Information Sheet

CIHI's Long-Term Care Data and HSO's LTC Services Standard

About this document

This information sheet provides an overview of the long-term care (LTC) data collected by the Canadian Institute for Health Information (CIHI) and its alignment with criteria in the Long-Term Care Services standard published by the Health Standards Organization (HSO).

Note: The table in this document is not intended to be comprehensive. LTC homes that participate in CIHI's data collection may find that data captured supports additional criteria to those outlined in this document.

CIHI's LTC data

CIHI collaborates with federal, provincial/territorial, regional and other stakeholders to identify and address LTC information needs and priorities. We support the development, reporting and use of timely and comparable data related to this topic.

The main sources of CIHI's LTC data are 2 of its data holdings: the Continuing Care Reporting System (CCRS) and Integrated interRAI Reporting System (IRRS). These data holdings contain demographic, administrative, clinical and resource use information on individuals who receive LTC services in Canada. The data is collected through interRAI's LTC resident assessment instruments — the Resident Assessment Instrument–Minimum Data Set 2.0 © (RAI-MDS 2.0) and the interRAI Long-Term Care Facilities © (interRAI LTCF).

These assessment instruments enable comprehensive, standardized evaluation of the needs, strengths and preferences of LTC home residents. Resident information is entered into a computer at the point of care. Outputs such as Clinical Assessment Protocols (CAPs) and outcome scales can be used to flag resident risks and inform care planning, and quality indicators (QIs) can be used by the LTC home for quality improvement activities. The information then flows to CIHI's reporting systems. With no additional collection effort, evidence is available to guide care and system-wide planning, as well as quality improvement.

CIHI

CIHI publicly reports LTC data aggregated at 3 levels: facility, region and province/territory. LTC homes receive additional metrics quarterly via a secure reporting tool. Researchers can request data through CIHI's data request process.

Alignment with HSO's LTC Services standard

LTC homes that submit data to CIHI's CCRS or IRRS complete admission and quarterly resident assessments. The table below outlines how CIHI's LTC data can be used to support an organization's ability to meet criteria within HSO's LTC Services standard.

Table Alignment of CIHI data with HSO's LTC Services standard

HSO's LTC Services standard criteria	CIHI's data tools, outputs and products that support HSO's criteria	Data available publicly	Notes
1.1.5 The governing body ensures the LTC home has a comprehensive human resources plan.	• Resource Utilization Groups version III (RUG-III) Distribution and associated Case Mix Index	Yes	RUG-III can provide information to determine resource use. Submitters have access to detailed reports in private access tool.
1.1.9 The governing body demonstrates accountability for the quality of care that the LTC home delivers.	• Assessment instruments • Clinical Assessment Protocols (CAPs) • All public quality indicators (QIs)	Yes (QIs)	The assessment instruments, CAPs and all public QIs serve as monitoring tools to support accountability for the quality of care that the home delivers.
2.1.5 Teams follow the LTC home's procedure to determine residents' capacity to make their own care decisions.	• Cognitive Function QI • Cognitive Loss CAP • Cognitive Performance Scale • Assessment items on change in decision-making and daily decision-making	Yes (scales)	These items would contribute to determining residents' capacity to make their own care decisions.
2.1.7 Teams follow the LTC home's procedure to inquire whether residents have an appointed substitute decision-maker.	• Assessment items on decision-maker for personal care and property	No	None
2.2.7 Teams ensure residents are actively engaged in their daily life and care activities.	• Index of Social Engagement Scale (ISE) • Revised Index of Social Engagement Scale (RISE) • Assessment items on customary routine (e.g., cycle of daily events, eating, activities of daily living [ADLs], involvement patterns)	Yes (scales)	None

HSO's LTC Services standard criteria	CIHI's data tools, outputs and products that support HSO's criteria	Data available publicly	Notes
2.4.1 The LTC home leaders promote communication strategies that facilitate the engagement of all residents.	• Communication Scale (IRRS only) • Communication CAP	No	The Communication Scale and CAP help identify residents' communication status (i.e., their expressive and receptive communication), which can be used to inform tailoring of effective communication strategies.
4.1.1 The LTC home leaders provide teams with a validated template to conduct residents' comprehensive needs assessments.	• Assessment instruments	No	The assessment instruments are validated tools with reporting systems and associated minimum reporting standards.
4.1.2 The team conducts the resident's comprehensive needs assessment upon admission to the LTC home.	• Assessment instruments	No	Assessment instruments are initially completed upon admission.
4.1.3 The team uses the validated needs assessment template to evaluate the resident's basic needs.	• ADL scales	Yes	ADL scales evaluate residents' basic needs (e.g., bathing, walking, eating).
4.1.4 The team uses the validated needs assessment template to evaluate the resident's mental health needs.	• Depression Rating Scale • Mood CAP • Assessment items on mood and behaviour, mental health diagnoses upon admission, cycle of daily events, eating, ADLs and involvement patterns	Yes (scale)	Involvement pattern items include information related to having pets, contact with family, visits to places of worship, etc.
4.1.5 The team uses the validated needs assessment template to evaluate the resident's physical health needs.	• Assessment instruments	No	The assessment instruments are comprehensive, standardized assessments of residents' physical health needs, strengths and preferences.
4.1.6 The team uses the validated needs assessment template to evaluate the resident's social needs.	• Index of Social Engagement Scale (ISE) • Revised Index of Social Engagement Scale (RISE)	Yes	None
4.1.7 The team conducts ongoing needs assessments according to the resident's changing health status and care needs.	• Assessment items on overall changes in care needs • Reason for assessment	No	Quarterly assessments provide up-to-date information for care planning. Significant change criteria outline when a reassessment is required and must be completed within 3 days of the significant change. Return assessments are completed when a resident returns from the hospital or re-enters the LTC home after a short, planned absence.

HSO's LTC Services standard criteria	CIHI's data tools, outputs and products that support HSO's criteria	Data available publicly	Notes
4.1.8 The LTC home leaders provide teams with a validated template to develop individualized care plans.	• CAPs in general	No	Residents and teams use CAPs to identify potential status concerns to inform and develop individualized care plans.
4.1.9 The team engages with the resident to develop the resident's individualized care plan.	• Assessment items on person's expressed goals of care and on advance care planning	No	None
4.1.10 The team continually updates the resident's individualized care plan.	• Assessment items on overall changes in care needs • Reason for assessment: change in status	No	Quarterly assessments provide up-to-date information for care planning.
4.2.2 The team follows the LTC home's procedure for nutrition and hydration management.	• Feeding Tube QI • Weight Loss QI • Assessment items on resident eating and drinking capabilities (regardless of skill) • CAPs: Undernutrition, Feeding Tube, Dehydration	No	None
4.2.3 The team follows the LTC home's procedure for oral health management.	• Assessment items on inflamed gums (gingiva), swollen or bleeding gums, oral abscesses, and ulcers or rashes	No	None
4.2.4 The team follows the LTC home's procedure for skin integrity management.	• Pressure Ulcer Risk Scale (PURS)	Yes	None
4.2.5 The team follows the LTC home's procedure for pain management.	• Pain Scale • Experiencing Pain QI • Worsening Pain QI	Yes (QIs)	None
4.2.6 The team follows the LTC home's procedure for the reduction of injuries caused by falls.	• Falls QI • Assessment items on fall status, locomotion, modes of locomotion, test for balance, functional limitation in range of motion, and ADL functional rehab potential	Yes (QI)	None
4.2.7 The team follows the LTC home's procedure for the management of responsive behaviours.	• Behaviour QI • Aggressive Behaviour Scale • Behaviour CAP	Yes (QI, scale)	None
4.2.8 The team follows the LTC home's procedure on the use of least restraint.	• Restraint CAP • Percentage of Residents in Daily Physical Restraints QI	Yes (QI)	None
4.2.9 The team follows the LTC home's procedure to review the resident's medication profile.	• Appropriate Medications CAP	No	None

HSO's LTC Services standard criteria	CIHI's data tools, outputs and products that support HSO's criteria	Data available publicly	Notes
4.2.10 The team follows the LTC home's procedure to reconcile medications following a change in the resident's care plan that may result in a change in the medication profile.	• Assessment items on recently changed medications	No	None
4.2.11 The LTC home leaders implement a program to ensure the appropriate use of antipsychotic medication.	• Antipsychotic Without Diagnosis of Psychosis QI	Yes	None
6.1.2 Teams have a quality improvement plan for improving residents' quality of life.	• Quality of life CAPs (e.g., Activities, Social Relationship) • Index of Social Engagement Scale (ISE) • Revised Index of Social Engagement Scale (RISE) • Depression Rating Scale	Yes	Several items can be used to measure physical and mental health as quality-of-life dimensions.
6.1.3 Teams have a quality improvement plan for improving residents' quality of care.	• Physical and mental health CAPs • All public and private QIs	Yes (QIs)	QIs collected can inform quality improvement plans to improve residents' quality of care and to measure a change in quality of care over time.
6.1.5 The LTC home leaders communicate quality improvement outcomes to the LTC home's stakeholders.	• All public QIs	Yes	CIHI's public reporting of 9 LTC quality indicators can contribute to communicating QI outcomes to the LTC home's stakeholders.

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