

Assisted Living Registrar Registrant Handbook

Assisted Living : Seniors



Registrant Handbook

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Introduction

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1.1 Purpose and use of this handbook

The Office of the Assisted Living Registrar issues this handbook to operators of registered assisted living residences (registrants).

Its purpose is to set out your obligations under the *Community Care and Assisted Living Act*,¹ *Regulations*,² *Health and Safety Standards*³ and the Office of the Assisted Living Registrar's policies and procedures. It also provides reference material that will help you fulfill your obligations as a registrant.

You can use this handbook to guide your residence's operations, interact with the Registrar's Office and train staff.

The handbook is presented in a binder format, sectioned with tabs. Each tab contains stand-alone material. Some of the reference material has been extracted from other publications.

The Registrar's Office will send replacement contents from time to time as required to maintain the currency of the material. In order to keep the handbook up-to-date, you are expected to insert the replacement contents and discard outdated material.

1.2 About the Office of the Assisted Living Registrar

Registrar's mandate

B.C.'s Minister of Health appoints the Assisted Living Registrar. The first Registrar, Susan Adams, took office on Nov. 10, 2003. The Ministry of Health supports the operations of the Registrar's Office.

The Registrar's mandate is to protect the health and safety of assisted living residents. To meet this mandate, the Registrar:

- administers the registration of assisted living residences in the province;
- establishes and administers health and safety standards, policies and procedures;
- receives concerns or complaints and refers any that are not within the Registrar's jurisdiction to the appropriate authorities; and
- ensures the timely and effective investigation of complaints about the health and safety of residents living in assisted living residences.

1 SBC 2002, c. 75.

2 BC Reg 217/2004 and 218/2004.

3 See Policy Tab 4.

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The Registrar has jurisdiction over all assisted living residences in B.C., regardless of their form of ownership or funding.

The authority, powers and duties of the Registrar are specified in the *Community Care and Assisted Living Act*.⁴ The Act provides discretion to the Registrar to delegate any power or duty under the Act or regulations.

Guiding principles

To guide the conduct and operations of the Office, the Registrar has established the following guiding principles:

- protect the health and safety of residents;
- value resident and community perspectives;
- partner with operators to establish and maintain health and safety standards;
- pursue continuous improvement, in collaboration with partners and stakeholders;
- take the least intrusive action that is appropriate in the circumstances;
- promote education, counseling and peer review; and
- ensure fairness, transparency and accountability.

⁴ SBC 2002, c. 75.

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POLICY 1

Registrant Obligations

As a registrant, you have the following obligations:

- To comply with the *Community Care and Assisted Living Act*,¹ Regulations,² *Health and Safety Standards*,³ and the Office of the Assisted Living Registrar's policies and procedures.
- Not to house residents who are unable to make decisions on their own behalf⁴ with the following exceptions:
 - where the spouse of a resident lives with the person in the residence and can communicate on the resident's behalf;
 - where the resident is an involuntary patient on leave under section 37 of the *Mental Health Act*.⁵
- To maintain a 'watchful eye' over residents' health and safety.
- To establish and communicate your internal complaint process⁶ by:
 - communicating the complaint process in a manner that is readily accessible to the residents, staff and visitors; and
 - not preventing or intimidating anyone from making a complaint.
- To communicate the Registrar's complaint process⁷ by:
 - making the Registrar's complaint process and contact information readily accessible to residents, staff and visitors; and
 - not preventing or intimidating anyone from making a complaint to the Registrar's Office.
- To provide professional oversight of nonprofessional staff.
- To protect residents from abuse and neglect by:
 - complying with the *Criminal Records Review Act*⁸ to ensure that employees and contractors do not have a criminal record that would place the health and/or safety of residents in jeopardy; and
 - conducting personal background checks on volunteers or getting the volunteer's authorization to do a police or RCMP criminal record check.
- To operate within the number of resident units that you registered.⁹
 - The registration certificate indicates the number of registered units for which the residence is registered.

1 SBC 2002, c. 75.

2 BC Reg 217/2004 and 218/2004.

3 See Policy Tab 4.

4 See Policy Tab 5.

5 RSBC 1996, c. 288.

6 See Policy Tab 9.

7 See Policy Tab 9.

8 RSBC 1996, c. 86.

9 See Policy Tab 3.

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POLICY 1
Registrant Obligations

- To maintain your registration by:
 - renewing your registration annually; and
 - advising the Registrar in a timely manner of any pending changes in ownership and certain other material changes to registration information.¹⁰
- To maintain an emergency response system that meets the needs of your resident population.

¹⁰ See Policy Tab 3.

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POLICY 2

Operating an Assisted Living Residence

2.1 Philosophy and core principles

As a registrant, you are expected to embrace the philosophy and core principles of assisted living.

Assisted living is a semi-independent form of housing. The philosophy of assisted living is to provide housing, with appropriate support and personal assistance services to enable residents to maintain an optimal level of independence.

The core principles of assisted living – choice, privacy, independence, individuality, dignity and respect – derive from a recognition that adults, even when they need support and assistance in daily life, retain the ability and right to manage their own lives.

Residents maintain their privacy by living independently in their own lockable, personal space and they maintain their dignity by making choices about their daily activities, based on their personal preferences and lifestyles.

As an operator, you must provide choice and respect the privacy and independence of residents. When requested, staff should provide assistance that is least intrusive and supports residents to live as independently as possible.

The Registrar has produced a brochure, *Information About Assisted Living*, to provide information about what assisted living is and the philosophy behind it. It talks about the services provided in assisted living residences, how the residences are staffed, and entry and exit requirements. It also outlines residents' rights and what they can expect, as well as explaining the role of the Assisted Living Registrar. Copies are provided to new registrants for distribution to residents and those who care about them.¹

2.2 Standard of Care

While not usurping residents' own responsibility for their health and safety, assisted living operators have a duty to keep a 'watchful eye' over residents. As a standard of care, 'keeping a watchful eye' is higher than the responsibility expected of independent housing operators (where the person receives only housing from the operator) or supportive housing operators (where the person receives housing and one or more hospitality services, for example, meals or laundry, but no personal care, *from the operator*). It is not as high as that expected of operators of licensed residential care facilities.

In keeping a 'watchful eye,' registrants should not intrude unnecessarily into the private lives and personal decision-making of residents. However, if a registrant notices a problem in relation to a resident's health or safety, the registrant has a responsibility to follow up on the matter with the resident and/or their designated contact person.

¹ Additional copies are available from the Office of the Assisted Living Registrar on request.

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POLICY 2 Operating an Assisted Living Residence

As long as the resident appears capable of making decisions and is not putting the health or safety of others at risk, they have a right to make their own decisions, even where those decisions include accepting risks to themselves associated with the choices they are making. However, where there are signs that a resident's decision-making ability is declining, there is a greater onus on operators to assure themselves that the resident is making an informed decision to take the risk, mitigating any harm to themselves and not placing others in the residence at risk.

2.3 Resident population

Your application for registration form identified your target resident population (i.e., seniors; adults with physical disabilities; adults with mental disorders; adults with substance use disorders; or adults with acquired brain injuries). Your resident population may include more than one of these resident groups where their service needs can be accommodated within the one or two prescribed services offered in your residence.

You should be familiar with the following health and safety standards set out at Policy Tab 4:

- #1** Registrants must provide a safe, secure and sanitary environment for residents.
- #2** Registrants must ensure hospitality services do not place the health or safety of residents at risk.
- #4** Registrants must ensure residents are safely accommodated in their assisted living residence, given its design and available hospitality and prescribed services.

Because assisted living is intended for people who are able to live in a semi-independent environment, section 26(3) of the *Community Care and Assisted Living Act*² places an obligation on registrants not to house people who are unable to make decisions on their own behalf. Please refer to section 3.2 under Policy Tab 5, Entry and Exit, for an interpretation of how registrants should apply section 26(3).

2.4 Residence services

Your application for registration form also indicated the one or two prescribed services that you are offering to residents in your assisted living residence. You may not change the number or type of prescribed services offered without first notifying the Registrar. For example, if on your application for registration form you indicated that you offer one prescribed service – activities of daily living – then you may not add a second prescribed service without notifying the Registrar. You also may not change your one prescribed service without first advising the Registrar. For example, you may not cease providing activities of daily living and, instead, offer central storage, distribution, administration and monitoring of medications. Please see Policy Tab 3, How to Maintain Your Registration, for how to notify the Registrar of material changes to your registration information.

In addition to two prescribed services, you may offer any or all of the six personal assistance services at a 'support level.' Please refer to Policy Tab 6, Personal Assistance Services, for further information on personal assistance services and what constitutes support versus prescribed services.

2 SBC 2002, c. 75.

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POLICY 2 Operating an Assisted Living Residence

Please become familiar with the following health and safety standards and related policies set out at Policy Tab 4:

- #5 Registrants must develop and maintain *personal service plans* that reflect each resident's needs, risks, service requests and service plan.
- # 6 Registrants must ensure personal assistance services are provided in a manner that does not place the health or safety of residents at risk.

2.5 Dealing with two resident populations

Your application for registration form identified your target resident population(s) and the one or two prescribed services you offer.

Some registrants may choose to submit a second application to register a second residence serving a resident population that requires different prescribed services. For example, in one part of your premises you offer activities of daily living and medication as prescribed services to seniors and adults with physical disabilities. In another part of your premises, you offer psychosocial rehabilitation and medication services to adults with mental disorders.

Where you have registered two assisted living residences on one premises, you must house the two groups of residents in distinct areas of the building. For example:

1. on separate floors, where the resident units and common areas are for the exclusive use of each resident population; or
2. in separate wings, where the resident units and common areas are for the exclusive use of each resident population.

The two assisted living populations should not be mixed. This will ensure that each population receives no more than two prescribed services.

Registrants can gain economy of scale savings through shared support services, such as kitchen, laundry and housekeeping.

2.6 Staffing

The Registrar has not set specific staffing requirements. Instead, the health and safety standard, with which you should be familiar set out at Policy Tab 4, is that:

- #3 Registrants must ensure sufficient staff is available to meet the service needs of residents and that staff has the knowledge and ability to perform their assigned tasks.

Registrants must ensure that:

- site management is effective and appropriate to the resident population;
- staffing levels are adequate for the setting, number of residents, resident profile and the personal assistance services offered;

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POLICY 2 Operating an Assisted Living Residence

- volunteers and all staff, whether employed or contracted, have the necessary knowledge, skills, abilities and training to perform their designated tasks and to respond to emergencies; and
- personal services plans³ are developed by a person with appropriate training and skills.

Staff providing personal assistance services must have the same training as home support workers.⁴

Registrants must maintain documentation on staff selection, training, skills and abilities and have this available for the Registrar's review, upon request.

2.7 Role of health professionals

Residents of assisted living have access to professional care (such as physician services or nursing care) in the same way they would have if living independently in the community. Residents may access professional services through health authority programs (home care nursing, physiotherapy, dietitian) or by purchasing these services from a private agency.

Assisted living is primarily a nonprofessional staffing environment. However, each prescribed service includes a level of professional care and/or oversight. Registrants must employ or contract with appropriate health care professionals to provide the personal assistance and/or to delegate or assign professional health care tasks to nonprofessional staff, as appropriate. Professional practice will determine delegation procedures. Registrants are obliged to ensure professional supervision of any delegated tasks.

Please refer to Policy Tab 6, Personal Assistance Services, for further information on the delivery of prescribed services.

3 The personal services plan is an agreement between the individual resident and the operator and includes the nature of the resident's needs and service requests, the risks the resident is facing and a plan for the delivery of services.

4 Home support/care aide certification from an accredited educational institution or an equivalent combination of education and experience.

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POLICY 3

How to Maintain Your Registration

3.1 Policy statement

A person must not operate an assisted living residence that is not registered.¹

3.2 Maintaining registration

In order to maintain your registration in good standing, you should:

- post your current registration certificate in the residence;
- promptly notify the Registrar of changes to your registration information throughout the year; and
- renew your registration and update the information on file with the Registrar annually.

3.3 Registration certificate

You should post your current registration certificate in a public place in your residence. It shows that you meet the health and safety standards for assisted living operators under the *Community Care and Assisted Living Act*.² The registration certificate is valid for up to one year (to March 31). Each time you renew your registration, the Registrar will issue you a new certificate.

3.4 Registration changes

You should promptly notify the Registrar in writing about changes to your registration information throughout the year.

Administrative changes

Administrative changes include:

- residence information, including the residence name and/or other trade name, and contact information (address, phone number or e-mail address); and
- registrant contact information, including authorized representative, mailing address, phone number, or e-mail address.

This information is important because it enables the Registrar to know how to contact you. On receipt of such information, the Registrar will simply update the registry.

¹ *Community Care and Assisted Living Act*, SBC 2002, c. 75, s. 26(1).

² SBC 2002, c. 75.

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POLICY 3 How to Maintain Your Registration

Non-administrative changes

Non-administrative changes include:

- the residence site manager;
- the number of units registered as assisted living;
- the resident population;
- the prescribed services offered;
- residence building structure; and
- change in ownership of the registered residence (i.e., a change in the legal entity that operates the residence).

With the exception of a change of ownership, you should notify the Registrar about non-administrative changes within five working days of being aware of the change. The Registrar will review the changes and determine if any follow-up is warranted.

You should notify the Registrar's office about a pending change in ownership of your residence at least 60 days before its effective date, including the name, address and contact telephone numbers of the prospective new owner. Upon receipt of your notice, the Registrar will send an application for registration package to the pending new owner and request them to submit a new registration application and application fee at least 60 days before the effective date of the ownership change. This will allow the Registrar time to process the application prior to the date of the ownership change. When the Registrar is notified that the change in ownership transaction has been completed, the new registration will be issued. If the change in ownership does not proceed, the existing registration will remain in effect.

3.5 Registration renewal

In February of each year, the Registrar's office will send you a notice to renew your registration and an invoice for the annual registration fee.

You should:

- review and update the information about your residence; and
- submit the updated information and annual registration fee to the Registrar's office by March 31.

If there has been a change to your registration information, the Registrar will follow the same processes outlined above before renewing your registration. Upon renewal, you will receive a letter of approval and a new registration certificate effective April 1 to March 31 of the following year.

If the Registrar intends to refuse your application for renewal and/or attach conditions to your registration, the Registrar will send you a letter conveying the pending action and reasons for it. The notice will include information about the reconsideration process. The Registrar will send you this written notice at least 30 days before the effective date of the pending action.

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Policy

Health and Safety Standards

4.1 Policy statement

A registrant must ensure that the assisted living residence is operated in a manner that does not jeopardize the health and safety of its residents¹.

4.2 Introduction

This policy contains health and safety standards for assisted living residences. The standards are high level and outcome-based. This means that, rather than prescribe how to do something, the standards will state the outcome to be achieved. This policy elaborates on the desired outcomes for each of the proposed standards. Examples of compliance are also included to provide further guidance to registrants.

The health and safety standards are:

1. Registrants must provide a safe, secure and sanitary environment for residents.
2. Registrants must ensure hospitality services do not place the health or safety of residents at risk.
3. Registrants must ensure sufficient staff is available to meet the service needs of residents and that staff has the knowledge and ability to perform their assigned tasks.
4. Registrants must ensure residents are safely accommodated in their assisted living residence, given its design and available hospitality and prescribed services.
5. Registrants must develop and maintain personal services plans that reflect each resident's needs, risks, service requests and service plan.
6. Registrants must ensure personal assistance services are provided in a manner that does not place the health or safety of residents at risk.

This policy contains the six standards, followed by a table that contains the related polices in the left-hand column, and examples of compliance in the right-hand column.

A multi-stakeholder work group, including a number of registrants, developed the examples of compliance. These examples are not intended to limit or dictate how registrants will achieve the desired outcomes. Registrants are encouraged to adopt other innovative approaches and procedures that produce the desired outcome. The applicability of the examples will vary depending on the setting (such as the size of residence) and the resident population. What is appropriate in a large residence may not work in a smaller one. Registrants can use the examples as a guide to determining how they will comply with each of the standards.

¹ *Community Care and Assisted Living Act, SBC 2002, c. 75, section 26(5).*

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POLICY 4 Health and Safety Standards

1.1 Environment

Outcome	Examples of compliance ²
<p>1.1.1 Registrants must ensure that building design, construction and occupancy comply with the requirements of applicable legislation, regulations, bylaws and codes.</p>	<ul style="list-style-type: none"> • Records showing all required approvals and permits to operate are in place. Examples: <ul style="list-style-type: none"> - occupancy permit; - food premises permit; - approval of hair salon • Records of inspections by various authorities. Examples: <ul style="list-style-type: none"> - fire authority - environmental health
<p>1.1.2 Registrants must ensure the design of common areas and resident units accommodates the special needs of their resident population.</p>	<ul style="list-style-type: none"> • Building design allows freedom of movement and provides a barrier-free environment for persons with disabilities. Examples: <ul style="list-style-type: none"> - elevator for multi-story residence; - wheelchair accessibility; - bathrooms designed for persons with disabilities; adequate space for the safe mobility of persons using walkers and/or other mobility aids; - adequate space for the safe mobility of persons using walkers and/or mobility aids; - adequate space for attendants to assist residents with mobility and/or activities of daily living; - adaptable design, such as adaptable doorways for wheelchair accessibility, or alternate faucet handles and door handles. • Spot checks of residents' units demonstrate that the design is appropriate to their needs.
<p>1.1.3 Registrants must provide adequate and appropriate social and recreational space for residents.</p>	<ul style="list-style-type: none"> • Common space for social and recreational activities is: <ol style="list-style-type: none"> (a) proportionate to the number of residents, and (b) appropriate for the resident population

² Please see introductory comments on page 1. These examples are provided only as a guide. Registrants are encouraged to adopt other innovative approaches and procedures that will produce the desired outcomes.

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POLICY 4 Health and Safety Standards

Standard #1:

Registrants must provide a safe, secure and sanitary environment for residents

Outcome	Examples of compliance
<p>1.2 Building Maintenance</p> <p>1.2.1 Registrants must maintain buildings and grounds in a good state of repair and a safe and sanitary condition and in compliance with the requirements of applicable legislation, regulations, bylaws and codes.</p>	<ul style="list-style-type: none"> • All required permits are current • Documentation that applicable inspections have been conducted at required intervals. • Documentation that any orders have been acted upon to the satisfaction of the regulatory body. • Scheduled building maintenance and equipment replacement is consistent with industry practice. • Pest control program in place. • Housekeeping schedules and quality checks of common areas³ (e.g., inspections, audits) are consistent with industry practice. • Spot checks of different areas demonstrate the building and grounds are in good repair and sanitary. Examples: <ul style="list-style-type: none"> - furnishings and equipment are in good repair; - no obvious odours; - no build up of dirt; - no pests; - no obvious build up of garbage on the grounds; - no obvious hazards for residents due to poor maintenance (e.g., tripping hazards); - no safety hazards such as frayed cords or plugs or unsafely placed electrical extension cords. • Survey results show resident satisfaction with building maintenance and housekeeping (common areas)
<p>1.3 Security</p> <p>1.3.1 Registrants must provide building security that protects residents from intruders.</p>	<ul style="list-style-type: none"> • Security measures are appropriate to building design, environmental risk factors and the resident population. • Spot checks suggest ease of access for residents. • There is a 24/7 response capacity to breaches of security, (e.g., alarm linked to security company, link to the 24/7 resident emergency response service). • Staff is trained to deal with breaches of security. <p>Examples:</p> <ul style="list-style-type: none"> - orientation materials; - training modules; - records of staff participation in orientation and training. • Residents and families have been oriented to the importance of building security.

³ Housekeeping services for resident units are addressed in the hospitality services section. Standard #2

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POLICY 4
Health and Safety Standards

Standard #1:

Registrants must provide a safe, secure and sanitary environment for residents

Outcome	Examples of compliance
	<ul style="list-style-type: none"> • Emergency numbers for breaches of security are posted • Incidents where security is breached are documented and appropriate action is demonstrated. • Survey results show resident satisfaction with building security.
<p>1.3.2 Registrants must maintain the privacy of residents' personal information in accordance with applicable legislation, using it only as requires in the delivery of services.</p>	<ul style="list-style-type: none"> • Policies detail the circumstances under which residents' personal information may be accessed and whom may access the information. • Staff orientation includes maintaining the privacy and confidentiality of resident personal information. • Staff discussions regarding residents are held in private areas. • Resident files and personal information are stored in a secure manner. Examples: <ul style="list-style-type: none"> - locked file cabinets; - locked room; - computer security.
<p>1.3.3 Registrants must respect privacy, provide lockable doors to resident units and a lockable cabinet within each resident unit for valuables.</p>	<ul style="list-style-type: none"> • Resident privacy is respected. Examples: <ul style="list-style-type: none"> - written policies respecting resident privacy; - staff request permission prior to entry; - staff prearrange access whenever people; - progressive followup is used, starting with least intrusive, when a resident does not appear when expected; - emergency access to resident units is undertaken, only when all other options for verifying the safety of the resident have failed. • Staff is trained to respect resident privacy. Examples: <ul style="list-style-type: none"> - orientation materials; - training modules; - records of staff participation in orientation and training.

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POLICY 4 Health and Safety Standards

Standard #1:

Registrants must provide a safe, secure and sanitary environment for residents

Outcome	Examples of compliance
1.4 Emergency preparedness and fire safety	
1.4.1 Registrants must provide services and/or facilities that enable residents to self-preserve in the event of fires or other emergencies	<ul style="list-style-type: none"> • Emergency alarm systems are appropriate to the needs of the resident population. Example: <ul style="list-style-type: none"> - visual system to alert people who are deaf • The unique needs of residents are recorded in their personal services plans⁴ • The emergency plan documents the support each resident requires to self-preserve. Examples: <ul style="list-style-type: none"> - degree of direction required; - degree of physical assistance required. • Documentation that residents have been educated regarding emergency protocols. Examples: <ul style="list-style-type: none"> - documentation of drills; - emergency plan is posted showing exists, emergency shut off valves and location of fire extinguishers.
1.4.2 Registrants must ensure that staff is trained to respond appropriately to emergencies.	<ul style="list-style-type: none"> • An emergency plan is in place covering all types of emergencies (eg. bomb threat, earthquake, forest fire, flood, presence of firearms or other weapons) and includes an evacuation plan and linkages to the community emergency response plan. • Staff is trained to use safety equipment and respond to emergencies. Examples: <ul style="list-style-type: none"> - orientation materials; - training modules; - records of staff participation in orientation and training. • Documentation shows that, where staff is not on site 24/7, residents have been trained to respond appropriately to emergencies.
1.4.3 Registrants must ensure the fire safety requirements of the local fire authority are met.	<ul style="list-style-type: none"> • Fire safety plan submitted to, and reviewed with, the local fire authority. • Fire authority inspection reports, orders and correspondence demonstrate compliance with all requirements. Examples: <ul style="list-style-type: none"> - fire drills; - maintenance of fire detection and safety equipment.

⁴ The personal services plan is an agreement between the individual resident and the registrant and includes the nature of the resident's needs and service requests, the risk the resident is facing and a plan for the delivery of services. The plan is developed at the point of entry to the residence and is updated on a regular basis.

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POLICY 4 Health and Safety Standards

Standard #1:

Registrants must provide a safe, secure and sanitary environment for residents

Outcome	Examples of compliance
1.5 Accidents, deaths and medical emergencies	
1.5.1 Registrants must respond immediately and appropriately to missing residents, accidents, medical emergencies or deaths	<ul style="list-style-type: none">• There are written policies to guide the response to missing residents, accidents, medical emergencies or deaths.• Staff is trained to respond to missing residents, accidents, medical emergencies or deaths. Examples:<ul style="list-style-type: none">- orientation materials;- training modules;- records of staff participation in orientation and training.• Where staff is not available 24/7, residents are trained to respond appropriately in the event of missing residents, accidents, medical emergencies or deaths.• One staff person with valid first aid certification is on the premises or in close proximity at all times.• Serious incidents are documented and investigated. Actions taken to adjust procedures are noted.• A well-equipped first aid kit is kept in a convenient location and staff is aware of the location.
1.6 Infectious diseases	
1.6.1 Registrants must have a plan in place to prevent and control the spread of infectious diseases in assisted living residences in accordance with <i>Prevention and Control of Infectious Diseases</i> ⁵	<ul style="list-style-type: none">• Written policies and procedures provide guidance for:<ul style="list-style-type: none">- preventing and containing infectious diseases;- when to report infectious diseases to local public health.• Staff is trained to control the spread of infection and use good health practices. Examples:<ul style="list-style-type: none">- orientation materials'- training modules;- records of staff participation in orientation and training.

⁵ See Policy Tab 12

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POLICY 4 Health and Safety Standards

1.7 Resident abuse, neglect and self-neglect

1.7.1 Registrants must protect residents from abuse and neglect by: (a) responding promptly and effectively to allegations of abuse or neglect, (b) complying with the requirements of the *Criminal Records Review Act*⁶, and (c) by conducting personal background checks on volunteers or getting the volunteer's authorization to do a police or RCMP criminal record check.

- Written policies provide guidance for:
 - preventing abuse and neglect by residence staff;
 - identifying potential abuse and neglect by family, friends or other parties;
 - reporting allegations of abuse and neglect;
 - protecting resident health and safety during abuse/neglect investigations;
 - co-ordinating with other agencies such as the police, funding agency, PGT and local abuse and neglect designated agency;
 - co-ordinating with local licensing officers where the building houses both registered and licensed units and staff is shared.
- Documentation of abuse and neglect complaint follow up shows compliance with the residence's policies.
- Staff is trained in the prevention of, and response to, resident abuse, neglect and self-neglect. Examples: orientation materials, staff training modules, records of staff participation in orientation and training.
- Documentation shows compliance with the *Criminal Records Review Act*:
 - authorizations for criminal records checks from employees are retained for five years;
 - contractors have obtained authorizations for criminal record checks from their employees; and
 - a re-check of the criminal records check is completed every five years.
- Documentation shows registrants have conducted personal background checks on volunteers and obtained confirmation from contractors that they conduct personal background checks on volunteers, or registrants and contractors have obtained authorizations for police or RCMP criminal record checks from their volunteers.

1.7.2 Registrants must maintain a record of incidents that occur within the residence and report serious incidents⁷ to the Registrar in accordance with *Serious Incident Reporting*.⁸

- Written policies provide guidance to staff for documenting all incidents, including injuries that require emergency care or transfer to hospital.
- Copies of all incident reports are retained at the residence.

6 See Bulletin #4.

7 Serious incidents include attempted suicide by a resident; unexpected deaths reported to the coroner; abuse or neglect by staff reported to the local abuse and neglect designated agency or the Public Guardian and Trustee; medication error by staff that requires emergency intervention or transfer to hospital; and fire that causes personal injury or building damage.

8 See Policy Tab 8.

Registrant Handbook

POLICY 4
Health and Safety Standards

Standard #2:

Registrants must ensure hospitality services do not place the health or safety of residents at risk.

Outcome	Examples of compliance ²
2.1 Laundry services	
<p>2.1.1 Registrants must provide sanitary, non-allergenic flat linens and sanitary personal laundry, where a personal laundry service is offered.</p>	<ul style="list-style-type: none"> • Where laundry services are provided on-site: <ul style="list-style-type: none"> – documentation shows detailed procedures, consistent with infection control practices, for producing sanitary and non-allergenic flat linens; – documentation shows staff is trained on laundry procedures. Examples: <ul style="list-style-type: none"> ○ orientation materials; ○ training modules; ○ records of staff participation in orientation and training; – maintenance records show regular monitoring of laundry equipment and repairs, as required; – a spot check demonstrates that laundry practices meet generally accepted industry practices, (e.g., separate areas for clean and soiled laundry); – documentation shows that laundry staff is trained in infection control practices. • Where laundry services are provided off-site, quality control standards are documented. • Survey results show resident satisfaction with laundry services.
<p>2.1.2 Registrants must store clean laundry in a manner that prevents contamination.</p>	<ul style="list-style-type: none"> • A spot check of the linen storage area demonstrates that there are no apparent unsanitary conditions.
<p>2.1.3 Registrants must change linens at time intervals necessary to avoid health issues.</p>	<ul style="list-style-type: none"> • Written policies set out when linens are to be changed and provide flexibility to ensure this service is appropriate to individual resident needs. • The unique needs of residents are recorded in their personal services plans.⁴ • Service schedules demonstrate that laundry services have been adjusted to meet individual resident needs. • There is no indication of stains, dampness or odor associated with flat linens that are in use. • The inventory demonstrates there is an adequate supply of linens to maintain scheduled changes.
<p>2.1.4 Registrants must provide residents with access to safe and sanitary personal laundry equipment (or provide a personal laundry service).</p>	<ul style="list-style-type: none"> • Cleaning and maintenance records demonstrate that laundry equipment provided for resident use is maintained in a safe and sanitary condition. • A spot check demonstrates that laundry equipment meets generally accepted industry practices.

Registrant Handbook

POLICY 4
Health and Safety Standards

Standard #2:

Registrants must ensure hospitality services do not place the health or safety of residents at risk.

Outcome	Examples of compliance ²
2.2 Housekeeping services⁹	
<p>2.2.1 Registrants must provide housekeeping in resident units that maintains a safe, clean and sanitary environment.</p>	<ul style="list-style-type: none"> • Written policies and procedures cover a range of housekeeping practices. Examples: <ul style="list-style-type: none"> – routine and spot cleaning; – storage of cleaning supplies and equipment; – resident safety while cleaning is in progress; – move in/move out cleaning. • Housekeeping policies set out frequency of service and provide flexibility to ensure service is appropriate to individual resident needs. • The unique needs of residents are recorded in their personal services plans.⁴ • Cleaning schedules and records demonstrate that service is provided according to residence policy. • Staff is trained in housekeeping procedures for resident units. Examples: <ul style="list-style-type: none"> – orientation materials; – training modules; – records of staff participation in orientation and training. • Spot checks of residents' units demonstrate that: <ul style="list-style-type: none"> – housekeeping services meet acceptable industry standards; – there are no safety hazards such as frayed cords or plugs or unsafely placed electrical extension cords. • Survey results show resident satisfaction with housekeeping services provided in resident units.

⁹ Applies to resident units only. Housekeeping services for common areas is addressed under building maintenance.

Registrant Handbook

POLICY 4
Health and Safety Standards

Standard #2:

Registrants must ensure hospitality services do not place the health or safety of residents at risk.

Outcome	Examples of compliance ²
2.3 Meal services	
<p>2.3.1 Registrants must offer meals in accordance with <i>Meal and Dietary Services</i>¹⁰ and that provide balanced and adequate nutrition for residents.</p>	<ul style="list-style-type: none"> • Menus for the past year demonstrate that: (a) meals are based on <i>Canada's Food Guide</i>,¹¹ (b) menu rotations are used to provide balanced nutrition, and (c) menu options are available to ensure adequate nutrition for residents with a variety of health conditions. • Staff is trained to deliver meals according to menus. Examples: <ul style="list-style-type: none"> – orientation materials; – training modules; – records of staff participation in orientation and training. • A spot check demonstrates that: (a) meals are nutritious, (b) meals follow <i>Canada's Food Guide</i>,⁹ and (c) menu options are available to residents as required for their health conditions. • Survey results show resident satisfaction with: (a) the nutritional value of meals provided, and (b) the variety and choice in meal selections.
<p>2.3.2 Where registrants agree to accommodate residents' special dietary needs¹² (special or therapeutic diets, food allergies or intolerances, and/or special needs associated with chewing or swallowing), registrants must establish an individual dietary plan¹⁰ as part of the residents' personal services plan.</p>	<ul style="list-style-type: none"> • Documentation shows that residents have an opportunity to: (a) identify their need for special or therapeutic diets and/or diets to address food allergies or intolerances, (b) identify needs associated with chewing and swallowing ability, and (c) provide input to menu planning to meet these needs. Examples: <ul style="list-style-type: none"> – policies and procedures; – resident handbook. • The unique dietary needs/plans of residents are recorded in their personal services plans.⁴ • A spot check demonstrates that meals are offered in accordance with individual resident dietary plans. • Survey results show resident satisfaction with: (a) their involvement in menu planning, and (b) the residence's response to their special dietary needs. • Where resident involvement in meal planning and preparation is required for the resident population (e.g., mental health program), this is reflected in the personal services plan.

¹⁰ See Policy Tab 10.

¹¹ See http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html.

¹² A 'dietary plan' is a written plan defining the requirements for producing food to meet the resident's individual dietary needs. It includes special instructions where needed (e.g., low sugar diet for diabetes). Where a registrant offers the prescribed service, *monitoring of food intake or of adherence to therapeutic diets*, the dietary plan should also describe relevant indicators of health status for the resident and activities undertaken to monitor the resident's health outcome.

Registrant Handbook

POLICY 4 Health and Safety Standards

Standard #2:

Registrants must ensure hospitality services do not place the health or safety of residents at risk.

Outcome	Examples of compliance ²
<p>2.3.3 Registrants must ensure that residents can access meals.</p>	<ul style="list-style-type: none"> • Policies make provision for: <ul style="list-style-type: none"> – meals being available in resident units when residents are temporarily confined to their units for medical reasons; – adaptive dishes, cups and cutlery are accommodated (e.g., where provided by resident) or provided as required; – residents are assisted in getting to the dining room, as required.
<p>2.3.4 Registrants must obtain professional advice from a Registered Dietitian or food service supervisor/diet technician¹³ to plan menu rotations for their regular menu plan, as well as menu rotations designed to address individual resident's special or therapeutic diets, and food preparation to accommodate chewing and swallowing abilities.¹⁴</p>	<ul style="list-style-type: none"> • Documentation shows that appropriate professional advice and instruction has been obtained to: (a) ensure proper planning of menus to address special or therapeutic diets, and (b) provide direction to staff regarding needs associated with chewing and swallowing ability (e.g., texture modification). • Contract for dietitian or food service supervisor services.
<p>2.3.5 Registrants must adopt safe practices for the obtaining, storage, preparation and serving of meals.</p>	<ul style="list-style-type: none"> • Documentation shows compliance with requirements of environmental health officers in relation to safe food practices. Examples: <ul style="list-style-type: none"> – food premises permit; – correspondence; – inspection reports; – staff has FOODSAFE training. • Where residents are involved in the preparation of meals, documentation demonstrates that residents receive the necessary guidance and monitoring to ensure safe practices. Examples: <ul style="list-style-type: none"> – resident orientation materials; – instruction sheets; – posted signs with instructions; – resident education modules. • Staff is oriented and trained on the safe handling, preparation and serving of food. Examples: <ul style="list-style-type: none"> – orientation materials; – training modules; – training specific to residents with special needs such as blindness or arthritis; – training specific to residents with needs associated with chewing and swallowing abilities (e.g., need for food cut up, texture modification); – records of staff participation in orientation and training (e.g., FOODSAFE)

¹³ Eligible for membership in The Canadian Society of Nutrition Management.

¹⁴ Routine modifications to the regular menu plan (e.g., low sugar; low sodium; cut up, minced or pureed to make eating easier due to loose dentures) may be implemented without seeking professional advice.

Registrant Handbook

POLICY 4
Health and Safety Standards

Standard #2:

Registrants must ensure hospitality services do not place the health or safety of residents at risk.

Outcome	Examples of compliance ²
	<ul style="list-style-type: none"> • Spot checks show that residents' special meal service needs are accommodated (e.g., adaptive plates or cutlery). • Survey results show resident satisfaction with the delivery of meal services.
2.4 24-hour emergency response system	
<p>2.4.1 Registrants must provide a 24-hour response to personal emergencies that is appropriate to the needs of the resident population.</p>	<ul style="list-style-type: none"> • There is a 24-hour response service that incorporates the following: <ul style="list-style-type: none"> – a means for residents to call for help; – protocols defining response time and the type of response to be provided; – coverage for 24/7. • There is a system that: (a) alerts staff to a resident calling for help, and (b) provides a protocol for locating the resident. • Documentation shows that the emergency response system is regularly tested. • An emergency response plan shows that the following are readily available to staff on all shifts: (a) directions, appropriate to the resident population, for responding to emergency situations, (b) emergency phone numbers (e.g., police, fire, ambulance), and (c) family contact information. • Documentation shows that staff is oriented and trained on the use of the emergency response system and their responses to various situations. Examples: <ul style="list-style-type: none"> – orientation materials; – staff training modules; – records of staff participation in orientation and training. • Documentation shows that residents are trained in how to use the emergency response system. Examples: <ul style="list-style-type: none"> – resident orientation materials; – resident handbook; – resident education modules. • For residences where staff is not available 24/7, documentation shows that residents are taught to respond appropriately to emergencies when staff is not on the premises. Examples: <ul style="list-style-type: none"> – resident orientation materials; – resident handbook; – resident education modules. • A spot check confirms that the activating devices for the call system are readily accessible to residents. • Survey results show resident satisfaction with the emergency response service.

Registrant Handbook

POLICY 4
Health and Safety Standards

Standard #2:

Registrants must ensure hospitality services do not place the health or safety of residents at risk.

Outcome	Examples of compliance ²
2.5 Social and recreational opportunities	
<p>2.5.1 Registrants must ensure safe transportation to and from social and recreational outings.</p>	<ul style="list-style-type: none"> • Documentation shows compliance with the <i>Motor Vehicle Act</i>¹⁵ and regulations (e.g., driver's license classification). • Documentation shows that staff providing resident transportation are oriented and trained for this activity. Examples: <ul style="list-style-type: none"> – orientation materials; – staff training modules; – records of staff participation in orientation and training. • Survey results show resident satisfaction with the transportation service provided for social and recreational outings.
<p>2.5.2 Registrants must offer social and recreational programs that promote the mental well-being of residents.</p>	<ul style="list-style-type: none"> • Documentation shows that a variety of social and recreational opportunities are provided for residents on an ongoing basis. Example: <ul style="list-style-type: none"> – posted program of social and recreational events. • A spot check confirms that organized social and recreational activities are occurring with residents. Example: <ul style="list-style-type: none"> – activity room. • Documentation shows that staff is oriented and trained in the planning and implementation of social and recreational programs for residents. Examples: <ul style="list-style-type: none"> – orientation materials; – staff training modules; – records of staff participation in orientation and training. • Survey results show resident satisfaction with the social and recreational programs offered by the registrant.

¹⁵ RSBC 1996, c. 318.

Registrant Handbook

POLICY 4 Health and Safety Standards

Standard #3: Registrants must ensure sufficient staff is available to meet the service needs of residents and that staff has the knowledge and ability to perform their assigned tasks.

Outcome	Examples of compliance ²
3.1 Management	
<p>3.1.1 Registrants must ensure site management is effective and appropriate for the resident population.</p>	<ul style="list-style-type: none"> • The documented operating philosophy of the residence reflects the principles and values associated with assisted living. • Documentation demonstrates that: <ul style="list-style-type: none"> – policies and procedures are in place to direct all aspects of the operation of the residence that may impact on resident health and safety; – a quality assurance/quality improvement program is in place; – audits or reviews of residence operations have been conducted; – effective and appropriate hiring practices are in place. Examples: <ul style="list-style-type: none"> ○ position requirements are defined and appropriate to the role; ○ recruitment and selection practices are in place; ○ reference checks are documented; – all staff has job descriptions and have been issued clear instructions and/or statements of expectations regarding their work; – where services are contracted out, the contract stipulates that the contractor must hire qualified and appropriate staff. • Survey results show resident satisfaction with management of the residence. • The complaint history for the residence does not indicate problems with the management of the residence.
3.2 Staffing levels	
<p>3.2.1 Registrants must ensure staffing levels are sufficient to meet the hospitality service needs of residents and deliver the personal assistance services offered.</p>	<ul style="list-style-type: none"> • The staffing plan includes adequate coverage for vacations, illnesses and other absences. • Documentation suggests adequate staffing levels. Examples: <ul style="list-style-type: none"> – responses to residents' personal emergency calls occur within the time frames set out in residence policy; – scheduled services are provided on time. • The Registrar's complaint history for the residence does not indicate problems with staffing levels. • Survey results show resident satisfaction with service levels.
<p>3.2.2 Registrants must have plans in place to address situations where there is a disruption to the residence's regular work force.</p>	<ul style="list-style-type: none"> • A written contingency plan outlines strategies for dealing with situations where regular staff is not available due to job action, including general strikes, or any other reason.

Registrant Handbook

POLICY 4 Health and Safety Standards

Standard #3: Registrants must ensure sufficient staff is available to meet the service needs of residents and that staff has the knowledge and ability to perform their assigned tasks.

Outcome	Examples of compliance ²
3.3 Staff qualifications and ongoing training¹⁶	
<p>3.3.1 Registrants must ensure that staff has qualifications consistent with their job responsibilities. Staff providing personal assistance services must have home support/care aide certification from an accredited educational institution or an equivalent combination of education and experience.</p>	<ul style="list-style-type: none"> • Job descriptions, including duties and position qualifications, are in place for each position. • Personnel records show that staff meets the position requirements. • Personnel records, along with staff schedules and work assignments, demonstrate that staff providing personal assistance services has the college home support/care aide certification or an equivalent combination of education and experience. • Documentation demonstrates that staff qualifications and competencies are kept current. • Survey results show resident satisfaction with staff knowledge and skills.
<p>3.3.2 Registrants must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills.</p>	<ul style="list-style-type: none"> • Documentation of staff orientation shows that staff has been oriented to all key areas of service delivery. Examples: <ul style="list-style-type: none"> – orientation checklist completed at the time of hiring or major change. • Documentation shows that staff orientation and ongoing training is appropriate, considering staff responsibilities, and the profile and needs of the resident population. Examples: <ul style="list-style-type: none"> – staff orientation materials; – training modules; – staff education and training records.
3.4 Delegated tasks	
<p>3.4.1 Registrants must ensure appropriate delegation of professional tasks¹⁷ to nonprofessional staff, consistent with the <i>Personal Assistance Guidelines</i>.¹⁸</p>	<ul style="list-style-type: none"> • Documented policies and procedures defining the delegation of tasks: (a) are consistent with the provincial <i>Personal Assistance Guidelines</i>,¹⁶ and (b) set out the delegation process, including requirements for a health professional to: <ul style="list-style-type: none"> – assess needs associated with the delegated task; – educate and train nonprofessional staff; – oversee the implementation of the task and monitor ongoing delivery. • Documentation shows that delegation occurs according to policies and procedures. • The resident's personal services plan⁴ identifies: (a) the delegated tasks, (b) the requirements specific to these tasks, and (c) the professional who delegated the tasks.

¹⁶ Staff includes employees, practicum students and volunteers performing staff functions.

¹⁷ In addition, licensed practical nurses can assign a task to a non-professional staff member, provided the task is already within the education and knowledge base of the staff member. Licensed practical nurses cannot educate or train nonprofessional staff to perform a task that is not already within their scope of education and knowledge.

¹⁸ See Policy Tab 6, section 6.4.

Registrant Handbook

POLICY 4 Health and Safety Standards

Standard #4: Registrants must ensure residents are safely accommodated in their assisted living residence, given its design and available hospitality and prescribed services.

Outcome	Examples of compliance ²
4.1 Entry	
<p>4.1.1 Registrants must fully inform prospective residents about the hospitality and personal assistance services¹⁹ offered in the residence.</p>	<ul style="list-style-type: none"> • There are written policies related to: <ul style="list-style-type: none"> – end-of-life arrangements and circumstances where death in place can be accommodated; – the criteria or triggers that indicate the need for an increase, decrease or other change in services; – the criteria or triggers that require development of an exit plan for residents moving to other accommodation. • There is documentation informing prospective residents of entry and exit criteria, residence policies and available services. Examples: <ul style="list-style-type: none"> – brochure, resident orientation handbook or other literature; – copy of occupancy agreement.
<p>4.1.2 Registrants must screen residents for suitability in relation to building design features, personal assistance services offered and ability to make decisions on their own behalf.</p>	<ul style="list-style-type: none"> • Documentation demonstrates a screening process is in place to identify suitable residents. Examples: <ul style="list-style-type: none"> – resident profile; – screening criteria; – pre-occupancy interview checklist.
4.2 Exit plans	
<p>4.2.1 Where a resident's needs exceed the service delivery capacity of the residence or the resident becomes unable to make decisions on their own behalf, a registrant must develop an exit plan in consultation with: the resident; their physician; family and support network; and health authority case manager, if appropriate.</p>	<ul style="list-style-type: none"> • Documentation shows there is a process for developing exit plans in consultation with: the resident; their physician; family and support network; and health authority case manager, if appropriate. Examples: <ul style="list-style-type: none"> – policies and procedures; – resident manual. • Where residents are awaiting transfer out of the residence, spot checks show that personal services plans⁴ include an exit plan. • Exit plans show resident has applied for and is on wait/access lists for other forms of care/housing.
<p>4.2.2 Registrants must ensure that exit plans include strategies for providing increased services to minimize risk and meet the higher care needs of residents awaiting a move out of the residence.</p>	<ul style="list-style-type: none"> • Exit plans show the assessment of increased risk and service response for those awaiting exit from the residence. Examples: <ul style="list-style-type: none"> – if required, resident and/or family has arranged for registrant to provide increased service; – if required, health authority is providing added community health supports or home support services to residents awaiting placement in a licensed community care facility.

¹⁹ See Policy Tab 6.

Registrant Handbook

POLICY 4
Health and Safety Standards

Proposed Standard #5: Registrants must develop and maintain personal services plans that reflect each resident's needs, risks, service requests and service plan.

Outcome	Examples of compliance ²
<p>5.1 Personal services plans</p>	
<p>5.1.1 Upon a resident's entry to the residence, registrants must develop a personal services plan⁴ in conjunction with the resident. The plan must be reviewed on a regular basis and updated as the resident's needs change.</p>	<ul style="list-style-type: none"> • A qualified person²⁰ develops the personal services plans. • Documentation shows there is a process to develop and maintain personal services plans. Examples: <ul style="list-style-type: none"> – establishing an initial plan at the point of entry; – monitoring the resident's condition and the ongoing appropriateness of the personal services plan; – updating the plan based on changes to the resident's condition; – residents participate in personal service planning. Examples: <ol style="list-style-type: none"> 1. the resident, family and their support network are involved in the process of developing, reviewing and updating personal services plans; 2. agreement with the plan is obtained from the resident. • Documentation shows that staff is oriented and trained in the use of personal services plans. Examples: <ul style="list-style-type: none"> – orientation materials; – staff training modules; – records of staff participation in orientation and training. • Documentation shows that education is provided for residents, family and friends aimed at supporting residents to maintain their independence to the degree possible. • Spot checks show that: (a) all personal assistance services or unique hospitality services being provided are addressed in the personal services plan, (b) personal services plans have been approved by the resident, and (c) personal services plans are reviewed at regular intervals.
<p>5.1.2 Registrants must respect the personal decisions of residents and accommodate a resident's right to take risks, as long as the risks do not place other residents or staff in jeopardy.</p>	<ul style="list-style-type: none"> • Written policies are in place that balance resident choice with risks to self and others. • Written policies show ways to mitigate risks. Examples: <ul style="list-style-type: none"> – disable appliances; – negotiate appropriate locations for residents to smoke; – negotiate restrictions related to drinking where associated safety issues have been identified for the resident or others.

²⁰ Qualified person refers to an individual who, in the opinion of the registrant, has the necessary experience, training and skills to perform this activity.

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POLICY 4 Health and Safety Standards

Standard #6: Registrants must ensure personal assistance services are provided in a manner that does not place the health or safety of residents at risk.

Outcome	Examples of compliance ²
6.1 Regular assistance with activities of daily living, including eating, mobility, dressing, grooming, bathing or personal hygiene	
<p>6.1.1 Registrants must deliver activities of daily living in accordance with the <i>Personal Assistance Guidelines</i>¹⁶ and in such a way as to promote the safety and independence of residents.</p>	<ul style="list-style-type: none"> • Policies and procedures are consistent with the <i>Personal Assistance Guidelines</i>.¹⁶ • Spot checks show appropriate provision of activities of daily living services in accordance with residence policy and the <i>Personal Assistance Guidelines</i>.¹⁶ • Resident and staff surveys indicate satisfaction with the delivery of activities of daily living services.
6.2 Central storage of medication, distribution of medication, administering medication or monitoring the taking of medication	
<p>6.2.1 Registrants must deliver medication services in accordance with <i>Medication Services</i>²¹ and in such a way as to promote the safety and independence of residents.</p>	<ul style="list-style-type: none"> • Documentation and observation show compliance with the standards of practice contained in the <i>Medication Services</i>.¹⁹ • Resident and staff surveys indicate satisfaction with the delivery of medication services.
6.3 Maintenance or management of the cash resources or other property of a resident	
<p>6.3.1 Where financial services are provided at the support level, registrants must develop and maintain a system of accounting.</p>	<ul style="list-style-type: none"> • Documentation shows that a system is in place to record transactions. Examples: <ul style="list-style-type: none"> – a record of residents requesting service; – a record of transactions/payments; – regular resident statements; – resident authorization for each transaction; – spot checks show appropriate recording of services and transactions. • Surveys indicate resident satisfaction with the financial services.

²¹ See Policy Tab 7.

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POLICY 4 Health and Safety Standards

Standard #6: Registrants must ensure personal assistance services are provided in a manner that does not place the health or safety of residents at risk.

Outcome	Examples of compliance ²
<p>6.3.2 Where financial services are provided at the prescribed services level, registrants must develop and maintain a system of accounting under the supervision of a professional accountant.</p>	<ul style="list-style-type: none"> • Documentation shows that a system is in place to record transactions and keep funds secure and accessible to residents. Examples: <ul style="list-style-type: none"> – a record of residents receiving this service; – individual resident trust accounts and property records; – annual independent audits; – regular resident statements; – resident authorization for transactions; – property inventory list. • Spot checks show appropriate handling of resident cash and property. Examples: <ul style="list-style-type: none"> – secure storage for funds and belongings; – residents have reasonable access to financial records and their funds. • Surveys indicate resident satisfaction with the handling of their cash and property. • Documentation verifies the involvement of a professional accountant in the development, maintenance and supervision of the accounting system for residents receiving this assistance at the prescribed service level. Examples: <ul style="list-style-type: none"> – contract with accountant; – correspondence with accountant; – reports from accountant.
<p>6.4 Monitoring of food intake or of adherence to therapeutic diets</p>	
<p>6.4.1 Registrants must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, the service is provided in accordance with <i>Meal and Dietary Services</i>²² and a registered dietitian monitors the resident's health and nutritional status.</p>	<ul style="list-style-type: none"> • Policies and procedures associated with this prescribed service set out the roles of staff and the registered dietitian in: (a) assessing a resident's health/nutritional status and implementing a special or therapeutic diet, (b) monitoring food and fluid intake, (c) determining, charting and monitoring residents' weights, and (d) monitoring the appropriateness of a resident's special or therapeutic diet and modifying the diet where indicated. • Employment of or contract with registered dietitian, or verification of access to community dietitian. • Dietitian consultation reports are available on request.

²² See Policy Tab 10.

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POLICY 4 Health and Safety Standards

Standard #6: Registrants must ensure personal assistance services are provided in a manner that does not place the health or safety of residents at risk.

Outcome	Examples of compliance ²
6.5 Structured behaviour management and intervention; psychosocial rehabilitative therapy or intensive physical rehabilitative therapy	
<p>6.5.1 Registrants must ensure that qualified professionals:²³ (a) assess residents (or potential residents) and develop a written rehabilitation plan for each resident, (b) delegate tasks to nonprofessional staff, (c) train the residence's nonprofessional staff to perform delegated tasks, and (d) co-ordinate and oversee implementation of the plan and the ongoing delivery of rehabilitation or programming services.</p>	<ul style="list-style-type: none"> • Policies and procedures associated with these prescribed services set out: (a) how professional services are acquired – by employment, contractual arrangement or delivered separately through an external public or private agency, (b) the respective roles of the professional and the nonprofessional staff of the residence, and (c) restrictions to prevent nonprofessional staff from undertaking professional tasks without appropriate delegation from a professional. • The resident's personal services plan contains a rehabilitation plan that is: (a) developed by the professional, and (b) contains sufficient detail to guide nonprofessional staff. • Documentation shows that nonprofessional staff has been oriented and trained for the services they are delivering and have received external professional training and oversight on rehabilitation plans. Examples: <ul style="list-style-type: none"> – orientation materials; – staff training modules; – records of staff participation in orientation and training, including individualized training provided by the professional. • Spot checks show nonprofessional staff is performing tasks according to the rehabilitation plan.

²³ For psychosocial rehabilitation, qualified professional (case manager) includes primary care physician, psychiatrist, professional working from a mental health centre, professional in private practice, professional working from an alcohol and drug clinic and professional employed or contracted by the registrant. For intensive physical rehabilitation, qualified professional includes primary care physician, registered physical therapist or occupational therapist. For structured behavioural programs, qualified professional includes primary care physician, psychiatrist, social worker and rehabilitation professional in public or private practice.

Registrant Handbook

POLICY 5

Resident Entry and Exit

5.1 Policy statement

A registrant must ensure that the assisted living residence is operated in a manner that does not jeopardize the health or safety of its residents.¹ Registrants must fully inform prospective residents about the hospitality and personal assistance services offered in the residence.² Registrants must screen residents for suitability in relation to building design features, personal assistance services offered, and ability to make decisions on their own behalf.³

Where a resident's needs exceed the service delivery capacity of the residence or the resident becomes unable to make decisions on their own behalf, a registrant must develop an exit plan in consultation with: the resident; their physician; family and support network; and health authority case manager, if appropriate.⁴ Registrants must ensure that their exit plans include strategies for providing increased services to minimize risk and meet the higher care needs of residents awaiting a move out of the residence.

5.2 Entry and exit considerations

As a registrant, you must manage the entry to and exit by residents from your residence. The *Community Care and Assisted Living Act* places an obligation on you not to house people who are unable to make decisions on their own behalf.⁵ Please refer to section 5.3 below for further information on this fundamental prerequisite to residing in assisted living.

In terms of considering entry to your residence, you should fully inform prospective residents of:

- the requirement to be able to make decisions on their own behalf;
- the hospitality and personal assistance services you offer;
- the building's features that accommodate physical disabilities;
- the residence's emergency response system; and
- the building's evacuation plan.

In accepting a resident, you should ensure that the resident meets the following health and safety prerequisites:

- you are able to meet the prospective resident's service needs through the services you provide;
- the resident is able to express their wishes so as to be understood by personal assistance staff or by a spouse living with them who can communicate with staff on their behalf;

1 *Community Care and Assisted Living Act*, SBC 2002, c. 75, s. 26(5).

2 See Policy Tab 4, outcome 4.1.1.

3 See Policy Tab 4, outcome 4.1.2.

4 See Policy Tab 4, outcome 4.2.1.

5 SBC 2002, c. 75 s. 26(3).

Registrant Handbook

POLICY 5 Resident Entry and Exit

- the resident will not, through their behaviour, jeopardize the safety or well-being of others, and
- the resident is able to make the range of decisions that will allow them to function safely in the supportive semi-independent environment provided by an assisted living residence.

A resident is no longer suitable for your assisted living residence when the resident:

- no longer meets the above health and safety prerequisites;
- requires 24-hour supervision and continuous professional care; or
- is no longer able to make their own decisions.

Depending on their circumstances, such residents may move to extended care, a hospital or a family home.

To assist the transfer, you must develop an exit plan in conjunction with the resident and, as appropriate, their family, physician, support network and case manager. The exit plan should set out the resident's relocation plans, who is responsible for those arrangements and what additional services will be put in place to ensure the resident's health and safety while awaiting transfer to the new setting. Where the resident has been assessed eligible for placement into extended care, the local health authority must provide additional services to support the individual, just as it would if the resident were living in their own home in the community (see footnote 24).

5.3 How registrants should apply section 26(3) of the *Community Care and Assisted Living Act*

Section 26(3) of the *Community Care and Assisted Living Act* states that a registrant (an operator of a registered assisted living residence) must not house in an assisted living residence persons who are unable to make decisions on their own behalf. This policy will assist registrants⁶ in interpreting and applying this section of the Act.

What is the purpose of Section 26(3)?

Assisted living is a semi-independent form of housing. People live in their own private dwelling unit within the assisted living residence and can access the range of hospitality and personal assistance services the registrant provides.⁷ Residents contract⁸ with the assisted living registrant for their accommodation and the support services they require. In this way, assisted living promotes the privacy, independence and self-reliance of people who require help with some day-to-day tasks but who can otherwise live independently.

Section 26(3) has two purposes. First, it makes clear that, to live in the semi-independent environment of an assisted living residence, people must have the ability to make their own decisions. People who

6 When registrants provide 'publicly funded' assisted living, funding program case managers play an important role. See "What is the Role of Case Managers" at page 10 of this policy.

7 The definition of an assisted living residence in the *Community Care and Assisted Living Act* requires registrants to provide five hospitality services and one or two personal assistance services delivered at a prescribed service level.

8 Residents will often seek help from their family and/or case manager (where involved) to determine, along with the registrant, the type of accommodation and services they require.

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cannot make decisions on their own pose too great a risk to themselves, and potentially to others, and the Act does not allow registrants to house them, unless a spouse will be living with them in the residence or the person is on leave under section 37 of the *Mental Health Act*.⁹ See Appendix 1 for an explanation of these two exceptions.

Secondly, section 26(3) makes assisted living registrants responsible for ensuring that residents are able to make decisions on their own behalf. As a result, registrants must:

- Assure themselves, at the point of entry, that *prospective residents* are able to: 1) make an informed voluntary decision to enter the assisted living residence *and* 2) make the range of decisions necessary to function safely in the residence;
- Assure themselves, on an ongoing basis, that *residents* continue to be able to make the range of decisions necessary to function safely in the residence; and
- Initiate the exit process when residents are no longer able to make the range of decisions necessary to function safely in the residence.

By taking these measures, registrants will comply with section 26(3).

What decisions do assisted living residents need to be able to make?

The ability to make decisions on one's own behalf can span a broad range of competencies. Because the *Community Care and Assisted Living Act* addresses resident health and safety, not tenancy matters,¹⁰ the key competencies addressed by section 26(3) are the range of decisions that allow people to function safely in the supportive semi-independent environment provided by an assisted living residence.

Key areas of function include the ability to:

- initiate activities to the extent necessary to function safely for the periods they are alone in their unit;¹¹
- find their way within the assisted living residence given available cueing;
- recognize the consequences of decisions or actions and that some actions may result in injury or harm to themselves or others;
- recognize an emergency and summon help or follow directions;
- find their way back to the residence independently;¹²

9 RSBC 1996, c. 288.

10 The *Tenancy Statutes Amendments Act*, SBC 2006, c. 35 (Bill 27) was passed on May 18, 2006. This Act creates a framework in the *Residential Tenancy Act* that establishes the rights and responsibilities of landlords and tenants in assisted living and supportive housing. These amendments were not in force when this policy was issued. Please refer to <http://www.rto.gov.bc.ca/> for information on the status of the legislation. Until the amendments are brought into force, the Office of the Assisted Living Registrar will refer any complaints it receives about consumer protection to the appropriate contact at the Residential Tenancy Office.

11 Staff may assist residents with morning and evening routines but residents must be able to function safely when they are alone in the privacy of their room or suite.

12 While a resident may be experiencing a memory deficit, if they have an effective strategy to compensate for it, they may retain the ability to return safely to the residence. For example, a person may carry a card with the residence address that can be given to a taxi driver. Others may simply choose not to go out alone.

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- participate in regular reviews of their service needs, that is, respond to questions about needs and services offered; and
- seek assistance when they have a complaint about something happening at the residence, although family or friends may actually convey the matter to the Assisted Living Registrar.

The person must be able to perform all of these functions at the assisted living residence by himself or herself¹³ unless a spouse, who is willing and able to make decisions, is there to provide daily support on the person's behalf.

Where a court determines that a person is no longer able to make personal decisions related to their health care and daily living activities and has appointed a family member, friend, or the Public Guardian and Trustee to act as their committee of person then the person *is not appropriate* for assisted living unless their spouse is living with them in the residence. If a section 9 health care representation agreement has been fully enacted, meaning the person is now incapable, the person *is not appropriate* for assisted living.

In the following situations, a person would not necessarily be ineligible for assisted living. Further inquiry is needed to determine whether the person is still able to make the day-to-day decisions that would allow them to live safely in assisted living; that is, whether the person is able to perform the key functions listed above:

- the person has given a section 7 health care representation agreement;
- a temporary substitute decision maker is regularly making health care decisions for them; and/or
- the person has granted a power of attorney or a representation agreement, or the court has appointed a committee of estate, solely for the purpose of managing the person's financial and legal affairs.

See Appendix 2 for further information on the role and authority of formal substitute decision makers.

How do registrants decide if a person is unable to make decisions?

Since assisted living promotes residents' privacy, independence and self-reliance, registrants must be careful not to interfere unnecessarily in the private lives and personal decision making of residents. Instead, the Assisted Living Registrar expects registrants to keep a 'watchful eye'¹⁴ over residents.

The standard of care of 'keeping a watchful eye' means that registrants should not intrude by conducting tests of residents' decision-making ability. Instead, **the registrant's role is to watch for**

13 A person's ability to function may depend somewhat on the features of the specific assisted living unit or residence, for example, (1) a person may 'initiate' going to the bathroom appropriately when the bathroom is in plain view, whereas they may not remember to do so if the bathroom is out of sight at the end of a corridor; (2) a person may be able to find their way around a small residence, where distances are short and navigation within the building is simple. In a large residence, where distances are greater and involve a number of common areas, long corridors, elevators and multiple floors, it may be more complex for the resident to find their way.

14 As a standard of care, 'keeping a watchful eye' is higher than the responsibility expected of independent housing (where the person receives only housing from the operator) or supportive housing (where the resident receives housing and one or more hospitality services, for example, meals or laundry, but no personal care, *from the operator*) operators but not as high as that expected of operators of licensed residential care facilities. In other words, if a registrant notices a problem in relation to a resident's health or safety, they have a responsibility to follow up on the issue.

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behaviors or signs that suggest a person is not able to make decisions and, if such behaviors or signs are noted, make further inquiries of the person, and/or report the matter to the person's designated contact. In making such a report, the expectation is that the resident or their designated contact will engage a health professional, such as the family physician and/or case manager, to investigate the person's health status.

If the resident or their designated contact refuses to provide information or address the matter in a timely manner, and the registrant does not believe the resident is appropriate to enter or remain safely in the residence, the registrant should request that the person seek alternate accommodation.

Appendix 3 provides a flowchart of the steps a registrant will take to comply with section 26(3). The following sections describe the registrant's obligations at each step in the process.

What do registrants need to do at the point of entry?

This section outlines how registrants should screen prospective residents in terms of their ability to make the range of decisions that will allow them to function in the assisted living residence.

Presume ability to make decisions

Registrants should presume that prospective residents are able to make decisions *unless there are signs to the contrary*.¹⁵

Decide whether the person is making an informed decision to enter

Registrants must assure themselves that there are no signs that the prospective resident is unable to *make an informed voluntary decision* to enter the assisted living residence. Individuals on leave under section 37 of the *Mental Health Act*, or who will be living with a spouse in the residence, are exempted from the requirement to be able to make an informed decision to enter the assisted living residence.

During the pre-entry interview, registrants must give prospective residents information about the residence and its services, policies, and house rules. After providing the information, registrants should ask questions and look for signs that the person may not understand the information or may not be making a voluntary choice to enter the residence. If there are such signs, the registrant should make further inquiries to satisfy themselves that the person understands the information and is making an informed voluntary decision to enter the residence. Appendix 4 gives more information about this process.

Decide whether the person will be able to function safely

Registrants also must assure themselves that there are no signs that the prospective resident *will be unable to make the range of decisions necessary to function safely* in the residence. This requirement applies to seniors as well as to people with mental disorders and/or substance use disorders, including

¹⁵ This parallels section 3(1) of the *Adult Guardianship Act*, SBC 1996, c. 6, which states, "Until the contrary is demonstrated, every adult is presumed to be capable of making decisions about personal care..." Adopting this presumption does not absolve registrants from their obligations under section 26(3) of the *Community Care and Assisted Living Act*, SBC 2002, c. 75.

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those on leave under section 37 of the *Mental Health Act* (see Appendix 1). The key areas of function are described above in 'What decisions do assisted living residents need to be able to make?'

During the pre-entry interview, registrants should ask prospective residents questions about their general health, typical day and ability to function independently. In the discussion, the registrant should look for signs that the person *may not* be able to perform one or more of the key functions. If they see such signs, they should advise the person, their family and their case manager, where involved, that they require further information in order to gauge the person's ability to function safely in the residence. If the additional information is not forthcoming, the registrant must decline to accept the person.

Advise of their legal obligations as registrants

Registrants must explain that they have a legal obligation not to house people who are unable to make decisions on their own behalf and that this is interpreted to mean that residents must be on entry and remain able to perform the key areas of function described above in 'What decisions do assisted living residents need to be able to make?'

Registrants should also explain that if they see signs that a resident may not be able to perform one or more of the key functions, they will bring the matter to the resident's and their designated contact's attention, and the onus will be on the resident or their designated contact to have the matter reviewed by the health professionals, for example, the family physician and/or case manager, involved in the resident's care. When registrants provide assisted living to publicly subsidized assisted living residents, the registrant will also have an obligation to notify¹⁶ the case manager representing the funding program of any significant changes in the resident's ability to perform the key functions.

Before entry, registrants should provide prospective residents with written information about the section 26(3) requirements and ask them to acknowledge that:

- They or their designated contact¹⁷ may be asked by the registrant to review section 26(3) matters; and
- They will need to seek alternate accommodation if, based on observations or information from health professionals, the registrant concludes that the resident is unable to make the decisions that will allow them to live safely in that residence (such as, not be able to perform one or more of the key areas of function).

If the prospective resident is not able to perform one or more of the key areas of function but will be living with a spouse who is *willing and able* to make the decisions that will allow the resident to live safely, the registrant, and/or case manager if involved, must establish with the spouse a plan to support the resident when the spouse is absent for 1) an extended period of time, for example, due to a hospitalization, and 2) short periods of time, for example, an afternoon of shopping.

Appendix 5 provides a sample information sheet about these section 26(3) requirements. Registrants can use this sheet or develop their own written information for residents and their designated contacts.

¹⁶ Home and Community Care clients sign a consent that enables this exchange of information.

¹⁷ If a resident has no family member or friend who is willing and able to assist and the resident has given consent for the registrant to communicate directly with their physician or case manager, the registrant may contact the physician or case manager to inform them of the observations and concerns, and to request the physician or case manager to investigate the matter.

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What do registrants need to do on an ongoing basis?

Presume ability to make decisions

Registrants should presume that residents are able to make decisions *unless there are signs to the contrary*.

Observe the behavior of residents and identify concerns

Registrants must take reasonable steps to assure themselves that residents remain able to make the range of decisions necessary to function safely in the assisted living residence, or that their spouses remain willing and able to act on their behalf.

Assisted living is a supportive environment where staff have many points of contact with residents, which means that they have many opportunities to observe changes in their behavior or level of functioning. When staff note changes, they should monitor the situation and watch for signs of a possible decline in decision making ability. Signs include:

- A decline in functional ability, that is, where a resident's ability to perform tasks has declined; and
- Changes in behavior, habits, general appearance, social patterns, living conditions and overall health status.

See Appendix 6 for a listing of functional and behavioral signs that may indicate a decline in decision-making.

Registrants must have policies and procedures in place to guide staff in observing, documenting and reporting changes in resident functioning and behavior. If staff notice a sudden significant change in behavior or function, they should immediately report it to the registrant (or person in charge), who will then inform the designated contact and case manager, where involved.

In some cases, a resident's ability to function may be improved by a move to different unit in the residence, for example, closer to the dining area, or by modifications to the environment of their existing unit.

Report concerns to the resident and/or their designated contact

If staff observe a pattern of behaviors or functional decline that suggests that a resident has a problem with decision making, the registrant should bring the matter to the attention of the resident, and their designated contact, so that the person's health status can be reviewed by health professionals, that is the family physician and/or case manager involved in the resident's care. The review may include a consultation with a medical specialist, such as a geriatrician. See Appendix 7 for information on how health professionals assess a person's ability to make decisions.

The registrant is guided by the opinion of the health professionals involved in the resident's care. Where it appears that the underlying condition is manageable and the pace of decline in decision making ability/function is slow, or the condition is treatable and the decline in function is likely to be temporary and of short duration such that it will not have a significant impact on the resident's ability to

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live safely in the assisted living residence, the registrant is not required to initiate the exit process. In the latter case, adequate services should be put in place to maintain the resident's health and safety until their level of decision making ability/functioning is restored.

If it appears that the resident's condition is not temporary or remediable and the person is no longer able to make the range of decisions that will allow them to live safely in the assisted living residence, the registrant must initiate the exit process.

Resolve disagreements

If there is disagreement among any of the resident, family, registrant, or case manager about whether a resident is able to make the decisions necessary to function safely in the residence, various options for resolving the situation should be explored. For example, further information can be requested from health professionals, including the family physician. A geriatric or psychiatric consultation, or an assessment by the local mental health outreach team, could be sought. However, the role of health professionals is to provide a clinical opinion about the person's level of functioning in the area in question, not to determine if the resident should continue to live in the residence. The registrant or case manager, where involved, may set up a case conference with all parties to discuss the clinical findings, risks and available options, and determine a course of action.

Where consensus can not be reached among the resident, family, registrant, and case manager about whether a resident is able to make the decisions necessary to function safely in the residence, but the registrant does not believe the resident is appropriate to remain in the residence, the registrant should trigger the exit process by giving notice to the resident to end the tenancy.

What do registrants need to do at exit?

Where the registrant, in consultation with the resident, their designated contact and case manager, where involved, concludes that a resident is no longer able to make the range of decisions necessary to function safely in the residence, the registrant must initiate the exit process by requesting that the party acting on the resident's behalf, with the assistance of the case manager, where involved, seek alternate accommodation for the resident. In publicly funded assisted living, a case manager may initiate the move based on their assessment of a resident's level of functioning.

In either case, the registrant must develop an exit plan that sets out the resident's relocation plans, who is responsible for those arrangements and what additional services will be put in place in the intervening period to ensure the resident's health and safety is not in jeopardy while awaiting transfer. Registrants are expected to assist residents to relocate as quickly as possible, given alternate resources in the community. In this way, the registrant is complying with section 26(3).

What happens if the Registrar receives a complaint?

If the Registrar receives a complaint that a registrant is housing people who are unable to make decisions on their own behalf, the Registrar will investigate by requesting information from the registrant about:

- the manner in which the registrant disclosed their legal obligation not to house people who are unable to make decisions on their own behalf;

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- policies and procedures in place that guide registrant staff in watching for signs that residents are not able to make decisions/function safely in the residence and to bring those observations to the attention of the site manager or other person responsible.

Where the complaint involves a specific resident, the Registrar may request any documented observations or other information relevant to whether or not the resident is able to make the decisions necessary to function safely in the residence. The Registrar may request copies of the records¹⁸ cited by the registrant, such as a physician's opinion or a case manager's assessment. Where the information provided is considered insufficient or inconclusive, the Registrar will seek further information by asking the registrant to investigate the matter more fully with the resident and/or their designated contact. The resident or their designated contact would engage the resident's family physician or case manager in a further review of the resident's health status, which may trigger a geriatric or psychiatric consultation, or an assessment by the local mental health outreach team.

In some cases, the Registrar may visit the residence or delegate inspection powers to the Clinical Advisor or other inspector to review records or observe operating practices. The Registrar also may, under the *Freedom of Information and Protection of Privacy Act*,¹⁹ ask health authorities to disclose pertinent information and health authorities will respond according to their privacy policies. Based on the range of collateral information collected,²⁰ the Registrar may ask the Clinical Advisor to provide an opinion on whether a particular resident(s) is unable to make the range of decisions necessary to function safely in the residence.

If the Registrar's investigation leads to the conclusion that one or more people in the residence are unable to make the range of decisions that will allow them to live there safely, the Registrar may take action against the registrant's registration. The Registrar will develop policy to assist in the exercise of the Registrar's discretion about whether to apply or vary conditions to, or suspend or cancel a registration.²¹ For example, the Registrar would generally not take action against a registrant provided the registrant has responded in a timely way to develop an exit plan, has made every effort to ensure the resident's health and safety is not in jeopardy while awaiting transfer to alternate accommodation and has made every effort to expedite the relocation plan, recognizing that eviction is not usually a viable option.

18 Section 25(2)(b) of the *Community Care and Assisted Living Act* authorizes the Registrar to inspect and copy any records on the premises of a residence that is being inspected because the Registrar has reason to believe that a resident's health or safety is at risk.

19 *Freedom of Information and Protection of Privacy Act*, SBC 1996, c. 165.

S. 33.2: **Disclosure inside Canada only** – A public body may disclose personal information referred to in section 33 inside Canada as follows: (a) for the purpose for which it was obtained or compiled or for a use consistent with that purpose (see section 34); (c) to an officer or employee of the public body or to a minister, if the information is necessary for the performance of the duties of the officer, employee or minister; (d) to an officer or employee of a public body or to a minister, if the information is necessary for the delivery of a common or integrated program or activity and for the performance of the duties of the officer, employee or minister to whom the information is disclosed;

S. 34 (1): **Definition of consistent purposes** – A use of personal information is consistent under section 32 or 33.2 with the purposes for which the information was obtained or compiled if the use (a) has a reasonable and direct connection to that purpose, and (b) is necessary for performing the statutory duties of, or for operating a legally authorized program of, the public body that uses or discloses the information or causes the information to be used or disclosed.

20 Collateral information is information gathered from the registrant, family, physician or other key contacts that documents changes to the residents' behaviors, habits, general appearance and overall health status, typical social patterns and living conditions.

21 *Community Care and Assisted Living Act*, SBC 2002, s. 27 (a).

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What is the role of case managers?

When registrants provide 'publicly funded' assisted living, funding program case managers play an important role. Before referring their client to assisted living, the case manager will have screened the person in terms of their suitability for assisted living. As part of the screening process, the case manager also must form the opinion that the client has the ability to make the decisions necessary to function safely in an assisted living residence.²² While able to make decisions, some people may display behaviour that makes them unsuitable for most seniors' assisted living residences; for example, aggression or other socially unacceptable behaviour.

Where the screening process raises a concern about a client's capacity to function safely in assisted living, or a cognitive screening tool administered by the case manager or other health professional triggers the need for a more in-depth investigation of the client's cognitive capacity and decision making ability, the case manager will typically consult with the client's family physician, seek a geriatric or psychiatric consult about a particular issue or concern, and/or request that a mental health outreach team investigate the issue.

In discussing assisted living with their clients, case managers must explain to them, and any involved family members or designated contact that assisted living residents must have the ability to make the range of decisions necessary to function safely in an assisted living residence. Case managers also need to explain that a resident will have to seek alternate accommodation if the registrant, in conjunction with the case manager, determines that they are no longer able to make those decisions, such as, not be able to perform one or more of the key areas of function described above in 'What decisions do assisted living residents need to be able to make?'

If the client is not able to make the decisions necessary to function safely in an assisted living residence but will be living with a spouse who is *willing and able* to make decisions on their behalf, the case manager must establish, as part of the service plan, how to support the resident when the spouse is absent for both extended and short periods of time.

The case manager's involvement with the resident and screening does not absolve registrants from their responsibility under section 26(3). Registrants need to perform their own level of due diligence in screening prospective residents prior to entry to the residence, including reviewing functional assessment information provided by the case manager.

²² *Home and Community Care Policy Manual*, 5.E.3 Move In/Move Out Criteria Page 2 of 2 – Assessment Process – Health authorities are responsible for determining a client's eligibility for assisted living services based on a standardized assessment that includes identifying whether the person is able to make decisions on his or her behalf. Wherever possible, this assessment is to be conducted by a multidisciplinary clinical team, with involvement of the client, and where appropriate, their family.

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Case managers also play a key role in assessing their clients' ongoing functioning in the assisted living residence.²³ This role includes:

- Establishing protocols for registrants to notify them about changes in their client's level of functioning or behaviour;²⁴
- Initiating and/or attending ad hoc or regular case conferences;
- Conducting reassessments on an ongoing basis and when registrants or family note changes in a resident's level of functioning or behaviour;
- Consulting with family, physician, mental health outreach team, geriatrician, and others as necessary; and
- Where questions or concerns about decision making ability have been identified, working collaboratively with registrants to determine whether residents, or their live-in spouses, are able to make the range of decisions necessary to continue to function safely in assisted living.

When a client is no longer able to make the decisions necessary to function safely in assisted living, case managers must act to find the client alternate accommodation. This includes:

- Discussing relocation plans with the client and their family;
- Referring the person to a suitable alternate resource;
- Collaborating with the registrant as the registrant develops an exit plan, which sets out interim services the person will receive to ensure their health and safety is not jeopardized while awaiting transfer from the residence. The case manager authorizes additional services as required and allowed for under Home and Community Care Policy;²⁵ and
- Regularly reassessing how the client functions and collaborating with the registrant to review/update the interim service plan and priority for referral to another resource, until the transfer from assisted living occurs.

Some residents, who are living in an assisted living residence on a private pay basis, may choose to apply for benefits under the publicly subsidized Home and Community Care program, particularly, as their service needs increase and they require complex care. When the local Home and Community Care Program receives a referral from the assisted living resident or their family or physician, a case manager processes the referral in the same way as it would if the person were living in their own home in the community.

23 *Home and Community Care Policy Manual* 5.E.3, Move In/Move Out Criteria Page 1 of 2, Assessment Process – The clinical team is expected to re-assess the client's continued suitability for assisted living on an ongoing basis.

24 The case manager represents the program funding agency, which has a contractual relationship with the registrant. By referring a client and paying for their services, the case manager is expressing their view that the person is suitable for assisted living. If circumstances change, the case manager must be informed so that they can reevaluate their client's continued eligibility and suitability.

25 *Home and Community Care Policy Manual* 6.B.6, Page 1 of 1. Supports for Clients Awaiting Admission – Policy – Health authorities must ensure clients who are approved for admission to residential care are supported in the community with:

- an increase in the availability and flexibility of community health supports and home support services;
- a plan for crisis management; and
- preparation and counseling for admission to residential care.

Appendix 1 Exceptions to Section 26(3)

1. Living with spouse

Section 26(6) of the *Community Care and Assisted Living Act*²⁶ provides an exception to section 26(3). It states that:

- Subsection (3) does not apply to a person if the spouse of the person
- (a) will be housed in the assisted living residence with the person; and
 - (b) is able to make decisions on behalf of that person.

In other words, section 26(6) enables a person to enter or remain in an assisted living residence, even though they are no longer able to make the range of decisions that will allow them to function safely in the residence, if their spouse, who is able to make decisions, is there *and is willing* to provide daily support on their behalf.²⁷

If the prospective resident objects to entering the residence, the spouse may only make the decision on their behalf if the spouse is their formal personal representative (formal representation is granted through a Committee of Person order or a section 9 Representation Agreement; see Appendix 2 for an explanation. However, while the spouse may have legal authority to make the decision, if the person is objecting, they may not be able to enforce their decision.

2. On leave under section 37 of the *Mental Health Act*²⁸

Section 26(4) of the *Community Care and Assisted Living Act*²⁹ provides a partial exception. It states that:

- Subsection (3) does not apply to an involuntary patient on leave under section 37 of the *Mental Health Act*.

Under section 37 of the *Mental Health Act*, a person who has been involuntarily admitted to a designated mental health facility may leave the facility and live in a community specified by the Director

²⁶ SBC 2002, c.75.

²⁷ *Home and Community Care Policy Manual* 5.E.3, Move In/Move Out Criteria Page 1 of 2 – Criteria for Tenant Selection – A person can only be selected to move into an assisted living unit if the person meets all of the following criteria:

- requires both hospitality services and personal care services;
- is able to make decisions on his or her behalf that will allow the person to function safely in an assisted living residence, unless a spouse lives with the person and is willing and able to make decisions on the person's behalf;
- is at significant risk in their current living environment; and
- has been advised of the applicable client rate and permissible assisted living residence charges, and has agreed to pay all applicable costs.

²⁸ RSBC 1996, c. 288.

²⁹ SBC 2002, c. 75.

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of the facility. A form³⁰ sets out the conditions of the leave, which may include the specific location in the community and a prescribed medication regime. The person, who remains an involuntary patient, must abide by the conditions of the leave while living in the community, until discharged by the Director of the designated mental health facility.

Section 26(4) of the *Community Care and Assisted Living Act* enables people on leave under section 37 of the *Mental Health Act* to live in assisted living. The individual *is exempted from making an informed decision to enter* the assisted living residence as the Director of the mental health facility makes this decision for them.

Since this subsection does not establish, as does section 26(6), someone to live with the person and provide daily decision making support, the person *is not exempted from being able to make the range of day-to-day decisions* necessary to function safely in the assisted living residence. Prior to referring the person to assisted living, the Director should assure him/herself that the person will be able to make the range of decisions that will enable them to live safely there. In turn, the registrant should also consider this requirement at the point of entry to the residence.

³⁰ Form 20 under the Mental Health Act Regulation, BC Reg 233/99.

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Appendix 2

Legislative Approaches to Substitute Decision Making

All adults, that is, persons 19 years of age or older, are entitled to live in the manner they wish and to accept or refuse support, assistance or protection as long as they do not harm others and they are capable of making decisions about those matters.³¹ This includes accepting risks to themselves associated with the choices they are making.

However, risk to self becomes an issue if a person is no longer able to make decisions. While a fully capable person can accept any risk (regardless of whether others think it is best for them), as decision making ability declines, there is a greater onus on society to protect the individual by establishing a substitute decision maker to act on their behalf. Given some time and the necessary information and support, most adults can make their own decisions, either independently or with support from family or friends.

In BC, there are a number of laws that aim to assist adults who may not be capable of acting in their own best interests and are in need of decision making support. For example:

1. Under the *Mental Health Act*,³² when a person is seriously impaired because of a mental disorder, a physician licensed in BC can complete a **medical certificate** deeming the person no longer able to make their own admission and treatment decisions with respect to their mental disorder. The person can be admitted involuntarily to a designated mental health facility. Decision making, with respect to the person's admission, treatment and discharge, shifts to the Director of the designated mental health facility. Individuals can be admitted for up to 48 hours on the basis of one physician's certificate and up to 30 days when a second physician completes a certificate. The period of admission can be extended when a physician completes a renewal certificate.
2. Under the *Health Care (Consent) and Care Facility (Admission) Act*³³ health care providers³⁴ must seek **consent** from an adult before providing health care unless the adult is unable to give consent. The Act describes how health care practitioners decide whether an adult is incapable of giving consent. If the person is incapable of making the decision, someone else must make the decision on their behalf. The Act sets out a ranked list of substitute decision makers including: a Committee of Person, a representative or a temporary substitute decision maker, who is the nearest relative entitled to make the decision, or the Public Guardian and Trustee. The **temporary substitute decision maker** is limited to only making the health care decision at issue and for a limited period of time.

31 *Adult Guardianship Act*, SBC 1996, c. 6, s. 2(a), Guiding Principles.

32 RSBC 1996, c. 288.

33 RSBC 1996, c. 181.

34 For example: physicians, dentists, nurses, physiotherapists, psychologists, occupational therapists, optometrists, chiropractors and others.

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3. Under the *Patients Property Act*,³⁵ the Supreme Court can deem an adult incapable of managing their person or their affairs or both, and issue an order that appoints the applicant as their **committee**. In issuing the order, the Court hears evidence submitted by the applicant, including clinical evidence/opinions provided by two medical practitioners. If the medical evidence leads the Court to decide that the person is unable to manage their legal and financial affairs, the Court can appoint a **committee of estate**,³⁶ who has legal authority to make subsequent legal and financial decisions on the person's behalf. If the evidence leads the Court to decide that the person is unable to manage their personal affairs, that is, their health care and daily living decisions, the Court can appoint a **committee of person**,³⁷ who has legal authority to make subsequent personal decisions on the person's behalf. Committee orders remain in effect until the Court rescinds them because the adult is deemed to be capable.

In addition, the Director of a designated mental health facility can issue a 'certificate of incapability' under the *Patients Property Act*³⁸ that states an adult is incapable of managing their financial affairs and automatically appoints the Public Guardian and Trustee as their Committee of Estate. In practice, the Director decides to issue the certificate based on clinical evidence provided by a multidisciplinary incapability assessment. Based on subsequent clinical evidence, the Director may issue a 'certificate of capability'.

4. Under the *Representation Agreement Act*,³⁹ an adult may, when capable of doing so, plan for their future by making a **representation agreement**⁴⁰ authorizing a representative to make personal or financial decisions on their behalf if they are unable to make their own decisions. Section 9 of the Act sets out the range of personal decisions that a representative can be authorized to make. Section 7 sets out the financial and health care decisions a representative can make. The representation agreement comes into effect when a stipulated 'triggering condition' occurs.

35 RSBC 1996, c. 349.

36 *Patients Property Act*, RSBC 1996, c. 349, s. 15(1)(b)(1) Private Committee Handbook, p.1.

<http://www.trustee.bc.ca/pdfs/STA/PCS%20Handbook%20July%202004.pdf>

"As Committee of the Estate, you manage all the person's financial, business and legal affairs. This may include no more than apartment furnishings, and a pension, or it may be very large and complex." (p.1)

37 *Patients Property Act*, RSBC 1996, c. 349, s. 15(1)(b)(2). Private Committee Handbook, pp. 30–32.

<http://www.trustee.bc.ca/pdfs/STA/PCS%20Handbook%20July%202004.pdf>

"The role of a Committee of Person involves making decisions regarding an adult's personal care, where they are to reside, health care decisions, and who has access to visit with the adult." (p. 30)

38 RSBC 1996, c. 349.

39 RSBC 1996, c. 405.

40 *Representation Agreement Act*, RSBC, c. 405, s. 9(1) Other Provisions.

http://www.qp.gov.bc.ca/statreg/stat/R/96405_01.htm

In a representation agreement, an adult may also authorize his or her representative to do any or all of the following: (a) physically restrain, move or manage the adult, or have the adult physically restrained, moved or managed, when necessary and despite the objections of the adult; (b) give consent, in the circumstances specified in the agreement, to specified kinds of health care, even though the adult is refusing to give consent at the time the health care is provided; (c) refuse consent to specified kinds of health care, including life-supporting care or treatment; (d) give consent to specified kinds of health care, including one or more of the kinds of health care prescribed under section 34 (2) (f) of the *Health Care (Consent) and Care Facility (Admission) Act*; (e) accept a facility care proposal under the *Health Care (Consent) and Care Facility (Admission) Act* for the adult's admission to any kind of care facility; (f) make arrangements for the temporary care, education and financial support of (i) the adult's minor children, and (ii) any other persons who are cared for or supported by the adult; (g) do, on the adult's behalf, any thing that can be done by an attorney acting under a power of attorney and that is not mentioned in paragraphs (a) to (f) or in section 7 (1).

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Resident Entry and Exit

5. Under the *Power of Attorney Act*,⁴¹ an adult may appoint another adult to act as their attorney, under a **power of attorney**, for a defined period of time, with authority to conduct specific financial or legal transactions on their behalf. If the power of attorney includes an 'enduring' clause, the attorney's authority will continue indefinitely if the person becomes unable to make their own decisions. The 'enduring' clause is triggered by medical evidence that the person is no longer able to make decisions. It is important to note that a power of attorney cannot make personal or health care decisions on behalf of the adult.
6. Under the federal Income Security Program, a **pension trusteeship** can be established. A family member or friend applies to be a person's trustee by completing a standard form, which one physician signs declaring that the person is incapable. The trustee can manage only monies paid through OAS/GIS/ CPP, not any other income or assets.

Being found incapable of making decisions affects a fundamental right of adults. As a result, all of the legislative approaches described above include a level of procedural safeguard, including limiting the duration and scope of substitute decision making.

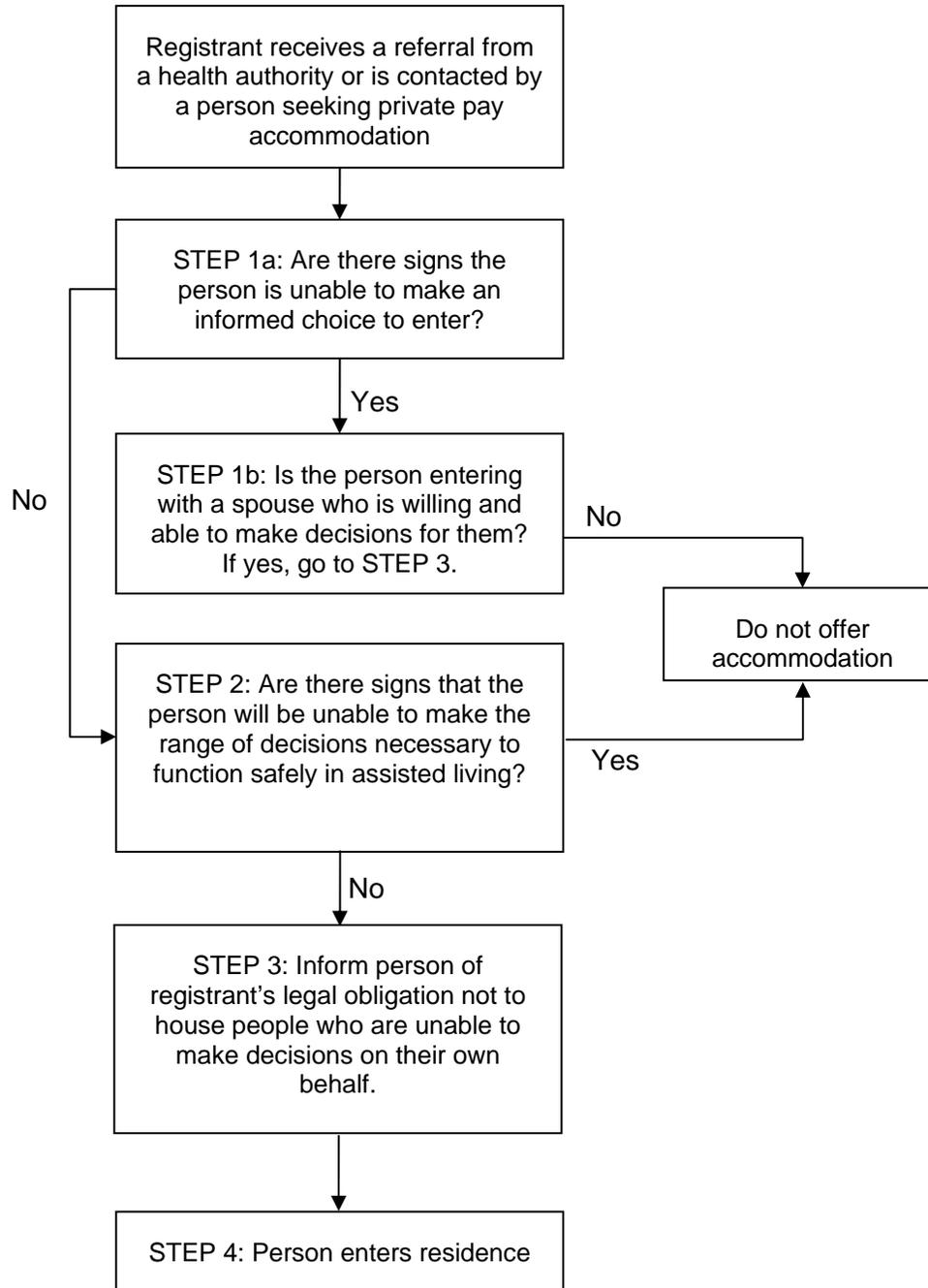
⁴¹ RSBC 1996, c. 370.

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Appendix 3 Steps to Complying with Section 26(3)

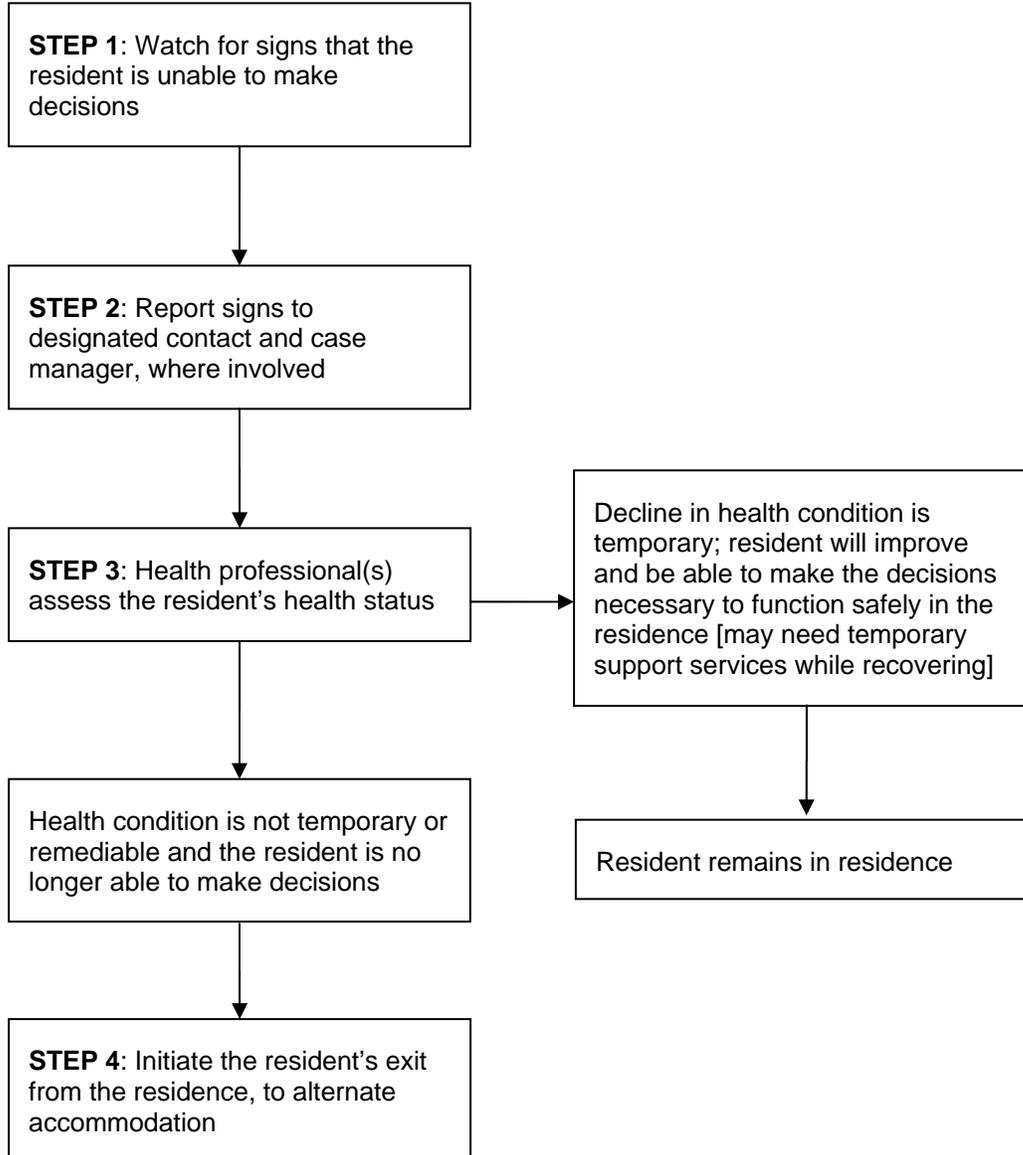
At Entry



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Ongoing



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Appendix 4 Making an Informed Decision

In discussions with a prospective resident, the registrant or their designate must:

- Communicate in a manner appropriate to the adult's skills and abilities; and
- Provide the level of information that a reasonable person would need in order to make decisions.

Typically, a family member or friend will accompany the person to help them understand the information presented, as well as help the person communicate their wishes and decisions.

Is the prospective resident making an informed decision to enter the assisted living residence?

This means that the prospective resident demonstrates an understanding of the information they have been given and, without coercion, indicates a *choice* to enter the residence. Individuals on leave under section 37 of the *Mental Health Act* would be *exempted from making an informed decision to enter* the assisted living residence as the Director of the mental health facility in which the individual has been residing makes this decision for them. Please see Appendix 1 for a discussion of what it means to be on leave under section 37 of the *Mental Health Act*.

The registrant gauges the person's understanding of the information that has been given by asking questions that will require the person to describe, in their own words, key information about the environment, the services provided and what is expected of residents.

The registrant *can assume* the person is making an informed voluntary decision *unless*, from the person's responses, the registrant concludes there are signs to the contrary. *Signs to the contrary* include where the person:

- Does not respond or provides inappropriate or unrelated responses to questions;
- Does not appear to understand what services are and are not offered;
- Does not appear to understand the consequences of not accepting the services available in assisted living;
- Does not appear to understand their own limitations and the associated risks of residing in the assisted living residence; or
- Is reluctant to sign a tenancy agreement.

Appendix 5

Information for Residents About Making Decisions in Assisted Living

Assisted living provides housing, hospitality services and personal care for people who can live independently, but need regular help with day-to-day activities (such as dressing, grooming, bathing or taking medications).

Under British Columbia's *Community Care and Assisted Living Act*, you must be able to make the decisions that allow you to function safely in assisted living.⁴²

What Making Decisions that allow you to Function Safely Means

When you apply for assisted living, the operator will discuss with you whether you are able to manage on your own in the supportive environment of assisted living. Besides being able to make decisions about the services you will receive, you must be able to function safely for the periods you are alone in your assisted living unit, including recognizing an emergency and calling for help or following directions.

When Assisted Living is No Longer Appropriate

A time may come when you are no longer able to make the decisions necessary to function safely in assisted living. At that time, you will need to move from assisted living to other housing and/or care services that are more appropriate for your needs. This fact sheet will help you, your family and the operator of your assisted living residence to plan for that time.

Your Responsibilities

Before you enter assisted living, the operator will ask you to:

- Name a contact person who can assist you – usually a family member or friend; and
- Agree that you will seek other accommodation if, based on observations or information from health professionals, the operator and case manager (where involved) conclude you are no longer able to make the decisions that allow you to live safely in the residence.

The Operator's Responsibilities

Under the *Community Care and Assisted Living Act*, residence operators must take reasonable steps to assure themselves that you are able to make the decisions that enable you to safely live in their residence. If a spouse is assisting you, the operator needs to ensure your spouse is willing and able to continue acting on your behalf.

⁴² In some cases, a person may not be able to make all the decisions necessary to live in assisted living. That person may have a spouse who will live with them in the residence and is willing and able to assist them with making decisions. If so, the operator will need to establish a plan to support the person when the spouse is absent for extended periods, such as while in hospital, and short periods, such as an afternoon of shopping.

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If an assisted living operator sees signs that you are no longer able to function safely on your own, they will talk to you and your contact person. You and/or your contact are responsible for involving health professionals, such as your case manager or family physician, in exploring whether you can still manage in assisted living. If a health professional decides that the decline in your health functioning is temporary or you are still able to make the decisions that allow you to function safely, you will likely be able to remain in assisted living. Services may need to be put in place to maintain your health and safety if you are experiencing a temporary decline in functioning.

When the decline in your health functioning is permanent or you become unable to make the decisions that allow you to function safely in assisted living, the operator must, by law, ask you to find another place to live.

If a Move is Necessary

When it is decided that a move is necessary, the operator will talk with you, your contact person and your case manager (where involved) about your plans for seeking other accommodation. You will be expected to move as quickly as possible, as soon as other alternatives are available.

The operator will work with you and your contact person to develop an exit plan that sets out:

- Your relocation plans;
- Who is responsible for making these arrangements; and
- What, if any, additional services will be put in place to protect for your health and safety while you are awaiting your move.

For More Information

For more information about moving out of assisted living, please contact your residence operator at:

Appendix 6

Signs of Declining Decision Making Ability

1. Signs of a decline in functional ability, that is, where the resident's ability to perform tasks has declined, may include:

- Overall – needing an increasing level of cuing or assistance to do things the person was able to do in the past, or where cuing becomes ineffective;
- Dressing – unable to make a suitable selection of clothing, or unable to determine the sequence or orientation of clothing; for example, pants or shirt on backwards; underwear on top of outer clothing;
- Eating – regularly missing meals (and not eating), even with reminders (unable to ensure adequate nutrition to maintain health);
- Medications – refusing essential medications without rational explanation;
- Decline in personal hygiene;
- Toileting – inappropriate handling of incontinence (for example, placing soiled incontinent products in dresser drawer);
- Changes in sleep patterns;
- Way finding – frequently unable to locate own suite (or enters wrong suites). If problem occurs immediately after entry to assisted living, the matter may resolve once the resident has settled in;
- Wandering – wandering outside building and being unable to find way back (unable to problem solve and use alternative strategies to get back to the residence – for example, carry address and use taxi for return). If the problem occurs immediately following entry, the matter may resolve once the resident has settled in;
- Health and safety – declining ability to:
 - Use emergency call system (for example, internal call system or Lifeline), or alternatively, to call for help when problems arise;
 - Recognize the consequences of decisions or actions and that some actions may result in injury or harm to themselves or others;
 - Remember information crucial to their health and safety;
 - Comply with areas of the service plan that are critical to the person's health and safety; or
 - Participate in updates to the service plan (for example, does not express a choice in response to options; demonstrates that does not understand services, options and implications of decisions).

2. Changes in behaviour, such as new or increasing levels of behavior associated with:

- Hoarding, barricading in room, disheveled appearance;
- Becoming verbally aggressive/confrontational with other residents and staff;
- Repetitive behaviour (for example, repeatedly going to dining room or front desk asking if it is time for lunch; doing same after having eaten);

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- Increased activity at the end of the day, referred to as 'sun downing';
- High anxiety (for example, increased frequency of requests for reassurance);
- Self-neglect or engaging in unsafe activities;
- Frequent heavy consumption of alcohol or use of drugs;
- Allowing people into the residence who may place others at risk, for example, drug dealers; or
- Diminished communication, for example, responding inappropriately to questions/conversation.

Appendix 7

Assessing a Person's Ability to Make Decisions

Many individuals choosing to live in assisted living will have some impairment of their cognitive abilities, such as a mild dementia. To be appropriate for assisted living, the level of cognitive impairment must not interfere with the person's ability to make the range of decisions that will allow them to perform in the key functions described in 'What decisions do assisted living residents need to be able to make?'

Cognitive ability refers to the higher-level functions of the brain, including memory, comprehension, attention, initiation, calculation ability, use of speech, and executive functions such as planning, problem-solving and self-monitoring. Cognitive capacity refers to the *degree to which* someone possesses this broad range of abilities.

While cognitive capacity affects a person's ability to make decisions, tests of cognitive capacity⁴³ cannot fully predict whether a person is capable of making a decision and carrying out that decision, as evidenced by their ability to perform a particular function. Some individuals are able to compensate for their cognitive impairment and continue to function adequately.⁴⁴

Changes in behavior may also indicate a decline in cognitive capacity.⁴⁵ For example, a person displaying:

- New, or increasing, socially inappropriate behaviors;
- Self-neglect or unsafe activities;
- Increasing difficulty in initiating activities; and/or
- Increasing anxiety, repetitive behaviour or requests for reassurance.

If it is concluded that the person's cognitive capacity is declining, their ability to make decisions *may* be compromised.

When health professionals receive reports from assisted living registrants of changes in behavior or changes in a resident's level of functioning, they conduct a more in-depth assessment of the person's health status including an investigation into the underlying causes for any change in the person's ability to function/make decisions. This will most often include an investigation into the person's medical condition⁴⁶ and an assessment of the resident's ability to function in the assisted living environment.⁴⁷

43 Common assessments of cognitive capacity include the Mini Mental Status Examination (MMSE), the Modified Mini-Mental State (3MS) examination, and the Cognitive Performance Scale (CPS) derived from the MDS Assessment (used by Home and Community Care).

44 In December 1999, the Supreme Court of Canada's **Grismer** decision raised issues about the methods that driver licensing authorities use to assess driver fitness. The Court said that it was not enough to have a blanket rule that persons with a certain medical condition, or cognitive test score, cannot drive. Instead, drivers licensing authorities need to provide an individualized functional assessment to determine whether the person is able to compensate for their disability and still perform the function, that is, drive.

45 University of California, San Francisco – Memory and Aging Center: Alzheimer's Disease Research Center – <http://memory.ucsf.edu/Education/Topics/execfunction.html>.

46 Conducted by their family physician, with referrals to medical specialists as required.

47 Carried out most often by occupational therapists employed by the health authorities.

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Under section 26(3), health professionals cannot compel a resident to undergo an assessment of their decision making/functional abilities. The person will need to comply with the request voluntarily.

If the person does not comply with the request, the health professional, or team, may form an opinion based on collateral information. For example, collateral information can be gathered from the registrant, family, or other key contacts – documenting any changes to behaviors, habits, general appearance and overall health status, typical social patterns and living conditions.

A person should not be considered to be ‘unable to make decisions’ if their decline in function is likely to be temporary and of short duration such that it will not have a significant impact on their ability to live safely in the assisted living residence. For example, in residences housing people with mental health or addiction issues, there will be residents whose illnesses involve cycles, relapses and remissions, where decision making will vary during those different periods. A temporary decline in decision making ability could also be caused by a change in drug regimes.

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POLICY 6

Personal Assistance Services

6.1 Definition of an assisted living residence

“**Assisted living residence**” means a premises or part of a premises, other than a community care facility,

- (a) in which housing, hospitality services and at least one but not more than 2 prescribed services are provided by or through the operator to 3 or more adults who are not related by blood or marriage to the operator of the premises, or
- (b) designated by the Lieutenant Governor in Council to be an assisted living residence.¹

6.2 Support versus prescribed level of personal assistance

Six personal assistance service areas are identified, in regulation,² as prescribed services:

- regular assistance with **activities of daily living**, including eating, mobility, dressing, grooming, bathing or personal hygiene;
- central storage of **medication**, distribution of medication, administering medication or monitoring the taking of medication;
- maintenance or **management** of the **cash resources** or other property of a resident or person in care;
- monitoring of food intake or of adherence to **therapeutic diets**;
- structured **behaviour management** and intervention; and
- **psychosocial rehabilitative therapy** or **intensive physical rehabilitative therapy**.

When you registered, you determined the one or two personal assistance services that would be offered at the prescribed level in your assisted living residence. In addition to the one or two prescribed services, you may offer any of these personal assistance services at a less intensive support level. Please refer to section 6.4, *Personal Assistance Services Matrix*, and the *Personal Assistance Services Self-assessment Worksheet* at Forms Tab 1 for information on which services are classified as support versus prescribed.

Regardless of the level of service, you should ensure that personal assistance services:

- respect and respond to residents’ preferences, needs and values;
- promote maximum dignity and independence for residents; and
- involve family and friends.

1 *Community Care and Assisted Living Act*, SBC 2002, c. 75, s. 1.

2 *Community Care and Assisted Living Regulation*, BC Reg. 217/2004, s. 2.

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POLICY 6 **Personal Assistance Services**

All personal assistance services must conform to the following two health and safety standards and related policies set out at Policy Tab 4:

- #5** Registrants must develop and maintain personal services plans that reflect each resident's needs, risks and service requests
- #6** Registrants must ensure personal assistance services are provided in a manner that does not place the health or safety of residents at risk.

6.3 Health and safety standards for prescribed services

Please refer to Policy Tab 4 for the health and safety standards associated with the delivery of the prescribed services. The *Personal Assistance Services Self-assessment Worksheet* set out at Forms Tab 1 provides information on activities associated with each personal assistance service area.

6.4 Personal assistance guidelines

Registrants must ensure appropriate delegation of professional tasks to non-professional staff consistent with the *Personal Assistance Guidelines*³ beginning on the following page.

³ See Policy Tab 4, outcome 3.4.

PERSONAL

ASSISTANCE

GUIDELINES

MINISTRY OF HEALTH SERVICES

November, 2008



Prepared By

Home and Community Care Branch

Health Authorities Division

Ministry of Health Services

November, 2008

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Purpose

The Personal Assistance Guidelines (PAGs) document provides direction to clarify the boundaries of practice, roles and responsibilities for the Unregulated Care Provider (UCP), the Health Authority (HA), Home and Community Care (HCC) staff and service provider staff.

The PAGs document:

- Provides a set of decision making tools to assist the HA/HCC staff to determine whether a task is assignable or delegable.
- Identifies the process involved in an Assignment or Delegation of Task.
- Defines the responsibilities of all parties involved in an Assignment or Delegation of Task.

Overview

Personal Assistance Guidelines

This document is a revision to and replaces the Ministry of Health Services (The Ministry) 1997 PAGs. The updated content reflects current language and models of service delivery associated with Home and Community Care services. These guidelines should be used in conjunction with health authority and organization specific policy and procedures. This document will continue to be revised based on changes in legislation, policy and/or delivery of care services.

Much has changed since 1997, with a shift in the nature and type of assignable and delegable tasks performed by UCPs in response to several factors, including the increasing complexity of client care needs, client desires to remain at home for as long as possible, and demands from the acute sector for faster response time to move clients home.

As a result, health authorities have responded by developing and providing their own training over and above the curriculum for UCPs. Simultaneously, the Ministry has developed a *Framework of Practice for Community Health Workers and Resident Care Attendants (2007)*, which includes a set of occupational standards and competencies and reflects the change in current practice. Based on this *Framework*, the Ministry of Advanced Education has developed a new updated curriculum that reflects the expanded role UCPs play in the HCC sector. The curriculum is expected to be introduced across the province this year.

The new format for the PAGs document recognizes that as UCPs' competencies increase in certain areas and the practice environment evolves over time, certain tasks that were thought of as commonly delegable may become assignable, and tasks that have never been delegable previously may become delegable. The Personal Assistance Guidelines is an evolving document. Revisions may occur from time to time in response to client need and the challenges of service provision.

Unregulated Care Providers (UCPs) provide care to clients who require personal assistance with activities of daily living. UCPs are defined as paid care providers who are neither registered nor licensed by a regulatory body and who have no legally defined scope of practice (CRNBC, 2000). UCPs include, but are not limited to: resident care aides, home support workers, community health workers, health care assistants, assisted living workers, rehabilitation assistants and special education assistants. Their work setting includes client homes, group homes, assisted living residences, residential care facilities and schools.

The tasks performed by UCP's fall into two general areas:

1. **Assignable Tasks**
2. **Delegable Tasks** (or delegation of a professional task)

Assignable Tasks are tasks that are within the UCP's role description and training as defined by the employer/supervisor. These tasks are not considered to be client specific and do not require ongoing professional judgement or monitoring.

The Service Provider is responsible and accountable to develop role descriptions that clearly outline the tasks that can be assigned to a UCP in that agency/health authority. Service Providers should ensure the UCP has completed an appropriate training program and supplement this training if needed, with on-the-job training.

The UCP's supervisor, usually a health care professional, is responsible and accountable for providing ongoing supervision to assess the UCP's ability to perform tasks within the role description.

UCPs are accountable to their supervisor for the satisfactory performance of these tasks.

Delegable Tasks are tasks that are client-specific and are outside the role description and basic training of the UCP. Registered Nurses (RN), Registered Psychiatric Nurses (RPN), Physical Therapists (PT), or Occupational Therapists (OT) are responsible for delegating a professional task to a Service Provider. Delegable tasks are normally performed by a RN, RPN, PT, OT, but under certain circumstances it may be in the best interest of the client to delegate the task to a UCP.

Although not able to delegate tasks to UCPs, Registered Dietitians (RD), Registered Respiratory Therapists (RRT), and Licensed Practical Nurses (LPNs) are able to provide consultation and training to UCPs for the delegable tasks. These professionals are usually health authority (HA) staff but may be contracted by the HA or employed by the service provider.

The UCP must receive training and demonstrate competence in the performance of the task. It is the task, not the function that is delegated to the UCP. The UCP's supervisor is responsible to ensure the UCP has been trained in the specific task and for ongoing assessment of the UCP's ability to perform the task as taught.

The health care professional who delegates the task remains responsible for the determination of client status, care planning, interventions and evaluation of care until the client no longer requires the task.

Since not all Service Providers employ a RN/RPN as a supervisor, the term "Service Provider Supervisor" will be used throughout this document.

General Guiding Principles

A number of factors must be considered in providing care and support to clients and their families or significant others who need assistance in managing their daily health care.

- The right of the client to receive safe, appropriate cost-effective care.
- The right of the client, their family and informal caregiver to be given all information necessary to make informed, voluntary decisions and to share responsibility in the planning and delivery of care.
- HA/HCC Professionals ensure that appropriate consent for the health care treatment or procedure has been obtained from the client or the client's substitute decision maker.
- The responsibility of the client to maintain optimal personal and functional independence wherever possible.
- The right of the client to live at risk without putting others at risk.
- The right of Service Providers to refuse a Delegation of Task from the HA/HCC professional without prejudice when they are unable to meet conditions of insurance liability and risk.
- The right of the UCP to refuse to perform a task not authorized by the Service Provider without prejudice.
- The right of the UCP to refuse to perform a task they do not feel competent to perform.
- The responsibility of health care professionals to maintain their practice competencies and abide by their standards of practice.
- Service to the client will be delivered as a result of a collaborative team approach and with the assurance of effective communication among all parties.
- Routine Practices will be followed at all times.

Assignable Tasks

Assignable Tasks

- Assignable Tasks are tasks that may be performed routinely by a UCP, who has the training, knowledge, and skills based on provincial core competencies.
- Employers may provide additional training to their UCPs as needed. HAs and Service Providers may develop training modules to teach UCPs specific tasks that then become part of the core competencies for that group of UCPs.
- Assignable Tasks must have a written service plan developed by the HA in collaboration with the client/caregiver and Service Provider.
- Adequate supervision of the UCP must be available from the Service Provider.
- Assignable Tasks may have additional complex practice components and therefore may require a Community Rehabilitation Therapist (OT, PT), Registered Respiratory Therapist (RRT) or Registered Dietitian (RD) consultation to assist the Service Provider to develop a written service plan (e.g. feeding issues when there are swallowing difficulties, prosthetics/orthotics where there is circulatory impairment, a client lift, or complex transfer).
- Even if a task is categorized as assignable, falls under the role of the UCP, and the UCP is competent in the performance of the task, it must not be assumed that it is safe or appropriate to assign the task in all situations. An example is the application of a non-prescription skin cream labelled “not to be ingested” for a client who has dementia with the obsessive habit of licking their skin. In this case, the task could not be assigned as safety controls would need to be put in place, making the task client-specific, and therefore delegable.
- See Table 5 (page 12) Roles and Responsibilities for information on roles and responsibilities for all involved parties regarding assignment and delegation of tasks.
- See Appendix I (page 13) for Agency and Community Collaboration for assignment and delegation.

Delegable Tasks

Professional staff (RN/RPN/OT/PT)* are responsible for the decision to delegate a professional task to a Service Provider. The Service Provider is responsible for the decision to accept the task. HA/HCC staff requesting a delegation must make the request directly to the Service Provider.

Delegation of responsibility for a specific task is not a transfer of professional responsibility and liability. Delegated tasks are client specific and therefore are not transferable between clients.

All delegable tasks require an individualized written service plan developed by the HA in collaboration with the client/caregiver and Service Provider. The client's ability to direct care is one of the key factors in determining whether a task may be delegated.

*In most cases, the Professional Staff are employees of the HA, but in some situations it will be an employee of the Service Provider.

Professional Staff Responsibilities

When Professional Staff delegate a task to the UCP, the Professional Staff is accountable for:

- the decision to delegate the professional task to the UCP;
- assessing the client's ability to direct own care;
- educating the UCP in situations where the Service Provider does not employ the appropriate professional or where the Service Provider supervisor seeks direction;
- reviewing and/or developing the client's service plan;
- consulting with Choice in Supports for Independent Living (CSIL) Program client or Client Support Group (CSG) as employer on complex tasks, where appropriate;
- monitoring to evaluate client outcomes and effectiveness of interventions related to the delegated task until the client no longer requires the task.

See Appendix II (Assignment and Delegation Decision Tree).

Service Provider Responsibilities:

- accepting or declining the delegated task;
- determining that the UCP has the necessary knowledge and skills to perform the task safely either through Direct or Indirect Supervision (see Glossary of Terms);
- teaching the task to the UCP if the Service Provider has the appropriate Professional employed;
- supervising the UCP in the performance of the task;
- reporting any change in client condition to the delegating Professional Staff.

See *Table 5 (page 12): Roles and Responsibilities of Health Care Parties* for further information about both assignment and delegation of tasks to UCPs.

Note:

In areas where HA Community Rehabilitation Therapists are not available, or when the client is receiving therapy from a private therapist, private practice therapists may delegate tasks. The same procedures with regard to referral, training and care development are used.

User fees are the responsibility of the client.

A CSIL client or CSG, as employer, is responsible for teaching tasks to their employees. The Community Rehabilitation Therapist may be consulted for complex tasks.

Criteria for the Delegation of a Professional Task

A UCP may be requested to perform a delegable task when:

- A HA/HCC professional, and the client (where the client is able to direct their own care*) have determined that the task needs to be done.
- The delegation of task is considered after other alternative care options have been explored.
- The task cannot be managed by the client and there is no other person in the client's support system to do the task, or the regular caregiver needs respite.
- It is in the best interest of the client, and the client (or responsible family member) consents to the Delegation of the Task to a UCP.
- The client's health status is stable and/or the client's response to the proposed task or procedure is predictable.
- There is adequate supervision and monitoring of the UCP by the Service Provider or other Professional (i.e. Community Rehabilitation Therapist).
- The Service Provider accepts the Delegation of the Task.
- A UCP is available and demonstrates the competency (or has been previously trained or has equivalent competencies – see Glossary of Terms, Indirect Supervision) to do the specific task.
- An HCC professional is available from the HA for assistance with training, monitoring and back-up as needed.
- HAs and Service Providers have policies and procedures in place to implement task delegations.

*See definition of "Client Able to Direct Own Care" in Glossary of Terms

The following Tables (1 through 4) are meant to assist the delegating Professional to determine whether it is safe and suitable to delegate a task to a UCP, or to support a decision to not delegate the task. Mitigating strategies must be put in place to reduce the risk in situations deemed to be high risk.

Appendix III, Sample "Decision to Delegate Tool", is based on the four types of factors to be considered and may be used as a decision tool in determining if it is safe and suitable to delegate a task to a UCP or not. A decision may be made to assign the task instead.

Factors to be Considered Prior to Delegating a Task

(adapted from *Assigning and Delegating to Unregulated Care Providers*, CRNBC, 2000)

TABLE 1: CLIENT/FAMILY FACTORS - CONSIDER CARE NEEDS AND INFORMAL SUPPORTS

Lower Risk		Higher Risk
Client with a stable condition (physical and psychosocial). No changes anticipated	←→	Client with unstable condition (physical and psychosocial). Changes anticipated
Well defined, straightforward care needs	←→	Complex care needs
Client is willing and able to direct own care	←→	Client unwilling or unable to direct care.
Family willing and able to direct care.	←→	Family unwilling or unable to direct care.
Client environment conducive to task.	←→	Environmental barriers to performing task.

TABLE 2: TASK FACTORS

Lower Risk		Higher Risk
Low risk for harm	←→	High Risk for harm
High predictability; no/limited judgment required: <ul style="list-style-type: none"> • stable need for task • stable response to task • predictable outcome of the task 	←→	Low predictability; judgment required: <ul style="list-style-type: none"> • varying need for task • unpredictable or changeable response to task • unpredictable outcomes of task
Task has few steps and requires minimal technical/psychomotor skill	←→	Task has numerous steps and requires a high degree of technical/psychomotor skill
Task done frequently to maintain skills and knowledge of UCP	←→	Task done infrequently
Task is not altered in different settings	←→	Task must be altered in different settings

TABLE 3: PROFESSIONAL SUPPORT FACTORS

Lower Risk		Higher Risk
Ongoing assessment, care planning and evaluation by health professional is available as needed.	←→	Ongoing assessment, care planning and evaluation by health professional is limited or unavailable.
Adequate time for UCP training; clear written procedures available to UCPs.	←→	Limited time for UCP training; no written procedures available to UCPs.
Appropriate supervision and support of UCP by health care professional. Available organizational support for delegation: <ul style="list-style-type: none"> • clear policies and procedures • clear responsibility and authority for delegation • Expert clinical consultation for health professional available 	←→	Limited supervision and support of UCP by health professional. Limited organizational support for delegation: <ul style="list-style-type: none"> • policies and procedures are unclear or unavailable • responsibility and authority for delegation unclear • no clinical consultation for health professional
Health professional is competent in delegation.	←→	Health professional has limited competence in delegation.

TABLE 4: UCP SUPPORT FACTORS

Lower Risk		Higher Risk
Few UCPs needed; infrequent staff changes.	←→	Large number of UCPs needed; frequent staff changes.
UCPs have a standard skill base e.g., resident care aide course.	←→	UCP have no standard skill base.
Delegation requires minor upgrading of skills and knowledge of UCP.	←→	Delegation requires significant upgrading of skills and knowledge of UCP.
Task commonly delegated in other similar circumstances.	←→	Task not usually delegated in other similar circumstances.

Other

By Exception – Tasks not normally delegated:

Complex care tasks that go beyond the current expectations for the delegation of professional task to a Service Provider are sometimes requested. The decision to perform the intervention is made in consultation with the health care team, the client and family or the client's substitute decision maker.

The health care team must consider the client's best interest, client safety, quality of life, available resources and the safety of the UCP. HAs and Service Providers must develop procedures for review and approval of these kinds of requests.

Delegation and/or Assignment of Task does not apply to the following:

- Family members
- Informal caregivers (e.g. friends, neighbours)
- Private care hired by client and/or family

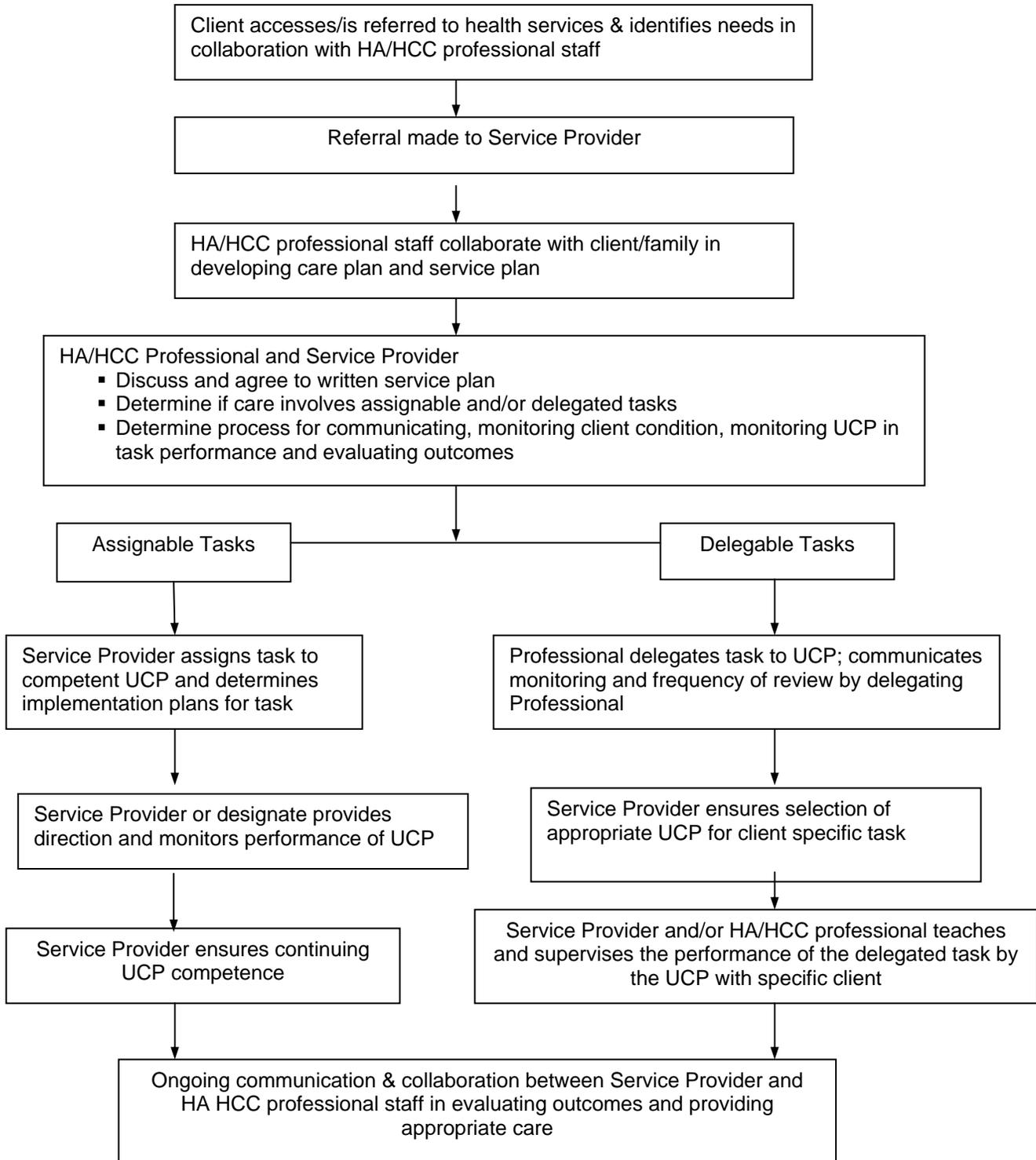
TABLE 5: ROLES AND RESPONSIBILITIES OF HEALTH CARE PARTIES

The provision of safe care is a shared responsibility and is achieved through the collaborative efforts of the regulatory professional bodies, health authorities, health care professionals, service providers and UCPs.

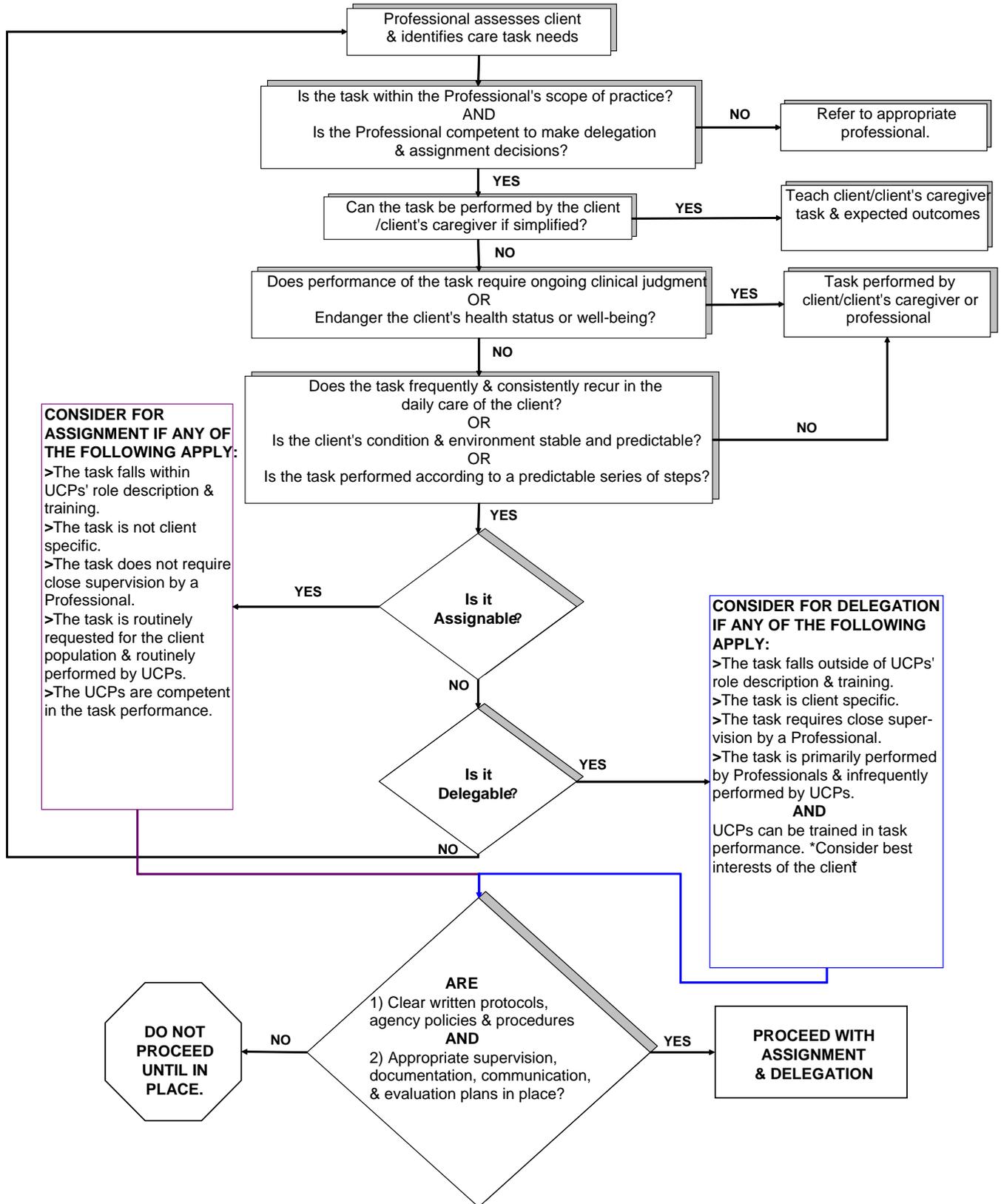
Regulatory Professional Bodies	
<ul style="list-style-type: none"> • Identify scope of practice for the health professionals • Establish professional standards of practice • Establish requirements for continuing competence • Provide support for health professionals to understand and apply standards of practice. 	
Health Authority Management	Health Care Professionals
<ul style="list-style-type: none"> • Establishes current standards of practice, policies and procedures • Outlines the roles, responsibilities and accountability of individuals involved • Creates organizational supports to foster competent, safe and ethical practice • Establishes competencies for UCPs necessary to accept delegated tasks consistent with provincial practice standards for UCPs • Creates policy to effectively manage risk 	<ul style="list-style-type: none"> • Understand current policies, procedures and standards • Ensure that all alternate care options have been explored • In collaboration with the health care team, clarify whether the client can or cannot direct own care • Use professional judgment and clinical assessment skills to determine when a delegable task can be delegated • Demonstrate competence in the performance of the delegated task • Demonstrate competence in the process of delegating according to standards and within the scope of professional practice • Provide ongoing assessment, planning, implementation and evaluation functions • Collaborate and consult with health care team throughout the process
Service Providers – HA or Publicly Funded HS or AL Service Providers	Unregulated Care Providers
<ul style="list-style-type: none"> • Establish operational policies and procedures relating to accepting a delegation of task • Ensure continued competence in UCPs and service provider health professionals • Assess ability of the organization to meet and maintain the requirements of a delegated task • Collaborate with health care team • Monitor and supervise employees for task performance • Report changes in client condition according to directions from service plan to responsible health care professional 	<ul style="list-style-type: none"> • Perform delegated tasks only when authorized by the Service Provider • Perform delegated tasks only when delegated by a Professional • Competently perform assigned tasks as written in the client-specific service plan • Competently perform delegated tasks as taught • Report changes in client condition according to directions from service plan and according to organizational/agency policies

APPENDIX I

ASSIGNMENT & DELEGATION: AGENCY AND COMMUNITY COLLABORATION



APPENDIX II: ASSIGNMENT AND DELEGATION DECISION TREE



APPENDIX IV: GLOSSARY OF TERMS

Glossary of Terms	
Care Plan	The part of the Clinical Process in which the over all plan to meet clients' needs and achieve the health goals is identified. The Service Plan and the plan for Delegated Tasks are components of the overall care plan.
Choice in Supports for Independent Living (CSIL)	A program in which eligible HCC Care clients are responsible for purchasing their own home support services and are funded directly. The client or Client Support Group (CSG) is the employer of the UCP and assumes all liability and accountability for decisions related to the delivery of their home support service including ongoing monitoring of UCP performance.
Client Able to Direct Care	One who is cognitively capable to make decisions regarding their care related to the task being delegated and can communicate effectively (verbally or nonverbally through communication devices) so as to be understood by any authorized caregiver. This client has the potential to make informed, voluntary decisions regarding care based on knowledge and adequate information provided by an appropriate health care professional, related to the task being delegated. Delegating Professional makes determination.
Client Unable to Direct care	One who is cognitively incapable to make decisions regarding their care relevant to the specific task and/or cannot communicate essential information in an adequate manner to the authorized caregiver. This client will not be able to make informed, voluntary decisions regarding the specific task. Delegating Professional makes determination.
Client Specific	Restricted to one particular individual, situation, relationship and outcomes.
Direct Supervision	To be physically present to direct, teach and to have a monitoring plan in place.
Function	A client care intervention. Performing a function includes assessing when to perform the function, planning and implementing the care and evaluating and managing the outcomes of the care (CRNBC, 2000).
HA/HCC Health Care Professional	Refers to nursing, physiotherapy, occupational therapy, nutrition, social work and case management. Where a particular discipline is referenced, that discipline will be noted in the document.

Health Care Team	Members may include the Service Provider Administrator, RN, RPN, LPN, Supervisor, Scheduler, UCP, Case Manager, PT, OT, Dietitian, Social Worker, Pharmacist, Respiratory Therapist and Physician.
Indirect Supervision	<p>The Professional may delegate a specific task to a UCP who, in the Professional's opinion, has the necessary competencies to complete the task. The Professional does not have to be physically present to teach the task to the UCP if the following criteria are met:</p> <ul style="list-style-type: none"> • The Professional has determined that the UCP has the necessary knowledge, skills and ability to perform the task. • The UCP's competency level in performing the task has been demonstrated. • The client's circumstance is known to the Professional. • There is an established written service plan in place for the delegated task and the plan is immediately accessible to the UCP. • The client's safety is not jeopardized. • A monitoring plan is in place.
Routine Practices	Precautions that are applied universally to all persons regardless of their presumed infectious status.
Service Plan	Outline of all tasks, both assigned and delegated as authorized by a HCC professional to be carried out by a UCP. Copy of the plan must be in a standardized area of the client's home.
Service Provider	The agency or organization that provides services directly to HCC clients. May include HA or publicly funded agencies. Refers to both professionals and UCPs.
Stable	The anticipated client response to the task or procedure is not likely to change.
Unregulated Care provider (UCP)	Paid care providers who are neither licensed nor registered by a regulatory body and who have no legally defined scope of practice e.g. community health workers, home support workers, assisted living workers, resident care attendants, health care assistants, therapy assistants, etc.
Without Prejudice	With no negative repercussions.

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Ministry of
Health Services

Registrant Handbook

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POLICY 7

Medication Services

7.1 Policy statement

Registrants must deliver medication services in accordance with *Medication Services* and in such a way as to promote the safety and independence of residents.¹

7.2 General requirements

The following apply to all levels of medication service.

The registrant must have written policies and procedures that:

- describe the scope and level of medication services offered to residents;
- support/promote the self-administration and in suite storage of medications with access controlled by residents;
- detail the requirements for certification^{2, 3} and/or in-service training⁴ for staff involved in delivering medication services; and
- address how medication errors⁵ are handled (e.g., monitor, record and follow up).

Staff may physically assist residents who are fully able to self-direct the taking of their medications (e.g., open medication packaging, put medications in resident's hand, steady a resident's hand).

A resident's medication service must be documented in their personal services plan. Registrants must monitor resident's ability to manage their medications. Incidents or a decline in health status will trigger the registrant to review with the resident, their family and/or physician/pharmacist whether a change in medication service is needed. The registrant must notify the resident's pharmacist of any apparent negative reaction to medication.

Registered nurses and licensed practical nurses (LPNs) employed or contracted by a registrant may administer narcotics, PRN⁶ medications, or injectable medications (e.g., daily insulin, monthly B12 or annual vaccines).

The *Personal Assistance Guidelines*⁷ apply to practice and professional oversight of medication assistance in assisted living residences.

1 See Policy Tab 4, outcome 6.2.

2 Successful completion of a medication administration module for home support workers/residential care aides from an accredited educational institution.

3 The unregulated care provider must have successfully completed a medication administration module for home support workers/residential care aides from an accredited educational institution.

4 General orientation and training on the safe and effective storage, handling and administration of medications.

5 Errors in the storage, handling or administration of medications.

6 PRNs are medications that do not have to be taken at a certain time and are taken as needed.

7 See Policy Tab 6.

Registrant Handbook

POLICY 7
Medication Services

7.3 Outcomes by level of service

Level of service	Occupant profile	Description	Storage	Requirements
Support services				
1 – Self administration	<p>Resident participates in and directs own service plan.</p> <p>Resident is cognitively alert, with no memory impairment.</p>	<ul style="list-style-type: none"> Resident is fully independent in medication administration. Registrant provides no assistance, except physical assistance, if required. Resident orders and receives medications from pharmacy or registrant receives medications from pharmacy on behalf of resident. 	In suite; resident controls access.	<ul style="list-style-type: none"> Resident has choice of own or residence pharmacist. Compliance packaging⁸ is not required but resident may choose to arrange it with their pharmacy.
2 – Reminder with no follow-up or documentation	<p>Resident participates in and directs own service plan.</p> <p>Resident is cognitively alert, with minimal short term memory impairment.</p>	<ul style="list-style-type: none"> Resident is relatively independent in medication administration. Registrant provides periodic support: reminders with no follow up or documentation and physical assistance if required. Resident orders and receives medications from pharmacy or registrant receives medications from pharmacy on behalf of resident. 	In suite; resident controls access.	<ul style="list-style-type: none"> Resident has choice of own or residence pharmacist. Compliance packaging is not required but resident may choose to arrange it with their pharmacy.

⁸ Compliance packaging means that all medications for a given medication time are packaged together.

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POLICY 7
Medication Services

Level of service	Occupant profile	Description	Storage	Requirements
Prescribed services				
<p>3 – Remind, observe and record whether medications are taken or not</p>	<p>Resident participates in and directs own service plan with ongoing staff support, support from live-in spouse, or family support.</p> <p>Resident experiences mild memory impairment and/or is in the early stages of dementia, requiring cues and reminders on a consistent basis.</p>	<ul style="list-style-type: none"> • Registrant provides a reminder, observes and records whether a resident takes their medications for a given date and time, and follows up on missed medication as directed in the resident's personal services plan. • Registrant provides physical assistance, if required. • If resident is unable to secure own medications, registrant must secure the medications in resident's room or centrally. • Registrant observes/reports effects of medications on resident. • Registrant may provide PRN prescription medication. 	<p>In suite with access controlled by resident.</p> <p>In suite or central with access controlled by registrant.</p>	<ul style="list-style-type: none"> • This level of medication administration must be done by a registered nurse or a LPN who is certified in medication administration.⁹ Registered nurses can delegate medication tasks to an unregulated service provider. LPNs can assign medication tasks to unregulated service providers who are trained in medication administration.³ • Registrant may recommend using residence pharmacist (so that all compliance packaging is the same) but resident retains choice of pharmacy. • If resident wants registrant to initiate refills and/or receive medications from the pharmacy, the registrant must obtain the resident's written designation. • If medications are centrally stored, registrant must consult with a pharmacist regarding the registrant's medication storage and distribution policy. A record of the pharmacist's consultation must be available for review by the Registrar on request. • If medications are centrally stored, policies and procedures exist for return of expired or unused medications to the pharmacy. • If medications are centrally stored, either staff take medication to resident or resident obtains it from staff and medications are provided to residents at indicated times. • Compliance packaging is required for non-PRN prescription medications. • Registrant must document the protocols associated with staff administration of PRN medications and train staff to follow the protocols. • PRN prescription medication must be monitored-dose packaged¹⁰ or appropriately labeled by the pharmacist in those instances when the form of the medication does not permit such packaging (e.g., liquids, inhalers, eye drops).

⁹ See *Personal Assistance Guidelines* set out at Policy Tab 6.

¹⁰ Each pill is placed in a separate blister so the rate of use is clearly evident.

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POLICY 7
Medication Services

Level of service	Occupant profile	Description	Storage	Requirements
4 – Temporary administration	Residents may be palliative, convalescent, or transitional (awaiting placement in a residential care facility) and are unable to make decisions about taking medications.	<ul style="list-style-type: none"> • Provided by exception. • Registrant determines medications for a given time, gives to resident, and records medications by person, date and time. • If resident is unable to secure own medications, registrant must secure the medications in resident's room or centrally. • Registrant may use residence pharmacist or resident's own pharmacist. • Registrant initiates refills and receives delivery of medications. • Registrant observes/reports effects of medications on resident. • Registrant may provide PRN prescription medication. 	<p>In suite; access controlled by registrant.</p> <p>Central; access controlled by registrant.</p>	<ul style="list-style-type: none"> • Registrant must maintain a log of all medication errors and make the log available for review by the Registrar on request. • Registrant must notify the resident's pharmacist of any apparent negative reaction to medication. • Registrant must report to the Registrar errors in the administration of medications that result in emergency intervention or transfer to hospital. <hr/> <ul style="list-style-type: none"> • This level of medication administration must be done by a registered nurse or by an LPN.⁹ Registered nurses can delegate medication tasks to an unregulated service provider. LPNs can assign medication tasks to unregulated service providers who are trained in medication administration.³ • Registrant may use residence pharmacist or resident's own pharmacist. • Drug information sheets are stored with the resident's medications and other medical records. • If medications are centrally stored, registrant must consult with a pharmacist regarding the registrant's medication storage and distribution policy. A record of the pharmacist's consultation must be available for review by the Registrar on request. • If medications are centrally stored, policies and procedures exist for return of expired or unused medications to pharmacy. • Compliance packaging is required for non-PRN prescription medications. • Registrant must document the protocols associated with staff administration of PRN medications and train staff to follow the protocols. • PRN prescription medication must be monitored-dose packaged¹⁰ or appropriately labeled by the pharmacist in those instances when the form of the medication does not permit such packaging (e.g., liquids, inhalers, eye drops). • Registrant must maintain a log of all medication errors and make the log available for review by the Registrar on request.

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Medication Services

Level of service	Occupant profile	Description	Storage	Requirements
				<ul style="list-style-type: none">• Registrant must report to the Registrar errors in the administration of medications that result in emergency intervention or transfer to hospital.• Registrant notifies the resident's pharmacist of any apparent negative reaction to medication.

Registrant Handbook

POLICY 8

Serious Incident Reporting

8.1 Policy statement

Registrants must maintain a record of incidents that occur within the residence and report serious incidents to the Registrar in accordance with this policy.¹

8.2 Criteria for reporting a serious incident

Serious incidents² include:

1. attempted suicide by a resident;
2. unexpected deaths reported to the Coroner;
3. abuse or neglect³ by staff reported to the local abuse and neglect Designated Agency or the Public Guardian and Trustee;
4. medication error by staff that requires emergency care by a physician or transfer to hospital; and
5. fire that causes personal injury or building damage.

8.3 Purposes of recording and tracking incidents generally

To ensure resident health and safety, registrants should keep track of all incidents at the residence. The recording of incidents and subsequent analysis is a management tool, which can be used to reduce risk and improve the quality of services and operations.

8.4 Purposes of reporting *serious* incidents to the Registrar

Reporting *serious* incidents gives the Assisted Living Registrar information about any actual or potential risks to resident health and safety. Reporting provides the Registrar with an opportunity to do a risk assessment and consider whether further follow up or an inspection of the registrant's residence is warranted. Reporting also provides the Registrar with information about patterns of risk for individual operators and enables the Registrar to identify trends in health and safety risks occurring across assisted living residences.

1 See Policy Tab 4, outcome 1.7.2.

2 This definition was prepared by a multi-stakeholder work group, which included a number of operators. It is an inclusive definition. Therefore, if an operator considers an incident not listed here to be sufficiently serious to warrant reporting it should do so.

3 "**Abuse**" means the deliberate mistreatment of an adult that causes the adult (a) physical, mental or emotional harm, or (b) damage to or loss of assets, and includes intimidation, humiliation, physical assault, sexual assault, overmedication, withholding needed medication, censoring mail, invasion or denial of privacy or denial of access to visitors. "**Neglect**" means any failure to provide necessary care, assistance, guidance or attention to an adult that causes, or is reasonably likely to cause within a short period of time, the adult serious physical, mental or emotional harm or substantial damage to or loss of assets, and includes self neglect. *Adult Guardianship Act*, RSBC 1996, c. 6, s. 1.

Registrant Handbook

POLICY 8
Serious Incident Reporting

8.5 Procedure for filing the serious incident report

1. The site manager/designate of the registrant completes the Serious Incident Report form (see Forms Tab 2).
2. Submit the report to the Office of the Assisted Living Registrar by fax or email.
3. Submit the report no later than the next business day following the serious incident.

Note: This report is not intended to replace any internal incident report or incident reporting process.

8.6 Follow up by the Registrar

The Registrar will review the serious incident report and contact the site manager or equivalent if more information is required. The Registrar will then assess the risk to resident health and safety. If the Registrar considers that there is no risk to resident health and safety and the incident does not require any further follow up, the Registrar will log the incident and place the report on the registrant's file.

The Registrar may conduct an inspection where there is a concern about the health or safety of a resident. Factors influencing whether there is a concern about resident health and safety include the specific nature of the incident, the operator's history of serious incidents and/or substantiated complaints, and the operator's awareness of and compliance with the *Health and Safety Standards*. The Registrar will also look for emerging patterns in the registrant's compliance history.

The Registrar has the discretionary power to take action against a registrant's registration (attach or vary conditions or suspend or cancel the registration). Enforcement of the *Community Care and Assisted Living Act* will be progressive. See Policy Tab 3, How to Maintain Your Registration.

The Registrar will take into consideration the actions the operator has taken both immediately after the serious incident and follow up plans intended to reduce the risk of or prevent a recurrence of a similar incident in the future. The Registrar may also review the policies and procedures the operator has in place to manage and reduce similar risks.

Form

Forms Tab 2, Serious Incident Report.

Reference

Health and Safety Standards, outcome 1.7.2.

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POLICY 9

Complaint Resolution

9.1 Your internal complaint process

As a registrant, you should establish and make residents and those who care about them aware of a clear, written internal complaint process. You should also publish prominently the contact information for the Office of the Assisted Living Registrar.

Registrants should distribute the brochure *Complaint Resolution for Assisted Living Residents*¹ to all new residents on entry to the residence and make copies available to their families and support networks.

You must not prevent or intimidate anyone from initiating a complaint through the Office of the Assisted Living Registrar.

9.2 Complaints to the Registrar

Anyone with a concern about the health and safety of assisted living residents may make a complaint to the Office of the Assisted Living Registrar. Complaints can be made by phone, email, mail, fax or in person. The Registrar will encourage complainants to address their concerns through the operator's internal complaints resolution process first. If a complainant does not want to use a registrant's internal complaint process, the person may make a complaint directly to the Office of the Assisted Living Registrar. The complaint will be investigated in a fair and transparent manner and, if the complainant requests, while maintaining their confidentiality.

The Registrar has jurisdiction to address the following types of complaints:

- **non-compliance with *Health and Safety Standards***² – a registrant is alleged to be operating the residence in a manner that is placing the health or safety of a resident at risk.
- **resident is unable to make decisions on own behalf**³ – a registrant is alleged to be housing a resident who is unable to make the range of decisions that will allow the person to function safely in the supportive, semi-independent environment of an assisted living residence.
- **operation of an unregistered assisted living residence**⁴ – a person is alleged to be offering assisted living services (housing, hospitality services and one or two prescribed services), but the residence is not registered.

1 Additional copies are available from the Office of the Assisted Living Registrar on request.

2 See Policy Tab 4.

3 See Policy Tab 5.

4 SBC 2002, c. 75, s. 26(1).

Registrant Handbook

POLICY 9
Complaint Resolution

9.3 The Registrar's role

The Registrar's role is to ensure that assisted living residences are operated in a manner that does not jeopardize the health and safety of residents. The purpose of complaint investigation is remedial – to ensure the operator complies with the *Health and Safety Standards* or brings itself into compliance. The Registrar's approach to investigating complaints is to promote good practice, prevent poor practice, intervene in unacceptable practice, and not to compromise resident health or safety. The Registrar will generally follow the least intrusive, but most appropriate, course of action first.

When the Registrar's Office is contacted, it will determine whether the person requires information only or would like to initiate a complaint. If the person is making a complaint, the Office will assess whether it relates to the types of complaints that the Registrar has jurisdiction to address (see section 9.2). Complaints that are not within the Registrar's jurisdiction are redirected to the appropriate authorities (see section 9.4).

The Registrar will analyze the complaint and determine the best approach to investigate it (educate the operator and/or complainant about the regulatory model for assisted living and the health and safety standards; gather more information; conduct a review to ensure the operator complies with the *Health and Safety Standards*; and/or conduct an inspection of the residence). Reports about the status of the investigation will be provided as needed. At the conclusion of the investigation, the Registrar will advise the operator whether it complies with the *Health and Safety Standards* or whether it needs to take action to bring itself into compliance. Where requested, the Registrar will also report out to the complainant on the outcome of the investigation.

Where a registrant fails to bring itself into compliance with the *Health and Safety Standards*, the Registrar may take progressive enforcement action. The *Community Care and Assisted Living Act* authorizes the Registrar to attach or vary conditions to a registration; suspend a registration; cancel a registration; and impose a fine on an unregistered residence. The Registrar will make public situations in which conditions are attached to a registration or where a registration is suspended or cancelled.

If the Registrar intends to take enforcement action against the registrant, the Registrar will send the registrant a letter outlining the pending action and reasons for it. The letter will be sent at least 30 days before the effective date of the action. The registrant then has the right to ask the Registrar to reconsider the action. The Registrar's letter will include information about the reconsideration process.

If a complainant is not satisfied with the investigation or outcome, the complainant may initiate an internal complaint to the Registrar. If, having followed the Registrar's internal complaint process, the complainant is still not satisfied the complainant may contact the Office of the Ombudsman to review the Registrar's handling of the complaint.

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POLICY 9
Complaint Resolution

9.4 Complaints and tenancy

The Registrar does not have jurisdiction to address complaints related to tenancy (such as rent increases) or service protection (such as dissatisfaction with meals), unless the complaint relates directly to residents' health or safety.

The Ministry of Forests and Range, Minister Responsible for Housing is developing a new model of consumer protection for residents and providers of assisted living and supportive housing accommodation. The *Tenancy Statutes Amendments Act*,⁵ was passed on May 18, 2006. This Act creates a framework in the *Residential Tenancy Act* that establishes the rights and responsibilities of landlords and tenants in assisted living and supportive housing. These amendments were not yet in force when this policy was issued. Please refer to <http://www.rto.gov.bc.ca/> for information on the status of the legislation. Until the amendments are brought into force, the Office of the Assisted Living Registrar will refer any complaints it receives about consumer protection to the appropriate contact at the Residential Tenancy Office.

9.5 Other complaints outside of the Registrar's jurisdiction

As well, the Registrar does not deal with complaints about the conduct of residence staff or other operating issues of the residence, unless they relate directly to the health or safety of a resident. The Registrar will refer complaints that a registrant is offering more than two prescribed services to Community Care Facilities Licensing for follow up.

⁵ SBC 2006, c. 35 (Bill 27).

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POLICY 10

Meal and Dietary Services

10.1 Introduction

Operators of assisted living residences provide meal and dietary services to residents in two ways:

1. All operators must provide a meal service to residents as one of five hospitality services.
2. Some operators may offer monitoring of food intake or of adherence to therapeutic diets as a prescribed service.

This Policy describes each category of service.

10.2 Policy statement

Registrants must offer meals in accordance with this policy and that provide balanced and adequate nutrition for residents.¹ Registrants must establish an individual dietary plan with residents who require a special or therapeutic diet, have food allergies or intolerances, and/or have special needs associated with chewing or swallowing.² Registrants must obtain appropriate professional advice (Registered Dietitian or food service supervisor/diet technician) to plan menu rotations, special or therapeutic diets, and food preparation to accommodate chewing and swallowing abilities.³

Registrants must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors the residents' health and nutritional status.⁴

10.3 Meals as a hospitality service

Operators of assisted living residences must offer a menu plan that provides a rotation⁵ of balanced and nutritious meals. Appropriate professional advice (Registered Dietitian or food service supervisor/diet technician⁶) should be sought in planning menu rotations.

Operators typically respond to an individual resident's request for:

- the regular menu plan; and
- routine modifications to the regular menu plan (e.g., low sugar, low sodium, cut up, minced, pureed).⁷

1 See Policy Tab 4, outcome 2.3.1.

2 See Policy Tab 4, outcome 2.3.2.

3 See Policy Tab 4, outcome 2.3.4.

4 See Policy Tab 4, outcome 6.4.1.

5 Dietitians of Canada recommends a menu plan that provides a minimum of four weeks of menu rotations.

6 Eligible for membership in The Canadian Society of Nutrition Management.

7 In this instance, texture modification is a personal choice, e.g., where the resident finds it easier or more comfortable to eat a minced meal because of chewing difficulties associated with loose dentures.

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POLICY 10 Meal and Dietary Services

If an operator agrees to a resident's request to modify the menu plan *beyond routine modifications* to the regular menu plan, they must seek professional advice to develop an appropriate menu plan that will provide balanced, nutritious meals consistent with the resident's request. This will include requests such as:

- a special diet to address preferences, religious practices and cultural customs (e.g., vegetarian, ethnic);
- a special diet to address food allergies and/or intolerances; or
- a therapeutic diet (including modified texture diets) prescribed by a physician.⁸

Where an operator agrees to respond to a resident's request for a routine or beyond routine modification to the regular menu plan, the operator must ensure that the resident's unique dietary requirements and menu plan are recorded in a dietary plan.⁹ The dietary plan should form part of the resident's personal services plan.

The *Health and Safety Standards*¹⁰ associated with the delivery of meal services reinforce these points by stating:

2.3.2 Where registrants agree to accommodate residents' special dietary needs (special or therapeutic diets, food allergies or intolerances, and/or special needs associated with chewing or swallowing), registrants must establish an individual dietary plan⁹ as part of the residents' personal services plan.

2.3.4 Registrants must obtain professional advice from a Registered Dietitian or food service supervisor/diet technician⁶ to plan menu rotations for their regular menu plan, as well as menu rotations designed to address individual resident's special or therapeutic diets, and food preparation to accommodate chewing and swallowing abilities.¹¹

3.3.1 Registrants must ensure that staff has qualifications consistent with their job responsibilities.

3.3.2 Registrants must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills.

In providing meals as a hospitality service, the operator's responsibility relates to the production of balanced, nutritious meals. The operator has no obligation to monitor a resident's adherence to their dietary plan or to observe changes in eating habits. The resident assumes full responsibility for selecting the meal service being received, monitoring the impact of the menu plan on their own nutritional/health status and advising the operator of any changes that may be required in their dietary plan. The resident may do this in consultation with their physician or dietitian.

⁸ Generally, only physicians prescribe therapeutic diets. However, a physician may delegate this task to another health professional, such as a Registered Dietitian.

⁹ A 'dietary plan' is a written plan defining the requirements for producing food to meet the resident's individual dietary needs. It includes special instructions where needed (e.g., low sugar diet for diabetes). Where a registrant offers the prescribed service, *monitoring of food intake or of adherence to therapeutic diets*, the dietary plan should also describe relevant indicators of health status for the resident and activities undertaken to monitor the resident's health outcome.

¹⁰ See Policy Tab 4.

¹¹ Routine modifications to the regular menu plan (e.g., low sugar; low sodium; cut up, minced or pureed to make eating easier due to loose dentures) may be implemented without seeking professional advice.

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The operator may provide a voluntary program for residents to be weighed or may weigh a resident upon that person's request. As the resident in assisted living is directing their own care, taking weights is intended only to provide information back to the resident so that they can adjust their own consumption habits. An operator should not interpret the weight information or make adjustments to a resident's dietary plan as a result of the information, unless the resident requests it. (See Appendix 1 to distinguish activities that can be done as a support to residents and those that form part of the prescribed service.)

10.4 Monitoring of food intake or of adherence to therapeutic diets

Monitoring of food intake or of adherence to therapeutic diets is one of six prescribed services that can be offered to residents by an assisted living operator. At the prescribed service level, an operator would provide the expertise necessary to assess a resident's health/nutritional status and implement a therapeutic or special diet. The operator is responsible for observing and monitoring whether the resident is complying with the therapeutic or special diet. The operator may measure food/fluid intake, may chart weight and may modify the resident's dietary plan or therapeutic diet as required.

The Registrar's health and safety standard associated with this level of service is:

6.4.1 Registrants must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, the service is provided in accordance with *Meals and Dietary Services* and a Registered Dietitian monitors the resident's health and nutritional status.

At the prescribed service level the operator's responsibilities relate not only to the production of appropriate meals, but also to the development of a dietary plan. It also includes the ongoing monitoring and evaluation of health status as it relates to nutrition and includes making adjustments to dietary plans as required. (See Appendix 1 to distinguish activities that form part of the prescribed service and those that can be done as a support to residents.)

10.5 Living at risk

If a person could manage eating independently in their own home, then they should be able to manage eating with an acceptable level of safety in an assisted living residence. Some residents may choose not to follow their dietary plan and place themselves at risk of dehydration, malnutrition or exacerbating a health condition (e.g., diabetes). This is a personal choice. Operators may remind residents of their dietary plan and, if the resident is regularly not following it, an operator may bring the matter to the attention of the resident's family.

Some residents may be at risk of choking due to the medical condition dysphagia, which is described in Appendix 2. Where an effective dysphagia management plan has been developed that allows the person to eat with minimal coughing and with minimal risk of food or drink going into their airway or choking, dysphagia should not be a barrier to the person residing in an assisted living residence. Independent of issues associated with dysphagia management, residence staff should be trained to respond appropriately if any resident chokes.

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Appendix 1 Extract from the Personal Assistance Services Matrix¹²

Monitoring of food intake or of adherence to therapeutic diets is one of six service areas for personal assistance. A service area may be provided at either a less intensive support level or a more intensive prescribed service level. Operators may perform some or all of the activities in the support services column without triggering a prescribed service. Registered assisted living operators must perform at least one service, but no more than two, at the prescribed service level.

Service Areas	Support Services	Prescribed Services
	The personal assistance activities listed in this column are <i>not</i> prescribed service activities. Registered assisted living operators may perform all activities in this column.	Performing any one activity in this column indicates the service listed in the corresponding service areas column is a prescribed service.
Monitoring of food intake or of adherence to therapeutic diets	<ul style="list-style-type: none"> Modify meals in accordance with diets requested by residents and as recommended and monitored by the resident's dietitian or physician: <ul style="list-style-type: none"> includes provision of expertise necessary to prepare individual menu plans for diets requested by the resident and incorporate same into rotating menus. Provide a voluntary program for residents to weigh in or weigh a resident upon their request. Monitor food consumption for purposes of resident satisfaction and quality control. Observe changes in eating habits and bring changes of concern to resident's or other's attention. 	<ul style="list-style-type: none"> Monitor/measure/record food/fluid intake. Determine and chart residents' weights on a regular and/or compulsory basis. Provide expertise to assess a resident's health/nutritional status and implement a special or therapeutic diet. Provide expertise to monitor the appropriateness of a resident's special or therapeutic diet and modify the meal plan where indicated. Observe/report whether resident complies with special or therapeutic diet.

¹² See Policy Tab 6.

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Appendix 2

Dysphagia

'Dysphagia' can involve "difficulty in eating, drinking or swallowing." Where there is the presence of dysphagia, or screening for entry to an assisted living residence identifies a swallowing problem, an assessment by an appropriate professional should be obtained to determine the safety for the person eating unsupervised in the common dining area of the assisted living residence.

Speech and language pathologists, occupational therapists and dietitians with specialized training and skills can conduct swallowing assessments and provide strategies to eat/drink safely and/or recommendations for diet texture modifications.

In most cases of dysphagia, a dysphagia management plan is developed following an assessment. The plan may include a modified texture diet, drink consistency and/or strategies to help with eating/drinking safely, (e.g., cut up, minced or pureed foods, thickened fluids, postural changes/support, adaptive eating aids).

In most situations where there is 'dysphagia,' the person should be able to eat safely, without close monitoring, as long as they follow the recommendations in the dysphagia management plan. Where an effective dysphagia management plan has been developed that allows the person to eat with minimal coughing and with minimal risk of food or drink going into their airway or choking, dysphagia should not be a barrier to the person residing in an assisted living residence.

Where there is a high risk of food/drink going into the airway or of choking, it is critical that the person be fully capable of directing their own care. Specifically, the resident must:

1. understand the dysphagia management plan that is required for eating and drinking safely; and
2. be able to identify and confirm that the meal presented has been prepared according to the diet modification requirements.

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11.1 Introduction

The Food Premises Regulation¹ made under the *Health Act*² has been amended to exempt small assisted living residences (no more than six residents), which would otherwise be used as single-family residences, from the application of that regulation. This policy outlines safe food practices for operators of small assisted living residences. Operators of larger assisted living residences (seven or more residents) are still covered by the Food Premises Regulation, but may also be interested in this policy.

11.2 Policy statement

Registrants must adopt safe practices for the obtaining, storage, preparation and serving of meals.³

11.3 Purpose

Reduce health and safety risks associated with shopping, transport, storage, preparation and service of food.

11.4 Learn about food safety

You can learn about food safety and receive a certificate by taking a course. Operators of small residences or operators living in small communities may have difficulty attending courses or sending staff to courses. There are some options available to these operators. The food safety short course for group homes is a three-hour course, which can be delivered in your home. Contact your local health authority.

An alternative would be to take FOODSAFE Level 1 by correspondence.⁴

If you are able to be off-site for a day, FOODSAFE is a one-day course offered by community colleges, private companies and health authorities.⁵ This is the preferred course curriculum. You can also learn more about food safety by accessing on-line resources and having printed resource materials on site.⁶

1 BC Reg. 210/99.

2 RSBC 1996, c. 179.

3 See Policy Tab 4, outcome 2.3.5.

4 For information, contact: go2 FOODSAFE Coordinator, Web: <http://www.go2hr.ca/static/FoodSafe/index.aspx>, Telephone: 604 930-9770, Toll-free: 1 800 665-8883, Fax: 604 930-9771.

5 See Appendix 1: Useful Links and Contacts, for how to locate FOODSAFE course information in your area.

6 See Appendix 1: Useful Links and Contacts.

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11.5 Food safety plan

A written food safety plan⁷ minimizes the chances of a food-borne illness. Food-borne illness, often called 'food poisoning', occurs when a person gets sick by eating food that has been contaminated with bacteria, parasites or viruses, also known as 'microbes' and 'pathogens.'⁸ Contamination can occur at any point from the grower to the producer to the kitchen. In the kitchen, where food is prepared, inadequate cooking or cross contamination of foods after cooking, could allow harmful bacteria to grow and cause illness.

Food can also be contaminated with chemicals such as pesticides or things such as glass or metal. Food is labelled to inform buyers what the ingredients are for those who have a food intolerance, which can cause another type of food poisoning.

The food safety plan should also contain some steps to address food allergens and allergies, prevention of chemical contamination of food and a response plan for food recalls. Food recalls are usually announced in local papers and on the news. Check with your local health department about how to be notified of recalls.

You can reduce the risk of food borne illness by following these four simple steps:⁹

1. CLEAN

Wash hands thoroughly and wash utensils and surfaces with hot soapy water before, during and after preparing foods. Sanitize countertops, cutting boards and utensils with a mild bleach and water solution. Wash all produce thoroughly before eating or cooking.

2. SEPARATE

Keep raw meats and poultry away from other foods during storage and preparation. Always keep food covered to protect it from cross-contamination.

3. COOK

Cook food thoroughly – cooking times and temperatures vary for different meat and poultry. Prepare foods quickly and serve immediately so foods don't linger at room temperature (the danger zone) where bacteria can grow.¹⁰

4. CHILL

Refrigerate or freeze perishables, prepared food and leftovers within two hours. Make sure the refrigerator is set at a temperature of 4°C (40°F) or lower for food safety. Keep the freezer at -18°C (0°F) or lower for best food quality.

7 See Appendix 2: Sample Food Safety Plan.

8 See Appendix 3: The "Top Ten" Food Handling Practices that Cause Food Poisoning, and visit <http://www.canfightbac.org/english/ccentre/ccentree.shtml>.

9 See http://www.canfightbac.org/english/fight_bac/stepse.shtml.

10 See Appendix 4: Potentially Hazardous Foods (PHFs).

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11.6 Applying the four steps

Here are some tips to applying the steps:

Shopping

When shopping, be aware that time, temperature and cold containers are key. Here are some tips:

- When running errands, do your grocery shopping last.
- Pick up food in order of least to most perishable: non-perishables, baked goods, produce, meat, poultry, fish, ready-to-eat items such as deli meats and BBQ chicken and dairy products. Separate raw meat, poultry and seafood from other foods in your grocery cart.
- Check for and follow best before dates.

Transporting food

As with shopping, when transporting food, time, temperature and cold containers are key:

- If possible, use a cooler to transport food from the store to your residence (best practice).
- Put refrigerated and frozen food together when transporting.
- When available, use insulated, foil freezer bags that can be purchased at most grocery stores and collapsible coolers to transport frozen foods.
- Once home, refrigerate/freeze food as soon as possible.

Storage

When storing food, follow these tips:

- Don't overstuff the refrigerator. Cold air needs to circulate above and beneath food to keep it safe. Separate raw meat, poultry and seafood from other foods in your refrigerator.
- To prevent juices from raw meat, poultry or seafood dripping onto other foods in the refrigerator, place these raw foods in sealed containers or plastic bags on the *bottom shelves*.
- Cold foods should be stored at 4°C (40°F) or colder.

Preparing food

When preparing food:

- If possible, use one cutting board for fresh produce and a separate one for raw meat, poultry and seafood. This helps prevent cross contamination.
- When marinating foods:
 - Marinate foods in the refrigerator.
 - Sauce that is used to marinate raw meat, poultry or seafood should not be used on cooked foods or otherwise used again to marinate.
 - Boil leftover marinade before using it for basting or prepare extra for basting cooked food.

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- Wash and sanitize your brush or use separate brushes when marinating raw and cooked foods.
- Thoroughly wash fresh produce under running water to remove dirt and residue.
- Scrub fruits and vegetables that have firm surfaces, such as oranges, melons, potatoes and carrots.
- Cut away any damaged or bruised areas on produce (where bacteria thrive).
- Remove and discard outer leaves on leafy produce.
- Never place cooked food back on the same plate or cutting board that previously held raw food.

Advance preparation

When preparing foods in advance get the foods out of the danger zone (4°C to 60°C or 40°F to 140°F) as soon as possible. You should also:

- Cook only as much food as can be refrigerated/frozen.
- Portion the food to be frozen so it can be defrosted individually.

Cooking

Be sure to cook foods to proper temperatures. Follow these tips:

- Foods are properly cooked when they are heated for a period of time at high enough temperature to kill harmful bacteria that can cause food borne illness.¹¹
- Use a clean thermometer, which measures the internal temperature of cooked foods, to make sure meat, poultry, egg dishes, casseroles and other foods are cooked all the way through. Insert the thermometer in the thickest part of the food when measuring the temperature.
- When cooking in a microwave oven, make sure the food is cooked thoroughly. For best results, cover food, stir and rotate for even cooking and follow suggested standing times.

Serving food

- When serving food over a period of time, keep it piping hot (at above 60°C or 140°F) before serving with chafing dishes, crock pots and warming trays.
- When serving cold food at a buffet, picnic or barbeque, keep these cool tips in mind:
 - Keep all perishable foods chilled right up until serving time.
 - Place containers of cold food on ice for serving to make sure they stay cold.
 - Refrigerate custards, cream pies and cakes with whipped cream or cream cheese frostings. Don't serve them if refrigeration is not available up to serving time.

11 See Appendix 5: Safe Cooking, Reheating Times and Temperatures; Appendix 6: Safe Cooking Internal Times and Temperatures for Roast Beef and Corned Beef Only; and Appendix 7: Sample Oven Temperature Record.

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Leftovers

Minimize the risk of food poisoning when using leftovers by following these tips:

- Cool food quickly by separating large amounts of leftovers, such as beef stew, into small, shallow containers (less than two inches high).
- Use portion control and menu design to minimize leftovers.
- Reheat leftovers to proper temperatures.
- Reheat leftovers only once.
- Throw out any leftovers that have already been cooked, cooled and already reheated once.

Chilling and defrosting food

When chilling food, you want to get it out of the danger zone (4°C to 60°C or 40°F to 140°F) as soon as possible (60°C to 20°C in two hours and 20°C to 4°C in four hours, total six hours). Follow these tips:

- Verify fridge and freezer temperatures weekly with a suitable thermometer kept in the fridge in plain view.¹²
- Following cooking, keep foods out of the danger zone (4°C to 60°C or 40°F to 140°F) as soon as possible. The best cooling takes food from 60°C to 20°C in two hours and 20°C to 4°C in four hours, total six hours.
- Refrigerate or freeze perishables, prepared foods and leftovers within two hours or less.
- Thaw frozen food in the refrigerator, in cold water or in the microwave if you will be cooking it immediately. Never defrost at room temperature.

Cleaning

- Always wash your hands for at least 20 seconds in warm soapy water before handling food and after handling meat, poultry, eggs and seafood. You should also wash your hands after other daily tasks, such as changing diapers, touching pets, sneezing, using the washroom and handling money.
- Options for hand washing (in descending order from best to minimum practice):
 - Have one sink for washing dishes and preparing food and another sink for washing hands.
 - Keep dish washing and hand washing separate when using a double sink.
 - Use a dual-purpose sink.
 - Air-dry dishes or dry them in the dish washer (best practices) or use one hand towel for drying hands and one hand towel for drying dishes.
 - In between hand washing or in a pinch, use liquid hand sanitizers or a hand-sterilizing unit with a soap dispenser.

¹² See Appendix 8: Sample Refrigerator and Freezer Temperature Record. Some operators may want to check temperatures more often than weekly.

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- Wearing gloves is not a substitute for washing hands. Gloves should not be used to handle food where tongs, servers or other utensils are appropriate. Wear gloves when cleaning and rinse in sanitizing¹³ solution between jobs.
- Minimize the risk of cross-contamination by following these tips:
 - Consider using paper towels to wipe kitchen surfaces or change dishcloths daily to avoid the possibility of cross-contamination and the spread of bacteria.
 - Avoid using sponges (harder to keep bacteria free).
 - Wash your food thermometer with hot soapy water before using it again. Sanitize it for the safest results.
 - Clean and then sanitize countertops, cutting boards and utensils with a mild bleach solution (5ml/1 tsp bleach per 750ml/3 cups water) before and after food preparation.
 - Where other chemicals are used for cleaning, provide staff with written instructions about appropriate concentrations.
 - Wash and sanitize your food thermometer after each use.
 - *Deal with insect and rodent infestations immediately.*
 - Discard worn cutting boards that can harbour bacteria.
 - Clean, sanitize and dry insulated foil freezer bags before reusing.

Illness plan

If you or staff who handle food are ill, you/they should not work with food. If this is not possible in your small residence, you can reduce risks by:

- Engaging in good personal hygiene – wash your hands.
- Cover cuts, sores, burns and lesions with a disposable glove.¹⁴
- Ordering in from a restaurant while you are sick.
- Making and serving previously frozen meals.

Infection control

Where a worker or resident has diarrhea or vomits, quickly clean and disinfect any contaminated surfaces. Then sanitize the area with bleach (one part bleach to nine parts water); allow the bleach to sit for two minutes before rinsing. If the residence is experiencing a Norovirus outbreak, surfaces should be cleaned regularly and disinfected to kill the virus (use a diluted bleach solution of one part household bleach to 49 parts water).

¹³ Sanitize means reducing or killing bacteria on a surface that has already been cleaned.

¹⁴ Disposable gloves are available in latex and, for those with latex allergies, in vinyl or nitrile, all with or without cornstarch.

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Appendix 1

Useful Links and Contacts

Health Authority FOODSAFE Contacts

For up to date FOODSAFE course information and availability, visit <http://www.foodsafe.ca/> and click the “courses” option at the top of the page. Or, if you do not have Internet access, consult the health authorities listing in the blue pages of your telephone book.

Workers' Compensation Board

Workers' Compensation Board has policies for making the food service area a safe working place.

You may wish to purchase the Food Service Worker's Safety Guide:
<http://tourism.healthandsafetycentre.org/s/Prevention-FoodBeverage.asp>

Workers' Compensation Board of British Columbia
6951 Westminster Highway
Richmond B.C. V7C 1C6
604 273-2266; 1 800 661-2112 or 1 800 972-9972
Fax: 604 276-3151
<http://www.worksafebc.com/>

Prevention Services Information Line:
604 276-3100,
Toll-free: 1 888 621-SAFE (ext. 7233)

After-hours safety and health emergency reporting:
604 273-7711; 1 888 621-SAFE (ext. 7233)

Contacts for WCB of B.C. offices:
http://www.worksafebc.com/contact_us/regional_locations/default.asp

Ministry of Health Publications

Ensuring Food Safety – Write Your own Food Safety Plan – The HACCP Way, A Guide for Food Service Operators, Ministry of Health and Ministry Responsible for Seniors, 1999 or see
<http://www.bccdc.org/download.php?item=1143>.

Canadian Restaurant and Food Services Association

316 Bloor Street West
Toronto, ON. M5S 1W5
416 923-8416; 1 800 387-5649
Fax: 416 923-1450

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Other links

<http://www.canfightbac.org/> – general overview of the importance of food safety in the home

<http://www.beefinfo.org/> – food safety resource related to beef

<http://www.chicken.ca/> – food safety resource related to chicken

http://www.cfis.agr.ca/english/regcode/frfsrc-amendmts/frfsc01_e.shtml –
Food Retail and Foodservice Code for Canada

<http://www.crfa.ca/> – Canadian Restaurant and Food Services Association

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Appendix 2 Sample Food Safety Plan*

↑ GOOD PRACTICE ↓	COOK – SERVE	READY TO EAT	↑ CRITICAL ↓
	RECEIVING Approved suppliers	RECEIVING¹ Approved suppliers	
	STORAGE Max 4°C/-18°C	STORAGE² Max 4°C/-18°C	
	THAW / PREPARATION <ul style="list-style-type: none"> • Good hygiene • Hand washing • Sanitized equipment • Defrost in fridge 	PREPARATION² <ul style="list-style-type: none"> • Good hygiene • Hand washing • Cross contamination • Minimize bare hand contact • Utensils/papers • Sanitized equipment 	
	COOK³ Min 74°C	COLD HOLDING² Max 4°C	
	HOT HOLDING² Min 60°C	LEFTOVERS Label and date ↓	
	COOL LEFTOVERS 60°C – 20°C 2 hours max. 20°C – 4°C 4 hours max. Label and date	COLD STORAGE² Max 4°C	
	COLD STORAGE² Max 4°C	COLD HOLDING² Max 4°C	
	REHEAT^{3,4} To 74°C quickly	DISCARD LEFTOVERS After 72 hours	
NO LEFTOVERS			

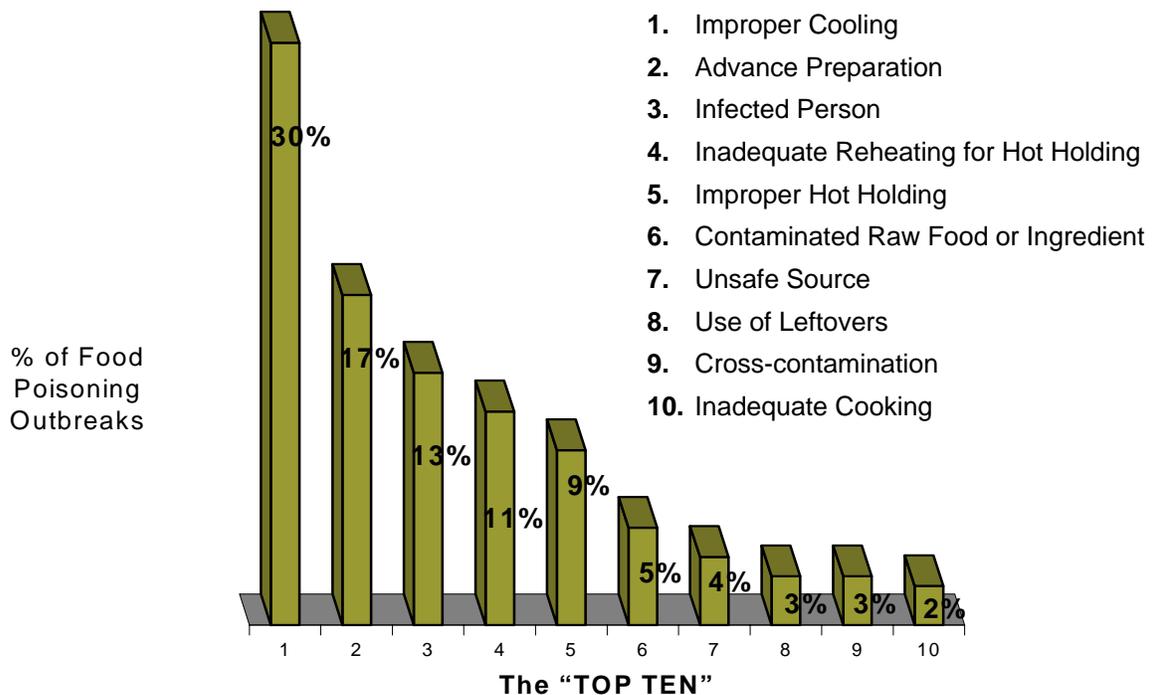
Corrective Action – If Fail To Meet Limits

- 1 Refuse product if it is damaged, not cold (4°C) or not from an approved source.
- 2 Discard if mishandled or temperature abused.
- 3 Continue cooking until you reach a minimum of 74°C.
- 4 Leftovers should only be reheated once.

* Courtesy of Interior Health Authority.

Appendix 3

The “Top Ten” Food Handling Practices That Cause Food Poisoning*



These “TOP TEN” food-handling practices cause almost all food-poisoning outbreaks in food service establishments. The top five cause 80 per cent of all outbreaks.

If you can get rid of these practices in your operation, you will reduce the risk of causing a food-poisoning outbreak to nearly zero. You will be sure that the food you serve your customers is safe. For more information on the TOP TEN list, see Appendix 1* – The TOP TEN List: Dos and Don’ts to Prevent Problems.

* Dr. Frank Bryan, Journal of Food Protection, 1988.

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Appendix 4 Potentially Hazardous Foods (PHFs)

PHFs are those foods that are considered perishable. They will spoil or “go bad” if left out at room temperature. PHFs are foods or food ingredients that support the growth or survival of disease causing bacteria (called “pathogens”) or foods that may be contaminated by pathogens. Generally, a food is a PHF if it is:

1. Of animal origin, such as meat, milk, eggs, fish, shellfish, poultry (or if it contains any of these products).
2. Of plant origin (for example, vegetables, beans, fruit) that has been heat-treated or cooked.
3. Any of the raw sprouts (for example, bean, alfalfa, radish).
4. Any cooked starch (for example, rice, pasta).
5. Any type of soya protein (for example, soya milk, tofu).

Examples of:

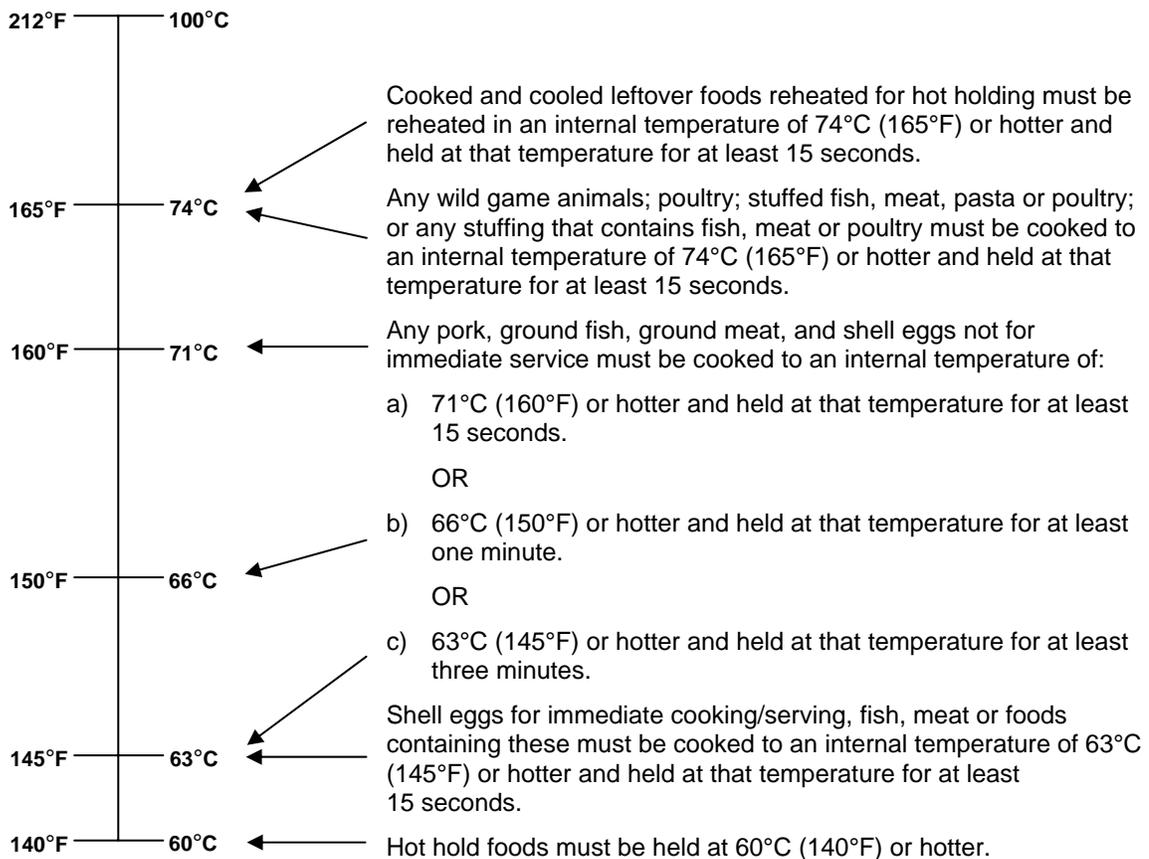
PHFs	Not PHFs
Chicken, beef, pork and other meats	Beef jerky
Pastries filled with meat, cheese or cream	Bread
Cooked rice	Uncooked rice
Fried onions	Raw onions
Opened cans of meat, vegetables	Unopened cans of meat, vegetables (as long as they are not marked with “keep refrigerated”)
Tofu	Uncooked beans
Coffee creamers	Cooking oil
Fresh garlic in oil	Fresh garlic
Fresh or cooked eggs	Powdered eggs
Gravy	Flour
Dry soup mix with water added	Dry soup mix

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Appendix 5

Safe Cooking, Reheating Times and Temperatures



Microwave:

Foods cooked or reheated in a microwave oven must be:

- cooked/reheated in a covered container;
- rotated or stirred at least once during the cooking/reheating;
- allow to stand covered for two minutes after cooking before serving.

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Appendix 6

Safe Cooking Internal Times and Temperatures for Roast Beef and Corned Beef Only

Meat Temperature No Lower Than		Meat Must be Held in Oven for At Least
°F	°C	Holding Time
130	54	121 minutes
132	56	77 minutes
134	57	47 minutes
136	58	32 minutes
138	59	19 minutes
140	60	12 minutes
142	61	8 minutes
144	62	5 minutes
145	63	3 minutes

Example:

If the maximum internal temperature of the roast or corned beef is only 56°C (132°F), then the meat must be kept at this temperature for at least 77 minutes in order to kill off potential pathogens. When measuring the internal temperature, be sure to insert the end of the thermometer in the middle of the cut and not near a bone.

Ensuring Food Safety – Write Your own Safety Plan – The HACCP Way, A Guide for Food Service Operators, Ministry Responsible for Seniors, 1999, page 8 or see <http://www.bccdc.org/download.php?item=1143>.

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Appendix 7 Sample Oven Temperature Record

Check temperature weekly. If there is a problem, please notify the manager.

Week	Oven One	Oven Two	Other	Checked By	Comments
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					

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Week	Oven One	Oven Two	Other	Checked By	Comments
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
36					
37					
38					
39					
40					
41					
42					
43					
44					
45					
46					
47					
48					
49					
50					
51					
52					

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Appendix 8 Sample Refrigerator and Freezer Temperature Record

Check temperature weekly. If there is a problem, please notify the manager.

Week	Fridge One	Fridge Two	Freezer One	Freezer Two	Checked By	Comments
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						

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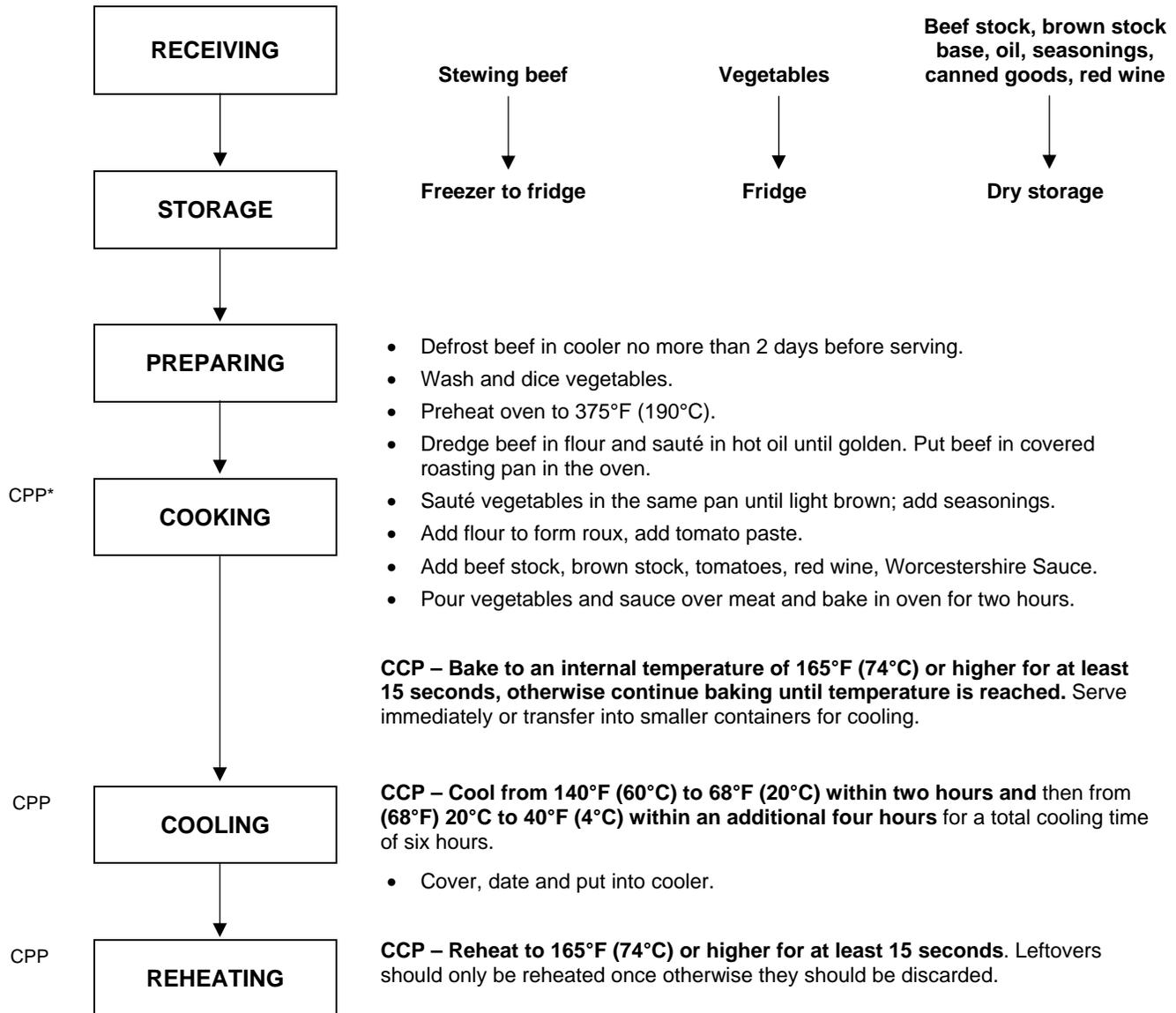
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Week	Fridge One	Fridge Two	Freezer One	Freezer Two	Checked By	Comments
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36						
37						
38						
39						
40						
41						
42						
43						
44						
45						
46						
47						
48						
49						
50						
51						
52						

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Appendix 9 Sample Beef Stew Flow Chart



*CCP = Critical Control Point.

Standard Operating Procedures: Measure all internal product temperatures with a cleaned and sanitized thermometer. Properly wash hands and exposed parts of arms before handling food, after handling raw food and after any interruption that might contaminate hands. Wash, rinse and sanitize all equipment and utensils before and after use. Return all ingredients to refrigerated storage if preparation is interrupted.

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Appendix 10 Sample Beef Stew Recipe

PREPARATION

- Preheat oven to 375°F (190°C).
- Dredge beef in flour and sauté in hot oil until golden brown. Put beef in a covered roasting pan in the oven.
- Wash and dice vegetables.

CCP*

COOKING

- Sauté onions, carrots, celery, mushrooms, garlic until light brown.
- Add seasonings.
- Add flour to form roux. Cook the roux until golden brown.
- Add tomato paste. Add beef stock, brown stock, Worcestershire Sauce, tomatoes, red wine.
- Pour vegetables and sauce over meat.
- Put in the oven and bake for two hours.
- **Bake to an internal temperature of 165°F (74°C) or higher for at least 15 seconds, otherwise continue baking until temperature is reached.**
- Serve immediately or transfer into small containers for cooling.

CCP

COOLING

- Put into smaller container and place in ice water.
- Cool from 140°F (60°C) to 68°F (20°C) within two hours and then from 68°F (20°C) to 40°F (4°C) within an additional four hours for a total cooling time of six hours.
- Cover, date and place in cooler.

CCP

REHEATING

- Reheat to 165°F (74°C) or higher for at least 15 seconds within two hours.
- Serve within two hours.
- Use only one time.

* CCP = Critical Control Point.

Standard Operating Procedures: Measure all internal product temperatures with a cleaned and sanitized thermometer. Properly wash hands and exposed parts of arms before handling food, after handling raw food and after any interruption that might contaminate hands. Wash, rinse and sanitize all equipment and utensils before and after use. Return all ingredients to refrigerated storage if preparation is interrupted.

INGREDIENTS

Yields: 2 KG

1 kg	stewing beef
75 g	flour
80 ml	oil
300 g	onions
300 g	carrots
300 g	celery
200 g	mushrooms
2 cloves	garlic
	allspice
	rosemary
	salt
	pepper
	parsley
1	bay leaf
100 ml	tinned tomatoes
400 ml	beef stock
500 ml	brown stock
10 ml	Worcestershire sauce
20 g	tomato paste
40 ml	red wine

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POLICY 12

Prevention and Control of Infectious Diseases

12.1 Introduction

The purposes of this policy are:

- to explain how registrants (operators of registered residences) can meet outcome 1.6.1 of the *Health and Safety Standards* regarding the prevention and control of infectious diseases; and
- to outline the role of public health in response to infectious diseases in assisted living residences.

12.2 Policy Statement

The *Health and Safety Standards* require that registrants must:

1. Provide a safe, secure and sanitary environment for residents¹;
2. Ensure hospitality services do not place the health or safety of residents at risk²; and
3. Ensure sufficient staff is available to meet the service needs of residents and that staff has the knowledge and ability to perform the assigned tasks³.

The health and safety outcomes specifically associated with infection are:

1.6.1 Registrants must have a plan in place to prevent and control the spread of infectious diseases in assisted living residences in accordance with *Prevention and Control of Infectious Diseases*.

3.2.2 Registrants must have plans in place to address situations where there is a disruption to the residence's regular work force.

Registrants must conduct and document staff orientation and ongoing training in each element of the plan set out below.

12.3 Policies and Procedures for Preventing Infection

The *Health and Safety Standards* for the prevention and management of the spread of infection focus on the content of the registrant's written policies and procedures and scope of staff training and resident education. To prevent the spread of infection, registrants must have written policies and procedures for staff that include:

- good health practices that everyone should follow;
- a protocol for hand washing;
- basic hygiene and infection control practices associated with laundry and housekeeping (frequency of service and the products to be used);

¹ Office of the Assisted Living Registrar, *Registrant Handbook*, Policies Tab 4, Health and Safety Standard #1, (August 31, 2007).

² Standard #2.

³ Standard #3.

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Prevention and Control of Infectious Diseases

- safe practices for the preparation and delivery of meals;
- how staff illness will be handled; and
- asking for guidance from public health on infection control as needed.

Registrants must provide residents with general information about basic hygiene and infection prevention and control. Registrants should also have a policy to recommend staff and residents receive the influenza vaccine annually. Registrants may also have a policy to recommend staff and residents receive other appropriate immunizations.

12.4 Recognizing a Change from Normal Conditions

Early recognition of infectious illness in an assisted living residence is generally beneficial in minimizing its impact on residents, visitors, staff and other service providers. Registrants must have written policies and procedures for staff to understand the importance of recognizing a change from normal conditions affecting residents and/or staff⁴. Registrants are expected to keep a watchful eye⁵ over residents and, if aware of one or more cases of infectious disease among residents and/or staff, follow written policies and procedures and consult with public health in the geographic area of the residence as needed⁶.

12.5 Contacting Public Health

Public health and/or case managers within each health authority may provide registrants with information about which infectious illnesses or situations to report, how to report, to whom to report, when to report and why reporting is expected⁷. Registrants should contact public health as soon as possible when a change from normal conditions is recognized and needs consultation. Informing public health does not mean that public health takes over management of the situation. This responsibility remains with the registrant.

If public health receives laboratory results that suggest one or more assisted living residents may have an infectious disease, it may contact the registrant.

⁴ Although the mandate of the Assisted Living Registrar under the *Community Care and Assisted Living Act* is to ensure the delivery of assisted living services does not jeopardize *resident* health and safety, the health of staff can affect the health and safety of residents.

⁵ As a standard of care, 'keeping a watchful eye' is higher than the responsibility expected of operators of independent housing (where the person receives only housing from the operator) or supportive housing (where the resident receives housing and one or more hospitality services, for example, meals or laundry, but no personal assistance, from the operator) but not as high as that expected of operators of community care facilities. In other words, if a registrant notices a problem in relation to a resident's health or safety, they have a responsibility to follow up with the resident.

⁶ Some health authorities have developed infection prevention and control toolkits, which registrants with publicly subsidized units should use to manage the spread of infection.

⁷ The health authorities' infection prevention and control toolkits may specifically state notification is not required.

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Prevention and Control of Infectious Diseases

12.6 Reporting to the Case Manager

In assisted living residences with publicly subsidized units, registrants must also advise and consult with the health authority case manager about any change in normal conditions and the management of publicly subsidized residents who have increased personal assistance needs.

12.7 Management When a Change from Normal Condition

- Registrants must have written policies and procedures in place for staff concerning hygiene and infection control during a change from normal conditions.
- Registrants must educate and encourage residents about how to minimize the spread of infection.
- Registrants can also recommend residents get (annual) influenza and other recommended vaccinations.
- Registrants should follow written policies and procedures about how to control the spread of infection and include when to consult with public health and/or the case manager for the residence as needed. Whether public health is aware of anything unusual at an assisted living residence depends on the information it receives from registrants, laboratories and physicians.
- Registrants must consider the advice they receive from public health. In certain limited circumstances (e.g., a staff member or resident with active tuberculosis), public health may require certain control measures. Registrants should avoid ineffective or unnecessary restrictions on residents.
- The public health advice about an unexpected increase in the number of cases of infectious illness among residents or staff at an assisted living residence will be similar to its advice when this situation occurs at any other congregate, unlicensed setting in the community⁸.
- The public health advice about a change from normal conditions will recognize the infrastructure and resources available to the registrant. For example, registrants would not be asked to conduct surveillance in the same way as it is conducted at community care facilities or to make diagnoses. Diagnosis and required laboratory testing should be arranged by the resident's physician as it is in any other community setting.
- Whether meals are cooked on or off-site, public health has some oversight over the preparation of meals through the issuance of Food Premises Permits.
- Registrants and public health accept that restrictions on new residents are less likely to be of value in assisted living residences than in community care facilities. However, a registrant can choose to close an assisted living residence temporarily to new residents moving in, or take other control measures, during the occurrence of a respiratory or gastrointestinal illness.
- Registrants should keep contact information up-to-date and accessible to facilitate timely contact with public health and/or case managers.

⁸ Examples of similar settings to assisted living residences, where people live semi-independently, include supportive housing and boarding schools. In assisted living residences, there is limited infrastructure and staff is not necessarily on site 24/7. Staff is mainly non-health professional, although a registered nurse or licensed practical nurse provides clinical oversight of nonprofessional staff.