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Continuing Care Home Guide for Case Managers

For more information
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Seniors Health & Continuing Care
Policy, Practice, Access & Case Management

Disclaimer

Acknowledgements

This resource Guide has been prepared by Provincial Seniors Health and Continuing Care in partnership with the Coordinated Access Working Group.

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Introduction

Continuing care homes (CCHs) are publicly funded facility-based accommodations that provide care, including health and support services, appropriate to meet the **assessed needs** of Albertans. All CCHs provide privacy and independence with the comfort of health and personal care services onsite to support resident needs. The CCH Guide for Case Managers (Guide) provides tools and resources to assist healthcare providers (HCPs), in collaboration with residents, to determine the most appropriate type of accommodation to meet their needs.

This Guide is part of the framework for **coordinated access** and gives HCPs the information needed to support eligible Albertans to access (assessment, waitlist and transition) an appropriate CCH to meet their needs and preferences. This Guide aligns with the:

- CCH Access and Waitlist Management Procedure,
- AHS CCH Waitlist Management Guide
- Access to a CCH in Alberta: Supporting Transitions in Care Guide.

Purpose

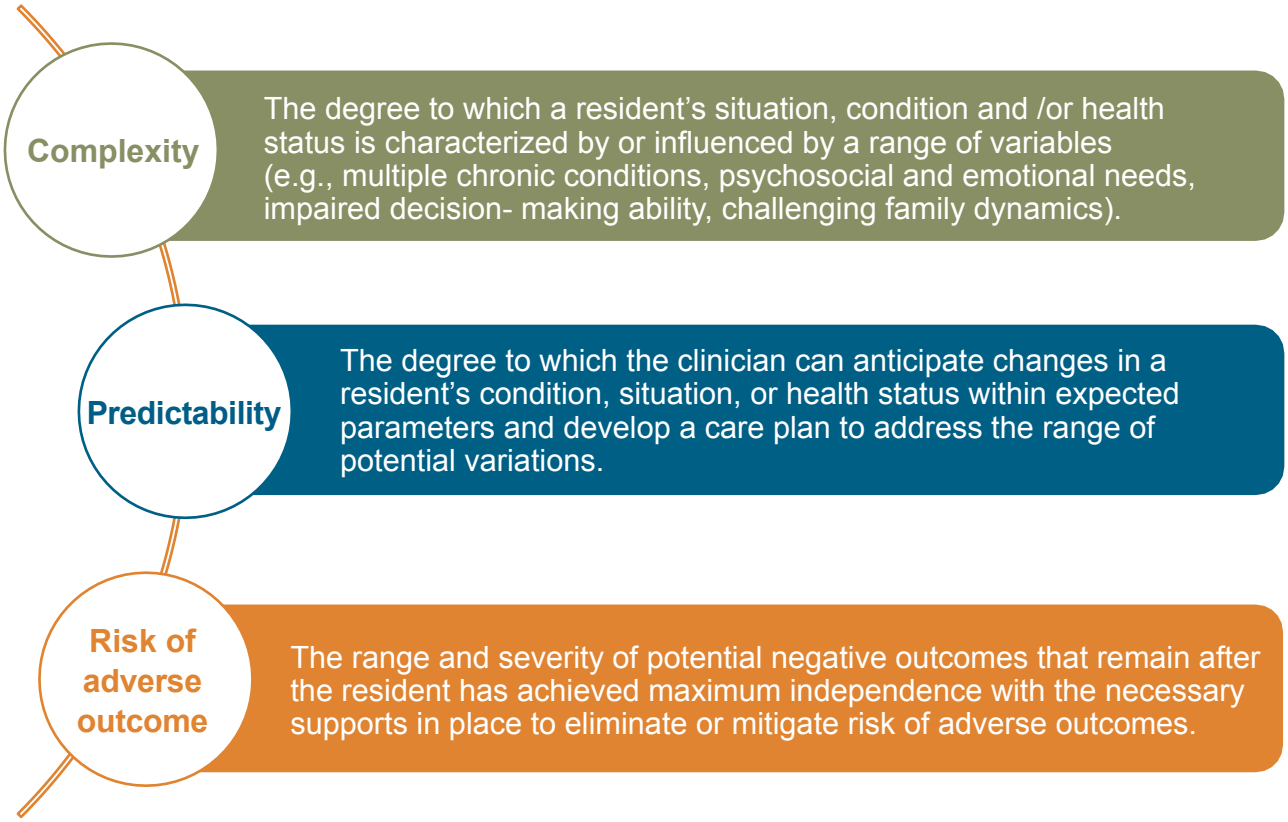
This Guide is intended as a reference for case managers when assessing and supporting residents eligible to transition to a CCH. The Guide is not meant to be rigid or overly prescriptive.

Recommendations in this Guide:

- support resident choice for care.
- promote the **reuni ication** of close relationships.
- focus on providing the right care, in the right place, at the right time.

NOTE: The first reference to bolded terms that are used through the document (except titles) are defined terms that can be found in the Definitions section at the end of this document.

The following three (3) key factors related to the resident's health status are considered during decision-making:



Assessment, Waitlist and Transition

All Albertans receiving continuing care services are assessed for the most appropriate care to meet their needs. Residents should be supported with continuing care services to live as independently as possible for as long as possible in their homes. Home and/or community is the optimal environment for Albertans to live independently and to recover from acute illnesses and/or hospitalization.

Assessment, using the appropriate interRAI instrument (e.g., Resident Assessment Instrument - Home Care (RAI-HC) or interRAI HC), will provide case managers the information required to inform clinical and organizational decision-making. Comprehensive assessment is a collaborative and interdisciplinary approach that involves the resident and requires assessment and feedback from all the HCPs involved in a resident's care.

Comprehensive assessment supports the collection of information on a broad range of physical, mental, and social abilities to determine the most appropriate level of

care to meet the resident's needs and support their preferences for care.

> Almost 100 per cent of Canadians 65 years of age and older, plan on supporting themselves to live safely and independently in their own home as long as possible.
>
> *Retrieved from: https://www.niageing.ca/commentary-posts/2020/9/22/almost-100-per-cent-of-older-canadians-surveyed-plan-to-live-independently-in-their-own-homes-but-is-this-even-possible*

Once the comprehensive assessment is complete, case managers should refer to the Clinical Decision Support Tool (Appendix A) which provides access criteria for each CCH type to support decisions related to waitlisting. Access criteria provide a general guideline, but each resident must be assessed individually. A change in health status may occur with acute episodes of illness, falls, post-hospitalization, and with a significant passing of time a reassessment may be required. When assisting residents to access a CCH that supports their assessed needs, additional information, such as resident and family preferences and consideration of reunification of close relationships, should be used to inform the search for the most appropriate CCH. Efforts will be made to support residents to remain in their desired or chosen living option to enable 'aging in place' whenever possible.

The continuing care system provides a range of services designed to accommodate residents' needs in various settings. Information on what to expect during a move/transition to a CCH will help support the resident's social, emotional, psychological, cultural, and spiritual needs. More information can be found in the Moving to a continuing care home: An information and decision-making guide for Albertans.

Access Criteria: Special Considerations

CCHs provide safe and secure environments for residents to meet a variety of **complex care needs** across the continuum of care. Not all care needs can be met in every environment due to a variety of considerations.

Healthcare Provider

Availability

When assessing and determining the most appropriate level of care, consideration must be given to the availability of healthcare providers to assess and respond to resident health needs based on complexity, predictability and risk of adverse outcomes.

Case managers should be aware of the varied availability of healthcare providers across the CCH types (e.g., healthcare aides (HCA) are onsite 24 hours a day to provide resident support in all CCH, but regulated nursing is not onsite in every CCH). When determining the most appropriate CCH, and when assisting residents to choose their preferred site(s), case managers should consider which care needs may require regulated healthcare providers to provide unscheduled onsite assessment and intervention. Residents who are at risk of adverse outcomes and/or acute care hospitalization, when regulated healthcare providers are not available to provide treatment, may benefit from a CCH that meets those needs even when their functional ability does not dictate that choice (e.g., recommending admission to a Type A CCH where a registered nurse (RN) is available onsite 24 hours a day instead of a Type B CCH). Additional considerations such as medical complexity, cognition, functional ability, socioeconomic needs, and informal supports should be considered when determining the most appropriate CCH.

Scope of Practice

Using the resident's comprehensive assessment, the case manager can identify the level of complexity, predictability and risk of adverse outcomes related to the resident's care needs. The case manager should then consider which regulated HCP is required to meet those needs and whether they are needed on a scheduled or unscheduled basis. Regulated HCP availability differs at each CCH. Considerations must be given to each regulated HCPs scope of practice when determining which care activities require a scheduled or unscheduled HCP.

Health Care Needs

Mental Health

Residents with a psychiatric diagnosis (e.g., schizophrenia, bipolar disorder) may be safely supported in CCH settings. Each resident's assessed needs and most appropriate CCH will be different. Some residents may benefit from small units with a higher ratio of staffing where staff has enhanced training in supporting individuals with a mental health diagnosis. Younger residents with a psychiatric diagnosis may benefit from being part of a larger campus of care or a community-based small care home to facilitate integration into the community. As with any resident, and any diagnosis, the case manager would need to use critical thinking and professional judgment to determine the most appropriate setting and CCH for the individual.

Nutritional Health

Nutrition management and support for **complex nutritional needs** (such as enteral tube feed) vary at each CCH. If unique nutritional management is required, the case manager working in a role that supports wait list management and CCH offers can request information from each of the CCH sites when helping to support residents choosing their preferred CCH.

Genitourinary and Gastrointestinal Health - Elimination

When the resident's care needs include support for complex elimination, such as inappropriate voiding or defecating (e.g., fecal smearing), or for elimination related behaviours that may impact other residents, an assessment must consider the availability of staff and appropriate environment to ensure the resident's care needs can be supported.

Functional Health – Activities of Daily Living and Instrumental Activities of Daily Living

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.

Instrumental Activities of Daily Living (IADL) 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.

Case managers must consider the complexity of ADLs and IADLs when determining the appropriate CCH(s). Residents may need the support of HCPs at one time to complete one ADL or IADL task (e.g., two person transfer). The frequency and complexity of these interventions must factor into the CCH selections offered to each resident.

CCH Types

Refer to (Appendix A) for a summary of the different access criteria for each CCH. For case study examples see (Appendix B).

Continuing Care Homes

CCHs are inclusive of facility-based care settings that offer services across three different types of facilities for residents with a range of healthcare needs.

CCH Type A and Type B are covered in this guide. For Hospice (CCH Type C) please refer to Appendix C of the Palliative and End-of-Life Care Alberta Provincial Framework Addendum 2021.

CCH Type A - Scheduled and unscheduled professional and personal care support provided by RNs and HCAs

This environment provides onsite registered nurse (RN) and/or registered psychiatric nurse (RPN) care, assessment and/or treatment 24-hours a day. Licensed practical nurse(s) (LPNs) may also be onsite in addition to the onsite personal care and support provided by HCAs. CCH Type A may also have a secure space.

Some sites may have specialized programs and services available for residents with complex clinical or complex functional care requirements (e.g., rehabilitation). See exclusion considerations in Appendix A.

Medical Conditions	Cognitive Status	Functional Status
Medically complex and unpredictable care needs that can be safely supported with onsite RN/RPN. Requires chronic disease management. Scheduled and unscheduled professional assessments (e.g., physical therapist, pharmacist, etc.) may be required to adjust the care plan. Scheduled and unscheduled nurse practitioner (NP) and/ or physician support for complex health assessments requiring onsite services.	Any severity of cognitive changes. May display unpredictable behaviours with effective interventions to minimize risk of self-harm or harm to others. May lack awareness of personal space of others and may require frequent re- direction and support.	ADL and IADL needs may be able to be scheduled but are flexible based on the day-to- day/moment to moment needs of the resident. Unscheduled needs. Independent, partial, or complete meal assistance. Diet or texture modifications with complex nutritional needs requiring frequent and unscheduled interventions and assessments. May be unable to alert staff using a call bell system.

CCH Type B - Scheduled and unscheduled professional and personal care support provided by LPNs and HCAs in a secure space

This environment provides a purposeful home-like design with small groupings of private bedrooms and associated spaces with security features (i.e., **secured spaces**), 24-hour a day onsite scheduled and unscheduled professional and personal care, and support is provided by LPNs and HCAs. Case management and specialty services (e.g., Allied Health, palliative resource nurse, etc.) are available on a scheduled onsite, on-call or virtual basis based on resident's care needs. Exclusion considerations (Appendix A).

Medical Conditions	Cognitive Status	Functional Status
May have complex care needs that are mostly stable and predictable and can be safely managed with onsite LPN. May require chronic disease management. Scheduled and unscheduled additional professional assessments (e.g., RPN/RN, Allied Health professional, etc.) may be required to adjust the resident's plan of care. Scheduled and unscheduled NP and/or physician support through a combination of onsite and off-site appointments.	Moderate to severe cognitive changes (CPS of 3 or greater). May have a high risk of elopement. May display unpredictable behaviours with effective interventions to minimize risk of self-harm or harm to others. May lack awareness of the personal space of others and require frequent re-direction and support.	ADL and IADL needs might be able to be scheduled but are flexible based on the day- to-day/moment-to-moment needs of the resident. Occasional unscheduled needs. Independent, partial, or complete meal assistance. Diet or texture modifications can be accommodated. May be unable to alert staff using a call system.

CCH Type B - Scheduled and unscheduled professional and personal care support provided by LPNs and HCAs

This environment provides 24-hour a day onsite scheduled and unscheduled professional and personal care. Support is provided by LPNs and HCAs. Case management and specialty services (e.g., Allied Health, palliative resource nurse, etc.) are available on a scheduled onsite, on-call or a virtual basis based on resident's care needs. See exclusion considerations in Appendix A.

Medical Conditions	Cognitive Status	Functional Status
May have complex care needs that are mostly stable and predictable and can be safely managed with onsite LPN. May require chronic disease management. Scheduled and unscheduled additional professional assessments (e.g., RPN/RN, Allied Health professionals, etc.) may be required to adjust the residents plan of care. Scheduled and unscheduled NP and/or physician support through a combination of onsite and off-site appointments.	Varying levels of cognitive impairments. May wander and is assessed as no or minimal risk for elopement. Predictable behaviour needs with effective interventions to minimize risk of self-harm to self or harm to others. Should display some awareness of personal space of others or easy to re-direct.	Most ADL and IADL needs can be scheduled. Independent, partial, or complete **meal assistance**. Diet or texture modifications can be accommodated. Complex nutritional needs require scheduled interventions and assessments. Ability to alert staff using a call system or alternately, needs are met through scheduled comfort rounds.

CCH Type B - Scheduled and unscheduled personal care support provided by HCAs

This environment provides scheduled and unscheduled personal care with HCAs onsite 24-hours a day. **Case management** and specialty services (e.g., Allied Health, palliative resource nurse, etc.) are available on a scheduled onsite, on-call or virtual basis based on resident's care needs. See exclusion considerations in Appendix A.

Medical Conditions	Cognitive Status	Functional Status
Residents must be medically stable with predictable needs that do not require unscheduled onsite RN, RPN, or LPN level of care. Scheduled professional assessments and interventions (e.g., RN/ RPN, LPN, Allied Health professional, etc.). Scheduled NP and/or physician support provided at off-site appointments.	Mild cognitive changes that may cause the resident to wander with no known risk of elopement. May require unscheduled interventions. Displays awareness of personal space of others. Demonstrates the appropriate social behaviours for the environment. Shows no known risk of self- harm or harm to others.	Mobilizes independently or with one-person transfer. Cueing and minimal assistance with meals, transportation to meals and set up for meals. Minimal modifications to diet texture. ADL and IADL can be mostly scheduled. Ability to alert staff using a call system.

Definitions

Assessed needs: The care requirements that remain after the strengths and resources of the resident and family and the community has been considered in relation to the functional deficits identified on assessment.

Case management: A collaborative, resident-centered strategy for providing quality health and supportive services through the effective and efficient use of available resources to support the resident to achieve their goals.

Case manager: A regulated health care professional(s) accountable for case management services for an assigned caseload. A case manager comprehensively assesses all factors contributing to the resident's care needs for transitioning through the care stream, while working with the resident, family and healthcare team to mitigate any risks.

Complex care needs: A resident requires specific equipment, and/or physician or nursing expertise and/or specialty personnel to ensure the appropriate level of care.

Complex nutritional needs: Nutrition management and support for complex nutritional needs vary at CCH.

> Examples of complex nutritional needs are renal diet, gastrointestinal conditions that put a person at risk for malnutrition and dehydration (e.g., high output ostomies), multiple food restrictions (e.g., allergies, gluten, vegan), texture modified diet (e.g., minced, pureed, thickened fluids) for swallowing problems, enteral nutrition (tube feeding), and parenteral nutrition (IV nutrition).

Continuing Care Home (CCH): Publicly funded facility-based accommodation that provides care (health and support services) appropriate to meet the resident's assessed needs. The type of care needed is determined through a standardized assessment and single point of entry process and consists of Type A, Type B and Type C.

interRAI instruments: A suite of standardized tools designed to be compatible across health sectors. This improves continuity of care, promotes a person-centered approach, and improves the organization's capacity to measure clinical outcomes. Instruments are built on a "core" set of items with identical definitions.

> **interRAI Home Care (interRAI HC):** a standardized, minimal assessment and screening tool that focuses on assessing and monitoring the status of persons in community settings.
>
> **Resident Assessment Instrument- Home Care (RAI-HC):** a standardized, minimal assessment and screening tool designed for clinical use.

Meal assistance: Support offered to residents during mealtimes is referred to as “meal assistance.” Meal assistance provided varies based on the resident’s needs from day to day. Meal assistance can include: assisting them to the dining room and ensuring they are seated comfortably for eating, ensuring food and beverages are within reach, opening packages/ lids, cutting food, providing encouragement and verbal cues during a meal, providing assistive devices to make eating and drinking easier, assisting resident to eat on days when they are unable to do it themselves or at specific times of the day when their ability to do it themselves is limited, assisting resident to eat every day (continuous eating assistance).

Predictable: The extent to which one can identify in advance a resident’s response based on observation, experience, or scientific reason. It involves an assessment of how effectively the health condition is managed, the changes likely to occur, and whether the type or timing of change can be anticipated.

Reunification: Reuniting close relationships when residents require a Continuing Care Home. Close relationships are determined by the residents.

Secure space: A secure unit within a facility, a secure facility, or a technological measure that limits a resident’s ability to exit a facility or unit that is used with the intention of protecting a resident from harm. For clarity, a technological measure includes, but is not limited to, a wander alert system as per the Continuing Care Health Service Standards (2018, Alberta).

Appendix A: Clinical Decision Support Tool for Case Management

Type A	Type B		
Scheduled and unscheduled professional and personal care support provided by RNs and HCAs	**Scheduled and unscheduled professional and personal care support provided by LPNs and HCAs in a secure space**	**Scheduled and unscheduled professional and personal care support provided by LPNs and HCAs**	**Scheduled and unscheduled personal care support provided by HCAs**
• Onsite RN/RPN care. • LPN may also be onsite in addition to 24 hr. onsite personal care and support provided by HCAs. • Specialist consultative services may require off-site or virtual support.	• Scheduled and unscheduled professional and personal care support provided by LPNs and HCAs. • Professional nursing care, such as RN or RPN is available 24-hours a day (may be onsite, on-call or virtual).	• Scheduled and unscheduled professional and personal care support provided by LPNs and HCAs. • Professional nursing care, such as RN or RPN is available 24-hours a day (may be onsite, on-call or virtual).	• Scheduled and unscheduled personal care with 24-hour a day onsite HCA. • Professional nursing care, such as LPN, RN, RPN, is available 24-hours a day but may be onsite, on-call or virtual.
Medical Conditions: • Medically complex, unpredictable health needs that can be safely supported with 24 hr. onsite RN/RPN. • Requires chronic disease management. • Scheduled and unscheduled professional assessments (physical therapist, pharmacist, etc.) may require adjustments of the care plan. • Scheduled and unscheduled NP and/or physician support for complex health assessment requires onsite services.	**Medical Conditions:** • May have complex medical needs that are mostly stable and predictable and can be safely managed with onsite LPN. • May require chronic disease management. • Scheduled and unscheduled additional professional assessments (RPN/RN, Allied Health etc.) may be required to adjust the plan of care. • Scheduled and unscheduled NP and/or physician support provided through a combination of onsite and off-site appointments.		**Medical Conditions:** • Resident must be medically stable with predictable needs and does not require 24 hr. onsite RN/RPN or LPN Scheduled professional assessments and interventions by RN/RPN, LPN, Allied Health etc.). • Scheduled NP and/or physician support provided through offsite appointments.
Cognitive Status: • Any severity of cognitive changes. • May display unpredictable behaviours with effective interventions to minimize risk of self-harm to others. • May lack awareness of personal space of others and may require frequent re-direction and support.	**Cognitive Status:** • Moderate to severe cognitive changes (CPS 3 or greater). • May have a high risk of elopement. • May display unpredictable behaviours with effective interventions to minimize risk of self or harm to others. • May lack awareness of personal space of others and require frequent re-direction and support.	**Cognitive Status:** • Varying levels of cognitive impairment, may wander and is assessed as no or minimal risk for elopement. • Predictable behaviour needs with effective interventions to minimize risk of self or harm to others. • Should display some awareness of personal space of others or easy to re-direct.	**Cognitive Status:** • Mild cognitive changes. • May wander with no known risk of elopement. • May require unscheduled interventions. • Displays awareness of personal space of others • Demonstrates the appropriate social behaviours for the environment. • Shows no risk of self-harm or harm to others.

Functional Status: • ADL and IADL needs might be able to be scheduled but are flexible based on the day-to- day/moment-to-moment needs of the resident. • Unscheduled needs. • Independent, partial or complete meal assistance. • Diet or texture modifications with complex nutritional needs requiring frequent and unscheduled interventions and assessment. • May be unable to alert staff using a call bell system.	**Functional Status:** • ADL and IADL needs might be able to be scheduled but are flexible based on the day-to-day/moment- to-moment needs of the resident. • Occasional unscheduled needs. • Independent, partial or complete meal assistance. • Diet or texture modifications can be accommodated. • May be unable to alert staff using a call system.	**Functional Status:** • Most ADL and IADL needs can be scheduled with occasional-frequent unscheduled needs. • Independent, partial, or complete meal assist. • Diet or texture modifications can be accommodated. • Complex nutritional needs require scheduled interventions and assessment. • Ability to alert staff using a call system or alternately, needs able to be met through scheduled comfort rounds.	**Functional Status:** • Mobilizes independently or with one- person transfer. • Cueing and minimal assistance with meals, transportation to meals and set up for meals. • Minimal modifications to diet or texture. • ADL and IADL can be mostly scheduled. • Ability to alert staff using a call system.
Exclusion Considerations: • Unpredictable behaviours placing self or others at risk. • Note: May not be an exclusion in some facility settings; may require specialty services. • Unable to support rehabilitation requirements through a combination of self- management, care planning and scheduled services (either onsite or off-site). • Unstable/acute medical or mental health needs requiring unscheduled care above RN scope of practice.	**Exclusion Considerations:** • Unpredictable behaviours placing self or others at risk. • Note: May not be an exclusion in some facility settings. • Unable to support rehabilitation requirements through a combination of self-management, care planning and scheduled services (either onsite or off-site). • Unscheduled needs requiring RN scope of practice.		**Exclusion Considerations:** • Complete meal assistance. • Two, or more, person transfer and/or mechanical lift. • Unscheduled needs requiring LPN or RN scope of practice.
RAI-HC Outcome Scales Expected Range: • Cognitive Performance Scale (CPS): 2-4 • ADL Hierarchy: 2-5 • IADL Difficulty: 5-6 • CHESS Scale: 2-4 • MAPLe Scale: High or Very High	**RAI-HC Outcome Scales Expected Range:** • CPS: 3-5 • ADL Hierarchy: 1-3 • IADL Difficulty: 5-6 • CHESS Scale: 0-3 • MAPLe Scale: High or Very High	**RAI-HC Outcome Scales Expected Range:** • CPS: 2-4 • ADL Hierarchy: 2-4 • IADL Difficulty: 5-6 • CHESS Scale: 0-3 • MAPLe Scale: Mod, High or Very High	**RAI-HC Outcome Scales Expected Range:** • CPS: 0-3 • ADL Hierarchy: 0-3 • IADL Difficulty: 4-6 • CHESS Scale: 0-3 • MAPLe Scale: Mod, High or Very High
interRAI Home Care Outcome Scales Expected Range: • CPS: 2-4 • CPS2: 4-8 • ADL Self Performance Hierarchy: 3-6 • IADL Capacity Hierarchy: 5-6 • CHESS: 2-5 • Aggressive Behaviour Scale (ABS): 0-12 • MAPLe*: 4-5	**interRAI Home Care Outcome Scales Expected Range:** • CPS: 3-5 • CPS2: 4-8 • ADL Self Performance Hierarchy: 2-4 • IADL Capacity Hierarchy: 5-6 • CHESS: 0-3 • ABS: 0-12 • MAPLe*: 4-5	**interRAI Home Care Outcome Scales Expected Range:** • CPS: 2-4 • CPS2: 0-5 • ADL Self Performance Hierarchy:1-3 • IADL Capacity Hierarchy: 4-6 • CHESS: 0-3 • ABS: 0-4 • MAPLe*: 3-5	**interRAI Home Care Outcome Scales Expected Range:** • CPS: 0-3 • CPS2: 0-3 • ADL Self Performance Hierarchy: 0-3 • IADL Capacity Hierarchy: 3-6 • CHESS: 0-3 • ABS: 0-8 • MAPLe*: 2-5

*An updated MAPLe is pending release spring 2024

Appendix B: CCH Case Studies

<table>
<tr><th colspan="7">Type A - Scheduled and unscheduled professional and personal care support provided by RNs and HCAs</th></tr>
<tr><td>Situation</td><td colspan="6">Janet is a 60-year-old lady who suffered an ischemic cerebrovascular accident (CVA). She is currently in hospital unable to return home to wait for CCH due to high physical and medical needs.</td></tr>
<tr><td>Background</td><td colspan="6">Diagnosis – Multiple CVA’s bilaterally, vascular dementia, type 1 diabetes, renal transplant related to diabetes, hyperparathyroidism, dyslipidemia, diverticulitis, and macular degeneration.

Janet attained a grade 11 education and worked as a bank teller for many years. She has no children and has lived common-law for 34 years. She had a kidney transplant 11 years ago related to complications from diabetes. A CVA three years ago left her with mild memory and physical impairment. She has been receiving personal care through home care twice daily and attended an adult day support program twice a week. She relies on her spouse for all IADL. She was taken to the emergency department following acute onset of severe confusion. A new ischemic CVA was discovered.

Progression of symptoms led to complete loss of functional abilities. She has receptive and expressive aphasia and is unable to follow a 1-stage command. She calls out frequently. A feeding tube was inserted due to involuntary eating. She has pulled out the tube several times (at least weekly) and experiences frequent infections at the insertion site. Her spouse is supportive and caring and is completely overwhelmed with the sudden changes to their life. Janet no longer recognizes him. He is very concerned about the stability of her kidney transplant given her medical history.</td></tr>
<tr><td>Assessment</td><td colspan="6">• Mechanical lift for transfers, dependent in a wheelchair.
• Total care for all bathing, grooming, dressing, hygiene.
• Peri-care for bowel incontinence, currently has urinary catheter which may be removed prior to transition.
• Total management of PEG tube, supplements orally with minced diet, and regular fluids as tolerated.
• Requires medication management, basal bolus insulin routine.</td></tr>
<tr><td></td><td>RAI-HC</td><td>CPS: 5
Depression Scale: 0
Pain Scale: 2
ADL Hierarchy: 5</td><td>IADL Difficulty: 6
CHESS Scale: 3
MAPLe Scale: Very High</td><td>interRAI Home Care</td><td>CPS: 4
ADL Hierarchy: 6
IADL Hierarchy: 6</td><td>CHESS Scale: 2
ABS: 2
MAPLe Scale: Very High</td></tr>
<tr><td>Recommendation</td><td colspan="6">CCH Type A with scheduled and unscheduled professional and personal care support provided by RNs and HCAs.</td></tr>
<tr><td>Rationale</td><td colspan="6">Janet requires a CCH that can provide on-site monitoring by an RN. Her care needs are:
• Complex: Due to multiple medical conditions; advanced assessment skills are needed due to her aphasia.
• Unpredictable: The complexity of her medical conditions makes it difficult to anticipate changes in her health. Sudden changes in her condition require immediate assessment by an RN.
• Risk of adverse outcomes: Janet is at high risk for complications due to her multiple medical conditions.</td></tr>
</table>

Type A - Scheduled and unscheduled professional and personal care support provided by RNs and HCAs in a secured space						
Situation	Richard is a 75-year old brought into the emergency department by police after an episode of physical aggression towards his spouse. He was admitted under Form 1 and is currently in a secured geriatric unit waiting for a CCH. He has no home, and his children refuse to take him back because of his aggressive behaviours.					
Background	Diagnosis – Alzheimer's type dementia with executive function disorder, intermittent explosive disorder. Richard was a military officer. He and his spouse have been living with each of their 9 children for a few months at a time over the past several years. He has a history of aggression towards his older children and used severe corporal punishment to discipline them for what most would consider minor incidents. Prior to hospitalization, he had not been assessed by a physician as he believes in faith healing over traditional medicine. Upon admission, he was assessed by a psychiatrist as having bipolar mood disorder which was refuted by a second opinion later. It was suggested, along with the diagnosis indicated above, he may also have a history of attention deficit hyperactivity disorder. Richard can be pleasant and cooperative with caregivers but becomes easily agitated with excessive stimulation. His memory and judgment are poor. He has no regard for the personal safety or personal space of others and is at high risk for elopement. He experiences increased anxiety over any perceived threat and can rapidly escalate to anger and psychotic episodes. Once agitated it takes several days for him to return to baseline. He does respond well to a gentle approach and requires a consistent approach to care.					
Assessment	• Independent with transfers and ambulation. • Set up and cue for all dressing, bathing, grooming, hygiene, and meals. • Assistance with incontinence products and peri-care for frequent urinary and occasional bowel incontinence. • Requires medication management.					
	RAI-HC	CPS: 5 Depression Scale: 4 Pain Scale: 0 ADL Hierarchy: 2	IADL Difficulty: 5 CHESS Scale: 3 MAPLe Scale: Very High	**interRAI Home Care**	CPS: 5 ADL Hierarchy: 2 IADL Hierarchy: 5	CHESS Scale: 3 ABS: 5 MAPLe Scale: Very High
Recommendation	CCH Type A with scheduled and unscheduled professional and personal care support provided by RNs and HCAs in a secured space.					
Rationale	Richard requires a secure space in long term care facility living to provide on-site monitoring by an RN in a safe environment. His care needs are: • Complex: Due to the combination of dementia with other undetermined psychiatric conditions Richard requires the advanced assessment skills of an RN. • Unpredictable: Sudden escalation of behaviours and psychotic episodes require immediate assessment and intervention by an RN. • Risk of adverse outcomes: Richard's lack of regard for personal safety and his rapidly escalating behaviours put him and others at high risk for negative outcomes. Would need to be matched to an appropriate population/cohort.					

<table>
<tr><th colspan="7">Type B - Scheduled and unscheduled professional and personal care support provided by LPNs and HCAs in a secure space</th></tr>
<tr><td>Situation</td><td colspan="6">Sylvia is a 79-year-old who was brought to the hospital by police after threats to kill her daughter and an attempt to flee her residence. She is currently in a secured geriatric assessment unit. Her daughter refuses to take her home as she fears for her personal safety.</td></tr>
<tr><td>Background</td><td colspan="6">Diagnosis – Alzheimer's type dementia, fractured left hip two years ago, arthritis in the left knee and hip, previous history of alcohol abuse.

Sylvia is a widow who lives with her daughter in her daughter's home. She has had dementia for many years with strong frontal lobe features. Her ability to remain independent was compromised two years ago when she fell and fractured her hip. Upon recovery, she was resistive to any caregivers coming into her home. Her daughter feels extremely guilty about transitioning her mother into care and has recently been spending up to six hours per day assisting her with meals, household management, and care needs. Sylvia has poor short-term memory and extremely poor insight. She is aggressive and verbally abusive towards her daughter which escalated into rage and threats of violence the night she was brought into the hospital. Since coming to the hospital, Sylvia is much more calm, pleasant, and cooperative. She has a pro re nata (PRN) antipsychotic which has been used less than weekly once she settled on to the unit.

She interacts well with staff and caregivers and responds well to humour and a kind approach. She continues to demonstrate negative thoughts and behaviours towards her daughter and expresses fear that her family is "taking me for everything I have." She is a high elopement risk requiring one-to-one care at times to redirect her from the door.</td></tr>
<tr><td>Assessment</td><td colspan="6">• Independent with transfers and mobility, could use a walker for support but she refuses.
• Stand-by assist and cueing for bathing and hygiene, refuses tub bath.
• 1 person assist with dressing. Independent with toileting but requires monitoring to ensure continence product has been changed and clothing adjusted.
• Has been losing weight and requires supervision and encouragement to eat meals.
• Requires medication management.</td></tr>
<tr><td></td><td>RAI-HC</td><td>CPS: 3
Depression Scale: 3
Pain Scale: 1
ADL Hierarchy: 1</td><td>IADL Difficulty: 6
CHESS Scale: 1
MAPLe Scale: Very High</td><td>interRAI</td><td>CPS: 4
ADL Hierarchy: 2
IADL Hierarchy: 6</td><td>CHESS Scale: 1
ABS: 8
MAPLe Scale: Very High</td></tr>
<tr><td>Recommendation</td><td colspan="6">CCH Type B with scheduled and unscheduled professional and personal care support provided by LPNs and HCAs in a secure space.</td></tr>
<tr><td>Rationale</td><td colspan="6">Due to a high elopement risk, Sylvia requires a secure space and would not be suitable for a CCH facility without this service. Her progressive dementia requires professional nursing to intervene if behaviours start to escalate. Her needs are quite predictable (as indicated by infrequent use of PRN medications) and she is medically stable. Her professional nursing needs could be met by an on-site LPN with consultation by an AHS RN and other healthcare professionals.</td></tr>
</table>

<table>
<tr><th colspan="7">Type B - Scheduled and unscheduled professional and personal care support provided by LPNs and HCAs</th></tr>
<tr><td>Situation</td><td colspan="6">John is an 83-year-old man recently diagnosed with pancreatic cancer. He is currently in acute care with a prognosis of 12-24 months. His primary need is for unscheduled personal care, monitoring of disease progression and palliative and end-of-life care.</td></tr>
<tr><td>Background</td><td colspan="6">Diagnosis – Pancreatic cancer with liver metastasis, history of prostate cancer (CA), history of basal cell CA on the face, hypertension, history of cerebrovascular accident (CVA).

John previously lived in his own apartment but was not coping well. He was admitted to the hospital with an inability to cope and a high WBC count. Because he had declined quite rapidly in the previous weeks and had advanced pancreatic cancer ,he was transferred to the Palliative Care unit. His status improved significantly, and his current prognosis is 12-24 months. He has no family but has the support of several friends who visit and assist him to manage his affairs. Upon initial admission to Palliative Care, his apartment was released, and his possessions (including clothing) were dispersed. He is unable to be transferred to Hospice as his prognosis is greater than three months. Currently, he is mobile, his pain is managed with medication, and he would benefit from a more social environment. He will require ongoing monitoring of disease progression. He has some short-term memory deficits but still makes personal decisions with assistance from his friends.</td></tr>
<tr><td>Assessment</td><td colspan="6">• Transfers and mobility using 4-wheeled walker, usually independent.
• Fatigues easily and experiences shortness of breath on exertion and occasional vertigo.
• 1-assist with bathing, grooming, hygiene, dressing.
• Incontinent bowel and bladder, 1-assist with peri-care and pad change.
• Requires meal set-up, eats independently, is cachexic.
• Requires medication management and pain management.</td></tr>
<tr><td></td><td>RAI-HC</td><td>CPS: 2
Depression Scale: 1
Pain Scale: 0
ADL Hierarchy: 2</td><td>IADL Difficulty: 5
CHESS Scale: 2
MAPLe Scale: High</td><td>interRAI Home Care</td><td>CPS: 2
ADL Hierarchy: 2
IADL Hierarchy: 5</td><td>CHESS Scale: 2
ABS: 0
MAPLe Scale: High</td></tr>
<tr><td>Recommendation</td><td colspan="6">CCH Type B with scheduled and unscheduled professional and personal care support provided by LPNs and HCAs</td></tr>
<tr><td>Rationale</td><td colspan="6">John is currently a stable palliative resident. Although at present his needs are for unscheduled personal care, he requires close monitoring of disease progression to anticipate his impending personal care and medical needs. It is expected that he will require skilled nursing care soon. Because his health status is stable these professional nursing needs could be met in a CCH with on-site LPN care and oversight by an AHS case manager and other health care professionals.

His RAI-HC/interRAI Home Care Outcome Measures are within the expected range of a Type B CCH with LPN on-site.</td></tr>
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<table>
<tr><th colspan="7">Type B - Scheduled and unscheduled personal care support provided by HCAs</th></tr>
<tr><td>Situation</td><td colspan="6">Elizabeth is an 80-year-old widow residing in a private retirement residence. Staff are providing increasing levels of unscheduled assistance with mobility and personal care.</td></tr>
<tr><td>Background</td><td colspan="6">Diagnosis – Hypertension, atrial-fib, spinal compression fractures, dizziness (with no apparent cause).
Elizabeth has been managing well in a private lodge for several years. Although she has some mild short term memory impairment, she has good procedural memory. The family is supportive, and she relies on her daughter for “major” decisions only. Elizabeth has a long-term tracheostomy which she managed independently for over 10 years. She also has a speech appliance implanted which allows her to speak when the hole is plugged. She has had two recent falls related to her environment with trips to the emergency department but no sustained injuries. Fall precautions have been implemented. Her need for unscheduled care is increasing and interventions by staff are becoming more frequent.</td></tr>
<tr><td>Assessment</td><td colspan="6">• Assist with bathing, grooming, dressing, hygiene (cueing or hands on assistance with one person depending on time of day).
• Medication assistance, including PRN analgesia and laxatives that she is increasingly not able to manage independently.</td></tr>
<tr><td></td><td>RAI-HC</td><td>CPS: 2
Depression Scale: 0
Pain Scale: 0</td><td>ADL Hierarchy: 2
IADL Difficulty: 2
CHESS Scale: 1
MAPLe Scale: Moderate</td><td>interRAI Home Care</td><td>CPS: 2
ADL Hierarchy: 2
IADL Hierarchy: 3</td><td>CHESS Scale: 1
ABS: 0
MAPLe Scale: Moderate</td></tr>
<tr><td>Recommendation</td><td colspan="6">CCH Type B with scheduled and unscheduled personal care support provided by HCAs.</td></tr>
<tr><td>Rationale</td><td colspan="6">Elizabeth’s primary care need that cannot be met in the lodge is her need for unscheduled assistance with medication management, personal care and some mobility to the bathroom and common areas. This is an ADL and can be done by HCAs. No on-site RN or LPN is needed because:
• Elizabeth can direct her care and request help when needed.
• Elizabeth will have regular monitoring by her AHS case manager as required, RN is available on-call 24/7.</td></tr>
</table>

Resources

Governance Documents

1. AHS Continuing Care Home: Access and Waitlist Management Procedure
2. Alternate Level of Care Accommodation Charges - Patients Waiting for Continuing Care Policy

Supplemental Resources for Residents

1. Moving to a Continuing Care Home: An information and decision-making guide for Albertans

Insite Resources for HCPs

1. Coordinated Access to Publicly Funded Continuing Care Health Services: Directional and Operational Guide
2. AHS Continuing Care Home Waitlist Management Guide

AHS Resources for HCPs

1. Accessing a Continuing Care Home in Alberta: Supporting Transitions in Care Guide
2. Continuing Care Home Waitlist Referral form