

Alberta Health

Continuing Care Health Service Standards

Continuing Care Branch

January 2016

(Amended July 16, 2018)

Updates

The contents of the *Continuing Care Health Service Standards* are revised and updated from time to time. Updates are published on-line¹ and Operators are notified when updates are made.

The table below records the changes made to the January 2016 version of the *Continuing Care Health Service Standards*.

Revision	Page Number
Title Page – Date Updated all headers and footers	All Throughout
Deleted definition of “Council”	6
Amended definition of “Restraint”	10
Added definition of “Secure Space”	10
Amended Standard 12.0 to remove the requirement for medication reconciliation after an interdisciplinary team conference	28
Amended Standard 16 to allow a Nurse Practitioner to perform restraint management	33-34
Added content to Standard 16 that identifies specific requirements for “Secure Spaces”	34-35
Amended Standard 18.0 to remove 18.3 and 18.4. Requirements are now set out in the <i>Resident and Family Councils Act</i> (effective April 1, 2018).	N/A

Continuing Care Health Service Standards (2018)

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Purpose

The Ministry of Health is committed to supporting the delivery of Quality Health Care to Albertans in the continuing care system through the application of the *Continuing Care Health Service Standards* (CCHSS). The CCHSS are a legislated requirement of Operators pursuant to the *Nursing Homes General Regulation* under the *Nursing Homes Act*, the *Co-ordinated Home Care Program Regulation* under the *Public Health Act* and pursuant to a Ministerial Directive under the *Regional Health Authorities Act*. The CCHSS set the minimum requirement that Operators in the continuing care system must comply with in the provision of Health Care.

Scope

In Alberta, the continuing care system provides Albertans with access to Health Care to promote the maximum independence possible.

The continuing care system encompasses the Co-ordinated Home Care Program, Publicly Funded Supportive Living Facilities and Long-Term Care Facilities. In the CCHSS, an individual receiving publicly funded Health Care in the continuing care system is referred to as a Client. Clients are not defined by age, diagnosis or the length of time they may require services but by their need for Health Care.

Funding for Health Care is provided by the Ministry of Health to Alberta Health Services (AHS). Health Care is delivered by AHS or by an AHS contracted Operator.

Responsibility and Accountability

In the continuing care system, the Ministry of Health is ultimately responsible for ensuring the delivery of Quality publicly funded Health Care. The responsibilities and accountabilities within the continuing care system can best be understood by looking at the different roles of the Ministry of Health, AHS and Operators (Fig. 1).

Contact Details

This document can be found on the Alberta Health website: www.health.alberta.ca. For general information, call Alberta Health Continuing Care at 780-638-4495 (for toll-free access within Alberta, first dial 310-0000) and your call will be directed to the appropriate personnel.

Figure 1

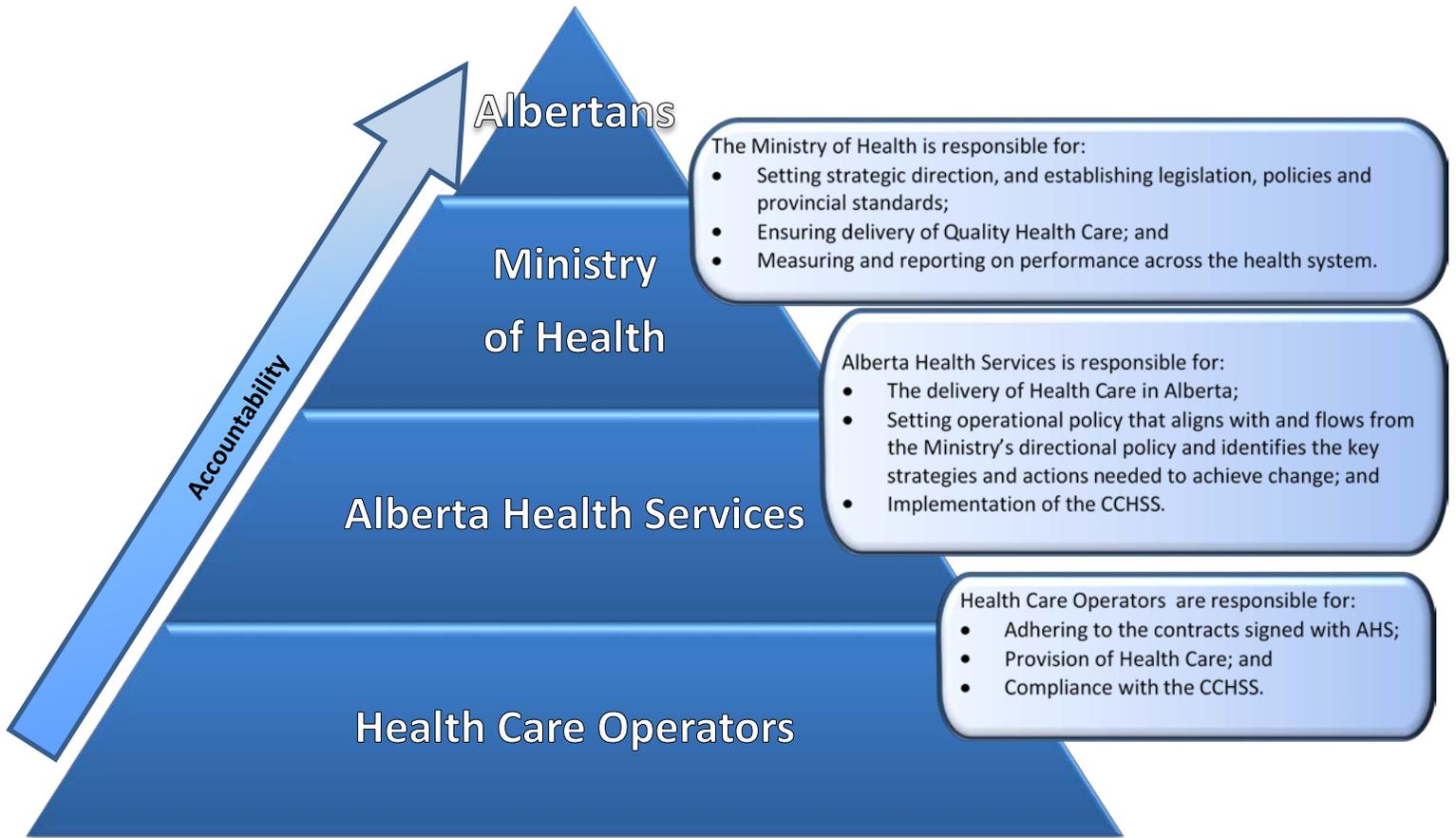


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Definitions

Advance Care Planning	A process undertaken by a Client, their family and Health Care Providers to communicate and document the Client's Health Care goals to be taken into consideration should there be a time in the future when the Client cannot express their wishes.
Alberta Health Services (AHS)	The legal entity as defined and governed by the <i>Regional Health Authorities Act</i> . AHS delivers Health Care on behalf of the Ministry of Health.
Assistive Equipment	Equipment that allows a Client to maintain mobility and social connectedness, and complete activities of daily living and instrumental activities of daily living. Examples of Assistive Equipment include but are not limited to the following: a) walkers; b) wheelchairs; c) canes; d) scooters; e) motorized wheelchairs; f) grab bars; g) bath chairs; or h) mechanical lifts.
Care Plan	A written working document developed by the Interdisciplinary Team that includes a Client's assessed Unmet Health Care Needs, related Health Care goals and interventions.
Client	An individual receiving publicly funded Health Care in the continuing care system.
Co-ordinated Home Care Program	The program that operates under the authority of the <i>Co-ordinated Home Care Program Regulation</i> under the <i>Public Health Act</i> , and the purpose of which is to assist the Client to maintain well-being and independence at home through the provision of Health Care. Also known as Alberta's Home Care Program.
Enduring Power of Attorney	A legal document that appoints another person to make financial and legal decisions on behalf of a Client and meets the requirements of the <i>Powers of Attorney Act</i> .

Health Care	The care provided to a Client by a Health Care Provider for any of the following purposes: <ul style="list-style-type: none">a) protecting, promoting or maintaining physical and mental health;b) preventing illness;c) assistance with or providing personal care services;d) diagnosing and treating illness;e) rehabilitation; orf) caring for the health needs of the ill, disabled, injured or dying.
Health Care Aide	An Unregulated Health Care Provider responsible for providing direct care to assist in the activities of daily living, comfort and safety of the Client.
Health Care Provider	A Regulated or Unregulated Health Care Provider employed or contracted by an Operator for the provision of Health Care to Clients.
Health Information	Information that is “health information” as defined in the <i>Health Information Act</i> .
Health Status	A description or measurement of the health of a Client at a particular point in time that may require intervention by a Regulated Health Care Provider.
Interdisciplinary Team	A group comprised of Health Care Providers, the Client or the Client’s legal representative, if applicable, and other individuals of the Client’s choosing, who meet for the purposes of planning, coordinating and delivering Health Care services to the Client. The Health Care Providers on the Interdisciplinary Team are determined by the Client’s assessed Health Care needs.
InterRAI Instruments	Comprehensive, standardized assessment instruments developed by InterRAI for evaluating a Client’s needs, preferences and strengths. The InterRAI Instruments have a number of outputs that highlight areas that require further investigation, evaluate current Health Status and facilitate the allocation of resources.
Long-Term Care Facility	A facility that is a “nursing home” as defined in the <i>Nursing Homes Act</i> or an “auxiliary hospital” as defined in the <i>Hospitals Act</i> .

Medical Care	Any diagnostic or screening procedure, treatment, drug, or therapeutic diet prescribed for or provided to a Client by a Physician or a Nurse Practitioner.
Medical Status	A description or measurement of the health of a Client at a particular point in time that may require intervention by a Physician or a Nurse Practitioner.
Medical/Surgical Supplies	Supplies used for medical or surgical treatments.
Medication Assistance	A service provided to a Client to facilitate the Client's ability to self-administer medication and to ensure medication is taken as intended by the prescriber. For example, handing a medication container to the Client or opening the packaging that holds medication(s).
Medication Management	The processes required to ensure safe and effective medication therapy for a Client, including prescribing, communication of medication orders, medication reconciliation, dispensing, delivery, storage, medication support, documentation and follow-up.
Medication Reminder	A service provided by a Health Care Provider to remind a Client to self-administer medication and ensure that medication is taken as intended by the prescriber.
Medication Review	A critical examination by the Interdisciplinary Team of a Client's medications for appropriateness, effectiveness, interactions, and adverse reactions for the purposes of optimizing the impact of medications and minimizing the number of medication related problems.
Non-Critical Medical Devices	A medical device that is intended to provide Health Care to more than one Client at different times. The Non-Critical Medical Device either touches only intact skin, but not mucous membranes, or does not directly touch the Client.
Nurse Practitioner	A registered nurse with advanced education, knowledge, skills and competencies who is licensed to practice as a Nurse Practitioner in Alberta and is regulated by the College and Association of Registered Nurses of Alberta.

Operator	A legal entity that receives public funding for the provision of Health Care directly to Clients.
Palliative and End-of-Life Care	The continuum of care that enables a Client with a life limiting illness to receive integrated and coordinated care, and which incorporates the Client and their family's values, preferences, and goals from early diagnosis to End-of-Life, including bereavement.
Person Centered Care	The following principles of Health Care delivery that inform a Client's experience: a) transparency; b) individualization; c) recognition; d) respect; e) dignity; and f) choice.
Personal Directive	A legal document which empowers a person to act as an agent on behalf of a Client with respect to personal matters and which meets the requirements of the <i>Personal Directives Act</i> .
Physician	A person qualified and licensed to practice medicine in Alberta and is a regulated member of the College of Physicians and Surgeons of Alberta.
Publicly Funded Supportive Living Facility	Any supportive living facility that receives funding from AHS to provide Health Care.
Quality	The six dimensions of Quality according to the Health Quality Council of Alberta's <i>Alberta Quality Matrix for Health</i> : a) acceptability; b) accessibility; c) appropriateness; d) effectiveness; e) efficiency; and f) safety.
Regulated Health Care Provider	A Health Care Provider who is a member of a regulated health profession in Alberta and is required to practice in accordance with the <i>Health Professions Act</i> .

Responsive Behaviour	<p>A significant subset of the behavioural and psychological symptoms of dementia (BPSD) that are thought to be an expression of:</p> <ul style="list-style-type: none">a) an unmet need;b) a response to a stimulus in a Client's environment;c) a psychological need; ord) a response to the approach of Health Care Providers or other Clients.
Restraint	<p>Any measure that is pharmacological, environmental, mechanical or physical that is used with the intention of protecting a Client from self-harm or preventing harm to another person. For clarity, a Restraint does not include a Secure Space.</p>
Reusable Medical Device	<p>A medical device that can be reprocessed and reused to diagnose and treat multiple Clients. The Reusable Medical Device is designed and labeled by its manufacturer for multiple uses and is reprocessed by thorough cleaning and high-level disinfection or sterilization between Clients.</p>
Risk Management	<p>The systematic identification, evaluation, and mitigation of potential risk to a Client's Health Care. Risk Management is a process that recognizes the Client's right to live at risk and respect for the Client's choice.</p>
Secure Space	<p>A secure unit within a facility, a secure facility or a technological measure that limits a Client's ability to exit a facility or unit that is used with the intention of protecting a Client from harm. For clarity, a technological measure includes, but is not limited to, a wander alert system.</p>
Significant Change in Health Status	<p>A consistent pattern of change in a Client's Health Status which is evidenced by at least two areas of decline or improvement according to the InterRAI Instrument or Standardized Assessment Tool used, and as determined by a Regulated Health Care Provider.</p>
Staff	<p>All employees of an Operator.</p>
Standardized Assessment Tool	<p>A formal tool that enables comprehensive standardized evaluation of the Health Care needs, strengths, and preferences of a Client.</p>

Technology	Technology which allows for automatic and continuous real-time monitoring for emergencies or Technology that supports Clients and their caregivers in completing activities of daily living and instrumental activities of daily living. Examples of Technology include but are not limited to: a) assistive personal emergency response systems; b) fall detection and prevention systems; c) environmental monitoring and alarms; or d) appliance monitoring and control.
Unmet Health Care Needs	The requirements for Health Care that remain after the abilities, existing supports and resources of the Client, the Client's family and their community have been considered upon completion of a standardized assessment.
Unregulated Health Care Provider	A Health Care Provider that is not registered or licensed by a regulatory body. An Unregulated Health Care Provider does not have a legally defined scope of practice and must work under the direct or indirect supervision of a Regulated Health Care Provider.

1.0 Standardized Assessment and Person-Centred Care Planning

- 1.1 An Operator must ensure that a Client's Health Care needs are assessed using the appropriate InterRAI Instrument upon the Client's commencement of services provided in the Co-ordinated Home Care Program, or upon admission to a Publicly Funded Supportive Living Facility or Long-Term Care Facility and:
- a) where an InterRAI Instrument is not appropriate, AHS must designate the Standardized Assessment Tool to be used;
 - b) the assessment is conducted by a Regulated Health Care Provider trained in the appropriate InterRAI Instrument or Standardized Assessment Tool;
 - c) Clients receiving services in a Long-Term Care Facility must be reassessed:
 - i) quarterly; and
 - ii) upon a Significant Change in the Client's Health Status;
 - d) Clients receiving services in the Co-ordinated Home Care Program or in a Publicly Funded Supportive Living Facility must be reassessed:
 - i) annually; and
 - ii) upon a Significant Change in the Client's Health Status.
- 1.2 An Operator must ensure that care planning begins upon the Client's commencement of services provided in the Co-ordinated Home Care Program, or upon admission to a Publicly Funded Supportive Living Facility or Long-Term Care Facility and that the Care Plan:
- a) reflects the findings of the assessment in 1.1;
 - b) is kept up to date and relevant to the Client's Health Status; and
 - c) is revised by a Regulated Health Care Provider based on any reassessments.
- 1.3 An Operator must ensure that the Care Plan addresses:
- a) a Client's physical, mental, emotional, social, intellectual and spiritual Health Care needs and corresponding goals;
 - b) a description of the necessary interventions related to the assessment in 1.1 and which Interdisciplinary Team member is responsible for providing those interventions; and
 - c) where a Client has a legal representative:

- i) identification of the Client’s legal representative;
 - ii) identification of the source of their legal authority; and
 - iii) contact information for the legal representative.
- 1.4 An Operator of a Long-Term Care Facility must have documented processes in place that ensure a Physician or a Nurse Practitioner conduct:
 - a) a Medical Status assessment of a Client upon admission; and
 - b) reassessments of a Client’s Medical Status on an annual basis and when there is a significant change in the Client’s Medical Status.
- 1.5 An Operator must ensure a Client or and the Client’s legal representative, if applicable, have the opportunity to:
 - a) participate in the development and review of the Client’s Care Plan, including the determination of Health Care needs and service options;
 - b) invite individuals of their choosing to participate in the development and review of the Care Plan; and
 - c) access the Client’s Care Plan upon request.
- 1.6 Where a Client or the Client’s legal representative, if applicable, is unable or unwilling to participate in the development or review of the Client’s Care Plan, the Operator must ensure this is documented in the Client’s Care Plan.
- 1.7 An Operator must ensure that:
 - a) an Interdisciplinary Team conference is held to create a Care Plan upon the Client’s commencement of services provided in the Co-ordinated Home Care Program or upon admission to a Publicly Funded Supportive Living Facility or Long-Term Care Facility; and
 - b) a Client has an Interdisciplinary Team conference to review and make necessary updates to the Client’s Care Plan:
 - i) annually; and
 - ii) upon a Significant Change in the Client’s Health Status.
- 1.8 An Operator must ensure that all Care Plan reviews address whether:
 - a) the Care Plan addresses the Unmet Health Care Needs of the Client;
 - b) the Client’s Health Care needs and goals are being met;
 - c) the interventions that have been implemented related to the Client’s Health Care needs and goals have been effective; and

- d) any revisions are required.
- 1.9 An Operator must ensure that any change to a Client's Care Plan is documented and communicated to the Client, the Interdisciplinary Team and the Client's Health Care Providers.
- 1.10 An Operator of a Long-Term Care Facility must ensure that the Client's responsible Physician or Nurse Practitioner is contacted regarding the review of the Client's Care Plan for the purposes of providing input.

2.0 Case Management

- 2.1 Upon the Client's commencement of services provided in the Co-ordinated Home Care Program or upon admission to a Publicly Funded Supportive Living Facility or Long-Term Care Facility, an Operator must ensure that each Client has an assigned Regulated Health Care Provider, qualified to provide case management, who is responsible for coordinating, integrating and facilitating Health Care services for the Client.

- 2.2 An Operator must ensure that each Client and the Client's legal representative, if applicable, is provided with information on who they should contact should they have questions or require assistance regarding the Client's Health Care or Care Plan.

3.0 Access to Physician or Nurse Practitioner Services

- 3.1 An Operator of a Long-Term Care Facility must ensure the following is in place:
- a) a documented procedure available to all Regulated Health Care Providers on how to access the on-call Physician or Nurse Practitioner outside of regular daytime or evening shifts; and
 - b) a Physician to act as a medical director and who is responsible for:
 - i) overseeing the Quality of Medical Care;
 - ii) providing expertise in the provision of Medical Care; and
 - iii) advising on medical program policies and medical follow-up processes.

4.0 Client Access to Information

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

- c) when the Client transfers between different levels of care within the same Operator; and
- d) following any Interdisciplinary Team conference.

5.0 Palliative and End-Of-Life Care

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

6.0 Assistive Equipment, Technology And Medical/Surgical Supplies

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

7.0 Sharing of Client Information

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

8.0 Health Care Providers

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

9.0 Staff Training

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

- f) the training in 9.2(a) through 9.2(e) occurs within six months from the date of hire, and every two years thereafter.
- 9.3 An Operator must establish, implement and maintain documented policies and procedures to ensure:
- a) training for all Health Care Providers in;
 - i) the CCHSS;
 - ii) Health Information management;
 - iii) the *Health Information Act* and the Freedom of Information and *Protection of Privacy Act*;
 - iv) the prevention and reporting of Client abuse; and
 - v) incident reporting pursuant to 19.2, 19.3 and 19.4;
 - b) training for registered nurses, licensed practical nurses and Health Care Aides on Personal Directives, Enduring Power of Attorney, guardianship and trusteeship in the provision of Health Care; and
 - c) the training in 9.3(a) and 9.3(b) occurs within six months of the date of hire and within three months of any significant update or revisions to the related training materials.
- 9.4 An Operator must document compliance with the requirements in 9.1, 9.2, and 9.3.

10.0 Risk Management

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

11.0 Infection Prevention and Control (IPC)

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

- 11.3 An Operator shall ensure that Staff has access to the necessary equipment and supplies to carry out the policies and procedures in 11.1.
- 11.4 An Operator must ensure that there is a documented procedure available to all Staff on how to contact the local IPC or Public Health resource.

12.0 Medication Management

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

- i) right medication;
 - ii) right Client;
 - iii) right dose;
 - iv) right time;
 - v) right route;
 - vi) right reason;
 - vii) right documentation; and
 - viii) right to refuse a medication;
- m) roles and responsibilities of Regulated Health Care Providers; and
 - n) roles and responsibilities of Unregulated Health Care Providers.

12.2 An Operator must ensure that a Client is provided with the option of Medication Reminders or Medication Assistance to support and enable the Client to competently self-administer some or all of the Client's medications for as long as possible.

12.3 Where a Client is assessed as being unable to competently self-administer their medication, an Operator must ensure that the Client is provided with a plan for assistance in accordance with the Medication Management policies and procedures.

12.4 An Operator must ensure that a Client's plan for Medication Management will be reassessed at the Client's Interdisciplinary Team conference and updates documented in the Care Plan.

13.0 Nutrition and Hydration Management

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

14.0 Oral Care Assistance and Bathing Frequency in Publicly Funded Supportive Living and Long-Term Care Facilities

- 14.1 An Operator of a Publicly Funded Supportive Living Facility or a Long-Term Care Facility must establish, implement and maintain documented policies and procedures regarding:
- a) the provision of oral care assistance to a Client; and
 - b) bathing frequency.
- 14.2 The policies and procedures in 14.1(a) must provide the Client with the opportunity for assistance with oral care twice a day and more frequently when required, as documented in the Client's Care Plan.
- 14.3 The policies and procedures in 14.1(b) must provide the Client with the opportunity for bathing at a minimum of twice a week by the method of the Client's preference, and more frequently based on the Client's Unmet Health Care Need.
- 14.4 A Client's preference for method and frequency of bathing must be documented in the Client's Care Plan.
- 14.5 For the purposes of 14, "bathing" means showers, tub baths, full body sponge baths and bed baths.

15.0 Safe Bath and Shower Water Temperature

- 15.1 An Operator must establish, implement and maintain documented policies and procedures regarding safe water temperatures where a Client is assisted by Health Care Providers with tub baths or showers. The policies and procedures must:
- a) require safe water temperatures between 38 and 43 degrees Celsius;
 - b) require monitoring and documentation of the water temperature of each assisted tub bath or shower;
 - c) require reporting of any variation from the established safe water temperatures; and
 - d) describe the competencies of a Health Care Provider assisting the Client with tub baths or showers.
- 15.2 An Operator of a Publicly Funded Supportive Living Facility or Long-Term Care Facility must establish, implement and maintain documented policies and procedures regarding:
- a) monitoring and maintenance of the water supply system; and
 - b) documentation of daily water temperature checks for each therapeutic tub prior to the first daily use.
- 15.3 For the purposes of 15.2, a “therapeutic tub” is a tub into which a Client is lifted or is fully accessible, for example by a side door.

16.0 Restraint Management and Secure Spaces

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

- d) a Physician's order or Nurse Practitioner's order, within 72 hours of initiation of the Restraint, authorizing the use of the Restraint;
 - e) the method and frequency for monitoring the Client when the Restraint is in use; and
 - f) assessment of the Client while the Restraint is being used and review of the ongoing need for the Restraint.
- 16.4 An Operator must establish, implement and maintain documented policies and procedures regarding Secure Spaces that require:
- a) information on the Secure Space must be provided to the Client or the Client's legal representative, if applicable, prior to or on initiation of the Secure Space and upon request while the Client lives within or is subject to the Secure Space;
 - b) the method and frequency for monitoring the Client while the Client resides in, or is subject to, the Secure Space; and
 - c) criteria for the discontinuation of the use of a Secure Space.
- 16.5 An Operator must ensure that when a Secure Space is used that the appropriateness of the Secure Space is documented and reviewed by the Interdisciplinary Team:
- a) upon a client's admission to, or the initiation of, the Secure Space;
 - b) on a frequency determined by the Interdisciplinary Team; and
 - c) upon a significant change in the behaviour or Responsive Behaviour that led to the use of a Secure Space.
- 16.6 While a Client resides in, or is subject to, a Secure Space, an Operator must ensure the following is documented in a Client's chart and Care Plan:
- a) evidence of the reason for the use of the Secure Space for the Client;
 - b) the method and frequency for monitoring the Client; and
 - c) ongoing review of the appropriateness and effectiveness of the Secure Space in meeting the needs of the Client.
- 16.7 For the purposes of 16.1 and 16.3, "supportive interventions" are positive, non-restrictive and non-pharmacological interventions including, but not limited to:
- a) meaningful activity participation;
 - b) assessment and management of the Client's pain;
 - c) assisting the Client to the toilet;
 - d) assisting the Client with repositioning;
 - e) social interactions; or

- f) environmental interventions.
- 16.8 For the purpose of 16.1(c), the “least restrictive Restraint” means only that degree of Restraint, used for the least amount of time, which is necessary for the avoidance of harm to the Client or harm to others.
- 16.9 For the purposes of 16.2 and 16.5 a “significant change” in the Client’s behavioural symptoms is a pattern of change in the behaviour or Responsive Behaviour that led to the use of a Restraint or Secure Space. The assessment or determination that a significant change has occurred must be made by a Regulated Health Care Provider.

17.0 Continuity of Health Care

- 17.1 An Operator must establish, implement, and maintain documented emergency preparedness, pandemic, and contingency plans to provide for the continuity of Health Care to a Client in the event of a disruption to the services.
- 17.2 An Operator must ensure the emergency preparedness plan, pandemic plan, and contingency plan:
- a) mitigate the risk and impact of the disruption of Health Care to a Client;
 - b) are reviewed and updated annually and after each implementation;
 - c) are communicated and made available to the Client or the Client's legal representative, if applicable:
 - i) upon the Client's commencement of services provided in the Co-ordinated Home Care Program, or upon admission to a Publicly Funded Supportive Living Facility or Long-Term Care Facility; and
 - ii) after any update.

18.0 Concerns Resolution on Health Care

- 18.1 An Operator must establish, implement, and maintain a documented policy and procedure for responding to concerns about the Health Care provided. The policy and procedure must:
- a) be accessible to the Client, the Client's legal representative, if applicable, and the Client's family:
 - i) upon the Client's commencement of services provided in the Co-ordinated Home Care Program, or upon admission to a Publicly Funded Supportive Living Facility or Long-Term Care Facility and
 - ii) upon request;
 - b) identify the method and a timeframe in which the Operator will respond to concerns from a Client, the Client's legal representative, if applicable, or the Client's family;
 - c) include:
 - i) information on how the Client, the Client's legal representative, or the Client's family can make a concern known and to whom;
 - ii) the Operator's process for responding to a concern;
 - iii) record keeping by the Operator of any actions taken; and
 - iv) a requirement that this information must be provided to a Client or the Client's legal representative, if applicable, the Client's family and Staff.
- 18.2 An Operator must provide the Client, the Client's legal representative, if applicable, or the Client's family with written information on relevant external complaints and concerns resolution processes:
- a) upon the Client's commencement of services provided in the Co-ordinated Home Care Program, or upon admission to a Publicly Funded Supportive Living Facility or Long-Term Care Facility; and
 - b) upon request.

19.0 Quality Improvement Reporting

- 19.1 An Operator must establish, implement, and maintain documented Quality improvement policies and programs to evaluate and improve its delivery of Health Care.
- 19.2 An Operator must establish, implement, and maintain, documented policies and procedures for the documentation, tracking, and trending of:
- a) any incident that could pose an adverse risk to a Client; and
 - b) any near miss that could have resulted in negative consequences for a Client but did not because of chance or timely intervention.
- 19.3 An Operator must establish, implement and maintain documented policies and procedures for the prevention, reporting, review and follow-up of reportable incidents.
- 19.4 Reportable incidents must be reported in accordance with the process and guidelines set out by the Ministry of Health.
- 19.5 A reportable incident is an unexpected or normally avoidable outcome that negatively affects a Client's health or quality of life and occurs in the course of Health Care or has the potential to alter the Client's Health Status. Reportable incidents include:
- a) death or serious harm to a Client caused by:
 - i) error or omission in the provision of Health Care;
 - ii) error or omission in the provision of accommodation services;
 - iii) equipment malfunction or error in operation;
 - iv) accommodation grounds or equipment in disrepair or unsafe; or
 - v) assault/aggression;
 - b) Client being unaccounted for;
 - c) unplanned activation of a contingency plan caused by:
 - i) disruption of utilities;
 - ii) evacuation;
 - iii) Staff disruption;
 - iv) severe weather; or
 - v) loss of essential equipment.

- d) extensive damage to the accommodation caused by:
 - i) fire or flood;
 - ii) disaster; or
 - iii) building or equipment failure.

19.6 An Operator must ensure that InterRAI assessment data is collected and submitted in accordance with the process and guidelines set out by the Ministry of Health once a month through the Alberta Continuing Care Information System (ACCIS).