



Retirement Homes  
Regulatory Authority

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## Frequently Asked Questions

Interdisciplinary Care Conference Guidance



**Purpose:**

This document offers clarity and guidance to help licensees and operators implement the requirements of the *Retirement Homes Act, 2010* and Ontario Regulation 166/11 as they relate to interdisciplinary care conferences. Please refer to the Act and Regulation for the specific legislative requirements. If you have questions about the information in this document or would like further support, please contact RHRA's Licensee Engagement and Support team by emailing [info@rhra.ca](mailto:info@rhra.ca).

## About Interdisciplinary Care Conferences

### 1. What is an interdisciplinary care conference and why are they important?

An interdisciplinary care conference enables collaboration amongst the resident, their substitute decision maker or power of attorney and other “disciplines” (e.g. retirement home staff, external care providers, etc.) to inform the development of a plan of care that is tailored to the resident’s needs and preferences.

### 2. How can an interdisciplinary conference be conducted?

The overall goal of an interdisciplinary care conference is to gather input from individuals involved in different aspects of the resident’s care to inform the development of the plan of care. Input may be gathered in different ways, such as through a meeting or by consulting with individuals separately, in-person, by phone or through virtual means. The information gathered must then be considered when developing the plan of care.

### 3. When is an interdisciplinary care conference required and how often should they occur?

An interdisciplinary care conference must occur when a resident’s assessment<sup>1</sup> identifies a potential need for [dementia care, skin and wound care](#) or the use of [personal assistance service devices \(PASDs\)](#). Where these care services may be required, an assessment **and** interdisciplinary care conference must be held as part of the development of the plan of care.

Interdisciplinary care conferences must also occur when resident is reassessed. The Act requires a reassessment every six months, or earlier if any of the following have occurred: a goal in the plan of care is met, the care services are no longer necessary or effective or if the resident’s care needs change. Changes that do not impact or have limited impact on the resident may not require a reassessment. Where it may not be clear if a reassessment is appropriate, it may be helpful to engage with the resident, their substitute decision maker or power of attorney, if one is appointed. Documenting these discussions, including who was involved, the date(s), considerations, and outcomes can demonstrate compliance in this area.

### 4. Who may be involved in an interdisciplinary care conference?

The resident, the resident’s substitute decision maker or power of attorney (if any), and any other individuals designated by the resident, or the resident’s substitute decision maker must be given the opportunity to participate in the interdisciplinary care conference. It may also include retirement home staff, such as the Director of Care, Activity Director, dietary staff, nurses, and personal support workers. Other individuals who may be considered include health care professionals involved in various aspects of the resident’s care such as the physician, specialists, and external care providers, including those to whom referrals have been made.

### 5. What if invited parties cannot attend or do not respond?

Licensed retirement homes are encouraged to obtain input from relevant parties even if they’re unable to meet at the same time. This means that homes may need to reach out to each party individually to obtain information which can be used in the development of the plan of care. In cases where there is no response, homes should be able to demonstrate that reasonable efforts were made to contact relevant parties for input. This may include documentation such as emails, documented phone calls, voicemails and meeting minutes that include who was invited and whether they attended. Homes are encouraged to keep a written record of these attempts, including dates and times, to demonstrate that efforts were made.

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<sup>1</sup> For information on Initial Assessments and Full Assessments, please reference RHRA’s [Assessments and Plans of Care Compliance Assistance Module](#) or its accompanying transcript, which can be found [here](#).

**6. Why should the resident and family members be involved in an interdisciplinary care conference?**

Including the resident and family members in the interdisciplinary care conference facilitates the reflection of the resident’s preferences, values and goals in their plan of care.

**7. How can an interdisciplinary care conference be documented?**

Documentation of the interdisciplinary care conference should clearly reflect how and when information was gathered. This includes the date and time of any meeting held, a list of the attendees or contributors, and a summary of key discussions, outcomes, insights and information provided by individuals who were consulted separately.

Key points to document may include goals, interventions, directions to staff and any preferences to be incorporated into the plan of care. As the interdisciplinary care conference forms part of the resident’s record, any related documentation must be easily accessible and readily available upon request.

## Dementia Care

**8. How do I know if a resident may need dementia care?**

Receiving a diagnosis of dementia can take time and should not be the only consideration to determine if dementia care is needed<sup>2</sup>. In cases where a resident does not have a diagnosis of dementia, an assessment may reveal signs and symptoms consistent with dementia, indicating that dementia care may be required. Staff may also observe indications that the resident may need dementia care during daily interactions and when providing care. Some signs and symptoms consistent with dementia can be found on the Alzheimer’s Society of Canada’s [10 warning signs of dementia](#) resource and may include, but is not limited to:

- Memory changes that affect day-to-day ability
- Difficulty doing familiar tasks
- Changes in language and communication
- Disorientation in time and place
- Impaired judgement
- Problems with abstract thinking
- Misplacing things
- Changes in mood, personality and behaviour
- Loss of initiative
- Changes in understanding visual and spatial information

If the initial assessment of a resident indicates that dementia care may be needed, an assessment must be completed by a member of a regulated health profession, as defined in the *Regulated Health Professions Act, 1991*. If the resident’s care needs include dementia care, the assessment must be carried out using a clinically appropriate assessment tool that is specifically designed for the assessment of dementia and related conditions. Some examples of common assessment tools include the Montreal Cognitive Assessment (MoCA), Mini Mental State Examination (MMSE), and Mini-Cog.

**9. Does a resident have to be diagnosed with dementia before an interdisciplinary care conference can occur?**

While a dementia diagnosis may prompt the home to coordinate an interdisciplinary care conference, it is not required. If signs and symptoms observed during the resident’s assessment suggest dementia care *may* be required, an interdisciplinary care conference must be held as part of the development of the resident’s plan of care.

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<sup>2</sup> [How to get tested for dementia: Tips for individuals, families and friends | Alzheimer Society of Canada](#)

## Skin and Wound Care

### 10. How do I know if a resident may need skin and wound care?

As residents age, skin becomes thin, causing it to be more prone to tears, injury and skin conditions<sup>3</sup>. Staff should monitor residents for altered skin integrity during assessments, daily interactions with the resident and when care is being provided. *Altered skin integrity* is described as a state where the skin is damaged or unhealthy, compromising its ability to act as a protective barrier against injury and infection<sup>3</sup>.

If the initial assessment of a resident indicates skin and wound care may be needed, the home must ensure that the assessment is conducted by a member of a regulated health profession, as defined in the *Regulated Health Professions Act, 1991*. A regulated health professional can consider underlying health issues when developing the plan of care.

A list of signs and symptoms can be found in Wounds Canada's [Best Practice Recommendations for Skin Health and Wound Management](#) resource and includes, but is not limited to:

- Colour changes — reddening, purple hues or black discoloration
- Swelling (edema) — fluid collecting around the affected site
- Inflammation — redness, warmth and swelling
- Open wounds — lacerations, abrasions, lesions or breaks in the skin
- Dryness, Flaking, Scaling — dry, rough, brittle skin surface
- Thin or fragile skin — less resilient and prone to tears

For more information on a licensed retirement home's responsibilities related to skin and wound care, including when the service is provided by a third party, please see RHRA's **Skin and Wound Care Information Sheet**, which can be found [here](#).

### 11. What if my home does not offer skin and wound care?

If a licensed retirement home does not provide skin and wound care but the resident's assessment indicates that it may be needed, the home must ensure an assessment is conducted by a registered health professional, provide information to the resident and the resident's family on how to access the care from an external care provider, and hold an interdisciplinary care conference. For more information on licensed retirement home responsibilities when skin and wound care is not offered by the home, please see RHRA's **Skin and Wound Care Information Sheet**, which can be found [here](#).

## Personal Assistance Services Devices (PASDs)

### 12. How do I know if a resident uses or may need to use a personal assistance services device (PASD)?

The assessment of a resident should identify the care and support they require, which may include the need for a PASD and note devices already in use. Using the criteria below can help determine whether these devices are considered PASDs.

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<sup>3</sup> [Wounds Canada](#)

A device is considered to be a PASD if it meets *all* of the following criteria:

1. The device is intended to assist the *particular resident* with a routine activity of living, *and*
2. If the *particular resident* uses the device, it will limit or inhibit his or her freedom of movement, *and*
3. If the *particular resident* uses the device, he or she is not physically or cognitively able to release themselves from the device.

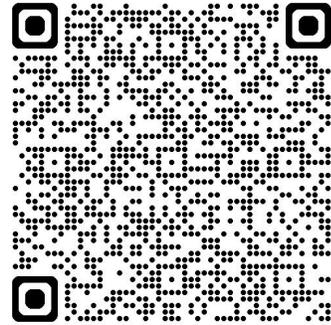
If a specific device has all three of these features for a particular resident, it is considered a PASD and is subject to the requirements under the Act and Regulation regarding the use of PASDs, which includes an interdisciplinary care conference.

For more information on PASDs, please refer to RHRA’s **Guidance Document: Personal Assistance Services Devices (PASDs)**, which can be found [here](#).

*If you have questions about the information in this resource or would like further support, please contact RHRA’s Licensee Engagement and Support team by emailing [info@rhra.ca](mailto:info@rhra.ca).*

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