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Care Planning Education Resource

For more information
continuingcare@ahs.ca

Seniors Health & Continuing Care
Policy, Practice, Access & Case Management

Disclaimer

Disclaimer

References to continuing care (including home care, designated supportive living, long term care and hospice) may not reflect the updated language or terms found in the new Alberta *Continuing Care Act* which is anticipated to take effect April 1, 2024. Please refer to the definitions/glossary section of the document or website for updated terms.

Contact

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Table of Contents

Scope/Intent

This document is a resource for all Alberta Health Services (AHS) home care (HC), supportive living (SL) and long term care (LTC) leaders, educators and staff who create, edit or read a client's care plan, including the entire healthcare team (may also be referred to as interdisciplinary team) and contract service providers.

Note: The term client is used throughout this document and applies to patient, resident and client's co-decision-maker with the person, alternate decision-maker on behalf of the person, parent, or guardian as applicable.

Introduction

The Alberta Health Services (AHS) Patient First Strategy establishes a framework for ensuring clients and families "are at the centre of all that we do and every decision we make." The process for care planning in continuing care must ensure the client is the driver of all care-related decisions. The entire healthcare team, with the client at the center, works collaboratively to develop an integrated and comprehensive care plan.

Comprehensive care planning and care delivery in continuing care should follow the principles and competencies established in the CoACT Collaborative Care Framework (2019), including:

- establishing practices such as the development of care hubs
- implementing processes such as integrated assessment, care planning and provision of comfort rounds
- building a quality culture

*Note – Ongoing work is occurring to implement collaborative care throughout all care streams in AHS.

The minimum requirements established in the 2018 Alberta *Continuing Care Health Service Standards* (CCHSS) legislation support the care planning process. Clinicians must have a working knowledge of the CCHSS and provide education to clients and families about the standards and requirements for care provision.

Use of Icons

Please access this workbook throughout the course as it will be used in the synchronous sessions.

 Click link to find resources

 Information

 Watch Video

Care Planning Process

Care planning encompasses assessment, decision-making, planning, communication and evaluation (see Appendix A). Care planning is a fluid process that must start with a comprehensive assessment of the client and all their strengths and abilities, and their health and wellness needs. Shared decision-making then occurs with the healthcare team, including the client, individuals of their choosing (e.g., family, friends, and support persons), healthcare providers, physicians, nurse practitioners, and allied health team members. The healthcare team uses these decisions to guide the development of the most relevant goals to the client. The healthcare team collaborates with the client to plan the interventions to implement to meet their goals. The care plan is then communicated to the healthcare team and then, after an established period of time, evaluated for effectiveness. Then the process of assessment restarts.

The comprehensive care plan consists of two documents:

- A document that consists of identified categories/problems and the related reason for the concern, goals statements and interventions that will help the client reach the goal (care plan).
- A document that outlines the day-to-day care needs of the client and is typically used by the Health care aide (HCA) (Bedside Care Plan, Service Authorization, Behaviour Support Plan etc.).

Strength-based approach

A strength-based nursing philosophy builds on the assumption that every client has inherent strengths.

According to McGill University (2020), There are four pillars to this approach:

- person-centred
- empowerment
- relational
- innate capacities

As per the Alberta Health Case Management Training Learner Toolkit (2022), using a strength-based approach ensures the care planning process is person-centred. Strength is defined as the capacity for individuals to cope with difficulties, to maintain functioning in the face of stress, to bounce back in the face of significant trauma, to use external challenges to motivate growth and to use community and social supports as a source of resilience (McGill University, 2020). A strength-based approach focuses on a client's positive attributes (e.g., self-determination, resilience, family support) rather than the 'negative' ones (e.g., health problem, illness) to empower individuals to meet their health goals. A relational approach allows the healthcare team, including the client, to develop a care plan that focuses on what the client wants and can achieve.

Family means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including but not limited to, family members, legal guardians, friends, and informal caregivers.

Consider strengths when developing goals and interventions. Assessments that focus on the client's strengths create the opportunity to establish positive and attainable expectations for the client, build on their innate capacities and empowers the client in making decisions regarding their treatment. This approach may be a challenging shift for some individuals accustomed to a hierarchical, top-down medical model approach. In collaboration with the healthcare team, case managers may need to introduce this approach and support clients and team members.

Examples of strength-based inquiry:

- "What are some of the things you do to take care of yourself and manage your diabetes?"
- "What is one thing that would improve your health and wellbeing?"
- "Tell me about who is important in your life and how they contribute to your health."

The healthcare team will continue to follow best practice guidelines for health promotion and prevention and reduce injury risk. The strength-based approach aims to meet the client's needs and wants and optimal evidence-informed practice outcomes.

Personhood: The foundation of a strength-based person-centred care plan

The Alberta Health Case Management Training Learner Toolkit (2022) explains personhood as the distinct personality of an individual, how the client identifies in relationships and as a social being. A person-centred care plan's foundation is genuinely knowing your client and their personhood, identity and cultural consideration, strengths and abilities, and likes and dislikes. When we collaborate with clients to develop a unique care plan with client-specific goals to address unmet needs, we honour their personhood.

TIP: A good relationship with the client is necessary to provide effective care, prevent crisis from developing and potentially causing harm to the client. Improved care at the client level improves care integration and system integration. We are all a part of the system, and it is our job to identify and remove barriers that impact clients' lives.

Discovering personhood is more than completing a comprehensive assessment. The foundation of person-centred care is dignity and respect, a culture of open communication and information sharing, and a partnership with the client and other care providers. Encourage the client to use and develop their strengths to support self-care efforts, avoiding unnecessary dependencies. Working with clients and families/support persons in partnership honours their personhood rather than doing to or for them. Gaining a better understanding of a client's personhood can enhance the quality of care and improve client outcomes (e.g., respecting client decision to receive comfort measures at home vs. being transferred to the hospital).

Role of case management in care planning

In continuing care, the CCHSS establishes the requirement to have a regulated healthcare professional qualified to provide case management assigned to each client. The case manager (CM) role, in AHS continuing care, is primarily responsible for overseeing the comprehensive care of each client. Staff who are designated or assigned duties of a CM (either by job title or role description) have a leadership role organizing and collaborating with the healthcare team, ensuring continuity of care, and overseeing the client's care. This role may include leading the care planning process, developing the care plan, or overseeing care plan implementation.

Case manager – for the purposes of this document, case manager is defined as a regulated healthcare provider qualified to provide case management who has responsibility for the oversight, development and/or implementation of the care plan.

Although the CM often has a leadership role in coordinating the client's care, case management functions (e.g., collaborating, communicating, advocating, supporting self-sufficiency, etc.) apply to all team members. Case management is collaborative and aims to provide holistic and coordinated care with clients. Collaboration involves engaging the most appropriate healthcare team member(s) in the healthcare team, along with the client and family/support person(s). The healthcare team members may include allied health, nursing, pharmacy, primary care, physician, healthcare aide and other health disciplines as necessary. Again, the client must be at the center of this process and driving all care decisions.

Case management is about a collaborative team effort with the client, each doing their part in supporting them to manage their chronic conditions, improve/maintain their functional status, and achieve their health-related goals with interventions of their choosing. Including strength-based care in case management is not about providing care to clients or providing care for clients. Strength-based care is about providing care with clients, at their direction and based on their identified unmet needs, focusing on their strengths and abilities, a client and family-centred approach.

Case management is also about the experience of the continuing care system from the client perspective. CM's must spend time getting to know their clients, using assessments and questions that help us discover their personhood and strengths to build a comprehensive care plan that identifies the clients' goals. The healthcare system is complex, and the CM can use their expert knowledge of the system to advocate for clients and to help the client navigate their health and social support services to match their goals.

Assessment and decision-making

There are a multitude of comprehensive assessments utilized in continuing care. Comprehensive assessments are inclusive of all primary and secondary health assessments that occur to develop a holistic picture of all elements of a client's health and wellness inclusive of all the determinants of health. Healthcare teams complete different assessments specific to client needs and program areas. Assessments target different health factors and collectively create a holistic picture of the client's unmet needs. The client must be provided with the opportunity to be an active participant in the assessment and decision-making process.

The healthcare team reviews all the information available from multiple sources (e.g., Alberta comprehensive assessments, standardized interRAI assessments, Allied Health assessments, medical history, provincial inter-RAI tracking tools, documentation, medication management assessment, etc.). The team will discuss the findings with the client. The client may need support to understand the meaning or significance of the assessment findings but must be provided with all the information available to ensure they can participate in an informed decision-making process. All comprehensive and interRAI assessments are standardized assessments meant to capture a holistic assessment of the client's health and wellbeing.

TIP: Consider using the Client Case Review Discussion Guide as a tool to help case manager's and the healthcare team in a guided case review.

How are the findings from a comprehensive assessment translated to the care plan? Who decides what goes into the care plan?

The client has the ultimate say over what problems, goals, interventions, and content goes into the care plan. Getting to that point is a negotiation. Negotiation is a balance of addressing important medical needs in a way that respects:

- the health system and its limitations
- the client and their abilities
- the healthcare team's desire for the client to realize positive results

The CM works with the client to ensure all their options are understood and makes recommendations based on best practice. Respecting personhood gives the client the ability to make decisions that are "not best-practice"/"not in the client's best interest" (as seen from a medical model/medical diagnosis approach).

When should a Managed Risk Agreement (MRA) be considered?

An MRA may be indicated when a client has an assessed unmet need, and the client chooses an alternate approach to the best practice recommendations from the healthcare team. The healthcare team first negotiates alternative interventions to support the client's needs and reduce risk. If the healthcare team is unable to accommodate the client's choice to live at risk, an MRA may be considered. The CM works with the client and the healthcare team in developing and maintaining the MRA. Alternate decision-makers (ADMs) have legislated duties and obligations to comply with when making decisions on behalf of the client. Consultation with AHS Health Law and/or AHS Clinical Ethics may be required in complex situations. Refer to the AHS Managed Risk Agreement Guideline and additional information available on AHS Insite and Continuing Care Connection (CCC).

How do I know when to care plan this problem? Do I need to identify all the problems on the care plan? How do I prioritize?

A negotiation and a discussion with the client and the healthcare team is required. The assessment process can reveal or identify issues that may not be "true" or actual problems for the client due to the assessment tool's sensitivity, the complexity of the client's health status or the client may not be interested or see the need as a priority. Not every identified problem/issue needs to be care planned. Problems may be interrelated or combined with other issues. The health record must contain documentation to support why/why not each identified finding has associated goals and interventions in the care plan.

Examples:

- Communication issues and depressed mood are identified findings from the comprehensive assessment. Further discussion indicates these are related to lack of informal social supports = Supports will be the problem added to the care plan.

- Client is 'calling out' frequently, and cognition and risk of delirium are finding from the comprehensive assessment. Further discussion indicates this is related to fear of abuse = Abuse/Neglect will be the problem added to the care plan.
- Falls are identified as a finding from the comprehensive assessment and review of the client's health record. The care team and client determine this was due to a change in health status that has resolved. The CM documents that this will not be care planned to.

There is often a need for the case manager (CM) to be part negotiator, educator and detective to ensure the care plan is meaningful and achievable.

Key Points:

- Assessment
  - complete a comprehensive assessment
  - include a head to toe physical assessment
  - include all pertinent healthcare assessments = holistic picture
  - review documentation, health history and information from care team
- Decision-making
  - client driven = must involve the client/alternate decision-maker
  - includes the healthcare team
  - determine root cause of problems/issues
  - combine interrelated outcomes/findings based on root cause
  - document why outcomes/finding will or will not be added to the care plan
  - validate the assessment findings

Care plan development

The provision of quality care continues to be one of the primary goals of healthcare professionals. It is not just about technical quality of the care and service provided but also about ensuring that the client's experience while receiving that care meets the highest standard. The CCHSS provide a road map for quality healthcare, establishing minimum standards for quality care, which identifies that the care plan is the center of care delivery. When everyone on the healthcare team, including the client, is aware of the minimum requirements of the CCHSS, it places the focus of care plan development on the client and person-centred care.

A well-developed care plan:

- supports the effective and efficient use of resources
- decreases risk of error or harm to client and care team
- provides an individualized picture of client needs (takes more time upfront, but saves time and energy down the road)
- supports client independence and builds capacity
- identifies social supports and community services that can be utilized to assist in care provision
- supports optimal assignment of healthcare providers (right care, right person - supporting all providers working to full scope)
- ensures emergency preparedness, including the development of contingency plans
- provides a plan of action if client's caregiver is away or unavailable (e.g., Is there anything that client support person(s) is concerned about that the care providers should be aware of in their absence?)

Care plan development consists of:

- writing a problem statement
- writing a goal statement
- planning interventions

Writing a problem statement

How do we get from the vast amount of information we have collected and know about the client to develop and write a comprehensive problem statement? The problem should identify the issue, what it is related to and why. Information from the assessment and decision-making process translates into the problem statement. Defining the problem statement may be more time consuming on an initial assessment or when a change in health status occurs. However, when done well, it will save time and improve efficiency for follow-up care plan revisions.

Examples:

- Supports are identified as the core issue during the assessment. The problem statement may be that {Client's name} has identified an inability to manage all aspects of their care needs due to a lack of informal supports, resulting in difficulty communicating care needs and a sad mood.

- Abuse/Neglect is identified as the core issue during the assessment. The problem statement may be {Client's name} has identified a fear of mental abuse related to a history of physical and emotional abuse during childhood, resulting in 'calling out' for help frequently throughout the day.

A clear problem statement identifies how the assessment relates to the care plan and connects the findings with the care plan. There is no right and wrong to which problems are chosen, as this will be specific for each individual. In the above examples, the client and healthcare team may determine that care plan goals and interventions would better fit under communication, mood, behaviour or other. The key message is to try and focus on the root cause and streamlining problems and interventions. If more than one problem has the same interventions, then the problem's root cause may not be identified.

Writing a goal statement

The healthcare team can assist the client in formulating a goal statement related to the problem. The goal statement should follow the SMART formula for goal writing. The goals must be:

- specific to the problem (relate to the problem statement)
- measurable (consider how the goal will be evaluated for effectiveness)
- attainable (can this actually be accomplished)
- relevant (meaningful to the client and impactful to unmet needs)
- time-based (over what period of time will this be achieved)

SMART Goals

Specific
Measurable
Attainable
Relevant
Time-based

A strength-based goal will focus on what the client wants and is able to achieve (attainable).

Examples:

- A problem statement has been developed related to Supports (see above under problem statement examples). The case manager discusses the unmet needs and goals with the client. The client decides they want to have a family member assist with communication during activities, making them happier. A goal statement is developed - {Client name} will receive necessary supports from their daughter to manage communication needs when accessing activities once per week in the facility as evidenced by an improvement in the client's reported mood (Depression Rating Scale (DRS) reducing from 2 to 0 over the next 3 months).
- A problem statement has been developed related to Abuse and Neglect (see above under problem statement examples). The case manager discusses with the client and alternate decision-maker who wants to trial using a gentle approach in conjunction with familiar items from home to reduce episodes of calling out for help. A goal statement is developed - {Client name} will demonstrate actions or responses consistent with prevention of mental abuse, as evidenced by reduced episodes of calling out for help from multiple daily episodes to 1-2 episodes daily, as evidenced by the behaviour tracking over the next 30 days.

Planning interventions

Interventions provide key details about how the care plan goals will be implemented. Without client-specific information in the interventions, care plans become repetitive and meaningless.

The healthcare team shall collaborate with the client to determine appropriate interventions for maintaining or improving the problem and achieving the clients' goals. Interventions must:

- be specific
- be realistic
- identify who is responsible for implementing the intervention

The CCHSS provides additional information on the minimum requirements for interventions (e.g., offering minimum of twice-weekly bathing in facility-based care settings, offering choices based on client preference, frequency of oral care, etc.) and specify that the responsible provider for each intervention be identified on the care plan.

Client preferences (likes/dislikes; elements to reflect personhood) must also be added to the interventions to promote person-centred care. These elements should be pulled in from comprehensive assessments and discussions related to choosing problems and goals for the care plan.

Examples:

- A goal statement has been developed related to supports. The client has identified interventions that would assist and promote meeting the established goals. The intervention statement reads:
  - Coordination to address the inability to manage all aspects of care related to informal supports not being available - {client's name} daughter will be notified weekly of upcoming activities.
  - The daughter will alert {client's name} when she cannot attend so that the schedule can be adjusted.
  - Refer to recreation therapist for follow up.

- A goal statement has been developed related to Abuse/Neglect. The client's alternate decision-maker has identified interventions that could be trialled to meet the established goal. The intervention statement reads:
  - Care will be provided using a gentle approach (use a quiet tone of voice, call to client from door before entering, and start a conversation with "Hi {client's name,} can I come say hello?" Wait for a response before approaching closer than arm's length).
  - Provide {client name} with familiar items from home every 30 minutes during comfort rounds and before all care tasks. See HCA Bedside Care Plan for additional detail.

After completing the care plan interventions, consider what details need to be included in the service authorization (HC and SL) or the bedside care plan (LTC), where applicable. These additional details will finalize the development of a comprehensive care plan.

Implementation, communication and evaluation

Implementation of the care plan requires a collaborative and organized approach. Find out for your organization, facility-based care setting, site or team what the process is for implementing care plans. Communication is the key to implementation. All care areas use communication tools to communicate the client's care needs to the care team. Either a service authorization or bedside care plan is most common. Some programs may use electronic medical records, whiteboards, communication binders or report logs.

Changes to the comprehensive care plan (including service authorization/bedside care plan) need to be communicated to the care team and client. Review what this process is for your clinical area/site.

Daily communication of any changes in the client's care needs and any care planning issues is important. Changes in the client's behaviours (calling out, unsettled) or usual daily activity (difficult to rouse/sleepy, not wanting to participate in routine activities) can signal a change in health status or condition. Additional considerations (not wanting to eat, difficulty with elimination, resisting care) will also help identify health status changes. The healthcare team and family are the eyes and ears for early identification and prevention of potential concerns. Team huddles or care hubs can be utilized to transfer information and communication of care plan updates. Team huddles are shown to improve teamwork, improve understanding of client care needs, improve the timeliness of reporting changes in client health status and improve client outcomes (Collaborative Care Resource Guide, 2018).

Once the comprehensive care plan has been implemented, the process of evaluation begins. Following timelines established in the clients' goals, the client and healthcare team's evaluation will determine what interventions are working to attain the client's goals and which intervention were not as effective or require modification. This evaluation will inform the next assessments and lead to a revision of the clients' comprehensive care plan.

Key messages for healthcare and family conferences

Person-centred care planning is not effective with a hierarchical approach to care and goal setting. Although the healthcare team will have evidence-based interventions and rationale, clients maintain the right to agree or disagree with the healthcare team's suggestions and direct their care. Remember that the client is the driver of care; with their own experiences, education, and knowledge, care is provided with the client and their support. There is a need for a balanced approach when, either due

to an assessed lack of insight or absence of an alternate decision-maker, the risk of harm or adverse outcome from a client-led decision cannot be managed in the care environment. Please refer to the Managed Risk Agreement resources (e.g., Managed Risk Agreement Guideline) in these situations. The combination of evidenced-based information and client-specific information leads to evidence-informed and person-centred care.

Scheduling of healthcare conferences, family conferences, restraint reviews, falls reviews (the list goes on) seems daunting and time-intensive. Every program and facility-based care setting will develop their own best practices for how this works for their care teams and families/support persons. Consider combining meetings, establishing agendas, clearly defining roles and responsibilities and communicating out to all attendees before each meeting so that everyone can come as prepared as possible. Keep meetings focused and on task. Focus on how client experiences and outcomes/results are interrelated and what improvements can be achieved with small changes.

The CCHSS also provides minimum requirements for care planning and care plan development. Refer to established practices in your care setting to guide healthcare and family conferences to ensure all required elements are addressed. Utilize the Care Plan Requirements (Appendix B) resource as a guide.

Have you used PDSA cycles in your practice? Look at what others are doing in Alberta to make small changes that result in big impacts in client care.

Timelines for completion

The care planning process can feel disjointed for teams. Teams should consider developing a process or following a process that works well to achieve a streamlined flow. Teams should discuss if all of the care planning process steps flow from one to the next easily and succinctly. Collaborative practice (as an element of collaborative care) resources can be utilized to ensure each member of the care team is aware of their roles and responsibilities for each element of the process and can identify gaps where no one has been assigned or thought that it was someone else's task to complete. Reviewing the Collaborative Practice in Continuing Care resources on Insite or CCC will assist teams in discussing roles and responsibilities and developing program or site-based processes to support comprehensive care planning.

Establishing timelines for completion for each step of the care plan process can also help build a seamless process for the healthcare team, client and families/support persons.

The CCHSS also provides minimum standards for when care planning steps should occur and who to include in each step of the way:

- on commencement of services provided in the coordinated HC program
- on admission to publicly funded SL or LTC
- at routine intervals and after a significant change in health status

Ultimately the care plan must be kept up to date, be relevant to the client's health status and must be supported by and reflective of assessment findings (CCHSS, 2018). Timelines have been established for home care, non-designated supportive living, designated supportive living and long term care, and are available on Insite and CCC.

Specific information for interRAI Assessment systems

Everyone in continuing care must have a documented care plan that integrates strategies from every discipline on that person's care team and input from the client and their family. The components of the interRAI systems relevant to care planning are the completed assessment, clinical assessment protocols (CAPs) and Outcomes Scale results.

A completed interRAI assessment plus CAPs and outcome scales create a picture of the needs, strengths and preferences of a client and give clinicians information as a starting point to help them develop a person-centred care plan. Their clinical judgment, critical thinking and discussions with the care team, the client and their family contribute to the person-centred care plan.

The care plan is a living document that is updated each time an interRAI system assessment is completed and with any significant change in health status. Follow up assessments allow for validation and evaluation of the care plan.

Documenting the care plan in Connect Care

To support care planning, Connect Care documentation provides 22 categories/areas to reflect the unmet needs, goals, and interventions for clients. Based on the root cause of identified issues or related unmet needs, the CM can utilize each category/area at their discretion. In the following sections, definitions are provided to assist the CM, healthcare team and client when determining which category/area the identified unmet need and goals best relate. There are additional considerations, example goals and interventions provided for using a strength-based approach.

Connect Care provides training on using the care plan documentation, the bedside care plan, flowsheets and other related content. The following resources serve as foundational content to support strength-based person-centred care planning and evidence-informed clinical practice.

Summary

Care planning is a complex, multi-step process that engages clients, families/support persons and healthcare team. Effective comprehensive care planning must be an inclusive and collaborative process that allows clients to define their care needs and goals. Providing care with clients as the healthcare team's central member enhances care delivery and improves client outcomes.

AHS strives to create an environment that highly values diversity and welcomes and respects people's contributions.
Access additional care planning resources at:

Indigenous Peoples in Canada

LGBTQ2S+ / Sexual and Gender Diversity

Seniors and Continuing Care – LGBTQ2S+ Resources for Providers

What is Cultural Sensitivity?

Abuse/Neglect

Provincial and federal laws define abuse and neglect. CMs and healthcare teams must be familiar with applicable laws, legislation, and regulations for their care stream or related to a client's age and/or status. It is mandatory for specific care streams to report abuse or neglect of vulnerable adults to Protections for Persons in Care Act. Child abuse is defined by the Child, Youth and Family Enhancement Act. If a child is believed to be at risk, it must be reported.

Assessment for abuse and neglect should include discussing with the client their current situation and any history of such experiences. Past experiences may profoundly impact the client's everyday interaction with the environment, other persons, and their socioeconomic situation. All clients should feel safe, secure and comfortable within their home and with their assigned caregivers. Disclosure of past harmful events that may influence care should be encouraged and supported with attention to providing appropriate staff to support that disclosure.

It is imperative to respond to evidence of potential abuse and/or neglect. Careful consideration should be given to providing resources to individuals experiencing potential abuse and/or neglect while recognizing that offering and/or utilizing that support may place the client in a vulnerable position.

Abuse and neglect can be mental, psychological, physical, emotional, financial, sexual, cultural and/or related to an individual's gender or identity. Consider the following when determining if the identified unmet need relates to abuse and/or neglect:

- power dynamics
- bullying
- being a vulnerable person
- exposed to illegal drugs or alcohol
- relationship strain or stress due to caregiver responsibilities
- financial burden (e.g., a child with extensive costs related to health needs, client or family member moving to a Designated Living Option (DLO))

Using a strength-based approach

A strength-based approach to care planning for abuse and/or neglect may focus on providing support and acceptance to the client concerning their identified unmet need or disclosure of harm. The client may need guidance to determine the level of interventions and support they want and or that legislation may dictate.

A strength-based approach may focus more on safety and reduce the risk of injury instead of "fixing" or treating the cause if the client is unable (potentially due to imminent threat), unprepared or reluctant to receive services or support.

Exploring any triggers (without assigning blame) that may elicit the experience of abuse or neglect is important to aid in identifying proactive approaches to avoid/reduce risks or manage abuse/neglect. Clients may also choose not to care plan related to abuse or neglect. The CM may need to complete follow-up assessments to determine that the client is making an informed choice while also encouraging care planning and support that focuses on interventions that improve the quality of life and well-being from the client's perspective.

Establishing goal statements

Once comprehensive assessments are completed with the client and abuse and/or neglect is identified as an unmet need, consider the following when developing goals:

- Work with the client to develop meaningful goals (e.g., reduce risk of injury and provide resources for support in the community).
- Collaborate and review the goals related to abuse and neglect with the client, their family and the healthcare team.

Examples:

- {Client name} and her partner {name} will exhibit improved communication toward each other on the unit, evidenced by less frequent outbursts. Partner's {name} will visit in the morning when both are more rested.
- {Client name} will reduce alcohol intake through adherence to a collaboratively developed tapering plan and no alcohol deliveries in the next 30 days.
- The client will contact one (1) community resource regarding abuse within 14 days.

Developing interventions

The client and their family's goals guide the interventions provided. Consider if the people on both sides of the interactions are receptive to intervention. Is there an immediate risk to the client?

Consider interventions in multiple domains:

- Teaching:
  - Discuss and educate including the client, ADM and/or and family, as appropriate, on legal resources.
  - Provide information and refer to external programs/agencies as needed (specify).
  - Provide emotional support, counselling, validation and reassurance to client/ family.
  - Provide information and encourage self-care.
  - Provide information on grief and coping strategies.
  - Explain the roles/responsibilities of healthcare team members.
  - Explore client/family expectations of care. Negotiate realistic expectations.

- Coordination:
  - Reassure and listen to spouse/family concerns.
  - Encourage the client and/or family involvement in decision-making and care planning.
  - Staff to reassure (spouse/family) that the client is being cared for by staff and their needs will be met.
  - Consider referrals to social work, geriatric teams, addiction and mental health, psychiatry and/or recreation.
  - Include care team, family (as appropriate) in discussions about the client's response to interventions where abuse and/or neglect is historical and impacting their interactions with other persons and the environment.
  - Report and collaborate with appropriate investigators.

- Care Provision:
  - Facilitate the development and monitoring of protective measures.
  - Mediate to resolve conflict.

- Assessment:
  - Assess for abuse and neglect in the past or present.
  - Encourage disclosure of past harmful events that may influence current care.
  - Conduct interviews with both the client and their supports together and/or separately (as appropriate).

- Monitoring:
  - Regularly check-in with the client and supports (specify).
  - Plan/facilitate family conferences in follow up.
  - Plan/facilitate team conferences in follow up.

Communication and evaluation

Consider the delicate nature of abuse and/or neglect concerns when communicating and documenting. Use proactive language and do not assign blame or assume. State the facts clearly to ensure that the care team and all those involved in care provision can safely and respectfully provide the client's support as needed and desired.

During the evaluation process, consider abuse and neglect concerns in the client's overall health and wellness.

- Has the healthcare team consistently provided the care required (e.g., monitoring for risk of injury, teaching about available resources)?
- Have there been changes in the client's health status that impacted the client's goal (e.g., improved strength and ability to manage care needs, which led to client being able to access support services)?
- Have there been any areas of improvement noted (e.g., change in client's environment that results in reduced risk, ability to connect with community supports)?
- Have there been psychosocial impacts on the client (e.g., loss of spiritual support, change in mental health status, vulnerability due to cognitive changes)?

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client-centred goals and interventions

Activities of Daily Living (ADL)

Activities of daily living (ADL) encompass various basic daily living tasks, including toileting, bed mobility, transfers, mobility, dressing/undressing, eating ability, personal grooming, hygiene, oral care, and bathing. Providing skills and strategies to support ADL performance helps enable the client's independence, reduces the impact of the client's health condition and improves function. These supports may help sustain clients in their current living environment.

Establishing goal statements

Once the comprehensive assessment has been completed, and ADL's are identified as a concern, establish goals and develop a care plan with the client. Create a goal that considers a strength-based approach while improving ADL performance, maintaining the current level of independence or slowing further functional loss. This goal will lead to the development of a comprehensive client and person-centred care plan.

Collaborate and review each goal related to ADL with the client and healthcare team.

Example goal statements:

- {Client name} self-performance with transfers will improve as evidenced by the ability to self-transfer for 8/10 transfers daily over the next three months.
- (Client name} will receive the necessary physical assistance with toileting during comfort rounds every 2 hours and as requested by {client's name} to enhance comfort while encouraging a scheduled routine.
- {Family/caregiver} will demonstrate to the nurse or physiotherapist how to safely transfer {client's name} within 30 days.
- {Client name} will bathe weekly, as evidenced by improved hygiene to enhance skin condition.

Developing interventions

The client's goals lead to the development of interventions. When developing interventions, consider:

- current skills and knowledge about the intervention
- assistive devices, environmental modification and skills retraining
- frequency of care needs, including CCHSS requirements
- unscheduled care needs
- opportunities for increased self-performance
- motivation to perform the activity
- activities that focus on fine/gross motor tasks, coordination, memory and visual processing to help improve functional status and problem-solving
- alternatives based on the client's preferences (e.g., adaptive clothing instead of fastenings requiring dexterity)
- medical concerns or treatments
- facility-based care routines such as comfort or scheduled rounds

Consider which members of the care team are most appropriate to assist the client in meeting their goals (e.g., Consider a referral to occupational therapy if multiple ADL concerns are present, or if more complex problem solving is required to support ADLs; or speech language pathology for concerns with eating or swallowing ability). Developing interventions collaboratively with the client will ensure that the client is more informed about their care related to ADL concerns, and each team member's responsibilities, including their own.

Example interventions:

- teaching related to transfers
- care provision related to toileting
- equipment or assistive devices
- referral to occupational therapy for ADL and equipment assessment

Communication and evaluation

Daily communication of any changes or issues in ADL care needs is essential. Through observation and interaction with the client, the healthcare team can monitor for early identification and prevention. Changes in the client's ability to perform ADL can sign changes in health status or condition.

During an evaluation, consider ADL concerns in the context of the client's overall health and wellness.

- Has the healthcare team consistently provided the care required (e.g., assistance with dressing or toileting, teaching support for self-transfers)?
- Have there been changes in the client's health status that impacted the client's goal? (e.g., chronic conditions affecting client's ADL self-performance)
- Have there been any areas of improvement noted?
- Have there been psychosocial impacts on the client? (e.g., decline in health status or hospitalization of spouse/caregiver)
- Have referrals to allied health team members been initiated for further assessment?

Ongoing clinical evaluation of the client's care plan and review of the outcomes is necessary. A change to intervention strategies may be required to meet the client's goals. Also, the client's goals may change depending on fluctuating health status conditions.

Use standardized evaluation tools (for example, Functional Independence Measure) or more informal measures (i.e. reduced frequency of teaching/review) to guide follow-up assessments, thereby continuing the care planning process.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client-centred goals and interventions.

Communication

Communication encompasses sending and receiving information in verbal and non-verbal forms. Communication is affected by sensory skills (vision/hearing) and cognitive domains (attention, memory, orientation). Clients communicate to convey and gain information, meet basic needs, and facilitate social/emotional needs (Paslawski, 2017). Communication includes hearing, understanding, verbally formulating and expressing thoughts and speech sounds and voice clarity. There are several normal age-related changes in communication and many medical conditions that can affect communication (e.g., Progressive Supranuclear Palsy and Parkinson's, Aphasia, Dementia, Amyotrophic Lateral Sclerosis, Multiple Sclerosis). Hearing loss affects more than 70% of older adults in supportive living and long term care, which further compounds communication impairments (McReedy et al., 2018).

> Not being able to speak is not the same as not having anything to say.
>
> *Rosemary Crossley*

When people have challenges communicating, consider:

- They may speak English as a second language (or not have English language skills) and require modified communication approaches with the addition of translation supports or communication boards (pictures and words in their primary language).
- They may call out for help or repeatedly use the few verbal words they can use or may know. Their messages about symptoms, preferences, needs and concerns may be frequently missed or misinterpreted by others.
- They may have difficulty understanding and providing informed consent.
- They are three times more likely than others to experience preventable adverse events and are the most likely group to experience multiple adverse events (Bartlett et al.)
- They report feeling confused, anxious, panicked, dehumanized and depressed while receiving health services. These feelings can lead to sleeplessness, social withdrawal and aggressive behaviours.

Did you know: 89% of people with Parkinson's have voice problems (e.g., quiet voice, monopitch) that affects communication and Alberta has 3.8 times the world prevalence of Parkinson's (Logemann et al., 1978; Svenson et al., 1993)

Simple and effective strategies can help people with communication challenges about their health and wellness and help them better understand information, express thoughts, needs and preferences.

Using a strength-based approach

Individual goals and interventions should be established to support the client's desired participation level in communication activities.

A strength-based approach to care planning communication needs will:

- Respect the humanity of communication and the health benefits of connection. We all need to communicate, feel heard, and be socially included regardless of impairment.
- Tailor communication approaches to specific situations or interventions (e.g., client does not speak English and requires a translator for medical appointments but is satisfied to use gestures during personal care).
- Focus on the client's preferred method of providing and receiving information.
- Allow the client to decide what communication goals they would like to achieve and which interventions are manageable and attainable for themselves and the care team.
- Ensure access to communication aids and communication strategies (e.g., communication board at the bedside, voice amplifier, specific communication strategies to maximize participation).
- Promote the healthcare team's education, including support persons, on the importance of modifications, social inclusion, and positive interactions.

In most cases, a strength-based approach will focus more on maximizing the individual's communication abilities instead of attempting to rehabilitate persistent deficits. Supporting a strength-based approach in care planning communication concerns ensures that care is being provided with individuals and that they decide what is best and needed for them – meeting individuals where they are in their health journey.

Establishing goal statements

After performing a standardized assessment, initiate a discussion with the client and/or family. Minimize the impact of the communication deficit and use communication aids to improve communication. This will lead to the development of a comprehensive and collaborative client and family-centred care plan. Review and revise each goal with the healthcare team, including the client and family.

Examples of goal statements include:

- {Client name} will use word-finding strategies and a communication board to improve verbal attempts with site staff and others, evidenced by client reported a decrease in frustration at three-month review.
- {Client name} will use speech strategies (e.g., reduced rate, increased volume) to maximize articulation during the next three months as evidenced by ability to make self-understood during everyday interactions and activities reported by client, family, and site staff.
- Staff will provide {Client name} with communication tools and additional time to respond and speak at a reduced rate using written key words to maximize the client's understanding of information during morning care over the next three months to decrease client frustration and improve participation.

Developing interventions

Interventions related to communication in the care plan aim to increase safety, enhance the quality of care and improve health outcomes. Maximizing the use of sensory and communication provisions such as hearing aids, pocket talkers, communication boards, and picture dictionaries can greatly improve a clients' experience with care, reduce responsive behaviours, and improve their ability to interact with their environment. Also, healthcare teams should trial strategies specific to communication impairment, focusing on slowing the pace of speech, using gestures to avoid abstract language (Bond & Adamson, 2020). Clients with communication challenges benefit from techniques such as listening, repeat-back, and displays of positive, non-verbal language (smiling, eye contact, nodding).

Supporting clients with communication challenges will lead to:

- a better understanding of information by presenting verbal and written communication in ways they can best hear, see and comprehend
- improved expression of client thoughts, needs, preferences, interests and stories in their preferred manner with appropriate compensatory strategies and aids
- the consideration of risks and benefits and the ability to make decisions and provide informed consent

Developing interventions with the client and family will ensure that they are informed about their care and each team member's responsibilities, including their own. Determine strategies that the client and the care team can implement to maximize meaningful interactions. Relevant sensory aspects affecting communication should be identified and incorporated into daily care (e.g., glasses, hearing aids, dentures).

Focus should be on strategies that work and an awareness of what does not work for the individual. Instructions should be provided to staff when devices are a part of making the goal attainable. Regardless of the type of intervention, documentation must also include which members of the healthcare team would be most appropriate to assist the client in meeting their goals.

Examples of interventions include:

- Staff members will allow adequate time for {Client's name} to respond to questions and make decisions during each care intervention, as evidenced by {client's name} reduced responsive behaviour of calling out being reduced to one episode weekly over the next three months.
- Care provision daily related to vision abilities in receptive communication, as evidenced by {client's name} having their glasses on during all waking hours.

TIP: Consider a referral to a speech-language pathologist in your zone to receive specialized support and strategies for clients with communication concerns.

Communication and evaluation

Evaluation of goals is based on the client's view of goal success combined with the review of health-related documentation and healthcare team members' observations. For example, reduction in responsive behaviours and the client's expression of satisfaction with communication status would be communicated by family, staff and/or client to demonstrate a decrease in client frustration related to communication impairments. Further, review of documentation would serve as communication demonstrative that hearing aids have been applied the majority (e.g., 75%) of the time.

The care plan is a living document and the evaluation is a process that helps to determine if the outlined interventions have been successful in achieving the client's goals. If goals are not met with current interventions, evaluation allows for timely revisions to the care plan. Additionally, the care plan's evaluation is completed with a change in the client's status, at the client's request, or staff's request and as outlined within the goal statement. Remember that reviewing goals at a predetermined frequency allows for timely refinement and reevaluation of a client's progress as it corresponds to their communication abilities.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client-centred goals and interventions.

Community Resources

Interaction with community resources is important to remain connected to peers and social networks and impact the client's physical, mental health, and quality of life. Community resources may include religious organizations, cultural heritage groups, libraries, social clubs, recreational centres, healthcare providers, personal care services and special interest groups. Interaction with the community and engagement in meaningful activities is important to maintaining a positive outlook and feeling of self-esteem, satisfaction through a sense of connection and purpose.

Access to community resources may be impacted by:

- unfamiliarity with options or process for obtaining services
- dissatisfaction with services
- inadequate, inappropriate or unavailable resources
- mobility or transportation barriers
- limited access to/or inability to use services, information or goods available in the community
- isolation
- culture, language or communication barriers
- limited social contact
- minimal outside leisure activities or contact
- lack of staff knowledge of, and access to, resources

Establishing goal statements

Once comprehensive assessments have been completed and identify a need for additional community resource supports, discuss the client's goals.

Examples of goal statements:

- {Client name} will contact a community art group within the next 30 days, as evidenced by client describing the art group.
- {Client name} will connect with the recreation therapist within thirty days, as evidenced by creating an intervention plan that reduces {client's name} self-reported feelings of isolation and meaningful engagement over the next three months.

- {Client name} to maintain community connections by actively participating in community programming once per week on an ongoing basis to reduce social isolation, improve mood and provide a sense of purpose.
- {Client name} will have access to the necessary community resources, including parent support group, to meet their needs regarding caregiver burden, as evidenced by reduced symptoms of postpartum depression during monthly visits.
- {Client name} to decrease feelings of loneliness and depression by engaging in a wheelchair biking group twice per week for six weeks, as evidenced by improvements on the depression rating scale from 3 to 1.

Developing interventions

The client goals guide the interventions provided. Consider if the people on both sides of the interactions are receptive to the intervention.

Consider interventions in multiple domains:

- Teaching
  - Provide connections for the client to learn new skills they desire.
  - Assist the client with requesting services from agencies.
  - Empower the client to express dissatisfaction with services in a constructive way.
- Coordination
  - Assist and/or support the client in making connections with age/cultural/leisure specific groups.
- Care Provision
  - Provide suitable leisure activities within the facility or arrange for community resources to interact with the client virtually and/or in person.
- Assessment
  - Assist client in identifying desired interaction with community & age-appropriate clubs/organizations.
  - Explore previous interactions within the community and state reasons for change and the client's desire to maintain those connections.
- Monitoring
  - Review the action plan every three months with the client to determine the effectiveness.

Communication and evaluation

In collaboration with the client's informal supports and the healthcare team, client-focused interventions improve the client's frequency of interaction and satisfaction with community resources. Regularly check in with the client regarding their satisfaction and reaffirm goals are being met. Communicating any changes or issues related to community resources with the team or the client's perspective is essential. Changes in the client's ability to interact with community resources can sign a change in health status or condition.

The client's ability to access community resources depends on client-specific factors (cognition, interest, motivation, financial resources and available informal supports). It should be considered in evaluating the effectiveness of the care plan. During the evaluation, consider community resources in the context of the client's overall health and wellness and quality of life.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client-centred goals and interventions.

Elimination

Elimination issues are specific to bowel and bladder function. These encompass a wide range of medical diagnoses and can be signs or symptoms of other health issues. Elimination impairment or dysfunction can have long-lasting psychosocial effects and can impact a client's ability to live independently.

Bowel and/or bladder incontinence is NOT a normal part of healthy aging. All issues related to bowel and/or bladder impairment or dysfunction should be reviewed by the healthcare team and potentially referred to a specialist for further investigation as deemed appropriate.

> Bowel and bladder incontinence is **NOT** a normal part of healthy aging.

Care planning for issues or concerns related to bowel and bladder elimination should focus on comfort and dignity for the client and resolve or manage root-cause diagnosis.

Medically necessary care must be offered to all individuals experiencing elimination concerns. A strength-based approach may focus more on comfort and dignity instead of 'fixing' or treating any health issues based on the client's wishes. Clients may choose not to seek medical care that the healthcare team recommends and may choose to focus on interventions that improve quality of life and feelings of wellbeing such as:

- scheduled care to meet elimination needs
- preventative strategies to promote routine elimination
- medication review to reduce medications that can impact elimination

Establishing goal statements

Once the comprehensive assessment is complete, and the client wants to care plan to the concern of elimination, establish goals with the client. The goals will lead to the development of a comprehensive client and family-centred care plan. Collaborate and review each goal related to elimination with the client and healthcare team.

Example goal statements:

- {Client name} will receive the necessary assistance to meet bladder needs related to continence every 2 hours or more frequently as needed. {Client name} will be clean, dry and odour-free.
- {Client name}'s current bowel function level will be maintained, as evidenced by daily bowel movements.
- {Client name} will self-catheterize three times daily, as evidenced by decreased dysuria and pain.
- To improve independence, the {family/caregiver} will demonstrate how to change ileostomy, with client assistance, to nursing staff.

TIP: Consider that elimination issues/concerns may be related to or causing other issues. For example: Frequency of falls may reduce if a toileting schedule is in place. Incontinence may be reduced with adequate hydration.

Developing interventions

The client's goals lead development of the type and frequency of interventions.

- Proactive, preventative strategies may include dietary fiber, hydration, or movement to lessen or eliminate reliance on more invasive interventions.
- Consider which members of the care team would help the client meet their goals (e.g., healthcare team to complete medication review, LPN to support the assessment of input and output, HCA to support ADL related care tasks).
- Consider how frequently care tasks would need to be scheduled to meet the client's needs (e.g., tracking or using a bowel and bladder record may help determine a usual routine).
- Does the client have unscheduled needs (e.g., due to new ileostomy, high output, or illness exacerbating a condition) that would require more frequent care?
- Are there other medical concerns or treatments that impact the chosen interventions (e.g., medications that cause constipation or diarrhea, undiagnosed reason for the bladder continence issues)?

Developing interventions with the client will ensure that the client is more informed about their care related to elimination concerns, and each team member's responsibilities, including their own.

Example interventions:

- care provision to address bladder concerns related to continence every 2 hours or more frequently at {client name} request
- monitoring to address bowel concerns related to medications that increase the risk of constipation
- daily review of documentation

Communication and evaluation

Communicating any changes in the elimination care needs and any issues related to elimination daily is important. Changes in the client's output (bowel/bladder) or intake (nutrition/hydration) can indicate a change in health status or condition. Additional considerations (such as output colour, odour, and consistency/clarity) will also aid in early identification of health status changes.

During the evaluation, consider elimination concerns in the context of overall health and wellness.

- Has the healthcare team consistently provided the care required (e.g., every two-hour comfort rounds with toileting)?
- Have any changes in the client's health status impacted the client's goal (e.g., new medication that has the effect of constipation)?
- Have there been any areas of improvement noted (e.g., client is continent with routine toileting)?
- Have any issues arisen (e.g., developing a pressure injury related to skin wetness caused by incontinence, pain expressions during elimination, development of hemorrhoids or anal fissures)?
- Have there been psychosocial impacts on the client (e.g., expressions of fear or anxiety, mood changes, withdrawal from social outings, or withdrawal from intimacy)?

Use the evaluation and any areas of consideration identified to guide follow-up assessments, which will continue the care planning process.

TIP: Consider using a Bladder and Bowel Record or Bladder and Bowel Diary to assist in problem solving or finding areas of improvement (i.e. low fluid intake, time of diuretic administration, high caffeine intake).

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client-centred goals and interventions.

Fall Risk

A fall is defined as unintentionally coming to rest on the ground, floor or other lower level with or without an injury (Canadian Falls Prevention Curriculum Education, 2007). Falls are the **leading** cause of injury among older Canadians, with 20-30% of seniors 65 years and older experiencing one or more falls each year (Government of Canada, 2021). This number increases to 50% for those 80 years of age and older (NICE, 2013). Falls can have various outcomes ranging from no injury or minor injury to serious injury or death.

Falls can significantly impact the individual, their family and friends, and the healthcare system. A comprehensive falls risk management strategy is important across the continuum of care to support client safety and quality improvement.

> Falls are NOT a normal part of healthy aging. There are actions you can take to prevent falls.

Several age-related changes occur, which can increase someone's risk of falling. However, falls are not a normal part of healthy ageing. There are actions you can take to prevent falls. When care planning to reduce falls or reduce the risk of injury from falls, consider the impact of the following:

- mental status (cognition, behaviour, substance abuse)
- impact of medications (polypharmacy, side-effects such as dizziness)
- physical status (diagnosis, gait, frailty, mobility)
- risk factors (previous falls, decline in health, environment)

Using a strength-based approach

Preventing or reducing falls and injury from falls requires a balance between reducing the risks and maintaining a person's freedom, dignity, and quality of life (AMDA, 2011, as cited in RNAO, 2017).

Clients who are at risk of falling will have one or more underlying risk factors. Over 400 risk factors for falls have been identified and can be classified as either modifiable (i.e., amenable to interventions) or non-modifiable (i.e., unchangeable, such as age) (College of Occupational Therapists, 2015 as cited in RNAO, 2017).

A strength-based approach should focus on client goals and reduce risk of injury from falls, instead of preventative measures that inadvertently constrain their independence. Healthcare organizations are cautioned to avid “an excessively custodial and risk-averse approach” (Australian Commission on Safety and Quality in Healthcare, 2009). Organizational vigilance is required to avoid harmful or adverse approaches to prevent falls, such as physical restraints, sedating medications, or restricting mobility (Miake-Lye et al., 2013). Ensure the client and their family/decision-maker perspective on what they want to achieve is included.

Addressing falls risk is a multifactorial approach; there can be many risks that are often interrelated, and care plans should address all issues. A healthcare multifactorial approach is considered best practice for falls risk management and injury prevention. The multifactorial approach will allow for a broad perspective and specialized knowledge in each client’s interventions.

Establishing goal statements

Once the comprehensive assessment has been completed, healthcare providers can use motivational interviewing strategies to gain insight into the person’s understanding and perceptions of their risk and enhance a client’s intrinsic motivation to change. When the client/family/decision-maker has agreed they would like to address their falls risk, you can establish goals with the individual. The client may not say that their goal is to prevent falls. They may say that their goal is to stay independent and in their own home for as long as they can, or they want to spend time with their grandchildren, or they want to avoid being in a wheelchair. This discussion will lead to the development of a comprehensive client and family-centred care plan.

Example goal statements:

- {Client name} risk of falls will improve within three months, as indicated by a Scott Fall Risk Assessment score from 14 to 9.
- {Client name} will have a reduced risk of injury from falls over the next 12 months, as evidenced by fewer fall reports from client, family, and AHS staff.
- {Client name/family} will implement three fall prevention strategies in their home to reduce the client’s risk of injury from falls from 2 fall injuries to 0 fall injuries over the next three months.

Developing interventions

Universal falls precautions are general safety precautions that can be implemented in all healthcare settings to prevent falls or decrease the risk of falling for anyone. Universal falls precautions are automatically applied for all clients, regardless of whether they are deemed at risk for falls. Additional targeted multifactorial interventions should be implemented to address the client’s specific assessed risk factors. These clinical interventions are used in addition to universal falls precautions and are unique for each client.

Developing interventions with the client and family/decision-maker will ensure that they are more informed about their care related to fall risk concerns. Each healthcare team member, including the client and their family/decision-maker, has a responsibility to reduce risk.

TIP: Refer to Falls Risk Management Suggested Interventions on Insite and CCC to assist in problem solving or finding areas of improvement (e.g., dizziness, mobility/balance, visual impairments, etc.).

Example interventions:

- Care provision to address actual risk of falls related to unsteady when standing/ walking/turning. Interventions for the care team may include:
  - reminding client to use walker when mobilizing
  - providing stand-by assistance when mobilizing for evening meal, and at client request
  - providing one-person assistance to transfer onto bath chair for twice weekly bathing
- Assessment to address potential risk of falls related to impaired mobility. Interventions for the care team may include:
  - refer to PT/OT for environmental assessment
  - refer to PT for assessment and walking program/strengthening exercises to promote mobility and functional ability
- Teaching to address potential risk of falls related to disease process (impulsivity). Interventions for the care team may include:
  - remind {client name} to:
  - sit at side of bed before standing to prevent dizziness
  - rest when feeling short of breath
  - apply brakes to walker before sitting

MyHealth.Alberta.ca has a wealth of education, client teaching handouts and resources to guide care plan development.

Communication and evaluation

Communication amongst the healthcare team about changes in fall risk and care needs will mitigate risk. If a fall occurs, making changes in real-time can help to prevent another fall from occurring. Communication frequency should be proportionate to the risk.

It is important to monitor if implemented falls risk management interventions are effective. This can be done by establishing measurable goal statements and monitoring changes in the progression of the care plan outcomes. Some measures may include number of falls, number of fall-related injuries, and number of visits to the ER or admissions to acute care due to a fall. Additionally, other measures may include improving/maintaining functional outcomes meaningful to the client (i.e., getting in and out of the shower safely with 1-person assist). The care plan should identify the root cause of the fall. Evaluation of the care plan should be based on functional outcomes.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Growth and Development

Growth and development focus on developmental progression through the early life stages from prenatal to adulthood. Growth refers to physical characteristics, whereas development refers to cognitive, social and emotional health and wellbeing. Growth and development care planning include fine motor, gross motor, self-help skills, adaptive functioning, communication, sensory processing and social/emotional/cognitive behaviours.

The following factors should be considered when assessing growth and development:

- impact of disease process
- comorbidities
- caregiver knowledge
- environment
- developmental screening results
- prolonged illness
- prematurity

Using a strength-based approach

There are many opinions about what is normal or accepted regarding growth and development that may conflict with evidence-based care. A strength-based approach to care planning for growth and development focuses on listening to clients/family/support persons, establishing the caregiver's priorities, acknowledging and exploring perspectives, reflecting and providing reassurance, and navigating strategies together (The LEARN Model). Using an evidence-informed approach will encourage open shared clinical decision-making that includes caregivers' perspectives and choices.

The **LEARN Model** uses open-ended questions for insights and context and close-ended questions for clarification and verification.

TIP: New parents/caregivers may be overwhelmed; use clinical judgement to assist with prioritizing care planning goals. Focus on immediate health needs first.

Establishing goal statements

Once the comprehensive assessment has been completed and issues related to growth and development are identified as concerns that the client wants to care plan to establish goals with the client. The goals will lead to the development of a comprehensive client and family-centred care plan. Collaborate and review each goal on growth and development with the client and healthcare team.

Example goal statements:

- {Client name} function will be optimized within six months, as evidenced by ability to grasp small objects and hold independently.
- {Client name} will follow expected growth curve for weight/height over the next eight-week period.
- {Caregiver name} will implement strategies to optimize development within six months.
- {Caregiver name} will understand {client name}'s developmental profile within three months as evidenced by {caregiver} verbally reviewing profile with professional staff at each home visit.

Developing interventions

The client's goals lead development of the type and frequency of interventions.

- Proactive, preventative strategies may include encouraging scheduled wellness clinic assessments, discussing milestone variations in children with health challenges and available community resources/funding that may provide supports.
- Consider which members of the care team would assist the client in meeting their goals (e.g., RN/LPN to support assessment of health status and growth, Caregiver to support daily care needs).
- Consider how frequently care tasks would need to be scheduled to meet the client's needs (e.g., scheduled home visits every month to check physical growth, weekly virtual health visits to assess caregiver fatigue).
- Does the client have unscheduled needs (e.g., teaching a new procedure to parent(s), change in condition that requires daily assessment) that would require more frequent care?
- Are there other medical concerns or treatments that impact the chosen interventions (e.g., change in health status that requires hospitalization)?

Example interventions:

- Teaching related to developmentally appropriate behavioural strategies includes incorporating age-appropriate activities for caregivers to utilize when environment or activity is too stimulating for {client's name}.
    - Activities could include: listening to nature sounds, counting blocks, breathing techniques, colouring pictures.

Communicating and evaluating

Communicating any changes in the clients' unmet growth and development needs and any issues related to growth and development on a routine basis is important. Changes in the clients' growth (weight loss or gain) or development (not within normal limits, parental or nursing concerns) can sign a change in health status or condition. Additional considerations (expressions of caregiver stress/fatigue, difficulty settling or unusual fussiness) will also help identify health status changes.

During evaluation, consider growth and development concerns in the context of overall health and wellness.

- Have the healthcare team or parents/caregivers consistently provided the care required (e.g., feeding per schedule)?
- Have any changes in the client's health status impacted the success of the client's goal (e.g., exacerbation of existing comorbidity or acute illness)?
- Have there been any improvement areas noted (e.g., client is within normal limits of expected growth)?
- Have any issues arisen (e.g., new developmental screening results)?
- Have there been psychosocial impacts on the client or parent/caregivers (e.g., domestic violence concerns, family adjustment issues)?

Use the evaluation of goals and interventions and any areas of consideration identified to guide follow-up assessments that will continue the care planning process.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Health Status/Conditions

Health status/conditions encompass many areas that can impact a client's health, such as cardiorespiratory, endocrine, neurological and gastrointestinal systems.

Care planning for appropriate health status condition must include:

- ongoing assessment of the clients' status (related comprehensive assessment findings and triggered CAPs)
- consideration of the frequency of specific interventions
- interventions that address client wishes while following best practice
- consideration of how one condition will affect or influence other conditions or systems (e.g., shortness of breath can affect mood and behaviour, attendance in recreation programs, sleep, wound healing and cardiovascular issues)

Using a strength-based approach

A strength-based approach to care planning health status/conditions will:

- Address both the underlying contributors to chronic disease while also seeking to mitigate further deterioration from chronic disease.
- Consider the systemic impacts of organ failure or disease process (e.g., high blood pressure affects both the heart and kidneys).
- Acknowledge the correlation between health status/conditions and lifestyle, mental health/addictions, socioeconomic factors.
- Support clients through chronic disease management trajectory, including helping them live well with chronic disease.
- Connect the client to community resources such as outpatient clinics and support groups.

Establishing goal statements

Once the comprehensive assessment is completed and health status has been identified as a concern, the care team needs to:

- identify with client/family if they would like to work on this concern
- work with the client and/or family to develop a goal
- collaborate and review each goal related to health status with the client and healthcare team

Cardiorespiratory status

- {Client name} will walk from room to recreation area three times a week.

  OR

- {Client name} will learn to manage shortness of breath by learning when and how to use PRN Salbutamol with Aerochamber, as evidenced by client's report of improved management of shortness of breath.

Neurological status

- {Family/caregiver} will verbalize to professional staff how to detect and intervene with early or worsening neurological changes, as evidenced by follow up conversation in one month.

Renal status

- {Client name} will create a plan with professional staff to detect and intervene with early or worsening renal changes to maintain electrolyte balance over the next 90 day assessment period.

  OR

- {Client name} will adhere to __ litre per day fluid restriction recommended by client's physician. Site staff will record client's fluid intake on intake and output record daily.

Developing interventions

The client's and/or family goals lead development of the type and frequency of interventions.

Using the above goal examples related to health status, it is evident that the client will require assistance to meet their goal.

- Consider which members of the care team would assist the client in meeting their goals (e.g., physiotherapy for walking program, RN/LPN for health status assessment)?
- Consider how frequently care tasks would need to be scheduled to meet the client's needs (e.g., daily morning weight, blood work weekly for INR)?
- Does the client have unscheduled needs that would require more frequent care (e.g., frequent interventions to alleviate shortness of breath, increased need for health monitoring while titrating medications)?
- Are there other medical concerns or treatments that impact the effectiveness of the chosen interventions (e.g., shortness of breath that results in increased anxiety and affects mood, postural hypotension that increases need for assistance when mobilizing)?

Developing interventions with the client will ensure that the client is informed about their care related to health status concerns and each team member's responsibilities, including their own.

Example interventions:

- assessing to address cardiovascular system status concerns related to disease process
- teaching to address concern related to post-operative care requirements following hip surgery
- monitoring to address gastrointestinal system status related to infection
- following physician recommendations for titrating medication dosage to reduce pharmacological restraint
- monitoring for neurological system status concern related to side effects of medications, including lethargy, nausea, and tardive dyskinesia

Communication and evaluation

Changes in the client's behaviours (calling out, unsettled, difficult to rouse) can sign a change in health status or condition. Additional considerations (not wanting to eat, difficulty with elimination, resisting care) will also help identify health status changes.

Once interventions have been implemented for a designated amount of time, the healthcare team evaluates the care plan's impact and effectiveness.

- Have there been any changes in the client's health status treatment plan that impacted the success of the client's goal (e.g., new-onset shortness of breath that has prevented walking from room to recreation area three times a week)?
- Have there been any areas of improvement noted (e.g., ability to maintain electrolyte balance)?
- Have any issues arisen (e.g., adverse reaction to medication, worsening symptoms)?

Use the evaluation and any areas of consideration identified to guide follow up assessments, which will continue the care planning process.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Instrumental Activities of Daily Living (IADL's)

Instrumental Activities of Daily Living (IADL) are tasks that require a higher level of cognitive ability to complete than basic ADLs. IADLs encompass various daily living tasks, including laundry, grocery shopping, managing finances, preparing meals, transportation, productivity (work/school/volunteer), telephone use, computer/technology use and other housework.

A loss of self-sufficiency in IADLs is often the first expression of a later, more widespread general decline in functioning.

The client's cognition, financial resources, available informal supports, and sense of purpose are determinants in developing and maintaining a care plan that addresses loss of IADL performance. IADL supports assist clients, families, and caregivers in modifying environments and supporting inclusion in societal roles, helping sustain clients in their current living environment. During assessment, consider issues that may impact a client's ability to complete IADL tasks independently, including:

- mental health status
- social supports
- finances
- cognitive abilities
- access to resources

Using a strength-based approach

A strength-based approach to care planning should support the client to obtain the skills necessary for IADL performance while considering the willingness, ability, and availability of the client/family to participate or learn. Assessment of the client's physical, social, cultural, and economic environments will help identify existing support availability.

The client must be allowed to function within their ability to perform IADL tasks. Supporting IADL improvement/maintenance may counter the effects of dependence on others (such as low self-esteem, depressed mood, and feelings of incompetence).

IADL supports may also reduce caregiver strain or burden, enabling clients and their families to participate in roles, relationships, and important activities actively.

The care plan should also plan for future improvements or decline in IADL function.

Establishing goal statements

Once the comprehensive assessment is completed and IADLs is a concern that the client wants to care plan, proceed to establish goals with the client. The goals will lead to the development of a comprehensive client and family-centred care plan.

Collaborate and review each goal related to IADL with the client and healthcare team.

Example goal statements:

- {Client name} will demonstrate understanding of how to manage finances within six months.
- {Client name} will receive assistance with light meal preparation at suppertime.

Developing interventions

The client's goals lead the development of the type and frequency of interventions. When developing interventions, consider:

- current skills and knowledge about the task
- assistive device, environmental modification and skills retraining
- frequency of care needs
- opportunities for increased self-performance
- cognitive and executive functioning
- motivation to perform the activity
- activities that focus on reasoning, decision-making, memory and visual processing to help improve functional status and problem-solving
- alternatives based on the client's preferences (for example, pursuing supportive housing or paid assistance)
- additional community/formal resources (for example, Adult Day Program)

Example interventions:

- teaching related to managing finances, which includes connecting with community supports and attending workshops on financial planning
- coordination and monitoring related to transportation, which includes obtaining support in planning public transportation routes and gaining exposure to public transit

Communication and evaluation

In collaboration with the client's informal supports and the healthcare team, client-focused interventions improve IADL outcomes. Communicating any changes or issues in IADL performance from the team's or the client's perspective is essential. Changes in the client's ability to perform IADL can sign a change in health status or condition.

IADL performance and participation and functional assessments, quality of life, and client-specific factors (cognition, financial resources, available informal supports and sense of purpose) should be considered in evaluating the effectiveness of the care plan. During evaluation, consider IADL concerns in the context of the client's overall health and wellness.

Ongoing clinical evaluation of the client's care plan and review of outcomes is necessary. A change to intervention strategies may be required to meet the client's goals. Also, the client's goals may change depending on fluctuating health status conditions.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Medication Management

Medication management is defined within the *Continuing Care Health Service Standards* (CCHSS, 2018) as the "processes required to ensure safe and effective medication therapy for a Client, including prescribing, communication of medication orders, medication reconciliation, dispensing, delivery, storage, medication support, documentation and follow-up." (pg. 8).

How much is too much? Watch Dusty's Story to learn more.

A collaborative approach to care planning for medication management includes the healthcare team and client.

- Support clients in obtaining and maintaining an accurate list of medications.
- Complete a best possible medication history (BPMH).
- Complete comprehensive assessments.
- Complete medication reconciliation.
- Participate in medication reviews.
- Identify the need for medication support services (e.g., medication assistance program [MAP]).
- Ensure allergies are documented.

Considerations when assessing medication management include, but are not limited to:

- complexity of medication regimen
- frequency of medication administration
- number of medications
- non-adherence to medication regime (intentional or unintentional)
- client's physical or cognitive barriers
- knowledge deficit
- lack of access to medication
- hazardous medication

- high-alert medication (e.g., narcotic infusion)
- pharmacological restraint or concerns with appropriate use of medication

Care planning for issues or concerns related to medication management should focus on promoting independence and self-management as much as possible, as well as resolving or managing the root cause(s).

Using a strength-based approach

A strength-based approach to care planning for medication management may require providing additional education related to medications and underlying medical conditions to the client. Supporting a strength-based approach to medication management concerns ensures that care is provided with individuals. They decide what is best and needed for them, meeting individuals where they are at in their health journey.

Consider:

- What supports the client has to promote independent medication management (pharmacy delivery, blister packaging, family/support person assistance).
- What is the least invasive level of assistance to meet their needs (e.g., automated medication delivery, assistance from family/support person, verbal reminders, physical assistance, medication administration).

Establishing goal statements

The goal of addressing medication management concerns will vary depending on the client's choice, capacity, and situation. The outcomes of the comprehensive assessment (e.g., triggered CAPs from an interRAI assessment, outcomes of the Medication Management Risk Assessment) are shared with the care team. Along with a medication review, all of this information is used to collaboratively develop appropriate goals to maximize client participation in medication management for as long as possible.

Example goal statements:

- {Client name} medications will be administered safely, every day for 30 days, as evidenced by no missed doses of medication.
- There will be reduced risk of harm and improved safety related to {Client name} medication management within 90 days through consistent use of appropriate disposal practices for hazardous medication waste.

Developing interventions

Identifying interventions to support the client's goals is done in collaboration with the healthcare team, including the client and family.

Specify interventions to assist the client in meeting their goals.

- What is the frequency of support required (e.g., daily or more than once a day)?
- Does the client support needs vary, or are scheduled or unscheduled (e.g., support with PRN medication at various times or support at scheduled times only)?
- Are there specific observations healthcare providers need to know when performing interventions (e.g., medication side-effects or expected outcomes)?
- Are there identified risks in the environment, or with the activity which need to be considered (e.g., hazardous medication, medical sharps, etc.)?
- Are there other concerns that impact the intervention, such as lack of financial resources/benefits to pay for pharmacy packaging and dispensing medication assistance fees?

Example interventions:

- Coordination to address concerns with unintentional medication non-adherence:
  - request pharmacy package medication into a controlled dosage system
  - collaborate with family to program medication reminders on client's smartphone
- Teaching the client to take medications as directed by their prescriber.

Communication and evaluation

Documentation of client care provided for medication management is a source of important information. Any identified changes or concerns in the client's behaviour or function must be communicated immediately to ensure appropriate assessment is conducted by a healthcare professional and/or to implement appropriate treatment strategies (e.g., change in health status when titrating medications, change in symptoms that may be due to medication side effects etc.).

Ongoing evaluation will include completing the Medication Risk Management Assessment (AHS, 2016) and Medication Reconciliation at appropriate intervals (e.g., transitions in care, change in status, routine assessment) to help identify medication management changes that may affect care plans.

When reviewing effectiveness of interventions, consider:

- Is the frequency of medication management services supporting client independence (e.g., more frequent medication assistance may reduce pain and reduce the need for ADL/IADL supports)?
- Has the teaching and reinforcement of knowledge helped the client effectively manage medication?
- Has the coordination and monitoring of client response to high-alert medication resulted in improved safety and reduction/prevention of adverse events?

- Is there an alternate medication or dose that may have fewer side effects/interactions and be more effective for the client?
- Has there been a measurable improvement in the client's cognitive or functional abilities after deprescribing or reducing the number of medications?

Consider associated concerns with interventions:

- What are the side effects or outcomes of the client's prescribed medication (e.g., change in mood, impotence, drowsiness, nausea, change in health status)?
- Does the client's medication's scheduled frequency interfere with sleep, activities, or impact their routine otherwise?
- Is there a cost impact of the medication or required packaging of medication?
- Are there quality of life considerations such as inability to participate in social activities due to medication side effects or warnings (e.g., do not drive)?

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Mood/Emotion, Behaviour and Cognition

Mood/Emotion and Behaviour

At its most basic, mood is how a person feels inside, and includes “the more sustained emotional makeup” (Martin, D., 1990) of the client’s personality. Emotions are a conscious mental reaction (such as anger or fear) subjectively experienced as strong feeling usually directed toward a specific object and typically accompanied by physiological and behavioral changes in the body (Merriam-Webster, 2023). Behaviour is how a person acts - what others can see. Mood, behaviour and thoughts are closely related and can influence each other (Rector, 2010)). Factors contributing to mood and behaviour symptoms may be related to adverse childhood experiences, traumatic events, disease processes, or other environmental factors. Recognition and early interventions for mood disorders have powerful impacts on function, wellbeing and safety.

The healthcare team including the client and family, work together to reassess, review, monitor outcomes, revising the client care plan along the client’s health journey.

When clients have unmet needs related to mood and behaviour, they may experience:

- an increased risk for abuse, isolation, or marginalization
- altered social interaction
- lack of motivation or initiation in areas of IADL/ADL performance
- physical and other manifestations of mood-related symptoms
- feelings of fear, helplessness, anxiety, frustration, and responsive behaviours
- higher and longer hospital readmission rates

A comprehensive assessment will reveal mood and behaviour patterns, triggers, or extreme variances from the client’s baseline. A standardized assessment tool, completed at regular intervals may help uncover triggers or confirm a mood or behaviour problem or unmet need is present; a secondary assessment may further reflect the severity and intensity of the symptoms experienced.

Assessment to establish baseline related to mood includes reviewing level of function before requiring care and when care is in place. Additional considerations include the individuals behaviour, diagnoses, and available formal/informal supports.

Other important assessment elements include:

- secondary assessments (e.g., suicide risk screening, Cornell depression scale, confusion assessment method, behaviour mapping)
- medication review
- involvement of healthcare team including historical mental health professionals, as appropriate

> Left untreated, mood disorders are disabling and associated with high mortality, functional decline and unnecessary suffering by the person, family and caregivers
>
> *(p., 58, 2008, interRAI CAPs manual).*

Using a strength-based approach

Mood and/or behaviour issues must be approached respectfully, acknowledging possible sensitivities. The client's perspective and interpretation should be incorporated where possible, keeping in mind the need to build rapport with the client and their family before exploring this domain.

As the care plan is created or modified, aim to address care goals and related issues in collaboration with the client, ensuring that the client's priorities are reflected.

For example, a client's lack of participation (behaviour) is easily observed and troublesome to a healthcare provider. Meanwhile, the client experiences depression (mood), which less apparent to others and still influences every other aspect of the client's physical, cognitive and social wellbeing. If the cognitively intact client identifies that participating in the team's recommended activities is not a priority for them and that they only wish to alleviate suffering from depression, build the care plan in a way that is reflective of these priorities inclusive of client identified existing support structures, coping strategies and new or existing medical treatment.

When encountering reluctance to explore these issues in the interview with the client, it may help make an objective, non-judgmental statement about their mood and/or behaviour to promote discussion. An example of a conversation starter is as follows: "I noticed you hadn't played cards at all this week. Can you tell me more about that?". Be mindful of stigma and consequences experienced by the client when approaching these conversations but focus on past successes and current priorities.

Using a strength-based approach when addressing mood and behaviour issues is critical as it supports connection, which is often a key intervention in this problem area.

Establishing goal statements

Build goals using the comprehensive assessments as a starting point for a goal related conversation with the client. Ultimately, the client decides what goals they would like to achieve and what interventions are attainable for themselves and the care team. Focus on minimizing the impact of the mood/ behaviour while increasing activities that enhance coping, safety, or pleasure in life. Goals reflective of a strength-based approach to care planning for mood and behaviour may aim to:

- demonstrate understanding of the cause of the mood/behaviour (e.g., triggers, responsive behaviours)
- increase client and family awareness of the diagnosis and relevant factors
- address the effect of the behaviour on others (i.e. safety, ability to maintain or form interpersonal relationships)
- reflect the individual's ability and desire to improve outcomes and work with the IDT towards goals
- address appropriate caregiver approaches
- indicate necessary monitoring for response to treatment or interventions

The frequency of goal review will depend on the frequency of assessment determined in part by the care stream, the client's needs, and healthcare team recommendations.

Example goal statements:

- Mood
  - {Client name} mood will be improved with current strategies, as evidenced by a decrease in Depression Rating Score (DRS) from 5/14 to 3/14 over the next three months.
- Behaviour
  - {Client name} will experience fewer episodes of restlessness, as evidenced by an increase in instances of participating in care from once per day to 5 times per day over the next six months.

    OR
  - {Client name} will experience fewer episodes of aggression towards caregivers, as evidenced by an improvement in the Aggressive Behaviour Scale (ABS) score from 4/12 to 2/12 over the next three months.

Developing interventions

Interventions are tailored to each client and outline coordinated actions to be taken to lead to goal attainment. Interventions must also include which members of the healthcare team would be most appropriate to help the client meet their goals. Developing interventions in partnership with the client and family will allow them to be more informed about their care, and each team member's responsibilities, including their own.

Example mood interventions:

- RN/LPN will encourage {Client name} to verbalize feelings after visiting with family and provide validation of feelings/experiences.
- Recreation therapist to explore {Client name} preferred sources of relaxation. All staff to encourage indicated preferences when {Client name} expresses negative self-thoughts.
- Case manager to initiate consult to mental health professional for individualized therapy and care planning.
- Care provision to support mood concerns related to safety, independence, supports, relationships and daily care needs: See Behaviour Support Plan.

Examples of interventions within the Behaviour Support Plan:

- Provide structure, follow clients.
- Preferred routine.
- Clearly communicate choices, in some instances they may need to be limited.
- Sensory stimulation to engage and promote interaction – may include music therapy, music, images, bright light therapy or a hand massage.
- Encourage to participate in structured activities of interest which may consist of physical, spiritual, cognitive, social and / or emotional domains.
- Encourage participation in constructive social networks.
- Teaching related to mood to support client and caregiver concerns related to loss, lifestyle, and ability to cope with a mental illness.

Click here to view a short video clip:
Things Not Seen - Alicia's Story
Alicia was able to draw on family support and spirituality in a way that improved her mood by giving her hope and courage to overcome her limitations.

Click here to view a short video clip:
Changing Behaviours - Pat's Story
Notice how altering the team's response to Gracie's observed reactions effectively changed the course of her behavioural symptoms and addressed her need for connection.

Example behavioural interventions:

- RN/LPN/HCA to document new actions taken to encourage client participation in care, including, response/outcome. RN/LPN review {Client name} behaviour.
- Mapping with healthcare team monthly.
- Initiate one to one plan with {Client Name}. HCA to dedicate five minutes, two times per day outside of care activities, to be present with {Client name}. Use this time to connect with {Client name}, allowing client to lead conversation or activity.
- Care provision related to aggression. See Behaviour Support Plan.

Behaviour support plan may include:

- All staff respect personal space by knocking on the {Client name} door and waiting for them to answer. If {Client name} does not answer, return at a later time.
- Care provision related to wandering concerns related to safety, independence, daily care needs. See Behaviour Support Plan.

Examples of interventions within the Behaviour Support Plan:

- Provide structure, follow clients preferred routine.
- Introduce yourself to the client with each interaction and let them know why you are there. If the client declines, allow same and re-approach at least 30 minutes later.
- Modify environment to decrease triggers (direction signage, reduce noise; ambient lighting; quiet music, etc.)
- Teaching related to restlessness. See Behaviour Support Plan.

Communication and evaluation

Communication includes coordination and assignment of care to address mood and behaviour concerns. Additional follow-up and referral may be needed to evaluate goals and outcomes.

- referral to geriatric mental health, specialty nursing and/or psychiatric services
- referral to cognitive behavioural therapy (CBT) program
- evaluate treatment or interventions' effectiveness by incorporating the client's perspective, behaviour mapping (or documentation of other mood-related symptoms), and IDT observations

Both positive and negative symptoms of mood and/or behaviour change are significant when evaluating an intervention's impact. The case manager should evaluate with the client and review documentation (e.g., behaviour mapping), team huddles, care conferences, or day-to-day verbal and non-verbal expressions over time. Be aware of concurrent symptoms and ensure these are not overlooked. For example, an increase in depressive mood symptoms may equally result in social withdrawal or outward social aggression. Conversely, an improvement in mood may also improve aspects of physical and cognitive condition. For example, lessened intensity or severity of chronic pain, improved cognitive function or appetite.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Cognition

Cognition includes mental functions such as attention, memory, language, orientation, and executive functions such as planning, initiation, and decision-making. Although cognitive impairment is not considered part of normal ageing, it is more prevalent in later life. Approximately 12% to 18% of people age 60 or older have mild cognitive impairment (Alzheimer's Association, 2023) and more than 419,000 Canadians (6.9%) aged 65 years and older are living with a diagnosis of dementia (Public Health Agency of Canada, 2019).

While many individuals with a diagnosis of cognitive impairment are able to safely make their own decisions, more specialized assessment may be required to establish capacity when the client is at risk and there is question as to whether they understand the consequences related to the risk. Additional consideration when cognition is identified as a concern include:

- the need for follow up cognitive screening or assessment
- consideration of decision making ability (e.g., capacity assessment, advanced care planning discussions)

> "The cognitive hallmarks of an independent life include the ability to remember recent events and the ability to make safe daily decisions."
>
> *(interRAI CAPs manual p. 58).*

Using a strength-based approach

A strength-based approach to care planning for cognition requires learning about what matters most to your client about their cognitive status.

- Understand the cause of the cognitive loss or impairment (e.g., dementia, delirium, or depression).
- Be aware of the individual's diagnoses and potential for improvement.
- Create a care plan that reflects client preferences and priorities.
- Explore effective caregiver approaches.

- Consider the interplay between cognitive and physical domains of health.
- Emphasize strengths, which may include past coping strategies.
- Incorporate community based supports.
- Outline appropriate monitoring of response to interventions and treatment.

The AUA Toolkit is a core AHS resource for clinicians to utilize when care planning related to cognitive concerns.

Establishing goal statements

Goal development related to cognition concerns should focus on minimizing cognitive impairment while increasing activities that enhance independence, dignity, coping, safety, or pleasure in life.

Click here to view a short video clip:
Mountains and Valleys
What are important goals and interventions to highlight in Hank's care plan to ensure it reflects his personhood, and the man he is now?

Example goal statements:

- {Client name} will experience fewer aggression episodes related to poor response inhibition, as seen in behaviour mapping, within 6 months.
- Cognitive decline will be delayed as evidenced by maintenance of a Cognitive Performance Scale (CPS) remaining at 3/6 at next assessment (12 months).
- {Client name} participate in IADLs at their maximal functional ability, as evidenced by continued independence with grocery shopping in 12 months.

Developing interventions

Develop interventions, related to cognition concerns in partnership with the client and family to allow them to be more informed about their care and the responsibilities of each team member, including their own.

Example intervention:

- Assessment to establish cognitive baseline related to cognitive function, behaviour, diagnoses, and formal and informal supports. See Behaviour Support Plan.

Examples of interventions within the Behaviour Support Plan:

- secondary assessments such as the Confusion Assessment Method (CAM) Functional Independence Measure (FIM), Mini Mental State Examination (MMSE) and Rowland Universal Dementia Assessment Scale (RUDAS)
- medication review
- physical exam inclusive of blood work and neurological exam

Example intervention:

- Coordination and assignment of care to address safety concerns related to delirium, including caregiver burnout, mental fitness, independence and quality of life (see Behaviour Support Plan).

Examples of interventions with the Behaviour Support Plan:

- referral for secondary assessment (e.g., social worker, continuing care counsellor, geriatric/seniors mental health, behaviour specialists, recreation therapy, psychiatric services)
- provide teaching/instruction to HCA/family/support person about communication strategies to address client's abilities
- referral to AHS clinical ethics services in complex situations
- referral to occupational therapist for cognitive assessments and sensory strategies
- referral to a designated capacity assessor (note – assessment of capacity is considered a last resort)

Example intervention:

- Care provision to support cognition concerns related to safety with daily care needs: See Behaviour Support Plan.

Examples of interventions in the Behaviour Support Plan:

- provide structure, follow clients preferred routine
- clearly communicate choices; in some instances, they may need to be limited
- cue to activities and mealtime
- break complex tasks into smaller tasks and allow adequate time to perform
- provide environmental cues for orientation such as calendars, lighting and clocks
- involve in meaningful activities such as exercise or news and views
- allow adequate time for client to respond to questions and make decisions

Example intervention:

- Teaching related to cognition concerns to support client and caregiver feelings of loss, lifestyle changes and disease-specific questions

Mitigating safety and balancing quality of life in these situations can be quite stressful for all parties involved.

Consider referral for an Ethics consult where available.

> There are patients who may permanently lack capacity to consent, temporarily lack the capacity to consent, and those whose capacity may fluctuate.
>
> *(AHS Ethics Briefs)*

Communication and evaluation

Communication includes coordination and assignment of care to address cognition concerns. Fluctuations in a person's cognitive status may occur frequently (e.g., daily or more often when monitoring for signs of delirium). Ongoing communication and collaboration amongst all healthcare team members and the client is essential to achieve their goals. Additional follow-up and referral may be needed to evaluate goals and outcomes, such as:

- referral to geriatric mental health, specialty nursing and/or psychiatric services
- referral to cognitive behavioural therapy (CBT) program
- evaluate treatment or interventions' effectiveness by incorporating the client's perspective, behaviour mapping (or documentation of other mood-related symptoms), and IDT observations

Improvements in, maintenance of, and decline in cognitive status are all significant when evaluating an intervention's impact. The case manager should evaluate with the client and review documentation (e.g., behaviour mapping), team huddles, care conferences, or day-to-day verbal and non-verbal expressions over time. Be aware of concurrent symptoms and ensure these are not overlooked.

For example:

- An increase in confusion may result in social withdrawal or outward social aggression or maybe a symptom of a serious health status change.
- An improvement in cognitive status may improve aspects of physical and emotional condition.
- Maintaining current cognitive status may be the result of managing chronic pain or improved nutrition and hydration status.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Nutrition/Hydration

Nutrition (food) and hydration (fluids) provide the necessary energy and building blocks to maintain life and health. Adequate nutrition status is associated with successful ageing, lower susceptibility to disease, prevention of pressure injuries, improved wound healing, better cognitive and physical performance, and a supported quality of life.

Nutrition & Hydration provide necessary building blocks to maintain life and health.

When problems with nutrition and hydration arise, consider the following:

- Dehydration/fluid maintenance concerns related to:
  - {amount/type} of fluid intake
  - diarrhea
  - excessive fluid loss
  - decline or refusal to consume fluids
  - vomiting
  - medication (e.g., diuretics)
- Tube feeding requirements related to:
  - inadequate oral intake
  - altered anatomical structure
  - aspiration
  - disease process
- Risk of {sub-optimal nutritional status/weight loss/weight gain/dehydration} related to:
  - alteration in {taste/smell}
  - altered anatomical structure
  - cognitive impairment
  - appetite

- difficulty in {chewing/swallowing}
- disease process
- food {preferences/Intolerances}
- nausea/vomiting

Due to the consequences of inadequate nutrition and hydration, screening is recommended for all continuing care clients, including seniors and people identified as frail. AHS recommends assessment tools, including the Edmonton Frailty Scale, the Clinical Frailty Scale, and the Electronic Frailty Index when assessing for frailty and associated nutrition risks. Follow established protocols for screening and assessment.

Consider the following:

- Ask, “Are you consistently eating less than 75% of your meals or are you drinking less than 5 cups of fluids daily?”
- Assess if the client has a 5% weight loss in one month, or 10% weight loss or greater in the last six months.
- Physical examination for the degree of tenting of the skin when pinched or the dryness of the mucous parts of the mouth is usually not recommended.
- Risk factors for poor nutrition and hydration status include: altered hunger or thirst perception, decreased mental and functional ability, medication side-effects or polypharmacy, dietary restrictions, social isolation, food insecurity, chronic diseases, dysphagia, mental health, as well as cultural and religious beliefs.

A holistic approach that includes all facets of a client’s life and health is key to supporting nutrition and hydration status.

Using a strength-based approach

When nutrition and hydration are identified as areas of concern, encouraging the client and family to have preferred or comfort foods available can positively impact a nutrition and hydration status.

Additional consideration may need to be given for client’s who require texture modified diets, receive enteral or parenteral nutrition and clients who have additional determinants of health-related concerns. When nutrition and hydration concerns are identified, it is essential to discuss specific health, nutrition and hydration goals with the client. Establishing goals and interventions for a comprehensive nutrition and hydration care plan that the client understands, agrees with, and is feasibly able to maintain will promote and support nutrition and hydration status.

Establishing goal statements

The nutrition and hydration care plan are specifically written with the client's goals and preferences for caring for them. The client's food desires, preferences, cultural, and religious dietary requirements must also be considered. It is recommended that a variety of foods be offered to align with updated recommendations from Canada's Food Guide with emphasis on foods high in protein.

Example goal statements:

- {Client name} will understand how to manage tube feeding requirements, as evidenced by completing all associated tube feeding tasks independently within one month.
- {Client name} will use proactive strategies to ensure the enjoyment of nutrition will be maintained, including a selection of colourful food choices and communicating food preferences to the family, as evidenced by maintenance of current weight over the next three months.

Developing interventions

Interventions should focus on improving or maintaining nutrition and hydration status by understanding the root causes of the inadequate intake and devising effective strategies with the client to address these causes.

Consider the following when developing interventions:

- level of interaction during meal times
- food served at the proper temperature
- texture modification and preference
- level of dependence
- ideal positioning (e.g., in an upright position during a meal and 30 minutes after)
- implement a treatment plan to ensure adequate caloric intake and thus prevent further weight loss/gain
- monitoring fluid intake and body weight

Example interventions:

- Care provision related to tube feeding requirements to prevent negative consequences of malnourishment or hydration/fluid imbalance.
- Monitoring laboratory testing to ensure recovery and maintenance of appropriate nutrition and hydration/fluid balance.
- Monitoring related to dehydration and associated complications, including abnormal blood pressure, falls, fatigue, delirium, defecation imbalance/stool consistency.
- Care provision related to dehydration and risk of sub-optimal nutrition status.

- Monitoring related to the risk of choking and aspiration.
- Support {Client name} choice to eat and drink normal texture and consistency of food and fluids. See Managed Risk Agreement (MRA) for additional risk reduction strategies.

Communication and evaluation

Any diet or fluid texture modifications must be communicated to the healthcare team quickly to reduce risks of choking and aspiration. In the facility-based care setting, nutrition and food services and recreation therapy will need to be notified immediately to ensure the change is made in time for the next meal.

When evaluating the care plan for effectiveness, consider:

- Identify warning signs of problems with eating and drinking:
  - coughing, voice change, unexplained weight loss, difficulty chewing/swallowing, mouth pain, refusing to eat, drooling, pocketing, or holding food in the mouth, unable to swallow medications or new need for medications to be crushed
- Review the recommended nutrition/hydration plan (e.g., are modifications still needed, are interventions meeting recommended daily intake).
- Include appropriate members of the healthcare team (e.g., SLP, dietitian, OT may need to be notified/consulted when a client's condition or ability changes concerning nutrition and hydration).

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Pain management

Pain is defined as “an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage (International Association for the Study of Pain, IASP).” IASP further provides six key factors that should be considered when assessing pain:

- Pain is always a personal experience influenced by biological, psychological, and social factors (called total pain).
- Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.
- Through their life experiences, individuals learn the concept of pain.
- A person’s report of their pain experience should be respected (document what the person describes instead of an interpretation).
- Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.
- Verbal description is only one of several behaviours to express pain; the inability to communicate with words does not negate the possibility that a human or a nonhuman animal experiences pain (Raj et al., 2020).

Pain is often under recognized and under treated in the frail, elderly and cognitively impaired population.

Clients living with chronic or acute pain face challenges not only in regard to physical function but also with the stigma that comes with pain management and treatment. Pain is also the most under-recognized and under-treated condition in seniors and older adults. Fear of addiction to medications and medication side-effects can lead to under treatment and poor pain management.

Care planning for appropriate pain management must include:

- frequency of monitoring, assessment and re-assessment of the individual’s pain and the standardized pain assessment tool appropriate for that person
- follow up interventions (consider what works for that person to reduce/improve pain) related issues that could be contributing to total pain

- consideration of how pain can affect or cause other conditions/issues (e.g., responsive behaviours, impact on ability to complete ADL's, impact on sleep, mobility etc.)

Did You Know?

45-80% of people in facility experience pain?

Persistent pain contributes to depression, anxiety, decreased socialization, decreased appetite, functional impairment (Baras, 2017 as cited in AHS, 2022).

Using a strength-based approach

Medically necessary care must be offered to all individuals experiencing pain management concerns (e.g., investigation for fracture following a fall, medication review where ineffective pain management is identified). It is important that a baseline pain assessment is completed on admission and as part of the comprehensive assessment process.

A strength-based approach to care planning pain management issues will:

- focus on client education to build mutual understanding of the individual's pain.
- allow the client to decide what goals they would like to achieve and what interventions are manageable and attainable for them and the care team.
- focusing on maximizing information i.e. type of pain, how client expresses pain, what makes it better or worse.

A strength-based approach may focus more on comfort and dignity instead of 'fixing' or treating any health issues. Individuals may choose not to seek medical care that the healthcare team recommends and may choose to focus on interventions that improve quality of life and feelings of wellbeing. Supporting a strength-based approach in care planning pain management concerns ensures that care is being provided with individuals and that they are deciding what is best and needed for them – meeting individuals where they are in their health journey.

TIP: Providing Comfort Rounds will play a key role in ensuring that client goals and interventions are met.

Establishing goal statements

After identifying pain as an unmet need using a standardized assessment, initiate discussion with the client regarding their goals related to management of pain. Ask the client what their pain goal is. This will lead to the development of a comprehensive client and family-centred care plan. Collaborate and review each goal related to pain management with the client and healthcare team.

SMART Goals

Specific
Measurable
Attainable
Relevant
Time-based

Example goal statements:

- {Client name} pain scale score will improve from 8/10 to 5/10 over the next three months.
- {Client name} will resume former activity levels as evidenced by participation in physiotherapy exercises daily over the next year and physical activities promotion CAP triggered with potential for improvement.
- {Client name} expression of pain symptoms will reduce as evidenced by the number of instances of calling out for “HELP” being reduced daily to weekly over the next three months.

TIP: Consider that pain management issues/concerns may be related to or causing other issues. E.g., Responsive behaviours, such as calling out, may decrease if pain is managed appropriately.

Developing interventions

The client’s goals lead the development of the type and frequency of interventions.

- Document which members of the care team would be most appropriate to assist the client to meet their goals (e.g., LPN or RN for daily pain assessment and medication management, HCA providing ADL care and exercise assistance).
- Consider how frequently care tasks would need to be scheduled to meet the client’s needs (e.g., spread out care tasks throughout the day to avoid exacerbation, provide pain medication 30-60 min before mobilizing).
- Does the client have unscheduled needs that would require more frequent pain assessment?
- Are there other medical concerns or treatments that impact the chosen interventions (e.g., short term wound care that results in increased pain, undiagnosed reason for low back pain, delayed assessment at a chronic pain clinic)?

Developing interventions with the client will ensure that the client is more informed about their care related to pain management concerns and each team member's responsibilities, including their own.

Example interventions:

- Assessment to address chronic pain related to disease process using PAINAD scale three times daily before care provision.
- Care provision to address chronic pain related to disease process. Provide opportunity for {client name} to participate in physiotherapy exercises daily. See HCA Bedside Care Plan.

Monitoring to address chronic pain related to disease process. Document responsive behaviours on Behaviour Tracking Tool. Weekly review of Behaviour Tracking Tool for responsive behaviour of calling out. Follow physician recommendations for titrating analgesics based on number of responsive behaviour episodes. Monitor for side effects of analgesic, including lethargy and constipation.

Communication and evaluation

Communicating any changes in the client's pain management care needs and any issues related to pain management to the care team immediately - changes in the client's behaviours (calling out, unsettled, difficult to rouse) or changes in routine (staying in bed, not wanting to eat or drink) can be signs of a change in health status or condition. Additional considerations (irritability, difficulty with elimination, resisting care) will also aide in identifying a change in status or experience of pain.

During evaluation, consider pain management concerns in the context of overall health and wellness.

- Has the healthcare team consistently provided the care required (e.g., every two-hour comfort rounds with pain assessment, consistent staffing to improve familiarity with expressions of pain, consistent tracking, consistent implementation of interventions)?
- Has the healthcare team considered utilizing different tools to capture total pain accurately (e.g., consider difficulties with cognition, expression, communication, consider if other signs and symptoms may be an expression of pain)?
- Have there been any changes in the client's pain management treatment plan that impacted the client's goal (e.g., change in analgesic dose or route)?
- Have there been any improvement areas noted (e.g., client is settled and alert with increased analgesic dose and routine frequency)?
- Have any issues arisen (e.g., adverse reaction to analgesic, worsening symptoms)?

Document the evaluation and any areas of consideration identified to guide follow-up assessments, which will continue the care planning process. Stress the importance of documenting what strategies have been trialed. Consults are not always the first option or may not be readily available. System navigation support through case management will enable to client to seek out the support services and referrals that they need.

TIP: Consider a referral to an appropriate consult service or a palliative resource nurse in your zone to receive specialized support for clients with pain management concerns.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Psychosocial well-being

Psychosocial well-being encompasses psychological and social concepts related to a personal sense of mastery, personal growth, and the ability to relate to others (Burns, 2016). A client's psychosocial well-being encompasses their mental, emotional, social, physical and spiritual wellness, all of which influence the ability to cope with and address illness (Upton, 2013).

These factors include, but are not limited to:

- social support
- loneliness
- marriage status
- social disruption
- bereavement
- work environment
- social status
- social integration (Upton, 2013)

> "Increasing evidence supports the health protective features of psychological well-being in reducing risk for disease and promoting length of life."
>
> *(Ryff, 2014).*

Important additional aspects impacting psychosocial well-being involve managing stress and rebound effectively following stressful life events. Moreover, addiction and mental health disorders should also be at the forefront when addressing this domain, as they can negatively affect the client's self-esteem, resilience and coping skills.

According to interRAI Clinical Assessment Protocols (CAPS), triggers for a potential need to address psychosocial well-being include:

- withdraw from care activities
- conflict with staff
- unhappy with roommate
- unhappy with other clients
- conflict with family/friends
- grief over loss of status/roles

- daily routine is different from prior pattern in the community
- depressed mood
- alcohol or drug use

Often identifying root cause is not straightforward as these issues tend to coexist and compound one another. Strong and thorough healthcare team management is required to ensure contributing factors are identified and understood. Interventions can take a step-by-step or a multifaceted approach. For example, the healthcare team may decide it is best to treat an addiction or mental health disorder before offering relationship counselling.

Using a strength-based approach

A strength-based approach to care planning psychosocial well-being will:

- Provide a holistic, multi-pronged approach based on maintaining or improving the client's social determinates of health.
- Identify barriers and seek to mitigate or remove them (e.g., client does not understand how to navigate the healthcare system to access monetary or other supports).
- Connect the client and support persons to available informal and formal resources.
- Be founded in an understanding of all of the contributing factors impacting the client's psychosocial well-being.
- Focus on client education to identify the clients understanding of self-care practices and the benefits of physical, psychological, spiritual, emotional, and interpersonal relationship self-care.
- Allow the client to decide what goals they would like to achieve and what interventions are manageable and attainable for them and the care team.
- Assess for and understand the client's capacities and limitations to identify/practice/advocate wellness practices.
- Assist in a way that is responsive and respectful to client abilities.

Establishing goal statements

After completing the comprehensive assessment to identify a client at risk for, or is experiencing psychosocial well-being concerns, initiate discussion with the client and family. Ask the client to identify specific issues they are experiencing or areas they wish to see personal improvement in, and use this information to develop formal goal statements. The goal statements will lead to developing a comprehensive and collaborative client and family centred care plan. Review and revise each goal with the healthcare team, including the client and family.

Example goal statements:

- {Client name} will demonstrate a decrease in social isolation by attending one social program once per week over the next six months.
- {Client name} will demonstrate a decrease in negative symptoms associated with feelings of abandonment, as evidenced by positive progress in establishing professional boundaries with the care team members before the next annual reassessment.
- {Client name} will demonstrate a decrease in sleep disturbances associated with the loss of his/her mother/father/brother/sister/friend, as evidenced by an increase in total hours of sleep in a twenty-four hour period over one month.

Developing interventions

After identifying the client's need for assistance in achieving their goals, appropriate interventions must be chosen.

- Document which members of the healthcare team would be most appropriate to help the client meet their goals.
- Consider how frequently interventions would need to be scheduled to meet the client's needs (e.g., daily 1:1, weekly wellness discussions, participation in recreation activities twice weekly).
- Does the client have unscheduled needs that would require more frequent intervention?
- Are there other medical concerns or care needs that impact the effectiveness of the chosen interventions?
- Are there any relevant historical elements that may impact the client's ability to navigate their goals (e.g., mental health/addictions concerns/conditions, previous reactions to similar events/circumstances)?

Provide your reader with ideas on working with the client to choose interventions that will meet their goals.

Example interventions:

- thorough life history to be completed to determine preferences and past interests, tracking attendance to recreational activities, reminders or physical assistance to attend activities, buddy system with co-client
- behaviour tracking of verbal and physical cues to staff, additional time allotted to provide reassurance, teaching to client and care providers regarding boundary setting
- institution of sleep hygiene measures (e.g., reestablish routine that may have been lost, relaxation measures, lighting, etc.), sleep tracking including naps, analyzing consumption patterns of substances like drugs/alcohol/food and fluids that may impede sleep

- monitoring related to feelings of abandonment
- teaching related to developing boundaries

Communication and evaluation

Communicating any changes in the client's care needs daily is important. Changes in the client's behaviours can be a sign of a change in health status or condition. Additional considerations, such as changes in appetite, activity levels, and behaviour and mood, will also help identify a change in status.

Evaluation consists of measuring the effectiveness of the process of assessment, planning, and implementation. Evaluation may include analyzing the client's responses to intervention, identifying factors that contributed to success/failure, and planning future care needs. During the evaluation, consider concerns in the context of overall health and wellness.

- Has the healthcare team consistently provided the care required (e.g., participating in scheduled teaching sessions, holding group therapy sessions as scheduled)?
- Have there been any changes in the client's treatment plan that impacted the success of the client's goal (e.g., change in health status resulting in inability to travel out in the community)?
- Have there been any areas of improvement noted (e.g., improvements/stability in relationships)?
- Have any arisen (e.g., client not attending to teaching sessions)?

Document the evaluation and any areas of consideration identified to guide follow-up assessments, which will continue the care planning process.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Restraints

A restraint is any measure used to limit the activity or control a client's behaviour or a portion of their body. Restraints are pharmacological, environmental, mechanical, or physical interventions used to protect a client from self-harm or prevent harm to another person. For clarity, restraint does not include a secure space within continuing care settings *(CCHSS, 2018)*.

The intent and effect of a device, intervention or medication should be considered when care planning for restraint.

Resources and publications have various different definitions of restraint. However, it is important to remember that it is the intent and effect of a device, intervention, or medication that makes it a restraint, and not the definition. The healthcare team minimizes restraint use through assessing for conditions such as delirium or behavioural and psychological symptoms of dementia (BPSD), in addition to performing healthcare evaluations like behaviour mapping and medication reviews.

Using a strength-based approach

The healthcare team should only consider a restraint as a last resort, and only once all alternatives have been trialed and deemed ineffective. Alternatives, or supportive interventions, are at the forefront of providing a strength-based, individualized approach to care and are often informed by the client and family.

A strength-based approach to care planning restraint management will:

- Focus on education to build mutual understanding of the risks of restraint and the benefits of seeking alternatives.
- Allow the client and family to decide the goals they would like to achieve and what interventions are manageable and attainable. A strength-based approach to care planning may focus more on supporting the client's preferred activities and preserving their dignity instead of 'fixing' or treating health issues. Clients and families may choose to focus on interventions that improve quality of life and feelings of wellbeing, rather than those the healthcare team recommends.

Supporting a strength-based approach when care planning for restraints ultimately means that the healthcare team seeks to mitigate the need for a restraint, and when a restraint is deemed necessary, the least restrictive restraint is used, for the least amount of time possible.

TIP: Behaviour mapping is one of the best ways to track and trend effective alternatives and interventions.

Establishing goal statements

Initiate discussion with the client/family when assessment identifies the client may need a restraint due to behaviours posing a risk to themselves or others. Focus on supportive interventions that will reduce or eliminate the need for a restraint. Provide education on the hazards of using a restraint while promoting knowledge of alternatives. Education will lead to the development of a comprehensive and collaborative client and family centred care plan. Review and revise each goal with the healthcare team, including the client and family.

SMART Goals

Specific
Measurable
Attainable
Relevant
Time-based

Example goal statements:

- {Client name} verbal outbursts will decrease from 3 per day to 2 per day over the next three months.
- {Client name} will resume former social activity levels as evidenced by participation in social programs one day per week over the next year.
- {Client name} will eat dinner in the dining room without use of a lap tray one day per week over the next month.
- {Family name} will demonstrate understanding of the benefits of alternatives to restraint as evidenced by increasing alternatives from 2 per day to 3 per day within six months.

TIP: Focus on goal statements that seek to increase client function and capacity and decrease undesired behaviours.

Developing interventions

The client's goals lead development of the type and frequency of interventions. Using the above goal examples, it is evident that the client will require assistance to meet their goal. Document which members of the healthcare team would be most appropriate to help the client meet their goals.

Consider the following:

- How frequently do care tasks need to be scheduled to meet the client's needs?
- Does the client have unscheduled needs that would require more frequent care?
- Are there other medical concerns or care needs that impact the effectiveness of the chosen interventions (e.g., client requires personal care that results in increased agitation that impacts social or recreational goals)?

Developing interventions with the client and family will ensure that they are more informed about their care and each team member's responsibilities, including their own.

Example interventions:

- Map behaviours, including changes in environment and potential triggers precipitating verbal outburst, every hour for seven days. Minimize potential triggers using distraction and preferred activities.
- Care provision to address social isolation related to disease process. {Client name} will be registered in an Adult Day Support Program 1 day per week to increase independence and promote socialization.
- Remove lap tray on client's wheelchair during dinner on Mondays. Perform range of motion exercises, monitor skin integrity and reposition daily. Document responsive behaviours on Behaviour Tracking Tool every 2 hours daily. Weekly review of Behaviour Tracking Tool for agitation with plan to gradually discontinue mechanical restraint.
- Increase family visits from weekly to every evening, promoting time for visiting and storytelling.

Communication and evaluation

Communicating any changes in the client's care needs daily is important. Changes in the client's behaviour (calling out, unsettled, difficult to rouse) may indicate a change in health status or condition. Additional considerations (not wanting to eat, difficulty with elimination, resisting care) will also help identify a change in status.

During evaluation, consider concerns in the context of overall health and wellness:

- Has the healthcare team consistently provided the care required (e.g., comfort rounds every two hours)?
- Have there been any changes in the client's treatment plan that impacted the client's goal (e.g., changes in medication or environment)?
- Have there been any improvement areas noted (e.g., client has settled with consistency in routine or caregiver)?
- Have any issues arisen (e.g., adverse reactions, worsening behaviours)?

Document the evaluation and any areas of consideration identified to guide follow-up assessments, which will continue the care planning process.

Refer to Appendix C for Core and Additional Resources to help identify the problem and develop client centred goals and interventions.

Secure Spaces

Secure spaces are secure units within a facility, a secure facility or a technological measure that limits a client's ability to exit a facility, or a unit used to protect a client from harm. For clarity, a technological measure includes, but is not limited to, a wander alert system (CCHSS, 2018). Additionally, some clients choose to live in a secure space because it is the only available care in the community of choice. This distinction is important to make in the category summary as not all clients "require" a secure space. However, care planning to minimize risk is still required.

Secure spaces and environmental restraints have similar management requirements, with a few exceptions.

In continuing care, secure spaces are often identified as a specialized program of care within a facility that a client, family, chooses as a preferred living option to protect the safety of a loved one with dementia or cognitive deficits. Secure spaces also include technological measures that limit a client to a specified area within a facility (e.g., WanderGuards). As per the Restraint as a Last Resort Procedure, secure spaces require similar management processes to environmental restraints (e.g., consent, monitoring, review), except for obtaining an order from an authorized prescriber.

Using a strength-based approach

Healthcare teams must carefully consider a secure space's appropriateness, including weighing the risks and benefits specific to each client's unique situation. The healthcare team must also care plan to the evidence underlying the need for a secure space.

A strength-based approach to care planning secure spaces will:

- Focus on the balance between preserving a safe living environment while maximizing quality of life.
- Allow the client and family to decide the goals they would like to achieve and what interventions are manageable and attainable.

A strength-based approach to care planning may focus more on supporting the client's preferences and preserving their dignity instead of fixing or treating health issues. Clients and families may choose to focus on interventions that improve quality of life and feelings of wellbeing, rather than those the healthcare team recommends. Supporting a strength-based approach when care planning for secure spaces ultimately means that the healthcare team seeks to mitigate the need for a secure space. When one is deemed necessary, a care plan is developed to reduce the impact of the secure space.

When a secure space is utilized, personhood continues to be recognized and honoured.

Establishing goal statements

After performing a standardized assessment, initiate discussion with the client and family. Focus on minimizing the impact of the secure space while maximizing safety. This will lead to the development of a comprehensive and collaborative client and family centred care plan. Review and revise each goal with the healthcare team, including the client and family. The frequency of review will depend on frequency of assessment determined in part by the care stream, the client's needs, and healthcare team recommendations.

Example goal statements:

- {Client name} will have reduced episodes of exit seeking from 3 per day to 2 per day, as evidenced by behaviour mapping tool.
- {Client name} will remain safe on the unit, as evidenced by a decreased need for monitoring, from Q2h to Q4h within 12 months.

Developing interventions

The type and frequency of interventions related to secure spaces stem from the client's goals. They most often relate to providing a supportive environment where routines are maintained, and meaningful activity is promoted.

Interventions should:

- Enhance safety in ways that prevent escalation of behaviours while avoiding triggers (e.g., environmental alterations that disguise doors).
- Provide heightened monitoring by addressing both scheduled and unscheduled needs.
- Maintain dignity and individuality. For example, when a client chooses to reside in a secure space but does not clinically require it, interventions are designed to maintain independence (providing the code for the door so they can enter and exit at will).

Regardless of the type of intervention, documentation must also include which members of the healthcare team would be most appropriate to help the client meet their goals. Developing interventions with the client and family will ensure that they are informed about their care and each team member's responsibilities, including their own.

Example interventions:

- Map behaviours, including changes in environment and potential triggers precipitating exit seeking, every hour for seven days. Minimize potential triggers using distraction and preferred activities. For example, if the client attempts to exit, approach in a calm, compassionate and dignified manner and provide distraction and redirection. Offer to take the client to the courtyard.
- Monitor the secure space by performing comfort rounds Q2h, including completion of the following supportive interventions during each round:
  - confirming the client's safety and well-being (say hi to the client and ask how he/she is doing or feeling (report any signs/symptoms of distress or abnormal behaviour such as agitation or increased confusion)
  - offering to assist the client with toileting or positioning
  - observing client for signs and symptoms of pain (refer to FACES pain scale)
  - offering the client a small snack and encourage them to drink fluids

Communication and evaluation

Changes in the client's cognition or physical functioning can signal a change in health status or condition that may impact the client's need for a secure space or safety in a secure environment. Ruling out changes in status such as delirium, or improvements/declines in health status that render a secure space unnecessary, is a key part of evaluating the secure space. Communication of such changes should occur immediately if a risk to the client's safety or wellbeing is identified. Remember that immediate evaluation always occurs in addition to scheduled evaluation (e.g., annual care conference), as some changes are gradual and do not put the client at risk.

The care plan is a living document and evaluation is a process that helps to determine if the outlined interventions have been successful in achieving the client's goals. During evaluation, consider whether the client adapted to their new environment. Does the client continue to exit seek (e.g., is removal of WanderGuard indicated)? Does the client no longer require a secure space due to decreased mobility or palliative status? What is the effect of an audible alarm on the client's behaviour? Document the evaluation and any areas of consideration identified to guide follow-up assessments in a continuation of the care planning process.

TIP: Focus on minimizing the impact of the secure space while maximizing safety.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Sexual Expression

According to the current working definitions from the World Health Organization (WHO), "Sexuality is a central aspect of being human throughout life…" and sexual health is:

> "a state of physical, emotional, mental and social well-being with sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships and the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (2006).

Intimacy and sexuality are often overlooked but are important contributors to health, well-being and quality of life. There are different forms of sexual experience and expression, including thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.

Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.

A client's sexual expression may require care planning for support and/or assistance when it affects others' safety and security or impacts their dignity, or health and wellness. Some impacts which may affect someone's sexual expression include, but are not limited to: neurocognitive impairment, need for affection, illness/injury, medication, and intoxication. Baseline assessment information, including observation of client interactions and behaviour tracking/mapping, will provide key information.

The healthcare team must be aware of and understand organizational values, policies and/or practices related to sexual expression within their setting. The healthcare team may also need to examine their feelings and thoughts to determine comfort level in engaging a client and support persons in conversations about sexuality.

Consider concerns related to sexual expression that may include:

- lack of privacy to conduct consensual intimate relationships in a congregate living setting and/or semi-private room
- unwanted sexual expression secondary to neurocognitive impairment
- unfulfilled and unrecognized needs for touch, intimacy, affection and loneliness
- feelings of discrimination due to sexual orientation, or suppression of sexuality from a fear of discrimination

Using a strength-based approach

A strength-based approach to care planning should normalize and enable the expression and experience of sexuality while still balancing others' needs and safety. The healthcare team should seek out and provide education during the care planning process, as sexuality is often misunderstood or neglected. Supporting a strength-based approach to care planning for issues or concerns related to sexual expression acknowledges the importance of inclusion and intimacy, is respectful of client choice, focusing on client dignity, safety and well-being.

An additional consideration for a strength-based approach to care planning may include review of consent to sexual activity.

Consent

All clients must feel safe, secure and comfortable within their home and should have the freedom to express their sexuality. Sex is a basic human need; care planning must consider client interest, ability, and capability to consent. Consent is permission for something to happen, which may be demonstrated verbally, or through body language. Assessing the client's capacity to consent to sexual activity differs from performing a capacity assessment for alternate decision-making ability. The capability to consent to sexual activity should be assessed using a consent tool.

The Government of Alberta's *Personal Directives Act* (2000) and *Adult Guardianship and Trusteeship Act* (2008) does not address sexual acts. The healthcare team must be mindful of client confidentiality when engaging others in discussions of a sensitive nature; an individual, the client, identifies as "family" may not be a legal alternate decision-maker (ADM). Multiple resources suggest that no other person can provide consent for another person's engagement in sexual activity. There is no clear direction regarding the ADM related to the client's ability to consent to sexual activity. The healthcare team must carefully consider who is the most appropriate to involve in care planning. Family who are not in an ADM role should only be involved when invited by the client, or the client has provided consent for their participation.

Best practices for capability to consent for sexual activity include assessing the client(s) for:

- a basic knowledge and understanding of sex
- ability to avoid exploitation and express personal choice (i.e., ability to say "no" to uninvited sexual contact verbally or through body language)
- ability for the client to recognize distress or refusal in their partner and stop activity
- understanding the possible risks & consequences of sexual activity to self/partner
- ability to understand appropriate/inappropriate times/locations for sexual activity

Clients must have an accurate understanding of who they are having sex with in order to consent to the action. Refer to Additional Resources in this document for more information on assessing capacity for consent to sexual activity.

Establishing goal statements

Once the comprehensive assessments have been completed, and sexual expression is identified as an area that the client wants to address in their care plan, establishing goals is the next step. A goal is the client's desired status with the concern or problem and includes actions intended to support the client in reaching that goal. Goals will lead to the development of a comprehensive client-centred care plan.

Goals to support sexual expression will vary depending on the client's choice, assessed capability to consent, decision-making status, and the situation. There may be multiple goals for a concern or problem.

Example goal statements:

- {Client name} will be supported in safely meeting her sexual expression and intimacy needs within 90 days, as evidenced by improved mood and behaviour.
- {Client name} will have reduced incidents of unwanted sexual touching of others within six months, as evidenced by the reduction of reported incidents.
- {Client name} will be able to express his sexuality in a respectful and dignifying way, as evidenced by improved mood and behaviour and no reported concerns or observed risks to self or others.

Developing interventions

Identifying interventions to support the client's goals is done in collaboration with the healthcare team, including the client, ADM and/or and family, as appropriate. Developing interventions with the client, ADM as appropriate, and family the client wishes to have involved ensures the client is more informed about their care related to sexual expression and establishes each team member's responsibilities. Promote open, honest discussion, recognizing the sensitive nature of the topic.

Specify interventions to assist the client in meeting their goals:

- Are client care needs scheduled or unscheduled?
- What are the observations the healthcare providers need to be aware of before implementing specific interventions?
- Are there client safety considerations that require referral (e.g., occupational therapy)?
- Are there safe, private locations for client sexual expression to occur?
- When sexual expression involves a partner, are there any concerns regarding both individuals' capability to consent to sexual activity?
- Are there other concerns that impact the intervention (e.g., prescribed medication with a side effect of impotence which frustrates the client)?

Example interventions:

- Coordination of care to address lack of privacy for intimate relationships related to congregate living environment and shared room. See HCA Bedside Care Plan where the following examples of interventions may be identified:
  - Respect client privacy when "do not disturb" sign is placed on client's door; do not enter room until sign is removed.
- Monitor behaviours of groping of others and misidentification of spouse, related to neurocognitive impairment and need for affection.
  - Review completed Behaviour Tracking Tools monthly to identify incidents and patterns of behaviour.
  - HCA Bedside Care Plan may list the following examples of interventions:
    - Document responsive behaviours on Behaviour Tracking Tool daily (every shift) for three (3) days; repeat first week of every month for six (6) months.
- Care provision to address exposure of genitalia and making unwanted requests for sexual activity related to neurocognitive impairment and desire for sexual activity. The HCA Bedside Care Plan may list the following examples of interventions:
  - During comfort rounds every 2 hours, observe client for touching own genital area:
    - assist as needed with toileting and adjustment of clothing
    - offer client private time in his room
  - If unwanted requests for sexual activity are made towards others:
    - offer client something to eat or drink, assist with mobility or repositioning
    - provide an activity (e.g., assembling nuts and bolts on activity board)
    - engage client in reminiscence/redirect conversation to a topic of his interest such as dancing or horses
    - report observations of expression of pain or discomfort (e.g., grimacing)

Communication and evaluation

The client's care plan is typically the most common communication tool used in continuing care and should be accessible to all members of the healthcare team.

Documentation of client care provided is another method of communication in continuing care. Documentation includes completion of flow sheets, behaviour tracking and documenting specific observations (e.g., observed client holding spouse's hand and smiling), care provided (e.g., redirected client to bedroom) and other information (e.g., client asked writer "Where can I have sex?").

Changes in a client's behaviour must be communicated to the care team to ensure that the appropriate healthcare professional completes assessment (when indicated). In some instances referral to specialist (e.g., specialized geriatric services, sexual health services, etc.) may be indicated, or family members may need to be involved in the event a client's capacity for decision-making is in question. A healthcare team conference may be needed to strategize how to support the client safely and respectfully.

Members of the healthcare team participate in reviewing client outcomes and status of problems (e.g., new, ongoing, resolved) based on identified measures of effectiveness in the care plan goal statement (e.g., improved mood and behaviour, no reported concerns, etc.) within the established time frame.

- Behaviour tracking/mapping identifies responsive behaviour(s) and triggers, frequency and pattern of responsive behaviour(s).
- Review the need to regularly assess the client's capability to provide consent to sexual expression (e.g., annually) and more frequently as indicated.
- Review all documentation (e.g., staff observations of client behaviours, responses and relationship[s]), including identified outcome measures to evaluate effectiveness of interventions.

Measures used to document client care provide information necessary to evaluate effectiveness of interventions, including but not limited to frequency and pattern of responsive behaviours, and client expressed satisfaction with interventions to support intimacy and sexual expression. When evaluating outcomes, consider the following:

- Does the client feel safely and respectfully supported in meeting their need for sexual expression?
- Does the family have any observations or concerns to share?
- When reviewing behaviour tracking, are there any changes identified, such as new behaviours, fewer or more behaviours, or a change in pattern?
- Does the client respond effectively to the care plan interventions?

- Consider associated concerns with interventions:
  - Is there a potential impact to client (e.g., stigmatization from others, increased anxiety for themselves)?
  - Does the client need education on safe sexual practices?
  - What supports will healthcare providers require to support the client's sexual expression?
  - Are there potential unintended consequences for family (e.g., spousal estrangement) related to client's sexual expression?

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Skin integrity

Skin is the largest organ in the human body. Skin functions as a protective barrier against pathogenic organisms and contains internal structures. Skin is also responsible for thermoregulation, water retention and electrolyte balance; it functions as a sensory organ, provides storage (e.g., fat), performs synthesis (e.g., vitamin D), and promotes immune system function. If the skin or underlying tissues are impaired or damaged, these functions are disrupted.

A systematic, comprehensive assessment is necessary to identify client risks for skin breakdown, or factors that may impair the healing of wounds. Skin integrity and pressure injury screening and/or assessments are completed following clinical practice requirements for the care setting. Consultation with the healthcare team members, including the client (or alternate decision-maker when appropriate) and family, is required when a potential or actual problem is identified. Secondary assessments may be required to determine the cause or contributing factors to the problem. Tools used within continuing care to measure pressure injury risk include the Braden Scale, and interRAI Pressure Ulcer Risk Scale (PURS) for adults, and the Braden Q and Glamorgan for pediatric clients. Outcome Scales and Clinical Assessment Protocols (CAPs) generated from interRAI assessments also provide guidelines to support effective care planning.

A problem is an issue or area of concern where the client needs support or assistance.

A systematic, comprehensive assessment is necessary to identify client risks for skin breakdown, or factors that may impair healing of wounds.

Actual or potential skin integrity concerns may be a result of friction, shear, moisture, edema, poor tissue perfusion, mobility/immobility, chronic disease process, medical devices in use, nutritional deficit, skin tears or wound, surgical wounds, lifestyle choices, pressure injury or history of pressure injury, and trauma (e.g., thermal injury). Additional considerations or concerns may include:

- actual skin integrity concern related to pressure injury
- potential skin integrity concern related to immobility, chronic disease process and prior pressure injury

Care planning for issues or concerns related skin integrity should focus on comfort, dignity and well-being of the client and resolve or manage root cause(s).

Using a strength-based approach

A strength-based approach to care planning focuses on education and awareness for the client and family, to encourage and promote maximum independence and participation in self-care strategies. This foundational knowledge will help the decide what goals they would like to achieve, such as preventing or managing skin integrity concerns and what interventions are manageable. A strength-based approach to care planning may focus more on interventions for comfort and dignity rather than those intended to "fix" or resolve a health issue. For example, a client may value and benefit from socialization with others at meals or other activities where prolonged sitting is required. This activity may impair healing to an existing coccyx wound but heightens quality of life. The healthcare team may develop a care plan to mitigate risk for further injury or delayed wound healing while still supporting the client's choice.

Establishing goal statements

Once the comprehensive assessments have been completed and skin integrity is identified as a concern that the client wants to address in their care plan, establishing goals is the next step. Determining healability of a wound is vital to establishing goals and interventions. A goal is the client's desired status with the concern or problem and includes actions intended to support the client in reaching that goal.

The goal of preventing or managing skin integrity concerns may vary depending on the client's desire, ability and context. There may be multiple goals for a concern or problem. Goals may include improving or maintaining skin integrity, preventing injury, reducing the extent or degree of injury, promote healing, maintain status or focus on the client receiving appropriate wound management.

Example goal statements:

- {Client name} wound severity will be reduced within 90 days, as evidenced by decrease in wound size.
- {Client/family} will complete wound care at home 6/7 day a week.
- {Client name} skin integrity will improve within 90 days, as evidenced by maintaining size and status of chronic wound and intact skin integrity to rest of body.

Developing interventions

Identifying interventions to support the client's goals is done in collaboration with the healthcare team, including the client and family. Maximize client and family ability to participate in care through teaching.

The AHS Wound Care and Prevention Clinical Care Topic (CCT) provides care planning guidance for all ages. Refer to Additional Resources.

- Consider if the goal is to prevent or manage a concern with skin integrity. Identify members of the healthcare team who assist the client (e.g., dietitian to recommend caloric intake to promote wound healing; HCA to ensure pressure-relieving cushion is in place when the client mobilizes in a wheelchair).
- Establish the frequency of interventions required to achieve optimal outcomes, such as repositioning the client every 2 hours while awake and every 4 hours while asleep to prevent pressure injury and limit disturbance to the wound bed (e.g., dressing changes every two days as compared to daily, when appropriate).
- Consider the type and characteristics of wound care products to meet client needs; reduce the frequency of dressing changes where possible and appropriate for the type and location of wound (e.g., absorbent product for draining wounds, skin barrier to protect wound edges and intact skin).
- Are there other concerns that impact the intervention (e.g., client with cognitive loss frequently removes dressing)?

Example interventions:

- Teaching to address actual skin integrity concerns related to skin tears or wounds, mobility, lifestyle choice and chronic disease process:
  - how to maintain a clean and intact dressing
  - smoking cessation options to improve vascular health
  - wear long sleeves and pants to protect fragile skin
  - maintaining optimal blood glucose levels for improved wound healing
- Coordination to address actual skin integrity concerns related to edema, nutritional deficit; poor tissue perfusion, chronic disease process:
  - medication review
  - referral to dietitian
  - referral to occupational therapist for offloading plantar pressure
  - referral to Nurse Specialized in Wound, Ostomy and Continence (NSWOC) for wound debridement.

- Care provision to address potential skin integrity concerns related to moisture, medical device, prior pressure injury: See HCA Bedside Care Plan where the following examples of interventions may be identified:
  - apply skin barrier cream twice a day after morning and evening hygiene
  - assist with toileting and continence management every 2 hours
  - pad area behind ears when nasal cannula in use
  - ensure the pressure-relieving device is placed correctly on the client's chair when seated
  - remove mechanical lift sling from underneath the client after transfer complete
  - reposition every 2 hours when awake and every 4 hours when asleep
- Assessment to address potential skin integrity concerns related to poor tissue perfusion and altered foot sensation:
  - ankle-brachial index testing annually
  - monofilament testing annually

Communication and evaluation

Any identified changes or concerns in the client's skin integrity must be communicated immediately to ensure assessment (when indicated) is conducted by the appropriate healthcare professional and/or to implement appropriate treatment strategies and reduce risk of further injury. Changes in the client's wound size, drainage amount, odour or pain level may indicate the need for different or more frequent interventions, including referral to NSWOC and/or physician or nurse practitioner. Slower than expected healing may indicate a need for additional support such as nutritional supplements, increased hydration, and/or pressure reduction. Multiple healthcare team members may be notified when a client's condition changes and work collaboratively to address client care needs and goals. Direct communication with other healthcare providers may occur through telephone, facsimile, shift report, team huddles, care hubs, or other notification methods established in the care area. Documentation should also be reviewed, including flow sheets, treatment records and observations (e.g., amount of wound drainage), care provided (e.g., wound cleansing and dressing) and other information (e.g., client states "wound is not as painful as last week").

When a client's wound is not healing as anticipated, consider a referral to a healthcare professional specialized in wound care such as a Nurse Specialized in Wound, Ostomy and Continence (NSWOC).

Members of the healthcare team participate in reviewing client outcomes and status of problems (e.g., new, ongoing, resolved) based on identified measures of effectiveness in the care plan goal statement (e.g., increased granulation tissue), within the established time frame.

- Reassessments using tools such as the Braden (adults) and the Glamorgan (pediatrics) provide information on client risk factors and should be used to monitor change.
- Review documentation and outcome measures to evaluate the effectiveness of the interventions. Measures used to document client care provide information necessary to evaluate effectiveness of interventions, including but not limited to: results of skin assessments, wound measurements, tissue type and percentage, drainage type and amount, and frequency of dressing changes, including unscheduled changes.
  - Has the frequency of repositioning prevented pressure injury?
  - Has providing support with continence management promoted wound healing?
  - Has the support surfaces (i.e., wheelchair cushion and bed surface) reduced pressure on the wound and contributed to healing?
  - Is another type of wound product or frequency of dressing change indicated to improve the client's wound healing?
- Consider associated concerns with interventions:
  - Has the client experienced any issues or reactions to wound care products (i.e., cleansers, dressings, adhesives)?
  - Is the client's sleep disrupted by the frequency of repositioning to prevent pressure injury?
  - Is there a cost impact to the client for recommended wound care products or preventative devices (e.g., pressure-relieving device applied to the client's bed surface)?
  - Are there quality of life considerations for some interventions (e.g., social activity limitations due to negative pressure therapy)?

The healthcare team including the client and family, work together to reassess, review, monitor outcomes, revising the client care plan along the client's health journey.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Sleep and rest

Sleep and rest is defined as a period of inactivity, relaxation, or sleep. The body typically maintains a consistent cycle of sleep triggered by hormones but can also take cues from the environment and the body's level of activity.

Altered sleep patterns can occur due to:

- environmental factors
- lifestyle
- physiological factors
- medications
- pain
- psychological factors (nightmares, fear)
- sensory overload
- sleep cycle disruption

Using a strength-based approach

Maintaining a routine and finding out about the individuals' normal sleep and wake patterns will enhance person-centred care and improve health outcomes. Completing a sleep log or diary can assist with developing a strength-based care plan.

Consider the following when care planning for sleep and rest concerns:

- What is the clients' normal routine (i.e. sleep/wake patterns, work history/shift routine)?
- Are sleep issues the trigger/root cause for any other identified concerns (e.g., confusion, exacerbated behavioural and psychological symptoms of dementia (BPSD), falls, incontinence, reduced functional capacity, etc.)?
- Does the environment promote or inhibit sleep (e.g., light, noise, activity, frequent disturbances/rounds, temperature, etc.)?
- Is the sleep disturbance/issue new (e.g., undiagnosed insomnia, side effect of new treatment or medication, increased pain, etc.)?

Establishing goal statements

After identifying sleep and rest as an unmet need using comprehensive assessment(s), initiate discussions with the client about their goals for adequate sleep and rest. Ask the client what they want to achieve, recognizing that a full 8-9 hours of uninterrupted sleep may be unrealistic in a few short weeks/months. Aim for shorter goals that improve sleep health with smaller changes. Collaborate with the healthcare team to determine if additional/external referrals (e.g., sleep clinic, further assessment for sleep apnea) will be needed to achieve the client's stated goals.

Example goal statements:

- {Client name} will list two strategies for managing altered sleep pattern related to pain over the next 30 days.
- {Client name}'s altered sleep pattern related to environmental factors will improve over the next 90 days, as evidenced by increased total awake time to 16 hours daily.

Look to the AUA Toolkit for additional information on Responsive Behaviours and Sleep

Developing interventions

The clients' goals lead development of the type and frequency of interventions.

- Document which members of the care team would be most appropriate to help the client meet their goals (e.g., LPN/RN/PT for teaching related to sleep health, HCA providing supportive environment and completing sleep log/diary).
- Consider how frequently interventions would need to be scheduled to meet the client's needs (e.g., weekly teaching, weekly reduction/titration of "sleeping pills," daily sleep time routine).
- Does the client have responsive behaviours that would require more frequent sleep health assessment/intervention (e.g., modifying activities daily to engage and redirect and promote wake pattern)?
- Are there other medical concerns or treatments that impact the chosen interventions (e.g., short term condition that results in reduced sleep, undiagnosed reason for sleep disturbance, delayed assessment at a sleep apnea clinic)?

Example interventions:

- Teaching to address altered sleep pattern related to pain, including participation in a tailored physiotherapy program weekly, focusing on reducing pain and improving sleep. See physiotherapy care plan.
- Care provision to address altered sleep pattern related to environmental factors each evening, including providing calming activity at 8 pm, reducing fluids after 7:00 pm, reducing light at 10:00 pm and engaging in evening ADL care at 10:30 pm. See HCA Bedside Care Plan.

TIP: More ideas and interventions can be found in the AUA Toolkit Guidelines for a Good Night's Sleep

Communication and evaluation

Communicate any changes in the client's care needs and any issues related to sleep patterns to the care team immediately. Changes in the client's behaviours (calling out, unsettled, difficult to rouse) or changes in routine (staying in bed, not wanting to eat or drink, and staying up all night) can be signs of a change in health status or condition. Additional considerations (irritability, changes in elimination patterns, resisting care) will also help identify a change in status.

DID YOU KNOW?

Colour and light have an impact on sleep quality.

Remember: **RED** to sleep and **BLUE** to wake.

During evaluation, consider sleep and rest concerns in the context of overall health and wellness. Has the healthcare team been able to consistently provide the care required (e.g., sleep routine every evening)? Have there been any changes in the client's treatment plan that impacted the client's goal (e.g., change in medication)? Have there been any improvement areas noted (e.g., client is settled and alert throughout the day and can sleep for 6 hours each night)? Have any issues arisen (e.g., required acute medical interventions, worsening symptoms)? Document the evaluation and any areas of consideration identified to guide follow-up assessments, which will continue the care planning process.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Socioeconomic

Socioeconomic factors related to financial resources may include low or no income, lack of financial supports covered by medical insurance, imbalance in income vs expenses or challenges accessing appropriate supports to apply or access programs or resources. Clients may be experiencing indigence or financial mismanagement, abuse or complex financial situations. Socioeconomic factors may include occupation, education, living environment or systemic barriers outside of the client's control.

Clients may have a limited ability to access or manage their financial resources related to:

- cognition
- knowledge
- skills
- complex financial situations
- privacy concerns
- literacy
- factors out of client control (e.g., system policies)
- inability to manage finances due to health challenges

Using a strength-based approach

A strength-based approach to care planning should support the client in gaining the skills necessary for optimal financial management independence. Client factors such as willingness, ability, and availability of client/family to participate and learn new strategies are important parts of strength-based care. Assessment of the client's physical and social environments will help to identify availability of existing supports.

It is important the client be allowed to function within their capacity to perform financial tasks and have some degree of involvement when possible. Supporting involvement may counter the effects of dependence on others (such as low self-esteem, depressed mood, and feelings of incompetence). There are cases where it may be necessary to provide formal assistance with financial management, such as creating a power of attorney. It is important to advise clients and their supports on the importance of making these decisions and the process for completing the documents. When the client lacks capacity for making decisions about financial matters, enacting an enduring power of attorney to name a trustee (e.g., family or provincially appointed) may be required.

Establishing goal statements

Once comprehensive assessments have been completed and socioeconomic issues are identified with the client and their supports as an unmet need, initiate discussion with the client regarding their goals. These goals will lead to the development of a comprehensive client and family-centred care plan.

Example goal statements:

- {Client name} demonstrates three strategies taught for managing financial resources to professional staff within 30 days.
- {Client name} will contact at least three financial assistance sources within three months to help pay bills and provide a set allowance/month.
- {Family/caregiver name} will pursue formal trusteeship within 90 days.

Developing interventions

The client's goals lead to the development of the type and frequency of interventions. When developing interventions, consider:

- current skills or knowledge about budgeting or resources
- if there are opportunities to increase self-performance
- if alternatives are available (i.e., informal supports to manage finances)
- capacity to manage finances (e.g., Is an enduring power of attorney in place? Is a trustee needed?)
- if referrals to other healthcare team members are needed

Example interventions:

- Teaching:
  - Provide information about/facilitate/ensure reasonable access to financial resources.
- Assessment:
  - Assess client's knowledge, skill, and ability in managing finances.
  - Determine client's financial needs and assist in prioritizing needs & desires.
  - Assess for suspected mismanagement and/or abuse.
- Coordination:
  - Referral to a social worker.
  - Review income support programs with client and/or supports.
  - Advocate with governmental systems to ensure reasonable access to increased finances.

- Provide assistance with accessing emergency financial assistance or food.
- Report to and collaborate with appropriate investigators.
- Facilitate centre based informal financial management.
- Provide information on options for informal financial management.

Communication and evaluation

In collaboration with the client's informal supports and the healthcare team, client-focused interventions improve socioeconomic status. Communicating any changes or issues in finances from both the client's perspective and potential unmet needs from the healthcare team's perspective is essential. Changes in the client's ability to perform financial management can sign a change in health status or condition.

The client's ability to participate in financial management is dependent on client-specific factors (cognition, motivation, financial resources and available informal supports). It should be considered in evaluating the effectiveness of the care plan. During evaluation, consider socioeconomic concerns in the context of the client's overall health and wellness and quality of life and the client's goals and priorities and how they might fit within the context of the care plan. Consider if referrals for Personal Directive's or more formal management of finances are needed; for example, Power of Attorney.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Spirituality

Spirituality may be defined as the experience of meaning and connection in relation to self, others and Other (what one considers to be ultimate or transcendent). Spirituality may be expressed through beliefs and practices that support an individual's sense of purpose in life, and their ability to make sense of their experiences. For many clients spirituality is connected with religious and cultural beliefs and practices; for others it may take a more individual expression that is not based in religion. Spiritual distress occurs when there is a loss of meaning and connection in relation to self, others and Other, and can have profound impacts on health, healing and overall physical, mental and social wellbeing.

Spirituality influences attitudes on health and healthcare, decisions about treatment, communication with care providers, and health related behaviours and practices

A client's spirituality is important to consider when providing care, because this influences attitudes on health and healthcare, decisions about treatment, communication with care providers, and health related behaviours and practices. Spiritual healthcare can assist clients, families and caregivers to find strength and trust, to build resilience, and to cope with suffering, and changes in health and illness-related loss. Spiritual healthcare is also important in assisting individuals and families to reconcile beliefs with healthcare decisions

Clients may be asking questions such as:

- Why is this happening to me?
- What will happen to me or my loved ones?
- Who am I now? Will I ever be "myself" again?
- Where do I find strength?
- How can I cope with this?
- Do my beliefs make sense?
- What do I value most in life?
- How can I decide what to do?
- Who will be there for me? Who can I talk do?
- Who and what do I trust?

Using a strength-based approach

Spiritual healthcare is always client and family-centred. It should be confidential, respectful and compassionate. Communication about religious beliefs and practices should be centered on what clients and family members express. Health care providers need to ensure that their own beliefs, values and biases are not imposed during care. Quality spiritual healthcare can assist clients, family members and care providers to find and understand their sources of meaning and connection. These provide the inner strength and resilience needed to cope with challenges and changes that occur with injury, illness, aging and dying. Healthcare providers are encouraged to engage in conversation about spirituality using the AHS Spiritual History Tool. This supports a strength based approach to spiritual healthcare delivery that is person-centred, empowers clients, explores significant relationships and helps to discover innate capacities for spiritual strength and wellbeing.

Establishing goal statements

Once the comprehensive assessment has been completed and spirituality is identified as a concern that the client wishes to address, establish goals with the client. Goals will lead to the development of a comprehensive client and family-centred care plan.

Collaborate with the client and review each goal related to spirituality with both the client and the healthcare team.

Example goal statements:

- {Client name} will verbalize three grief coping strategies to a healthcare professional within one month.
- {Client name} will contact two community resources regarding support to cope with changes in health status within two months.

Developing interventions

The client's goals inform the development of the type and frequency of interventions. When developing interventions, consider:

- motivation to engage in activities that focus on self-reflection, awareness, cognition, emotional and spiritual support
- lack of skills or knowledge about the religious, spiritual, or cultural concern
- assessment of client's religious, spiritual and/or cultural community affiliation(s) to access needed support from community resources

Example interventions:

- consultation with spiritual care professional for spiritual health assessment
- support client to connect to religious, spiritual and cultural communities

- engagement in spiritual practices
- provide information to client on available religious, spiritual and or cultural community resources

Communication and evaluation

Spiritual health holds the tension between spiritual well-being and spiritual distress. It is essential to communicate any spiritual distress and changes or issues in spiritual well-being from either the team or the client's perspective. Changes in the client's spiritual health can be a sign of a change in health status or condition.

During the evaluation, consider spirituality concerns in the context of overall health and wellness. Spiritual well-being, quality of life, and client-specific factors such as cognition, behaviours, motivation, and available religious, spiritual and or cultural community and informal supports should be considered in evaluating the effectiveness of the care plan.

Ongoing evaluation of the client's care plan and review of outcomes is necessary. A change to intervention strategies may be required to meet the client's goals. Also, the client's goals may change depending on fluctuating health status conditions.

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Supports

Supports refer to the client's ability to manage all aspects of care and the degree of help or assistance available to the client. There are two types of supports. Formal support refers to paid care providers who deliver direct services or care to the client for Instrumental Activities of Daily Living (IADLs) and Activities of Daily Living (ADLs). Informal support refers to the unpaid care providers whose help includes emotional/ advice, IADL's and ADL's.

Identifying potential risks and gaps in support can be achieved by completing a comprehensive assessment in consultation with the client and/or decision-maker, the healthcare team and formal and informal caregivers.

Identified risks related to the lack or inability to access formal and informal support will alert the healthcare team of need to learn more about the issue impacting the client's health and wellness.

Both formal and informal supports can be used to address actual or potential challenges in managing numerous aspects of care, which may include:

- developing relationships, caregiver supports
- illness, fatigue, burnout, guilt, concerns related to the living environment, complex or end-of-life care needs
- communication needs, transportation
- limited or unavailable support networks

Using a strength-based approach

A strength-based approach to care planning goals related to supports focuses on education and awareness for the client and family to encourage and promote maximum independence and self-care strategies. This foundational knowledge will help the client decide what goals they would like to achieve to address the concern and what interventions are manageable and attainable. Consideration will need to be given to what supports are available. This can vary dramatically between urban, rural and remote locations. Accessibility issues may be overcome by advancements in technology and virtual healthcare.

The client may also not have access to family or social supports due to distance or breakdown in relationships. Consider that the client may not want to focus on fixing/repairing relationships that are seen as broken but may focus on building new support networks that meet their needs.

Establishing goal statements

In consultation with the client and family, the healthcare team reviews the areas of concern related to supports and determine which areas are priority and together develop goals to support the client in mitigating the area of concern.

Example goal statements:

Goals related to the support problem may include improving or maintaining living situations or changes in the living environment, support for informal caregivers such as spouses and parents, support for siblings, obtaining formal emotional assistance for the client/client or caregiver, or supporting complex care needs.

- {Client name} feelings of loneliness will decrease as evidenced by an increase in the Social Engagement Scale from 2 to 4, by the next RAI assessment.

  OR

- {Caregiver name} burnout will improve as evidenced by improved Care Support Needs Assessment Tool (CSNAT) score in the next 90 days.

Developing interventions

Identifying interventions to support the client's goal(s) is completed in collaboration with the healthcare team, including the client and family. Identify members of the healthcare team who will assist the client and establish a frequency of interventions required to achieve optimal outcomes. Determine which concerns impact the client's formal and informal support and leverage help from the client's informal support system. Ensure that the chosen interventions are aligned with the client's goal, and that the client, family, and alternate decision-maker agree with the chosen intervention. Interventions include resources that can be accessed from internal and external agencies such as community resources like support groups and adult day programs, personal support services such as housekeeping and meals, guardianship and trusteeship resources, and financial benefits/programs support.

Example interventions:

- Caregiver not coping:
  - authorization of respite services to provide the informal caregiver with time away
  - referral to adult day support programs
  - housekeeping support in home
  - authorization for formal services to support ADL and IADLs
- Change in living environment:
  - support arrangements to move to lodge or seniors apartment complex
  - assessment of client for a DLO
- Complex care support:
  - set up for self-managed care, added care, extraordinary care services
- Emotional support:
  - referrals to support groups, e.g., Alzheimer's Society, bereavement support groups, social worker, recreation therapy
- Social supports/lack of informal caregiver:
  - assess for recreation therapy and client likes/dislikes
  - refer to social worker/other appropriate staff member to assess finances and access to financial benefits
  - application for guardianship/trusteeship/specific decision-making

Communication and evaluation

When evaluating effectiveness of support interventions, consider the following:

- Has providing support to the informal caregiver resulted in improved ability to cope?
- Has the referral to a social worker for financial assessment resulted in improved financial resources for the client?
- Has appointment for guardianship given the client the formal support needed to make decisions on ADLs and IADLs?
- Has providing support with ADLs and IADLs given the client opportunity to remain in current living situation?
- Has the change in living environment (e.g., move to DLO) stabilized the client's health needs?

Members of the healthcare team are notified when a client's condition changes, and work collaboratively with the client and family to address the client's care needs and goals.

Consider any associated concerns with interventions.

- Has the client experienced any issues with implementing the intervention (e.g., unable to access virtual health appointments due to lack of technology)?
- What is the impact on personhood and quality of life (e.g., family lives far away and resulting in loss of identity and depression)?
- Is the client able to maintain or improve their ability to be involved in their care if able and interact with others (e.g., attending group exercise classes that build strength and help reduce need for formal care supports)?

Refer to Appendix C for Core and Additional Resources to help identify the problem, and develop client centred goals and interventions.

Appendix A – Care Planning Process

Evaluation

How will you know when the "goal is achieved"?

- Review the measures identified in the goal.
- Involve the client and the healthcare team.
- Have the interventions been helpful and need to continue?
- Has the problem been resolved?
- Re-assess if the problem has changed or interventions need modification.

Assessment

Identify area of concern or problem after assessment:

- assessed unmet need.
  - client desire to address an area.

Decision-Making

What is causing the area of concern/problem?

- Identify exact/root cause and contributing issues.
- Complete secondary assessments as needed, to get a better understanding.

What is the desired outcome or goal?

- To prevent, improve, maintain, reduce, understand, receive, be able to.
- Within a timeframe of # of days, weeks, months, or years.
- Evidenced by a measurement used to identify progress or signal when the goal has been achieved. Scales, scores, or some outcome must be identified.

Communication

Who needs to know about the care plan to help the client reach their goals?

- Who is responsible for professional interventions such as teaching, care provision, assessment, monitoring, etc.?
- Are interventions documented on the Service Authorization, Bedside Care Plan or Behaviour Support Plan?
- Are changes communicated during transitions in care, shift report and/or on a white board?

Planning

- What interventions does the client want to help to achieve their goals?
- How frequently do the interventions need to be completed?
- Which team member is responsible for the interventions?

Appendix B – CCHSS Care Plan Requirements

Continuing Care Health Service Standards
Care Plan Requirements

Alberta Health Services

*These are the **minimum** requirements prescribed by the CCHSS. Your program/area/site may have additional requirements. Please follow the requirements in your area.*

- ☐ Designated care giver (individual who consistently provides unpaid support, care and assistance in a variety of ways. May be a family member or friend and may be the same as the legal representative).
- ☐ Legal Representative (if applicable): Name, source of authority, and contact information. If copy of legal documents on file, indicate so.
- ☐ Signed Managed Risk Agreement (if applicable). If client and/or legal representative refused to sign, indicate so.
- ☐ Restraints (if applicable): Review date, specific name and type of restraint, method (visual inspection, assessing consciousness etc.), frequency of monitoring, behavior(s) client was exhibiting that put themselves or others at risk of harm, supportive interventions that were tried, the indications for the initial use of a restraint, the assessment of the client while restrained, and the review of the ongoing need for the restraint. Indicate where doctor's order is.
- ☐ Client's physical, mental, emotional, social, intellectual, and spiritual Health Care needs and corresponding goals; palliative and end-of-life goals if applicable.
- ☐ Interventions to meet unmet assessed needs and the responsible healthcare provider, including the following if applicable:
  - ☐ Medication management plan, reviewed and updated at every interdisciplinary team conference.
  - ☐ Nutrition and hydration directions as recommended by Registered Dietitian and reviewed by Regulated Health Care Provider.
  - ☐ In Supportive Living and Long-Term Care facilities, oral care assistance twice per day, or more frequently if required.
  - ☐ In Supportive Living and Long-Term Care facilities, Client's preference for method and frequency of bathing. Must be offered twice per week, at minimum. Document if Client prefers a bathing temperature lower than 38 degrees Centigrade.
- ☐ Must reflect the findings of the assessment (this may mean having the RAPs/CAPs triggered on the care plan, or the use of another document that shows the link from the assessment to the care plan.)
- ☐ If the client and/or the legal representative was unwilling or unable to participate in the review of the care plan.
- ☐ If client is receiving palliative and end-of-life care, include relevant instructions from any legal documents regarding palliative and end-of-life care (i.e., Goals of Care Designation, Personal Directive).
- ☐ Revisions are made by a Regulated Health Care Provider

Questions? Contact CCHSS@ahs.ca

Revised December 2, 2019

Appendix C – Care Planning: Resources

Core Resources

The healthcare team should review available core resources and then proceed to Additional Resources for each topic area as needed.

Patient Care Handouts

- Available on https://myhealth.alberta.ca/health/aftercareinformation/Pages/default.aspx
- Use clinical judgement to determine if a handout from other sources (e.g., Lippincott Advisor, program resources) is appropriate for the client/resident.

Lippincott Advisor provides nursing care plans for medical diagnosis and problem based care plans. See Appendix D on how to access these resources through AHS or Continuing Care Connection (CCC).

InterRAI Clinical Assessment Protocols (CAPs) Manual (2008) is designed to work with a variety of interRAI's community and long-term care assessment instruments. Care guidelines help the user to think through the relevant underlying issues and move toward a plan of care. CAPs guide the plan of care to resolve problems, reduce the risk of decline or increase the potential for improvement. Follow the click paths below to access this manual.

AHS Insite	Continuing Care Connection (CCC)
Home > Teams > Seniors Health > Seniors Health Provincial and then filter items to search for interRAI CAPs Manual, 2008	**Home > Resources > Practice Resources > Assessment** and then scroll down to the sub-heading Common Resources to find interRAI CAPs Manual, 2008

AHS Clinical Guidance Viewer contains provincially developed and approved clinical guidance and practice standards.

- Available on https://www.albertahealthservices.ca/cgv/Page15918.aspx
- Clinical Knowledge Topics (CKTs) are best practice/evidence-informed clinical guidance for defined diseases/conditions, specific patient populations or segments of a clinical pathway.
- Clinical Care Topics (CCTs) are comprehensive practice support tools that equip healthcare providers with evidence-based clinical guidance.

Additional Resources

Note: the following are not a comprehensive list of resources.

Click paths are provided for way-finding to these additional resources on AHS Insite, CCC or the internet.

Topic	AHS Insite	Continuing Care Connection	External Links
Abuse/Neglect	• **Home > Teams > Seniors Health > Seniors Health Provincial** and then filter items to search for sexuality: ○ Identifying and Managing Sexual Abuse in Designated Living Option Sites • **Home > Teams > Domestic Violence (DV)**	• **Home > Resources > Practice Resources > Client Safety** and then scroll to: Abuse	• **Abuse helpline** https://www.alberta.ca/abuse-helpline.aspx • **What is child abuse, neglect and sexual exploitation | Alberta.ca** https://www.alberta.ca/what-is-child-abuse-neglect-and-sexual-exploitation.aspx • **brainXchange** https://brainxchange.ca/Public/Home • **Keeping Patients Safe from Abuse Policy** https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-keeping-patients-safe.pdf • **Patient Safety & Quality Healthcare** https://www.albertahealthservices.ca/info/patientsafety.aspx • **Protection for Persons in Care** https://www.alberta.ca/protection-for-persons-in-care.aspx • **Reportable Incidents Decision Process** https://open.alberta.ca/publications/reportable-incident-decision-process • **Sagesse Domestic Abuse Resource Hub** https://hub.sagesse.org/

Additional Resources

Activities of Daily Living (ADLs)

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Activities of Daily Living (ADLs)</td><td>• Home > Teams > Health Professions Strategy & Practice > Education & Orientation > Practice Wise
• Suggested search terms on Insite and Learning Link: oral care, feeding, safe client handling, nutrition education resources, pressure injury prevention, safe bathing, compression stockings, etc.</td><td>• Home > Resources > Practice Resources and then select from a variety of topics including: oral care, feeding, safe client handling, nutrition education resources, pressure injury prevention, safe bathing, compression stockings, etc.</td><td rowspan="2">• Alberta Health Services:
https://www.albertahealthservices.ca/default.aspx
• Rehabilitation Information for Health Professionals
https://www.albertahealthservices.ca/info/Page17198.aspx
• Elder Friendly Care Toolkit
https://www.albertahealthservices.ca/scns/Page13345.aspx
• Nurselabs
https://nurseslabs.com/self-care-deficit/
• Nurse Together
https://www.nursetogether.com/self-care-deficit-nursing-diagnosis-care-plan/
• Oral Health
Oral Health | Alberta Health Services</td></tr>
<tr><td colspan="2">CORE Resources
• interRAI CAPs Manual (on Insite & CCC)
• Lippincott Advisor for problem-based care plans (e.g., ADL deficit)
• MyHealth.Alberta.ca for patient care handouts</td></tr>
</table>

Additional Resources

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Communication</td><td>

- **Home > Teams > Interpretation & Translation Services**
- **Home > Teams > Health Professions Strategy & Practice > Education & Orientation > Communication Access**
- **Home > Teams > Professional Practice Councils > Provincial > Speech Language Pathology**
- **Suggested search terms on Insite and Learning Link:** speech language pathology, communication, communication and dementia

</td><td></td><td rowspan="2">

- **AHS Eye-Gaze with Short Demonstration (video)** https://ahamms01.https.internapcdn.net/ahamms01/Content/InSite_Videos/HPSP/tms-hpsp-demo-eye-gaze.mp4
- **American Sign Language (ASL) \| AHS** https://www.albertahealthservices.ca/info/Page16974.aspx
- **BrainXchange** https://brainxchange.ca/Public/Home
- **Communication Access \| Alberta Health Services** https://www.albertahealthservices.ca/cmac/Page17532.aspx
- **Communication Disabilities Access Canada** https://www.cdacanada.com/
- **Patient-Provider Communication** https://www.patientprovidercommunication.org/
- **Tools & Resources for Specific Communication Needs** https://www.albertahealthservices.ca/cmac/Page17538.aspx
- **Virtual Health \| AHS** https://www.albertahealthservices.ca/vh/Page17094.aspx

</td></tr>
<tr><td colspan="2">

CORE Resources

- **interRAI CAPs Manual** (on Insite & CCC)
- **Lippincott Advisor** for:
  - problem-based care plans (e.g., dementia resident communication)
  - Textbook resources (e.g., Lippincott Manual of Nursing Practice, Healthy Aging: Principles and Clinical Practice for Clinicians)
- MyHealth.Alberta.ca for patient care handouts

</td></tr>
</table>

Additional Resources

Community Resources

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Community Resources</td><td></td><td></td><td rowspan="2">

- **211 Alberta**
  https://ab.211.ca/
- **Continuing Care Facility Directory**
  https://www.albertahealthservices.ca/cc/Page15328.aspx
- **Community Links | The Family & Community Resource Centre (albertahealthservices.ca)**
  http://fcrc.albertahealthservices.ca/community-links/
- **Healthy Aging CORE Alberta**
  https://corealberta.ca/
- **Inform Alberta**
  https://informalberta.ca/
- **Primary Care Network** Search for PCN in your geographical area
- **Primary Health Care Resource Centre**
  https://www.albertahealthservices.ca/info/Page11929.aspx
- **What Matters to You | AHS**
  https://www.albertahealthservices.ca/info/Page15982.aspx

</td></tr>
<tr><td colspan="2">

CORE Resources

- **interRAI CAPs Manual** (on Insite & CCC)
- MyHealth.Alberta.ca for patient care handouts

</td></tr>
</table>

Additional Resources

Elimination

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Elimination</td><td>

Suggested search terms on Insite:

Bladder and Bowel Record
Bowel Management
Comfort rounds
Constipation
Ostomy Management
Urinary continence assessment screening tool
Urinary incontinence management

Suggested search terms on My Learning Link:

incontinence

</td><td>

Home>Resources>Practice Resources> Elimination
Suggested search terms on CCC:

Bowel Management
Constipation
Comfort rounds
Ostomy Management
Urinary incontinence management

</td><td rowspan="2">

A Proactive Approach to Bladder and Bowel Management in Adults (RNAO)
https://rnao.ca/sites/rnao-ca/files/bpg/Bladder_and_Bowel_Management_FINAL_WEB.pdf
AHS Care of Patients with Spinal Cord Injury
https://www.albertahealthservices.ca/scns/Page13965.aspx
AHS Digestive Health SCN:
https://www.albertahealthservices.ca/scns/Page13909.aspx
AHS Find Healthcare (e.g., continence clinic, pelvic floor clinic)
https://www.albertahealthservices.ca/findhealth
AHS Urinary Catheter Management Clinical Care Topic:
https://www.albertahealthservices.ca/cgv/Page16666.aspx
Canadian Continence Foundation:
https://www.canadiancontinence.ca/EN/
Canadian Nurse Continence Advisor Resources
https://cnca.ca/resources/
Centre for Effective Practice: Managing Urinary Incontinence in Women
https://cep.health/media/uploaded/CEP_UI_2020.pdf

</td></tr>
<tr><td colspan="2">
CORE Resources

interRAI CAPs Manual (on Insite & CCC)
Lippincott Advisor for:

problem-based care plans (e.g., constipation)
Textbook resources (e.g., Lippincott Manual of Nursing Practice, Healthy Aging: Principles and Clinical Practice for Clinicians)

MyHealth.Alberta.ca for patient care handouts

</td></tr>
</table>

Additional Resources

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Fall Risk</td><td>

Home>Teams>Accreditation> Required Organizational Practices>Falls Prevention
Home>Teams>Falls Risk Management
Search for education on MyLearningLink:

Falls Risk Management in Home Living and Supportive Living
Upstream Approach to Fall Prevention

Suggested search terms on Insite:

Falls

</td><td>

Home > Resources > Practice Resources >Client Safety

Falls Long-Term Care Toolkit (Calgary Zone)
AHS Falls Risk Management

</td><td rowspan="2">

AHS Injury Prevention & Safety Preventing Falls
https://www.albertahealthservices.ca/injprev/Page15787.aspx
Canadian Falls Prevention Resources
http://canadianfallprevention.ca/resources-and-links/
Fall Prevention Community of Practice Loop
https://www.fallsloop.com/
Finding Balance Alberta
https://findingbalancealberta.ca/
Government of Canada: Aging and Seniors
https://www.canada.ca/en/public-health/services/health-promotion/aging-seniors.html
Preventing Falls and Reducing Injury from Falls (RNAO)
https://rnao.ca/sites/rnao-ca/files/bpg/FALL_PREVENTION_WEB_1207-17.pdf
U of A Centre for Active Living
https://www.ualberta.ca/kinesiology-sport-recreation/research/centres-and-units/centre-for-active-living.html

</td></tr>
<tr><td colspan="2">
CORE Resources

interRAI CAPs Manual (on Insite & CCC)
Lippincott Advisor for:

problem-based care plans (e.g., falls)
Textbook resources (e.g., Lippincott Manual of Nursing Practice, Healthy Aging: Principles and Clinical Practice for Clinicians)

MyHealth.Alberta.ca for patient care handouts

</td></tr>
</table>

Additional Resources

Growth & Development

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Growth & Development</td><td>• Home>Teams>Healthy Children & Families and click on the Well Child tab to access:
○ eLearning self-study module
○ Nursing Guidelines and more
• My Learning Link E-Modules
○ Growth Chart Training Modules</td><td>• Home > Learning Opportunities > Education > CCHSS Standard 9 Education and scroll down to
○ Pediatric</td><td rowspan="2">• Canadian Paediatric’s Society
https://cps.ca/
• Children’s Healthcare Canada
https://www.childrenshealthcarecanada.ca/en/index.aspx
• Government of Alberta Children’s Services
https://www.alberta.ca/childrens-services.aspx
• McMaster University CanChild
https://www.canchild.ca/en/
• World Health Organization
https://www.who.int/activities/promoting-healthy-growth-and-development</td></tr>
<tr><td colspan="2">CORE Resources
• interRAI CAPs Manual (on Insite & CCC)
• Lippincott Advisor for:
○ problem-based care plans (e.g., constipation)
○ Textbook resources (e.g., Lippincott Manual of Nursing Practice, Healthy Aging: Principles and Clinical Practice for Clinicians)
• MyHealth.Alberta.ca for patient care handouts</td></tr>
</table>

Additional Resources

Health Status/ Conditions

Health Status/ Conditions

AHS Insite

- **Suggested search terms on Insite:**
  - Hypertension
  - Diabetes
  - Multiple sclerosis
  - Parkinson's
  - Pain
  - Palliative care
  - Substance management

Continuing Care Connection

- **Suggested search terms on CCC:**
  - Diabetes
  - Nutrition
  - Pain
  - Palliative care
  - Substance management

CORE Resources

- **interRAI CAPs Manual** (on Insite & CCC)
- **Lippincott Advisor for:**
  - problem-based care plans (e.g., altered health maintenance)
- MyHealth.Alberta.ca for patient care handouts

External Links

- **Advancing Dementia Care & Support in Alberta**
  https://www.albertahealthservices.ca/scns/Page13343.aspx
- **AHS Addiction & Mental Health**
  https://www.albertahealthservices.ca/info/Page11536.aspx
- **AHS Chronic Diseases and Conditions**
  https://www.albertahealthservices.ca/info/Page7736.aspx
- **AHS Clinical Knowledge Topics**
  https://www.albertahealthservices.ca/cgv/Page15918.aspx
- **AHS Diabetic Foot Care Pathway Toolkit**
  https://www.albertahealthservices.ca/scns/Page13331.aspx
- **AHS Infection Prevention & Control**
  https://www.albertahealthservices.ca/ipc/ipc.aspx
- **AHS Palliative & End-of-Life Care**
  https://www.albertahealthservices.ca/info/Page14778.aspx
- **AHS Pediatric Rehabilitation**
  https://www.albertahealthservices.ca/info/Page16633.aspx
- **AHS Strategic Clinic Networks (™)**
  https://www.albertahealthservices.ca/scns/scn.aspx
- **AHS Youth**
  https://www.albertahealthservices.ca/y2a/Page16483.aspx
- **Arthritis Society**
  https://arthritis.ca/
- **Diabetes Canada**
  https://diabetes.ca/
- **Kidney Foundation**
  https://kidney.ca/
- **Multiple Sclerosis Society**
  https://mssociety.ca/
- **Parkinson Association of Alberta**
  https://parkinsonassociation.ca/

Additional Resources

Instrumental Activities of Daily Living (IADLs)

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Instrumental Activities of Daily Living (IADLs)</td><td>

Home > Teams > Health Professions Strategy & Practice > HPSP Resources
Search Power Mobility in Congregate Living Facilities – Occupational Therapy Practice Guide
Home > Teams > Professional Practice Council > Occupational Therapy under Resources & Clinical Tools
Driving Retirement
OT Practice guide for Enabling Participation in Driving
Role of Occupational Therapy in the Assessment of Decision-Making Capacity Guide

</td><td>

Home > CCHSS Standards > Standard 6.0 Education
Assistive Equipment, Technology and Medical/ Surgical Supplies
Home > Resources > Practice Resources > Equipment & Assistive Devices

</td><td rowspan="2">

Adult Community Rehabilitation | Alberta Health Services
https://www.albertahealthservices.ca/info/Page15329.aspx
Alberta College of Occupational Therapists
https://acot.ca/
Search under practice resources
Canadian Association of Occupational Therapists (CAOT)
https://caot.ca/
search under practice resources
Management of Assistive Equipment and Technology Directive HCS-266 (ahsnet.ca)
https://extranet.ahsnet.ca/teams/policydocuments/1/clp-prov-continuing-care-assistive-equipment-hcs-266.pdf
Society of Alberta Occupational Therapists (SAOT)
https://www.saot.ca/

</td></tr>
<tr><td colspan="2">
CORE Resources

interRAI CAPs Manual (on Insite & CCC)
Lippincott Advisor for:
problem-based care plans (e.g., IADL deficit)
MyHealth.Alberta.ca for patient care handouts

</td></tr>
</table>

Additional Resources

Medication Management

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr>
<td rowspan="2">Medication Management</td>
<td>

Home > Teams > Seniors Health > Seniors Health Provincial > and then filter items to search for:
Medication
Home > Teams > Seniors Health > Seniors Health Zones > select Zone and then scroll or filter through zone resources
Home > Teams > Provincial Medication Safety > Provincial Medication Safety Initiatives & Resources for:
Hazardous Medication
Insulin Safety & Diabetes Management
Home > Teams > Knowledge Resource Services (KRS) for:
DynaMed
Lexicomp
CPS/Therapeutic Choices
My Learning Link: various eLearning modules
Home > Teams > Pharmacy Services for:
Drug Information Centre
Parenteral Manuals

</td>
<td>

Home > Resources > Practice Resources > Diabetes
Home > Resources > Practice Resources > Medication Management:
Hazardous Medication
High-Alert Medication
Independent Double Check
Medication Reconciliation
Medication Risk Management
Home > Learning > Practice/ Business Resource Education > Medication Management:
Medication Reconciliation (MedRec) eLearning Module
Home > Resources > Zone Resources > select Zone and then scroll though zone resources

</td>
<td rowspan="2">

AHS Appropriate Prescribing & Medication Use Strategy for Older Albertan’s
https://www.albertahealthservices.ca/scns/Page13799.aspx
AHS Appropriate Use of Antipsychotics (AUA) Toolkit
https://www.albertahealthservices.ca/scns/auatoolkit.aspx
AHS Drug Safe
https://www.albertahealthservices.ca/info/Page12491.aspx
AHS Medication Assistance Program
https://www.albertahealthservices.ca/info/Page10406.aspx
AHS Medication Reconciliation
https://www.albertahealthservices.ca/info/Page12614.aspx
AHS Poison & Drug Information Services for Health Professionals
https://www.albertahealthservices.ca/info/Page11976.aspx
Choosing Wisely Canada
https://choosingwiselycanada.org/recommendations/
Deprescribing
https://deprescribing.org/
Healthy Aging.org
https://www.healthinaging.org/medications-older-adults
Institute for Safe Medication Practices Canada
https://ismpcanada.ca/

</td>
</tr>
<tr>
<td colspan="2">
CORE Resources

interRAI CAPs Manual (on Insite & CCC)
Lippincott Advisor for:
problem-based care plans (e.g., Knowledge deficit)
MyHealth.Alberta.ca for patient care handouts

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</tr>
</table>

Additional Resources

Mood/Emotion and Behaviour

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Mood/Emotion and Behaviour</td><td>

Home > Teams > Addiction & Mental Health > AMH Practice Resources > Geriatric Services Educational Series: Eye-Level In-Services
Home > Teams > Health Professions Strategy & Practice > Education for > Psychological Trauma Toolkit
My Learning Link: various eLearning modules (e.g., Mental Health First Aid, Suicide Prevention, Non Violent Crisis Intervention)
Suggested search terms on Insite and Learning Link: mood, cognition

</td><td>

Home > Resources > Practice Resources > Dementia
Home > Learning Opportunities > Education > CCHSS Standard 9 Education > Standard 9.2 a ii > Responsive Behaviours

</td><td rowspan="2">

AHS Addiction and Mental Health Resources
https://www.albertahealthservices.ca/info/Page11536.aspx
AHS Suicide Risk Management in Designated Living Options
https://www.albertahealthservices.ca/info/Page10914.aspx
AHS Appropriate Use of Antipsychotics (AUA) Toolkit
https://www.albertahealthservices.ca/scns/auatoolkit.aspx
AHS Postpartum Depression Resources
https://www.albertahealthservices.ca/services/Page15072.aspx
AHS Youth
https://www.albertahealthservices.ca/y2a/Page16483.aspx
Advancing Dementia Care & Support in Alberta
https://www.albertahealthservices.ca/scns/Page13343.aspx
AHS Pain & Mood Toolkit
https://www.albertahealthservices.ca/info/Page17547.aspx
brainXchange
https://brainxchange.ca/Public/Home
Centre for Addiction and Mental Health Cognitive Behavioral Therapy
https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/cognitive-behavioural-therapy
Canadian Coalition for Seniors Mental Health
https://ccsmh.ca/
Canadian Mental Health Association
https://cmha.ca/find-info/mental-health/

</td></tr>
<tr><td colspan="2">
CORE Resources

interRAI CAPs Manual (on Insite & CCC)
Lippincott Advisor for:

problem-based care plans (e.g., IADL deficit)

MyHealth.Alberta.ca for patient care handouts

</td></tr>
</table>

Additional Resources

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Cognition</td><td>• Search for education on MyLearningLink for AHS and CLiC for Covenant Health:
○ Decision-Making Capacity Assessment
• Home > Teams > Knowledge Resource Services (KRS)
• My Learning Link: various eLearning modules</td><td>• Home > Resources > Practice Resources > Dementia
• Home > Resources > Practice Resources > Assessment and then scroll to:
○ Decision-Making Capacity Assessment</td><td rowspan="2">• Advancing Dementia Care & Support in Alberta
https://www.albertahealthservices.ca/scns/Page13343.aspx
• AHS AUA Toolkit
https://www.albertahealthservices.ca/scns/auatoolkit.aspx
• Alzheimer Society of Canada
https://alzheimer.ca/en
• BrainXchange
https://brainxchange.ca/Public/Home
• Canadian Remote Access for Dementia Learning Experiences (CRADLE+)
https://www.conestogac.on.ca/subsidized-training/health/canadian-remote-access-for-dementia-learning-experiences
• Clinical Knowledge Topics: Seniors/PEOLC (see Delirium and Dementia)
https://www.albertahealthservices.ca/cgv/Page15920.aspx
• Dementia Video Series | Island Health
https://www.islandhealth.ca/learn-about-health/seniors/dementia-video-series
• Elder Friendly Care Toolkit
https://www.albertahealthservices.ca/scns/Page13345.aspx</td></tr>
<tr><td colspan="2">CORE Resources
• interRAI CAPs Manual (on Insite & CCC)
• Lippincott Advisor for:
○ problem-based care plans (e.g., Memory Impairment)
○ Textbook resources (e.g., Healthy Aging: Principles and Clinical Practice for Clinicians)
• MyHealth.Alberta.ca for patient care handouts</td></tr>
</table>

Additional Resources

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Nutrition/Hydration</td><td>• Home > Teams > Health > Professions Strategy & Practice Resources > Eating, Feeding & Swallowing – Allied Health Adults
• Home > Teams > Seniors Health > Seniors Health Provincial > Choking Prevention & Safe Mealtime Management</td><td>• Home > CCHSS Standards > Standard 13.0 Nutrition and Hydration Management
• Home > Practice Resources > Client Safety
• Home > Practice Resources > Nutrition
• Home > Practice Resources > Oral Care</td><td rowspan="2">• Basic Life Support (BLS)
Basic Life Support (BLS) (heartandstroke.ca)
• Healthy Eating Starts Here
Healthy Eating Starts Here | Alberta Health Services
• Nutrition Services
Nutrition Services | Alberta Health Services
• Oral Health
Oral Health | Alberta Health Services
• Time to Eat Toolkit
Time to Eat Toolkit | Alberta Health Services</td></tr>
<tr><td colspan="2">CORE Resources
• Lippincott Advisor for:
○ problem-based care plans (e.g., nutrition, hydration, etc.)
• MyHealth.Alberta.ca for patient care handouts</td></tr>
</table>

Additional Resources

Pain Management

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Pain Management</td><td>• Search terms on Insite:
○ Pain
○ Chronic Pain
○ Pain Management
○ Pain and Mood</td><td>• Home > Resources > Practice Resources > Pain & Mood</td><td rowspan="2">• Chronic Pain: Primary Healthcare Resource Centre
https://www.albertahealthservices.ca/info/Page14874.aspx
• Pain & Mood Toolkit
https://www.albertahealthservices.ca/info/Page17547.aspx
• Pain and Dementia
https://www.albertahealthservices.ca/assets/about/scn/ahs-scn-srs-phsigsi-workshop3-2018-pain.pdf
• Mood Disorders and Behaviours
https://www.albertahealthservices.ca/assets/info/seniors/if-sen-pm-mood-behaviours.pdf</td></tr>
<tr><td colspan="2">CORE Resources
• interRAI CAPs Manual (on Insite & CCC)
• Lippincott Advisor for:
○ problem-based care plans (e.g., pain, nerve block, etc.)
• MyHealth.Alberta.ca for patient care handouts</td></tr>
</table>

Additional Resources

Psychosocial Well-Being

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Psychosocial Well-Being</td><td>• Home > Teams > Addiction & Mental Health > AMH Practice Resources
• Suggested search terms on Insite:</td><td>• Home > Resources > Practice Resources > Substance Management
• Home > Learning Opportunities > Education > CCHSS Standard 9 Education > Standard 9.2 a ii > Responsive Behaviours</td><td rowspan="2">• AHS Addiction & Mental Health: Information for Health Professionals
https://www.albertahealthservices.ca/info/Page11536.aspx
• AHS Cancer Care: Psychosocial & Rehabilitation Oncology
https://www.albertahealthservices.ca/cancer/Page16332.aspx
• AHS Chronic Diseases and Conditions
https://www.albertahealthservices.ca/info/Page7736.aspx
• AHS Pain & Mood Toolkit
https://www.albertahealthservices.ca/info/Page17547.aspx
• Enhancing Concurrent Capability Toolkit
https://www.albertahealthservices.ca/info/Page14889.aspx
• Help in Tough Times
https://www.albertahealthservices.ca/amh/Page16759.aspx</td></tr>
<tr><td colspan="2">CORE Resources
• interRAI CAPs Manual (on Insite & CCC)
• Lippincott Advisor for:
○ problem-based care plans (e.g., relationships, behavioural health)
• MyHealth.Alberta.ca for patient care handouts</td></tr>
</table>

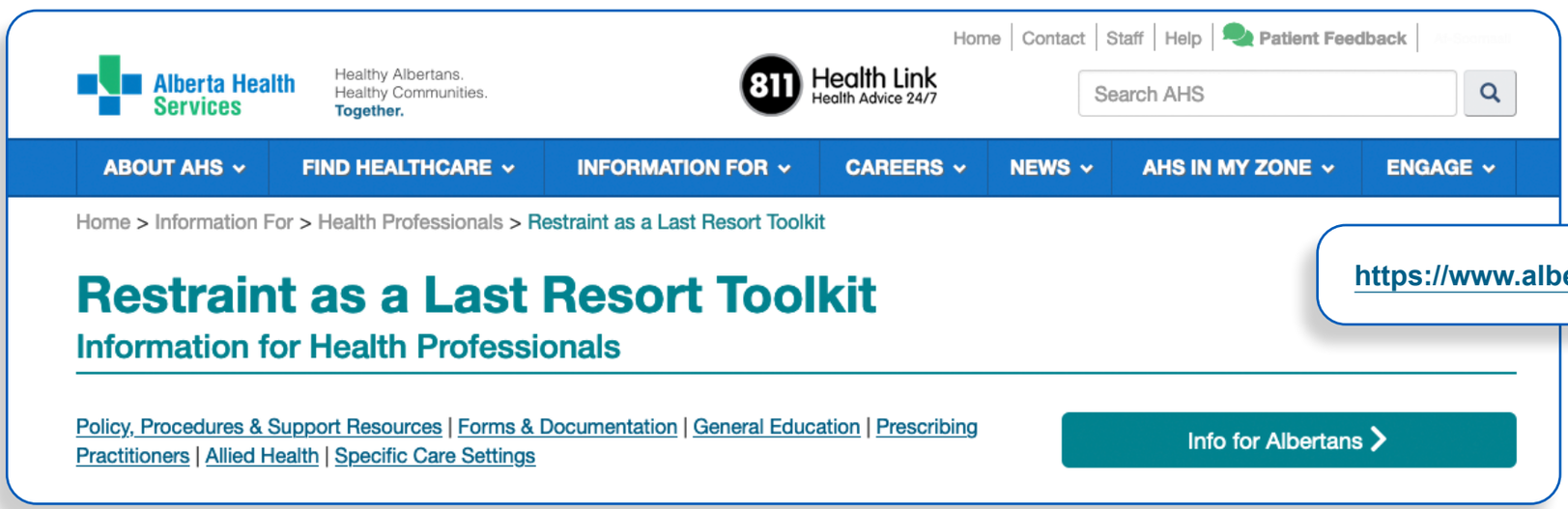
Note: For psychosocial wellbeing resources, also refer to additional resources within this appendix for supports, spirituality, mood & behavior

Additional Resources

Restraints and Secure Spaces

Topic	AHS Insite	Continuing Care Connection	External Links
Restraints and Secure Spaces	• **Home > Teams > Seniors Health > Seniors Health Provincial >** and then filter items to search for: ○ Restraint	• **Home > CCHSS Standards > Standards > 16.0 Restraint Management and Secure Spaces** • **Home > Practice Resources> Restraints**	• **Appropriate Use of Antipsychotics (AUA) Toolkit** https://www.albertahealthservices.ca/scns/auatoolkit.aspx • **AHS Restraint as a Last Resort Toolkit** https://www.albertahealthservices.ca/info/Page15702.aspx ***Note:*** Older adult and pediatric resources available • **AHS Restraint as a Last Resort: Older Adults in Acute Care, Elder Friendly Care** https://www.albertahealthservices.ca/scns/Page13414.aspx • **Alberta Government Continuing Care Health Service Standards Information Guide** https://open.alberta.ca/publications/9781460138649 • **Appropriate Use of Antipsychotics (AUA) Toolkit** https://www.albertahealthservices.ca/scns/auatoolkit.aspx
	CORE Resources • **interRAI CAPs Manual** (on Insite & CCC) • **Lippincott Advisor for:** ○ problem-based care plans (e.g., injury risk, safety) • MyHealth.Alberta.ca for patient care handouts		

Restraints and Secure Spaces



https://www.albertahealthservices.ca/info/Page15702.aspx

Additional Resources

Sexual Expression

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Sexual Expression</td><td>

Home > Teams > Seniors Health > Seniors Health Provincial >
Category Clinical Practice Development – Subcategory Sexuality
Home > Teams > Professional Practice Councils > Provincial > Social Work >
AHS Social Work Guiding Documents
My Learning Link E-Modules:
Decision-Making Capacity Assessment

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Home > Resources > Practice Resources > Decision-Making Capacity Assessment >
eLearning Modules and Additional Learning Resources
Home > Resources > Practice Resources > Sexuality

</td><td rowspan="2">

AHS Consent Resources for Practitioners
https://www.albertahealthservices.ca/info/Page3084.aspx
AHS Seniors and Continuing Care: LGBTQ2S+ Resources for Providers
https://www.albertahealthservices.ca/info/Page16102.aspx
brainXchange
https://brainxchange.ca/Public/Resource-Centre-Topics-A-to-Z/Intimacy-and-Sexuality
Egale 2SLGBTQI Dementia Networks of Support
https://egale.ca/egale-in-action/2slgbtqi-dementia-care/
Sexual Expression in Continuing Care
https://www.sexualexpressionincare.com/
Vancouver Coastal Health & Providence Health Care:

Supporting Sexual Health and Intimacy in Care Facilities: Guideline
https://www.vch.ca/sites/default/files/import/documents/Facilities-licensing-supporting-sexual-health-and-intimacy-in-care-facilities.pdf
Supporting Choices Decision Support Tool
http://shop.healthcarebc.ca/PHCVCHDSTs/BD-00-07-40114.pdf

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<tr><td colspan="2">
CORE Resources

interRAI CAPs Manual (on Insite & CCC)
Lippincott Advisor for:

problem-based care plans (e.g., behavioural health, patient safety)
Textbook resources (e.g., Lippincott Manual of Nursing Practice, Lippincott Essentials for Nursing Assistants)

MyHealth.Alberta.ca for patient care handouts

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Additional Resources

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Skin Integrity</td><td>

Home > Tools > Clinical Guidance Viewer > Clinical Care Topics (A-Z) >
Wound Care & Prevention: Adult & Pediatric Clinical Care Topic (CCT)
Home > Teams > Accreditation > Required Organizational Practices >
Pressure Injury Prevention
Home > Teams > Clinical Neurosciences – Calgary >
Neurosciences Point of Care Resources for Nurses
Suggested search terms on Insite:
debridement
negative pressure wound therapy
pressure injury

</td><td>

Home > Resources > Practice Resources > Skin, Wound Care & Ostomy >
Wound Care & Prevention: Adult & Pediatric – All Locations Clinical Care Topic (CCT)
Suggested search terms on CCC:
debridement
negative pressure wound therapy
pressure injury

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AHS Diabetic Foot Care Pathway Toolkit
https://www.albertahealthservices.ca/scns/Page13331.aspx
British Columbia Connecting Learners with Knowledge (CLWK): Resource Library
https://www.clwk.ca/groups/
International Skin Tear Advisory Panel (ISTAP)
https://www.skintears.org/
National Pressure Injury Advisory Panel (NPIAP)
https://npiap.com/
Wounds Canada
https://www.woundscanada.ca/
Wounds International
https://www.woundsinternational.com/

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<tr><td colspan="2">
CORE Resources

interRAI CAPs Manual (on Insite & CCC)
Lippincott Advisor for:
problem-based care plans (e.g., skin, wounds, patient safety)
Textbook Resources (e.g., Wound Care Essentials)
MyHealth.Alberta.ca for patient care handouts

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Additional Resources

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr>
<td rowspan="2">Sleep and Rest</td>
<td>• Home > Teams > Seniors Health > Seniors Health Provincial > Care Planning > Sleep and Rest</td>
<td>• Home > Learning Opportunities > Education > CCHSS Standard 9 Education > Standard 9.2 a ii Responsive Behaviours</td>
<td rowspan="2">• AUA Toolkit – QI Project: Support Sleep in Dementia
https://www.albertahealthservices.ca/scns/auatoolkit.aspx
• BrainXchange
https://brainxchange.ca/
• Canadian Sleep Society
https://css-scs.ca/
• Elder Friendly Care Toolkit – Learning Workshop #3
https://www.albertahealthservices.ca/scns/Page13345.aspx
• Physical Activity, Sedentary Behaviour and Sleep (PASS) Indicator
https://www.canada.ca/en/services/health/monitoring-surveillance/physical-activity-sedentary-behaviour-sleep.html
• Public Health Agency of Canada: Are Canadians Getting enough sleep
https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-adults-getting-enough-sleep-infographic.html
• Safe Infant Sleep
https://www.albertahealthservices.ca/info/Page14359.aspx
• SCN Seniors Health
https://www.albertahealthservices.ca/scns/Page7702.aspx</td>
</tr>
<tr>
<td colspan="2">CORE Resources
• interRAI CAPs Manual (on Insite & CCC)
• Lippincott Advisor for:
○ problem-based care plans: Fatigue
• MyHealth.Alberta.ca for patient care handouts</td>
</tr>
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Additional Resources

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Socioeconomic</td><td>Home > Teams > Seniors Health > Seniors Health Provincial > Subheading Case Management > Financial Screening >
Early Financial Screening Toolkit
Home > Teams > Professional Practice Councils > Provincial > Social Work > AHS Social Guiding Documents > Seniors and Continuing Care >
Working with Clients in the Continuing Care Process</td><td>Early Financial Screening Toolkit -Home > Resources > Practice Resources > Case Management</td><td rowspan="2">Children and Families
https://www.alberta.ca/children-families.aspx
Family and Social Supports
https://www.alberta.ca/family-social-caregiver-supports.aspx
Financial Assistance For Seniors
https://www.alberta.ca/financial-assistance-for-seniors.aspx
Financial Planning – Continuing Care
https://www.albertahealthservices.ca/cc/Page15481.aspx</td></tr>
<tr><td colspan="2">CORE Resources
interRAI CAPs Manual (on Insite & CCC)
Lippincott Advisor for:
problem-based care plans (e.g., socio-economic,’ ‘economic,’ ‘financial’)
Textbook Resources (e.g., socioeconomic, economic, financial)
MyHealth.Alberta.ca for patient care handouts</td></tr>
</table>

Additional Resources

Spirituality

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Spirituality</td><td>• Home > Teams > Professional Practice Councils > Provincial >
○ Spiritual Care
• Home > Teams > Seniors Health > Seniors Health Provincial >
○ Category Case Management – Subcategory Training Resources: Case Management Toolkit - Strengths Based Approach
• Home > Teams > Indigenous Health > Resources > Accommodating Traditional Spiritual Ceremonies</td><td>• Introduction to Palliative & End of Life Care (PPT, eLearning Module, PDF)
○ Home > Learning Opportunities > Education > CCHSS Standard 9 Education – under subheading Standard 9.2 d iv
• Standard 5.0 Palliative & End-of-Life Care:
○ Home > CCHSS Standards > Standard 5.0</td><td rowspan="2">• Canadian Association for Spiritual Care
https://spiritualcare.ca/
• CLPNA – Integrating Spirituality Into Care
https://www.clpna.com/2019/06/integrating-spirituality-into-care-video/
• Spiritual Care Services Information for Patients & Families
https://www.albertahealthservices.ca/services/Page13213.aspx</td></tr>
<tr><td colspan="2">CORE Resources
• interRAI CAPs Manual (on Insite & CCC)
• Lippincott Advisor for:
○ Care Planning
• MyHealth.Alberta.ca for patient care handouts</td></tr>
</table>

Note: Collaborate with culturally appropriate supports when care planning

Additional Resources

<table>
<tr><th>Topic</th><th>AHS Insite</th><th>Continuing Care Connection</th><th>External Links</th></tr>
<tr><td rowspan="2">Supports</td><td>

- **Home > Teams > Professional Practice Councils > Provincial > Social Work > Practice Information > Decision Making Toolkit**
- **Home > Teams > Seniors Health > Seniors Health Provincial > Home Care Services Guidelines**
- **Home > Teams > Professional Practice Councils > Provincial > Social Work > AHS Social Guiding Documents > Working with Clients in the Continuing Care Process**
- **Suggested search terms on Insite and Learning Link: informal supports**

</td><td>

- **Home > Resources > Practice Resources > Decision-Making Capacity Assessment**

</td><td rowspan="2">

- **A guide to supported decision-making : protecting individual rights and reducing the risk of elder abuse [2017] - Open Government (alberta.ca)**
  https://open.alberta.ca/publications/9781460135709
- **Adult Day Support Program Brochure**
  https://www.albertahealthservices.ca/assets/info/seniors/if-sen-adult-day-programs-brochure.pdf
- **Long-term care | Alzheimer Society of Canada**
  https://alzheimer.ca/en/help-support/im-caring-person-living-dementia/long-term-care
- **Palliative and End-of-Life care**
  https://myhealth.alberta.ca/palliative-care/what-is-it
- **Advance Care Planning | Alberta Health Services**
  https://www.albertahealthservices.ca/info/page12585.aspx
- **Personal Decision Making**
  https://www.albertahealthservices.ca/cc/Page15483.aspx
- **Self-Managed Care**
  https://www.albertahealthservices.ca/assets/info/seniors/if-sen-self-managed-care-brochure.pdf
- **What to Expect When Moving to a Facility**
  https://www.albertahealthservices.ca/cc/Page15494.aspx

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CORE Resources

- **interRAI CAPs Manual** (on Insite & CCC)
- **Lippincott Advisor for:**
  - problem-based care plans (e.g., caregiver fatigue)
- MyHealth.Alberta.ca for patient care handouts

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Appendix D – Lippincott Procedures

Lippincott Procedures & Lippincott Advisor for Care Planning

What are Lippincott Procedures?

Lippincott Procedures are AHS's primary evidence-based procedures reference, providing access to step-by-step guides for over 1,800 procedures and skills for a wide variety of nursing practice areas. It should be used in consideration of your clinical experience, context-specific information, and with attention to current provincial policies and other organizational references.

How do I access Lippincott Procedures?

Access is available in various ways for AHS employees and is provided via the Continuing Care Connection (CCC) for contracted service providers.
See the directions for wayfinding below.

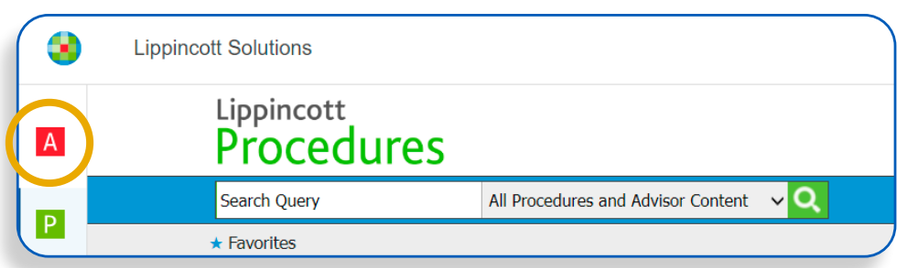
Navigation for AHS employees	Navigation for Contracted Service Providers
• Desktop icon on all AHS computers • Knowledge Resource Service (Library) website • Connect Care quick access (e.g. Resource Links dropdown) • Follow this click path: Home>Tools>Clinical Tools>Lippincott Procedures	• Log into CCC with your credentials ○ Follow this click path: Learning>Education>Additional Resources> Lippincott Procedures

What is Lippincott Advisor?

Lippincott Advisor provides evidence-based information about diseases, conditions, signs and symptoms, diagnostic tests, and treatments.
Lippincott Procedures focuses on how to perform clinical procedures. Both Lippincott Procedures and Lippincott Advisor are approved and encouraged for use at AHS.

How do I access Lippincott Advisor?

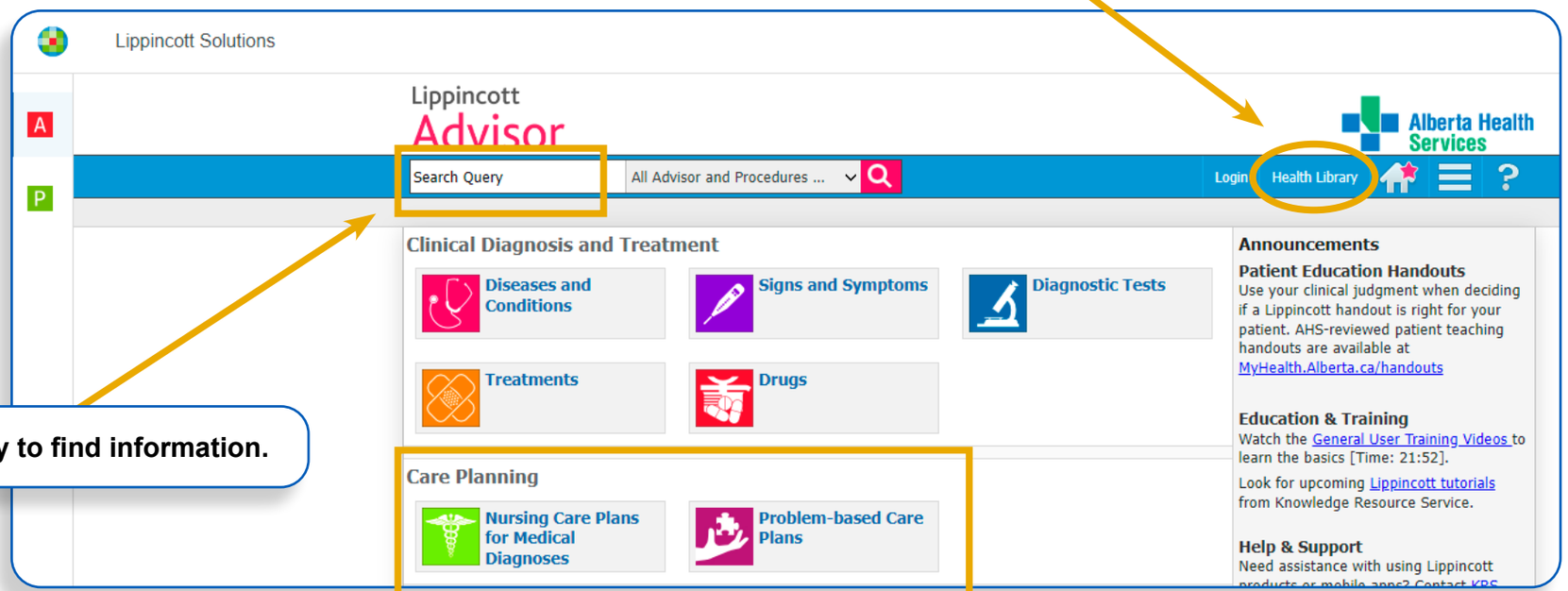
Once on the Lippincott Procedures page, click on the "A" icon in the top left as shown here.



See also: https://krs.libanswers.com/faq/207685

Lippincott Advisor has many resources. Once you click on the Health Library, select Browse Texts to access full length textbook on topics such as healthy aging, physical examination, wound care and more.

Care planning information can be found by searching textbooks electronically.



Use the search query to find information.

Nursing care plans are available on the landing page here. Information such as goals, interventions and problems can be helpful to support client-centered care planning.

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