Deliverable Description	Outcome Requirements

Collaborative Care Major Strategic Alignment

The alignment of efforts with organizational strategies and streams of work.

Organizational alignments with AHS vision, values and foundational strategies and strategic priorities to maximize the value of collective investment through leveraging interdependences and minimizing duplication.

Couples to: *All Collaborative Care Elements*

- AHS Vision
- AHS Values
- AHS Four Foundational Strategies
  1. Resident First Strategy
  2. Our People Strategy
  3. Research, Innovation and Analytics
  4. Information Management /Information Technology
- AHS Health & Business Plan
- Professional Practice in Action
- Accreditation Canada Required Organizational Practices
- Strategic Clinical Networks Clinical Pathways (e.g., ERAS, Elder Friendly)
- Operational Best Practices
- AHS Clinical Information System (CIS)
- AHS Leadership System
- Continuing Care Quality Plan
- Continuing Care Health Service and Accommodations Standards
- Resident and Family Council Act

Collaborative Care Practices

Care Hub

A Care Hub is a team of healthcare providers working together towards common resident care goals, providing day-to-day direct care to a group of residents.

Care Hubs are primarily comprised of Regulated Nursing Professionals (e.g., Registered Nurses, Registered Psychiatric Nurses, and Licensed Practical Nurses), Health Care Aides, and Psychiatric Aides and can include other members of the Collaborative Care Team as appropriate to the care needs of residents. The Care Hub lead must be a Regulated Professional.

Performance Measures

Primary

↑ Residents' perceptions of their own and family/friends' engagement
(e.g., ↑satisfaction, ↓ complaints)

↑ Provider experience
(e.g., ↑ job satisfaction, communication, teamwork)

Secondary

↑ Clinical Best Practice
(e.g., CCHSS compliance %, # admitted / discharged)
*CCHSS specific question compliance will be compared with each corresponding CoACT element).

↓ Nursing sensitive adverse events
(e.g., ↓ falls, ↓ pressure ulcers)

↓ Provider Absenteeism

↓ Provider Turnover Rate

Couples to: *Assignment of Care, Resident Handover Care Hub Huddles, Collaborative Care Orientation, Comfort Rounds, Integrated Care Suite (ICS), Name-Occupation-Duty (NOD), Resident Bedside Whiteboard, Resident Orientation, Collaborative Care Team Rounds, Scheduling—Resident's Plan for the Day*

- Care Hub team roles intentionally aligned with credentialed capabilities, to enable Collaborative Care (best meet the day-to-day resident care needs)*
- Defined processes for communicating and addressing resident care needs amongst the Care Hub team
- Functions as a hub for enacting the Care Plan for each resident
- Care Hub membership, which is dependent on resident needs and current staffing levels, will vary from practice setting-to- practice setting and shift-to-shift
- The Care Hub Leader works with the Care Hub team to assess, plan, implement, evaluate and re-evaluate resident care
- Care Hub members contribute to overall resident care in a manner that fully employs their current skills, abilities and credentials
- Care Hub functioning includes two key elements:**
  1. Assignment of Care in which members, through discussion, negotiation, shared decision making, application of the nursing process and use of critical thinking skills, determine who is most appropriate to provide care to residents
  2. Care Hub Huddles are scheduled, regular discussions that facilitate the ongoing monitoring of resident progress, review and updating of care plans and distribution of workload among Care Hub team members

Notes:
**The Care Hub is core for day-to-day resident care around which other services revolve*
*** Refer to Care Hub Huddles (Assignment of Care) in Collaborative Care Processes*

Deliverable Description	Outcome Requirements
Collaborative Care Leadership The Canadian Interprofessional Health Collaborative (CIHC) defines Collaborative Care Leadership as "learners and practitioners work[ing] together with all participants, including residents/ clients/ families, to formulate, implement and evaluate care/services to enhance health outcomes." - *Canadian Interprofessional Health Collaborative: National Interprofessional Competency Framework, 2010, p. 11* ***Performance Measures:*** Primary ↑ Provider experience (e.g., ↑ job satisfaction, ↑ communication, ↑ teamwork, ↑ leadership rounding) ↑ Residents' perceptions of their own and family/friends' engagement (e.g., ↑ satisfaction, ↓ complaints) Secondary ↓ Provider Absenteeism ↓ Provider Turnover Rate ***Couples to:*** *Resident Handover Care Hub Huddles, Collaborative Care Orientation, Comfort Rounds, Integrated Care Suite (ICS), Name-Occupation-Duty (NOD), Resident Bedside Whiteboard, Resident Orientation, Quality Councils, Quality Boards, Quality Board Huddles, Quality Dashboards, Quality Touchpoints, Collaborative Care Team Rounds, Scheduling—Resident's Plan for the Day, Standard Transition Process, Team Charter*	• In every care setting, Collaborative Care Leadership exists to support the successful implementation and sustainability of Collaborative practice, processes and performance, as well as a commitment to Quality Culture and continuous improvement • Collaborative Care leadership aims to support leaders to take action based on their own needs, as well as the needs of their system and their teams • AHS, through CoACT, provides training and support for all levels of leadership and management, including practice setting representation to drive system level and local improvement and implementation • CoACT has chosen to use practice setting teams to strengthen Collaborative Care Leadership competencies. Unit teams are the leaders in unit-level implementation - The team is made up of the Unit Manager, Education Lead, Unit Lead, and Physician Lead - Members of the team act as the local resource and expertise to assist in the successful implementation and sustainability of Collaborative Care elements at in-scope facilities *Notes: Unit lead funding is temporary, available only during implementation. This is determined in consultation with the CoACT Zone Support team*

Deliverable Description	Outcome Requirements

Collaborative Care Team

At the individual resident level, the entire care team, including the resident and family, work together daily to pursue high quality, proactive, integrated care to meet evolving resident care needs to achieve the best possible health outcomes.

The care team's composition reflects population health needs, enables and supports optimized professional practice, integrated care processes inclusive of structured communication and quality commitment.

Collaborative practice, as a function, includes the development of high performing teams.

- Competencies referenced from *A National Interprofessional Competency Framework* (CIHC 2010)
- *HPSP Collaborative Practice Principles Supporting Resident and Family Centred Care (March 2015)*

Couples to: *Integrated Care Suite (ICS), Name-Occupation-Duty (NOD), Resident Bedside Whiteboards, Quality Councils, Quality Boards, Quality Board Huddles, Quality Touchpoints, Collaborative Care Team Rounds, Scheduling—Resident's Plan for the Day, Standard Transition Process, Team Charter*

- Care team composition, including resident and families, reflects resident care needs within the context of the care setting, specific resident demographic, and specialties required, including:
  - Physicians
  - NPs, RNs, RPNs, LPNs
  - HCAs, Psychiatric Aides
  - Allied Health Members
  - Support Services
  - Leadership
- Clinicians are fully engaged at the highest and unique level of their legislated scope of practice and/or job description.
- Team members demonstrate the following competencies* essential for collaborative practice within a Collaborative Care Team:
  - **Resident/Family Centered Care**—Team members seek out, integrate and value, as a partner, the input and the engagement of the resident/family in designing and implementing care/services
  - **Interprofessional Communication**—Team members from different professions communicate with each other in a collaborative, responsive and responsible manner
  - **Role Clarification**—Team members understand their own role and the roles of those in other professions and use this knowledge appropriately to establish and achieve resident/family and community goals
  - **Team Functioning**—Team members understand the principles of team dynamics and processes to enable effective interprofessional collaboration
  - **Collaborative Leadership**—Team members work together with all participants, including residents/families, to formulate, implement and evaluate care/services to enhance health outcomes
  - **Interprofessional Conflict Resolution**—Team members actively engage self and others, including the resident/family, in positively and constructively addressing disagreements as they arise

Notes:
**Adapted from the Canadian Interprofessional Health Collaborative (CIHC) National Interprofessional Competency Framework*

Collaborative Care Processes

Resident Care Handover

A verbal transfer of accountability between outgoing and incoming Care Hub team, primary responsibility of designated hub lead (RN or LPN). The resident/family is involved in the conversation when possible.

Performance Measures:

Primary

↑ Residents' perceptions of their own and family/friends' engagement
(e.g., ↑ satisfaction, ↓ complaints)

Secondary

↑ Clinical best practice
(e.g., CCHSS compliance %, # admitted / discharged)
*CCHSS specific question compliance will be compared with each corresponding CoACT element).

↓ Nursing sensitive adverse events
(e.g., ↓ falls, ↓ pressure ulcers)

↑ Provider experience
(e.g., ↑ communication, ↑ teamwork)

Couples to*: Care Hub, Collaborative Care Team, Integrated Care Suite (ICS), Resident Bedside Whiteboards*

- Transfer of Accountability (TOA) at change of shift occurs between outgoing and incoming hub lead (RN/LPN)*
- Update of resident status and care needs between incoming and outgoing staff
- Resident/family is an active member of the discussion (when possible)
- All care hub members participate in Resident Handover
- Incoming Hub Lead completes initial round of residents of concern or identified at risk
- HCA complete NOD round and safety check following shift change

Notes:
**CoACT recommends completing safety checks concurrent with Resident Handover*
.

Deliverable Description	Outcome Requirements
Care Hub Huddles Resident care needs are regularly assessed and evaluated within the Care Hub. The Care Hub team works together to ensure residents receive the right care, at the right time by the most appropriate provider. Resident needs addressed in a timely manner enabling the Care Hub team to work to optimized scope of practice or job description (see Collaborative Care Team) ***Couples to:*** *Care Hub, Assignment of Care, Care Plan, Integrated Assessment*	• Care Hub Huddles—team members meet face-to-face at minimum 3 times in 8 hours to ensure ongoing monitoring and adjustments to the care plan as needed to safely meet resident care needs by: - Updating priority resident care activities/care needs and emerging issues - Updating professional nursing staff about any changes in resident condition - Re-distributing workload as required to maintain balance amongst team members
Assignment of Care Assignment of care occurs by professional staff within the first Care Hub Huddle, and is reviewed as required. ***Couples to:*** *Care Hub, Care Hub Huddles, Care Plan, Integrated Assessment*	• At every change of shift: - Residents and providers are assigned to Care Hubs • Assignment of Care within the first Care Hub Huddle:** - Discuss priority resident care activities / needs and emerging issues - Review and negotiate workload requirements as they relate to provider scope of practice, job description, current skills, abilities, credentials, and experience - Distribute workload to create balance amongst team members *Notes:* ***Assignment of care occurs within the first Care Hub Huddle of the shift and is reviewed in subsequent Care Hub Huddles for any required adjustments.*
Collaborative Care Orientation Permanent and non-permanent team members (including Physicians) have functional understanding of Collaborative Care practice, process and performance to participate fully. ***Couples to:*** *Resident Handover Care Hub Huddles, Collaborative Care Orientation, Collaborative Care Team, Comfort Rounds, Integrated Care Suite (ICS), Name-Occupation-Duty (NOD), Resident Bedside Whiteboard, Resident Orientation, Collaborative Care Team Rounds, Scheduling—Resident's Plan for the Day, Standard Transition Process*	• Orientation to local Collaborative Care practices and expectations • For every team member: permanent and non-permanent
Comfort Care Rounds Scheduled structure for proactively and intentionally addressing resident needs and improving safety in the domains of pain, personal needs (e.g., toileting), possessions, and positioning. ***Performance Measures:*** Primary ↑ Residents' perceptions of their own and family/friends' engagement (e.g., ↑satisfaction, ↓ complaints) ↓ Nursing sensitive adverse events (e.g., ↓ falls, ↓ pressure ulcers) Secondary ↑ Clinical best practice (e.g., CCHSS compliance %, # admitted / discharged) *CCHSS specific question compliance will be compared with each corresponding CoACT element). ***Couples to:*** *Care Hub, Care Hub Huddles, Integrated Care Suite (ICS)*	• Comfort Care Rounds address the following: - resident safety (e.g. use of restraints, fall prevention) - pain - position/location (consider socialization needs) - personal needs (e.g., toileting, hydration, hygiene, mobility, oral care) - possessions • Resident is asked, "Is there anything else I can do for you?" • Provider tells resident when they will be back • Minimum of every two hours: more frequently as required • Unit based role accountability is clear and understood by the team

Deliverable Description	Outcome Requirements
Integrated Assessment A holistic approach to Integrated Assessment of bio-psycho-social-spiritual resident care needs by appropriate Collaborative Care Team members occur at the initial visit, at regular intervals as per the CCHSS guideline. ***Couples to:*** *Collaborative Care Team, Integrated Care Suite (ICS)*	• Assessment process informs the content of the Care Plan • Resident health care needs are assessed using the appropriate Inter RAI instrument • Reassed quarterly in Long Term Care and annually in Coordinated Home Care program, and upon significant changes in health status • Medical assessment is completed by Physician or Nurse Practioner on admission, reassessed annually and with significant change in resident condition *Notes:* *Government of Alberta. (2018). Alberta Health Continuing Care Health Service Standards (ISBN 978-1-4601-2158-0)*

Integrated Care Plan
 	
Collaborative planning, implementation, evaluation and reconciliation of each resident's plan of care. One source of truth to document and communicate within and amongst care teams, integrating the management of health issues and care goals across the care continuum. Evidence-informed clinical interventions identified.
 	
Performance Measures:
↑ Improvement in CCHS standard one compliance
 	
Couples to: *Collaborative Care Team, Diagnostic Imaging, Emergency Medical Services, Environmental Services, Integrated Care Suite (ICS), Laboratory Services, Quality Touchpoints, Collaborative Care Team Rounds, Standard Transition Process*
	• One summative Integrated Care Plan based on the appropriate Inter RAI instrument
	• Interdisciplinary team conference is held to create a Care Plan: Developed with input from the resident and family
	• Initiated upon commencement of services
	• Updated quarterly in Long Term Care and annually in Coordinated Home Care program, and upon significant changes in health status
	• Reconciled at each resident transition
	• Addresses the following
	  - residents physical, mental, emotional, social, intellectual and spiritual needs
	  - specific goals for each care need
	  - specific investigations, treatments and interventions for each care need
	  - most accountable Collaborative Care Team member identified
	  - identification of legal representative, their authority and contact information (where applicable)
	  - special circumstances, resident's values and preferences governing the overall plan
	
	Notes:
	Government of Alberta. (2018). Alberta Health Continuing Care Health Service Standards (ISBN 978-1-4601-2158-0)

NOD Name-Occupation-Duty
 	
Residents know who is working with them and what they are doing.
 	
Performance Measures:
Primary
↑ Residents' perceptions of their own and family/friends' engagement
(e.g., ↑satisfaction, ↓ complaints)
 	
Couples to: *Resident Handover Care Hubs, Collaborative Care Team, Resident Bedside Whiteboards, Resident and Family Centered Care*
	• Each person entering the resident's room , knocks and introduces themselves:*
	  - My name
	  - My role
	  - Why I am here
	
	Notes:
	**Unit staff, Allied Health, Physicians, Support Services, etc. If a resident indicates they are familiar with the person's name and role, the person does not need to repeat them, but still needs to identify why they are here/the purpose of the interaction.*

Deliverable Description	Outcome Requirements
Resident Bedside Whiteboard A bedside whiteboard provides visual information to inform the resident and family of the following: names of care providers, information regarding activities related to the plan of care and resident goals, and an opportunity to share information including resident/family questions. ***Performance Measures:*** Primary ↑ Residents' perceptions of their own and family/friends' engagement (e.g., ↑satisfaction, ↓ complaints) Secondary ↑ Clinical best practice (e.g., CCHSS compliance %, # admitted / discharged) *CCHSS specific question compliance will be compared with each corresponding CoACT element). ↓ Nursing sensitive adverse events (e.g., falls, pressure ulcers) ***Couples to:*** *Collaborative Care Team, Integrated Care Suite (ICS), Collaborative Care Team Rounds, Standard Transition Process*	• Visual communication within view of the resident • Team process in place for updating information daily and more frequently as required • Data elements on the Resident Bedside Whiteboard: - Date updated daily—morning - Care Manager/Case Manager Name - Care Providers Name - Schedule/Appointments - Mobility/Transfer status - What Matters To Me/ Resident Goals - A place for family and/ or care team to write questions or concerns *Notes:* *Privacy compliance for minimal data set has been approved at enterprise level; additional elements will need approval*
Resident/Family Orientation Early engagement with residents and families to welcome and orient them to what they can expect in the care setting as active participants of the care team. ***Performance Measures:*** Primary ↑ Residents' perceptions of their own and family/friends' engagement (e.g., ↑satisfaction, ↓ complaints) Secondary ↓ Nursing sensitive adverse events (e.g., falls, pressure ulcers) ↑ Clinical best practice (e.g., CCHSS compliance %, # admitted / discharged) *CCHSS specific question compliance will be compared with each corresponding CoACT element). ***Couples to:*** *Resident Handover Care Hubs, Comfort Rounds, Name-Occupation-Duty (NOD), Resident Bedside Whiteboards, Collaborative Care Team Rounds*	• The resident/family receives orientation information for every admission and or transfer to a care setting • The resident/family receives prepared written material with information to satisfy the Continuing Care Health Service Standards (CCHSS) and Accommodation Standards • Verbal review of written materials with resident/family and confirmation of understanding • The care environment includes information about supporting family as part of the care team • Clear accountability in the care setting for who will conduct the resident orientation • Resident and family participation in the care process is discussed, encouraged and enabled *Notes:* **Resident/family role in safety (Inform and educate resident and families of Collaborative Care processes that directly involve the resident)*

Deliverable Description	Outcome Requirements
Collaborative Care Team Rounds Scheduled structure for the entire Collaborative Care Team, regarding all residents to: 1. Address resident questions or concerns 2. Refresh Integrated Care Plan 3. Any changes to Goals of Care Designation? 4. Any significant changes? ***Performance Measures:*** Primary ↑ Residents' perceptions of their own and family/friends' engagement (e.g., ↑satisfaction, ↓ complaints) ↑ Clinical best practice (e.g., CCHSS compliance %, # admitted / discharged) *CCHSS specific question compliance will be compared with each corresponding CoACT element). ↑ Provider experience (e.g., ↑ communication, teamwork) Secondary ↓ Nursing sensitive adverse events (e.g., falls, pressure ulcers) ***Couples to:*** *Collaborative Care Team, Integrated Care Suite (ICS), Standard Transition Process*	• Once per week* • Representation from full Collaborative Care Team (membership may vary from practice setting to practice setting):** - Health Care Aide - Licensed Practical Nurse (LPN) - Occupational Therapist (OT) - Pharmacists - Physician - Physical Therapist (PT) - Psychiatric Aide - Recreational Therapist - Registered Nurse (RN) - Registered Psychiatric Nurse (RPN) - Respiratory Therapist - Registered Dietitian (RD) - Social Worker (SW) - Speech Language Pathologist (SLP) - Spiritual Care - Transition Services / Care Coordinator - Other_____ • Review all residents • Five questions about each resident: 1. Address resident questions or concerns 2. Any significant changes /emerging issues for the Care Plan 3. Any changes to Goals of Care designation 4. Medication Review due/required? (Narcotics, antipsychotic etc.) 5. Any Quality of life needs (rec, spiritual etc.) • Identification of any resident transitions occurring • Identification of upcoming Inter-RAI Assessments • Information updated on Rounds' communication tool (for example: whiteboard) • Update Care Plan *** *Notes:* *** Members who cannot attend must have a proxy to communicate their content to rounds and to update them with pertinent content following rounds.* ****Treatments, activities*
Scheduling–Resident's Plan for the Day Maximize efficiency through time management. Resident/family knows the schedule for the day. Prioritization is based on acuity. Scheduling has three components: resident schedule, provider schedule for the day, unit level scheduling ***Performance Measures:*** Primary ↑ Clinical best practice (e.g., CCHSS compliance %, # admitted / discharged) *CCHSS specific question compliance will be compared with each corresponding CoACT element). ↑ Residents' perceptions of their own and family/friends' engagement (e.g., ↑satisfaction, ↓ complaints) Secondary ↓ Nursing sensitive adverse events (e.g., ↓ falls, ↓ pressure ulcers) ***Couples to:****, Care Hub, Collaborative Care Team, Emergency Medical Services, Integrated Care Suite (ICS), Resident Bedside Whiteboards, Standard Transition Process*	• Each resident/family knows their schedule for the day • The Collaborative Care Team knows the resident's daily schedule • Appropriate team members prioritize and book resident time according to care requirements * • Scheduling of tests and activities are prioritized based on resident acuity *Notes:* **This includes any activities, treatments, interventions, or off-service activities that could result in double-booking a resident's time and require rescheduling for care providers and support services*

Deliverable Description	Outcome Requirements
Standard Transition Process (Transfer) Proactive planning for transitions (transfer/ discharge) with a standardized communications, notifications and flagging systems to ensure coordinated planning. ***Couples to:*** *Bed Turn Process, Collaborative Care Team, Diagnostic Imaging, Emergency Medical Services, Environmental Services, Integrated Care Suite (ICS), Laboratory Services, Collaborative Care Team Rounds*	• Standard written communication with receiving care team • Standard spoken communication with receiving care team • Standard transition checklist is completed • Examples of transitions may include - Transfer to Emergency - Outpatient procedures (IV meds, blood transfusions etc.) - Scheduled transfer to another living option/ site - Admission to acute care
Quality Culture	
Quality Boards Visual displays of quality management activities and data focused on care setting specific goals and broader program/site goals. ***Performance Measures:*** Primary ↑ Residents' perceptions of their own and family/friends' engagement (e.g., ↑satisfaction, ↓ complaints) ↑ # of quality improvement initiatives (Quadruple AIM category) Secondary ↑ Clinical best practice (e.g., CCHSS compliance %, # admitted / discharged) *CCHSS specific question compliance will be compared with each corresponding CoACT element). ↑ Provider experience (e.g., ↑ job satisfaction, ↑ communication, teamwork) ***Couples to:*** *Collaborative Care Team, Quality Councils, Quality Board Huddles*	• Quality Board on each unit • Accessible to viewing by all staff • Accessible to viewing by residents and families • Reflects current focus of local-level Quality Management processes, for example: - Antipsychotic usage - Restraint usage - Falls - Resident and Family experience survey - CCHSS - Feedback and commendations - SCN initiatives
Quality Board Huddles Intentional team gatherings at the Quality Board to provide the opportunity for participation and discussion of the quality initiatives currently being addressed by the care team. ***Performance Measures:*** Primary ↑ Residents' perceptions of their own and family/friends' engagement (e.g., ↑satisfaction, ↓ complaints) ↑ Provider experience (e.g., ↑ job satisfaction, ↑ communication, teamwork) Secondary ↑ Clinical best practice (e.g., CCHSS compliance %, # admitted / discharged) *CCHSS specific question compliance will be compared with each corresponding CoACT element). ***Couples to:*** *Collaborative Care Team, Quality Boards, Quality Councils, Quality Touchpoints*	• Representation from full Collaborative Care Team & Quality Champion - Resident and Family - Professional Nursing Staff - Health Care Aide (HCA) - Physician - Professional Allied Health Staff - Paraprofessional Staff - Transition Services/Care Coordinator - Quality Champion - Support Services - Other_____ • Quality Board Huddles occur weekly* • Held at the Quality Board • Discuss continuous quality management (planning, improvement, monitoring) activities *Notes:* **Frequency to be defined for continuing care setting*

Deliverable Description	Outcome Requirements
Quality Councils A forum for the Collaborative Care Team to create, own and monitor real-time data to inform decision making and continuous quality improvement efforts. ***Couples to:*** *Collaborative Care Team, Home Team/Home Unit, Quality Boards, Quality Board Huddles*	• Meets monthly • Representation from full Collaborative Care Team & Quality Champion: - Resident and Family - Professional Nursing Staff - Health Care Aide (HCA) - Physician - Professional Allied Health Staff - Paraprofessional Staff - Transition Services/Care Coordinator - Quality Champion - Other_____ • Evidence of local quality planning activities: - Quality Planning - Quality Control - Quality Improvement
Quality Dashboards A profile of quality measures developed by the Collaborative Care Team used to monitor performance data in support of improving resident outcomes.	• Local data is made easily available* • Collaborative Care Teams incorporate local data: - into conversations about team performance - into decision making regarding opportunities for improvement into quality management activities *Notes:* **Data sources include: Tableau Dashboards and Reporting and Learning System (RLS)*
Quality Touchpoints Brief daily reviews of quality opportunities that may include single real-time measures the team is working to improve today. ***Couples to:*** *Resident Handover Care Hub Huddles, Collaborative Care Orientation, Collaborative Care Team, Comfort Rounds, Care Plan, Integrated Care Suite (ICS), Name-Occupation-Duty (NOD), Resident Bedside Whiteboard, Resident Orientation, Collaborative Care Team Rounds, Scheduling—Resident's Plan for the Day, Standard Transition Process, Team Charter, Quality Boards, Quality Board Huddles, Quality Councils, Quality Touchpoints*	• Five days per week* • Review real-time measures of interest with the Collaborative Care Team • Representation from full Collaborative Care Team: - Resident and Family - Professional Nursing Staff - Health Care Aide (HCA) - Physician - Professional Allied Health Staff - Paraprofessional Staff - Transition Services/Care Coordinator - Quality Champion - Other_____ - *Notes:* **To be defined for continuing care setting*
Team Charter Collaboratively developed description of the team member's responsibilities, accountabilities and working relationships in the care environment. ***Couples to:*** *Collaborative Care Team, Quality Councils*	• A signed, team-created charter

Deliverable Description	Outcome Requirements
Enablers	
Bed Turn Process A standardized method for efficiently transitioning a resident bed from the time of one discharge to the time the bed is ready for the arrival of the next admission, ensuring maximized efficiency in bed turnover and bed readiness. ***Couples to:*** *Assignment of Care, Collaborative Care Team, Quality Culture Right Enviroment/First Time, Standard Transition Process*	• Standard work for bed turn process articulated and available at team level • Ensure role clarity amongst all persons involved in the process • Standard communication processes in place (e.g., paging system, phone calls)
Home Team, Home Unit Residents have a familiar team managing their care co-location of residents and providers maximize opportunity for building relationships, interaction and communication. ***Couples to:****, Resident Handover Care Hub Huddles, Collaborative Care Orientation, Collaborative Care Team, Comfort Rounds, Name-Occupation-Duty (NOD), Resident Bedside Whiteboard, Resident Orientation, Quality Culture, Collaborative Care Team Rounds, Scheduling—Resident's Plan for the Day, Standard Transition Process*	• Collaborative Care Team members (Residents, Physicians, Nurses, Allied Health members and Clinical Support Services), are assigned as much as possible to consistent care areas maximizing resident and whole team interaction
Right Environment, First Time Right Environment, First Time maximizes facility and service level capacity management through decision rules regarding, bed allocation and performance monitoring. Teams use their own performance data to improve efficiency of resource utilization. ***Performance Measures:*** <u>Primary</u> ↑ Clinical best practice (e.g., CCHSS compliance %, # admitted / discharged) ↑ Patients' perceptions of their own and support persons' engagement (e.g., ↑satisfaction, ↓ complaints) <u>Secondary</u> ↑ Provider experience (e.g., ↑ job satisfaction, ↑ communication, teamwork) ***Couples to:****, Resident Handover Care Hub Huddles, Collaborative Care Team, Collaborative Care Orientation, Comfort Rounds, Home Team/Home Unit, Integrated Care Plan , Integrated Assessment Name-Occupation-Duty (NOD), Resident Bedside Whiteboard, Resident Orientation, Quality Culture, Quality Board Huddles, Collaborative Care Team Rounds, Scheduling—Resident's Plan for the Day, Standard Transition Process*	• Care is provided in the best environment to meet resident needs • Resident and family input in respected and considered in decision making • Support resident/family choice and right to live at risk • Work respectfully with residents to reduce the number of moves to meet resident care needs in the right environment • At a facility and program level access is determined following the "Access to Designated Living Options " policy and procedure • Waitlist Management Guidelines are utilized to plan and predict service demands • Resident are given knowledge related to their service needs and the location to best meet their needs in order to support their decision related to choice of living options. *Notes:* *Access to Designated Living Option Policy and Procedure* *Coordinated access framework*

Deliverable Description	Outcome Requirements

Partnerships

Diagnostic Imaging

***Couples to:**, Collaborative Care Team, Resident Bedside Whiteboards, Collaborative Care Team Rounds, Scheduling—Resident's Plan for the Day*

- Diagnostic Imaging prioritized according to clinical priority

Notes:

Order Processing confirms:
- *Imaging request complete,*
- *Priority clinically correct*

Diagnostic Imaging schedules and prioritizes tests according to:
- *Clinical priority*

Diagnostic Imaging coordinates and schedules multiple tests for the same resident.

Unit ensures RN/LPN & Physician review results (STAT or routine) within defined Key Performance Indicators (KPIs).

Emergency Medical Services (EMS)

Inter-Facility Transport (IFT) and Repatriation are sub-components of EMS.

***Couples to:**, Collaborative Care Team, Integrated Care Suite (ICS), Collaborative Care Team Rounds, Scheduling—Resident's Plan for the Day,*

Adherence to EMS requirements for Interfacility Transport and repatriation:
- Candidates for Repatriation are identified within 24 hours of admission/transfer
- Referral, Access, Advice, Placement, Information & Destination (RAAPID) is notified within 24 hours of admission of all identified potential Repatriation residents
- AHS EMS Inter-Facility Transfer (IFT) requests are submitted by 1400 hours the day before transfer is required
- iRequest web booking tool should be used to request AHS EMS transfers
- For all transports, bookings can be checked on the day of transition (transfer/discharge) by using the Resident Search field of iRequest

Notes:
Repatriation Policy and Procedure

Health Information Management

***Couples to:**, Collaborative Care Team, Integrated Care Suite (ICS)*

- Transition documentation is complete and communicated at the time of transition

Laboratory Services

***Couples to:** Collaborative Care Team, Integrated Care Suite (ICS), Resident Bedside Whiteboards, Collaborative Care Team Rounds, Scheduling—Resident's Plan for the Day*

- STAT results notification to accountable clinician within 30 minutes of result availability

Notes:

Clinical Unit:
- *complete AM labs order processing by 1700h day prior*
- *ensure collection priority clinically correct*
- *reconcile multiple lab orders for same resident prior to request*
- *document collection time on sample/requisition for all RN-collected samples*
- *ensure porter or HCA (as determined by unit) completes hourly sweeps of collected specimens*
- *ensures STAT results notification to appropriate care team member within 30 minutes of receipt on unit*

Laboratory services
- *develop routine collection times based on need for results availability*
- *complete collections in priority order (STAT, timed orders, routine)*
- *communicate sweep time frequency ensure specimens are delivered to lab on 30 min intervals*

RAAPID (Referral, Access, Advice, Placement, Information & Destination)

***Couples to:**, Emerngency Medical Services, Standard Transition Process, Collaborative Care Team Rounds, Right Enviroment, First Time*

- Coordinates the transfer of residents who have completed a current episode of care at an urban tertiary, regional or rural health care facility, and are determined to be ready to return to a care facility in their home community.