Guidelines

There is an ethical review process to determine when to involve a resident in a research activity. Research activities may include clinical trials, assessments of new protocols, or changes to existing protocols. Residents and families are included in participatory research project design and implementation where appropriate, (e.g., gathering qualitative data for quality improvement initiatives).

Client-centred
Services

7.12

Ethics-related issues are proactively identified, managed, and addressed.

Guidelines

Ethics-related issues are ones in which values may be in conflict, making it hard to reach a decision. The issues may be very serious, life-and-death matters, or related to day-to-day activities. Examples include conflicts of interest; respecting a resident's choice to live at risk; triaging community members during an emergency; requests to withdraw or end services, including life-sustaining supports or treatments; and end-of-life care.

The organization's ethics framework is used to manage and address ethic-related issues. They may be addressed by an ethics committee or consultation team that may include health service professionals, clergy, or ethicists. In addition to clinical consultation, the ethics committee may be involved in policy review and ethics education.

Ethics-related issues involving particular residents are documented in the resident record.



Appropriateness



7.13

Residents and families are provided with information about their rights and responsibilities.

Guidelines

Resident and family rights include the right to have privacy and confidentiality protected; be aware of how resident information is used; have access to their record and information about them; be treated with respect and care; maintain cultural practices; pursue spiritual beliefs; live at risk; and be free from abuse, exploitation, and discrimination.

Resident and family rights regarding service delivery include the right to refuse service or refuse to have certain people involved in their service; participate in all aspects of their service and make personal choices; have a support person or advocate involved in their service; appeal a care plan decision or file a complaint; take part in or refuse to take part in research or clinical trials; receive safe, competent service; and raise concerns about the quality of service.

Resident and family responsibilities include treating others with respect, providing accurate information, reporting safety risks, and observing rules and regulations.

The information is provided at intake or admission and is adapted to meet diverse needs such as language, culture, level of education, lifestyles, and physical or mental disability. When the information cannot be provided to the resident and family on intake, it is provided at the earliest opportunity.



Safety

7.14

Information and education about recognizing and reporting abuse is provided to residents and families.

Guidelines

The information includes the signs and types of abuse and to whom they should report if they are being abused or witness others being abused.



Safety



7.15

The organization's strategy on preventing abuse is understood and followed by the team.

Guidelines

An abuse prevention strategy may include developing a policy and an abuse reporting protocol; educating team members, residents, families; and establishing tools to identify residents at risk for abuse.



Safety

7.16

Alleged and actual allegations of abuse are responded to and reported by the team in a timely way.

Guidelines

All incidents of abuse are responded to, whether they are between team members and residents, between residents, residents and family, residents and visitors, or others. Applicable legislation is followed when reporting incidents of abuse.

Client-centred
Services

7.17

Residents and families are provided with information about how to file a complaint or report violations of their rights.

Client-centred
Services

7.18

A process to investigate and respond to claims that residents' rights have been violated is developed and implemented with input from residents and families.

Guidelines

An environment where residents, families, and team members feel comfortable raising concerns or issues is promoted. The organization may provide access to a neutral, objective person from whom residents and families can seek advice or consultation. Where electronic health records are used, there is a process to receive and respond to resident complaints and questions regarding the privacy of the electronic record.

Claims brought forward by team members or other teams are also addressed.



Safety



7.19

The use of anti-psychotic medications is assessed for appropriateness and the information is used to make improvements.

Guidelines

The team determines whether it is appropriately using anti-psychotics (i.e., they are being used to treat indicated conditions or if they are being used to manage responsive behaviours, they are only used when other options have failed), and uses the information to improve services.

8.0

Care plans are developed in partnership with the resident and family based on a comprehensive assessment.



Appropriateness



8.1

Each resident's physical and psychosocial health is assessed and documented using a holistic approach, in partnership with the resident and family.

Guidelines

Elements of physical health include:

- Medical history
- Allergies
- Medication profile
- Health status
- Nutritional status
- Palliative care needs
- Dietary needs

Elements of psychosocial health include:

- Functional and emotional status family and caregiver involvement
- Communication and self-care abilities and strengths
- Mental health status, including personality and behavioural characteristics
- Cognitive status
- Socio-economic status
- Cultural and spiritual beliefs and needs.



Client-centred Services

8.2 The assessment process is designed with input from residents and families.

Guidelines

The assessment process is as streamlined and straightforward as possible, so that residents are not required to repeat information to multiple providers or team members. Where applicable, an interdisciplinary or collaborative assessment may be completed with the resident, family, and appropriate team members.



Client-centred Services

8.3 Goals and expected results of the resident's care and services are identified in partnership with the resident and family.

Guidelines

The resident's physical and psychosocial needs, choices, and preferences as identified in the resident assessment are used to develop service goals. Service goals and expected results suit the resident's individual circumstances, are achievable, measurable, and complement those developed by other team members and organizations with which the resident is involved.



Client-centred
Services

- 8.4 Standardized assessment tools are used during the assessment process.

Guidelines

Tools are standardized and adopted across the team, and where applicable, across the organization. Assessment tools are designed to assist the team to systematically collect and interpret all of the information gathered during the assessment process. Benefits of using standardized tools for the resident and the care provider include being more efficient, collecting more accurate information, consistency of assessment, and reliability of results and improved opportunity for communication between the resident and the care provider.

The standardized assessment tools used will vary depending on the needs of the resident and the type and range of services provided. Examples of standardized assessment tools are the Glasgow Coma Scale, the Clinical Frailty Scale, the Beck Depression Inventory, or the InterRAI tool. The standardized assessment tools used are evidence-informed and meaningful for the services provided.



Safety



- 8.5 **REQUIRED ORGANIZATIONAL PRACTICE:** Medication reconciliation is conducted in partnership with the resident, family, or caregiver to communicate accurate and complete information about medications across care transitions.

Guidelines

Poor communication about medications is common as residents transfer between long-term care and other service environments (e.g., acute care, rehabilitation services, another long-term care facility, or home care). Medication reconciliation is a structured process to communicate accurate and complete information about the resident's medications across transitions of care.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications the resident is taking including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements. The BPMH also details how they are being taken including the dose, frequency, route of administration, and strength, if applicable. Creating the BPMH involves interviewing the resident, family, or caregivers, and consulting at least one other source of information such as the resident's previous health record, or a community pharmacist. Once generated, the BPMH is an important reference tool for reconciling medications at care transitions.

Medication reconciliation at admission can be achieved using one of two models. In the proactive model, the BPMH is used to generate admission medication orders. In the retroactive model, the BPMH is generated after admission medication orders have been written; a timely comparison of the BPMH and admission medication orders is then made. Regardless of the model used, it is important to identify, resolve, and document medication discrepancies.

At care transitions, in addition to the medications the resident is currently receiving, it is important to also consider the medications that were taken prior to admission (as identified in the BPMH), which may be appropriate to continue, restart, discontinue, or modify. For example, medication reconciliation should happen at admission, re-admission back to long-term care from another service environment, or transfer out of long-term care.

Residents should be regarded as active partners in the management of their medications and provided with information about the medications they should be taking in a format and language they understand.

Test(s) for Compliance

- Major** 8.5.1 Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with the resident, family, health care providers, or caregivers (as appropriate).
- Major** 8.5.2 The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.
- Major** 8.5.3 Upon or prior to re-admission from another service environment (e.g., acute care), the discharge medication orders are compared with the current medication list and any medication discrepancies are identified, resolved, and documented.
- Major** 8.5.4 Upon transfer out of long-term care, the resident and next care provider (e.g., another long-term care facility or community-based health care provider) are provided with a complete list of medications the resident is taking.



Safety



- 8.6** **REQUIRED ORGANIZATIONAL PRACTICE:** To prevent falls and reduce the risk of injuries from falling, a risk assessment is conducted for each resident and interventions are implemented.

Guidelines

Reducing falls and injuries from falls can increase quality of life, prevent loss of mobility and pain for residents, and reduce costs.

Effective fall prevention and injury reduction requires an interdisciplinary approach and support from all levels of an organization. It is helpful to implement a coordinated approach to fall prevention and injury reduction within the organization, while recognizing the unique needs of different settings or sites, and to designate individuals to facilitate its implementation.

A wide range of risk assessment tools are available to identify specific risk profiles of residents in order to create individualized targeted fall prevention plans. Examples of risk assessment tools appropriate for long-term care include:

- Area Ellipse of Postural Sway
- Berg Balance Test
- Mobility Fall Chart

Common serious injuries that occur as a result of a fall in the elderly are hip fractures (Fuller, 2000). Recommendations for preventing fracture in long-term care can include vitamin D supplementation, use of hip protectors, exercise, multifactorial interventions, and pharmacologic therapies (Papaioannou et al., 2015).

It is important to identify and adopt assessment tools and interventions that align with the type of clinical setting and individual needs of residents, including their right to live at risk. Education about the risk assessment, protocol, and procedures to prevent falls and reduce injuries from falling is provided regularly to team members and volunteers. Residents, families, and caregivers are provided with easy to understand information that empowers them to play an active role in fall prevention and injury reduction.

It is important to regularly evaluate whether or not current activities to prevent falls and reduce injuries from falling are having the desired impact and are meeting resident, family, and team member needs. Effectiveness can be evaluated through a variety of means, whether informal discussions, interviews, surveys, or audits. Measurement for improvement initiatives and post-fall debriefings may also help identify safety gaps and to prevent the recurrence of falls or reduce injuries from falling.

Test(s) for Compliance

- Major** 8.6.1 An initial fall prevention and injury reduction risk assessment is conducted for residents upon admission, using a standardized tool.
- Major** 8.6.2 A standardized process is followed to reassess residents at regular intervals and when there is a significant change in their health status.
- Major** 8.6.3 Protocols and procedures (based on best practice guidelines when available and applicable to the setting) are implemented to prevent falls and reduce injuries from falling.
- Major** 8.6.4 Interventions to prevent falls and reduce injuries from falling are documented in the resident record and communicated to the team.
- Major** 8.6.5 Team members and volunteers are educated, and residents, families, and caregivers are provided with information to prevent falls and reduce injuries from falling.
- Minor** 8.6.6 The effectiveness of fall prevention and injury reduction activities (e.g., risk assessment process and tools, protocols and procedures, documentation, education, and information) are evaluated, and results are used to make improvements when needed.



Safety



- 8.7** Universal fall precautions, applicable to the setting, are identified and implemented to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.

Guidelines

Organizations should identify and adopt precautions for all clients, regardless of risk of falling. The acronym S.A.F.E. (Safe environment; Assist with mobility; Fall-risk reduction; and Engage client and family) describes the key strategies for universal fall precautions. The following are examples of universal fall precautions: familiarize clients to new environments; if you have call buttons (e.g., in washrooms) ensure they are within reach; have sturdy handrails in bathrooms, rooms, and hallways; use appropriate lighting; provide chairs that are appropriate for clients with mobility issues; have mobility aids on hand as appropriate to your client population; keep floor surfaces clean and dry; clean up all spills promptly; keep hallways and care areas uncluttered. It is important to identify precautions that align with the clinical setting and needs of clients in that setting, including their right to live at risk.



Safety



8.8

REQUIRED ORGANIZATIONAL PRACTICE: Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented.

Guidelines

Pressure ulcers have a significant impact on client quality of life, resulting in pain, slower recovery, and increased risk of infection. Pressure ulcers are also associated with increased length of stay, cost, and mortality. Effective pressure ulcer prevention strategies can reduce the incidence of pressure ulcers and are an indication of higher quality care and services.

Pressure ulcer prevention strategies require an inter-disciplinary approach and support from all levels of an organization. It is useful to develop a plan to support comprehensive education on pressure ulcer prevention, and to designate individuals to facilitate the implementation of a standardized approach to risk assessments, the uptake of best practice guidelines, and the coordination of health care teams.

Effective pressure ulcer prevention starts with a validated risk assessment scale, such as:

- The Braden Scale for Predicting Pressure Sore Risk
- The Norton Pressure Sore Risk Assessment Scale
- interRAI Pressure Ulcer Risk Scale (long-term care)
- The Waterlow Score
- The Gosnell Scale
- The Knoll Scale
- SCIPUS (Spinal Cord Injury Pressure Ulcer Scale)

A number of best practice guidelines are also available to inform the development of pressure ulcer prevention and treatment strategies, including risk assessments, reassessments, interventions, education, and evaluation. In Canada, comprehensive guidelines have been developed by the Registered Nurses Association of Ontario. International guidelines have been developed in collaboration between the European Pressure Ulcer Advisory Panel and the American National Pressure Ulcer Advisory Panel.

Test(s) for Compliance

Major	8.8.1	An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.
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Major	8.8.2	The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status.
Major	8.8.3	Documented protocols and procedures based on best practice guidelines are implemented to prevent the development of pressure ulcers. These may include interventions to prevent skin breakdown; minimize pressure, shear, and friction; reposition; manage moisture; optimize nutrition and hydration; and enhance mobility and activity.
Minor	8.8.4	Team members, clients, families, and caregivers are provided with education about the risk factors and protocols and procedures to prevent pressure ulcers.
Minor	8.8.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.



Safety



8.9 **REQUIRED ORGANIZATIONAL PRACTICE:** Clients are assessed and monitored for risk of suicide.

Guidelines

Every year close to 3,700 people in Canada die by suicide. Many of these deaths could be prevented by early recognition of the signs of suicidal thinking and offering appropriate intervention.

Test(s) for Compliance

Major	8.9.1	Clients at risk of suicide are identified.
Major	8.9.2	The risk of suicide for each client is assessed at regular intervals or as needs change.

- Major** 8.9.3 The immediate safety needs of clients identified as being at risk of suicide are addressed.
- Major** 8.9.4 Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.
- Major** 8.9.5 Implementation of the treatment and monitoring strategies is documented in the client record.



Appropriateness

8.10 Each resident's preferences and options for services are discussed as part of the assessment, in partnership with the resident and family.

Guidelines

The resident's expressed needs, preferences and the options for care and service are discussed with the resident and family. The team and resident engage in shared-decision making that considers resident preferences, expected outcomes, and risks and benefits of the options.

For example, various strategies to manage pain—such as analgesics including opioids and adjuvants, as well as physical, behavioural, and psychological interventions—may be discussed and the resident is able to select the preferred option.

Other preferences that are discussed include options for self-care, privacy, visitors, treatments and testing, and personal care, such as sleeping, bathing, and eating.



Client-centred Services

8.11 Each resident's wishes and preferences concerning advance care planning/directives are reviewed in partnership with the resident and family during the assessment process and on an ongoing basis.

Guidelines

Residents and families receive information, verbally and in writing, of their right to establish an advance care plan/directives and how to do so. Residents have sufficient opportunity to discuss the advance care plan/directives with the team, including when their health status changes, when their wishes change, or at the discretion of the resident.

As part of the discussion, the risks and benefits associated with the resident's wishes are explained. The discussion may include topics such as cardiopulmonary arrest, ventilation, and other potentially life-sustaining treatments.



Appropriateness

8.12

Each resident's advance care plan/directives, including those that address the use of potentially life-sustaining treatment, is documented in the resident's file.

Guidelines

Residents may have an advance care plan/directives to guide certain or all decisions. Advance care plans/directives are shared with providers within and outside the organization, as appropriate.

Examples of potentially life-sustaining treatments include oxygen, hydration, assisted ventilation, and parenteral nutrition.



Appropriateness

8.13

Each resident's oral health status and needs are regularly assessed in partnership with the resident and family.

Guidelines

The assessment includes overall oral health status, determining the resident's ability to perform regular cleaning, whether dentures are used and their cleaning requirements, and individual care requirements, including access to a dentist.

The frequency of assessment is based on each resident's unique oral health needs.



Client-centred
Services



8.14

Each resident's mental health status, including risk of harm and care requirements, is assessed in partnership with the resident and family.

Guidelines

Depression is highly prevalent in long-term care residents and can significantly impact quality of life. Examples of tools to assess mental health include RAI-MDS, the Beck Depression Inventory, and the Cohen-Mansfield Agitation Inventory.

Harm may be self-harm (including suicide) and the risk of harming others. Warning signs of potential self-harm include withdrawal from family or friends; change in sleep patterns (e.g., sleeping a lot or not sleeping at all); increase in reckless behavior; anxiety or agitation; dramatic changes in mood; or talking or writing about death, dying, or suicide.



Client-centred
Services

8.15

An assessment of the resident's palliative and end-of-life care needs is completed, where appropriate, in partnership with the resident and family.

Guidelines

The need for a palliative care assessment may be expressed by the resident or family or identified by the team. The types of services that may be required are identified. Early identification of palliative care needs allows residents and families to be involved in care planning and can improve the quality of care and family satisfaction throughout the process.

In an organization or service area that does not provide palliative and end-of-life care, the assessment identifies the need to connect the resident and family to the appropriate services.



Continuity

8.16

Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.



Continuity

8.17 The results of the assessment are shared with the resident and other team members in a timely and easy-to-understand way.

Guidelines

Sharing assessment results as applicable improves clarity and prevents duplication. In order to provide information that is easy to understand, information is tailored to the resident's literacy level, language, and culture.



Continuity



8.18 A comprehensive and individualized care plan is developed and documented in partnership with the resident and family.

Guidelines

The care plan is based on the results of the assessment and the resident's service goals and expected results. It includes the roles and responsibilities of the team, other organizations, and residents and their families. It includes detailed information about the resident's history, assessments, diagnostic results, allergies, and medication, including any medication issues or adverse drug reactions.

The plan addresses where and how frequently services will be delivered; timelines for starting services, reaching the service goals and expected results, and completing services; how achievement of the service goals and expected results will be monitored; and plans for transition or follow-up once service ends, if applicable.



Client-centred
Services

8.19 Where appropriate, an individualized palliative and end-of-life plan is developed for each resident in partnership with the resident and family.

Guidelines

Palliative care includes end-of-life care, however palliative care begins earlier, when the death is expected but not yet imminent. End-of-life care is for residents where death is imminent.

A palliative and end-of-life care plan is individualized for each resident and includes strategies for enhanced pain management and symptom relief, emotional and spiritual support for the resident, family support and education, spiritual care, specialized dietary support, social work, life enrichment, recreation, and restorative care, as appropriate to the resident's needs. The care plan is reassessed as the resident's needs change.

Early identification of palliative care needs allows residents and families to be involved in care planning and can improve the quality of care and family satisfaction throughout the process.

A framework for developing palliative care programs in long-term care has been developed by the Quality Palliative Care in Long Term Care Alliance. The website (<http://www.palliativealliance.ca/>) offers several tools and resources, including a self-assessment tool, and the Palliative Performance Scale to monitor the condition of the resident.



Client-centred
Services

8.20

Planning for care transitions, including end of service, are identified in the care plan in partnership with the resident and family.

Guidelines

Including information in the care plan about transition planning, whether to home, another team, an alternate level of care, or end of service, enhances coordination among teams or partner organizations and helps prepare residents for the end of service. Resident involvement in end-of-service planning ensures the resident and family are prepared and know what to expect.

Discussions about the resident's transition and post-care needs and preferences are part of developing the care plan. The discussion may include post-care follow up, ability to perform self-care, referrals to community supports, or other anticipated needs or challenges.



Appropriateness

9.0 Care plans are implemented in partnership with residents and families.

9.1 The resident's individualized care plan is followed when services are provided.



Safety



9.2 **REQUIRED ORGANIZATIONAL PRACTICE:** Working in partnership with residents and families, at least two person-specific identifiers are used to confirm that residents receive the service or procedure intended for them.

Guidelines

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

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

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

Test(s) for Compliance

Major 9.2.1 At least two person-specific identifiers are used to confirm that residents receive the service or procedure intended for them, in partnership with residents and families.



Appropriateness

9.3 All services received by the resident, including changes and adjustments to the care plan, are documented in the resident record.

Guidelines

The resident record is accessible to the team involved in care, including the resident, and is contained in a single resident record.



Appropriateness



9.4 Treatment protocols are consistently followed to provide the same standard of care in all settings to all residents.



Appropriateness



9.5 The resident's health status is reassessed in partnership with the resident, and updates are documented in the resident record, particularly when there is a change in health status.

Guidelines

Delays or failures to report a change in health status, in particular deterioration in a resident's condition, are significant barriers to safe and effective care and services. Changes in the resident's health status are documented accurately, in a timely manner, and communicated to all team members.



Safety



9.6 There is a least-restraints policy that is followed by the team.

Guidelines

The use of restraints by the team is minimized, and care is provided in a safe, competent and ethical manner, which respects resident's rights, dignity, autonomy and right to safety.

Restraints are used only as a last resort to reduce imminent harm to the resident or others when all alternative methods have failed. Restrictive methods are not used to teach behaviour, punish, or for convenience. Alternatives to the use of restraints are sought in order to improve the quality and safety of services.

The policy includes team orientation, education and training on the philosophy of least restraints and use of restraints, the cases where restraints may be used, and the appropriate follow-up requirements.



Safety



9.7

A procedure is followed to appropriately implement restraints, monitor a resident in restraint, and document the use in the resident's record.

Guidelines

Considerations to be taken when restraints must be used include how the resident will be monitored, and the specific types of care required if a resident must be restrained. The team follows All applicable legislation and evidence-informed practices are followed when restraints are used.

Documentation regarding the use of restraints includes when, where, why, and for how long restraints were required, as well as all the alternative measures that were attempted and that failed prior to using restraints.



Safety



9.8

A process to monitor the use of restraints is established by the team, and this information is used to make improvements.

Guidelines

Each use of restraints, as well as the general use of restraints at a program level, is assessed with the aim of moving toward the goal of using restraint only as a last resort, and to ultimately reduce reliance on restraints.



Appropriateness

- 9.9 Oral care or cues for residents to perform their own oral care are provided on a daily basis, at minimum.

Guidelines

Oral care is performed ideally twice a day or after eating. All applicable legislation related to oral care is followed.



Appropriateness

- 9.10 Residents' access to dental services is facilitated by the team.

Guidelines

Access to a dentist or other oral health services is facilitated where possible, based on residents' requests or at the recommendation of the team. Opportunities to access dental services are offered to and coordinated for residents. Contract with dentists or other dental service providers may or may not exist.



Appropriateness

- 9.11 Changes in a resident's condition are monitored and managed in partnership with the resident and family.

Guidelines

Changes to a resident's physical condition (e.g., hydration) are closely monitored in order to respond quickly to changes, meet changing care needs, and minimize hospitalizations.

The Palliative Performance Scale and the Clinical Frailty Scale are useful clinical tools to monitor a resident's health status.



Safety



9.12

There are regular, standardized interdisciplinary reviews of each resident's medications and adjustments are made as necessary.

Guidelines

Members of the team, including residents, families, nurses, pharmacy staff, physicians, and the resident participate in a discussion regarding the resident's medications, outcomes, satisfaction, and side effects. The review process is documented where possible, including the reasons for adding or discontinuing new medications.

Tools to assess the appropriateness of medication use, including the American Geriatric Society's Beers Criteria of potentially inappropriate medication use in the elderly are used by the team.



Appropriateness

9.13

Resident progress toward achieving goals and expected results is monitored in partnership with the resident, and the information is used to adjust the care plan as necessary.

Guidelines

Documenting progress toward goals is done using both qualitative and quantitative methods and includes the resident and family. It may include the use of standardized assessment tools, discussion with residents and families, and observation.

Client-centred
Services

9.14

Access to spiritual space and care is provided to meet residents' needs.

Guidelines

Spiritual care is available to meet the needs of residents, as required. It includes access to a spiritual leader appropriate to the resident's beliefs (e.g., a chaplain, imam, rabbi, or non-denominational counsellor). Residents and families have access to a designated space to observe spiritual practice.

The resident's spiritual needs and preferences are seen as integral to the care and healing process, and are discussed when making care decisions that may involve an ethical or spiritual component.



Client-centred
Services

- 9.15 Residents and families have access to psychosocial and/or supportive care services, as required.

Guidelines

Emotional support and counselling can help residents and families cope with the health needs and health-related issues. Supports may address coping with a diagnosis, help with decision making, dealing with side effects, or ethics-related issues such as advance directives.



Client-centred
Services

- 9.16 There is a process for initiating palliative and end-of-life care, as required.

Guidelines

Services are initiated by the team, resident, or family, and take into consideration the assessment results. Involvement in palliative and end-of-life care will differ depending on the services provided by the team and the residents served. Where palliative and end-of-life care is not provided by the team, residents are connected with the appropriate services.



Client-centred
Services

- 9.17 Support for the family, team members, and other residents is provided throughout and following the death of a resident.

Guidelines

Relevant information is shared with residents and families about the dying process, such as the signs and symptoms of imminent death; coping strategies; how to provide support and comfort during the final hours; and grief and bereavement services.

The resident's family and friends are encouraged to use community support systems. When these are insufficient, or when family and friends are identified as being at risk for complex grief reactions, access is facilitated to bereavement services for residents, families, team members, and volunteers, including volunteer support or professional services.



Appropriateness

- 9.18 Strategies are used to reduce avoidable admissions/readmissions to the hospital.

Guidelines

Hospitalizations put residents at risk for complications such as delirium, falls, hospital-acquired infections, and pressure ulcers. Reducing avoidable admissions/readmissions to hospital can reduce these risks, as well as help ensure that the right care is provided in the right place.

Avoidable admissions can be reduced by:

- Monitoring residents' conditions and preventing them from becoming severe enough to require hospitalization
- Managing residents' conditions within the long-term care organization when feasible and safe
- Improving communication with the resident/family and the advance care planning process.

The INTERACT (<http://interact2.net>) program provides tools, resources, and strategies to reduce avoidable hospital admission.



Safety



9.19

REQUIRED ORGANIZATIONAL PRACTICE: Information relevant to the care of the resident is communicated effectively during care transitions.

Guidelines

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

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

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

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

Test(s) for Compliance

- | | | |
|--------------|--------|---|
| Major | 9.19.1 | The information that is required to be shared at care transitions is defined and standardized for care transitions where residents experience a change in team membership or location: admission, handover , transfer, and discharge. |
| Major | 9.19.2 | Documentation tools and communication strategies are used to standardize information transfer at care transitions. |

- Major** 9.19.3 During care transitions, residents and families are given information that they need to make decisions and support their own care.
- Major** 9.19.4 Information shared at care transitions is documented.
- Minor** 9.19.5 The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:
 - Using an audit tool (direct observation or review of resident records) to measure compliance with standardized processes and the quality of information transfer
 - Asking residents, families, and service providers if they received the information they needed
 - Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).

10.0 The needs of the whole person, including but not limited to their spiritual, cultural, social, and recreational needs are addressed by the team in partnership with the resident and family.

10.1 Residents and families are provided with an environment that is flexible and meets their needs.

Guidelines

Ways to support a flexible, home-like environment include encouraging residents to decorate with personal belongings; giving residents privacy when in their rooms or when visiting with family; offering residents choices about their daily routine regarding bathing, dressing, eating, and sleeping; and inviting family to join residents for meals, where appropriate.

10.2 Residents and families are provided with opportunities to engage in activities that are meaningful and important to the them.



Client-centred Services



Client-centred Services

Guidelines

Opportunities are provided in a way that respects residents' privacy, dignity, and diversity in language, cuisine, and cultural or religious practices, and foster the resident's strengths and capabilities.

Meaningful activities may include daily routines such as cleaning, community activities, contact with pets, cooking, exercise/mobility, gardening, hobbies, intimacy, recreation, or social or spiritual care. The team encourages friend and family visits and the development of peer and other relationships, celebrates ethnic and religious holidays, facilitates visits out when possible, and ensures access to a telephone or other method of communication that can be used privately and at any time.

The Alzheimer Society of Canada's Guidelines for Care: Person-Centred Care of People with Dementia Living in Care Homes may assist teams to adopt resident-centred principles and activities.



Client-centred
Services

10.3

A pleasant dining experience is facilitated for each resident.

Guidelines

The social and cultural aspects of the dining experience are important elements of the resident's quality of life that is considered regardless of where services are provided. Considerations include discussions about resident's personal and cultural food preferences; making available a variety of food and beverage choices and responding to resident requests wherever possible; offering supports for differing capacities to eat; providing modified diets as necessary; and encouraging residents to eat with friends and family to share the social and cultural aspects of eating. Residents are aided in making informed choices about dining that may impact quality of life (e.g., when residents choose to dine in the manner they wish, despite the risks involved).



Client-centred
Services

10.4

Feedback regarding individual food preferences and nutrition requirements is gathered from the resident and family, as needed.

Guidelines

The feedback gathered may include information about the resident's culture, religious practice, preferences, allergies, therapeutic diet requirements, acute interactions with resident's medications, preferred eating times and other habits.

Feedback may be obtained from residents upon moving in or returning from transfers, with health status changes, or at defined intervals.



Client-centred
Services

10.5 Residents are involved in menu planning.

Guidelines

Residents are included in the planning and selection of the menu cycle to take into account their preferences about food and the dining experience, and to try to prevent loss of appetite due to lack of choice.

The opportunity to be involved in menu planning may be in the form of a food council, where interested residents can participate in the process in a structured way.



Appropriateness

11.0 Point-of-care testing (POCT) is provided in a safe and effective manner.

11.1 Policies and procedures for POCT are developed with input from residents and families.

Guidelines

The policies and procedures include:

- Health professionals' roles and responsibilities in maintaining equipment and assuring overall quality
- Guidelines for completing the quality control check, including visual inspection and more advanced types of quality control checks, and the frequency with which they are performed
- The expectations of contracted services
- Test specific policies, including the purpose and limitations of the test; step-by-step instructions; how to properly complete the test and use the corresponding instruments; reference ranges for the results, including critical values; criteria for accepting and rejecting samples
- How to maintain sample integrity
- How to verify equipment is in proper working order.



Appropriateness

11.2

Responsibility for overseeing the delivery of POCT and maintaining quality is assigned to a health care professional.

Guidelines

The supervision of POCT is assumed by a health care professional with the appropriate qualifications to verify and maintain the day-to-day quality of POCT. This health care professional may be a physician, medical technologist, registered nurse, licensed practical nurse, or pharmacist, provided they are licensed members in good standing with their professional college and have received appropriate training.

The individual that manages the day-to-day operations of POCT is responsible for implementing the POCT policies and procedures of the organization; managing health professionals delivering POCT; managing quality control; managing reagents; and seeking external or contracted services, where required.



Appropriateness

11.3

Orientation and training on POCT policies and procedures is provided to all health care professionals delivering POCT.

Guidelines

The training covers all of the POCT policies and procedures, including details of the tests the health care professionals would be required to perform (which may be conducted at the time required), knowing when to replace equipment, and how to follow the appropriate quality control measures. Training is offered when the organization introduces a new test or different equipment for a familiar test.

The health care professionals receiving training may include physicians, pharmacists, registered nurses, licensed practice nurses, medical technologists, emergency medical technicians, or inhalation therapists.



Safety



11.4

The date and time of the point-of-care test, the individual carrying out the test, the results of the test, and the action required when the results are outside the normal range are recorded in the resident's record by the health care professional who conducts the POCT.

12.0

Residents and families are partners in planning and preparing for transition to another service or setting.



Client-centred
Services



12.1

Residents and families are actively engaged in planning and preparing for transitions in care.

Guidelines

Residents and families are involved in all transition planning. The team, resident and family discuss the resident's care plan, goals, and preferences; the care provided; outstanding issues, clinical or otherwise; what to expect during transition; follow-up appointments; exercise and nutrition plans, where applicable; contact information for the team members and details on when they should be contacted.

Continuity of care is improved when residents participate in transition planning and preparation and have comprehensive information about transitions and end of service.

Examples of key transition moments include rounds, shift changes, handoffs, moving in or out of an organization, to another community provider or at end of service.

Talking with the resident and family about transitions helps them understand the process and provides an opportunity to ask any questions. It also helps ensure all information is accurate and complete, and that the resident's wishes are respected.



Client-centred
Services

12.2

The resident's physical and psychosocial readiness for transition, including their capacity to self-manage their health, is assessed.

Guidelines

This assessment happens as early as possible within the care process. Instances where self-management would benefit the resident are determined. Capacity to self-manage is influenced by factors such as access to a support network, community care options, cognitive and physical ability, and literacy level.



Client-centred
Services

12.3

Residents are empowered to self-manage conditions by receiving education, tools, and resources, where applicable.

Guidelines

Education that promotes empowerment and helps residents self-manage chronic conditions may include action planning; modeling behaviors and problem solving strategies; reinterpreting symptoms; and social persuasion through group support and guidance for individual efforts. Self-management training topics should include exercise; nutrition; symptom management techniques; risk factor management; fatigue and sleep management; use of medications; managing emotions; cognitive and memory changes; training in communication with health professionals and other individuals; and health-related problem solving and decision making.

Tools and resources made available to help residents to self-manage and are tailored to each resident's needs. For example, tools and resources can be modified based on level of understanding, literacy, language, disability, and culture.



Continuity

12.4

Appropriate follow-up services for the resident, where applicable, are coordinated in collaboration with the resident, family, other teams, and organizations.

Guidelines

Responsibility for the resident's care continues until service has ended or the resident has been transferred to another team, service, or organization.

Follow-up services may include primary care, home and community services, community-based rehabilitation, psychological counselling services, and recommendations for ongoing care. Working together to establish proper placement for the resident helps ensure the resident receives the most appropriate services in the most appropriate setting, and minimizes temporary solutions or unnecessary transfers.

To ensure residents receive seamless and continuous care, placement and follow up includes a process for when transitions do not go as planned.



Continuity

12.5

The transition plan is documented in the resident record.



Client-centred
Services

- 12.6 A resident's wish to end or limit services, transfer to another service, or transition home, is respected.

Guidelines

Shared decision making regarding a resident's transition takes place in consultation with the family or substitute decision maker, when required, and takes the resident's decision-making capacity into consideration. The risks of the transition are discussed with the resident and family, as well as other community-based services that are available to them after the transition.

An ethical or values-based decision making framework is used when working with residents who have chosen options against the team's recommendation. In the event the resident wishes to continue service against the team's recommendation or beyond the capacity of the organization, an ethical or value-based decision making framework is used to ensure a fair and equitable outcome for the resident and the organization.



Appropriateness

- 12.7 The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from residents and families.

Guidelines

At regular intervals, a sample of residents, families, or referral organizations is contacted to determine the effectiveness of the transition or end of service, monitor resident perspectives and concerns after the transition, and monitor follow-up plans. Evaluating transitions is an opportunity to verify that resident and family needs were met and concerns or questions addressed.

Resident feedback and the overall results of the evaluation are shared with the organization's leaders and the governing body and the information is used to improve transitions.

MAINTAINING ACCESSIBLE AND EFFICIENT INFORMATION SYSTEMS



Appropriateness



13.0 Resident records are kept accurate, up-to-date, and secure.

13.1 An accurate, up-to-date, and complete record is maintained for each resident, in partnership with the resident and family.

Guidelines

Resident records are accessible and up-to-date. Information is easy to find and identify, and is organized for ease of use. The record includes the dates of service, is signed by the appropriate authority, and is legible.

Only recognized abbreviations are used in the record, and critical resident information is prominently displayed.

The resident record is updated whenever there is a change in health status, the care plan, the resident's medications, or when the resident is transitioned to another level of care or service.

Organizational and professional standards are followed when determining what information is needed for the resident record to be considered complete. These include significant changes in condition, diagnostic results, alert notations, progress notes, significant events or patient safety incidents, and others.

Residents and families are involved in providing and documenting information, and ensuring the information captured is accurate and complete. The team may partner with the resident and family in various ways depending on the service setting and individual circumstances. For example, in community settings or primary care, documentation can often be completed in the room, with the resident and family. This is not always possible in all care settings, particularly if the resident record is maintained in a central location, concurrent documentation detracts from the care or service being delivered, or urgent care is being delivered.

When documenting in the resident record with the resident and family is not possible, the team works to include the resident and family in the process as much as possible (e.g., taking notes with them, confirming information) to ensure that what is documented is accurate and reflects the nature of the service provided, intervention, or conversation.



Appropriateness

13.2

A standardized set of health information is collected to ensure resident records are consistent and comparable.

Guidelines

Collecting standardized information applies whether the resident records are paper-based or electronic.

The nature of the health information collected will vary depending on the type of organization and the services provided. Standards for data collection may be set out in provincial/territorial or national guidelines. Standardized data elements can be found through the Canadian Institute for Health Information, as well as provincial platforms for electronic records (e.g., e-Health Ontario). Where information is not available, the organization works with partner organizations and/or the health region to determine what information to collect for each resident.



Appropriateness



13.3

Policies and procedures to securely collect, document, access, and use resident information are followed.

Guidelines

Policies outlining authorized access to resident information are available to the team, including how, when, and what information they may access. Only team members who are actively involved in a resident's care have access to the resident record.

The team is aware of and knows how to comply with applicable legislation to protect the privacy and confidentiality of resident information. Applicable legislation may be provincial, territorial, or federal.

Client-centred
Services

13.4

Residents are able to access information in their records, including electronic medical/health records, in a routine, resident-centred, and timely way.

Guidelines

Resident access to their records is facilitated in a proactive way, according to the organization's policy and applicable legislation. The processes to access records are resident-centred and support residents to access their information. Residents have opportunities to discuss the information, ask questions, provide feedback.



Client-centred
Services

- 13.5 Information is documented in the resident's record in partnership with the resident and family.

Guidelines

Residents are the owners of their health information. They are included in the process of documenting information in their record and can provide input on the information being documented. Residents are given the right to read and comment on information that is recorded. The charting or documentation process may be conducted in partnership with the resident as part of their care, or access to their records may be provided electronically.



Appropriateness



- 13.6 Policies and procedures for securely storing, retaining, and destroying resident records are followed.

Guidelines

Relevant legislation, including the federal Privacy Act and the federal Personal Information Protection and Electronic Documents Act, are followed, where applicable. Each province and territory refers to their respective privacy laws, and laws governing health information protection, where relevant.



Continuity

- 13.7 The flow of resident information is coordinated among team members and other organizations, in partnership with the resident and in accordance with legislation.

Guidelines

While respecting the resident's right to privacy and with the resident's consent, information is shared as required to facilitate a resident-centred approach to service delivery. Effective information sharing helps the team better meet the needs of residents and reduces duplication in obtaining resident information. The team obtains resident consent to share information.

Residents are involved in sharing information (e.g., maintaining and sharing a current list of medications, or providing a discharge summary to appropriate providers).



13.8

There is a process to monitor and evaluate record-keeping practices, designed with input from residents and families, and the information is used to make improvements.

Guidelines

Record-keeping may be paper-based and/or electronic. The monitoring and evaluation process meets any applicable legislation or requirements. The process examines privacy breaches, as well as accuracy and effectiveness of practices.

Evaluation may be done for a sample of records on an irregular or regular basis. Where record-keeping is electronic, evaluation can be triggered based on certain events, such as unusual activity, attempt to retrieve certain data, or unmasking of data.

All electronic activities are linked to a unique user identifier, date and time stamped, and an activity log is maintained to ensure practices can be appropriately monitored.

14.0

Health information is managed to support the effective delivery of services.



14.1

Training and education about legislation to protect resident privacy and appropriately use resident information are provided.

Guidelines

Training is provided to all team members and may be formal or informal. Further training or education is provided when there are changes to legislation or after an extended period of time.



Appropriateness

14.2

Policies on the use of electronic communications and technologies are developed and followed, with input from residents and families.

Guidelines

Policies regarding the use of electronic mail, texting, web applications and social media are determined using the perspectives of residents and families. This may include inter-team communication, communication with residents, or communication with partners and potential residents.

When determining what electronic communications and technologies to use, considerations are made for how to manage issues of privacy, professionalism, security of information, resident communication preferences, and legislation. Technologies may be used to assist in service provision or care, (e.g., demonstrating procedures on a tablet).



Appropriateness

14.3

Policies and procedures for disclosing health information for secondary use are developed and followed.

Guidelines

Secondary use refers to using health information for a purpose other than direct service provision, such as clinical program management, health system management, public health surveillance, and research.

Policies and procedures cover the appropriate circumstances in which to disclose the data and how to ensure resident privacy is maintained (e.g., by de-identifying or aggregating data prior to disclosure). Where identifiable or re-identifiable data is requested, the team follows an ethics approval process and assesses risk prior to disclosure.

MONITORING QUALITY AND ACHIEVING POSITIVE OUTCOMES

15.0 **Current research, evidence-informed guidelines, and best practice information is used to improve the quality of services.**



Appropriateness



15.1 There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.

Guidelines

Guidelines may be selected by a committee, council, or individual who makes recommendations to the team on which guidelines to use and how they can be integrated into service delivery.

Guidelines from other organizations or associations can be adopted by the team. The process for selecting guidelines is standardized and formalized. It may include using content experts; a consensus panel; Grades of Recommendation Assessment, Development and Evaluation (GRADE); or the Appraisal of Guidelines Research and Evaluation (AGREE) II instrument, which allows organizations to evaluate the methodological development of clinical practice guidelines from six perspectives: scope and purpose, stakeholder involvement, rigour of development, clarity and presentation, applicability, and editorial independence.



Client-centred
Services

15.2 The procedure to select evidence-informed guidelines is reviewed, with input from residents and families, teams, and partners.

Guidelines

A collaborative approach is used to select guidelines that are appropriately linked to improved resident experience and outcomes.

Organizations will use a comprehensive procedure to select evidence-informed guidelines. Depending on the scope of the project, this may include a comprehensive literature review, an environmental scan, consulting other organizations about their practices, and an evaluation with partners and stakeholders.

As with any activity that affects resident care and experience, organizations gather and consider input from residents and families when reviewing the procedure to select evidence-informed guidelines. Although residents and families may not be involved in a technical or scientific review, their perspectives on residents' experiences of care are valuable. Resident and family perspectives can be gathered through their attendance at procedural review committees, their review of procedural documents, and by shadowing the use or implementation of the procedure in practice.



Appropriateness



15.3

There is a standardized process, developed with input from residents and families, to decide among conflicting evidence-informed guidelines.

Guidelines

Comprehensive documents that synthesize the evidence from several guidelines may be used. For example, the Cochrane Collaboration conducts systematic reviews of the available evidence that can help teams and organizations with their review process. Residents and families are consulted to determine whether the method of deciding among guidelines follows a resident-centred approach (e.g., helping to determine which guideline is more resident-centred, reviewing whether a guideline was developed with the resident perspective)..



Appropriateness



15.4

Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from residents and families.

Guidelines

Selected guidelines and evidence are used to develop procedures and protocols to improve service delivery and provide standardized care to residents. The procedures and protocols may enhance patient safety, improve inter-team collaboration, increase efficiency, and minimize variation in service delivery. Resident and family perspectives are considered when evaluating improvements. As the recipients of care, residents and families are often best positioned to help identify unnecessary variations or duplications in service.

Research knowledge is adapted and applied to each unique care setting.



Appropriateness



15.5

Guidelines and protocols are regularly reviewed, with input from residents and families.

Guidelines

The review process includes accessing the most up-to-date research and information and determining its relevance (e.g., through literature reviews, content experts, or national organizations or associations). Research information may include intervention research, program evaluations, or clinical trials.

The review process informs the procedure to select evidence-informed guidelines.

Although residents and families may not be involved in a technical or scientific review, their perspectives on residents' experiences while receiving care driven by guidelines and protocols are valuable to the review process.



Appropriateness



15.6

There is a policy on ethical research practices that outlines when to seek approval, developed with input from residents and families.

Guidelines

The need for ethics approval is evaluated and, if necessary, sought, prior to undertaking research or activities (including quality improvement activities), where information is collected.



Safety



16.0 Resident and team safety is promoted within the service environment.

16.1 A proactive, predictive approach is used to identify risks to resident and team safety, with input from residents and families.

Guidelines

A proactive, predictive approach is designed to address potential issues by mitigating a risk or hazard before it occurs. While it may not be possible to identify all risks in a service setting, a comprehensive process is used to identify the most probable risks.

Through this approach, the team works to address processes that create errors, delays, or inefficiencies and may be viewed as beyond the team's control. These may be small, continuously occurring interruptions to work flow that create significant loss of resources as time goes on (e.g., having to look up commonly used information, having to search for commonly used items).

Information is gathered to determine the causes of potential problems and strategize possible solutions. These activities include conducting audits, talking to residents, talking to team members, monitoring areas for risk, identifying interruptions, participating in safety briefings, and addressing areas where there is a high margin of error.

Regular opportunities to share information about potential problems and actual incidents can reduce risk and the likelihood of an incident occurring or recurring.



Safety



16.2 Strategies are developed and implemented to address identified safety risks, with input from residents and families.

Guidelines

The team works together to increase participation in risk mitigation strategies. Resident and family perspectives are incorporated in the process of developing and implementing risk mitigation strategies. The strategies are tested on a small scale and results are monitored. Strategies will vary depending on the types of risks identified and may include action planning and working with other team members to address identified risks.



Safety



16.3

Verification processes are used to mitigate high-risk activities, with input from residents and families.

Guidelines

To identify high-risk activities, the team may review its services and use this information to develop and implement checking systems to reduce the risk of harm to residents and team members.

Across the care continuum, verification systems vary depending on services. Examples may include but are not limited to:

- Repeat back or read back processes for diagnostics or verbal orders
- Checking systems for water temperature, especially for bathing
- Standardized tracking sheets for residents with complex medication management needs
- Automated alert systems for communication of critical test results
- Computer-generated reminders for follow-up testing in high-risk patients
- Two person verification process for blood transfusions
- Independent double checks for dispensing and administering high-risk medications
- Medication bar coding systems for drug dispensing, labeling, and administration
- Decision support software for order entry or drug interaction checking
- Safety monitoring systems for teams in community-based organizations or for residents in high-risk environments
- Standardized protocols to monitor vital signs (e.g., fetal heart rate during medical induction/augmentation of labour, or in high-risk deliveries)
- Systems to monitor vaccine fridge temperatures
- Standardized protocols for the use of restraints
- Standardized screening processes for allergies to contrast media.



Safety



16.4

There is process to identify populations at risk of complications from pneumococcal disease and administer the vaccine accordingly.

Guidelines

Clients and team members may both be at risk for complications from pneumococcal disease. The organization identifies those at risk and follows a procedure to provide the vaccine.



Safety



16.5

Safety improvement strategies are evaluated with input from residents and families.

Guidelines

Adjustments are made as needed to ensure positive change is sustained.



Safety



16.6

Patient safety incidents are reported according to the organization's policy and documented in the resident and the organization record as applicable.

Guidelines

Reporting and recording is done in a timely way. Patient safety incidents include harmful incidents, no harm incidents, and near misses, as per the World Health Organization International Classification for Patient Safety.

Client-centred
Services

16.7

Patient safety incidents are disclosed to the affected residents and families according to the organization's policy, and support is facilitated if necessary.

Guidelines

The Canadian Patient Safety Institute (CPSI) publishes a guide to disclosing patient safety incidents, for health care providers, interdisciplinary teams, organizations, and regulators who are developing and implementing disclosure policies, practices, and training methods.

Support following a patient safety incident is an important part of the process. Support is provided to residents and families as well as team members affected by a patient safety incident.



Safety



16.8

Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from residents and families.

Guidelines

Analyzing patient safety incidents includes determining the contributing factors, taking action to prevent the same situation from recurring, and monitoring the effectiveness of those actions. Organizations use this information when developing strategies to proactively anticipate and address risks to resident and team safety.

The Canadian Patient Safety Institute offers a framework for incident management. It provides an in-depth description of the process of analyzing and managing patient safety incidents. An online Incident Analysis Learning Program series is available to assist organizations to apply the principles of incident analysis at www.patientsafetyinstitute.ca/.

17.0

Indicator data is collected and used to guide quality improvement activities.



Client-centred
Services

17.1

Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from residents and families, team members, and partners.

Guidelines

Information and feedback is collected in a consistent manner from key stakeholders about the quality of services. Feedback can take the form of resident and family satisfaction or experience data, complaints, indicators, outcomes, scorecards, incident analysis information, and financial reports. It may be gathered by a variety of methods, including surveys, focus groups, interviews, meetings, or records of complaints.



Appropriateness

17.2

The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from residents and families.

Guidelines

Feedback and other forms of information, observation, and experience are used to identify and prioritize areas for quality improvement initiatives. This is done using a standardized process based on criteria such as expressed needs of residents and families, resident-reported outcomes, risk, volume, or cost.



Appropriateness



17.3

Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from residents and families.

Guidelines

Quality improvement objectives define what the team is trying to achieve and by when. Appropriate quality improvement objectives are typically short term, have targets that exceed current performance, and are usually aligned with longer-term strategic priorities or patient safety areas. The timeframe will vary based on the nature of the objective.

The SMART acronym is a useful tool for setting meaningful objectives. The objectives should be Specific, Measurable, Achievable, Realistic, and Time-bound. The United States Centers for Disease Control and Prevention offers a guide to writing SMART objectives.



Appropriateness

17.4

Indicator(s) that monitor progress for each quality improvement objective are identified, with input from residents and families.

Guidelines

Indicators are used to monitor whether the activities resulted in change and if the change is an improvement. Primarily, indicators are selected based on their relevance and whether they can accurately monitor progress. When there are multiple potential indicators, criteria such as scientific validity and feasibility are used to select them.

If there are difficulties selecting indicators, it may mean the quality improvement objective needs clarification.



Appropriateness



17.5

Quality improvement activities are designed and tested to meet objectives.

Guidelines

Quality improvement activities are the actions that are undertaken to initiate improvements, and are part of the larger quality improvement plan. Activities are first designed and tested on a small scale to determine their effect prior to implementing them more broadly.

The Getting Started Kit for Improvement Frameworks is a resource created by the Canadian Patient Safety Institute and is based on the Model for Improvement. The Institute for Healthcare Improvement offers a framework to guide quality improvement activities using Plan, Do, Study, Act cycles.



Appropriateness

17.6

New or existing indicator data are used to establish a baseline for each indicator.

Guidelines

Establishing a baseline reference point makes it possible to monitor progress towards meeting quality improvement objectives by comparing pre- and post-activity data and noting changes. Establishing a baseline may require one or many data points and occurs over a defined period of time. Once the baseline is established, the team may need to reevaluate its quality improvement objectives to ensure they remain feasible and relevant.



Appropriateness

17.7 There is a process to regularly collect indicator data and track progress.

Guidelines

How indicator data will be collected and how often is determined. Regularly collecting data allows the team to track its progress and understand the normal variation of values.



Appropriateness



17.8 Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.

Guidelines

The team compares the intended and actual effects of its quality improvement activities, and, if the objective has not been achieved, adjusts its actions accordingly to meet the objective.

Analyzing data helps identify trends and may reveal areas that could be considered for future quality improvement initiatives. Indicator data can be displayed in a run chart or control chart, both of which are valid means of data analysis.

Safer Healthcare Now! offers Patient Safety Metrics, a web-based tool where organizations can submit data on various interventions, analyze results, and generate reports.

If it is not within the team's capacity to analyze the data, it seeks qualified internal or external assistance.



Appropriateness



17.9

Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.

Guidelines

The way in which activities are implemented broadly will vary based on the scope and scale of the team's services and the timeframe (e.g., an effective activity is implemented in more than one area of care and for a longer period of time).



Population Focus

17.10

Information about quality improvement activities, results, and learnings is shared with residents, families, teams, organization leaders, and other organizations, as appropriate.

Guidelines

Information is tailored to the audience and considers the messaging and language that is appropriate for each audience.

Sharing the results of evaluations and improvements helps familiarize stakeholders with the philosophy and benefits of quality improvement and engage them in the process. It is also a way for organization to spread successful quality improvement activities and demonstrate its commitment to ongoing quality improvement.

Among other benefits, sharing indicator data externally allows for comparisons with organizations offering similar services.



Appropriateness

17.11

Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from residents and families.

Guidelines

The evaluation of quality improvement initiatives includes activities, objectives, and indicators. Results are used to plan future quality improvement initiatives including how and when to sustain or spread existing initiatives.

Outcomes of the quality improvement initiatives are considered with respect to how they align with the organization's overall quality improvement plan, goals and objectives, mission and values, and strategic plan. The team evaluates whether objectives were met within the timeframes and whether the timeframes are still relevant.

Based on the review of the initiatives, objectives and indicators may be added, amended, or removed as appropriate. The rationale for amending or removing them is documented.

Resources

- Association of Public Health Observatories (APHO). (2008). *The Good Indicators Guide: Understanding how to use and choose indicators*. NHS Institute for Innovation and Improvement.
- Audet, A.M. (2006). Adoption of Patient-Centered Care Practices by Physicians: Results From a National Survey. *Arch Intern Med*, 166(7):754-9.
- Balik, B. (2011). Leaders' role in patient experience: Hospital leadership must drive efforts to better meet patients' needs. *Healthcare Executive*. 26(4):76-78.
- Balik, B. (2012). Patient- and Family-Centredness: Growing a Sustainable Culture. *Healthcare Quarterly* 15: 10-12.
- Balik, B., J. Conway, L. Zipperer & J. Watson. (2011). *Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care*. IHI Innovation Series White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement.
- Bate, P., & Robert, G. (2006). Experience-based design: from redesigning the system around the patient to co-designing services with the patient. *Qual Saf Health Care*, 15: 307-310.
- BC Patient Safety & Quality Council. (2010) *Measurement strategies for improving the quality of care: A review of best practice*. Vancouver BC.
- Bergeson, S.C. (2006). A Systems Approach to Patient-Centered Care. *JAMA*, 296 (23): 2848-51.
- Black, N. (2013). Patient reported outcome measures could help transform healthcare. *BMJ*, 346: f167.
- British Columbia Ministry of Health (2011). *Integrated primary and community care patient and public engagement Framework*. www.impactbc.ca
- Canadian Foundation for Health care Improvement (2013). *On Call Webinars - Patient Engagement Series*. www.cfhi-fcass.ca
- Canadian Institutes of Health Research (2011). News Release. Government of Canada puts patients first with new research strategy. August 22, 2011. www.cihr-irsc.gc.ca
- Canadian Malnutrition Task Force (2014). *Canadian Malnutrition Task Force Screening Tool*. June 2014. www.nutritioncareincanada.ca

- Canadian Medical Association (2007). Putting Patients First: Patient-Centred Collaborative Care, A Discussion Paper. July 2007. www.cma.ca
- Canadian Medical Association (2010). Health care transformation, *Change that Works. Care that Lasts.* Building a culture of patient-centred care. Charter for Patient-Centred Care. www.cma.ca
- Cancer Quality Council of Ontario (2013). Environmental Scan: Patient and Family Experience June 2013.
- Centers for Disease Control and Prevention (2003). *Prevention Works: CDC Strategies for a Heart-Healthy and Stroke-Free America.* Atlanta, GA: U.S. Department of Health and Human Services. www.cdc.gov
- Chan, & Wood (2010). Preparing Tomorrow's Healthcare Providers for Interprofessional Collaborative Patient-Centred Practice Today. *UBCMJ* 1(2).
- Change Foundation (2011). Winning Conditions to improve patient experiences: integrated healthcare in Ontario. www.changefoundation.ca
- Chow, S., Teare, G., & Basky, G. (2009). Shared decision making: Helping the system and patients make quality health care decision. Saskatoon: Health Quality Council. www.hqc.sk.ca
- Conway, et al. (2006). Partnering with Patients and Families To Design a Patient- and Family-Centered Health Care System, A Roadmap for the Future. www.ipfcc.org
- Coulter, A. (2012). Leadership for patient engagement. The King's Fund. London: UK. www.kingsfund.org.uk
- Coulter, A. (2012). Patient Engagement-What Works? *J Ambulatory Care Manage*, 35(2): 80-89.
- Davis, R., Sevdalis, N., & Vincent, C. (2010). Patient involvement in patient safety: How willing are patients to participate? *BMJ Quality and Safety*, 20: 108-114.
- Dentzer, S. (2013). Rx for the 'Blockbuster Drug' of Patient Engagement. *Health Affairs*, 32(2):202.
- Epstein, R.M., & Street, R.L. (2011). The values and value of patient-centered care. *Annals of Family Medicine*, 9(2): 100-103.
- Epstein, R.M., Fiscella, K., Lesser C.S., & Stange, KC. (2010). Why The Nation Needs A Policy Push On Patient-Centered Health Care. *Health Affairs*, 29(8): 1489-1495.

- Frampton, S., Charmel, P. Eds. (2009) *Putting Patients First: Best Practices in Patient-Centered Care*, Second edition. San Francisco: Planetree, Inc.
- Frampton, S., Guastello, S., Brady, C., Hale, M., Horowitz, S., Bennett Smith, S., & Stone, S (2008). *Patient-Centered Care Improvement Guide*. Derby, Connecticut: Planetree. www.ihl.org
- Frankel, et al (2011). Crossing the Patient-Centered Divide: Transforming Health Care Quality Through Enhanced Faculty Development, *Academic Medicine*, 86(4), 445-452.
- Hall, J., Peat, M., Birks, Y., Golder, S. et al (2010). Effectiveness of interventions designed to promote patient involvement to enhance safety: A systematic review. *BMJ Quality and Safety in Health Care*, 19(5):e10.
- Hibbard, J.H., Greene, J., & Overton, V. (2013). Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' 'Scores'. *Health Affairs*, 32(2): 216-222.
- Hudon, et al (2011). Measuring Patients' Perceptions of Patient-Centered Care: A Systematic Review of Tools for Family Medicine, *Annals of Family Medicine*, 9:155-164.
- Institute for Healthcare Improvement (IHI) (2012). How to Improve. www.ihl.org
- Institute for Healthcare Improvement, the National Initiative of Children's Healthcare Quality, the Institute for Patient and Family-Centered Care (2011). *Patient- and Family-Centered Care Organizational Self-Assessment Tool*. www.ihl.org
- Institute for Healthcare Improvement (2004). Strategies for Leadership: Patient-and Family-Centred Care: A Hospital Self-Assessment Inventory. www.ihl.org
- Johnson, et al (2008). Partnering with Patients and Families to Design a Patient and Family-Centered Health Care System: Recommendations and Promising Practices. The Institute for Patient- and Family-Centered Care. www.ipfcc.org
- Kingston General Hospital (2012). Press Release: KGH wins patient-centred care award from NRC Picker. www.kgh.on.ca
- Langley, G.L., Nolan, K.M., Nolan, T.W., Norman, C.L., & Provost, L.P. (2009). *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers.

Levinson, W. (2011). Patient-centred communication: a sophisticated procedure. *British Medical Journal of Quality and Safety*, 20(10): 823-825.

Lewis, S. (2009). Patient-Centered Care: An Introduction to What It Is and How to Achieve It: A Discussion Paper for the Saskatchewan Ministry of Health. www.health.gov.sk.ca

Lloyd, R. (2004) *Quality healthcare: A guide to developing and using indicators*. Sudbury MA. Jones and Bartlett Publishers.

Longtin, Y., Sax, H., Leape, L., Sheridan, S., Donaldson, L., & Pittet, D (2010). Patient Participation: Current Knowledge and Applicability to Patient Safety. *Mayo Clinic Proceedings*, 85: 53-62.

Luxford, et al. (2011). Promoting Patient-centred care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving patient experience, *International Journal for Quality in Health Care*, 23(5): 510-15.

National Committee for Quality Assurance. The Patient-Centred Medical Home: Health Care that Revolves Around You. An Established Model of Care Coordination. www.ncqa.org

New Brunswick Health Council (2010). Our Health. Our Perspectives. Our Solutions. Results of our First Engagement Initiative with New Brunswick Citizens. www.nbhc.ca

Ontario Medical Association (2010). Patient-Centred Care, Ontario Medical Review, Policy Paper, June 2010. www.oma.org

Picker Institute (2012). Always Events: Health Care Solutions Book. Publications. www.alwaysevents.pickerinstitute.org/?p=1759

Raleigh, V.S., & Foot, C. (2010). *Getting the Measure of Quality: Opportunities and Challenges*. London: The King's Fund.

Safer Healthcare Now! (2011). Improvement Frameworks Getting Started Kit. Canadian Patient Safety Institute. www.saferhealthcarenow.ca

Safer Healthcare Now! Patient Safety Metrics: Measuring to Reduce Harm. www.saferhealthcarenow.ca

Saint Elizabeth Health Care (2011). Client-Centred Care in the Canadian Home and Community Sector: A Review of Key Concepts. September 2011. www.saintelizabeth.com

Saskatchewan Ministry of Health (2011). Patient- and Family-Centred Care in Saskatchewan: A Framework for Putting Patients and Families First. www.health.gov.sk.ca

Shaller, D., & Darby, C. (2009). High-Performing Patient and Family-Centered Academic Medical Centers: Cross-Site Summary of Six Case Studies. The Picker Institute.

Shaller, D. (2007). Patient-Centered Care: What Does it Take? The Commonwealth Fund. www.commonwealthfund.org

Smith, et al (2011). Behaviorally Defined Patient-Centered Communication-A Narrative Review of the Literature, *Journal of General Internal Med* 26(2): 185-91.

Spragins, & Lorenzetti (2008). Public Expectation and Patient Experience of Integration of Health Care: A Literature Review. The Change Foundation. www.changefoundation.ca

Stange, K.C., Nutting, P.A., et al (2010). Defining and Measuring the Patient-Centered Medical Home. *Journal of General Internal Med*, 25(6): 601-12. www.commonwealthfund.org

The Australian Council on Healthcare Standards (ACHS) (2010). The ACHS Equip5 Guide: Book 2- Accreditation, Standards, and Guidelines-Support and Corporate Functions. Sydney, Australia: ACHS.

The Australian Commission on Safety and Quality of Health Care (2010). Patient-Centred Care: Improving Quality and Safety by Focusing Care on Patients and Consumers, Discussion paper. www.safetyandquality.gov.au

The Health Council of Canada (2008). How Engaged are Canadians in their Primary Care? Results from the 2010 Commonwealth Fund International Health Policy Survey. Canadian Health Care Matters. Bulletin 5. www.healthcouncilcanada.ca

The Health Council of Canada (2012). Turning what we know into action: A commentary on the National Symposium on Patient Engagement. www.healthcouncilcanada.ca

The Health Foundation (2013). Evidence Scan: Involving patients in improving safety. The Evidence Centre. London: UK. www.health.org.uk

The King's Fund (2013). Patient Centred Leadership: Rediscovering our Purpose. www.kingsfund.org.uk

Wagner, et al (2012). Guiding Transformation: How Medical Practices Can Become Patient-Centred Medical Homes. The Commonwealth Fund. February 2012. www.commonwealthfund.org

Wasson, & Baker (2009). Balanced Measures for Patient-Centered Care. *J Ambulatory Care Manage*, 32(1), 44-55.

Weingard, S.N. (2013). Patient Engagement and Patient Safety: Perspective on Safety. Agency for Healthcare Research and Quality: WebM&M. www.webmm.ahrq.gov

WIHI. Recognizing Person- and Family-Centered Care: Always Events at IHI Radio Broadcast. September 26, 2013. www.ihl.org

World Health Organization (2007). People-Centred Health Care: A Policy Framework. Geneva. www.who.int

Wynia, & Matiasek (2006). Promising Practices for Patient-Centred Communication with Vulnerable Populations: examples from eight hospitals. The Commonwealth Fund. August 2006. www.commonwealthfund.org

Service-specific Resources

Abbey Pain Scale. Retrieved from www.apsoc.org.au

Alzheimer Society of Canada (2011). Guidelines for Care: Person-Centred Care of People with Dementia Living in Care Homes - Framework. Available online: www.alzheimer.ca

Alzheimer Society of Canada (2010). Rising Tide: The Impact of Dementia on Canadian Society. Available online: www.alzheimer.ca

British Columbia. Office of the Ombudsperson (2009). Getting It Right for Seniors in British Columbia (Part 1) Public Report No. 46 to the Legislative Assembly of British Columbia. Available online: www.bcombudsperson.ca

British Columbia. Office of the Ombudsperson (2012). The Best of Care: Getting it Right for Seniors in British Columbia (Part 2). Public Report No. 47 to the Legislative Assembly of British Columbia. Available online: www.bcombudsperson.ca

Canadian Dental Association (2010). Position Paper on Access to Oral Health Care for Canadians. Available

online: www.cda-adc.ca

Canadian Hospice Palliative Care Association www.chpca.net

Canadian Institute for Health Information (2013). When a Nursing Home is Home - How do Canadian Nursing Homes Measure Up on Quality? Continuing Care Reporting Series. Available online: www.secure.cihi.ca

Chan, A. & Easty, A. (2009). Order Sets in Health Care: An Evidence-Based Analysis. Centre for Global eHealth Innovation. University Health Network: Toronto. Available online: www.ehealthinnovation.org

Frampton, S. et. al. (2010). Long-Term Care Improvement Guide. Planetree, Inc. and Picker Institute. Available online: www.planetree.org

Institute for Safe Medication Practices (2010). Guidelines for Standard Order Sets. Available online: www.ismp.org

Long-Term Care Innovation Expert Panel (2012). Why Not Now? A Bold, Five-Year Strategy for Innovating Ontario's System of Care for Older Adults. Summary Report. Available online: www.oltca.com

Long-Term Care Task Force on Resident Care and Safety Ontario (2012). Report: An Action Plan to Address Abuse and Neglect in Long-Term Care Homes. Available online: www.longtermcaretaskforce.ca

Office of the Chief Coroner 2011 Annual Report of the Geriatric and Long-Term Care Review Committee. Province of Ontario. Available online: www.mcscs.jus.gov.on.ca

Ontario Behavioural Support Systems: A Framework for Care. Available online: www.BSSproject.ca

Ouslander, J.G. (February 13 2013). "Improving Nursing Home Care and Reducing Unnecessary Hospital Transfers, Admissions, and Readmissions." Presented at the OLTCA Long-Term Care Applied Research Education Day 2013, Toronto, ON.

Ouslander, J.G. & Maslow, K. (2012). "Measurement of Potentially Preventable Hospitalizations." Retrieved from: www.ltqa.org

Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC). Retrieved from www.geriatricpain.org

Pain Assessment in Advanced Dementia (PAINAD). Retrieved from www.healthcare.uiowa.edu

Quality Palliative Care in Long Term Care Alliance www.palliativealliance.ca

Registered Nurses' Association of Ontario. (2012). Promoting Safety: Alternative Approaches to the Use of Restraints. Toronto, ON: Registered Nurses' Association of Ontario. Available online: www.rnao.ca

Registered Nurses' Association of Ontario (2008). Nursing Best Practice Guidelines: Oral Health: Nursing Assessment and Interventions. Available online: www.rnao.ca

Resident Assessment Instrument - Minimum Data Set (RAI-MDS).

Revera Jasper Place Continuing Care. February 13, 2013. Antipsychotic Utilization Review Process. Presented at the OLTCALong-Term Care Applied Research Education Day 2013, Toronto, ON.

Sinha, S. (2012). Living Longer, Living Well: Recommendations to Inform a Seniors Strategy for Ontario. Ontario Ministry of Health and Long-Term Care. Available online: www.health.gov.on.ca

Stein, P.S. (2009). Poor Oral Health in Long-Term Care. *The American Journal of Nursing*, 109(6): 44 - 50.

Stuart Egier, S. & Brown, L. February 13, 2013. The Use of Order Sets to Enhance Long-Term Care. Presented at the OLTCALong-Term Care Applied Research Education Day 2013, Toronto, ON.

The American Geriatric Society (2012). American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults: The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. *The Journal of the American Geriatrics Society: Special Article*.

Together to Reduce Elder Abuse - B.C.'s Strategy (2013). *Promoting Well-Being and Security for Older British Columbians*. Available online: www.seniorsbc.ca

Wagner, L. & Rust, T. (2008) Safety in Long-Term Care Settings: Broadening the Patient Safety Agenda to Include Long-Term Care Services. Canadian Patient Safety Institute. Available online: www.patientsafetyinstitute.ca

Wahl, J. (2009). Sexuality in Long-Term Care. Advocacy Centre for the Elderly. Summer 2009 Newsletter. Available online: www.ancelaw.ca

World Health Organization (2007). Palliative Care. Cancer control : knowledge into action : WHO guide for

effective programmes; module 5. Geneva. Available online: www.who.int

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For example: I would like to provide comments on the Long-Term Care Services standards, criterion 3.12. Clients should be included in this process. I suggest you change the wording to "The team engages staff, service providers, and clients in the process to plan services."

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