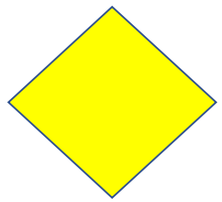
Momentum Conversion Platform (CP): platform used for interRAI LTCF and Care Planning

Denotes a Process

Identifies a document



Identifies where/ when a decision is made

Denotes an item that pertains to all Disciplines

A custom shape used in this document for Consultants

Identifies either the Start or the End of a Process

A custom shape used in this document for a special note

ABBREVIATIONS

ACP: Advanced Care Planning
BPMH: Best Possible Medication History
CAPs: Clinical Assessment Protocols (used for Care Planning)
GOC: Goals of Care
HCA: Health Care Assistant
LOA: Leave of Absence
LTCF: Long Term Care Facility
Momentum CP: Momentum Convergence Platform (often referred to as just Momentum)
MRP: Most Responsible Provider
NUA: Nursing Unit Assistant (at some LTC Homes called either CSC – Clinical Support Clerk or UC - Unit Clerk)
Nurse: includes RNs, LPNs, and RPNs
OCS: Outcome Scales (used to validate that coding accurately describes the Person AND for Care Planning)
PAT: Priority Access
PSLS: Patient Safety & Learning System
RAI: Resident Assessment Instrument
RCC/CNL/COS: Resident Care Coordinator/Clinical Nurse Leader/Clinical Operations Supervisor
SIC: Serious Illness Conversations

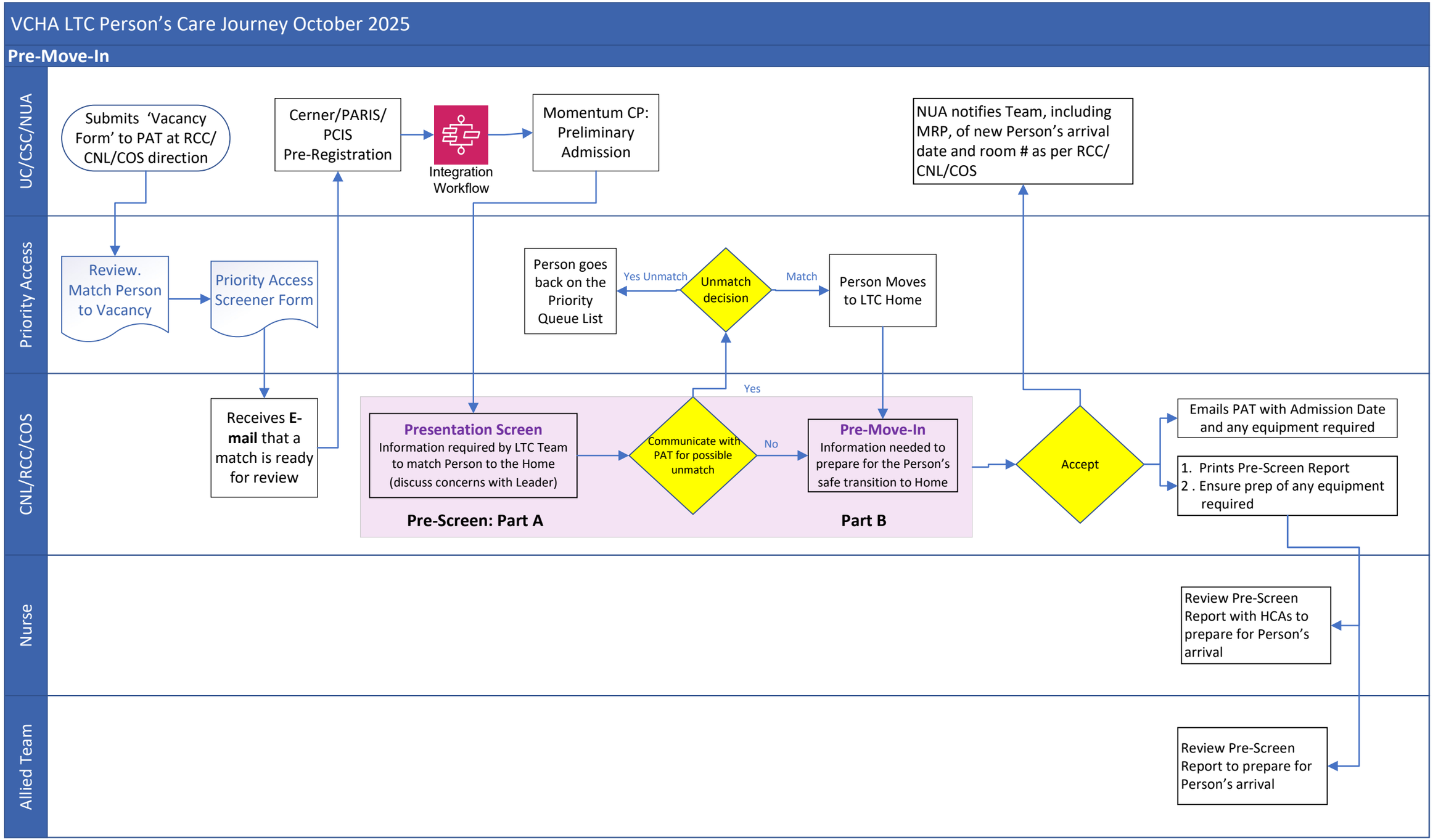
NOTE: The Complete Care Plan includes:

- the Interdisciplinary Care Plan and
- the Care Guide (supports HCA workflow)

LTC Homes across VCHA are transitioning to interRAI LTCF
This workflow applies to when LTC Homes have transitioned to interRAI LTCF

VCHA LTC Person's Care Journey October 2025

Pre-Move-In



VCHA LTC Person's Care Journey October 2025

Move-In Day

UC/CSC/NUA

- Change Pre-registration to Registration in Cerner/ PARIS/PCIS
- Integration Workflow
- Momentum CP Full Registraton
- Takes Person's Photo. Uploads in CP
- Updates Contact Information. Prints Face Sheet (places on chart)
- Prints basic chart pack and any ad hoc forms required (e.g. Diabetic Record)
- Add Person to internal lists as per site (e.g. monthly weight)
- Submits 'Admission Form' to PAT at RCC/ CNL/COS direction

CNL/RCC/COS

- Ensure interventions e.g. bed alarm, identified on Screen are available
- Review Consent Forms for completion
- Reviews Care Plan on move-in to support Person's needs for safety and comfort
- Shares the 'Welcome' booklet to the Person/ Care Partner

Nurse

- Reviews the Pre-Screen Report and OCSs pre-arrival: shares with HCAs at Report
- Reviews and updates BPMH
- Notifies MRP for Medication Orders and Code Status
- Notifies Pharmacy of arrival
- If RD not available, notifies the Kitchen of arrival and diet type
- Reviews Food, Drug and Contact Allergies for completion. Updates as needed
- Completes required moving-n assessments and documentation in chart
- Completes additional assessments and screening as identified by RCC following pre-screen/intake assessment
- Initiates Care Plan for comfort and safety

PT/OT

- Reviews Pre-Screen Report including Outcome Scales
- Completes and documents Discipline Specific Assessments and Screening
- Contributes to Care Plan and prints updated ID Care Plan/Care Guide reports as necessary.

RD

- Notifies Kitchen of arrival and diet type
- Enters food allergies and intolerances as needed

SW

- Identifies TSDM
- Assists Person/ Care Partner to set up Comfort Fund
- Discusses/arranges a time to discuss Advanced Care Planning (ACP)/Goals of Care (GOC)/Serious Illness Conversations (SIC)
- Discusses/arranges a time to discuss financial and funeral arrangements

VCHA LTC Person's Care Journey October 2025

Move-In Day Continued

MRP

- Reviews Pre-Screen Report and information in PAT package
- Reviews Medication Reconciliation with Pharmacy (Med. Rec)
- Orders Medication and Pre-Printed Admission Orders
- Completes and Documents Medical Assessment
- Discusses ACP/ GOC/SIC with Person/Care Partner and enters Code Status

Pharmacy

- Reviews Pre-Screen Report and Medication List
- Participates with MRP in BPMH and Medication Reconciliation
- Labels personal meds/supplements that Person brings in from home

Recreation/ Music Therapy

- Reviews Pre-Screen Report including OCS
- Meets with Person/Care Partner to identify activity preferences and determine if Therapy would be beneficial
- Completes and documents Discipline Specific Assessments and Screening
- Contributes to Care Plan and prints updated ID Care Plan/Care Guide reports as necessary.

Spiritual Health

HCA

- Greets the Person
- Assists Person/ Care Partner to unpack
- Ensures clothing, dentures, etc are labelled
- Ensures Person is set up with supplies needed for ADLs e.g. wash basin
- Gives a tour of Neighbourhood
- Introduces Person to roommate(s) and tablemate(s)
- Completes 24 hour close observation form/BSO-DOS and observation flow sheets initiated by Nurse
- Completes LTC Daily Care Flow Sheet

Person/Care Partner

- Informs of any updates to Contact Information
- Meets with RCC/SW (contacts)
- Gives Nurse Over the Counter medications and supplements for lablelling

VCHA LTC Person's Care Journey October 2025

Day 1-10: First LTCF Observation Period: | **Day 1- 3** | **Day 4-5** | **Day 10**

UC/CSC/NUA

- Adds Person to Conference List - books 1st conference within 6 weeks of moving-in
- Ensures Person is added to Annual Conference List
- Ensures transportation is booked for appointments as needed and communicates details to staff
- PSLS are required for an incident that occurs while the Person is living at the Care Home (move-in to discharge)

CNL/RCC/COS

- LTCF Assessor initiates First Assessment (sets ARD for Day 3)
- Handler: Follow-ups on PSLS incidents where Person is injured. Notifies Licensing for follow-up prn.
- Ensures interRAI First Assessment is complete
- Validates the Outcome Scales and Clinical Assessment Protocols (CAPs). Signs off the assessment by day 4-5 and submits. Manages any rejections.
- Discusses care needs with Person/Care Partner. **By Day 10 updates** the Care Plan as necessary based on discussion and assessment. Prints ID Care Plan and Care Guide whenever updated

Nurse

- Reviews the HCA observation reports (can include tool for documenting LTCF observations) to update the Care Plan
- Ensures moving-in assessments are completed
- Completes any outstanding screening assessments
- Completes PSLS/ incident reports as needed. Inform RCC if serious injury.

PT/OT

- Contributes to interRAI assessment as per **VCH Standardized Education Process for RAI Assessors & Leads**

RD

- Completes PSLS/ incident reports as needed. Communicates with Nurse

SW

VCHA LTC Person's Care Journey October 2025

Day 1-10: First LTCF Observation Period: | **Day 1- 3** | **Day 4-5** | **Day 10**

MRP

Completes any outstanding assessments including Code Status

Pharmacy

PSLS are required for an incident that occurs while the Person is living at the Care Home (move-in to discharge)

Recreation/ Music Therapy

Contributes to interRAI assessment as per **VCH Standardized Education Process for RAI Assessors & Leads**

Spiritual Health

Completes PSLS/ incident reports as needed. Communicates with Nurse

Discuss care needs with Person/Care Partner. **By Day 10 updates** the Care Plan as necessary based on discussion and assessment. Prints ID Care Plan and Care Guide whenever updated

Consultants

Consultants include SLP, Mental Health, NSWOC, etc.

Completes Discipline specific assessment and documents. Updates Care Plan as needed

Contributes to interRAI assessment as per **VCH Standardized Education Process for RAI Assessors & Leads**

HCA

Completes daily observation tools and other observation tools as assigned by Nurse

Completes LTC Daily Care Flow Sheet

Person/Care Partner

Shares personal history and preferences to support care needs

VCHA LTC Person's Care Journey October 2025

On-Going

UC/CSC/NUA

- Book appointments and transportation as directed
- Supports MRP order processing prn
- Prints the Weekly Assessments Due Report for LTCF
- Submits Admission, Discharge and Vacancy Notification to PAT as directed by CNL/ RCC/COS
- Sends notification letter to Care Partner(s) for conference.
- Schedules conferences annually and as directed for each Person
- Prints and posts Care Conference Schedule
- Updates Person lists as necessary e.g. weights
- Supports outings, appointments, special orders prn e.g. bagged lunch
- Updates Photo and uploads in CP when appearance changes and at least annually

CNL/RCC/COS

- Arrange Person/ Care Partner meetings as necessary
- Reviews all PSLS/Incident Reports. Follows up as needed with appropriate discipline and licensing officer
- Ensures each Person has an LTCF assessment each Quarter and when needed for Significant Change. Validates OCS before submitting. Manages rejections.
- Sends consults as needed E.g. SLP
- Participates in Care Conference as necessary

Nurse

- Shift report: communicates pertinent information
- Reviews flowsheets and completes any focused assessments
- Prepares for and participates in Care Conference
- Completes Person assessments as necessary. Updates the Care Plan and prints the Care Plan/ Care Guide reports whenever updated.
- Reviews and confirms Outcome Scales for the Person prior to completing an assessment and at each care conference
- Contributes to at least 10 LTCF assessments annually to maintain LTCF coding competency
- Completes Coding Evaluation annually for LTCF coding competency E.g. Relias
- Has discussions with Person/Care Partners on ACP/ GOC/SIC. Updates/ prints as needed

PT/OT

RD

SW

- Arrange Person/ Care Partner meetings as necessary
- Discusses and documents ACP/SIC, funeral arrangements PRN with Person/Care Partner

VCHA LTC Person's Care Journey October 2025

On-Going

MRP

- Sends referrals as needed e.g. Psychiatry
- Participates in Care Conference
- Completes assessments annually and as needed for condition changes
- Reviews and Updates GOC and Code Status as necessary

Pharmacy

- Participates in Care Conference
- Participates in Neighbourhood Clinical Rounds
- Performs Medication Reviews

Recreation/ Music Therapy

- Prepares for and participates in Care Conference
- Completes Person assessments as necessary. Updates the Care Plan and prints the Care Plan/ Care Guide reports whenever updated.
- Reviews and confirms Outcome Scales for the Person prior to completing an assessment and at each care conference
- Contributes to at least 10 LTCF assessments annually to maintain LTCF coding competency
- Completes Coding Evaluation annually for LTCF coding competency E.g. Relias
- Has discussions with Person/Care Partners on ACP/ GOC/SIC. Updates/ prints as needed

Spiritual Health

Consultants

- SLP completes Person assessments on consulting basis. Contributes to, and updates, the Care Plan. Prints the Care Plan/Care Guide reports as necessary
- SLP completes Relias Coding Evaluation annually for LTCF coding competency e.g. Relias

HCA

- Completes daily flow sheets
- Observes the Person for changes, completes observation tools and reports to Nurse
- Attends Report at start of shift
- Communicates with Nurse to report on Persons in assignment
- Completes 3 Day Observation Tool during LTCF observation period

Person/Care Partner

- Participates in Care and Care Decisions. Ensures Person's wishes are known.

VCHA LTC Person's Care Journey October 2025

When There is a Change

UC/CSC/NUA

- Follows direction from MRP and RCC for appointments, transportation, orders, scheduling of care conference, taking new photo, etc. as per on-going workflow

CNL/RCC/COS

- Reviews and follows up on PSLS/incident reports with appropriate discipline. Notifies Licensing prn
- Initiates a Care Conference as necessary
- Completes a Significant Change LTCF assessment as needed

Nurse

- Completes PSLS/ incident reports as needed
- Keeps Person/Care Partner informed and involved in decision making
- Initiates ACP, SIC, and GOC with Person/Care Partner to confirm wishes. Documents in chart and inform MRP
- Initiates Consults to PT, OT, RD, SHP, SLP and SW as needed
- Completes Nursing Assessments. Updates Care Plan. Prints updated Care Plan and Care Guide reports. Documents in Chart

Allied Team

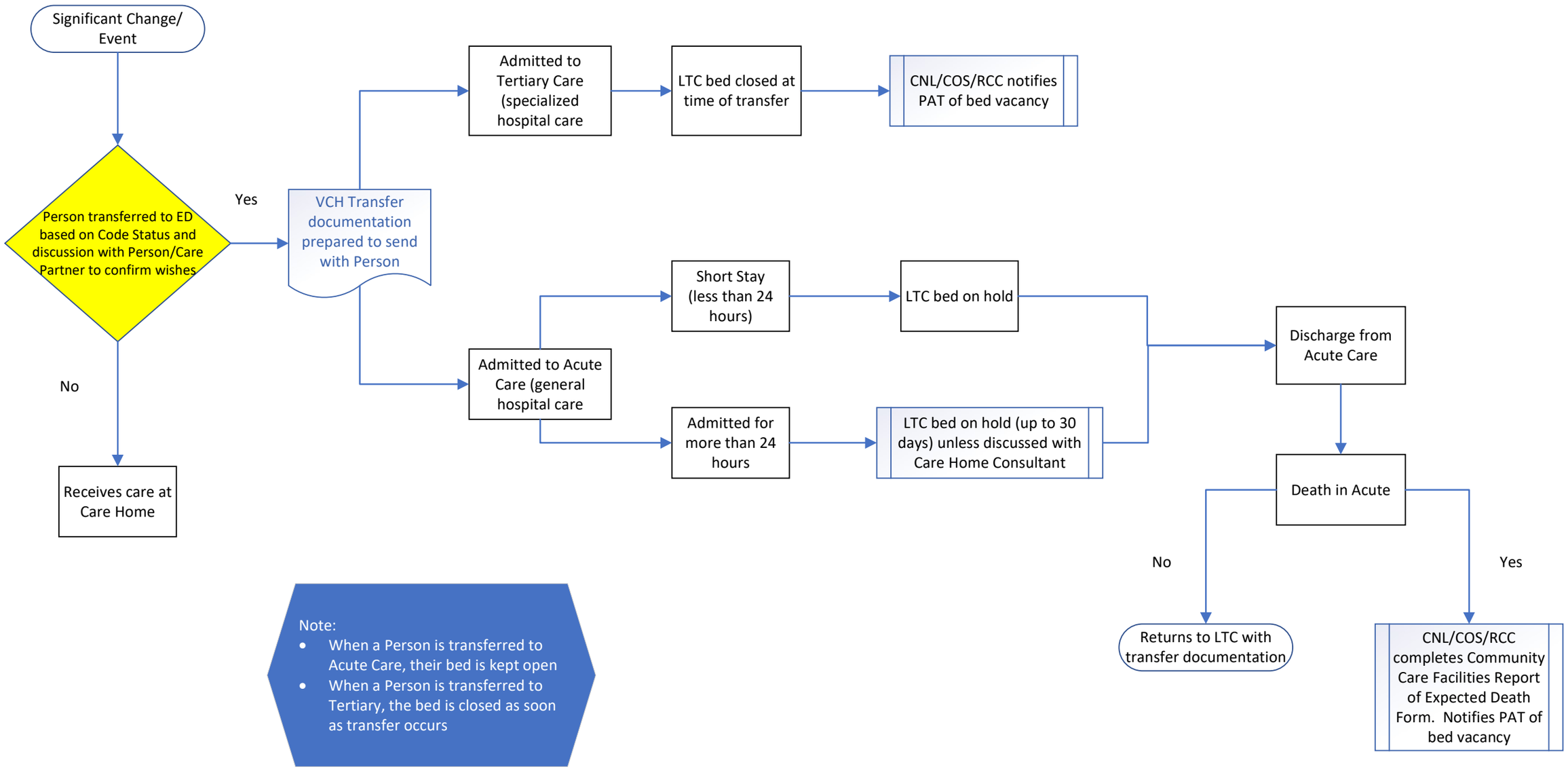
- Completes consults for assessment/support. Updates Care Plan - prints updated ID Care Plan and Care Guide. Documents in Chart

MRP

- Reviews ACP, SIC and GOC with Person/Care Partner. Updates Code Status as necessary
- Orders for Comfort/End of Life care as appropriate

Person/Care Partner

Transfer to Acute



Note:

- When a Person is transferred to Acute Care, their bed is kept open
- When a Person is transferred to Tertiary, the bed is closed as soon as transfer occurs

VCHA LTC Person's Care Journey October 2025

Return to LTC (LOA greater than 24 hours/Admitted to Acute)

UC/CSC/NUA

- Returns Person from LOA in Cerner
- Notifies Team, including MRP, that Person has returned
- Updates contact information as needed
- Prints LTC Ad Hoc forms as needed
- Updates photograph as necessary
- Ensures Person is on internal lists e.g. weight

CNL/RCC/COS

- Reviews Transfer Information
- Completes Significant Change LTCF by end of 3rd day after determining that a significant change has occurred in two or more areas of health status/ function
- Completes focused discipline assessments. Updates Care Plan and prints updated Care Plan and Care Guide Reports as necessary

Nurse

- Updates as necessary: diet, allergies, new orders
- Notifies MRP. Obtains orders as needed

PT/OT

RD

- Updates diet as necessary

SW

- Discusses ACP and GOC with Person/Care Partner(s). Updates – prints and places in chart.

Note:
All disciplines to continue with on-going workflow

VCHA LTC Person's Care Journey October 2025

Return to LTC (LOA greater than 24 hours/admitted to Acute)

MRP

- Reviews Transfer information
- Discusses ACP/GOC with Person/Care Partner and enters Code Status. Documents in chart
- Completes Medical assessment
- Reviews Medication Reconciliation with Pharmacy (Med. Rec)
- Orders Medication and Pre-Printed Admission Orders

Pharmacy

- Participates with MRP in BPMH and Medication Reconciliation
- Reviews and enters Drug allergies and intolerances as needed

Recreational/ Music Therapy

- Reviews Transfer information
- Completes focused discipline assessments. Updates Care Plan and prints updated Care Plan and Care Guide Report as necessary

Spiritual Health

HCA

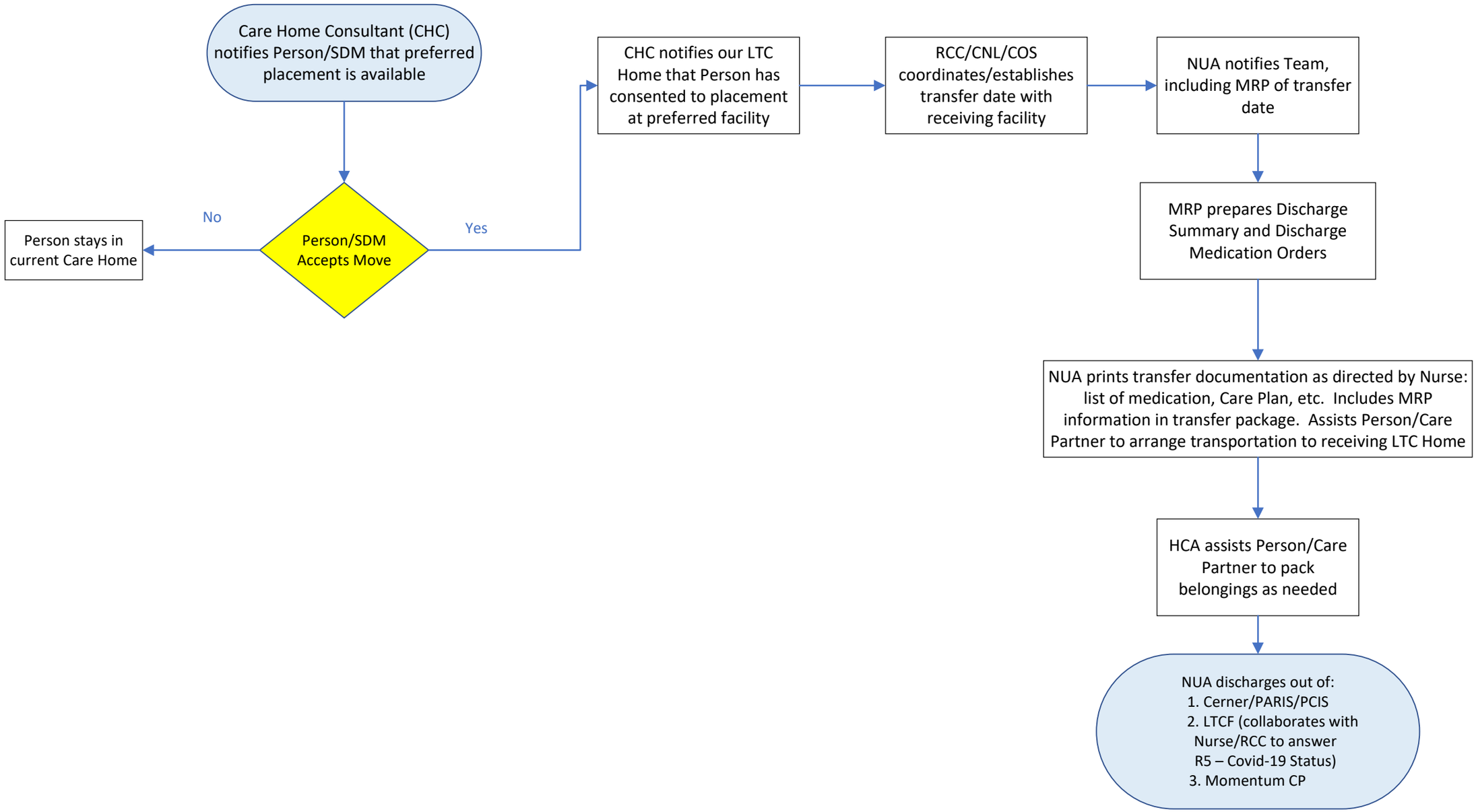
- Completes observation tools as assigned by Nurse
- Ensures Person is set up with supplies needed for ADLs e.g. wash basin
- Completes LTC Daily Care Flow Sheet on each shift
- Communicates with Nurse to report on Persons in assignment

Person/Care Partner

- Informs of any updates to Contact Information
- Ensures Person's wishes are known by MRP, Nurse and SW regarding Code Status and GOC.

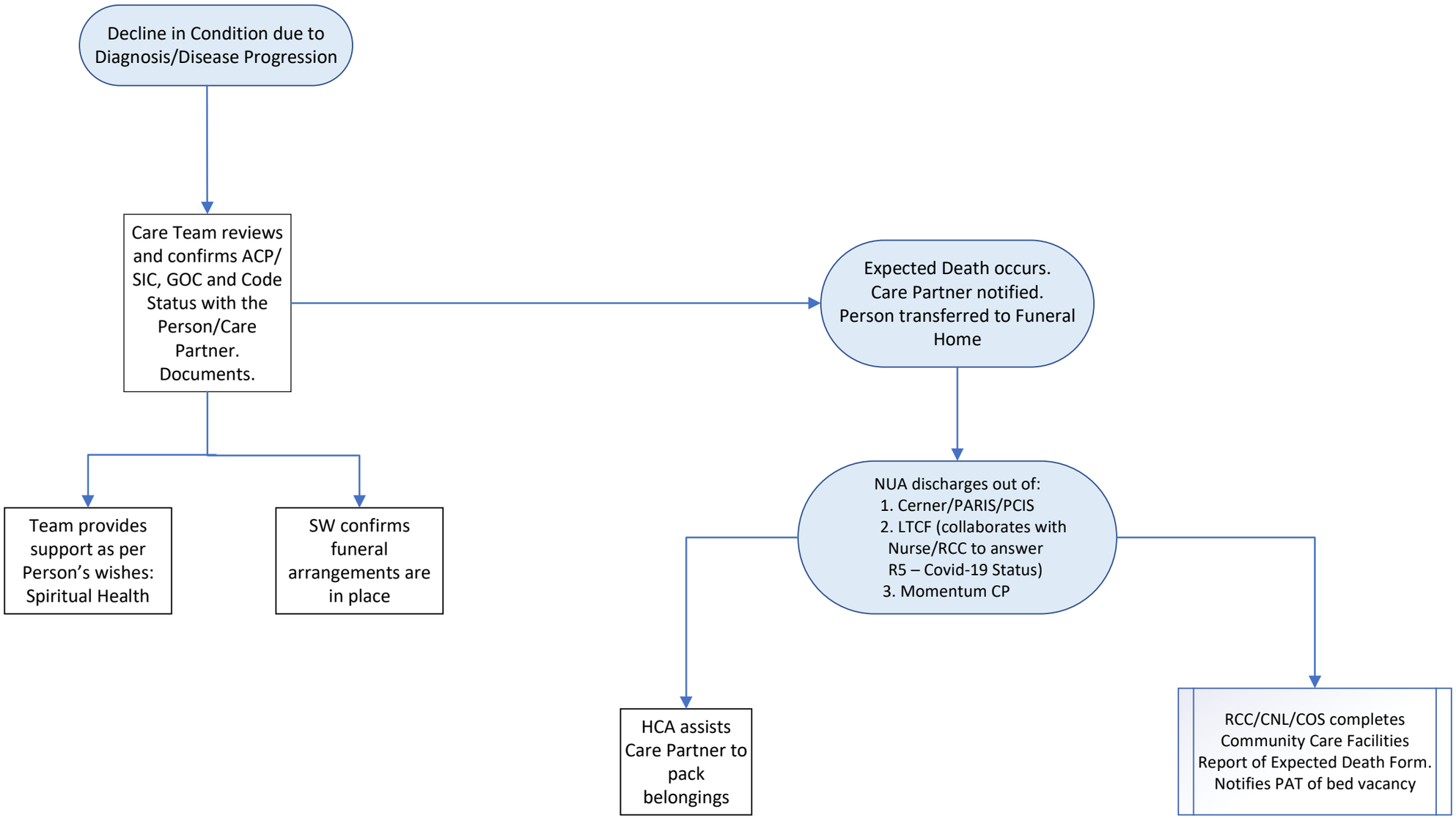
Note:
All disciplines to continue with on-going workflow

Transfer to Another Care Home



VCHA LTC Person's Care Journey October 2025

Discharge (Deceased at Care Home): **Expected** Death



Discharge (Deceased at Care Home): **Unexpected** Death