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Intent

To describe health authorities' responsibilities in planning and delivering publicly subsidized long-term care services.

Policy

Health authorities must plan and deliver publicly subsidized long-term care services to clients as part of their established care plans, which can include short-stay services provided as:

- convalescent care;
- hospice care;
- respite care; or
- services for other purposes determined appropriate by a health authority to meet the unique needs of the client.

Health authorities must:

- ensure that long-term care services are delivered in compliance with the Residential Care Regulation;
- establish local service delivery models that will provide clients with access to long-term care services within their community or within accessible distance to their community;
- authorize and manage access to long-term care services, including short-stay services, by:
 - determining the client's needs using assessment criteria (Long-Term Care Access Guidelines), clinical judgment and best evidence, identifying the appropriate service for the identified needs, and facilitating access to long-term care services where appropriate;
 - informing clients, substitutes and their caregivers of the process for managing the waitlist and admission;
 - establishing a plan with clients and their families/caregivers to assist them to remain safely at home with support services where required until they are admitted to a long-term care service;
 - providing information to the client, substitute and their caregivers about the relevant long-term care services available at the long-term care homes appropriate for the client's care needs, as set out in the Long-Term Care Access Guidelines; and

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- ensuring that consent for admission to a long-term care home is obtained as per the *Health Care (Consent) and Care Facility (Admission)* (see 6.D.2, Consent to Long-Term Care Home Admission)

Definitions

care and accommodation refers to the long-term care services that are being offered to the client when a vacancy becomes available in either an interim care home or a preferred care home.

Community Care Licensing provides licensing, inspection and monitoring of the health and safety of individuals living in community care facilities licensed under the *Community Care and Assisted Living Act* and Residential Care Regulation as delegated by the Medical Health Officer.

convalescent care is a short-stay service provided to clients with defined and stable care needs who require a supervised environment for reactivation or recuperation usually prior to discharge home, most commonly following an acute episode of care.

hospice care is a short-stay service provided in a hospice bed to clients who require support with comfort, dignity and quality of life in the final days or weeks of their lives, and is distinct from the end-of-life care provided to clients residing in a long-term care home.

interim care home is specific to each client and is a long-term care home that is not one of the client's preferred care homes.

long-term care home is a facility designated by the health authority to provide long-term care services, including short-stay services, and includes licensed community care facilities, private hospitals and extended care hospitals.

long-term care services provide a secure supervised physical environment, with accommodation and care, to clients who:

- cannot have their care needs met in their own home or in an assisted living residence on a permanent basis; or
- require convalescent care, hospice care or respite care on a short-term basis.

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Patient Care Quality Office is the central complaints office within each health authority that receives, investigates and responds to complaints regarding the quality of care that a client received, and derives its authority from the *Patient Care Quality Review Board Act*.

preferred care home is specific to each client and is a long-term care home selected by the client or substitute as a care home where they prefer to be admitted.

RAI MDS 2.0 is a comprehensive, standardized instrument for evaluating the needs, strengths and preferences of people in long-term care settings.

resident/family council is a group of people who are either clients living in a long-term care home, or are their family members or close friends, who meet regularly to identify opportunities to maintain and enhance the quality of life for clients of the care home, and to engage with staff to contribute a voice in decisions which affect the clients of the care home.

respite care is a short-stay service provided for the purpose of allowing the client's principal caregiver a period of relief, or to provide the client with a period of supported care to increase independence.

short-stay services are facility-based services provided on a short-term basis (usually less than three months) and include a safe, supervised physical environment, with accommodation and care to those who need convalescent care, hospice care or respite care.

substitute means:

- the client's committee of person, or
- if there is no committee of person, the person chosen by the manager, under section 22 of the *Health Care (Consent) and Care Facility (Admission) Act*, to give or refuse consent to admission to, or continued residence, in a long-term care home, on behalf of a client who has been determined to be incapable of giving or refusing this consent.

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References

Community Care and Assisted Living Act

Director of Licensing Standard of Practice Number: 01/08/2006

Health Care (Consent) and Care Facility (Admission) Act

Hospital Act

Patient Care Quality Review Board Act

Long-Term Care Access Guidelines

Residential Care Regulation

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Intent

To describe health authorities' responsibilities in determining the appropriate short-stay services to meet the client's needs.

Policy

Health authorities are responsible for determining the appropriate short-stay services to meet the client's needs.

Short-Stay Services

Short-stay services may include:

- convalescent care;
- hospice care;
- respite care; or
- services for other purposes determined appropriate by a health authority to meet the unique needs of the client.

Service Needs Determination

Health authorities can approve short-stay services for a client who:

- has been assessed as requiring short-stay services (see Policy 2.D, Assessment);
- has agreed to pay the applicable daily rate (see Policy 7.C.1, Short-Stay Services Rates);
- has given consent to admission to the care home or consent has been given by the client's substitute; and
- has agreed to vacate the care setting at the end of the agreed upon period of short-stay care.

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Intent

To describe health authorities' responsibilities in determining the appropriate publicly subsidized long-term care services to meet the client's needs.

Policy

Health authorities are responsible for determining the appropriate long-term care services to meet the client's needs.

Service Needs Determination

Health authorities can approve long-term care services for a client who:

- has been assessed as having 24-hour professional nursing supervision and care needs that cannot be adequately met in the client's home or by housing and health services;
- is at significant risk by remaining in their current living environment, and the degree of risk is not manageable within available community resources and services;
- has an urgent need for long-term care services;
- has been investigated and treated for medical causes of disability and dependency that may have been remedial;
- has a caregiver living with unacceptable risk to their well-being, no longer able to provide care and support, or there is no caregiver available to the client;
- has given consent to admission to the care home or consent has been given by the client's substitute; and
- has agreed to pay the assessed client rate (see Policy 7.B, Income-Based Client Rates) and any additional charges (see Policy 6.F, Benefits and Allowable Charges) after being fully informed about those costs.

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Client Characteristics for Long-Term Care Services Options

Clients eligible for long-term care services, not including short-stay services, refers to those who:

- have severe behavioural problems on a continuous basis;
- are cognitively impaired, ranging from moderate to severe;
- are physically dependent, with medical needs that require professional nursing care, and a planned program to retain or improve functional ability; or
- are clinically complex, with multiple disabilities and/or complex medical conditions that require professional nursing care, monitoring and/or specialized skilled care.

Reference

Health Care (Consent) and Care Facility (Admission) Act

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Intent

To describe health authorities' responsibilities in managing timely access to long-term care services, including short-stay services, using a consistent, principle-based and transparent approach with the objective of achieving the best match between the client and the service.

Policy

Health authorities must coordinate access to all long-term care services, including short-stay services, consistent with the following:

- give priority for service to clients who have been assessed as having the highest care needs and/or the highest levels of risk; and
- determine which clients will have priority for admission or transfer for care and accommodation in a long-term care home, where more than one client's assessment of need and risk are equal.

Health authorities must facilitate access to long-term care services, other than short-stay services, consistent with the following requirements:

- manage access to long-term care services and transfer of clients between long-term care homes, based on the preference of the client or substitute and the available resources in the community;
- ensure clients and/or substitutes are fully informed of the long-term care access policy and processes at the earliest opportunity;
- ensure that the client or substitute has up to 72 hours to identify up to 3 preferred care homes, in no ranked order;
- where circumstances permit, allow the client or substitute to choose more than 3 preferred care homes;
- allow the client or substitute to change their choices of preferred care homes up until they are offered care and accommodation in one of their preferred care homes with no impact to their original waitlist date;
- ensure a client maintains their place on the waitlist for their preferred care homes while waiting for admission, even if they move into an interim care home;
- obtain consent to admission to the client's preferred care homes, as per the Policy 6.D.2, Consent to Long-Term Care Home Admission;
- monitor all clients waiting for admission to one of their preferred care homes to ensure they continue to meet eligibility requirements for access, as per Policy 6.C, Long-Term Service Needs Determination;
- determine the relative priority of all clients who have been assessed as eligible for publicly subsidized long-term care services for admission or transfers using criteria set out in the Long-Term Care Access Guidelines;

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- manage, in an equitable manner, a client’s transfer to a preferred care home where a client’s request for a preferred care home cannot be met on admission;
- admit couples to the same care home where both members of a couple meet the eligibility criteria for long-term care services, and when desired by the couple;
- develop a consultation process with a service provider to determine whether a long-term care home is appropriate for the needs of the client, and/or how the care home can address the needs of the client, where the service provider has requested that the referral decision be reviewed. This does not constitute an authority for a service provider to accept or reject specific clients. A client’s specific diagnosis or a client’s history of colonization or infection with a multiple antibiotic resistant organism is not, in itself, grounds to request a review of a referral decision; and
- monitor continuously the status of clients approved and waiting for admission to long-term care services, including:
 - an increase in the availability and flexibility of community health supports and home support services;
 - a care plan that meets the needs of the client while waiting for placement; and
 - preparation and information regarding placement in long-term care services.

Access Prioritization Criteria

The prioritization process begins immediately after:

- the client or substitute has been provided with a list of long-term care homes that align with the client’s geographical and cultural preferences, and can meet the client’s care needs;
- the clinician and client or substitute have had a comprehensive conversation about admission/transfer options and processes including what happens when a client or substitute declines an offer of care and accommodation in a preferred or interim care home; and
- the client or substitute has identified the client’s preferred care homes or identified that the client or substitute is willing to accept an admission into any long-term care home that can meet the client’s needs.

Offer of Care and Accommodation

An offer will be made to the client when care and accommodation becomes available in one of the client’s preferred care homes.

The client or substitute has up to 48 hours to make a decision on whether to accept the offer, and, if accepted, move into the preferred care home.

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If there are no vacancies in any of the client's preferred care homes, the client may be offered care and accommodation in an interim care home when one becomes available, if the client or substitute has agreed to consider interim care homes. The client or substitute has up to 72 hours to make a decision on whether to accept the offer, and, if accepted, move into the interim care home.

A client is eligible for transfer from an interim care home to one of their preferred care homes upon being admitted to the interim care home.

While residing in the interim care home, unless the client or substitute decides the client will remain there, the client will retain their priority position on the waitlist for transfer to one of their preferred care homes.

Changing Selection of Preferred Care Homes

Clients and substitutes can change their selected preferred care home(s) up until they are offered care and accommodation in one of their preferred care homes and, upon making the change, will maintain their original waitlist date.

If the client or substitute changes their selection at the time of or after being offered care and accommodation in one of their preferred care homes, their waitlist date for admission will be changed to the date at which the client or substitute amended their list of preferred care homes.

Declining an Offer of Care and Accommodation

If the client or substitute declines an offer of care and accommodation in an interim care home or in one of their preferred care homes, they will be advised of options for publicly-subsidized and/or private pay services, and support from family/friend caregivers.

If the client is in hospital and remains there, they will be subject to client charges based on provincial acute care policy.

If the client or substitute declines an offer of care and accommodation in one of their preferred care homes, they may still be offered care and accommodation in that particular long-term care home as an interim care home. The policy regarding changing choice of preferred care homes will apply in these situations.

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Complaints Resolution

Clients or persons acting on behalf of the client may, at any time, initiate a complaint regarding the access process for publicly subsidized long-term care services. See HCC Chapter 2.E Complaint Process for details on how to submit a complaint.

Veterans Priority Access Beds

Veterans Affairs Canada priority access beds are beds designated by the Ministry and Veterans Affairs Canada for veterans who are eligible for a long-term care home as set out in this manual and under the *Department of Veterans Affairs Act*.

Health authorities must:

- refer a veteran who is eligible for home and community care services to Veterans Affairs Canada for an assessment of eligibility for federal benefits; and
- manage and maintain a veterans' priority access bed waitlist in those long-term care homes with veterans' priority access beds.

Eligibility for Federal Benefits

Veterans Affairs Canada will:

- advise the health authority if a veteran is eligible for federal benefits and, upon admission, will advise the service provider of the costs of health care payable by the veteran; and
- determine the Veteran Admission Priority Category (A, B or C).

Veterans' Priority Access Bed Waitlist

The name of a veteran who is eligible and agrees to admission to a veterans' priority access bed is to be placed on the regular health authority priority access list, as well as the veterans' priority access bed waitlist at those long-term care homes with veterans' priority access beds. This ensures veterans are not penalized if a suitable regular bed becomes vacant before a veterans' priority access bed becomes available. Veterans occupying regular beds will be transferred to veterans' priority access beds when their names reach the top of the veterans' priority access bed waitlist for a long-term care home.

The veteran's position on a priority access bed waitlist is first determined by the veteran's need for placement and the veteran's admission priority category. Those in category A are the highest priority for admission, followed by B, and then C, provided that the need for placement is equal. The only exception is that a veteran hospitalized from a priority access bed and awaiting placement in the originating

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long-term care home is to be admitted to the next priority access bed available, regardless of the veteran's service priority category.

If there is no veteran on the waitlist for a veterans' priority access bed, vacant beds may be offered to non-veterans. When a veteran's name is subsequently placed on the veterans' priority access bed waitlist, the next vacant bed in the long-term care home is to be designated a veterans' priority access bed.

Non Resident Admissions

A veteran who is not a client may be admitted to George Derby Centre (Burnaby), Brock Fahrni Pavilion (Vancouver) or The Lodge at Broadmead (Victoria) if the veteran:

- would be eligible as a client but for the required residency period; and
- is eligible for a veterans' priority access bed.

Veterans Affairs Canada will pay the full cost of care (less a portion for which the veteran is responsible as determined by Veterans Affairs Canada) for the veteran until the veteran is eligible to receive publicly subsidized home and community care services.

Client Transfers between Health Authorities

Clients eligible for or receiving a long-term care service may, at any time, request admission to a long-term care home in another health region that is appropriate to meet the client's care needs.

The health authority where the client currently resides must contact the receiving health authority responsible for the long-term care home or location requested and must:

- determine whether the client meets the access criteria for the long-term care service requested; and
- provide the receiving health authority with the most recent assessment and full documentation to support the request; and
- provide information to the client or substitute about the relevant long-term care services available at the long-term care homes appropriate for the client's care needs, in the receiving health authority, as set out in the Long-Term Care Access Guidelines.

Where the client is in hospital and wants to transfer to another health authority, and where there is no availability in either a preferred or interim care home in the receiving health authority, the health authority where the client currently resides must offer care

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and accommodation to the client in an interim care home until something becomes available in the receiving health authority.

The receiving health authority is required to:

- manage access to the long-term care home in their region for out of region clients in the same manner as for clients currently living in that region;
- ensure that the client or substitute is personally aware of, and consents to, any plans for transfer that have been initiated by family members or responsible health care professionals.

Temporary Absences

A client may be temporarily absent from a long-term care home:

- due to hospitalization or admission to specialized services; or
- if a reasonable period of absence is in the best clinical or personal interests of the client.

The cumulative client absences due to hospitalization or admission to specialized services are not limited during a calendar year.

The cumulative client absences for personal reasons are limited to 30 days in a calendar year unless the health authority approves otherwise.

The client is required to continue to pay their client rate during a temporary absence from the long-term care home unless arrangements have been made for another person to temporarily use the client's bed. In this case, the temporary client is responsible for paying the client rate.

Reference

Hospital Policy Manual: Eligibility, Benefits, and Reporting

Long-Term Care Access Guidelines

Veterans Affairs Canada/Ministry of Health Services Transfer Agreement, 1974

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SUBSECTION: 1	SUPPORTING SPOUSES WITH DIFFERING CARE NEEDS	EFFECTIVE: JULY 15, 2019

Intent

To ensure that health authorities involve spouses, families and their caregivers in exploring a range of options available to support and maintain the continuity of spousal relationships when only one spouse requires long-term care services.

Policy

When only one spouse meets the eligibility criteria for long-term care services, and the spouses have requested to continue living together, health authorities will work with spouses and their families or primary caregivers to identify options that support the continuity of an ongoing spousal relationship. A planning meeting will be held and information provided on:

- implications and potential challenges for both spouses;
- options that could provide reasonable arrangements; and
- practical considerations like costs and processes.

Definitions

campus of care is a situation where more than one level of housing, services and care is provided in a residence or group of buildings, e.g., assisted living services in one building and long-term care services in an adjacent building.

non-eligible spouse is a spouse that does not meet the eligibility criteria for admission to long-term care services.

reasonable arrangements are alternatives determined by making an assessment of available resources while using diligence and good faith.

Reasonable Arrangements

Health authorities are not required to admit individuals into publicly subsidized long-term care homes who do not meet the criteria for long-term care services (see Policy 6.C. Long-Term Care Services, Service Needs Determination). In those rare instances, where spouses feel that separation as a result of long-term care placement is a significant hardship to their health and well-being, health authorities will engage in a collaborative approach to explore reasonable arrangements that would enable spouses to maintain and support their relationship.

Reasonable arrangements may include:

- facilitation of the spouses to spend time together in the long-term care home on a regular basis including shared meals;

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- identifying transportation options that may assist a non-driving spouse to visit the long-term care home;
- identifying opportunities for accommodation for the non-eligible spouse in a nearby independent housing unit, apartment block, or other housing accommodation;
- considering any opportunities for co-location in a campus of care setting;
- considering any opportunities for co-location in an assisted living unit (see Policy 5.B, Service Needs Determination).

Co-locating in a Long-term Care Home

In exceptional circumstances where no other reasonable arrangement or appropriate and available community resources exist to meet the combined care needs of both spouses, health authorities may consider the non-eligible spouse for residency within the same long-term care home as the eligible spouse.

Exceptions will be guided by an assessment of the following criteria:

- capacity of the long-term care home to accommodate an individual who does not need care services;
- need to support the language, cultural customs, values and beliefs of the spouses;
- impacts of separation on the health and well-being of both spouses;
- impacts of admission to long-term care on the non-eligible spouse; and
- impacts for other individuals eligible for long-term care, should their admission be delayed in order to accommodate a non-eligible spouse.

Planning Meeting

Health authorities must coordinate a planning meeting that involves the spouses, family members and caregivers (if requested by the spouses), their primary health care provider and the health authority care manager, prior to approving an exception for joint residency of a couple with a non-eligible spouse. Areas to be discussed include:

- a review of reasonable arrangements for accommodating the spousal relationship;
- expectation of family responsibility for supporting reasonable arrangements;
- financial costs to both spouses of all publicly subsidized options;
- description of services, programs and benefits within the long-term care home for the non-eligible spouse;

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- conditions in which the exit of the non-eligible spouse may be required; and
- considerations for the non-eligible spouse including:
 - potential loss of privacy and choice in routines, activities and meals;
 - potential for increasing dependence;
 - potential impact of changing care needs on the spousal relationship;
 - their changing care-giver role in relation to the care that will be provided to the spouse in the long-term care home; and
 - adjustment to the new environment and risks that may be associated with the complex care provided in long-term care homes.

Admission Agreement

When a non-eligible spouse is admitted to a long-term care home with the sole or primary purpose of accompanying an eligible partner, health authorities must ensure that there is a signed written agreement prior to admission that includes:

- costs to the non-eligible spouse including access to programs, benefits and services while residing in the long-term care home;
- a waiver of any care services normally provided in the long-term care home, yet not required by the non-eligible spouse at admission; and
- an exit plan (should the eligible spouse pre-decease the non-eligible spouse) that includes the health authority's responsibility for assisting the non-eligible spouse to relocate to an appropriate housing environment within 6 months.

The conditions of an existing admission agreement for the non-eligible spouse may be removed in the event that the non-eligible spouse is assessed to require long-term care services. When this occurs, the spouse becomes a permanent resident of the long-term care home.

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SUBSECTION: 2	CONSENT TO LONG-TERM CARE HOME ADMISSION	EFFECTIVE: NOVEMBER 4, 2019

Intent

To ensure that health authorities comply with Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act* including the requirements to seek and obtain consent from a client or their substitute prior to admission into a long-term care home and to assess a client when there is reason to believe a client may be incapable of giving or refusing consent.

Policy

Health authorities must ensure that:

- consent is obtained prior to a client's admission to a long-term care home (including short-stay services);
- the consent is voluntary, informed, given by a capable adult of giving or refusing consent to care facility admission, and specific to the facility to which they are admitted;
- if the client seems unable to understand and appreciate the information provided about long-term care homes, they are assessed to determine if they are incapable of giving or refusing consent to care facility admission;
- if the client is determined to be incapable of giving or refusing consent to a care facility, consent to care facility admission is sought from a substitute as set out in section 22 of the *Health Care (Consent) and Care Facility (Admission) Act*, and
- when a client expresses the desire to no longer remain residing at a long-term care home, the requirements in the *Health Care (Consent) and Care Facility (Admission) Act* and Residential Care Regulation for continued residence are followed.

Health authorities are expected to follow the Practice Guidelines for Seeking Consent to Care Facility Admission in its admission processes and when assessing if a client is incapable of giving or refusing consent to care facility admission.

Definitions

assessor refers to the person who is responsible for assessing whether a client is incapable of giving or refusing consent to admission to, or continued residence in, a care home, and who is qualified to make a determination of incapability according to the *Health Care (Consent) and Care Facility (Admission) Act*.

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capable means capable of giving or refusing consent to admission to, or continued residence in, a care home.

capable client means a client who has not been determined to be incapable of giving or refusing consent to admission to, or continued residence in, a care home.

committee of person is the person (or Public Guardian and Trustee) appointed by the court according to the *Patients Property Act* to make personal and health care decisions for a person who is declared by the Court to be incapable of managing themselves.

designated person means the persons designated by the health authority to receive reports of a substitute who is acting in a manner that may be abusive or harmful to the client for whom they are making decisions.

incapability assessment means an assessment made according to section 26 of the *Health Care (Consent) and Care Facility (Admission) Act*, to determine if a client is incapable of giving or refusing consent to admission to, or continued residence in, a care facility.

incapable means incapable of giving or refusing consent to admission to, or continued residence in, a care home.

incapable client means a client who has been determined through an incapability assessment to be incapable of giving or refusing consent to admission to, or continued residence in, a care home.

manager means the person responsible for coordinating the admission process, and seeking and obtaining consent for care facility admission.

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Manager Responsible for Seeking Consent to Admission

Before a client is admitted into a long-term care home, consent for the admission must be obtained from the manager. For an admission to a care home, the manager will be the health authority employee who is responsible for coordinating the admission process, unless the health authority does not coordinate admissions for the care home (in which case the person responsible for this process at the care home will be the manager).

Health authorities must ensure managers fulfill this responsibility in accordance with the Practice Guidelines for Seeking Consent to Care Facility Admission. It is also expected that managers successfully complete the course, Consent to Care Facility Admission in British Columbia: A Course for Managers and Assessors.

When Consent to Admission is Obtained

Consent to admission must be obtained prior to the client moving into the long-term care home. For long-term care services, other than short-stay services, consent for admission will be sought and obtained at the time when preferred care homes are identified, as per policy 6.D, Access to Services. Prior consent to admission to a preferred care home or interim care home does not prevent a client or substitute from revoking their consent before or when care and accommodation becomes available.

Informed Consent

The requirements for providing information to a client or substitute when seeking consent to care facility admission are set out in section 21 (1) (d) of the *Health Care (Consent) and Care Facility (Admission) Act* and described in the Practice Guidelines for Seeking Consent to Care Facility Admission. The Long-Term Care Access Guidelines specify the requirements for providing information about the care provided and services available in long-term care homes. In addition to this information, health authorities are required to provide information about the circumstances under which the adult may leave the care facility (see Continued Residence, below).

Documenting Consent

Health authorities are required to document consent to care facility admission, whether it is provided orally, in writing or inferred from conduct. Health authorities can use the Care Facility Admission Consent form (HLTH 3909) to document consent. An adapted or different form can be used to document consent if the form:

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- clearly identifies the adult to be admitted;
- clearly identifies the facility or facilities for which consent to admission has been given;
- identifies if consent has been given by a substitute;
- identifies if consent has been given orally, in writing or inferred from conduct;
- can be signed by the client to indicate their consent;
- can be signed by the substitute to indicate their consent, if substitute consent is given;
- is signed by the manager if consent from the client or substitute has been given orally or is inferred from conduct;
- indicates specific consent for any specific care home for which consent has been given (as opposed to a single consent provided for multiple facilities)

The completed form must be provided to the long-term care home where the adult is admitted, prior to admission.

When an Incapability Assessment is Conducted

An incapability assessment is only required when the manager has reason to believe the client may be incapable of giving or refusing consent to care facility admission. While the indicators of the need to conduct an incapability assessment may emerge during the process of seeking consent, if an incapability assessment is required, it must occur before preferred care homes are selected and consent for admission to these care homes obtained.

Assessor Responsible for Conducting Incapability Assessments

A determination of incapability must be made by an incapability assessment conducted by a:

- medical practitioner,
- registered nurse,
- nurse practitioner,
- registered psychiatric nurse,
- occupational therapist,
- psychologist, or
- social worker.

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Health authorities must ensure assessors fulfill this responsibility in accordance with the Practice Guidelines for Seeking Consent to Care Facility Admission. It is also expected that assessors successfully complete the course, Consent to Care Facility Admission in British Columbia: A Course for Managers and Assessors.

The manager is responsible for determining what assessor will conduct the incapability assessment when one is required.

Second Assessment

The Health Care Consent Regulation requires that a client is informed of the assessor's determination when an incapability assessment has been conducted. If the client has been determined to be incapable and the adult disagrees with this determination, they may request a second assessment. In these circumstances a second assessment must be conducted by a different assessor. The second assessment is determinative. A second assessment is not required if an adult is confirmed to be capable and a person disagrees with this determination.

When a second assessment is required it must be conducted by a medical practitioner or nurse practitioner, unless the initial assessment was conducted by a medical practitioner or nurse practitioner. If the initial assessment was conducted by a medical or nurse practitioner, the second assessment can be conducted by any qualified assessor.

Documenting the Assessment

The Health Care Consent Regulation requires that upon completing an assessment the assessor complete an assessment report. Health authorities can use the Incapability Assessment Report form (HLTH 3910) to detail the assessment. An adapted or different form can be used to detail the assessment if the form includes:

- information identifying the client who was assessed;
- the name, professional designation of the assessor, the assessor's regulatory college and registration number;
- confirmation that medical information was reviewed, including the client's relevant diagnoses and prognoses;
- the factors that were considered in making the determination of the client's capability or incapability;
- the conclusions that were reached on the basis of those factors; and

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- a summary of information gathered from consulting with, or collecting information from, others (including information relied upon if the client refused or was unable to participate in the assessment).

Manager for Continued Residence

Health authorities must determine whether the manager responsible for fulfilling the continued residence responsibilities will be a health authority or care home employee.

Continued Residence

For clients residing in a long-term care home:

- if a client who has not been determined to be incapable expresses a desire to leave the care home, they cannot be prevented from doing so; and
- if the substitute for a client who has been determined to be incapable expresses a desire for the client to leave the care home, the client cannot be prevented from leaving the care home.

If a client is expressing a desire to leave a care home, they must be assessed for incapability if:

- the client has not been determined to be incapable and the manager doubts that the client is capable; or,
- the client has been determined to be incapable and the manager doubts that the client remains incapable.

If an incapable client expresses a desire to leave a care home, the manager must seek consent to continued residence in the care home from the client's substitute, unless:

- the client was admitted to the care home within the last 30 days; or
- consent for continued residence has been obtained from the substitute within the last 90 day.

Documenting Substitute Consent to Continued Residence

Substitute consent to continued residence must be documented whether it is provided orally or in writing. The Consent For Continued Residence form (HLTH 3911) can be used to document substitute consent. An adapted or different form can be used to document consent if the form:

- identifies the name of the client and the care home where they reside;

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- identifies whether the substitute consent was obtained in writing, orally or by email;
- can be signed by the substitute to indicate their consent; and,
- is signed by the manager to confirm substitute consent is obtained.

Protection from Abuse or Harm

Health authorities must designate persons to receive reports that a client's substitute may be acting in a manner that may be abusive or harmful to the client.

If a manager believes a client's substitute is acting in a manner that may be abusive or harmful to the adult, including removing the client from a care home into harmful circumstances, the manager must:

- immediately notify a person designated to receive such reports; and
- take steps that the manager believes are necessary to protect the client, including preventing the client from being removed from the care home, until the designated person instructs otherwise.

Reference

Health Care (Consent) and Care Facility (Admission) Act
 Health Care Consent Regulation
Community Care and Assisted Living Act
Hospital Act
Adult Guardianship Act
Representation Agreement Act
Patients Property Act
Power of Attorney Act
Public Guardian and Trustee Act
 Practice Guidelines for Seeking Consent to Care Facility

CHAPTER: 6	LONG-TERM CARE SERVICES	NUMBER:	6.E
SECTION: E	ASSESSMENT	PAGE:	1 OF 1
SUBSECTION:		EFFECTIVE:	JULY 15, 2019

Intent

To describe health authorities' responsibilities to ensure that all clients receiving publicly subsidized long-term care services receive an assessment using the RAI MDS 2.0 assessment tool and have a current care plan.

Policy

Health authorities must ensure that all clients receive an assessment using the RAI MDS 2.0 assessment tool and have a current care plan compliant with the Residential Care Regulation Section 80 and 81, as set out below:

- complete an assessment for all long-term care clients admitted to the care home on a permanent basis and develop a care plan for each client within 21 days of admission to the service;
- complete subsequent assessments on a quarterly and annual basis, or as needed, for each long-term care client and make appropriate changes to the client's care plan.

Reference

Residential Care Regulation

CHAPTER: 6	LONG-TERM CARE SERVICES	NUMBER: 6.F
SECTION: F	BENEFITS AND ALLOWABLE CHARGES	PAGE: 1 OF 5
SUBSECTION:		EFFECTIVE: JULY 15, 2019

Intent

To clarify the benefits and chargeable items for clients receiving publicly subsidized long-term care services.

Policy

Health authorities must ensure that service providers:

- provide long-term care benefits to clients at no additional charge over and above the client rate;
- do not charge administrative fees for services or supplies required by the client's care plan;
- that offer chargeable items, do so at a reasonable cost at or below market rates and on an optional basis (purchase of chargeable items is at the discretion of the client);
- explain fees for chargeable items to the client, and ensure the client has agreed in advance of any billing for chargeable items; and
- provide a written statement of the refund policy when an individual pays in advance for services.

Definitions

benefits are the services, programs and supplies provided to clients at no additional cost over and above the client rate pursuant to applicable regulations, this policy manual, or the contract between the service provider and health authority.

chargeable items are services, programs or supplies that are not included as a benefit and are offered by the service provider.

companion service is any non-care social support or activity service provided to clients that is beyond the services a service provider is expected to provide. Companion service is a voluntary arrangement initiated by clients, their families, or individuals acting on behalf of the clients, and is the financial responsibility of the clients.

meal replacement is a commercially formulated product that, by itself, can replace one or more daily meals. It does not include vitamin or mineral preparations.

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nutrition supplement is a food that supplements a diet inadequate in energy and essential nutrients, and typically takes the form of a drink but may also be a pudding, bar or other form. It does not include vitamin or mineral preparations. Homemade milkshakes or house brand supplements may be used where the care plan or the client's physician do not specifically require a named commercial brand for medical reasons.

therapeutic diet is any medically prescribed diet that is under the supervision of the client's attending physician (e.g., diabetic and low sodium diets).

Benefits Include:

- standard accommodation as outlined in Part 3 of the Residential Care Regulation;
- development and maintenance of care plans for each client, as set out in the Residential Care Regulation Section 81, that includes:
 - skilled care, with professional supervision consistent with the needs of the client;
 - a falls prevention plan;
 - a bathing and skin care plan; and
 - other routines to meet the unique needs of the client.
- clinical support services such as rehabilitation and social work services consistent with the client's care plan;
- ongoing, planned physical, social and recreational activities, such as exercise or music programs, crafts, games;
- meals, including therapeutic diets if prescribed by the client's physician, and tube feeding;
- meal replacements and nutrition supplements specified in the care plan or by a physician:
 - homemade milkshakes or house brand supplements may be used where the care plan or the client's physician do not specifically require a named commercial brand for medical reasons;
- routine client laundry service for bed linens, towels, washcloths, and all articles of clothing that can be washed without special attention to the laundering process;
- general hygiene supplies for all clients, including but not limited to soap, shampoo, toilet tissue, and special products required for use with the bathing equipment in the long-term care home;
- routine medical supplies, including but not limited to:

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- sterile dressing supplies
 - glucose strips
 - disposable under pads for bed and chair use
 - equipment for general use of all clients, such as lifts, bed alarms, specialized mattresses, surveillance system devices
 - surveillance systems to support client safety
 - bandages (elastic or adhesive)
 - syringes
 - equipment physically attached to the long-term care home
 - shared equipment for short-term general use, such as shared wheelchairs and walkers
 - disposable gloves: sterile or non-sterile
 - wound care supplies and dressings
- incontinence management including but not limited to:
 - toileting program, including individualized scheduled toileting plan to assist in maintaining continence and, where necessary, an incontinence plan;
 - single use, disposable under pads, briefs and inserts;
 - catheters – indwelling, straight, catheterization tray, drainage tubing, drainage bag, irrigation set, irrigation solution, leg bag drainage set; and
 - condom drainage sets;
 - basic wheelchairs for personal exclusive use, as per Policy 6.F.1;
 - basic cleaning and basic maintenance of wheelchairs, as per Policy 6.F.1;
 - any other specialized service (such as specialized dementia or palliative care) that the service provider has been contracted to provide.

Chargeable Items May Include:

- personal cable connection and monthly fee;
- personal telephone connection and basic services;
- nutrition supplements, where the client requests a specific commercial brand rather than the brand provided by the service provider;
- personal newspaper, magazines and periodicals;
- hearing aids and batteries, including replacement batteries;
- personal transportation;
- extra or optional craft supplies, entertainment and recreational activities that are additional to activities and supplies provided as benefits above, and are chosen by the client;
- an administration or handling fee associated with the service, where reasonable, to perform a task or service that would normally be the client's responsibility;
- purchase or rental of equipment that is for the exclusive use of the client, such as walker, crutches, canes or other devices, and maintenance as required;

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SUBSECTION:		EFFECTIVE: JULY 15, 2019

- modifications to basic wheelchairs/ modified wheelchairs, specialized wheelchairs, as per Policy 6.F.1;
- therapist fees for assessment and determination of modified wheelchair and specialized wheelchairs;
- miscellaneous charges associated with wheelchair cleaning and maintenance such as non-basic maintenance services, emergency cleaning, and damage;
- companion services;
- personal dry cleaning, or laundry services for items requiring special attention; and
- personal hygiene and grooming supplies that the client chooses in preference to general supplies provided by the service provider including:
 - facial tissue
 - hand lotion
 - denture cleaner
 - brush and comb
 - toothpaste
 - hair shampoo and conditioner
 - talcum powder
 - shaving cream
 - special soap
 - preferred incontinence supplies

Medications and Devices

Eligible prescription drugs, ostomy supplies and pre-approved prosthetic devices are provided under PharmaCare/Plan B.

Some non-prescription medications in community care facilities licensed under the *Community Care and Assisted Living Act* are considered a Chargeable Item.

Special Services

Health authorities must ensure that service providers do not request a client or a family to enter into a private arrangement to obtain staff assistance to which the client is entitled under the Residential Care Regulation and Ministry policy.

In some circumstances clients, families or friends may wish to obtain extra direct care or complementary services. Arrangements for such special services are permitted, subject to the following:

- the health authority and service provider are informed of the provision of the special service in the long-term care home;
- services provided are the responsibility of clients, in cooperation with the service provider;
- payment is the responsibility of clients; and
- if requested, the service provider is provided with regular detailed information on the service provided and outcomes for inclusion in the client's health record.

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References

Community Care and Assisted Living Act

Continuing Care Act

Hospital Insurance Act

Residential Care Regulation

Wheelchair Policy Interpretation Guide, Ministry of Health, 2016

CHAPTER: 6	LONG-TERM CARE SERVICES	NUMBER: 6.F.1
SECTION: F	BENEFITS AND ALLOWABLE CHARGES	PAGE: 1 OF 2
SUBSECTION: 1	BASIC WHEELCHAIR BENEFIT	EFFECTIVE: JULY 15, 2019

Intent

To clarify, the benefits and chargeable extras for clients receiving wheelchairs for personal exclusive use.

Policy

Health authorities must ensure that service providers:

- provide a basic wheelchair for personal exclusive use to the client at no additional charge to the client over and above the client rate;
- provide basic maintenance and basic cleaning of the basic wheelchair at no additional charge to the client over and above the client rate;
- do not provide a basic wheelchair benefit to any client who is eligible for similar or better wheelchair benefits from another source such as the Ministry of Social Development and Poverty Reduction, Veteran’s Affairs Canada, WorkSafeBC, or any other provincial or federal government Ministry, agency, program or crown corporation;
- do not provide a basic wheelchair to any client for whom a basic wheelchair would not be safe and clinically appropriate;
- inform and receive client consent before charging fees for chargeable items associated with modifications to basic wheelchairs, modified wheelchairs and specialized wheelchairs, including assessments, maintenance, cleaning services, and damages; and
- advise clients that the basic wheelchair must be returned to the service provider in its original condition when no longer required.

Definitions

Basic cleaning and basic maintenance is regular cleaning, disinfection, and minor adjustments of a wheelchair at regular intervals to address wear and tear to preserve clinical effectiveness and client dignity and safety.

Basic wheelchair is a manual, self-propelled, safe and durable wheelchair that enhances personal mobility; has a basic contoured seat cushion; and which is reasonable to obtain and maintain.

Customized/ Specialized wheelchair is a wheelchair with significant manual/ technical upgrades and modifications and includes custom made wheelchairs to meet an individual’s unique needs and/ or lifestyle.

CHAPTER: 6	LONG-TERM CARE SERVICES	NUMBER: 6.F.1
SECTION: F	BENEFITS AND ALLOWABLE CHARGES	PAGE: 2 OF 2
SUBSECTION: 1	BASIC WHEELCHAIR BENEFIT	EFFECTIVE: JULY 15, 2019

Modified basic wheelchair is a basic wheelchair with appropriate adjustments, modifications and upgrades to cushion, armrests, and/or back, and excludes all physical (frame) and permanent alterations to the basic wheelchair. Modifications must be non-permanent so that the attributes of the basic wheelchair remain available for the next client who uses the wheelchair.

Personal exclusive use is exclusive non-restricted use by a single client.

Wheelchair is a device providing wheeled mobility and seating support for a person with mobility issues.

Wheelchair Benefits Include:

- provision of a basic wheelchair for personal exclusive use;
- basic cleaning and basic maintenance of the basic wheelchair.

Chargeable Wheelchair Items May Include:

- modifications to the basic wheelchair;
- specialized wheelchairs;
- therapist and other fees related to modifications and specialized wheelchairs;
- non- basic cleaning and maintenance; and
- damages and related expenses.

References

Wheelchair Policy Interpretation Guide, Ministry of Health, 2016

CHAPTER: 6 LONG-TERM CARE SERVICES	NUMBER: 6.G
SECTION: G CLIENT FUNDS AND BELONGINGS	PAGE: 1 OF 2
SUBSECTION:	EFFECTIVE: JULY 15, 2019

Intent

To describe health authorities' responsibilities to safeguard personal funds and belongings of clients receiving publicly subsidized long-term care services.

Policy

Health authorities must ensure service providers establish reasonable accounting and security measures to receive and control funds for the personal comfort of the client, and make adequate provision for the custody and safekeeping of the client's personal funds and belongings.

Client Personal Needs Funds

Health authorities must ensure that, for all transactions undertaken on behalf of a client, service providers:

- maintain a separate personal needs account in a non-interest bearing account within the province of British Columbia for funds used to pay for personal items and charges on behalf of the client;
- maintain simple books that must clearly show additions, withdrawals, and a balance for each client; and
- keep the personal needs account up to date at all times, supported by receipts.

A client's personal needs account shall be maintained at a level that is consistent with the monthly discretionary spending of the client, and must not exceed \$500.00 at any one time unless approved by the client.

Client Belongings

Health authorities must ensure service providers:

- are requested to assist the client in safekeeping only those personal effects and jewellery that are for everyday use of the client; and
- take immediate steps to request that the client arrange for safekeeping of the article in another location where the client has personal effects or jewellery exceeding this definition.

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SECTION: G CLIENT FUNDS AND BELONGINGS	PAGE: 2 OF 2
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Conflict of Interest

Health authorities must ensure that no service provider or employee, or spouse or relative of either, may accept any benefit from clients by gift or will, or influence a client in the conduct of their financial affairs for the benefit of the service provider or employee, or spouse, relative or friend.

Where an employee of a service provider has a family or personal relationship with a client, the employee must provide notice of this relationship in writing to the service provider, to be retained on the client's health record.

The service provider must ensure that a client's funds or belongings are not handled by the specific employee without management supervision.

References

Community Care and Assisted Living Act (Part 2, section 18)

Hospital Act (Part 1, section 41)

Residential Care Regulation Section Part 6

CHAPTER:	6	LONG-TERM CARE SERVICES	NUMBER:	6.H
SECTION:	H	RESIDENT AND FAMILY COUNCILS	PAGE:	1 OF 3
SUBSECTION:			EFFECTIVE:	FEBRUARY 12, 2024

Intent

To describe health authorities' responsibilities to ensure that resident/family councils are encouraged and supported, and to hold regular regional council meetings.

Policy

Health authorities must encourage the development of resident/family councils and support the ongoing function of resident/family councils as an opportunity for clients and their families to identify challenges and opportunities and suggest quality of life improvements in long-term care homes.

Health authorities must ensure that long-term care service providers:

- are aware of the Residential Care Regulation requirements for resident/family councils;
- encourage the development of resident/family councils, where none are currently established;
- allow resident/family councils to meet four times per year or more often, as reasonable, if requested by the resident/family council;
- provide the necessary and reasonable administrative and logistical support for effective meetings, including:
 - providing an inclusive meeting space to allow for council members to participate in-person, by telephone or virtually, and,
 - providing secretarial support required and requested by the council including facilitating meeting invitations, taking meeting minutes, distributing agendas and minutes; and
- provide an opportunity, at least twice a year, for the resident/family council to meet with the service provider to provide feedback, raise concerns, ask questions, and make recommendations.

Health authorities must ensure that service providers support the intent for resident/family councils to be independent and member driven. Council members must be allowed to determine the level of service provider involvement, including secretariat support and any assistance the resident/family council request with facilitating or chairing meetings. Resident/family council members will determine if service provider staff attend meetings and whether portions of the meeting will occur without staff attendance.

At the Ministry's request, health authorities must provide service providers with informational materials to be provided to resident/family councils, as described in the Residential Care Regulation.

Health authorities must ensure that where there is no council established, service providers meet the relevant requirements in the Residential Care Regulation, including that service providers offer clients and families the opportunity to meet twice per year.



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SECTION:	H	RESIDENT AND FAMILY COUNCILS	PAGE:	2 OF 3
SUBSECTION:			EFFECTIVE:	FEBRUARY 12, 2024

Definitions

resident/family council is a group of long-term care clients and/or their family members or close friends (and may include family members of people who have been clients within the last year) who meet regularly to identify and resolve issues, share education and support quality of life improvements for long-term care clients.

regional council is the group of long-term care clients and/or their family members or close friends (and may include family members of people who have been clients within the last year) representing the resident/family councils in a region and health authority representatives who meet semi-annually (at minimum) to identify and resolve issues, share education, and support quality of life improvements for long-term care clients.

Regional Councils

Regional councils are intended to strengthen the partnership between clients, their family members, resident/family councils and the health authority. At regional council meetings, resident/family councils can bring forward current concerns and feedback to health authority staff about common and systemic issues they identify related to quality of life for long-term care clients and resident/family councils.

Health authorities must establish one or more regional councils, which will meet two or more times per year.

Regional councils consist of:

- the client or family member chair of each resident/family council, (or co-chair, or delegate as chosen by the resident/family council)
- health authority representatives
- health authority secretariat support
- guests invited by the regional council, which may include Ministry staff or other interested partners.

Regional council meetings are co-chaired by:

- a health authority representative, and
- one or more client/family member representatives chosen by the client/family member regional council members.

Health authorities must ensure effective operation of regional council meetings by:

- coordinating meetings, preparing meeting materials, keeping records, and providing updates on follow-up actions;
- accommodating in-person or virtual participation;
- outlining and documenting the common goals and expectations of the regional council, such as the responsibilities of co-chairs, health authority staff, and regional



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SECTION:	H	RESIDENT AND FAMILY COUNCILS	PAGE:	3 OF 3
SUBSECTION:			EFFECTIVE:	FEBRUARY 12, 2024

- council members; and,
- documenting details of regional council meetings to be shared with the Ministry of Health, including:
 - Date of meeting
 - Number of attendees (including which long-term care homes are represented)
 - Topics discussed
 - Items put forward by the regional council for Ministry of Health consideration.

Provincial Forum

The Ministry of Health will host a regular forum to promote best practices, discuss systemic issues, and advance quality of life for long-term care clients. Attendees will include client and family members representatives from each regional council chosen by client and family regional council representatives, Ministry staff, and health authority staff. Agenda items will include suggestions put forward by regional councils and items identified by the Ministry.

Reference

Residential Care Regulation

Developing, Supporting and Maintaining Resident Councils and Resident and Family Councils

CHAPTER:	6	LONG-TERM CARE SERVICES	NUMBER:	6.1
SECTION:	I	RESIDENTS' BILL OF RIGHTS / PATIENTS' BILL OF RIGHTS	PAGE:	1 OF 1
SUBSECTION:			EFFECTIVE:	JULY 15, 2019

Intent

To define health authorities' responsibilities to inform clients and families about the Residents' Bill of Rights for adults who live in community care facilities licensed under the *Community Care and Assisted Living Act*, or the Patients' Bill of Rights which applies to persons in care who live in private hospitals and extended care facilities regulated by the *Hospital Act*, and to ensure that clients and families know how to raise concerns.

Policy

Health authorities must ensure that:

- the resident or patient rights are fully incorporated into the delivery of long-term care services;
- the Residents' Bill of Rights or the Patients' Bill of Rights is posted in a prominent place in all long-term care homes;
- staff receive training about the meaning and intent of the Residents' Bill of Rights and/or the Patients' Bill of Rights;
- information on the Residents' Bill of Rights or the Patients' Bill of Rights, how to resolve a concern and contacts for Community Care Licensing and the Patient Care Quality Office are provided to both clients and family members upon admission to a long-term care home;
- decisions to limit a client's rights are clearly documented and supported by appropriate background information in the client's record; and
- no action will be taken to evict, discharge or intimidate an individual who makes a complaint regarding their care or the application of resident / patient rights.

References

Community Care and Assisted Living Act
Patient Care Quality Review Board Act
 Patients' Bill of Rights Regulation
 Residential Care Regulation
 Residents' Bill of Rights

CHAPTER: 6	LONG-TERM CARE SERVICES	NUMBER: 6.J
SECTION: J	MOVEMENT OF CLIENTS – CLOSURES OR RENOVATIONS	PAGE: 1 OF 2
SUBSECTION:		EFFECTIVE: NOVEMBER 4, 2019

Intent

To outline health authorities' responsibilities in managing the change process for clients as a result of an operational decision by a health authority or service provider to close a long-term care home, close beds in a long-term care home or renovate a long-term care home that results in the movement of clients.

Policy

Health authorities must plan and manage the change process for clients where a long-term care home is being closed, beds in an existing long-term care home are being closed or the long-term care home is being renovated, consistent with the following requirements:

- ensure that maintenance of the quality and safety of the client's care is the priority throughout the process;
- ensure that a client will not be required to move more than once unless requested by the client;
- provide the client or substitute with information on the long-term care homes in the health service area that are appropriate to the client's needs, and the options for choosing other long-term care homes;
- offer each client an opportunity to meet with health authority and long-term care home staff through a care conference to identify the key concerns in making the move to a new long-term care home and develop an individual placement plan for the client;
- ensure that a client is not moved until the care conference has occurred and an individual placement plan has been developed;
- offer placement options that take into consideration the distance, time and terrain that the client's caregivers will need to travel in order to visit the client;
- ensure couples are relocated together in the new long-term care home, even if their care needs differ, when the couple is currently residing in the long-term care home and they have requested to stay together; and
- facilitate the move to another health region if a client, substitute or couple requests such a move.

CHAPTER: 6	LONG-TERM CARE SERVICES	NUMBER: 6.J
SECTION: J	MOVEMENT OF CLIENTS – CLOSURES OR RENOVATIONS	PAGE: 2 OF 2
SUBSECTION:		EFFECTIVE: NOVEMBER 4, 2019

Health Authority Process

Health authorities must develop operational policy and procedures that include the following:

- a process for working with clients to provide opportunities for a care conference with health authority and long-term care home staff, and to develop an individual placement plan;
- timely communication with the client, and an opportunity for follow up discussion of questions and concerns;
- a reasonable time frame for the client to plan for the relocation;
- a process to assess the client's needs and evaluate the suitability of their long-term care homes preferences;
- a process to ensure consent is obtained for admission into the receiving long-term care home, as per Policy 6.D.2, Consent to Long-Term Care Home Admission; and
- a process to communicate the client's current clinical and special clinical needs to staff in the receiving long-term care home.

Moving Costs

Health authorities are responsible for the costs associated with a client move, including transportation, address notification, medication transfer and one-time reconnection costs for personal phone and cable television, with the following exceptions:

- where the client or substitute chooses to move to a long-term care home in another health region, the costs related to the move are the responsibility of the client; and
- the client is responsible for any new costs they initiate, such as upgrading their telephone or cable services, or hooking-up a new appliance.

Retention of Benefits

Clients receiving publicly subsidized long-term care services who move to an assisted living residence because their long-term care home is being closed will retain their PharmaCare Plan B benefits.

Reference

Provincial Guidelines for Closure of Residential Care Facilities, Ministry of Health Services, June 2009

CHAPTER: 6	LONG-TERM CARE SERVICES	NUMBER: 6.K
SECTION: K	LARGE-SCALE STAFF REPLACEMENTS	PAGE: 1 OF 1
SUBSECTION:		EFFECTIVE: JULY 15, 2019

Intent

To ensure that the quality and safety of client care is maintained during a large-scale staff replacement, meaning mass staff turnover through the change from one contracted service provider to another or through a change in ownership.

Policy

Health authorities must ensure service providers plan and manage the change process for clients where a service provider is planning a large scale staff replacement, consistent with the following requirements:

- ensure that maintenance of the quality and safety of the client's care is the priority throughout the process;
- provide the client with information about the upcoming change;
- offer clients and families an opportunity to meet with service provider staff to identify the key concerns in the changeover in staff; and
- ensure that the staff replacement does not happen until all clients are informed and have had an opportunity to have their concerns heard.

Health Authority Process

Health authorities must ensure service providers develop operational policy and procedures that include the following:

- timely communication with the client, and an opportunity for follow up discussion of questions and concerns;
- timely communication to the community care licensing office;
- measures to assist clients with loss of continuity in their care;
- a process to communicate the client's current clinical and special clinical needs to new staff; and,
- a process to monitor and mitigate impacts from the change.