



Objective

To establish clear, standardized guidance for managing **Leave of Absence (LOA)** in Continuing Care Homes (CCH) Type A and B, that strikes an appropriate balance between (i) respect for residents' wishes, clinical needs and legal rights, and (ii) system-level obligations such as responsible stewardship of limited resources. This guide outlines expectations for LOAs, supports equitable access to care, and provides clarity for CCH operators, case managers, residents, **alternate decision-makers**, as appropriate, and **designated family and support person(s)**.

Note: While fees/charges are outside the scope of this document, generally, when an individual has a CCH type A or B space, they are responsible for any fees/charges that may be applicable for that space.

Principles

Respect for Autonomy: Residents should be provided the opportunity to make choices about their health and life, based on their own preferences, values, and beliefs, and offered appropriate information to be able to make such choices.

Stewardship of public resources: Those in charge of health care resources should dispense of them thoughtfully and effectively for the good of all. Health care resources are not unlimited and should be used in a way that creates overall benefits, taking into account particularly vulnerable segments of society.

Promoting Resident Well-Being: The wellbeing of residents is understood broadly to include residents' physical, mental, social, psychological, cultural and spiritual needs.

Transparency and accountability: Decisions should be based on the best information available, and gathered through processes that are collaboratively determined, well-considered, well-communicated, and consistently applied. Decisions made regarding the allocation of health care resources should be based on criteria that are publicly available and subject to review.

Equity and Fairness: Residents should be treated equitably. Decisions regarding LOA management should not be made with arbitrary or irrelevant criteria. Any differences between residents may require different responses from health care providers.

Collaboration: Stakeholders, including residents, should, to the extent reasonable and possible, be empowered to participate in the decision-making process and have their needs and preferences given due regard.



Social LOA

A social leave of absence from a continuing care home typically refers to a temporary, planned absence where a resident leaves the facility for non-medical, personal, or social reasons, such as visiting family, attending a community event, going on vacation, etc.

Quality of life has been recognized as a primary priority within the *Continuing Care Act (2024 Alberta)*. Social LOAs should be identified as part of the resident's individualized care plan to support their quality of life and well-being. LOAs that constitute a significant or frequent deviation from the resident's care plan would suggest the need for a review of the resident's wishes and care needs to determine if something has changed that may need to be part of their care plan, including a change in level of care. Likewise, patterns of absences that would not be otherwise extended to others in a similar setting should be reviewed because it raises questions about whether this continues to be the right type or level of care for the resident.

Any pattern of social LOAs that falls outside the scope of the care plan should prompt a review to determine whether the resident's current care setting is most appropriate. This review should include an assessment of the resident's overall needs, a discussion of the residents' goals, exploration of potential adjustments to their care and/or care plan, and/or potential change to a different type or level of care, noting that a review will not necessarily result in discharge or change in care level.

Key considerations include:

- Social LOAs need to take into consideration the goals outlined in the resident's care plan.
- Extended or frequent social LOAs may indicate that a different type or level of care is more suitable and should be assessed accordingly.
- While there is no specific number of social LOA days that may be identified in the care plan, any adjustment needs to be made through **collaborative decision-making** agreement between the CCH operator, case manager as applicable, the resident, alternate decision-maker (as appropriate) and their designated family or support person(s). Where there is disagreement, resolution should be sought through existing mechanisms which may include the concerns resolution, appeal process or dispute resolution processes.

Clinical Care LOA

Clinical care LOA may include but are not limited to admissions to health care units outside of the resident's usual CCH for: acute care, mental health or addictions treatment, rehabilitation, dementia stabilization unit, etc. When a resident is on a clinical care LOA from a CCH Type A or B, they may be occupying two publicly funded beds at the same time, which can eventually lead to concerns about responsible stewardship of public resources.



ALA advises CCH facilities to handle the following scenarios as outlined here, noting that if there were a change towards shorter time frames an earlier review would be indicated. The responsibility for coordinating and conducting the review rests with the transition services team within ALA or equivalent at the site.

- **Short-Term Admissions (<30 days)** for needs with a clear discharge plan. These may include either an unanticipated admission for acute need, or anticipated admissions of limited duration to address underlying needs.
 - Unanticipated admissions should follow usual process between the acute care/mental health and/or addictions/dementia stabilization unit and the CCH, and case manager where applicable, in terms of review and resident return.
 - Anticipated repeat admissions for a chronic condition should be reflected in the resident's care plan and are not necessarily an indication that a resident's needs exceed the capabilities of their CCH facility.
- **Longer-Term Admissions (≥30 days)** where recovery or stabilization requires extended admission.
 - Where a longer-term admission for care is predicted, a comprehensive collaborative review on the longer-term admission unit should be completed every 30 days. Short-term medical admissions that become longer-term admissions also require a more comprehensive collaborative review every 30 days.
 - Planned longer-term admissions should include communication, facilitated by transition services or site equivalent, between the care team and the admitted site, the resident, alternate decision-maker (as appropriate), their designated family or support person(s), and the CCH and case manager (as appropriate) regarding the review process as part of the temporary transfer. This communication should also occur when a short-term admission exceeds 30 days.
 - Where a resident has a longer-term mental health and/or addictions, rehabilitation or dementia stabilization unit admission, a comprehensive collaborative review should be completed after the initial 60 days from the date of admission, and every 30 days thereafter. The purpose of these reviews is to ensure ongoing thoughtful long-term planning over the



extended timeframe available in order to avoid premature or last-minute decisions.

- If this type of LOA is expected to be greater than 30 days but less than 60 days, a review may be initiated earlier.

- **Non-Return Scenarios:**

- If, after the resident's care plan has been reviewed, and the resident's most current health status and needs are identified, it is determined through the collaborative review process that the resident's care needs can no longer be supported at their CCH, this must be identified as soon as feasible to allow alternative planning to occur, including the bed being assigned to another resident.

Conducting Reviews of Type of Care/Care Setting

The purpose of the review, whether following a social LOA or clinical care LOA, is to explore:

- whether the resident's care needs have changed (e.g., reassessment);
- whether their current CCH can safely support their return with or without additional supports;
- anticipated further duration of LOA; and
- alternative options, if needed.

If the resident's care needs evolve beyond what is outlined in their care plan, such as through significant medical deterioration, mental health and/or addictions, behavioral changes, or other issues, this may indicate that their current CCH is no longer an appropriate location for their care. In these cases, a reassessment should be initiated on or before the scheduled review date to identify the resident's care needs, note uncertainty regarding outcomes of illness progression or treatments, and determine the most suitable path forward.

Key considerations during the review may include:

- All decisions should be collaborative and involve the resident inclusive of alternate decision-maker(s), as appropriate, their designated family/support persons, the CCH operator, case manager where applicable, and the site where the resident is admitted.
- Identifying factors that may be important to the resident, their support system, and the CCH site.
- The resident's current medical and/or mental health and/or addictions status and prognosis.
- The CCH's ability to manage medical, behavioral and/or mental health and/or addictions needs, including staffing and environmental factors.



- The availability of additional care or specialized supports to facilitate a safe return including considerations in accordance with Added or Extraordinary Care Funding policy HCS-98.

During the review process for a resident on a clinical care LOA, the discharge planning team where the resident is admitted along with CCH operators, case managers where applicable, residents, alternate decision-makers (as appropriate), and designated family / support person(s), should consider the residents' existing CCH care plan as the primary reference point for transitioning between the admitted unit and the CCH. The review should identify progress towards the resident's baseline; the potential for return with or without increased supports vs. the need for a different type of care; and an anticipated return date. The care plan outlines the type of support the resident required prior to admission for the clinical LOA and what their CCH is now equipped to provide for that resident. If the resident's condition remains within the scope of the facility, efforts should be made to facilitate a safe and timely return to their CCH. Importantly, the review process is an opportunity to ensure that all partners are aligned and that system resources are being used effectively. It is not an automatic decision to discharge the resident from their CCH.

Outcome

Any decision to evict the resident from their continuing care home shall align with the terms and conditions set forth in their Resident Agreement. Documentation of the resident's evolving condition, the rationale for continued stay on the admitted unit, and the outcomes of collaborative discussions should be maintained to support transparency and consistency across the system. Further, any decisions shall be based on the elements of the [Continuing Care Home Access and Waitlist Management Procedure HCS-117-01](#) balancing the capacity of acute care and community.

For guidance on concern resolution and disputes, refer to additional resources below.



Definitions

Alternate decision-maker: means a person who is authorized to make decisions with or on behalf of the patient. These may include specific decision-maker, a minor's legal representative, a guardian, a 'nearest relative' in accordance with the Mental Health Act (Alberta) or an agent in accordance with a personal directive or a person designated in accordance with the Human Tissue and Organ Donation Act (Alberta). This also includes what was previously known as the substitute decision-maker.

Collaborative Decision-Making: All decisions should involve the resident (inclusive of alternate decision-maker(s), as appropriate), their designated family/support persons, the CCH operator, case manager where applicable, and the site where the resident is admitted.

Designated family / support person(s): means one or more individuals identified by the patient as preferred support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family, caregivers, relatives, friends, and hired care providers

Leave of Absence means a resident's absence from the Facility for a determined period of time. A leave of absence may be due to social, bereavement or medical reasons and must align with the Resident's Care Plan.

Additional Resources

[APPEAL PANEL PROCESS Procedure HCS-146-01](#)

[DISPUTE PREVENTION AND RESOLUTION IN CLINICAL SETTINGS policy PRR-03](#)

[DISPUTE PREVENTION AND RESOLUTION IN CLINICAL SETTINGS procedure PRR-03-01](#)

[Patient Concerns Resolution Process policy PRR-02](#)

[Patient Concerns Resolution Process procedure PRR-02-01](#)

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