ACCREDITATION
CANADA

QMENTUM GLOBAL™ FOR LONG-TERM CARE

Assessment Manual

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Terms and Definitions

Below is a list of terms and definitions that are used throughout this assessment standard. Different terms and definitions may be used for the same concepts across jurisdictions.

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).

adverse drug reaction. An unintended 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.

assistive devices and technologies. Systems, products, and services that maintain or improve a person's functioning and independence (World Health Organization, 2018). Examples include eyeglasses, hearing aids, communication aids, and mobility aids such as lifts and walkers.

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

care. Actions taken in any setting to address a resident's social, physical, personal, emotional, psychological, cultural, spiritual, and medical needs to support their health and well-being (International Organization for Standardization, 2021). Care is relational and founded in relationships that emphasize and embrace the unique experiences, values, perspectives, and personhood of both the resident and the provider (Beach & Inui, 2006).

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).

clinical decision aid tool. Tool that provides teams, clients, and designated support persons with evidence-informed information to facilitate decision-making. This tool aims to improve the quality of

care by limiting unexpected variations using a standardized approach, thus reducing patient safety incidents. The clinical decision aid tool can be available on various platforms.

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.

communication. “An interactive, two-way process that involves both understanding and being understood. Communication includes speech, gestures, body language, writing, drawing, pictures, symbol, and letter boards” (Communication Disabilities Access Canada, n.d.).

competencies. The total sum of knowledge, skills, abilities, attitudes, and behaviours required to be successful in a workplace role.

cultural humility. “A process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience” (First Nations Health Authority, 2016).

cultural safety. “An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health system. It results in an environment free of racism and discrimination, where people feel safe” when receiving and providing care and interacting with the health system (First Nations Health Authority, 2016). A culturally safe environment is one that is physically, socially, emotionally, and spiritually safe without challenge, ignorance, or denial of a person's identity (Turpel-Lafond, 2020). Practising cultural safety requires having knowledge of the colonial, sociopolitical, and historical events that trigger health disparities and perpetuate and maintain ongoing racism and unequal treatment (Allan & Smylie, 2015).

decision-making. A process taken by a resident, or if incapable, their substitute decision maker, and the team member providing care to determine the best option or course of action to meet the resident's goals, needs, and preferences. decision-making has three steps: introducing and describing the choices to the resident; helping the resident explore how the options meet their goals, needs, and preferences; and giving the resident time to consider the information, understand it, and have their questions answered before being asked to make a decision.

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. Current or imminent situation that presents a significant danger capable of causing serious harm to people or damage to property. The situation may be caused by a force of nature, a disease or other health risk, or an accident or intentional or unintentional act and calls upon one or more first responders such as fire fighters, police, ambulance paramedics, and transportation or public works personnel. While an emergency situation requires rapid intervention, it does not surpass response capacity, such that, in contrast to disasters, the impact of an emergency is generally limited.

emergency and disaster management. A comprehensive approach to preventing, planning for, responding to, and recovering from situations that require action to avoid serious damage or harm and exceed the ability of the affected population to cope using its own resources. Emergency and disaster management requires concerted actions from multiple stakeholders. Examples of emergencies and disasters include pandemics and outbreaks, fires, natural disasters, industrial accidents, and acts of terrorism.

environmental stewardship. Efforts to protect the environment and to identify and mitigate the potential environmental repercussions of an organization's activities. The goal of environmental stewardship is to limit negative environmental effects of operations and, where possible, to create positive effects (Natural Resources Canada, 2019). Environmental stewardship includes climate resilience, environmental sustainability, and net zero carbon.

equity, diversity, and inclusion approach. An approach that strives to create an environment where everyone feels included, welcomed, valued, and respected. It aims to create fair access to resources and opportunities; improve communication and participation by diverse communities; and eliminate discrimination (Centre for Global Inclusions, n.d.).

essential care partner. A person or persons chosen by a resident, or if incapable, their substitute decision maker, to participate in the resident's ongoing care. An essential care partner can be a family member, close friend, private care provider, or other caregiver. A resident has the right to include or not include an essential care partner in any aspect of the resident's care. Depending on the jurisdiction, an essential care partner may be referred to by other terms, such as designated support person or essential family caregiver (Healthcare Excellence Canada, 2021).

evidence-informed approach. An approach to informing policies, procedures, and practices that integrates quantitative and qualitative knowledge from research, implementation science, and people with expertise and those with lived experiences. Combining research, expertise, and lived experience is an inclusive approach that ensures evidence reflects the person, the context, and the evolving nature of knowledge (Alla & Joss, 2021).

evidence-informed practice. Refers to the use of the best available and current evidence, along with clinical expertise and consideration of resident values and preferences, to guide healthcare decision-making and the delivery of resident care.

executive leader. The senior-most leader of the organization (e.g., the chief executive officer) and head of the senior leaders. The executive leader reports to the governing body.

external partner. Service provider of an organization, community group, or entity that collaborates with another health care organization. External partners include government and community organizations, pharmaceutical companies, community pharmacies, medical clinics, and partners in daycare centres, schools, municipalities, public security, and different workplaces.

family. See essential care partner.

formulary. A list of medications that are approved for use by a health organization, insurer, or health system. The formulary consists of medications determined to be safe, effective, and appropriate for use in patients, clients, and residents, as approved by an interdisciplinary committee. Formulary decisions may also be based on factors such as the availability and safety of similar agents, direct costs, and the total cost of care with the new medication compared with medications of the same class that are on the current formulary. The formulary provides information on use, dosage, possible adverse effects, contraindications, and warnings as well as selecting the right medication for the condition.

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

governing body. The body that holds authority, ultimate decision-making power, and accountability for an organization and its services. This may be a board of directors, a council, a Chief and Council, or another decision-making body. A governing body may work independently or with government in jurisdictions where government is responsible for one or more governance functions.

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

health care equipment. A non-invasive health care apparatus, appliance, or material that comes in contact only with a person's intact skin. Examples include wheelchairs, lifts, blood pressure cuffs, and grab bars.

health care-associated infection. Infection that is transmitted within a health care setting (also referred to as nosocomial) during the provision of health care. Symptoms of the infectious disease can appear during or after the stay in the health care setting. Examples include *Clostridioides difficile*, surgical site infections, seasonal influenza, noroviruses, and urinary tract infections.

health record. The collection of confidential information about a person's health history and socio-demographic data. A health record includes information about the person's conditions and care activities. The information is documented by all health professionals providing care (Health Information Management, n.d.).

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.

independent double check. A procedure that involves an independent verification of each component of the entire drug administration process, including prescribing, dispensing, and verifying the medication order. To eliminate any bias, the verification needs to be done separately, with the verifiers being alone and apart from each other, and is followed by a comparison of results (ISMP, 2013).

individualized care plan. A documented plan that outlines the integrated activities required to meet a resident's goals, needs, and preferences. An individualized care plan is developed collaboratively with the resident and informed by ongoing comprehensive assessments of basic, physical, mental, and social needs. The individualized care plan is shared with appropriate team members. Individualized care plans support care that is seamless and safe.

information and communication technology. Any communication device and the various applications and services associated with them. Information and communication technology allows the transfer of information among people and systems (Huth, 2017). Examples include call systems, clinical information systems, staff scheduling systems, Wi-Fi, and tablets.

integrated quality improvement plan. Documented series of steps taken with teams to improve the quality of care. The plan includes objectives and measurement indicators as well as actions to be taken.

jurisdiction. A geographical area over which a government is responsible for the design, management, and delivery of services to a defined population (Jackman, 2000).

long-term care (LTC) home. A setting where people with complex health care needs live. Also referred to as continuing care, personal care, or nursing homes, LTC homes are formally recognized by jurisdictions with a licence or permit and are partially funded or subsidized to provide a range of health and support services, such as lodging, food, and personal care for their residents 24 hours a day, 7 days a week (Canadian Institute for Health Information, n.d.).

LTC home leaders. People in an LTC home who work in a formal or informal leadership capacity to support, manage, and recognize their teams and organizations. Leaders include executive and other senior leaders. For the purpose of this standard, an LTC home's governing body is not included in the term leaders or LTC home leaders.

medical device. An article, instrument, apparatus, or machine used for prevention, diagnosis, treatment, monitoring, rehabilitation, or palliation. Medical devices range from simple thermometers to

complex surgical instruments and implantable devices and are classified as critical, semi-critical, or non-critical.

medical equipment. A non-invasive medical apparatus, appliance, or material that comes in contact only with a client's intact skin. Examples include wheelchairs, IV poles, and commodes. Medical equipment requires cleaning and low-level disinfection procedures and may require preventive maintenance and repair. Some medical equipment, such as blood pressure cuffs and medical imaging equipment, could also require calibration.

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

medication management. Management of the whole process related to storing, prescribing, preparing, distributing, administering, documenting, and disposing of medications. Medication management also includes monitoring drug therapy to ensure the safe, accurate, and consistent use of medications across the organization.

medication storage area. Area where medications are stored in resident service areas.

organizational leader. see LTC home leader

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

palliative care. An approach that aims to relieve suffering of a person experiencing a life-threatening condition or a serious illness. Palliative care aims to improve quality of life, reduce, or relieve physical or psychological symptoms, and provide ongoing support to those who care for the person (Health Canada, 2021).

partner. An organization or person who works with others to address a specific issue by sharing information or resources. Partnership can occur at the organization level, team level, or through individual projects or programs.

patient. See resident

people-centred care. "An approach to care that consciously adopts the perspectives of individuals, [essential care partners,] 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). People-centred care adopts the perspectives of all people involved in care, those providing care, and those receiving care.

personal protective equipment (PPE). Equipment that is used to provide a barrier that prevents potential exposure to chemical products, cytotoxic medications and 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. The documented rules and regulations that guide an organization. A policy provides consistency, accountability, and clarity on how an organization operates. A policy needs to comply with jurisdictional requirements.

polypharmacy. The use of more medications than are medically necessary. These medications may not be indicated, may not be effective, or could be duplicative (Maher et al, 2014).

procedure. The documented steps for completing a task, often connected to a policy. Procedures are evidence informed and comply with jurisdictional requirements.

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 improvement. A systematic and structured team effort to achieve measurable improvements in care delivery, experiences, and outcomes.

quality of life. A person's sense of well-being and their experiences in life in the context of their culture and value systems and in relation to their goals, expectations, and concerns. Quality of life is a broad-ranging concept that is affected in a complex way by a person's physical health, psychological state, personal and spiritual beliefs, existential concerns, social relationships, and their relationship to salient features of their environment (Cohen et al., 2016; World Health Organization, n.d.-a).

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.

resident. A person who lives in an LTC home.

resident-centred care. An approach based on the philosophy of people-centred care that ensures that the resident is a partner and active participant in their care. The resident's goals, needs, and preferences drive decision-making for care.

resources. Human, financial, material, informational, and technological resources required to ensure safe, high-quality care.

restraint. A physical or chemical measure that controls or limits a resident's movement, behaviour, or mobility. The use and definitions of restraints may vary by jurisdiction and population type. Except in an

emergency, the use of restraints requires the informed consent of a capable resident, or if incapable, their substitute decision maker.

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 harmed or did harm a client. Safety incidents experienced by clients (also referred to as patient safety incidents) may include medication errors, choking incidents, injuries, infections, mistakes during care, falls, or clients leaving the care environment without notice.

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 regulations.

service provider. Health care professionals involved at any point, based on their scope of practice, in the medication management process.

stakeholder. An individual with an interest in or concern for the organization and its services. Stakeholders may include the workforce, clients, designated support persons, organizational leaders, and external partners. Stakeholders may be internal (e.g., staff) or external (e.g., community members).

strategic plan. A strategic plan articulates the LTC home's vision, mission, and goals to guide the delivery of high-quality services that meet the diverse needs of the LTC home's residents and workforce. The strategic plan, updated every three to five years, or sooner if required, is informed by relevant data that include stakeholders' needs and experiences.

substitute decision maker. A person or persons who have legal authority to make a care decision for a resident if the resident is incapable of making the decision for themself. Depending on the jurisdiction, a substitute decision maker may be referred to by other terms, such as health care representative, agent, proxy, personal guardian, committee of the person, temporary decision maker, or attorney for personal care.

team. People collaborating to meet the goals, needs, and preferences of the resident. The team includes the resident and, if incapable, their substitute decision maker; essential care partners with consent; and workforce members involved in the resident's care. Depending on the care provided, the team may also include LTC home leaders, volunteers, learners, external service providers, and visitors.

team-based care. A model of care in which a team collaborates to provide safe, effective, resident-centred, and accessible care, based on goals defined by the resident.

timely. Happening within a time limit that is acceptable, relevant, and appropriate.

traditional or alternative remedies. Remedies that are founded on knowledge, practices, theories, beliefs, and experiences originating from different cultures, that may or may not be explicable. Traditional medicine is used for the prevention, diagnosis, improvement, or treatment of physical and mental illness as well as for the maintenance of health (World Health Organization, 2013).

trauma-informed care. An approach to care that recognizes that many people have experienced psychological or emotional trauma, the lasting effects of which may influence their physical and mental health, behaviour, and engagement with health service providers and services. Trauma-informed care makes people feel safe and comfortable and avoids re- traumatizing them (Alberta Health Services, n.d.; Trauma Informed Oregon, n.d).

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.

virtual health. Means of providing a service (not the service itself) that creates a virtual network to complement in-person care. Virtual health services occur at a distance, using information technology and telecommunications, interaction between users, including clients, designated support persons and the care team, to facilitate or maximize the quality and efficiency of care provided to clients.

visitor. A person who enters an LTC home to interact with a resident or member of the workforce. A visitor could be, for example, a substitute decision maker, essential care partner, external health care professional, business adviser, friend, or family member.

well-being. A state of global life satisfaction that includes the presence of positive emotions and moods, the absence of negative emotions, satisfaction with life, fulfillment, and positive functioning. A state of well-being includes physical, economic, social, emotional, psychological, intellectual, and spiritual fulfillment (Centers for Disease Control and Prevention, 2018).

workforce. Everyone working in or on behalf of an organization on one or more teams. The workforce includes those who are salaried and paid hourly, in term or contract positions, clinical and non-clinical roles, regulated and non-regulated health care professionals, and all support personnel who are involved in delivering services in the organization.

NOTE: To ensure consistency in required organizational practice (ROP) terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. ‘Client’ and ‘patient’ refer to ‘resident’, ‘family and friends’ and ‘designated support person’ refers to ‘essential care partner’, ‘team leadership’ and ‘organizational leaders’ refers to ‘LTC home leaders’, and ‘organization’ refers to ‘LTC home’.

Introduction

Qmentum Global for LTC is grounded in a customized assessment manual developed from CAN/HSO 21001:2023 (E) *Long-Term Care Services* and additional HSO standards to meet the needs of LTC homes, residents, essential care partners, workforces, and the community.

An assessment manual is a collection of content (i.e., criteria and guidelines) that is consolidated and customized from selected assessment standards, based on the services provided by a client organization. Therefore, assessment manuals are built from assessment standards. An assessment standard is an HSO standard that applies classifications for each criterion, (see Criteria Classification, below).

LTC homes can access the assessment manual on the OnboardQi digital platform.

Purpose

The assessment manual contains the 152 assessment criteria including 16 ROPs that enable your LTC home to learn, implement, and drive improvements to provide safe, reliable, and high-quality care for residents.

Applicability

Your LTC home uses the assessment manual to perform self-assessments and attestation assessments, and to prepare for the on-site assessment. Surveyors use the assessment manual to perform on-site assessments.

Jurisdictional legislation, regulations, and public health requirements take precedence over any requirements in the assessment manual. The assessment manual is meant to support your LTC homes as it implements the requirements defined by jurisdictions.

Development

The assessment manual was developed in consultation with subject-matter experts. The content of the assessment manual is based on HSO standards that reflect evidence-informed practices and people-centred care principles.

The content of the assessment manual is informed by the following HSO standards:

- HSO 21001:2023 (E) *Long-Term Care Services*
- HSO 2001:2020 (E) *Leadership*
- HSO 1001:2022 (E) *Governance*
- HSO 0001:2020 (E) *Service Excellence*
- HSO 3001:2019 (E) *Medication Management*
- HSO 4001:2018 (E) *Infection Prevention and Control*
- HSO 9002:2020 (E) *Emergency and Disaster Management*

Structure

The assessment manual is organized into thematic chapters that define actionable criteria and guidelines:

- **Chapters**. The assessment manual is organized into eight chapters. Each chapter begins with an introduction to the purpose of the chapter and its content.

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

- **Criteria**. Each chapter 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 (see Criteria Classification, below).

- **Guidelines**. Each criterion has corresponding guidelines that provide additional information to help users understand the criterion statement. Guidelines do not contain new evaluation content.

Chapter 1: Governing LTC Home's Strategies, Activities, and Outcomes

- Contains: 15 criteria (1 ROP included: HSO 5000: 2021 (E) *Accountability for Quality of Care*)

Chapter 2: Upholding Resident-Centred Care

- Contains: 25 criteria (0 ROPs included)

Chapter 3: Enabling a Meaningful Quality of Life for Residents

- Contains: 11 criteria (0 ROPs included)

Chapter 4: Ensuring High-Quality and Safe Care

- Contains: 43 criteria (9 ROPs included: HSO 5010: 2018 (E) *Client Identification*, HSO 5063:2024 (E) *Optimizing Skin Integrity Program*, HSO 5060:2024 (E) *Preventing Falls and Reducing Injuries from Falls*, HSO 5014:2024 (E) *Maintaining an Accurate List of Medications during Care Transitions*, HSO 5002: 2018 (E) *Patient Safety Incident Management*, HSO 5001:2018 (E) *Patient Safety Incident Disclosure*, HSO 5065:2024 (E) *Venous Thromboembolism Prophylaxis*, HSO A5064:2023 (E) *Suicide Prevention*, HSO 5012: 2018 (E) *Information Transfer at Care Transitions*

Chapter 5: Enabling a Healthy and Competent Workforce

- Contains: 19 criteria (1 ROP included: HSO 5043:2006 *Preventive Maintenance Program*)

Chapter 6: Enabling Infection and Prevention Control Practices

- Contains: 17 criteria (2 ROPs included: HSO 5055:2024 (E) *Cleaning and Low-Level Disinfecting Medical Equipment*, HSO 5050:2024 (E) *Improving Hand Hygiene Practices*)

Chapter 7: Maintaining Safe Medication Management Practices

- Contains: 17 criteria (3 ROPs included: HSO 5011: 2023 (E) *Adhering to a 'Do Not Use' List of Abbreviations, Symbols, and Dose Designations*, HSO 5033:2023 (E) *Managing High Alert Medications*, HSO 5035:2023 (E) *Limiting High Concentration and High Total Dose Opioid Formulations*)

Chapter 8: Promoting Quality Improvement

- Contains: 5 criteria (0 ROPs included)

Criteria Classification

Each criterion in the assessment manual is given the following classifications to make it assessment-ready:

- criterion type (required organizational practice, high-priority criterion, normal-priority criterion)
- assessment method (attestable criterion, on-site criterion)

These classifications are indicated in the assessment manual through corresponding titles beside the criteria. The classifications serve as a guide to help your LTC home better understand the criteria by thematic groupings and the methodologies that will be used to assess compliance against them.

Criterion Type

Each criterion is classified by criterion type:

- **Required organizational practice.** A required organizational practice is a criterion that describes a standardized practice that an LTC home must have in place to enhance resident safety and minimize risk to deliver reliable and high-quality care to the population the organization serves. If the standardized practice is not in place, harm could result.

A required organizational practice includes the following elements:

- Required organizational practice statement. A required organizational practice statement is a thematic statement that introduces the tests for compliance. The statement specifies the objective of the required organizational practice and who is accountable for the objective.
- **Tests for compliance**. Tests for compliance are requirements informed by evidence that describe what is needed by people to achieve a particular activity. Each test for compliance outlines the action to be taken and who is accountable for the action.
- **Guidelines.** Guidelines provide additional information and evidence to support the implementation of each test for compliance.

- **High-priority criterion**. A high-priority criterion is related to safety, ethics, risk management, and quality improvement.

- **Normal-priority criterion**. A normal-priority criterion is a criterion that is neither a high-priority criterion nor a required organizational practice.

Assessment Method

Each criterion is classified by assessment method:

- **Attestable criterion**. A criterion that is classified as an attestable criterion is assessed by your LTC home in the attestation assessment in year 3.

- **On-site criterion**. A criterion that is classified as an on-site criterion is assessed by surveyors in the on-site assessment in year 4.

These assessment methods are used to assess your LTC home's conformity with the assessment criteria. They support progressive learning throughout the accreditation cycle that is informed by both evidence and lived experience. All assessment method classifications are transparent and visible within the assessment standards.

Chapter 1: Governing LTC Home's Strategies, Activities, and Outcomes

This chapter focuses on governance practices of the long-term care (LTC) home. Accountability is to the governing body, which is the body that holds authority, ultimate decision-making power, and accountability for an organization and its services. This may be a board of directors, a council, a Chief and Council, or another decision-making body. A governing body may work independently or with government in jurisdictions where government is responsible for one or more governance functions. Themes covered in this chapter include roles and responsibilities of the governing body related to strategic planning and oversight of operational action plans, and accountability for the quality of care provided to residents.

1.1 The governing body guides and oversees the LTC home to ensure it delivers high-quality services that respond to the diverse needs of its residents and workforce.

1.1.1 The governing body ensures the LTC home has a current strategic plan informed by stakeholder input to guide the delivery of its services.

Priority: **Normal Priority** | Quality Dimension: **Population Focus** | Assessment Method: **Attestation**

Guidelines

A strategic plan articulates the LTC home's vision, mission, and goals to guide the delivery of high-quality services that meet the diverse needs of the LTC home's residents and workforce.

The strategic plan, updated every three to five years, or sooner if required, is informed by relevant data that include stakeholders' needs and experiences.

Stakeholders include residents, substitute decision makers, essential care partners, the LTC home's leaders and workforce, external service providers, volunteers, visitors, the community, and jurisdictional authorities.

The strategic plan provides the LTC home with

- a vision, mission, and values consistent with providing resident-centred care;
- goals for delivering high-quality services that meet the diverse needs of the LTC home's residents and include a commitment to equity, diversity, and inclusion and cultural safety and humility;
- guiding principles for ethical decision-making;
- a human resources strategy that promotes a healthy and competent workforce;
- a framework for delivering services that respect the principles of team-based and trauma-informed care;
- an evidence-informed infection prevention and control program; and
- goals for environmental stewardship to mitigate the LTC home's negative impacts on the environment.

In some cases, the accountability of strategic planning is under the authority of jurisdictions. In these cases, the governing body collaborates with the jurisdictional authorities to inform the development and review of the strategic plan.

1.1.2 The governing body ensures the LTC home delivers services that respond to the diverse needs of its residents.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

Keeping residents safe and healthy is foundational to the mission of LTC homes. Delivering high-quality care requires that LTC homes provide services that meet the care needs of residents 24 hours a day, 7 days a week.

The type, range, and priority of services an LTC home offers is informed by ongoing resident feedback on care experience, resident and population health data, data from infection surveillance and practice audits, and other information obtained from environmental scans and other stakeholders. Sources of information include surveys, public forums, consultations, regular general meetings, inspection and accreditation findings.

The LTC home provides services that comply with jurisdictional requirements.

1.1.3 The governing body ensures the LTC home complies with its legal, regulatory, and contractual obligations.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

The delivery of LTC services is complex and provided in a highly regulated environment. Funding models, governance structures, and regulatory requirements vary between jurisdictions.

The governing body ensures that its role and accountabilities, including its responsibilities and oversight of the provision of services, comply with obligations stated in relevant laws, regulations, contractual arrangements, and inspection and accreditation reports.

The governing body stays informed about changes in laws, regulations, and contractual obligations that may affect the delivery of LTC services, the LTC home's resident profiles, and the qualifications of the workforce. When changes are required in the delivery of services, the governing body ensures the LTC home's strategic plan is aligned to those changes.

1.1.4 The governing body ensures the LTC home engages with jurisdictional authorities to address systemic challenges to delivering high-quality services.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

Systemic challenges that may prevent LTC homes from delivering high-quality care and services are multifactorial. They can include inadequate funding, understaffing, lack of equipment and technology, dated infrastructure, compromised working conditions, and jurisdictional funding formulas.

Addressing systemic challenges is a shared accountability. The governing body collaborates with a variety of stakeholders and system partners to overcome these challenges. It nurtures good working relationships with various jurisdictional authorities, such as provincial or territorial ministries, professional regulatory authorities, regional health authorities, and municipal councils.

Building relationships with jurisdictional authorities may involve, for example, requesting and attending meetings, sending correspondence, holding and attending media briefings, and engaging with a range of departments such as health and social services, transportation, and education.

1.1.5 The governing body ensures the LTC home has a comprehensive human resources plan. talent management

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

LTC homes are both homes and workplaces, where the conditions of work are the conditions of care. A healthy and competent workforce is key to creating a home-like environment and delivering high-quality, resident-centred care.

The LTC home's human resources plan is reviewed and updated regularly. It is informed by the overall human resources strategy and based on equity, diversity, and inclusion and cultural safety and humility principles. The plan includes

- assessment of current and future needs;
- recruitment and retention practices;
- regular performance appraisals;
- a learning program that includes orientation, training, and continuous competency development;
- an occupational health and safety program;
- recognition programs and initiatives; and
- contingency plans to address periods of disruption, increasing or shifting care needs, and workforce absences.

1.1.6 The governing body oversees the LTC home's integrated risk management plan for the delivery of its services.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **Attestation**

Guidelines

Integrated risk management promotes a systematic, proactive, and continuous process to understand, manage, and communicate risk from an organization-wide perspective.

The risk management plan is an integral part of all the LTC home's processes and decision-making. It identifies clear roles and responsibilities and explicitly addresses uncertainty in a structured and timely way. The plan is based on the best available information and tailored to take human and cultural factors into account. It is transparent, inclusive, dynamic, iterative, and responsive to change.

The governing body oversees the LTC home's overall risk management plan. Typically, the plan is based on a recognized risk management framework that measures, analyzes, and evaluates risks; suggests actions; and monitors risks so they are managed at an acceptable level.

The governing body is informed of real and potential risks that have a high likelihood of occurrence or severe impact and will affect the delivery of high-quality and safe services. The governing body guides the LTC home in addressing the risks and learning from misses and near-misses to minimize future risks and improve responses.

1.1.7 The governing body ensures that the LTC home has a comprehensive emergency and disaster preparedness plan.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **Attestation**

Guidelines

Planning and preparing for emergencies and disasters is key to mitigating the risks and outcomes of major unexpected events, including pandemics. The COVID-19 pandemic exposed significant gaps in the ability of LTC homes to provide high-quality, resident-centred care. Pandemic preparedness and management is included in the comprehensive emergency disaster and management plan.

The governing body ensures that the LTC home has a regularly updated, comprehensive emergency and disaster preparedness plan to meet resident care needs and respond to additional service and resource needs created by an emergency or disaster. The plan includes measures related to

- risk assessment and mitigation;
- the needs of vulnerable populations;

- interventions to be implemented in the context of an emergency or disaster;
- interventions to be implemented for recovery;
- training, simulation, and debriefing practices;
- communication plans;
- monitoring, evaluation, and improvement; and
- procedures for securing needed human resources, equipment, and products.

1.1.8 The governing body ensures the LTC home has a trauma-informed approach to care to support the delivery of services.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

Trauma occurs when overwhelming stress exceeds a person's ability to cope. Both aging and admission to an LTC home can worsen the symptoms, and the impact of trauma can especially affect people with dementia.

Workforce members may also have their own experiences with trauma, which may be multiplied by the stresses of their work and working conditions.

A trauma-informed approach to care intentionally supports residents and members of the workforce who may have a history of traumatic stress. The approach recognizes the negative effects of trauma, adjusts the care environment to prevent re-traumatization, and offers support in a way that is appropriate to those who have experienced trauma. Trauma-informed care emphasizes physical, psychological, and emotional safety of teams. It creates opportunities for those who have experienced trauma to rebuild a sense of control and empowerment.

The LTC home's approach for trauma-informed care outlines how to respond to situations that create traumatic stress and implement measures that avoid initiating a new trauma or reactivating an old one. The approach requires investment into needed resources, such as education, support groups, and access to regional or shared trauma support teams.

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

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. ‘Client’ and ‘patient’ refer to ‘resident’, ‘family and friends’ and ‘designated support person’ refers to ‘essential care partner’, ‘team leadership’ and ‘organizational leaders’ refers to ‘LTC home leaders’, and ‘organization’ refers to ‘LTC home’.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Test(s) for Compliance

1.1.9.1 The governing body applies a recognized framework for guiding the activities related to quality of care provided by the organization.

Guidelines

The framework is adopted from existing jurisdictional or international frameworks such as the Canadian Quality and Patient Safety Framework. It includes a standardized approach that the governing body uses to address quality. The framework is tailored to the individuals and communities receiving services from the organization.

1.1.9.2 The governing body provides its members with education and continuous learning on the topic of quality of care – quality frameworks, key quality principles, key quality indicators.

Guidelines

The education and continuous learning helps governing body members understand the need for quality to be embedded in their service delivery.

There are different ways the education and continuous learning can be undertaken. The education and continuous learning approach can use a combination of didactic or online training, community engagement, and reflective practice to increase the knowledge and skills. The governing body leverages resources available to provide this education and continuous learning.

1.1.9.3 The governing body ensures the organization's executive leader(s), who report directly to the governing body, have an accountability for quality of care in their performance objectives.

Guidelines

The governing body sets and evaluates performance objectives for the organization's executive leader(s), who report directly to it. By doing so, the governing body can hold the executive leader(s) accountable for achieving the established quality of care goals and associated quality indicators. Monitoring the executive leader(s) performance objectives will be an on-going activity of the governing body in addition to providing constructive and actionable feedback on the leader's performance.

1.1.9.4 The governing body ensures there is an organizational action plan to address quality of care.

Guidelines

The action plan is developed using a co-designed approach that includes recipients of care, community/system partners organization's workforce. The action plan identifies themes and priorities the organization wants to address, the activities, roles and responsibilities of those involved and how the organization will measure change. A governing body action plan should include elements highlighted in the selected recognized framework.

1.1.9.5 The governing body has quality of care as a standing agenda item in its regular meetings where it monitors the organization's action plan.

Guidelines

The governing body demonstrates a clear commitment to quality of care by having it as a standing agenda item for each regular meeting and ensuring that sufficient time is allotted to review and discuss the organization's action plan to address quality of care.

Discussions need to be supported with indicator data that includes feedback from multiple stakeholders, including clients, families, and communities. Key quality indicators that measure quality at the

organization level (i.e., 'big-dot' indicators) will help answer the questions "what does quality of care look like and how do we know it is improving?".

Examples of big-dot indicators can include:

- number of clients who were harmed
- number of complaints from clients
- timely access to care
- quality of worklife reported by the workforce, including measures of job engagement, retention and satisfaction that can influence the organization's clinical human resource capabilities
- client experience survey results

1.1.10 The governing body ensures the LTC home uses resident experience feedback to improve the quality of its services.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

Understanding residents' experiences and satisfaction with the LTC home's services is essential to delivering high-quality, resident-centred care.

The governing body ensures that the LTC home has an approach for collecting, analyzing, and using feedback about residents' experiences for ongoing continuous improvement. Resident experiences can include topics such as daily activities, quality of care, quality of life, access to various services, degree of engagement with the care team, and whether residents feel safe in the LTC home.

Feedback from residents can be gathered using different methods, such as day-to-day interactions, surveys, suggestion boxes, resident council meetings, reports on violation of rights, and resident representation on committees or the governing body.

1.1.11 The governing body ensures the LTC home uses workforce experience feedback to improve the quality of its services.

Priority: **High Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

Understanding the experiences and satisfaction of workforce members is essential to improving their physical and psychological safety and is foundational to delivering high-quality, resident-centred care.

The governing body ensures that the LTC home has an approach for collecting, analyzing, and using feedback about the workforce's experiences for ongoing continuous improvement. Workforce experiences can include topics such as safety, the work environment, well-being and work–life balance, engagement with the teams and LTC home leaders, and perceived quality of care.

Feedback from the workforce can be gathered using different methods, such as day-to-day interactions, surveys, suggestion boxes, team meetings, performance appraisals, interviews, and workforce representation on committees or the governing body.

The goal is to have a workforce that is comfortable and generally satisfied with their work life and work environment when providing care. The workforce feels supported by their leaders and able to provide care without undue work-related stress or fatigue. They also feel motivated to provide high-quality care and improve systems. Workforce members should feel able to ask questions that will be answered and receive advice.

1.1.12 The governing body holds the executive leader accountable for the delivery of the LTC home's services.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

The executive leader is responsible for directing the activities of the LTC home, and the governing body is responsible for defining the duties of the executive leader.

The executive leader's duties, including roles, responsibilities, and accountabilities, are described in an executive leader position description. The

description is kept current with applicable laws, regulations, and contractual obligations.

The governing body recruits the executive leader, respecting the principles of equity, diversity, and inclusion defined in the LTC home's human resources plan. The executive leader is selected based on the desired competencies and qualifications for the position and the candidate's alignment with the LTC home's vision, mission, and values.

The governing body also supports the executive leader's professional development.

In some cases, jurisdictional authorities may appoint the executive leader or define the executive leader's role, responsibilities, and accountabilities. In these cases, the governing body collaborates with the jurisdictional authorities to inform their selection.

1.1.13 The governing body demonstrates it has the required competencies to fulfill its mandate to the LTC home.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

The governing body requires a mix of competencies and experiences among its members to oversee the LTC home's vision, mission, and goals and to guide the delivery of high-quality services to meet the diverse needs of the LTC home's residents and workforce.

The composition of the governing body adheres to principles of equity, diversity, and inclusion and reflects a balance of competencies that are needed from individual members to serve the governing body as a whole. To maintain transparency and avoid bias, the governing body openly shares its procedures for selecting its members.

The governing body recognizes that the competencies it requires will change over time. It regularly reviews and adjusts its recruitment and training to address any gaps. The governing body also staggers the terms of its members to balance the knowledge of experienced members with the introduction of new members.

In some cases, the composition of the governing body may be determined by jurisdictional authorities. In these cases, the governing body collaborates with the jurisdictional authorities to inform their selection.

1.1.14 The governing body provides its members with ongoing education so that it can fulfill its role and responsibilities to the LTC home.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

Ongoing education helps the governing body fulfill its roles and responsibilities.

The governing body orients its new members, providing them with information about

- the LTC home's governance structure, accountabilities, bylaws, policies and procedures, and meeting schedules and protocols;
- laws, regulations, and contractual obligations that apply to the LTC home and the governing body;
- the LTC home's strategic plan, human resources plan, and integrated risk management plan; and
- the LTC home's structure and operational environment.

The governing body is provided with ongoing learning opportunities on resident-centred care, team-based and trauma-informed approaches to care, safe practices, and quality improvement activities.

1.1.15 The governing body demonstrates a commitment to advancing environmental stewardship.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

The health care sector contributes to climate change in various ways, from the energy consumed by medical equipment to the use of toxic chemicals for

cleaning. LTC homes have a role to play in reducing their environmental footprint and mitigating the effects of their operations.

The governing body ensures the LTC home leaders include goals for environmental stewardship in the operational plan. The LTC home leaders consider environmental effects in their decision-making, such as with decisions related to waste management, water consumption, and procurement of medical equipment and food items.

The LTC home leaders educate the workforce on environmental practices. They encourage the workforce to participate in environmental initiatives, such as recycling and composting.

Chapter 2: Upholding Resident-Centred Care

This chapter focuses on how LTC home leaders’ and teams’ approach the delivery of resident-centred care. High-quality, safe, resident-centred LTC services requires balancing multiple forces, such as the rights and choices of individual residents while protecting the well-being and safety of the collective; and approaches to providing care that ensure consistency and continuity while respecting individualization. Themes include respecting residents’ rights and responsibilities, enabling resident-centred care, promoting essential care partners, and actively communicating with residents.

2.1 The LTC home leaders and teams respect residents’ rights and responsibilities.

2.1.1 The LTC home leaders provide teams with a policy and procedures that uphold residents' rights and responsibilities.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

Respecting, promoting, and protecting residents' rights is the foundation of resident-centred care. The LTC home's policy acknowledges residents' rights, including the right to

- be treated with courtesy and respect;
- be properly sheltered, fed, clothed, groomed, and cared for;
- freely move and mobilize without barriers;
- be involved in all aspects of their care;
- have their privacy and confidentiality protected;
- be free from neglect and protected from abuse, exploitation, and discrimination;
- be protected from infection;

- have their lifestyle preferences and choices respected, including a choice to live with risk; and
- pursue their social, cultural, religious, spiritual, and other interests.

When a resident is admitted to an LTC home, it becomes their home. The LTC home is also a congregate setting with common spaces that are shared with others, such as dining areas, recreational areas, and outdoor gardens. LTC home leaders encourage residents to treat others with respect and report any concerns and safety risks.

The LTC home has procedures to uphold residents' rights and responsibilities. Procedures include how to

- communicate with residents about their rights and responsibilities,
- address complaints,
- determine the capacity of residents to make their own care decisions and obtain informed consent, and
- identify and communicate with substitute decision makers.

2.1.2 Teams follow the LTC home's procedure to inform residents about their rights and responsibilities.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Residents are entitled to know their rights, what is expected of them, and what they are accountable for while living in the LTC home.

Teams inform residents about their rights and responsibilities on admission and on an ongoing basis. The information is accessible and adapted to meet diverse needs such as language, culture, level of education, and cognitive abilities.

Residents are given time to consider the information about their rights and responsibilities, understand it, and have their questions answered. Teams note in residents' health records how and when information about residents' rights was provided.

2.1.3 Teams follow the LTC home's procedure to address claims that residents' rights have been violated.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Responding to claims that residents' rights have been violated contributes to a positive and trusting environment. It also ensures that residents can live securely and comfortably, experiencing daily life and care without fear of repercussion for speaking out.

Teams promote an environment where everyone feels comfortable raising concerns or issues. Any person, including residents, substitute decision makers, essential care partners, volunteers, visitors, and any other team member, can make a claim about a violation of residents' rights.

The LTC home's procedure establishes how to report a violation of residents' rights, such as poor, inadequate, or improper care or an incident of racism, discrimination, or abuse. The LTC home leaders ensure that the steps for filing a claim are clearly outlined and accessible to everyone. Teams share that information with residents on admission and on an ongoing basis.

The procedure is intended to protect those making a claim from negative consequences. It reassures the person that submitting a claim will not restrict or otherwise negatively affect the resident's care. The procedure ensures that the confidentiality, privacy, and security of the person submitting the claim and the contents of the claim itself are protected.

The procedure outlines the process for addressing the claim and communicating its outcomes. The LTC home makes every effort to address claims in a timely manner.

Residents are also provided with information about resources available to them outside the LTC home, such as advocates, ombudspersons, regulatory bodies, or privacy commissioners.

2.1.4 Teams use a risk management approach to balance residents' right to live with risk with the safety of others.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Residents may choose to engage in activities that could put others at physical, emotional, or psychological risk. A risk management approach helps teams balance residents' autonomy with the safety of others.

When a resident chooses a risk activity, the team uses a risk management approach. The resident, or if incapable, their substitute decision maker, and their essential care partners with consent are involved. Together, the team assesses the resident's chosen risk activity, the nature of the potential harm, who will be affected, and the probability and severity of the risk. Throughout the approach, the team reflects upon and avoids potential biases that may affect their involvement.

The team ensures the resident, or if incapable, their substitute decision maker, understands the proposed approach and accepts the risk or the options for managing an intolerable risk. The team supports the resident in making an informed decision without undue influence from others. The team communicates the risk mitigation plan to others to maintain the safety of all.

2.1.5 Teams follow the LTC home's procedure to determine residents' capacity to make their own care decisions.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Residents' capacity to understand information and make care decisions can change with time and circumstances. A resident's capacity to make care decisions is assessed with each decision before obtaining informed consent. The team collaborates with the resident to determine whether they understand and appreciate

- the reasons for and nature of the proposed care,
- the anticipated effect of the proposed care, and
- the immediate and long-term implications of their decision or not making a decision.

Disagreeing with a resident's decision is not a reason for determining that the resident lacks the capacity to make care decisions. When a resident is determined to be incapable, the team establishes what actions need to be taken in compliance with jurisdictional requirements.

Teams document all required information in residents' health records.

2.1.6 Teams follow the LTC home's procedure to obtain residents' informed consent to receive care.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Obtaining informed consent before beginning care protects residents' fundamental right to control what happens to their person.

Teams follow the LTC home's procedure for obtaining informed consent. The procedure complies with jurisdictional requirements. The most appropriate team members explain to residents the care options and the benefits, risks, side effects, alternative courses of care, anticipated outcomes, and likely consequences of not having the care. Residents are given time to consider the information, understand it, and have questions answered before being asked to provide consent.

Consent can be implied, usually by a resident's conduct or actions, such as rolling up a sleeve to have a blood pressure taken, or consent can be explicitly expressed, usually verbally or in writing. The LTC home's procedure defines which care activities require expressed consent. Teams respect residents' decisions.

If a resident is incapable of consenting, the resident's substitute decision maker will make decisions on the resident's behalf. The resident is still informed about and involved in making decisions about their care as much as possible. The team values the resident's questions and input and continues to respect the resident's rights. The team respects the principle of resident assent and communicates with the substitute decision maker when the resident refuses care.

In emergencies, obtaining informed consent may not be possible. If the resident has made a wish known that applies to the situation (which may, but is not required to, be in an advance care plan), the team must comply with that wish.

Teams document all required information in residents' health records.

2.1.7 Teams follow the LTC home's procedure to inquire whether residents have an appointed substitute decision maker.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

A substitute decision maker is someone who makes a care decision on behalf of a resident if the resident has been found incapable of making the decision for themself. Residents can appoint their substitute decision makers in a legal document, such as a power of attorney for personal care or a representation agreement. Substitute decision makers may also be appointed by a court or tribunal or identified through a hierarchy found in legislation.

Teams follow the LTC home's procedure and determine at admission whether a resident has an appointed substitute decision maker. Copies of documentation and contact information are obtained and the information is recorded in the resident's health record and individualized care plan. If the resident is capable of making decisions and has not appointed a substitute decision maker, the team provides the resident with information about appointing one and the consequences of not appointing one.

Teams also inform residents of their right to revoke an existing substitute decision maker appointment and, if they wish, to appoint another person, assuming the resident has the capacity to make those decisions. If a resident is capable of making or revoking an appointment, the team reviews the choice of substitute decision maker with the resident at least annually. Should circumstances change during the year, such as the death or incapacity of the appointed substitute decision maker, procedures are followed in compliance with jurisdictional requirements to identify a new substitute decision maker.

If a resident is incapable and has not appointed a substitute decision maker, teams follow the LTC home's procedure for identifying who the substitute decision maker would be in compliance with jurisdictional requirements.

2.1.8 Teams follow the LTC home's procedure to communicate with residents' substitute decision makers.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Teams follow the LTC home's procedure to uphold the roles and responsibilities of substitute decision makers. The procedure complies with jurisdictional

requirements and clearly outlines what and how to communicate with substitute decision makers who are making decisions on behalf of incapable residents, including

- what needs to be communicated,
- when it needs to be communicated,
- who on the team communicates with the substitute decision maker to obtain informed consent,
- who the substitute decision maker communicates with for information,
- how to proceed if substitute decision makers cannot be reached in a timely manner, and
- the process for communication regarding emergency care.

Teams ensure that substitute decision makers' contact information is recorded in residents' health record and individualized care plans and is reviewed regularly.

2.2 The LTC home leaders and teams enable resident-centred care.

2.2.1 The LTC home leaders uphold the principles of resident-centred care in the delivery of services.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

Resident-centred care is based on the philosophy of people-centred care, which organizes care around the health needs and expectations of people rather than diseases. In LTC homes, delivery of services is organized around residents' goals, needs, and preferences.

Resident-centred care upholds residents as active participants and decision makers in their daily life and care activities. Resident-centred care is team-based, and residents are recognized as active team members. Team members work collaboratively, each bringing different skills and experiences.

LTC home leaders promote a resident-centred, team-based culture of care. They demonstrate a commitment to learning from challenges, and they lead by forming

connections with and building trust among team members. They apply the four principles of a people-centred approach to care: they uphold the expertise of people in their lived experiences of care; they communicate and share complete and unbiased information; they ensure people from diverse backgrounds are included in conversations; and they encourage humility and continuous learning.

2.2.2 The LTC home leaders demonstrate a commitment to equity, diversity, and inclusion.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

Employing equity, diversity, and inclusion practices in an LTC home recognizes the diversity in residents' race and ethnicity, gender identity and expression, religion and spirituality, language and socio-economic status, and other factors.

LTC home leaders uphold principles of equity, diversity, and inclusion in the design and delivery of care. For example, they

- acknowledge people's diversity;
- educate about and address issues of stigma and discrimination;
- co-design services to ensure they are just and fair;
- demonstrate value and respect in providing relational care;
- collect socio-demographic information and use it to design services;
- ensure conversations about peoples' lived experiences are structured to be safe;
- provide teams with materials and training that support equity, diversity, and inclusion practices; and
- invite people to express their chosen pronouns.

2.2.3 The LTC home leaders demonstrate a commitment to cultural safety and humility.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

Cultural safety is an outcome of respectful engagement that is based on recognizing and working to address inherent power imbalances in the health system. It results in an environment free of racism and discrimination, where people feel safe when receiving and providing care and when interacting with the health system.

Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. It involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.

LTC home leaders are committed to establishing zero tolerance for racism and discrimination. Their commitment to cultural safety and humility is demonstrated by ensuring awareness, training, and practices in the LTC home that reflect

- the contexts of people's lives, circumstances, and communities;
- awareness of structures and systems that produce and perpetuate racism;
- trauma-informed compassionate care;
- strategies for practising cultural safety and humility;
- stereotyping and stigma awareness;
- anti-racist practices; and
- an understanding of ways in which racism and discrimination manifest in care.

The LTC home promotes cultural safety and humility awareness and ensures training and materials are provided to its workforce based on the population and communities it serves and in compliance with jurisdictional requirements. This should include specific cultural safety and humility awareness and training that addresses the racism experienced by First Nations, Métis, and Inuit peoples. The workforce is educated about Indigenous- specific history, practices, and culture.

2.2.4 The LTC home leaders implement a trauma-informed approach to care in the delivery of services.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

A trauma-informed approach to care recognizes that many residents have been exposed to experiences of trauma in their lives. These past experiences may be reactivated, or new experiences of trauma initiated as a result of aging, dementia, or moving into an LTC home.

A trauma-informed approach to care ensures that

- the LTC home's commitment to trauma-informed care is reflected in its culture, strategy, policies, and procedures;
- universal trauma precautions are used;
- communication creates an environment of safety and well-being;
- residents and the workforce are educated to recognize trauma-induced symptoms and adopt strategies for prevention and management of symptoms;
- residents are assessed for past experiences of trauma and trauma-related symptoms;
- residents and the workforce have access to both recovery-oriented practices and mitigation and supportive practices depending on their expressed wishes and their capacities; and
- additional and responsive support is available to both residents and the workforce after a major incident.

A trauma-informed approach to care also embraces the needs of the workforce, some of whom may have experienced trauma that affects the work that they do.

Teams have access to appropriately trained professionals who can help with assessing residents for experiences with trauma, educate the workforce about trauma-informed approaches to care, and support the workforce and residents with appropriate psychosocial care and recovery-oriented practices when desired.

2.2.5 Teams use the LTC home's ethical decision-making approach to support the delivery of care.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

An ethical decision-making approach supports teams in reflecting on what should be done when there is uncertainty, a conflict in values, or difficult decisions that affect care. Examples of ethical decisions include how to balance residents' right to live with risk with the safety of others, how to apply a visitation policy that may be restricted by public health requirements, and what care options to offer near the end of life.

LTC home leaders ensure teams are informed about and use the LTC home's ethical decision-making approach to encourage transparency and accountability in decision-making about care and to increase understanding, respect, and tolerance among teams. The ethical decision-making approach prompts the team to

- identify the problem, acknowledge their feelings, and gather the facts;
- consider alternatives, examine the values or fundamental ethical principles that are affected, and evaluate alternatives;
- articulate the decision and implement the plan; and
- accept their own responsibility for fostering an ethical work environment and culture.

Teams are aware of the resources that can support them in resolving ethical conflict, including an ethicist if available to the LTC home to support difficult decision-making.

2.2.6 Teams enable residents' autonomy in their daily life and care activities.

Priority: **Normal Priority |** Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Autonomy is to have control in one's life and be free to act on or make decisions based on individual choice or preference. Acknowledging and enabling residents'

autonomy in managing their daily life and care activities enhances their well-being and quality of life.

Teams support residents' autonomy by enabling residents to

- make their own decisions based on their goals, needs, and preferences, without controlling influences;
- engage independently in daily life and care activities;
- maintain and restore their mobility;
- maintain and restore their functional capacity; and
- socially engage with people they choose.

2.2.7 Teams ensure residents are actively engaged in their daily life and care activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Residents who are actively engaged partners in their care tend to be more empowered and have better care experiences and outcomes. They participate as team members to the best of their ability in planning, delivering, managing, and improving the quality of their own care.

Teams promote opportunities for residents' engagement in various ways. For example, they

- understand and respect residents' diversity and lived experiences,
- practice cultural safety and humility,
- include residents in designing their care and choosing their essential care partners if residents wish to have them,
- have ongoing conversations with residents about their experiences living in the LTC home, and
- communicate in a positive way to maintain residents' engagement.

2.2.8 Teams take time to build caring relationships with residents.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Caring relationships start with human connections that build trust, safety, security, belonging, and continuity. Relational care that is meaningful and purposeful is associated with better outcomes and safer care and promotes a resident-centred, team-based culture.

Building and sustaining relationships is an ongoing process that takes dedicated time and effort. Teams are flexible with routines and ways of living. They endeavour to be emotionally present to residents and aware of factors that can shape their responses.

Teams recognize that care involves more than required task-oriented activities. Working conditions support the teams' capacity to take the time needed to build caring relationships with residents.

2.3 The LTC home leaders and teams promote the role and presence of essential care partners.

2.3.1 The LTC home leaders enable teams to support the presence of essential care partners in residents' daily life and care activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Essential care partners are people chosen by a resident, or if incapable, their substitute decision maker, to participate in the resident's daily life and ongoing care activities.

LTC home leaders build a culture that acknowledges, respects, and encourages the role and diversity of essential care partners. Essential care partners may provide physical, psychological, spiritual, or emotional support. For example, they may assist residents with activities of daily living and advocate for their needs and interests.

Essential care partners may also support the workforce in providing or coordinating direct care.

LTC home leaders ensure that teams actively engage essential care partners. They promote a culture of flexibility and accommodation in daily life and care activities to support the needs of residents and essential care partners. They ensure that teams provide essential care partners with the timely information they need to actively participate in residents' life activities.

2.3.2 Teams ensure residents have the opportunity to choose essential care partners to participate in their daily life and care activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Residents, or if incapable, their substitute decision makers, have the right to include, exclude, or redefine whom they choose as their essential care partners. They also have the right to choose when and how essential care partners participate in their daily life and ongoing care. Their right to designate a different essential care partner or change how an essential care partner is involved in their care is ongoing.

Teams respect residents' decisions about choosing their essential care partners and their roles. Teams document the information in residents' health records and individualized care plans and regularly review residents' essential care partner choices and roles.

Changes in a resident's individualized care plan may affect the essential care partner's role. Teams support essential care partners in assessing their ability to participate in residents' daily life and ongoing care.

Residents who do not have an essential care partner and wish to have more support may be invited to appoint a volunteer or advocate as an essential care partner.

2.3.3 Teams provide essential care partners with information about their rights and responsibilities when participating in residents' daily life and care activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Essential care partners must understand their rights and responsibilities as partners in care and members of the team. Teams provide essential care partners with accessible information that addresses

- the role of essential care partners;
- their responsibilities, such as treating others with respect and reporting safety risks;
- how information is shared;
- how to access the LTC home and its facilities;
- emergency preparedness protocols; and
- infection prevention and control practices.

2.3.4 Teams ensure timely communication with essential care partners to support their participation in residents' daily life and care activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Ongoing and timely communication with essential care partners ensures relevant information about residents' needs is effectively and appropriately shared. Communication also supports essential care partners in voicing residents' needs and concerns.

Teams provide essential care partners with information about

- what to communicate with the team, who to contact, and how;
- the different roles that team members play and which team members should be contacted depending on the day of the week or time of day; and
- a resident's status and any changes in their needs or care in keeping with the role the resident has defined for their essential care partners.

When sharing information, teams follow the LTC home's procedures for protecting residents' privacy and confidentiality, in compliance with jurisdictional requirements. They communicate in plain language, considering the essential care partner's needs, level of understanding, and preferred language. Teams use communication methods that uphold the principles of equity, diversity, and inclusion; create cultural safety for the essential care partners; and facilitate a shared understanding of the information and concerns. For example, teams may ask essential care partners to restate directions in their own words or teams may restate essential care partners' concerns to ensure the shared information has been understood correctly.

Teams ensure a contact person at the LTC home is available to essential care partners 24 hours a day, 7 days a week.

2.3.5 The LTC home leaders provide teams with a visitor policy and procedures that promote the presence of essential care partners and other visitors.

Priority: **High Priority |** Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

Visitors play a critical role in residents' lives. A policy and procedures that promote a visitor-friendly culture help to ensure residents' quality of life.

The policy and procedures identify and accommodate the different types of visits and visitors that residents value, including general visitors, essential care partners, and professional advisers. Different residents may value different visitors for different reasons.

The policy considers principles of residents' well-being and safety for all, equitable access, and flexibility. For example, the policy accommodates flexible visiting hours with minimal restrictions for essential care partners to respect caregiving relationships and minimize isolation and loneliness. If visits from essential care partners are restricted, LTC home leaders use an ethical decision-making approach to balance residents' well-being, preferences, and risk tolerance with other risks, such as safety.

General visitors may be subject to different limitations or restrictions, which are reflected in the LTC home's procedures. The procedures for all visitors consider everyone's safety and well-being. All visitors are expected to comply with safety practices such as infection and prevention control.

All visitors are supported with a public, visitor-friendly space where they may visit with residents. Visits are facilitated both indoors and outdoors.

2.4 The LTC home leaders and teams actively communicate with residents.

2.4.1 The LTC home leaders promote communication strategies that facilitate the engagement of all residents.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

The use of communication strategies that are engaging, relational, and enable team-based care is foundational to high-quality care.

LTC home leaders ensure residents' literacy levels, cultural norms, and ability to use technology are understood to optimize residents' participation in their daily life and care. Teams and the environment are set up to encourage verbal and non-verbal communication that matches residents' goals, needs, and preferences.

Communication methods such as information boards, non-verbal techniques, and call responder systems (call bells) are available to support verbal and written communication. Modifications to the physical environment, such as sound abatement, quiet spaces, wayfinding, and signage, promote effective communication and social interactions.

Teams and residents have access to community services and associations to support ongoing learning about communication techniques and interventions.

2.4.2 The LTC home leaders ensure timely translation and interpretation services are available to meet residents' needs.

Priority: **Normal Priority** | Quality Dimension: **Accessibility** | Assessment Method: **On-site**

Guidelines

Translation and interpretation services may be needed by a resident so they can participate fully in their daily life and care activities. These services are particularly important when making decisions for care and developing individualized care plans.

Teams ensure residents, substitute decision makers, and essential care partners are aware of available services, such as sign language for deaf residents and interveners for deafblind residents. Translation and interpretation services are provided by trained and qualified individuals. Alternative forms of communication such as visual or oral aids and technology such as translation apps may address some language barriers and be useful in urgent situations when interpretation services are not available in a timely way.

The LTC home leaders ensure that written materials provided by the LTC home are available in the languages commonly spoken by the residents.

2.4.3 Teams use active communication to engage residents in their daily life and care activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Respectful communication involves exchanging information in a positive, clear, complete, and timely way so that residents can participate in their daily life and care activities. This is key to maximizing residents' comprehension, ensuring their active participation in care, and reducing their social isolation.

Teams promote two-way communication and sharing of information that accommodates residents' individual needs and levels of understanding. Health literacy principles are used to ensure information shared with residents is written in plain language, in an accessible format, and at an appropriate literacy level. Special attention is paid to communicating with residents who have severe cognitive impairments, language or communication deficits, or are non-verbal.

Teams are responsive when residents share information, requests, or complaints. Timing of responses may vary depending on the urgency. For example, responding to a call bell would be considered urgent. Responding to a request to participate in a recreational activity could be considered important but not urgent. When responses are delayed or will require time, teams acknowledge receipt of the request and give an estimated time of when they will respond.

2.4.4 Teams address residents' complaints in a timely manner.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Acknowledging and acting on complaints that LTC home leaders and teams receive about residents' experiences fosters a safe environment and upholds continuous quality improvement practices. Complaints can come from residents, substitute decision makers, essential care partners, the workforce, volunteers, or others. Complaints can be communicated verbally or in writing, including electronically.

Teams are aware of how complaints can be made, what steps need to be taken to address a complaint, and how complaints will be resolved in a timely manner. They ensure residents, substitute decision makers, essential care partners, and other members of the teams know how to voice a concern or complaint. Allowing complaints to be made anonymously and treating all complaints confidentially helps to ensure that those who make a complaint are protected from negative consequences. Responses to complaints are timely and documented according to the LTC home's procedures.

Information about how complaints are addressed is clear and accessible to all. Information about making complaints is shared through pamphlets, the LTC home's website, and regular conversations with residents.

Chapter 3: Enabling a Meaningful Quality of Life for Residents

This chapter focuses on the promotion of a meaningful quality of life for residents by LTC home leaders and teams. The key themes are prioritizing the rights, needs, and satisfaction of residents; caring, compassionate, and competent interprofessional care teams; and a home-like environment with meaningful community experiences that fulfill residents' physical, spiritual, intellectual, social, cultural, and creative needs.

3.1 The LTC home leaders and teams enable residents' meaningful quality of life by providing a welcoming, home-like environment and purposeful daily activities.

3.1.1 The LTC home leaders ensure the home's physical environment meets residents' comprehensive needs to enhance their quality of life.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

<u>Guidelines</u>

A home-like and accommodating physical environment that meets the goals, needs, and preferences of residents is essential to providing resident-centred care and enhancing residents' quality of life. LTC leaders co-design the physical environment with residents to ensure that it is safe and welcoming, minimizes the risk of transmitting micro-organisms, and promotes physical safety.

The privacy and confidentiality of residents is respected. Residents are provided with spaces that offer privacy for basic needs such as bathing, hygiene, sleeping, care procedures, and intimacy with others. Private spaces are available when external services are provided.

The environment is universally accessible to enable resident autonomy. For example, adequate space is provided to promote safe mobility for all residents, including those who require assistive devices. Appropriate lighting, noise reduction, and clear wayfinding at entrances and hallways enhance accessibility for residents with communication, visual and sensory, or cognitive impairments.

Common areas offer space for eating, socializing, and participating in group activities that include creative activities, mobility programs, and exercise classes.

Lounging and meeting areas allow residents to meet and dine with visitors, observe spiritual practices, and host committee meetings or small gatherings. A welcoming space for visitors is provided with clear signage, comfortable areas to visit, and places to walk or sit outside.

3.1.2 Teams follow the LTC home's procedures to ensure residents' safety.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

<u>Guidelines</u>

Upholding physical and psychological safety within the LTC home prevents harm to residents. This is balanced with respecting residents' freedom of choice and mobility.

Teams follow the LTC home's procedures to promote physical safety and security. Resident rooms, staff areas, and the building itself have secured access. Controlled access points restrict who, when, and how a person can enter restricted areas, such as medication rooms and food service areas. Other access systems, such as wander control, can help ensure the safety of residents with cognitive impairment, returning wandering residents to a safe place.

Teams follow procedures to promote psychological health and safety throughout the LTC home. They act on identified risk factors and signs of harassment, abuse, neglect, and other threats to the psychological safety of residents. Teams encourage the emotional well-being of residents, promoting practices such as trauma-informed care and visitation to reduce the negative effects of social isolation. Residents report experiencing a healthy state of well-being living in the LTC home.

3.1.3 The LTC home leaders enable meaningful daily activities that foster residents' sense of purpose.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

<u>Guidelines</u>

Meaningful daily activities contribute to residents' quality of life. They foster a sense of purpose, allow for social interactions, enhance physical and mental health, and alleviate loneliness, helplessness, and boredom.

The LTC home offers meaningful daily activities that contribute to satisfying residents' physical, spiritual, intellectual, social, intergenerational, cultural, and creative needs. LTC home leaders ensure that activities are co- designed and programmed with residents, substitute decision makers, and essential care partners. The activities reflect the diverse population of the LTC home. Recreation facilitators can help with coordinating and facilitating the LTC home's activities.

Activities may also include those offered through community organizations, volunteer programs, educational organizations, and other groups. LTC home leaders ensure that these activities respect the safety of all. This includes ensuring that infection prevention and control practices are followed, that activities are offered in appropriate spaces, and that the visitor policy and procedures are followed.

Residents are informed of activity plans and schedules. Teams assist residents in accessing and participating in their selected activities. When desired activities cannot be provided by the LTC home, the LTC home leaders endeavour to support residents with access to broader community programming.

3.1.4 The LTC home leaders enable meaningful mealtime experiences that meet residents' needs and preferences.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

<u>Guidelines</u>

Mealtimes support residents' nutritional, emotional, and social needs.

The LTC home leaders ensure mealtime experiences meet residents' needs and preferences. They ensure that food and beverage selections are current and include seasonal variation.

Teams engage residents in planning menus and choosing food and beverages for meals and snacks. Specific requests from residents, such as requests for culturally appropriate foods, are met whenever possible, and diets are modified as necessary. Food and beverages are served at the intended temperature. Residents who require assistance with eating and drinking are supported in a respectful and dignified manner.

A pleasant mealtime experience includes a clean, bright, and calm space. Dining is an activity that allows residents to socialize with their peers, substitute decision

makers, essential care partners, the workforce, and volunteers. Meals are not rushed, giving residents sufficient time to enjoy their food and observe their cultural and spiritual practices.

All efforts are made to accommodate resident preferences around food and dining, allowing residents to dine in the manner they wish, despite possible risks.

3.1.5 Teams provide residents with flexible food and beverage options outside set mealtimes.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Flexible food and beverage options outside set mealtimes help to prevent residents' dehydration and malnutrition and ensure that residents have the energy, nutrients, and fluids they need to function optimally throughout the day.

Strategies to maintain normal hydration include regularly offering and encouraging residents to drink, offering smaller amounts to drink more frequently, and reducing obstacles to drinking. Similar strategies can maintain optimal nutrition.

Food and beverage options meet residents' goals, needs, and preferences. Flexible options could include a snack and beverage trolley service or a snack and beverage station stocked with healthy snacks and meal alternatives. Residents may need to be supported in accessing food and beverages beyond set mealtimes, for example by opening packages, pouring beverages, and assisting residents who require support with eating and drinking.

3.1.6 Teams promote access to nature and outdoor activities that meet residents' goals, needs, and preferences.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Access to nature and outdoor activities improves residents' well-being and quality of life, sleep, and memory attention and mood. Outdoor activities also increase residents' sense of belonging and social connection to neighbourhoods and

communities. For residents living with dementia, outdoor activities can decrease agitation.

Teams promote access to nature and outdoor activities on an ongoing basis. Residents are assisted in accessing outdoor gardens, pathways, seating, shade, and open structures. Seasonal and environmental conditions are considered, and residents are appropriately dressed and protected during outdoor activities.

Residents benefit from indoor connections to the outdoors, created through the use of natural light, balancing open and closed spaces, and providing good air quality.

3.1.7 The LTC home leaders support the role of volunteers in enabling residents' meaningful quality of life.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

Volunteers play an important role in enhancing residents' quality of life. They provide relational care through social and cultural activities that can enhance residents' mental health and general well-being and reduce social isolation and loneliness.

Volunteers are unpaid and participate in activities such as friendly visiting and mealtime assistance. They organize and support special programming and events such as pet therapy and music, and they contribute to administrative duties and fundraising.

The LTC home leaders promote volunteer programming with teams. They ensure volunteer roles and responsibilities are clearly defined and procedures are in place for recruiting, screening, training, coordinating, and retaining volunteers.

3.1.8 The LTC home leaders promote residents' participation in community activities.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Community resources, events, and programs provide opportunities for social interactions, a sense of belonging, and intergenerational connections. Examples

include resources such as libraries, recreational facilities, parks, and transportation; events such as art shows and concerts; special interest and faith organizations; and school and volunteer programs such as storytelling.

The LTC home leaders recognize the importance of the broader communities' roles and the resources they offer, and they include them when planning activities for residents. They strive to engage residents with community social groups and activities as much as possible by engaging with community stakeholders, inviting them to the LTC home, and promoting resident awareness of community services and events.

Teams support residents in accessing transportation so they may participate in community activities.

3.1.9 Teams use information and communication technology to promote social interactions that enhance residents' quality of life.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Information and communication technology can empower residents to be socially engaged, enhancing their quality of life.

Promoting social interaction through information and communication technology can include enabling access to phones, televisions, radios, tablets or computers, a Wi-Fi network, and information boards. Technologies are available to make devices accessible for residents with sensory or cognitive impairments. For example, telephones, computers, and video phones may be equipped with increased font size or assistive programming capabilities. While technology can enable social interactions, it is not meant to replace human interactions.

Teams support residents in accessing technologies by providing technical support based on residents' goals, needs, abilities, and preferences. For example, teams may assist residents with charging and turning on equipment or activating the technology's accessibility tools.

3.1.10 Teams facilitate access to appropriate transportation services that meet residents' needs, abilities, and preferences.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Residents of LTC homes depend on accessible transportation to access services, appointments, and events outside the home.

Residents are informed of the transportation options available to them for non-urgent medical needs and social needs, such as shopping, attending events or religious services, and keeping non-medical appointments such as hairstyling. Transportation for non-medical needs can include public transportation or private arrangements.

Teams consider whether residents should be accompanied based on residents' needs and abilities.

The LTC home supports residents' needs by coordinating with transportation providers, posting public transportation schedules, and ensuring that recommended or provided transportation services are safe and reliable.

3.1.11 The LTC home leaders communicate the results of annual quality-of-life surveys to teams.

Priority: **Normal Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

Quality of life is an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, needs, and preferences.

Quality-of-life surveys are based on self-reported methodologies and provide the LTC home with qualitative information on residents' perception of both their objective and subjective well-being.

Domains covered by quality-of-life surveys include physical capacity and function, psychological well-being, level of autonomy with decision-making, social relationships including those with staff, sense of purpose, and a subjective sense of lifestyle satisfaction.

Surveys should be easy to understand, easy to administer, and adapted for those residents who may have cognitive or communication barriers. For those residents unable to participate, reporting by proxy by substitute decision makers and essential care partners is encouraged. Workforce feedback is also considered.

As team members, residents, substitute decision makers, and essential care partners are engaged in planning, administrating, and communicating the outcomes of the quality-of-life survey. Data collection, analysis, and reporting is done by people who have the required competencies. A system is in place to ensure collected data are anonymized, and privacy measures protect resident confidentiality. The results of the quality-of-life survey are communicated to the workforce and residents in a timely manner and in a format that is clear and accessible for residents.

Chapter 4: Ensuring High-Quality and Safe Care

This chapter focuses on the delivery of high-quality and safe resident care by LTC home leaders and teams. Themes include conducting comprehensive assessments, developing resident's individualized care plans, ensuring the safety and effectiveness of care, and timely access to appropriate care and services.

4.1 The LTC home leaders and teams collaborate to develop, implement, and continuously update residents' individualized care plans based on comprehensive assessments of residents' needs.

4.1.1 The LTC home leaders provide teams with a validated template to conduct residents' comprehensive needs assessments.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

A comprehensive needs assessment provides the team with a holistic understanding of a resident's needs. The assessment gathers information about the resident's basic care, mental health, physical health, and social needs. The assessment template provides structure to assess the resident's needs and enables the team to develop an individualized care plan that promotes the resident's autonomy and functional capacity and enhances their quality of life.

LTC home leaders provide teams with a validated template to help them assess residents' needs consistently and reduce unintended variation. The selected template is evidence informed and supports resident-centred care. The template also embeds evidence-informed tools, such as a validated observational pain assessment checklist for residents with a limited ability to communicate.

4.1.2 The team conducts the resident's comprehensive needs assessment upon admission to the LTC home.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

The team uses evidence-informed, validated assessment tools to comprehensively assess a resident's needs and gather information about the resident's basic care, mental health, physical, and social needs. The team collects this information with the resident, or if incapable, their substitute decision maker, and essential care partners with consent.

Based on the information collected, the team may request a detailed assessment by other health care professionals within or outside the LTC home, such as a rehabilitation professional or physician. This team-based, interdisciplinary approach ensures a thorough assessment of the resident's needs.

Completing the assessment over a few encounters gives the team the chance to observe, engage with, and get to know the resident. The team establishes the resident's immediate needs first, then continually assesses the resident's evolving needs over time.

The assessment process provides the team with the information needed to develop and implement the resident's individualized care plan.

4.1.3 The team uses the validated needs assessment template to evaluate the resident's basic needs.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

Care provided in LTC homes includes assisting residents in meeting their basic needs and accomplishing their daily life activities.

The team assesses the resident's ability to meet their basic needs:

- **Eating and Hydrating**. The team assesses the resident's food and eating preferences (including cultural preferences), food allergies, ability to eat and swallow, and capacity for self-feeding and hydrating.
- **Dressing**. The team assesses the resident's ability to dress themself.
- **Sleep**. The team assesses the resident's sleep patterns and preferences.
- **Hygiene**. The team assesses the resident's bladder and bowel continence and ability to manage grooming, bathing, oral hygiene, and toileting.

- **Mobility and ambulation**. The team assesses the resident's ability to move, transfer, and walk and their risk of falls.

The team documents the results of the assessment in the resident's health record and individualized care plan and shares the information with appropriate team members.

4.1.4 The team uses the validated needs assessment template to evaluate the resident's mental health needs.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

LTC home residents are likely to experience significant life changes, increasing frailty and reduced capacity, and the effects of multiple chronic diseases. These factors put them at higher risk for experiencing mental health symptoms and mental illness.

The team uses a trauma-informed, culturally safe approach aligned with the principles of equity, diversity, and inclusion to gather information about the resident's mental health needs, cognition, past and present life experiences, and history of mental illnesses and addictions.

Team members take care to observe the resident when engaging with them for any interaction or care encounter. They observe the resident's reactions or behaviour and any changes or observable patterns. They note when these changes occur, what triggers them, and any actions that calm the resident.

When necessary, the team seeks mental health and addictions expertise within or outside the LTC home.

The team documents the resident's mental health needs in the resident's health record and individualized care plan and shares the information with appropriate team members.

4.1.5 The team uses the validated needs assessment template to evaluate the resident's physical health needs.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

A thorough understanding of the resident's physical health needs is essential to providing high-quality care. The team gathers information about the resident's physical health needs, including the following:

- **Nutritional status**. The team assesses the resident's intake of fluids and food, nutrient use by the body, food requirements or restrictions, and height and weight. Regular nutritional assessments help to prevent and identify dehydration and malnutrition.

- **Experience of pain**. The team uses verbal and non-verbal evidence-informed methods to assess the resident's experience of pain, taking particular care with residents with a limited ability to communicate and unable to tell others when they experience pain. Every attempt is made to minimize pain for the resident.

- **Sensory capacity**. The team assesses the resident's senses of sight, hearing, smell, touch, and spatial awareness. Sensory assessments may identify the need for assistive devices, changes to the environment, or special consideration in delivering some types of care.

- **Oral health**. The team assesses the health of the resident's head and neck structures, gums, soft tissues, lips, tongue, and teeth, as well as the condition of any oral appliances (e.g., dentures, crowns, bridges). These assessments help to prevent tooth decay, gum disease, and oral lesions and enable healthy nutrition.

- **Skin integrity**. The team assesses the resident's skin colour, moisture, temperature, texture, and elasticity and inspects for skin lesions and tears. Regular skin assessments are essential to promote comfort and to prevent complications such as skin infections and wounds.

- **Medication profile**. The team generates a best possible medication history for the resident, including the names of the medications the resident is taking and their dosage, route of administration, and frequency. The medication profile includes prescription medications, over-the-counter medications, supplements, and any traditional or alternative remedies. Regular review of the resident's current and complete medication profile minimizes the risk of medication errors and adverse drug reactions.

- **Medical profile**. The team reviews the resident's relevant medical diagnoses (present and past), vital signs, medication and other allergies, adverse drug reactions, antibiotic-resistant colonization status, infection status, and immunization status. A complete medical profile provides the team with essential information about the resident's physical health.

When necessary, team members seek the expertise of other health care professionals within or outside the LTC home to assist with assessing the resident's physical needs.

The team documents the resident's physical needs in the resident's health record and individualized care plan and shares the information with appropriate team members.

4.1.6 The team uses the validated needs assessment template to evaluate the resident's social needs.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

Social isolation and loneliness contribute to an increased risk of disease, cognitive decline, and mental health challenges. LTC residents who are socially engaged and participate in meaningful daily activities experience better health outcomes, well-being, and quality of life.

The team uses a trauma-informed, culturally safe approach aligned with the principles of equity, diversity, and inclusion to understand the resident's social needs. The team gathers information on the resident's social needs, including

- preferred social experience and activities;
- preferred recreational activities, including those done alone or with others;
- experience with social and recreational activities, including any past trauma that could influence the resident's participation in some activities;
- mental and physical abilities and desire to interact with others;
- preferred spiritual practices;
- preferred cultural interests and activities; and

- gender identity, sexual expression, and opportunities to support the resident's sexual health and intimacy needs.

When necessary, team members seek the expertise of social care professionals within or outside the LTC home to assist with assessing the resident's social needs.

The team documents the resident's social needs in the resident's health record and individualized care plan and shares the information with appropriate team members.

4.1.7 The team conducts ongoing needs assessments according to the resident's changing health status and care needs.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

<u>Guidelines</u>

The resident's health status and care needs can change quickly and often. Delays or failures in identifying or reporting a change in health status can negatively affect the resident's overall safety, health, and well-being.

All team members take the time to observe and engage with the resident in every interaction and care encounter, wherever the encounter takes place. They pay close attention to the resident's health and well-being for any cues that something is different or not right, such as signs of new or worsened pain or changes in the resident's behaviour or mobility. The team continually learns about the resident's needs through regular conversations and check-ins and when they are providing one-on-one care activities with the resident.

The team documents the results of ongoing needs assessments in the resident's health record and individualized care plan and shares the information with appropriate team members.

Ongoing needs assessments comply with jurisdictional requirements.

4.1.8 The LTC home leaders provide teams with a validated template to develop individualized care plans.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

Individualized care plans provide a holistic roadmap of care that reflects residents' goals, needs, and preferences. The care plans use information from the comprehensive resident needs assessment to promote resident comfort, autonomy, and functional capacity.

The LTC home leaders provide a validated template to enable teams to use a consistent approach to develop and implement individualized care plans and reduce unintended variation. The selected template should be evidence informed and designed to support resident-centred care.

The LTC homes ensure teams use a trauma-informed, culturally safe approach aligned with the principles of equity, diversity, and inclusion to develop residents' individualized care plans. Individualized care plans are shared with appropriate team members.

4.1.9 The team engages with the resident to develop the resident's individualized care plan.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

The team uses a trauma-informed, culturally safe approach aligned with the principles of equity, diversity, and inclusion to develop the resident's individualized care plan. The team engages with the resident, or if incapable, their substitute decision maker, and essential care partners with consent to co-design the individualized care plan. Completing the care plan over a few encounters gives the team the chance to fully understand the resident's needs and ensure they are reflected in the care plan.

The individualized care plan includes

- pertinent information from the resident's needs assessments, any relevant documentation completed on evaluation prior to admission, and any new or updated documentation received from other health care professionals outside the LTC home;
- the resident's goals of care, needs, and preferences;
- the team members involved in the resident's care;

- the type of care, internal and external services, and meaningful daily activities to be provided to the resident;
- the assistive devices and technologies the resident requires to support mobility and sensory deficits; and
- the resident's safety plan.

The individualized care plan also includes the resident's advance care plan, should the resident choose to have one. An advance care plan may specify the resident's wishes for anticipated care, such as not to resuscitate in specified or all circumstances or not to have certain life-sustaining treatments, including hospital or intensive care. Advance care plans are not a form of consent. The team follows the appropriate steps to respect a resident's wishes in compliance with jurisdictional requirements.

The team documents and implements the individualized care plan, taking the time to provide care at the resident's pace. The individualized care plan is shared with appropriate team members. The appropriate information is documented in the resident's health record.

4.1.10 The team continually updates the resident's individualized care plan.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

Keeping the resident's individualized care plan current is essential to providing high-quality care.

The team collaborates with the resident, or if incapable, their substitute decision maker, and their essential care partners with consent to update the resident's individualized care plan to include

- changes in the resident's health or behaviour captured in the resident's ongoing needs assessments;
- changes in the resident's goals of care or wishes for care, including wishes for palliative or end-of-life care;
- changes in care or services prescribed by a health care professional, including those outside the LTC home, such as a physician, dentist, or

registered dietitian; and

- any other relevant information or documentation from the resident, or if incapable, from their substitute decision maker.

The team documents the changes and shares the resident's updated individualized care plan with appropriate team members. The appropriate information is documented in the resident's health record.

4.1.11 The team follows the LTC home's procedure to share the resident's individualized care plan with appropriate team members.

Priority: **Normal Priority** | Quality Dimension: **Continuity of Services** | Assessment Method: **On-site**

Guidelines

Having access to the right information at the right time enables team members to understand all aspects of the resident's care, answer any questions the resident might have, and fully participate in the delivery of care.

The team follows the LTC home's procedure for sharing the resident's individualized care plan. The procedure complies with health privacy legislation for sharing of information and outlines who has full or limited access to the care plan. The procedure provides steps for securely sharing confidential information, including electronic documents and photos, by email, telephone, or other methods. All communication about the resident's care should be clear, timely, and aligned with the principles of health literacy.

The team is encouraged to share non-confidential elements of the resident's individualized care plan in creative ways. For example, special meals, activities, or events may be displayed on an information board or shared in an announcement or group message. Creating elements of fun contributes to a warm home environment for the resident.

4.2 The LTC home leaders and teams collaborate to design, deliver, and continuously evaluate the safety and effectiveness of care.

4.2.1 Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. 'Client' and 'patient' refer to 'resident', 'family and friends' and 'designated support person' refers to 'essential care partner', 'team leadership' and 'organizational leaders' refers to 'LTC home leaders', and 'organization' refers to 'LTC home'.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method**: On-site**

Test(s) for Compliance

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

Guidelines

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

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

Client identification is done in partnership with clients and families by explaining the reason for this important safety practice and asking them for the identifiers (e.g., "What is your name?"). When clients 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.

4.2.2 The team follows the LTC home's procedure for nutrition and hydration management.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

LTC residents are vulnerable to malnutrition and dehydration, as well as unintentional weight loss. Proper nutrition and hydration are the foundation of residents' health and well-being and are an important element of effective pain and wound management.

Using a team-based approach, the team follows the LTC home's procedure to assess the resident's individual nutritional and hydration needs and prevent malnutrition and dehydration. The procedure is aligned with evidence- informed practices and includes steps to regularly observe and monitor the resident's food and fluid intake and weight, their ability to feed themself and swallow without choking, and any difficulties with food or fluid textures.

The team documents the resident's nutrition and hydration status in the resident's health record and individualized care plan. The information is shared with appropriate team members.

4.2.3 The team follows the LTC home's procedure for oral health management.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

LTC home residents are at greater risk of oral conditions such as dry mouth, bleeding gums, tooth decay, reduced sense of taste and smell, and lip and oral lesions.

Poor oral hygiene and care can result in worsened pain, increased risk of malnutrition, and communication problems, all affecting a resident's quality of life. Inadequate oral care can also result in a need for specialized care provided by a dentist or other health care professional.

Using a team-based approach, the team follows the LTC home's procedure to ensure ongoing oral care is provided. They regularly assess the resident's gums, lips, tongue, and oral cavity. Dental appliances are assessed for proper fit and

damage. The team facilitates the resident's access to dental health care professionals for both preventive and acute care as needed.

The team documents all oral hygiene management activities in the resident's health record and individualized care plan. The information is shared with appropriate team members.

4.2.4 The team participates in the organization's evidence-informed program to optimize skin integrity.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. ‘Client’ and ‘patient’ refer to ‘resident’, ‘family and friends’ and ‘designated support person’ refers to ‘essential care partner’, ‘team leadership’ and ‘organizational leaders’ refers to ‘LTC home leaders’, and ‘organization’ refers to ‘LTC home’.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Test(s) for Compliance

4.2.4.1 The team follows the organization's procedure to conduct screening for risk of impaired skin integrity.

Guidelines

Screening is a brief, evidence-informed process to proactively identify a client’s health needs and risks that may require further assessment.

The organization’s procedure identifies the selected screening tools to determine a client’s risk of impaired skin integrity. The selected tools are evidence-informed and appropriate for the care setting and populations served. The organization’s procedure also defines when screening is conducted and repeated, such as when care begins and when a client’s health status changes.

In some care settings it may be appropriate to screen all clients for impaired skin integrity. Selective screening of clients, as defined in the organization’s procedure, may be more appropriate for other care settings. If appropriate, clients may use the tools to screen themselves.

The screening results are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

4.2.4.2 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of impaired skin integrity.

Guidelines

When screening results are positive, indicating that the client may be at risk of impaired skin integrity, a comprehensive assessment is conducted to determine appropriate interventions.

The assessment is timely and complete as defined in the organization's procedure. If the team does not have the required competencies to conduct the assessment, a referral may be made to a specialized health care professional outside of the organization or team.

The assessment is conducted using evidence-informed tools that reflect the services being provided, the care setting, and the populations served.

The selected assessment tools may include methods for assessing

- skin colour, moisture, temperature, texture, elasticity, and presence of lesions or tears;
- the client's sensory perception, degree of physical activity, mobility, and exposure to friction, shear, moisture, and environmental risk factors;
- the client's ability to manage their own skin integrity, including maintaining good hygiene, nutrition, and hydration; and
- associated risks from co-morbidities, such as diabetes, or planned interventions, such as surgery or cancer therapies.

The information collected during the assessment is documented in the client's health record and individualized care plan. The

information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

4.2.4.3 The team implements interventions to optimize skin integrity as part of the client's individualized care plan.

<u>Guidelines</u>

Interventions to optimize skin integrity are informed by the assessment results and the client's decisions about their care. Interventions may include

- implementing strategies to optimize skin integrity, such as movement, hydration, nutrition, and use of topical protectants;
- conducting safety checks and reassessments;
- reviewing medications that may impact skin integrity; and
- providing equipment or devices such as lifts, pressure-reduction cushions, or mattresses.

The selected interventions are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The interventions are regularly assessed. Client progress is measured and documented. The information is also shared during care transitions.

4.2.4.4 The team follows the organization's procedure to report health care associated impaired skin integrity as a safety incident.

<u>Guidelines</u>

An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

Health care associated impaired skin integrity is when a skin tear, infection, pressure, or other skin injury is caused by a care intervention or unintended variation in care.

The organization's procedure to report health care associated impaired skin integrity as a safety incident is aligned with evidence-informed practices and jurisdictional requirements. The procedure outlines what types of incidents need to be reported and how to report them. The procedure is simple, clear, and focused on system improvement.

Safety incidents are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Safety incidents inform the organization's integrated quality improvement plan.

4.2.4.5 The team participates in continuous learning activities about the program to optimize skin integrity.

Guidelines

Continuous learning helps the team implement safety practices to prevent harm and optimize skin integrity. As a member of the team, the client receives information and resources that enable them to play an active role in their care, make informed decisions, and manage their own health.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of optimizing skin integrity as a safety practice;
- identification of preventable and non-preventable risks to skin integrity;

- the importance of assessing surfaces and devices that are in contact with the skin;
- the importance of assessing devices that cross the skin barrier, such as intravenous lines; and
- reporting health care associated impaired skin integrity as a safety incident.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

The team is involved in the development and evaluation of continuous learning activities. The team is given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

4.2.4.6 The team participates in activities to improve the program to optimize skin integrity as part of the organization's integrated quality improvement plan.

Guidelines

Quality improvement involves a team-based approach to understanding the organization’s strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback. It also includes identifying and implementing actions that improve the organization’s program to optimize skin integrity.

Aims, measures, and outcomes are documented in the organization’s integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of documentation to assess the team's adherence to the organization's procedures to optimize skin integrity;
- assessing the impact of interventions to prevent injury and optimize skin integrity;
- root cause analysis of safety incidents related to health care associated impaired skin integrity;
- feedback from the team, including the client, on the organization's program to optimize skin integrity; and
- feedback from the team, including the client, on the continuous learning opportunities provided by the organization on optimizing skin integrity.

The team is given time to participate in, reflect on, and share quality improvement learnings and experiences.

4.2.5 The team follows the LTC home's procedure for pain management.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

Pain is an unpleasant sensory and emotional experience usually associated with actual or potential tissue or nerve damage. Pain includes acute pain, which usually lasts for short periods, and chronic pain, which persists or recurs for longer than three months. Many LTC residents experience some type of chronic pain. Preventing and minimizing all types of pain reduces the resident's suffering and significantly improves their quality of life.

The team is attentive to and helps to mitigate the effects of pain on the resident's function and social, spiritual, and psychological well-being. Using a team-based approach, the team follows the LTC home's procedure to manage the resident's pain. The procedure is aligned with evidence-informed practices and takes a culturally safe approach to pain management. The procedure applies the principles of a multimodal approach that includes the following:

- **Physical strategies**. These interventions help improve the way the body functions physically. Examples include helping the resident with

conditioning exercises, movement, and turning and repositioning in bed. Physical strategies also include mitigating pain with the use of specialized or adaptive equipment.

- **Psychosocial strategies**. These interventions address thoughts, emotions, and behaviours to help the resident influence their experience of pain. Examples include social and recreational activities and, in some cases, mindfulness meditation.

- **Pharmacological strategies**. These interventions involve the use of medication to relieve pain.

The team also considers the potential for experiencing pain when providing care, such as wound care. The team takes steps to prevent and minimize pain.

The team documents all pain management interventions in the resident's health record and individualized care plan. The information is shared with appropriate team members.

4.2.6 The team participates in the organization's evidence-informed program to prevent falls and reduce injuries from falls.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. ‘Client’ and ‘patient’ refer to ‘resident’, ‘family and friends’ and ‘designated support person’ refers to ‘essential care partner’, ‘team leadership’ and ‘organizational leaders’ refers to ‘LTC home leaders’, and ‘organization’ refers to ‘LTC home’.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Test(s) for Compliance

4.2.6.1 The team follows the organization's procedures for providing a safe physical environment to prevent falls and reduce injuries from falls.

Guidelines

A safe and barrier-free indoor and outdoor physical environment is essential to preventing falls and reducing injuries from falls.

The organization's procedures are current, informed by evidence, and aligned with jurisdictional requirements. The procedures identify how to provide a safe physical environment, such as

- keeping floors clean and dry and cleaning up spills promptly;
- providing mobility aids and furniture that are appropriate for the population served;
- ensuring structural features that enhance safety and accessibility are in place and in good working order, such as ramps, handrails, grab bars, non-slip flooring, and adequate lighting;
- minimizing overcrowding and reducing clutter; and
- conducting ongoing safety checks of the care setting and public spaces such as the cafeteria, entrance, and parking areas.

The client, as a member of the team, is encouraged to ask questions, share concerns, and participate in conversations about the safety of the physical environment.

4.2.6.2 The team follows the organization's procedure to conduct screening for risk of falls and injuries from falls.

Guidelines

Screening is a brief, evidence-informed process to proactively identify a client's health needs and risks that may require further assessment.

The organization's procedure identifies the selected screening tools to determine a client's risk of falls and injuries from falls. The selected tools are evidence-informed and appropriate for the care setting and populations served. The organization's procedure also defines when screening is conducted and repeated, such as when care begins and when a client's health status changes.

In some care settings it may be appropriate to screen all clients for risk of falls and injuries from falls. Selective screening of clients, as defined in the organization's procedure, may be more appropriate

for other care settings. If appropriate, clients may use the tools to screen themselves.

The screening results are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

4.2.6.3 The team follows the organization's procedure to ensure a comprehensive assessment is conducted for a client who screens positive for risk of falls or injuries from falls.

Guidelines

When screening results are positive, indicating that the client may be at risk of falls or injuries from falls, a comprehensive assessment is conducted to determine appropriate interventions.

The assessment is timely and complete as defined in the organization's procedure. If the team does not have the required competencies to conduct the assessment, a referral may be made to a specialized health care professional outside of the organization.

The assessment is conducted using evidence-informed tools that reflect the services being provided, the care setting, and the populations served. The selected tools may include methods for assessing gait, balance, mood, vision, cognition, medication history, co-morbidity, fall history, management of daily activities, and use of assistive devices.

The information collected during the assessment is documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

4.2.6.4 The team implements interventions to prevent falls and reduce injuries from falls as part of the client's individualized care plan.

Guidelines

Interventions to prevent falls and reduce injuries from falls are informed by the assessment results and the client's decisions about their care. Interventions may include

- organizing the client's environment to minimize clutter and placing necessary items within reach;
- client self-management techniques to protect against falls such as improving strength and balance and learning to fall safely;
- reviewing medications that may increase risk of falls; and
- providing equipment or devices to improve the client's safety and mobility.

The selected interventions reflect the organization's procedure on the use of least restraint. The interventions are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The interventions are regularly assessed. Client progress is measured and documented. The information is also shared during care transitions.

4.2.6.5 The team follows the organization's procedure to report falls and injuries from falls as safety incidents.

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client. Falls and injuries from falls that occur in the care setting or public space are reported as safety incidents.

The organization's procedure to report falls and injuries from falls as a safety incident is aligned with evidence-informed practices and jurisdictional requirements. The procedure outlines what types of incidents need to be reported and how to report them. The procedure is simple, clear, and focused on system improvement.

Safety incidents are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Safety incidents inform the organization's integrated quality improvement plan.

4.2.6.6 The team participates in continuous learning activities about the program to prevent falls and reduce injuries from falls.

Guidelines

Continuous learning helps the team implement safety practices to prevent falls and reduce injuries from falls. As a member of the team, the client receives information and resources that enable them to play an active role in their care, make informed decisions, and manage their own health.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of fall prevention and injury reduction as a safety practice;
- prevention strategies that engage the interdisciplinary team, such as sharing the client's mobility status on the client's communication board;
- strategies for team members to reduce their risk of falls and injuries when supporting clients; and
- what to do when a fall or injury from a fall occurs in the care setting or public space, including reporting it as a safety incident.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and

simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

The team is involved in the development and evaluation of continuous learning activities. The team is given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

4.2.6.7 The team participates in activities to improve the program to prevent falls and reduce injuries from falls as part of the organization's integrated quality improvement plan.

Guidelines

Quality improvement involves a team-based approach to understanding the organization’s strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback. It also includes identifying and implementing actions that improve the organization’s program to prevent falls and reduce injuries from falls.

Aims, measures, and outcomes are documented in the organization’s integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of documentation to assess the team’s adherence to the organization’s procedures to prevent falls and reduce injuries from falls;
- assessing the impact of interventions to prevent falls and reduce injuries from falls;
- root cause analysis of safety incidents related to falls and injuries from falls;
- feedback from the team, including the client, on the organization’s program to prevent falls and reduce injuries from falls; and

- feedback from the team, including the client, on the continuous learning activities provided by the organization on preventing falls and reducing injuries from falls.

The team is given time to participate in, reflect on, and share quality improvement learnings and experiences.

4.2.7 The team follows the LTC home's procedure for the management of responsive behaviours.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Responsive behaviours are actions, words, or gestures presented by people with certain conditions related to cognitive impairment and intellectual disabilities. Experiences of past trauma and new or worsening pain may also contribute to a responsive behaviour.

Using a team-based approach, the team follows the LTC home's procedure to prevent, assess, and manage responsive behaviours. The procedure is aligned with evidence-informed practices and includes preventive approaches such as knowing the resident's history, preferences, and routines; maintaining a daily routine; assisting the resident with daily exercise; and planning simple activities and social time. Calming and soothing activities, such as music, pet visitations, weighted blankets, and lowered noise levels, can also help to prevent and manage responsive behaviours.

The team takes a trauma-informed, culturally safe approach to supporting the resident who is experiencing responsive behaviours. Antipsychotics and sedative medications should not be the first choice for treatment of responsive behaviours. The team collaborates to identify potential causes for the responsive behaviours and non- pharmacological approaches to address the behaviours. When possible, the team calms and redirects the resident and takes steps to address the cause of the behaviours.

The team facilitates access to appropriate health care professionals for assessment and support if a resident's responsive behaviours do not respond to strategies developed by the team.

The team documents the resident's responsive behaviours and the actions taken to address them in the resident's health record and individualized care plan. The information is shared with appropriate team members.

4.2.8 The team follows the LTC home's procedure on the use of least restraint.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

The use of restraints, whether physical or chemical, has significant adverse effects on the physical, mental, and emotional well-being of the resident. Physical restraints can cause loss of muscle mass, reduced mobility, skin breakdown, constipation, and incontinence. Chemical restraints, such as sedatives and antipsychotics, can lead to strokes, muscle contractions, involuntary movements, problems with balance, falls, and drowsiness. While these medications can be used to treat an illness, their risk of harm significantly outweighs any benefit when used to intentionally subdue, sedate, or restrain a resident. Restraints of all types can also lead to psychosocial effects such as shame, hopelessness, and agitation.

The use of restraints is rarely indicated. When restraints are indicated, they are only used as a short-term, temporary intervention. Except in an emergency to prevent risk of harm to self or others or to allow essential medical treatment to proceed, the use of restraints requires the informed consent of a capable resident, or if incapable, their substitute decision maker.

The LTC home's procedure promotes a team-based and trauma-informed approach to care. It identifies and addresses symptoms related to the use and appropriateness of restraints and provides alternative care approaches to limit their use. The procedure includes requirements for when restraints in use are reassessed, documentation, and consent for any use of restraints.

The team uses a least-restraint approach to care and provides safe, competent, and ethical care that upholds the resident's rights, dignity, and autonomy and complies with jurisdictional requirements. The team documents any use of restraints in the resident's health record and individualized care plan. The information is shared with appropriate team members.

4.2.9 The team follows the LTC home's procedure to review the resident's medication profile.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

<u>Guidelines</u>

Regular reviews of the resident's medication profile are an important safety practice. Medication reviews should occur whenever there is a change in the resident's needs, goals of care, or diagnoses. If nothing has changed, medication reviews should occur every three months, or sooner if indicated. The resident, or if incapable, their substitute decision maker, may also request a medication review at any time.

Using a team-based approach, the team follows the LTC home's procedure to review the resident's medication profile. The procedure is aligned with evidence-informed practices and adheres to the following principles:

- **Prescribe appropriately**. When appropriate indicators exist, residents are offered the opportunity to be prescribed a medication that could improve their overall health and well-being. Residents are closely monitored for intended outcomes and side effects. Medications are reduced or stopped if they are not providing the intended outcome or are causing harm. Antibiotics, such as those used to treat urinary tract infections, are prescribed according to evidence-informed practices.

- **Use antipsychotics appropriately**. Antipsychotics are not used as a first choice to treat behavioural and psychological symptoms of dementia or sleep-related issues.

- **Reduce the use of multiple medications (polypharmacy)**. Using multiple medications can affect the resident's mobility, cognitive function, nutritional status, and quality of life and is avoided when possible.

The team documents any changes in medications in the resident's health record and individualized care plan. The information is shared with appropriate team members.

4.2.10 The team follows the organization's medication reconciliation procedure to maintain an accurate list of medications during care transitions.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. ‘Client’ and ‘patient’ refer to ‘resident’, ‘family and friends’ and ‘designated support person’ refers to ‘essential care partner’, ‘team leadership’ and ‘organizational leaders’ refers to ‘LTC home leaders’, and ‘organization’ refers to ‘LTC home’.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Test(s) for Compliance

4.2.10.1 The team follows the organization's procedure to obtain a best possible medication history during care transitions.

Guidelines

A best possible medication history is a complete and accurate list of medications the client is taking. Care transitions occur when a client moves from one care setting to another.

The organization’s procedure defines how to obtain a best possible medication history during care transitions, including at least the following:

- Virtual or in-person conversations with the client or the person most responsible for medication management. These conversations are conducted in a way that encourages complete and accurate information about medication use, including prescription medications, over-the-counter medications, cannabis for medical purposes, supplements, and any traditional or alternative remedies.
- Verifying the client’s list of medications with at least one other reliable source of information. Sources of information may include a community pharmacy record, health record, hospital discharge medication list, or medication administration record.

The organization’s procedure is current and informed by evidence. The procedure identifies care transitions where a best possible medication history is completed. Examples include a client’s transition to or from a hospital or long-term care home, an ambulatory care setting such as a cancer clinic, or a primary care setting where medication is being managed.

The best possible medication history is documented in the client’s health record. The information is shared with the client and other authorized team members in a clear and accessible format.

4.2.10.2 The team follows the organization's procedure to resolve medication discrepancies during care transitions in a timely way.

Guidelines

Unresolved medication discrepancies, both intentional and unintentional, can result in medication errors and cause harm to the client, unplanned clinical encounters, and related costs for the health system. Medication discrepancies include errors related to inappropriate prescribing, duplication of therapies, and omitted medications.

Medication discrepancies are identified and documented by a designated and trained member of the team. The best possible medication history is compared with what has been recently prescribed or is intended to be prescribed.

Identified discrepancies are documented and communicated to the client’s most responsible prescriber. Discrepancies are resolved in a timely way as defined in the organization’s procedure.

Resolution of discrepancies can occur prospectively or retrospectively. However, the risk of medication discrepancies is significantly reduced when a best possible medication history is completed before a prescription is written. The use of interoperable information technology helps to make medication reconciliation more reliable and effective.

Medication changes are discussed with the client to ensure the changes reflect the client’s goals, abilities, and preferences. These conversations help the client understand which medications need to be stopped or changed; potential interactions with over-the-counter medications, cannabis for medical purposes, supplements, and any traditional or alternative remedies; and how to dispose of unnecessary medications.

The accurate list of medications is documented in the client’s health record. This information is shared with the client and other authorized team members in a clear and accessible format.

4.2.10.3 The team follows the organization's procedure to report incidents that could have harmed or did harm a client related to maintaining

an accurate list of medications during care transitions as safety incidents.

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

Incidents related to maintaining an accurate list of medications during care transitions include when medication reconciliation is not completed, is done incorrectly, or is not completed in a timely manner and could have harmed or did harm a client.

The organization's procedure to report incidents related to maintaining an accurate list of medications during care transitions as safety incidents is aligned with evidence-informed practices and jurisdictional requirements. The procedure outlines what types of incidents need to be reported and how to report them. The procedure is simple, clear, and focused on system improvement.

Safety incidents are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Safety incidents inform the organization's integrated quality improvement plan.

4.2.10.4 The team participates in continuous learning activities about the medication reconciliation procedure to maintain an accurate list of medications during care transitions.

Guidelines

Continuous learning helps the team implement safety practices to maintain an accurate list of medications during care transitions. As a member of the team, the client receives information and resources that enable them to play an active role in their care, make informed decisions, and manage their own health.

If the organization offers clinical practicums, students, residents, and fellows participate in required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of maintaining an accurate list of medications during care transitions as a safety practice;
- strategies to actively engage the client in maintaining an accurate list of medications during care transitions, including assessing the client’s medication literacy;
- communicating medication changes during care transitions;
- training on the organization’s medication reconciliation tools and interoperable technology; and
- reporting incidents related to maintaining an accurate list of medications during care transitions as safety incidents.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

The team is involved in the development and evaluation of continuous learning activities. The team is given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

4.2.10.5 The team participates in activities to improve the medication reconciliation procedure to maintain an accurate list of medications during care transitions as part of the organization's integrated quality improvement plan.

Guidelines

Quality improvement involves a team-based approach to understanding the organization’s strengths, opportunities for

improvement, risks, and challenges to delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback. It also includes identifying and implementing actions that improve the organization’s medication reconciliation procedure to maintain an accurate list of medications during care transitions.

Aims, measures, and outcomes are documented in the organization’s integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of documentation to assess the team’s adherence to the organization’s medication reconciliation procedure, including assessing the reliability and accuracy of best possible medication histories and assessing medication discrepancy resolution rates and timeliness;
- root cause analysis of safety incidents related to maintaining an accurate list of medications during care transitions;
- feedback from the team, including the client, on the applicability of the organization’s medication reconciliation procedure to maintain an accurate list of medications during care transitions; and
- feedback from the team, including the client, on the continuous learning activities provided by the organization on the medication reconciliation procedure to maintain an accurate list of medications during care transitions.

The team is given time to participate in, reflect on, and share quality improvement learnings and experiences.

4.2.11 The LTC home leaders implement a program to ensure the appropriate use of antipsychotic medication.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Residents of LTC homes may be admitted with mental health conditions, such as major mood disorders or psychotic illnesses, that require the use of antipsychotic medications. Antipsychotic medications are second-line therapies for other conditions such as the management of complex responsive behaviours. The use of antipsychotic medications when not indicated can seriously harm residents.

As with any medication, informed consent from the resident, or if incapable, from their substitute decision maker, is required before giving an antipsychotic medication.

Teams are involved in educational initiatives to better understand the appropriate use of antipsychotic medication in treating medical conditions and their limited role in the treatment of responsive behaviours. Teams learn about the risks and benefits of antipsychotic medications, ways to replace inappropriate use with non-drug interventions when possible, approaches to reducing and possibly discontinuing antipsychotic medication when they are no longer needed, and when to seek support from mental health professionals.

Medication reviews include assessing how a given symptom or illness is responding to the prescribed antipsychotic and whether side effects are evident. A review includes feedback from the team, including the prescriber and, ideally, a consulting pharmacist.

Teams have an approach to taper residents off potentially inappropriate antipsychotic medication. The approach reduces the medication gradually and includes close monitoring.

4.2.12 The team uses validated order sets for the management of common infections.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Validated order sets are used to treat a resident based on evidence-informed criteria and practices for a specific condition. Common infections among residents include urinary tract infections, skin and soft tissue infections, gastroenteritis, and respiratory infections.

Using a team-based approach, the team consults validated order sets for evidence-informed details on appropriate assessment and testing, investigation for diagnosis, and criteria for the proper use of antimicrobial medication. For

example, the team only uses antibiotics for urinary tract infections when the resident meets the criteria for treatment.

Many residents with serious or progressive illness want to avoid tests and interventions that may cause harm, particularly at the end of life. The team consults with the resident to understand the resident's goals, needs, and preferences before offering tests or interventions.

The team documents all orders in the resident's health record and shares this information with appropriate team members.

4.2.13 The LTC home leaders ensure immunization programs are provided to optimally protect people from infectious diseases.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **Attestation**

Guidelines

Group living settings and complex health conditions increase residents' risk of contracting infectious diseases. Immunization programs are an important part of care that protect residents' health and quality of life by reducing the incidence of infections. These programs also mitigate the risk of infectious disease outbreaks in the LTC home.

The LTC home leaders advocate immunization programs in the LTC home. They promote the implementation of evidence-informed immunization programs that

- inform residents of the vaccines available to them, including publicly funded vaccines and non-publicly funded vaccines, and any associated costs;
- obtain informed consent from the resident, or if incapable, their substitute decision maker, after providing information on the risks, benefits, and side effects of the vaccines;
- align with provincial and territorial vaccine schedules;
- coordinate with local public health services, other health care professionals, and community pharmacists for vaccine access, storage, and administration;
- report any adverse events; and

- document vaccine administration in residents' health record.

The LTC home leaders evaluate and update the immunization programs on a regular basis.

4.2.14 A patient safety incident management system that supports reporting and learning is implemented.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. ‘Client’ and ‘patient’ refer to ‘resident’, ‘family and friends’ and ‘designated support person’ refers to ‘essential care partner’, ‘team leadership’ and ‘organizational leaders’ refers to ‘LTC home leaders’, and ‘organization’ refers to ‘LTC home’.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

In a culture of patient safety, everyone is encouraged to report and learn from patient 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. Clients and families may report patient 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 clients, and can be part of team member training and included in written and verbal communication to clients and families about their role in safety.

The immediate response to a patient 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 in order to make improvements. Analyzing similar patient 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 clients and families, governance, leadership, clinical teams, and external partners) builds confidence in the incident management system and promotes learning from patient safety incidents. Global Patient Safety Alerts is an on-line, searchable database where lessons learned from patient safety incidents are shared.

Test(s) for Compliance

4.2.14.1 A patient safety incident management system is developed, reviewed, and updated with input from clients, families, and team members, and includes processes to report, analyze, recommend actions, and monitor improvements.

4.2.14.2 Information is shared with clients, families, and team members so they understand what, when, and how to report patient safety incidents.

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

4.2.14.4 There are procedures to review patient safety incidents and established criteria are used to prioritize those that will be analyzed further.

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

4.2.14.6 Information about recommended actions and improvements made following incident analysis is shared with clients, families, and team members.

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

- Gathering feedback from clients, families, and team members about the system
- Monitoring patient safety incident reports by type and severity
- Examining whether improvements are implemented and sustained

- Determining whether team members feel comfortable reporting patient safety incidents

4.2.15 A documented and coordinated approach to disclosing patient safety incidents to clients and families, that promotes communication and a supportive response, is implemented.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. 'Client' and 'patient' refer to 'resident', 'family and friends' and 'designated support person' refers to 'essential care partner', 'team leadership' and 'organizational leaders' refers to 'LTC home leaders', and 'organization' refers to 'LTC home'.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

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

- Informing those affected that a patient 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 client 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 (clients, families, 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 patient safety incident that affects multiple clients (e.g., failures in sterilization, privacy breaches) includes additional elements, for example:

- Identifying which clients have been exposed to risk

- Deciding which clients should be contacted and how
- Locating and communicating with clients who have been affected
- Informing the community, other organizations, and the media

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

Test(s) for Compliance

4.2.15.1 There is a documented and coordinated process to disclose patient safety incidents to clients and families that identifies:

- Which patient 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

4.2.15.2 The disclosure process is reviewed and updated, as necessary, with input from clients, families, and team members.

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

4.2.15.4 Communication occurs throughout the disclosure process with clients, families, and team members involved in the patient safety incident. Communication is documented and based on their individual needs.

4.2.15.5 As part of the disclosure process, practical and emotional/psychological support is offered to clients, families, and team members involved in the patient safety incident.

4.2.15.6 Feedback is sought from clients, families, and team members about their experience with disclosure and this information is used to make improvements, when needed, to the disclosure process.

4.2.16 The LTC home leaders provide teams with an updated policy and procedures for emergency and disaster management.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **Attestation**

Guidelines

Emergency and disaster preparedness and management, including pandemic preparedness and management, helps to ensure the health and safety of residents, the workforce, and the community.

The LTC home leaders collaborate with teams and community partners, such as emergency response services and public health organizations, to develop a policy and procedures to respond to emergencies and disasters. The LTC home leaders ensure that the policy and procedures comply with jurisdictional and public health requirements.

The procedures include

- how to respond to potential hazards, such as power outages, fires, floods, heat waves, winter storms, bomb threats, infectious disease outbreaks, and cyber attacks;
- roles and responsibilities of the workforce and external partners;
- a procedure for ensuring timely communications;
- required resourcing and contingencies;
- a supplies and procurement strategy and plans for isolation and workforce reorganization in the event of an outbreak;
- a recovery strategy, including ways to support people's mental health and well-being; and
- processes to debrief after an emergency or disaster, including opportunities to improve response.

The LTC home leaders regularly review and update all procedures and relevant documentation. They ensure teams are aware of the policy and procedures, understand them, and have access to the latest versions.

4.2.17 The LTC home leaders provide teams with the LTC home's evacuation procedure.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

When residents can no longer be safely cared for in the LTC home due to an emergency or disaster, clear and tested evacuation procedures keep residents safe and ensure they continue to receive the care they need.

The LTC home leaders collaborate with teams and local community partners, such as emergency response services and public health organizations, to develop an evacuation procedure for the LTC home.

The evacuation procedure includes

- steps to quickly assess which residents must be evacuated and when;
- triage protocols to identify residents who need to be moved to an alternate care location and residents who may be safely transferred to the care of others, such as substitute decision makers or essential care partners;
- agreements with local services to help move residents who are unable to mobilize independently;
- agreements with local health care or community organizations to provide alternate care locations;
- steps for ensuring the LTC home has adequate and functioning evacuation equipment;
- plans for securely sharing confidential resident data that are essential to the continuity of care;
- plans for communicating with everyone affected throughout the evacuation process; and
- any activities needed to comply with jurisdictional requirements.

The procedure also includes proposed simulation activities to test the evacuation plans.

4.2.18 The team conducts regular simulations of the LTC home's emergency procedures.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Simulations of the LTC home's emergency procedures help the team prepare for emergencies or disasters. Given ongoing changes in resident populations and the workforce in LTC homes, these simulations must be conducted regularly.

Using a team-based approach, the team conducts simulations of the emergency procedures at the intervals and in the manner outlined in the procedures. The team conducts at least one physical, in-person simulation of one type of emergency or element of the procedures annually. Other simulation exercises may be conducted virtually. Jurisdictional requirements may dictate more frequent simulations, such as fire drills.

Once a simulation has been completed, the team conducts a debrief to evaluate the response and recommends improvements to the procedure to the LTC home leaders.

The emergency procedures are updated following simulation activities and any time there is a change in the LTC home environment that would affect the procedures, such as a loss of a common room or other space. Teams are informed of any changes in the procedures and provided with the updated versions.

4.2.19 The team participates in the organization's evidence-informed program to prevent venous thromboembolism.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. 'Client' and 'patient' refer to 'resident', 'family and friends' and 'designated support person' refers to 'essential care partner', 'team leadership' and 'organizational leaders' refers to 'LTC home leaders', and 'organization' refers to 'LTC home'.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Test(s) for Compliance

4.2.19.1 The team follows the organization's procedure to conduct screening for risk of venous thromboembolism.

Guidelines

Screening is a brief, evidence-informed process to proactively identify a client's health needs and risks that may require further assessment.

The organization's procedure identifies the selected screening tools to determine a client's risk of venous thromboembolism. The selected tools are evidence-informed and appropriate for the care setting and populations served. The organization's procedure also defines when screening is conducted and repeated, such as when care begins and when a client's health status changes.

The selected screening tools identify risk factors for venous thromboembolism such as the client's history of venous thromboembolism, decreased mobility, advanced age, health conditions, and specified surgical and interventional procedures.

In some care settings, it may be appropriate to screen all clients receiving care for risk of venous thromboembolism. Selective screening of clients, as defined in the organization's procedure, may be more appropriate for other care settings. If appropriate, clients may use the tools to screen themselves.

The screening results are documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

4.2.19.2 The team follows the organization's procedure to use clinical decision support tools to determine appropriate interventions for a client who screens positive for risk of venous thromboembolism.

Guidelines

Clinical decision support tools provide the team, including the client, with evidence-informed information to support decision-making. Clinical decision support tools may be embedded in order sets.

When screening results are positive, indicating that the client may be at risk of venous thromboembolism, evidence-informed clinical decision support tools are used to determine appropriate interventions. If the team does not have the required competencies to determine appropriate interventions, a referral may be made to a specialized health care professional outside of the team or the organization.

The information collected from the use of the clinical decision support tools is documented in the client's health record and individualized care plan. The information is shared with the client and other authorized team members in a clear and accessible format. The information is also shared during care transitions.

4.2.19.3 The team implements interventions to prevent venous thromboembolism as part of the client's individualized care plan.

Guidelines

Interventions to prevent venous thromboembolism are informed by the clinical decision support tools and the client's decisions about their care. Interventions may include

- daily strategies such as hydration, mobilization, positioning, and wearing loose-fitting clothing;
- longer-term strategies such as maintaining a healthy weight and avoiding a sedentary lifestyle;
- pharmacological thromboprophylaxis; and
- mechanical thromboprophylaxis, such as using an intermittent pneumatic device.

The timing of initiation, duration, and monitoring requirements for thromboprophylaxis interventions are specified and tailored to the characteristics of the client. Client characteristics include risk of bleeding, weight, physiological functions, and risk factors such as falls and skin integrity.

The selected interventions are documented in the client's health record and individualized care plan. The information is shared with

the client and other authorized team members in a clear and accessible format. The interventions are regularly assessed. Client progress is measured and documented. The information is also shared during care transitions.

4.2.19.4 The team follows the organization’s procedure to report health care associated venous thromboembolism as a safety incident.

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

Health care associated venous thromboembolism is when a blood clot in a vein or in the lungs is caused by a care intervention.

The organization’s procedure to report health care associated venous thromboembolism as a safety incident is aligned with evidence-informed practices and jurisdictional requirements. The procedure outlines what types of incidents need to be reported and how to report them. The procedure is simple, clear, and focused on system improvement.

Safety incidents are documented in the client’s health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization’s procedure.

Safety incidents inform the organization’s integrated quality improvement plan.

4.2.19.5 The team participates in continuous learning activities about the program to prevent venous thromboembolism.

Guidelines

Continuous learning helps the team implement safety practices to prevent venous thromboembolism. As a member of the team, the client receives information and resources that enable them to play

an active role in their care, make informed decisions, and manage their own health.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of venous thromboembolism prevention as a safety practice;
- current guidance on identifying a client's risk of venous thromboembolism and appropriate preventive strategies including pharmacological and mechanical interventions; and
- reporting health care associated venous thromboembolism incidents as safety incidents.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

The team is involved in the development and evaluation of continuous learning activities. The team is given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

4.2.19.6 The team participates in activities to improve the program to prevent venous thromboembolism as part of the organization's integrated quality improvement plan.

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback. It also includes identifying and implementing actions that improve the organization's program to prevent venous thromboembolism.

Aims, measures, and outcomes are documented in the organization's integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of documentation to assess the team's adherence to the organization's procedures to prevent venous thromboembolism;
- assessing the impact of interventions to prevent venous thromboembolism;
- root cause analysis of safety incidents related to health care associated venous thromboembolism;
- feedback from the team, including the client, on the organization's program to prevent venous thromboembolism; and
- feedback from the team, including the client, on the continuous learning opportunities provided by the organization on venous thromboembolism prevention.

The team is given time to participate in, reflect on, and share quality improvement learnings and experiences.

4.2.20 The team leadership ensures the team demonstrates the required competencies to follow organizational procedures to prevent suicide.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. 'Client' and 'patient' refer to 'resident', 'family and friends' and 'designated support person' refers to 'essential care partner', 'team leadership' and 'organizational leaders' refers to 'LTC home leaders', and 'organization' refers to 'LTC home'.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Test(s) for Compliance

4.2.20.1 The team leadership ensures the team follows organizational procedures to minimize safety risks and ensure a secure environment for all.

Guidelines

The team conducts regular safety checks of the physical environment to minimize risks to clients, designated support persons, and the workforce, regardless of the care settings. Clients and their designated support persons are involved in identifying risks and determining what needs to be done to keep themselves safe irrespective of care settings. The individualized safety plan should include client-specific measures to minimize risk.

The safety checks are conducted transparently and the results are made available to the relevant stakeholders. The team works towards the maintenance of a safe environment for all.

4.2.20.2 The team leadership ensures the team receives appropriate training and education to deliver safe suicide prevention services.

Guidelines

Training and education are fundamental to enabling a team to conduct screening, assessment and provide safety planning for suicide prevention including care planning for populations experiencing potential risk for suicide. Having the appropriate skills, behaviours and attitudes is important to deliver suicide risk assessment, appropriate interventions and postvention services.

The team is provided with culturally safe training to deliver suicide prevention and support services that match the goals, abilities, and preferences of the population they serve.

4.2.20.3 The team leadership ensures the team conducts standardized routine screening for suicide risk, using evidence-informed tools provided by the organizational leaders.

Guidelines

The team conducts suicide risk screening as an initial step to determine the need for a suicide risk assessment and intervention. It then implements the appropriate follow-up in the event of positive screens.

The information that is collected during the suicide risk screening is recorded and documented in the client record so appropriate team members can easily access the information.

The suicide risk screening tools are evidence-informed and appropriate to the care setting in which the screening is conducted. In some care settings, universal screening (i.e., screening of all clients who are in contact with the organization) may be appropriate when needing to identify those who may not have otherwise self-identified as suicidal or experiencing potential risk for suicide. However, selective screening of clients with warning signs and/or risk factors for suicide or who are in physical or mental distress may be more appropriate for other settings.

4.2.20.4 The team leadership ensures the team refers clients who screen positive for suicide risk to a person with the competencies to do a suicide risk assessment and put the necessary safety plan in place.

Guidelines

When the screening identifies a risk for suicide, the client is kept safe, a timely suicide risk assessment is conducted, and a safety plan is developed with the client. The team may refer the client to a person with the competencies, either within or outside the organization, to conduct a suicide risk assessment. The person is a competent team member who has the skills, attitudes, and behaviours to conduct the suicide risk assessment. The team follows appropriate guidelines for the referral to ensure it is timely and complete and based on the level of risk identified during the screening.

The risk of suicide is higher during transitions of care and is a possible deficiency in the delivery of safe care. When a care transition is necessary, the team ensures information relevant to the care of the client is communicated effectively. There is a potential safety risk during care transition when relevant information is not transferred appropriately.

4.2.20.5 The team leadership ensures the team develops an individualized safety plan, based on the goals, abilities and preferences of the person.

Guidelines

Based on the result of the suicide risk screening and/or assessment, the team develops an individualized safety plan for suicide prevention that:

- Includes reasons for living ("What is important to the client?")
- Is culturally safe
- Addresses imminent behaviours that can cause harm to self or others
- Includes personal warning signs
- Ensures the person is being provided with the care in the safest care setting
- Identifies the designated support person, caring contact or most relevant care provider to call in case of an emergency or when help is needed
- Provides information on accessing local crisis services
- Focuses on reducing access to lethal means (could include medication overdose, dangerous chemicals and weaponry)

The individualized safety plan is based on the needs and level of risk of the client that may include a care transition recommendation. The underlying objective of the safety plan is to ensure the ongoing support and safety of the client.

The individualized safety plan is documented and shared with the client and the appropriate team members and could be accessible to the designated support person and/or caring contact with the client's consent. The individualized safety plan includes any care transition planning. The individualized safety plan is regularly re-assessed. When possible and coherent with care-setting, in addition to safety planning, developing an intervention plan that includes the

client's goal for recovery as an integrated practice, that mitigates risks of recurring suicidal ideation.

4.3 The LTC home leaders and teams coordinate to ensure residents receive appropriate care and services when, where, and how they need it.

4.3.1 The LTC home leaders ensure the scope of services provided to residents complies with jurisdictional requirements.

Priority: **Normal Priority** | Quality Dimension: **Accessibility** | Assessment Method: **Attestation**

Guidelines

The services provided to residents in LTC homes are mandated by jurisdictional requirements. The minimum services required and funded by jurisdictions varies widely across the country.

The LTC home leaders ensure residents receive the services required by jurisdictional requirements. They also ensure the LTC home is properly staffed to deliver the required services 24 hours a day, 7 days a week. The LTC home may charge a fee for some additional or optional services.

The scope of provided services and any fees associated with additional services are clearly communicated to residents, substitute decisions makers, and essential care partners.

The LTC home leaders confirm to the governing body that the LTC home complies with jurisdictional requirements. Where there has been a gap in services, the LTC home leaders explain the reasons for the gap, how it was mitigated, and the recommended actions to be taken to prevent it from happening again.

4.3.2 The LTC home leaders ensure there is clear accountability in clinical decision-making.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

Clinical oversight ensures the clinical services provided in the LTC home are safe and of high-quality.

A clinical leader is appointed to be accountable for overseeing clinical decisions within the LTC home. The clinical leader may be a medical director, director of care, or other health care professional demonstrating the required qualifications and competencies for that role. Jurisdictional requirements may dictate the requirements to be a clinical leader.

The clinical leader oversees decisions on the services provided to residents and how they are delivered and by whom. The clinical leader's oversight responsibilities may include

- assessing when residents' needs exceed the scope of services provided within the LTC home and where external expertise is recommended;
- reviewing policies and procedures related to the provision of care;
- approving validated order sets, use of clinical decision tools, and delegated acts according to the requirements of professional regulatory bodies;
- overseeing contracts with external service providers, such as community-based pharmacies and biomedical laboratories; and
- overseeing the contracts of physicians, nurse practitioners, and other regulated health care professionals authorized to provide care in the LTC home.

The LTC home leaders communicate the clinical leader's role and responsibilities to team members.

4.3.3 The LTC home leaders establish formal agreements with external health service providers.

Priority: **Normal Priority** | Quality Dimension: **Population Focus** | Assessment Method: **Attestation**

Guidelines

Meeting the full spectrum of residents' needs often requires coordination with service providers outside the LTC home. External service providers may include community-based pharmacies, health care professionals, clinics in the community, hospitals, and organizations providing diagnostic services.

The LTC home leaders identify the required partnerships and put in place formal agreements with external service providers that comply with any jurisdictional requirements. The agreements stipulate the services that will be provided to ensure residents receive the right care, by the right people, at the right time. Through these agreements, the LTC home leaders hold the service providers accountable for the quality of the services they provide and confirm their willingness to collaborate on quality improvement initiatives.

4.3.4 The LTC home leaders provide teams with a policy and procedures for the appropriate delivery of virtual health services.

Priority: **Normal Priority** | Quality Dimension: **Accessibility** | Assessment Method: **Attestation**

Guidelines

Virtual health services can be provided through a variety of ways, such as voice, text, or video conferencing, and can extend to applications residents may have on their devices that promote self-management. When used appropriately, virtual health services can significantly relieve some of the challenges that residents experience with receiving in-person care, such as travelling to appointments.

The LTC home leaders ensure a policy and procedures that support virtual health services are part of the LTC home's strategy for delivering care. Virtual health services are offered when appropriate and are supported with adequate resources, including

- information to help residents and substitute decision makers understand whether and how to receive virtual health services and their related rights and responsibilities;
- equipment to support the delivery of virtual health services, such as communication devices;
- procedures to facilitate residents' access to virtual health services in the LTC home; and
- service agreements between the LTC home and providers delivering virtual health services where appropriate.

An appropriate team member accompanies the resident during a virtual care encounter when required.

When virtual care is offered, it is offered with the same standards of care as in-person care. Confidentiality is protected, continuity of care is ensured, and documentation requirements in the resident's health record are upheld.

4.3.5 The LTC home leaders facilitate residents' access to non-medical services.

Priority: **Normal Priority** | Quality Dimension: **Accessibility** | Assessment Method: **On-site**

Guidelines

Residents may need support in accessing non-medical services, such as banking or legal services. Facilitating residents' access to these services helps them accomplish their daily life activities and promotes their autonomy.

The LTC home leaders engage with residents and substitute decision makers to identify how best to support them in accessing the non-medical services residents need.

Access to non-medical services is coordinated in ways that are most helpful to residents, including access to in- person or virtual services. For example, some residents might require accessible transportation to an appointment, while others might need to be accompanied by a team member. Some residents who require legal services might benefit from referrals to local bar associations and law societies for additional information.

4.3.6 The team follows the LTC home's procedure to provide the resident with a timely referral to an appropriate health care professional.

Priority: **Normal Priority** | Quality Dimension: **Accessibility** | Assessment Method: **On-site**

Guidelines

Knowing when to ask for help empowers the team to respond in a timely way to changes in the resident's needs. Evidence-informed criteria guide the team, indicating when to trigger a referral to another health care professional or service provider for additional assessment or care.

Efforts are made to ensure the required care will be provided in the most appropriate care setting by the most appropriate team. Examples include urgent care provided in an emergency department, rehabilitation care provided in an

outpatient setting or the LTC home, and planned care, such as dental care, provided in a community clinic.

The team follows the LTC home's procedure to trigger a referral to an appropriate health care professional in a timely way. The procedure uses established criteria to determine when additional expertise is needed, such as to conduct an assessment, request additional care, or provide care in a different care setting.

The team documents the referral and the circumstance that triggered it in the resident's health record and the individualized care plan. The information is shared with appropriate team members.

4.3.7 The team follows the LTC home's procedure to provide the resident with timely access to appropriate health care professionals outside the LTC home.

Priority: **High Priority** | Quality Dimension: **Accessibility** | Assessment Method: **On-site**

Guidelines

The resident's needs are assessed on admission and on an ongoing basis. If the resident's physical or mental health needs fall outside the scope, expertise, or resources of the LTC home, the team facilitates access to external health care.

The team follows the LTC home's procedure to coordinate timely and safe access to external health care. Services can be provided either on-site at the LTC home or off-site at the service provider's location.

Timeliness means that the resident's access to care reflects the urgency of their needs. For example, if the resident falls and injures themself, urgent care is required. Other care, such as a consultation with a specialist for an opinion, can be planned and delivered at a scheduled time. In cases where external health care has been scheduled, the team takes a judicious approach and considers whether the appointment is required or could be provided through alternative methods such as virtual care.

After the resident has received the external health care, the team documents any changes in the resident's health record and individualized care plan. The information is shared with appropriate team members.

4.3.8 The LTC home leaders enable the delivery of end-of-life care.

Priority: **High Priority** | Quality Dimension: **Accessibility** | Assessment Method: **On-site**

Guidelines

A palliative approach to care aims to relieve suffering and improve the quality of living over a continuum that includes end-of-life care. End-of-life care requires ongoing assessment and adjustments in a resident's individualized care plan to address disease management; physical, psychological, social, spiritual, and practical needs; loss and grief; pain management and palliative sedation; and ongoing emotional and psychosocial support to the resident, substitute decision maker, and essential care partners.

When providing end-of-life care, the team has the qualifications and competencies needed to provide end-of-life care 24 hours a day.

The LTC home leaders have an obligation to inform residents, substitute decision makers, and essential care partners of the palliative services offered by the LTC home, including end-of-life care. Should the LTC home not be able to provide end-of-life care, every effort is made to develop service agreements with external services that can provide end-of-life care within the LTC home. Community hospice programs that provide respite to loved ones during this time can be helpful.

4.3.9 Information relevant to the care of the client is communicated effectively during care transitions.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. ‘Client’ and ‘patient’ refer to ‘resident’, ‘family and friends’ and ‘designated support person’ refers to ‘essential care partner’, ‘team leadership’ and ‘organizational leaders’ refers to ‘LTC home leaders’, and ‘organization’ refers to ‘LTC home’.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

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

Information relevant to the care of the client will depend on the nature of the care transition. It usually includes, at minimum, the client's full name and other identifiers, contact information for responsible providers, reason for transition, safety concerns, and client 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 clients and families to repeat information. Clients and families need information to prepare for and improve care transitions; this may include written information or instructions, action plans, goals, signs or symptoms of declining health status, and contact information for the team.

Test(s) for Compliance

4.3.9.1 The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.

4.3.9.2 Documentation tools and communication strategies are used to standardize information transfer at care transitions.

4.3.9.3 During care transitions, clients and families are given information that they need to make decisions and support their own care.

4.3.9.4 Information shared at care transitions is documented.

4.3.9.5 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 client records) to measure compliance with standardized processes and the quality of information transfer

- Asking clients, families, and service providers if they received the information they needed

- Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).

4.3.10 The team designates a team member to coordinate the resident's care before, during, and after a consultation with a health care professional outside the LTC home.

Priority: **Normal Priority** | Quality Dimension: **Continuity of Services** | Assessment Method: **On-site**

Guidelines

The resident will often have planned or unplanned appointments with health care professionals outside the LTC home, such as with a dentist, optometrist, or medical specialist. Coordination ensures the resident receives seamless care.

The team selects the team member responsible for planning the resident's consultation and coordinating their care. The designated team member considers the resident's transportation needs, such as a taxi or adapted transportation, and whether they recommend that the resident be accompanied to the consultation.

The designated team member also identifies the equipment, supplies, and information needed to support the resident and enable the external health professional to provide high-quality care, such as

- the resident's health record and individualized care plan or summary, including their medication profile and other relevant information, such as whether the resident has a nothing-by-mouth (NPO) order;
- the resident's required medications;
- the resident's mobility aids;
- the resident's assistive devices to enhance good communication; and
- a small amount of food or meal.

The selected team member ensures there is no lapse in care and that the resident is engaged throughout the process. The selected team member also clarifies any recommendations or orders made by the consulting health care professional.

4.3.11 The team follows the LTC home's procedure to facilitate medical transportation when required for the resident to access external care.

Priority: **Normal Priority** | Quality Dimension: **Continuity of Services** | Assessment Method: **On-site**

Guidelines

Residents may require emergency or non-emergency medical transportation to access external care.

The team follows the LTC home's procedure to arrange for medical transportation and ensures the resident is cared for throughout the process. The procedure includes discussions with the resident; the person managing their finances, if any, should there be a cost; and if the resident is incapable, their substitute decision maker to coordinate appropriate transportation for the resident depending on the external care required, the resident's status, and the location of the external service provider.

The procedure also involves gathering the medication, equipment, supplies, and any relevant information needed to enable the external service provider to provide high-quality care, such as

- the resident's health record and individualized care plan or summary, including their medication profile and other relevant information, such as whether the resident has a nothing-by-mouth order;
- the resident's required medications;
- the resident's mobility aids; and
- the resident's assistive devices to enhance good communication.

4.3.12 The team follows the LTC home's procedure for admitting, transferring, and discharging the resident.

Priority: **High Priority** | Quality Dimension: **Continuity of Services** | Assessment Method: **On-site**

Guidelines

An established procedure for admitting, transferring, and discharging residents helps to ensure a smooth and seamless experience for residents throughout

these processes. The procedure also supports consistent data collection and continuous improvement in the LTC home.

The procedure includes steps to

- prepare the resident with the appropriate information for their admission to the LTC home;
- ensure the resident transfers from one care provider to another safely and seamlessly;
- prepare the resident for discharge and, in the event of death, communicate the death to the resident's substitute decision maker and essential care partners, offer condolences, and provide appropriate support to help them carry out their responsibilities; and
- document all socio-demographic information in the appropriate information system.

Data collected during admission, transfer, and discharge may be used to assess the LTC home's efficiencies and identify opportunities to improve productivity and access to care.

Chapter 5: Enabling a Healthy and Competent Workforce

This chapter focuses on how LTC home leaders enable team-based care by providing supportive working conditions, that promote a healthy and competent workforce. A healthy and competent workforce is key to providing safe, high-quality resident care. Themes include skill mix of the workforce; providing proper training on care practices, use of health care equipment and information and communication technology and collecting information on the workforce that includes workforce experience data.

5.1 The LTC home leaders enable competent teams, provide supportive working conditions, and ensure the health and safety of the LTC home's workforce.

5.1.1 The LTC home leaders demonstrate that the number and skill mix of the workforce is evidence informed to enable team-based care.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

Meeting the needs of residents 24 hours a day, 7 days a week requires the right competencies and the right number of people on the team at the right time. Proper staffing supports workforce well-being, resident quality of life, and safe, high-quality care.

The LTC home leaders demonstrate that the number and skill mix of the workforce, including the leadership team, is evidence informed to enable team-based care. The LTC home leaders plan staffing based on the following considerations:

- **Staffing mix**. The LTC home leaders identify the required mix of roles, skills, behaviours, and attitudes to provide high-quality care. They ensure the workforce has the proper qualifications to provide care based on their role.
- **Staffing ratios**. The LTC home leaders establish the required number and qualifications of workforce members to respond to residents' needs. The

composition of workforce members on the team reflects the number of residents being cared for and their care needs.

- **Staffing levels**. The LTC home leaders ensure they adapt the number of workforce members working at any one time to sufficiently meet the changing care needs of the residents and the required operations of the LTC home at different times of the day.

Jurisdictional authorities and regulatory bodies may also set minimum staffing requirements for LTC homes, which the LTC leaders must meet.

The average required hours of direct care per resident day will vary depending on the LTC home's resident population, the complexity of their needs, and workforce composition. Evidence indicates that LTC home residents require a minimum of 4.1 hours of direct care per day. Higher staffing levels improve quality of care, especially as residents' care needs become more complex.

The LTC home leaders collect data on workforce composition. They consider the workforce's qualifications and characteristics; full-time, part-time, and casual employment numbers; and the LTC home's work environment.

The LTC home leaders ensure conditions enable workforce members to work to their full scope of practice in carrying out team-based care.

5.1.2 The LTC home leaders ensure the workforce has the appropriate training before using standardized templates and tools for comprehensive needs assessments and individualized care plans.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **On-site**

Guidelines

Workforce training is essential to providing high-quality, resident-centred care, which contributes to residents' quality of life.

The LTC home leaders ensure appropriate training is provided during orientation and ongoing training is provided regularly to keep the workforce's skills and knowledge up to date. Training includes the following topics:

- **Templates and tools**. The workforce understands why the templates and tools are used, what information they collect, how they are used, when they are used, and how they are adapted to promote a resident's active participation.

- **Assessment techniques**. The workforce has the skills to use assessment techniques that recognize a resident's abilities to actively participate in the assessment process. Examples of assessment techniques include direct observation, active engagement, and reflective listening.

- **Communication techniques**. The workforce develops a range of techniques and skills to communicate effectively with residents, who have diverse needs and vary in their own ability to communicate.

- **Care planning**. The workforce understands the care planning process, including how to develop, use, and revise an individualized care plan.

- **Documentation**. The workforce understands the importance of proper documentation of residents' needs and care plans to ensure seamless care is provided to residents and relevant information is shared with appropriate team members.

5.1.3 The LTC home leaders ensure the workforce has access to ongoing training on safety practices.

Priority: **High Priority** | Quality Dimension: **Worklife** | Assessment Method: **On-site**

<u>Guidelines</u>

Ongoing training on safety practices benefits both the workforce and residents. It safeguards the workforce and residents from harm, promotes health and well-being, and provides workforce members with the competencies they need to provide high-quality, resident-centred, team-based care.

LTC home leaders ensure the workforce receives regular and up-to-date training to embed safety practices in care and daily life activities. Training topics include how to

- transfer and mobilize residents safely;

- prevent and respond promptly to safety incidents;

- prevent and manage responsive behaviours;

- implement infection prevention and control measures;

- handle food safely and provide safe, resident-centred assistance with eating;
- participate in emergency preparedness and response activities; and
- apply a least-restraint approach to care.

Training is provided in various ways to engage workforce members with different educational backgrounds, abilities, and learning styles. Examples include in-person training and simulation sessions, online instruction and webinars, written materials and infographics, reflective practice, and mentorship initiatives.

New members of the workforce require orientation, mentorship, and support on safety practices. Some education and training is mandatory to comply with jurisdictional or regulatory requirements.

Residents are invited to participate in ongoing workforce training by sharing lived experiences that will contribute to improving safety practices.

5.1.4 The LTC home leaders ensure the workforce has access to continuous learning activities to support ongoing learning and career development.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

In addition to orientation and ongoing training on safety practices, continuous learning activities help workforce members develop the skills and knowledge they need to provide high-quality care. These activities also enhance the workforce's confidence and satisfaction, improve recruitment and retention, and create the potential for career advancement.

Workforce members are provided with access to continuous learning activities on topics such as resident-centred and relational care, culturally safe care, trauma-informed care, team-based care, and meeting specific care needs of residents in the LTC home.

The LTC home leaders demonstrate support for continuous learning activities. They create opportunities for each member of the workforce to pursue learning activities that align with the LTC home's mission and values, residents' needs, and the workforce member's role and plans for development. Examples include asking a member of the workforce to

- lead a change to improve the delivery of care,
- champion the implementation of new health care equipment,
- provide in-service training (with peer support),
- act as a peer mentor, or
- participate in external learning opportunities.

Workforce members have the opportunity and time to participate in continuous learning activities during working hours. When possible, incentives are provided to promote participation, such as financial support toward course fees, paid leave to pursue training, and recognition upon earning a certification.

Performance management programs recognize the continuous learning activities undertaken by workforce members and identify opportunities for future development.

5.1.5 The LTC home leaders have effective strategies for recruitment and retention.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

Recruitment and retention strategies help ensure the LTC home is adequately staffed and workforce members feel valued, respected, and recognized for providing high-quality care.

As the LTC home leaders implement the human resources plan, they consider focusing on one or a few retention and recruitment strategies. For example, the LTC home leaders prioritize current strategies that

- integrate the principles of equity, diversity, and inclusion and cultural safety and humility;
- support the transitions of workforce members as they join and orient themselves to a new LTC home;
- ensure equitable, adequate, and competitive compensation and benefits, subject to terms set by jurisdictional authorities and collective agreements;

- provide opportunities for full-time employment;
- provide education, training, and continuous learning opportunities;
- involve the workforce in scheduling work and making decisions about overtime;
- promote work–life balance and leave policies that enable well-being and minimize the risk of burnout; and
- recognize the contributions of the workforce in formal and informal ways.

5.1.6 The LTC home leaders have procedures in place to mitigate understaffing.

Priority: **High Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

An LTC home may be understaffed due to anticipated events, such as vacation or maternity leave, or unforeseen events, such as weather conditions or illness. Understaffing leads to excessive overtime, fatigue and other negative health effects, and higher rates of workforce turnover. It also results in lower-quality resident care and can lead to higher rates of injury and harm among the workforce and residents.

The staffing plan includes strategies to avoid understaffing, mitigate risks, and improve the LTC home's resilience to unplanned events. The staffing plan includes the following elements:

- **Minimum thresholds**. The staffing plan identifies the minimum number of workforce members and the qualifications required in all areas of the LTC home at any given time to provide safe care.
- **Required response**. The staffing plan describes how the workforce should implement an escalating response when the minimum thresholds are not met. The plan includes a procedure for when and how to notify residents, substitute decision makers, and essential care partners when the LTC home is understaffed, as well as alerting jurisdictional authorities as required.
- **Contingency plans**. The staffing plan outlines steps for maintaining an internal staffing pool for short- term or on-call employment and establishing a pool of qualified and experienced external staff. The LTC

home leaders ensure all external staff have the training they need before providing care for residents. A contingency plan also anticipates how services may need to be temporarily reduced or modified to cope with staffing shortages.

The LTC home leaders review the staffing plan with the workforce at least once a year.

5.1.7 The LTC home leaders follow the LTC home's occupational health and safety policy and procedures.

Priority: **High Priority** | Quality Dimension: **Worklife** | Assessment Method: **On-site**

Guidelines

The occupational health and safety of the workforce is key to providing high-quality care. Upholding an occupational health and safety policy and procedures and establishing workforce wellness programs safeguards the workforce from accidents, illness, and physical and psychological injuries.

The LTC home leaders collaborate with the workforce to develop, implement, and maintain a policy and procedures that support a safe and healthy working environment. The policy and procedures

- involve routine assessment and develop strategies to address risks and hazards to the workforce in the LTC home;
- establish and promote an immunization program for the workforce;
- support a barrier-free environment;
- address the psychological health and well-being of the workforce;
- reflect trauma-informed approaches;
- promote a culture of psychological safety;
- address violence, harassment, and microaggressions;
- promote timely and transparent reporting of risks, accidents, illnesses, and injuries;
- protect the confidentiality of those who raise concerns;

- include whistleblower protection strategies; and
- comply with jurisdictional requirements.

The policy and procedures are available to all workforce members and are supported with ongoing training. They are used to encourage a learning and continuous quality improvement culture throughout the LTC home.

The LTC home leaders enable the active participation of the workforce in the joint occupational health and safety committee. The committee regularly monitors workplace health and safety indicators and shares the results with the workforce.

5.1.8 The LTC home leaders ensure the workforce has access to wellness programs.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

Workforce members in LTC homes experience excessive work pressure, heavy workloads, understaffing, and higher rates of workplace harassment and physical injury than in other workplaces. Investing in the well-being of the workforce helps to mitigate the effects of these conditions and can improve the LTC home's culture, workforce retention, and productivity.

The LTC home leaders collaborate with the workforce to provide access to programs, activities, and spaces within or outside the LTC home that meet the workforce's specific needs for improving well-being. Activities vary to respond to the workforce's preferences. Examples include

- fitness, mindfulness, and meditation sessions;
- smoking cessation programs and other public health programs;
- employee assistance programs offering confidential mental health support for stress, addictions, and grief;
- space such as dedicated quiet rooms and change rooms for workforce members; and
- outdoor space and activities dedicated to the workforce.

5.1.9 The LTC home leaders follow the LTC home's policy and procedures to address claims that the rights of the workforce have been violated.

Priority: **High Priority** | Quality Dimension: **Worklife** | Assessment Method: **On-site**

Guidelines

All workforce members have the right to a workplace free of prejudice, discrimination, racism, harassment, abuse, and violence of any kind. An equitable and safe work environment supports a healthy and engaged workforce, improves workforce retention, and contributes to high-quality care.

The LTC home leaders commit to providing an equitable and safe work environment as part of the human resources plan. They promote an environment where everyone feels comfortable and safe raising concerns or issues.

The LTC home leaders collaborate with the workforce to develop and follow a policy and procedures that

- establish the rights of the workforce to a safe and equitable workplace;
- describe what constitutes a violation of rights, such as experiencing racism, discrimination, harassment, or abuse;
- outline clear steps for reporting incidents safely and confidentially;
- explain the process for addressing the claim and communicating its outcomes;
- protect those making a claim from negative consequences;
- ensure claims are addressed in a timely manner; and
- comply with jurisdictional requirements and collective agreements.

The policy and procedures are regularly updated and easily accessible to all workforce members. Ongoing information and training sessions are provided as well.

5.1.10 The LTC home leaders address the workforce's concerns in a timely manner.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **On-site**

<u>Guidelines</u>

Acknowledging and acting on concerns from the workforce in a timely manner contributes to a safe work environment and upholds continuous quality improvement practices.

Concerns may relate to inadequate supplies, unsafe equipment, challenges in caring for a resident, or other issues. Concerns can be communicated verbally or in writing. The LTC home leaders ensure a timely response to all workforce concerns.

The LTC home leaders ensure that processes regarding concerns are well communicated and followed. For example, LTC home leaders can make information about the process available through regular conversations with the workforce and dedicated time during team meetings.

Should a concern be considered a claim of a violation of rights, LTC home leaders and teams follow the policy and procedures pertaining to violation of rights.

5.1.11 The LTC home leaders establish effective communication strategies to support active engagement with the workforce.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **On-site**

<u>Guidelines</u>

Communicating effectively with the workforce increases workforce engagement, supports a team-based approach to care, and enables high-quality care.

The LTC home leaders establish effective communication strategies. They are readily available to the workforce and communicate with them in a positive, clear, respectful, and transparent way. They promote timely, respectful, two-way communication and sharing of information.

The LTC home leaders use standardized communication procedures and tools to share information, including information about the LTC home, its organizational structure and policies, organizational decisions, plans for change, training, and opportunities for continuous learning. Communications are provided in clear language, in a format that all workforce members can easily access and understand. The LTC home leaders continuously adapt the communication strategies based on the feedback received by the workforce.

5.2 The LTC home leaders provide health care equipment and information and communication technology to improve working conditions and support the provision of high-quality, resident-centred care.

5.2.1 The LTC home leaders ensure the workforce has access to appropriate health care equipment that enables the delivery of high-quality care.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

<u>Guidelines</u>

Health care equipment, such as lifts for resident transfers and grab bars, can help the workforce provide high-quality care by assisting residents with accomplishing their daily life activities safely, efficiently, and comfortably. Health care equipment, used correctly, prevents workforce injury and stress.

The LTC home leaders invest in up-to-date health care equipment that meets the needs of the workforce to provide safe care. Health care equipment is chosen based on evidence supporting its safety and effectiveness and with the input of the workforce and residents.

Procurement processes are in place to assess the criticality and added value of the health care equipment, the knowledge and skills needed to operate and clean it, and the requirements to comply with occupational health and safety practices.

5.2.2 The LTC home leaders ensure the workforce has access to evidence-informed information and communication technology that supports the delivery of high-quality care.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

<u>Guidelines</u>

Evidence-informed information and communication technology enhances communication among workforce members and supports them in providing high-quality, resident-centred care.

Supportive information and communication technologies include telephones, video phones, computers, call systems, safety devices, security monitoring equipment, digital devices for documentation, and tools for conducting ongoing clinical assessments. Some of these technologies are equipped with sound amplification, larger fonts, and assistive programming capabilities to meet

residents' needs. The technologies are used to support social interactions and share information such as clinical assessments, care planning, laboratory and imaging data, and resource allocation.

The LTC home leaders collaborate with the workforce to co-design and maintain an information and communication technology strategy. Workforce members help to assess the risks and benefits of each technology and choose the most appropriate technology that will enable the delivery of high-quality care.

Procedures are in place to minimize the potential for data breaches and ensure system backups. Contingency plans, such as reverting to paper records, are in place to avoid loss of information should the technology fail.

The LTC home leaders promote the use of selected technologies to enable safe and high-quality care. They provide ongoing training on the use of the technologies, related security measures, and how to protect the privacy and confidentiality of information.

5.2.3 The LTC home leaders ensure the workforce has received the appropriate training before using new health care equipment and information and communication technologies.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Training on how to safely use new health care equipment and information and communication technologies safeguards the workforce and residents from harm during care and daily life activities.

The LTC home leaders ensure the workforce has the opportunity and dedicated time to undertake training on new health care equipment and information and communication technologies, such as a new call system. Targeted training for appropriate workforce members is planned and structured to be clear and understandable.

The workforce has ongoing access to information and training on health care equipment and information and communication technologies to ensure their knowledge and skills remain current. Examples include regular training for use of lifts, donning and doffing of personal protective equipment, and documentation in a clinical information system. Spot audits, coaching, and peer support help to

ensure the workforce maintains the required skills and has access to proper resources.

5.2.4 A preventive maintenance program for medical devices, medical equipment, and medical technology is implemented.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. 'Client' and 'patient' refer to 'resident', 'family and friends' and 'designated support person' refers to 'essential care partner', 'team leadership' and 'organizational leaders' refers to 'LTC home leaders', and 'organization' refers to 'LTC home'.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

An effective preventive maintenance program helps ensure medical devices, medical equipment, and medical technology are safe and functional. It also helps identify and address potential problems with medical devices, medical equipment, or medical technology that may result in injury to team members or clients.

Test(s) for Compliance

5.2.4.1 There is a preventive maintenance program for all medical devices, medical equipment, and medical technology.

5.2.4.2 There are documented preventive maintenance reports.

5.2.4.3 There is a process to evaluate the effectiveness of the preventive maintenance program.

5.2.4.4 There is documented follow up related to investigating incidents and problems involving medical devices, equipment, and technology.

5.3 The LTC home leaders ensure that data on the LTC home's workforce are collected, analyzed, reported, and used to understand workforce needs, create staffing plans, and allocate resources.

5.3.1 The LTC home leaders invest in the required resources to collect workforce data to support improvements to working conditions.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

Collecting high-quality data on the workforce provides the LTC home leaders with valuable insights and evidence to respond to the needs of the workforce. Data can be used to address disparities and vulnerabilities among the workforce and to inform human resources policies, staffing and service plans, occupational health and safety practices, and recruitment and training activities.

The LTC home leaders invest in the people, systems, and processes needed to collect, analyze, use, and, as appropriate, share information about the workforce. Data collected may include

- self-reported socio-demographic data, such as race, ethnicity, religion, spirituality, language, ability, and gender;
- employment status, including self-reported information about employment at other LTC homes;
- hours scheduled and worked, including overtime hours;
- sick and leave time;
- vacation time used and outstanding;
- turnover rates; and
- incidence of workplace injury.

Data collection systems are secured and protect the privacy and confidentiality of the workforce. Data are aggregated and information is communicated accurately and intentionally.

Information is reported to the governing body and jurisdictional authorities as required.

5.3.2 The LTC home leaders ensure socio-demographic workforce data are collected to support improvements to working conditions.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

Collecting socio-demographic data on the workforce can provide the LTC home leaders with insights and evidence to mitigate the stressors that can compromise the workforce's health and well-being. These data can also be used to inform policies, procedures, and practices that integrate the principles of equity, diversity, and inclusion.

The LTC home leaders collect self-reported socio-demographic data about the workforce. They clearly communicate to the workforce what socio-demographic data are required and what data may be provided on a voluntary basis. All socio-demographic data are collected and safeguarded to protect the privacy and confidentiality of the workforce.

Data may include race, ethnicity, religion, spirituality, language, education, ability, and gender. The LTC home leaders use these data to improve working conditions. For example, communication practices and training exercises may be adapted to share some information in more culturally safe and appropriate ways.

5.3.3 The LTC home leaders ensure retention indicators are collected to better understand workforce engagement and turnover.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

Retention indicators such as workforce injuries, illnesses, absences, rights violations, turnover, and results from workforce experience surveys and exit interviews can signal workforce stressors, influence staffing levels and hiring decisions, and highlight the need to improve health and safety of the workforce.

The LTC home leaders ensure that information on retention indicators is collected, monitored, and analyzed. The information from these indicators is used to inform and improve the human resources plan, implement workforce wellness programs, and address the risks and factors that are impeding the health and safety of the workforce.

5.3.4 The LTC home leaders ensure workforce experience surveys are administered at least annually.

Priority: **Normal Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

Workforce experience reflects the workforce's well-being, their work environment, and their perception of the quality and safety of care. Inviting open feedback from the workforce enables the LTC home leaders to better understand the perspectives of workforce members. It also provides information that can lead to improvements in the working conditions and the quality and safety of care.

The LTC home leaders have the tools and resources to administer at least one self-reported workforce experience survey annually. They collaborate with the workforce to plan, administer, and communicate the outcomes of the survey. Ongoing and sustained efforts are often needed to achieve high levels of participation in surveys.

The surveys are simple to administer, easy to understand, provided in the language of choice, and sensitive to the cultural diversity of the workforce. Survey topics may explore experiences related to safety and security, work–life balance, continuous learning, recognition, support from leadership, and overall well-being and engagement.

Data collection, analysis, and reporting of the workforce experience survey are completed by people who have the required competencies. Collected data are anonymized and privacy and confidentiality measures are respected.

The results of the workforce experience survey are communicated to the workforce, LTC home leaders, and the governing body in a timely manner, in a format that is clear and accessible. The results are used to support continuous quality improvement.

Chapter 6: Enabling Infection and Prevention Control Practices

This chapter focuses on enabling infection and prevention control practices in LTC homes to reduce the transmission of infections to keep residents and the workforce safe and healthy. LTC homes have an infection prevention and control program in place that is aligned with public health requirements. The program supports the adherence to routine hand hygiene practices; proper use of personal protective equipment (PPE) based on a risk assessment at point of need; evidence informed procedures for cleaning and disinfection of the physical environment and medical equipment; and having procedures in place for the management of outbreaks.

6.1 The LTC homes leaders and teams follow evidence informed infection and prevention control practices to ensure the health and safety of residents and the workforce.

6.1.1 The LTC home leaders use evidence-informed practices to develop the infection prevention and control program.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

<u>Guidelines</u>

An infection prevention and control program in the LTC home is essential for safeguarding the health of all. It involves a comprehensive approach to prevent, identify, and manage infections, that ensures a safe environment.

Core components of an infection prevention and control program can include:

- evidence informed procedures and clinical decision tools on routine infection prevention and control practices;
- proper cleaning and disinfection procedures of the physical environment and medical equipment;
- appropriate education and training based on the team members roles and responsibilities;

- a surveillance program to mitigate outbreaks and antimicrobial resistance; and
- ongoing monitoring, audit, and feedback activities.

LTC homes are encouraged to review their infection prevention and control program on an annual basis to ensure any new knowledge is incorporated. Updates to specific infection prevention and control practices are important for a program to remain current and relevant.

Relevant information can be found on the World Health Organization (WHO) and jurisdictional public health websites, as well as infection prevention and control associations and societies that advocate for evidence-informed practices.

Evidence to support assessment of this criterion includes documentation of the LTC home's infection prevention and control program.

6.1.2 The LTC home leaders collaborate with the public health department on sharing all relevant information that can impact their respective service offerings related to infection prevention and control, according to jurisdictional legislation.

Priority: **Normal Priority** | Quality Dimension: **Population Focus** | Assessment Method: **On-site**

Guidelines

The general mandate of public health organizations is to protect the health of populations. They have the responsibility (under jurisdictional legislation) to detect, prevent and respond to transmission of pathogens and infectious diseases at the population level. Information regarding the health status of the community, the ongoing risk of communicable diseases (surveillance), ensuring regulations and expected infection prevention and control practices are communicated by public health to the LTC home leaders responsible for the infection prevention and control program.

The sharing of timely information between the LTC home and public health teams is critical for outbreak management both within the LTC home and in the community. Relevant information shared can include outbreaks, laboratory confirmed cases of notifiable diseases and relevant information from a surveillance program such as the prevalence of antimicrobial resistance organisms. Timely and accurate reporting to public health enables teams to implement appropriate interventions that will ultimately protect the health and wellbeing of residents, the workforce, and the community.

Engagement with public health subject matter experts can include collaboration, where advice is sought and considered in any recommendations or decisions about the LTC home's infection prevention and control program.

Relevant information can be found on jurisdictional public health websites.

6.1.3 The LTC home leaders provide a defined procedure to ensure timely access to a microbiology laboratory that offers expertise to the LTC home about identifying health care-associated infections.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

Timeliness of screening and testing for infectious diseases has direct impact on enabling the LTC home to provide resident-centred care and services. A structured approach with defined procedures that are shared by both the LTC home and its identified biomedical laboratory, is critical for decision making. Type of screening and required testing is often defined in public health procedures and jurisdictional requirements. The procedures should include preanalytical evidence informed guidelines including storage of specimen and transportation; and timely communication of laboratory results to inform proper decision making.

A mechanism for validating the quality of the services provided by the biomedical laboratory is in place.

Contracts and supporting quality assurance reports are provided to the LTC home leaders responsible for the infection prevention and control program.

6.1.4 Teams are required to participate in the infection prevention and control education program at orientation and on a regular basis based on their roles and responsibilities.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **Attestation**

Guidelines

Education programs help teams understand the importance of an infection prevention and control program and how it contributes to keeping people safe in LTC homes. Education programs cover proper hand hygiene practices, proper use of PPE, sharps management and mitigating risks of outbreaks. Orientation

sessions and regular refreshers keep team members informed and competent in evidence informed practices.

Ongoing education is based on the identified needs of teams. The learnings are provided in various ways to engage teams with different educational backgrounds, abilities, and learning styles.

Examples include in-person training and simulation sessions, online instruction and webinars, written materials and infographics, reflective practice, and mentorship initiatives. Evidence that will demonstrate compliance includes attendance records, evaluation of practices, and decreased infection rates.

6.1.5 Teams ensure that residents, essential care partners and visitors are provided with information about routine practices and additional precautions as appropriate in a format that is easy to understand.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Residents, essential care partners, and visitors need to be actively engaged in infection prevention and control practices to promote a safe and healthy LTC environment for all.

Educating people on why infection prevention and control practices are relevant is motivating and make them more accountable to follow routine practices and additional precautions. The information provided includes proper hand and respiratory hygiene practices, use of appropriate PPE and relevant actions needed during outbreak management.

The education tools and content are provided in a format that respects health literacy principles. Written materials may be available in a variety of languages depending on the populations served. They are written in simple language and may include visual aids to improve understanding.

Relevant information to support educational activities can be found on the WHO, public health, and infection prevention and control quality improvement websites.

6.1.6 The LTC home leaders ensure team members have access to alcohol-based hand rubs at the point of need.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Having the appropriate equipment and supplies for hand hygiene practices at the point of need enables hand hygiene practices to be performed by all people throughout the LTC home including all entrances to the building. Having the equipment and supplies visible, accessible, and the presence of visual aids will also promote routine hand hygiene practices.

In certain circumstances, based on the resident population and setting, the use and positioning of alcohol-based hand rubs and supplies may need to be modified to ensure the safety of the residents.

Methods to support assessment of this criterion include documentation review, as well as observational activities.

6.1.7 The organizational leaders are accountable to demonstrate improvement in hand hygiene practices as part of the organization's infection prevention and control program.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. 'Client' and 'patient' refer to 'resident', 'family and friends' and 'designated support person' refers to 'essential care partner', 'team leadership' and 'organizational leaders' refers to 'LTC home leaders', and 'organization' refers to 'LTC home'.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Test(s) of Compliances

6.1.7.1 The organizational leaders define an aim for improving hand hygiene practices.

Guidelines

Hand hygiene can significantly reduce the risk of transmission of infections and enhance client and workforce safety when performed correctly and consistently.

A clear and measurable aim to improve hand hygiene practices for the organization is defined and documented in the hand hygiene quality improvement plan. The aim is a statement that is focused on

the outcome and articulates the targeted improvement over a specified time frame.

The aim takes into consideration improving hand hygiene practices in all care, administrative, and public settings across the organization.

The aim is defined collaboratively with partners and informed by baseline data on hand hygiene compliance.

6.1.7.2 The organizational leaders invest in resources to improve hand hygiene practices.

Guidelines

Investing in resources demonstrates commitment to improvement and supports the achievement of the hand hygiene aim.

Resources include people, finances, infrastructure, equipment, and information.

The resources needed to support the improvement of hand hygiene practices will depend on the defined aim. Examples of resources include

- a person or team that has the responsibility and protected time to improve the organization's hand hygiene practices;
- infrastructure to support hand hygiene practices, including accessible equipment such as sinks and dispensers, and just-in-time supplies such as alcohol-based hand rub, soap, and paper towels; and
- an established methodology for collecting and analyzing data on hand hygiene compliance such as direct observation or electronic monitoring systems.

6.1.7.3 The organizational leaders ensure that a hand hygiene quality improvement plan is developed.

Guidelines

A quality improvement plan provides essential information about how hand hygiene improvement activities will be implemented, managed, and evaluated.

Activities to improve hand hygiene practices require a multi-faceted and multidisciplinary approach that is tailored to the setting and populations served.

Examples of hand hygiene improvement activities include

- innovative approaches to quickly identifying where supplies are needed such as visual indicator tags or quick response (QR) codes;
- just-in-time supplies such as alcohol-based hand rub, soap, and paper towels;
- multimodal continuous learning activities for teams that are developed in collaboration with clients, designated support persons, visitors, and external partners on the importance of hand hygiene and correct techniques;
- innovative approaches for hand hygiene auditing such as electronic monitoring systems; and
- multimodal performance feedback such as on-the-spot feedback, team huddles, visual displays, and electronic dashboards.

For each of the selected activities, the person or team responsible and allocated resources are identified and documented in the hand hygiene quality improvement plan.

6.1.7.4 The organizational leaders monitor hand hygiene improvement activities over time based on identified indicators.

Guidelines

The systematic collection and analysis of qualitative and quantitative indicators enables organizational leaders to ensure resources for improving hand hygiene practices are allocated properly and activities are achieving results.

Indicators are selected according to the hand hygiene improvement activities and may include

- structural indicators relating to hand hygiene infrastructure and the availability of hand hygiene supplies and equipment such as sinks and alcohol-based hand rub dispensers;
- process indicators such as compliance with the organization's procedures on performing hand hygiene at key moments; and
- outcome indicators such as the use of alcohol-based hand rub and soap, improved hand hygiene practices, decreased infection rates, and qualitative feedback on the user experience.

The results are documented in the organization's hand hygiene quality improvement plan.

6.1.7.5 The organizational leaders ensure the infection prevention and control program is informed by learnings from hand hygiene improvement activities.

Guidelines

A learning organization recognizes that quality improvement affects all parts of the organization. Sharing and implementing learnings also helps the organization promote a culture of safety and quality, rather than a culture of blame.

Learnings from the hand hygiene quality improvement activities are shared in a timely manner and in a format that is clear and appropriate for each audience. Quality improvement activities that demonstrate positive change are implemented, sustained, and spread as part of the infection prevention and control program. These efforts include adjusting policies and procedures, clinical decision support tools, and other resources.

Sharing of learnings through established networks, communities of practice, publications, and at conferences is encouraged to further improve the spread and scale of hand hygiene practices.

6.1.8 Teams ensure residents are screened to determine whether additional precautions are required based on the risk of infection at point of care.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

Screening for the likelihood of exposure to infectious agents is considered a routine practice that is a critical component of the LTC home's infection prevention and control program. The screening, also known as point of care risk assessment (PCRA), informs the selection of appropriate actions and additional use of PPE required prior to interacting with a resident. The screening includes three steps: assessing the resident, the task that needs to be carried out, and the physical environment prior to the interaction with the resident.

PPE includes gloves, gowns, facial protection and N95 respirator or equivalent.

In complex cases, additional guidance is made available through subject matter experts. Additional actions may require isolation, use of negative pressure rooms, and cohorting.

The screening result and the choice of appropriate PPE required is documented in the individualized care plan. It is also communicated to all team members.

6.1.9 Teams follow clinical decision aid tools for using personal protective equipment that are appropriate to the task.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **Attestation**

Guidelines

Clinical decision aid tools provide the LTC home's workforce, residents, and essential care partners the information, usually at the point of need, to make a timely decision on a task.

Clinical decision aid tools are often visual. They are a well-known learning technique that serves three purposes: sharing just in time information, improving memory recall to help retain information, and reinforcing standardized procedures. To be effective, they are placed to be seen by those that need to do the task. Visual aids should be able to be cleaned and disinfected properly.

Several clinical decision aid tools exist to promote evidence informed practices regarding infection prevention and control. Point of care risk assessment to determine the type of PPE required based on the task is an example of a clinical decision aid tool. As well, tools are made available to support the proper procedure for putting on (donning), taking off (doffing) and disposing of PPE.

Examples of clinical decision aid tools related to evidence informed PPE practices can be found on WHO and public health websites.

6.1.10 The LTC home leaders implement an immunization policy for the workforce.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **Attestation**

Guidelines

Maintaining a current immunization policy for the workforce in LTC homes contributes to the multifaceted approach required to safeguard the health of residents and the workforce. The policy aligns with public health goals, regulatory requirements, and ethical considerations, contributing to a safer and healthier environment within the LTC home.

The policy is developed with input from the workforce. The policy identifies the required and suggested vaccinations, the monitoring of immunization rates as well as activities to promote immunization rates. The purpose is to create a culture of immunization that prioritizes the health and safety of both residents and staff within the LTC home.

Regular documentation, reporting, and communication are components of demonstrating ongoing compliance.

6.1.11 Teams follow evidence informed practices for the management of sharps.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Sharps are items that can cause cuts, punctures, and wounds. Examples of sharps includes needles, razor blades and sharp instruments. They are used frequently in the delivery of care in long-term care homes and present a significant exposure to safety incidents and accidents such as needlestick injuries.

Informed practices for the management of sharps reduces the risk of transmission of microorganisms such as hepatitis B, C, and HIV.

Management of sharps include:

- avoiding unnecessary use of sharp;
- using ‘needle free’ equipment when available for a certain task;
- using ‘safer sharp’ technologies to prevent accidental injury;
- minimizing handling of sharps; and
- providing sharp containers with proper closed mechanisms at the point of use.

Resources such as visual aid tools, continuous learning activities are made available to the teams.

In the event of a sharp injury, the LTC home’s procedures address the actions needed to be taken. This includes timely care interventions, reporting the injury as a safety incident, and quality improvement activities to reduce risk.

6.1.12 The LTC home leaders provide the necessary resources to support quality improvement activities related to infection prevention and control.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

Investing in the appropriate resources demonstrates the LTC home’s commitment to supporting quality improvement activities in infection prevention and control.

Resources may be people, finances, infrastructure, equipment, and information. The resources needed to support infection prevention and control quality improvement activities will depend on the areas of improvement identified and the actions needed to improve.

Examples of investment in resources include:

- a person or team that has been given the responsibility and protected time to review the LTC homes immunization policy;
- an infrastructure project that renovates flooring to facilitate cleaning of the environment;
- reviewing the supply chain to ensure sufficient supplies of PPE at point of need; and
- introduction of new equipment to improve hand hygiene practices.

The invested resources are documented in the LTC home's the quality improvement plan.

6.2 The LTC home's leaders and teams follow evidence informed procedures for the cleaning and disinfection of the physical environment and medical equipment, contributing to the health and safety of residents and the workforce.

6.2.1 Teams ensure medical equipment is cleaned and low-level disinfected to minimize cross-contamination and mitigate the risk of transmission of health care associated infections.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. 'Client' and 'patient' refer to 'resident', 'family and friends' and 'designated support person' refers to 'essential care partner', 'team leadership' and 'organizational leaders' refers to 'LTC home leaders', and 'organization' refers to 'LTC home'.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

6.2.1.1 Teams follow the organization's procedure to clean and low-level disinfect medical equipment.

Guidelines

Effective cleaning and low-level disinfection of medical equipment is a critical component of the organization's infection prevention and control program. Each type of medical equipment has specific requirements for cleaning and low-level disinfecting between each use, when visibly soiled, and on a regular basis.

The organization's procedure and other supportive materials such as manufacturer's instructions are available at the point of use. These materials provide guidance on the activities, supplies, and chemical agents required to properly clean and low-level disinfect medical equipment according to standardized practices.

The organization's procedure to clean and low-level disinfect medical equipment includes

- roles and responsibilities of in-house and contracted teams;
- the type and frequency of cleaning and low-level disinfection required for medical equipment, classified according to risk of infection; the care setting such as acute care, long-term care, or home care; or service setting such as diagnostic imaging, laboratory, or rehabilitation gym;
- specific instructions for medical equipment that is difficult to clean and low-level disinfect, including disassembly and reassembly;
- the required activities to identify, handle, transport, and store medical equipment that needs cleaning and low-level disinfection;
- the required activities to identify, handle, transport, and store medical equipment that has been cleaned and low-level disinfected and is ready for re-use;
- appropriate areas and required precautions for cleaning and low-level disinfecting medical equipment;
- proper storage, preparation, and use of chemical agents for cleaning and low-level disinfection of medical equipment; and
- periodic assessments of compliance and evaluation methods such as visual observation.

6.2.1.2 Teams coordinate activities to ensure medical equipment is effectively cleaned and low-level disinfected.

Guidelines

Roles and responsibilities for cleaning and low-level disinfecting medical equipment are clearly defined, including for contracted teams, as well as alternate team members responsible for these activities as part of contingency planning.

The required activities are communicated, coordinated, and completed according to the organization's procedure. For example, medical equipment that requires cleaning and low-level disinfection is identified with a visual cue and placed in the appropriate area for cleaning and low-level disinfection by the responsible team member. The cleanliness of medical equipment is validated, and discrepancies are reported and addressed with the appropriate person or group.

Clients and designated support persons are encouraged to ask questions, share concerns, and participate in conversations about the cleanliness of medical equipment.

6.2.1.3 Teams use proper cleaning and low-level disinfection equipment and supplies in an appropriate area.

Guidelines

Equipment and supplies include chemical agents, dilution and concentration testing materials, and personal protective equipment.

Medical equipment is cleaned and low-level disinfected in appropriate areas with the required precautions, according to the organization's procedure.

Equipment and supplies are stored appropriately, safely transported, and disposed of according to manufacturers' instructions and jurisdictional requirements for workplace hazardous materials.

6.2.1.4 Teams participate in continuous learning activities about cleaning and low-level disinfection of medical equipment.

Guidelines

Continuous learning helps teams ensure medical equipment is effectively cleaned and low-level disinfected, stored appropriately,

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and made ready for reuse, according to the organization's procedure.

Learning activities are provided during orientation, when products or procedures change, and on a regular basis. If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning topics relevant to team roles and responsibilities can include

- the importance of cleaning and low-level disinfecting medical equipment as a safety practice;
- understanding the Globally Harmonized System of Classification and Labelling of Chemicals (GHS) and the Workplace Hazardous Materials Information System (WHIMS);
- appropriate selection and use of cleaning and low-level disinfection chemicals, methods, and technologies for different areas and surfaces; and
- reporting medical equipment that has not been properly cleaned and low-level disinfected as a safety incident.

Learning activities are provided in various ways to engage team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

Teams are involved in the development and evaluation of continuous learning activities. Teams are given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

6.2.1.5 Teams participate in activities to improve the cleaning and low-level disinfection of medical equipment as part of the organization's quality improvement plan that informs the infection prevention and control program.

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Participation in quality improvement activities includes supporting the collection of quantitative and qualitative data, engaging in reflective learning practices, and providing feedback. It also includes identifying and implementing actions that improve the cleaning and low-level disinfection of medical equipment.

Aims, measures, and outcomes are documented in the organization's integrated quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits to assess teams' adherence to the organization's procedure to clean and low-level disinfect medical equipment, such as walk arounds to ensure proper identification and storage of clean and soiled medical equipment;
- root cause analysis of safety incidents related to cleaning and low-level disinfecting medical equipment;
- feedback from teams, including clients, on the organization's procedure to clean and low-level disinfect medical equipment; and
- feedback from teams on the continuous learning activities provided by the organization on cleaning and low-level disinfecting medical equipment.

Teams are given time to participate in, reflect on, and share quality improvement learnings and experiences.

6.2.2 Teams use decision aid tools for cleaning and disinfecting the physical environment.

Priority: **Normal Priority** | Quality Dimension: **Safety** | Assessment Method: **Attestation**

Guidelines

All surfaces within the LTC home require appropriate cleaning procedures. Special attention is given to high-touch surfaces such as tables, sinks, and keyboards. Procedures are made available to the teams for cleaning the walls, floors, windows, and ceilings; waste management; promptly cleaning and managing spills; and maintaining general tidiness. Decision aid tools address the daily cleaning of rooms and final cleaning of rooms, with additional precautions when required, after a resident is discharged or transferred. Procedures include the proper supplies and PPE required for the task. Documentation of cleaning activities includes the date and time, the team member's name, and the cleaners or disinfectants used.

Decision aid tools also outline the roles and responsibilities of those responsible for cleaning and disinfecting the physical environment, such as team members in environmental services. Responsibilities include assigning team members to clean and disinfect 'grey' areas in the physical environment (areas or surfaces where cleaning is not done or done properly). The roles and responsibilities of other team members are also specified, especially those related to auditing activities to assess the cleanliness of the physical environment and reporting the results to the LTC home leaders that has oversight on cleaning and disinfection of the physical environment.

6.2.3 The LTC home leaders ensure that when cleaning services are contracted to external service providers, a contract is established and maintained with each provider that requires consistent levels of quality and compliance to accepted standards of practice.

Priority: **Normal Priority** | Quality Dimension: **Safety** | Assessment Method: **Attestation**

Guidelines

Maintaining contracts with external cleaning service providers in LTC homes is essential for upholding standards of cleanliness and respecting infection prevention control practices. This enables a safe and healthy environment for all and contributes to the overall quality of care, quality of life and fosters the health and well-being of residents.

The contracts with external providers are in alignment with the LTC home's current infection prevention and control program to maintain a clean and healthy environment. Expected cleaning and disinfection procedures are followed and incorporated into appropriate procedures that involve the LTC home's workforce and those that provide the contracted services.

A mechanism for validating the quality of environmental services provided is in place. Contracts and supporting quality assurance reports are provided to the LTC home leaders responsible for the infection prevention and control program.

6.3 The LTC home's leaders and teams are involved in outbreak management activities, contributing to the health and safety of residents and the workforce.

6.3.1 The LTC home leaders collaborate with partners such as infection prevention and control practitioners, public health and occupational health and safety teams to define outbreaks in terms of person, place, and time.

Priority: **Normal Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

Using the "person, place, and time" approach helps characterize the outbreak and provides the LTC home with guidance about strategies to control health care-associated infections.

Describing the "person" helps to define the population at risk of acquiring the infection. Resident demographics and characteristics such as age, underlying illness, possible exposures to microorganisms, and procedural or therapeutic risks are evaluated.

Describing the "place" in terms of service, unit, or location helps to determine whether the outbreak is localized or whether it is likely to affect the whole LTC home or the community.

Describing the "time" involves defining the exact period of the outbreak, from the first case or first indications, and drawing the epidemic curve. This determination is based on diagnosis and a probable period of exposure. It helps identify whether the outbreak is from a single source or a propagated source. A single source outbreak has one common source, while a propagated outbreak has a continuing source or person-to-person transmission.

6.3.2 Teams use clinical decision aid tools to contribute to the management of outbreaks in the LTC home.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **Onsite**

Guidelines

LTC homes are congregate settings that present a higher risk of infectious disease outbreaks than the community. An infectious disease outbreak can lead to significant spread of disease, illness, tragic loss of life as well as significant impact on quality of life for residents and the workforce. Outbreaks in LTC homes include gastroenteritis and common seasonal respiratory viruses. Infectious diseases, such as COVID-19 are at higher risk of outbreaks in LTC homes as well. Outbreak management is a continuum of actions that include preventing, identifying, mitigating and addressing outbreaks when they occur. Everyone has a role to play in outbreak management.

Clinical decision aid tools provide teams with timely information to make proper decisions regarding outbreak management. Tools can include:

- order sets to support proper screening of common infectious diseases in the LTC home;
- point of care risk assessment tool to enable proper PPE use;
- outbreak surveillance case definitions to determine if criteria for an outbreak are met;
- report potential outbreaks to the person responsible for management outbreak; and
- protocols for isolating individuals who are infected from others who are not known to be infected.

Guidance documents such as clinical decision aid tools to effectively manage outbreaks in the LTC home are provided by public health departments.

Documentation pertaining to outbreak management is a component of the LTC home’s infection prevention and control program.

Chapter 7: Maintaining Safe Medication Management Practices

This chapter focuses on how LTC home leaders and teams maintain safe medication management practices. Accountability for medication management is a shared responsibility amongst the team and is based on the scope of practice and delegation of roles that vary depending on jurisdictional regulation, the LTC home and the team member's roles. Themes covered in this chapter include taking a collaborative approach to medication management; providing up-to-date policies and procedures; and assigning responsibilities for prescribing, storing, preparing, and administering medications, and monitoring their effects.

7.1 The LTC home leaders ensure teams maintain safe medication management practices to ensure the health and safety of resident in the LTC home.

7.1.1 The LTC home leaders provide clinical teams with a procedure for the management of medications brought by residents.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

All prescribed and over-the-counter medications, natural health products, and cannabis products brought by residents are subject to organizational principles of medication management and applicable regulations. The LTC home's procedure addresses

- when and how such medications and products can be used;
- the need to visually inspect the medications;
- the prohibited use of medications or products that cannot easily be identified;
- the appropriate storage and disposal of medications that may be contaminated; and

- the requirement to return medications to residents or essential care partner when residents are transferred to another care setting or discharged from the LTC home, if applicable.

7.1.2 The LTC home leaders ensure that all new team members receive education in medication management adapted to their role.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Education on medication management is adapted to the role and responsibilities of each team member and is provided before their first shift. Education deals with safety issues, such as medications with similar appearance or names, high-alert medications, medications that are new on the market or on the drug formulary, misinterpreted abbreviations, and independent double-checking. Education on new medications and new administration protocols is provided before these medications are used.

Education can be included as part of an orientation program and can be provided in person or online, through meetings, checklists, service notes, or posters.

7.1.3 The LTC home leaders ensure that clinical teams receive education and maintain the necessary competencies on how to prevent, recognize and report safety incidents related to medications.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Education on safety incidents related to medications is adapted to the role and responsibilities of each team member. For example, members of the environmental services management team may only need information on the risks associated with medications, such as what they should do when medications are found in unsafe areas. Members of teams who administer medications need more specialized education to prevent safety incidents related to medications. Education might cover the LTC home’s policies on the use of medications, prevention of adverse reactions, reporting of safety incidents related to medications, and strategies to prevent such incidents.

7.1.4 The LTC home leaders ensure that clinical teams have access at all times to a pharmacist on call.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **On-site**

Guidelines

Access to pharmacy services to address urgent medication needs is essential to the well-being and safety of residents.

Contact information for the pharmacist on call is provided. Clinical teams also have access to procedures for communicating with the pharmacist on call, including guidance on the types of situations that warrant after-hours consultation.

7.1.5 The organizational leaders implement a risk mitigation strategy to safely manage high-alert medications.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. ‘Client’ and ‘patient’ refer to ‘resident’, ‘family and friends’ and ‘designated support person’ refers to ‘essential care partner’, ‘team leadership’ and ‘organizational leaders’ refers to ‘LTC home leaders’, and ‘organization’ refers to ‘LTC home’.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Test(s) for Compliance

7.1.5.1 The organizational leaders provide clinical teams with a current list of high-alert medications available in the organization.

Guidelines

High-alert medications are drugs that can cause significant harm to clients if they are administered incorrectly.

A risk assessment is conducted to identify and create a list of high-alert medications available in the organization. The risk assessment takes into consideration, at a minimum, anticoagulants, insulins, chemotherapeutic agents, opioids, neuromuscular-blocking agents, and concentrated electrolytes. The risk assessment also considers the type of care provided; the care setting, such as surgical care, palliative care, acute care, long-term care, or home care; and the

populations served, such as newborns, children, youth, adults, or older adults.

The list of high-alert medications available in the organization is developed from research, evidence-informed safety practices, and error-reporting data at the organizational, jurisdictional, and national levels. The list is also informed by the latest version of high-alert medication lists developed by professional regulatory bodies or jurisdictionally designated safety-focused organizations such as the Institute for Safe Medication Practices Canada.

7.1.5.2 The organizational leaders ensure clinical teams follow the organization's procedure to safely manage high-alert medications.

Guidelines

The organization's procedure to safely manage high-alert medications is developed from evidence-informed safety practices and reflects the type of care provided, the care setting, and the populations served. The organization's procedure aims to mitigate the risk of harm and optimize the safe use of high-alert medications.

The organization's procedure to safely manage high alert medications includes the following safety practices.

Procuring

- Informing clinical teams about changes to the organization's drug formulary, including updated guidance for safe prescribing and administering.

Storing

- Using assistive technologies such as bar coding to identify when medications are received, stored, or returned to stock.
- Limiting access to high alert medications in the care setting.
- Conducting routine audits, including identifying medications such as insulin, concentrated electrolytes, or high concentration or high total amount heparin that are safely stored in the care setting.

- Implementing additional safety practices when a decision is made to store high alert medications in the care setting.

Prescribing

- Using predefined order sets and standardized protocols to support the safe use of high alert medications.

Dispensing

- Using commercially available or pharmacy-prepared premixed products or prefilled syringes.
- Providing premixed products or prefilled syringes, where feasible, to make available ready-to-use products at the point of care.
- Adding auxiliary warning labels to high alert medications if bar coding technology is not used at point of care.

Administering

- Using programmable pumps with drug libraries that incorporate limits for dosing and/or infusion volume.
- Using programmable pump automated alerts that are consistent with predefined order sets and standardized protocols.
- Employing independent double checks, including the use of bar-coding technology.

Monitoring

- Integrating monitoring parameters into predefined order sets and standardized protocols.
- Considering the potential of a medication error or adverse drug reaction when a client's clinical status significantly changes.

7.1.5.3 The organizational leaders ensure the list of high-alert medications available in the organization is regularly updated to incorporate learnings from medication safety incident reporting and analysis.

<u>Guidelines</u>

An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

Medication safety incidents related to high-alert medications are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Safety incident reporting and analysis related to high-alert medications informs regular updates to the list of high-alert medications used in the organization and associated safety practices.

Safety incidents inform the organization's medication management quality improvement plan.

Findings and recommendations from the analysis of safety incidents are communicated to clinical teams in the organization. The organizational leaders are encouraged to also communicate safety incident findings and recommendations to relevant partners, including professional regulatory bodies and jurisdictionally designated safety-focused organizations.

The list of high-alert medications used in the organization is kept current to reflect changes to organizational practices, the introduction of new care practices, and newly available drugs in the formulary. Changes to the list are communicated according to the organization's procedure to safely manage high-alert medications.

7.1.5.4 The organizational leaders provide clinical teams with continuous learning activities about the organization's risk mitigation strategy to safely manage high-alert medications.

Guidelines

Continuous learning helps clinical teams implement safety practices to prevent harm. Clinical teams include those who prescribe, prepare, dispense, and administer high-alert medications.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning activities are provided in various ways to engage clinical team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, medication safety rounds, and mentorship initiatives.

Clinical teams are involved in the development and evaluation of continuous learning activities. The lived experiences of clients and designated support persons also provide knowledge that is used to inform continuous learning activities.

Clinical teams are given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

7.1.5.5 The organizational leaders ensure the organization's medication management quality improvement plan includes activities to improve safety practices related to high-alert medications.

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Quality improvement activities include collecting quantitative and qualitative data, engaging in reflective learning practices, and gathering feedback. Quality improvement activities also include identifying and implementing actions that improve safety practices related to high-alert medications.

Aims, measures, and outcomes are documented in the organization's medication management quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of medication storage areas to assess clinical teams' adherence to the organization's procedure to safely manage high-alert medications,
- root cause analysis of safety incidents related to high-alert medications,
- feedback from clinical teams on the list of high-alert medications used in the organization and the organization's procedure to safely manage high-alert medications, and
- feedback from clinical teams on the continuous learning activities provided by the organization on high-alert medication safety.

7.1.6 The organizational leaders implement a risk mitigation strategy to limit the availability of and access to high-concentration and high-total-dose opioid formulations.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. 'Client' and 'patient' refer to 'resident', 'family and friends' and 'designated support person' refers to 'essential care partner', 'team leadership' and 'organizational leaders' refers to 'LTC home leaders', and 'organization' refers to 'LTC home'.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Test(s) for Compliance

7.1.6.1 The organizational leaders provide clinical teams with a current list of high-concentration and high-total-dose opioid formulations available in the organization.

Guidelines

Pharmaceutical formulations with high-concentration and high-total-dose opioid can increase the risk of harm due to their potency, the

total amount of opioid in the package, and the frequent requirement for calculation and dilution steps before the formulation is administered to a client.

A risk assessment is conducted to identify and create a list of opioid formulations available in the organization that pose a risk to clients. The risk assessment takes into consideration the high-concentration and the high-total-dose of opioid; the type of care provided; the care setting, such as surgical care, palliative care, acute care, long-term care, or home care; and the populations served, such as newborns, children, youth, adults, or older adults.

The list of high-concentration and high-total-dose opioid formulations available in the organization is developed from research, evidence-informed safety practices, and error-reporting data at the organizational, jurisdictional, and national levels. The list is also informed by recommendations from professional regulatory bodies and jurisdictionally designated safety-focused organizations such as the Institute for Safe Medication Practices Canada.

Examples of high total dose opioid formulations for acute and long-term care settings include

- fentanyl ampoules or vials with total dose greater than 100 mcg,
- HYDROmorphone ampoules or vials with total dose greater than 2 mg,
- morphine ampoules or vials with total dose greater than 15 mg per formulation in adult care settings and 2 mg in pediatric care settings, and
- opioid infusion bags and cassettes.

Examples of high concentration opioid formulations for acute and long-term care settings include

- HYDROmorphone 50 mg/mL vials,
- morphine 50 mg/mL vials, and
- methadone 10 mg/mL oral concentrate.

Examples of dispensing high volume opioid formulations for home care settings include

- HYDROmorphone long-acting 30 mg tablet minimally limited to a one-month supply,
- fentanyl transdermal patch 100 mcg/hr in a carton of 5 patches,
- prefilled syringes each containing 5 mg of morphine in an envelope of 10 syringes, and
- methadone oral solution 1 mg/mL in 100 mL bottles.

7.1.6.2 The organizational leaders ensure clinical teams follow the organization’s procedure to limit the availability of and access to high-concentration and high-total-dose opioid formulations.

Guidelines

The organization’s procedure to limit the availability of and access to high-concentration and high-total-dose opioid formulations is developed from evidence-informed safety practices and reflects the type of care provided, the care setting, and the populations served. The organization’s procedure aims to mitigate the risk of harm and ensure proper opioid availability and access.

The organization’s procedure incorporates safety practices such as

- avoiding storage of high total dose opioid formulations in the client care setting;
- limiting inventory of high concentration opioids in the client care setting;
- providing opioids in ready-to-use formats to avoid the need for calculations at the point-of-care or the need to dilute the product;
- dispensing opioids in the community setting in limited quantities, such as four-day supplies rather than monthly;
- providing opioids in unit-dose packaging;

- providing a lockbox for opioid storage in client homes; and
- ensuring timely and effective disposal or removal of unneeded and wasted opioids.

7.1.6.3 The organizational leaders ensure the list of high-concentration and high-total-dose opioid formulations available in the organization is regularly updated to incorporate learnings from all opioid-related medication safety incident reporting and analysis.

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

Medication safety incidents related to the availability of and access to high-concentration and high-total-dose opioid formulations are documented in the client's health record and the safety incident reporting system. The information is shared with the client and other authorized team members in a clear and accessible format as required by the organization's procedure.

Opioid-related safety incident reporting and analysis informs regular updates to the list of high-concentration and high-total-dose opioid formulations available in the organization and associated safety practices.

Safety incidents inform the organization's medication management quality improvement plan.

Findings and recommendations from the analysis of opioid-related safety incidents are communicated to clinical teams in the organization. The organizational leaders are encouraged to also communicate safety incident findings and recommendations to relevant partners, including professional regulatory bodies and jurisdictionally designated safety-focused organizations.

The list of high-concentration and high-total-dose opioid formulations available in the organization is kept current to reflect changes to organizational practices, the introduction of new care

practices, and newly available formulations. Changes to the list are communicated according to the organization's procedure to limit the availability of and access to high-concentration and high-total-dose opioid formulations.

7.1.6.4 The organizational leaders provide clinical teams with continuous learning activities about the organization's risk mitigation strategy to limit the availability of and access to high-concentration and high-total-dose opioid formulations.

Guidelines

Continuous learning helps clinical teams implement safety practices to prevent harm. Clinical teams include those who prescribe, prepare, dispense, and administer high-concentration and high-total-dose opioid formulations.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning activities are provided in various ways to engage clinical team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, medication safety rounds, and mentorship initiatives.

Clinical teams are involved in the development and evaluation of continuous learning activities. The lived experiences of clients and designated support persons also provide knowledge that is used to inform continuous learning activities.

Clinical teams are given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

7.1.6.5 The organizational leaders ensure the organization's medication management quality improvement plan includes activities to improve safety practices related to the availability of and access to high-concentration and high-total-dose opioid formulations.

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Quality improvement activities include collecting quantitative and qualitative data, engaging in reflective learning practices, and collecting feedback. Quality improvement activities also include identifying and implementing actions that improve safety practices related to the availability of and access to high-concentration and high-total-dose opioid formulations.

Aims, measures, and outcomes are documented in the organization's medication management quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of medication storage areas to assess adherence to the organization's procedure to limit the availability of and access to high-concentration and high-total-dose opioid formulations,
- root cause analysis of safety incidents related to the availability of and access to high-concentration and high-total-dose opioid formulations,
- feedback from clinical teams on the organization's procedure to limit the availability of and access to high-concentration and high-total-dose opioid formulations and the list of high-concentration and high-total-dose opioid formulations available in the organization, and
- feedback from clinical teams on the continuous learning activities provided by the organization on opioid safety.

7.1.7 The LTC home leaders provide teams with a procedure for receiving medications from external pharmacies.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

<u>Guidelines</u>

When medications are obtained from an external pharmacy, the documentation required at reception specifies that medications are to be checked before use.

The procedure identifies the people who can confirm that the correct medications are received and proceed with internal distribution.

7.1.8 The LTC home leaders restrict access to areas where medications are stored.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

The level of security required for medication storage areas depends on the types of medication stored. For example, medications may be stored in restricted areas that use keypads or magnetic cards granting different levels of access, medication carts that can be locked and always monitored, or in a medication storage area that is always staffed. The best way to restrict access to medication storage areas is determined based on the needs of the LTC home and the risk of unauthorized access to these areas.

7.1.9 Teams ensures appropriate conditions for medication storage.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **On-site**

Guidelines

Appropriate storage conditions consider temperature, humidity, light sensitivity, packaging, and delivery containers. For example, vaccines, insulin, and injectable lorazepam are stored in refrigerators equipped with temperature regulators. Medication monographs are consulted to ensure correct storage temperatures.

7.1.10 The LTC home leaders provide teams with a procedure for the disposal of contaminated medications.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

The medication storage area is considered a clean area. No medication that has been in contact with a resident should be stored in the medication storage area. This practice helps to reduce the risk of health care-associated infections, such as hepatitis B. Methods for disposing of contaminated medications comply with environmental protection laws.

7.1.11 The organizational leaders ensure clinical teams adhere to a current do-not-use list of abbreviations, symbols, and dose designations in all medication-related communication.

NOTE: To ensure consistency in ROP terminology across all standards, any language referring to the following terms correspond to their appropriate long-term care setting alternatives. ‘Client’ and ‘patient’ refer to ‘resident’, ‘family and friends’ and ‘designated support person’ refers to ‘essential care partner’, ‘team leadership’ and ‘organizational leaders’ refers to ‘LTC home leaders’, and ‘organization’ refers to ‘LTC home’.

ROP Priority: **ROP** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Test(s) for Compliance

7.1.11.1 The organizational leaders provide clinical teams with a current list of do-not-use abbreviations, symbols, and dose designations that applies to all medication-related communication.

Guidelines

Misinterpreted abbreviations including drug name abbreviations, symbols, and dose designations can cause medication safety incidents such as incorrect medications, incorrect doses, or incorrect directions for use that may result in client harm.

The organization’s do-not-use list is developed from research, evidence-informed safety practices, and error-reporting data at the organizational, jurisdictional, and national levels. The list is also informed by recommendations from professional regulatory bodies and jurisdictionally designated safety-focused organizations such as the Institute for Safe Medication Practices Canada.

Examples of abbreviations, symbols, and dose designations that should be avoided in all medication-related communication include short forms of drug names; u for unit; symbols such as @, >, or <; and leading or trailing zeros.

7.1.11.2 The organizational leaders ensure clinical teams follow the organization’s procedure to adhere to the do-not-use list of abbreviations, symbols, and dose designations in all medication-related communication.

Guidelines

The organization’s procedure to adhere to the do-not-use list is developed from evidence-informed safety practices and reflects the type of care provided, the care setting, and the populations served. The organization’s procedure aims to prevent, detect, and resolve in a timely manner the use of listed abbreviations, symbols, and dose designations in all medication-related communication.

The do-not-use list applies to all written and electronic medication-related communication throughout the medication management process. Medication-related communication includes handwritten prescriptions; medication and storage location labels; information in automated dispensing cabinets and smart infusion pumps; information in order entry systems including free text fields, standardized order sets, pharmacy master formulas, medication administration records, and health records; and continuous learning materials.

Resolving non-adherence to the do-not-use list may include a clarification of order note in the medical record that is signed off by the appropriate team member as defined in the organizational procedure. The resolution should not be a limiting factor to dispensing the medication, which could have a significant impact on the care outcome.

7.1.11.3 The organizational leaders ensure the use of misinterpreted abbreviations, symbols, and dose designations that could have harmed or did harm a client are reported as medication safety incidents.

Guidelines

An organizational culture of safety promotes and supports reporting of safety incidents to avoid harm, reduce errors, and lessen the impact of errors. Safety incidents are events or circumstances that could have harmed or did harm a client.

Medication safety incidents related to misinterpreted abbreviations, symbols, and dose designations are documented in the client’s health record and the safety incident reporting system. The information is shared with the client and other authorized team

members in a clear and accessible format as required by the organization’s procedure.

Relevant safety incident reporting and analysis informs regular updates to the do-not-use list and associated safety practices.

Safety incidents inform the organization’s medication management quality improvement plan.

Findings and recommendations from the analysis of safety incidents are communicated to clinical teams in the organization. The organizational leaders are encouraged to also communicate safety incident findings and recommendations to relevant partners, including professional regulatory bodies and jurisdictionally designated safety-focused organizations.

The do-not-use list is kept current to reflect changes to organizational practices and the introduction of new care practices. Changes to the list are communicated according to the organization’s procedure to adhere to the do-not-use list.

7.1.11.4 The organizational leaders provide clinical teams with continuous learning activities about the organization’s procedure to adhere to the do-not-use list of abbreviations, symbols, and dose designations.

Guidelines

Continuous learning helps clinical teams implement safety practices to prevent harm. Clinical teams include those who prescribe, prepare, dispense, and administer medications.

If the organization offers clinical practicums, students, residents, and fellows participate in the required learning activities before providing care.

Learning activities are provided in various ways to engage clinical team members with different educational backgrounds, abilities, and learning styles. Examples include in-person or virtual training and simulation sessions, awareness campaigns, reflective practice, and mentorship initiatives.

Clinical teams are involved in the development and evaluation of continuous learning activities. The lived experiences of clients and designated support persons also provide knowledge that is used to inform continuous learning activities.

Clinical teams are given time to participate in, reflect on, and share learnings and experiences. Learning activities are documented.

7.1.11.5 The organizational leaders ensure the organization's medication management quality improvement plan includes activities to improve adherence to the do-not-use list of abbreviations, symbols, and dose designations.

Guidelines

Quality improvement involves a team-based approach to understanding the organization's strengths, opportunities for improvement, risks, and challenges in delivering high-quality and safe care.

Quality improvement activities include collecting quantitative and qualitative data, engaging in reflective learning practices, and collecting feedback.

Quality improvement activities also include identifying and implementing actions that improve adherence to the do-not-use list of abbreviations, symbols, and dose designations.

Aims, measures, and outcomes are documented in the organization's medication management quality improvement plan. Qualitative and quantitative measures may include

- observational activities and audits of medication-related communication to assess clinical teams' adherence to the do-not-use list;
- root cause analysis of safety incidents related to misinterpreted abbreviations, symbols, and dose designations;

- feedback from clinical teams on the do-not-use list and the organization's procedure to adhere to the do-not-use list; and
- feedback from the clinical team on the continuous learning activities provided by the organization on the do-not-use list.

7.1.12 Teams keep single-dose oral medications in the manufacturer's or pharmacy's packaging until they are administered.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Keeping all medications in the provided packaging reduces the risk of error. Medications are not poured in advance in care areas. It is important that the service provider is able to identify all oral medications.

7.1.13 The LTC home leaders ensure that emergency, urgent and stock medications are accessible within delays established by the LTC home.

Priority: **High Priority** | Quality Dimension: **Accessibility** | Assessment Method: **Attestation**

Guidelines

The terms emergency, urgent and stock are defined by the LTC home. For example, these terms may be used to refer to types of medications or clinical indications.

7.1.14 Teams follow the procedure for the administration of a medication.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

The resident profile is reviewed to ensure medications are administered under the "right" conditions. This means that the right medication is given, at the right dose, by the right route, at the right time, to the right person, with the right documentation, for the right reason, and with the right result.

7.1.15 Teams follow the procedure for documenting the administration of all vaccines.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

Lot numbers and expiration dates of vaccines are recorded in residents' health records after vaccines are administered. The recording of lot numbers and expiration dates complies with jurisdictional requirements.

7.1.16 Teams monitor residents to detect potential safety incidents related to medications and report them according to organizational procedure.

Priority: **High Priority** | Quality Dimension: **Safety** | Assessment Method: **On-site**

Guidelines

Residents who take multiple high-alert medications are at greatest risk of safety incidents related to medications. Team members are given information on how to monitor safety incidents related to medications, including signs to look for and how to react.

7.1.17 The LTC home leaders monitor scientific evidence and changes to laws and regulations around medication management to update the LTC home's policies and procedures.

Priority: **High Priority** | Quality Dimension: **Appropriateness** | Assessment Method: **Attestation**

Guidelines

Evidence sources include peer-reviewed journals, regulatory agencies and guidelines, pharmacovigilance systems and health technology assessment agencies.

Chapter 8: Promoting Quality Improvement

This chapter focuses on the promotion of and commitment to quality improvement by LTC home leaders and teams. Quality improvement in long-term care plays an important role in achieving better care and quality of life for residents.

8.1 The LTC home leaders and teams demonstrate an ongoing commitment to quality improvement.

8.1.1 The LTC home leaders have dedicated resources for quality improvement activities.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

Quality improvement is a systematic and structured team effort to achieve measurable improvements in care delivery, experiences, and outcomes.

The LTC home leaders and teams identify quality improvement priorities that align with the LTC home's vision, mission, and values. They ensure quality improvement teams are formed and supported with protected time, resources, and information systems to collect the data needed to implement quality improvement activities.

The LTC home's quality improvement teams include a representation of residents, substitute decision makers, essential care partners, and quality champions of the workforce who have the experience, expertise, and support or are provided with the education and assistance needed to engage in quality improvement activities. The LTC home leaders encourage teams to develop quality improvement plans for setting improvement aims, establishing measures, selecting and testing changes and actions, and implementing, sustaining, and spreading successful change strategies, using rapid improvement cycles.

The LTC home leaders ensure teams have quality improvement plans specific to improving residents' quality of life and quality of care and enabling a healthy and competent workforce and culture.

Aggregated data collected through surveys, ongoing feedback from teams, observational audits, and surveillance data, as well as quantitative data collected from documentation and reports, are used to inform the plans.

8.1.2 Teams have a quality improvement plan for improving residents' quality of life.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

The systematic, continuous collection of information and feedback from residents and teams can support LTC homes in improving residents' quality of life.

Teams are equipped by the LTC home leaders to use a quality improvement plan to set aims, measures, and actions for improving residents' quality of life that

- improve psychological and spiritual well-being,
- maintain and promote residents' autonomy and decision-making,
- strengthen social relationships including those with teams and the workforce, and
- enhance residents' engagement and sense of purpose through meaningful activities.

Teams are supported by LTC home leaders to collect a variety of quantitative and qualitative data on residents' quality of life. Data sources may include day-to-day interactions with residents and team members, annual quality- of-life surveys, committee activities, focused interviews, compliments, and complaints.

Aims, measures, actions, and outcomes to improve residents' quality of life are documented in the quality improvement plan and comply with jurisdictional requirements. Quality improvement actions that demonstrate positive change are implemented, sustained, and spread.

8.1.3 Teams have a quality improvement plan for improving residents' quality of care.

Priority: **High Priority** | Quality Dimension: **Client-centred Services** | Assessment Method: **Attestation**

Guidelines

The systematic collection of continuous information and feedback from residents and teams can support LTC homes in improving residents' quality of care.

Teams are equipped by the LTC home leaders to use a quality improvement plan to set aims, measures, and actions for improving residents' quality of care that

- demonstrate improved pain management,
- increase adherence to immunization recommendations,
- reduce the incidence of infections,
- reduce injuries related to falls,
- decrease the inappropriate use of antipsychotic medication,
- decrease the use of restraints, and
- optimize the use of antibiotics.

Teams are supported by LTC home leaders to collect quantitative and qualitative data on residents' quality of care in various ways. Data sources include residents' individualized care plans, day-to-day interactions with residents and teams, safety incident reports, surveillance, and routinely collected resident data.

Aims, measures, actions, and outcomes to improve residents' quality of care are documented in the quality improvement plan and comply with jurisdictional requirements.

8.1.4 The LTC home leaders have a quality improvement plan for enabling a healthy and competent workforce.

Priority: **High Priority** | Quality Dimension: **Worklife** | Assessment Method: **Attestation**

Guidelines

Data on the workforce and feedback on their work-life experience help the LTC home leaders understand the needs of the workforce and identify actions to support their health and competencies.

The LTC home leaders collect quantitative and qualitative data on the workforce and their work-life experience in various ways, such as an annual workforce

experience survey, special surveys, exit interviews, and day-to-day interactions with workforce members.

The LTC home leaders set aims, measures, and actions for improving the health and competencies of the workforce that

- demonstrate improved competencies of the workforce through ongoing learning opportunities;
- promote a respectful, compassionate, and trauma-informed culture;
- provide the workforce with consistent and supportive leadership;
- increase workforce satisfaction;
- reduce workforce absenteeism and the number of work-related injuries; and
- reduce claims that workforce rights have been violated.

Actions to enable a healthy and competent workforce are documented in the quality improvement plan and comply with jurisdictional requirements.

8.1.5 The LTC home leaders communicate quality improvement outcomes to the LTC home's stakeholders.

Priority: **Normal Priority** | Quality Dimension: **Population Focus** | Assessment Method: **On-site**

Guidelines

Communicating the results of quality improvement activities to all LTC home stakeholders—including residents, substitute decision makers, essential care partners, other members of the team, and the broader community— builds trust, promotes transparency, and demonstrates leaders' and the governing body's commitment to providing high-quality and safe care. Communicating the results is essential to successfully move from a culture of blame to a culture of safety and quality.

The results of quality improvement activities are shared in a timely manner and in a format that is clear and appropriate for each audience.

The LTC home leaders ensure the communication of quality improvement outcomes complies with jurisdictional requirements.