

Resident-related – Triggered

Home Name: _____ Inspection Number: _____ (*hard copy use only*)
 Date: _____
 Inspector ID: _____

| Definition / Description | |
|--|--|
| Personal Support Services: | Services to assist with the activities of daily living including personal hygiene and supervision in carrying out those activities (LTCHA). |
| Activities of Daily Living (ADL): | Daily activities of residents which relate to their personal care needs including hygiene and grooming, bathing, oral care, foot care, dressing, transferring, positioning, personal aids, mobility devices, and bedtime routines. |
| Positioning: | The resident who is unable to move limbs freely to change positions or who is partially or totally dependant because of injury or disease may require the assistance of others to be moved at regular intervals. <i>(Positioning Techniques in Long-Term Care: Self-Directed Learning Package for Health Care Providers, RNAO, May 2007)</i> |
| Restorative Care: | This is interdisciplinary care that promotes and maximizes independence of residents living in long-term care homes, and includes, but is not limited to, physiotherapy and other therapy services which may be arranged or provided by the licensee (LTCHA). |

| Use |
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| <p>This is a resident-related triggered IP, used to review personal support services, activities of daily living (ADLs), positioning or physical functioning during the annual inspection of the LTC home for a sampled resident.</p> <p>The inspector may also select and complete this IP when a concern(s) related to personal support services is raised, while conducting any type of inspection.</p> <p>The inspection focuses on the licensee’s obligations to meet personal support services requirements related to the:</p> <ul style="list-style-type: none"> • Assessment of individualized care • Provision of individual care that promotes dignity, choice and privacy • Strategies to maximize the resident’s independence and abilities to perform activities of daily living. |

| Procedure |
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| <p>Each section within this IP contains statements that provide guidance to the inspector in the collection of information and may not be applicable in every situation. The information collected will be used to determine whether a home is in compliance with the LTCHA.</p> |

This IP contains two (2) parts:

- Part A: Resident Risk and Care Outcomes
- Part B: Contributing Factors

During the Annual Inspection:

1. The inspector(s) will complete one (1) IP for each selected resident.
2. All applicable questions in Part A must be completed unless not applicable to the specific resident's condition.
3. If non-compliance is identified in Part A, the inspector(s) will proceed to Part B and complete the applicable questions.
4. If there is no non-compliance identified in Part A, Part B is not required to be completed unless other concerns related to personal support services have been identified.
5. The inspector must document evidence to support non-compliance in the 'Notes' section when answering 'No'.

PART A: Resident Risk and Care Outcomes

Initial Record Review

Relevant documents for review include:

MDS assessment:

- Section B (cognitive patterns)
- Section C (communication/hearing patterns)
- Section D (vision patterns)
- Section E (mood and behaviour patterns) e.g. E4e resists care, E5 (change in behavioural symptoms)
- Section G (physical functioning and structural problems) – e.g. G1aA (mobility in bed), G1bA (transfers), G1eA (locomotion), G1gA (dressing), G1hA (eating), G1iA (toilet use), G1jA (personal hygiene), G1aA (bed mobility self performance), G1cA (walk in room self performance), G2 bathing, G4 (functional limitation in range of motion), G5 modes of locomotion, G6 (modes of transfer), G8 (ADL functional rehabilitation potential), G9 (decline in ADL)
- Section I (disease diagnoses) – e.g. musculoskeletal (I1l-p), neurological (I1q-ee), psychiatric/mood (I1ff-ii), sensory (I1ll-oo)
- Section J (health condition) – e.g. J2a (frequency of pain), J2b (intensity of pain), J5c (end stage disease)
- Section L (oral/dental status)
- Section M (skin condition)
- Section O (medication) – e.g. O4f (analgesic)
- Section P (special treatments and procedures) – e.g. therapies (P1b), dressing or grooming program (P3g), eating or swallowing program (P3h), transfer (P3e) etc.

The history, physical assessment, physician orders, plan of care, progress notes, pharmacist reports, lab reports and any flow sheets, intake and output records.

| No. | | | Information Gathering | |
|-------|--|--|------------------------------|--|
| | | | Initial Record Review | |
| Notes | | | | |

| Resident/Substitute Decision-Maker Interview | | | | |
|---|--|--|---------------------------------|--|
| Interview the resident, family or responsible party to determine: <ul style="list-style-type: none"> • Whether the personal care interventions are provided in accordance with the plan of care • Whether staff provide individual care that promotes dignity, choice and privacy • Whether concerns related to ADL and positioning needs are responded to • Whether timely and appropriate assistance is provided for care requests. | | | | |
| No. | | | Information Gathering | |
| | | | Resident / SDM Interview | |
| Notes | | | | |

| Staff Interviews | | | | |
|---|--|--|-------------------------|--|
| Interview staff on various shifts when concerns about personal support services have been identified to determine: <ul style="list-style-type: none"> • Awareness and understanding of the ADL plan of care approaches • Whether care is provided using safe techniques, respect and dignity and is reflective of choice and preferences • Whether the staff have actively sought information from the resident and/or SDM regarding individual needs and preferences. | | | | |
| No. | | | Information Gathering | |
| | | | Staff Interviews | |
| Notes | | | | |

| Assessment | | | | |
|---|--|--|--|--|
| Determine whether the assessment includes, as appropriate: <ul style="list-style-type: none"> • Strengths and abilities of the resident that can contribute to improvement in ADL performance and/or in range of motion • The presence and degree of contractures and associated pain or discomfort and/or skin breakdown • Risk and contributing factors for: <ul style="list-style-type: none"> • any limitations in physical functioning that affect ADL, positioning and Range of Motion (ROM) • decline or lack of improvement in ADL or ROM | | | | |

- any resistance to care.

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|--------------|--|--|------------------------------|--|
| | | | Information Gathering | |
| | | | Assessment | |
| Notes | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|--------------|--------------------------|--------------------------|--------------------------|--|---------------------|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other? | s. 6 (4) (a) |
| Notes | | | | | |

Plan of Care

Review the plan of care to determine whether the plan is based upon the goals, needs, and strengths specific to the resident and reflects the comprehensive assessment. Determine whether the plan of care addresses:

- Quantifiable, measurable objectives with reassessment timeframes
- Interventions with clear instructions to guide the provision of care, services and treatment for the resident who requires encouragement, assistance or cueing with ADLs including hygiene, grooming, dressing, oral care, transfer, ambulation, eating, toileting, visual, hearing and communication/language needs and personal aids, in respect of the following:
 - Based upon resident choices and preferences and interdisciplinary expertise
 - Promotion of respect and dignity
 - Prevention of skin breakdown in areas where contractures are present
 - Pain relief prior to the provision of ADLs and passive/active ROM as applicable
 - Environmental approaches and devices to promote ADL independence and to maximize independent functioning
 - Positioning interventions and monitoring
- Restorative care approaches include the plan of action that both the resident and the staff will take to improve and or maintain ADL functioning and range of motion.

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|--------------|--|--|------------------------------|--|
| | | | Information Gathering | |
| | | | Plan of Care | |
| Notes | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-----|-----|----|-----|----------|----------|
|-----|-----|----|-----|----------|----------|

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|-------|--------------------------|--------------------------|--------------------------|---|------------------|
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the care set out in the 24-hour admission care plan based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator? | r. 24 (4) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|--------------------|
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the plan of care based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living including hygiene and grooming? | r. 26 (3) 7 |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|---------------------|
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the plan of care based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene? | r. 26 (3) 12 |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|---------------------|
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the plan of care based on an interdisciplinary assessment of the resident's sleep patterns and preferences? | r. 26 (3) 21 |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|--------------------|
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the plan of care based on an interdisciplinary assessment of the resident's communication abilities, including hearing and language? | r. 26 (3) 3 |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|--------------------|
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the plan of care based on an interdisciplinary assessment of the resident's vision? | r. 26 (3) 4 |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-----|--------------------------|--------------------------|--------------------------|---|---------------------|
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the plan of care based on an interdisciplinary assessment of the | r. 26 (3) 18 |

| | | | | | |
|-------|--|--|--|--|--|
| | | | | resident's special treatments and interventions? | |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|-------------------|
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the plan of care set out clear directions to staff and others who provide direct care to the resident? | s. 6 (1) c |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|-----------------|
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the plan of care based on an assessment of the resident and the resident's needs and preferences? | s. 6 (2) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|-----------------|
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has the resident, the SDM, if any, and the designate of the resident/SDM been given an opportunity to participate fully in the development and implementation of the plan of care? | s. 6 (5) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|-----------------|
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are staff and others who provide direct care to a resident kept aware of the contents of the plan of care and given convenient and immediate access to it? | s. 6 (8) |
| Notes | | | | | |

Observations / Provision of Care

Observe the resident to determine whether staff:

- Provide care with respect, dignity and privacy
- Encourage and assist the resident in making individual choices
- Provide encouragement, assistance and cueing with ADLs such as hygiene care, grooming, bathing, dressing, eating, brushing teeth, personal aids, eating aids, positioning and ROM
- Implement preventative measures for decline in physical function and ability
- Address risks and/or contributing factors to minimize complications
- Are responsive to individual hearing, vision or communication concerns (such as adequate lighting, reduction of glare, removal of clutter, reduction of background noise etc.)

- Use supportive and assistive devices/equipment correctly in interacting with residents (such as hearing aids, magnifying glasses, hand signals, use of pictures, large communication boards, etc.)
- Use safe technique with positioning and safe transfer aid, devices, equipment as appropriate
- Have access to supplies, equipment and devices as needed.

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| | | | Information Gathering | |
| | | | Observations / Provision of Care | |
| Notes | | | | |

Bathing

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|------------------|
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the resident bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition? | r. 33 (1) |
| Notes | | | | | |

Communication

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|--------------|
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are strategies developed and implemented to meet the needs of those residents with compromised communication and verbalization skills, residents with cognitive impairment and residents who cannot communicate in the languages used in the home? | r. 43 |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|----------------------|
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the home have a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times? | r. 17 (1) (a) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|--------------------|
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the resident have the right to communicate in confidence, receive visitors of his or her own choice and consult in private with any person without interference? | s. 3 (1) 14 |
| Notes | | | | | |

Dressing

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|--------------|
| 17. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the resident receive the assistance required to dress? Is the resident dressed appropriately, suitable to the time of day and in accordance with their preferences, in their own clean clothing and appropriate clean footwear? | r. 40 |
| Notes | | | | | |

End-of-Life Care

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|--------------|
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the resident requiring end-of-life care receive care in a manner that meets their needs? | r. 42 |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|--------------------|
| 19. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has the licensee ensured that the right of the dying or very ill resident to have family and friends present 24 hours per day has been respected and promoted? | s. 3 (1) 15 |
| Notes | | | | | |

Foot Care and Nail Care

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|------------------|
| 20. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the resident receive preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection? | r. 35 (1) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|------------------|
| 21. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the resident receive fingernail care, including the cutting of fingernails? | r. 35 (2) |
| Notes | | | | | |

Hygiene & Grooming

| No. | Yes | No | N/A | Question | Act/Reg. |
|-----|--------------------------|--------------------------|--------------------------|---|--------------|
| 22. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the resident receive individualized personal care, including hygiene care and grooming on a daily basis? | r. 32 |

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| Notes | |
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Oral/Dental Care

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|--------------------|
| 23. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the resident receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures? | r. 34 (1) a |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|----------------------|
| 24. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the resident who cannot brush their own teeth receive physical assistance or cueing? | r. 34 (1) (b) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|------------------|
| 25. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the resident receive assistance, if required, to insert dentures prior to meals and at any time when requested by the resident or required by the resident's plan of care? | r. 34 (2) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|--------------------|
| 26. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the resident offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required? | r. 34 (1) c |
| Notes | | | | | |

Personal Aids/ Equipment

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|----------------------|
| 27. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the resident have their personal items, including personal aids such as dentures, glasses and hearing aids, cleaned as required? | r. 37 (1) (b) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-----|--------------------------|--------------------------|--------------------------|---|------------------|
| 28. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the resident receive assistance to use personal aids, if required? | r. 37 (2) |

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| Notes | |
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| No. | Yes | No | N/A | Question | Act/Reg. |
|-----|--------------------------|--------------------------|--------------------------|--|--------------|
| 29. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are supplies, equipment and devices readily available to meet the nursing and personal care needs of the resident? | r. 44 |

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| Notes | |
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| No. | Yes | No | N/A | Question | Act/Reg. |
|-----|--------------------------|--------------------------|--------------------------|--|--------------|
| 30. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are mobility devices including wheelchairs, walkers and canes, available at all times to residents who require them on a short-term basis? | r. 39 |

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|--------------|--|
| Notes | |
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| No. | Yes | No | N/A | Question | Act/Reg. |
|-----|--------------------------|--------------------------|--------------------------|---|--------------------|
| 31. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are the equipment, supplies, devices, assistive aids, or positioning aids, used for the personal support services program appropriate for the resident based on the resident's condition? | r. 30 (1) 2 |

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|--------------|--|
| Notes | |
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Repositioning

| No. | Yes | No | N/A | Question | Act/Reg. |
|-----|--------------------------|--------------------------|--------------------------|---|----------------------|
| 32. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has the resident who is dependent on staff for repositioning been repositioned: <ul style="list-style-type: none"> • every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and • while asleep if clinically indicated? | r. 50 (2) (d) |

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| Notes | |
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Restorative Care & Therapy Service

| No. | Yes | No | N/A | Question | Act/Reg. |
|-----|--------------------------|--------------------------|--------------------------|--|------------------|
| 33. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are restorative care approaches integrated into the care provided to the resident? | r. 57 (a) |

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| Notes | |
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| No. | Yes | No | N/A | Question | Act/Reg. |
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|-------|--------------------------|--------------------------|--------------------------|---|------------------|
| 34. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are restorative care approaches coordinated so that the resident is able to maintain or improve their functional and cognitive capacities in all aspects of daily living, to the extent of their abilities? | r. 57 (b) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|--------------------|
| 35. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the resident provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible? | r. 73 (1) 9 |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|------------------|
| 36. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the resident receiving on-site physiotherapy service on an individualized basis or in a group setting based on his/her assessed care needs? | r. 59 (a) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|------------------|
| 37. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the resident receiving occupational therapy and/or speech-language therapy based on his/her assessed needs? | r. 59 (b) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|------------------|
| 38. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is there a sufficient supply of therapy equipment available at all times to meet the needs of the resident? | r. 60 (2) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|--------------------|
| 39. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the resident receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible? | s. 3 (1) 12 |
| Notes | | | | | |

Transferring and Positioning Techniques

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|--------------|
| 40. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do staff use safe transferring and positioning devices or techniques when assisting residents? | r. 36 |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|-----------------|
| 41. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the care set out in the plan of care provided to the resident as specified in the plan? | s. 6 (7) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|----------------------|
| 42. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Was a care conference of the interdisciplinary team held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any: <ul style="list-style-type: none"> • within six weeks of the admission of the resident, and • at least annually after that? | r. 27 (1) (a) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|------------------------------|
| 43. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has the licensee ensured that: <ul style="list-style-type: none"> (b) the resident, their SDM, if any, and any other person that either of them may direct is invited to participate in these care conferences, and (c) a record is kept of the date, the participants, and the results of the conferences? | r. 27 (1) (b) and (c) |
| Notes | | | | | |

Monitoring/ Evaluation/ Revision

Determine whether the staff have been monitoring the resident's response to interventions and have evaluated and revised the plan of care based on the resident's response, outcomes, and needs.

Both the RAI outcome scale and the quality indicators are evidence of the care intervention effectiveness.

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| | | | | Information Gathering | |
| | | | | Monitoring / Evaluation/ Revision | |

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| Notes | |
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| No. | Yes | No | N/A | Question | Act/Reg. |
|--------------|--------------------------|--------------------------|--------------------------|--|----------------------|
| 44. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the resident reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary? | s. 6 (10) (b) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|--------------|--------------------------|--------------------------|--------------------------|--|--------------------|
| 45. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the resident reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective? | s. 6 (10) c |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|--------------|--------------------------|--------------------------|--------------------------|---|----------------------|
| 46. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care? | s. 6 (11) (b) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|--------------|--------------------------|--------------------------|--------------------------|---|------------------|
| 47. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Has the licensee ensured that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented? | r. 30 (2) |
| Notes | | | | | |

PART B: Contributing Factors

(Complete applicable questions if non-compliance is identified in Part A)

Restorative Care Program in home

| No. | Yes | No | N/A | Question | Act/Reg. |
|-----|--------------------------|--------------------------|--------------------------|---|---------------------|
| 48. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is there an interdisciplinary restorative care program that: (a) promotes and maximizes independence, and (b) includes, but is not limited to, physiotherapy and other therapy services, where relevant, which may be arranged or provided by | s. 9 (1) (a) |

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|-------|--|--|--|---------------|--|
| | | | | the licensee. | |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|-----------------|
| 49. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the interdisciplinary restorative care program include services for residents with cognitive impairment and those who are unable to leave their room? | s. 9 (2) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|--------------------|
| 50. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is there a written description of the personal support services program that includes the following: <ul style="list-style-type: none"> • goals and objectives • relevant policies, procedures and protocols, and • methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources? | r. 30 (1) 1 |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|--------------------|
| 51. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the restorative care program evaluated and updated annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices? | r. 30 (1) 3 |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|--------------------|
| 52. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is there a written record of each evaluation that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented? | r. 30 (1) 4 |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|------------------|
| 53. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the resident/SDM notified when the resident's personal aids or equipment are not in good working order or require repair? | r. 38 (a) |
| Notes | | | | | |

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|--|------------------|
| 54. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the resident/SDM notified when the resident requires new personal belongings? | r. 38 (b) |
| Notes | | | | | |

Policies to be followed

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|-------------------------|
| 55. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the licensee of the home ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is: a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and b) (b) complied with? | r. 8 (1) (a) (b) |
| Notes | | | | | |

General Requirements for Programs

| No. | Yes | No | N/A | Question | Act/Reg. |
|-------|--------------------------|--------------------------|--------------------------|---|--------------------|
| 56. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the licensee of the home ensure for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there is a written description of the program that includes its: <ul style="list-style-type: none"> • goals and objectives • relevant policies, procedures, protocols • methods to reduce risk • methods to monitor outcomes, and • protocols for the referral of residents to specialized resources? | r. 30 (1) 1 |
| Notes | | | | | |

Based on information collected during the inspection process, the inspector may determine the need to select and further inspect other related care/services areas. When this occurs, the inspector will document reason(s) for further inspection in Ad Hoc Notes, select and complete other relevant IPs related to Personal Support Services, for example:

- Admission Process
- Continence Care and Bowel Management
- Critical Incident Response
- Dignity, Choice and Privacy
- Falls Prevention

Ministry of Health and Long-Term Care
Performance Improvement and Compliance Branch

- Infection Prevention and Control
- Medication
- Minimizing of Restraining
- Nutrition and Hydration
- Pain
- Prevention of Abuse, Neglect and Retaliation
- Quality Improvement
- Reporting and Complaints
- Responsive Behaviours
- Safe and Secure Home
- Skin and Wound Care
- Sufficient Staffing
- Training and Orientation