# Qmentum® Long-Term Care

Program Manual

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# Preface

Health Standards Organization (HSO) develops world class, evidence-based standards that aim to improve health outcomes for residents, families, caregivers, and communities. I was honoured to be one of several members of a working group that revised the current Long-Term Care Services Standard (HSO A21001:2020) and associated program content to better meet the needs of this community sector. This program manual will serve as a tool to facilitate the assessment of long-term care homes in the context of the Qmentum® Long-Term Care Program. I am thrilled to have played a part in reaching this exciting milestone alongside HSO and Accreditation Canada.

My family's experience of caring and advocating for my father with Alzheimer's disease while in a long-term care home was challenging with many opportunities for learning along the way. Having poured so much time and energy into this journey, I kept asking myself what meaning I could bring to this experience, how I could help others going through similar experiences, and how I could help to better shape the future of health care. Through my involvement in this work at HSO and Accreditation Canada, I had the opportunity to collaborate with sector professionals to help strengthen the long-term care sector by joining our voices. I was amazed by the team's passion and dedication to seeing and understanding the resident, family and caregiver experience and seeing the standard come together.

For me, the result has been an enormous amount of learning about the value of the standards, the assessment and the critical importance of walking down the long-term care path together – resident, family, caregivers and professionals – in the development of improved standards that align to the principles of continuous care improvement.

People-centred care is at the heart of the Qmentum® Long-Term Care Program, and I am proud to have played a part in its development.

Sue Bartleman, HSO Resident and Family Partner

# Disclaimer

The content within HSO and Accreditation Canada's Program Manuals is drawn from a combination of national and international resources, as well as actionable criteria found within HSO's evidence-based standards.

HSO and Accreditation Canada Program Manuals do not replace jurisdictional legislation or professional regulatory requirements. They should be used in conjunction with relevant clinical practice guidelines and other detailed resources.

HSO and Accreditation Canada welcome feedback or suggestions for additional resources. Please contact: communications@healthstandards.org

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# Glossary

## General Terms

**Additional precautions:** Extra measures taken when routine practices alone may not interrupt transmission of an infectious agent. Additional precautions are used in addition to routine practices. They may be used when the consistent application of routine practices is not possible (e.g., care of an incontinent adult, a cognitively impaired individual, or a young child). How additional precautions are applied is specific to the health care setting (e.g., ambulatory care, long-term care, home care).

**Administering medication:** Providing of a medication directly to a resident for immediate ingestion or introduction into the body (e.g., by injection or other method), according to a prescription.

**Advance directives:** Documents containing explicit instructions regarding consent or refusal of treatment in specific circumstances, or that appoint an individual who will be authorized to make decisions on behalf of the resident should the resident becomes incapable. Also called living wills.

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

**Alcohol-based hand rub:** An alcohol-containing preparation (liquid, gel, or foam) designed for application to the hands to remove or kill microorganisms. These preparations contain one or more types of alcohol (e.g., ethanol, isopropanol, or n-propanol), and may contain emollients and other active ingredients.

**Automated dispensing cabinet:** Decentralized medication distribution system that provides computer-controlled storage, dispensing, and tracking of medication.

**Care delivery model:** A conceptual model that broadly outlines the way services are delivered. It is based on a thorough assessment of a resident's needs, involving a collaborative approach and stakeholder input, which considers the best use of culturally appropriate resources and services. The benefits of using a care delivery model include improving access to services, providing safe and quality care, promoting a people-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.

**Caregiver:** An unpaid individual that provides physical, psychological and emotional support, as deemed important by the resident. This can include support in decision making, care coordination, and continuity of care. Caregivers can include family members, close friends, or other individuals and are identified by the resident or substitute decision maker (adapted from CFHI, 2020).

**Care plan:** May also be known as the service plan, plan of care, or treatment plan. It is developed in collaboration with the resident, family, and/or caregiver 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 people-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.

**Cleaning (specific to medical equipment and devices):** The removal of foreign and organic material (blood, secretions) prior to further processing. Cleaning is a necessary step in the decontamination process and essential prior to disinfection or sterilization as the effectiveness of disinfection or sterilization processes can be impacted by residual debris or soil on instruments. In addition, cleaning (manual, automated) removes visible debris and soiling to render the item safe for further handling by persons involved in reprocessing when these persons use appropriate barriers (e.g., gloves, gowns, and face protection).

**Client:** See Resident.

**Collaboration:** A recognized relationship between different organizations, sectors, or groups, which has been formed to act on an issue in a way that is more effective or sustainable than might be achieved by the organization or public health sector acting alone. Collaboration in this sense is meant to encompass the full spectrum of collaboration, from coordinating services (sharing information), to integrating services that entails shared delivery of services, and shared accountability of outcomes.

**Community-based organization**: An organization that represents community needs and works to address them. They may be associated with a particular area of concern or segment of the community and reflect the everyday lives of community members.

A community-based organization may provide care for people of all ages who require care assistance. Community-based care is coordinated and integrated care provided in a range of community settings, such as people's homes, health care clinics, LTC Homes, physicians' offices, public health units, and hospices.

**Controlled substance:** A drug or chemical substance whose possession and use are controlled by law.

**Decontamination:** The process of cleaning by physical or chemical means to remove or inactivate pathogenic micro-organisms to render an object safe for handling.

**Disability:** Any restriction or lack (resulting from any impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

**Disinfectant:** A product that is used on surfaces or medical equipment/devices which results in disinfection of the surface or equipment/device. Disinfectants are applied only to inanimate objects. Some products combine a cleaner with a disinfectant.

**Disinfection:** A procedure that eliminates many or all pathogenic microorganisms (except bacterial spores) on inanimate objects or environments by chemical means or by inactivating agents.

**Dispensing:** Provision of a medication by a pharmacist or other team member operating within their scope of practice in accordance with a prescription or a medication order.

**Emergency:** A situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property, and that is caused by the forces of nature, a disease (including epidemics) or other health risks, an accident, or an act whether intentional or otherwise.

**Equipment:** See Medical equipment.

**Ethics framework:** An ethics framework provides common approaches to making decisions in an ethical way and working through ethical issues. Having an ethics framework helps promote ethical behaviour and practices throughout the organization and clarifies ethical issues when they arise. The ethics framework may address issues related to organizational ethics, business ethics, research ethics, clinical ethics, and bioethics, as applicable. The framework can include codes of conduct, guidelines, processes, and values to help guide decision making.

**Executive leader:** Refers to the individual who has the most authority in the organization. This individual may also be called the Chief Executive Officer (CEO), executive director, chief executive director, or administrator. The executive leader often has a team of executives.

**Family:** Person or persons who are related to a resident 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.

**Governance:** The system by which authority, decision-making ability, and accountability are exercised in an organization.

**Governing body:** The legitimate body that holds authority, ultimate decision-making power, and accountability for an organization and its services. This may be a board of directors, a Health Advisory Council, a Chief or Council, or other decision-making body.

**Hand hygiene:** A comprehensive term that refers to handwashing or hand antisepsis and to actions taken to maintain healthy hands and fingernails.

**Hand washing:** A process for the removal of visible soil/organic material and transient microorganisms from the hands by washing with soap (plain or antiseptic) and water.

**Health care-associated infection:** Infection that is transmitted within a health care setting (also referred to as nosocomial) during the provision of health care. Examples include *C. difficile*, surgical site infections, seasonal influenza, noroviruses, or urinary tract infections.

**High-alert medication:** A medication associated with an increased risk of causing significant harm to a resident if it is incorrectly used. High-alert medications may also be called high-risk medications and are often defined by organizations that promote safe medication practices.

**Incident analysis:** A structured process following a reported safety incident to identify what happened, how and why it happened, what can be done to reduce the risk of recurrence and make care safer, and what was learned.

**In partnership with the resident and family:** Health care professionals collaborate with residents and families as equal members of direct care or organizational/system level teams in each aspect of decisions including the development of alternatives and the identification of the preferred course of action (International Association for Public Participation, 2014). See also *People-centred care*.

**Interdisciplinary committee:** A group of individuals from various teams and different areas of expertise working toward common goals (for example, medication management or infection prevention and control). The committee may include residents, caregivers, and families.

**Long-term care (LTC) home:** Organizations that provide its residents with 24-hour health and personal care 7 days a week. LTC homes are typically funded or subsidized by provincial or territorial governments and governed by provincial or territorial legislation.

**Medical devices:** An article, instrument, apparatus, or machine that is used for:

- Preventing, diagnosing, treating, or alleviating of illness or disease
- Supporting or sustaining life
- Disinfecting other medical devices

Some examples include blood pressure cuffs, glucose meters, breathalyzers, thermometers, defibrillators, scales, foot care instruments, lifts, wheelchairs, and syringes. This also includes single-use items such as blood glucose test strips. Medical equipment is a subset of medical devices - any medical device that requires calibration, maintenance, repair, and user training.

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

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

**Medication delivery device:** Any device used to prepare, dispense, and administer medications. Medication delivery devices include insulin pens, safety-engineered needles, infusion pumps, and resident-controlled analgesia pumps.

**Medication management:** The goal of medication management is to ensure the safe, accurate, and consistent use of medications across the organization. Medication management includes selecting and procuring medications; storing medications in the pharmacy; preparing, dispensing, and delivering medications; administering medications and monitoring the effects of medications on residents.

**Medication order:** Hand-written or electronic order for a medication by an authorized team member for administration to a resident. This includes routine and as needed medications. Standing orders, orders to resume previous medications and the blanket reinstatement of previous orders are not acceptable medication orders.

**Multi-dose vial:** Medication that is packaged for the injectable administration of multiple doses. The medication is drawn from the vial by a needle. All needles and syringes used are single patient use only.

**Organization's leader:** Leader at all levels, including directors, managers, supervisors, clinical leaders, and others who have leadership responsibilities within the organization.

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

**Patient:** See Resident.

**Partner:** An organization or person who works with others 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.

**People-centred care:** An approach to care that consciously adopts the perspectives of individuals, families, and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases (World Health Organization, 2016).

**Personal protective equipment:** Equipment that is used to provide a barrier that prevents potential exposure to microorganisms. For example, gowns, gloves, masks, facial protection (e.g., masks and eye protection, face shields or masks with visor attachment) or respirators.

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

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

**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.

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

**Quality assurance:** A process involving assessment to determine whether expected requirements are fulfilled.

**Quality improvement:** Systematic, continuous action(s) focused on people, processes, and systems and that lead to measurable improvement.

**Reprocessing:** The steps required to prepare used medical equipment or devices for use (i.e., cleaning, disinfection, sterilization).

**Resident:** Individuals who participate in, and benefit from health systems and services, as co-producers of health. Depending on the health setting or context, resident may be referred to as a patient or client or community member. Individuals could include caregivers and families when desired by the resident. When the organization does not provide services directly to individuals, resident refers to the community or population that is served by the organization.

**Resident service area:** The physical space where residents receive health care services or support in activities of daily living; may be in a facility or in a community setting (e.g., rooms, dining areas, recreational and exercise and living areas, washrooms, exam rooms, and treatment rooms).

**Resources:** Human, financial, equipment, and/or informational resources needed to support a project or initiative.

**Restraints:** Restraints may be physical, chemical, or environmental measures that control or limit a resident or a portion of their body. Physical restraints (e.g., a table fixed to a chair or a bed rail that the resident is unable to open) limit a resident's movement. Environmental restraints (e.g., a secured unit or area, seclusion area) control a resident's mobility. Chemical

restraints are any form of psychoactive medication used not to treat illness, but to intentionally inhibit a particular behaviour or movement. What is defined as restraint, use of restraints, and relevant legislation governing the use of restraints may vary by region, service area, and population.

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

**Routine practices:** A comprehensive set of infection prevention and control measures that must be used in the routine care of all residents to reduce the risk of transmitting microorganisms. Examples of routine practices include point-of-care risk assessment; hand hygiene (including point-of-care, alcohol-based hand rubs); aseptic techniques; the provision and use of personal protective equipment; cleaning and disinfecting the physical environment; and handling waste and linen.

**Safety incident:** An event or circumstance that could have or has resulted in unnecessary harm to a person. Triggers an incident analysis. Types of safety incidents are:

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

**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.

**Self-administration:** Active administration of a medication by a resident, rather than by a health care provider.

**Stakeholder:** A person with an interest in or concern for the organization and its services. Stakeholders may be internal (e.g., staff) or external (e.g., community members).

**Sterilization:** A validated process used to render a device free from viable micro-organisms. In a sterilization process, the nature of microbial death is described by a mathematical function. Therefore, the presence of micro-organisms on any individual device can be expressed in terms of probability. While this probability can be reduced to an exceptionally low number, it can never be reduced to zero.

**Strategic plan:** A strategic plan is a roadmap to achieving the health organization's vision for the next year or more. It provides a vision, a way to achieve that vision and a way to evaluate the outcomes associated with the vision. It sets broad strategic goals and contributes to effective decision making regarding resource allocation or difficult operational choices. It addresses broad questions such as: Who are we? Where are we now? What is the environment (physical, cultural, political) that we operate in? Where do we want to go? How should we get there?

**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.

**Unit dose:** A package that contains one dose of a medication intended for one resident.

**Urgent care:** A clinical situation which, although the condition does not appear life threatening, requires care in a timely manner to prevent a serious deterioration of a person's health status.

**Worklife:** Supporting wellness of team members in the work environment.

## Qmentum® Program Terms

**Accreditation decision committee (ADC):** The committee responsible for conferring accreditation decisions. The ADC may include HSO and Accreditation Canada staff members, surveyors, or members of the public.

**Accreditation status:** An award given to client organizations that have successfully completed the requirements of accreditation based on assessment results and the accreditation decision guidelines.

**Assessment methods:** Methods used by organizations or surveyors to assess an organization's conformity against criteria and to support a progressive learning journey that is informed by both evidence and lived experience.

**Attestation:** A formal procedure where an organization attests their conformity against identified assessment criteria.

**Co-design**: A process that involves collaboration among all people involved in each service, care process, or experience, including residents, to identify gaps, plan and create solutions to improve these services, care processes and experiences. Co-design recognizes that combining the expertise of residents through lived experience, with the professional expertise of frontline staff and clinicians, from project inception to delivery, leads to better results.

**Governance functioning tool (GFT):** An HSO/AC survey instrument that is completed by an organization's governing body participating in the Qmentum® program. The purpose of the GFT is for each member of the governing body to reflect on their role in governance of the organization.

**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 health or service outcome. Indicators need to have a definition, inclusion, and exclusion criteria, and a 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 because 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.

**On-site assessment:** A review conducted on-site by surveyors to assess an organization's conformity against identified assessment criteria.

**Quality improvement action plan (QIAP):** A living document developed by an organization to plan systematic actions, processes, and measuring mechanisms to support continuous and people-centred improvement in relation to the program content. The QIAP is intended to be updated and referenced regularly throughout an organization's accreditation journey to identify and enable the actions that are required to generate and sustain continuous quality improvement.

**Self-assessment:** An important step in an organization's journey toward effective outcomes. The self-assessment activity allows organizations and their teams to reflect, work together, and engage the voice of all to develop an understanding of their current state in relation to the program content.

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

**Surveyor:** An individual with subject matter expertise working in the same field who demonstrates the competencies needed to assess an organization against the requirements of the accreditation program. A surveyor can also be a resident, a family member or a caregiver with significant lived experience of the health care system.

**Survey instrument:** A questionnaire designed to obtain responses from a person in order to obtain data for reporting, analysis and action planning. Some responses can be quantitative in which case there is a limited number of possible responses, for example 'yes' or 'no'. Other responses can be qualitative in which the person writes a descriptive piece of text.

**Team/team members:** All individuals working, volunteering, or learning together within the organization to meet the needs of residents, families, and the community, including leaders, management, staff, residents, social and health care

professionals who hold privileges, contracted providers, volunteers, and students. As partners in care, residents and family members who residents identify as essential partners in care, are recognized and treated as members of the team, and share in decision making and accountability. The specific composition of a team depends on the type(s) of service(s) provided and/or activity performed.

**Tracer methodology:** An interactive activity used during an on-site assessment. Surveyors, accompanied by a staff person, "trace" the path of a resident or an administrative process to gather evidence about the organization's quality and safety of care services.

**Virtual assessment:** A review conducted virtually by surveyors to assess an organization's conformity against identified assessment criteria.

## Abbreviations

ADC: Accreditation Decision Committee

APAC: Asia Pacific Accreditation Cooperation

BPMH: Best Possible Medication History

CEO: Chief Executive Officer

CIO: Chief Information Officer

EMT: Emergency Medical Technician

GFT: Governance Functioning Tool

HSO: Health Standards Organization

ID: Identification

IPC: Infection Prevention and Control

ISMP: Institute for Safe Medication Practices

ISQua: International Society for Quality in Health Care

LTC: Long-Term Care

MDR: Medical Device Reprocessing

PCC: People-Centred Care

PPE: Personal Protective Equipment

QIAP: Quality Improvement Action Plan

ROP: Required Organizational Practice

SCIPUS: Spinal Cord Injury Pressure Ulcer Scale

SDO: Standards Development Organization

WSWQS: Workforce Survey on Well-being, Quality and Safety

# About Health Standards Organization and Accreditation Canada

Health Standards Organization (HSO) and Accreditation Canada are affiliated organizations that are committed to inspiring people to make positive change that improves the quality of health and social services in Canada and around the world. HSO develops world-class and evidence-based standards, assessment programs, and quality improvement solutions. HSO is recognized as a Standards Development Organization (SDO) by the Standards Council of Canada which imposes a rigorous development and public engagement process to create standards. This includes the use of evidence; formation of a technical committee comprising subject matter experts, care providers, policy makers, and patients/residents; and regular updates to ensure alignment with jurisdictional and regulatory requirements. HSO is the only SDO in Canada solely focused on developing evidence-based health and social service standards.

Accreditation Canada delivers a wide range of high-impact assessment and recognition programs powered by HSO standards and customized to local needs. Accreditation Canada works with more than 900 expert surveyors who are health care and social service practitioners, managers, and educators, all of whom are trained in Accreditation Canada's customized, continuous assessment program. Our surveyors assist organizations in their continuous quality improvement journeys, building capacity in local communities and assessing progress.

HSO and Accreditation Canada work with governments, associations, health care organizations including hospitals, and community-based programs and services in the private, public, and education sectors. We are present in more than 15,000 locations in 38 countries, including all 10 Canadian provinces and 3 territories. We leverage our unparalleled experience, understanding, and knowledge to create flexible, integrated assessment models that cover the full spectrum of health services, from large networks and health systems to long-term care (LTC), home care, community health, and primary care sectors.

HSO has more than 410 patients, residents, family members, service providers, system administrators, experts, educators, and policy makers actively participating in our standard and assessment development technical committees, working groups, and advisory councils. People Powered Health™ is HSO and Accreditation Canada's core philosophy of involving patients/residents and their families, providers, educators, and policy makers in everything we do ("nothing about me without me"). Our People Powered Health™ philosophy brings together different perspectives, experiences, learnings, and insights to foster positive change and continuous quality improvement.

HSO and Accreditation Canada are independent, non-governmental, not-for-profit organizations headquartered in Ottawa, Ontario, Canada. Our programs meet extensive third-party accreditation requirements set by the Standards Council of Canada, the International Society for Quality in Health Care (ISQua), and the Asia Pacific Accreditation Cooperation (APAC).

## People-Centred Care Philosophy and Approach

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

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

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

1. Integrity and relevance: Upholding the expertise of people in their lived experiences of care; Planning and delivering care through processes that make space for mutual understanding of needs/perspectives and allow for outcomes that have been influenced by the expertise of all.

2. Communication and trust: Communicating and sharing complete and unbiased information in ways that are affirming and useful; Providing timely, complete, and accurate information to effectively participate in care and decision making.
3. Inclusion and preparation: Ensuring that people from diverse backgrounds and contexts have fair access to care and opportunities to plan and evaluate services; Encouraging and supporting people to participate in care and decision making to the extent that they wish.
4. Humility and learning: Encouraging people to share problems and concerns in order to promote continuous learning and quality improvement; Promoting a just culture and system improvement over blame and judgement.

# Welcome to the Qmentum® Long-Term Care Program

## Overview

Long-term care (LTC) homes provide 24-hour care in a living environment to adults with complex care needs. There are heightened expectations for LTC homes to provide residents with care that aligns with the core values of respect, dignity, compassion, trust, and quality of life. Safe and reliable high-quality practices are foundational to achieve these values and the mandate of LTC homes. Furthermore, investing in a healthy and competent workforce is essential to implement and sustain safe, reliable, and high-quality LTC practices.

Accreditation Canada's Qmentum® Long-Term Care program is an accreditation program that guides and supports LTC homes on a continuous quality improvement journey to deliver safe, high-quality, and reliable care to their residents. Founded on principles of people-centred care, the program provides LTC homes with the relevant assessment methods, assessment tools, and resources to enhance accountability and accelerate improvements against evidence-informed standards.

The Qmentum® Long-Term Care program, developed from Accreditation Canada's Qmentum® program[1], has been customized to meet the needs of LTC homes. Co-designed with insights and guidance from a diverse group of LTC stakeholders, the program ensures meaningful engagement that includes all members of LTC homes – from governing bodies to frontline workforce, to residents and families, to community partners. The program uses a collaborative approach and a blend of quality assurance and quality improvement principles to support LTC homes to meet required standards while striving to fine-tune organizational practices and processes in ways that result in measurable improvements.

Key themes addressed in the Qmentum® Long-Term Care program include: governance and leadership; resident care experiences; infection prevention and control practices; medication management; emergency disaster management; and delivery of care models.

The program's key features include:

- ✓ A **continuous accreditation cycle** that spreads the accreditation requirements and activities across four phases.
- ✓ An **Assessment Tool** customized for LTC homes that is organized into thematic chapters and defines actionable criteria and guidelines.
- ✓ A **suite of assessment methods** to support the continuous accreditation cycle and understand strengths and areas for improvement.
- ✓ Two **survey instruments** – the Governance Functioning Tool which provides members of the governing body with an opportunity to reflect on the governing body's mandate, processes, and overall effectiveness; and the Workforce Survey on Well-being, Quality and Safety which allows LTC homes to obtain workforce members' input on resident safety, care quality, their work environment, and their well-being.
- ✓ A **quality improvement action plan (QIAP)** that will help LTC homes identify and action areas for improvement throughout the continuous accreditation cycle.
- ✓ Program **resources and training** to support LTC homes to succeed.
- ✓ **Digital platforms** that enable the successful completion of program activities, and support both a high-quality user experience and the overall continuous quality improvement journey.
- ✓ A **transparent reporting** and **accreditation process**.

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[1] Accreditation Canada's Qmentum® program provides a framework for organizations to assess the safety and quality of their services consistently and holistically. The program fosters an organization-wide awareness of quality and safety by embedding standards into daily operations and is a powerful tool for accountability and serves as a roadmap for quality improvement. Organizations use the Qmentum® program to gain momentum to achieve organizational priorities.

## Design Principles

The design of the Qmentum® Long-Term Care program reflects HSO and Accreditation Canada's commitment to the following core principles:

### 1. Resident and family-centred approach

The Qmentum® Long-Term Care program is co-designed with subject matter experts, people with lived experiences of receiving and/or providing care, and other relevant stakeholders. The co-design process purposefully includes the voice of all to ensure that the outcomes of the program reflect and meet the needs of the people within the participating LTC homes in order to achieve the best quality of life for residents and their families.

### 2. Safe, reliable, and high-quality care

The Qmentum® Long-Term Care program was developed to support LTC homes in the provision of safe, reliable, and high-quality care. The content of the program encompasses evidence-informed policies, procedures, standardized practices, and resources needed to keep residents and the workforce safe. The Qmentum® Long-Term Care program supports LTC homes to ensure the workforce is equipped with the relevant knowledge, skills, behaviours, and attitudes to deliver safe care practices and the best quality of care to residents.

### 3. Healthy and competent workforce

The Qmentum® Long-Term Care program helps LTC homes understand how they can support and maintain a healthy LTC workforce. Ensuring that the workforce receives the training they require, that they are provided with appropriate and safe working conditions, and that they are supported in their day-to-day interactions enables them to provide the highest quality of mindful and purposeful LTC services to residents and their families.

### 4. Continuous quality improvement

The Qmentum® Long-Term Care program is designed to focus on progressive learning approaches through continuous quality improvement. The continuous quality improvement process involves reflection and assessment of how the LTC home is doing, what it does well, and where it can improve. Continuous quality improvement promotes workforce empowerment, a culture of accountability, and sustainability of improvements over time through continuous self-monitoring and action planning.

## Key Features

### 1. Continuous Accreditation Cycle

The Qmentum® Long-Term Care program introduces an innovative continuous accreditation cycle. With this approach, LTC homes can spread the accreditation program requirements and activities over the four phases of the continuous accreditation cycle. As a result, LTC homes are better able to maintain a sustainable focus on planning, implementing, and evaluating improvements.

### 2. Assessment Tool

The Qmentum® Long-Term Care program contains updated assessment content in the form of an Assessment Tool customized for LTC homes. The Qmentum® Long-Term Care Assessment Tool ("Assessment Tool") was developed in consultation with LTC subject matter experts, caregivers, and families. The Assessment Tool is organized into chapters that address the key themes relevant to LTC homes, such as: governance and leadership; infection prevention and control; medication management; emergency disaster management; delivery of care models; and resident care experience. Principles of people-centred care are embedded within each chapter of the Assessment Tool.

### 3. Assessment Methods

HSO and Accreditation Canada work in partnership with a network of international researchers and subject matter experts in the field of quality improvement and health services assessment to ensure its assessment methods are informed by the latest evidence. The Qmentum® Long-Term Care program introduces assessment methods that engage the workforce in

new ways and provide an overview from different lenses against key elements that are embedded in the program's assessment content. The assessment methods are used in each of the four phases of the continuous accreditation cycle, allowing LTC homes to focus and maintain momentum throughout their quality improvement activities. The following assessment methods are used in the Qmentum® Long-Term Care program throughout the continuous accreditation cycle:

- **Self-assessment:** LTC homes and their teams assess themselves against the Assessment Tool criteria to reflect, work together, and engage the voice of all. Self-assessment helps LTC homes develop an understanding of their current state, as well as their desired state, in relation to the Assessment Tool criteria.
- **Attestation:** LTC homes assess themselves against identified attestable criteria in the Assessment Tool. A formal declaration is then signed by the LTC home to attest that the results are accurate and reliable to the best of the signatory's knowledge. Organizations are not required to submit evidence and/or supporting documentation for attestable criteria, however, evidence and/or supporting documentation should be readily available upon request.
- **Virtual assessment:** Accreditation Canada surveyors formally assess LTC homes against applicable criteria in the Assessment Tool. Virtual assessments are completed through online discussions and interviews with LTC homes and provide an opportunity for LTC homes to undergo an assessment by and receive feedback from surveyors. Results from virtual assessments provide LTC homes with valuable results and feedback to help identify areas of strength and areas for improvement.
- **On-site assessment:** Accreditation Canada surveyors formally assess LTC homes against applicable criteria in the Assessment Tool. Surveyors perform on-site assessments by following Accreditation Canada's tracer methodology. Tracers are completed through reviewing, listening, and observing the LTC home environment. Through these tracers, on-site assessments allow for a thorough assessment of the LTC home in relation to the criteria in the Assessment Tool. Results from on-site assessments provide LTC homes with valuable results and feedback to help understand areas of strength and areas for improvement.

### 4. Survey Instruments

The Qmentum® Long-Term Care program contains two survey instruments: the Governance Functioning Tool (GFT) and the Workforce Survey on Well-being, Quality and Safety (WSWQS).

The GFT provides members of the governing body with an opportunity to reflect on the governing body's mandate, processes, and overall effectiveness. The WSWQS allows LTC homes to obtain workforce members' input on resident safety, care quality, their work environment, and their well-being. Together, the survey instruments' results provide useful insights and offer LTC homes a unique, overall view of a wide range of critical topics. LTC homes should review the survey instrument and the assessment method results as complementary pieces of information.

### 5. Digital Platforms

LTC homes enrolled in the Qmentum® Long-Term Care program will be provided with access to cloud-based, secure, digital platforms to successfully prepare for and complete the required activities for each phase of the continuous accreditation cycle. The platforms allow LTC homes to monitor and drive their quality improvement journey through action planning, reporting tools, and results dashboards.

## How the Qmentum® Long-Term Care Program Works

The Qmentum® Long-Term Care program is an accreditation program that guides and supports LTC homes on a continuous quality improvement journey to deliver safe, high-quality, and reliable care to their residents. LTC homes are engaged in a four-phased continuous accreditation cycle that spreads accreditation requirements over four-years to maintain a sustainable focus on planning, implementing, and evaluating improvements (see Figure 1).

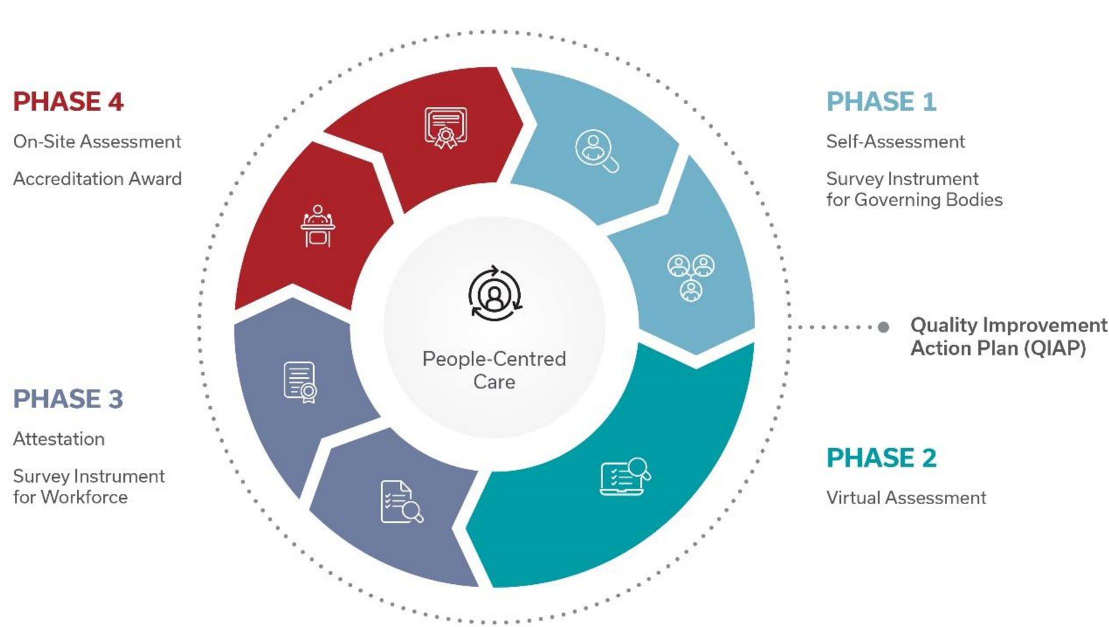
At the heart of the Qmentum® Long-Term Care program is a focus on people-centred care, reflected in the Assessment Tool, the survey instruments, and the program's various assessment methods. The Quality Improvement Action Plan (QIAP) is a core component of the program that will guide LTC homes in identifying and actioning areas for improvement. The QIAP

will be developed, updated, and actioned by LTC homes throughout all four phases of the continuous accreditation cycle to generate and sustain continuous quality improvement.

Each phase of the continuous accreditation cycle is comprised of activities that must be completed by the LTC home. Accreditation Canada will provide support to LTC homes throughout the continuous accreditation cycle, including customer support, performing virtual and on-site assessments, and providing feedback on the assessment results and QIAP. It is expected that each phase will take approximately 10–14 months for LTC homes to complete, depending on the LTC home and their individual progress on completing the required activities. Upon an LTC home's completion of Phase 4, the Accreditation Decision Committee (ADC) determines the LTC home's accreditation status based on the program's accreditation decision guidelines. The ADC is responsible for conferring accreditation decisions. Members of the ADC may include HSO and Accreditation Canada staff members, surveyors, or members of the public with relevant clinical and administrative knowledge and expertise.

In alignment with quality improvement principles, after an accreditation decision is rendered, LTC homes will enter Phase 1 of a new cycle and continue their continuous quality improvement journey through building on the learnings of past accreditation cycles. Through the completion of the assessments, survey instruments, and their QIAP, LTC homes will better understand what's working well, what needs to be improved, and what actions can be taken to implement improvements to provide safe, reliable, and high-quality care.

**Figure 1:** Qmentum® Long-Term Care Continuous Accreditation Cycle




## Phase 1

In Phase 1, LTC homes will self-reflect, work together, and engage the voice of all by performing the self-assessment and administering the Governance Functioning Tool (GFT) survey instrument. Results from these activities will help LTC homes understand their current state and identify actions for improvement by developing their QIAP.

*Note:*

- LTC homes that are completing their first accreditation cycle will create their QIAP based on the completion of the self-assessment and GFT survey instrument results.

- LTC homes that have completed a previous cycle will update their QIAP with results from past accreditation cycles, as well as the results of the self-assessment and GFT survey instrument.

Once Phase 1 is complete, LTC homes will have developed their QIAP and initiated or continued their continuous quality improvement journey.

In Phase 1, LTC homes will:

- Perform a self-assessment against all criteria in the Assessment Tool
- Administer the Governance Functioning Tool (GFT) survey instrument
- Develop or update their QIAP based on the results of the self-assessment and GFT, including:
  - At least one action per Assessment Tool chapter
  - At least one action based on the GFT survey instrument results
  - All unmet Required Organizational Practices (ROPs)[2] identified in the self-assessment[3] or, if applicable, the previous accreditation cycle
  - Any required actions from the previous accreditation cycle, if applicable
- Implement actions identified in their QIAP

**QIAP:** Throughout Phase 1, LTC homes will develop or update their QIAP and use it as a guide to action what is needed to address their areas for improvement identified through the self-assessment and GFT results.

By continuously updating and using their QIAP, LTC homes can implement the changes needed for improvement and prepare for the virtual assessment in Phase 2.

## Phase 2

In Phase 2, LTC homes will continue to implement actions identified in their QIAP from Phase 1 and undergo a virtual assessment by Accreditation Canada's surveyors. The virtual assessment is an opportunity for LTC homes to receive an assessment by surveyors against applicable criteria within the Assessment Tool to identify strengths and areas for improvement. The virtual assessment results and surveyor feedback will be used by LTC homes to update their QIAP.

In Phase 2, LTC homes will:

- Continue to implement actions identified in their QIAP
- Prepare for the virtual assessment
- Participate in the virtual assessment led by Accreditation Canada surveyors
- Review and update their QIAP with:
  - Results and surveyor feedback from the virtual assessment
  - All unmet Required Organizational Practices (ROPs) identified in the virtual assessment results

[2] Required Organizational Practices (ROPs) are criteria that contain essential practices that LTC homes must have in place to enhance resident safety and minimize risk.

[3] Unmet criteria from the self-assessment results are defined as those with aggregate data showing more than 50% of respondents rated the criteria as unmet.

  - Any action items identified by the Accreditation Decision Committee

**QIAP:** Throughout Phase 2, LTC homes will update their QIAP based on the virtual assessment results and work to implement the actions identified.

By continuously updating and using their QIAP, LTC homes can implement changes needed for improvement, and prepare for the attestation assessment in Phase 3.

### Phase 3

In Phase 3, LTC homes will progress in their continuous quality improvement journey by: continuing to implement and build on the actions from prior phases; assessing their own performance against identified attestable criteria in the Assessment Tool; and deploying the Workforce Survey on Well-being, Quality and Safety (WSWQS) to its workforce. The results of the attestation assessment and WSWQS survey instrument will inform updates to their QIAP.

In Phase 3, LTC homes will:

- Continue to implement actions identified in their QIAP
- Complete the attestation assessment of identified attestable criteria in the Assessment Tool
- Administer the Workforce Survey on Well-being, Quality and Safety (WSWQS) survey instrument
- Review and update their QIAP with:
  - All unmet attestable criteria from the attestation assessment
  - At least one action item based on the WSWQS survey instrument results
  - All unmet Required Organizational Practices (ROPs)[4] identified in prior assessments
- Complete any follow-up requirements identified by the Accreditation Decision Committee from Phase 2

**QIAP:** Throughout Phase 3, LTC homes will update their QIAP based on the attestation assessment and WSWQS results and continue to implement the actions identified.

By continuously updating and implementing the actions in their QIAP, LTC homes will be prepared for the on-site assessment in Phase 4.

### Phase 4

In Phase 4, LTC homes will continue to action their QIAP, prepare and participate in an on-site assessment by Accreditation Canada's surveyors, and receive their accreditation decision. The on-site assessment is an opportunity for LTC homes to undergo a thorough assessment against identified on-site criteria within the Assessment Tool. LTC homes will receive a detailed report from the on-site assessment that outlines strengths, areas for improvement, and feedback on their continuous quality improvement journey. Upon completion of the on-site assessment, LTC homes are provided with an accreditation decision.

Completion of Phase 4 marks the end of an accreditation cycle. However, LTC homes will use the results and learnings to prepare for their next accreditation cycle (beginning with Phase 1) by maintaining or continuing to strive for accreditation status and advancing their journey toward providing safe, reliable, and high-quality care for their residents.

[4] Required Organizational Practices (ROPs) are criteria that contain essential practices that LTC homes must have in place to enhance resident safety and minimize risk.

In Phase 4, LTC homes will:

- Continue to implement actions identified in their QIAP
- Prepare for the on-site assessment
- Participate in the on-site assessment led by Accreditation Canada surveyors
- Review and update their QIAP with:
  - Results and surveyor feedback from the on-site assessment
  - All unmet Required Organizational Practices (ROPs) identified in the on-site assessment results
  - Any action items identified by the Accreditation Decision Committee

**QIAP:** Throughout Phase 4, LTC homes will update their QIAP based on the on-site assessment results and continue to implement the actions identified.

By continuously updating and implementing the actions in their QIAP, LTC homes can demonstrate positive outcomes, prepare for their next continuous accreditation cycle, and remain focused and committed to their continuous quality improvement journey.

## Accreditation Decision Guidelines

The Qmentum® Long-Term Care program applies decision guidelines that outline the specific requirements for all four phases that LTC homes must meet to achieve or maintain accreditation status. Throughout the four phases of the continuous accreditation cycle, the LTC home's progress will be monitored, and the Accreditation Decision Committee (ADC) may take action if the requirements are not met. The ADC may assign follow-up requirements to LTC homes, including a report and/or a supplementary visit, depending on the outcome of their review of the LTC home's assessment and survey instrument results. Following the Phase 4 on-site assessment, the ADC renders an accreditation decision of either Accredited or Not Accredited based on the accreditation decision guidelines, including completion of the required activities in each phase and thresholds for criteria ratings from assessment results.

For detailed information on the accreditation decision guidelines that will be applied following the Phase 4 assessment, please refer to the document titled "Qmentum Long-Term Care Decision Guidelines".

Information on the specific requirements and thresholds to move from one phase to another throughout the continuous accreditation cycle will be available at a later date.

## Results and Final Report

Throughout Phases 1 to 4, results of completed assessments and survey instruments are provided to LTC homes through a digital platform.

Upon completion of the on-site assessment in Phase 4, a detailed final report will be provided to LTC homes containing the assessment results, the accreditation decision (i.e., Accredited or Not Accredited), as well as identified strengths and areas for improvement. The final report provides LTC homes with quantitative information on how they have demonstrated the evidence to meet the Assessment Tool criteria, as well as qualitative information provided by surveyors. The information in the report provides helpful, actionable feedback for LTC homes on what is going well and what needs to be improved to help support their continuous quality improvement journey.

## Surveyors

The virtual assessment in Phase 2 and on-site assessment in Phase 4 are conducted by surveyors who are trained by Accreditation Canada.

Surveyors are peers from other organizations and subject matter experts who demonstrate the skills, attitudes, and behaviours needed to assess an LTC home's continuous quality improvement journey. Surveyors provide LTC homes with meaningful coaching and support to guide them on their learning and improvement journey.

The core competencies of Qmentum® Long-Term Care surveyors include:

- Lived experience of people-centred care, as a care provider, caregiver, or resident
- Demonstrated knowledge of and experience in LTC programming and practices
- Demonstrated experience in quality improvement activities and implementation of change projects
- Demonstrated knowledge of organizational learning principles (learning practitioner)

# About the Qmentum® Long-Term Care Assessment Tool

The Qmentum® Long-Term Care Assessment Tool ("Assessment Tool") contains the assessment criteria that enables LTC homes to progress, learn, motivate, and be awarded for their efforts to provide safe, reliable, and high-quality care for their residents. The Assessment Tool is organized into thematic chapters that define actionable criteria and guidelines.

LTC home will use the Assessment Tool to perform self-assessments and attestation assessments, as well as prepare for virtual assessment and on-site assessments.

Accreditation Canada surveyors will use the Assessment Tool to perform virtual assessments and on-site assessments.

The Assessment Tool embeds a people-centred care focus in alignment with the Qmentum® Long-Term Care program design principles. People-centred care is successful when everyone has an equal voice and is included in decision making. Within the Assessment Tool, the term "team" is defined and used to include the voice of all. Throughout their accreditation journey, LTC homes will strive to include residents, families, and/or caregivers as **equal** team partners. Identifying who within the team is appropriate to be engaged and when is at the discretion of the LTC home, based on the areas of care and services being assessed.

*Note:* Jurisdictional legislation, regulations, and public health requirements take precedence over any requirements in the Assessment Tool. The tool is meant to support LTC homes as they implement the requirements defined by jurisdictions.

## Chapters

The Assessment Tool is organized into six chapters to support LTC homes on their continuous quality improvement journey. Each chapter begins with an introduction to the purpose of the chapter and its content.

- ***Chapter 1: Governance and Leadership*** addresses criteria assessed by governing bodies and/or leadership teams and defines the standards under which the organization or LTC home's management operates.
- ***Chapter 2: Delivery of Care Models*** addresses thematic areas related to team management, talent development, worklife, information management, quality improvement and delivery of virtual health services.
- ***Chapter 3: Emergency Disaster Management*** addresses emergency, disaster, and outbreak management, focusing on reducing risk and being prepared to respond to and recover from an emergency, disaster or outbreak that occurs inside or outside of the organization.
- ***Chapter 4: Infection Prevention and Control*** addresses organizational infection prevention and control (IPC) practices that promote a collaborative approach in providing safe and reliable services and preventing transmission of pathogens and health care-associated infections.
- ***Chapter 5: Medication Management*** addresses organizational medication management practices that promote a collaborative approach in providing safe and reliable services.
- ***Chapter 6: Residents' Care Experience*** focuses on ensuring the needs of LTC home residents are met by providing safe and quality individualized care from competent teams.

## Sub-chapters

Criteria within each chapter are organized into sub-chapters that address actionable themes.

## Criteria

Each chapter of the Assessment Tool contains practice-specific, actionable criteria. Criteria consist of statements that contain the requirements to be evaluated as part of an assessment. Each criterion outlines the intent, action, and accountability.

## Guidelines

Each criterion has a corresponding guideline that provides additional information to help users understand the criterion statement. Guidelines do not contain new evaluation content.

The criteria and guidelines in the Qmentum® Long-Term Care Assessment Tool have been developed in consultation with subject matter experts and have been adapted from HSO standards that reflect evidence-informed practices and people-centred care principles.

The Qmentum® Long-Term Care Assessment Tool content is informed by the following HSO standards[5]:

- HSO 21001:2020 *Long-Term Care Services*
- HSO 34012:2018 *Leadership for Small, Community-Based Organizations*
- HSO 1001:2018 *Governance*
- HSO 0001:2018 *Service Excellence*
- HSO 34014:2019 *Medication Management for Community-Based Organizations*
- HSO 11011:2018 *Reprocessing of Reusable Medical Devices*
- HSO 34011:2018 *Infection Prevention and Control for Community-Based Organizations*
- HSO 9002:2020 *Emergency and Disaster Management*
- HSO 83001:2018 *Virtual Health*

## Criteria Types

Each criterion in the Assessment Tool is given a classification of a specific assessment method (e.g., on-site, attestation, virtual), priority level (e.g., high priority, normal priority, Required Organizational Practice), and quality dimension. These classifications are indicated in the Assessment Tool through corresponding icons and serve as a guide to help LTC homes further understand criteria by thematic groupings and understand the methodologies that will be used to assess compliance against them.

### Assessment Method

Attestable criteria: The criteria classified with "attestable" means that the criteria will be assessed by LTC homes in the attestation assessment. LTC homes will attest their conformity against these identified attestable criteria.

In the Assessment Tool, attestable criteria are identified by this icon.

On-Site criteria: The criteria classified with "on-site" means that the criteria will be assessed on-site by a surveyor.

In the Assessment Tool, on-site criteria are identified by this icon[6].

Virtual criteria: The criteria classified with "virtual" means that the criteria will be assessed virtually by a surveyor.

In the Assessment Tool, virtual criteria are identified by this icon.

[5] Any updates to these HSO standards will result in an update to the Qmentum® Long-Term Care Assessment Tool.
[6] Additional criteria may be reviewed on-site, as deemed appropriate by surveyors.

## Priority Levels

Normal priority criteria: Any criteria that are not related to high priority themes are classified as normal priority and are not identified by an icon in the Assessment Tool.

High priority criteria: Select criteria are classified as high priority when they are considered essential. High priority criteria are related to safety, ethics, risk management, and quality improvement themes. High priority criteria are weighted more heavily in the accreditation decision guidelines.

In the Assessment Tool, high priority criteria are identified by this icon.

Required Organizational Practices (ROPs): ROPs are essential practices that LTC homes must have in place to enhance resident safety and minimize risk.

In the Assessment Tool, ROPs are identified by this icon.

The technical content of the ROP consists of the ROP statement, guidelines, and tests for compliance.

*ROP statement:* Defines the practice that is expected.

*Guidelines:* Provide context and rationale on why the ROP is important to resident safety and risk management. They also show supporting evidence and provide information about meeting compliance tests. While the guidelines provide insight and information, they are not considered a requirement.

*Tests for compliance:* The specific expectations that surveyors assess to determine whether the LTC home complies with the ROP statement. Note: Not every test for compliance is required to be met to ensure that an ROP is met. An overall minimum requirement for tests for compliance needs to be achieved.

## Quality Dimensions

HSO's Quality Framework includes eight quality dimensions that all play a part in providing safe, high-quality care in every health and social services sector. Each criterion within the Assessment Tool is classified as one of the eight quality dimensions using their respective icons, listed below.

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

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

**Safety:** Keep me safe

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

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

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

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

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

# Qmentum® Long-Term Care Assessment Tool

# Chapter 1: Governance and Leadership

Chapter 1 assesses governance and leadership across Long-Term Care (LTC) homes. Governance and Leadership criteria apply to governing body (boards and committees) and leadership teams. Themes covered in this chapter include strategy and operational plans, roles and responsibilities of governance and leadership, organizational policies and procedures, decision support systems, integrated quality management, and risk management. HSO's principles of people-centred care are embedded throughout the chapter.

## 1.1 Governance

1.1.1 The roles, responsibilities, and legal obligations of the governing body are defined and regularly reviewed.

**Guidelines**

As a rule, the governing body is accountable for the quality of services/care, and supports the organization to achieve its goals, consistent with its mandated objectives and its accountability to stakeholders. In carrying out this mandate, the governing body selects the executive leader of the organization, oversees processes for granting privileges (where applicable), approves major policies, makes decisions that impact the organization's long-term sustainability, oversees the organization's performance, and serves as an external advocate.

Applicable legislation is considered when defining or updating roles, responsibilities, and accountabilities.

Where there are several levels of governance, the roles and responsibilities are well defined and understood by each level, information flows smoothly and consistently between levels, and the governing body coordinates and integrates its work with each level.

When government is actively involved in the oversight of the organization, the scope of authority and roles and responsibilities of the governing body and the government are well defined, either by government or by government working with the governing body.

The governing body defines what “regularly” means and adheres to that schedule.

1.1.2 There are established mechanisms in place for the governing body to hear from and incorporate the voice and opinion of residents, families and/or caregivers.

**Guidelines**

Mechanisms may include establishing resident, family and/or caregiver advisory councils, inviting community health boards to present, or hearing directly from residents, families and/or caregivers about their experience(s) with the organization.

1.1.3 The governing body has processes in place to oversee the functions of audit and finance, quality and safety, and talent management.

**Guidelines**

Depending on the size and organization of the governing body, these functions may be overseen by the governing body itself as a committee as a whole, or by separate sub-committees. In instances where separate sub-committees are required, the governing body defines terms of reference and reporting requirements for each committee.

The processes used by the governing body or its sub-committees to monitor these functions may include defining the number of meetings where audit and finance, quality and safety, and talent management will be discussed and setting regular opportunities to connect with the organization's leaders to get updates on the organization's activities.

1.1.4 The governing body provides oversight of the organization's efforts to build meaningful partnerships with residents, families and/or caregivers.

**Guidelines**

A growing body of evidence demonstrates that improving the resident experience and developing meaningful partnerships with residents, families and/or caregivers are linked to improved health outcomes. Governing bodies educate themselves on the principles of people-centred care and demonstrate the organization's culture is focused on people - centred care.

1.1.5 The governing body monitors and evaluates the organization's initiatives to build and maintain a culture of people-centred care.

**Guidelines**

There are a variety of ways that governing bodies can evaluate the people-centred care initiatives, including reviewing resident experience results, measuring the number of teams that have implemented the organization's people-centred care philosophy and how they have done so, and monitoring the number of resident, family and/or caregiver advisors actively participating on advisory councils.

1.1.6 The governing body oversees the recruitment and selection of the executive leader of the organization.

**Guidelines**

Where the executive leader is appointed by an external body such as government or is specified in legislation, the governing body still plays a role in identifying potential candidates and in the screening, nomination, and selection process.

1.1.7 In partnership with the executive leader of the organization, the governing body sets performance objectives for the executive leader and reviews them annually.

**Guidelines**

The performance objectives are tied to the organization's strategic goals and objectives, and quality and safety outcomes.

1.1.8 The governing body has a mechanism in place to receive updates or reports from the executive leader of the organization.

**Guidelines**

Governing bodies may choose to have the executive leader provide a written report or present at the governing body's meetings.

1.1.9 The governing body approves the organization's capital and operating budgets.

**Guidelines**

The governing body reviews the annual capital and operating budgets and the impact of these budgets on the organization's mandate, the strategic goals and objectives, and health outcomes.

1.1.10 When approving resource allocation decisions, the governing body evaluates the impact of the decision on quality, safety, and resident experience.

**Guidelines**

Depending upon the organization's scope of services, resources may be distributed across populations, geographic regions served, and the continuum of service. Before approving budgets or making allocation decisions, the governing body assesses the costs and benefits of each decision and the impact on the ability to provide services according to the organization's mandate, while giving consideration to the impact on residents, families and/or caregivers ethics, values, social costs and benefits, value for money, and sustainability.

1.1.11 The governing body monitors organization-level measures of resident safety.

**Guidelines**

The governing body receives regular reports and updates on measures related to resident safety, such as organization-wide infection rates, or data on resident falls or medication reconciliation. The data are compiled at the organization level rather than at the program or team level, presenting a global picture of resident safety in the organization, and play an integral part in the governing body's strategic planning process.

1.1.12 The governing body regularly hears about quality and safety incidents from the residents, families and/or caregivers that experience them.

**Guidelines**

Hearing about a safety incident provides additional context that cannot be gleaned from hearing about numbers or frequency of incidents. This context provides valuable information on next steps for improvement and incident prevention.

The information can be shared directly (face-to-face), in writing, through a representative group, or in other ways that best meet the organization's, governing body's, and community's needs.

1.1.13 The governing body demonstrates accountability for the quality of care provided by the organization.

**Guidelines**

Governing bodies are accountable for the quality of care provided by their organizations. When governing bodies are engaged in overseeing quality, their organizations have better quality performance (better care, better resident outcomes, better worklife, and reduced costs).

The members of the governing body need to be aware of key quality and safety principles if they are to effectively understand, monitor, and oversee the quality performance of the organization. Knowledge gaps among the membership can be addressed through targeted recruitment for specific competencies (e.g., quality assurance, risk management, quality improvement, and safety) from health care or other sectors (e.g., education or industry) or by providing education through workshops, modules, retreats, virtual networks, or conferences.

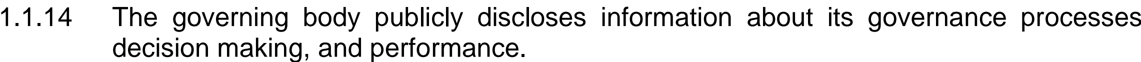
The governing body can demonstrate a clear commitment to quality when it is a standing agenda item at each meeting. Often the governing body overestimates the quality performance of an organization, so discussions need to be supported with indicator data and feedback from residents, families and/or caregivers. A small number of easily understood performance indicators that measure quality at the system level (i.e., big-dot indicators) such as the number of residents who died or were harmed by resident safety incidents, quality of worklife, number of complaints, and resident experience results will help answer the question, “are the services we provide getting better?”

Quality performance indicators need to be linked to strategic goals and objectives and balanced across several priority areas. Knowledge gained from the review of quality

performance indicators can be used to set the agenda, inform strategic planning, and develop an integrated quality improvement plan. It can also be used to set quality performance objectives for senior leadership and to determine whether they have met their quality performance objectives.

**Tests for compliance**

| | |
|---|---|
| 1.1.13.1 | The governing body is knowledgeable about quality and safety principles, by recruiting members with this knowledge or providing access to education. |
| 1.1.13.2 | Quality is a standing agenda item at all regular meetings of the governing body. |
| 1.1.13.3 | The key system-level indicators to be used for monitoring the quality performance of the organization are identified. |
| 1.1.13.4 | At least quarterly, the quality performance of the organization is monitored and evaluated against agreed-upon goals and objectives. |
| 1.1.13.5 | Information about the quality performance of the organization is used to make resource allocation decisions and set priorities and expectations. |
| 1.1.13.6 | As part of their performance evaluation, leaders who report directly to the governing body (e.g., the CEO, Executive Director, Chief of Staff) are held accountable for the quality performance of the organization. |



1.1.14 The governing body publicly discloses information about its governance processes, decision making, and performance.

**Guidelines**

Expectations for public disclosure apply particularly to public sector organizations.

While these expectations continue to evolve, most governing bodies are expected to disclose information about:

- membership and processes for identifying new members
- scope of authority and roles and responsibilities
- any sub-committees, including terms of reference and membership
- the roles and responsibilities of the chair
- the roles and responsibilities of individual members and the process to assess their performance
- their attendance, and remuneration if applicable
- the position profile of the executive leader and process for evaluating the executive leaders' performance
- the ethics framework and the process to disclose conflicts of interest
- the approach to the orientation and education of its members
- the communication plan and practices of public disclosure

## 1.2 Leadership

1.2.1 Support is provided for activities that improve the quality of worklife and health and safety of the work environment.

**Guidelines**

The organization's healthy and safe work environment activities are aligned with its strategic direction, goals, and objectives. Activities that improve quality of worklife and create a healthy and safe work environment may include:

- role modelling
- teaching and coaching teams
- motivating teams
- providing worklife balance
- supporting open communication and collaborative decision making
- providing rewards and recognition
- setting and implementing criteria for recognizing and promoting team members

The organization's leaders can support these activities by:

- providing access to educational activities such as workshops, conferences, or courses
- providing access to research and best practice information
- allocating human or financial resources specifically to improving quality of worklife in the organization
- reorganizing existing team responsibilities to provide additional time for initiatives to improve quality of worklife
- communicating concrete examples of leadership's commitment to quality of worklife in the organization

1.2.2 The organization adopts a comprehensive approach to promote and support organizational health and safety.

**Guidelines**

The organization demonstrates its commitment to the health and safety of everyone associated with the organization, by developing and adopting a comprehensive approach that embeds physical, psychological, and cultural safety and wellness as part of the organizational culture. It uses a variety of methods such as:

- Recognizing its responsibility to promote a culture of safety and humility by specifying staff, resident, family and/or caregiver safety as an organizational priority that is aligned with its vision, mission, and values
- Establishing organizational health and safety goals; assigning the organizational leaders with defined accountabilities for achieving the goals, and for reporting to the governing body on organizational health and safety initiatives and progress toward achieving the goals
- Engaging stakeholders in organizational health and safety efforts and activities
- Developing organizational health and safety policies in collaboration with staff, residents, families and/or caregivers, including policies on safety incident management, non-discrimination and stigma, workplace violence, and immunization
- Measuring and collecting organizational health and safety data (e.g., measuring harm)

- Identifying and assessing health and safety risks to staff, residents, families and/or caregivers; preventing safety incidents, reducing harm, and managing risk
- Educating staff, residents, families and/or caregivers about organizational health and safety, including safe practices to mitigate risk from safety hazards (e.g., musculoskeletal disorders from lifting and transferring; slips, trips, and falls; exposure to infectious diseases; work-related stress; workplace violence; stigma and discrimination), some aspects of staff training on safety may be mandatory
- Promoting a just culture that encourages people to report and learn from mistakes and safety incidents
- Having the organizational leaders promote a safety culture by regularly discussing safety with staff and supporting staff participation in improving health and safety (e.g., engaging with staff to identify meaningful initiatives; supporting staff to participate in or lead initiatives; identifying health and safety champions and supporting them through coaching and mentoring)
- Developing and implementing health and safety plans and initiatives to enable continuous improvement of staff, resident, family and/or caregiver safety; monitoring and evaluating the effectiveness of health and safety initiatives and activities (e.g., through regular safety audits) and updating them as needed to achieve health and safety goals
- Defining roles to promote health and safety (e.g., safety officer) and allocating time and resources for improving safety

1.2.3 A documented and coordinated approach to prevent workplace violence is implemented.

**Guidelines**

Workplace violence is more common in health care settings than in many other workplaces, with one-quarter of all incidents of workplace violence occurring at health services organizations. It is an issue that affects staff and health providers across the health care continuum.

This ROP has adopted the modified International Labour Organization definition of workplace violence, as follows: “Incidents in which a person is threatened, abused or assaulted in circumstances related to their work, including all forms of harassment, bullying, intimidation, physical threats, or assaults, robbery or other intrusive behaviours. These behaviours could originate from customers or co-workers, at any level of the organization.”

A strategy to prevent workplace violence should be in compliance with applicable regional or national legislation and is an important step to respond to the growing concern about violence in health care workplaces.

**Tests for compliance**

1.2.3.1 There is a written workplace violence prevention policy.

1.2.3.2 The policy is developed in consultation with team members and volunteers as appropriate.

1.2.3.3 The policy names the individual(s) or position responsible for implementing and monitoring adherence to the policy.

1.2.3.4 Risk assessments are conducted to ascertain the risk of workplace violence.

1.2.3.5 There are procedures in place for team members to confidentially report incidents of workplace violence.

1.2.3.6 There are procedures in place to investigate and respond to incidents of workplace violence.

1.2.3.7 The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and improve the workplace violence prevention policy.

1.2.3.8 Information and training are provided to team members on the prevention of workplace violence.

1.2.4 The organization's mission, vision, and values are shared with team members, residents, their families and/or caregivers, and the community.

**Guidelines**

Ways to share the mission and vision include posting them in the organization's reception/lobby, on computer screensavers, templates for letterhead or presentations, team identification (ID) cards, or on the organization's website.

1.2.5 Annual operational plans are developed to support the achievement of the strategic plan, goals, and objectives, and to guide day-to-day operations.

**Guidelines**

Operational plans describe short-term ways to achieve the goals and objectives set out in the strategic plan, and the required activities and resources.

An operational plan is often the basis for the organization's annual operating budget.

In a small organization, multiple plans (for example, the strategic plan, operational plan, risk management plan, disaster and emergency preparedness plan, resident safety plan, and quality improvement plan) may be compiled into one document.

1.2.6 The organization's leaders develop partnerships to efficiently and effectively deliver and coordinate services.

**Guidelines**

Meeting the full range of the community's service needs is beyond the capacity of any one organization. The organization's leaders identify the partnerships needed to provide access across the continuum of service. They also look for ways to reduce duplication and share resources with other organizations.

Partnerships may be formed with organizations providing acute care, primary care, community-based programs, public health services, outpatient services, home care, counselling services, and others as appropriate.

1.2.7 The physical environment is managed to protect resident and team health and safety.

1.2.8 The organization's leaders ensure that plans for maintaining, upgrading, and replacing medical devices and equipment are followed.

**Guidelines**

The plans include:

- schedules for maintenance, upgrades, and replacement of medical devices and equipment
- procedures for service checks and routine and preventive maintenance
- procedures for safe, secure, and efficient storage

- instructions for emergency servicing or repair

1.2.9 Steps, including introducing back-up systems, are taken to reduce the impact of utility failures on resident and team health and safety.

**Guidelines**

Utilities include electricity, heat, potable water, telephone service, and sterile water.

In the absence of a back-up system, the organization's leaders prepare a plan for what to do in the event of a sustained utilities failure, for example how to protect medications and vaccinations that require refrigeration, or how and where to relocate residents.

1.2.10 Reporting relationships for all team members are defined and regularly reviewed.

**Guidelines**

Reporting relationships are clearly understood by everyone in the organization and may be shown in an organizational chart.

1.2.11 Roles and responsibilities for resident safety are defined in writing.

**Guidelines**

Everyone in the organization plays an important role in resident safety. Roles and responsibilities for resident safety may be defined in position profiles, performance appraisals, handbooks, and orientation material.

1.2.12 The privacy and confidentiality of resident information are protected, in accordance with applicable legislation.

**Guidelines**

Applicable legislation may be national or regional.

1.2.13 Teams are provided with access to information on best practices, Leading Practices, and practice guidelines.

**Guidelines**

Best practices are methods of carrying out tasks that have shown to provide superior results over time — in other words, it is considered the “best way” of doing something.

Leading practices are emerging methods that show promise but have not yet achieved the status of best practice.

Practice guidelines are documents or statements used to guide health care providers in carrying out these best or Leading Practices.

Information on best practices, Leading Practices, and practice guidelines is often provided by professional associations or by government bodies.

The organization's leaders ensure that teams have access to this type of information on a regular basis, as appropriate to their roles, and in a timely manner for urgent or emergency situations. Ways to give access include:

- providing access to online databases, books, journals, and association websites
- sending team members to conferences where best and Leading Practices will be discussed

- printing copies of guidelines and best practices and posting them in the organization or handing them out to team members
- holding regular education sessions to introduce or discuss new practice guidelines or practices

1.2.14 Policies and processes for selecting and negotiating contracted services are developed and implemented.

**Guidelines**

The organization has policies and procedures for:

- selecting contracted services
- negotiating the terms of the agreement
- signing, reviewing, and updating all contracts
- anticipating and addressing risks associated with contracted services

1.2.15 A resident safety plan is developed and implemented for the organization.

**Guidelines**

There is an important connection between excellence in care and safety. Ensuring services are provided safely is one of an organization's primary obligations to residents and team members. Resident safety can be improved when organizations develop a targeted resident safety plan.

Resident safety plans need to consider safety issues in the organization, the delivery of services, and the needs of residents, families and/or caregivers. They may include a range of topics and approaches, such as mentoring team members, the role of leadership (e.g., resident safety leadership walkabouts), implementing organization-wide resident safety initiatives, accessing evidence and best practices, and recognizing team members for innovations to improve resident safety.

**Tests for compliance**

| | |
|---|---|
| 1.2.15.1 | Resident safety issues for the organization are assessed. |
| 1.2.15.2 | There is a plan and process in place to address identified resident safety issues. |
| 1.2.15.3 | The plan includes resident safety as a written strategic priority or goal. |
| 1.2.15.4 | Resources are allocated to support the implementation of the resident safety plan. |

1.2.16 Resident safety training and education that addresses specific resident safety focus areas are provided at least annually to leaders, team members, and volunteers.

**Guidelines**

Annual education on resident safety is made available to the organization's leaders, team members, and volunteers. Specific resident safety focus areas such as safe medication use, reporting resident safety incidents, human factors training, techniques for effective communication, equipment and facility sterilization, handwashing and hand hygiene, and infection prevention and control are identified.

**Test for compliance**

| | |
|---|---|
| 1.2.16.1 | There is annual resident safety training tailored to the organization's needs and specific resident safety focus areas. |

1.2.17 A resident safety incident management system that supports reporting and learning is implemented.

**Guidelines**

In a culture of resident safety, everyone is encouraged to report and learn from resident safety incidents, including harmful, no-harm, and near miss. A reporting system that is simple (few steps), clear (what needs to be reported, how to report, and to whom), confidential, and focused on system improvement is essential. Residents, families and/or caregivers may report resident safety incidents differently than team members, but everyone needs to know how to report. Information about how to report can be tailored to the needs of team members or residents, and can be part of team member training and included in written and verbal communication to residents, families and/or caregivers about their role in safety.

The immediate response to a resident safety incident is to address the urgent care and support needs of those involved. It is also important to secure any items related to the incident (for testing and review by the analysis team), report the incident using the approved process, begin the disclosure process (if required), and take action to reduce any risk of imminent recurrence.

Through incident analysis (also known as ‘root cause analysis'), contributing factors and recommended actions can be identified to make improvements. Analyzing similar resident safety incidents (such as near misses) together, to look for patterns or trends, can yield helpful information, as can analyzing incidents in isolation. Communicating incident analysis findings broadly (e.g., with residents, families and/or caregivers, governance, leadership, clinical teams, and external partners) builds confidence in the incident management system and promotes learning from resident safety incidents.

*Global Patient Safety Alerts* is a searchable online database where learnings from resident safety incidents are shared.

**Tests for compliance**

1.2.17.1 A resident safety incident management system is developed, reviewed, and updated with input from residents, families and/or caregivers, and team members, and includes processes to report, analyze, recommend actions, and monitor improvements.

1.2.17.2 Information is shared with residents, families, and/or caregivers, and team members so they understand what, when, and how to report resident safety incidents.

1.2.17.3 Training is provided, and documented, for team members on the immediate response to resident safety incidents.

1.2.17.4 There are procedures in place to review resident safety incidents and established criteria are used to prioritize those that will be analyzed further.

1.2.17.5 All recommended actions resulting from the analysis of resident safety incidents are reviewed and the rationale to accept, reject, or delay implementation is documented.

1.2.17.6 Information about recommended actions and improvements made following incident analysis is shared with residents, families and/or caregivers, and team members.

1.2.17.7 The effectiveness of the resident safety incident management system is evaluated, and improvements are made based on feedback received. Evaluation mechanisms may include:

- Gathering feedback from residents, families and/or caregivers, and team members about the system
- Monitoring resident safety incident reports by type and severity

- Examining whether improvements are implemented and sustained
- Determining whether team members feel comfortable reporting resident safety incidents

1.2.18 A documented and coordinated approach to disclosing resident safety incidents to residents, families and/or caregivers, that promotes communication and a supportive response, is implemented.

**Guidelines**

Disclosure of resident safety incidents is an ongoing discussion that includes the following core elements:

- Informing those affected that a resident safety incident has occurred and offering an apology
- Explaining what happened and why, as facts are known
- Discussing the immediate actions taken to care for the resident and mitigate further harm
- Reviewing recommended actions to prevent future incidents
- Offering support to all involved

The support provided meets the needs of those involved (residents, families and/or caregivers, and the team), and can be practical (e.g., reimbursement for out-of-pocket expenses) or emotional/psychological (e.g., helping with access to support groups or offering counselling).

Disclosing a resident safety incident that affects multiple residents (e.g., failures in sterilization, privacy breaches) includes additional elements, for example:

- Identifying which residents have been exposed to risk
- Deciding which residents should be contacted and how
- Locating and communicating with residents who have been affected
- Informing the community, other organizations, and the media

When asked for their feedback, residents, families and/or caregivers are encouraged to speak from their own perspective and in their own words about their experience.

**Tests for compliance**

1.2.18.1 There is a documented and coordinated process in place to disclose resident safety incidents to residents, families and/or caregivers that identifies:

- Which resident safety incidents require disclosure
- Who is responsible for guiding and supporting the disclosure process
- What can be communicated and to whom about the incident
- When and how to disclose
- Where to document the disclosure

1.2.18.2 The disclosure process is reviewed and updated, as necessary, with input from residents, families and/or caregivers, and team members.

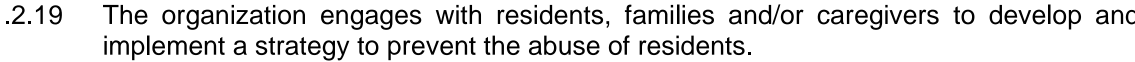
1.2.18.3 Those responsible for guiding and supporting the disclosure process are provided with training on disclosure.

1.2.18.4 Communication occurs throughout the disclosure process with residents, families and/or caregivers, and team members involved in the

resident safety incident. Communication is documented and based on their individual needs.

1.2.18.5 As part of the disclosure process, practical and emotional/psychological support is offered to residents, families and/or caregivers, and team members involved in the resident safety incident.

1.2.18.6 Feedback is sought from residents, families and/or caregivers, and team members about their experience with disclosure and this information is used to make improvements, when needed, to the disclosure process.



1.2.19 The organization engages with residents, families and/or caregivers to develop and implement a strategy to prevent the abuse of residents.

**Guidelines**

Abuse includes all improper treatment of a resident. Types of abuse include physical abuse, verbal abuse, emotional abuse, financial abuse or exploitation, sexual abuse, and neglect.

Residents are in a vulnerable position, putting them at risk of abuse. It is important to identify risk factors within the organization that make the potential for abuse and neglect more likely. These include:

- organization risk factors (e.g., low staffing, team stress and burnout, high turnover, negative organizational culture, absence of an abuse prevention policy)
- resident risk factors (e.g., dementia, high degree of dependence, social isolation)
- resident relationship risk factors (e.g., past conflicts with the team, family and/or caregiver, little to no contact with family and/or caregiver)

An organizational strategy to prevent abuse can include many factors, including a policy on abuse prevention, education for teams, residents, families and/or caregivers, tools to identify residents at risk for abuse, and an abuse reporting protocol.

Creating an abuse prevention policy is a good first step in reducing the risk of abuse within an organization. The policy should include information on how to recognize the signs and symptoms of abuse, and reporting and investigation procedures, and should be consistent with legislation. Team education and training is critical in prevention of abuse, and should include such topics as communication skills, anger management, behaviors or symptoms that put an individual at risk for abuse such as mental illness or dementia, and how to respond appropriately to issues and confrontations.

1.2.20 A quality improvement plan is developed and implemented.

**Guidelines**

A quality improvement plan incorporates performance measurement, including monitoring strategic goals and objectives, resident safety, and quality improvement. It recognizes that these activities are interrelated and therefore need to be coordinated.

As part of the quality improvement plan, the organization's leaders may use a balanced scorecard, which aligns performance measurement and quality improvement with strategic goals and objectives. Similarly, the scorecard may be used to translate the strategy into actions. Involving relevant departments and leaders at all levels is important. The scorecard is adaptable to the organization's goals and objectives. It may address financial issues; resident and team experience; and internal systems or process performance information.

Using information from the scorecard, the organization's leaders can share performance information with the governing body, where appropriate; generate dashboards or scorecards for specific programs or teams; generate resident or team experience reports; and generate information related to other system-wide measures.

One approach for analyzing and improving processes is the Lean methodology, which focuses on understanding the system from the experience of the resident and using that information to increase efficiency, minimize waste, and increase quality.

The Six Sigma methodology is another approach that can be used to improve quality and minimize variability in services. It uses data and statistical analysis to identify where errors are occurring.

In a small organization, multiple plans (for example, the strategic plan, operational plan, risk management plan, disaster and emergency preparedness plan, resident safety plan, and quality improvement plan) may be compiled into one document.

1.2.21 The organization has acted on their resident experience assessment results.

**Guidelines**

Actions could include (but are not limited to):

- Sharing results with the team, resident, families and/or caregivers
- Identifying areas that are already strong, as well as areas that require improvement
- Selecting one or more areas for improvement that could be addressed through improvement projects
- Setting a baseline against which future assessments can be compared

1.2.22 The results of the organization's quality improvement activities are communicated broadly, as appropriate.

**Guidelines**

Broad communication includes communicating with the governing body (where applicable), teams, and residents, families and/or caregivers. The organization's leaders may also share the results of quality improvement activities with partners, stakeholders, and the community.

Results are communicated in accordance with legislation that protects information related to quality, safety, risk management, and personal health information.

## Chapter 2: Delivery of Care Models

Chapter 2 assesses the delivery of safe and reliable care models that meet the needs of LTC homes and is reliant on the effective team-level implementation of the organization's model of service delivery and the policies and practices that support it. The common elements of excellence in service delivery include strong team leadership, competent and collaborative teams, up-to-date information systems and virtual health services to support service delivery and decisions, regular monitoring and evaluation of processes and outcomes, and an overarching culture of safety and continuous quality improvement.

This section applies to the organization's leaders and team members.

### 2.1 Service Excellence

2.1.1 A universally-accessible environment is created with input from residents, families and/or caregivers.

**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, families and/or caregivers to support accessibility.

2.1.2 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.

2.1.3 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, family and/or caregiver 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.

2.1.4 An appropriate mix of skill level and experience within the team is determined, with input from residents, families and/or caregivers.

**Guidelines**

Ensuring an appropriate and optimal mix of skill level and experience supports safe, effective, people-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, families and/or caregivers 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, families and/or caregivers may be well positioned to recognize a resource or knowledge gap on the team (e.g., knowledge of community resources; experience working with residents, families and/or caregivers 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, families and/or caregivers).

2.1.5 Credentials, qualifications, and competencies are verified, documented, and kept updated.

**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 regional and organizational policies.

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

2.1.6 A comprehensive orientation is provided to new team members and resident, family and/or caregiver 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 people-centred care and how to apply its principles to practice
- roles, responsibilities, and performance expectations
- policies and procedures, including confidentiality
- worklife balance initiatives
- 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.

2.1.7 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 people-centred care, and contribute to the values of the organization.

It may also consider the individual's strengths; opportunities for growth; contributions toward resident 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 people-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.

2.1.8 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 service 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.

2.1.9 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.

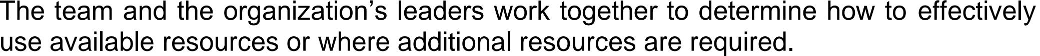
Recognition can be formal or informal and may be verbal, written, or focus on promoting an atmosphere where team members feel appreciated for their contributions.

2.1.10 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.

2.1.11 The effectiveness of resources, space, and staffing is evaluated with input from residents, families and/or caregivers, 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, families and/or caregivers, the team, and stakeholders is gathered through surveys, focus groups, advisory committees, and informal feedback.

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

**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 resident safety, improve inter-team collaboration, increase efficiency, and minimize variation in service delivery. Resident, family and/or caregiver perspectives are considered when evaluating improvements. As the recipients of care, residents, families and/or caregivers are often best positioned to help identify unnecessary variations or duplications in service. Research knowledge is adapted and applied to each unique care setting.

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

2.1.14 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.

2.1.15 There is a standardized procedure in place 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 the guidelines to be used 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.

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

**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 resident safety incidents, and others.

Residents, families and/or caregivers are involved in providing and documenting information, and ensuring the information captured is accurate and complete. The team may partner with the resident, family and/or caregiver 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, family and/or caregiver. 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, family and/or caregiver is not possible, the team works to include the resident, family and/or caregiver 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.

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

**Guideline**

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.

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

**Guidelines**

Policies regarding the use of electronic mail, texting, web applications and social media are determined using the perspectives of residents, families and/or caregivers. 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).

## 2.2 Virtual Health

2.2.1 The organization promotes and enables the use of virtual health services by the care team and management.

**Guidelines**

The organization provides the resources and supports necessary to design, implement and maintain a comprehensive virtual health system that meets the needs of residents, families and/or caregivers, as well as service providers as an effective alternative and/or adjunct to conventional in-person care. The virtual health services provided by the organization is supported by appropriate infrastructure, tools, policies, and procedures to facilitate its use by team members, as well as ensure privacy and information security.

The organization promotes and facilitates the use of virtual health services by considering acceptable use-cases, ease of use, alignment with current processes in terms of time, level of effort and/or remuneration (e.g., appointment scheduling time frames and administrative and system requirements). Similarly, requirements for intake and treatment consent, as well as security of information at all points during the delivery of virtual health services must be addressed.

The organization, in collaboration with residents, families and/or caregivers, develops and tests a series of use-cases to identify potential bottlenecks, cross boundary issues, and system modifications/mitigations required to safely and securely implement virtual health services.

Effective virtual health services should be phased in gradually to ensure smooth integration with end-user processes and capabilities at all levels. Gradual roll-out enables organizations to identify localized problems and resolve these prior to introduction of each subsequent part.

The organization ensures team members, including residents, families and/or caregivers, receive appropriate education, training, and support relevant to their role and responsibilities, on the virtual health services used by the organization.

2.2.2 The organization collaborates with residents, as required, to develop a mechanism to prevent a breach in resident safety when receiving virtual health services.

**Guidelines**

The organization, in collaboration with team members, will develop and maintain evidence-informed virtual care management strategies, policies, procedures and control measures to support high-quality and safe treatment, monitoring, and documentation practises when providing virtual health services (e.g., virtual monitoring of wound care treatment plan).

The organization's strategies to support residents receiving virtual health services include a Chief Medical Officer responsible for developing evidence-informed residents health and safety systems, including policies and procedures such as decision pathways for identification and management of critical incidents; for example, determination of responsibility for calling EMT/ambulance if the residents start to decompensate. Relevant policies, procedures and pathway decisions outline provider responsibility and accountability when resident safety incidents take place.

The organization includes the role of a Chief Information Officer (CIO) or equivalent to lead the organization through the development and maintenance of system

Confidentiality, Integrity and Accessibility. The CIO or equivalent ensures the system has the capacities and safeguards to support resident safety and health, and to prevent breaches by keeping resident data and information secure.

Other considerations include, but are not limited to, the licensure of the systems, cross boundary communication, validity of informed consent obtained virtually, provision of training on the use of virtual health technology, and system upgrading and improvement.

2.2.3 The organization obtains and documents the resident's informed consent before providing virtual health services.

**Guidelines**

Informed consent consists of reviewing service information with the resident, family and/or caregiver, 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 resident is informed where their data are stored, as per jurisdictional law.

There is a process to obtain consent in a timely manner. Consent complies with the standards of practice for virtual health services. Consent is informed and ongoing throughout the provision of virtual health services. As part of informed consent, the resident must be willing to accept the identified risk associated with virtual care.

2.2.4 The organization collaborates with residents, other teams, and organizations to provide residents with appropriate follow-up virtual health services, where applicable.

**Guidelines**

Where a need for a follow-up is identified by virtual health services, the appropriate type and method are determined. This includes the responsibilities of the care team such as following up on testing, providing a referral to a partner organization, setting timelines for resident contact, or reminding the resident of an appointment. It also includes resident responsibilities such as following up with other clinicians, reporting worsening or changing symptoms, and taking medications as prescribed. 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 for virtual health 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 they receive the most appropriate services in the most appropriate setting and minimize temporary solutions or unnecessary transfers.

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

2.2.5 The organization has a written agreement between the off-site service delivering virtual health services and the direct resident care site receiving virtual health services.

**Guidelines**

The site delivering virtual health services off-site has a written agreement with the site of direct resident care receiving virtual health service. The consultant and local clinician must reach an agreement regarding roles and responsibilities before virtual health services are provided.

The agreement addresses the following:

- Reimbursing clinicians

- Securing and protecting health information
- Obtaining appropriate informed consent
- Documenting and storing resident health records
- Protecting resident rights to privacy, confidentiality, and quality care
- Liabilities and responsibilities of each organization
- Dispute resolution
- How to prepare, transmit, and receive data

Guidelines for written agreements may be based on relevant provincial/territorial legislation or regulations.

# Chapter 3: Emergency and Disaster Management

Chapter 3 assesses emergency, disaster and outbreak planning and management for the LTC home. An emergency is a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property, and that is caused by the forces of nature, a disease (including epidemics) or other health risk, an accident, or an act whether intentional or otherwise.

Themes covered in this chapter include up to date disaster, emergency and outbreak preparedness plans, appropriate training provided to the workforce and residents, engaging with community partners, and communication plans (internal and external).

Assessment of emergency and disaster management criteria apply to the organization including its leadership, personnel and support care teams, and is inclusive of residents, families and/or caregivers.

## 3.1 Emergency and Disaster Management

3.1.1 A disaster and emergency preparedness plan is developed and implemented.

**Guidelines**

The plan identifies immediate actions to respond to disasters and emergencies. This includes internal and external roles and responsibilities (e.g., those of community partners) and establishes lines of authority. The plan addresses all hazards identified by the organization's leaders, the risk assessment, and the business impact analysis.

The plan identifies the essential information and messages that must be sent and received, to whom they should be communicated, and how the organization will send communications internally and externally, including to the public.

Organizations with two or more sites follow the same or similar plans to prepare for and reduce the risk of disasters and emergencies.

In a small organization, multiple plans (for example, the strategic plan, operational plan, risk management plan, disaster and emergency preparedness plan, resident safety plan, and quality improvement plan) may be compiled into one document.

3.1.2 Regular drills of the emergency and disaster preparedness plan are carried out.

**Guidelines**

Depending on the level of risk, regular testing of at least one type of emergency or one element of the plan is done at least quarterly, and annual evacuation drills are held for each shift. The timing and frequency of drills and exercises may depend on the time sensitivity or complexity of the emergency plans. A facility that experiences a high degree of turnover may need more frequent exercises. Training and exercise schedules are often linked to seasonal hazards or to trigger events.

The organization's leaders encourage as many team members as possible to participate in testing disaster and emergency plans and monitor and document participation.

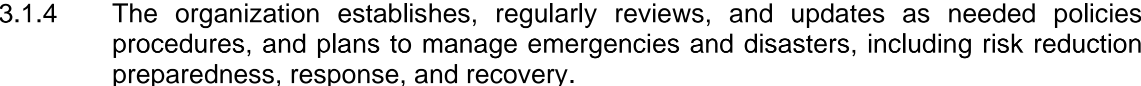
3.1.3 The organization establishes, regularly reviews, and updates as needed policies and procedures to safely evacuate its facility or part of its facility if it is unable to safely provide services during an emergency or disaster.

**Guidelines**

When residents can no longer be cared for safely in their current facility, the organization has policies and procedures that outline how it will safely evacuate the affected facility.

The policies and procedures may include:

- Rapid assessment protocols to determine the extent to which a facility has been or is expected to be affected; whether partial or full evacuation is necessary; the time frame during which safe evacuation is possible; and the safest routes by which to evacuate
- Triage protocols to identify residents that need to be transferred to an alternate care location, residents that may be safely discharged or transferred from inpatient to outpatient care, and residents that may be safely transferred to home and community services
- Identification of alternate care locations inside or outside the organization that have sufficient capacity and resources to accommodate the health care needs of those being evacuated. The organization may establish mutual aid agreements with other local health care or community organizations to provide alternate care locations or services
- Protocols for communication with alternate care locations or services to plan and coordinate the transfer of those being evacuated; and to facilitate the secure transmission of confidential residents' data that is essential to the continuity of care
- Protocols to safely deploy evacuated staff to alternate care locations where possible, and as required; and to provide staff with the necessary information for successful deployment
- Protocols for temporary safe shelter of residents and staff, where needed, at or near the affected location or facility while transport is being arranged
- Protocols to confirm that everyone is accounted for following evacuation and that no one remains inside the evacuated area
- Protocols to inform residents, families and/or caregivers that evacuation is anticipated, imminent, or has taken place, and information on how to reach the residents
- Protocols to ensure that each care location has adequate evacuation equipment and devices, and that the equipment and devices are regularly maintained and tested
- The organization ensures that the policies comply with relevant laws and regulations



3.1.4 The organization establishes, regularly reviews, and updates as needed policies, procedures, and plans to manage emergencies and disasters, including risk reduction, preparedness, response, and recovery.

**Guidelines**

The organization ensures that the policies, procedures, and plans comply with relevant laws and regulations.

3.1.5 The organization follows a structured and inclusive process to engage with internal and external stakeholders in emergency and disaster planning.

**Guidelines**

The organization ensures that the emergency planning committee has a structured and inclusive process to regularly engage with internal stakeholders, including other organizational committees; and with external stakeholders including emergency planning committees of other organizations in the community and jurisdiction.

Engaging in a structured and inclusive manner with internal and external stakeholders enables the committee to coordinate planning for risk reduction, preparedness, response, and recovery; plan for areas where help may be needed; learn about best practices; and

be part of a coordinated approach to emergency and disaster planning that is appropriate to the geographic region and the diverse cultures and risk profiles in the region.

3.1.6 The organization provides residents with information that enables them to be prepared to take care of their health needs in emergencies and disasters.

**Guidelines**

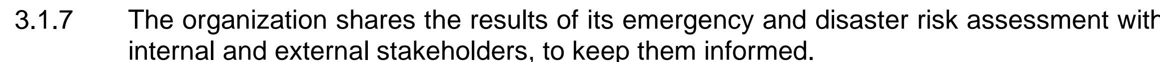
The organization provides information to residents, their families and/or caregivers about emergencies and disasters that the organization may be at risk for, including information on how they can take care of themselves during an emergency or disaster. The organization may inform residents at arrival or admission about emergency and disaster procedures (e.g., lockdown, evacuation, discharge, or relocation if there is a surge). The information is provided in a format that allows the residents, families and/or caregivers to review it at time that is convenient for them.

The organization also provides information to residents living in the community such as those with chronic or complex health issues, to help them understand:

- The emergency and disaster risks in the community and environment
- Their options for service during an emergency or disaster, such as knowing whether to go to the health care facility or where to find alternate locations for treatment, vaccines, or medical supplies
- How they can prepare for a period of self-care during an emergency or disaster if access to care services is affected

The organization works with residents, families and/or caregivers, and the community to develop information on being prepared for emergencies and disasters. It also works with other health care providers in the community, public health services, and jurisdictional organizations to develop and disseminate the information. Where available, the organization may use information that has already been developed by trusted sources, enabling the organization to align its information with other messaging in the community and ensure it is sharing reliable information.

The organization provides information to residents prior to an emergency or disaster, as well as during the response and recovery phases.



3.1.7 The organization shares the results of its emergency and disaster risk assessment with internal and external stakeholders, to keep them informed.

**Guidelines**

The organization shares results of the emergency and disaster risk assessment in a manner that is customized, appropriate, and relevant to the stakeholders.

3.1.8 The organization integrates its emergency and disaster plan with community emergency and disaster plans, to ensure a coordinated response to a recovery from an event.

**Guidelines**

As part of its planning process, the organization consults with leaders and governing bodies in the community to determine whether community emergency plans have been developed, and how the organization may integrate its emergency and disaster plan with the community's plans.

3.1.9 The organization engages with stakeholders to establish, regularly review, and update as needed a business continuity plan to ensure the continuation of essential care services during and following an emergency or disaster.

**Guidelines**

The organization's business continuity plan is aligned with its emergency and disaster plan. As part of its business continuity planning, the organization engages with internal and external stakeholders to evaluate the potential impact of interruptions on its operations and services (that may be referred to as a business impact analysis); and to identify time sensitivities, associated resource requirements, and interdependencies. Based on this analysis, and in compliance with relevant laws and regulations, the organization identifies and prioritizes essential care services that need to be preserved.

The organization also identifies the essential utilities and systems (that may be referred to as critical infrastructure) needed to be able to provide the essential care services. Essential utilities include electricity, potable water, sterile water, sewage, wastewater, fuel, medical gases, and vacuum systems. Essential systems include elevators and escalators; heating, ventilation, and cooling systems; steam for sterilization; communication systems (e.g., telephones, faxes, mobile phones, pagers, intercoms); and information systems.

The organization defines the actions that need to be taken to ensure continuation of essential care services. Actions may include ensuring it has back-up systems for essential services, utilities, and systems and that they comply with relevant laws and regulations. If laws or regulations do not exist, they should, at a minimum, meet local needs. For example, if the organization uses technology-based systems (e.g., electronic information systems such as electronic health records) in its normal operations, the organization has back-up systems and procedures to address power failures. This may involve reverting to paper-based systems or having a back-up generator. Actions may also include regularly testing the back-up systems to build resilience.

3.1.10 The organization plans for how it will manage potential barriers to staff reporting for work during or following an emergency or disaster, to ensure safe levels of staffing.

**Guidelines**

Barriers to staff reporting for work may include staff being directly affected by the emergency or disaster (e.g., staff illness during a pandemic); real or perceived threats to staff safety; limited or no access to the workplace (e.g., road closures, transportation system limitations); or increased familial responsibilities including the need to care for the elderly or young family members (e.g., daycare closures, lack of access to carers or babysitters).

The organization takes these barriers into account as part of its planning.

3.1.11 The organization has mechanisms to manage flow, access, and security during an emergency or disaster.

**Guidelines**

The organization identifies its unique needs related to flow, access control, and security in an emergency or disaster and incorporates them into its emergency and disaster planning.

Flow, access control, and security may relate to both physical and electronic environments. The organization incorporates measures to manage both in its planning.

3.1.12 The organization establishes, regularly reviews, and updates as needed policies and procedures to safely relocate staff, residents, equipment, resources, and supplies, if necessary, during or following an emergency or disaster.

**Guidelines**

The organization should move staff, residents, equipment, resources, and supplies to a location only after the safety of that location is established. The location may be an

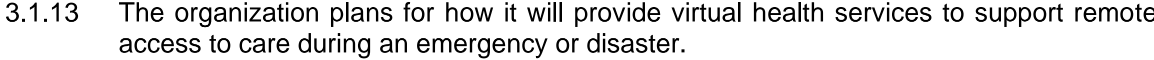
alternate care location during an emergency or disaster, or it may be a recertified facility following an emergency or disaster. A recertified facility is one that the organization had previously evacuated for safety reasons but has since been restored and formally confirmed as being safe and fit for care delivery.

The organization's procedures should consider all factors that may affect safe transport and relocation, including:

- Sequencing or ordering of priority for resident relocation
- Handoff procedures among the originating location, transport, and destination
- Mode of transport (e.g., type of vehicle)
- Vehicle decontamination and preparation
- Preparing residents and staff prior to transport
- Level of care required during transport
- Identifying, tracking, and monitoring residents among locations
- Maintaining infection control protocols, information security, and privacy during transport
- Addressing resident emergencies during transport (e.g., cardiac arrest)
- Providing psychosocial support before, during, and after relocation

The organization should also develop procedures for enhanced surveillance following relocation, to monitor whether safety indicators that it considers relevant and necessary (e.g., rates of facility-associated infections, occupational illnesses, and injuries) are exceeding expected levels.

The organization ensures that the policies comply with relevant laws and regulations.



3.1.13 The organization plans for how it will provide virtual health services to support remote access to care during an emergency or disaster.

**Guidelines**

If the organization provides health services from a distance using information and communication technologies as part of its normal operations, it plans for the use of these virtual health services (that may also be referred to as telemedicine services) during emergencies and disasters to provide access to care from any location.

3.1.14 The organization plans for how it will provide staff with required and up-to-date personal protective equipment (PPE), to keep them safe during an emergency or disaster.

**Guidelines**

The organization determines the types and quantities of PPE required by staff based on its emergency and disaster risk assessment, evidence from past experiences, and its emergency and disaster plans that include planning for the management of contaminated residents.

The organization provides staff with information and training on PPE. This may include where to find it, who is required to use it, and when and how to use it. PPE may include gowns, gloves, N-95 masks, or full-face masks.

The organization's PPE is updated every two years, at minimum, and the organization maintains a stockpile of PPE and supplies that will last for a period defined by the organization. (e.g., a two-week stockpile). The organization may follow recommendations in regional or jurisdictional emergency and disaster plans, where available.

3.1.15 The organization has procedures to proactively monitor, prioritize, and respond to notifications and warnings from public health and public safety organizations about potential emergencies and disasters.

**Guidelines**

Notifications and warnings may be issued for potential natural disasters, industrial mishaps, outbreaks, and pandemics. The organization's monitoring process is designed to ensure that the organization is made aware of the potential emergency or disaster as early as possible.

3.1.16 The organization regularly evaluates the effectiveness of its emergency and disaster planning based on the outcomes of completed exercises and past events, and uses the results to make improvements.

**Guidelines**

The organization ensures its evaluations use a validated or credible methodology. It pre-defines the criteria to evaluate the success of the exercises and responses. It ensures its evaluation tools are based on these criteria and integrates the tools into the emergency management system.

Data for evaluation may include findings and recommendations from after-action reports from debriefings; reviews of policies, procedures, plans, and exercises; and events.

The organization documents the results of each evaluation and uses the results to identify areas for improvement in emergency and disaster planning and business continuity planning.

The emergency planning committee creates a quality improvement plan to address the areas for improvement in emergency and disaster planning. It documents all improvements made, including actions taken to update emergency and disaster management policies and plans.

3.1.17 The organization keeps stakeholders informed as it transitions towards resuming services following an emergency or disaster.

**Guidelines**

The organization keeps all affected stakeholders informed, including staff, residents, the community, and related organizations about its plans to transition toward resuming services.

The organization works with the community to acknowledge the event that occurred (e.g., through community gatherings), support a culture of healing and wellness, and share information about how it will move toward resuming services.

# Chapter 4: Infection Prevention and Control

Chapter 4 covers organizational safety practices for LTC homes related to infection prevention and control (IPC). The purpose of this chapter is to ensure those both working and receiving services from the organization stay safe and healthy by preventing, mitigating risk, and controlling the transmission of pathogens and/or infections. Themes presented include having a team with relevant IPC subject matter expertise, maintaining updated documentation (policies and procedures), implementing standardized practices (e.g., hand hygiene, PPE, environmental cleaning and disinfection, medical device and equipment cleaning, supply chain management, outbreak management), continuous learning activities, and continuous quality improvement to support organizations in achieving their IPC aims.

This section applies to the organization including its leadership, personnel, and support care teams.

## 4.1 Infection Prevention and Control

4.1.1 Compliance with infection prevention and control policies and procedures is monitored and improvements are made to the policies and procedures based on the results.

**Guidelines**

This includes a process for team members, volunteers, and residents, families and/or caregivers to provide feedback, and report non-compliance with policies and procedures to the person(s) responsible for infection prevention and control (e.g., Infection Prevention and Control Coordinator).

Audit tools can be used to monitor compliance with policies and procedures.

Some organizations perform “flash audits,” where they observe team members during their day-to-day work, but do not disclose the activities they are auditing.

4.1.2 There are policies and procedures in place for using appropriate personal protective equipment.

**Guidelines**

Team members have access to personal protective equipment as needed. Team members that require the use of a respirator (e.g., N95) are provided with regular (e.g., annual) fit testing.

4.1.3 Protocols are established for the safe handling of soiled linen where applicable.

**Guidelines**

Team members handle soiled linen carefully to avoid transmitting microorganisms. Clean linen is transported separately from soiled linen and is stored in a manner that prevents contamination by dust, which may contain fungal spores.

4.1.4 A risk assessment is completed to identify activities that have a high risk for spreading infections, and the activities are addressed in infection prevention and control policies and procedures.

**Guidelines**

Examples of high-risk activities include handling spills, specimens, and sharps; exposure to blood and body fluids; and exposure to contaminated waste.

4.1.5 Infection prevention and control policies and procedures are made readily available to team members and volunteers.

**Guidelines**

Policies and procedures are available in a written or electronic format and team members, and volunteers can easily access them.

4.1.6 Information on how to safely perform high-risk activities is provided, including appropriately using personal protective equipment as outlined in policies and procedures.

**Guidelines**

High-risk activities require the use of personal protective equipment appropriate to the task. Team members learn how to select personal protective equipment based on the type of exposure anticipated, durability, appropriateness, and fit. Team members also know when to wear, and how to wear, change, and remove the personal protective equipment appropriately. This information can be provided through education sessions and/or reminders that are posted or shared (e.g., via email) throughout the organization.

4.1.7 Residents, families and/or caregivers, and visitors are provided with information about routine practices and additional precautions in a format that is easy to understand.

**Guidelines**

Residents, families and/or caregivers play an important role in promoting infection prevention and control activities. Information may include the appropriate use of personal protective equipment, hand hygiene, and respiratory hygiene.

Information is provided verbally and in writing. Written materials may be available in a variety of languages depending on the populations served. The language used is easy to understand and may include visual cues to improve understanding. Written materials may include pamphlets or posters.

4.1.8 Residents are screened to determine if additional precautions are required based on the risk of infection.

**Guidelines**

Team members are trained to determine whether additional precautions are required to prevent the transmission of infection. Team members refer to the applicable infection prevention and control policies and procedures and may need to involve the person responsible for infection prevention and control in the organization to complete the risk assessment.

This information is documented in the resident record.

4.1.9 An immunization policy is developed or adopted that includes providing information to residents and team members about how to access vaccinations.

**Guidelines**

Vaccination is a cost-effective method of preventing illness. Vaccinations that may be recommended to team members include tetanus, diphtheria, influenza, and hepatitis B. In some jurisdictions, specific vaccinations may be required.

The immunization policy addresses how the organization will handle situations where team members refuse immunization.

In some jurisdictions, the organization follows the immunization policy set by government.

4.1.10 There are policies and procedures in place for the disposal of sharps at the point of use in appropriate puncture-, spill-, and tamper-resistant sharps containers.

**Guidelines**

Sharps include needles and blades.

Applicable regulations provide guidance on safe and appropriate sharps disposal. Residents who use sharps in their homes (e.g., hypodermic needles) are advised how to dispose of them in accordance with applicable regulations.

4.1.11 Safety engineered devices for sharps are used.

**Guidelines**

Safety engineered devices protect the user from exposure to bio-hazardous or chemical substances (e.g., blood-borne pathogens, cytotoxic medications). They have a built-in mechanism to protect the user from a sharp injury (e.g., needles that retract after use).

In settings where residents self-administer medications via injection, the organization can advise the use of safety engineered devices; however, residents are not required to use them.

4.1.12 There are policies and procedures in place that are in line with applicable regulations, evidence, and best practices, and organizational priorities.

**Guidelines**

Policies and procedures are clear and concise. Topics include hand hygiene, work restrictions related to infection, aseptic techniques when handling injectable products, appropriate use of personal protective equipment, and handling contaminated items.

Organizations seek input from residents, families and/or caregivers when developing policies and procedures.

4.1.13 Hand-hygiene education is provided to team members, caregivers and volunteers.

**Guidelines**

Hand hygiene is critical to infection prevention and control programs, but adherence to accepted hand-hygiene protocols is often poor. It has been shown that the costs of health care-associated infections significantly exceed those related to implementing and monitoring hand-hygiene programs.

Training on hand hygiene is multimodal and addresses the importance of hand hygiene in preventing the transmission of microorganisms, factors that have been found to influence hand-hygiene behaviour, and proper hand-hygiene techniques. Training also includes recommendations about when to clean one's hands, based on the four moments for hand hygiene:

1. Before initial contact with the resident or their environment.
2. Before a clean/aseptic procedure.
3. After body fluid exposure risk.
4. After touching a resident or their environment.

**Test for compliance**

4.1.13.1 Team members, caregivers and volunteers are provided with education about the hand-hygiene protocol.

4.1.14 Team members, residents, families and/or caregivers, and volunteers have access to alcohol-based hand rubs (or alternatives) at the point of client interaction.

**Guidelines**

The point of resident interaction may also be referred to as the “point of care.”

Existing guidelines on hand hygiene in health care require that hand rubs be within one metre of where care is delivered. However, fire regulations or other considerations may limit the placement of alcohol-based hand rubs.

Hand rubs are placed as close to the point of resident interaction as possible (e.g., in the resident's room, at the bedside, carried by the team member, or directly in the resident's home).

The availability of hand-hygiene resources in the service environment is audited.

4.1.15 Compliance with accepted hand-hygiene practices is measured.

**Guidelines**

Hand hygiene is considered the single most important way to reduce health care-associated infections, but compliance with accepted hand-hygiene practices is often poor. Measuring compliance with hand-hygiene practices allows organizations to improve education and training about hand hygiene, evaluate hand-hygiene resources, and benchmark compliance practises across the organization. Studies show that improving compliance with hand-hygiene practices decreases health care-associated infections.

Direct observation (audits) is the best method to measure compliance with hand-hygiene practices. This involves watching and recording the hand-hygiene behaviours of team members and observing the work environment. Observation can be done by a trained observer within an organization, by two or more health care professionals working together, or by residents, families and/or caregivers in the organization or in the community. Ideally, direct observation measures compliance with all four of the moments for hand hygiene:

1. Before initial contact with the resident or their environment
2. Before a clean/aseptic procedure
3. After body fluid exposure risk
4. After touching a resident or their environment

Direct observation should be used by all organizations working out of a fixed location (i.e., residents come to them). Organizations that provide services in residents' homes and find that direct observation is not possible may consider alternative methods. As these alternatives are not as robust as direct observation, they should be used in combination (two or more) to give a more accurate picture of compliance with hand-hygiene practices.

**Tests for compliance**

4.1.15.1 Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in residents' homes, a combination of two or more alternative methods may be used, for example:

- Team members recording their own compliance with accepted hand-hygiene practices (self-audit)
- Measuring product use
- Questions on resident satisfaction surveys that ask about team members' hand-hygiene compliance
- Measuring the quality of hand-hygiene techniques (e.g., using ultraviolet gels or lotions)

4.1.15.2 Hand-hygiene compliance results are shared with team members and volunteers.

4.1.15.3 Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.

4.1.16 Roles and responsibilities are assigned for cleaning and disinfecting the physical environment.

**Guidelines**

Roles and responsibilities address those individuals most involved in cleaning and disinfecting the physical environment. They also address the roles and responsibilities of other team members, and volunteers in checking the cleanliness of the physical environment and reporting problems to the appropriate individual or group.

4.1.17 There are policies and procedures in place for cleaning and disinfecting spaces used by residents who are on additional precautions.

**Guidelines**

The organization is only responsible for cleaning areas that are under its control (e.g., offices, clinics, long-term care facilities). The organization is not responsible for the cleanliness of residents' homes or community spaces where team members may meet with residents.

4.1.18 Current manufacturers' instructions are upheld when cleaning, disinfecting, or sterilizing medical devices and equipment.

4.1.19 Appropriate personal protective equipment is worn when cleaning, disinfecting, or sterilizing medical devices and equipment.

**Guidelines**

Depending upon the task, the appropriate personal protective equipment may include gloves that are appropriate to the task; a fluid-resistant cover garment with sleeves (e.g., backless gown, jumpsuit, or surgical gown); and a full-face shield or a fluid-impervious face mask to fully protect eyes, nose and mouth.

4.1.20 Detergents, solutions, sterilants, and disinfectants selected are in line with manufacturers' instructions, and are compatible with the devices being cleaned, disinfected, or sterilized, and with the equipment and processes for cleaning, disinfection, or sterilization.

**Guidelines**

All disinfectants have a unique identifier. Others in the organization may need to be consulted (e.g., infection prevention and control, or occupational health and safety) when selecting appropriate detergents or disinfectants.

4.1.21 Health care-associated infections are tracked, information is analyzed to identify outbreaks and trends, and this information is shared throughout the organization.

Note: This ROP only applies to organizations that have beds and provide nursing care.

**Guidelines**

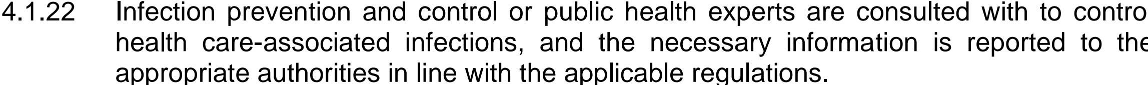
The health care-associated infections most common to the organization's services and resident populations are identified and tracked. These could include Clostridium difficile (C. difficile), surgical site infections, seasonal influenza, noroviruses, urinary tract infections, and other reportable diseases and antibiotic-resistant organisms. Tracking methods for health care-associated infections may focus on a particular infection or

service area or may be organization- or system-wide. They may include data analysis techniques to help detect previously unrecognized outbreaks. Tracking may include frequencies and changes in frequencies over time, associated mortality rates, and attributed costs.

Teams that are well informed about health care-associated infection rates are better equipped to prevent and manage them. The role or position responsible for receiving information about health care-associated infection rates is identified and a plan is established to regularly disseminate information (e.g., quarterly reports to all departments). In addition to team members, the governing body needs to be informed about health care-associated infection rates and associated infection prevention and control issues. This may be done directly through senior management or a medical advisory committee.

**Tests for compliance**

| | |
|---|---|
| 4.1.21.1 | Health care-associated infection rates are tracked. |
| 4.1.21.2 | Outbreaks are analyzed and recommendations are made to prevent recurrences. |
| 4.1.21.3 | Information about relevant health care-associated infections and recommendations from outbreak reviews are shared with team members, senior leadership, and the governing body. |



4.1.22 Infection prevention and control or public health experts are consulted with to control health care-associated infections, and the necessary information is reported to the appropriate authorities in line with the applicable regulations.

**Guidelines**

Experts may include medical microbiologists, nurses, and other professionals. Certain health care-associated infections must be reported in terms of frequency and location to authorities such as public health agencies. Reporting requirements vary per jurisdiction.

4.1.23 There are policies and procedures in place for identifying and responding to outbreaks; and these are in line with the applicable regulations.

**Guidelines**

An organization may be responsible for identifying an outbreak or may only be responsible for responding to an outbreak that others have identified.

Policies and procedures regarding outbreaks address how to detect an outbreak, how to identify the cause of the outbreak (if it stems from within the organization), how residents, team members, and volunteers should respond and behave during an outbreak, and how to contain an outbreak once it is identified.

4.1.24 Team members and volunteers are provided with information about the organization's role during an outbreak.

4.1.25 When appropriate, information is communicated about outbreaks to residents, families and/or caregivers, team members, volunteers, public health, and other stakeholders.

**Guidelines**

Those responsible for communicating and reporting information about outbreaks are identified.

4.1.26 If services for reprocessing of reusable medical devices are contracted to external providers, a written agreement is maintained with each provider that outlines requirements and respective roles and responsibilities.

**Guidelines**

The agreement requires that contracted service providers adhere to accepted standards of practice and that the quality of reprocessing services is monitored. Examples include daily monitoring of printouts or electronic records, maintaining records of each sterilization cycle, and having a process to report issues with reprocessed medical devices (e.g., defective wraps or medical devices and equipment that arrive soiled).

4.1.27 Safe work practices and infection prevention and control precautions are followed when handling contaminated medical devices and equipment.

**Guidelines**

All medical devices received in the decontamination area are considered contaminated with infectious material.

4.1.28 Point of use cleaning of a device or equipment is performed as part of the decontamination process and occurs immediately after use and prior to decontamination in a Medical Device Reprocessing (MDR) department and following manufacturers' instructions.

**Guidelines**

Pre-cleaning at point of use is required when soil or dried organic matter is present on a device. This may include removing soil and flushing lumens as required. Prior to decontamination in the MDR department, devices should be kept moist using an approved product to prevent organic matter from drying, as dried soil is difficult to remove with normal decontamination measures.

Inorganic and organic matter (e.g., blood, protein) retained on devices can inhibit the cleaning, disinfection, sterilization process by providing a medium for the growth of micro-organisms, rendering chemical germicides inactive, or by physically protecting micro-organisms from the sterilization process.

4.1.29 For each cleaner and disinfectant, manufacturers' instructions for use are followed including ventilation requirements, contact time, shelf life, storage, appropriate dilution, testing for appropriate concentration and effectiveness, and required personal protective equipment.

## Chapter 5: Medication Management

Chapter 5 covers organizational safety practices for LTC homes related to medication management. Themes covered in this chapter include a collaborative approach to medication management, up-to-date policies and procedures, the assignment of responsibilities in relation to prescribing, storing, preparing, and administering medications. Medication reconciliation is also addressed.

This section applies to the organization, including its leadership, personnel, and support care teams.

### 5.1 Medication Management

5.1.1 A committee is responsible, and an individual is accountable for managing medications in the organization.

**Guidelines**

Medication management activities include procuring, storing, prescribing, dispensing, administering, assisting with, and disposing of medications.

Oversight of medication management may be handled by a committee, group, or individual that may be specifically assigned to medication management or have medication management as one of its functions. This body or individual is responsible for planning a comprehensive medication management system that ensures the safe and appropriate use of medications in the organization. This includes developing medication management policies and procedures, maintaining the organization's medication supply, and evaluating medication use and resident safety incidents involving medications.

The oversight structure may vary depending on the size and complexity of the organization and its role in medication management activities.

5.1.2 Policies and procedures for all activities related to medication management are developed and implemented.

**Guidelines**

Policies and procedures help to ensure that medications are used in a consistent manner across the organization.

Activities related to medication management include:

- Selecting and procuring medications
- Storing medications in the pharmacy and resident service areas
- Prescribing, ordering, and transcribing medications
- Preparing, dispensing, and delivering medications
- Administering medications or assisting residents with administering medications
- Documenting the administration or assistance
- Monitoring residents
- Managing sample medications
- Managing the recall of medications

5.1.3 Teams can readily access the medication management policies and procedures.

**Guidelines**

The organization only needs policies and procedures for the activities it conducts.

5.1.4 The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.

**Guidelines**

Misinterpreted abbreviations can result in omission errors, extra or improper doses, administering the wrong drug, or giving a drug in the wrong manner.

**Tests for compliance**

5.1.4.1 The organization's 'Do Not Use' List is inclusive of the abbreviations, symbols, and dose designations, as identified by an Institute for Safe Medication Practices (ISMP) list of error-prone abbreviations, symbols, and dose designations.

5.1.4.2 The organization implements the 'Do Not Use' List and applies this to all medication-related documentation when handwritten or entered as free text into a computer.

5.1.4.3 The dangerous abbreviations, symbols, and dose designations identified on the 'Do Not Use' List are not used on any pharmacy-generated labels and forms.

5.1.4.4 The organization educates staff about the 'Do Not Use' List during orientation and whenever changes are made to the list.

5.1.4.5 The organization updates the 'Do Not Use' List and implements necessary changes to the organization's processes.

5.1.4.6 The organization audits compliance with the 'Do Not Use' List and implements process changes based on identified issues.

5.1.5 The organization implements a comprehensive strategy for the management of high-alert medications.

**Guidelines**

Implementing a comprehensive strategy for the management of high-alert medications is a valuable use of resources to enhance resident safety, and to reduce the possibility of serious harm.

The Institute for Safe Medication Practices has produced a list of high-alert medications specifically for community/ambulatory settings, which can be found online. To prevent harm from medication errors, a policy for the management of high-alert medications is required. Strategies for the safe use of high-alert medications may include but are not limited to:

- Applying warning labels to products as soon as they are received in the pharmacy
- Using visible warning and auxiliary labels according to the organization's policy
- Providing training about high-alert medications
- Employing automated or independent double checks

A policy for the management of high-alert medications may place additional emphasis on strategies for high-risk resident populations including the elderly, pediatrics, and neonates. Organizations should systematically evaluate each high-alert medication or class of medications and establish an action plan to improve the safe use of these medications.

**Tests for compliance**

| | |
|---|---|
| 5.1.5.1 | The organization has a policy for the management of high-alert medications. |
| 5.1.5.2 | The policy names the role or position of individual(s) responsible for implementing and monitoring the policy. |
| 5.1.5.3 | The policy includes a list of high-alert medications identified by the organization. |
| 5.1.5.4 | The policy includes procedures for storage, prescribing, preparation, administration, dispensing, and documentation for each high-alert medication, as appropriate. |
| 5.1.5.5 | The organization establishes a mechanism to update the policy on an ongoing basis. |
| 5.1.5.6 | The organization provides information and ongoing training to staff on the management of high-alert medications. |

5.1.6 Medications are returned when they are formally recalled or discontinued by an external body such as a government agency or the manufacturer.

**Guidelines**

Information on how to return recalled or discontinued medications is often provided by government or the manufacturer. The organization's process includes contacting residents who have been exposed to recalled medications when possible.

5.1.7 Criteria are established to add, restrict, and remove medications from the list of stocked medications.

**Guidelines**

Having a list of medications that can be stocked in the organization minimizes the number of medications that team members need to be familiar with while ensuring the availability of effective medication therapy based on best practice and evidence.

When identifying the criteria for selecting medications, the needs of residents, prescribers, and other service providers are considered, as are safety, effectiveness, cost, and the need to avoid product duplication. Applicable regulations and formularies as well as available research, evidence, and expert opinions from clinicians are considered in the decision. The medication's potential for harm, interactions with other medications, the likelihood of causing resident safety incidents, and the potential for abuse are also evaluated.

5.1.8 The availability of heparin products is evaluated and limited to ensure that formats with the potential to cause resident safety incidents are not stocked in resident service areas.

**Guidelines**

Heparin is a high-alert medication. Limiting its availability and ensuring that high-dose formats are not stocked in resident service areas are effective strategies to minimize the risk of death or disabling injury associated with these agents.

For specific care circumstances, it may be necessary for heparin products to be available in select resident service areas. In these cases, an interdisciplinary committee for medication management (e.g., Pharmacy and Therapeutics Committee and Medical Advisory Secretariat) reviews and approves the rationale for availability and safeguards are put in place to minimize the risk of error.

For flushing intravenous lines, organizations are encouraged to consult best practice guidelines to explore options other than heparin.

**Tests for compliance**

5.1.8.1 An audit of unfractionated and low molecular weight heparin products in resident service areas is completed at least annually.

5.1.8.2 High dose unfractionated heparin (50,000 units total per container) is not stocked in resident service areas.

5.1.8.3 Steps are taken to limit the availability of the following heparin products in resident service areas:

- Low molecular weight heparin: use of multi-dose vials is limited to critical care areas for treatment doses
- Unfractionated heparin (high dose): greater than or equal to 10,000 units total per container (e.g., 10,000 units/1 mL; 10,000 units/10 mL; 30,000 units/30 mL) is provided on a resident-specific basis when required
- Unfractionated heparin for intravenous use (e.g., 25,000 units/ 500 mL; 20,000 units/500 mL) is provided on a resident-specific basis when required

5.1.8.4 When it is necessary for the previous heparin products to be available in select resident service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.

5.1.9 The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause resident safety incidents are not stocked in resident service areas.

**Guidelines**

Narcotics (or opioids) have been identified as high-alert medications. Limiting their availability and ensuring that high dose formats are not stocked in resident service areas are effective strategies to minimize the risk of death or disabling injury associated with these agents.

For specific care circumstances, it may be necessary for narcotic products to be available in select resident service areas, for example:

- Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
- Hydromorphone: 10 mg/mL ampoules or vials may be provided based on the following criteria and must be removed when no longer required; intermittent intravenous, subcutaneous, or intramuscular doses greater than 4 mg

In these cases, an interdisciplinary committee for medication management (e.g., Pharmacy and Therapeutics Committee and Medical Advisory Secretariat) reviews and approves the rationale for availability and safeguards are put in place to minimize the risk of error.

Organizations serving pediatric populations are encouraged to implement practice recommendations specific to their resident population, including the use of standardized concentrations for opioid infusions.

To optimize the safe use of narcotic products, organizations may also consider establishing a pain management team.

**Tests for compliance**

5.1.9.1 An audit of the following narcotic products in resident service areas is completed at least annually:

- Fentanyl: ampoules or vials with total dose greater than 100 mcg per container

- Hydromorphone: ampoules or vials with total dose greater than 2 mg
- Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas

5.1.9.2 Stocking the following narcotic products is avoided in resident service areas:

- Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
- Hydromorphone: ampoules or vials with total dose greater than 2 mg
- Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas

5.1.9.3 When it is necessary for narcotic (opioid) products to be available in select resident service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.

5.1.10 The organization has developed and implemented a procedure for the handling of medications brought in by residents, families and/or caregivers.

**Guidelines**

The procedure for handling medications brought into the organization by residents, families and/or caregivers specifies that all prescription and non-prescription medications brought in by residents, families and/or caregivers are subject to the organization's medication management processes (e.g., storage, administration). Where applicable, the procedure adheres to local regulations.

The procedure should address:

- When and how such medications can be used
- The need for a visual inspection of the medications
- Prohibiting the use of medications that cannot be easily identified
- Appropriately storing or disposing of the medications
- Returning the medications to the resident, family and/or caregiver at the end of service or at a transition, as appropriate

5.1.11 When selecting medications to stock, the organization considers the risk of medication shortages.

**Guidelines**

Medication stocks are appropriately matched to community needs.

5.1.12 Access to medication storage areas is limited to authorized team members.

**Guidelines**

The level of security required depends on the types of medications stored. For example, access to medication storage areas can be controlled using key pad code entry or swipe cards with different levels of access, medication carts can be locked or never left unattended, or medications can be stored in an area that is continuously staffed.

The organization determines how best to restrict access to medication storage areas based on its needs and the risk of unauthorized access to the storage area.

5.1.13 Medication storage areas are regularly cleaned and organized.

**Guidelines**

Regular cleaning schedules for medication storage areas are maintained, and approved cleaning products are available. Medications are stored by generic name and in groups for easy identification and access based on pharmacy standards. Inspections should be documented with the use of a checklist.

5.1.14 The organization maintains medication storage conditions that protect the stability of medications.

**Guidelines**

Appropriate storage conditions consider the temperature, light sensitivity, packaging, and delivery containers. For example, vaccines, insulin, and lorazepam injectables are stored in refrigerators with temperature controls.

Medication monographs should be referred to regarding storage temperatures for medications.

5.1.15 Lighting in medication storage areas is sufficient for team members to read medication labels and information sheets.

**Guidelines**

Accessibility tools can be provided for staff to magnify labels.

5.1.16 Medication storage areas meet legislated requirements and regulations for controlled substances.

**Guidelines**

Medications are kept in a locked, secure environment using a double lock procedure at a minimum (e.g., in a locked cabinet in a locked room).

Controlled substances should be stored in dedicated locking/high-security pockets in automated dispensing cabinets.

Residents being cared for in their home are encouraged to store their medications safely and securely.

The organization is not responsible for managing the security of controlled substances that residents store in their homes.

5.1.17 Unit dose oral medications are kept in manufacturer or pharmacy packaging until they are administered.

**Guidelines**

Administration may be at the point of care or in an ambulatory setting. Pre-pouring medications is not an acceptable practice.

5.1.18 Concerns with medication names, packaging, or labelling are identified, reported to the pharmacy or manufacturer, and shared with team members in the pharmacy and in resident service areas.

**Guidelines**

The organization may store medications with problematic names, packaging, or labelling in a separate area, or place label enhancements or warnings on them.

5.1.19 Pending removal, expired, discontinued, recalled, damaged, or contaminated medications are stored separately in the medication storage areas from medications that are in use.

**Guidelines**

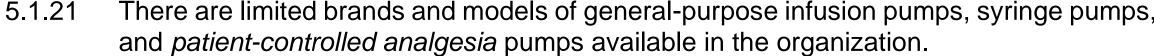
Separating or isolating expired, discontinued, recalled, damaged, or contaminated medications prevents confusion and promotes safety.

5.1.20 Regular inventories of the medication storage area(s) are conducted and compared against usage records.

**Guidelines**

Inventory audits of medication storage areas, when compared to usage records (e.g., compounding logs in pharmacy, medication administration records in resident records), examine the medication use process from the time a medication was received to when it was administered to a resident.

Audits may follow procedures to address inventory management, storage, transportation, and disposal of medications. These procedures allow organizations to assess whether proper controls are in place to detect fraud, waste, or abuse. They also support the safe and effective use of medications, in compliance with professional standards and accordance with organizational policies.



5.1.21 There are limited brands and models of general-purpose infusion pumps, syringe pumps, and *patient-controlled analgesia* pumps available in the organization.

**Guidelines**

Limiting the variety of equipment helps reduce the need for training and retraining, and the risk of error.

5.1.22 Team members participate in orientation prior to their first shift, and receive continuing education and training based on their roles and responsibilities for managing medications within their scope of practice.

**Guidelines**

Medication management orientation is appropriate to the role of the team member involved and is provided prior to their first shift. Training covers safety issues such as look-alike medications, sound-alike medications, high-alert medications, Do Not Use abbreviations, medications new to the market or to the formulary, and independent double checks. If required, training is provided on new medications and new medication delivery devices before they are used.

Training may be provided as part of the orientation program and may be delivered using checklists or online, as well as through meetings, memos, or posters.

5.1.23 Teams are educated about how to prevent, recognize, respond to, and report resident safety incidents involving medications.

**Guidelines**

Education on resident safety incidents involving medications is appropriate to the role of the team member involved. For example, environmental services team members may need to be aware of only select medication-related risks (e.g., what to do if medications are found in an unsecured area) while team members who administer medications receive specialized education to avoid resident safety incidents involving medications.

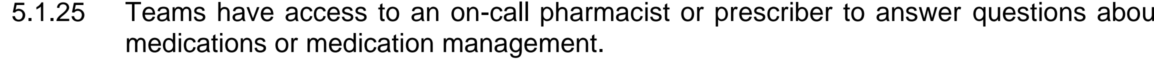
The education may address organizational policies regarding medication use, preventing side effects, reporting resident safety incidents involving medications, resident safety

incidents in other organizations, and strategies to prevent resident safety incidents involving medications.

5.1.24 Team members can readily access accurate and up-to-date medication information specific to the populations served.

**Guidelines**

Medication information tools should be specific to the populations served by the organization (e.g., psychiatry, pediatrics, geriatrics) and available in written or electronic formats. Examples include pocket references, medication information cards, standards sets, protocols or checklists, resident service information, and compounding recipes. These tools are reviewed, approved, and updated regularly. The approval process includes a review by a pharmacist and by other team members who use the tools.



5.1.25 Teams have access to an on-call pharmacist or prescriber to answer questions about medications or medication management.

**Guidelines**

A pharmacist or prescriber is always available while the organization is delivering services.

5.1.26 Medication orders are accurately transcribed into clinical documents such as medication administration records.

**Guidelines**

Transcribed medication orders are verified by a second person. For example, the medication order may be transcribed by a clerk and double-checked by a nurse for accuracy.

5.1.27 The team discusses medications prior to the initial dose and when the dose is adjusted, documents the discussion, and gives highest priority to the wishes of the resident, family and/or caregiver.

**Guidelines**

The extent of the information provided about the medication depends on the resident's capacity. Educating residents about their role in safe medication administration may include discussing potential questions about medications and encouraging them to show their identification (e.g., name bracelet, band number) and stating their name clearly before medications are administered.

Information shared with residents, families and/or caregivers includes the name of the medication, what it is used for, and when the next dose is due, as well as the medication's potential benefits and adverse effects, how to use the medication safely and properly, the risks of non-adherence, and what to do in the case of an adverse drug reaction.

Information can be shared verbally or in writing. Written and verbal information should be simple, easy to understand, and provided in the appropriate language. Information about the cost of the medication may be provided. Pharmacists may be directly involved in this process.

If a resident, family and/or caregiver is incapable, objects to or rejects the medication that is prescribed, the team must respect this decision and resolve it by offering an alternate solution.

Discussions about medications may not be possible in an emergency.

5.1.28 The team gathers information about allergies and previous adverse drug reactions, and it is recorded in the resident's medication profile, as part of the resident record.

**Guidelines**

Team members who are responsible for collecting and updating allergy and adverse drug reaction information in the resident record are identified. Resident allergies are a required field in the profile and the type of reaction, severity, and the date the allergy was identified are documented.

5.1.29 Team members document in the resident record all verbal or written medication-related information that is provided to the resident.

**Guidelines**

Residents can sustain an injury when they misunderstand or cannot remember a clinician's oral advice. Residents who are not educated about their medication may have unrealistic expectations of the outcome of treatment. Verbal information can be supplemented with written handouts and instructions to help inform residents about their condition, medication, or treatment. This also shares the responsibility with them and reduces the risk of error.

5.1.30 Teams have timely access to the resident medication profile and essential resident information.

**Guidelines**

The resident record contains a current list of medications and medication therapy records for each admission or each episode of service provided by the organization. Essential resident information includes age; gender; diagnosis; co-morbidities or concurrently occurring conditions such as hypertension, diabetes, or renal or liver impairment; and allergies and past sensitivities. It may also include weight and height, relevant inpatient or outpatient laboratory values, and pregnancy and lactation status.

5.1.31 Team members reinforce medication information that is provided to residents, families and/or caregivers and respond to concerns or questions they may have about their medication.

**Guidelines**

Residents' understanding of their medication depends on their capacity. If the resident does not have the capacity to understand, a family member and/or caregiver or substitute decision maker is included in the conversation.

Verifying that residents understand their role in safe medication administration may include providing them with information or education, responding to their questions or concerns, helping them identify medication-related questions to ask when they meet with their service providers or pharmacists, or consulting with their service providers or pharmacists if they have concerns that require an immediate response and cannot be answered by team members.

To assess comprehension and verify understanding, the resident can be asked to repeat back the information provided.

5.1.32 There is a policy and procedure in place to ensure resident self-administration of medication is safely managed.

**Guidelines**

The policy should state what medications residents can self-administer. A consent form for resident self-administration and medication adherence strategies could be included in the policy and procedure.

5.1.33 Established criteria are used to determine the medications residents can self-administer.

**Guidelines**

The criteria include the mode of delivery, monitoring requirements for the medication, possible adverse drug reactions, and the resident's history of allergic reactions.

5.1.34 Established criteria are used to assess whether a resident can self-administer medications.

**Guidelines**

The criteria include the resident's competency, ability, and agreement to self-administer medications.

Medication adherence may be critical to the resident's treatment regimen. Residents require sufficient education and understanding of their medication regimen and administration procedures (e.g., inhalers, injections) to be able to manage these at home.

During self-administration, the most common types of resident safety incidents involving medications are wrong dosages, taking unnecessary medications, interactions with other prescription and non-prescription medications, and non-adherence.

5.1.35 Each resident who self-administers medications is provided with appropriate education and supervision prior to self-administration, and this is documented in the resident record.

**Guidelines**

The organization has a comprehensive and carefully supervised program to support the self-administration of medications. It may include print and online resources to explain the rationale for prescribing the medication, the importance of taking the medication regularly, and the possible side effects. Medication education improves adherence as residents have a better understanding about their medication therapy and can thus exercise more independence and control.

5.1.36 Medications that are self-administered by residents are stored and labelled safely and appropriately.

**Guidelines**

For example, medications for self-administration can be stored in a cabinet with limited access, or in a safe, or at the bedside in a locked drawer. Appropriate storage could mean refrigeration of the medication. Residents being cared for in their home are encouraged to store their medications safely and securely.

5.1.37 There is documentation in the resident record that the resident self-administers their medications.

**Guidelines**

Each occasion of self-administration does not need to be recorded, but an overall statement should be noted in the record indicating that the resident self-administers their medications.

5.1.38 The ability of residents to self-administer medications safely is regularly re-evaluated.

**Guidelines**

Re-evaluations take place on a regular basis, as well as whenever there are changes in the resident's condition that might affect their ability to self-administer.

5.1.39 Team members who administer medications are assigned a level of responsibility that is within their scope of practice.

**Guidelines**

Responsibility may differ by medication class and administration route.

Non-professional team members with prior organizational training, certification, or supervision may assist in distributing or administering designated medications.

5.1.40 Standard administration schedules are established for medications that are administered by the organization, including residential facilities.

**Guidelines**

Standard administration schedules with dosing windows should be in place for all ongoing medications.

5.1.41 Before medication is administered, the resident's profile is consulted to verify the “rights” of medication administration, which are the right medication, the right dose, the right route, the right time, to the right person, with the right documentation, for the right reason, and with the right response.

**Guidelines**

The organization may have established criteria for the information to be verified, in which case the team should adhere to these criteria.

5.1.42 Designated medications are taken under the supervision of the team member responsible for administering the medication.

**Guidelines**

The responsible team member verifies that designated medications are ingested (e.g., by asking the resident to talk after taking the medication).

5.1.43 An independent double check of high-alert medications identified by the organization is conducted at the point of care before these medications are administered.

**Guidelines**

Independent double checks help prevent medication errors during selection, preparation, and administration of medications identified by the organization as high risk. The process involves having a second person verify the resident's identity, the medication, the concentration, pump programming, and the line attachment. The second person should be trained to perform this check and performing the check should be within their scope of practice.

In situations where another person is not available, it is recommended that a strategy be implemented to mitigate the risk of errors. For example, the person doing the check could complete the first check, perform another task, and then complete the second check. Alternatively, medication administration could be scheduled to take place around shift changes when extra personnel are available. Certain components of an independent

double check can be completed electronically (e.g., using a barcode) such as verification of resident identity and correct medication.

5.1.44 Lot numbers and expiry dates for vaccines are documented in the resident record following administration of the medication.

**Guidelines**

Requirements to document vaccine lot numbers and expiry dates may vary among jurisdictions. The organization follows jurisdictional requirements.

5.1.45 When pharmacy services are not available, there is controlled access to a night cabinet or automated dispensing cabinet for a limited selection of urgently required medications.

5.1.46 A record is kept of the medications accessed from the night cabinet or automated dispensing cabinet.

**Guidelines**

Keeping a record of medications accessed from the night cabinet or automated dispensing cabinet gives the team up-to-date data about accessed medications.

5.1.47 When automated dispensing cabinets are used, there are policies and procedures that address access, location, type of medication information, verification, and restocking of medications.

**Guidelines**

A well-organized and secure medication storage system can reduce the risk of medication errors including those associated with high-risk medications.

5.1.48 Steps are taken to protect the health and safety of team members who transport, administer, and dispose of cytotoxic or other hazardous medications.

**Guidelines**

Exposure to cytotoxic or other hazardous medications is minimized by special handling procedures such as using personal protective equipment (e.g., double gloves), and plastic bags and plastic containers.

5.1.49 A readily accessible hazardous spill kit is located wherever cytotoxic or other hazardous medications are dispensed and administered.

**Guidelines**

Spill kits and other clean up materials are in the immediate areas where there is potential for exposure to hazardous medications. Staff are informed about the location and proper use of spill kits.

5.1.50 There is a procedure in place to manage the return of medications to the pharmacy.

**Guidelines**

The return procedure includes procedures to account for and prevent the diversion of returned medications, integrity checks, and stability checks.

5.1.51 The organization has a policy and procedure to manage how it procures and tracks medications.

**Guidelines**

The policy addresses how medications arrive at the organization, how they are received, the steps taken once they are in the organization, and how the process is documented.

5.1.52 The effects of medications on resident treatment goals are monitored and documented in the resident record.

**Guidelines**

The effects of medications may include the resident's own perceptions, laboratory results, vital signs, and clinical response/efficacy. Failure to adequately monitor the effects of medications can compromise safety and increase the risk of resident safety incidents involving medications.

5.1.53 Residents are monitored for possible resident safety incidents involving medications.

**Guidelines**

Seniors taking multiple medications and residents taking high-risk medications are at high risk for resident safety incidents involving medications. Team members are provided with information on how to monitor for resident safety incidents involving medications including what signs to look for and how to react.

5.1.54 The organization discloses resident safety incidents involving medications to the resident, family and/or caregiver at the earliest opportunity.

**Guidelines**

The policy for disclosure is based on best practice and guidance from regulatory bodies.

The process for disclosure is consistent with the organization's processes for disclosing other resident safety incidents.

5.1.55 Resident safety incidents involving medications are reported in accordance with the organization's resident safety incident management system.

**Guidelines**

Resident safety incidents involving medications are reported internally and the organization is encouraged to also report them externally.

The organization's resident safety incident management system defines reporting lines and requirements related to drug safety incidents and potential drug safety incidents, including what kinds of reports need to be made and to whom, and over what period. These may include reports to appropriate internal staff, partners, and external organizations.

The organization should have a formal incident management process that meets its needs for a fair, transparent, and just process.

5.1.56 Resident safety incidents involving medications are reviewed and established criteria are used to prioritize those that will be analyzed further.

**Guidelines**

A medication safety subcommittee may be established to review resident safety incidents involving medications. This includes trending and developing plans for prevention. The committee's review of drug safety incidents may consist of a root cause analysis or a similar process. It may include analyzing and using published drug safety incident

experiences from other organizations to proactively improve the organization's own resident safety incident management system.

5.1.57 Teams are involved in the analysis of resident safety initiatives involving medications.

**Guidelines**

Team members may be able to provide information on contributing factors and what can be done to avoid recurrence. The analysis of incidents promotes a just culture and shared accountability and avoids targeting an individual.

5.1.58 Information about recommended actions and improvements made following incident analysis is exchanged with residents, families and/or caregivers, and other team members.

**Guidelines**

Information about resident safety incidents involving medications and risk reduction strategies is exchanged with team members in accordance with applicable legislation and includes de-identifying resident and other information to maintain confidentiality.

5.1.59 The organization conducts an annual evaluation of the medication management system.

**Guidelines**

The evaluation may be one portion of the medication management system. Examples include participating in an external quality control or accreditation program.

5.1.60 Process and outcome indicators for medication management are monitored.

**Guidelines**

The organization selects indicators as part of its comprehensive evaluation of its medication management system. Indicators may be selected based on local priorities.

Examples of medication management-related indicators include:

- Number of drug safety incident-related hospitalizations or emergency department visits
- Percentage of residents whose medication history was recorded at the beginning of service
- Medication reconciliation rate

5.1.61 Evaluation results, areas of success, and opportunities for improvement are shared with teams.

**Guidelines**

Sharing the results of evaluations and improvements helps team members become familiar with the concept and benefits of quality improvement. Recognizing success encourages a positive culture within teams.

5.1.62 Medication reconciliation is conducted in collaboration 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, readmission 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.

**Tests for compliance**

5.1.62.1 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).

5.1.62.2 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.

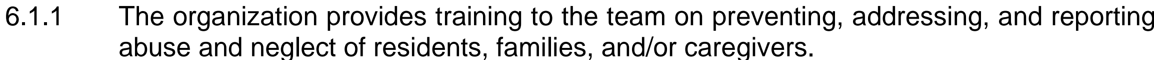
5.1.62.3 Upon or prior to readmission from another service environment (e.g., acute care), the discharge medication orders are compared with the current medication list and any medication discrepancies are identified, resolved, and documented.

5.1.62.4 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.

## Chapter 6: Residents' Care Experience

Chapter 6 focuses on criteria related to the care experience of a resident in a LTC home. The themes covered in this chapter include building a competent team to provide care and services based on HSO's people-centred care principles and delivering safe and reliable care that meets the needs of residents and how they define their quality of life. The chapter emphasizes the importance of residents and caregivers as active participants in the care and services provided. Individualized care plans are informed by resident needs and goals, shared decision making, and self-management and are based on ethical principles of respect, dignity, confidentiality, trust, and informed consent.

### 6.1 Building a Competent Team



6.1.1 The organization provides training to the team on preventing, addressing, and reporting abuse and neglect of residents, families, and/or caregivers.

**Guidelines**

Abuse and neglect can be physical, verbal, emotional, sexual, or financial. Incidents of abuse may occur between residents, between residents and families and/or caregivers or between residents and team members.

The team receives education and training 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.

6.1.2 The organization provides training to the team on preventing and managing residents' responsive behaviours.

**Guidelines**

Responsive behaviours are actions exhibited by a person with dementia to express something important about their personal, social, or physical environment. The responsive behaviour is often unintentional and results from changes in the brain that can affect memory, judgment, orientation, mood, and behaviour. The responsive behaviour may include verbal outbursts or physical agitation. Responsive behaviours may be directed at themselves or others (e.g., co-resident, family, friends, caregivers) (Alzheimer Society of British Columbia, 2017).

6.1.3 The organization provides training to the team on the use of minimal restraints.

**Guidelines**

The use of restraints has been linked to negative health outcomes, which may affect the physical, psychological, and emotional well-being of residents, families, and/or caregivers.

Restraints should only be used as a last resort, to reduce imminent harm to self or others when all positive people-centred, recovery-oriented, or alternative practices have failed. Positive people-centred and recovery-oriented care refers to providing safe, competent, and ethical care that respects individual rights, including human rights, dignity, and autonomy.

Policies and protocols should reflect the use of minimal restraint and be grounded in a trauma and violence-informed approach based on evidence-informed guidelines. These include procedures for the safe use of minimal restraints, such as how frequently residents in restraint must be monitored or how residents are cared for when restraints are used.

Restraints are not used to teach acceptable behaviour, to punish, or for the convenience of the organization.

The organization should seek alternatives to the use of minimal restraints to improve the quality and safety of its services. The organization also adheres to jurisdictional and regional requirements in the use of minimal restraints.

6.1.4 The organization provides training to the team on safe mobility and transfer.

**Guidelines**

The organization ensures team members are trained on how to safely use equipment and mobility devices, to keep themselves and the residents safe during position changes, mobilization, lifts, and transfers.

Training and education should address safe, independent, or minimally assisted ambulation or transfers; safe manual resident handling; and training in biomechanics for manual lifts and transfers.

The organization also provides training and education to team members on how to assess residents' ambulation status, including how to assess their repositioning, lifting, and transferring abilities.

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

**Guidelines**

Cultural education and training build the skills, knowledge, and attitudes that are required to deliver interventions and services safely and appropriately 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.

6.1.6 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 and/or caregivers about end-of-life issues, and how and when to initiate discussions about palliative and end-of-life care.

Regional and national legislation and regulations regarding consent and substitute decision making are followed.

## 6.2 Providing People-Centred Care

6.2.1 The team is familiar with the services provided by the organization.

**Guidelines**

Services may be offered by the organization or community partners. Some services may be provided at no additional cost to the resident, while others may be provided at a cost. The organization is transparent about its service fees and discloses them to residents, families, and/or caregivers.

6.2.2 The team uses defined criteria to determine when to initiate services with residents.

**Guidelines**

The organization uses evidence-informed protocols and defined criteria to identify potential residents, such as those with a progressive life-limiting illness, those who have experienced a significant decline in health, and those who are in transition.

Changes in health status and care settings needs are assessed simultaneously. Residents who have a progressive life-limiting illness are recognized as likely to benefit from a palliative approach to care.

The defined criteria and the results of a comprehensive assessment are used to determine what services will be initiated and when, as per the residents' individualized care plan. The assessment should include elements of the resident's physical, psychosocial, and spiritual health as well as information from the resident, family, and/or caregiver, and other community partners, as needed. To increase efficiency, the assessment should recognize the validity of prior assessments done in other care settings including home care and support services.

6.2.3 The team facilitates access to other services when it is unable to meet a resident's needs.

**Guidelines**

If the team is unable to meet a resident's needs (e.g., for diagnostic services), the team explains the reason to the resident and facilitates access to other services.

Information about lack of access to alternate services is documented for use in service planning.

6.2.4 The team communicates with residents, families, and/or caregivers who the resident's key contact person is and how to reach that person.

**Guidelines**

The key contact person is someone who can respond to the resident, family, and/or caregiver's request or concern.

6.2.5 The team provides services for residents, families, and/or caregivers with respect and dignity.

**Guidelines**

Team members develop respectful and transparent relationships 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 opportunities for questions, input, and feedback
- respecting cultural and religious beliefs or lifestyles
- respecting confidentiality and privacy

6.2.6 The team enables residents, families, and/or caregivers to actively participate in their care, within their capacity to do so.

**Guidelines**

Active resident, family, and/or caregiver participation begins with being informed. The team encourages residents, families, and/or caregivers to be active participants in the resident's care, ask questions, and provide input at all stages of the care process.

6.2.7 The team shares complete and accurate information with team members, including residents, families, and/or caregivers, in a timely way.

**Guidelines**

There is a process to share complete and accurate information with residents, families, and/or caregivers, and team members. This is critical to informed choice and shared decision making.

Information that is shared with residents, families, and/or caregivers is delivered according to individual needs and interests, as well as levels of understanding. Residents, families, and/or caregivers 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
- how to reach team members in an emergency or crisis

Different types of information may be required at different points in a resident's care, and this is accommodated wherever possible. Similarly, different messages will require different communication methods.

Health literacy principles are used to communicate and evaluate the resident, family, and/or caregiver's understanding of the information that has been shared.

6.2.8 The team facilitates access to translation and interpretation services.

**Guidelines**

Appropriate translation and interpretation resources are used to support communication with residents, families, and/or caregivers. The team ensures residents, families, and/or caregivers are aware of these resources.

6.2.9 The team determines residents' capacity to provide informed consent.

**Guidelines**

The process of evaluating a resident's capacity to consent is carried out on an ongoing basis. Capacity means the ability to understand the information relevant to the decision, appreciate foreseeable consequences of a decision or failure to decide, and weigh the risks and benefits of that decision.

6.2.10 The team obtains and documents informed consent from residents, families, and/or caregivers before providing services.

**Guidelines**

Informed consent consists of informing the resident or substitute decision maker about available options and providing time for questions before obtaining consent.

When working with the elderly, minors, or those deemed incapable of consenting, the team involves them to the greatest extent possible in making decisions about services and values their questions and input.

6.2.11 The team provides residents, families, and/or caregivers with information about their rights and responsibilities, and ensures they understand the information provided.

**Guidelines**

Resident, family, and/or caregiver rights include, but are not limited to:

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

Resident, family, and/or caregiver rights regarding service delivery include, but are not limited to:

- 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
- question an individualized care plan decision or file a complaint
- take part in or refuse to take part in research or clinical trials
- receive safe, competent service
- raise concerns about the quality of service

Resident, family, and/or caregiver responsibilities include, but are not limited to:

- treating others with respect
- providing accurate information
- reporting safety risks
- observing rules and regulations

Information about rights and responsibilities is provided at intake or admission and is adapted to meet diverse needs such as language, culture, level of education, lifestyle, and physical or cognitive ability. When the information cannot be provided to the resident, family, and/or caregiver on intake, it is provided at the earliest opportunity.

6.2.12 The team follows the organization's procedure to address claims of violations of residents' rights.

**Guidelines**

The organization creates and sustains an environment where residents, families, and/or caregivers, and team members feel comfortable raising concerns or issues. The organization may provide access to a neutral, objective person from whom residents, families, and/or caregivers can seek advice or consultation.

Where electronic health records are used, there is a process to receive and respond to resident complaints and questions about the privacy of the electronic record.

Claims about violations of a residents' rights that are brought forward by other teams are also addressed.

6.2.13 The team develops and documents an individualized care plan for each resident, based on their needs and goals.

**Guidelines**

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

The resident's physical and psychosocial needs, choices, and preferences as identified in the resident assessment are used to develop the individualized care plan. Preferences include wishes expressed in advance care plans or directives.

6.2.14 The team assesses residents' mental health status and emotional wellness.

**Guidelines**

Residents are assessed for mental health and emotional wellness issues (e.g., anxiety, stress), as such issues can have a significant negative impact on quality of life.

6.2.15 The team reassesses residents' health status in a timely manner and updates their individualized care plans accordingly.

**Guidelines**

The team uses standardized processes and valid assessment tools to re-assess residents' health status.

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 to a resident's physical condition (e.g., hydration, pain, skin integrity) are closely monitored so the team can respond quickly, meet changing care needs, and minimize unintended complications.

The team puts residents' safety and health first in emergency situations.

Changes in a resident's health status are documented accurately and in a timely manner and communicated to all team members.

6.2.16 The team plans for care transitions, including end of service, and identifies them in the individualized care plan.

**Guidelines**

Including information in the individualized care plan about transition planning, whether to home, another team, an alternate level of care, or end of service, enhances coordination among teams or other organizations and helps prepare residents for the end of service.

Resident involvement in end-of-service planning ensures the resident, family, and/or caregiver are prepared and know what to expect.

6.2.17 The team follows a minimal restraint procedure.

**Guidelines**

The team establishes a process to monitor the use of restraints. Documentation about the use of restraints includes when, where, why, and for how long restraints were required, as well as the alternative measures that were attempted unsuccessfully prior to using restraints.

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

6.2.18 The team facilitates resident, family, and/or caregiver access to psychosocial and/or supportive care services.

**Guidelines**

Emotional support and counselling can help residents, families, and/or caregivers cope with the resident's health and social needs and health-related issues.

Support may address coping with a diagnosis, helping with decision making, dealing with side effects, or ethics-related issues such as advance directives.

## 6.3 Delivering Safe and Reliable Care

6.3.1 To prevent falls and reduce the risk of injuries from falling, a risk assessment is conducted with 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 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 because 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 regularly provided 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 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.

**Tests for compliance**

| | |
|---|---|
| 6.3.1.1 | An initial fall prevention and injury reduction risk assessment is conducted for residents upon admission, using a standardized tool. |
| 6.3.1.2 | A standardized process is followed to reassess residents at regular intervals and when there is a significant change in their health status. |
| 6.3.1.3 | 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. |
| 6.3.1.4 | Interventions to prevent falls and reduce injuries from falling are documented in the resident record and communicated to the team. |
| 6.3.1.5 | Team members and volunteers are educated, and residents, families, and caregivers are provided with information to prevent falls and reduce injuries from falling. |
| 6.3.1.6 | 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. |

6.3.2 An interprofessional and collaborative approach is used to assess residents who need skin and wound care and provide evidence-informed care that promotes healing and reduces morbidity and mortality.

**Guidelines**

Wound healing is a complex process that depends on the resident (e.g., comorbidities, age, nutritional status, etc.), the type of skin and wound, the resident's environment (e.g., cleanliness, social support, mobility aids, etc.), and what type of care is provided. Many wounds can be prevented through proper skin care and preventive measures.

Once they have occurred, most wounds can be healed through proper assessment, accurate diagnosis, appropriate treatment, and proper self-care. Appropriate care can reduce resident suffering (e.g., intractable pain, infection, amputation, hospital admission, reduced quality of life) and save lives. Residents who need skin and wound care are a high-volume service (more than one-third of all home care need wound care) and wounds are costly to health care systems. Effective skin and wound care programs result in better resident outcomes and lower costs.

Comprehensive interprofessional collaboration using standardized, evidence-informed protocols is the most effective way to provide skin and wound care. A wide range of expertise is needed, and interprofessional collaboration can be achieved in different ways (e.g., interdisciplinary teams, rounds, virtual networks, telehealth). It is important to identify when and how care providers can access expertise to ensure accurate diagnosis of the wound(s) and seamless skin and wound care. To support interprofessional collaboration, the team, residents, families, and caregivers need information and education that is tailored to their roles in providing appropriate care.

Effective skin and wound care start with a comprehensive assessment to obtain an accurate diagnosis of the wound. It includes assessing the resident's skin and wound and

reviewing resident factors, the resident's environment, and the care the resident has already received. Evidence-informed best practice guidelines for skin and wound care are available. Adopting guidelines helps organizations strengthen the skin and wound care they provide through proper assessment, accurate diagnosis, appropriate products and treatments, appropriate interdisciplinary referrals, and ongoing monitoring. Given the plethora of wound care products available, care is strengthened when organizations have a standardized product list that includes criteria for use. A standardized approach for accurate and comprehensive documentation of all aspects of care is needed for professionals to communicate effectively.

Giving providers timely access to information about wounds has been shown to dramatically improve resident outcomes and healing time, so organizations need a process to share complete information as the resident moves between providers and services. Indicator data related to care processes and resident outcomes can help evaluate the effectiveness of the approach to skin and wound care. Possible indicators include home care data (e.g., length of stay, wound dimensions, number of visits).

**Tests for compliance**

6.3.2.1 There is a documented and coordinated approach to skin and wound care that supports physicians, nurses, and allied health care providers to work collaboratively and provides access to the range of expertise that is appropriate for the resident population.

6.3.2.2 Team members have access to education on appropriate skin and wound care, including products and technologies, assessment, treatment, and documentation.

6.3.2.3 Residents, families, and/or caregivers are provided with information and education about skin and wound self-care, in a format that they can understand.

6.3.2.4 An evidence-informed assessment of new residents is used to determine or confirm the diagnosis of the wound and develop an individualized care plan that addresses the cause(s) of the wound.

6.3.2.5 Standardized skin and wound care that optimizes skin health and promotes healing is delivered.

6.3.2.6 Standardized documentation is implemented to create a comprehensive record of all aspects of the resident's skin and wound care (including assessment, treatment goals, treatment provided, and outcomes).

6.3.2.7 There is a process in place to share information between providers, especially at care transitions, about the resident's skin and wound care.

6.3.2.8 The effectiveness of the skin and wound care program is monitored by measuring care processes (e.g., accurate diagnosis, appropriate treatment, etc.) and outcomes (e.g., healing time, pain, etc.) and this information is used to make improvements.

6.3.3 Each resident's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented.

Note: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.

**Guidelines**

Pressure ulcers have a significant impact on resident 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 interdisciplinary 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:

- Braden Scale for Predicting Pressure Sore Risk
- Norton Pressure Sore Risk Assessment Scale
- interRAI Pressure Ulcer Risk Scale (long-term care)
- Waterlow Score
- Gosnell Scale
- 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.

**Tests for compliance**

6.3.3.1 An initial pressure ulcer risk assessment is conducted for residents upon admission, using a validated, standardized risk assessment tool.

6.3.3.2 The risk of developing pressure ulcers is assessed for each resident at regular intervals and when there is a significant change in the resident's status.

6.3.3.3 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.

6.3.3.4 Team members, residents, families, and caregivers are provided with education about the risk factors and protocols and procedures to prevent pressure ulcers.

6.3.3.5 The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.

6.3.4 Residents are assessed and monitored for risk of suicide.

**Guidelines**

Suicide is a global health concern. Every year more than 800,000 people die by suicide, according to the World Health Organization. Many of these deaths could be prevented by early recognition of the signs of suicidal thinking and offering appropriate intervention.

**Tests for compliance**

6.3.4.1 Residents at risk of suicide are identified.

6.3.4.2 The risk of suicide for each resident is assessed at regular intervals or as needs change.

6.3.4.3 The immediate safety needs of residents identified as being at risk of suicide are addressed.

6.3.4.4 Treatment and monitoring strategies are identified for residents assessed as being at risk of suicide.

6.3.4.5 Implementation of the treatment and monitoring strategies is documented in the resident record.

6.3.5 Collaborating 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, family, or caregiver), 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, family, or caregiver, is not person-specific and should not be used as an identifier.

Resident identification is done co-designed 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 for compliance**

6.3.5.1 In collaborating with residents and families, at least two person-specific identifiers confirm that residents receive the service or procedure intended for them.

6.3.6 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.

**Tests for compliance**

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| 6.3.6.1 | 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 members or location: admission, handover, transfer, and discharge. |
| 6.3.6.2 | Documentation tools and communication strategies are used to standardize information transfer at care transitions. |
| 6.3.6.3 | During care transitions, residents and families are given information that they need to make decisions and support their own care. |
| 6.3.6.4 | Information shared at care transitions is documented. |
| 6.3.6.5 | The effectiveness of communication is evaluated, and improvements are made based on feedback received. Evaluation mechanisms may include:<br>• Using an audit tool (direct observation or review of resident records) to measure compliance with standardized processes and the quality of information transfer<br>• Asking residents, families, and service providers if they received the information they needed<br>• Evaluating safety incidents related to information transfer (e.g., from the resident safety incident management system) |

6.3.7 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.

When evaluations reveal problems with infusion pump design, organizations can work with manufacturers to make improvements. Organizations are encouraged to report problems externally so that other organizations can implement safety improvements.

**Tests for compliance**

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|---|---|
| 6.3.7.1 | Instructions and user guides for each type of infusion pump are always easily accessible. |
| 6.3.7.2 | Initial and re-training on the safe use of infusion pumps are provided to team members:<br>• 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
- When infusion pumps are used very infrequently, just-in-time training is provided

6.3.7.3 When residents are provided with resident-operated infusion pumps (e.g., *patient-controlled analgesia*, insulin pumps), training is provided, and documented, to residents, families and/or caregivers on how to use them safely.

6.3.7.4 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.

6.3.7.5 The effectiveness of the approach is evaluated. Evaluation mechanisms may include:

- Investigating resident safety incidents related to infusion pump use
- Reviewing data from smart pumps
- Monitoring evaluations of competence
- Seeking feedback from residents, families, and team members

6.3.7.6 When evaluations of infusion pump safety indicate improvements are needed, training is improved, or adjustments are made to infusion pumps.

6.3.8 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 workflow 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.

6.3.9 Residents 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 are made in a timely way. Resident safety incidents include harmful incidents, no harm incidents, and near misses, as per the *World Health Organization International Classification for Patient Safety*.

6.3.10 The team provides residents with an accommodating environment that meets their needs and those of their families and/or caregivers.

**Guidelines**

Providing an accommodating, home-like environment includes, but is not limited to:

- encouraging residents to decorate with personal belongings
- giving residents privacy when they are in their rooms or have visitors
- offering residents choices about their daily routine regarding bathing, dressing, eating, and sleeping
- inviting families and/or caregivers to join residents for activities of daily living, including meals, where the opportunity arises

6.3.11 The team protects the physical security and psychological safety of residents.

**Guidelines**

The level of security required to maintain the physical security of residents will vary depending on the nature of the organization and the population it serves. The organization determines the level of risk and decides what measures (e.g., compulsory sign-in of visitors) are necessary to protect residents' security.

Strategies to protect the psychological safety of residents are developed in collaboration with residents, families, and/or caregivers to ensure that they are appropriate to the person's needs. The team documents the identified strategies in the individualized care plan and makes it available to all relevant team members involved in the resident's care.

The team works collaboratively with all members involved in the resident's care to ensure that strategies designed to manage safety risks are implemented in a standardized way across teams and services, and that the information is regularly updated and shared on an on-going basis.

6.3.12 The team provides residents, families, and/or caregivers with opportunities to engage in activities that are meaningful, enjoyable, feasible, and important to them.

**Guidelines**

Activities are provided in a way that respects residents' privacy, dignity, and diversity in language, cuisine, and cultural or religious practices, and fosters residents' quality of life, strengths, and capabilities.

Meaningful activities may meet social, intellectual, or spiritual needs.

6.3.13 The team provides a pleasant dining experience for residents.

**Guidelines**

Residents are helped to make informed choices about dining that may impact their quality of life (e.g., residents may choose to dine in the manner they wish, despite risks).

The social and cultural aspects of the dining experience are important elements of residents' quality of life and these aspects are considered regardless of where dining services are provided.

Considerations to create a pleasant dining experience include, but are not limited to:

- discussions about residents' personal and cultural food preferences
- making a variety of food and beverage choices available and responding to specific requests wherever possible

- offering support for differing capacities to eat
- providing modified diets as necessary
- encouraging residents to eat with friends, family and/or caregiver to share the social and cultural aspects of eating

6.3.14 The team collects feedback from residents, families, and/or caregivers about individual food preferences and nutritional requirements.

**Guidelines**

Feedback related to food preferences and nutritional requirements includes, but is not limited to:

- information about the resident's culture
- religious practises
- preferences
- allergies
- therapeutic diet requirements
- preferred eating times
- potential interactions with the resident's medications

The information is obtained when the resident moves in, when the resident's health status changes, or at defined interval.

# Appendix A: Required Organizational Practices (ROPs)

Table of Required Organizational Practices included in Qmentum® Long-Term Care Assessment Tool by sub-chapters.

| Sub-chapters | Required Organizational Practices | Test(s) for Compliance |
|---|---|---|
| **1.1 Governance** | **1.1.13 The governing body demonstrates accountability for the quality of care provided by the organization.**<br><br>**Guidelines**<br><br>Governing bodies are accountable for the quality of care provided by their organizations. When governing bodies are engaged in overseeing quality, their organizations have better quality performance (better care, better resident outcomes, better worklife, and reduced costs).<br><br>The members of the governing body need to be aware of key quality and safety principles if they are to effectively understand, monitor, and oversee the quality performance of the organization. Knowledge gaps among the membership can be addressed through targeted recruitment for specific competencies (e.g., quality assurance, risk management, quality improvement, and safety) from health care or other sectors (e.g., education or industry) or by providing education through workshops, modules, retreats, virtual networks, or conferences.<br><br>The governing body can demonstrate a clear commitment to quality when it is a standing agenda item at each meeting. Often the governing body overestimates the quality performance of an organization, so discussions need to be supported with indicator data and feedback from residents, families and/or caregivers. A small number of easily understood performance indicators that measure quality at the system level (i.e., 'big-dot' indicators) such as the number of residents who died or were harmed by resident safety incidents, quality of worklife, number of complaints, and resident experience results will help answer the question, "are the services we provide getting better?"<br><br>Quality performance indicators need to be linked to strategic goals and objectives and balanced across a number of priority areas. Knowledge gained from the review of quality performance indicators can be used to set the agenda, inform strategic planning, and develop an integrated quality improvement plan. It can also be used to set quality performance objectives for senior leadership and to | 1.1.13.1 The governing body is knowledgeable about quality and safety principles, by recruiting members with this knowledge or providing access to education.<br><br>1.1.13.2 Quality is a standing agenda item at all regular meetings of the governing body.<br><br>1.1.13.3 The key system-level indicators to be used to monitor the quality performance of the organization are identified.<br><br>1.1.13.4 At least quarterly, the quality performance of the organization is monitored and evaluated against agreed-upon goals and objectives.<br><br>1.1.13.5 Information about the quality performance of the organization is used to make resource allocation decisions and set priorities and expectations.<br><br>1.1.13.6 As part of their performance evaluation, leaders who report directly to the governing body (e.g., the CEO, Executive Director, Chief of Staff) are held accountable for the quality performance of the organization. |

determine whether they have met their quality performance objectives.

## 1.2 Leadership

**1.2.3 A documented and coordinated approach to prevent workplace violence is implemented.**

**Guidelines**

Workplace violence is more common in health care settings than in many other workplaces, with one-quarter of all incidents of workplace violence occurring at health services organizations. It is an issue that affects staff and health providers across the health care continuum.

This ROP has adopted the modified International Labour Organization definition of workplace violence, as follows: “Incidents in which a person is threatened, abused or assaulted in circumstances related to their work, including all forms of harassment, bullying, intimidation, physical threats, or assaults, robbery or other intrusive behaviours. These behaviours could originate from customers or co-workers, at any level of the organization.”

A strategy to prevent workplace violence should be in compliance with applicable regional or national legislation and is an important step to respond to the growing concern about violence in health care workplaces.

| | |
|---|---|
| 1.2.3.1 | There is a written workplace violence prevention policy in place. |
| 1.2.3.2 | The policy is developed in consultation with team members and volunteers as appropriate. |
| 1.2.3.3 | The policy names the individual(s) or position responsible for implementing and monitoring adherence to the policy. |
| 1.2.3.4 | Risk assessments are conducted to ascertain the risk of workplace violence. |
| 1.2.3.5 | There are procedures in place for team members to confidentially report incidents of workplace violence. |
| 1.2.3.6 | There are procedures in place to investigate and respond to incidents of workplace violence. |
| 1.2.3.7 | The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety, reduce incidents of violence, and improve the workplace violence prevention policy. |
| 1.2.3.8 | Information and training is provided to team members on the prevention of workplace violence. |

**1.2.15 A resident safety plan is developed and implemented for the organization.**

**Guidelines**

There is an important connection between excellence in care and safety. Ensuring services are provided safely is one of an organization's primary obligations to residents and team members. Resident safety can be improved when organizations develop a targeted resident safety plan.

Resident safety plans need to consider safety issues in the organization, the delivery of services, and the needs of residents, families and/or caregivers. They may include a range of topics and approaches, such as mentoring team members, the role of leadership (e.g., resident safety leadership walkabouts), implementing organization-wide resident safety initiatives, accessing

| | |
|---|---|
| 1.2.15.1 | Resident safety issues for the organization are assessed. |
| 1.2.15.2 | There is a plan and process in place to address identified resident safety issues. |
| 1.2.15.3 | The plan includes resident safety as a written strategic priority or goal. |
| 1.2.15.4 | Resources are allocated to support the implementation of the resident safety plan. |

evidence and best practices, and recognizing team members for innovations to improve resident safety.

**1.2.16 Resident safety training and education that addresses specific resident safety focus areas are provided at least annually to leaders, team members, and volunteers.**

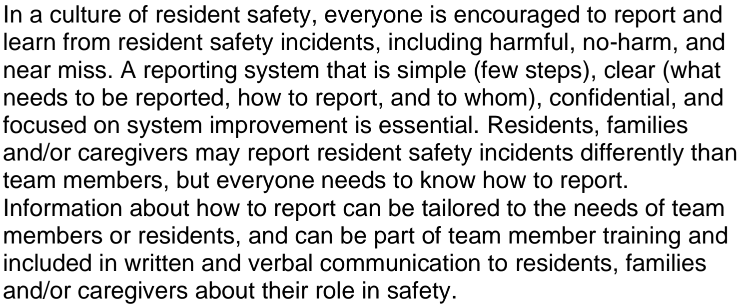
**Guidelines**

Annual education on resident safety is made available to the organization's leaders, team members, and volunteers. Specific resident safety focus areas such as safe medication use, reporting resident safety incidents, human factors training, techniques for effective communication, equipment and facility sterilization, handwashing and hand hygiene, and infection prevention and control are identified.

1.2.16.1 There is annual resident safety training tailored to the organization's needs and specific resident safety focus areas.

**1.2.17 A resident safety incident management system that supports reporting and learning is implemented.**

**Guidelines**



In a culture of resident safety, everyone is encouraged to report and learn from resident safety incidents, including harmful, no-harm, and near miss. A reporting system that is simple (few steps), clear (what needs to be reported, how to report, and to whom), confidential, and focused on system improvement is essential. Residents, families and/or caregivers may report resident safety incidents differently than team members, but everyone needs to know how to report. Information about how to report can be tailored to the needs of team members or residents, and can be part of team member training and included in written and verbal communication to residents, families and/or caregivers about their role in safety.

The immediate response to a resident safety incident is to address the urgent care and support needs of those involved. It is also important to secure any items related to the incident (for testing and review by the analysis team), report the incident using the approved process, begin the disclosure process (if required), and take action to reduce any risk of imminent recurrence.

Through incident analysis (also known as 'root cause analysis'), contributing factors and recommended actions can be identified to make improvements. Analyzing similar resident safety incidents (such as near misses) together, to look for patterns or trends, can yield helpful information, as can analyzing incidents in isolation. Communicating incident analysis findings broadly (e.g., with residents, families and/or caregivers, governance, leadership, clinical teams, and external partners) builds confidence in the incident

1.2.17.1A resident safety incident management system is developed, reviewed, and updated with input from residents, families and/or caregivers, and team members, and includes processes to report, analyze, recommend actions, and monitor improvements.

1.2.17.2 Information is shared with residents, families and/or caregivers, and team members so they understand what, when, and how to report resident safety incidents.

1.2.17.3 Training is provided, and documented, for team members on the immediate response to resident safety incidents.

1.2.17.4 There are procedures to review resident safety incidents and established criteria are used to prioritize those that will be analyzed further.

1.2.17.5 All recommended actions resulting from the analysis of resident safety incidents are reviewed and the rationale to accept, reject, or delay implementation is documented.

1.2.17.6 Information about recommended actions and improvements made following incident analysis is shared with residents, families and/or caregivers, and team members.

1.2.17.7 The effectiveness of the resident safety incident management system is evaluated, and improvements are made based on feedback received. Evaluation mechanisms may include:

management system and promotes learning from resident safety incidents.

Global Patient Safety Alerts is a searchable online database where learnings from resident safety incidents are shared.

- Gathering feedback from residents, families and/or caregivers, and team members about the system
- Monitoring resident safety incident reports by type and severity
- Examining whether improvements are implemented and sustained
- Determining whether team members feel comfortable reporting resident safety incidents

**1.2.18 A documented and coordinated approach to disclosing resident safety incidents to residents, families and/or caregivers, that promotes communication and a supportive response, is implemented.**

**Guidelines**

Disclosure of resident safety incidents is an ongoing discussion that includes the following core elements:

- Informing those affected that a resident safety incident has occurred and offering an apology
- Explaining what happened and why, as facts are known
- Discussing the immediate actions taken to care for the resident and mitigate further harm
- Reviewing recommended actions to prevent future incidents
- Offering support to all involved
- The support provided meets the needs of those involved (residents, families and/or caregivers, and the team), and can be practical (e.g., reimbursement for out-of-pocket expenses) or emotional/psychological (e.g., helping with access to support groups or offering counselling).
- Disclosing a resident safety incident that affects multiple residents (e.g., failures in sterilization, privacy breaches) includes additional elements, for example:
  - Identifying which residents have been exposed to risk
  - Deciding which residents should be contacted and how
  - Locating and communicating with residents who have been affected
  - Informing the community, other organizations, and the media

1.2.18.1 There is a documented and coordinated process to disclose resident safety incidents to residents, families and/or caregivers that identifies:

- Which resident safety incidents require disclosure
- Who is responsible for guiding and supporting the disclosure process
- What can be communicated and to whom about the incident
- When and how to disclose
- Where to document the disclosure

1.2.18.2 The disclosure process is reviewed and updated, as necessary, with input from residents, families and/or caregivers, and team members.

1.2.18.3 Those responsible for guiding and supporting the disclosure process are provided with training on disclosure.

1.2.18.4 Communication occurs throughout the disclosure process with residents, families and/or caregivers, and team members involved in the resident safety incident. Communication is documented and based on their individual needs.

1.2.18.5 As part of the disclosure process, practical and emotional/psychological support is offered to residents, families and/or caregivers, and team members involved in the resident safety incident.

1.2.18.6 Feedback is sought from residents, families and/or caregivers, and team members about their experience with disclosure and this information is used to make improvements, when needed, to the disclosure process.

When asked for their feedback, residents, families and/or caregivers are encouraged to speak from their own perspective and in their own words about their experience.

**4.1 Infection Prevention and Control**

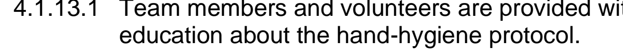
**4.1.13 Hand-hygiene education is provided to team members and volunteers.**

**Guidelines**

Hand hygiene is critical to infection prevention and control programs, but adherence to accepted hand-hygiene protocols is often poor. It has been shown that the costs of health care-associated infections significantly exceed those related to implementing and monitoring hand-hygiene programs.

Training on hand hygiene is multimodal and addresses the importance of hand hygiene in preventing the transmission of microorganisms, factors that have been found to influence hand-hygiene behaviour, and proper hand-hygiene techniques. Training also includes recommendations about when to clean one's hands, based on the four moments for hand hygiene:

1. Before initial contact with the resident or their environment.
2. Before a clean/aseptic procedure.
3. After body fluid exposure risk.
4. After touching a resident or their environment.



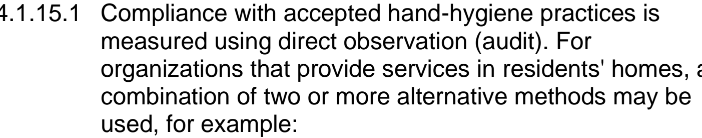
4.1.13.1 Team members and volunteers are provided with education about the hand-hygiene protocol.

**4.1.15 Compliance with accepted hand-hygiene practices is measured.**

**Guidelines**

Hand hygiene is considered the single most important way to reduce health care-associated infections, but compliance with accepted hand-hygiene practices is often poor. Measuring compliance with hand-hygiene practices allows organizations to improve education and training about hand hygiene, evaluate hand-hygiene resources, and benchmark compliance practises across the organization. Studies show that improving compliance with hand-hygiene practices decreases health care-associated infections.

Direct observation (audits) is the best method to measure compliance with hand-hygiene practices. This involves watching and recording the hand-hygiene behaviours of team members and observing the work environment. Observation can be done by a trained observer within an organization, by two or more health care professionals working together, or by residents, families and/or



4.1.15.1 Compliance with accepted hand-hygiene practices is measured using direct observation (audit). For organizations that provide services in residents' homes, a combination of two or more alternative methods may be used, for example:

- Team members recording their own compliance with accepted hand-hygiene practices (self-audit).
- Measuring product use.
- Questions on resident satisfaction surveys that ask about team members' hand-hygiene compliance.
- Measuring the quality of hand-hygiene techniques (e.g., through the use of ultraviolet gels or lotions)

4.1.15.2 Hand-hygiene compliance results are shared with team members and volunteers.

4.1.15.3 Hand-hygiene compliance results are used to make improvements to hand-hygiene practices.

caregivers in the organization or in the community. Ideally, direct observation measures compliance with all four of the moments for hand hygiene:

1. Before initial contact with the resident or their environment
2. Before a clean/aseptic procedure
3. After body fluid exposure risk
4. After touching a resident or their environment

Direct observation should be used by all organizations working out of a fixed location (i.e., residents come to them). Organizations that provide services in residents' homes and find that direct observation is not possible may consider alternative methods. As these alternatives are not as robust as direct observation, they should be used in combination (two or more) to give a more accurate picture of compliance with hand-hygiene practices.

**4.1.21 Health care-associated infections are tracked, information is analyzed to identify outbreaks and trends, and this information is shared throughout the organization.**

**Note: This ROP only applies to organizations that have beds and provide nursing care.**

**Guidelines**

The health care-associated infections most common to the organization's services and resident populations are identified and tracked. These could include Clostridium difficile (C. difficile), surgical site infections, seasonal influenza, noroviruses, urinary tract infections, and other reportable diseases and antibiotic-resistant organisms. Tracking methods for health care-associated infections may focus on a particular infection or service area or may be organization- or system-wide. They may include data analysis techniques to help detect previously unrecognized outbreaks. Tracking may include frequencies and changes in frequencies over time, associated mortality rates, and attributed costs.

Teams that are well informed about health care-associated infection rates are better equipped to prevent and manage them. The role or position responsible for receiving information about health care-associated infection rates is identified and a plan is established to regularly disseminate information (e.g., quarterly reports to all departments). In addition to team members, the governing body needs to be informed about health care-associated infection rates and associated infection prevention and control issues. This may be done directly through senior management or a medical advisory committee.

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|---|---|
| 4.1.21.1 | Health care-associated infection rates are tracked. |
| 4.1.21.2 | Outbreaks are analyzed, and recommendations are made to prevent recurrences. |
| 4.1.21.3 | Information about relevant health care-associated infections and recommendations from outbreak reviews are shared with team members, senior leadership, and the governing body. |

**5.1 Medication Management**

**5.1.4 The organization has identified and implemented a list of abbreviations, symbols, and dose designations that are not to be used in the organization.**

**Guidelines**

Misinterpreted abbreviations can result in omission errors, extra or improper doses, administering the wrong drug, or giving a drug in the wrong manner.

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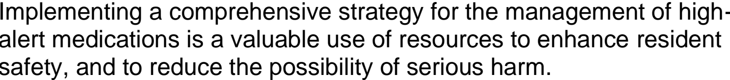
|---|---|
| 5.1.4.1 | The organization's 'Do Not Use' List is inclusive of the abbreviations, symbols, and dose designations, as identified by an Institute for Safe Medication Practices (ISMP) list of error-prone abbreviations, symbols, and dose designations. |
| 5.1.4.2 | The organization implements the 'Do Not Use' List and applies this to all medication-related documentation when handwritten or entered as free text into a computer. |
| 5.1.4.3 | The dangerous abbreviations, symbols, and dose designations identified on the 'Do Not Use' List are not used on any pharmacy-generated labels and forms. |
| 5.1.4.4 | The organization educates staff about the 'Do Not Use' List during orientation and whenever changes are made to the list. |
| 5.1.4.5 | The organization updates the 'Do Not Use' List and implements necessary changes to the organization's processes. |
| 5.1.4.6 | The organization audits compliance with the 'Do Not Use' List and implements process changes based on identified issues. |

**5.1.5 The organization implements a comprehensive strategy for the management of high-alert medications.**

**Guidelines**



Implementing a comprehensive strategy for the management of high-alert medications is a valuable use of resources to enhance resident safety, and to reduce the possibility of serious harm.

The Institute for Safe Medication Practices has produced a list of high-alert medications specifically for community/ambulatory settings which can be found online. To prevent harm from medication errors, a policy for the management of high-alert medications is required. Strategies for the safe use of high-alert medications may include but are not limited to:

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|---|---|
| 5.1.5.1 | The organization has a policy for the management of high-alert medications. |
| 5.1.5.2 | The policy names the role or position of individual(s) responsible for implementing and monitoring the policy. |
| 5.1.5.3 | The policy includes a list of high-alert medications identified by the organization. |
| 5.1.5.4 | The policy includes procedures for storage, prescribing, preparation, administration, dispensing, and documentation for each high-alert medication, as appropriate. |
| 5.1.5.5 | The organization establishes a mechanism to update the policy on an ongoing basis. |

- Applying warning labels to products as soon as they are received in the pharmacy
- Using visible warning and auxiliary labels according to the organization's policy
- Providing training about high-alert medications
- Employing automated or independent double checks

A policy for the management of high-alert medications may place additional emphasis on strategies for high-risk resident populations including the elderly, pediatrics, and neonates. Organizations should systematically evaluate each high-alert medication or class of medications and establish an action plan to improve the safe use of these medications.

5.1.5.6 The organization provides information and ongoing training to staff on the management of high-alert medications.

**5.1.8 The availability of heparin products is evaluated and limited to ensure that formats with the potential to cause resident safety incidents are not stocked in resident service areas.**

**Guidelines**

Heparin is a high-alert medication. Limiting its availability and ensuring that high-dose formats are not stocked in resident service areas are effective strategies to minimize the risk of death or disabling injury associated with these agents.

For specific care circumstances, it may be necessary for heparin products to be available in select resident service areas. In these cases, an interdisciplinary committee for medication management (e.g., Pharmacy and Therapeutics Committee and Medical Advisory Secretariat) reviews and approves the rationale for availability and safeguards are put in place to minimize the risk of error.

For flushing intravenous lines, organizations are encouraged to consult best practice guidelines to explore options other than heparin.

5.1.8.1 An audit of unfractionated and low molecular weight heparin products in resident service areas is completed at least annually.

5.1.8.2 High dose unfractionated heparin (50,000 units total per container) is not stocked in resident service areas.

5.1.8.3 Steps are taken to limit the availability of the following heparin products in resident service areas:

- Low molecular weight heparin: use of multi-dose vials is limited to critical care areas for treatment doses
- Unfractionated heparin (high dose): greater than or equal to 10,000 units total per container (e.g., 10,000 units/1 mL; 10,000 units/10 mL; 30,000 units/30 mL) is provided on a resident-specific basis when required
- Unfractionated heparin for intravenous use (e.g., 25,000 units/ 500 mL; 20,000 units/500 mL) is provided on a resident-specific basis when required

5.1.8.4 When it is necessary for the previous heparin products to be available in select resident service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.

**5.1.9 The availability of narcotic products is evaluated and limited to ensure that formats with the potential to cause resident safety incidents are not stocked in resident service areas.**

**Guidelines**

Narcotics (or opioids) have been identified as high-alert medications. Limiting their availability and ensuring that high dose formats are not stocked in resident service areas are effective strategies to minimize the risk of death or disabling injury associated with these agents.

For specific care circumstances, it may be necessary for narcotic products to be available in select resident service areas, for example:

- Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
- Hydromorphone: 10 mg/mL ampoules or vials may be provided based on the following criteria and must be removed when no longer required: intermittent intravenous, subcutaneous, or intramuscular doses greater than 4 mg

In these cases, an interdisciplinary committee for medication management (e.g., Pharmacy and Therapeutics Committee and Medical Advisory Secretariat) reviews and approves the rationale for availability and safeguards are put in place to minimize the risk of error.

Organizations serving pediatric populations are encouraged to implement practice recommendations specific to their resident population, including the use of standardized concentrations for opioid infusions.

To optimize the safe use of narcotic products, organizations may also consider establishing a pain management team.

5.1.9.1 An audit of the following narcotic products in resident service areas is completed at least annually:

- Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
- Hydromorphone: ampoules or vials with total dose greater than 2 mg
- Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas

5.1.9.2 Stocking the following narcotic products is avoided in resident service areas:

- Fentanyl: ampoules or vials with total dose greater than 100 mcg per container
- Hydromorphone: ampoules or vials with total dose greater than 2 mg
- Morphine: ampoules or vials with total dose greater than 15 mg in adult care areas and 2 mg in paediatric care areas

5.1.9.3 When it is necessary for narcotic (opioid) products to be available in select resident service areas, an interdisciplinary committee for medication management reviews and approves the rationale for availability, and safeguards are put in place to minimize the risk of error.

**5.1.62 Medication reconciliation is conducted in collaboration 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.

5.1.62.1 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).

5.1.62.2 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.

5.1.62.3 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

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.

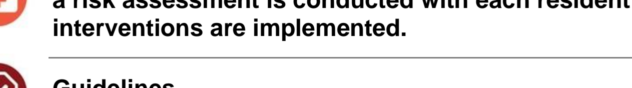
At care transitions, in addition to the medications the resident is currently receiving, it is important to also consider the medications that were taken prior to admission (as identified in the BPMH), which may be appropriate to continue, restart, discontinue, or modify. For example, medication reconciliation 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.

any medication discrepancies are identified, resolved, and documented.

5.1.62.4 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.

**6.3 Delivering Safe and Reliable Care**



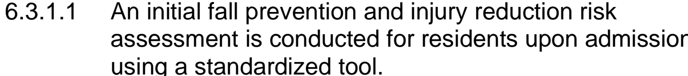
**6.3.1 To prevent falls and reduce the risk of injuries from falling, a risk assessment is conducted with each resident and interventions are implemented.**

**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 require 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 to create individualized targeted fall



6.3.1.1 An initial fall prevention and injury reduction risk assessment is conducted for residents upon admission, using a standardized tool.

6.3.1.2 A standardized process is followed to reassess residents at regular intervals and when there is a significant change in their health status.

6.3.1.3 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.

6.3.1.4 Interventions to prevent falls and reduce injuries from falling are documented in the resident record and communicated to the team.

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 regularly provided 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 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.

6.3.1.5 Team members and volunteers are educated, and residents, families, and caregivers are provided with information to prevent falls and reduce injuries from falling.

6.3.1.6 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.

**6.3.2 An interprofessional and collaborative approach is used to assess resident who need skin and wound care and provide evidence-informed care that promotes healing and reduces morbidity and mortality.**

**Guidelines**

Wound healing is a complex process that depends on the resident (e.g., co-morbidities, age, nutritional status, etc.), the type of skin and wound, the resident's environment (e.g., cleanliness, social support, mobility aids, etc.), and what type of care is provided. Many wounds can be prevented through proper skin care and preventive measures.

Once they have occurred, most wounds can be healed through proper assessment, accurate diagnosis, appropriate treatment, and proper self-care. Appropriate care can reduce resident suffering (e.g., intractable pain, infection, amputation, hospital admission, reduced quality of life) and save lives. Residents who need skin and wound

6.3.2.1 There is a documented and coordinated approach to skin and wound care that supports physicians, nurses, and allied health care providers to work collaboratively and provides access to the range of expertise that is appropriate for the resident population.

6.3.2.2 Team members have access to education on appropriate skin and wound care, including products and technologies, assessment, treatment, and documentation.

6.3.2.3 Residents, families, and caregivers are provided with information and education about skin and wound self-care, in a format that they can understand.

6.3.2.4 An evidence-informed assessment of new residents is used to determine or confirm the diagnosis of the wound

care are a high-volume service (more than one-third of all home care need wound care) and wounds are costly to health care systems. Effective skin and wound care programs result in better resident outcomes and lower costs.

Comprehensive interprofessional collaboration using standardized, evidence-informed protocols is the most effective way to provide skin and wound care. A wide range of expertise is needed, and interprofessional collaboration can be achieved in different ways (e.g., interdisciplinary teams, rounds, virtual networks, telehealth). It is important to identify when and how care providers can access expertise to ensure accurate diagnosis of the wound(s) and seamless skin and wound care. To support interprofessional collaboration, the team, residents, families, and caregivers need information and education that is tailored to their roles in providing appropriate care.

Effective skin and wound care starts with a comprehensive assessment to obtain an accurate diagnosis of the wound. It includes assessing the resident's skin and wound and reviewing resident factors, the resident's environment, and the care the resident has already received. Evidence-informed best practice guidelines for skin and wound care are available. Adopting guidelines helps organizations strengthen the skin and wound care they provide through proper assessment, accurate diagnosis, appropriate products and treatments, appropriate interdisciplinary referrals, and ongoing monitoring. Given the plethora of wound care products available, care is strengthened when organizations have a standardized product list that includes criteria for use. A standardized approach for accurate and comprehensive documentation of all aspects of care is needed for professionals to communicate effectively.

Giving providers timely access to information about wounds has been shown to dramatically improve resident outcomes and healing time, so organizations need a process to share complete information as the resident moves between providers and services. Indicator data related to care processes and resident outcomes can help evaluate the effectiveness of the approach to skin and wound care. Possible indicators include home care data (e.g., length of stay, wound dimensions, number of visits).

and develop an individualized care plan that addresses the cause(s) of the wound.

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| 6.3.2.5 | Standardized skin and wound care that optimizes skin health and promotes healing is delivered. |
| 6.3.2.6 | Standardized documentation is implemented to create a comprehensive record of all aspects of the resident's skin and wound care (including assessment, treatment goals, treatment provided, and outcomes). |
| 6.3.2.7 | There is a process in place to share information between providers, especially at care transitions, about the resident's skin and wound care. |
| 6.3.2.8 | The effectiveness of the skin and wound care program is monitored by measuring care processes (e.g., accurate diagnosis, appropriate treatment, etc.) and outcomes (e.g., healing time, pain, etc.) and this information is used to make improvements. |

**6.3.3 Each resident's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented.**

**Note: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.**

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| 6.3.3.1 | An initial pressure ulcer risk assessment is conducted for residents upon admission, using a validated, standardized risk assessment tool. |
| 6.3.3.2 | The risk of developing pressure ulcers is assessed for each resident at regular intervals and when there is a significant change in the resident's status. |

**Guidelines**

Pressure ulcers have a significant impact on resident 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:

- Braden Scale for Predicting Pressure Sore Risk
- Norton Pressure Sore Risk Assessment Scale
- interRAI Pressure Ulcer Risk Scale (long-term care)
- Waterlow Score
- Gosnell Scale
- 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.

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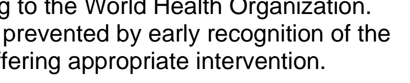
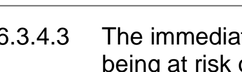
| 6.3.3.3 | Documented protocols and procedures based on best practice guidelines are implemented to prevent the development of pressure ulcers. These may include interventions to prevent skin breakdown; minimize pressure, shear, and friction; reposition; manage moisture; optimize nutrition and hydration; and enhance mobility and activity. |
| 6.3.3.4 | Team members, residents, families, and caregivers are provided with education about the risk factors and protocols and procedures to prevent pressure ulcers. |
| 6.3.3.5 | The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed. |

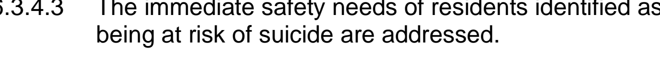
**6.3.4 Residents are assessed and monitored for risk of suicide.**

**Guidelines**

Suicide is a global health concern. Every year more than 800,000 people die by suicide, according to the World Health Organization. Many of these deaths could be prevented by early recognition of the signs of suicidal thinking and offering appropriate intervention.







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| 6.3.4.1 | Residents at risk of suicide are identified |
| 6.3.4.2 | The risk of suicide for each resident is assessed at regular intervals or as needs change. |
| 6.3.4.3 | The immediate safety needs of residents identified as being at risk of suicide are addressed. |
| 6.3.4.4 | Treatment and monitoring strategies are identified for residents assessed as being at risk of suicide. |
| 6.3.4.5 | Implementation of the treatment and monitoring strategies is documented in the resident record. |

**6.3.5 Collaborating with residents and families, at least two person-specific identifiers are used to confirm that residents receive the service or procedure intended for them.**

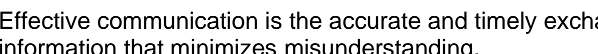
**Guidelines**

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, family and/or caregiver), 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, family and/or caregiver, is not person-specific and should not be used as an identifier.

Resident identification is done co-designed 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.

6.3.5.1 When collaborating with residents and families, at least two person-specific identifiers confirm that residents receive the service or procedure intended for them.



**6.3.6 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.

6.3.6.1 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 members or location: admission, handover, transfer, and discharge.

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

6.3.6.3 During care transitions, residents and families are given information that they need to make decisions and support their own care.

6.3.6.4 Information shared at care transitions is documented.

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.

6.3.6.5 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 resident safety incident management system).

**6.3.7 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.

When evaluations reveal problems with infusion pump design, organizations can work with manufacturers to make improvements. Organizations are encouraged to report problems externally so that other organizations can implement safety improvements.

6.3.7.1 Instructions and user guides for each type of infusion pump are easily accessible at all times.

6.3.7.2 Initial and re-training on the safe use of infusion pumps is provided to team members:

- 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
- When infusion pumps are used very infrequently, just-in-time training is provided

6.3.7.3 When residents are provided with resident-operated infusion pumps (e.g., *patient-controlled analgesia*, insulin pumps), training is provided, and documented, to residents, families and/or caregivers on how to use them safely.

6.3.7.4 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.

6.3.7.5 The effectiveness of the approach is evaluated. Evaluation mechanisms may include:

- Investigating resident safety incidents related to infusion pump use
- Reviewing data from smart pumps
- Monitoring evaluations of competence

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| | • Seeking feedback from residents, families, and team members |
| 6.3.7.6 | When evaluations of infusion pump safety indicate improvements are needed, training is improved, or adjustments are made to infusion pumps. |