Long-Term Care Services

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SCC Foreword

A National Standard of Canada is a standard developed by a Standards Council of Canada (SCC) accredited Standards Development Organization, in compliance with requirements and guidance set out by SCC. More information on National Standards of Canada can be found at www.scc.ca.

SCC is a Crown corporation within the portfolio of Innovation, Science and Economic Development (ISED) Canada. With the goal of enhancing Canada's economic competitiveness and social well-being, SCC leads and facilitates the development and use of national and international standards. SCC also coordinates Canadian participation in standards development and identifies strategies to advance Canadian standardization efforts.

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This standard was developed in compliance with the Standards Council of Canada's Canadian Standards Development: Requirements & Guidance—Accreditation of Standards Development Organizations.

Technical Committee Members

Long-Term Care Services

HSO's Technical Committees lead the development of HSO's standards. The Technical Committees are diverse and made up of representatives from multiple stakeholder groups, including people with lived experience, the workforce, researchers, and policy and decision makers. Each Technical Committee works with an HSO project team to oversee the development of a standard, ensuring that all points of view are represented.

The development and publication of this standard would not have been possible without the contributions of the Technical Committee members listed below. The generous time commitment and insights each member provided are greatly appreciated.

Please note that the views of the Technical Committee members on HSO's Technical Committee TC 008 Long-Term Care Services are representative of their expertise and not of their respective organizations.

Residents and Essential Care Partners

Naomi Black
Nova Scotia, Canada

Mary Brachaniec, BScPT, MAHSR
New Brunswick, Canada

Debra Funk
Saskatchewan, Canada

Susan George, LLB
Ontario, Canada

Devora Greenspon
Ontario, Canada

Wayne Hykaway
Alberta, Canada

Irene Lubbers
Yukon, Canada

Kathryn Pfaff, RN, MScN, PhD
Ontario, Canada

Long-Term Care Workforce

Jocelyn Borras, RPN, BScN
Trillium Health Partners and Cooksville Care Centre
Ontario, Canada

Genelle Butler
Saint Luke's Homes–Eastern Health
Newfoundland, Canada

Elaine Connelly
Tideview Terrace Home for Special Care
Nova Scotia, Canada

Jennifer Dockery, RN, MHA
Seniors Services and Long-Term Care–City of Toronto
Ontario, Canada

Marlene Hemmings, PSW
Sherwood Court Long-Term Care Home
Ontario, Canada

Joyce Kristjansson, RN, BSN, MBA
Manitoba Association of Residential Care Homes for the Elderly
Manitoba, Canada

Benoît Robert, MD, MBA
Perley Health
Ontario, Canada

General Expertise and Experience

Pat Armstrong, PhD, FRSC
York University
Ontario, Canada

Julie Bessant Pelech, BES, CGeront, MA
Bessant Pelech Associates Inc.
Ontario, Canada

Carole A. Estabrooks, CM, PhD, RN, FRSC, FCAHS, FAAN, FCAN
University of Alberta
Alberta, Canada

Heather Keller, RD, PhD, FDC, FCAHS
Schlegel–UW Research Institute for Aging and
University of Waterloo
Ontario, Canada

Hazel Markwell, PhD, DTh
Saint Paul University
Ontario, Canada

Jane Meadus, BA, LLB
Advocacy Centre for the Elderly
Ontario, Canada

Allison McGeer, MSc, MD, DSc (Hons), FRCPC, FAMMI, FIDSA
Sinai Health System, University of Toronto
Ontario, Canada

Samir Sinha (Chair), MD, DPhil, FRCPC, AGSF
Sinai Health System, University Health Network, and National Institute on Ageing
Ontario, Canada

Carol Ward, MD, FRCPC
Hillside Center, Interior Health
British Columbia, Canada

Policy and Decision Makers

Joe Barnes
Kenora Chiefs Advisory
Ontario, Canada

Veronique Boscart, RN, MScN, MEd, PhD
Conestoga College Institute of Technology and Advanced Learning
Ontario, Canada

Brigitte Brabant, MA, MAP
CIUSSS de l'Est-de-l'Île-de-Montréal
Québec, Canada

Carolyn Bubbar, BSP, ACPR, PharmD
Lower Mainland Pharmacy Services, Fraser Health
British Columbia, Canada

Janice Keefe, PhD, FCAHS
Mount Saint Vincent University
Nova Scotia, Canada

Ben Mortenson, BScOT, MSc, PhD, OT, FCAOT
Faculty of Medicine, University of British Columbia
xʷməθkʷəy̓əm (Musqueam) Traditional Territory
British Columbia, Canada

Jan Rogerson, MD, MPH
Health PEI
Prince Edward Island, Canada

James Silvius, BA(Oxon), MD, FRCPC
Alberta Health Services
Alberta, Canada

Advisers

Cheryl Osawabine-Peltier, MBA
Wikwemikong Nursing Home
Ontario, Canada

Preface

Health Standards Organization (HSO) develops evidence-based health and social service standards, assessment programs, and quality improvement solutions. Recognized by the Standards Council of Canada as a Standards Development Organization, HSO works with leading experts and people with lived experiences from around the world, using a rigorous public engagement process to co-design standards that are people-centred, integrated, and promote safe and reliable care. For more information, visit www.healthstandards.org.

HSO's People-Centred Care Philosophy and Approach

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

People-centred care guides both what HSO does and how HSO does it. It calls for a renewed focus on the interaction and collaboration between people, leading to stronger teamwork, higher morale, and improved coordination of care (Frampton et al., 2017). This ensures people receive the right care, in the right place, at the right time, by the right people.

With a vision for safer care and a healthier world, HSO's mission is to empower and enable people around the world to continuously improve quality of care. HSO has developed the following guiding principles for people-centred care:

- **Integrity and relevance**. Uphold the expertise of people in their lived experiences of care; plan and deliver care through processes that allow mutual understanding of people's goals, needs and preferences and facilitate outcomes that have been influenced by the expertise of all.
- **Communication and trust**. Communicate and share complete and unbiased information in ways that are affirming and useful; provide timely, complete, and accurate information to enable people to effectively participate in care and decision-making.
- **Inclusion and preparation**. Ensure that all people have equitable access to care and the opportunity to plan and evaluate services; empower people to participate in care and decision-making to the extent that they wish.
- **Humility and learning**. Encourage people to share problems and concerns to promote continuous learning and quality improvement; promote a just culture and system improvement over blame and judgment.

About HSO's Standards

HSO's standards are the foundation on which leading-edge accreditation programs and evidence-informed public policy are built. Standards create a strong people-centred health care system that stakeholders can rely on to enable people around the world to continuously improve quality of care.

HSO's standards are formatted using the following structure:

- **Section title**. A section of the standard that relates to a specific topic.
- **Clause**. A thematic statement that introduces a set of criteria.
- **Criteria**. Requirements based on evidence that describe what is needed by people to achieve a particular activity. Each criterion outlines the intent, action, and accountability.
- **Guidelines**. Additional information and evidence to support the implementation of each criterion.

About This Standard

CAN/HSO 21001:2023 (E) *Long-Term Care Services* standard is a revision of the HSO 21001:2020 *Long-Term Care Services* standard.

CAN/HSO 21001:2023 (E) *Long-Term Care Services* is based on findings from literature reviews, clinical expertise, evidence-informed practices, and those with lived experiences. The published evidence used to inform this standard can be found in the bibliography.

The standard focuses on promoting good governance; upholding resident-centred care and enabling a meaningful quality of life for residents; ensuring high-quality and safe care; fostering a healthy and competent workforce; and promoting a culture of quality improvement and learning across long-term care (LTC) homes. The target audiences for the use of this standard include LTC home residents, substitute decision makers, essential care partners, the workforce, leaders, and governing bodies.

The content of this standard is structured into the following sections:

1. Governing LTC Home's Strategies, Activities, and Outcomes
2. Upholding Resident-Centred Care
3. Enabling a Meaningful Quality of Life for Residents
4. Ensuring High-Quality and Safe Care
5. Enabling a Healthy and Competent Workforce
6. Promoting Quality Improvement

This standard integrates the principles of equity, diversity, and inclusion outlined in Annex A: Guiding Principles for Equity, Diversity, and Inclusion.

This standard guides LTC home teams, leaders, and governing bodies on

- providing evidence-informed, resident-centred care that values compassion, respect, dignity, trust, and a meaningful quality of life;
- working in a team-based way to deliver high-quality care that is culturally safe and trauma-informed to meet residents' goals, needs, and preferences;

- enabling a healthy and competent LTC home workforce and healthy and safe working conditions; and
- upholding strong governance practices and a culture that is outcome-focused and committed to continuous learning and quality improvement.

In addition to the above, the standard also provides

- external assessment bodies with evidence-informed content that can be used in assessment programs; and
- decision makers with a quality and safety blueprint to guide policy development and requirements to ensure the delivery of high-quality, resident-centred care and enable a healthy and competent workforce.

The published evidence used to inform this standard can be found in the bibliography.

This standard is intended to be used as part of a conformity assessment. This standard will undergo periodic maintenance. HSO will review and publish this standard on a schedule not to exceed five years from the date of publication.

Acknowledgements

This National Standard of Canada was produced with funding and support from the Standards Council of Canada (SCC). It is the result of collaboration between SCC, HSO, and the Canadian Standards Association (CSA Group) to develop two new complementary National Standards of Canada for long-term care.

HSO is grateful to and acknowledges the valuable contributions of the British Columbia Cultural Safety and Humility Technical Committee in developing HSO 75000:2022 *British Columbia Cultural Safety and Humility* which informed this standard.

Disclaimer

The intended application of this standard is stated below under Scope. Users of this standard are responsible for judging its suitability for their particular purposes.

HSO's standards are not intended to replace clinical, management, or best practice guidelines or to contravene existing jurisdictional regulations.

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Long-Term Care Services

Introduction

Why long-term care services matter now more than ever

There is growing public pressure to ensure that long-term care (LTC) services meet the needs of Canada's population effectively and sustainably. LTC homes are settings that offer a wide range of health and personal care services for people with complex needs who require 24-hour nursing care, personal care, and other therapeutic and support services (Canadian Institute for Health Information, 2021). While the demand for LTC services in Canada is only expected to grow, the reliable delivery of high-quality, safe, resident-centred care continues to be compromised by a complex and vulnerable system (National Institute on Ageing, 2019).

In Canada, LTC is one of the most significant areas of health care that is neither publicly guaranteed nor insured under the *Canada Health Act.*[1] With LTC services governed by provincial and territorial legislation and not a part of Canada's universal health coverage model, there is variation across the country in what services are offered, how care is assessed, what costs are covered, and how facilities are governed (Health Canada, 2004).

Various reports over the past decade have underscored challenges, needs, and areas for improvement across Canada's health systems, including the integration of services provided in LTC homes (Healthcare Excellence Canada, 2020; Marrocco et al., 2021; Office of the Seniors Advocate British Columbia, 2021; Royal Society of Canada, 2020; Wong et al., 2021).

Spotlights have been shone on the need for

- adequate and coordinated federal and provincial/territorial investments and funding into services provided in LTC homes;
- investment in a healthy and competent LTC workforce;
- capacity of the health system to respond to the growing and complex needs of LTC residents;
- stronger infection prevention and control practices; and
- standards and accountability measures to enable the delivery of high-quality, safe, resident-centred care.

A necessary wake-up call on the state of long-term care services in Canada

Close to a quarter of a million people live in LTC homes in Canada (Statistics Canada, 2021). The COVID-19 pandemic exposed significant gaps in the ability of LTC homes to provide high-quality care to these residents.

The delivery of high-quality LTC care means care that is

- resident-centred: responding to individual goals, needs, and preferences;
- effective: providing evidence-informed health services to those who need them;

[1] The *Canada Health Act* sets out conditions that provincial and territorial health insurance plans must meet to receive the full federal cash contribution for which the provinces and territories are eligible under the Canada Health Transfer program. Government of Canada. (2011). "What is the Canada Health Transfer (CHT)?" https://www.canada.ca/en/department-finance/programs/federal-transfers/canada-health-transfer.html

- safe: avoiding harm to all people involved in care; and
- accessible: receiving care that is timely and equitable.

As of December 2021, LTC residents accounted for 43 per cent of all COVID-19 deaths in Canada (National Institute on Ageing, n.d.). During the first few months of the global pandemic, 81 per cent of Canada's known COVID-19 deaths occurred within its LTC and retirement homes. Further, the risk of dying from COVID-19 at the outset of the pandemic was found to be 73.7 times greater among older Canadians who lived in LTC and retirement homes than among those who lived in their own private dwellings (Sepulveda et al., 2020). As of July 2022, 63 per cent of Canada's LTC and retirement homes recorded cases of COVID-19, with over 17,177 resident and 32 workforce deaths.

Enabling the future of long-term care in Canada with new national standards for long-term care

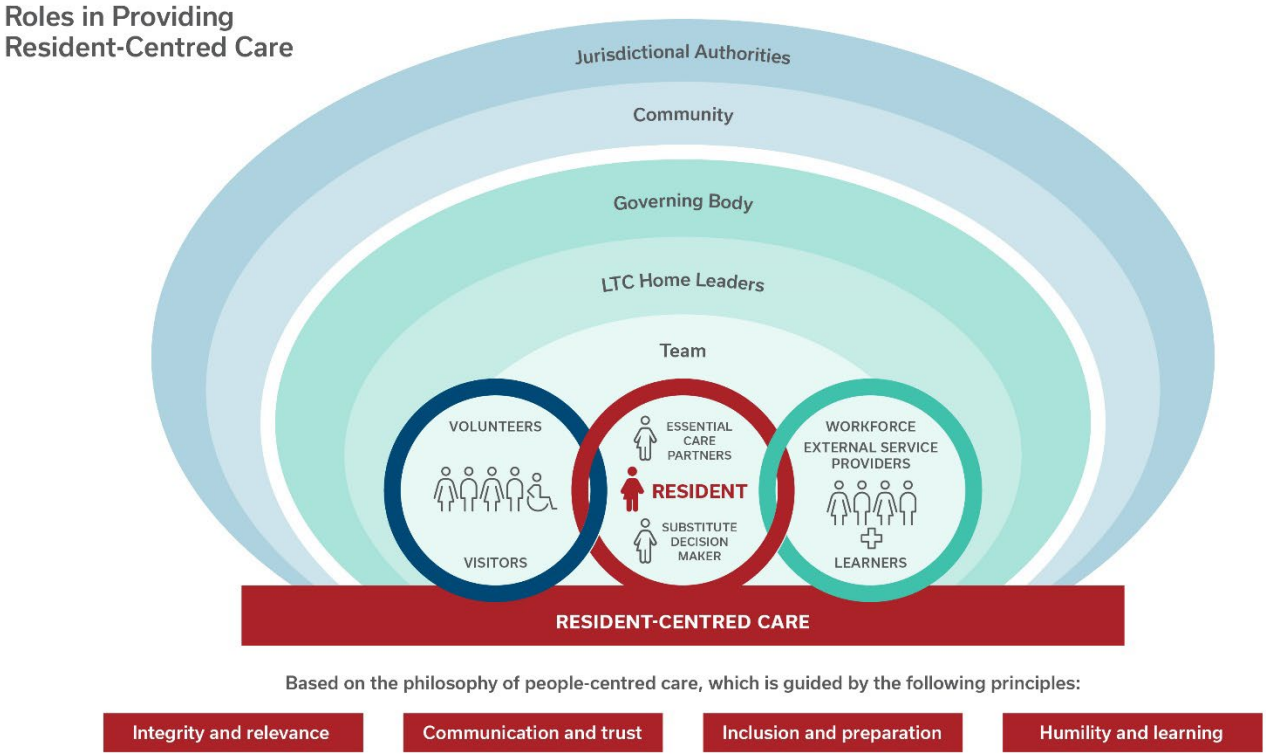
Considering the existing crisis in LTC homes, and in response to the federal government's commitment in 2020 to improve the provision of LTC across Canada, the Standards Council of Canada (SCC), Health Standards Organization (HSO), and the Canadian Standards Association (CSA Group) agreed to work collaboratively on the development of two new complementary national standards for LTC. A commitment was made to ensure the standards were shaped by the needs and voices of Canada's LTC home residents, substitute decision makers, essential care partners, the workforce, local communities, and members of the public. The national standard developed by HSO addresses the delivery of safe, reliable, and high-quality care, while the national standard developed by CSA Group addresses the design, operation, and infection prevention and control practices in LTC homes.

To guide the development of the LTC Services standard, HSO established a 32-member LTC Services Technical Committee that included diverse representation from multiple stakeholder groups and conducted extensive research and public engagement activities that generated participation and insights from over 18,800 Canadians. Findings from public engagement highlighted what matters most to Canadians when it comes to the provision of LTC services now and in the future. A three-part series of *What We Heard* reports summarizing the findings from the public engagement activities is available at https://longtermcarestandards.ca/.

At the onset of designing HSO's LTC Services standard, the Technical Committee identified the following six foundational principles to guide and inform the standard's development.

- High-quality, safe, resident-centred care focuses on adopting residents' perspectives to meet the goals, needs, and preferences of residents.
- 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.
- Team-based care is evidence informed and enables equity, diversity, and inclusion and cultural safety approaches.
- LTC home residents have the right to choose to live with risk.
- Quality improvement requires investing in continuous data collection and monitoring.
- The delivery of LTC services complies with jurisdictional requirements.

As illustrated in the following diagram, resident-centred, team-based care is brought to life through the dynamic roles and commitment of multiple stakeholders, including residents, substitute decision makers, essential care partners, the workforce, LTC home leaders, governing bodies, and jurisdictional authorities.



The delivery of high-quality, safe, resident-centred LTC services requires balancing multiple forces, such as

- the reality of the LTC home environment as both a home and a workplace;
- 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 through the use of standards while respecting individualization.

Jurisdictional requirements, professional regulations, funding, bargaining agreements, and determining who can own or operate LTC homes are the responsibility of provincial and territorial governments. Principles of a shared vision, a common purpose, and shared accountabilities of all stakeholders are required to have a collective impact that will enable the successful implementation of HSO's new national LTC Services standard.

Scope

Purpose

This standard provides LTC home teams, leaders, and governing bodies with criteria and guidelines for delivering resident-centred, high-quality care, enabled by a healthy and competent workforce.

Applicability

This standard applies to teams, leaders, and governing bodies of LTC homes. LTC homes, also referred to as continuing care, personal care, or nursing homes, are settings where people with complex health care needs live. 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.).

The defined resident population for this standard are adults who live in LTC homes.

In this standard, we use the term “resident” to refer to people who live in an LTC home. We recognize that this term might not be appropriate in all contexts. LTC home teams and leaders will respect the preference of those living in the LTC home as to what they would like to be called.

Normative References

A normative reference is a reference to a part or all of another standard or document that constitutes a requirement of this standard. The normative references listed below serve as criteria in this standard. If the normative reference does not have an associated date in its title, the most current version should be used.

- HSO 4001 *Infection Prevention and Control*

Terms and Definitions

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

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.

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.

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.

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.). (For more information, see Annex A.)

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, 2021b).

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).

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.

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 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.).

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.

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*.

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).

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.

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

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).

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.

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.

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.

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).

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.

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.

Abbreviations

CSA Group – Canadian Standards Association

HSO – Health Standards Organization

LTC – Long-term care

SCC – Standards Council of Canada

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

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.

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.

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, and 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.

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.

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.

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.

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.

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.

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 that the LTC home delivers.

Guidelines

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. High-quality health services should be

- resident-centred: responding to individual goals, needs, and preferences;
- effective: providing evidence-informed health services to those who need them;
- safe: avoiding harm to all people involved in care; and
- accessible: receiving care that is timely and equitable.

The governing body ensures the LTC home is using a recognized continuous quality improvement framework and quality of care measures to monitor the LTC home's performance. Quality of care measures include those that assess

- structure: the LTC home's capacity, systems, and practices;
- process: what the LTC home does to improve residents' health and quality of life; and
- outcome: the effect of the care and services.

The governing body demonstrates commitment to improving quality of care by including it as a standing agenda item for regular meetings. Sufficient time is allocated at meetings to discuss key quality indicators, such as the number of patient safety incidents (such as infections), resident experience survey results, quality of work life reported by the workforce, and feedback and complaints from residents, the workforce, and others.

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

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.

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.

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.

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.

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.

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.

2 Upholding Resident-Centred Care

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

For more information, see Annex A: Guiding Principles for Equity, Diversity, and Inclusion.

See CSA Z8004 (section 4.5) for additional information on organizational commitments that promote equity, diversity, and inclusion principles.

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

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.

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.

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.

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.

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,
- practise 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.

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.

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.

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.

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.

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.

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.

The LTC home complies with jurisdictional requirements regarding visitation.

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.

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.

See CSA Z8004 (section 5.6) for additional information on operational communications.

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

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.

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.

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.

3 Enabling a Meaningful Quality of Life for Residents

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.

Guidelines

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.

See CSA Z8004 (section 8) for additional information on design and operational considerations that enhance residents' quality of life.

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

Guidelines

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.

Guidelines

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.

Guidelines

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.

See CSA Z8004 (sections 5.5 and 8.2.5) for additional information on nutrition and food management and design of dining areas.

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

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.

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.

See CSA Z8004 (section 8) for additional information on design and access to outdoor spaces.

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

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.

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.

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.

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.

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.

4 Ensuring High-Quality and Safe Care

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.

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.

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.

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.

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.

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.

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.

See CSA Z8004 (section 4.3) for additional information on design and operational considerations related to sexual expression and intimacy.

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

Guidelines

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.

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.

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.

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.

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 The team follows the LTC home's procedure to confirm the identity of the resident before providing care.

Guidelines

Confirming a resident's identity ensures the correct resident receives the intended care. This process helps to avoid harmful incidents, such as privacy breaches, medication errors, wrong care, or transfers to the wrong location.

Using a team-based approach, the team follows the LTC home's procedure to confirm the resident's identity with the resident, or if incapable, with their substitute decision maker, and essential care partners with consent. The team explains the reason for the safety practice and asks for at least two person-specific identifiers, such as

- the resident's full name,
- an accurate photograph of the resident, or

- facial recognition.

A resident's room or bed number that has not been confirmed with the resident, substitute decision maker, or essential care partner is not person-specific and should not be used as an identifier.

If the resident, substitute decision maker, or essential care partner is unable to provide the requested information, the team can check government-issued identification. The team documents the confirmation in the resident's health record and shares this information with appropriate team members.

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

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.

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 follows the LTC home's procedure for skin integrity management.

Guidelines

Adults with complex needs are at risk of developing skin tears, bruising, pressure injuries, and skin infections. Inappropriate skin care can result in residents experiencing worsened pain, wounds, and wound infections.

Using a team-based approach, the team follows the LTC home's procedure to protect the resident's skin integrity and reduce the risk of injuries. The team regularly assesses the resident's skin, nails, and mouth; identifies any problem areas; and addresses them promptly.

The team is vigilant about prevention practices, intervening early and regularly to reduce the risk of injuries. For example, the team can help to reduce the risk of skin irritations by ensuring the resident has access to regular hygiene practices. They can reduce the risk of pressure ulcers by regularly changing the resident's position and

reducing bruising and tears during repositioning activities. Using assistive devices, such as lifts and pressure-reduction cushions and mattresses, can also preserve skin integrity when a resident's mobility is limited.

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

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

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 follows the LTC home's procedure for the reduction of injuries caused by falls.

Guidelines

Approximately half of all residents living in an LTC home will fall each year, and of those who fall, 40 per cent of them will fall two or more times. These falls can result in acute pain; cause physical injuries such as fractures, head injuries, and bruising; and affect residents' mental health and well-being. The outcome of the injury may result in reduced functional capacity and even death.

Using a team-based approach, the team follows the LTC home's procedure to prevent and reduce the incidence of falls and related injuries for all residents. Team members mitigate the risk of falls on an ongoing basis. The use of assistive devices adapted to the resident's needs can significantly reduce the risk of falls. The approach balances the resident's rights, need for autonomy, and right to live with risk.

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

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

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.

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.

Guidelines

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 LTC home's procedure to reconcile medications following a change in the resident's care plan that may result in a change in the medication profile.

Guidelines

Maintaining an up-to-date medication profile for each resident is a safety practice that keeps all residents safe.

Using a team-based approach, the team follows the LTC home's procedure to reconcile the resident's medications following any changes in the resident's care that may involve a change in medication. For example, if a resident transitions from an acute care facility back to the LTC home, the team needs to reconcile the medication profile for any additions, dosage modifications, or stopped medications.

The procedure is aligned with evidence-informed practices and provides steps for the team to

- confirm the resident's current medication (best possible medication history) and their use of any traditional or alternative medicines with the resident, or if incapable, with their substitute decision maker;

- consult any new medication-related information;

- compare the resident's current medication profile with the proposed medication profile and reconcile as appropriate;

- communicate the new medication profile to the appropriate team members; and

- document any changes to the resident's health record and individualized care plan.

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

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 conforms to the requirements in HSO 4001 *Infection Prevention and Control* to plan, implement, and evaluate an effective infection prevention and control program.

See CSA Z8004 (section 7) for additional information on infection prevention and control requirements.

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

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.

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

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.

4.2.15 The team follows the LTC home's procedure for reporting a safety incident experienced by the resident.

Guidelines

A safety incident is an event or circumstance that could have harmed or did harm a resident. Safety incidents experienced by residents (also referred to as patient safety incidents) may include medication errors, choking incidents, injuries, infections, mistakes during care, falls, or residents leaving the LTC home without notice.

The team follows the LTC home's procedure to report a safety incident experienced by the resident. The procedure is aligned with evidence-informed practices. It outlines what types of incidents need to be reported, how to report them, and to whom. The procedure is simple, clear, confidential, and focused on system improvement.

Safety incidents are defined in the procedure, in compliance with jurisdictional requirements.

The team documents the safety incident in the resident's health record and the safety incident reporting system. The information is shared with appropriate team members.

4.2.16 The team follows the LTC home's procedure for disclosing a safety incident experienced by the resident.

Guidelines

Disclosure is a formal process involving open discussion between a resident, or if incapable, their substitute decision maker, and representatives from the LTC home's workforce about a safety incident. Disclosure provides the means for communication throughout the incident management process, contributes to the maintenance of trust, supports safety improvement, and promotes healing for those involved.

Disclosure is an ongoing process in which multiple disclosure conversations occur over time, beginning with the initial disclosure and progressing to the post-analysis disclosure, after the reasons for the event are better understood.

The team follows the LTC home's procedure to disclose a safety incident to the resident, or if incapable, their substitute decision maker, and essential care partners with consent. The procedure complies with jurisdictional requirements and evidence-informed practices and outlines which safety incidents must be disclosed, who leads and supports the disclosure process, what can be communicated and to whom, when and how to disclose information about the incident, and how to document the disclosure. The procedure also outlines the types of support that may be offered to the resident and others involved in the safety incident.

The team collaborates with the resident, or if incapable, their substitute decision maker, and other team members to learn about their experience with the disclosure. This feedback may be used to improve the disclosure process.

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

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.

See CSA Z8004 (section 11) for additional information on catastrophic event management.

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

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.

4.2.19 The team conducts regular simulations of the LTC home's evacuation procedure.

Guidelines

Simulations of the LTC home's evacuation procedure 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 evacuation procedure at the intervals and in the manner outlined in the procedure. The team conducts at least one physical, in-person simulation of one type of emergency or element of the evacuation procedure 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 evacuation procedure is updated following simulation activities and any time there is a change in the LTC home environment that would affect the procedure, such as a loss of a common room or other space. Teams are informed of any changes in the procedure and provided with the updated version.

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.

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.

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.

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.

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.

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.

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.

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.

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 The team follows the LTC home's procedure for communicating appropriate information following a change in care.

Guidelines

Information relevant to the resident's care must be communicated effectively whenever there is a change in care. This information is essential to ensuring the resident receives continuous, seamless care from all providers.

The team follows the LTC home's procedure for communicating appropriate information to team members or other health care professionals whenever there is a change in care. Changes in care include all situations in which the resident receives care from new people or in a new care setting. Examples of changes in care include admission to the LTC home, handover at shift changes, transfer to another care setting, and discharge from the LTC home.

The information shared will depend on the nature of the change in care. It can include updates on the resident's status and activities; details about the resident's medications, allergies, medical diagnoses, test results, procedures, and advance care plan; and contact information for the resident, their substitute decision maker and essential care partners, and other team members.

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

4.3.10 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.

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.

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.

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.

5 Enabling a Healthy and Competent Workforce

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.

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.

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.

Guidelines

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.

See CSA Z8004 (section 12) for additional information on training and simulation for the workforce.

5.1.4 The LTC home leaders ensure the workforce has access to continuous learning activities to support ongoing learning and career development.

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.

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.

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.

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.

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.

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.

Guidelines

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.

Guidelines

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.

Guidelines

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.

Guidelines

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.

See CSA Z8004 (section 10) for additional information on information technology

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.

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 The LTC home leaders establish a preventive maintenance program for health care equipment.

Guidelines

An effective preventive maintenance program helps ensure health care equipment is safe to use and operates as required.

The LTC home leaders establish a preventive maintenance program that safeguards people from harm caused by malfunctioning health care equipment. The program prioritizes maintenance of critical equipment, such as defibrillators and suctioning machines. The preventive maintenance program includes procedures to

- clean and low disinfect health care equipment,
- store health care equipment safely and securely,
- perform routine and preventive maintenance that includes calibration when required,
- report and investigate incidents of malfunctioning health care equipment,
- prioritize procurement of new health care equipment based on defined criteria, and
- evaluate the effectiveness of the preventive maintenance program.

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.

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.

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.

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.

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.

6 Promoting Quality Improvement

6.1 The LTC home leaders and teams demonstrate an ongoing commitment to quality improvement.

6.1.1 The LTC home leaders have dedicated resources for quality improvement activities.

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.

6.1.2 Teams have a quality improvement plan for improving residents' quality of life.

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.

6.1.3 Teams have a quality improvement plan for improving residents' quality of care.

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.

6.1.4 The LTC home leaders have a quality improvement plan for enabling a healthy and competent workforce.

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.

6.1.5 The LTC home leaders communicate quality improvement outcomes to the LTC home's stakeholders.

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.

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Annex A (Informative)

Guiding Principles for Equity, Diversity, and Inclusion

Health and social service organizations aim to provide high-quality care and services to all people regardless of their race and ethnicity, gender, sexual orientation, religion, socio-economic status, or other attributes. However, health inequities have persisted, leaving many people unable to access timely, equitable, and safe care in a way that respects their needs.

Health inequities are the socially constructed, unfair, and avoidable differences in the opportunities groups of people have to achieve optimal health. These inequities are influenced by and further intensify the social determinants of health, leading to stigma and biases in the way that care and services are designed and delivered to marginalized groups.

A health or social service organization that is inattentive to the needs of marginalized people is unable to serve those who need it most. If people do not feel a sense of belonging, they lose their hope and desire to seek help.

Health and social service organizations are encouraged to integrate the following principles of equity, diversity, and inclusion in the design and delivery of care and services:

- Adhere to the principles of equity-oriented health care to co-design and co-deliver care and services in a just and fair way.
- Respect, acknowledge, and make the effort to understand the beliefs, values, and identities of all populations served.
- Work directly with members of all populations served to effectively co-design and co-deliver culturally safe and appropriate care and services that meet their needs.
- Adopt an inclusive approach and build intercultural competencies by establishing and fostering a multicultural group of providers across all settings and by carrying out equity training to effectively meet the needs of all populations served.
- Recognize and respect the health and well-being needs of ethnocultural groups, including those of Black people, and create care delivery models that meet these needs.
- Recognize and respect the health and well-being needs of two-spirit, lesbian, gay, bisexual, transgender, queer, or questioning (2SLGBTQ+) people and create care delivery models that meet these needs.
- Recognize, understand, and work collaboratively to address issues of stigma and discrimination faced by marginalized people.
- Recognize, understand, and work collaboratively to eliminate systemic racism.
- Foster shared accountability for equitable health outcomes with partners in the community.

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