

Issue Brief: Code of Practice for Care Homes Consultation

31 January 2018

CODE OF PRACTICE FOR CARE HOMES OVERVIEW:

Authority: The Residential Care Home and Nursing Homes Amendment Act 2017 established the Code of Practice. Compliance with the Code will be tied to regulatory action and to the 2019 re-registration fees and grades.

Application: The Code applies to all residential care homes and nursing homes licensed under the Residential Care Homes and Nursing Homes Act 1999

Purpose :

- To continue the path of raising quality of life, care, management and of the physical environment in care homes through person centered practices.
- To be a single resource document of all current requirements for licensed care homes.
- To be a living document updated on an ongoing basis

Content:

- Existing standards and criteria – from current Regulations and criteria.
- New or substantially improved standards and criteria– determined by:
 - * Identified high risk priorities in relation to care quality and quality of life.
 - * Consideration of impact on care homes due to resources restraints and current compliance levels.
 - * Consequences of the 2017 Amendment .

Development:

The content of the Code was developed from:

- 2012-2015 recommendations and reports
- Current standards of practices for healthcare professionals
- Other jurisdictions' Care Home Codes of Practices and legislation (e.g. Alberta & Ontario, Canada; Ireland; England,)
- Best practice guidelines (e.g. NICE, APIC, RNAO, BNSC)
- 2016 Working Group review of proposed changes. The group included Administrators, care home nurses, advocates, Elder Care Team Inspectors and healthcare professionals in specific fields. 2017 subgroups reviewed priority sections for the Code with new standards and criteria.

HOW TO RESPOND

Consultation period: Jan 31– Feb 20 2018

Draft Code located at: <https://www.gov.bm/health-public-consultations>

Primary Areas for feedback :

- Consent and Decision Making
- Managing Challenging Behaviors
- Restraints
- Assessments
- Care planning
- Quality and Risk Assessment
- Health and personal care services
- Dementia and End of Life care
- Staffing
- Financial Management

Feedback to be sent to:

Email: ads@gov.bm

Written responses:

Attn: Code of Practice Consultation
Ageing and Disability Services
Continental Building,
25 Church Street, Hamilton
HM12

Responses must indicate name and if you are representing an organization.

NEXT STEPS:

- Finalize Code & Implementation plan- March 2018
- Comprehensive inspections- 2018
- Care Home education on the Code -2018
- Re-Registration tied to Code– 2019

Code of Practice for Care Homes

STANDARDS, CRITERIA AND GUIDELINES FOR CARE HOMES
UNDER THE RESIDENTIAL CARE HOMES AND NURSING HOMES
ACT 1999 AND REGULATIONS 2001

DRAFT V.0.1 31 JAN 2018

Consultation Process:

- Subject:** The Draft Code of Practice for Care Homes v 0.1
- Scope:** The Residential Care Home and Nursing Homes Act 1999 requires consultation with Administrators on the proposed Code of Practice prior to publication.
- Consultation Period:** **January 31 2018- February 21st 2018**
- How to provide feedback:**
- Ageing and Disability Services**
- Mailing address: P.O. Box HM 1195,
Hamilton, HM EX
- Email: ads@gov.bm
- Street Address: Ageing and Disability Services
Continental Building
25 Church Street, Hamilton
- Phone: 292-7802
- Development:** The Draft Code of Practice includes all existing requirements in addition to new requirements in priority areas for the operation of a care home. Content was developed from previous reports and recommendations; reviewing Codes of Practice from other jurisdictions and best practice guidelines; and consultation with key stakeholders including care home administrators, advocates and health and social care providers.

DRAFT Code of Practice for Care Homes v.1, 180131

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A. Introduction

Purpose

The Code of Practice sets the minimum requirements for the operation of care homes registered under the Residential Care Homes and Nursing Homes Act 1999 and Regulations 2001. The Code includes:

Standards	Mandatory requirements
Criteria	Requirements to uphold the standard
Guidelines	Requirements to uphold specific criteria
Recommended Criteria	Not required, indicated by 'should'
Resources and references	For general guidance

Application

This Code applies to licensed care homes that provide room, board and personal care to 2 or more unrelated persons who are seniors and/or have a disability. This includes care homes that contract out some or all care services to external service providers; or coordinate care services provided by external service providers.

There are two types of care homes: residential care homes and nursing homes, the difference being the maximum level of care of a person who can be admitted to home.

Type of Care Home	Maximum level of Care
Residential care homes	Personal care
Nursing homes	Intermediate to complex care

The Code was developed to apply to all care homes and care recipients, recognizing that how a criteria is fulfilled may depend on the level of care, the specific population being served and the model of care by the home (see Appendix 2). In specific circumstances, and with prior approval, criteria may be adjusted or exempted based on the model of care and care recipients' needs.

The term **care recipient** is used when standards and criteria apply to residents, respite persons and day care attendees.

Regulatory Authority

Ageing and Disability Services (ADS) is responsible for administration and compliance monitoring for this Code, under the Chief Medical Officer of the Ministry of Health. Non-compliance with requirements in this Code is subject to regulatory action under the Residential Care Homes and Nursing Homes Act 1999 and Regulations 2001.

Bill of Rights for Persons in Care

These fundamental rights must be upheld for persons in care homes through the standards, criteria and guidance in this Code. Care recipients are:

1. To be treated with dignity, consideration and respect in a manner that fully recognizes their individuality, independence and right to privacy.
2. To be provided care and services that are adequate and appropriate to their care needs and in compliance with all relevant laws, standards and codes of practice.
3. To have access to information in an accessible format appropriate to their individual needs, and for their relevant persons where appropriate, to assist in decision making.
4. To have a contract with the care home stipulating services to be provided, terms of use and all fees and additional charges and reasonable grounds and conditions for termination.
5. To be protected from sexual, physical, psychological and financial abuse and neglect.
6. To be free from chemical and physical restraint unless authorized in accordance with legislation and the Code.
7. To be able to, in consideration of the health, safety and wellbeing of persons in the home, receive visitors at any time and associate and communicate privately with people and groups of their own choice and initiative. This includes the right to engage in intimate relationships.
8. To exercise their rights as a citizen.
9. To pursue their social, cultural, religious, spiritual and other interests and are given reasonable assistance by the care home in doing so and are able to refuse participation in any activity.
10. To be able to raise (themselves or by their relevant parties) complaints, concerns or suggestions regarding the services and operation of the care home, without fear of coercion and retaliation.
11. To participate fully, and/or their relevant persons where appropriate, in all decision making pertaining to their care and treatment.
12. To give or refuse consent to any care and treatment (or for their relevant person to do so when the care recipient is unable to) and be informed of the consequence of giving or refusing consent.
13. To have their personal and clinical information held in confidence and not disclosed without the appropriate consent, unless in emergency circumstances.
14. To have and use their own possessions, where reasonable, and have an accessible, lockable space for personal valuables.
15. To manage their own finances and needs unless this authority is delegated to another person.
16. To be informed of any conditions, restrictions or changes to the license of the care home. The relevant person is notified as appropriate.

B. Quality of Life

1. Privacy, dignity, independence and right to privacy

Standard:

Care recipients are treated with dignity, consideration and respect in a manner that fully recognizes their individuality, independence and right to privacy.

Criteria

- 1.1. Arrangements are in place to ensure that the care recipient's independence, privacy and dignity are respected at all times, and with particular regard to:
 - a. maintaining social contacts to the extent to which they wish to do so
 - b. spending time alone, in accordance with their wishes
 - c. expressions of intimacy and sexuality
 - d. wearing their own clothing
 - e. dressing and undressing
 - f. being assisted to eat and drink
 - g. consultations with advocates, social care and other professionals
 - h. examinations by health care professionals
 - i. personal caregiving
 - j. circumstances where confidential and/or sensitive information is being discussed (including details of medical condition or treatment)
 - k. entering bedrooms, toilets and bathrooms; permission is sought before entering these rooms
 - l. addressing and communicating with care recipients, including being addressed by their preferred terms
 - m. care received prior to and at the time of death
- 1.2. In shared rooms, screening is provided that ensures privacy when required and requested.
- 1.3. The care recipient can associate and communicate privately and without restriction with people and groups of their own choice, or initiative, at any reasonable hour.
 - a. The protection of the health and safety of all care recipients is to be considered with visitors. If restrictions on visiting are needed due to these reasons it is done in consultation with the care recipient.
- 1.4. Care recipients are supported, as far as possible, to make choices about their own care and receive reasonable responses to requests made.

- 1.5. Residents are able to keep their clothes, personal requisites and toiletries for their own exclusive use.
- 1.6. The care recipients' social, religious and cultural beliefs and values are respected and accommodated within the routines of daily living.
- 1.7. No religious beliefs or practices are imposed on a care recipient.
- 1.8. All care recipients must have access to appropriate communication methods including:
 - a. A telephone for use in private.
 - b. Writing instruments, postage and stationary (at their own expense). Residents' mail is received promptly and unopened unless assistance is requested.
 - c. Access to a computer should be available when requested.
- 1.9. Confidential information about care recipients is treated confidentially and respectfully which includes:
 - a. Staff share confidential information when it is needed for the safe and effective care of an individual.
 - b. When confidential information is shared it must be relevant, necessary and proportionate.
 - c. Information shared for the benefit of the community is anonymized (unless there is a legal obligation to disclose).
 - d. Any individual who objects to the sharing of their confidential information is respected, unless there is a legal obligation to do so.
 - e. Policies and procedures should be in place to ensure confidentiality rules are followed.

2. Consent and Informed decision making

Standard:

Care recipients participate fully in all decisions pertaining to their care and treatment and consent is given or refused after appropriate information is shared with resident or their relevant person.

Criteria

- 2.1. Care recipients are provided access to information in an accessible format appropriate to their individual needs, and for their relevant persons where appropriate, to assist in decision making.

This information should include:

- a. Advantages and disadvantages of the proposed action
 - b. Likely side effects
 - c. Available alternatives
- 2.2. Care recipients' consent, wishes and choices relating to treatment and care are discussed and documented in their records, and as far as possible, implemented and reviewed regularly with them.
- 2.3. This standard applies to all care recipients including those with diminished capacity.
- a. See Appendix 3 for guidelines regarding consent and capacity.
 - b. When there are relevant persons with legal responsibilities for the care recipient (e.g. receivers, enduring power of attorney); they must be the primary persons involved, with the care recipient, in the decision making process.

3. Resident Access to Information

Standard:

Care recipients have access to information on the operation and services of the care home in a format that they are able to understand.

Criteria:

- 3.1. The care home license is on display in a public area.
- 3.2. Information must be provided to care recipients and potential care recipients in plain English and made available in a format suitable for potential and existing care recipients upon request.
- 3.3. The information should be provided in a guide or attached to the service contract and should include:
- a. The information in the statement of purpose
 - b. A description of the individual accommodation and communal space provided
 - c. The costs of the home (standard fee) and any additional costs outside of the standard fee
 - d. A copy of the most recent inspection report
 - e. A copy of the contract to be signed to receive services
 - f. Contact information for Ageing and Disability services and relevant authorities
 - g. Policies pertaining to:
 - General terms and conditions for living in the home
 - Complaints procedure
 - Requirements for personal belongings to brought into the home

- Managing money/personal affairs of residents
- The arrangements for residents who require treatment at outpatients' services or admission to hospital, including arrangements for accompany the resident and ensuring their medical notes are transported with them
- Communication with relevant persons about changes in condition and care needs
- Avenues for resident/family involvement in the care home

4. Service Contracts

Standard:

Care recipients have a contract with the care home stating the services to be provided, terms of use and all fees and additional charges and reasonable grounds and conditions for termination.

Criteria

- 3.1. The contract must include the following information, specific to the individual care recipient:
 - a. Rooms to be occupied or program to attend
 - b. Overall care and services covered by fee and time period (e.g. number of days per week for day care attendees)
 - c. Fees payable and by whom and by when (care recipients, government department, relative or another)
 - d. Services (including toiletries and equipment) to be paid for in addition to the fees
 - e. The circumstances that could lead to, and terms and conditions of, termination of the contract

- 3.2. Reasonable grounds for the termination of contracts include:
 - a. The wishes and preference by the resident for discharge
 - b. Non-payment of fees
 - c. The protection of the health and safety of the care recipient or other care recipients
 - d. The care home is unable to meet the care needs of the senior based on their license and/or conditions attached to such

- 3.3. Required terms and conditions for the termination of a contract include:
 - a. The resident has the right to appeal to the care home any proposed termination. All appeals must be considered by the provider.

- b. A 30 day minimum notification period is in place unless there is imminent risk to the health and safety of the care recipient or other care recipients in the home. Notification must be made to the care recipient, their identified relevant person(s) and their primary physician.
- c. Notwithstanding the resident's freedom to discharge him/herself from the care home, discharge decisions are based on:
 - An assessment and the resident's care plan
 - Discussion and planning with the resident or their relevant person.
- d. To ensure continuity of care, information concerning the resident's circumstances, medication, treatment and/or ongoing support by medical and other professionals is provided to their next care provider by the Administrator, as appropriate.

5. Complaints and suggestions

Standard:

Staff, care recipients and relevant persons can raise complaints, concerns or suggestions regarding the services and operation of the care home, without fear of coercion and retaliation.

Criteria

- 5.1. A simple, clear and accessible complaint and suggestion policy and procedure is in operation that includes:
- a. Care recipients, staff and their relevant persons are informed of policy and procedure.
 - b. How to make a complaint or suggestions internally and how to raise complaints to Ageing and Disability Services.
 - c. No coercion regarding making a complaint nor retaliation for having made complaints or suggestions will be tolerated.
 - d. Ensuring reasonable responses are provided by the Administrator to suggestions made.
 - e. Investigations into all complaints
 - f. Maintaining a record of all complaints, investigations and actions taken by Administrators.

In addition the complaints policy should ensure

- e. Care recipients, staff and their relevant persons are supported to take up issues in the most appropriate way.
- f. The views, feelings and wishes of care recipients, relevant persons and staff are taken into account in delivering care and in decisions impacting their day to day

lives. Methods should be in place to obtain this feedback (e.g. resident or family council).

- g. Care recipients and staff receive feedback and are kept informed of progress within agreed timescales.

6. Protection from abuse

Standard:

Each care recipient is protected from all forms of abuse.

Criteria

- 6.1. There is a policy and procedure in operation on the prevention, detection and response to abuse within the care home.
- 6.2. Qualified staff are employed through appropriate screening and required references, qualifications and training, and criminal record checks (see s.19).
 - a. No person can be hired to provide services (including management services) at a care home that has been convicted under the Senior Abuse Registrar Act or who has been convicted of a crime against a vulnerable person.
- 6.3. Staff receive orientation and ongoing training in prevention, protection and responding to abuse (see s.19 and Appendix 8 Part II)
- 6.4. Sufficient staffing numbers are in place to meet care recipients' needs and there is consistent and ongoing supervision of staff.
- 6.5. The needs of persons with cognitive impairments including those with challenging behaviors are supported to decrease potential incidences that may be abuse.
- 6.6. All staff must report, as soon as they are alerted, any suspected, alleged or actual abuse, or the risk of abuse. Reporting includes:
 - a. The police and/or hospital in high risk cases with immediate jeopardy to the physical or mental wellbeing of the care recipient;
 - b. Ageing and Disability Services (ADS); and
 - c. The care recipient's relevant persons, as appropriate.
- 6.7. The appropriate persons in charge must investigate all incidents and allegations of abuse and take appropriate remedial action. These may include:
 - a. Providing or facilitating the securing of physical and mental health support to the care recipient(s) who was allegedly or known to be abused.

- b. The removal of the suspected abuser immediately from the premises until the validity of the allegation is determined.
 - c. The termination of employment pending any internal and external investigations.
 - d. Compliance with any action required by a notice or order issued by an inspector, ADS or the Senior Abuse Registrar
- 6.8. Care recipients, families and staff know how to report suspected or known abuse.
- 6.9. No person (e.g. staff member, care recipient or relevant person) may be retaliated against for reporting any allegation of abuse to the care home or the relevant authority. The person receiving the report, must guarantee the reporter's confidentiality.

7. Managing Challenging behaviors

Standard:

The philosophy and provision of care is the least restrictive and controlling possible for the individual care recipient.

Criteria

- 7.1. There is a policy that sets out the residential care setting's philosophy of care and response to behavior that is challenging. It provides:
- a. Guidance on understanding why the behavior is occurring including: investigating the cause(s) of the behavior and how to assess and respond to behaviour that is challenging.
 - b. outlines acceptable interventions based on best practice evidence that minimize the occurrence of the behavior and how to safely deescalate the situation in the least restrictive way; and
 - c. outlines interventions that are prohibited in the care home
- 7.2. An assessment occurs for behavior that is challenging, with symptoms objectively documented and qualified that includes:
- a. Investigations into the underlying causes (e.g. pain;/discomfort)
 - b. documented evidence that the symptoms are persistent, preventable or treatable/reversible (e.g. delirium, UTI) causes have been ruled out, and
 - c. the risks and benefits of the use of physical restraint or medication in relation to the level of distress or potential harm without such interventions have been evaluated.

- 7.3. Where a care recipient's behavior presents a risk to themselves or others, their care plan sets out a plan of care that meets their individual assessed needs. The plan is reviewed regularly to assess its effectiveness and reflect the care recipient's changing needs. Records of review meetings and/or case conferences are kept and shared with those in attendance.
- 7.4. All staff have up-to-date knowledge and skills, appropriate to their role, to enable them to manage and respond to behaviour that is challenging. There are arrangements in place to obtain advice, training and support from professionals with the required expertise.
- a. Staff raise any concerns with the person in charge about their ability to provide planned care. When concerns are raised, the person in charge responds appropriately and without delay.
- 7.5. The person-in-charge ensures that all interventions in response to behaviour that is challenging are reviewed regularly and inform learning and practice development. Reviews take place in a spirit of staff support.
- 7.6. Positive (non-restrictive and non-pharmacological) interventions are the preferred method of providing support to the care recipient experiencing behavioral disturbances. There is documented evidence that these interventions have been implemented or attempted. When restrictive intervention is deemed necessary, it must be implemented alongside a positive support plan (See Resources).

8. Restraints

Standard:

Restraints and restrictive practices are used as a last resort and in the best interests of the care recipients. If required and authorized, the level, nature and type of any restraint or restrictive practice must be proportionate to the risk it is attempting to address.

Criteria

- 8.1. Appropriate assessments and care planning occur to determine if and when a restraint or restrictive practice is required (also see s.7, 13, 14 and Appendix 5)
- a. Expert advice is sought where necessary on a behaviour management and activity plan before commencing psychotropic medication (anti-psychotic, atypical antipsychotic, antidepressant or anxiolytic) or ongoing use of physical restraint.
- 8.2. Any family requests or physician orders for restraint must be in accordance with least restrictive practices and process for determining such to be implemented by care home staff.

- 8.3. The care recipient is free from any restraint imposed for the purpose of discipline or staff convenience that is not required to treat their specific medical symptom(s).
- 8.4. Except in rare, time-limited emergencies, or for brief provision of essential care, no physical restraint is used that causes the resident distress, discomfort, anger, agitation, pleas for release, calls for help or constant attempts to untie or release him/herself.
- 8.5. The number of care recipients and incidents where restraint is used are recorded and reviewed by the care home and reported as required:
 - a. Any use of restraint in emergency circumstances (as outlined below) is reported to Ageing and Disability Services (ADS).
 - b. Inappropriate use of restraints is a form of physical and psychological abuse and must be reported to ADS.
- 8.6. If restraint and/or restrictive practices are used, it must be ensured that:
 - a. Restrictive practices are only used as a last resort
 - b. Restrictive practices are not being used to punish or for the sole intention of inflicting pain, suffering or humiliation
 - c. There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken
 - d. The care recipient's human rights are protected at all times
 - e. Prevention strategies are evidenced and in place to minimize the need for the use of restraint/restrictive interventions
 - f. Care recipients are treated with compassion and dignity at all times
 - g. Care recipients continue to have their physical, psychological and spiritual needs attended to
 - h. The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm
 - i. Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need
 - j. Any restriction is imposed for no longer than absolutely necessary
 - k. Care recipients and their relatives are supported to be involved with and participate in the process. They must be informed and consent obtained regarding the use of restraints and obtain necessary information regarding the risks around such
 - l. The use of restraint must be documented and reviewed on an ongoing basis

- 8.7. Wherever restraint or restrictive practices are used in emergency circumstances it must be evident that:
- a. There is a necessity to act to avoid harm to the care recipient or others
 - b. The intervention is proportionate to the level of harm or risk to the care recipient or others
 - c. The least restrictive approach is used
 - d. The intervention is used for no longer than is absolutely necessary;
 - e. What is done, for what reasons and the outcome and any consequences are recorded in the care recipient's file
 - f. The staff responsible for care supervision must review all circumstances when restraint is used to determine if: alternative actions could have taken place or if changes in care practices or assistance to the care recipient is necessary to prevent the escalation of the behavior that resulted in a restraint.
- 8.8. The care home has a policy in operation on the use of physical and chemical restraint that is evidence-based and adheres to legislation, the Code and best practice guidelines. See Appendix 5 for additional guidelines to support this criteria and Appendix x for Resources.

9. Nutrition, meals and mealtime

Standard:

Residents receive a nutritious and varied diet appropriate to sustain or promote good health and wellbeing.

Criteria

- 9.1. Homes must provide at least three meals daily to residents.
- 9.2. Meals and food provided to care recipients must be nutritious and suited to their individual care needs. This requires:
- a. Written meal plans are in place and followed.
 - b. The care recipient's nutritional, emotional, religious, cultural and therapeutic needs and preferences are reflected in the meal plan and/or a care recipient's individual menu.
 - c. The meal plan is designed by or reviewed by a registered nutritionist or dietician.
 - d. The mini diet manual¹ is used to guide the provision of Medical Nutrition Therapy (MNT) meals.

¹ Provided by Dept of Health Nutrition Services (see Contact Information).

- e. Menus are revised a minimum of 2 times a year.
 - f. **Menus should be posted for residents to view.**
- 9.3. Exceptions may be granted to the number of meals provided by the care home depending on the model of care of the home, capacity of residents and service contracts. The care home must apply to Ageing and Disability Services for any exceptions.
- 9.4. Drinking water must be readily available and offered continuously throughout the day.
- 9.5. All care recipients must receive an assessment upon admission and as required to determine if and what are medical needs in relation to nutrition. Needs include:
- a. Dietary restrictions or allergies
 - b. Feeding challenges – e.g. swallowing or chewing difficulties
 - c. GI tubes
 - d. oral supplement requirements due to risk of malnutrition or health needs
- 9.6. A written food service policy is in place that includes:
- a. Overview of food services provided
 - b. Appropriate hydration policy and practice
 - c. Meals and snacks available at regular intervals
- 9.7. There must be a 2 week supply of food in the care home at all times.
- a. **There should be, in addition to the 2 week supply of food, a 2 week emergency supply stored appropriately during Hurricane season.**
- 9.8. There is a sufficient number of staff present to ensure meals are served on time and to offer assistance when necessary and manage risks when residents are eating and drinking. Assistance should be offered discreetly, sensitively and individually.
- 9.9. Staff receive training in safe food handling, appropriate to their role, and are compliant with safe food handling requirements (see Section 19).
- 9.10. **Mealtimes should be viewed as social occasions; this includes:**
- a. **staff should be encouraged to participate in and view mealtimes as opportunity to communicate, engage and interact with care recipients.**
 - b. **Opportunities should be provided for the resident's family and friends to dine with them on special occasions.**
 - c. **The resident's family and friends should be supported to assist them during mealtimes.**

- 9.11. When care recipients are suffering from memory loss or are disordered regarding time the following should occur:
- a. Where possible, care recipients should be involved in the tasks around meals and mealtimes and food is used as part of reminiscence work with them in conversation about food memories and likes and dislikes.
 - b. There is a selection of food and drink available at all times to ensure meals are available according to the care recipients' needs.

10. Activities

Standard:

An appropriate daily program of activities and recreational opportunities are available to care recipients

Criteria:

- 10.1. Staff, who plan, develop, coordinate and deliver activities have the necessary training and qualifications, as required, to meet the needs of the residents. (see s.19)
- 10.2. Up-to-date information on activities is provided to each care recipient in formats suited to their capacity and a record of activity provided is available for inspection.
- 10.3. Care recipients are supported to pursue their social, cultural, religious, spiritual and other interests and are given reasonable assistance by the care home in doing so. This includes:
 - a. Care recipients have access to daily activities in keeping with their needs, abilities, wishes and lifestyle, and within the resources of the care home.
 - b. Residents are able exercise their rights as a citizen if desired, e.g. participate in voting.
- 10.4. No religious practices or beliefs are imposed on any care recipient and their spiritual or religious needs are met, including:
 - a. If requested by resident, or their relevant person, informing their clergy man of admission to the home.
 - b. Allowing resident to attend religious service of their choice.
- 10.5. Activities programs provide opportunities for participation in meaningful and purposeful activity, occupation or leisure activities, both inside and outside the care home, that suit care recipients' needs, preferences and capacities.
 - Particular consideration is given to care recipients with dementia and other cognitive impairments, care recipients with visual, hearing or dual sensory

impairments, care recipients with communication difficulties and care recipients with physical or learning disabilities

- 9.6. The opinions of the care recipients in planning and providing activities and the program is responsive to their opinions and comments
- 9.7. Daily opportunities are given for appropriate exercise and physical activity.
- 9.8. Where the home, either provides or arranges personal choice services(e.g. hairdressing, manicures, massage) the person in charge must ensure the services:
 - a. are offered and provided based on the needs and preferences of the care recipients,
 - b. are provided in a space that is appropriate for the purpose; and
 - c. Are provided by a person who holds the required license or training, if any, for the services.

11. Contact with family, friends, community

Standard

Care recipients are able to, in consideration of the health, safety and wellbeing of persons in the home, receive visitors at any time and associate and communicate privately with people and groups of their own choice and initiative.

Criteria:

- 11.1. Care recipients' links with family and friends are encouraged and facilitated.
- 11.2. The care recipient can receive visitors in private, choose who they see and do not see, and their wishes are respected and recorded.
- 11.3. The person-in-charge ensures that there are no restrictions on visitors except when requested to do so by the care recipient or when the visit or the timing of the visit is deemed to pose a risk to the resident or others.
- 11.4. Care recipients are not prevented from engaging in consensual intimate relationships.
- 11.5. Links with and involvement of local community groups and/or volunteers in the care setting should be encouraged and maintained by the care home.
- 11.6. Care recipients have access to community information on local events etc (e.g. radio, television programs, newspapers, magazines, information via computer and a notice board).

12. Resident money and possessions

Standard:

Residents manage their own funds unless such has been delegate to another identified person.

Criteria

- 12.1. Delegation of the management of a care recipient's funds must be done in consultation with the resident and their relevant person recognizing any existing legal authority in place (e.g. receivership, power of attorney).
 - a. The care home must keep a record of the agreement to manage the resident's funds.
 - b. Up to date account records must be maintained of all residents' funds.
 - c. The residents, or their responsible person, may request and be shown their account information at any time.

- 12.2. The Administrator must maintain an up to date list of resident possessions (e.g items of value, furniture)

C. Quality of Care

13. Assessments

Standard:

Each care recipient has their needs comprehensively assessed prior to admission and on a as required basis, to ensure the care home can meet the care recipients' ongoing and changing care needs.

Criteria

- 13.1. No person is admitted to the care home where their health and safety needs cannot be met by the care home.
- 13.2. Assessment must occur:
 - a. Prior to admission to determine suitability for placement in care home
 - b. Upon admission- to obtain additional information or update pre-admission assessment
 - c. At least annually and in response to changes in the care recipient's condition
- 13.3. The **Ministry of Health LTC Needs Assessment tool** is used to obtain a comprehensive assessment (see Resources). A comprehensive assessment includes:
 - a. Healthcare providers' information
 - b. Health Conditions- including those requiring RN intervention
 - c. Physical assessment- including risk assessments relating to: pain, falls & pressure sores
 - d. Medications- types, ability to self-administer, allergies and vaccination status and history
 - e. Nutritional status including: diet, eating and swallowing, dietary preferences;
 - f. Communication and sensory needs- hearing, speech, vision, comprehension
 - g. Cognitive status- including personal safety, mood and behavior, capacity assessment (mini mental test score)
 - h. Mental health status- including personal safety, mood and behaviour
 - i. Functional abilities – ADLs and IADLs including determining:
 - personal care capacity – self-bathing/ feeding/ dressing
 - oral health and dental care needs;
 - foot care;
 - mobility and transfers;
 - range of motion and dexterity;
 - history of falls;

- continence
 - j. social interests, hobbies, religious and cultural needs and preferences;
 - k. relevant persons involvement and other social contacts/relationships.
 - l. Resuscitation status
- 13.4. Assessments are completed by a Registered Nurse (RN) or medical practitioner (MD). Other health care professionals may contribute to the completion of the assessment but the ultimate responsibility must be with an RN or MD.
- 13.5. Care recipients participate in and contribute to assessments, with the support of their relevant person(s) in accordance with the care recipient's wishes.

Pre-admission

- 13.6. Necessary information relating to the care recipient's health, personal and social care needs is obtained prior to admission.
- 13.7. In the case of emergency admissions, this information is obtained as soon as possible after admission and no later than 72 hours.
- 13.8. There are protocols in place to ensure appropriate continuity of care upon admission (see care coordination).

On and subsequent to admission

- 13.9. A comprehensive assessment of the care recipient's health, personal and social care needs, is completed within 72 hours of their admission or sooner if necessary due to risks identified by the pre-admission assessment.
- a. Some components of the assessment may require additional assessment by specific healthcare professionals (e.g Physical Therapist or Nutritionist) these may be obtained as soon as possible, outside of the 72hour timeframe.
 - b. If a resident assessed with an intermediate or complex level of care has not obtained a physician's assessment within 30days prior to admission, the care home must ensure a physician sees the resident within 30days of admission.
 - c. If the comprehensive assessment identifies potential conditions without treatment in place a referral to the GP/medical consultant must be made immediately.
- 13.10. The assessment is reviewed as needed due to the care recipient's changing needs or circumstances, and no less than once per year. Reassessment is required, but not limited to:
- a. After significant treatment process, or lack thereof
 - b. After new symptoms are identified or significant medical changes occur;

- c. When significant behavioral changes are observed
 - d. When there is a change in functioning
- 13.11. All care recipients must be reassessed after their first 3 months at a new care home.
- 13.12. Assessment findings are communicated to the care recipient, and the appropriate relevant persons when required, in accordance with their wishes and legal responsibilities.

Prior to discharge

- 13.13. Notwithstanding the care recipient's freedom to discharge themselves from the care home, discharge decisions are based on assessment and are in accordance with their care plan.
- 13.14. The care recipient is discharged from the care home in a planned manner and the discharge is discussed, planned for and agreed with the care recipients or their relevant person.
- 13.15. To ensure continuity of care, information concerning the care recipient's care needs and ongoing support by healthcare professionals is provided by the person-in-charge to the subsequent care provider, as appropriate.

14. Care planning

Standard

The arrangements to meet each care recipients assessed needs are set out in an up to date, personalized care plan, developed and agreed with each resident or, in the case of a resident with cognitive impairment, with their relevant person.

Criteria

- 14.1. The care recipient's comprehensive care planning is completed within 7 days of admission, or earlier if indicated by a general risk assessment or comprehensive assessment drawn up with the resident. (See the section: Assessment).
- a. An initial nursing and personal care plan must be in place within 48 hours
- 14.2. The care plan reflects the assessment findings and sets out in detail the action to be taken by staff, to ensure that all aspects of the care recipient's individual health, personal and social care needs are met to improve or maintain current health and wellbeing. **NOTE-** a care home may use multiple tools to create a care plan.
- a. The care plan includes goals, desired outcomes, means to achieve such and identified staff responsible for the actions.
 - b. The care plan must be orientated towards:

- Preventing avoidable declines in functioning or functional levels
 - Managing risk factors
 - Addressing resident strengths
 - Using current standards of practice/clinical guidelines in the care planning process
 - Evaluating treatment objectives and outcomes of care
 - Respecting the resident's right to refuse treatment
- c. The care plan must include the following key areas:
- Functional Status
 - Rehabilitation/Restorative nursing
 - Health Maintenance – physical and mental wellness; advanced care directives & end of life care
 - Medications
 - Daily care needs and preferences- ADLS and IADLS;
 - Nutrition and Fluid
 - Activities- physical, spiritual, creative etc
 - Personal and social relationships and engagements
 - Memory enhancement & communication - Life History book for persons with dementia
- 14.3. Care planning is documented, communicated and accessible to the care team and care is provided in accordance with the care plan. Any deviations from the care plan and the reasons for such are documented.
- 14.4. The care plan is discussed, agreed and drawn up with the involvement of the care recipient and/or their relevant person. If the care recipient is unable or unwilling to participate, this is documented. Care recipients with dementia/ cognitive impairment, are actively encouraged to participate in this process.
- 14.5. The care plan is formally evaluated by staff in consultation with the care recipient and their relevant person. It is continuously updated based on the care recipient's changing needs and circumstances and current objectives for health, personal and social care.
- a. Review and updating of care plans occurs at least every 6months, in the absence of any change of conditions or preferences, and any changes made to the care plan are documented immediately.
- 14.6. The care recipient's or their relevant person has access to the care plan and is kept informed of changes.

- 14.7. A life story book is created for each care recipient with limited capacity, memory loss and/or communication difficulties to reflect information about their history, values, preferences and how best to engage with them. This information is constantly updated and new information is obtained as preferences and means of engagement change.

15. Health and Personal Care Services

Standard

The care home promotes and maintains care recipients' health and ensures access to health care and personal care services to meet assessed needs.

Criteria

Personal Care Services

- 15.1. Care services are person centered to respond to the care recipients' individual needs and preference and staff encourage and support the care recipient's own capacity for self-care whenever possible.
- 15.2. Care recipients' personal care needs are monitored and met as required in accordance with their needs and preferences and care home resources. For residents this includes (but is not limited to):
- a. hair – washed, cut and styled as preferred by resident
 - b. Dressed in their preferred clean clothing
 - c. Nails- cleaned and cut
 - d. Feet – nails kept clean and cut
 - e. Eye and hearing care- ensuring residents are using glasses or hearing aids;
 - f. Teeth and mouth- Oral hygiene care is performed at least once a day for residents including those who are tube –fed. Dental appliances are cleaned and maintained regularly.
 - g. Bathing and personal hygiene
 - h. General grooming- shaving, make up etc.
- 15.3. Any dental, ear or eye equipment that is ill fitting or unsuitable for the care recipients' use is identified by care staff. For residents an appropriate referral is made for assessment and replacement and for other care recipients their relevant person must be notified.
- 15.4. Any change in condition of the care recipient noticed during daily personal care by care staff is:

- a. documented; and
 - b. when necessary, the Nurse in charge is notified; and
 - c. for residents a prompt and appropriate referral to a medical practitioner or specialist is made, when deemed appropriate by the RN;
 - d. Notification of relevant person as appropriate.
- 15.5. Opportunities are given for daily appropriate exercise and physical activity; appropriate interventions are carried out for care recipients identified as at risk of falling.

Health Care Services

- 15.6. All care services provided by regulated healthcare professionals uphold the policies, standards of practice and codes of conduct/ethics stipulated by their respective health care regulatory bodies and healthcare professionals' Boards or Councils.
- 15.7. The general health and welfare of care recipients is monitored and recorded.
- a. Residents and persons receiving respite promptly receive or are referred to the following health care services including:
 - Primary care: GP; Dentist,
 - Secondary care: KEMH clinics e.g wound care clinic; Fall prevention; mood and memory
 - Specialist services: Geriatrician, Oncologist, Palliative Care practitioners, Dementia specialists
 - Allied health professionals: Podiatrist/Chiropodist; Occupational Therapists, Physical Therapists; Speech, Language Pathologists; medical social work; dieticians
 - b. Day care attendees' relevant person are notified of any healthcare services required.
- 15.8. A record is maintained of all referrals and follow-ups for each resident.
- 15.9. Care recipients are supported in accessing assistive devices to meet their assessed needs.
- 15.10. Policies and procedures that adhere to this Code and best practice guidelines are available to, and in operation by, staff for common conditions for the care recipients in the home. (See Appendix 7)
- 15.11. Where direct medical care services are not provided by the care home, the resident has an identified medical practitioner for regular and timely consultations, including after hours.

- 15.12. Care recipients have the right to maintain their GP of choice in care facilities with medical care services.
- 15.13. General healthcare screening is ensured by the home at least annually for each resident, if not required more frequently. In addition:
- a. Nutritional screening by the registered Nurse is undertaken at least every 6 months, a record maintained of nutrition, including weight gain or loss, and appropriate action taken including referral to a dietician or speech language practitioner for swallowing assessment, when required.
 - b. Residents with chronic diseases are seen by a medical practitioner every 3-6 months depending on the stability of their condition.
 - c. Care recipients' mental and emotional health and wellbeing are monitored regularly and assessed in accordance with the general assessment criteria. Preventive and restorative care is provided in line with best practice.
 - d. *Each resident should be offered vaccinations as per the current [Bermuda Adult Immunization Schedule](#). Facilities should obtain consent at admission and use standing orders for annual influenza vaccination*
- 15.14. When a care recipient refuses any medical care or referral, the refusal is documented in their file.
- 15.15. When a care recipient requires transport to and from medical appointments, there are clearly understood arrangements in place for care recipients and their relevant persons for such transport including timing and responsibilities of all parties.
- 15.16. With the agreement of the care recipient, specified relevant persons are made aware of developments in their health and wellbeing.

Care coordination

- 15.17. To ensure care coordination and continuation, when care recipients are transferred to another care setting or receive services from an external provider the care home must have processes in place to ensure appropriate, up to date information is shared with the external providers and received from the external providers.
- a. A transfer form is sent by the care homes for care recipients moving to new care settings (including ER visits and moving to another care home).
 - b. Care recipients' records and care plans are updated accordingly.
- 15.18. When care recipients with confusion or dementia are transferred to another care setting, their life story documentation must also accompany them.

16. Medications -Management, monitoring, review, storage & recordkeeping

Standard:

Safe medication practices and medication management policy and procedures are established and implemented to protect care recipients from risks associated with the unsafe use and management of medicines.

Criteria

16.1. Policies and procedures are in place for and adhered to the safe administration of medication, for the prescription, supply, receipt, self-administration by residents, recording, storage, handling, and disposal of medicines that accord with legislation, professional regulatory requirements and best practices.

Preparation and Administration

- 16.2. Care recipients may self-administer medications if:
- a. The risks have been assessed and their competence to self-administer is confirmed; and
 - b. Any change to the initial risk assessment is recorded and arrangements for self-administering medicines are kept under review; and
 - c. Residents have a lockable space to store medication, to which suitably trained, designated care staff may have access with the resident's permission.
- 16.3. A Nurse, or pharmacists, is responsible to prepare all medication with clean and appropriate equipment for care recipients requiring assistance.
- 16.4. A Nursing Associate may, in accordance with their regulated scope of practice:
- a. Assist a care recipient with taking their oral medication;
 - b. Applying creams and lotions to intact skin.
- 16.5. Any medication to be administered via injection, feeding tube, or rectally must be administered by a Registered Nurse.
- 16.6. Medicines are administered in accordance with the prescriber's instructions. All persons preparing, serving, administering or supporting care recipients in taking their medications must refer to the care recipient's medication record to ensure it is:
- a. The right resident
 - b. The right medication
 - c. The right time and/or frequency,
 - d. the right route and
 - e. The right dose

- 16.7. Non-prescribed medicines are administered in accordance with qualified medical or pharmaceutical advice. If a medical practitioner is unable to provide orders for such medications a Registered Nurse may administer medication not already prescribed if ALL of the following are fulfilled:
- a. There is a set of internal standing orders for the administration of medication by a Registered Nurse;
 - b. The medication is only for the symptomatic relief of common minor ailments (e.g. diarrhea, headache, sore throat etc)
 - c. The medicine to be administered is 'over the counter'.
 - d. The medicine is not administered by a Registered Nurse for a period exceeding 24hours without review or verbal order by a medical practitioner.

Recording and Reporting

- 16.8. Records are kept to account for all medicines in the care home. This includes:
- a. Personal medication record (including for those self-administering)which includes:
 - Care recipient demographic and identifying information
 - Diagnosis
 - Allergies to medicines and contra-indications, if any
 - Prescription details: names of medicines, doses, routes, forms, frequency, dates started and discontinued
 - Last review date by medical practitioner
 - b. Medicines administration chart for each resident- updated upon administration of medication.
 - c. Medicines requested and received
 - d. Medicines transferred out of the home
 - e. Medicines disposed of
 - f. The record format and requirements for controlled drugs must be in accordance with the Misuse of Drugs Regulations (s. 10, 13 & 14).
- 16.9. All medication errors, refusals, suspected adverse reactions and incidents are recorded in the care recipient's file; and when necessary (due to the likelihood of having an adverse effect on their health and wellbeing) reported to the appropriate supervisor and/or medical practitioner.
- 16.10. All medication errors or incidents are reviewed by Administrator, Nurse Supervisor/Director of Nursing and staff and analyzed within an open culture of reporting. Learning is fed back to improve patient safety and prevent reoccurrence.

16.11. Use of antibiotics is monitored by the Nurse Supervisor/Director of Nursing.

Medication Reviews

16.12. The condition of the resident on medication is monitored and subject to review when visited by a medical practitioner:

- a. A minimum of once per year;
- b. When there is a significant change in condition or care;
- c. At least every 3 months for the following medications:
 - antipsychotic medication
 - sleeping tablets and other sedating medication
 - anticonvulsant medication
 - medication for the management of depression
 - analgesic medications (pain management)
 - medication for the management of constipation
 - antiplatelet and anticoagulant medication (prevention of stroke)
 - influenza and pneumococcal vaccines
 - non-steroidal anti-inflammatory drugs

16.13. All prescribed medication is clearly documented by the doctor in the resident's file including any changes to the medication.

16.14. Staff actively promote the care recipients' understanding of their health needs relating to medication.

Medication Storage and Disposal

16.15. Medicines are safely and securely stored and disposed of in accordance with the manufacturer's instructions and the Pharmacy and Poisons Act and Regulations and Misuse of Drugs Act and Regulation. Controlled drugs must be stored in a locked cabinet.

16.16. Consultation with the government pharmacy inspector must occur to ensure appropriate disposal of prescription medicines and controlled drugs. All medicines must be disposed of properly when they have:

- a. Expired
- b. Show signs of deterioration
- c. Medication is no longer required by a resident or resident is no longer at the care home
- d. A recall has been issued by the drug manufacturer or regulatory authority.

17. End of Life Care

Standard:

Each resident continues to receive care at the end of their life which meets their physical, emotional, social and spiritual needs and respects their dignity and autonomy.

Criteria

- 17.1. Resident's palliative care needs must be assessed, documented and regularly reviewed. The information derived from these assessments is explained to, and options discussed at regular intervals with the resident, their relevant person, in accordance with the resident's wishes.
- 17.2. The resident's wishes and choices regarding end of life care must be discussed and documented, and, in as far as possible, implemented and reviewed regularly with the resident. This includes their preferred place of care, religious, spiritual and cultural practices and the extent to which their relevant persons are involved in the decision making process. Where the resident can no longer make decisions on such matters, due to an absence of capacity, their relevant person is consulted.
- 17.3. In accordance with the resident's assessed needs, referrals are made to specialist palliative care services so that an integrated multi-disciplinary approach to end of life care is provided.
- 17.4. Staff are provided with training and guidance in end of life care as appropriate to their role.
- 17.5. The care home must be able to support end of life care so that the resident is not unnecessarily transferred to an acute setting except for specific medical reasons, and in accordance with their or their relevant person's wishes.
 - a. Every effort is made to ensure that the resident's choice for their place of death, including the option of a single room or returning home, is identified and respected where possible.
- 17.6. The resident's family and friends must be facilitated to be with the resident when they are very ill or dying.
 - a. 24hour visiting, in consideration of roommates and space availability.
 - b. Upon the death of the resident, time and privacy are allowed for the relevant persons.
 - c. An atmosphere of peace and calm is maintained at all times.
- 17.7. There must be a procedure for staff to follow after the death of a resident in relation to the verification and certification of death.

- 17.8. The deceased resident's body must be treated with respect and dignity in accordance with their wishes, if stated, or in accordance with the wishes of their relevant person, and in accordance with the resident's cultural and religious beliefs and best practice.
- 17.9. Upon the death of a resident, relevant persons should be offered practical information (verbally and in writing) on available bereavement resources and required next steps.
- 17.10. Procedures are in place for the return of the care recipient's personal possessions in accordance with their wishes, in a timely and respectful fashion following death. The return of personal effects is formally documented and signed.
- 17.11. Following the death of a resident, support must be provided to other residents and staff. Where residents would like to have a remembrance event, this is facilitated.
- 17.12. Ageing and Disability Services is notified following the death of a resident.

18. Dementia Care

Standard:

Staff are able to recognize and respond appropriately to signs of dementia, and recognize that the person with dementia may have fluctuating capacity and the care provided reflects a person centered, strength-based approach to assessment, care planning and service provision and promotes the right to self-determination.

Criteria

Recognizing the signs of dementia and responding to need

- 20.1. Staff demonstrate awareness of the signs, symptoms and disabilities associated with dementia and know how to seek further advice and assistance on how to effectively support a care recipient who is experiencing difficulty with:
- a. Memory
 - b. Communication
 - c. Delirium
 - d. Visual perception- recognition & co-ordination
 - e. Orientation
 - f. Changes in behavior, judgment & moods
 - g. Completion of daily life skills
 - h. Nutrition and hydration.
- 20.2. Where a resident displays the signs or symptoms of dementia, they must be referred for a thorough assessment in a timely manner and the person in charge ensures staff

obtain the necessary professional help and guidance to be able to provide the person appropriate care. For day care attendees their relevant person must be notified and the home again ensure they can meet the person's needs once assessed.

- 20.3. Where a care recipient is diagnosed with dementia, this is handled sensitively and they and their relevant persons are offered access to timely and appropriate information, resources and support.
- 20.4. The care home actively facilitates and maintains links with local resources that can provide support to individuals and groups. Care recipients and their relatives are made aware of such support and the steps to be taken to access it.

Approach to Care

- 20.5. Care recipients with dementia are supported to make choices and decisions about their lives and how their personal care needs will be met in the home (also see s.2 and Appendix 4):
- a. The resident is provided with appropriate support to settle into the home, to promote orientation and feelings of safety and security (e.g. through a "buddy" system).
 - b. Records of the care recipient's decisions and how they were made are kept in their file.
 - c. Care recipients' right to make decisions and choices are respected and staff work to ensure they understand the consequences of decisions made, but do not undermine their right to make such choices.
 - d. Staff respect the care recipient's rights to decline or refuse a care intervention whilst considering the overall outcome for them and other residents.
 - e. Staff work in partnership with relevant persons, sharing information as appropriate and recognizing their valid feelings about the resident's move to the home and changing care needs as dementia progresses
- 20.6. Staff understand and demonstrate knowledge of approaches to promote effective methods of communication with care recipients in various stages of dementia, including advanced stages. This includes:
- a. Alternative forms of communication such as music, song and touch are used as appropriate.
 - b. Pictures or other means of communication are used to discuss and make decisions where appropriate.
 - c. Staff choose the most appropriate environment and time of day to discuss choices and decisions with residents.

- 20.7. Advice must be sought from professionals on appropriate methods of, and aids to, communication.
- 20.8. Staff must follow this Code and best practice guidance in the use of anti-psychotic medication for residents with dementia. This includes ensuring the appropriate staff:
- a. are aware of potential side effects such as physical deconditioning, incontinence, distress/agitation, and rescued skin integrity; and
 - b. ensure other issues including infection; constipation; hydration; poor hearing or eyesight and pain are not masked by the effects of the medication.
 - c. work with prescribers to ensure regular medication reviews with a view to reducing medication as per best practice guidance. (see section on Restraint)
- 20.9. Care recipient's daily routines are built around their preferences and choices as far as possible and accommodate instances where activity level or behavior may change according to the time of day.
- 20.10. Staff have a knowledge and understanding of:
- a. the range of distressed behaviour that may be experienced (including but not limited to walking or pacing/activity disturbance; refusing help and assistance; being withdrawn; repetition; difficulties with continence; and sexual expression).
 - b. the reasons why such behaviour may occur; and
 - c. how to respond appropriately (in accordance with other sections of this Code and guidelines in Appendix 6).
- 20.11. A record must be kept of all distressed behaviours in order to identify triggers and patterns in order to support the analysis and understanding of the unmet need being communicated through the behaviour.
- 20.12. Strategies are in place to respond to the behaviour in a caring and supportive manner.
- a. care plans and risk management plans are amended to reflect the agreed strategy.
 - b. The agreed strategy is communicated to all staff, residents and relevant persons and is regularly reviewed.
- 20.13. Staff must recognize the care recipient's right to privacy and acknowledge that sexual expression is part of normal adult behavior. Staff explore physical or emotional reasons behind sexualised or inappropriate behaviour and respond with empathy in a manner that respects the resident's feelings and dignity whilst managing the situation.

19. Staffing

I. Minimum staffing levels

Standard

At all times the type of staff, numbers and ratios of staff on duty, including management, direct care staff, food and housekeeping service staff meets the assessed care, social, and recreational needs of care recipients; taking into account the size and layout of the home, the model of care, organizational structure, fire safety requirements and legislation.

Criteria:

- 19.1. All facilities must have at a minimum the following roles filled in accordance with Appendix 8- staff qualifications, roles and responsibilities etc.
 - a. An administrator responsible for day to day operations;
 - b. A Deputy Administrator to fulfill role of administrator when absent
 - c. A medical consultant for residents without a GP
 - a. Registered Nurse as a supervisor of Care for Residential Care Homes
 - b. Registered Nurse as a Director of Care Nursing Homes
 - c. Activities Coordinator
 - d. Direct care staff to meet care needs of care recipients
 - e. In accordance with the Code, consultation with required health care professionals including Nutritionists and Occupational and Physiotherapists.
- 19.2. In addition to 19.1, there must be sufficient numbers of staff to ensure that all standards relating to the operation of the care home including direct service provision, management and maintenance/housekeeping are upheld. This includes ensuring adequate on call staff availability.
- 19.3. A care home may have one person fulfilling multiple roles depending on the number of care recipients, organizational structure, layout of the care home in accordance with this Standard. This must be approved by Ageing and Disability Services.
- 19.4. A planned and actual 24/7 staff schedule, showing all staff on duty must be maintained.

Required types and numbers of direct care staff

- 19.5. The following staffing requirements must be upheld in all care homes in case of emergencies and to meet both the planned and unplanned care needs of residents:
 - a. There must be a minimum of 2 staff, on site, at all times, regardless of the total number of residents. One of the two must always be a registered healthcare professional (e.g. Nursing Associate, RN, etc).

- b. Overnight staff must be onsite and awake.
- 19.6. In addition to in 19.5, a minimum ratio of one direct care staff to ten residents must be maintained when **ALL** residents are ambulatory and orientated; meaning they can call for help and evacuate with no assistance.
- a. When **ALL** residents are not ambulatory and orientated, the number and type of direct care staff to residents must increase to meet the residents' care and safety needs.
- 19.7. To determine the specific number and skill mix of staff required based on individual care needs the following must occur:
- a. A comprehensive assessment is used to assess the level of care and care plans required by each care recipient. See Appendix 3 for the levels of Care.
- b. Based on the care recipient's levels of care and specific care plan, the estimated minimum hours per resident in Table 1 is used to calculate the required staffing levels and skill mixes. Overall staffing levels must ensure:
- They meet highest level of care required in the home with residents with different levels of care
 - They adapt to changing care needs
 - minimum supervision, oversight and scheduling requirements are met
 - The layout of the care home is taken into account

Table 2:

Level of Care	Estimated minimum hours of direct care per resident & minimum RN oversight requirements
Personal Care	<ul style="list-style-type: none"> • 1-2 hrs/day of care services* • RN- minimum on site hours determined by number of residents, care needs and supervision role.
Intermediate care	<ul style="list-style-type: none"> • 2.5 hrs/day of nursing care**; 0.5-1.5 of the hours are by an RN • An RN must be on site for 10hours per day, 7 days a week and on call for the remainder of the day
Complex Care	<ul style="list-style-type: none"> • 4 hrs/day of nursing care; 1.6 of the hours are by an RN • An RN must be on site 24hours per day, 7 days per week

*Care services include those provided by RN, Nursing Associates and caregivers.

**Nursing Care – refers to care services provided by: Registered Nurses and Nursing Associates.

- 19.8. Exceptions to the minimum staffing requirements may be pre-approved by Ageing and Disability Services based on care recipients' care needs (e.g. independent mobility and cognitive capacity) and the type and model of the care home (e.g homes where all residents leave during the day).

- 19.9. To ensure care recipients know their direct care staff and that the direct care staff know the needs and preferences of the care recipients for person centered care and early prevention and detection the following should occur:
- a. 75%, fulltime, direct care staff employment.
 - b. If part time or on call staff are used, they should be used consistently to limit the number of staff providing services in the home who are unfamiliar with the care recipients. No shift should have only staff on that are new or unfamiliar with the care recipients.

II. Recruitment and Roles

Standard:

The recruitment of staff ensures the protection, safety, health and wellbeing of care recipients.

Criteria

- 19.10. All staff are required to submit the following for employment. Hiring decisions must be based on these at a minimum:
- a. Comprehensive criminal records check, not less than 6months old.
 - No person convicted of senior abuse is allowed to be a care worker for seniors; or manage or have a financial interest in any home or other institution that cares for seniors.
 - Hiring of applicants with offences must take into account the following considerations:
 - The nature of the crime including the type of crime and if the victim was a vulnerable person
 - the length of time since the conviction,
 - the record of the person since conviction, and
 - the specific role, responsibilities and supervision of the applicant at the care home.
 - b. Two written references
 - c. Medical certificate for direct care staff, Administrators and Deputy Administrators in the form required (see Resources) or with equivalent information, not less than 1 month old.
 - d. Qualifications:
 - Current CPR and First Aid certification
 - minimum qualification requirements in Appendix 8, Part I
 - e. Resume – gaps in employment history are explored

- 19.11. All staff have written job descriptions and a copy of their terms and conditions of employment prior to commencing post. Including:
- a. Job qualifications
 - b. Scope and responsibilities of the position
 - c. Self-disclosure requirement for any regulatory action against the employee, or criminal convictions once employed.
- 19.12. The person in charge must assign duties to staff that are consistent with the job specifications for the staff's position.
- 19.13. All staff must work within their professionally regulated scope of practice and/or competencies and uphold the conduct and practice standards established by their respective professional regulations, legislation and this Code of Practice.
- 19.14. To ensure both care recipients and staff safety, operators must have a policy requiring direct care staff to report if and when they have outside employment to prevent scheduling a person without adequate rest.
- a. No staff in a care home should be working more than 16hours per day, (including outside employment) as there should be a mandatory 8hour rest period.
 - b. No staff should be working more than 80hours in a 7day period.
- 19.15. To ensure maintenance of resident and staff health the following should be in place:
- a. Policies for managing employee/volunteer illness should include:
 - Prompt reporting of signs and symptoms of potentially communicable disease by the employee/volunteer to a supervisor
 - A non-punitive work-exclusion policy discouraging staff/volunteers from coming to work with signs or symptoms of communicable diseases (e.g. cough, rash, and diarrhea) until clearance to return to work is given by a physician.
 - b. Staff records should indicate any employee exposure to blood or body fluids or communicable diseases.
 - c. The Administrator should maintain an up to date written record of the employee's current immunization status.
 - Employees should have current immunization as recommended for healthcare workers by the current *Bermuda Adult Immunization Schedule*.
 - It is recommended that all employees obtain the influenza vaccine annually, with care home documentation of receipt or declination
- 19.16. Volunteers' roles and responsibilities are set out in a written agreement between the care home and the individual.

- 19.17. Volunteers are vetted appropriately to their role and level of involvement in the care home and receive appropriate supervision and support.

III. Training and Supervision

Standard

Staff are adequately trained for their roles and responsibilities and obtain ongoing training and supervision.

Criteria

- 19.18. There is ongoing staff supervision, appraisal and individual training to ensure staff:
- a. meet the specific and changing needs of their care recipients (e.g. dementia care; support to persons with intellectual disabilities etc)
 - b. fulfil the aims and philosophies of the care home and the Bill of Rights for Persons in Care;
 - c. understand and adhere to the Code and policies and procedures of the care home and other regulatory bodies; and
 - d. are suitably competent to carry out their role.
- 19.19. All newly appointed staff receive a structured orientation that at a minimum includes:
- a. Overview of the philosophy, programs, policy and procedures of the care home
 - b. Introduction and overview of residents
 - c. Review of the Code of Practice
 - d. Required in-service and mandatory training requirements (see 19.20)
- 19.20. The Administrator must that ensure all on site staff complete the required mandatory training every 2 years. Additional training may be required depending on the specific care needs of residents and care staff qualifications.
- a. See Appendix 7, Part III for mandatory training requirements.
- 19.21. New staff without the mandatory training completed in the 2 years before starting at the care home must at least obtain in service training within their first month.
- 19.22. All staff are supervised on a regular basis pertinent to their role. Supervision includes both visual observation and verification of documentation.
- a. Nursing Associates and unregulated caregivers receive appropriate supervision from a Registered Nurse, evidence of supervision is documented.
- 19.23. Annual appraisals are completed for all staff by their respective supervisors.
- 19.24. Staff records indicate completion of training, appraisals and supervision.

19. Mandatory reporting

Standard:

Mandatory reporting requirements within care homes and to external agencies occurs in a timely and appropriate manner.

Criteria:

- 19.1. Ageing and Disability Services (ADS) is notified by the appropriate staff member at the care home in the following circumstances:
- a. Any suspected or reported abuse of a care recipient
 - b. Any incident resulting in injury, ER visits, hospitalization or death of a care recipient
 - c. Any unauthorized use of restraint in emergency circumstances
 - d. Missing persons
 - e. Changes to the Administrator or Deputy Administrator
 - f. Any regulatory or legal action that may impact the operation of the care home and the health, safety and wellbeing of care recipients (see Resources).
- 19.2. An incident report book is maintained by staff to record incidents at time of occurrence. Incidents include but are not limited to:
- | | |
|--------------------|-----------------------|
| a. hospitalization | e. unexplained injury |
| b. accident | f. suspected abuse |
| c. dangerous falls | g. occurrences |
| d. missing persons | h. fire |
- And information recorded must include:
- a. care recipient name
 - b. date and time of incident;
 - c. person on duty at time of incident
 - d. type of incident
 - e. action taken by person on duty including: immediate intervention; reporting to supervisor, GP and responsible persons; mandatory reporting (who & when); Signature of reporting person
- 19.3. Weekly bed status statistics and annual statistical reports are submitted to ADS in the required format.
- 19.4. Ageing and Disability Services may request additional or updated reports from care homes for purposes of compliance monitoring.

20. Quality and risk assessment

Standard:

Processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided and mitigate risks relating to the health, safety and welfare of care recipients and others at the care home.

Criteria:

- 20.1. The Administrator and appropriate staff review individual serious incidents and makes changes to policy and practice when required to mitigate risk and improve quality care.
- 20.2. The following must be considered when assessing quality and safety of services provided:
 - a. Appropriate professional and expert advice and best practice standards;
 - b. Inspection reports;
 - c. Investigation into a staff member's conduct by the relevant health care professional body or the Senior Abuse Registrar;
 - d. Standards, criteria and guidance issued by the Ministry of Health (e.g. the Code of Practice).
 - e. Information collected as part of care recipient and staff records (clinical, administrative etc);
 - f. Complaints, comments and suggestions of care recipients and their responsible persons
 - g. Review of care home data collected on:
 - Level of care of residents
 - Incidences of infectious and communicable diseases
 - incidences of chemical and physical restraints (both planned and emergency, including type of restraint)

The following data should also be collected and reviewed in addition to the above:

- incidences of urinary tract infections
 - incidences of pressure sores
 - incidences of falls
 - transfer to emergency rooms and hospital admissions
- 22.3. Reports may be requested by Ageing and Disability Services, from care homes, on how quality improvement and risk assessment is occurring and any plans for the improving of the standard of services provided to ensure care recipient's health and welfare.

D. Quality of Management

21. Statement of purpose

Standard:

A statement of purpose is in place that describes the care home's structure and operation.

Criteria

- 21.1. The Statement of Purpose must be submitted for the initial registration of a care home.
- 21.2. Every home has a Statement of purpose that includes:
 - a. The aims and objectives of the home, including their philosophy of care
 - b. The total number of rooms and size of rooms
 - c. The intended number of residents and day care program participants (if any)
 - d. The name and address of the registered operator and Administrator
 - e. The number, relevant qualifications and experience of the staff in the home
 - f. The organizational structure of the home
 - g. The demographics of the residents to be admitted to the home
 - h. The care needs of the residents to be met by the home (including level of care etc)
 - i. Admission criteria for care recipients including policy and procedure for emergency admissions
 - j. Details of any specific therapeutic techniques or specialized services
 - k. Fire, disaster and emergency procedures
 - l. A list of key policies that inform practice in the care home
- 21.3. The day to day operation of the care home reflects the statement of purpose and functions.
- 21.4. Before any changes are made which affect the purpose and function of the care home, Ageing and Disability Services is notified and consulted to determine if any changes to their license, conditions or if reassessment is required.

22. Financial management

Standard:

Care recipients' health, safety and wellbeing are protected and ensured through the accounting and financial procedures of the care home.

Criteria:

- 22.1. Suitable accounting and financial procedure are in place to demonstrate financial viability and to ensure there is effective and efficient management of the home. This includes but is not limited to:
- a. Management accounts must be kept and be available for inspection. This includes at a minimum:
 - An income statement and a balance sheet. Additional financial details may be required or an internal audit on a case by case basis.
 - b. There is no co-mingling of personal and business accounts. This includes:
 - Operator's personal or other business account(s) with the care home business account(s)
 - Any residents' personal funds held by the care home with the care home's business accounts (see s. 22).
 - c. Insurance coverage should be in place to cover loss or damage to assets and to provide for interruption costs.
 - d. A current business and financial plan for the care home should be maintained, as is required for initial registration.

23. Policies and Procedures

Standard

Policies and procedures are up to date, in operation and stored in an accessible location for respective staff and care recipients.

Criteria:

- 23.1. All policies and procedures are written in clear language for staff and stored in a location accessible for staff.
- 23.2. Care recipients and their relevant persons are provided access to all policies and procedures.
- 23.3. The following are the minimum required policies and procedures:
- a. Admission, discharge and care coordination for residents
 - b. Medication administration, management, storage and disposal

- c. Protection from abuse, use of restraints and managing challenging behaviours
- d. Incidents and unusual occurrences which include prevention and interventions for the following circumstances:
 - missing persons
 - Falls
 - Abuse
- e. Emergency and Disaster Response- Hurricane Guideline Procedures
- f. Labour dispute plan to ensure adequate staffing
- g. Food service and Nutrition
- h. Infection control
- i. Best practice clinical guidelines for common conditions

24. Record Management

I. Resident Records

Standard:

Secure, accurate and up to date care recipient records including records of all care and treatment provided and decision in relation to care and treatment must be maintained.

Criteria

- 24.1. Each care recipient has an up to date administrative record kept in a secure location that includes the following:
- a. Demographic information
 - b. Admission and discharge dates and circumstances
 - c. Service contract
 - d. Contact information for relevant persons and healthcare professionals include phone and email
 - e. all legal or specified delegation of authority regarding personal, financial or health care requirements
 - f. the financial arrangements and accounts pertaining to their use of services and any funds held on the care recipient's behalf
 - g. all belongings brought into the home by or for the specified care recipient;
 - h. complaints, concerns, reports and recommendations from or regarding the care recipient by the care recipient, relevant persons or other agencies.
 - i. life history and current social, cultural, recreational preferences, interests and dislikes.
 - j. a current photograph of the care recipient

- 24.2. Each resident has an up to date medical record, kept in a secure location accessible to appropriate staff. The record must include the following information:
- a. Demographic information
 - b. Contact information for relevant persons and healthcare professionals
 - c. Pre-admission and ongoing assessments
 - d. Pre-existing and ongoing medical conditions (as needed for day care attendees)
 - e. All orders, referrals, special examinations, progress notes and recommendations of care by healthcare professionals (as needed for day care attendees)
 - f. Daily care records of persons' health, condition and treatment, as required based on care needs and in accordance with practice standards.
 - g. Care plans including details of any plans regarding personal care, nursing care, specialist health care, nutrition (as needed for day care attendees)
 - h. Medication records and medication errors
 - i. any refusal of consent for care or treatment
 - j. Condition on discharge
 - k. End of life care preferences and requirements
 - l. date, time and cause of death
- 24.3. Records must be kept in appropriate storage locations based on information contained within and intended use. This includes:
- a. Residents' financial information is kept in a locked location and is only accessible to administrative staff.
 - b. Medical Records are kept in location that is accessible to appropriate care staff.

II. Staff Records

Standard:

Secure, accurate and up to date records, as are necessary, must be kept in relation to persons employed by, or volunteering for, the care home.

Criteria

- 24.4. All staff and consistent, ongoing volunteers have the following information relevant to their roles and responsibilities in their staff record:
- a. demographic and contact information
 - b. particulars of education, training, experience, previous employment
 - c. ongoing supervision, appraisal, training and professional development, as required.
 - d. evidence of current professional license, qualifications, character references, medical certification and criminal record check as required.

E. Quality of the Physical Environment

25. Physical Environment

Standard:

The physical environment of the care home is clean, safe and comfortable for care recipients and meet their needs and abilities.

Criteria:

General

- 25.1. The internal and external structure, design, exterior environment and plant are in a condition that ensures and facilitates the health, safety and wellbeing of care recipients. This includes, but is not limited to:
- a. The care home is kept weatherproof and dry this includes ensuring the ceilings, walls and floors are free of damp, mold or moisture.
 - b. Doors and windows are functioning, in good condition and lockable.
 - c. Floors, stairs and ramps throughout the care home are in good condition and:
 - have non-skid finishing or coating
 - are free from tripping hazards (e.g. electrical cords, clutter, rugs etc)
 - d. Handrails are secure, adequate handrails and installed on all ramps and stairways (internal and external). Handrails may also be required in hallways depending on assessment.
 - e. All electrical outlets are covered appropriately and in good repair.
 - f. Exits and surrounding areas are maintained in good condition, including accessibility requirements, these areas are:
 - Driveway surface
 - Parking for wheelchair accessible vehicles
 - Entrance and exists ramps
 - g. All hazardous materials are locked away from care recipients.
 - h. The furniture in the care home is in good condition, easily cleaned and appropriate for the needs and abilities of the care recipients.
 - i. All elevators or elevating devices are maintained in good working condition with up to date service certificates.
 - j. There is adequate social and recreational community space for all care recipients (at least 20x20ft) including: living room, recreation room and dining room. This must ensure:
 - Space is accessible for persons with assistive devices
 - Furniture is appropriate to needs of care recipients:

- Height of table, chairs and sofa for easy sitting and rising.
- Chairs- armrests and firm
- No tripping hazards (e.g. carpets, throw rugs)
- k. For care homes with persons with dementia, the care home design must take into account requirements to assist their orientation; as well as remove design features that contribute to disorientation or safety concerns.
- l. Any new building and renovations are compliant with Bermuda Building Code requirements for accessible design as required.

Lighting

- 25.2. The home is adequately lighted this includes but is not limited to:
- a. The care home and lighting system is designed, equipped and maintained to avoid high brightness, highly reflective surfaces and glare.
 - b. At least 60 watt bulbs are used for lighting fixtures
 - c. Nightlights in bathrooms, hallways and resident bedrooms
 - d. Outside entrances are well lit at all times they are likely to be in use.
 - e. All Stairs and steps are well lit
 - f. All window sills in rooms occupied by residents are not more than 3 feet from the floor

Heating and Ventilation

- 25.3. The home is adequately heated and vented. This includes but is not limited to:
- a. Compliance with the Bermuda Building Code and International mechanical code standards
 - b. Heating and cooling systems are located to prevent drafts to residents
 - c. Every home is well ventilated through windows, forced air or both.
 - d. Air filters are provided in AC units and a record is kept of their maintenance including proper cleaning
 - e. All windows can be opened

Sanitation and pest control

- 25.4. The home has good sanitation and effective pest control in place which includes but is not limited to:
- a. Garbage containers are structurally sound, clean, and adequate for their use and garbage is stored in a clean and appropriate area.
 - b. Cesspits have sufficient capacity for the projected wastewater flows in accordance with the Residential Building Code 2014, where appropriate.
 - c. Cesspits or septic tank systems are in good condition and in accordance with the Public Health Privies and Cesspit Regulations 1930

- d. There are no conditions that support the breeding of pest e.g.: Dry good storage adequate to prevent rodent/pests
- e. Entry of pests into the care home is prevented by screened windows and doors that are in good condition.
- f. Records of treatment for pest control are maintained by the care home and available upon inspection.

Water supply

- 25.5. The home must ensure the water catchment, storage and supply are in good condition. This includes but is not limited to:
- a. Catchment (roof) kept in good condition, clean and free of debris
 - b. Tanks cleaned every 6 years
 - c. Screens over vents of the tank
 - d. If supplemental water supply (well or piped) was determined as required, it is maintained and in good condition
 - e. All water used for consumption meets the Department of Health water testing standards
 - f. There must be no cross contamination of other water source with potable water supply
 - g. There must be an adequate supply of hot water for residents available at all times.
 - h. For sinks, showers and bathtubs used by residents the water temperature must not exceed 110F
 - A separate water supply that is greater than 180F must be used for dishwashing unless a chemical sanitizer is used.
- 25.6. *A water disinfection, continual treatment system should be in place to maintain Department of Health water testing standards at all times.*

Laundry and housekeeping

- 25.7. There must be one supply closet on each floor which is locked and contains a sink, shelves and sufficient space for storing housekeeping and cleaning supplies.
- 25.8. The care home is maintained in a clean condition through regularly scheduled routine housekeeping in accordance with infection control requirements (see s.27).
- 25.9. Resident laundry is collected and washed by the appropriate staff to ensure residents have a continuous supply of clean clothing.
- 25.10. Where feasible, residents who wish to wash small amounts of their own are able to do so.

- 25.11. An adequate supply of clean linen (bed sheets and towels) is supplied at least once per week to residents.
- 25.12. Laundry is handled (collected, transported, sorted, washed and dried) to minimize contamination including (but not limited to):
- a. Personal laundry is handled separate from bed linens
 - b. Soiled linen is:
 - taken to a designated dirty laundry storage area in closed hampers or bags
 - never taken through food storage or prep areas
 - kept separate from clean linen at all times
 - separate carts used for soiled linen collection and distribution of clean linens
 - soiled linen is kept in identifiable bags
 - c. Laundry workers wear an identifiable uniform used only while doing laundry

Kitchen

- 25.13. The kitchen must provide a functional, clean and safe working environment for staff and to provide required food services. This includes, but is not limited to:

Food storage

- a. Adequate storage space for food that is separate from all cleaning products and chemicals.
- b. Refrigerator and freezers are clean and free of mold
- c. Temperature and storage of foods is safe for their preservation. This includes:
 - Food is stored in the manner and location recommended by the producer.
 - Refrigerator temperature is maintained at 35-40 degrees Fahrenheit
 - Freezer temperature is maintained below 0 degrees Fahrenheit

Sanitation

- d. Sufficient food safety apparel (gloves, hair nets, aprons)
- e. All surfaces and equipment clean and food contact surfaces sanitized
- f. All utensils and equipment are washed after each use, drained to air dry, no cloths used.
- g. Equipment is available and functioning that washes all utensils and equipment for food and drink preparation, cooking and serving. This includes:
 - Triple sink for ware washing, unless otherwise approved by an Environmental Health Officer.
 - Separate single hand washing sink

Equipment and design

- h. The kitchen provides adequate, clean space for preparing food.

- i. All cooking units are hooded and vented According to Intl Mechanical Code (under the Bermuda Building Code) and in safe and good working order, unless otherwise approved by Environment Health Officer.
- j. All catering equipment is kept in a location to ensure resident safety, guarded where necessary, and maintained in a safe operating condition (e.g. electrical).

Bedrooms

- 25.14. There must be no more than 3 people to a room.
 - a. There should be a maximum of 2 persons sharing a room. Three should only be done as an exception when there is sufficient space and design to maximize privacy.

- 25.15. All bedrooms must meet the following room design criteria and ensure there is ample space for the mobility of the resident(s):
 - a. Minimum space per persons (excluding closets, toilet rooms, wardrobes, furniture & vestibules):
 - single rooms- 120 sq. feet
 - double & triple rooms- 90 sq ft
 - b. Min total room dimensions (excluding closets & toilets):
 - single and double rooms minimum wall lengths: 10ft x 12ft
 - Triple rooms no single wall less than 12ft.
 - c. Minimum of 3 feet between the beds and the window and heating elements
 - d. At least one window and an egress to the hallway
 - e. At least one light must be accessible from the door

- 25.16. The bedrooms must be designed and equipped for the comfort and accessibility of residents. The following must be provided, in accordance with the residents' specific needs:
 - a. A hospital or adaptive and height adjustable bed
 - b. Bedside table or cabinet with lockable storage space – if not lockable an alternative lockable location for valuables
 - c. Individual reading lamp (60watt bulb)
 - d. Comfortable armchair appropriate to resident needs
 - e. No caster or rolling furniture unless with working locks.
 - f. Sufficient storage space for personal clothing and effects
 - g. Night lights
 - h. No scatter rugs

- i. If keys are provided, staff must have access to duplicates for housekeeping and emergencies
 - j. Available upon request, a flame resistance, washable curtain or portable screen that completely conceals the bed for privacy
- 25.17. All residents must be able to decorate and furnish their area/room with items of their preference, taking into consideration the impact on their roommates and storage capacity of the care home.

Bathrooms

- 25.18. Each care home must have at least:
- a. One functioning wash basin and toilet for every 4 residents,
 - b. one bathtub for every 6 residents; and
 - c. at least one bathroom is accessible and useable to residents in wheelchairs in accordance with the current American Disability Act standards and International Code Council Accessible and Usable Building and Facilities Standards (see Resources). Additional accessible bathrooms may be required based assessment by an inspector.
- 25.19. In care homes with more than 20 residents, there must be a toilet and wash basins near the community space.
- 25.20. The minimum size for a room with only a toilet is: 3ftx6ft.
- 25.21. All doors to any bathroom must:
- a. Be at least 3ft wide
 - b. Have fittings that are operational from inside and outside
 - c. Not open onto any dining room, kitchen, pantry, food preparation or storage room.
- 25.22. Bathrooms meet the general safety and comfort requirements of the residents including but not limited to:
- a. Raised toilet seat for persons with lower limb muscle weakness &/ arthritis
 - b. Shower bench or seat with handheld shower wand
 - c. Grab bars in all bathrooms and toilets in accordance with American Disability Act standards
 - d. Handrails are sturdily mounted on walls in towels and bathrooms in accordance with American Disability Act standards
 - e. Simple to use faucets are required for all bathrooms (i.e. faucet levers, no spring loaded or pressure operated faucets).

- f. Non-skid surface in tubs
- g. No glass doors on showers
- h. No throw rugs
- i. Disposable hand towels in all bathrooms

Outdoor and surrounding environment

- 25.23. An accessible and secure outdoor area must be available to care recipients.
- 25.24. The outside and surrounding environment must be:
- a. free from hazardous and noxious smoke and fumes
 - b. Where possible, away from loud and irritating sounds
 - c. Without hazardous surroundings including cliffs and bodies of water unless suitable structures provide safety for residents e.g. walls, gates, fences

26. Health and safety

Standard:

Care homes provide safe and healthy environments for staff, care recipients and visitors in accordance with requirements under legislation.

Criteria

- 26.1. No smoking is allowed inside a care home. Staff are not allowed to smoke on the property. Residents may smoke on the property in accordance with Department of Health policy.
- 26.2. Care home vehicles are roadworthy, insured and are only driven by staff with the appropriate driving license. A record is kept of maintenance checks. All incidents occurring during transport are reported and recorded in the incident book and reported to the appropriate management and authorities.
- 26.3. Staff are provided a reasonable functional working environment which includes and is not limited to:
- a. Adequate staff supplies, protective clothing and equipment suitable for their responsibilities and to prevent risk of harm or injury to themselves or others. This includes but is not limited to the following being readily accessible in resident care areas:
 - Personal Protective Equipment (PPE) (e.g. gloves, gowns, masks)
 - Supplies for safe injection practices (e.g. single use lancets, sharps containers)
 - First Aid supplies

- b. Adequate working space for staff and areas exclusive to staff including a designated staff room, toilets and shower facilities
- c. Compliance with the Occupational Health and Safety Act and Regulations

Medical devices and equipment

- 27.6. An appropriate quantity and quality of equipment is available to meet residents' care needs. This includes but is not limited to:
- a. Require clinical care tools for health assessment and monitoring (e.g. scale, bp equipment)
 - b. Hoists and lifts
 - c. Defibrillator
 - d. Standard wheelchairs and walkers for unexpected changes in care recipients' mobility
 - e. Slide sheets
 - f. Gait belts
- 27.7. All equipment in the care home is maintained in accordance with manufacturing requirements including documentation of ongoing required calibration and service certificates.

27. Infection Prevention and Control

Standard:

An infection prevention and control program, in compliance with all relevant legislation, to prevent the development and spread of disease and infection is in place and maintained.

Criteria:

Administration

- 27.1. A qualified staff member (e.g. a Registered Nurse), familiar with the care recipient population, must be responsible for overseeing and monitoring infection control activities in the care home. This includes the following components:
- a. Surveillance
 - b. Outbreak control
 - c. Isolation and precautions
 - d. Care recipient health (see Quality of Care section)
 - e. Employee health (see Staffing section)
- 27.2. The care home must have a multidisciplinary review of Infection Prevention and Control within the care home on a regular basis (minimum quarterly).

- a. A multidisciplinary team means staff representation from key infection control areas in the home e.g. Nursing, housekeeping, kitchen. The review can occur at a staff meeting.
 - b. The review must include:
 - review infection control data
 - recommend and review IPAC policies and procedures at least annually
 - monitor infection prevention and control activities.
- 27.3. Written Infection Prevention and Control policies and procedures must be available and based on evidence-based guidelines and in accordance with OCMO policies.
- 27.4. Consultation must be sought as needed with an infectious disease physician or other professional with relevant expertise.

Facility - see also section 26

- 27.5. Areas in the care home with unique infection control concerns should have the appropriate policies and procedures in operation. These include: kitchen, laundry, physical therapy and infectious medical waste.

Surveillance

- 27.6. Data collection on infections must start at admission, be ongoing and reported to the Nurse assigned to oversee infection control. Data collected must contain the information required by the OCMO policies. Infections include but are not limited to: communicable diseases (e.g. influenza, MRSA) and urinary tract infections.

Outbreak control

- 27.7. Surveillance data on infections in the home must be used to detect an increase in infections above normal
- 27.8. The care home must define internal reporting protocols and authority for intervention during an outbreak.
- 27.9. Illness that are not usually expected must be reported to the Epidemiology and Surveillance Unit (ESU), Office of the Chief Medical Officer via established protocols. The ESU will provide assistance with outbreak response.

Isolation and Precautions

- 27.10. Isolation and precautions systems must include the following, in accordance with evidence based guidance and OCMO policy:
- a. Standard precautions for all residents
 - b. transmission-based precautions (Contact, Droplet, Airborne)
 - c. Multidrug Resistant Organisms (such as MRSA, VRE) policy that is compatible the care home setting.

Hand hygiene

- 27.11. Hand hygiene facilities and supplies (soap, water, paper towel, alcohol-based hand rub) must be available and readily accessible to residents, staff and visitors.
- 27.12. A hand hygiene policy in line with evidence based guidance and OCMO policies is required with ongoing hand hygiene education. **This policy should include compliance monitoring and documentation.**

Cleaning, Disinfection & Sterilization

- 27.13. The care home must follow written cleaning and disinfection policies which include routine, terminal cleaning, and disinfection of resident rooms, high touch surfaces, and shared equipment/medical devices.
- 27.14. All reusable items and equipment, other than disposables must be cleaned, disinfected or sterilized following published guidelines and manufacturer's recommendations.
- 27.15. The care home must ensure that supplies necessary for appropriate cleaning and disinfection are available (e.g. EPA-registered products).
- 27.16. Specific resident care procedures that require aseptic technique are identified and known to staff.

Antibiotic Stewardship- also see s.16

- 27.17. A specific policy for antibiotic prescribing is in operation

Disease Reporting

- 27.18. Reportable communicable diseases, as required under the Public Health Act, must be reported to the Epidemiology and Surveillance Unit, Office of the Chief Medical Officer as per established protocols. The care home must have a current list of diseases reportable to public health authorities (see Resources).

28. Fire Safety

Standard:

All care homes uphold fire safety requirements to ensure the safety and well-being of persons in the care home.

Criteria

Exits

- 28.1. There must be at least two exits from every home, located to minimize any risk of both exits being blocked by fire, smoke or fumes simultaneously.

- 28.2. All exit and other doors used as means of escape must have push bars or similar fittings which do not require the use of keys or special tools to operate.
- 28.3. Locks or fastenings must not be installed that may prevent free escape from a home or a patient's room, unless based on prior approval by Bermuda Fire and Rescue.
- 28.4. All exit doors must open in line of exit travel.
- 28.5. All exit ways must remain clear and unobstructed and a minimum width of forty-four inches is maintained at all times.
- 28.6. Exit doors must not open directly to a flight of stairs or a landing that is less than the width of the door.
- 28.7. Every exit from a home must be clearly visible and marked with exit signs.
- 28.8. Directional exit signs, where necessary, shall be provided to indicate the direction of travel to reach such exit.

Equipment and design

- 28.9. Every home must have:
 - a. emergency lighting must be provided and maintained for all exits, exit ways and community spaces.
 - b. adequate fire detection and alarm system must be provided and maintained.
 - c. A certificate or record of testing indicating the annual testing for the Fire Alarm System kept on file.
 - d. All doors leading into hallways fitted with working self-closing devices.
 - e. adequate fire extinguishing equipment clearly marked and immediately accessible.
 - f. a standby generator which is inspected and tested on an annual basis. The documentation of findings and test must be forwarded to Bermuda Fire and Rescue for review.
- 28.10. The following may be deemed necessary based on the Fire assessment:
 - a. Fire sprinkler system - The fire sprinkler system must be inspected and tested on an annual basis. The documentation of findings and test must be forwarded to Bermuda Fire and Rescue for review.
 - b. Fire pump - The fire pump must be inspected and tested on an annual basis. The documentation of findings and test must be forwarded to Bermuda Fire and Rescue for review.

Fire Procedure Rules

- 28.11. An operator must post, in an obvious place in the home, the action to be taken in the event of fire ("Fire Procedure Rules").
- 28.12. All staff must be aware of the action to be taken in the event of a fire.
- 28.13. Fire Procedure Rules must include the following:
 - a. action to be taken on discovery of fire
 - b. evacuation plan
 - c. extinguishment of fire
- 28.14. An operator must keep a log book in the care home. The log book must record every:
 - a. fire drill
 - b. fire training session
 - c. test of fire alarm system and
 - d. any outbreak of fire
- 28.15. Each entry in the log must be signed by the person conducting the drill, training session or testing of the fire alarm system or, in the case of an outbreak of fire, by the person in charge of the home at the time of the outbreak.

F. Appendices

1. Definitions

Abuse:	A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to or violates their human or civil rights. Abuse or neglect may be deliberate or the result of negligence or ignorance. This includes:
Physical abuse	The non-accidental infliction of physical force that results in a bodily injury, pain or impairment including hitting, slapping, pushing, kicking, misuse of medication and inappropriate use of physical or chemical restraint
Sexual abuse	Any sexual act (including rape and sexual assault) to which the person has not consented, or could not consent, or into which they were compelled to consent
Psychological abuse	Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks that results in mental or physical distress
Financial exploitation-	The unauthorized and improper use of funds, property or any resources of an older person including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions; or the misuse or misappropriation of property, possessions or benefits.
Neglect	The repeated deprivation of assistance, needed for important activities of daily living including medical or physical care needs such as: failure to provide access to appropriate health or social care including disregard for a person's emotional, social and physical wellbeing; and withholding of the necessities of life such as medication, adequate nutrition and heating, by a person with a duty to provide care
Activities of Daily Living (ADL)-	<ol style="list-style-type: none"> a. Assistance with moving from one place to another while performing activities b. Bathing and showering c. Dressing d. Self-feeding e. Personal hygiene and grooming f. Toilet hygiene g. Personal safety
Administrator	The designated person responsible for day to day operations of the care home.

Care recipient	Any person who receives services from the registered provider, this includes day care program attendees and residents
Day Care Program	Programs that assume responsibility for the care of the person while in attendance, i.e. their personal caregiver is not required to attend the day program with the individual. Typically programs are more than 3 hours per day and participants attend more than one day a week, to differentiate from a day activity.
Instrumental Activities of Daily Living (IADLs)-	Instrumental Activities of daily living include: <ul style="list-style-type: none"> a. Preparing meals b. Taking medications as prescribed c. Shopping for groceries or clothing d. Use of telephone or other form of communication e. Transportation
Operator	The owner of the care home, including individuals, Trusts and Boards.
Personal care	Assistance be it direct or through supervision or promoting with activities of daily living.
Person in charge	This terms is used to refer to the appropriate person with the role or responsibilities indicated in the criteria.
Relevant person	People who have an interest in the care of the care recipient. This includes family members, friends, and caregivers in addition to their legal representative.
Resident	A person residing in the care home on a short term or long term basis (including respite).
Restraint	For the purposes of this document, restraint and restrictive practice includes, but are not limited to: <ul style="list-style-type: none"> a. direct physical, chemical or mechanical restraint on a single person (for example physical intervention, arrangement of furniture, bedrails, medication, lap belts, hand mitts, wrist or vest restraints); b. restraint that limits an individual's freedom (tagging, alarms, surveillance, seclusion, segregation, admission to care home against person's wishes); and c. restraint that affects all residents (locks on doors, fences, staff instructions and/or care home rules that prevent residents from expressing freedom, choice and control). <p>The following provides definitions on types of restraint:</p>

- Physical restraint** Any direct physical contact where the intervener's intention is to prevent, restrict or subdue movement of the body, or part of the body of another person.
- Mechanical restraint** The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioral control.
- Chemical restraint** The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behavior, where it is not prescribed for the treatment of a formally identified physical or mental illness.
- Seclusion** The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving. Its sole aim is the containment of severely disturbed behavior which is likely to cause harm to others.
- Segregation** The situation where a person is prevented from mixing freely with other people who use a service.

2. Care home models and terminology

Care home models and terminology changes over time, below are definitions for common terms used in this sector for regulatory purposes.

1. Independent Living

Independent living, as a model of care, is a philosophy from the disability rights movement that means to “live in the way you choose, with people you choose. It means having choices about who helps you and the ways they help. It is not necessarily about doing things for yourself, it is about having control over your day to day life.”² Typically this model requires maximum participation by the care recipients in the governance of the care home in conjunction with an assisted living model.

This is not to be confused with independent living as a level of care which is the provision of room and board but no personal care services. There can be services such as laundry, housekeeping and dining but without personal care coordination or provision they do not fall under this legislation.

2. Assisted living

For the purposes of this Code, assisted living refers to care homes that provide a greater range of choice in the use of services and independence based on the facility design. For example, the facility provides a minimum of a private bedroom, private bath, living space, kitchen capacity, adequate storage space and a lockable door. In addition, there is greater choice with regard to which services are purchased by the resident versus being able to bring in their own supports.

For care homes that prioritize an assisted living model where residents manage their own care and have more independent service options as a result, exceptions to mandatory requirements may be pre-authorized on a case by case basis. The level of care can range depending on the criteria of the care home.

3. Rest homes

A typical term used in the community for a residential care home with a program that provides housing, health and support services for seniors. Residents require a low level of care (personal care). The facility design includes shared: bedrooms, living spaces and bathrooms and centralized dining.

² National Centre for Independent Living in the UK. <https://www.independentliving.org/docs6/hasler2003.html>

4. Group homes

Care homes that combines housing, health, and supportive services targeted to persons with cognitive or mental impairments including intellectual disabilities and mental health. Group homes provide shared living in a small home environment.

5. Eden Alternative

The Eden Alternative is a model of care that strives to create Elder-centered communities thriving on close and continuing relationships, meaningful interactions, opportunities to give and to receive and a rich and diverse daily life. It is founded on ten principles that drive person centered care as well as organizational structure and leadership. For more information go to: <http://www.edenalt.org/>

3. Levels of Care

The levels of care are from the Ministry of Health's Long Term Care Needs Assessment Tool which determines medical, nursing and functional care needs.

Complex Care- (Complex skilled nursing) Predictable and unpredictable complex care needs. Frequent need for revisions to care plan, treatments or medications. May have 6-8 episodes of health exacerbations/year requiring extra MD visits:	
Medical & Nursing Care Needs	Functional Care Needs for ADL's
<ul style="list-style-type: none"> ○ 3 or more chronic fluctuating medical conditions, needing unscheduled medical adjustments to treatment plan, ○ Mood, memory or behavioral conditions that post moderate to severe risk to self or others, ○ Includes predicted and unpredicted nursing assessments due to changing conditions, ○ Greater than once daily pain management, ○ Skin and wound care for Stage 3 & 4 complex wounds, ○ IV therapy includes daily infusions, or central line care or TPN, ○ Tube feedings, ○ Isolation precautions for skin and stool antibiotic resistant bacteria, ○ Oxygen, airway, and/or chronic ventilator management, ○ Care planning and coordination 	<ul style="list-style-type: none"> ○ Needs physical assistance or has total dependence for 3 or more ADL limitations, ○ Total dependence for mobility/positioning self in bed.
Intermediate Care: (Skilled Nursing):	
Medical & Nursing Care Needs	Functional Care Needs for ADL's
<ul style="list-style-type: none"> ○ Complex but stable chronic medical conditions, needing unscheduled medical adjustments to treatment plan. ○ Predicted and unpredicted nursing assessments due to changing conditions, ○ Mood, memory or behavioral conditions that may pose moderate to severe risk to self or others, easily redirected ○ Episodic pain management ○ Skin and wound care for Stage 1 & 2 wounds ○ Tube feedings ○ Isolation precautions for skin and stool antibiotic resistant bacteria, ○ Ostomy care, with well-established and intact stoma ○ IV therapy, episodic or infrequent ○ Care planning and coordination 	<ul style="list-style-type: none"> ○ Physical assistance or total dependence for 2 or more ADL, ○ May need cueing or supervision for some ADLs ○ Total dependence for mobility/positioning in bed
Personal Care:	
Medical & Nursing Care Needs	Functional Care Needs for ADL's
<ul style="list-style-type: none"> ○ Relatively stabilized (physical or mental) chronic disease, ○ Mild – moderate dementia ○ Predictable health assessments ○ Episodic nursing for medication management, interventions, assessments or treatments, ○ Simple wound care ○ Elder fragility (more than 85 yrs.) ○ Care planning and coordination 	<ul style="list-style-type: none"> ○ Supervision or verbal cueing for ADLs or personal safety ○ Physical assist for mobility ○ Needs assist for IADLs (meal prep, grocery shopping, housekeeping, transport, laundry, etc.)

4. Consent and Capacity Guidelines

The following are guidelines for staff to assist care recipients with diminished capacity in decision making based on the UK Mental Capacity Act 2005 and UK MCA Code of Practice 2007.

1. Care recipients are presumed capable of making informed decisions in the absence of evidence to the contrary and provided appropriate information, explanation and assistance to do so. The care recipient's lack of capacity to give informed consent on one occasion is not assumed to be the case on another occasion.
 - Some people may need help to be able to make a decision or to communicate their decision. However, this does not necessarily mean that they cannot make that decision – unless there is proof that they do lack capacity to do so.
 - It is important to balance people's right to make a decision with their right to safety and protection when they can't make decisions to protect themselves. But the starting assumption must always be that an individual has the capacity, until there is proof that they do not.
 - Anyone supporting a person who may lack capacity should not use excessive persuasion or 'undue pressure'. This might include behaving in a manner which is overbearing or dominating, or seeking to influence the person's decision, and could push a person into making a decision they might not otherwise have made. However, it is important to provide appropriate advice and information.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them do have been taken without success.
 - It is important to do everything practical to help a person make a decision for themselves before concluding that they lack capacity to do so. People with an illness or disability affecting their ability to make a decision should receive support to help them make as many decisions as they can. This principle aims to stop people being automatically labelled as lacking capacity to make particular decisions
 - Where there is any doubt as to the care recipient's capacity to decide on any medical treatment or intervention, their capacity to make the decision in question is assessed by a suitably qualified professional using evidence-based best practice.
 - In some situations treatment cannot be delayed while a person gets support to make a decision (e.g. emergency situations). In these situations, decisions are made on the care recipient's behalf in their best interest and persons should try to communicate with the person and keep them informed of what is happening.

3. A person is not treated as unable to make a decision merely because they make an unwise decision
 - Everybody has their own values, beliefs, preferences and attitudes. A person should not be assumed to lack the capacity to make a decision just because other people think their decision is unwise. This applies even if family members, friends or healthcare or social care staff are unhappy with a decision. There may be cause for concern if somebody:
 - repeatedly makes unwise decisions that put them at significant risk of harm or exploitation; or
 - makes a particular unwise decision that is obviously irrational or out of character.These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation, taking into account the person's past decisions and choices

4. Where the care recipient is deemed to lack the capacity to give or withhold consent a decision should be made in their best interests. Best interest are determined by taking into account:
 - a. past and present wishes of care recipient;
 - b. the care recipient's needs and preferences, where they are ascertainable;
 - c. their general well-being and cultural and religious convictions;
 - d. the wishes of their relevant person; and
 - e. the decision or action required is the least restrictive to the person's rights and freedom of action.

5. Restraint Guidelines

The following guidelines support criteria 8.8 of the Code.

Use of Psychotropic Medication

1. When medication being used as a restrictive practice to manage behavior that is challenging is only used under strictly controlled conditions that promote the wellbeing and best interests of the care recipient. This includes:
 - 1.1. Pharmaceutical advice is accessed when needed.
 - 1.2. the appropriate drug is selected with reference to evidence-based practice, started at the lowest dosage possible, and increased slowly until either there is a therapeutic effect, side effects emerge, or the maximum recommended dose is reached.
 - 1.3. The care recipient taking psychotropic medication is assessed for potential hypotension, risk of falls, drug-related physical/cognitive/behavioural functional decline and drug-related discomfort.
 - 1.4. The resident's psychotropic medication is subject to an initial review, and then as indicated by the resident's changing needs and circumstances but no less frequently than at three monthly intervals.
 - 1.5. Where such drugs are prescribed on a PRN as required basis, the indications for giving or withholding the medication, and its effects, are documented.

Use of Physical Restraint

2. Physical restraint is not used in response to the following behavioral symptoms:
 - a. wandering behavior or rummaging and attempts to leave the facility
 - b. risk of falls, unless the risk of falling is immediate, as in severe imbalance
 - c. removal of a medical device, unless the resident requires emergency care and physical restraint is used for a brief period to permit medical treatment to proceed.
3. Assessment are documented prior to the initiation of physical restraint. At a minimum, the assessment identifies and considers:
 - a. the specific medical symptom to be treated by the use of physical restraint
 - b. the steps taken to identify the underlying physical and/or psychological causes of the medical symptom
 - c. the alternative measures that have been taken, for how long, how recently, and with what results
 - d. the evidence that a physical restraint will benefit the symptom
 - e. the risks involved in using the physical restraint
 - f. the specific circumstances under which physical restraint is being considered

- g. the type of physical restraint; period of physical restraint; and location of physical restraint
- 3.1. Where a care recipient's unanticipated behaviour places them or others in imminent danger, short-term, proportionate and non-dangerous physical restraint measures may be taken by staff without prior formal assessment. Precipitating factors and behaviours, and the actions taken are clearly recorded in the care recipient's file and the care home's incident log.
- 3.2. The care recipient is not restrained without their informed consent:
- a. The care recipient is informed of the potential negative outcomes and hazards of physical restraint use.
 - b. Where the care recipient is judged to lack the capacity to consent, physical restraint is not used if they expresses a clear and consistent preference not to be restrained.
 - c. The single exception to b. is the physical restraint of the resident as an emergency measure when their unanticipated behaviour places them in imminent danger of serious physical harm. In such circumstances the use of the physical restraint does not exceed beyond an immediate episode.
- 3.3. Routine, 'as needed' or indefinite orders for physical restraint are not used.
- 3.4. Any use of physical restraint is for the shortest possible duration. Where physical restraint is used there is documented evidence that in an emergency situation or during periods of extreme behavior:
- a. the care recipient is continuously observed the care recipient is checked regularly at intervals defined in their care plan ;
 - b. an opportunity for motion and exercise is provided for a period of not less than ten minutes during each two hour period in which the care recipient is awake.

6. Dementia Care Guidelines - Understanding and responding to distressed behavior

The following are additional guidelines to support criteria 18.13.

1. Staff understand and recognise patterns of behaviour and develop routines to accommodate rather than control behaviour which may challenge staff. Distressed behaviours are understood to be a method of communication or an indicator of unmet need. Strategies are implemented in an attempt to meet the care recipient's need.
2. Staff follow best practice guidance in relation to pain management this includes:
 - a. recognizing where behaviour may be caused by pain and report their findings to a Registered Nurse or medical practitioner.
 - b. appropriate staff are trained to use a validated pain assessment tool to ascertain if residents with dementia are in pain and respond effectively to the need for pain relief.
 - c. Pain-relieving medication (including over the counter remedies) is available in the home along with equipment such as specialist chairs and mattresses that can assist in pain management.
3. Where care recipients use walking or pacing/activity disturbance to communicate, a proportionate risk assessment is undertaken to allow residents to walk safely or ensure they are informed of the risk of doing so when they wish to.
4. Staff must demonstrate a knowledge and understanding of individual care recipient rights, preferences and routines so that a sudden refusal of care and assistance can be understood and responded to. The care recipient individual right to refuse assistance or care is not over-ruled by staff's values and principles.
5. Where a care recipient demonstrates distressed behaviour during personal care, staff must sensitively try to identify the potential factors that may be causing the behaviour such as personal choice; embarrassment; pain; or lack of understanding of the task. Staff must change their style of intervention or technique to alleviate distress based on their findings and consult with appropriate professionals (RN, dementia specialist, medical practitioner) when required.
6. Where a care recipient refuses medication, staff investigate possible underlying causes and respond appropriately. Where a care recipient who lacks capacity refuse their medication, this must be reviewed in consultation with the prescriber, and relevant person where required.

7. Where care recipient become withdrawn, staff work with them to determine if a care need is unmet (e.g. the resident is depressed, bored or lonely or experiencing a side effect of medication). Staff must:
 - f. Make a conscious effort to engage with care recipient who have become withdrawn and use gentle, sensitive and clear explanations as to their actions.
 - g. Offer opportunities for meaningful engagement that meet their functional level and interests.
 - h. Monitor for symptoms of depression, seeking professional assessment and treatment as needed.

7. Common Conditions Guidance and Guidelines

The following are common conditions found in many care homes as guidance for care homes when identifying their required policies and procedures under s.15.

- a. Pain assessment and management
- b. Skin care and pressure damage
- c. Continence management
- d. Urinary Tract Infections
- e. Falls prevention
- f. Pneumonia
- g. Nutritional screening (see section 9 and 15.13)
- h. Dementia (see section 18 and Appendix 6)
- i. End of life care (see section 17)

The following are guidelines for the policies and procedures of the above common conditions, in accordance with the Code:

Pain Management

1. Comprehensive assessments include a pain management assessment upon admission and when there are significant changes to their condition.
2. A resident is referred to a medical practitioner for the appropriate identification of the pain and determination of a pain management program which is recorded in the care recipient's file.
3. Pain relief medication is administered based on the type and severity of the pain, in accordance with the care recipient's pain management plan.
4. The home will monitor for pain relief, side effects and complications of pain medication
5. Pain relief medication must not be given for more than 24hours to relieve pain and discomfort without a review or verbal orders by a medication practitioner.
6. A pain management program must be implemented and assessed in a consistent, standardized and systematic manner to monitor and treat including:
 - a. Assessing the intensity, location, onset and progression of the resident on a pain management program on a daily basis.
 - b. The use of monitoring tools such as: numerical pain rating scales, verbal descriptor scales, location charts and symptom checklist

Skin care and Pressure sores:

1. Care recipients are assessed, by a Nurse, to identify those who have developed, or are at risk of developing, pressure sores and appropriate intervention is recorded in the plan of care to maintain skin as a barrier to infection as per evidence based guidelines. The Braden Scale is an appropriate assessment tool
2. Assessment occurs:
 - a. Upon admission
 - b. Daily as part of the process of providing care and assistance with bathing or other activities
3. Prevention methods are in place to maintain the skin including:
 - a. Routine and frequent turning for those unable to turn themselves
 - b. Keeping residents clean and dry
 - c. Routine skin inspection
 - d. Provision of appropriate nutrition
 - e. Prompt care for pressure ulcers and other breaks in skin integrity
4. The incidence of pressure sores, their treatment and outcome, are recorded in the care recipient's individual plan of care and reviewed on a continuing basis.
5. Equipment necessary for the promotion of tissue viability and prevention or treatment of pressure sores is provided.
6. When a pressure sore is found treatment is provided without delay and the following is assessed, monitored and recorded:
 - a. Location, size, stage, condition, order amount and type of exudates
 - b. Presence, location and extent of sinus tracts, pain and signs of infection, condition of surrounding skin and general condition of care recipient.
7. Providers of daily care to care recipients check for any wound related abnormalities or complications.
8. Skin care and prevention of skin damage information is available to all staff, care recipients and relevant persons.
9. Referral to specialist services occurs when required, e.g. the wound care clinic at KEMH.

Fall prevention

1. Homes take all reasonable steps to ensure the home (both the interior and exterior) is safe to encourage and promote mobility as falls or a fear of falls is not necessarily a barrier to allowing walking. This includes, for example: securing floor coverings and rugs, ensuring suitable lighting and suitable placing of furniture to allow for free movement.

2. Staff are appropriately trained in fall prevention and ensure an ambulance is only requested for residents with a clinical need to attend hospital.
3. An assessment for the risk of falls is carried out no later than 24 hours after admission to the home that takes into account the falling that may impact the care recipient's risk level :
 - a. History of falls
 - b. Medical status
 - c. Medications
 - d. Functional, behavioral and cognitive status
4. If the resident is deemed to be at risk of falls, following risk assessment, a detailed falls care plan is put in place, documented and communicated. This plan should include education regarding fall prevention to the resident and their relevant persons.
5. The falls assessment and preventative measures are carried out in line with best practice guidance that take into account and prioritize the benefits of promoting mobility and appropriate risk taking and the preferences of the care recipient.
6. The falls risk assessment is reviewed in response to changes in the resident's condition and no less frequently than monthly and the care plan amended accordingly.
7. Residents' footwear is checked to ensure their safety when walking and they have any necessary mobility equipment or aids and assistance to use them safely.
8. A post-falls review is carried out within 24 hours of a resident sustaining a fall to determine reason for falling and any preventative action to be taken. This is in addition to existing mechanisms to record incidents within the home. The care plan is amended accordingly.
9. Falls are reviewed and analyzed on a monthly basis to identify any patterns or trends and appropriate action is taken.

Continence Management

1. Where residents require continence management and support, assessments are carried out by the home and care plans are reviewed to ensure individual needs are met.
2. Where residents have continence management difficulties, they are regularly and discreetly checked.
3. In the case where a resident may be found to have wet or soiled clothing this is changed immediately.

4. The care home ensures that professional advice about the promotion of continence is sought and acted upon and aids and equipment needed are provided.
5. The continence management plan includes protocols for promoting continence and bowel management.
6. Catheters cannot be used without valid medical justification in accordance with evidence based guidelines. If a catheter is used, the home must provide appropriate treatment and services to prevent urinary tract infection and to restore as much normal bladder function as possible.

Urinary Tract Infections

1. Professional advice is obtained to ensure appropriate prevention, assessment, testing, diagnosis, monitoring and treatment occurs.
2. Prevention methods including hand hygiene and appropriate hydration are in place.
3. Appropriate clinical assessment (as per evidence based guidelines) occurs before a diagnosis of urinary tract infection is made.
4. Appropriate use and maintenance of catheters follows evidence based guidelines to prevent UTI's. This includes but is not limited to:
 - nursing care practices to prevent infections with indwelling urinary catheters
5. Supervision and education of staff occurs to ensure adherence with policies and procedures.

Influenza and Pneumonia

1. Care recipients are assessed to identify those who have developed, or are at risk of developing pneumonia and appropriate intervention is recorded in the plan of care as per evidence based guidelines.
2. Persons in Charge and staff ensure appropriate influenza and pneumonia prevention, control and treatment policies and procedures are implemented as per evidence based guidelines. This includes but is not limited to:
 - Education for care recipients, staff and visitors
 - Annual vaccination programs for staff and residents
 - Standard precautions and transmission based precautions as appropriate
 - Consultation with healthcare and infection control professionals when required.

3. Surveillance and outbreak response procedures for staff, care recipients and visitors are in place to identify and prevent the spread of influenza within the facility in accordance with evidence based practices. This includes but is not limited to addressing:
- Monitoring of number of residents with influenza and pneumonia
 - Respiratory hygiene and cough etiquette
 - Ensuring adequate supplies of personal protective equipment for residents, staff and visitors
 - Implementation of appropriate transmission based precaution
 - Placement of care recipients
 - Movement of care recipients
 - Exclusion from work policies
 - Restrictions on visitors

8. Staffing: Qualifications, Roles and Responsibilities & Orientation and training

I. Qualifications:

The following is an overview of the minimum education and experience requirements for staff. On a case by case basis other qualifications may be considered based on defined positions, the organizational structure of the care home, associated responsibilities and residents' needs. Ageing and Disability Services must be contacted in advance of hiring to determine if qualifications are adequate and appropriate in relation to the criteria in this section.

Position	Qualification	Experience
Residential Care Home Administrator*	a. Management course(s) AND An Associate's degree in a health or social service field; OR b. Care Home Administrator Certification	3 years of clinical and management experience relevant to the field
Nursing Home Administrator*	a. Management Course AND A Registered Nurse with the BNC; OR BA as a health or social service professional; OR b. BA in healthcare administration or a health or social service field; OR c. Nursing Home Administrator License	3 years of clinical and management experience.
Deputy Administrator	Same as above for each type of care home	1 year of experience relevant to the field
Activities Coordinator	a. Bda College Activities Program Certificate or equivalent; AND b. BNC registration (as NA or RN); OR c. Allied Health Professionals Council Registration	Evidence of experience in providing services to the specific population group.
Care Staff	a. CPR and First Aid; and b. Direct care staff- Registered with BNC OR c. Companions/caregivers-Training approved by ADS	
Volunteers	Training meets assigned roles and responsibilities	
Food Service Personnel	Food handling course required by Environmental Health	

* All Administrators hired prior January 15th 2017 are subject to the previous qualification requirements; however some additional training may be required based on compliance rates with the Code.

A. Administrator Management Courses must be from an accreditation institution or approved by Ageing and Disability Services' (ADS) approved provider with content applicable to the management of a care home. A management course may not be required if the health or social service qualification includes evidence of training. Primary areas to be included in management training are:

- Human resource management
- Financial management
- Risk Management and quality improvement
- General Management and governance

B. Administrator health or social service qualification

- **Residential Care homes:** Associates degree from an accredited or ADS approved institution in a health or social service field including, but not limited to:
 - Healthcare or health facility administration;
 - Healthcare profession: e.g. Nursing, allied health, social work.
 - The Bermuda College's Associate of Science, Nursing is an approved program for this qualification. Note- the Bermuda College Nursing Associate Certification is not an Associate's degree
- **Nursing Homes-** A Bachelor degree from an accredited or ADS approved institution in a health or social service field which may include
 - health facility administration
 - health services administration
 - healthcare administration
 - Health care professional fields including but not limited to: Nursing, Medical Practitioners, Allied Health, Social Work

C. Care Home Administrator License or Certification- must be equivalent to or exceed the care home type (residential care home or nursing home) and approved by ADS.

D. Care Staff Qualifications- care staff are all persons providing health, social or personal care services to care recipients. Additional training of staff based on care recipients' needs, staff qualifications and demonstrated competencies may be required.

i. Direct daily care staff:

- Registered Nurses, Enrolled Nurses and Nursing Associates must have current registration with the Bermuda Nursing Council.
- Companions/caregivers- Training approved by ADS. Not all care staff must be registered professionals **however the requirements for staff roles and responsibilities, supervision, scheduling, orientation and mandatory training must be adhered to;**

Other care staff:

- **Regulated professionals-** Services that falls under a regulated scope of practice in Bermuda must be provided by the appropriate registered professional. This includes but is not limited to: Medical practitioners, Addiction councilors, Occupational and Physiotherapists, Dieticians etc.
 - **Non-regulated professionals and services-** Administrators must ensure when hiring professionals not regulated in Bermuda (e.g. art therapists, massage therapists, social workers) the person's qualifications and competencies can uphold their assigned role and responsibilities.
- E. Food service personnel** - Courses are required based on the roles and responsibility of the particular food staff. *See LTC Education and Training page for approved courses.*
- F. Operator-** The operator, regardless of their roles in the operation of the care home, must be able to demonstrate they are fit and proper to operate a care home. This includes:
- i. In the past 5 years the operator (including any Board or Trustee members) whether under the laws of Bermuda or any other jurisdiction:
 - been charged or convicted of an offence (excluding traffic violations) under any criminal law or other law in force?
 - been the subject of, or convicted in any regulatory, civil, or other action or proceeding?
 - been the subject of bankruptcy or receivership proceedings?
 - been the subject of a court judgment or writ, or failed to satisfy a judgment or writ?
 - had a business license or registration refused, suspended or cancelled?
 - ii. Prudent financial management through the business plan for registration and annual financials (see s.22).

II. Roles and responsibilities

The following are guidelines to assist care homes with the roles and responsibilities required of mandatory roles listed in criteria 19.1. Each care home has its own organizational structure so listed responsibilities may fall under other roles. What is necessary is **the assurance that the minimum responsibilities are performed by an appropriately qualified person who is operating within their scope of practice.**

Operator

The operator is the owner of the facility who the license is issued to and may be an individual or a Board depending on the business structure.

The operator has ultimate oversight over the operation of the facility to ensure compliance with legislation.

Administrator

Responsibilities include but are not limited to:

A. Program management:

- Monitors and directs execution of programs, policies and procedures and required changes
- Ensures compliance with RCHNH legislation and Code of practice and makes changes appropriately
- *Discusses care* of residents with Director of Nursing; Supervisor of Care; GPs/Medical Consultant
- Acts as the liaison between the nursing home, residents, families, hospital and community
- Represents the nursing home to the Board (if applicable)

B. Facility management

- Oversees or ensures environment and equipment evaluations necessary for functioning
- oversees the decisions on facility maintenance problems, equipment replacement, repairs and redecorating
- Ensures compliance with health and safety requirements

C. Financial management

- Identifies and oversees capital improvements
- Ensures budget conformance, compiles budget projections, revenues and expenses

- Liaises with family or other relevant persons regarding financial obligations to the home and requirements in relation to their service contract.

D. Human Resource management:

- Staff recruitment
- Training and in service education program
- pay roll and benefits administration
- oversees volunteer programs

Supervisor/Director of Care (RN)

Clinical administrative duties include:

A. Maintaining standards of care through the development (or review), implementation and monitoring of policies and procedures that adhere to best practices. Examples of such policies and procedures include:

- Care communication and coordination between staff, external health professionals and relevant persons
- Care plan development, implementation and review
- Incident reporting and monitoring
- Activity and recreational programs
- Specific clinical interventions: e.g. Wound care; Skin preservation; restraint use; infection control

B. Supervising and reviewing care staff's service provision and staffing requirements including but not limited to:

- Determining required care staff ratios and staffing schedules based on resident's needs
- Capacity assessments and identifying training requirements for staff
- Ensuring staff uphold regulated scope and standards of practice
- Ensure care plans are followed
- Ensuring care home's policies and processes established for care provision are adhered to.
- Reviewing record keeping of care staff

C. Managing and reviewing medical records

D. Communicating with doctors, residents and relevant persons regarding care needs, change of conditions and care coordination.

E. Conducting admissions assessments and determining applicant suitability based on program of care and services provided.

Medical Consultant

- A. Must provide medical care services to persons without a personal GP; or whose GP is not available to provide such. This includes:
 - Medical assessment, care and treatment when necessary, in non-emergency circumstances and when there is a change in the resident's condition.
 - Review of medical treatment plans
 - Consultation services for the Director of Nursing or Nursing Supervisor, including when a second opinion is required in relation to direction provided by the resident's GP.
- B. The medical consultant should provide oversight to ensure:
 - The overall health care program is meeting the healthcare needs of the residents.
 - All healthcare treatments are in alignment with best practice.

Dietician

- A. Review seasonal meal plan proposed for care recipients.
- B. Review meals against individual care needs
- C. Review individual care recipient's care plan and conducts nutritional assessments when required.

Activities Coordinator

- A. Managing and discussing activities with care recipients and relevant persons
- B. Planning and implementing a stimulating activity plan for each care recipient that is reflective of their interests and needs. This includes:
 - Individual activity plans
 - Group activity plans
 - Coordination and participation in community based groups, events and activities. Activities include social, physical, spiritual, hobbies/educational etc; and activities of Daily Living- in particular for dementia clients
- C. Determining and coordinating transportation, equipment and staffing requirements for activities.

Care Staff

- A. **Registered Nurse (RN)**- Provides skilled nursing care as defined by their scope and standards of practice by the BNC and roles within the care home. (www.bnc.bm)

- B. **Nursing Associates (NA)**- Provide personal care and basic nursing services. Their roles and responsibilities are defined by their scope of practice issued by the Bermuda Nursing Council (BNC) (www.bnc.bm)
- C. **Caregivers/companions**- provide non-medical assistance and support through prompting, supervision, guidance or minimal hands on assistance to residents with IADLs, ADLs and general activities in the care home. Minimal hands on assistance includes assisting the care recipients with mobility and transfers.
 - Direct care, i.e. hands on assistance with personal care, is reserved to BNC registered Nursing Associates unless the companion/caregiver has qualifications and criteria approved by ADS.

III. Orientation and training

1. Administrators must ensure all staff, including themselves, complete the required minimum training indicated below every 2 years.
 - 1.1. **Mandatory Training:**
 - a. CPR and First Aid (direct care providers not including companions must complete CPR for healthcare professionals)
 - b. Lifting and Handling
 - c. Infection control
 - d. Least restrictive practices- Protection from abuse, use of restraints & managing challenging behaviors
 - 1.2. Specified training, by ADS, for care staff and management based on resident care needs. This may include but is not limited to:
 - a. Dementia care training for all care staff in homes with residents with Dementia.
 - b. Fall prevention for all facilities with persons assessed at risk of falls
2. Content and providers must be approved by Ageing and Disability Services.
 - 2.1. Approved providers are listed on the ADS *long term care education and training page*.
 - 2.2. Training may be offered through an in-service provided by the care home's appropriate staff member with prior approval by ADS.
 - 2.3. Content of training provided by care home staff must align with:
 - a. Person centered care practices
 - b. Code of Practice requirements
 - c. Best Practice clinical guidelines
 - d. ADS and OCMO policies

G. Resources

Care Home Registration and Inspection Information:

For required documentation and regulatory information: <https://www.gov.bm/care-home-registration-and-inspection>

- Care Home Code of Practice
- MoH LTC Needs Assessment Tool
- Medical Certificate for care home staff

Relevant legislation

All legislation can be found at www.bermudalaws.bm

- Residential Care Homes and Nursing Homes Act and Regulations
- Bermuda Building Code
- Occupational Health and Safety Act
- Public Health Act
- Pharmacy and Poisons Act
- Misuse of Drugs Act and Regulations
- Companies Act
- Bermuda Nursing Act

LTC Education and Training (general)

- <https://www.gov.bm/long-term-care-education-and-training>

Best Practice Clinical Guidelines (General):

- OCMO Guidance: <https://www.gov.bm/health-data-and-monitoring>
- Registered Nurses Association of Ontario: <http://rno.ca/bpg/guidelines/clinical-guidelines>
- NICE guidelines: <https://www.nice.org.uk/guidance>

Restraints, behavior management and abuse:

- Senior Abuse Reporting Form: <https://www.gov.bm/senior-abuse-reporting-and-investigation>
- Positive and Proactive Care- reducing the need for restrictive interventions: <http://www.skillsforcare.org.uk/Documents/Topics/Restrictive-practices/A-positive-and-proactive-workforce.pdf>

Care Planning:

- Person Centered Support Plan for People with Dementia- Southwest Dementia Partnership: www.southwestdementiapartnership.org.uk
- Writing Good Care Plans: A good practice guide. <http://www.careplans.com>

Sample policy, procedures and training guides for common conditions

- AdvantAge Ontario. LTCHA Implementation Resources (viewed Jan 2018). https://www.advantageontario.ca/MediaCentre2/LTCHomesActCentralseeSiteNavigation/LTCHA_Resources.aspx

Infection Control and Prevention

- Mandatory Diseases Reporting: <https://www.gov.bm/health-data-and-monitoring>, see Reportable Diseases
- Best practice guidance- Centers for Disease Control (CDC), Healthcare Infection Control Practices Advisory Committee (HICPAC): <https://www.cdc.gov/longtermcare/index.html>
- NICE guidelines for Infections: <https://www.nice.org.uk/guidance/conditions-and-diseases/infections>

Building Design

- American with Disabilities Act standards for accessible design: https://www.ada.gov/2010ADASTandards_index.htm
- International Code Council Accessible and Usable Buildings and Facilities, ICC A117.1-2009: <http://shop.iccsafe.org/icc-a117-1-2009-accessible-and-usable-buildings-and-facilities-cd-rom-1.html>

Community Services

- www.helpingservices.bm

H. Contact Information

Agency	Topic	Contact info
Ageing and Disability Services	Care Home Registration	25 Church St. Hamilton 292-7802; ads@gov.bm
	Inspection and Complaints	https://www.gov.bm/care-home-registration-and-inspection
	Senior Abuse Reporting	25 Church St. Hamilton 292-7802; ads@gov.bm https://www.gov.bm/senior-abuse-reporting-and-investigation
	Accessibility consultation	25 Church St. Hamilton 292-7802; ads@gov.bm
Dept of Health	Community Rehabilitation	Hamilton Health Centre, 67 Victoria Street, 278-6427
	Nutrition Services	278-6467, 278-6468, or 278-6469 nutrition@gov.bm
	Environmental Health	278-5333 envhealth@gov.bm
	Occupational Safety & Health	278-5333 osho@gov.bm
Epidemiology and Surveillance Unit	Infection Control and Prevention	278-4900 ocmo@gov.bm
Bermuda Fire and Rescue Services	Fire Safety Standards and certification	49 King Street, Hamilton 292-5555
Bermuda Nursing Council	Nursing Associate and Registered Nurse registration	25 Church Street, Continental Bldg., Hamilton HM 12 292-0774 bermudanursingcouncil@gov.bm https://www.gov.bm/nursing

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LTC Needs Assessment Form Guidance

The LTC Needs Assessment form provides:

- comprehensive information for person-centered care plans in care homes, home care and the hospital;
- standardized information for transfers between care settings; and
- data for long term care systems planning

Who completes the assessment?

- A Registered Nurse or Enrolled Nurse (LPN) must complete the assessment. Caregivers and healthcare professionals may assist but the Nurse is ultimately responsible to ensure accurate and current information.

How do I get the information needed to complete the assessment?

- By interviewing:
 - the person being assessed, their needs and preferences must be of primary consideration;
 - the responsible person or family member; including persons power of attorney; receivership and/or with a care or support role (e.g. friend, family etc)
 - Any caregivers in place; and
- By direct observation or hands on assessment; and
- From current, existing assessments e.g. medication administration records (MAR); the MOCA. In the relevant section of the form, write the completion date and source of the existing assessment and input the results and/or attach a copy.

When is the assessment completed?

- The assessment is completed within 72 hours of admission, or before if there are pre-identified risks.
- A copy of the completed assessment is kept on file and accompanies persons transferred to new care settings.

What are the requirements for reassessment?

- If only minimal changes, the reassessment section (p.19) is completed to update the form. Substantial changes require a new assessment.
- Reassessment occurs:
 - After the first 3months for all new admissions to a new care setting.
 - A minimum of once per year for persons with stable conditions.
 - As a result of changing needs or circumstances including:
 - a. After significant treatment process, or lack thereof;
 - b. After new symptoms are identified or significant medical changes occur;
 - c. When significant behavioral changes are observed;
 - d. When there is a change in functioning;
 - e. When transferred to a new care setting.

How to Complete the Form:

General:

- **Complete all sections of the form and write NA (Not Applicable) when not appropriate for the care setting.**
- If additional space is required use 8x 11 paper and attach to the form

4.3 Medications

- If a current MAR is available, attach a copy and write 'see attached' in the area provided to list medications.

5.3 Instrumental Activities of Daily Living (IADL)

- To be completed in all care setting, including care homes to encourage people to engage in IADLs.

6. Social/Recreational Preferences

- Life books (e.g. This is me, All About Me) provide current and historical information about the person, including quality of life and care preferences, in an accessible format to facilitate person centered care and support by providers. They are used predominately for persons with limited or diminished communication or cognitive ability.

6.5 Housing/Environment:

- Obtain details of the person's current living environment to record any issue / barrier that may hinder them returning or remaining in their home.
- Write NA if obvious the person is not able to be supported in their own home.

7. Nursing Physical Assessment

- Head to Toe: complete on all patient/client, please check all relevant boxes.
- Pain assessment, face pain scale: Use with cognitively impaired or persons with verbal limitations. Match person's facial expression with picture or the person can point to the picture.
- Braden Scale- ensure a score is put in each column and all columns added for the total score.

9. Sign off

- To be signed by the Registered Nurse who completes the assessment.

10. Level of Care Calculation

- The level of care with the most ticks is the level assigned to the person.
- Staffing levels provided are guidance based on best practice and a single level of care. Most care settings have multiple levels of care and each setting must account for this when determining the:
 - Appropriateness of client for admission
 - Required staffing levels
 - Developing person centered care plans

Personal Home Care Needs Calculation Guide

- Only to be used for persons returning to or remaining in their own home. This is only guidance each calculation must be particular to the specific care needs of the person.

Transfers:

- When transferring a person to a new care setting (e.g. ER, care home), complete this section on the copy of the assessment form sent to the new care setting. Ensure the original form kept at your location is also updated.

Patient Name:

4. GENERAL HEALTH STATUS

4.1. HEALTH SELF PERCEPTION

Overall, how would you rate your physical health?

<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> No Response
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4.2. MEDICAL DIAGNOSIS OR CONDITIONS

Diagnosis: list primary diagnosis first/Current problems	Comments	Date of onset

4.3. MEDICATIONS

4.3.1. MEDICATION RISK FACTORS

Does the patient have any medication or food allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please list:
Has the patient had significant side effects from medications? No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, explain:
Has the patient had problems with taking or being given the incorrect number of medications? No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, explain:

4.3.2. PRESCRIPTION MEDICATIONS

Prescription Medications	Dosage	Route	Frequency	Purpose

Indicate if the patient receives the following vaccination: <input type="checkbox"/> A. Influenza Administered: <input type="checkbox"/> B. Pneumococcal Administered:
--

4.6. NUTRITION

<u>Eating and Swallowing</u>
<input type="checkbox"/> A. Loss of liquids/solids from mouth when eating or drinking.
<input type="checkbox"/> B. Holding food in mouth/cheeks or residual food in mouth after meals.
<input type="checkbox"/> C. Coughing or choking during meals or when swallowing medications.
<input type="checkbox"/> D. Complaints of difficulty or pain with swallowing.
<input type="checkbox"/> E. Chewing: <input type="checkbox"/> Some difficulty <input type="checkbox"/> More difficulty
<input type="checkbox"/> F. Unable to chew.
<input type="checkbox"/> G. None of the above.
<u>Diet – Specify Details:</u>
<input type="checkbox"/> A. Mechanically altered diet – require change in texture of food or liquids (e.g. pureed food, thickened liquids).
<input type="checkbox"/> B. Therapeutic diet (e.g. low salt, diabetic, low cholesterol).
<input type="checkbox"/> C. Regular diet.
<input type="checkbox"/> D. Nutritional supplement.
<input type="checkbox"/> E. Food preferences.
<input type="checkbox"/> F. Dislike.
<input type="checkbox"/> G. Religious related diet.

4.7. COMMUNICATION AND SENSORY PATTERN

<u>Hearing - Ability to hear (with hearing aid or hearing appliances if normally used).</u>
<input type="checkbox"/> Adequate – no difficulty in normal conversation, social interaction, listening to TV.
<input type="checkbox"/> Minimal difficulty – difficulty in some environments (e.g. when person speaks softly or setting is noisy).
<input type="checkbox"/> Moderate difficulty – speaker has to increase volume and speak distinctly.
<input type="checkbox"/> Highly impaired – absence of useful hearing.
<u>Speech Clarity - Select best description of speech pattern.</u>
<input type="checkbox"/> Clear speech – distinct intelligible words.
<input type="checkbox"/> Unclear speech – slurred or mumbled words.
<input type="checkbox"/> No speech – absence of spoken words.
<u>Makes Self Understood - Ability to express ideas and wants, consider both verbal and non-verbal expression</u>
<input type="checkbox"/> Understood
<input type="checkbox"/> Usually understood – difficulty communicating some words or finishing thoughts but is able if prompted or given time.
<input type="checkbox"/> Sometimes understood – ability is limited to making concrete requests.
<input type="checkbox"/> Rarely/Never understood.
<u>Ability to Understand Others - Understanding verbal content, however able (with hearing aid or device if used)</u>
<input type="checkbox"/> Understands – clear comprehension
<input type="checkbox"/> Usually understands – misses some part/intent of message but comprehends most conversation.
<input type="checkbox"/> Sometimes understands – responds adequately to simple direct communication only.
<input type="checkbox"/> Communicates with sign language – symbol board, written messages, gestures or interpreter.
<input type="checkbox"/> Rarely/Never understands.

Patient Name:

<u>Vision</u> - Ability to see in adequate light (with glasses or other visual appliances)	
<input type="checkbox"/>	Adequate – sees fine detail, such as regular print in newspapers/books.
<input type="checkbox"/>	Impaired – sees large print, but not regular print in newspapers/books.
<input type="checkbox"/>	Moderately impaired – limited vision; not able to see newspaper headlines but can identify objects.
<input type="checkbox"/>	Highly impaired – object identification in question, but eyes appear to follow objects.
<input type="checkbox"/>	Severely impaired – no vision or sees only light, colours or shapes; eyes do not appear to follow objects.
<u>Sensory Perception (e.g. – taste, smell, tactile, spatial)</u>	
<input type="checkbox"/>	No impairment.
<input type="checkbox"/>	Impaired – Specify:

4.8. DELIRIUM – SIGNS AND SYMPTOMS: check all that apply:

<input type="checkbox"/>	A. Inattention – Did the patient have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
<input type="checkbox"/>	B. Disorganized thinking – Was the patient’s thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)
<input type="checkbox"/>	C. Altered level of consciousness – Did the patient have altered level of consciousness (e.g., vigilant – startled easily to any sound or touch; lethargic – repeatedly dozed off when being asked questions, but responded to voice or touch; stuporous – very difficult to arouse and keep aroused for the interview; comatose – could not be aroused)?
<input type="checkbox"/>	D. Psychomotor retardation – Did the patient have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?
<u>Acute Onset Mental Status Change</u>	
Is there evidence of an acute change in mental status from the patient’s baseline? <input type="checkbox"/> No. <input type="checkbox"/> Yes	

4.9. MEMORY

4.9.1. BRIEF INTERVIEW FOR MENTAL STATUS (BIMS) - Attempt to conduct interview with all patients

Repetition of Three Words

Ask patient: “I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words.”

Number of words repeated after first attempt

Number of words repeated after first attempt:	Points
None	0 <input type="checkbox"/>
One	1 <input type="checkbox"/>
Two	2 <input type="checkbox"/>
Three	3 <input type="checkbox"/>

After the patient’s first attempt, repeat the words using cues (“sock, something to wear; blue, a color; bed, a piece of furniture. You may repeat the words up to two more times.

Temporal Orientation (orientation to year, month)

Ask patient: “Please tell me what year it is right now.”

A. Able to report correct year

Number of words repeated after first attempt:	Points
Missed by more than 5 years or no answer	0 <input type="checkbox"/>
Missed by 2-5 years	1 <input type="checkbox"/>
Missed by less than 2 years	2 <input type="checkbox"/>
Correct	3 <input type="checkbox"/>

Ask patient: “What month are we in right now?”

B. Able to report correct month

Number of words repeated after first attempt:	Points
Missed by more than 1 month or no answer	0 <input type="checkbox"/>
Missed by 6 days to 1 month	1 <input type="checkbox"/>
Accurate within 5 days	2 <input type="checkbox"/>

Patient Name:

Ask patient: "What day of the week is today?"

C. Able to report correct day of the week

Number of words repeated after first attempt:	Points
Incorrect or no answer	0 <input type="checkbox"/>
Correct	1 <input type="checkbox"/>

Recall

Ask patient: "Let's go back to an earlier question. What were those three words that I asked you to repeat?"
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock"

Number of words repeated after first attempt:	Points
No – could not recall	0 <input type="checkbox"/>
Yes, after cueing ("something to wear")	1 <input type="checkbox"/>
Yes, no cue required	2 <input type="checkbox"/>

B. Able to recall "blue"

Number of words repeated after first attempt:	Points
No – could not recall	0 <input type="checkbox"/>
Yes, after cueing ("a color")	1 <input type="checkbox"/>
Yes, no cue required	2 <input type="checkbox"/>

C. Able to recall "bed"

Number of words repeated after first attempt:	Points
No – could not recall	0 <input type="checkbox"/>
Yes, after cueing ("a piece of furniture")	1 <input type="checkbox"/>
Yes, no cue required	2 <input type="checkbox"/>

BIMS SCORE (Total):

Interpretation of Score: 13-15 Points: cognitively intact. 9-12 points: moderately impaired. 0-7 points severely impaired.

4.9.2. MEMORY/RECALL ABILITY

Check all that the patient was normally able to recall

<input type="checkbox"/> A. Current Season
<input type="checkbox"/> B. Location of own rooms or address of current residence
<input type="checkbox"/> C. Names and faces of family or staff
<input type="checkbox"/> D. That he or she is in a nursing home
<input type="checkbox"/> E. None of the above were recalled
<input type="checkbox"/> F. Day of the week or date

4.9.3. COGNITIVE SKILLS FOR DAILY DECISION MAKING – Use nursing judgment on the patient's ability to make decisions regarding tasks of daily life.

<input type="checkbox"/> A. Independent – decisions consistent/reasonable
<input type="checkbox"/> B. Modified independence – some difficulty in new situations only
<input type="checkbox"/> C. Moderately impaired – decisions poor; cues/supervision required
<input type="checkbox"/> D. Correct Severely impaired – never/rarely made decisions

Patient Name:

4.10. MOOD

4.10.1. SHOULD PATIENT MOOD INTERVIEW BE CONDUCTED? – Attempt to conduct interview with all patients

- Yes (Continue to Patient Mood Interview)
- No (patient is rarely/never understood)

4.10.2. PATIENT MOOD INTERVIEW

Say to patient: “Over the last 2 weeks, have you been bothered by any of the following problems?”

If symptom is present, tick column 1, Symptom Presence. If yes in column 1, then ask the patient: “About how often have you been bothered by this?” Enter score in column 2, Symptom Frequency. Score as follow: 0 = never or one day; 1 = 2 to 6 days (several days); 2 = 7 to 11 days (half or more of the days); 3 = 12 to 14 days (nearly every day).

To score mood symptoms total Column 2. If score greater than 22, consult psychiatrist/psychologist.

	1.Presence	2.Frequency
A. Little interest or pleasure in doing things	<input type="checkbox"/>	
B. Feeling down, depressed, or hopeless	<input type="checkbox"/>	
C. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	
D. Feeling tired or having little energy	<input type="checkbox"/>	
E. Poor appetite or overeating	<input type="checkbox"/>	
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	
G. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	
H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	
I. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	
J. Being short-tempered or easily annoyed	<input type="checkbox"/>	
K. Have you been anxious	<input type="checkbox"/>	
		Total =

4.11. BEHAVIOR – Indicate any behavioral symptoms or concerns observed or reported over the last 2 weeks.

4.11.1. POTENTIAL INDICATORS OF PSYCHOSIS – Check all that apply:

<input type="checkbox"/> A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli)
<input type="checkbox"/> B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality)
<input type="checkbox"/> C. None of the above

4.11.2. BEHAVIORAL SYMPTOM – PRESENCE & FREQUENCY

Scoring: Enter score in end box. 0 = Behavior not exhibited. 1 = Behavior of this type occurred 1 to 3 days. 2 = Behavior of this type occurred 4 to 6 days, but less than daily. Behavior of this type occurred daily.

Presence and Frequency	Score
Physical behavioural symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually).	
Verbal behavioural symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others).	
Other behavioural symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds).	
<u>Rejection of Care – Presence & Frequency</u> Did the patient reject evaluation or care (e.g., blood work, taking medications ADL assistance) that is necessary to achieve the patient’s goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the patient or family), and determined to be consistent with patient values, preferences, or goals.	
<u>Wandering – Presence & Frequency</u> Has the patient wandered?	
Total Score (Part 1)	

Patient Name:

Review each question below and answer either “Yes” or “No”. If “No”, enter 0 (zero) in the corresponding box. If the Answer is “Yes”, enter 1 in the box. Tally the total score in the “Total Score (Part 2) cell.

Impact of Behavioral symptoms	Score
Overall Presence of Behavioral Symptoms	
Were any behavioral symptoms in presence & frequency coded 1 or 2?	
Impact on Patient - Did any of the identified symptom(s)	
Put the patient at significant risk for physical illness or injury?	
Significantly interfere with the patient’s care?	
Significantly interfere with the patient’s participation in activities or social interactions?	
Impact on Others - Did any of the identified symptom(s):	
Put others at significant risk for physical injury?	
Significantly intrude on the privacy or activity of others?	
Significantly disrupt care or living environment?	
Wandering – Impact	
Does the wandering place the patient at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?	
Does the wandering significantly intrude on the privacy or activities of others?	
Does patient exhibit Sundowning symptoms? That is, in the late afternoon, early evening, appears restless, anxious or upset, confused, disoriented, suspicious, yell, pace, wander, hear or see things that aren’t there.	
If the patient does exhibit Sundowning symptoms, during what time of day are the symptoms most prevalent: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	
Total Score (Part 2)	

Behavioral Symptoms Guidance Score (add Part 1 and Part 2): TOTAL SCORE:

- 0 – 6 Moderate Supervision **(Personal Care)**
- 6 – 12 Institute additional safety measures **(Intermediate Care)**
- 12 – 16 If score is between 12 to 16, consider psychiatrist/psychologist plus safety measures **(Complex Care)**

4.11.3. CHANGE IN BEHAVIOR OR OTHER SYMPTOMS – Consider all of the symptoms assessed above.

How does patient’s current behavior status, care rejection, or wandering compare to prior assessment?	Score
Same	<input type="checkbox"/> 0
Improved	<input type="checkbox"/> 1
Worse	<input type="checkbox"/> 2
N/A because no prior assessment	<input type="checkbox"/> 3

Patient Name:

5. FUNCTIONAL ABILITIES

5.1. ACTIVITIES OF DAILY LIVING

Activity	Independent	Supervision or verbal Prompts/Cueing	Physical Assistance	Total Dependence
A. Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Grooming & personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Mobility in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Stair climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Mobility with wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Continent – Bowel and bladder				
<input type="checkbox"/> Continent with verbal or physical prompts				
<input type="checkbox"/> Continent except for specified periods of time (e.g. enuresis)				
<input type="checkbox"/> Incontinent – bladder				
<input type="checkbox"/> Incontinent – bowel				
Comments:				
Usual bowel pattern time and frequency (Specify):				
<input type="checkbox"/> Inappropriate toileting habits (e.g. fails to close door, use toilet paper, or wash hands, etc.)				

5.2. ASSISTIVE DEVICES/SPECIAL EQUIPMENT

Do you use (or need) any of the following special equipment or aids?
(If a Patient doesn't have an item but needs it, mark the "Needs" box)

None

Uses	Needs	Equipment/Aid	Uses	Needs	Equipment/Aid
<input type="checkbox"/>	<input type="checkbox"/>	Corrective Lenses (specify)	<input type="checkbox"/>	<input type="checkbox"/>	Harness/gait belt
<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Raised Toilet Seat
<input type="checkbox"/>	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Shower/tub bench, grab rail
<input type="checkbox"/>	<input type="checkbox"/>	Helmet	<input type="checkbox"/>	<input type="checkbox"/>	Bedside commode
<input type="checkbox"/>	<input type="checkbox"/>	Communication Devices	<input type="checkbox"/>	<input type="checkbox"/>	Transfer equipment
<input type="checkbox"/>	<input type="checkbox"/>	Adaptive eating equipment	<input type="checkbox"/>	<input type="checkbox"/>	Hospital Bed
<input type="checkbox"/>	<input type="checkbox"/>	Cane	<input type="checkbox"/>	<input type="checkbox"/>	Weighted blankets or vest
<input type="checkbox"/>	<input type="checkbox"/>	Walker	<input type="checkbox"/>	<input type="checkbox"/>	Medical phone alert
<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair (manual, electric)	<input type="checkbox"/>	<input type="checkbox"/>	Supplies, e.g. Incontinence pads
<input type="checkbox"/>	<input type="checkbox"/>	Brace (leg, back, prosthesis)	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify):

Patient Name:

5.3. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

Activity: How well can you...	Independent: Need no help or supervision	Need some help or occasional supervision	Need a lot of help or constant supervision	Total Dependence: Can't do it at all
Manage own medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepare meals for yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Answer the telephone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Make a telephone call?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handle your own money?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage shopping for food and other things you need?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage to do light housekeeping, like dusting or sweeping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do heavy housekeeping, like yard work, or emptying the garbage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your own laundry, including putting clothes in the washer or dryer, starting and stopping the machine, and drying the clothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you know your telephone number? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
Do you know your address? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
Transportation- How do you get to the places you want to go? (Check all that apply)				
<input type="checkbox"/> Walk		<input type="checkbox"/> Friend or family member drives		
<input type="checkbox"/> Bicycle		<input type="checkbox"/> Staff/Provider		
<input type="checkbox"/> Drive		<input type="checkbox"/> Take a bus or taxi		
<input type="checkbox"/> Other:				

6. SOCIAL/RECREATIONAL PREFERENCES

6.1. LIFE HISTORY

Does patient have Life Book or This is Me book completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
--

6.2. SOCIAL/RECREATIONAL

What is a typical day like for you? (Or ask: What do you usually do, starting from the morning?)
Comments:
What activities or things do you enjoy doing? For example, hobbies and interests.
Comments:
What, if anything, would you change about your typical day? Are there activities you would like to do more frequently?
Comments:
If you choose to practice a religion, are you able to attend as often as desired? <input type="checkbox"/> Yes (specify where) <input type="checkbox"/> No <input type="checkbox"/> N/A
Comments:
Who are the people in your life who are important to you?
Comments:

Patient Name:

6.3. EDUCATION/OCCUPATION

Highest level of education completed:
Prior occupation or role:

6.4. LITERACY – Assessor: Is the patient able to:

Read? Yes <input type="checkbox"/> No <input type="checkbox"/>	Write? Yes <input type="checkbox"/> No <input type="checkbox"/>	Sign his/her name? Yes <input type="checkbox"/> No <input type="checkbox"/>
--	---	---

6.5. HOUSING AND ENVIRONMENT

What is your current housing type?					
<input type="checkbox"/> Own Home (includes parent/guardian's home for children)		<input type="checkbox"/> Residential / Nursing Facility			
<input type="checkbox"/> Friend/Relative Home		<input type="checkbox"/> Homeless			
<input type="checkbox"/> Foster Care		<input type="checkbox"/> Other (Specify):			
Who lives in the home with the patient?					
Would you like to continue to live where you do now, or is there somewhere else you would prefer to live?					
<input type="checkbox"/> Continue to live here					
<input type="checkbox"/> Don't know					
<input type="checkbox"/> Prefer to live elsewhere (Specify and briefly describe the barriers, if any):					
Is there someone who regularly helps you care for your home or yourself, or who regularly helps with errands or other things? (For children, do NOT include the parent/guardian, but do include others who assist the parent/guardian.)					
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often?					
Caregiver's name: Contact #:					
Is the Patient at risk at home because of any of these conditions?					
Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Structural damage	<input type="checkbox"/>	<input type="checkbox"/>	Insufficient water or no hot water
<input type="checkbox"/>	<input type="checkbox"/>	Barriers to accessibility (step, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Insufficient heat
<input type="checkbox"/>	<input type="checkbox"/>	Electricity hazards	<input type="checkbox"/>	<input type="checkbox"/>	Fire hazard
<input type="checkbox"/>	<input type="checkbox"/>	Signs of careless smoking	<input type="checkbox"/>	<input type="checkbox"/>	Tripping hazards
<input type="checkbox"/>	<input type="checkbox"/>	Insects or pests	<input type="checkbox"/>	<input type="checkbox"/>	Unsanitary conditions
<input type="checkbox"/>	<input type="checkbox"/>	Poor lighting	<input type="checkbox"/>	<input type="checkbox"/>	Other - Specify
Are any home modifications needed? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify):					
ASSESSOR: Does the patient have deficits that pose a threat to his/her ability to live in the community?					
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure					

7. NURSING PHYSICAL ASSESSMENT

7.1. GENERAL

Arrived by: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Stretcher <input type="checkbox"/> Wheelchair	Height: feet inches
<input type="checkbox"/> Other:	Weight: <input type="checkbox"/> kg <input type="checkbox"/> lb.
T: P: R: BP:	O ₂ sat:

7.2. EENT

<input type="checkbox"/> No problem noted
<input type="checkbox"/> Impaired vision <input type="checkbox"/> Impaired hearing <input type="checkbox"/> Gums/teeth <input type="checkbox"/> Redness <input type="checkbox"/> Drainage <input type="checkbox"/> Lesion
Comments:

Patient Name:

7.3. NEUROLOGICAL

<input type="checkbox"/> No problem noted				
<input type="checkbox"/> GCS Score: /15	<input type="checkbox"/> Sedated	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Headache	<input type="checkbox"/> Numbness
<input type="checkbox"/> Confused	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Unsteady	<input type="checkbox"/> Paralyzed	<input type="checkbox"/> Tingling
<input type="checkbox"/> Slurred speech	<input type="checkbox"/> Unresponsive	<input type="checkbox"/> Weakness	<input type="checkbox"/> Aphasic	<input type="checkbox"/> Tremors
<input type="checkbox"/> Pupil size – Right: Left:	<input type="checkbox"/> Seizures	<input type="checkbox"/> Gag reflex diminished or absent		
Comments:				

7.4. RESPIRATORY

<input type="checkbox"/> No problem noted					
<input type="checkbox"/> Oxygen: FIO2: % L/min		Upper		Lower	
Mode: <input type="checkbox"/> Nasal Cannula	<input type="checkbox"/> Crackles:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Venti-Mask <input type="checkbox"/> Non-rebreather	<input type="checkbox"/> Diminished:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Ventilator <input type="checkbox"/> CPAP/BiPAP	<input type="checkbox"/> Wheezes:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Asymmetric <input type="checkbox"/> Tachypnea	<input type="checkbox"/> Absent:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Shallow <input type="checkbox"/> Cough	<input type="checkbox"/> Barrel chest	<input type="checkbox"/> Bradypnea		<input type="checkbox"/> Dyspnea	
	<input type="checkbox"/> Sputum:				
Comments:					

7.5. CARDIOVASCULAR

<input type="checkbox"/> No problem noted					
<input type="checkbox"/> Tachycardia	<input type="checkbox"/> Irregular	<input type="checkbox"/> Numbness	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Edema	<input type="checkbox"/> Diminished pulse:
<input type="checkbox"/> Bradycardia	<input type="checkbox"/> Murmur	<input type="checkbox"/> Tingling	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Absent Pulses:
<input type="checkbox"/> Pacemaker/Defibrillator	<input type="checkbox"/> AV fistula:	<input type="checkbox"/> Peripheral IV:			
Comments:					

7.6. GASTROINTESTINAL

<input type="checkbox"/> No problem noted					
<input type="checkbox"/> Hypo BS	<input type="checkbox"/> Distention	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Last BM:
<input type="checkbox"/> Hyper BS	<input type="checkbox"/> Absent BS	<input type="checkbox"/> Nausea/emesis	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Rigidity
<input type="checkbox"/> Tubes (type):	<input type="checkbox"/> Ostomy:				
Malnutrition Screening Tool (Source – Ferguson M, Capra S, Bauer J, Banks M. 1999. Adapted with permission):					
Does the patient have:					
Unintentional weight loss or gain? <input type="checkbox"/> No (0) <input type="checkbox"/> Yes (check the applicable measure below)					
<input type="checkbox"/> 2 – 13 lb. (1)	<input type="checkbox"/> Unsure (2)	<input type="checkbox"/> 14 – 23 lb. (2)	<input type="checkbox"/> 24 – 33 lb. (3)	<input type="checkbox"/> Greater than 33 lb. (4)	
Decreased appetite? <input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1)	Total Score:				
<i>For scores of 2 or more, refer to Dietitian</i>					
Comments:					

7.7. GENITOURINARY & REPRODUCTIVE

<input type="checkbox"/> No problem noted					
<input type="checkbox"/> Dysuria	<input type="checkbox"/> Frequency	<input type="checkbox"/> Hesitancy/Spasm	<input type="checkbox"/> Distention	<input type="checkbox"/> Urostomy	<input type="checkbox"/> Color
<input type="checkbox"/> Anuria	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Scrotal edema	<input type="checkbox"/> Menopausal	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Odor
<input type="checkbox"/> Discharge	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> LMP:	<input type="checkbox"/> Catheter (size, date of insertion):		
Comments:					

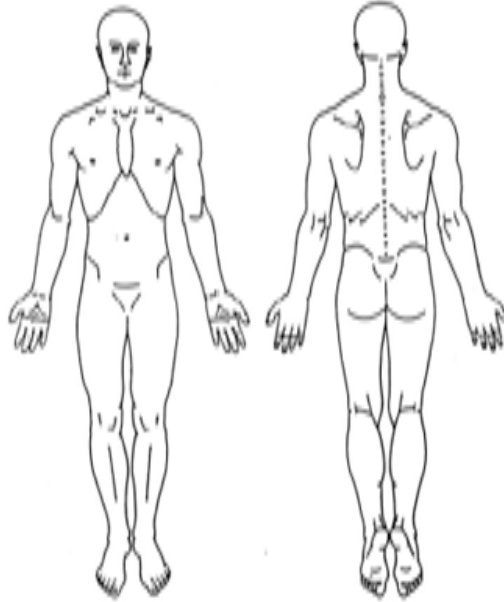
Patient Name:

7.10. WOUND/INCISION ASSESSMENT

None

Assign A, B, C to each wound

Location (A, B, C, etc.): Site Description:



7.11. BRADEN SCORE FOR PREDICTING PRESSURE ULCER RISK – Source: Barbara Braden and Nancy Bergstrom.

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Sensory Perception	Moisture	Activity	Mobility	Nutrition	Friction & Shear
1 = Completely limited	1 = Constantly moist	1 = Bed rest	1 = Completely immobile	1 = Very Poor	1 = Problem
2 = Very limited	2 = Very moist	2 = Chair fast	2 = Very limited	2 = Probably adequate	2 = Potential problem
3 = Slightly limited	3 = Occasionally moist	3 = Walks occasionally	3 = Slightly limited	3 = Adequate	3 = No apparent problem
4 = No impairment	4 = Rarely moist	4 = Walks frequently	4 = No limitations	4 = Excellent	
Score:	Score:	Score:	Score:	Score:	Score:
If total score is 12 or less, patient is at high risk for a pressure ulcer; implement skin care plan.					TOTAL SCORE:

7.12. FALL RISK – Review each item. In the Score column, enter 0 (zero) for “No” or enter 5 for “Yes”

Incontinence and urgency		Postural hypotension	
Greater than 65 years old		Environmental hazards	
Anxiety and emotional lability		Neurological Deficit	
Level of cooperation		Unable to ambulate on own	
Confused		Attachments (IV, O2, Foley, chest tube)	
Current medications		Unable to transfer	
Impaired judgment		History of falls (if “Yes” score 15)	
Assistance required for transfer			
			Total Score

For scores of 15 or more, implement SAFE fall Interventions

Initiated

Patient Name:

8. HEALTH NEEDS REQUIRING RN INTERVENTIONS

Key: C – Complex Care I – Intermediate Care P – Personal Care

Health Related Need	Description of Need	Time Required
Tube Feeding (Intermediate Care)		
Bolus Feedings		
Continuous tube feeding lasting longer than 12 hours/day		
Parenteral/IV Therapy (Complex Care)		
IV therapy more than two times per week lasting longer than 4 hours for each treatment		
Total parenteral nutrition (TPN) Daily		
Central-line Catheter Care		
Wounds (Complex or Intermediate Care)		
Wound Vac Care (C)		
Stage III or IV wounds (C)		
Multiple wounds (greater than 1) (C)		
Stage I or II wounds (I)		
Sterile or clean dressing changes (I)		
Open lesions or sites that require specialized care such as burns, fistulas, tube sites or ostomy sites (I)		
Respiratory Interventions (Intermediate Care or Complex Care Depending on stability of condition or frequency of care)		
Oxygen Therapy (Emergency BELCO Power/generator in place?) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Suctioning		
Tracheostomy Care		
BiPAP / CPAP		
Chronic Ventilator or Respirator Care(C)		
Nebulizer		
Chest PT		
Elimination Interventions (Intermediate or Personal Care)		
Sterile catheter changes more than 1 time/month		
Clean self-catheterization more than 6 times/day		
Ostomy care		
Bowel Program completed more than 2 times/week requiring more than 30 minutes completing e.g. enema.		
Isolation Precaution (Intermediate Care)		
Isolation precaution for active infectious diseases.	Type:	
Neurological Intervention (Intermediate Care)		
Seizures more than 2 times/week and requires significant physical assistance to maintain safety		
Swallowing disorders diagnosed by a physician and requires specialized assistance from another on daily a basis		
Pain Management		
Chronic Pain Management requires RN nursing assessment and judgment more than twice daily (C)		
Intermediate Pain Management requires RN nursing assessment and judgment less than once daily (I)		

10. LEVEL OF CARE CALCULATION

- Check all items that best describe medical/nursing and functional care needs.
- Choose care level that has the most items.

Medical & Nursing Care Needs	Functional Care Needs for ADL's	Level of Care
<ul style="list-style-type: none"> ○ 3 or more chronic fluctuating medical conditions, needing unscheduled medical adjustments to treatment plan, ○ Mood, memory or behavioral conditions that post moderate to severe risk to self or others, ○ Includes predicted and unpredicted nursing assessments due to changing conditions, ○ Greater than once daily pain management, ○ Skin and wound care for Stage 3 & 4 complex wounds, ○ IV therapy includes daily infusions, or central line care or TPN, ○ Tube feedings, ○ Isolation precautions for skin and stool antibiotic resistant bacteria, ○ Oxygen, airway, and/or chronic ventilator management, ○ Care planning and coordination 	<ul style="list-style-type: none"> ○ Needs physical assistance or has total dependence for 3 or more ADL limitations, ○ Total dependence for mobility/positioning self in bed. 	<p>○ Complex Care: (Complex skilled nursing) Predictable and unpredictable complex care needs. Frequent need for revisions to care plan, treatments or medications. May have 6-8 episodes of health exacerbations/year requiring extra MD visits.</p> <p><u>Recommended Minimum Staffing:</u> RN 24/7 on-site Average total nursing care hours 4 hrs/day/pt includes RN time of 1.6 hours/day/pt.</p> <p>MD on-site for assessment for admission, monthly for first 3 months and then quarterly as needed for change, transfers.</p> <p>MD on-call 24/7</p>
<ul style="list-style-type: none"> ○ Complex but stable chronic medical conditions, needing unscheduled medical adjustments to treatment plan. ○ Predicted and unpredicted nursing assessments due to changing conditions, ○ Mood, memory or behavioral conditions that may pose moderate to severe risk to self or others, easily redirected ○ Episodic pain management ○ Skin and wound care for Stage 1 & 2 wounds ○ Tube feedings ○ Isolation precautions for skin and stool antibiotic resistant bacteria, ○ Ostomy care, with well-established and intact stoma ○ IV therapy, episodic or infrequent ○ Care planning and coordination 	<ul style="list-style-type: none"> ○ Physical assistance or total dependence for 2 or more ADL, ○ May need cueing or supervision for some ADLs ○ Total dependence for mobility/positioning in bed 	<p>○ Intermediate Care: (Skilled Nursing)</p> <p><u>Recommended Minimum Staffing:</u> RN on site 24/7 Average total nursing care hours 2.5/day/pt.</p> <p>MD on-site assessment for admission, monthly for first 3 months and then quarterly, as needed for change, transfers.</p> <p>MD on-call 24/7</p>
<ul style="list-style-type: none"> ○ Relatively stabilized (physical or mental) chronic disease, ○ Mild – moderate dementia ○ Predictable health assessments ○ Episodic nursing for medication management, interventions, assessments or treatments, ○ Simple wound care ○ Elder fragility (more than 85 yrs.) ○ Care planning and coordination 	<ul style="list-style-type: none"> ○ Supervision or verbal cueing for ADLs or personal safety ○ Physical assist for mobility ○ Needs assist for IADLs (meal prep, grocery shopping, housekeeping, transport, laundry, etc.) 	<p>○ Personal Care:</p> <p><u>Recommended Minimum Staffing:</u> MD on site assessment for admission and then quarterly, or as needed for change, transfers</p> <p>MD on-call 24/7</p>

Patient Name:

HEALTH INSURANCE DEPARTMENT PERSONAL HOME CARE NEEDS CALCULATION GUIDE

Use the table below to assist in estimating the number of care hours a person staying in or returning to their own home may require to meet their care needs.

Care hour calculations should be adjusted for the following assumptions:

- Utilize community or charity services as first options, e. g. Meals on Wheels, Project Action, and community nursing for home health aide.
- Daycare, part time or full time, is most beneficial for mild to moderate dementia, depression, social isolation, decreased mobility due to fear of falling, night time agitation or difficulty sleeping (increased stimulation during the day often aids sleep at night).
- Family responsibility to provide some of care, minimum of 8 but up to 12 hours per day x 7 days/week.

1. Activity of Daily Living (ADLs) – if assistance prompting or supervision needed allow 1 hour per day	Time Estimate
* Mobility – Transfer self from chair to chair, chair to bed.	
* Mobility – Ambulation or moving self in wheelchair	
* Mobility –In bed	
Toileting	
Eating	
2. Risk factors that may require more care time	
If impairment with mobility* or dementia: Add more time if assistance needed for IADLs – changing bed linens, meal preparation, light cleaning, grocery shopping, and transport.	
If age more than 85 years, history of falls, or observed unsteadiness, then consider time to supervise bathing and ambulation.	
If unable to turn self in bed, consider adding time for positioning.	
If unable to communicate needs or call for help, consider additional time for personal safety.	
3. Complex Health Needs – specify additional time needed	
Tube feeding	
Ostomy or catheter care	
Wound dressing	
Range of motion exercises	
Respiratory suctioning, postural drainage and chest PT	
Seizures more than twice per week and requires physical assistance to maintain safety	
4. Dementia Related Care – adjust care calculation to consider risk factors below to provide 8 hours per day, 5 days per week. Additional hours require family support.	
Personal safety risk – due to wandering	
Impaired judgment putting self at risk (e.g. fire) or unable to seek help when alone	
Social/recreational activities	
Behaviors – resistance to care, excess anxiety or aggression	

Total estimated care hours per day _____

Date (DD/MMM/YYYY):

Signature:

Contact Information:

Patient Name:

LONG TERM CARE NEEDS REASSESSMENT

Care Setting: No Change Change, specify location and admission date:

ORIGINAL LEVEL OF CARE REQUIRED BASED ON FULL ASSESSMENT Complex Care Intermediate Care Personal Care

Reassessment Category	Changes Noted::
Medical Conditions <input type="checkbox"/> No Change	

Medications <input type="checkbox"/> No Change	

Functional Abilities <input type="checkbox"/> No Change	

Behavioral Cognitive Status <input type="checkbox"/> No Change	

Nursing related treatments and Interventions <input type="checkbox"/> No Change	

Other: <input type="checkbox"/> No Change	

LEVEL OF CARE REQUIRED BASED ON REASSESSMENT Complex Care Intermediate Care Personal Care

Date (DD/MMM/YYYY):

Signature:

Contact Information:

Patient Name:

LONG TERM CARE NEEDS REASSESSMENT

Care Setting: No Change Change, specify location and admission date:

ORIGINAL LEVEL OF CARE REQUIRED BASED ON FULL ASSESSMENT Complex Care Intermediate Care Personal Care

Reassessment Category	Changes Noted::
Medical Conditions <input type="checkbox"/> No Change	

Medications <input type="checkbox"/> No Change	

Functional Abilities <input type="checkbox"/> No Change	

Behavioral Cognitive Status <input type="checkbox"/> No Change	

Nursing related treatments and Interventions <input type="checkbox"/> No Change	

Other: <input type="checkbox"/> No Change	

LEVEL OF CARE REQUIRED BASED ON REASSESSMENT Complex Care Intermediate Care Personal Care

Date (DD/MMM/YYYY):

Signature:

Contact Information:



Ministry of Health

CONFIDENTIAL
MEDICAL CERTIFICATE FOR CARE HOME and HOME CARE PROVIDERS

PATIENT INFORMATION and AUTHORIZATION (to be completed by the PATIENT)

Name:	Date of Birth
<p>I authorize the release of this medical information to my potential employer and Ministry of Health inspectors to ensure compliance with the Residential Care home and Nursing Home Act 1999, Regulations 2001 and Code of Practice or ADS home care provider registration requirements.</p>	
Signature:	Date:

MEDICAL INFORMATION (To be completed by Physician)

This individual is or will be employed in a care home or home care setting. This form is to establish that the person named above is in good physical and mental condition as to not adversely affect the health or safety of those they care for.

Check to indicate if the patient is:

- Free from communicable disease
- Free from substance abuse
- Mentally fit and capable of caring for persons requiring care services or managing care homes

Provide details on the next page if any box above is unchecked or there is information to be considered in relation to your assessment.

Does the person have the physical capacity to perform the functions of their post?

- Yes ,specify e.g. assist with lifting and handling etc
- No-specify:

Immunization status:

- Influenza vaccine Date:_____
- [Adult Immunization Schedule](#): indicate which ones were received and when:

Comments (Please use back of this form if additional space is needed)

Physician's Signature:	Date:
Print Name:	Telephone Number: