NOVA SCOTIA

Department of Health
Continuing Care Branch
Long Term Care

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NURSING HOMES AND HOMES FOR THE AGED

(Community Continuing Care Centres)

Centre Name: Date:		
Mailing Address: **Phone:** **Fax:**		
Owner:	**Administrator:**	
Bed capacity (excluding respite):	**No. of approved respite beds:**	**Date of last licensing visit:**

Accreditation Status: **Dates:**

Licensing recommendations and actions taken since last license:

A. STATISTICAL INFORMATION

Current Information (Day of Visit)

Census:	**Vacancies:**	**Respite:**

Average Occupancy Year to Date:

Funding Agent:

1. **No. of residents who are cost shared**
2. **No. of residents who are private pay**
   - **of private pay indicate:# Self**
   WCB
   DVA
   First Nations
   Other, i.e. insurance

Approved Per Diem(s):	**Private Rate(s):**	**Respite Rate(s):**
$	$	$

Information from the last fiscal period (April 1 to March 31)

No. of Admissions:	**No. of Admissions to Acute Home Care Program:**	**No. of Discharges:** - **to home** -**to Community Services** -**lateral** -**hospital**
No. of Deaths:	**No. of Admissions to Hospital:**	

Respite Occupancy
No. of Private Pay:
No. of Cost Shared:

Municipalities of Settlement
(Attach list is required)

B. NURSING

Director of Care (Name)				
Assistant D.O.C. (Name)				
Number on and Hours Worked:	**Days:**	**Evenings:**	**Nights:**	**Weekends: DEN**
Supervisors				
RN				
LPN				
PCW				
Other				

EDUCATIONAL TRAINING AND QUALIFICATIONS	
No. of Staff with PCW Course:	
No. of Staff with Alzheimer and Dementia Course ➜	
Other, i.e. RN - Management Courses	
LPN - Post Graduate Course ➜	

C. THERAPEUTICS

Include No. and hours worked	Days	Facility Staff	Contracted Services	Budget Approved Yes No
Occupational Therapist				
Physiotherapist				
Physio aid - Certified Yes No				
Social Worker				

List Others: e.g. Chiropodist				

D. RESIDENT INFORMATION

RESIDENT DIAGNOSIS		
Please provide the following, based on your current resident population:		
Diabetics	**No. of residents diet controlled:** ➜	
	No. of residents on oral hypoglycemics:	
	No. of residents receiving insulin:	
	Total:	
Dementias	**No. of residents diagnosed with ALZHEIMERS:** ➜	
	No. of residents diagnosed with other dementias:	
	No. of residents non diagnosed but demonstrating similar symptoms of dementia:	
Specific Diagnosis	**No. of residents with HUNTINGTONS:** ➜	
	No. of residents with PARKINSONS:	
	No. of residents with ALS:	
	No. Of residents with MS:	
	No. of residents with MD:	
	No. of residents with post traumatic brain injury:	
	No. of residents with spinal cord injury:	
	No. of residents diagnosed with psychiatric illness:	
Please list your five (5) top diagnoses based on frequency:		
List any other diagnosis that is of special significance in your facility:		

RESIDENT AGE		
Age Groups	**Number of Persons**	
	Male	**Female**
18 - 44		
45 - 64		
65 - 69		
70 - 74		
75 - 79		
80 - 84		
85 - 89		
90 - 94		
95 - 99		
100+ (state age)		

Average age on admission:
Average age of total current population:

RESIDENT MOBILITY (relates to residents' ability to mobilize independently)				
Mobile - no staff assistance required: ➜	**Alone**	**Cane**	**Wheelchair**	**Walker**
Staff assistance to transfer but can mobilize independently: ➜	**Alone**	**Cane**	**Wheelchair**	**Walker**
Staff assistance to transfer and to mobilize: ➜	**Arm Support**	**Cane**	**Wheelchair**	**Walker**

NURSING CARE

No. of residents with the following: (Current Information)

Description	Number	Description	Number
Indwelling Catheters: **•Urethral ➜** **•Suprapubic ➜** **•Other**		**Gastrostomy:** **•Continuous feed ➜** **•Intermittent feed ➜** **Jejunostomy ➜** **•Continuous feed ➜** **•Intermittent feed ➜**	
Colostomies: **•Requiring full care ➜** **•Requiring some care ➜** **•Self care ➜**		**Oxygen Concentrator** **•Continuous ➜** **•Intermittent ➜** **O2 tanks on site: ➜** **Sizes:** **• ➜** **• ➜**	

Incontinent Residents **Type of system used:** **•Reusable ➜** **•Disposable ➜**		**Tracheostomy ➜** **Hemodialysis ➜** **Peritoneal Dialysis ➜**	

Skin Breakdown: •Minor ➜ •Major ➜		Brief Description

RESIDENT CARE DOCUMENTATION				
No. of Level 1:				
No. of Level 2:				
Is there an age restrictive admission policy?	**Yes**	**No**		
If Yes, Explain:				
When is the Medical History and Physical done?				
Comments:				
Who participates in Interdisciplinary Care meetings?				
How often are these meetings held?				
Are care goals set/reviewed?				
How is information disseminated after meetings?				
Are care plans current?	**Yes**	**No**	**Some**	**Mostly All**
Do P.C.W.'s document on resident charts?			**Yes**	**No**
Is there an interdisciplinary approach to documentation?			**Yes**	**No**

E. PHYSICIAN SERVICES

Name of Medical Advisor(s):

Is there an honorarium/salary **Yes** **No**

If yes, what is the amount paid?

If yes, is it funded in the per diem? **Yes** **No**

What other physician costs are incurred by the Home?

No. of other general practitioners who visit home:

Do physicians provide inservices? **Yes** **No**
If applicable, list topics during past year:

Do physicians participate in Interdisciplinary Committee meetings or other committees?

Yes **No**

If Yes, please elaborate:

F. PHARMACEUTICAL SERVICES

Provide the name and address of the licensed pharmacy providing services for this facility:

Provide the name of the pharmacist who is the usual contact person for regular ongoing communications and on-site visits:

If the pharmacy service is *not* externally purchased from a *pharmacy*, provide the name of the *consulting pharmacist* and the usual number of hours per week of on-site pharmacy coverage:

From where are OTC drugs purchased? ➜	**A. Pharmacy**	**B. Facility**	**C. Other**

PACKAGING:

are:	**BlisterRx Pack**	**in vial**	**Stock**
a) regular scheduled prescriptions for individuals			
b) regular scheduled OTC medications			
c) PRN medications			
d) Stock medications			

Is the pharmacy involved in the removal and disposal of outdated or unused medication from the facility? **If No, then describe the current disposal process.**
Are the medication lists reviewed by the charge nurse monthly (in consultation with the pharmacist/physician, if necessary) to determine if the medication should be discontinued or altered? **Yes** **No** **If no, please explain process.**
Are medications reordered quarterly? **Yes** **No**
What is your process?
Are all medication orders signed by a physician within 72 hours? **Yes** **No**

Comments:
List the current members of the Pharmacy Committee (include names and professional designation):
Dates of last four Pharmacy Committee meetings:
On an annual basis, how often does the pharmacist provide staff/inservice education sessions on drugs, drug distribution process, problem solving, etc?

List four (4) recent topics and dates:	
DRUG COST REPORTS	
Provide the following costs for the last fiscal year for the physician ordered medications that are paid for by this facility:	
•medication costs for residents 65 years and over ➜	**$**
•medication costs for residents under 65 years➜	**$**
Total➜	**$**

CURRENT STATISTICAL REVIEW OF MEDICATIONS						
Floors/Units/Facility		Number of Residents	Total Number of Prescriptions Ingested			All Other
			Regular	PRN	Total	
	Number					
	Average					
	Number					
	Average					
	Number					
	Average					
	Number					
	Average					
	Number					
	Average					

***All others include all physician orders, i.e., aerosols, drops, creams, ointments (excluding diabetic and ostomy supplies).**
BREAKDOWN:

Floors/Units/Facility		**Number of Residents**	**Hypnotics**	**Anti-** Depressants	**Benzodiazepines**	**Anti-** psychotics
	Number					
	Average					
	Number					
	Average					
	Number					
	Average					
	Number					
	Average					

Fill in the chart below as follows: **Top Line = Number of Oral Antibiotic Prescriptions**
For last 12 months **Bottom Line = Number of Residents**

0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

G. DIETARY

Director (Name) (If dietitian please indicate)

Assistant Director (Name)

Number on:	**Days:**	**Evenings:**	**Nights:**	**Weekends:**
Dietitian				
Supervisor				
Food Service Worker				
Cook				
Others (please list)				

EDUCATION, TRAINING AND QUALIFICATIONS

No. of staff completed:

A. Food Handlers' Course
B. Food Service Workers' Course

Qualifications of Cooks/Chefs:

Observe Eating Establishment License

NUTRITIONAL CARE			
MENU			
Number of cycles:	**Is menu posted throughout**	**Yes**	**No**
Are choices made available?		**Yes**	**No**
Comments:			
NUTRITIONAL SUPPLEMENTS & SPECIAL DIETS			
No. of residents receiving supplements:		**Monthly Average:**	
No. of residents receiving enteral feeds:			
For enteral feeds(products used):		**Monthly Cost: $**	
No. and types of special diets:			
MEAL TIME SKILLS **(Number of residents who):**			
Feed self with no difficulty			
Feed self/uses adaptive devices			
Feed self/constant supervision			
Need to be fed/minimal independence			
Fed totally			
Comments:			
RESIDENT INPUT			
Resident Dining Committee set up?	**Yes**	**No**	
Frequency of Meetings:			
If No, explain resident input process:			
Comments:			

FOOD SERVICE			
TYPE OF MEAL SERVICE			
Centralized	**Decentralized**	**Decentralized Trays**	
Comments:			
DINING AREA(S)			
No. of dining areas:	**No. of residents eating in room at their:**		
No. of meal settings:	**No. of residents eating in hallway:**		
Range of Resident Meal Hours	**Breakfast**	**Lunch**	**Supper**
Range of Staff Meal Hours	**Breakfast**	**Lunch**	**Supper**
Comments:			
KITCHEN			
Preventative Maintenance Schedule:	**Yes**	**No**	
	Monthly	**Quarterly**	
Refrigerator/Freezer:	**Clean floors, shelves, walls, doors:**	**Yes**	**No**
	Food properly covered and labelled:	**Yes**	**No**
	Containers of food stored off floor:	**Yes**	**No**
Types of Audits and Frequency Completed:			
Comments (Examples):			
NON-RESIDENT MEAL SERVICE			

Do you provide:	**meals to wheels**	**Yes**	**No**	**#**
	wheel to meals	**Yes**	**No**	**#**

If so, fee for consumer:

Do you provide:	**meals for staff**	**Yes**	**No**

If so, price for meals:

Do you provide food service to enriched housing residents? **Yes** **No**

If so, how many?

If so, fee for service:

Do you provide food service to any other? **Yes** **No**

If so, fee for service:

H. ENVIRONMENTAL SERVICES

Director (Name)				
Number on and Hours Worked:	**Days:**	**Evenings:**	**Nights:**	**Weekends: D.E.N.**
Supervisors				
Housekeepers				
Laundry Worker				
Seamstress				
Others				
Maintenance Director (Name)				
Maintenance Workers				

EDUCATION AND TRAINING	
No. of staff who have completed Environmental Workers' Course ➜	

LAUNDRY				
Is laundry done on site?		**Yes**		**No**
Purchased Services:				
Hours of Operation:				
Industrial Washers	**No.**	**Age**	**Propane**	**Electric**
Industrial Dryers	**No.**	**Age**	**Propane**	**Electric**
Personal Use Washers:	**No.**		**Age**	
Personal Use Dryers:	**No.**		**Age**	
Comments:				

HOUSEKEEPING		
Are resident rooms clean, tidy and free of clutter?	**Yes**	**No**
Comments:		
Are bedspreads/draperies in good order and repair?	**Yes**	**No**
Comments:		
Are there lingering odours?	**Yes**	**No**
Comments:		
Is soiled laundry self-contained until laundry pick-up?	**Yes**	**No**
Comments:		
Are Housekeeping carts clean	**Yes**	**No**
Are chemicals secured on carts? **In utility rooms?**	**Yes** **Yes**	**No** **No**
Number of housekeeping audits completed	**Quarterly**	**Yearly**

I. PHYSICAL PLANT

Age of building:	**New additions added with dates:**		
Type of structure:			
Square footage:			
No. of levels/floors:	**No. of bathrooms:** **No. of tubs/shower rooms:**	**Are they ventilated?** **Yes**	**No**
Is there adequate space to implement services?		**Yes**	**No**
Is there adequate storage space?		**Yes**	**No**
Comments:			
Type of Heat:			
Air exhaust system:		**Yes**	**No**
No. of smoking areas:		**Residents:**	**Staff:**
Are they ventilated and enclosed?		**Yes**	**No**
Schedule for painting/decorating:			
Preventative maintenance program:		**Yes**	**No**
for building **for equipment**		**Yes** **Yes**	**No** **No**
What maintenance programs are contracted?			
Regular Inspection			
of electrical appliances		**Yes**	**No**
of resident equipment **i.e., wheelchairs, lifts, etc.**		**Yes**	**No**
Is there policy for electrical equipment in resident rooms?		**Yes**	**No**
Is there process for reporting/correcting maintenance deficiencies?		**Yes**	**No**
Is there process for resident to request maintenance/repairs?		**Yes**	**No**
Are doorways, corridors and stairs free from obstacles?		**Yes**	**No**
Exit doors have automatic alarms		**Yes**	**No**
Residents have easy access to outdoors		**Yes**	**No**

All resident areas are wheelchair accessible:		
indoor areas	**Yes**	**No**
outdoor areas	**Yes**	**No**
Exits and floor surfaces provide a smooth ride for wheelchairs	**Yes**	**No**
All beds and bathrooms have access to a call system	**Yes**	**No**
***ASSESSORS OBSERVATIONS* (to include resident safety, i.e. grab bars in washroom areas, handrails in corridor, non-skid floor surfaces as well as the level of home-like atmosphere)**		
Do you have a secure unit/wing?	**Yes**	**No**
If yes, how is it secured?		
If yes, please complete single assessment sheet.		

J. RECREATION SERVICES

Director (Name) **Hours Worked:**

Number On and Hours Worked:	**Days:**	**Evenings:**	**Weekends: D.E.N.**
Supervisor/Coordinator			
Programmer			
Music Therapist			
Pastoral			
Volunteer Coordinator			
Other			

PROGRAMMING

Staff/resident ratio:

Is director responsible for program implementation/delivery?

Are there evening programs?

Are there weekend programs?

Please Attach A Description Of Programs/Services And A Copy Of Last Month's Act. Cal.

RESIDENT PARTICIPATION

Identify opportunities for resident input into program and special event planning:

Is there a Resident Council? **Yes** **No**
Name of President:

What percentage of the population is actively involved in programs?

Are resident participation statistics recorded for every program/service? **Yes** **No**

Is resident participation monitored on an individual basis? **Yes** **No**

Identify resident linkages with the community:

Indicate ways in which your department promotes/supports involvement of family members:

RECREATION DOCUMENTATION		
Is there a process in place for ongoing assessment of individual residents?	**Yes**	**No**
Is this a part of the overall care plan for each resident?	**Yes**	**No**
Comments:		
VOLUNTEER PROGRAM		
Is the recreation department responsible for the Volunteer Program? **facility-wide:** **within department:**	**Yes** **Yes**	**No** **No**
Is there a volunteer orientation program in place?	**Yes**	**No**
Do volunteers participate in inservices, educational opportunities?		
Identify primary volunteer roles: **How many regular volunteers?:**		
Describe other volunteer programs in facility if applicable:		
Describe Pastoral Care Program:		

K. ADMINISTRATION

Administrator's Name			
Assistant Administrator (Name)			
Number On and Hours Worked:	**Days:**	**Evenings:**	**Weekends:**
Receptionist			
Bookkeeper			
Business Manager			
Others			
BOARD OF DIRECTORS/OWNERS			
Name of Chairperson/Owner:			

Date of Appointment:				
Length of Term:				
Appointment Process:				
Board Membership structure:				
Board Committees:				
Is there a current written Mission Statement?	**Yes**	**No**		
Is there a Strategic Plan for Centre?	**Yes**	**No**		
Is there liability insurance? **Expiry Date:**	**Yes**	**No**		
DEPARTMENTAL DIRECTIVES - DO YOU HAVE?				
• **policy & procedure manuals?**				
• **goals & objectives?**				
• **statement of purpose?**				
Are the above reviewed annually?				
POLICIES				
Is there a written policy for:	**Yes**	**No**	**Date Reviewed**	**Audited/ Validated**
Physical Restraint:				
Resident at Risk				
Smoking - Resident -Staff				
Handling Resident Funds				
Personal Use Allowance				
Confidentiality				

JOB DESCRIPTIONS	
Is there a current (within 3 years) job description for each position?	**How often are job descriptions revised?**
Briefly explain process of revision:	
Please attach job descriptions/roles and responsibilities for all unlicensed personal care providers, i.e., PCW, Home Health Provider, etc.	
PERFORMANCE APPRAISALS	
How often are they done?	
Completed by whom?	
Are they part of the personnel files?	
Comments:	
CREDENTIALLING	
Is there a credentialing process for all professional staff? (Physician, RN, LPN, Dietitian, Physiotherapist, etc.)	
Comments:	
FOR ALL STAFF IN LAST FISCAL YEAR (Please attach list if necessary) **No. on Workers Compensation per department:** **No. on Early Return to Work Program per department:** **No. of paid sick hours per department:**	

STAFF EDUCATION PROFILE		
Name of Person Responsible for Staff Education:		
Please provide the following information *for the last 12 months*:		
Number of on-site inservice training sessions:		
List any five (5) inservice topics:		
Are there attendance records of staff who attended inservice:		
on-site	**Yes**	**No**
off-site	**Yes**	**No**
Is there a written orientation package for each department?		
Comment:		
Percentage of total staff who have completed Alzheimers Related Dementia course:		
List outside educational groups who receive training within your Centre:		
How are educational needs identified?		

Identify future educational needs for all disciplines:

L. SAFETY COMMITTEES

FIRE AND LIFE SAFETY ISSUES			
Fire Marshal's Report	**Date:**	**Deficiencies:**	**Yes No**
Actions to comply:			
Emergency lights functioning when tested at time of visit?			
Is there a generator?			
Does the Facility have a sprinkler system?			**Yes No**
Is there a Fire and Life Safety Education Program within the Facility?			**Yes No**
Who is the person responsible?			
Who is responsible for fire drills?		**Frequency:**	
Are there records of staff who:	**a) have participated in drills:**	**Yes**	**No**
	b) have participated in yearly fire and life safety programs:	**Yes**	**No**
DISASTER PLAN (EMO)			
Date of Plan:	**Date Submitted:**	**Date Approved:**	
Date of Fan Out Exercise:		**Date EMO Exercised:**	
HEALTH INSPECTION			
Health Inspector Report Date:		**Deficiencies:** **Yes**	**No**
Was entire facility inspected?		**Yes**	**No**
Is current Eating Establishment License posted?		**Yes**	**No**
Is there a beauty salon?		**Yes**	**No**
Is there a Cosmetology License posted?		**Yes** **Expiry Date:**	**No**
Is hairdresser's current license posted?		**Yes**	**No**

OCCUPATIONAL HEALTH AND SAFETY		
Is there an Occupational Health and Safety Committee? **Name of Chairperson:**	**Yes**	**No**
Frequency of Committee Meetings:		
Do the minutes of the meetings indicate that the intent of the legislation is being met?	**Yes**	**No**
Are minutes available for staff?	**Yes**	**No**
Occupational Health and Safety Inspection Visit Date: **Deficiencies:**	**Yes**	**No**
Have you applied for and received deviation? ***If yes, provide copy***	**Yes**	**No**
WHMIS		
Who is responsible for WHMIS staff education?		
Are all staff trained annually?	**Yes**	**No**
Date of last review/revision of manuals:		
Are MSDS sheets present in required areas?	**Yes**	**No**
Are chemicals safely stored?	**Yes**	**No**
Are chemicals labelled appropriately?	**Yes**	**No**
Comments:		
INFECTION CONTROL		
Who is responsible for infection control program?		
Is there an outbreak plan?	**Yes**	**No**
Are policy and procedures written?	**Yes**	**No**
Is there resident immunization for: Flu vaccine **Pneumovax**	**Yes** **Yes**	**No** **No**
Is there staff immunization: Flu vaccine **Other**	**Yes** **Yes**	**No** **No**
How are needles, syringes and contaminated waste properly disposed of?		

M. OTHER COMMITTEES

Committees	Meeting Frequency	Written Terms of reference for each: Yes No

Completed By: **Date:**

APPENDIX I
SINGLE UNIT ASSESSMENT

This form will be completed if: *A. The home is requested to do so.*
B. The home has a special program unit or a secure unit.

Unit:	**Bed Capacity:**	**Census:**

Staffing: **Unit Coordinator/Head Nurse**

	Days	**Evenings**	**Nights**
RN			
LPN			
PCW			
Others			

No. of staff with special training for this unit:

Resident Population:	**Females:**	**Males:**
Age Range:	**Females:**	**Males:**

Description of resident population (i.e. ambulatory/non-ambulatory/dementia):

Program design - on unit: (if written, please attach)

Physical plant description: (assessor's description)

F:\FORMS Classifications LTC\Blank Licensing Form - NH.wpd