Long-Term Care Services
Working Group on Long-Term Care Services

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It is important to note that the views of the Working Group members are representative of their expertise and not their respective organization.

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Preface

Health Standards Organization’s HSO 21001:2020(E) Long-Term Care Services is a revision of HSO 21001:2014 (E) Long-Term Care Services.

The standard was revised by a Working Group comprised of 9 individuals from across Canada, including experts in the field of long-term care services. Frontline care providers and resident, family and caregiver participants reviewed the standard with the purpose of improving clarity, flow, intent, and action. The revision was strengthened through a focused public stakeholder review.

The modified review process and revision did not change the standard content, nor create new criteria. Criteria have been modified to improve clarity and avoid duplication. Language has been adjusted to be person-centred and to ensure relevancy for those who work within the requirements. Language has been changed to ensure the standard is reflective of the community setting and be less acute-focused.

The technical content of HSO 21001:2020 (E) Long-Term Care Services is divided as follows:

- Building a Competent Team
- Providing Safe and Effective Services

This standard will be undergoing periodic maintenance. HSO will review and publish this standard on a schedule not to exceed five years from the date of publication.

Standard Type: This standard is intended to be used as part of a conformity assessment.

The technical content of the standard consists of clauses, criteria and guidelines.

- **Clause:** Introductory statement for a set of criteria. It is not a goal statement.
- **Criterion:** A requirement that is to be evaluated. May be referred to as a sub-clause.
- **Guideline:** Additional information to help understand the criterion. It does not contain new information of evaluation content.

**HSO’s People Centred Care (PCC)-Guiding Principles**

HSO is committed to working closely with people around the world who share our passion for achieving quality health services for all.

PCC is defined by the World Health Organization as “an approach to care that consciously adopts individuals’, carers’, families’ and communities’ perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people”. As such, a people-centred care philosophy guides both the development process and content of HSO’s standards. PCC calls for a renewed focus on the interaction and collaboration between people, much like what is suggested by those who use the expression “relationship-centered care” where it is acknowledged that stronger and more intentional connections lead to improved decision making and teamwork, higher morale, decreased hospitalizations, and improved trainee competence.

As an organization striving to develop the best health and social services standards for improved health outcomes, PCC truly reflects our mandate.

HSO’s principles of people-centred care are based on patient partners guiding principles, Standards Development guiding principles, and new principles added to cultural safety and humility charter, that all play a part in providing safe, high quality care in all health and social services sectors. These principles are HSO’s basis for people-centred care.
HSO’s principles of people-centred care are:

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

2. **Communication and trust**: Communicating and sharing complete and unbiased information in ways that are affirming and useful; Providing timely, complete, and accurate information to effectively participate in care and decision making.

3. **Inclusion and preparation**: Ensuring fair access to care and opportunities to plan and evaluate services to people from diverse backgrounds and contexts; Encouraging and supporting clients and families to participate in care and decision making to the extent that they wish.

4. **Humility and learning**: Encouraging people to share problems and concerns in order to promote continuous learning and improvements; Promoting system improvement over individual blame and judgement.
Disclaimer

Although the intended primary application of this Standard is stated in its Scope, it is important to note that it remains the responsibility of the users to judge its suitability for their particular purpose.

HSO standards are not intended to replace clinical or best practice guidelines. The intention of this publication is not to contravene existing national, provincial, or territorial legislation/regulations.

Patents/trademarks:

1. *(Identification of patent) NOTE* - The user's attention is called to the possibility that compliance with this standard may require use of an invention covered by patent rights.

By publication of this standard, no position is taken with respect to the validity of this claim or of any such claim(s) or of patent rights in connection therewith. If a patent holder has filed a statement of willingness to grant a license under these rights on reasonable and non-discriminatory terms and conditions to applicants desiring to obtain such a license, then details may be obtained from HSO.
Long-Term Care Services

Introduction

Long-term care (LTC) is for people requiring accommodation who can no longer live safely on their own. It provides, high levels of care, 24-hour nursing care, meals, and housekeeping, along with social and recreational activities for their residents. Quality care for residents is provided professionally and compassionately with the goal of physical, mental/psychological, emotional, social, spiritual and cultural requirements being met. The well-being of residents is promoted by upholding their safety, independence, and dignity (British Columbia Office of the Ombudsperson, 2012). There are challenges in this sector, and the care needs of residents have become more complex. Residents are older, have more co-morbidities, are more frail, have more behavioural issues and use more medication (Rust, Wagner, Hoffman, Rowe & Neumann 2008).

High-quality LTC is achieved through a resident, family and caregiver centred focus. Residents, families and caregivers are active partners in service delivery. Shared decision making and the development of individualized care plans are designed, and implemented together with the involvement of residents, families and caregivers.

It is essential for the LTC team to be consistently up to date regarding best practices in resident care. LTC workers must have the relevant competencies to provide safe and effective services for their residents. Staff training and education is an important investment and barriers such as the ability to cover staff while they are being trained should be removed. Topics that require education and training for employees include; communication, medication management, falls, responsive behaviours, infection control, identification of risks, use of equipment, and use of minimal restraints (Rust, Wagner, Hoffman, Rowe & Neumann 2008).

LTC needs to be balanced in its delivery, both protecting the rights of the resident and ensuring their safety, while not adversely affecting their quality of life (Rust, Wagner, Hoffman, Rowe & Neumann 2008). The use of restraints interferes with the dignity and personal freedom of residents (British Columbia Office of the Ombudsperson, 2012). Team members are trained in the use of minimal restraints, as their use is linked to negative health outcomes, which may affect the physical, psychological, and emotional well-being of residents, families, and/or caregivers (Registered Nurses’ Association of Ontario, 2012). Organizational processes and staff training on informed consent to care and use of minimal restraints are required to ensure the rights of this vulnerable population are protected (Seniors BC, 2013).

Physical security includes safe mobility measures and physical transfer procedures. Falls among frail residents are a long-standing safety issue in LTC. Safe mobility can be impacted by medications, the physical environment of the home, the social environment, equipment being used and policies within the home (Rust, Wagner, Hoffman, Rowe & Neumann 2008).

As the prevalence of dementia continues to rise in the population, so will the demand for LTC and need for specialized training for staff and caregivers. Responsive behaviours, are experienced by up to 90 per cent of persons with the illness. These behaviours can be incredibly challenging for LTC staff and family members (Sinha, 2012).

Abuse remains a concern for residents, families and caregivers in LTC homes. Safety of residents includes both physical and psychological security. Team members must prevent, recognize, address and report abuse and neglect of residents (Long-Term Care Task Force on Resident Care and Safety, 2012). Awareness initiatives and staff training are recommended to increase the ability to recognize abuse and mitigate it (Seniors BC, 2013).

LTC provides a safe, supportive, and welcoming environment for their residents. This includes providing activities that foster their quality of life, that are meaningful, enjoyable, and important to them. Involvement in their dining experience, including food choice, as well as social and cultural aspects may impact their quality of life positively (Frampton, et al., 2010; Sinha, 2012).

The objective of this standard is to guide organizations in providing residents with safe and high-quality LTC, and to address priority areas such as coordination of care, provider and volunteer competencies, and resident, family and/or caregiver involvement in individualized care.

HSO 21001:2020 (E)
The application of the elements in this standard will vary according to the local circumstances and resources of the health service or organization as well as the individual needs, strengths, and preferences of residents. However, the overall goal, which is to improve the quality and safety of LTC services, remains unchanged.

The references cited here, in the HSO Master Glossary (accessible through the Terms and Definitions section), and those used to inform the content of the standard can be found in the Bibliography.
Scope

Purpose

The HSO 21001:2020(E) Long-Term Care Services standard provides:

• Residents, families and/or caregivers with information about what they can expect from a high-quality and safe Long-Term Care (LTC) home and a description of their roles and responsibilities regarding how they may be partners in their care,
• A focus on resident-centred care through shared decision making and individualized care planning,
• Information and guidance for the protection of the physical and psychological security of residents in a LTC organization,
• Content on preventing, addressing and reporting abuse and neglect of residents,
• Content on preventing and managing residents’ responsive behaviours,
• Content on the safe use of minimal restraints,
• LTC providers with guidance on how to ensure high-quality and safe care in their organization, and
• External assessment bodies with measurable requirements to guide continuous quality improvement.

Applicability

The HSO 21001:2020(E) Long-Term Care Services standard is intended for use by organizations that provide accommodation, high levels of care, 24-hour nursing care, meals, and housekeeping, along with social and recreational activities for their residents.

Normative References

The HSO Standards below are also referenced in the criteria of this standard. For dated references, only the edition cited applies. For un-dated references, the latest edition of the referenced document (including any amendments) applies:

• HSO 0001 - Service Excellence.
• HSO 5014-5:2018 - Medication Reconciliation at Care Transitions - Long-Term Care.
• HSO 5060-2:2018 - Fall Prevention and Injury Reduction - Long-Term Care Services.
• HSO 5063: 2018 - Skin and Wound Care.
• HSO 5062:2018 - Pressure Ulcer Prevention.
• HSO 5064:2018 - Suicide Prevention.
• HSO 5010:2018 - Client Identification.
• HSO 5012:2018 - Information Transfer at Care Transitions.
Terms and Definitions

Definitions

HSO 0400 - HSO Terms and Definitions is a document that contains the terms and definitions that are used across HSO’s standards catalog. The terms and definitions included in this publication are terms that are used regularly in HSO standards. Please follow the link below to review the terms and definitions: https://healthstandards.org/files/HSO-MasterGlossaryList-2018E.pdf

Standard-Specific definitions

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

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

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

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

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

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

Abbreviations

HSO: Health Standards Organization
PCC: People-Centred Care
LTC: Long-Term Care
Quality Dimensions

HSO Quality Framework: Health and social services stakeholders around the world are committed to delivering the best quality possible. However, given the rapidly changing environment and the numerous challenges facing all health and social services sectors, quality can sometimes be perceived as complicated and difficult to achieve. Using a quality framework – also known as a structure underlying quality – provides common language as what it means, and brings focus on its key elements.

HSO Standards are based on the “HSO Quality Framework”, an eight-quality dimensions framework that all plays a part in providing safe, high quality care in all health and social services sectors. These dimensions are the basis for the standards, whereby each requirements (criterion) is linked to one of the eight quality dimensions. In this way, the underlying focus of each criteria is clear, and users of the standards understand the intent of the criterion.

These are the quality dimensions that underlie HSO’s quality framework:

- **Population Focus**: Work with my community to anticipate and meet our needs
- **Accessibility**: Give me timely and equitable services
- **Safety**: Keep me safe
- **Worklife**: Take care of those who take care of me
- **Client-centred Services**: Partner with me and my family in our care
- **Continuity of Services**: Coordinate my care across the continuum
- **Appropriateness**: Do the right thing to achieve the best results
- **Efficiency**: Make the best use of resources

These dimensions provide a common language about health care quality. The quality dimensions are strongly related to each other, can be mutually supporting, and help to ensure balance within the framework. At the same time, there may be a stronger emphasis on a particular dimension if the case/situation requires it.

HSO encourages health and social services professionals and policy-makers to explore this framework and use the dimensions of quality for strategic planning, program and service delivery, and evaluation and quality improvement activities. Ultimately, the quality framework will help health care providers assess and improve the health care services they deliver to patients and clients.
1 Building a Competent Team

1.1 The organization ensures that team members are qualified and have the relevant competencies.

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

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

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

1.1.2 The organization provides training to the team on preventing and managing residents’ responsive behaviours.

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

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

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

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

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

Restraints are not used to teach acceptable behaviour, to punish, or for the convenience of the organization.
The organization should seek alternatives to the use of minimal restraints to improve the quality and safety of its services. The organization also adheres to jurisdictional and regional requirements in the use of minimal restraints.

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

Guidelines:

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

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

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

2 Providing Safe and Effective Services

2.1 The team provides services for residents in a timely and coordinated manner.

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

Guidelines:

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

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

Guidelines:

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

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

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

**Guidelines:**

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

Information about the types of other services required by the residents and not currently offered by the organization is documented for use in future service planning.

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

**Guidelines:**

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

2.2 The team ensures residents, families, and/or caregivers are partners in service delivery.

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

**Guidelines:**

Team members develop respectful and transparent relationships with residents by:

- introducing themselves and explaining their role;
- asking permission before performing tasks;
- explaining what they are doing;
- using a respectful tone;
- expressing concern or reassurance;
- providing opportunities for questions, input, and feedback;
- respecting cultural and religious beliefs or lifestyles;
- and respecting confidentiality and privacy.

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

**Guidelines:**

Active resident, family, and/or caregiver participation begins with being informed. The team encourages residents, families, and/or caregivers to be active participants in the resident’s care, ask questions, and provide input at all stages of the care process.
2.2.3  The team shares complete and accurate information with team members, including residents, families, and/or caregivers, in a timely way.

Guidelines:

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

Information that is shared with residents, families, and/or caregivers is delivered according to individual needs and interests, as well as levels of understanding. Residents, families, and/or caregivers are made aware of:

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

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

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

2.2.4  The team facilitates access to translation and interpretation services.

Guidelines:

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

2.2.5  The team determines residents’ capacity to provide informed consent.

Guidelines:

The process of evaluating a resident’s capacity to consent is carried out on an ongoing basis. Capacity means the ability to understand the information relevant to the decision, appreciate foreseeable consequences of a decision or failure to make a decision, and weigh the risks and benefits of that decision.
2.2.6 The team obtains and documents informed consent from residents, families, and/or caregivers before providing services.

**Guidelines:**

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

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

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

**Guidelines:**

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

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

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

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

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

- treating others with respect;
- providing accurate information;
- reporting safety risks;
- and observing rules and regulations.
Information about rights and responsibilities is provided at intake or admission and is adapted to meet diverse needs such as language, culture, level of education, lifestyle, and physical or cognitive ability. When the information cannot be provided to the resident, family, and/or caregiver on intake, it is provided at the earliest opportunity.

2.2.8 The team follows the organization’s procedure to address claims of violations of residents’ rights.

Guidelines:

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

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

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

2.3 The team develops individualized care plans in collaboration with the resident, family, and/or caregiver, based on a comprehensive assessment.

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

Guidelines:

The individualized care plan is based on the results of the assessment and the resident's goals and preferences. It addresses the roles and responsibilities of the team, other organizations involved in providing services, and the resident, family, and/or caregiver. It includes pertinent information about the resident's history, assessments, diagnostic results, allergies, and medication, including any medication issues or adverse drug reactions.

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

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

2.3.2 The team assesses residents’ mental health status and emotional wellness.

Guidelines:

Residents are assessed for mental health and emotional wellness issues (e.g., anxiety, stress), as such issues can have a significant negative impact on quality of life.
2.3.3 The team reassesses residents’ health status in a timely manner and updates their individualized care plans accordingly.

**Guidelines:**

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

Delays or failures to report a change in health status, in particular deterioration in a resident’s condition, are significant barriers to safe and effective care and services.

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

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

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

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

**Guidelines:**

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

2.4 The team involves residents, families, and/or caregivers in the design and implementation of their individualized care plans.

2.4.1 The team follows a minimal restraints procedure.

**Guidelines:**

The team provides care in a safe, competent, and ethical manner that respects residents’ right to safety, dignity, and autonomy. The team minimizes the use of restraints as an important part of providing respectful care.

Restraints are used only as a last resort to reduce imminent harm to a resident or others when all positive person-centered, recovery-oriented, or alternative practices have failed.

Restraints are not used to teach, punish, or for convenience.

Factors to be considered when restraints must be used include how the resident will be monitored and the specific type of care required if a resident must be restrained. The team follows applicable legislation and evidence-informed practices when restraints are used.

The team establishes a process to monitor the use of restraints. Documentation about the use of restraints includes when, where, why, and for how long restraints were required, as well as the alternative measures that were attempted unsuccessfully prior to using restraints.
Each use of restraints, as well as the general use of restraints at a program level, is assessed, to move toward the goal of using restraint only as a last resort and to reduce any reliance on restraints.

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

**Guidelines:**

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

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

2.5 **The team delivers safe and reliable care.**

2.5.1 To help communicate accurate and complete information about medications long-term care settings, the organization shall conform to the requirements contained in HSO 5014-5:2018 - Medication Reconciliation at Care Transitions - Long-Term Care.

2.5.2 To help prevent falls and reduce injuries in long-term care service settings, the organization shall conform to the requirements contained in HSO 5060-2:2018 - Fall Prevention And Injury Reduction - Long-Term Care Services.

2.5.3 To help improve client outcomes and lower costs associated with skin and wound care, the organization shall conform to the requirements contained in HSO 5063: 2018 - Skin and Wound Care.

2.5.4 To help prevent pressure ulcers, the organization shall conform to the requirements contained in HSO 5062:2018 - Pressure Ulcer Prevention.

2.5.5 To help reduce the risk of suicide, the organization shall conform to the requirements contained in HSO 5064:2018 - Suicide Prevention.

2.5.6 To help avoid harmful incidents, the organization shall conform to the requirements contained in HSO 5010:2018 - Client Identification.

2.5.7 To help ensure accurate and timely exchange of information, the organization shall conform to requirements contained in HSO 5012:2018 – Information Transfer at Care Transitions.

2.5.8 To help organizations assess quality at the point of service delivery, the organization shall conform to the requirements contained in HSO 0001 – Service Excellence.
2.6 The team strives to provide a supportive and welcoming environment.

2.6.1 The team provides residents with an accommodating environment that meets their needs and those of their families and/or caregivers.

Guidelines:
Providing an accommodating, home-like environment includes, but is not limited to:

- encouraging residents to decorate with personal belongings;
- giving residents privacy when they are in their rooms or have visitors;
- offering residents choices about their daily routine regarding bathing, dressing, eating, and sleeping;
- and inviting families and/or caregivers to join residents for activities of daily living, including meals, where the opportunity arises.

2.6.2 The team protects the physical security and psychological safety of residents.

Guidelines:
The level of security required to maintain the physical security of residents will vary depending on the nature of the organization and the population it serves. The organization determines the level of risk and decides what measures (e.g., compulsory sign-in of visitors) are necessary to protect residents’ security.

Strategies to protect the psychological safety of residents are developed in collaboration with residents, families, and/or caregivers to ensure that they are appropriate to the person’s needs. The team documents the identified strategies in the individualized care plan and makes it available to all relevant team members involved in the resident’s care.

The team works collaboratively with all members involved in the resident’s care to ensure that strategies designed to manage safety risks are implemented in a standardized way across teams and services, and that the information is regularly updated and shared on an on-going basis.

2.6.3 The team provides residents, families, and/or caregivers with opportunities to engage in activities that are meaningful, enjoyable, feasible, and important to them.

Guidelines:
Activities are provided in a way that respects residents’ privacy, dignity, and diversity in language, cuisine, and cultural or religious practices, and fosters residents’ quality of life, strengths, and capabilities.

Meaningful activities may meet social, intellectual, or spiritual needs.

2.6.4 The team provides a pleasant dining experience for residents.

Guidelines:
Residents are helped to make informed choices about dining that may impact their quality of life (e.g., residents may choose to dine in the manner they wish, despite risks).
The social and cultural aspects of the dining experience are important elements of residents' quality of life and these aspects are considered regardless of where dining services are provided.

Considerations to create a pleasant dining experience include, but are not limited to:

- discussions about residents’ personal and cultural food preferences;
- making a variety of food and beverage choices available and responding to specific requests wherever possible;
- offering support for differing capacities to eat;
- providing modified diets as necessary;
- and encouraging residents to eat with friends and family to share the social and cultural aspects of eating.

2.6.5 The team collects feedback from residents, families, and/or caregivers about individual food preferences and nutritional requirements.

**Guidelines:**

Feedback related to food preferences and nutritional requirements includes, but is not limited to:

- information about the resident’s culture;
- religious practices;
- preferences;
- allergies;
- therapeutic diet requirements;
- preferred eating times;
- and potential interactions with the resident’s medications.

The information is obtained when the resident moves in, when the resident’s health status changes, or at defined intervals.
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