Central East Region Adult Day Program Guidelines

June 2020

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Purpose and Scope

The Adult Day Program Guidelines were developed utilizing a co-design methodology. Weekly structured meetings were conducted over a period of three months. These Guidelines have been informed by evidence, and the input and collective wisdom of over 40 representatives from all 17 known Adult Day Program providers[1] in the Ontario – East, Central East Region and the Seniors Care Network staff.

The goal of the guidelines is to minimize undesirable variation and facilitate the provision of consistent, high-quality programs and services across the Region.

[1] COTA Health (Cota) ABI Adult Day Program at Providence Healthcare was not included in the scope of this project.

Adult Day Program

Definition

An Adult Day Program (ADP) is an integrated support service which provides supervised programming in a group setting for individuals who require assistance with personal activities (e.g. hygiene, dressing, etc.). Clients include older adults and/or those living with frailty, dementia or related disorders or who routinely experience, physical challenges, cognitive challenges, who can manage certain personal activities with assistance, and/or who may be socially isolated. This service assists the participants to achieve or help maintain their maximum level of functioning, to prevent early or inappropriate institutionalization and provides respite and information to their care partners. Components of the service include planned social and recreational activities, meals, assistance with the activities of daily living and minor health care assistance, e.g. reminders for medications, etc.[2,3]

Goals

The goals of ADPs are to:

- Assist participants to:
  - live well in the community
  - maintain their choice of residence
  - facilitate the achievement of care/service plan goals
- Support care partners in their wellness and caring for their loved ones at home
- Collaborate with/contribute to a system of community based care[4]

Seventeen Adult Day Program providers, who deliver services at 44 sites (see Appendix 1) throughout the Central East Region of Ontario, were engaged in the co-design process. Currently there are three distinct types of ADPs: Traditional ADPs, Young Onset Dementia (YOD) ADPs and Acquired Brain Injury (ABI) ADPs. Traditional ADPs serve the older adult population, typically 65 years and older. Among the Traditional ADPs, *Centres D'Accueil Heritage* delivers services exclusively in French. The YOD ADPs serve individuals with a diagnosis of young onset dementia who are 65 years and younger. The ABI ADPs serve individuals with acquired brain injury.

[2] Ontario Healthcare Reporting Standards, 2019-20. *Chapter 10, Version 11.0.*
[3] A fee/co-payment may apply.
[4] Adapted from Champlain LHIN (2015). *Service Reference Document, Community Support Sector.*

ADP Guideline Development Process

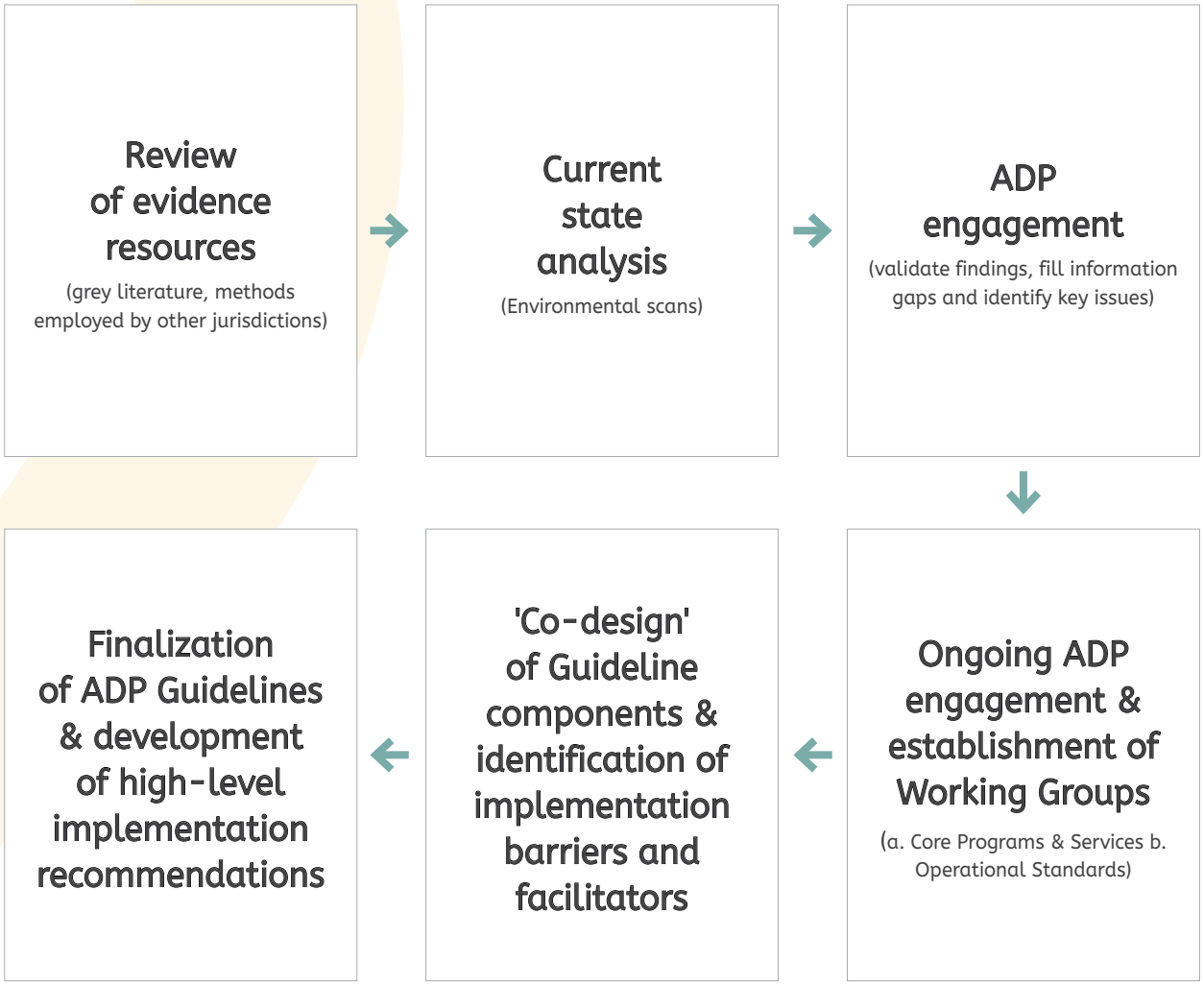
The following principles informed the ADP Guidelines development process:

- Client-centred care
- Supporting care partners
- Accessibility
- Cultural/Linguistic sensitivity
- Equity
- Accountability
- Alignment with the Institute for Healthcare Improvement Quadruple Aim[5]
- Building capacity to meet the evolving needs of ADP clients

[5] Refer to: Population Health, Patient Experience, Reduce Cost, and Provider Experience.

The following figure depicts the ADP Guideline development process:

Figure 1 – ADP Guideline Development Process



Guideline Components

These Guidelines provide an overview of the population served, the minimum basket of programs and services to be offered by each provider and the operational standards informing organizational processes.

There are three main components to these ADP Guidelines:

- Client Profiles
- Core Programs and Services
- Operational Standards

Client Profiles

The following tables provide an overview of the client characteristics, most common diagnoses and most common reasons for referral for the three types of ADPs.

Client Characteristics

	Traditional	Young Onset Dementia	Acquired Brain Injury
Average age	78	66	48
Females	64%	29%	30%
Males	36%	71%	69%
Other	0%	0%	1%
Live alone	11%	0%	47%
With care partner	85%	100%	38%
Other living situation	4%	0%	12%
With dementia	85%	100%	25%
With responsive behaviors	26%	15%	53%
Receiving formal support	74%	20%	71%
Receiving informal support	95%	55%	25%

Most Common Diagnoses

Traditional	Young Onset Dementia	Acquired Brain Injury
• Cognitive impairment • Alzheimer's Disease/Dementia • Parkinson's disease • Stroke • Depression/Isolation • Brain injury • Frailty • Cardiovascular disease	• Young Onset dementia	• Acquired brain injury • Young Onset dementia • Physical disabilities • Developmental disability • Mental health/addiction

Most Common Reasons for Referral

Traditional	Young Onset Dementia	Acquired Brain Injury
• Care partner respite • Socialization and recreation • Physical & intellectual/cognitive stimulation • Therapeutic exercise • Maximize 'function' • Meals • Safety	• Alternative to 'traditional' ADP • Recreation • Socialization • Care partner respite • Support for working care partners	• Socialization • Peer support • Community engagement • Care partner respite • Mental health/addiction support • Informal rehabilitation • Responsive Behaviors

Core Programs & Services

All ADPs are expected to deliver a core set of programs and services. This core set includes:

1. Physical Wellness
2. Therapeutic Recreation
3. Personal Care Services
4. Nutrition
5. Care Partner Support and Education
6. Community Engagement
7. Care Coordination and System Navigation

ABI Specific:

8. Life Skills

These programs and services are described further.

Physical Wellness

Physical wellness includes activities that promote proper care for optimal health and functioning. The activities are designed to assist individuals to maintain mobility through balance, flexibility, endurance, range of motion, stability, coordination and strength. These activities also provide important opportunities for socialization (e.g., exercise, falls prevention, walking, physical games, drum circle, etc.).

Therapeutic Recreation

Therapeutic recreation includes activities that provide social, emotional, intellectual, cognitive, physical, and spiritual stimulation to promote independence and enhance function[6] (e.g., tablet programs, music therapy, mental stimulation activities, dancing, art therapy, pet therapy, spiritual engagement, horticultural therapy, sensory stimulation, etc.). Therapeutic recreation should be delivered in a culturally sensitive manner and should be designed to actively engage the client by providing opportunities for a variety of activities with all levels of involvement.

Personal Care Services

Personal care services are unique to the client's needs. These services may include physical assistance or verbal cueing with activities of daily living depending on the client's functional ability (e.g., washroom assistance, feeding assistance, medication reminders, ambulation and transfers with no lifting, dressing/clothing assistance[7], etc.).

Medication Reminders

Medication reminders are a service provided to clients to ensure that medications are taken as intended by the prescriber when the client is self-administering their own medications. Medications are accessible to the client but may be stored in a locked central location and brought to the client for use at the required times. Site staff remind clients when to take their medications or provide them with specific instructions to get the most benefit from the medications. Medications taken during the hours the client is at the program are reviewed during the initial assessment and re-assessments (or as needed) with care partners and/or clients. Note that medication reminders primarily refer to non-delegated tasks.[8]

Nutrition

Hot or cold nutritious meals and snacks are individualized to dietary needs and served in settings that promote and foster positive social interactions (e.g., special event meals, birthday celebrations, cultural celebrations, baking classes, etc.). Nutrition related education and information may also be provided (e.g., diabetes education). All food preparation follows the Canada Food Guide and relevant staff hold Safe Food Handlers Certification.

[6] Adapted from Enhanced Adult Day Program Service Standards (2019). *Community Navigation and Access Program (Toronto Central LHIN), Working Group Report to the Ministry of Health and Long-Term Care.*
[7] Does not include wound dressing
[8] Central Local Health Integration Network (2018). *Adult Day Programs, Standard Manual and Best Practice.*

Care Partner Support & Education

Support, education, guidance and resources are provided for families and care partners who are caring for ADP clients. These may include:

- Education regarding the understanding of client's behaviours and changes in client's needs
- Information about other support services in the community
- Social events where families are invited to take part in special events held at the ADP
- Regular family conferences where care partners are invited and encouraged to attend care planning conferences when appropriate to the clients' situation

Care Coordination

Care coordination involves organizing client care activities and sharing information within the circle of care to achieve safe, appropriate and effective care. Care coordination enables:

- Client's needs and preferences to be known ahead of time
- Care/service plan to be based on individualized client needs[9]

System Navigation

System navigation involves collaborating with colleagues and/or community partners (e.g., Home and Community Care coordinator, hospital discharge planner, primary care provider) to determine what services a client and their family/care partner may need in the community, and identifying the appropriate agencies to contact prior to discharge (e.g., long term care waitlist).[10] The clients are assessed/re-assessed to identify and determine specific services that they may benefit from (e.g., home care support, specialized geriatric services, etc.). ADPs are committed to improving access, transitions, and coordination for clients and/or care partners.

Community Engagement

Community engagement is the process by which clients, care partners and/or community members are engaged to work and learn together on behalf of their communities. It can involve informing community members about an initiative, inviting their input, collaborating with them to generate solutions, and partnering with the community to address community issues. Community engagement increases community cohesion and allows for the community to be invested in the outcomes. (e.g., intergenerational programming, Earth Day clean-up, collections for food banks, student placements, stroke survivor group, etc.).[11]

[9] Adapted from Agency for Healthcare Research and Quality (2020). *Care Coordination.*
[10] Adapted from the College of Respiratory Therapists of Ontario, GROW. *Health System Navigator.*
[11] Tamarack Institute for Community Engagement (2020).

ABI Specific – Life Skills

Life Skills programs assist persons with a disability to learn the basic skills of daily living. Services may include training in the ability to travel about the community alone, to live independently in a private residence, to maintain health through self-care and use of medical services, to live within their personal income, to maintain grooming and appearance, and to cope with other requirements of successful independent living.[12]

Specialized Programs

In addition to the above stated Core Programs & Services, some sites also provide specialized programs such as:

- Programs for individuals with advanced complex care needs, e.g., those with higher personal care needs, post-stroke clients, individuals living with Parkinson's Disease or those with advanced/chronic renal disease or Chronic Obstructive Pulmonary Disease (COPD)
- Dementia specific ADPs for those living with dementia where staffing ratios are higher and includes sites with secure units.

[12] thehealthline.ca (2020). *Services for Central East.*

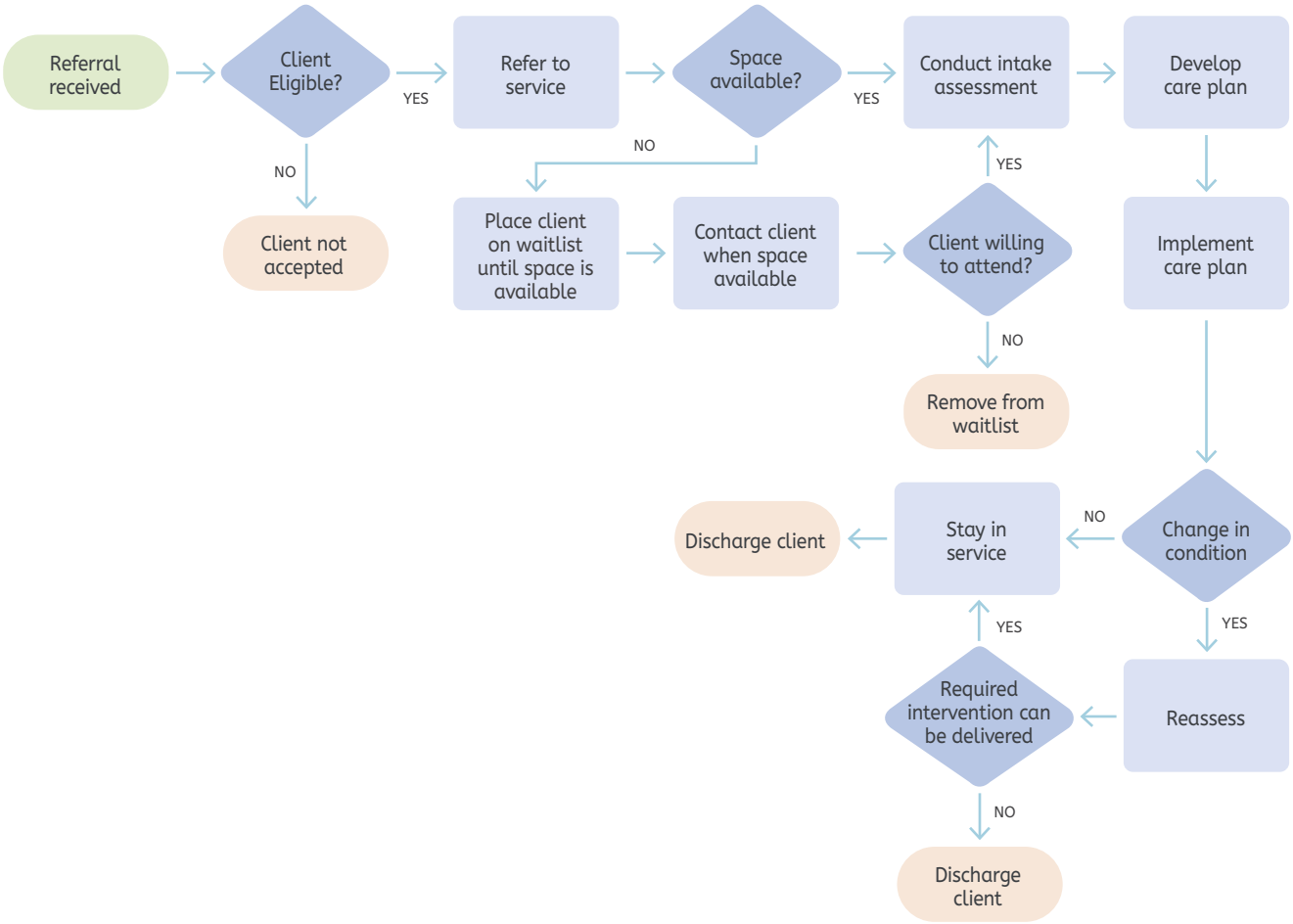
Operational Standards

The following standards have been established to guide the operations of Adult Day Programs.

Limits of Care

Limits of care refer to the client's journey from admission to discharge. The following figure is a pictorial overview of the process:

Figure 2 – Limits of Care Process Map



Eligibility Criteria

Clients are eligible for ADPs if they are:

- Insured under the Health Insurance Act
- 18 years of age or older
- Frail, elderly and/or living with dementia or related disorders; routinely experiencing physical and/or cognitive challenges but can manage certain personal activities with assistance; and/or are socially isolated
- Able to transfer independently, with supervision or one person assist
- Residents of Central East Ontario
- Presenting no serious risk to staff, volunteers and/or co-clients

Additionally, their care requirements cannot exceed the program's environmental or physical resources and staff expertise.

Intake Assessment

An intake assessment will be conducted for each client accepted into the ADP and will include information on the following:

- InterRAI Community Health Assessment or InterRAI Home Care Assessment
- Leisure interest
- Medical history
- Current medications
- Allergies/food sensitivities
- Substitute Decision Maker, Power of Attorney for Personal Care and/or Power of Attorney for Property
- Emergency contact information

A discussion with the client and care partner regarding the program, the terms of service, fees, subsidies available, privacy, Client Bill of Rights, consents/permission forms, transportation options, policies (e.g., vacation hold, hospital hold, respite hold, etc.) and the organization will be conducted.

Holds

Clients may be discharged if they are away from the program for more than 30 consecutive calendar days. This includes vacation, hospital and respite holds. However, this may be negotiated on a case by case basis. Clients will be required to meet the eligibility criteria prior to returning to the program. Clients are to be made aware of this policy at the time of intake.

Care/Service Plan

A comprehensive/holistic client-centred care/service plan will be developed for each ADP client and will include information on the following:

- Physical ability (e.g., mobility and ambulation, exercise tolerance, pain tolerance, etc.)
- Cognitive needs
- Psychosocial needs
- Personal interests and needs
- Presence of responsive behaviours (triggers and successful interventions)
- Accommodations required (e.g., dietary, environmental)
- Activities of Daily Living assistance (e.g., personal care/toileting)
- Sensory aids (e.g., vision and hearing)
- Program preferences
- Supports being received at home (formal and informal)

The care/service plan will be revised/updated every six months or more frequently if there is a significant change in the client's physical and/or mental health. A copy of the care/service plan (initial and any subsequent) will be provided to the client/care partner.

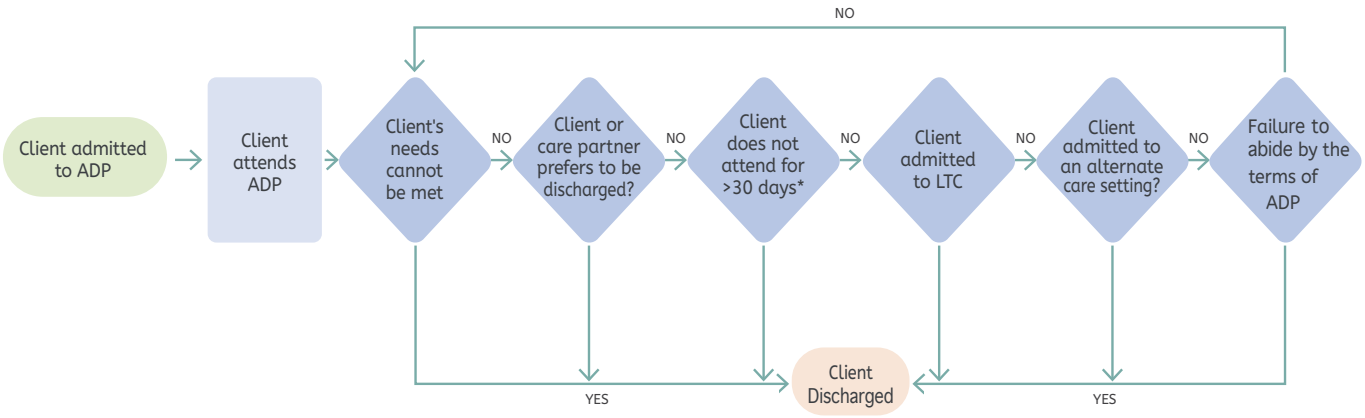
Client Discharge[13]

Adult Day Program providers may discharge clients if they pose risk to personal health and safety that cannot be managed by staff or if the client cannot be safely accommodated in the program.

- A client will be discharged from the program for the following reasons:
  - client needs can no longer be met by the program
  - upon admission to long-term care
  - upon admission to an alternate care setting
  - client and care partner preference
  - failure to attend the program for an extended period
  - failure to abide by the terms of service of the ADP
  - Additionally, client death warrants an automatic discharge.

The discharge criteria are depicted in the figure below:

Figure 3 – Discharge Criteria Process Map[14]



Once the decision to discharge has been made, the development of a transition plan will begin.[15] The client or care partner will be assisted to navigate to alternate services.

[13] Adapted from Enhanced Adult Day Program Service Standards (2019). *Community Navigation and Access Program (Toronto Central LHIN), Working Group Report to the Ministry of Health and Long-Term Care.*
[14] Adapted from Central Local Health Integration Network (2018). Adult Day Programs, Standard Manual and Best Practice.
[15] Client death being an exception.

Transition Plan

A transition plan will be developed for every client that is transitioned from the ADP into another facility/program and will include information on the following:

- Physical ability (e.g. mobility and ambulation, exercise tolerance, pain tolerance, etc.)
- Cognitive needs
- Psychosocial needs
- Personal interests and needs
- Presence of responsive behaviours (triggers and successful interventions)
- Accommodations required (e.g. dietary, environmental)
- Activities of Daily Living assistance (e.g. personal care/toileting)
- Sensory aids (e.g. vision and hearing)
- Program preferences
- Supports being received at home (formal and informal)
- Additional information to support the client

Human Resource Management

Staff Ratios

The staffing ratio may vary across different ADP types and throughout the day and week. An overview of the recommended staffing ratios is given below:

Type of ADP	Minimum Recommended Staffing Ratio
Traditional Programs	1:5
Specialized Programs	1:4
Young Onset Dementia	1:5
Acquired Brain Injury Programs - Regular	1:10
Acquired Brain Injury Programs – Dementia	1:5
Acquired Brain Injury Programs – Drop in	1:25

These ratios may require adjustment based on client's needs.

Staff Mix

Staff capacity and competency must be consistent with the defined needs of the clientele being served and the scope of services being provided. To better serve their client population, each provider should have the flexibility within their funding to select the appropriate staff mix. This flexibility is also required to allow providers to continually adapt their staffing to the evolving needs of their clientele.

Program human resources may include:

- Personal Support Workers
- Program Activationists, Recreationists, and/or those with education in Gerontology
- Social Service Workers
- Developmental Service Workers
- Managers
- Administrative Support
- Registered Nurses/Practical Nurses
- Therapy Assistants
- Therapy Aides
- Activity Conveners/Coordinators
- Dietitians
- Social Workers
- Cooks
- Drivers
- Volunteers

Additional supplemental staff may be required at various times.

Scope of Work[16]

The ADP provider shall recruit, train, supervise and provide sufficient numbers of qualified staff to meet the client care requirements described in the client care/service plans. The provider shall ensure that the staff assume responsibility for the care and support of each client in accordance with the care/service plan.

Staff should be able to communicate effectively, help clients and care partners navigate the health care system, link with other care providers, and have an awareness of other services offered in the community.

Staff are expected to provide services within their scope of practice and competency. They should cover for other roles when appropriate.

Role of Direct Program Staff

Direct program staff develop, organize and implement therapeutic recreation and physical activation programs that promote physical, social, emotional, intellectual and spiritual well-being. Additionally, they assist with personal support services (with the exception of YOD and ABI programs), medication reminders, and ambulation and mobility assistance (as applicable). All direct program staff require a Police Services vulnerable sector check.

[16] Central Local Health Integration Network (2018). *Adult Day Programs, Standard Manual and Best Practice.*

Job Descriptions

Job descriptions should be developed for all staff and should be made available to the respective individual.

Experience and Knowledge

All direct program staff may have experience/knowledge in/of the following:

- community-based settings
- person-centered care
- dementia care
- client safety
- responsive behavior management
- mental health and addictions
- complex, chronic health conditions
- elder abuse
- documentation requirements
- care/service planning
- community resources
- digital technology and devices

Recommended Staff Training Requirements

While the list is not exhaustive, below are the recommended staff training requirements:

- First Aid and CPR certification
- Exercise and Falls Prevention Education
- Food Safety Training certification
- Gentle Persuasive Approach (GPA), U-First, Validation, Montessori and related Behavioural Support Ontario tools
- Additionally, neuro-rehabilitation training is required for ABI direct program staff

Staff are to be provided with all necessary training to perform their job duties and serve their defined client population. In addition, access to ongoing education to maintain current competencies that are reflective of best practices should be facilitated.

Staff Orientation

(Based on Corporate Organizational Policies of ADP Providers)

The staff orientation may include, but is not limited to, the review of:

- Ontario Health – East, Central East Region, Adult Day Program Guidelines
- Purpose of the program
- Responsibilities of the clients, informal care partners and responsibilities of the program
- Services provided by program
- Respective job description
- Performance appraisal timelines
- Confidentiality, privacy and informed consent
- Occupational Health and Safety
- Infection Prevention and Control
- Workplace Hazardous Materials Information System (WHMIS)
- Customer Service
- Diversity and inclusion
- Incident reporting process
- Medication assistance procedures
- Client complaints processes
- Accessibility for Ontarians with Disabilities Act (AODA) training
- Workplace Violence and Harassment
- Policies and procedures of the service provider
- Complaint Resolution

Volunteer & Student Orientation

ADP providers may recruit volunteers and offer student placements. The volunteer and student orientation may include, but is not limited to, the review of:

- Organizational overview
- Code of conduct
- Dementia specific training
- Client specific care (understanding of client care needs and care/service plan, care/service plan will be shared as appropriate)
- Infection Prevention and Control
- Signs of abuse and neglect
- Privacy and confidentiality
- Safe food handling
- Personal care training (for students)
- Workplace Hazardous Materials Information System (WHMIS)
- Accessibility for Ontarians with Disabilities Act (AODA) training
- Workplace Violence and Harassment
- Complaint Resolution

Additionally, all students and volunteers require a Police Services vulnerable sector check.

Program Hours & Days of Operation

Hours of operation and days of operation vary among sites with a minimum of 5 programming hours per day. Operating hours per day range from 5-12.

Waitlist Management

There are various factors that need to be considered when managing a waitlist. These include:

- working status of care partner
- level of care required to accommodate the waitlisted client
- space availability
- ongoing needs of rostered clients
- needs of the waitlisted client
- accommodation at other program locations

Waitlisted clients may be invited to attend programs for shorter periods of time to facilitate integration, when possible.

Transportation

ADP providers will assist clients and/or care partners by referring and/or coordinating options for transportation through internal, contracted or community providers.

Clients and care partners accessing ADPs expect the high quality programs and services. While most ADPs are in organizations that define their own expectations for quality, there is also a need to consider quality through the lens of an inter-organization, networked system of ADPs.

Quality Improvement And Performance Management

Quality

The Institute of Medicine suggests that quality is

"the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge".[17]

Health Quality Ontario identifies the elements of quality as safe, effective, client-centred, efficient, timely and equitable.[18]

[17] Institute of Medicine (1990).
[18] Health Quality Ontario (2017). *Quality Compass*

Quality Improvement

Quality improvement is a systematic, formal approach to:

- the analysis of performance and efforts to improve it. In health care, quality improvement is a proven, effective way to improve care for patients, residents and clients, and to improve practice for staff. It is a continuous process at each home, practice or organization and should be an integral part of everyone's work, regardless of role[19]
- making changes that lead to better patient outcomes and stronger health system performance[20]

Every organization is expected to have compliments, complaints and incident management processes. It is expected that information obtained from these processes will be utilized to identify and implement quality improvement initiatives.

Performance Management

Performance Management is the organization wide effort to harness the power of all quality initiatives and to align them with the identified strategic priorities. Data collection and monitoring are key to effective performance management.

Logic Model

"*The program logic model is defined as a picture of how your organization does its work – the theory and assumptions underlying the program. A program logic model links outcomes (both short- and long-term) with program activities/processes and the theoretical assumptions/principles of the program.*"[21]

In order to determine a collective vision, standardize cross-regional performance management and facilitate the achievement of the IHI Quadruple Aim, the logic model on the following page has been developed:

[19] Health Quality Ontario (2017). *Quality Compass.*
[20] Adapted from Health Quality Ontario (2013). *Quality Improvement Science.*
[21] W.K. Kellogg Foundation (1998). *Logic Model Development Guide.*

Figure 4- System level Logic Model

VISION	A network of high functioning Adult Day Program providers collectively contributing to a system of high quality, client-friendly, community-based care			
AIM	Provision of high quality, standardized, person-centered, equitable and cost-effective ADP services across Central East Region of Ontario to enable individuals to achieve or help maintain their maximum level of functioning in their residence of choice			
OBJECTIVES	Achievement of IHI Quadruple Aim			
TARGET POPULATION	Residents of Central East Region of Ontario who are frail, elderly and/or those living with dementia or related disorders, or those who routinely experience, physical and/or cognitive challenges (but can manage certain personal activities with assistance), and/or those who may be socially isolated			
COMPONENTS (Target Audience)	**Population Health** (Public)	**Patient Experience** (Clients and Care partners)	**Reduce Cost** (Decision makers, Funders)	**Provider Experience** (Staff, volunteers and students)
INPUTS	Human Resources: • Administration • Front line • Support Staff • Volunteers and/or Students		Facilities Equipment & Supplies LHIN Funding Non-LHIN Funding Training (Staff & Volunteers) Transportation	
ACTIVITIES	• Design programs & services to meet the evolving/ emerging needs of the target population • Develop and distribute communication materials to increase public awareness about ADP programs & services	• Conduct intake assessments • Develop holistic person-centered care plans • Deliver programs and services • Provide care partner support and education • Conduct client and care partner Experience Surveys	• Deliver cost-effective programs and services • Enable equitable access	• Provide capacity building opportunities • Recruit and train staff • Recruit and train volunteers • Conduct Staff Experience Surveys • Recognize staff and volunteers contributions
INDICATORS	Indicators and frequency of reporting to be determined on an annual basis.			

Appendix 1

ADP Providers and Sites

Traditional ADPs

	Organization	Sites (37 sites)
1	Carefirst Seniors & Community Services Association	2 sites in Scarborough
2	Centres D'Accueil Heritage	Oshawa
3	Community Care City of Kawartha Lakes	2 sites in Lindsay, Bobcaygeon, Fenelon Falls, Little Britain, Omemee
4	Community Care Durham	Clarington, Pickering, Uxbridge, Whitby
5	Haliburton Highlands Health Services	Haliburton, Minden, Wilberforce
6	Oshawa Senior Citizens Centres	4 sites in Oshawa
7	Regional Municipality of Durham	Oshawa, Beaverton, Port Perry
8	Scarborough Centre for Healthy Communities	Scarborough
9	Senior Persons Living Connected	Scarborough
10	TransCare Community Support Services	Scarborough
11	Victorian Order of Nurses	Campbellford, Cobourg, Curve Lake, Havelock, Lakefield, Peterborough Square, Port Hope, Woodland
12	Yee Hong Centre for Geriatric Care	3 sites in Scarborough

Young Onset Dementia ADPs

	Organization	Sites (3)
1	The Alzheimer Society of Durham Region	Whitby
2	Alzheimer Society of Toronto	Scarborough
3	Alzheimer Society of Peterborough, Kawartha Lakes, Northumberland and Haliburton	Peterborough

Acquired Brain Injury ADPs

	Organization	Sites (4)
1	Brain Injury Association of Durham Region	Oshawa
2	Brain Injury Association Peterborough Region	2 sites in Peterborough, Lindsay

The following evidence resources were consulted in the preparation of this document:

Agency for Healthcare Research and Quality (2020). *Care Coordination.* Retrieved from https://www.ahrq.gov/ncepcr/care/coordination.html

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