2018
V.1.1

Code of Practice for Care Homes

STANDARDS, CRITERIA AND GUIDELINES UNDER THE RESIDENTIAL CARE HOMES AND NURSING HOMES ACT 1999 AND REGULATIONS 2001.

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Overview:

The Code of Practice contains the requirements for the operation of a care home regulated under the Residential Care Homes and Nursing Homes Act 1999 and Regulations 2001. It will be updated to reflect changing practices and regulatory requirements in consultation with care home operators, administrators and health care professionals in accordance with s.23A(4) of the Act.

Changes in version 1.1:

Correction made to Criteria 26.2 for required community space per care recipient to reflect the Regulations.

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Contents

A. Introduction

Purpose

The Code of Practice (the Code) sets the minimum requirements for the operation of care homes registered under the Residential Care Homes and Nursing Homes Act 1999 and Regulations 2001. The Code includes:

Standards	Mandatory requirements
Criteria	Requirements to uphold the standard
Recommended Criteria	Not required, indicated by '**should**'
Guidelines	Guidance to uphold criteria
Resources and references	For general guidance

Application

The Code applies to licensed care homes providing room, board and personal care to two or more unrelated persons who are seniors and/or have a disability. This includes care homes that contract out some or all care services to external service providers or coordinate these services for their residents.

There are two types of care homes defined under the legislation: residential care homes and nursing homes, the difference being the maximum level of care of a person who can be admitted to home.

Type of Care Home	Maximum level of Care
Residential care homes	Personal care
Nursing homes	Intermediate to complex care

The Code was developed for all types and models of care homes and care recipients, recognizing that how a Standard and criteria are fulfilled may depend on the level of care, the specific population being served and the model of care by the home (see Appendix 2). In specific circumstances, and with prior approval, criteria may be adjusted or exempted based on the model of care and care recipients' needs.

The term ***care recipient*** is used in the Code when standards and criteria apply to **residents, respite persons and day care attendees** in the care home.

Regulatory Authority

Ageing and Disability Services (ADS) is responsible for the administration and compliance monitoring for The Code under the Chief Medical Officer of the Ministry of Health. Non-compliance is subject to regulatory action under the Residential Care Homes and Nursing Homes Act 1999 and Regulations 2001.

Bill of Rights for Persons in Care

These fundamental rights are the foundation for the standards, criteria and guidance in this Code and must be upheld by all licensed homes.

Care recipients are:

1. To be treated with dignity, consideration and respect in a manner that fully recognizes their individuality, independence and right to privacy.
2. To be provided care and services that are adequate and appropriate to their care needs and in compliance with all relevant laws, standards and codes of practice.
3. To have access to information to assist in decision making that is in an accessible format appropriate to their individual needs, and for their relevant persons where appropriate.
4. To have a contract with the care home stipulating services to be provided, terms of use, all fees and additional charges, and reasonable grounds and conditions for termination.
5. To be protected from sexual, physical, psychological and financial abuse and neglect**.**
6. To be free from chemical and physical restraint unless authorized in accordance with legislation and the Code.
7. To be able to, in consideration of the health, safety and wellbeing of persons in the home, receive visitors at any time and associate and communicate privately with people and groups of their own choice and initiative.
8. To exercise their rights as a citizen.
9. To pursue their social, cultural, religious, spiritual and other interests and are given reasonable assistance by the care home in doing so and are able to refuse participation in any activity.
10. To be able to raise (themselves or by their relevant parties) complaints, concerns or suggestions regarding the services and operation of the care home without fear of coercion and retaliation.
11. To participate fully, and/or their relevant persons where appropriate, in all decision making pertaining to their care and treatment.
12. To exercise choice about the care and treatment they receive. If others are to make decisions on their behalf due to a lack of capacity the persons' best interests must be upheld.
13. To have their personal and clinical information held in confidence and not disclosed without the appropriate consent, unless in emergency circumstances.
14. To have and use their own possessions, where reasonable, and have an accessible, lockable space for personal valuables.
15. To manage their own finances and needs unless this authority is delegated to another person.
16. To be informed of any conditions, restrictions or changes to the license of the care home. The relevant person is notified as appropriate.

B. Quality of Life

1. Dignity, Independence and Right to Privacy

Standard:

Care recipients are treated with dignity, consideration and respect in a manner that fully recognizes their individuality, independence and right to privacy.

Criteria

1.1. Arrangements are in place to ensure that the care recipient's independence, privacy and dignity are respected at all times. Particular regard should be paid to:

- a. Maintaining social contacts to the extent to which they wish to do so
- b. Spending time alone, in accordance with their wishes
- c. Expressions of intimacy and sexuality
- d. Wearing their own clothing
- e. Dressing and undressing
- f. Being assisted to eat and drink
- g. Consultations with advocates, social care and other professionals
- h. Examinations by health care professionals
- i. Personal caregiving
- j. Circumstances where confidential and/or sensitive information is being discussed (including details of medical condition or treatment)
- k. Entering bedrooms, toilets and bathrooms; permission is sought before entering these rooms
- l. Addressing and communicating with care recipients, including being addressed by their preferred terms
- m. Care received prior to and at the time of death

1.2. Care recipients are supported, as far as possible, to make choices about their own care and receive reasonable responses to requests made.

1.3. All residents must be able to decorate and furnish their area/room with items of their preference, taking into consideration the impact on their roommates and storage capacity of the care home. In shared rooms, fire resistant screening is provided that ensures privacy when required and requested.

1.4. Residents are able to keep their clothes, personal requisites and toiletries for their own exclusive use and have access to appropriate laundry services. This includes:

- a. Laundry collected and washed by the appropriate staff to ensure a continuous supply of clean clothing.

b. An adequate supply of clean linen (bed sheets and towels) is provided at least once per week to residents.
c. Where feasible, residents who wish to wash small amounts of their own items are able to do so.

1.5. The care recipients' social, religious and cultural beliefs and values are respected and accommodated within the routines of daily living. No religious beliefs or practices are imposed on a care recipient.

1.6. Policies are in place to ensure confidential information about care recipients is treated appropriately which include:

a. Staff share confidential information when it is needed for the safe and effective care of an individual.
b. When confidential information is shared it must be relevant, necessary and proportionate.
c. Information shared for the benefit of the community is anonymized (unless there is a legal obligation to disclose).
d. Any individual who objects to the sharing of their confidential information is respected, unless there is a legal obligation to do so.

2. Consent and Informed Decision Making

Standard:

Care recipients participate, as appropriate, in all decisions pertaining to their care and treatment and consent is given or refused after appropriate information is shared with them and/or their relevant person.

Criteria

2.1. Care recipients are provided access to information in an accessible format appropriate to their individual needs, and for their relevant person where appropriate, to assist in decision making. Information to be provided includes:

a. Advantages and disadvantages of the proposed action
b. Likely side effects
c. Available alternatives

2.2. Care recipients' consent, wishes and choices relating to treatment and care are discussed and documented in their records, and as far as possible, implemented and reviewed regularly with them. See Appendix 4 for guidance for persons with diminished capacity.

a. When there are relevant persons with legal responsibilities for the care recipient (e.g. receivers, enduring power of attorney) they must be the primary persons involved, with the care recipient, in the relevant decision making process.

3. Access to Information

Standard:

Care recipients have access to information on the operation and services of the care home in a format that they are able to understand.

Criteria:

3.1. The care home license is on display in a public area.

3.2. Information on the operation and services of the home is provided to care recipients and potential care recipients in plain English and made available in a format suitable for potential and existing care recipients upon request.

3.3. The following information should be provided in a guide or attached to the service contract:

a. The information in the statement of purpose
b. A description of the individual accommodation and communal space provided
c. The costs of the home (standard fee) and any additional costs outside of the standard fee
d. A copy of the most recent inspection report
e. A copy of the contract to be signed to receive services
f. Contact information for Ageing and Disability services and relevant authorities
g. Policies pertaining to:

- General terms and conditions for living in the home
- Complaints procedures
- Requirements for personal belongings brought into the home
- Managing money/personal affairs of residents
- The arrangements for residents who require treatment at outpatients' services or admission to hospital, including arrangements for accompanying the resident and ensuring their medical notes are transported with them
- Communication with relevant persons about changes in condition and care needs
- Avenues for resident/family involvement in the care home

4. Service Contracts

Standard:

Care recipients have a contract with the care home stating the services to be provided, terms of use, all fees and additional charges and reasonable grounds and conditions for termination.

Criteria

4.1. Up to date service contracts are in place for all care recipients.

4.2. Service contracts include the following information for each care recipient:

a. Rooms to be occupied or program to attend

b. Overall care and services covered by fee and time period (e.g. number of days per week for day care attendees)

c. Fees payable and by whom and by when (care recipients, government department, relative or another)

d. Services (including toiletries and equipment) to be paid for in addition to the fees

e. The circumstances that could lead to, and terms and conditions of, termination of the contract. Required terms and conditions for the termination of a contract include:

- The resident has the right to appeal to the care home any proposed termination. All appeals must be considered by the Administrator/Operator.
- A 30 day minimum notification period unless there is imminent risk to the health and safety of the care recipient or other care recipients in the home. Notification must be made to the care recipient, their relevant person(s) and their primary physician.
- Notwithstanding care recipients' freedom to discharge themselves, discharge decisions are based on assessments, care plans and discussions with the care recipient and their relevant person as appropriate.
- All information concerning the social and health care needs is provided to their next care provider by the Administrator, as appropriate.

4.3. The home must have reasonable grounds for the termination of contracts, which include:

a. The wishes and preference by the resident for discharge.

b. The non-payment of fees.

c. The protection of the health and safety of the care recipient or other care recipients.

d. The care home is unable to meet the care needs of the senior based on their license and/or conditions attached to such.

5. Complaints and Suggestions

Standard:

Staff, care recipients and relevant persons can raise complaints, concerns or suggestions regarding the services and operation of the care home, without fear of coercion and retaliation.

Criteria

5.1. A simple, clear and accessible complaint and suggestion policy and procedure is in operation. This must ensure:

a. Care recipients, staff and their relevant persons know how to make a complaint or suggestions within the home and how to raise complaints to Ageing and Disability Services.

b. No coercion regarding making a complaint nor retaliation for having made complaints or suggestions is tolerated.

c. Reasonable responses are provided by the Administrator to suggestions made.

d. Investigations occur into all complaints.

e. A record of all complaints, investigations and actions is maintained by Administrators.

5.2. In addition the following should be in place with regard to complaints and suggestions:

a. Care recipients, staff and their relevant persons are supported to take up issues in the most appropriate way.

b. The views, feelings and wishes of care recipients, relevant persons and staff are taken into account in delivering care and in decisions impacting their day to day lives. Methods should be in place to obtain this feedback (e.g. resident or family council).

c. Care recipients and staff receive feedback and are kept informed of progress within agreed timeframes.

6. Protection from Abuse

Standard:

Each care recipient is protected from all forms of abuse.

Criteria

6.1. There is a policy and procedure in operation on the prevention, detection and response to abuse within the care home.

6.2. Qualified staff of good character are employed through appropriate screening via references, qualifications, training, and criminal record checks (see Standard 19).

6.3. Staff receive orientation (via the Code) and ongoing training in prevention, protection and responding to abuse (see Standard 19 and Appendix 7).

6.4. Sufficient staffing numbers are in place to meet care recipients' needs and there is consistent and ongoing supervision of staff.

6.5. The needs of persons with cognitive impairments including those with challenging behaviors are supported to decrease potential incidences of abuse (see Standard 7).

6.6. All staff must report to the appropriate persons as soon as they are alerted of any suspected, alleged or actual abuse, or the risk of abuse. Reporting includes:

a. All suspected, alleged or actual abuse must be reported to Ageing and Disability Services.
b. Reporting to police immediately in cases of imminent risk to care recipients.
c. Notification of the care recipient's relevant person(s).
d. Reporting to appropriate healthcare professional regulatory body as appropriate.

6.7. The appropriate persons in charge must investigate all incidents and allegations of abuse and take appropriate remedial action which may include:

a. Providing or facilitating the securing of physical and mental health support to the care recipient(s) who was allegedly or known to be abused.
b. The removal of the suspected abuser immediately from the premises until the validity of the allegation is determined.
c. The termination of employment pending any internal and external investigations where abuse is proven to have occurred.
d. Compliance with any action required by a notice or order issued by an inspector, Ageing and Disability Services or the Senior Abuse Registrar.

6.8. Care recipients, families and staff know how to report suspected or known abuse. No person may be retaliated against for reporting any allegation of abuse to the home or

the relevant authority. For senior abuse reporting, the person receiving the report must maintain the reporter's confidentiality.

7. Managing Challenging Behaviors

Standard:

The philosophy and provision of care is the least restrictive and controlling possible for the individual care recipient when managing challenging behaviours.

Criteria

7.1. There is a policy that sets out the care home's philosophy of care and response to behavior that is challenging. It must:

a. Uphold least restrictive practices and a person centered care approach

b. Provide guidance on conducting required assessments

c. Outline acceptable and unacceptable interventions for care plans

7.2. An assessment occurs to identify and address behavior that is challenging with symptoms objectively documented and qualified, this includes:

a. Determining the impact and risk of the behavior to the care recipient and other persons in the care home.

b. Investigating the underlying causes of the behavior specific to the individual including physical, environmental, emotional, and social considerations.

c. Evidence that the symptoms are persistent.

d. Evidence that preventable or treatable/reversible (e.g. delirium, UTI) causes have been ruled out.

e. Determining the risks and benefits for proposed interventions in relation to the level of distress and potential harm.

7.3. Where a care recipient's behavior presents a risk to themselves or others, their care plan sets out a plan of care that meets their individual assessed needs. The plan is reviewed regularly with staff, care recipients and relevant persons to assess its effectiveness and reflect the care recipient's changing needs. Records of review meetings and/or case conferences are kept and shared with those in attendance.

7.4. Positive and proactive interventions are always considered and documented as the first option to manage challenging behaviors. Positive interventions are non-restrictive and non-pharmacological and aim to reduce the frequency, intensity or duration of the behavior by:

a. Promoting positive alternatives to the behaviour based on best practice evidence.

b. Reducing potential triggers (e.g. adjusting the environment to be more supportive, addressing skills/communication deficits and/or addressing physical health problem such as pain, discomfort and dehydration).

c. Safely de-escalating the situation in the least restrictive way.

7.5. Staff have up-to-date knowledge and skills, appropriate to their role, to enable them to manage and respond to behaviour that is challenging. This may include:

a. Arrangements are in place to obtain advice, training and support from professionals with the required expertise.

b. Staff raise any concerns with the person in charge about their ability to provide planned care. When concerns are raised, the person in charge responds appropriately and without delay.

c. Reviews of staff interventions occur and inform learning and practice development and take place in a spirit of staff support.

See Standard 18 and Appendix 5 for specific criteria regarding dementia care and support.

8. Restraints

Standard:

Restraints and restrictive practices are only used as a last resort and in the best interest of the individual care recipient. If required and authorized, the level, nature and type of any restraint or restrictive practice must be evidence based and proportionate to the risk it is attempting to address.

Criteria

8.1. The care home has a policy in operation on the use of physical and chemical restraint that is evidence based and adheres to legislation, the Code and best practice guidelines.

8.2. After positive and proactive interventions have been ruled out, assessments and consultation with expert advice (when available and necessary) occur to determine if a restraint is necessary. This determination must uphold the following:

a. Restrictive practices are only used as a last resort.

b. There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.

c. Restrictive practices are not being used for staff convenience or to punish, discipline, for the intention of inflicting pain, suffering or humiliation.

d. Routine, ‘as needed’ or indefinite orders for physical restraint are not allowed.

e. The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm. Any action taken to restrict a person’s freedom of movement must be the least restrictive option that will meet the need. Physical restraint is not used in response to the following behaviors:

- Wandering behavior or rummaging and attempts to leave the facility
- Risk of falls, unless the risk of falling is immediate, as in severe imbalance and the care recipient and/or relevant persons has consented

f. A medical practitioner has ordered a specific required restraint.

g. Care recipients and their relevant persons are supported to participate in the process and their consent is obtained for the use of restraints. Information on the risks of using or refusing the restraint is provided to them and the decisions recorded in their record.

- The role of the relevant person is dependent upon the capacity of the care recipient to give consent (see Standard 2 and Appendix 4).
- Where the care recipient is judged to lack the capacity to consent, physical restraint is not used if they express a clear and consistent preference not to be restrained. The only exception is in an emergency circumstance which must occur in accordance with 8.3.

8.3. A care plan is in operation for any restraint or restrictive practice that ensures the least restrictive intervention is used, clearly indicates when and how the restraint is to be used and ensures the rights and safety of the care recipient while in use. This requires the following:

a. There is evidence of documented prevention strategies to minimize the need for the use of restraint/restrictive interventions.

b. The care recipient's human rights are protected at all times.

c. Care recipients are treated with compassion and dignity at all times.

d. Care recipients continue to have their physical, psychological and spiritual needs attended to while a restraint is in use.

- Physical restraint- opportunities for motion and exercise are provided for at least ten minutes each two hour period while care recipient is awake.

e. Any restriction is imposed for no longer than absolutely necessary and continuously monitored, specifically:

- Physical restraint- care recipient is checked regularly at intervals defined in their care plan
- Chemical restraint- see 8.3

f. The use of restraint is reviewed on an ongoing basis.

g. Staff are adequately trained in the use of the restraint.

8.4. Care recipients are assessed at regular intervals to monitor appropriate and safe use of chemical restraints (psychotropic medications). This requires:

a. The appropriate medication is selected by a physician with reference to evidence based practice, started at the lowest dosage possible, and increased slowly until

either there is a therapeutic effect, side effects emerge, or the maximum recommended dose is reached.

b. The care recipient is assessed by the RN for potential hypotension, risk of falls, drug-related physical/cognitive/behavioural functional decline and drug-related discomfort.

c. The medication is subject to an initial review by the prescribing physician, and then as indicated by the resident's changing needs and circumstances but no less frequently than at three monthly intervals. Where such drugs are prescribed on a PRN as required basis, the indications for giving or withholding the medication and its effects are documented.

d. Pharmaceutical advice is accessed when needed.

e. If there is no significant change in the behaviour, the medication is discontinued.

8.5. Restraint or restrictive practices may be used in emergency circumstances without prior formal assessment and care planning ONLY when and if ALL of the following occurs:

a. The behavior is unanticipated.

b. There is a necessity to act to avoid imminent harm to the care recipient or others. This may include a brief period of physical restraint to prevent removal of a medical device and permit medical treatment to occur.

c. The intervention is proportionate to the level of harm or risk to the care recipient or others.

d. The least restrictive intervention is used.

e. The intervention is used for no longer than is absolutely necessary.

f. What is done, for what reasons, the outcome and any consequences are recorded in the care recipient's file and the care home's incident log.

8.6. The staff responsible for care supervision must review circumstances when restraint is used to determine if: alternative actions could have taken place or if changes in care practices or assistance to the care recipient is necessary to prevent the escalation of the behavior that resulted in a restraint.

8.7. Except in rare, time-limited emergencies, or for brief provision of essential care, no physical restraint is used that causes the resident distress (e.g. discomfort, anger, agitation, pleas for release, calls for help or attempts to remove the restraints).

8.8. The number of care recipients and incidents where restraint is used are recorded and reviewed by the care home to improve practices.

8.9. Unauthorized use of restraint is reported to Ageing and Disability Services (ADS). This does not include when a restrictive practice occurs briefly for the provision of essential care in accordance with this Standard unless instructed to do so by ADS.

a. Inappropriate use of restraints is a form of physical and psychological abuse and must be reported to ADS.

8.10. Care recipient records have appropriate documentation to uphold this Standard. This includes:

a. A physician order for the restraint
b. The specific medical symptom to be treated by the restraint
c. The steps taken to identify the underlying physical and/or psychological causes of the medical symptom
d. The alternative measures that were taken, for how long, how recently, and with what results
e. The evidence that a restraint will benefit the symptom
f. The risks involved in using the restraint
g. The specific circumstances under which restraint is being considered
h. The type of restraint; period of restraint; and location of physical restraint

9. Resident Money and Possessions

Standard:

Residents manage their own funds unless such has been delegated to another identified and authorized person.

Criteria

9.1. Delegation of the management of a care recipient's funds must be done in consultation with the resident and their relevant person recognizing any existing legal authority in place (e.g. receivership, power of attorney).

a. The care home must keep a record of the agreement to manage the resident's funds.
b. Up to date account records must be maintained of all residents' funds.
c. The residents, or their responsible person, may request and be shown their account information at any time.

9.2. The Administrator must maintain an up to date list of resident possessions (e.g. items of value, furniture)

10. Contact with Family, Friends, Community

Standard

Care recipients are able to, in consideration of the health, safety and wellbeing of persons in the home, receive visitors at any time and associate and communicate privately with people and groups of their own choice and initiative.

Criteria:

10.1. Care recipients' links with family and friends are encouraged and facilitated.

10.2. The care recipient can receive visitors in private, choose who they see and do not see, and their wishes are respected and recorded.

10.3. Care recipients are able to associate and communicate privately and without restriction with people and groups of their own choice, or initiative, at any reasonable hour. This requires:

a. No restrictions on visitors except when requested by the care recipient or when the visit or the timing of the visit is deemed to pose a risk to the health, safety or well-being of the individual or other care recipients.

b. If restrictions are assessed as necessary it is done in consultation with the care recipient and alternatives provided when possible. For example, if the dining room is too small to have visitors due to impact on residents; can the resident eat in their room with the supervision of the visitor?

10.4. Care recipients are not prevented from engaging in consensual intimate relationships.

a. Engagement in such relationships must respect the privacy and well-being of other care recipients.

b. For persons with diminished capacity see the capacity and consent guidelines in Appendix 4.

c. Staff must never pursue sexual relationships with care recipients.

10.5. Care recipients must have access to appropriate communication methods. These are:

a. A telephone for use in private.

b. Writing instruments, postage and stationary (at their own expense). Residents' mail is received promptly and unopened unless assistance is requested.

c. Access to a computer should be available when requested.

10.6. Links with and involvement of local community groups and/or volunteers in the care setting should be encouraged and maintained by the care home.

10.7. Care recipients have access to community information on local events (e.g. radio, television programs, newspapers, magazines, information via computer and a notice board, etc.).

11. Nutrition, Meals and Mealtime

Standard:

Residents receive a nutritious and varied diet appropriate to sustain or promote good health and wellbeing.

Criteria

11.1. A written food services and hydration policy is in operation.

11.2. Food and water is available to residents throughout the day to meet their needs. This includes:

a. At least three meals daily and snacks to residents at regular intervals.
   - Exceptions may be granted to the number of meals provided by the care home depending on the model of care of the home, capacity of residents and service contracts. The care home must apply to Ageing and Disability Services for any exceptions.

b. Drinking water must be readily available and offered continuously throughout the day.

11.3. Meals and food provided is nutritious, varied and suited to care recipients' individual needs. This requires the following:

a. A written meal plan is designed by or reviewed by a registered nutritionist or dietician and is followed.

b. The care recipient's nutritional, emotional, religious, cultural and therapeutic needs and preferences are reflected in the meal plan and/or a care recipient's individual menu.

c. The mini diet manual, provided by the Department of Health, is used to guide the provision of Medical Nutrition Therapy (MNT) meals.

d. Menus are revised a minimum of 2 times a year.

e. Menus should be posted for residents and staff to view.

11.4. Assessments occur upon admission for a care recipient and as required (in accordance with Standards 13 and 15) to determine any nutrition based care needs such as:

a. Dietary restrictions or allergies

b. Feeding challenges e.g. swallowing or chewing difficulties

c. GI feeding tubes

d. Oral supplement requirements due to risk of malnutrition or health needs

11.5. There must be a two week supply of food for care recipients in the care home at all times.

a. There should be, in addition to the two week supply of food, a two week emergency supply stored appropriately during Hurricane season.

11.6. There is a sufficient number of staff present to ensure meals are served on time and to offer assistance when necessary and manage risks when care recipients are eating and drinking. Assistance is offered discreetly, sensitively and individually.

11.7. Staff have the appropriate training and skills appropriate to their role to ensure safe food handling and meal preparation according to the level of care provided by the home and individual care needs and preferences.

11.8. Mealtimes should be viewed as social occasions; this includes:

a. Staff should be encouraged to participate in and view mealtimes as opportunity to communicate, engage and interact with care recipients.

b. Opportunities should be provided for the resident's family and friends to dine with them on special occasions.

c. The resident's family and friends should be supported to assist them during mealtimes.

11.9. When care recipients are suffering from memory loss or are disoriented regarding time the following should occur:

a. Where possible, care recipients should be involved in the tasks around meals and mealtimes and food is used as part of reminiscence work with them in conversation about food memories and likes and dislikes.

b. There is a selection of food and drink available at all times to ensure meals are available according to the care recipients' needs.

12. Activities

Standard:

An appropriate daily program of activities and recreational opportunities are available to care recipients

Criteria:

12.1. Staff, who plan, develop, coordinate and deliver activities have the necessary training and qualifications, as required, to meet the needs of the residents. (see Standard 19)

12.2. Up-to-date information on activities is provided to each care recipient in formats suited to their capacity and a record of activity provided is available for inspection.

12.3. Care recipients are supported to pursue their social, cultural, religious, spiritual and other interests and are given reasonable assistance by the care home in doing so. This includes, but is not limited to:

a. Residents are able to exercise their rights as a citizen if desired, e.g. participate in voting.

b. No religious practices or beliefs are imposed on any care recipient and their spiritual or religious needs are met, including:

- If requested by resident, or their relevant person, informing their clergy man of admission to the home.
- Allowing resident to attend religious service of their choice.

12.4. Activities programs provide daily opportunities for participation in meaningful and purposeful activity, occupation or leisure activities, both inside and outside the care home, that suit care recipients' needs, preferences and capacities (within the resources of the home). Particular consideration is given to care recipients with: dementia and other cognitive impairments; visual, hearing or dual sensory impairments; communication difficulties; physical or learning disabilities.

12.5. The opinions of the care recipients are considered in planning and providing activities and the program is responsive to their opinions and comments

12.6. Daily opportunities are given for appropriate exercise and physical activity.

12.7. Where the home, either provides or arranges personal choice services (e.g. hairdressing, manicures, massage) the person in charge must ensure the services are:

a. Offered and provided based on the needs and preferences of the care recipients.

b. Provided in a space that is appropriate for the purpose.

c. Provided by a person who holds the required license or training, if any, for the services.

C. Quality of Care

13. Assessments

Standard:

Each care recipient has their needs comprehensively assessed prior to admission and on an as required basis, to ensure the care home can meet their ongoing and changing care needs.

Criteria

13.1. A written policy outlining admission requirements and procedures is in operation.

13.2. The **Ministry of Health LTC Needs Assessment tool** is used to obtain a comprehensive assessment (see Resources). A comprehensive assessment includes:

a. Healthcare providers' information
b. Health Conditions- including those requiring RN intervention
c. Physical assessment- including risk assessments relating to: pain, falls and pressure sores
d. Medications- types, ability to self-administer, allergies and vaccination status and history
e. Nutritional status including: diet, eating and swallowing, dietary preferences
f. Communication and sensory needs- hearing, speech, vision, comprehension
g. Cognitive status- including personal safety, mood and behavior, capacity assessment (mini mental test score)
h. Mental health status- including personal safety, mood and behaviour
i. Functional abilities – ADLs and IADLs including determining:
    - personal care capacity – self-bathing/ feeding/ dressing
    - oral health and dental care needs
    - foot care
    - mobility and transfers
    - range of motion and dexterity
    - history of falls
    - continence
j. Social interests, hobbies, religious and cultural needs and preferences
k. Relevant persons involvement and other social contacts/relationships
l. Resuscitation status

13.3. Assessments are completed by a Registered Nurse (RN) or Medical Practitioner (MD). Other health care professionals may contribute to the completion of the assessment but the ultimate responsibility must be with an RN or MD.

13.4. Care recipients participate in and contribute to assessments, with the support of their relevant person(s) in accordance with the care recipient's wishes. Assessment findings

are communicated to the care recipient, and the appropriate relevant person when required, in accordance with their wishes and legal responsibilities.

Pre-admission

13.5. Necessary information relating to the care recipient's health, personal and social care needs is obtained prior to admission to ensure persons are admitted who can be cared for by the home. This must ensure:

a. No person is admitted to the care home where their health and safety needs cannot be met.

b. In the case of emergency admissions, this information is obtained as soon as possible after admission and no later than 72 hours.

c. There are protocols in place to ensure appropriate continuity of care upon admission.

On and subsequent to admission

13.6. A comprehensive assessment of the care recipient's health, personal and social care needs, is completed within 72 hours of their admission or sooner if necessary due to risks identified by the pre-admission assessment.

a. Some components of the assessment may require additional assessment by specific healthcare professionals (e.g. Physical Therapist or Nutritionist) these may be obtained as soon as possible outside of the 72 hour timeframe.

b. Residents assessed as intermediate or complex level of care must be assessed by a physician within 30 days of admission (if a physician did not conduct the assessment upon admission).

c. If the comprehensive assessment identifies potential conditions without treatment in place a referral to the GP/Medical Consultant must be made immediately.

13.7. The assessment is reviewed and recompleted as needed based on the care recipient's changing needs or circumstances but no less than once per year. Reassessment is required after:

a. The first 3months in a new care home.

b. There is significant treatment process, or lack thereof.

c. New symptoms are identified or significant medical changes occur.

d. Significant behavioral changes are observed.

e. A change in functioning.

Prior to discharge

13.8. A discharge policy is in place which ensures that notwithstanding the care recipient's freedom to discharge themselves from the care home, discharge decisions are based on an assessment and are in accordance with their care plan. This must include:

a. The care recipient is discharged from the care home in a planned manner and the discharge is discussed, planned for and agreed with the care recipients or their relevant person.

b. To ensure continuity of care, information concerning the care recipient's care needs and ongoing support by healthcare professionals is provided by the person–in-charge to the subsequent care provider, as appropriate.

14. Care Planning

Standard

Each care recipients has an up to date, personalized care plan, developed and agreed upon by them and their relevant person (as appropriate) and implemented by the care home in order to promote, improve or maintain their health, safety and wellbeing.

Criteria

14.1. The care recipient's comprehensive care planning is completed within 7 days of admission, or earlier if indicated by a general risk assessment or comprehensive assessment drawn up with the care recipient. An initial nursing and personal care plan must be in place within 48 hours.

14.2. The care plan reflects the assessment findings and sets out in detail the action to be taken by staff. **NOTE**- a care home may use multiple tools to create a care plan.

a. The care plan includes goals, desired outcomes, means to achieve such and identified staff responsible for the actions.

b. The care plan must be orientated towards:
- Maintaining optimal functioning and functioning levels (preventing avoidable declines)
- Managing risk factors
- Addressing resident strengths
- Using current standards of practice/clinical guidelines in the care planning process
- Evaluating treatment objectives and outcomes of care
- Respecting the resident's right to refuse treatment

c. The care plan must include the following key areas:
- Functional Status
- Rehabilitation/Restorative nursing
- Health Maintenance – physical and mental wellness; advanced care directives and end of life care
- Medications
- Daily care needs and preferences- ADLS and IADLS
- Allergies (medicinal, food, environmental etc.)
- Nutrition and Fluid

- Activities- physical, spiritual, creative etc.
- Personal and social relationships and engagements
- Memory enhancement and communication

14.3. The care plan is discussed, agreed, written and implemented with the involvement of the care recipient and/or their relevant person. If the care recipient is unable or unwilling to participate, this is documented. Care recipients with dementia/ cognitive impairment, are actively encouraged to participate in this process.

14.4. Care planning is documented, communicated and accessible to the care team and care is provided in accordance with the care plan. Any deviations from the care plan and the reasons for such are documented.

14.5. The care plan is formally evaluated by staff in consultation with the care recipient and their relevant person as appropriate. It is continuously updated based on the care recipient's changing needs and circumstances and current objectives for health, personal and social care. This includes:

a. Review and updating of care plans occurs at least every 6months (in the absence of any change of conditions or preferences) and any changes made to the care plan are documented immediately.

b. The care recipient and/or their relevant person has access to the care plan and is kept informed of changes.

14.6. A life story book is created for each care recipient with limited capacity, memory loss and/or communication difficulties to reflect information about their history, values, preferences and how best to engage with them. This information is reviewed annually and updated when new information is obtained as preferences and means of engagement change.

15. Health and Personal Care Services

Standard

The care home promotes and maintains care recipients' health and provides or facilitates access to health and personal care services that are person centered to meet assessed needs.

Criteria

Personal Care Services

15.1. Care recipients' personal care needs are monitored and met as required in accordance with their needs, health status, preferences and care home resources. This includes:

a. Staff encourage and support care recipients' capacity for self-care whenever possible.

b. Particular attention is paid to the following areas for residents:

- Hair – washed and groomed as preferred by resident
- Dressed in their preferred clean clothing
- Nails- cleaned and filed
- Feet – nails kept clean and filed
- Eye and hearing care- ensuring residents are using glasses or hearing aids
- Teeth and mouth- Oral hygiene care is performed daily for all residents as needed, including those who are tube fed. Dental appliances are cleaned and maintained regularly.
- Bathing and personal hygiene
- General grooming- shaving, make up, etc.

15.2. Any prosthetics and dental, ear or eye equipment that is ill fitting or unsuitable for the care recipients' use is identified by care staff and appropriate action taken. This includes:

a. Care recipients' relevant persons are notified as appropriate.

b. For residents, coordination with the required healthcare and/or equipment provider or an appropriate referral is made for assessment and replacement.

15.3. Any change in condition of the care recipient noticed during daily personal care by care staff is reported to an RN or the Nurse in Charge and documented. Additionally the nurse and/or Administrator must ensure the following:

a. Prompt and appropriate coordination and liaising with a medical practitioner or required health care provider.

b. Notification of relevant person, as appropriate.

Health Care Services

15.4. Policies and procedures that adhere to this Code and best practice guidelines are available to, and in operation by, staff for common conditions for the care recipients in the home (see Appendix 6).All care services provided by regulated healthcare professionals uphold the policies, standards of practice and codes of conduct/ethics stipulated by their respective health care regulatory bodies.

15.6. Where direct medical care services are not provided by the care home, the resident has an identified medical practitioner for regular and timely consultations, including after hours. Care recipients have the right to maintain their GP of choice in care facilities with medical care services.

15.7. There is ongoing monitoring and recording of the general health and welfare of care recipients in accordance with their individual care needs and level of care. This includes:

a. Care recipients' mental and emotional health and wellbeing are monitored regularly, assessed and preventive and restorative care is provided in line with best practice.
b. Residents with chronic diseases are seen by a medical practitioner every 3 to 6 months depending on the stability of their condition.
c. Nutritional screening by an RN is undertaken at least every 6 months, a record is maintained of nutrition, including weight gain or loss, and appropriate action taken including referral to a dietician or speech language practitioner for swallowing assessment when required.
d. Resident should be offered vaccinations as per the current *Bermuda Adult Immunization Schedule.* Facilities should obtain consent at admission and use standing orders for annual influenza vaccination.

15.8. For residents and respite persons, the appropriate care home staff promptly liaises with other healthcare providers to facilitate access to required services and notifies the care recipient's relevant person(s), when applicable. Health care providers include, for example:

a. Primary care: e.g. Medical Consultant, GP, Dentist
b. Secondary care: e.g. KEMH clinics e.g. wound care clinic; fall prevention; mood and memory
c. Specialist services: e.g. Geriatrician, Oncologist, Palliative Care practitioners, Dementia specialists
d. Allied health professionals: e.g. Podiatrist/Chiropodist, Occupational Therapists, Physical Therapists, Speech, Language Pathologists, Medical Social Work, Dieticians

15.9. A record is maintained of all external healthcare appointments, referrals, results and follow-ups for each resident in their file.

15.10. Appropriate staff assist residents to access assistive devices to meet their assessed needs (e.g. specialized wheel chairs, communication tools, etc.).

15.11. When a care recipient refuses any care or referral:

a. The refusal is documented in their file.
b. Their relevant person(s) is notified as appropriate.
c. Their GP and/or relevant health care professional is notified.

15.12. With the consent of the care recipient, sharing of medical information is allowed only to specified relevant persons. Relevant persons with legally assigned health care decision making authority must be fully informed of medical information.

Care coordination

15.13. To ensure care coordination and continuation, when care recipients are transferred to another care setting or receive services from an external provider the care home must have a policy and processes in place to facilitate care coordination. This includes:

a. When a care recipient requires transport to and from medical appointments, there are clearly understood arrangements in place for care recipients and their relevant persons for such transport including timing and responsibilities of all parties.

b. To ensure appropriate, up to date information is shared with the external providers and received from the external providers:

- A transfer form is sent by the care homes for care recipients moving to new care settings (including ER visits and moving to another care home).
- Care recipients' records and care plans are updated accordingly.
- When care recipients with confusion or dementia are transferred to another care setting, their life story documentation accompanies them.

16. Medications

Standard:

Safe medication practices and medication management policy and procedures are established and implemented to protect care recipients from risks associated with the unsafe use and management of medications.

Criteria

16.1. Medication policies and procedures are in place and upheld in accordance with legislation, this Code and best practice.

Preparation and Administration

16.2. Care recipients may self-administer medications when:

a. The risks have been assessed and their competence to self-administer is confirmed.

b. Any change to the initial risk assessment is recorded and arrangements for self-administering medications are kept under review.

c. Residents who store medication in their own room while self-administering, they must have a lockable space to store the medication, to which suitably trained, designated care staff may have access with the resident's permission.

16.3. Medication preparation and administration uphold scopes and standards of practice for health care professionals. This includes (but is not limited to):

a. A Registered Nurse, or pharmacist, is responsible to prepare all medication for care recipients requiring assistance in accordance with this Standard.

b. A Nursing Associate may, in accordance with their regulated scope of practice:
   - Assist a care recipient with taking their oral medication when pre-loaded by a doctor, RN or pharmacist;
   - Apply creams and lotions to intact skin.

c. Any medication to be administered via injection, feeding tube, or rectally must be administered by a Registered Nurse.

16.4. Medications are administered in accordance with the prescriber's instructions. All persons pre-loading, serving, administering or supporting care recipients in taking their medications must refer to the care recipient's medication record to ensure it is:

a. The right resident

b. The right medication

c. The right time and/or frequency

d. The right route

e. The right dose

Medication Recording and Reporting

16.5. Up to date records are kept to account for all medications in the care home. This includes:

a. Personal medication record (including for those self-administering) which includes:
   - Care recipient demographic and identifying information
   - Allergies to medications and contra-indications, if any
   - Prescription details: names of medications, doses, routes, forms, frequency, dates started and discontinued

b. The diagnosis which each medication is prescribed for

c. Last review date by medical practitioner for each resident

d. Medications administration chart for each care recipient- updated upon administration of medication.

e. Medications ordered and received

f. Medications transferred out of the home (e.g. to ER or another care home)

g. Medications disposal

h. The record format and requirements for controlled drugs must be in accordance with the Misuse of Drugs Regulations.

16.6. All medication errors, refusals, suspected adverse reactions and incidents are:

a. Recorded in the care recipient's file

b. Reported to the appropriate supervisor and medical practitioner; and

c. Reviewed by Administrator, Nurse Supervisor/Director of Nursing and staff to improve patient safety and prevent reoccurrence. Reviews should be done to in an open culture to encourage staff to report and learn from errors.

Medication Reviews

16.7. All residents medication treatment plans are monitored and the records updated as appropriate, including:

a. A minimum annual review by medical practitioner

b. A review by a medical practitioner after a significant change in condition or care

c. At least every 3 months by a medical professional for the following:
   - Antipsychotic medication
   - Sleeping tablets and other sedating medication
   - Anticonvulsant medication
   - Medication for the management of depression
   - Analgesic medications (pain management)
   - Medication for the management of constipation
   - Antiplatelet and anticoagulant medication (prevention of stroke)
   - Non-steroidal anti-inflammatory drugs

d. Use of antibiotics is monitored by the Nurse Supervisor/Director of Nursing to ensure proper use and effect.

16.8. Staff actively promote the care recipients' understanding of their health needs relating to medication.

Medication Storage and Disposal

16.9. Medications are safely and securely stored and disposed of in accordance with the manufacturer's instructions and the Pharmacy and Poisons Act 1979 and Regulations and Misuse of Drugs Act 1972 and Regulation. This includes but is not limited to:

a. Controlled drugs are stored in a locked cabinet with required records.

b. Consultation with pharmacist occurs to ensure proper disposal.

c. All medications must be disposed of properly when they are:

- Expired
- Showing signs of deterioration
- No longer required by a resident or resident is no longer at the care home
- Recalled by the drug manufacturer or regulatory authority

17. End of Life Care

Standard:

Each resident continues to receive care at the end of their life which meets their physical, emotional, social and spiritual needs and respects their dignity and autonomy.

Criteria

17.1. Resident's palliative care needs are assessed, documented and regularly reviewed. The information derived from these assessments is explained to, and options discussed at regular intervals with the resident, their relevant person, in accordance with the resident's wishes. This includes but is not limited to:

a. The resident's wishes and choices regarding end of life care are discussed and documented, and, in as far as possible, implemented and reviewed regularly with the resident. This includes their preferred place of care, religious, spiritual and cultural practices and the extent to which their relevant persons are involved in the decision making process. Where the resident can no longer make decisions on such matters, due to an absence of capacity, their relevant person is consulted.

b. In accordance with the resident's assessed needs, the appropriate care home staff facilitate coordination with specialist palliative care services so an integrated multi-disciplinary approach to end of life care is provided.

17.2. Staff are provided with training and guidance in end of life care as appropriate to their role.

17.3. The care home must be able to support end of life care so that the resident is not unnecessarily transferred to an acute setting except for specific medical reasons, and in accordance with their or their relevant person's wishes.

a. Every effort is made to ensure that the resident's choice for their place of death, including the option of a single room or returning home, is identified and respected, where possible.

17.4. The resident's family and friends are facilitated to be with the resident when they are very ill or dying. This includes:

a. 24 hour visiting, in consideration of roommates and space availability.

b. Upon the death of the resident, time and privacy are allowed for the relevant persons.

c. An atmosphere of peace and calm is maintained at all times.

17.5. There is a policy and procedure in operation by staff after the death of a resident in relation to the verification, certification, notification of death and support. This includes:

a. Physician called to home to certify death

b. Notification of relevant persons

c. Notification of the indicated funeral home (as appropriate)

d. The deceased resident's body must be treated with respect and dignity in accordance with their wishes, if stated, or in accordance with the wishes of their relevant person, and in accordance with the resident's cultural and religious beliefs and best practice.

e. Procedures are in place for the return of the care recipient's personal possessions in accordance with their wishes, in a timely and respectful fashion following death. The return of personal effects is formally documented and signed.

f. Upon the death of a resident, relevant persons should be offered practical information (verbally and in writing) on available bereavement resources and required next steps.

g. Following the death of a resident, support is provided to other residents and staff. Where residents would like to have a remembrance event, this is facilitated and attendance to services outside of the care home is also facilitated where possible.

h. Ageing and Disability Services is notified of the death in accordance with Standard 20.

18. Dementia Care

Standard:

Staff are able to recognize and respond appropriately to signs of dementia and the care provided reflects a person centered, strength-based approach to assessment, care planning and service provision and promotes the right to self-determination.

Criteria

Recognizing the signs of dementia and responding to need

18.1. Staff demonstrate awareness of the signs, symptoms and disabilities associated with dementia and know how to seek further advice and assistance on how to effectively support a care recipient who is experiencing difficulty with:

a. Memory
b. Communication
c. Delirium
d. Visual perception- recognition and co-ordination
e. Orientation
f. Changes in behavior, judgment & moods
g. Completion of daily life skills
h. Nutrition and hydration

18.2. The following must take place when a care recipient displays the signs or symptoms of dementia:

a. The appropriate staff liaises with required healthcare professionals to access a thorough assessment in a timely manner.
b. The relevant person is notified.
c. The person in charge ensures staff obtain the necessary professional help and guidance to determine if and how they can provide the care recipient with appropriate care. This requires the care home to actively facilitate and maintain links with local resources that can provide support to individuals and groups.
d. When a care recipient is diagnosed with dementia, this is handled sensitively and they and their relevant persons are offered access to timely and appropriate information, resources and support.

Approach to Care

18.3. Care recipients with dementia are supported to make choices and decisions about their lives and how their care needs will be met in a manner that recognizes their choice, capacity and safety (also see Standard 2, Appendix 4 and 5). This includes but is not limited to:

a. The resident is provided with appropriate support to settle into the home, to promote orientation and feelings of safety and security (e.g. through a "buddy" system).
b. Care recipient's decisions and how they were made are noted in their file.
c. Care recipients' right to make decisions and choices are respected and staff work to ensure they understand the consequences of decisions made, but do not undermine their right to make such choices. Staff recognize that a person with dementia may have fluctuating capacity.
d. Staff respect the care recipient's rights to decline or refuse a care intervention whilst considering the overall outcome for them and other residents.
e. Staff work in partnership with relevant persons, sharing information as appropriate and recognizing their valid feelings about the resident's move to the home and changing care needs as dementia progresses
f. Care recipient's daily routines are built around their preferences and choices as far as possible and accommodate instances where activity level or behavior may change according to the time of day.

18.4. Staff understand and demonstrate knowledge of approaches to promote effective methods of communication with care recipients in various stages of dementia, including advanced stages. For example:
a. Alternative forms of communication such as music, song and touch are used appropriately.
b. Pictures or other means of communication (e.g. tools and strategies) are used to discuss and make decisions where and when appropriate.
c. Staff choose the most appropriate environment and time of day to discuss choices and decisions with residents.

18.5. The use of anti-psychotic medication for residents with dementia must uphold this Code of Practice. This includes ensuring the appropriate staff under the guidance of a Registered Nurse:
a. Are aware of potential side effects such as physical deconditioning, incontinence, distress/agitation, and rescued skin integrity.
b. Ensure other issues including infection, constipation, hydration, poor hearing or eyesight and pain are not masked by the effects of the medication.
c. Work with prescribers to ensure regular medication reviews with a view to reducing medication as per best practice guidance.

18.6. Staff have a knowledge and understanding of:
a. The range of distressed behaviour that may be experienced (including but not limited to walking or pacing/activity disturbance; refusing help and assistance; being withdrawn; repetition; difficulties with continence; and sexual expression).

b. The reasons why such behaviour may occur.
c. How to respond appropriately (in accordance with other sections of this Code and guidelines in Appendix 6).

18.7. Strategies are in place to understand and respond to distressed or challenging behaviour in a caring and supportive manner in accordance with Standard 7 Managing Challenging Behaviours. These strategies must include:

a. A record is kept of all distressed behaviours to identify triggers and patterns in order to support the understanding of the unmet need being communicated through the behaviour.
b. Care plans and risk management plans are amended to reflect the agreed strategy.
c. The agreed strategy is communicated to all staff, care recipients and relevant persons and is regularly reviewed.
d. Staff recognize the care recipient's right to privacy and acknowledge sexual expression as part of normal adult behavior. Staff explore physical or emotional reasons behind sexualized or inappropriate behaviour and respond with empathy in a manner that respects the resident's feelings and dignity whilst managing the situation.

19. Staffing

(I) Minimum Staffing Levels

Standard

At all times the type of staff, numbers and ratios of staff on duty, including management, direct care staff, food and housekeeping service staff meets the assessed care, social, and recreational needs of care recipients; taking into account the size and layout of the home, the model of care, organizational structure, fire safety requirements and legislation.

Criteria:

19.1. Care homes must have (but are not limited to) the positions listed below. A care home may have one person fulfilling multiple roles depending on their qualifications, responsibilities, and the number of care recipients, organizational structure and the layout of the home; however, this must be pre-approved by Ageing and Disability Services.

a. An Administrator responsible for day to day operations
b. A Deputy Administrator to fulfill role of administrator when absent
c. A medical consultant for residents without a GP
d. Registered Nurse as a Director of Care for Nursing Homes
e. Registered Nurse as a Supervisor of Care for Residential Care Homes
f. Activities Coordinator
g. Direct care staff to meet care needs of care recipients
h. In accordance with the Code, consultation with required health care professionals (e.g. Nutritionists, dementia care specialists)

19.2. There are sufficient numbers of staff to ensure that all Standards relating to the operation of the care home including care provision, management, food services, maintenance, housekeeping and laundry are upheld. This includes ensuring adequate on call staff availability.

19.3. A planned and actual 24/7 staff schedule, showing all staff on duty must be maintained and available.

a. Scheduling of fulltime, part time and on call staff ensures persons on shift are familiar with care recipients, their needs and the operation of the care home to enable person centered care and to uphold the Standards in the Code.

Required types and numbers of direct care staff

19.4. In case of emergencies and to meet care needs of residents:

a. There must be a minimum of two staff, on site, at all times, regardless of the total number of residents and care needs. One of the two must always be a registered healthcare professional (e.g. Registered Nurse, Nursing Associate).

b. Overnight staff must be onsite and awake.

19.5. Direct care staff must be employed in sufficient numbers and skills levels to meet the care needs of the care recipients. This requires:

a. A minimum ratio of one direct care staff to ten residents (1:10) is maintained when **ALL** residents are ambulatory and orientated; e.g. they can call for help and evacuate the premises with no assistance.

b. When **ALL** residents are not ambulatory and orientated, the number and type of direct care staff to residents must increase from 1:10 to meet the residents' individual care and safety needs. To determine the required staffing level:

- A comprehensive assessment is used to assess the level of care and develop the care plans required by each care recipient. See Appendix 3 for the Levels of Care.
- Based on the care recipient's levels of care and specific care plan, the estimated minimum hours per resident in Table 1 is used to calculate the required staffing levels and skill mixes. Overall staffing levels must ensure:
  - They meet highest level of care required in the home with residents with different levels of care
  - They adapt to changing care needs
  - Supervision, oversight and scheduling requirements are met
  - The layout of the care home is taken into account

Table 1:

Level of Care	Estimated minimum hours of direct care per resident and minimum RN oversight requirements
Personal Care	• 1-2 hrs/day of care services* • RN- minimum on site hours determined by number of residents, care needs and supervision role.
Intermediate care	• 2.5 hrs/day of nursing care**; 0.5-1.5 of the hours are by an RN • An RN must be on site for 10 hours per day, 7 days a week and on call for the remainder of the day
Complex Care	• 4 hrs/day of nursing care; 1.6 of the hours are by an RN • An RN must be on site 24hours per day, 7 days per week

*Care services include services provided by Registered Nurses, Nursing Associates and Caregivers.
**Nursing Care – refers to care services provided by Registered Nurses and Nursing Associates.

19.6. Exceptions to the minimum staffing requirements may be **pre**-approved by Ageing and Disability Services based on the care needs of care recipients, health and safety risks and the care home.

(II) Recruitment and Roles

Standard:

The recruitment of staff and volunteers and the assignment and fulfillment of roles ensures the protection, safety, health and wellbeing of care recipients.

Criteria

19.7. Care home staff have the appropriate qualifications, experience, character, and physical and mental health to fulfill their roles and responsibilities in accordance with this Code and relevant legislation and policy (see Appendix 7).

a. No person convicted of senior abuse may be a care worker for seniors and/or manage or have a financial interest in any home or other institution that cares for seniors.

b. Care homes are compliant with the Registrar General's Vulnerable Person Policy as required.

c. No staff can provide treatment or care to clients while suffering from a physical or mental impairment, disability, condition or disorder (including an addiction to alcohol or a drug, whether or not prescribed) that places, or is likely to place, care recipients at risk of harm.

d. Staff diagnosed with a contagious medical condition must follow advice from a suitably qualified health practitioner on the necessary steps to modify their practice to avoid the possibility of transmission.

19.8. All staff have written job descriptions and a copy of their terms and conditions of employment prior to commencing post. Including:

a. Job qualifications

b. Scope and responsibilities of the position

c. Self-disclosure requirement for any regulatory action against the employee, or criminal convictions once employed.

19.9. Staff are assigned duties that are consistent with the job specifications for their position, their scope of practice and competencies in accordance with any professional regulation, legislation and this Code of Practice.

19.10. Staff conduct ensures the safety and wellbeing of residents. In addition to the other Standards in this Code, this includes:

a. Operators and staff must never pursue a sexual, exploitative or other inappropriate relationship with a care recipient.

b. Staff must never work under the influence of alcohol or unlawful substances.

19.11. To ensure both care recipients and staff safety, operators have a policy requiring care staff to report if and when they have outside employment to prevent scheduling a person without adequate rest.

a. No staff in a care home should work more than 16 hours per day, (including outside employment) as there should be a mandatory 8 hour rest period.
b. No staff should work more than 60 hours in a 7 day period including one day off in that 7 day period.

19.12. To ensure maintenance of resident and staff health the following should be in place:
a. Policies for managing employee and volunteer illness including:
- Prompt reporting of signs and symptoms of potentially communicable disease by the employee/volunteer to a supervisor
- A non-punitive work-exclusion policy discouraging staff/volunteers from coming to work with signs or symptoms of communicable diseases (e.g. cough, rash, and diarrhea) until clearance to return to work is given by a physician.

b. Staff records indicate any employee exposure to blood or body fluids or communicable diseases.
c. The Administrator should maintain an up to date written record of the employee's current immunization status.
- Employees should have current immunization as recommended for healthcare workers by the current *Bermuda Adult Immunization Schedule.*
- It is recommended that all employees obtain the influenza vaccine annually, with care home documentation of receipt or declination.

19.13. Volunteers are vetted appropriately to their role and level of involvement in the care home and receive appropriate supervision and support. Their roles and responsibilities are set out in a written agreement between the care home and the individual.

(III) Training and Supervision

Standard

Staff are adequately trained for their roles and responsibilities and obtain ongoing training and supervision.

Criteria

19.14. Ongoing staff supervision, appraisal and individual training occurs to ensure staff:
a. Meet the specific and changing needs of their care recipients (e.g. dementia care; support to persons with intellectual disabilities etc.).
b. Fulfil the aims and philosophies of the care home and the Bill of Rights for Persons in Care.
c. Understand and adhere to the Code and policies and procedures of the care home and other regulatory bodies.
d. Are suitably competent to carry out their role.

19.15. All newly appointed staff receive a structured orientation that at a minimum includes:
   a. Overview of the philosophy, programs, policy and procedures of the care home
   b. Introduction to and overview of care recipients
   c. Review of the Code of Practice

19.16. The Administrator ensures all on site staff complete the required mandatory training every two years. Additional training may be required depending on the specific care needs of residents and care staff qualifications. See Appendix 7 for mandatory training requirements.

19.17. All staff are supervised on a regular basis pertinent to their role to assure their competency. Supervision includes both visual observation and verification of documentation.
   a. Nursing Associates and caregivers receive appropriate supervision from a Registered Nurse, evidence of supervision is documented.
   b. Staff receive in-service training or are referred to external training when determined as necessary by their supervisor.

19.18. Annual appraisals are completed for all staff by their respective supervisors.

19.19. Staff records indicate completion of training, appraisals and supervision.

(IV) Staff Records

Standard:

Secure, accurate and up to date records are kept in relation to persons employed by, or volunteering for, the care home.

Criteria

19.21 All staff and consistent, ongoing volunteers have the following information relevant to their roles and responsibilities in their staff record:
   a. Demographic and contact information
   b. Particulars of education, training, experience and previous employment
   c. Ongoing supervision, appraisal, training and professional development, as required
   d. Evidence of current professional license, qualifications, character references, medical certification and criminal record check as required (see Appendix 7)

20. Mandatory Reporting

Standard:

Mandatory reporting requirements within care homes and to external agencies occurs in a timely and appropriate manner.

Criteria:

20.1. A mandatory reporting and incident policy is in place and in operation.

20.2. Ageing and Disability Services (ADS) is notified by the appropriate staff member at the care home in the following circumstances:

a. Any suspected or reported abuse of a care recipient
b. Any incident resulting in injury, ER visits, hospitalization or death of a care recipient (including death suspected or related to communicable disease)
c. Unauthorized and inappropriate use of restraint
d. Missing persons
e. Changes to the Administrator or Deputy Administrator
f. Any regulatory or legal action that may impact the operation of the care home and the health, safety and wellbeing of care recipients (see Resources)

20.3. An incident log is maintained by staff to record incidents at time of occurrence, in addition to documentation in the care recipient's record. Incidents include, but are not limited to:

a. Hospitalization
b. Accidents
c. Dangerous falls
d. Missing persons
e. Unexplained injury
f. Suspected abuse
g. Unusual occurrences
h. Fire

Information recorded must include:

a. Care recipient(s) name
b. Date, time and location of incident
c. Staff involved in incident and staff on duty at the time
d. Names of witnesses to the incident
e. Type of incident
f. Action taken by person on duty including: immediate intervention; reporting to supervisor, GP and responsible persons; mandatory reporting (to whom and when); Signature of reporting person

20.4. Weekly bed status statistics and annual statistical reports are submitted to ADS in the required format.

20.5. Ageing and Disability Services may request additional or updated reports from care homes for purposes of compliance monitoring.

21. Quality and Risk Assessment

Standard:

Processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided and mitigate risks relating to the health, safety and welfare of care recipients and others at the care home.

Criteria:

21.1. The Administrator and appropriate staff review individual serious incidents and areas of non-compliance with the Code and make changes to policy and practice when required to mitigate risk and improve quality care. Reviews must use all available information at the time including:

a. Appropriate professional and expert advice and best practice standards
b. Inspection reports
c. Investigations into staff conduct by a regulatory body or the Senior Abuse Registrar
d. Standards, criteria and guidance issued by the Ministry of Health (e.g. the Code of Practice)
e. Information collected as part of care recipient and staff records (clinical, administrative etc.)
f. Complaints, comments and suggestions of care recipients and their responsible persons

21.2. The following data is collected by the care home and reviewed for quality improvement and to address identified risks:

a. Level of care of each care recipient
b. Incidences of infectious and communicable diseases
c. Incidences of chemical and physical restraints (both planned and emergency, including type of restraint)

The following data should also be collected and reviewed in addition to the above:

- Incidences of urinary tract infections
- Incidences of pressure sores
- Incidences of falls
- Transfer to emergency rooms and hospital admissions

21.3. Ageing and Disability Services may request reports on how quality improvement and risk assessment is occurring and any plans for improving services to ensure care recipients' health and welfare.

D. Quality of Management

22. Statement of Purpose

Standard:

A statement of purpose is in place that describes the care home's structure and operation.

Criteria

22.1. The Statement of Purpose must be submitted for the initial registration of a care home.

22.2. Every home has a Statement of purpose that includes:

a. The aims and objectives of the home, including their philosophy of care
b. The total number of rooms and size of rooms
c. The intended number of residents and day care program participants (if any)
d. The name and address of the registered operator and Administrator
e. The number, relevant qualifications and experience of the staff in the home
f. The organizational structure of the home
g. The demographics of the care recipients to be admitted to the home
h. The care needs of the care recipients to be met by the home (including level of care)
i. Admission criteria for care recipients including policy and procedure for emergency admissions
j. Details of any specific therapeutic techniques or specialized services
k. Fire, disaster and emergency procedures
l. A list of key policies that inform practice in the care home

22.3. The day to day operation of the care home reflects the statement of purpose and functions.

22.4. Before any changes are made which affect the purpose and function of the care home, Ageing and Disability Services is notified and consulted to determine if reassessment is required and/or changes to their license (including attaching or changing conditions).

23. Financial Management

Standard:

Care recipients' health, safety and wellbeing are protected and ensured through the accounting and financial procedures of the care home.

Criteria:

23.1. Suitable accounting and financial procedures are in place to demonstrate financial viability and to ensure there is effective and efficient management of the home. This includes but is not limited to:

a. Management accounts are kept and available for inspection. This includes at a minimum:

- An income statement and a balance sheet. Additional financial details may be required or an internal audit on a case by case basis.

b. There is no co-mingling of personal and business accounts. This includes:

- Operator's personal or other business account(s) with the care home business account(s)
- Residents' personal funds held by the care home with the care home's business accounts (see also Standard 9).

c. Insurance coverage should be in place to cover loss or damage to assets and to provide for interruption costs.

d. A current business and financial plan for the care home should be maintained, as is required for initial registration.

24. Record Management

Standard:

Secure, accurate and up to date care recipient records are maintained for care recipients including administrative and medical records.

Criteria

24.1. Each care recipient has an up to date administrative record kept in a secure location that includes the following:

a. Demographic information
b. Admission and discharge dates and circumstances
c. Service contract
d. Contact information for relevant persons and healthcare professionals (phone and email)
e. All legal or specified delegation of authority regarding personal, financial or health care requirements

f. The financial arrangements and accounts pertaining to their use of services and any funds held on the care recipient's behalf
g. All belongings brought into the home by or for the specified care recipient
h. Complaints, concerns, reports and recommendations from or regarding the care recipient by the care recipient, relevant persons or other agencies
i. Life history and current social, cultural, recreational preferences, interests and dislikes, including religious affiliation and the name and contact information for their clergyman when applicable
j. A current photograph of the care recipient

24.2. Each care recipient has an up to date medical record, kept in a secure location accessible to appropriate staff. The record must include the following information:

a. Demographic information
b. Contact information for relevant persons and healthcare professionals
c. Pre-admission and ongoing assessments
d. Pre-existing and ongoing medical conditions (as needed for day care attendees)
e. All orders, referrals, special examinations, progress notes and recommendations of care by healthcare professionals (as needed for day care attendees)
f. Daily care records of persons' health, condition and treatment, as required based on care needs and in accordance with practice standards
g. Care plans including details of any plans regarding personal care, nursing care, specialist health care, nutrition (as needed for day care attendees)
h. Medication records and medication errors
i. Any refusal of consent for care or treatment
j. Condition on discharge
k. End of life care preferences and requirements
l. Date, time and cause of death (when known)

24.3. Records must be kept in appropriate storage locations based on information contained within and intended use. This includes:

a. Residents' financial information is kept in a locked location and is only accessible to administrative staff.
b. Medical Records are kept in location that is accessible to appropriate care staff.
c. Medical records are maintained for a period of 6 years from the date of discharge or death of a care recipient.

25. Policies and Procedures

Standard

Policies and procedures are up to date, in operation and stored in an accessible location for respective staff, care recipients and relevant persons.

Criteria:

25.1. All policies and procedures are written in clear language for staff and stored in a location accessible for staff.

25.2. Care recipients and their relevant persons are provided access to all policies and procedures.

25.3. The following are the minimum required written policies and procedures for all care homes:

a. Admission, discharge and care coordination for residents
b. Medication administration, management, storage and disposal
c. Protection, detection and reporting of abuse
d. Managing challenging behaviours
e. Use of restraints and restrictive practices
f. Complaints and suggestions
g. Mandatory reporting and handling of incidents which include prevention and intervention procedures for incidents
h. Contingency Plans - Hurricanes, Labour, and Fire Safety
i. Food services and Nutrition
j. Infection control
k. Best practice clinical guidelines for common conditions in the care home
l. Confidentiality
m. Death of a care recipient

E. Quality of the Physical Environment

26. Physical Environment

(I) Comfort and Access

Standard:

The physical environment of the care home is comfortable for care recipients and meets their needs and abilities.

Criteria:

26.1. The general design and furnishings meets the needs and abilities of its care recipient's residents. This includes but is not limited to:

a. The building, exits and surrounding areas (e.g. driveways, parking lots) are accessible for persons with limited mobility.

- Ramp designs comply with American Disability Act (ADA) Standards (see Appendix 8).
- Any new building and renovations are compliant with Bermuda Building Code requirements for accessible design as required.

b. Handrails are installed, secure and appropriate for the residents on all ramps and stairways (internal and external). Handrails may also be required in hallways depending on assessment.

c. Homes providing dementia specific services must take into account design elements to assist their orientation. Care homes with care recipients with dementia remove identified design features that contribute to disorientation or safety concerns as appropriate (e.g. the number of care recipients with dementia, the impact on quality of care and quality of life, and care home resources).

Community Space

26.2. There is adequate social and recreational community space for all care recipients including: living room, recreation room and dining room. This must ensure:

a. The total community space is at least 25 feet square per care recipient.

b. Space is accessible for persons with assistive devices

c. Furniture is appropriate to needs of care recipients:

- Height of table, chairs and sofa for easy sitting and rising
- Chairs- armrests and firm seats

d. There are no tripping hazards (e.g. carpets, throw rugs)

Lighting

26.3. The home has adequately lighting, this includes but is not limited to:

a. The lighting system is designed, equipped and maintained to avoid high brightness, highly reflective surfaces and glare.
b. At least 60 watt bulbs are used for lighting fixtures.
c. Nightlights are in bathrooms, hallways and resident bedrooms.
d. Outside entrances are well lit at all times they are likely to be in use.
e. All stairs and steps are well lit.
f. All window sills in rooms occupied by residents are not more than three feet from the floor.

Bedrooms

26.4. The bedrooms are equipped for the comfort and accessibility of residents. The following is provided in accordance with the residents' specific needs:

a. Bed suitable to the needs of the care recipient. Nursing homes must have hospital beds (i.e. height adjustable with bed rails)
b. Bedside table or cabinet with lockable storage space – if not lockable an alternative lockable location for valuables
c. Individual reading lamp (60 watt bulb)
d. Comfortable armchair appropriate to resident needs
e. No caster or rolling furniture unless with working locks
f. Sufficient storage space for personal clothing and effects
g. Night lights
h. No scatter rugs
i. If keys are provided, staff must have access to duplicates for housekeeping and emergencies

26.5. All bedrooms must meet the following room design criteria for the comfort and accessibility of the resident(s):

a. There must be no more than three people to a room.
    - There should be a maximum of two persons sharing a room. Three should only occur as an exception when there is sufficient space and design to maximize privacy.

b. Minimum space per persons (excluding closets, toilet rooms, wardrobes, furniture and vestibules):
    - single rooms- 120 square feet
    - double & triple rooms- 90 square feet

a. Minimum total room dimensions (excluding closets and toilets):
    - Single and double rooms minimum wall lengths: 10 feet by 12 feet
    - Triple rooms: no single wall is less than 12 feet.

b. Minimum of three feet between the beds and the window and heating elements
c. At least one window and an egress to the hallway
d. At least one light must be accessible from the door

See Appendix 8 and Resources for information on wheelchair accessibility.

Bathrooms

26.6. There are a sufficient number of bathrooms for care recipients that meet the needs of the care recipients. At a minimum, each care home must have at least:

a. One functioning wash basin and toilet for every four residents
b. One bathtub for every six residents
c. At least one bathroom is accessible and useable to residents in wheelchairs in accordance with the current American Disability Act standards and International Code Council Accessible and Usable Building and Facilities Standards *(*see Resources and Appendix 8*)*. Additional accessible bathrooms may be required based on care needs and number of residents.
d. In care homes with more than 20 residents, there must be a toilet and wash basins near the community space.

26.7. Bathrooms meet minimum design requirements to ensure accessibility and safety for care recipients. This includes:

a. The minimum size for a room with only a toilet is 3 feet by 6 feet
b. All doors to any bathroom must:
    - Be at least 3 feet wide
    - Have fittings that are operational from inside and outside
    - Not open directly onto any dining room, kitchen, pantry, food preparation or storage room
c. Fittings and furnishings support accessibility and ensure safety of care recipients. This includes:
    - Raised toilet seat for persons with lower limb muscle weakness and arthritis
    - Shower bench or seat with handheld shower wand
    - Grab bars in all bathrooms and toilets in accordance with American Disability Act standards
    - Handrails sturdily mounted on walls in accordance with American Disability Act standards
    - Simple to use faucets in all bathrooms (i.e. faucet levers, no spring loaded or pressure operated faucets)
    - Non-skid surface in tubs
    - No glass doors on showers
    - No throw rugs
    - Disposable hand towels

Outdoor and surrounding environment

26.8. A secure outdoor area is available and accessible to care recipients. The outside and surrounding environment must be:

a. Free from hazardous and noxious smoke and fumes
b. Where possible, away from loud and irritating sounds
c. Without hazardous surroundings including cliffs and bodies of water unless suitable structures provide safety for residents e.g. walls, gates, fences
d. Designed and equipped for care recipient comfort and accessibility, for example: sufficient shade, appropriate seating, ramped if required

(II) Clean and Safe

Standard

The internal and external structure, environment and plant are maintained in a clean and safe condition for care recipients.

General

26.9. The structure of the building is maintained in a good condition and free of hazards. This includes but is not limited to:

a. The care home is kept weatherproof and dry. This includes ensuring the ceilings, walls and floors are free of damp, mold or moisture.
b. Doors and windows are functioning, in good condition and lockable.
c. Floors, stairs and ramps throughout the care home are in good condition.
d. Exists and surrounding areas (including driveways and parking lots) are maintained.
e. All electrical outlets are covered appropriately and in good repair.
f. All hazardous materials are locked away from care recipients.

26.10. The equipment, plant and furnishings are maintained in a clean and safe condition. This includes but is not limited to:

a. The furniture in the care home is in good condition and easily cleaned.
b. The care home is appropriately maintained in a clean condition. This requires:
    - Regularly scheduled routine housekeeping in accordance with infection control requirements (see Standard 28).
    - A supply closet on each floor which is locked and contains a sink, shelves and sufficient space for storing housekeeping and cleaning supplies
c. All elevators or elevating devices are maintained in good working condition with up to date service certificates.

Heating and Ventilation

26.11. The home is adequately heated and vented, this includes but is not limited to:

a. Homes are compliant with the Bermuda Building Code and International mechanical code standards.
b. Every home is well ventilated through windows, forced air or both.
c. Heating and cooling systems are located to prevent drafts to residents.
d. Air filters are provided in AC units and all air conditioning equipment is maintained in accordance with manufacturers' recommendations (including filter cleaning and refrigerant top ups etc.). Maintenance records are to be available upon request.
e. All windows can be opened.

Sanitation & pest control

26.12. The home has appropriate sanitation in place which includes but is not limited to:

a. Garbage containers are structurally sound, clean, and adequate for their use and garbage is stored in a clean and appropriate area.
b. Cesspits have sufficient capacity for the projected wastewater flows in accordance with the Bermuda Building Code 2014, where appropriate.
c. Cesspits or septic tank systems are in good condition and in accordance with the Bermuda Building Code 2014.

26.13. The home has effective pest control in place including, but not limited to:

a. There are no conditions that support the breeding of pests e.g.: Dry good storage adequate to prevent rodent/pests.
b. Entry of pests into the care home is prevented by screened windows and doors that are in good condition.
c. Records of treatment for pest control are maintained by the care home and available upon inspection.

Water supply

26.14. The home must ensure the water catchment, storage and supply are in good condition. This includes but not limited to:

a. The catchment (roof) is kept in good condition, clean and free of debris.
b. Tanks are cleaned every 6 years minimum (or as often as necessary due to contamination).
c. The tank overflow and all drain water leaders are appropriately screened to prevent the intrusion of organic matter.
d. There must be no cross contamination of other water source (e.g. well water) with potable water supply.
e. If supplemental water supply (well or piped) is required it is well maintained.

f. All water used for consumption meets the Department of Health standards for potable (drinking) water.

g. There must be an adequate supply of hot water for residents available at all times.

h. For sinks, showers and bathtubs used by residents the water temperature must not exceed 110F.

26.15. An approved continuous water disinfection treatment system should be in place to maintain Department of Health water testing standards at all times and maintenance records kept accordingly.

Laundry

26.16. Laundry is handled (collected, transported, sorted, washed and dried) to minimize contamination including, but not limited to:

a. Personal laundry is handled separate from bed linens

b. Soiled linen is:
- Taken to a designated dirty laundry storage area in closed hampers or bags.
- Never taken through food storage or prep areas.
- Kept separate from clean linen at all times.
- Collected and distributed in separate carts from clean linens.
- Kept in identifiable bags.

c. Laundry workers wear an identifiable uniform used only while doing laundry.

Kitchen

26.17. The kitchen has adequate food storage including:

a. There is appropriate storage space for food that is separate from all cleaning products and chemicals.

b. Refrigerator and freezers are clean and free of mold.

c. Temperature and storage of foods is safe for their preservation. This includes:
- Food is stored in the manner and location recommended by the producer.
- Refrigerator temperature is maintained at below 40 degrees Fahrenheit minimum.
- Freezer temperature is maintained below 0 degrees Fahrenheit.

26.18. Kitchen sanitation equipment and processes are in operation including:

a. There is appropriate food safety apparel (gloves, hair nets, aprons) are available and in use.

b. All surfaces and equipment are clean and food contact surfaces sanitized.

c. All utensils and equipment are washed after each use and drained to air dry (no cloths are used).

d. Equipment is available and functioning that washes all utensils and equipment for food and drink preparation, cooking and serving. This includes:
    - Triple sink for ware washing, unless otherwise approved by an Environmental Health Officer
    - Separate single hand washing sink
    - A separate water supply that is greater that 180F must be used for dishwashing unless a chemical sanitizer is used.

26.19. The kitchen design and equipment ensure clean and safe food preparation. This includes, but it not limited to:
    a. There is adequate, clean space for preparing food.
    b. All cooking units are hooded and vented according to International Mechanical Code (under the Bermuda Building Code) and in safe and good working order, unless otherwise approved by Environmental Health Officer.
    c. All catering equipment is kept in a location to ensure residents' safety, guarded where necessary, and maintained in a safe operating condition (e.g. electrical).

27. Health and Safety

Standard:

Care homes provide safe and healthy environments for staff, care recipients and visitors in accordance with requirements under legislation.

Criteria

27.1. No smoking is allowed inside a care home. Staff are not allowed to smoke on the property. Residents may smoke on the property in accordance with Department of Health policy.

27.2. Care home vehicles are roadworthy, insured and are only driven by staff with the appropriate driving license. A record is kept of maintenance checks. All incidents occurring during transport are reported and recorded in the incident book and reported to the appropriate management and authorities.

27.3. Contingency policies are in place for the following:
    a. Hurricanes
    b. Labour dispute plan (to ensure adequate staffing levels are maintained)

27.4. Staff are provided a reasonable functional working environment which includes and is not limited to:
    a. Adequate staff supplies, protective clothing and equipment suitable for their responsibilities and to prevent risk of harm or injury to themselves or others.

This includes but it not limited to the following being readily accessible in resident care areas:

- Personal Protective Equipment (PPE) (e.g. gloves, gowns, masks)
- Supplies for safe injection practices (e.g. single use lancets, sharps containers)
- First Aid supplies

b. Adequate working space for staff and areas exclusive to staff including a designated staff room, toilets and shower facilities.

27.5. An appropriate quantity and quality of equipment is available to meet residents' care needs. This includes, but it not limited to:

a. Required clinical care tools for health assessment and monitoring (e.g. digital scale, blood pressure equipment)
b. Hoists and lifts for all nursing homes. Other care homes must provide hoists and lifts as necessary for care recipient needs and staff safety
c. Defibrillator
d. Standard wheelchairs and walkers for unexpected changes in care recipients' mobility
e. Slide sheets
f. Gait belts

27.6. All equipment in the care home is maintained in accordance with manufacturing requirements including documentation of ongoing required calibration and service certificates. Staff are appropriately trained to use equipment as acquired and on first appointment.

27.7. In general, homes are required to be compliant with the Occupational Health and Safety Act and Regulations 1999. This includes requirements for a Health and Safety Committee or representative, annual accident reporting and associated policies, procedures and documentation.

28. Infection Prevention and Control

Standard:

An Infection Prevention and Control Program, in compliance with all relevant legislation, to prevent the development and spread of disease and infection is in place and maintained.

Criteria:

Administration

28.1. A qualified staff member (e.g. a Registered Nurse), familiar with the care recipient population, is responsible for overseeing and monitoring infection control activities in the care home. This includes the following components:

a. Surveillance
b. Outbreak control
c. Isolation and precautions
d. Care recipient health (see Quality of Care section)
e. Employee education

28.2. Care home staff from each key infection control area (e.g. nursing, housekeeping, kitchen, laundry) review Infection Prevention and Control (IPAC) within the care home at least every three months. This review can occur at a staff meeting. The review must include:

a. Review of infection control data
b. Recommend and review IPAC policies and procedures at least annually
c. Monitoring of infection prevention and control activities and making adjustments as required

28.3. Written Infection Prevention and Control policies and procedures are available and based on evidence-based guidelines and in accordance with Office of the Chief Medical Officer's (OCMO) policies.

28.4. Consultation must be sought as needed with an infectious disease physician or other professional with relevant expertise.

Facility

28.5. Areas in the care home with unique infection control concerns should have the appropriate policies and procedures in operation. These include: kitchen, laundry, physical therapy and infectious medical waste.

Surveillance

28.6. Data collection on infections must start at admission, be ongoing and reported to the Nurse assigned to oversee infection control. Data collected must contain the information required by the Office of the Chief Medical Officer (OCMO) policies.

Infections include but are not limited to: communicable diseases (e.g. influenza, MRSA) and urinary tract infections.

Outbreak control

28.7. Data collected on infections is reviewed to determine potential outbreaks and appropriate actions take place, this includes:

a. Staff report suspected or actual infectious outbreaks to the appropriate person in a timely manner. Outbreaks of illness must be reported immediately to the Epidemiology and Surveillance Unit (ESU) (see 28.16). The ESU will provide assistance with outbreak response.

Isolation and Precautions

28.8. Isolation and precautions systems include the following, in accordance with evidence based guidance and Office of the Chief Medical Officer policy:

a. Standard precautions for all residents

b. Transmission-based precautions (Contact, Droplet, Airborne)

c. Multidrug Resistant Organisms (such as MRSA, VRE) policy that is compatible the care home setting.

Hand hygiene

28.9. Hand hygiene facilities and supplies (soap, water, paper towel, alcohol-based hand rub) are available and readily accessible to residents, staff and visitors.

28.10. A hand hygiene policy in line with evidence based guidance and OCMO policies is required with ongoing hand hygiene education. This policy should include compliance monitoring and documentation.

Cleaning, Disinfection & Sterilization

28.11. The staff follow written cleaning and disinfection policies which include routine, terminal cleaning, and disinfection of resident rooms, high touch surfaces, and shared equipment/medical devices.

28.12. All reusable items and equipment, other than disposables are cleaned, disinfected or sterilized following published guidelines and manufacturer's recommendations.

28.13. The care home ensures that supplies necessary for appropriate cleaning and disinfection are available (e.g. EPA registered products).

28.14. Specific resident care procedures that require aseptic technique are identified and known to staff.

Antibiotic Stewardship

28.15. Antibiotic use is monitored and reviewed for completion and efficacy by the Nursing Supervisor/Director of Nursing. Prescribing of antibiotics by care home medical consultants is in accordance with best practice.

Disease Reporting

28.16. Reportable communicable diseases, as required under the Public Health Act, are reported to the Epidemiology and Surveillance Unit (ESU), Office of the Chief Medical Officer as per established protocols. The care home must have a current list of diseases reportable to ESU (see under Resources: Infection control and prevention-ESU Mandatory reporting).

29. Fire Safety

Standard:

All care homes uphold fire safety requirements to ensure the safety and well-being of persons in the care home.

Criteria

Exits

29.1. There are at least two exits from every home located to minimize any risk of both exits being blocked by fire, smoke or fumes simultaneously.

29.2. All exits and other doors used as means of escape have push bars or similar fittings which do not require the use of keys or special tools to operate.

a. Locks or fastenings must not be installed that may prevent free escape from a home or a patient's room, unless based on prior approval by Bermuda Fire and Rescue.

29.3. All exit doors must open in line of exit travel.

29.4. All exit ways remain clear and unobstructed and a minimum width of forty-four inches is maintained at all times.

29.5. Exit doors must not open directly to a flight of stairs or a landing that is less than the width of the door.

29.6. Every exit from a home is clearly visible and marked with exit signs. Directional exit signs, where necessary, are provided to indicate the direction of travel to reach such exit.

Equipment and design

29.7. Every home must ensure the following:

a. Emergency lighting is provided and maintained for all exits, exit ways and community spaces.

b. Adequate fire detection and alarm systems are provided and maintained.

c. A certificate or record of testing indicating the annual testing for the Fire Alarm System is kept on file.

d. All doors leading into hallways are fitted with working self-closing devices.

e. Adequate fire extinguishing equipment is clearly marked and immediately accessible.

f. A standby generator is on site which is inspected and tested on an annual basis. The documentation of test and findings are forwarded to Bermuda Fire and Rescue for review.

29.8. The following may be deemed necessary based on assessment by Bermuda Fire and Rescue Services:

a. Fire sprinkler system - The fire sprinkler system must be inspected and tested on an annual basis. The documentation of findings and tests must be forwarded to Bermuda Fire and Rescue for review.

b. Fire pump - The fire pump must be inspected and tested on an annual basis. The documentation of findings and tests must be forwarded to Bermuda Fire and Rescue for review.

29.9. An operator must post, in an obvious place in the home, the action to be taken in the event of fire ("Fire Procedure Rules") and include the following in accordance with the Fire Safety Act:

a. Action to be taken on discovery of fire

b. Evacuation plan

c. Extinguishment of fire

29.10. All staff are aware of the action to be taken in the event of a fire. An operator keeps a fire log book and:

a. Records every:

- Fire drill
- Fire training session
- Test of fire alarm system
- Any outbreak of fire

b. Each entry in the log is signed by the person conducting the drill, training session or testing of the fire alarm system or, in the case of an outbreak of fire, by the person in charge of the home at the time of the outbreak

F. Appendices

1. Definitions

Abuse:	A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to or violates their human or civil rights. Abuse or neglect may be deliberate or the result of negligence or ignorance. This includes:
Physical abuse	The non-accidental infliction of physical force that results in a bodily injury, pain or impairment including: hitting, slapping, pushing, kicking, misuse of medication and inappropriate use of physical or chemical restraint
Sexual abuse	Any sexual act (including rape and sexual assault) to which the person has not consented, or could not consent, or into which they were compelled to consent
Psychological abuse	Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks that results in mental or physical distress
Financial exploitation-	The unauthorized and improper use of funds, property or any resources of an older person including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions; or the misuse or misappropriation of property, possessions or benefits.
Neglect	The repeated deprivation of assistance, needed for important activities of daily living including medical or physical care needs such as: failure to provide access to appropriate health or social care including disregard for a person's emotional, social and physical wellbeing; and withholding of the necessities of life such as medication, adequate nutrition and heating by a person with a duty to provide care
Activities of Daily Living (ADL)-	a. Assistance with moving from one place to another while performing activities b. Bathing and showering c. Dressing d. Self-feeding e. Personal hygiene and grooming f. Toilet hygiene g. Personal safety
Administrator	The designated person responsible for day to day operations of the care home**.**

Care recipient	Any person who receives services from the registered provider, this includes day care program attendees and residents
Day Care Program	Programs that assume responsibility for the care of the person while in attendance, i.e. their personal caregiver is not required to attend the day program with the individual. Typically programs are more than three hours per day and participants attend more than one day a week to differentiate from a day activity.
Instrumental Activities of Daily Living (IADLs)-	Instrumental Activities of daily living include: a. Preparing meals b. Taking medications as prescribed c. Shopping for groceries or clothing d. Use of telephone or other form of communication e. Transportation
Operator	The owner of the care home, including individuals, Trusts and Boards.
Outbreak	A sudden start or increase in disease.
Personal care	Assistance be it direct or through supervision or promoting with activities of daily living.
Person Centered Care	Tailoring services to be responsive to the particular needs, values and preferences of individual care recipients.
Person in charge	This terms is used to refer to the appropriate person with the role or responsibilities indicated in the criteria.
Registered Nurse	A Registered Nurse for the purpose of this Code includes persons defined under the Nursing Act as: • Registered General Nurse; • Registered Specialist Nurse; • Registered Advanced Practice Nurse • Registered Mental Health Nurse • Enrolled Nurse- NOTE: there are limitations on an Enrolled Nurse's scope of practice. Accordingly their role and responsibilities must take this into account.
Relevant person	People who have an interest in the care of the care recipient. This includes family members, friends, and caregivers in addition to their legal representative/guardian.
Resident	A person residing in the care home on a short term or long term basis (including respite).

Restraint

For the purposes of this document, restraint and restrictive practice includes, but are not limited to:

a. Direct physical, chemical or mechanical restraint on a single person (for example physical intervention, arrangement of furniture, bedrails, medication, lap belts, hand mitts, wrist or vest restraints)
b. Restraint that limits an individual's freedom (tagging, alarms, surveillance, seclusion, segregation, admission to care home against person's wishes)
c. Restraint that affects all residents (locks on doors, fences, staff instructions and/or care home rules that prevent residents from expressing freedom, choice and control)

The following are definitions for specific types of restraint:

Physical restraint	Any direct physical contact where the intervener's intention is to prevent, restrict or subdue movement of the body, or part of the body of another person.
Mechanical restraint	The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioral control.
Chemical restraint	The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behavior, where it is not prescribed for the treatment of a formally identified physical or mental illness.
Seclusion	The supervised confinement and isolation of a person (i.e. away from other care recipients) in an area from which the person is prevented from leaving. Its sole aim is the containment of severely disturbed behavior which is likely to cause harm to others.
Segregation	The situation where a person is prevented from mixing freely with other people who use a service.

2. Care home models and terminology

The following are definitions to clarify common terms for regulatory purposes under this Code.

Independent Living (model of care) – is a philosophy from the disability rights movement which maximizes the control a person has over their day to day life. Typically this requires maximum participation by the care recipients in the governance of the care home in conjunction with an assisted living model.

Independent living (level of care) - the provision of room and board but no personal care services. There can be services such as laundry, housekeeping and dining but without personal care coordination or provision they do not fall under the legislation or this Code of Practice.

Assisted living- For this Code, these are residential care homes that provide a greater range of choice in the use of services and independence based on the facility design. For example, the facility provides a minimum of a private bedroom, private bath, living space, kitchen capacity, adequate storage space and a lockable door. In addition, there is greater choice with regard to which services are purchased by the resident versus being able to bring in their own supports. The level of care can range depending on the criteria of the care home. For care homes that prioritize an assisted living model (where residents manage their own care and have more independent service options as a result) exceptions to mandatory requirements may be pre-authorized on a case by case basis.

Rest homes- A typical term used for a residential care home with a program that provides housing, health and support services for seniors. Residents require a low level of care (personal care). The facility design includes: shared bedrooms, living spaces and bathrooms and centralized dining.

Nursing Homes- A residential care home with a program that provides housing, health and support services, typically for seniors. Residents require a higher level of care which requires RN oversight and intervention (intermediate care).

Group homes- Residential care homes that combine housing, health, and supportive services targeted to persons with cognitive or mental impairments including intellectual disabilities and mental health. Group homes provide shared living in a small home environment. The level of care can range depending on the home's admission criteria.

Eden Alternative- The Eden Alternative is a model of care that strives to create Elder-centered communities thriving on close and continuing relationships, meaningful interactions, opportunities to give and to receive and a rich and diverse daily life. It is founded on ten principles that drive person centered care as well as organizational structure and leadership. For more information go to: http://www.edenalt.org/

3. Levels of Care

The levels of care are from the Ministry of Health's Long Term Care Needs Assessment Tool which determines medical, nursing and functional care needs.

COMPLEX CARE- (Complex skilled nursing) Predictable and unpredictable complex care needs. Frequent need for revisions to care plan, treatments or medications. May have 6-8 episodes of health exacerbations/year requiring extra MD visits:	
Medical & Nursing Care Needs	**Functional Care Needs for ADL's**
○ **3 or more chronic fluctuating medical conditions, needing unscheduled medical adjustments** to treatment plan, ○ Mood, memory or behavioral conditions that post **moderate to severe risk to self or others,** ○ Includes **predicted and unpredicted nursing assessments** due to changing conditions, ○ Greater than once **daily pain management,** ○ Skin and wound care for **Stage 3 & 4** complex wounds, ○ IV therapy includes daily infusions, or central line care or TPN, ○ Tube feedings, ○ Isolation precautions for skin and stool antibiotic resistant bacteria, ○ Oxygen, airway, and/or chronic ventilator management, ○ Care planning and coordination	○ **Needs physical assistance or has total dependence** for **3 or more ADL** limitations, ○ **Total dependence** for mobility/positioning self in bed.
INTERMEDIATE CARE (Skilled nursing)	
Medical & Nursing Care Needs	**Functional Care Needs for ADL's**
○ **Complex but stable** chronic medical conditions, needing unscheduled medical adjustments to treatment plan. ○ **Predicted and unpredicted nursing assessments** due to changing conditions, ○ Mood, memory or behavioral conditions that may pose moderate to severe risk to self or others, **easily redirected** ○ **Episodic** pain management ○ Skin and wound care for **Stage 1 & 2** wounds ○ Tube feedings ○ Isolation precautions for skin and stool antibiotic resistant bacteria, ○ Ostomy care, with well-established and intact stoma ○ IV therapy, **episodic or infrequent** ○ Care planning and coordination	○ **Physical assistance or total dependence** for 2 or more ADL, ○ May need cueing or supervision for some ADLs ○ **Total dependence** for mobility/positioning in bed
PERSONAL CARE	
Medical & Nursing Care Needs	**Functional Care Needs for ADL's**
○ Relatively stabilized (physical or mental) chronic disease, ○ Mild – moderate dementia ○ **Predictable** health assessments ○ **Episodic** nursing for medication management, interventions, assessments or treatments, ○ Simple wound care ○ Elder fragility (more than 85 yrs.) ○ Care planning and coordination	○ Supervision or verbal cueing for ADLS or personal safety ○ Physical assist for mobility ○ Needs assist for IADLs (meal prep, grocery shopping, housekeeping, transport, laundry, etc.)

4. Consent and Capacity Guidelines

The following are additional guidelines for staff to help uphold the Standards and criteria in the Code pertaining to assisting persons with diminished capacity in decision making. These guidelines are based on the UK Mental Capacity Act 2005 and UK MCA Code of Practice 2007.

1. Care recipients are presumed capable of making informed decisions in the absence of evidence to the contrary and provided appropriate information, explanation and assistance to do so. The care recipient's lack of capacity to give informed consent on one occasion is not assumed to be the case on another occasion.

    a. Some people may need help to be able to make a decision or to communicate their decision. However, this does not necessarily mean that they cannot make that decision – unless there is proof that they do lack capacity to do so.

    b. It is important to balance people's right to make a decision with their right to safety and protection when they can't make decisions to protect themselves. But the starting assumption must always be that an individual has the capacity, until there is proof that they do not.

    c. Anyone supporting a person who may lack capacity should not use excessive persuasion or 'undue pressure'. This might include behaving in a manner which is overbearing or dominating, or seeking to influence the person's decision, and could push a person into making a decision they might not otherwise have made. However, it is important to provide appropriate advice and information.

2. A person is not to be treated as unable to make a decision unless all practicable steps to help them do have been taken without success.

    a. It is important to do everything practical to help a person make a decision for themselves before concluding that they lack capacity to do so. People with an illness or disability affecting their ability to make a decision should receive support to help them make as many decisions as they can. This principle aims to stop people being automatically labelled as lacking capacity to make particular decisions

    b. Where there is any doubt as to the care recipient's capacity to decide on any medical treatment or intervention, their capacity to make the decision in question is assessed by a suitably qualified professional using evidence-based best practice.

    c. In some situations treatment cannot be delayed while a person gets support to make a decision (e.g. emergency situations). In these situations, decisions are made on the care recipient's behalf in their best interest and persons should try to communicate with the person and keep them informed of what is happening.

3. A person is not treated as unable to make a decision merely because they make an unwise decision.
    a. Everybody has their own values, beliefs, preferences and attitudes. A person should not be assumed to lack the capacity to make a decision just because other people think their decision is unwise. This applies even if family members, friends or healthcare or social care staff are unhappy with a decision. There may be cause for concern if somebody:
        - Repeatedly makes unwise decisions that put them at significant risk of harm or exploitation; or
        - Makes a particular unwise decision that is obviously irrational or out of character.

        These things do not necessarily mean that somebody lacks mental capacity. But there might be need for further investigation, taking into account the person's past decisions and choices

4. Where the care recipient is deemed to lack the capacity to give or withhold consent a decision should be made in their best interests by the appropriate care home staff and relevant persons*. Best interests are determined by taking into account:
    a. Past and present wishes of care recipient
    b. The care recipient's needs and preferences, where they are ascertainable
    c. Their general well-being and cultural and religious convictions
    d. The wishes of their relevant person*
    e. The decision or action required is the least restrictive to the person's rights and freedom of action.

*When there is a relevant person with legal decision making responsibilities (e.g. Enduring Power of Attorney, Healthcare proxy etc.) this must be who the Administrator and the appropriate care staff refer to in the appropriate decision making process.

For more information and guidance on capacity and consent see the Resources section of the Code.

5. Dementia Care Guidelines - Understanding and responding to distressed behavior

The following are guidelines to support relevant Standards in the Code with regard to care for persons with dementia:

1. Staff understand and recognize patterns of behaviour and develop routines to accommodate rather than control behaviour which may challenge staff. Distressed behaviours are understood to be a method of communication or an indicator of unmet need. Strategies are implemented in an attempt to meet the care recipient's need.

2. Staff follow best practice guidance in relation to pain management this includes:
    a. Recognizing where behaviour may be caused by pain and report their findings to a Registered Nurse or medical practitioner.
    b. Appropriate staff are trained to use a validated pain assessment tool to ascertain if residents with dementia are in pain and respond effectively to the need for pain relief.
    c. Pain-relieving medication (including over the counter remedies) is available in the home along with equipment such as specialist chairs and mattresses that can assist in pain management.

3. Where care recipients use walking or pacing/activity a proportionate risk assessment is undertaken to allow residents to walk safely or ensure they are informed of the risk of doing so when they wish to.

4. Staff demonstrate a knowledge and understanding of individual care recipients' rights, preferences and routines so that a sudden refusal of care and assistance can be understood and responded to. The care recipient individual right to refuse assistance or care is not over-ruled by staff's values and principles.

5. Where a care recipient demonstrates distressed behaviour during personal care, staff sensitively try to identify the potential factors that may be causing the behaviour such as: personal choice, embarrassment, pain, or lack of understanding of the task. Staff must change their style of intervention or technique to alleviate distress based on their findings and consult with appropriate professionals (RN, dementia specialist, medical practitioner) when required.

6. Where a care recipient refuses medication, staff investigate possible underlying causes and respond appropriately. Where a care recipient who lacks capacity refuse their medication, this must be reviewed in consultation with the prescriber and relevant person where required.

7. When a care recipient becomes withdrawn, staff work with them to determine if a care need is unmet (e.g. the resident is depressed, bored or lonely or experiencing a side effect of medication). Staff must:
    a. Make a conscious effort to engage with care recipient who have become withdrawn and use gentle, sensitive and clear explanations as to their actions.
    b. Offer opportunities for meaningful engagement that meet their functional level and interests.
    c. Monitor for symptoms of depression, seeking professional assessment and treatment as needed.

6. Common Conditions- Guidelines

The following are common conditions found in many care homes as guidance to help identify the policies and procedures required under Standard 15.

a. Pain assessment and management
b. Skin care and pressure ulcers
c. Continence management
d. Urinary Tract Infections
e. Falls prevention
f. Pneumonia
g. Nutritional screening (see Standards 9, 15.13 and Resources)
h. Dementia (see Standard 18 and Appendix 6)
i. End of life care (see Standard 17)

The following are guidelines for the policies of the above common conditions.

Pain Management

1. Comprehensive assessments include a pain management assessment upon admission and when there are significant changes to their condition.

2. A resident is referred to a medical practitioner for the appropriate identification of the pain and determination of a pain management program which is recorded in the care recipient's file.

3. Pain relief medication is administered based on the type and severity of the pain, in accordance with the care recipient's pain management plan as ordered by a physician.

4. Appropriate care staff will monitor for pain relief, side effects and complications of pain medication.

5. Pain relief medication must not be given for more than 24hours to relieve pain and discomfort without a review or verbal orders by the prescribing practitioner in circumstances where:
    a. There has been a change in condition.
    b. The medication was prescribed on an as needed basis but there has been a period of time preceding when the medication has not been needed.

6. A pain management program must be implemented and assessed in a consistent, standardized and systematic manner to monitor and treat including:

    a. Assessing the intensity, location, onset and progression of the resident on a pain management program on a daily basis.

    b. The use of monitoring tools such as: numerical pain rating scales, verbal descriptor scales, location charts and symptom checklist.

Skin care and Pressure ulcers:

1. Care recipients are assessed by a RN or physician to identify those who have developed, or are at risk of developing pressure sores. Appropriate intervention is recorded in the plan of care to maintain skin as a barrier to infection as per evidence based guidelines. The Braden Scale is an appropriate recommended assessment tool, found in the LTC Needs Assessment tool.

2. Assessment occurs:
    a. Upon admission.
    b. Daily as part of the process of providing care and assistance with bathing or other activities.

3. Prevention methods are in place to maintain the skin including:
    a. Routine skin inspection
    b. Keeping residents clean and dry
    c. Routine and frequent turning for those unable to turn themselves
    d. Provision of appropriate nutrition
    e. Prompt care for pressure ulcers and other breaks in skin integrity

4. The incidence of pressure sores, their treatment and outcome, are recorded in the care recipient's individual plan of care and reviewed on a continuing basis.

5. Wound care of pressure ulcer management is provided without delay and the following is assessed, monitored and documented:
    a. Location, size, stage, colour, odour and amount and type of exudates
    b. Presence, location and extent of undermining and/or tunneling, pain and signs of infection, condition of surrounding tissue and general condition of care recipient including their nutritional status

6. Appropriate care staff monitor daily for any wound related abnormalities or complications and liaise with a health professional for referral to specialist services when required, e.g. the wound care clinic at KEMH.

Fall prevention

1. Homes take all reasonable steps to ensure the home (both the interior and exterior) is safe to encourage and promote mobility, as falls or a fear of falls is not necessarily a barrier to allowing walking. This includes, for example: securing floor coverings and rugs, ensuring suitable lighting and suitable placing of furniture to allow for free movement.

2. Staff are appropriately trained in fall prevention and ensure an ambulance is only requested for care recipients with a clinical need to attend hospital.

3. An assessment for the risk of falls is carried out no later than 24 hours after admission to the home. The assessment takes into account the following that may impact the care recipient's risk level:
    a. History of falls
    b. Medical status
    c. Medications
    d. Functional, behavioral and cognitive status

4. If the care recipient is deemed to be at risk of falls, following risk assessment, a detailed falls care plan is put in place, documented and communicated. This plan should include education regarding fall prevention to the resident and their relevant persons.

5. The falls assessment and preventative measures are carried out in line with best practice guidance that take into account and prioritize the benefits of promoting mobility and appropriate risk taking and the preferences of the care recipient.

6. The falls risk assessment is reviewed in response to changes in the care recipient's condition and no less frequently than monthly and the care plan amended accordingly.

7. Residents' footwear is checked to ensure their safety when walking. In addition residents have necessary mobility equipment or aids and assistance to use them safely.

8. A post-falls review is carried out within 24 hours of a care recipient sustaining a fall to determine reason for falling and any preventative action to be taken. This is in addition to existing mechanisms to record incidents within the home. The care plan is amended accordingly.

9. Falls should be reviewed and analyzed on a monthly basis to identify any patterns or trends and appropriate action is taken.

Continence Management

1. Where care recipients require continence management and support, assessments are carried out by the home and care plans are reviewed to ensure individual needs are met.

2. Where care recipients have continence management difficulties, they are regularly and discreetly checked.

3. In the case where a care recipients may be found to have wet or soiled clothing this is changed immediately.

4. The care home ensures that professional advice about the promotion of continence is sought and acted upon and aids and equipment needed are provided.

5. The continence management plan includes protocols for promoting continence and bowl management.

6. Catheters cannot be used without valid medical justification in accordance with evidence based guidelines. If a catheter is used, the home must provide appropriate treatment and services to prevent urinary tract infection and to restore as much normal bladder function as possible.

Urinary Tract Infections (UTIs)

1. Professional advice is obtained to ensure appropriate prevention, assessment, testing, diagnosis, monitoring and treatment occurs.

2. Prevention methods including hand hygiene and appropriate hydration are in place.

3. Appropriate clinical assessment (as per evidence based guidelines) occurs before a diagnosis of urinary tract infection is made.

4. Appropriate use and maintenance of catheters follows evidence based guidelines to prevent UTI's. This includes but is not limited to nursing care practices to prevent infections with indwelling urinary catheters.

5. Supervision and education of staff occurs to ensure adherence with policies and procedures.

Influenza and Pneumonia

1. Care recipients are assessed to identify those who have developed, or are at risk of developing pneumonia and appropriate intervention is recorded in the plan of care as per evidence based guidelines.

2. Persons in Charge and staff ensure appropriate influenza and pneumonia prevention, control and treatment policies and procedures are implemented as per evidence based guidelines. This includes but is not limited to:
    a. Education for care recipients, staff and visitors
    b. Annual vaccination programs for staff and residents
    c. Standard precautions and transmission based precautions as appropriate
    d. Consultation with healthcare and infection control professionals when required

3. Surveillance and outbreak response procedures for staff, care recipients and visitors are in place to identify and prevent the spread of influenza within the facility in accordance with evidence based practices. This includes but is not limited to addressing:
        a. Monitoring of number of residents with influenza and pneumonia

b. Respiratory hygiene and cough etiquette
c. Ensuring adequate supplies of personal protective equipment for residents, staff and visitors
d. Implementation of appropriate transmission based precaution
e. Placement of care recipients
f. Movement of care recipients
g. Exclusion from work policies
h. Restrictions on visitors

7. Staffing

(I) Qualifications

Summary of minimum staff education and experience requirements:

Position	Qualification	Experience
Residential Care Home Administrator*	a. Management course(s) AND An Associate's degree in a health or social service field OR b. Care Home Administrator Certification	Three years of service and management experience relevant to the field
Nursing Home Administrator*	a. Management Course AND A Nurse registered with BNC OR BA as a health or social service professional OR b. BA in Healthcare Administration or a health or social service field OR c. Nursing Home Administrator License	Three years of service and management experience relevant to the field.
Deputy Administrator	Same as above for each type of care home	One year of experience relevant to the field
Nurse Supervisor / Director of Nursing	a. Registered with BNC as an RN	
Care Staff:** - Nurse	a. Registered with BNC as an RN or Enrolled Nurse	
- Nursing Associate (NA)	a. Registered with BNC as an NA	
- Caregiver/Companion	a. CPR & First Aid certification b. Training based on roles, responsibilities and competency	
Activities Coordinator	a. Bda College Activities Program Certificate or equivalent; AND b. BNC registration (as NA or Nurse) OR c. Allied Health Professionals Council Registration	Experience providing services to the specific population group.
Volunteers	Training meets assigned roles and responsibilities	
Food Service Personnel	Food Handling ServeSafe Course. See E for additional recommendations	See section E or recommendations

* All Administrators hired prior to January 15th 2017 are subject to the previous qualification requirements; however additional training may be required based on compliance with the Code.
** Care staff may include other regulated or unregulated health professionals or care givers, see 4 below for requirements

The following provides more detail on the qualifications listed above. On a pre-approved, case by case basis, other qualifications may be considered by Ageing and Disability Services based on defined positions, organizational structure, roles and responsibilities and care recipient needs.

1. **Administrator Management Courses** must be from an accreditation institution, or an Ageing and Disability Services' (ADS) approved provider, with content applicable to the management of a care home. A management course may not be required if the health or social service qualification includes evidence of training. Primary areas to be included in management training are:
    a. Human resource management
    b. Financial management
    c. Risk management and quality improvement
    d. General management and governance

2. **Administrator health or social service qualification**

    a. **Residential Care homes:** Associate degree from an accredited or ADS approved institution in a health or social service field including, but not limited to:
        - Healthcare or Health Facility Administration;
        - Healthcare profession: e.g. Nursing, Allied health, Social work.

    Note- The Bermuda College's Associate of Science, Nursing is an approved program for this qualification. Note- the Bermuda College Nursing Associate Certification does NOT qualify for this position.

    b. **Nursing Homes-** A Bachelor degree from an accredited or ADS approved institution in a health or social service field which may include
        - Health facility administration
        - Health services administration
        - Healthcare administration
        - Health care professional fields including but not limited to: Nursing, Medical Practitioners, Allied Health and Social Work

3. **Care Home Administrator License or Certification-** must be equivalent to or exceed the care home type (residential care home or nursing home) and approved by ADS.

4. **Care Staff -** Care staff are all persons providing health, social or personal care services to care recipients in the care home. Care staff can include both regulated health care professionals and unregulated care workers.

    Regulated health care professionals- Services that falls under a regulated scope of practice in Bermuda must be provided by the appropriate registered professional. This includes but is not limited to: Medical Practitioners, Nurses, Allied Health Professionals (e.g. Addiction Councilors, Occupational and Physiotherapists, Dieticians etc.). All persons hired under this

category must have up to date registration with their respective healthcare professional regulatory Board or Council.

Unregulated care workers- There are various types of unregulated care providers in Bermuda, for example: art therapists, massage therapists, social workers and companions/caregivers. Administrators must ensure when hiring unregulated care workers that the person's qualifications and competencies are able to uphold their assigned role and responsibilities in accordance with the Code of Practice (see Roles and Responsibilities). Additional training may be required by ADS based on care recipients' needs, staff qualifications and evidenced competencies.

5. **Food service personnel –**
Up to date ServeSafe food handling courses are required for all food service personnel. Persons responsible for meal planning and preparation must have the skills to uphold the requirements in the Code. ADS may require training of staff if non-compliance with the Code is found. Recommended qualifications/experience include:
    a. Commercial kitchen experience
    b. Quantity cooking experience
    c. Therapeutic diet preparation and adaptation qualifications/experience

    The level of experience and qualification should reflect the care needs of the residents (the greater the care needs the higher the qualifications/experience required).

6. **Operator-** The operator, regardless of their roles in the operation of the care home, must be able to demonstrate they are fit and proper to operate a care home. This includes:

    a. In the past 5 years the operator (including any Board or Trustee members) whether under the laws of Bermuda or any other jurisdiction has not been:
        - Charged or convicted of an offence (excluding traffic violations) under any criminal law or other law in force
        - Subject of, or convicted in any regulatory, civil, or other action or proceeding
        - Subject of bankruptcy or receivership proceedings
        - Subject of a court judgment or writ, or failed to satisfy a judgment or writ
        - Refused or had suspended or cancelled a business license or registration.

    b. Prudent financial management through the business plan for registration and annual financials (see s.22).

(II) Recruitment

The following documentation must be obtained and used in the hiring decisions for Administrators, Deputy Administrators and all Direct Care staff to ensure good character and mental and physical fitness:

a. Comprehensive criminal records check, not less than 12 months old.
    - Hiring of applicants with offences must take into account the following:
        - The nature of the crime including the type of crime and if the victim was a vulnerable person (see Protecting Vulnerable Persons Policy under Resources)
        - The length of time since the conviction
        - The record of the person since conviction
        - The specific role, responsibilities and supervision of the applicant at the care home

b. Two written references

c. Medical certificate from a physician, not less than three months old, with information specified in the template form provided by the Ministry of Health (see Resources).

d. Resume – Gaps in employment history are explored.

(III) Roles and responsibilities

The following are guidelines to assist care homes with the roles and responsibilities required of mandatory roles listed in criteria 19.1. Each care home has its own organizational structure so listed responsibilities can fall under other roles. What is necessary is **the assurance that the minimum responsibilities are performed by an appropriately qualified person who is operating within their scope of practice**.

Operator

The operator is the owner of the facility who the license is issued to and may be an individual or a Board depending on the business structure.

The operator has ultimate oversight over the operation of the facility to ensure compliance with legislation.

Administrator

Responsibilities include but are not limited to:

a. Program management:
    - Monitors and directs execution of programs, policies and procedures and required changes

- Ensures compliance with legislation and Code of Practice and makes changes appropriately
- Discusses care of care recipients with Director of Nursing/Supervisor of Care, GPs/Medical Consultant
- Acts as the liaison between the nursing home, care recipients, families, hospital and community
- Represents the nursing home to the Board (if applicable)

b. Facility management
   - Oversees or ensures environment and equipment evaluations necessary for functioning
   - Oversees the decisions on facility maintenance problems, equipment replacement, repairs and redecorating
   - Ensures compliance with health and safety requirements

c. Financial management
   - Identifies and oversees capital improvements
   - Ensures budget conformance, compiles budget projections, revenues and expenses
   - Liaises with family or other relevant persons regarding financial obligations to the home and requirements in relation to their service contract

d. Human Resource management:
   - Staff recruitment
   - Training and in service education program
   - pay roll and benefits administration
   - oversees volunteer programs

Supervisor/Director of Care (RN)

Clinical administrative duties include:

a. Maintaining standards of care through the development (or review), implementation and monitoring of policies and procedures. Examples of such policies and procedures include:
   - Care communication and coordination between staff, external health professionals and relevant persons
   - Care plan development, implementation and review
   - Incident reporting and monitoring
   - Activity and recreational programs
   - Specific clinical interventions: e.g. wound care, skin preservation, restraint use, infection control

b. Supervising and reviewing care staff service provision and staffing requirements including but not limited to:
   - Determining required care staff ratios and staffing schedules based on resident's needs

- Staff competency assessments and training
- Ensuring staff uphold regulated scope and standards of practice
- Ensure care plans are followed
- Ensuring care home's policies and processes established for care provision are adhered to
- Reviewing record keeping of care staff

c. Managing and reviewing medical records

d. Communicating with doctors, care recipients and relevant persons regarding care needs, change of conditions and care coordination

e. Conducting admissions assessments and determining applicant suitability based on program of care and services provided

Medical Consultant

Responsibilities include but are limited to:

a. Provides medical care services to persons without a personal GP; or whose GP is not available to provide such. This includes:
   - Medical assessment, care and treatment when necessary in non-emergency circumstances and when there is a change in the resident's condition.
   - Review of medical treatment plans
   - Consultation services for the Director of Nursing or Nursing Supervisor, including when a second opinion is required in relation to direction provided by the resident's GP

b. The medical consultant should provide oversight to ensure:
   - The overall health care program is meeting the healthcare needs of the residents.
   - Healthcare treatments uphold best practice and this Code.

Dietician

Responsibilities include but are limited to:

a. Review of seasonal meal plan proposed for care recipients at a minimum of twice a year.

b. Review of meals against individual care needs.

c. Review of individual care recipient's care plan and conducts nutritional assessments when required.

Activities Coordinator

Responsibilities include but are limited to:

a. Manage and discuss activities with Director/supervisor of Nursing, care recipients and relevant persons.

b. Plan and implement a stimulating activity plan for each care recipient that is reflective of their interests and needs, this includes:

- Individual activity plans
- Group activity plans
- Coordination and participation in community based groups, events and activities. Activities include social, physical, spiritual, hobbies/educational etc. and Activities of Daily Living, in particular for dementia clients.

c. Determine and coordinate transportation, equipment and staffing requirements for activities in consultation with Director/Supervisor of Nursing and Administrator.

Care Staff:

a. **Registered Nurse (RN):** Provide direct skilled nursing care and/or supervision as defined by their scope and standards of practice by the BNC and roles within the care home and this Code. (www.bnc.bm or www.gov.bm/nursing)

b. **Nursing Associates (NA):** Provide direct personal care and basic nursing services. Their roles and responsibilities are defined by their scope of practice issued by the Bermuda Nursing Council (BNC) and this Code. (www.bnc.bm or www.gov.bm/nursing) A Registered Nurse may delegate tasks to a Nursing Associate in accordance with their scopes of practice and Ministry of Health policy.

c. **Caregivers/companions-** Unregulated care workers can provide the following care services in a care home:
   - Support through prompting, supervision and guidance with IADLs, ADLs and general activities
   - Minimal hands on assistance to care recipients with mobility and transfers for low risk care recipients
   - Emergency first aid and CPR

   The following tasks **cannot** be assigned to unregulated care workers employed as caregivers/companions:
   - Hands on assistance with personal care activities of daily living
   - Minimal hands on assistance for lifting and handling if care recipient is extremely frail or at high risk for skin damage
   - Medical assistance – including assistance with Medications

(IV) Orientation and training

1. Administrators ensure staff, including themselves, complete the required mandatory training every two years:
    a. CPR and First Aid
    b. Infection control
    c. Lifting and Handling
    d. Least restrictive practices- Protection from abuse, use of restraints & managing challenging behaviors

Note- The mandatory training requirement will be phased in based on available courses. ADS will appropriately notify all care homes of the requirements in advance of the re-registration period.

2. ADS may require specific training for staff and management based on resident care needs and their compliance with the Code. This may include but is not limited to:
    a. Dementia care training for all care staff in homes with residents with Dementia.
    b. Fall prevention for all facilities with persons assessed at risk of falls.
3. Training content and providers must be approved in advance by Ageing and Disability Services.
    a. Training may be offered through an in-service provided by the care home's appropriate staff member with prior approval by ADS.
    b. Content of training provided by care home staff must align with:
        - Person centered care practices
        - Code of Practice requirements
        - Best Practice clinical guidelines
        - ADS and OCMO policies

8. Building Design- Building Code Classification and Accessibility Standards

(I) Classifications

The following are the use and occupancy classifications for care homes. Contact the Department of Planning with any questions regarding these classifications.

International Building Code 2012 – Chapter 3: Uses and Occupancy Classification				
Group	**Description**	**Service Hours**	**Number of patients**	**Examples**
I-1 Institutional	For persons who reside in a supervised environment and receive *custodial care*. The persons receiving care are capable of self-preservation.	24-hour basis	More than 16 persons	Alcohol and drug centers Assisted living facilities Congregate care facilities Convalescent facilities Group homes Halfway houses Residential board and custodial care (personal care) facilities Social rehabilitation facilities
Group I-1 EXCEPTIONS	**Five or fewer persons receiving care.** A facility such as the above with five or fewer persons receiving such care shall be classified as Group R-3 or shall comply with the *International Residential Code* provided an *automatic sprinkler system* is installed in accordance with Section 903.3.1.3 or with Section P2904 of the *International Residential Code* (IRC) **Six to sixteen persons receiving care.** A facility such as above, housing not fewer than six and not more than 16 persons receiving such care, shall be classified as Group R-4.			
I-2 Institutional	For *medical care* for persons who are *incapable of self-preservation*.	24-hour basis	More than 5 persons	Foster care facilities Detoxification facilities Hospitals Nursing homes Psychiatric hospitals
Group I-2 EXCEPTIONS	**Five or fewer persons receiving care.** A facility such as the above with five or fewer persons receiving such care shall be classified as Group R-3 or shall comply with the *IRC.*			
I-4 Institutional (Day care facilities)	For *custodial care* by persons other than parents or guardians, relatives by blood, marriage or adoption, and in a place other than the home of the person cared for.	less than 24 hours	More than 5 persons of any age	Adult day care Child day care
Group I-4 EXCEPTIONS:	**Five or fewer persons receiving care.** A facility having five or fewer persons receiving *custodial care* shall be classified as part of the primary occupancy or shall comply with the *International Residential Code.* **Five or fewer persons receiving care in a dwelling unit.** A facility such as the above within a *dwelling unit* and having five or fewer persons receiving *custodial care* shall be classified as a Group R-3 occupancy or shall comply with the *International Residential Code.*			

Residential Group R	Residential Group R includes, among others, a building or structure, or a portion thereof, for sleeping purposes when not classified as an Institutional Group I or when not regulated by the *International Residential Code*.			
R-2 Residential	Residential occupancies containing sleeping units or more than two dwelling units	permanent	Rooming houses with more than five residents, not having transient occupancy; Therapeutic residences with more than 16 residents.	Apartment houses Convents Dormitories Fraternity and sorority houses; Hotels (non transient) Monasteries; Motels (non transient)
R-3 Residential Group.	Residential occupancies where the occupants are primarily permanent in nature and not classified as Group R-1, R-2, R-4 or I	permanent		Buildings that do not contain more than two dwelling units
			16 or fewer occupants	Boarding houses (no transient)
			10 or fewer occupants	Boarding houses (transient)
			5 or fewer persons receiving care	Care facilities that provide accommodations
			16 or fewer occupants	Congregate living facilities (non transient)
			10 or fewer occupants	Congregate living facilities (transient)
R-3 *EXCEPTIONS:*	Single occupancies, accessory to a dwelling unit, having more than five roomers or lodgers shall be classified as Group R-2 or I-1, as appropriate			
R-4 Residential	Residential occupancies that are supervised residential environment and receive *custodial care*. The persons receiving care are capable of self-preservation.	24-hour basis	5 to16 occupants, excluding staff; Prompt excavation where all occupants, residents, and staff can get to an exit in 3 minutes or less	Alcohol and drug centers Assisted living facilities Congregate care facilities Convalescent facilities Group homes Halfway houses Residential board and custodial care facilities Social rehabilitation facilities
Group R-4 occupancies shall meet the requirements for construction as defined for Group R-3, except as otherwise provided for in this code.				
Care facilities within a dwelling.	Care facilities for five or fewer persons receiving care that are within a single-family dwelling are permitted to comply with the *International Residential Code* provided an *automatic sprinkler system* is installed in accordance with Section 903.3.1.3 or with Section P2904 of the *International Residential Code.*			

(II) Accessible Design

The following are extracts from the American Disability Act (ADA) 2010 Standards for some primary accessible design considerations and requirements.

- Consult the ADA standards document (see Resources) for additional design options and considerations.
- Contact Ageing and Disability Services with questions regarding accessible design and ADA standards.

General wheel chair turning space (section 304 of ADA Standards):

304.3.1 Circular Space- The turning space shall be a space of 60 inches (1525mm) diameter minimum. The space is permitted to include knee and toe clearance complying with 306.

304.3.2 T-shape Space - The turning space shall be a T-shaped space within a 60 inch (1525mm) square minimum with arms and base 36 inches (915mm) wide minimum. Each arm of the T shall be clear of obstructions 12 inches (305mm) minimum in each direction and the base shall be clear of obstructions 24 inches (610 mm) minimum. The space shall be permitted to include knee and toe clearance complying with the 306 only at the end of either the base or one arm.

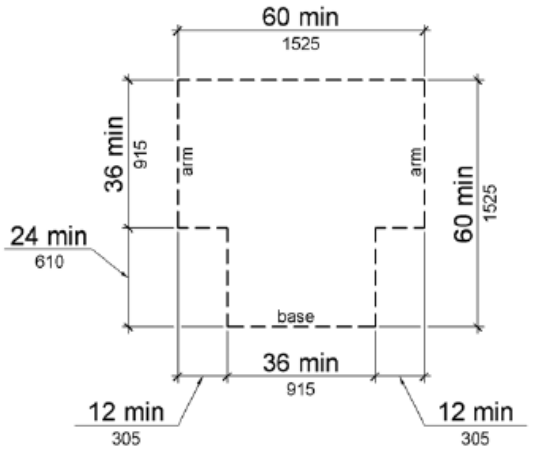

Figure 304.3.2
T-Shaped Turning Space

Ramp requirements (section 405 of ADA 2010 standards):

Building classification I1, I2, I4:

- Cannot exceed a 1:12 ratio (1 foot of ramp for each inch of rise) for example- a 20 inch rise requires a 20 foot ramp.
- No single run of ramp (without a rest or turn platform) can be more than 30 feet.

Building Classification R2, R3, R4-

- Cannot exceed a 2:12 ratio (one foot of ramp for each two inches in rise) e.g. a 20 inch rise requires a 10 foot ramp.

G. Resources

Care Home Registration and Inspection Information:

For the following required documentation and regulatory information go to https://www.gov.bm/care-home-registration-and-inspection

- Care Home Code of Practice
- Ministry of Health LTC Needs Assessment Tool
- Medical Certificate template

Relevant Government legislation and Policies:

Legislation can be found at www.bermudalaws.bm

- Residential Care Homes and Nursing Homes Act 1999 and Regulations 2001
- Development and Planning Act 1974
- Building Act 1988
- Bermuda Building Code 2014 (references International Building Code 2012)
- Occupational Health and Safety Act 1989 and Regulations
- Public Health Act 1949 and Regulations
- Pharmacy and Poisons Act 1979 and Regulations
- Misuse of Drugs Act 1972 and Regulations
- Bermuda Nursing Act 1997 and Rules
- Companies Act 1981
- Employment Act 2000
- Health Insurance Act 1970

- Protecting Vulnerable Persons Policy: https://www.gov.bm/sites/default/files/Vulnerable%20Persons%20Policy.pdf

LTC Education and Training (general)

- https://www.gov.bm/long-term-care-education-and-training
- Long-Term Care Best Practices Toolkit, 2nd Edition http://ltctoolkit.rnao.ca/ , Registered Nurses Association of Ontario, Dec 2017

Best Practice Clinical Guidelines (General):

- OCMO Guidance: https://www.gov.bm/health-data-and-monitoring
- Registered Nurses Association of Ontario Guidelines: http://rnao.ca/bpg/guidelines/clinical-guidelines
- NICE guidelines: https://www.nice.org.uk/guidance

Sample policy, procedures and training guides for common conditions:

- AdvantAge Ontario. LTCHA Implementation Resources (viewed Jan 2018). https://www.advantageontario.ca/MediaCentre2/LTCHomesActCentralseeSiteNavigation/LTCHA_Resources.aspx

Restraints, behavior management and abuse:

- Restraints: Practice Standard. College of Nurses of Ontario. 2017. http://www.cno.org/globalassets/docs/prac/41043_restraints.pdf
- Promoting Safety: Alternative Approaches to the Use of Restraints (RNAO 2012) : http://rnao.ca/bpg/guidelines/promoting-safety-alternative-approaches-use-restraints
- Positive and Proactive Care- reducing the need for restrictive interventions https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf
- Positive and Proactive workforce: a guide to workforce development for commissioners and employers seeking to minimize the use of restrictive practices in social care and health http://www.skillsforcare.org.uk/Documents/Topics/Restrictive-practices/A-positive-and-proactive-workforce.pdf
- Senior Abuse Reporting Form: https://www.gov.bm/senior-abuse-reporting-and-investigation

Assessments, Screenings and Care Planning:

- Ministry of Health, LTC Needs Assessment Tool https://www.gov.bm/care-home-registration-and-inspection
- Person Centered Support Plan for People with Dementia- Southwest Dementia Partnership: www.southwestdementiapartnership.org.uk
- Person and Family Centered Care, Clinical Best Practice Guidelines. RNAO 2017. http://rnao.ca/sites/rnao-ca/files/FINAL_Web_Version_0.pdf
- Writing Good Care Plans: A good practice guide. http://www.careplans.com

Infection Control and Prevention

- ESU Mandatory Diseases Reporting: https://www.gov.bm/health-data-and-monitoring, see Reportable Diseases
- Best practice guidance- Centers for Disease Control (CDC), Healthcare Infection Control Practices Advisory Committee (HICPAC): https://www.cdc.gov/longtermcare/index.html
- NICE guidelines for Infections: https://www.nice.org.uk/guidance/conditions-and-diseases/infections

Building Design

- American with Disabilities Act standards for accessible design: https://www.ada.gov/2010ADAstandards_index.htm
- International Code Council Accessible and Usable Buildings and Facilities, ICC A117.1-2009: http://shop.iccsafe.org/icc-a117-1-2009-accessible-and-usable-buildings-and-facilities-cd-rom-1.html

Care Services in the Community

- www.helpingservics.bm

H. Contact Information

Agency	Topic	Contact info
Ageing and Disability Services	Care Home Registration Inspection and Complaints	25 Church St. Hamilton 292-7802; ads@gov.bm https://www.gov.bm/care-home-registration-and-inspection
	Senior Abuse Reporting	25 Church St. Hamilton 292-7802; ads@gov.bm https://www.gov.bm/senior-abuse-reporting-and-investigation
	Accessibility consultation	25 Church St. Hamilton 292-7802; ads@gov.bm
Dept. of Health	Community Rehabilitation	Hamilton Health Center, 67 Victoria St. 278- 6427
	Nutrition Services	278-6467, 278-6468, 278-6469 nutrition@gov.bm
	Environmental Health	278-5333 envhealth@gov.bm
	Occupational Safety & Health	278-5333 osho@gov.bm
Epidemiology and Surveillance Unit	Infection Control and Prevention	25 Church St. Hamilton 278- 4900 Officeofcmo@gov.bm
Bermuda Fire and Rescue Services	Fire Safety Standards and certification	49 King Street, Hamilton 292- 5555
Bermuda Nursing Council	Nursing Associate and Registered Nurse registration	25 Church St. Hamilton, HM12 292-0774 bermudanursingcouncil@gov.bm www.bnc.bm www.gov.bm/nursing

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