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Designated Living Option Guide for Case Managers



For more information
continuingcare@ahs.ca



**Seniors Health &
Continuing Care**



Policy, Practice, Access
& Case Management

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Contact

For more information, contact: continuingcare@ahs.ca

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Introduction

Designated living options (DLO) are publicly funded residential accommodations that provide health and support services appropriate to meet the **assessed unmet needs** of Albertans. All DLOs provide privacy and independence with the comfort of health and personal care services onsite to support resident needs. The DLO Guide for **Case Managers** provides tools and resources to assist healthcare providers, in collaboration with residents, to determine the most appropriate designated living option level.

The DLO Guide for Case Managers (DLO Guide) is supported by the [Access to Designated Living Options \(ADLO\) Policy](#), [Access and Waitlist Management Procedure](#), [AHS Continuing Care Designated Living Option Waitlist Management Guide](#), and [the Continuing Care Zone to Zone Designated Living Option Referral Guide](#) that offer strategic and operational direction to healthcare providers on processes for assessing, waitlisting, and transitioning residents to an appropriate DLO to meet their needs and preferences.



Purpose

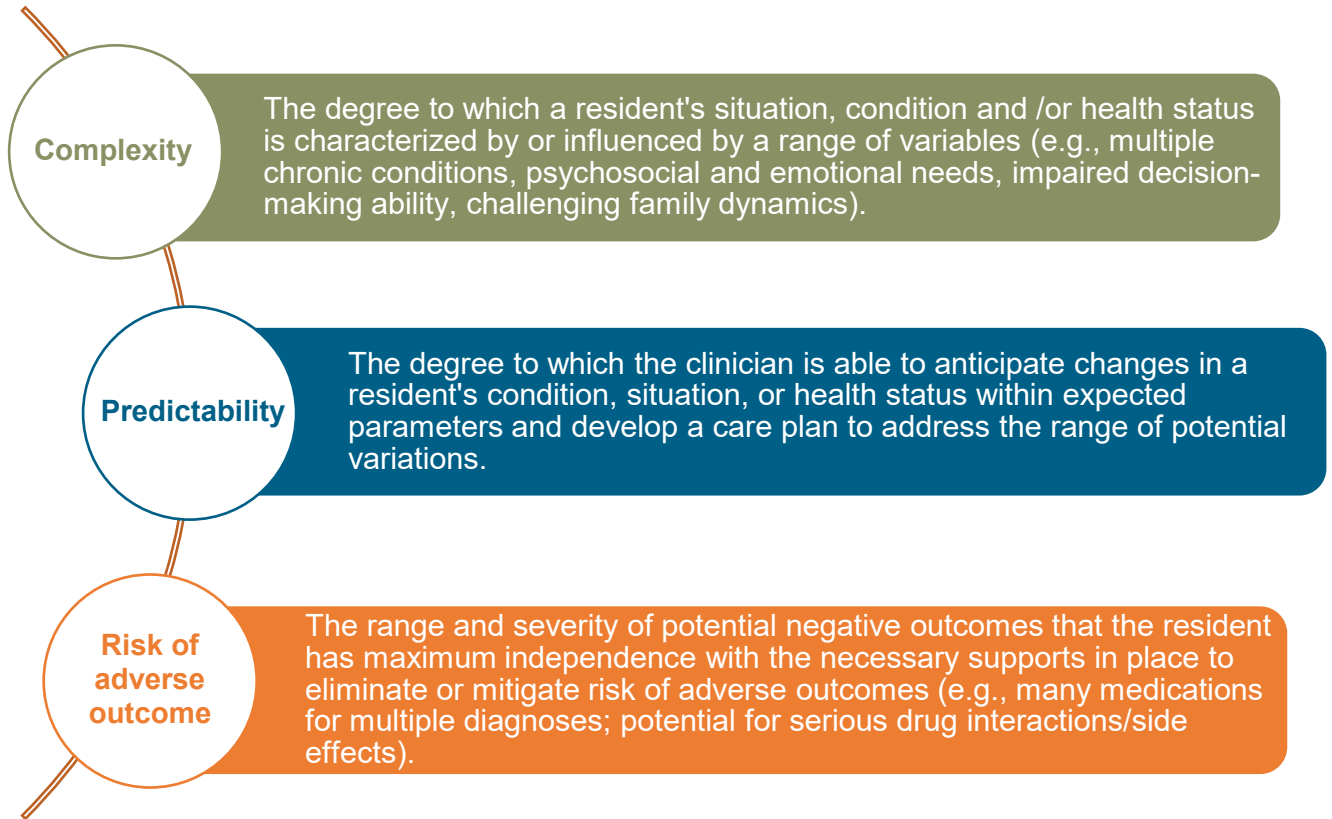
This guide is intended as a reference for case managers when assessing and supporting residents who require transition to a DLO. The guide is not meant to be rigid or overly prescriptive.

Recommendations in this guide:

- Support resident choice for care.
- Promote the **reunification** 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, Wait Listing and Transition

All residents admitted to continuing care are assessed for the most appropriate level of 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 residents to live independently and to recover from acute illnesses and/or hospitalization.

Assessment, using the **Resident Assessment Instrument - Home Care (RAI-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

Ninety percent of Albertans who responded to an online survey stated, "I want to live in my own home during my senior years."

Findings Report, Alberta Seniors and Community Supports, Demographic Commissions, December 2008

health care providers 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.

Once the comprehensive assessment is complete, case managers should refer to the access criteria ([Appendix A](#)) for each level of care to support decisions related to wait listing. Access criteria provides a general guideline, but each resident must be assessed individually. Temporary changes in status may occur with acute episodes of illness, falls and post-hospitalization and reassessment may be required. When assisting residents to access a DLO that supports their assessed unmet 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 resident's new home. Efforts will be made to support residents to stay 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 new home will help support the resident's social, emotional, psychological, cultural, and spiritual needs. More information can be found in the [Moving to a new home in continuing care: An information and decision-making guide for patients and families](#).



Access Criteria: Special Considerations

DLO facilities 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 levels of care (e.g., at all levels of DLO, healthcare aides (HCA) are onsite to provide resident support, personal care, and regularly scheduled and unscheduled assistance). When determining the appropriate level of DLO, and when assisting residents to choose their preferred site, 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 living option that meets those needs even when their functional ability does not dictate that choice (e.g. recommending admission to designated supportive living level 4 instead of designated supportive living level 3 where a licensed practical nurse (LPN) is available onsite 24 hours a day). Additional considerations such as medical complexity, cognition, functional ability as well as informal supports should be considered when determining level of care.

Scope of Practice

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

Health Care Needs

Mental health

Residents with a psychiatric diagnosis (e.g., schizophrenia and bipolar disorder) may be safely supported in DLO settings. 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 may also benefit from being part of a larger campus of care or a community-based personal care home to facilitate integration into the community. As with any resident the case manager would need to use critical thinking and professional judgment to determine the most appropriate setting and level of care for the individual.

Nutritional health

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

Genitourinary and Gastrointestinal Health - Elimination

As a general rule elimination needs related to incontinence can be managed at all levels of DLO with the support of HCAs and a comprehensive care plan. There may be occasions where interventions are not successful and the incontinence is complicated by other factors such as responsive behaviours.

When residents care needs include support for complex elimination related care needs, inappropriate voiding or defecating (such as fecal smearing), or for elimination related behaviours that may impact other residents, assessment must consider the availability of staff and site environment to ensure the residents 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 ADL and IADL when determining the appropriate level of care. Residents may need the support of multiple healthcare providers 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 level of care selected for each resident.

DLO Levels of Care

Refer to ([Appendix A](#)) for a summary of the different access criteria for each level of care. For case study examples see ([Appendix B](#)).

Designated Living Options

DLO are inclusive of facilities that offer services across four different levels of care for residents with a range of healthcare needs.

Designated Supportive Living Level 3 (DSL3)

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. For exclusion considerations see ([Appendix A](#)).

Medical Conditions	Cognitive Status	Functional Status
Residents must be medically stable with predictable needs that do not require unscheduled onsite registered nurse RN),	Mild cognitive changes may wander with no known risk of elopement.	Mobilizes independently or with one-person transfer. Cueing and minimal assistance with meals,

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Medical Conditions	Cognitive Status	Functional Status
<p>registered psychiatric nurse (RPN), or LPN level of care.</p> <p>Scheduled professional assessments and interventions (e.g., RN/RPN, LPN, Allied Health professional, etc.).</p> <p>Scheduled nurse practitioner (NP) and/or physician support provided at off-site appointments.</p>	<p>May require unscheduled interventions.</p> <p>Displays awareness of personal space of others.</p> <p>Demonstrates the appropriate social behaviours for the environment.</p> <p>Shows no known risk of self-harm or harm to others.</p>	<p>transportation to meals and set up for meals. Minimal modifications to diet texture.</p> <p>ADL and IADL can be mostly scheduled.</p> <p>Ability to alert staff using a call system.</p>

Designated Supportive Living Level 4 (DSL4)

This environment provides 24-hour 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. Exclusion considerations ([Appendix A](#)).

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

Designated Supportive Living Level 4 - Dementia (DSL4-D)

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 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
<p>May have complex care needs that are mostly stable and predictable and can be safely managed with onsite LPN.</p> <p>May require chronic disease management.</p> <p>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.</p> <p>Scheduled and unscheduled NP and/or physician support through a combination of onsite and off-site appointments.</p>	<p>Moderate to severe cognitive changes (CPS of 3 or greater).</p> <p>May have a high risk of elopement.</p> <p>May display unpredictable behaviours with effective interventions to minimize risk of self-harm or harm to others.</p> <p>May lack awareness of the personal space of others and require frequent re-direction and support.</p>	<p>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.</p> <p>Occasional unscheduled needs.</p> <p>Independent, partial or complete meal assistance. Diet or texture modifications can be accommodated.</p> <p>May be unable to alert staff using a call system.</p>

Long Term Care (LTC)

This environment provides onsite RN and/or registered psychiatric nurse (RPN) care, assessment and/or treatment 24 hours a day. LPNs may also be onsite in addition onsite personal care and support provided by HCAs. Long term care facilities care may have a secured space.

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

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Medical Conditions	Cognitive Status	Functional Status
<p>Medically complex and unpredictable care needs that can be safely supported with 24 hour onsite RN/RPN.</p> <p>Requires chronic disease management.</p> <p>Scheduled and unscheduled professional assessments (e.g., physical therapist, pharmacist, etc.) may require adjustments of the care plan.</p> <p>Scheduled and unscheduled NP and/or physician support for complex health assessments requiring onsite services.</p>	<p>Any severity of cognitive changes.</p> <p>May display unpredictable behaviours with effective interventions to minimize risk of self-harm or harm to others.</p> <p>May lack awareness of personal space of others and may require frequent re-direction and support.</p>	<p>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.</p> <p>Unscheduled needs.</p> <p>Independent, partial, or complete meal assistance. Diet or texture modifications with complex nutritional needs requiring frequent and unscheduled interventions and assessments.</p> <p>May be unable to alert staff using a call bell system.</p>

Definitions

Assessed unmet 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 the provision of quality health and supportive services through the effective and efficient use of available resources the resident's achievement of 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 DLO.

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).

Designated living option: Publicly funded residential accommodation that provides health and support services appropriate to meet the resident's assessed unmet needs. The level of care is accessed through a standardized assessment and single point entry process and consists of Designated Supportive Living Level 3 (DSL3), Designated Supportive Living Level 4 (DSL4) and Designated Supportive Living Level 4 Dementia (DSL4D) and Long Term Care (LTC).

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 on the basis of observation, experience, or scientific reason. It involves an assessment of

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how effectively the health condition is managed, the changes likely to occur, and whether the type or timing of change can be anticipated.

Resident Assessment Instrument- Home Care (RAI-HC): a standardized, minimal assessment and screening tool designed for clinical use. **Reunification:** Reuniting close relationships through transfer when both residents require a Designated Living Option. Close relationships are determined by the resident.

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 (Alberta).

Appendix A: Clinical Decision Support Tool for Case Management

DSL3	DSL4	DSL4D	LTC
<ul style="list-style-type: none"> Scheduled and unscheduled personal care with HCA 24 hour onsite Professional nursing care, such as LPN, RN, RPN 24 hrs. is available (may be onsite, on-call or virtual) 	<ul style="list-style-type: none"> Scheduled and unscheduled professional and personal care support provided by LPN and HCAs Professional nursing care, such as RN or RPN is available 24 hrs. a day (may be onsite, on-call or virtual) 		<ul style="list-style-type: none"> 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
<p>Medical Conditions:</p> <ul style="list-style-type: none"> 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 	<p>Medical Conditions:</p> <ul style="list-style-type: none"> 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 		<p>Medical Conditions:</p> <ul style="list-style-type: none"> 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
<p>Cognitive Status:</p> <ul style="list-style-type: none"> Mild cognitive changes May wander with no known risk of elopement 	<p>Cognitive Status:</p> <ul style="list-style-type: none"> Varying levels of cognitive impairment, may wander and is assessed as no or 	<p>Cognitive Status:</p> <ul style="list-style-type: none"> Moderate to severe cognitive changes (CPS 3 or greater) 	<p>Cognitive Status:</p> <ul style="list-style-type: none"> Any severity of cognitive changes May display unpredictable behaviours with effective

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DSL3	DSL4	DSL4D	LTC
<ul style="list-style-type: none"> • 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 	<p>minimal risk for elopement</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<p>interventions to minimize risk of self-harm to others</p> <ul style="list-style-type: none"> • May lack awareness of personal space of others and may require frequent re-direction and support
<p>Functional Status:</p> <ul style="list-style-type: none"> • 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 	<p>Functional Status:</p> <ul style="list-style-type: none"> • 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 	<p>Functional Status:</p> <ul style="list-style-type: none"> • 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 assist. • Diet or texture modifications can be accommodated • May be unable to alert staff using a call system 	<p>Functional Status:</p> <ul style="list-style-type: none"> • 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 assist. • 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

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DSL3	DSL4	DSL4D	LTC
<p>Exclusion Considerations:</p> <ul style="list-style-type: none"> • Complete meal assistance • Two or more person transfer and/or mechanical lift • Unscheduled needs requiring LPN or RN scope of practice 	<p>Exclusion Considerations:</p> <ul style="list-style-type: none"> • 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 		<p>Exclusion Considerations:</p> <ul style="list-style-type: none"> • Unpredictable behaviours placing self or others at risk Note *May not be an exclusion in some facility settings; may require specialty LTC 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
<p>RAI-HC Outcome Scales Expected Range: Cognitive Performance Scale: 0-3 ADL Hierarchy: 0-3 IADL Difficulty: 4-6 CHESS Scale: 0-3 MAPLe Scale: Mod, High or Very High</p>	<p>RAI-HC Outcome Scales Expected Range: Cognitive Performance Scale: 2-4 ADL Hierarchy: 2-4 IADL Difficulty: 5-6 CHESS Scale: 0-3 MAPLe Scale: Mod, High or Very High</p>	<p>RAI-HC Outcome Scales Expected Range: Cognitive Performance Scale: 3-5 ADL Hierarchy: 1-3 IADL Difficulty: 5-6 CHESS Scale: 0-3 MAPLe Scale: High or Very High</p>	<p>RAI-HC Scales Expected Range: Cognitive Performance Scale: 2-4 ADL Hierarchy: 2-5 IADL Difficulty: 5-6 CHESS Scale: 2-4 MAPLe Scale: High or Very High</p>

Appendix B: Case Studies

DSL3					
Situation	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.				
Background	<p><u>Diagnosis</u> – Hypertension, atrial-fib, spinal compression fractures, dizziness (with no apparent cause)</p> <p>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 trach 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.</p>				
Assessment	<ul style="list-style-type: none"> Assist with bathing, grooming, dressing, hygiene fluctuates with increasing unscheduled needs. Medication assistance, including PRN analgesia and laxatives that she is increasingly not able to manage independently. 				
	RAI HC Outcome Measures:	Cognitive Performance Scale: 2	Pain Scale: 0	IADL Difficulty: 2	MAPLe Scale: High
		Depression Scale: 0	ADL Hierarchy: 0	CHESS Scale: 1	
Recommendation	DSL3				

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DSL3

DSL3	
Rationale	<p>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 considered to be an activity of daily living and can be done by health care aides. No on-site RN or LPN is needed because:</p> <ul style="list-style-type: none"> • Elizabeth is able to direct her care and request help when needed. • Elizabeth will have regular monitoring by her Case Manager as required, RN is available on-call 24/7.

DSL4

DSL4				
Situation	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.			
Background	<p><u>Diagnosis</u> – Pancreatic cancer with liver metastasis, history of prostate cancer (CA), history of basal cell CA on the face, hypertension, history of cerebrovascular accident (CVA).</p> <p>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 currently, his 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.</p>			
Assessment	<ul style="list-style-type: none"> • 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. 			
	RAI HC Outcome Measures:	Cognitive Performance Scale: 2	Pain Scale: 0	IADL Difficulty: 5

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DSL4					
		Depression Scale: 1	ADL Hierarchy: 2	CHESS Scale: 2	
Recommendation	DSL4				
Rationale	<p>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 in the near future. Because his health status is stable these professional nursing needs could be met in DSL4 with on-site LPN care and oversight by an AHS Case Manager and other health care professionals.</p> <p>His RAI HC Outcome Measures are within the expected range of DSL 4 residents.</p>				

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DSL4D					
Situation	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.				
Background	<p><u>Diagnosis</u> – Alzheimer’s type dementia, fractured left hip two years ago, arthritis in the left knee and hip, previous history of alcohol abuse.</p> <p>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.</p>				
Assessment	<ul style="list-style-type: none"> • 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 assist with dressing. Independent with toileting but requires monitoring to ensure pad has been changed and clothing adjusted. • Has been losing weight and requires supervision and encouragement to eat meals. • Requires medication management. 				
	RAI HC Outcome Measures:	Cognitive Performance Scale: 3	Pain Scale: 1	IADL Difficulty: 6	MAPLe Scale: Very High
		Depression Scale: 3	ADL Hierarchy: 1	CHES Scale: 1	
Recommendation	DSL4D				
Rationale	Due to a high elopement risk, Sylvia requires a secure space and would not be suitable for a DSL4 facility. 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.				

Policy, Practice, Access & Case Management

LTC					
Situation	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 to move due to high physical and medical needs.				
Background	<p><u>Diagnosis</u> – Multiple CVA's bilaterally, vascular dementia, type 1 diabetes, renal transplant related to diabetes, hyperparathyroidism, dyslipidemia, diverticulitis, and macular degeneration</p> <p>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 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.</p>				
Assessment	<ul style="list-style-type: none"> • 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. 				
	RAI-HC Outcome Measures:	Cognitive Performance Scale: 5	Pain Scale: 2	IADL Difficulty: 6	MAPLe Scale: V e r y High
		Depression Scale: 0	ADL Hierarchy: 5	CHESS Scale: 3	
Recommendation	LTC				
Rationale	<p>Janet requires LTC to provide on-site monitoring by an RN. Her care needs are:</p> <ul style="list-style-type: none"> • 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 or know when the assessment will be needed. 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. 				

Policy, Practice, Access & Case Management

LTC – Secure Unit					
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 DLO. He has no home and his children refuse to take him back because of his aggressive behaviours.				
Background	<p><u>Diagnosis</u> – Alzheimer’s type dementia with executive function disorder, intermittent explosive disorder</p> <p>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 past 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 at a later date. 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.</p>				
Assessment	<ul style="list-style-type: none"> • 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 Outcome Measures	Cognitive Performance Scale: 5	Pain Scale: 0	IADL Difficulty: 5	MAPLe Scale: Very High
		Depression Scale: 4	ADL Hierarchy: 2	CHESS Scale: 3	
Recommendation	Long Term Care Facility-Secure space				
Rationale	<p>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:</p> <ul style="list-style-type: none"> • 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. 				

Resources

Governance Documents

1. [Access to a Designated Living Option in Continuing Care Policy](#)
2. [Designated Living Option: Access and Waitlist Management Procedure](#)
3. [Alternate Level of Care Accommodation Charges - Patients Waiting for Continuing Care Policy](#)

Supplemental Resources for Patients

1. [Moving to a new home in continuing care: An information and decision-making guide for patients and families](#)

Insite Resources

1. [Coordinated Access to Publicly Funded Continuing Care Health Services: Directional and Operational Guide](#)
2. [AHS Continuing Care Designated Living Option Waitlist Management Guide](#)
3. [AHS Continuing Care Zone to Zone Designated Living Option Referral Guide](#)