



**NOVA SCOTIA DEPARTMENT OF  
HEALTH AND WELLNESS**

**Home Care Policy Manual**

**June 1, 2011**

**With Addendum September 30, 2018**

**Policy:** Home Care Policy Manual

*Approval Date:* May 27, 2011

*Effective Date:* June 1, 2011

*Approved by:* Kevin McNamara  
Deputy Minister, Department of Health and Wellness

*Signature:* *Original signed by Kevin McNamara*

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*Version:* Replaces 1997 Home Care Nova Scotia (HCNS) Policy Manual

*Addendum:* September 30, 2018

*Approved by:* Denis Perret,  
Deputy Minister, Department of Health and Wellness

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# Addendum to the Home Care Policy Manual (2018)

This addendum to the Department of Health and Wellness Home Care Policy Manual (June 2011) aligns the manual with the *Health Authorities Act* (2014, C. 32), the *Health Authorities Act General Regulations* and the *Accountability Framework* between the department and the Nova Scotia Health Authority. Updates to the Home Care Policy Manual (policy manual) as described below, reflect amendments made to the Health Authorities Act effective April 1, 2015 to amalgamate Nova Scotia's nine District Health Authorities into one Provincial Health Authority.

1. **Terminology:** District Health Authority now the Nova Scotia Health Authority

The term District Health Authority, when used in the policy manual, refers to the Provincial Health Authority formed as of April 1, 2015 as an amalgamation of the previous district health authorities.

2. **Geography:** Districts now Management Zones

When used in the policy manual any references to districts should be disregarded, as the mandate of the Nova Scotia Health Authority is province-wide. The following management zones are established within the Province for delivering and managing health services on a regional level by the Provincial Health Authority:

Zone	Counties/Municipalities in Zone
Western Zone	Yarmouth County Shelburne County Digby County Queens County Annapolis County Lunenburg County Kings County
Eastern Zone	Guysborough County Antigonish County Richmond County Inverness County Victoria County Cape Breton County
Northern Zone	Municipality of the District of East Hants Colchester County Cumberland County Pictou County
Central Zone	Halifax County Municipality of the District of West Hants

3. **Duties and Responsibilities:** Department of Health and Wellness and the Nova Scotia Health Authority

The following three sections of the policy manual have been revised as described below to reflect the duties and responsibilities of the Department of Health and Wellness and the Nova Scotia Health Authority as established by the *Health Authorities Act* (2014 c.32), and the *Accountability Framework* between the department and the Nova Scotia Health Authority.

**Purpose of The Nova Scotia Department of Health and Wellness  
Home Care Policy Manual**

This section has been updated to reflect changes in terminology and geography, reference current legislation, and remove references to the responsibilities of the District Health Authorities.

**1.4 Nova Scotia Health Authority Responsibilities**

Section 1.4 of the policy manual outlines the responsibilities of the Nova Scotia Health Authority as defined in the *Health Authorities Act* (2000, C.6, s.1). This section of the policy manual has been revised to reflect section 19(1) of the *Health Authorities Act* (2014 c.32) which establishes the responsibilities of the Nova Scotia Health Authority.

**1.5 Department of Health and Wellness Responsibilities**

Section 1.5 of the Home Care Policy Manual outlines the responsibilities of the Department of Health and Wellness as defined in the *Health Authorities Act* (2000, C.6, s.1). This section of the policy manual has been revised to reflect sections 5 and 6 of the *Health Authorities Act* (2014, C.32) which establishes the responsibilities of the Department of Health and Wellness.

# ACKNOWLEDGEMENT

The Continuing Care Branch would like to acknowledge the work done by staff at both the Ministry of Health and the Regional Health Authorities in Saskatchewan in developing a comprehensive home care policy manual on which this document is based. The Saskatchewan Ministry of Health has been very generous in sharing their knowledge and in allowing us to model this document on the good work they have undertaken.

Continuing Care Branch  
Halifax, Nova Scotia  
June 2011

## **Maintenance of the Policy Manual & Policy Feedback**

The Nova Scotia Department of Health and Wellness is responsible to maintain the Home Care Policy Manual and to keep the policies contained within current and relevant. The Continuing Care Branch will undertake this maintenance role cooperatively and in consultation with the District Health Authorities and our other partners in the provision of care.

If you have identified any errors in this document or have suggestions for revisions to the policies contained in this manual, please complete the form on the following page, giving as much detail as possible, and forward by mail or fax to the Continuing Care Branch.

# HOME CARE POLICY FEEDBACK FORM

Submitted by:

Name:		
Organization:		
Telephone:		FAX:

Please identify the policy you are commenting on

Section: _____	Policy: _____	Page: _____

Fax or Mail to: Continuing Care Branch, Department of Health and Wellness  
Director, Standards & Policy Development  
P.O. Box 488  
Halifax, NS B3J 2R8  
Fax: 902-424-0558

## **PURPOSE OF THE NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS HOME CARE POLICY MANUAL**

The home care program in Nova Scotia is administered and delivered by the Nova Scotia Health Authority (NSHA) and funded by the Nova Scotia Department of Health and Wellness (DHW). This manual is designed to facilitate consistency in home care services and home care standards throughout the province. The program expectations in the delivery of home care are addressed in this, the Nova Scotia DHW Home Care Policy Manual.

This manual provides direction and guidance to the NSHA. The policies represent a statement of required course of action. Guidelines, on the other hand, are provided as recommendations to assist the health authority in meeting the expectations of policies. Adherence to the policies is one of the conditions under which funding is provided to the NSHA by the Minister of Health and Wellness.

The Nova Scotia Health Authority is vested with responsibility for the delivery of home care services. Though not limited to the following, the Nova Scotia Health Authority is responsible for the compliance with the *Health Authorities Act* (2014, C. 32), the *Health Authorities Act General Regulations Health Authorities Act* (2014), the *Co-ordinated Home Care Act* (1990, c.6, s.1), the *Homemaker Services Act* (R.S., c.201, s.1), the *Personal Directives Act* (2008, c.8, s.1) and any provincial policy pertaining to the delivery of home care. It should be noted that this manual does not address, in any detail, requirements that must be met as established by other legislation.

Home care is an integral part of the continuum of care that includes both community and institutional services necessary to ensure the best quality of life for people with varying degrees of short and long term illness or disability and support needs. An effective continuum of care requires strong community and institutional support sectors so that appropriate services can be accessed when and where they are needed.

The Nova Scotia Health Authority is accountable for the day-to-day delivery of health programs and services, including home care services and must provide a range of services to help maintain client independence and wellbeing at home, and strive to ensure that appropriate care is provided to clients. However, when considering the delivery of health care services, the Health Authority must take into consideration the needs of all four management zones in Nova Scotia (Eastern, Central, Northern and Western), within available resources.



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<b>Section: 1.0 INTRODUCTION</b>
<b>Policy: 1.1 Purpose of Home Care</b>

<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

### ***1.1. PURPOSE OF HOME CARE***

Home care helps people of all ages who need assistance to maintain their optimal well being and independence at home. Home care serves clients with acute, chronic and palliative needs. Home care encourages and supports the assistance provided by the family and/or community.

<b>Section: 1.0 INTRODUCTION</b>
<b>Policy: 1.2 Objectives</b>

<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

## 1.2. OBJECTIVES

1. To help people maintain optimal well being and independence at home by:
  - a) determining needs and abilities, developing and coordinating plans of care;
  - b) teaching self-care and coping skills;
  - c) improving, maintaining or delaying loss of functional abilities;
  - d) promoting and supporting family and community responsibility for care; and
  - e) supporting the palliative, supportive and acute care provided by family, friends and others.
  
2. To facilitate appropriate use of health and other community based services by:
  - a) preventing or delaying the need for admission to long-term care facilities;
  - b) supporting people waiting for long-term care admission;
  - c) preventing the need for hospital admission, making earlier discharge from hospital possible, and reducing the frequency of re-admission;
  - d) helping individuals and families access needed services;
  - e) promoting volunteer participation;
  - f) educating the public and community agencies about home care;
  - g) participating in local service planning and coordination; and
  - h) developing an awareness of and integrating complementary services provided by other organizations and agencies.
  
3. To make the best use of home care resources by:
  - a) serving people with the greatest need first;
  - b) operating economically and efficiently; and
  - c) communicating relevant information in a timely manner.
  
4. To meet client needs and optimize client well being and independence within available home care resources while working cooperatively with other community agencies, organizations and individuals.

<b>Section: 1.0 INTRODUCTION</b>
<b>Policy: 1.3 Philosophy</b>

<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

**1.3. PHILOSOPHY**

The provision of home care services is guided by the following principles:

1. People can usually retain greater independence and control over their lives in their own homes;
2. Most people prefer to remain at home and receive required services at home;
3. Support provided by families and friends should be encouraged and preserved and, if necessary, supplemented;
4. Services should assist individuals to maintain their optimal independence and well being and avoid creating unnecessary dependencies on home care;
5. Home care should assist people to access needed health and other community based services;
6. Service decisions in home care should be based on assessed client need and the risk to the client if service is not provided;
7. Clients and their supporters should help identify their needs, establish goals, and develop plans to meet goals;
8. People with the greatest need for home care should receive priority for service;
9. Individuals have the right to be treated with kindness, dignity, and respect;
10. An individual's autonomy is respected, which includes a person's right to knowingly live at risk to one's self and to accept or refuse services;
11. Individuals are presumed to have capacity unless evidence demonstrates otherwise;
12. Home care services should be provided in a manner that respects the client's cultural values;
13. District Health Authorities should have significant responsibility for planning and ensuring delivery of home care services;

14. Home care should provide high quality, safe, and effective services;
15. Home care utilizes service providers to the full scope of their practice;
16. Home care promotes continuity of care by providing the same service providers to clients where possible and appropriate; and
17. Home care recognizes that care in a facility is appropriate when the resources of the individual, the family, the community and the home care program cannot adequately sustain the individual in the home.

<b>Section: 1.0 INTRODUCTION</b>	
<b>Policy: 1.4 Nova Scotia Health Authority Responsibilities</b>	
<b>Effective date:</b> September 30, 2018	<b>Version:</b> Replaces HCPM Section 1.0, Policy 1.4, June 2011
<b>Approved by:</b> Denise Perret, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Denise Perret</i>	

**1.4. NOVA SCOTIA HEALTH AUTHORITY RESPONSIBILITIES**

1. Under Section 19(1) of the Health Authorities Act (2014, c.32) the Health Authority shall:
- (a) subject to any determination by the Minister under clause 9(a), determine priorities in the provision of health services by the health authority and allocate resources accordingly;
  - (b) recommend to the Minister which health services should be made available by the health authority;
  - (c) consult with the Minister and implement the provincial health plan;
  - (d) prepare and submit to the Minister a health-services business plan for each fiscal year;
  - (e) implement the health-services business plan for the health authority;
  - (f) assist the Minister in the development of and implementation of health policies and standards, health-information systems, human-resource plans for the health system and other Provincial health-system initiatives;
  - (g) meet any standards established by the Minister respecting the quality of health services provided by the health authority;
  - (h) comply with any directions, policies or guidelines issued or established by the Minister in respect of the health services provided by the health authority and the administration of such health services;
  - (i) provide to the Minister such information, including personal information and personal health information, as is required by the Minister for the purposes of monitoring and evaluating the quality, efficiency, accessibility and comprehensiveness of health services, and health-system planning;
  - (j) report on health-system performance as required by the Minister;
  - (k) develop and implement health-system improvement plans as required by the Minister;
  - (l) operate in accordance with any accountability framework established by the Minister;
  - (m) assess the health needs of the residents of the Province and create community profiles according to the requirements established by the Minister;
  - (n) provide to the Minister any other reports as required by the Minister; and
  - (o) carry out such additional responsibilities as the Minister may assign or as are prescribed by the regulations.

<b>Section: 1.0 INTRODUCTION</b>	
<b>Policy: 1.5 Department of Health and Wellness Responsibilities</b>	
<b>Effective date:</b> September 30, 2018	<b>Version:</b> Replaces HCPM Section 1.0, Policy 1.5, June 2011
<b>Approved by:</b> Denise Perret, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Denise Perret</i>	

**1.5. DEPARTMENT OF HEALTH AND WELLNESS RESPONSIBILITIES**

1. Under the Health Authorities Act (2014, C.32, s.5), the role of the Minister is to
- (a) provide leadership for the health system by setting the strategic policy direction, priorities and standards for the health system; and
  - (b) ensure accountability for funding and for the measuring and monitoring of health-system performance.

Under the Health Authorities Act (2014, c.32, s.6) the Minister shall

- (a) in consultation with the health authorities, set the strategic direction of the health system by establishing a multi-year provincial health plan;
- (b) in consultation with the health authorities, establish an accountability framework for the purpose of ensuring that the provincial health plan is implemented;
- (c) establish policies, standards and guidelines for the provision of health services and the administration of the provision of health services;
- (d) determine the health services to be provided by a health authority and administer the allocation of available resources for the provision of such health services by the health authority;
- (e) require a health authority to prepare and implement a health-services business plan and such other plans as the Minister considers appropriate, including information management and technology plans and health human-resource plans;
- (f) establish technical and informational requirements and standards for health-information systems; and
- (g) conduct financial and human resource planning.



<b>Section: 2.0 CLIENT ACCESS TO SERVICE</b>
<b>Policy: 2.1 Service Availability</b>

<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

## **2.1. SERVICE AVAILABILITY**

### **POLICY**

1. Planned, intermittent, and predictable service is available to eligible clients within the District at any time (e.g. weekends, evenings, nights, and holidays).

<b>Section: 2.0 CLIENT ACCESS TO SERVICE</b>	
<b>Policy: 2.2 Coordinated Access</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

## 2.2. COORDINATED ACCESS

### Definition

“Coordinated access” includes a case management approach which avoids duplication of service and ensures that appropriate service is provided. Coordinated access to home care services supports the prioritization of clients based on greatest need and assists the District Health Authority to identify gaps in programming, the need for new initiatives, and to effectively use resources within the District.

### POLICY

1. District Health Authorities, as a minimum, will provide coordinated access to home care through the provincial single entry access (SEA) process for Continuing Care services. Other services may be included, as appropriate.

<b>Section: 2.0 CLIENT ACCESS TO SERVICE</b>	
<b>Policy: 2.3 Eligibility Criteria</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

### 2.3. *ELIGIBILITY CRITERIA*

#### **POLICY**

1. Applicants for home care must meet one of the following criteria in order to have their applications considered:
  - a) meet the eligibility requirement for Nova Scotia's Health Insurance Plan, i.e. the person has been issued a valid Nova Scotia Health Card; or
  - b) be in the process of establishing permanent residence in Nova Scotia and have applied for coverage under Nova Scotia's Health Insurance Plan.
2. The applicant must demonstrate, through assessment, as detailed in Section 5.1 of this manual, a need for the services provided by home care.
3. Applicants requiring home care nursing services must have access to a physician willing to accept responsibility for the management of medical aspects of their care.
4. The applicant's condition limits his/her ability to reasonably access the needed services from community based services such as outpatient departments, ambulatory clinics or physicians' offices.
5. The applicant's environment must be safe and suitable for the provision of home care services, both for the applicant and for home care service providers, in accordance with current policies and as required under the *Occupational Health and Safety Act (1996, c.7, s.1)* and other applicable legislation.
6. District Health Authority home care programs may accept applications from non-Nova Scotia residents staying temporarily in the province. Charges for non-Nova Scotia residents are outlined in Section 14.5 of this policy manual.
7. The services required by the applicant should not generally exceed the cost of the equivalent level of services in a nursing home licensed by the Department of Health and Wellness.

<b>Section: 2.0 CLIENT ACCESS TO SERVICE</b>	
<b>Policy: 2.4 Acceptance Criteria</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

#### **2.4. ACCEPTANCE CRITERIA**

##### **POLICY**

1. The District Health Authority shall set priorities for home care service based on assessed need and level of risk.
2. The District Health Authority shall provide home care services to persons where:
  - a) the person meets program criteria;
  - b) the person requires care and support while living in the community;
  - c) the services to be provided do not replace the assistance usually provided by the family or community, unless necessary; and
  - d) the home care program has the resources to be able to provide the service.
3. The District Health Authority shall provide home care services to:
  - a) determine a person's needs and develop appropriate plans for service,
  - b) improve a person's ability to function independently by teaching self-care;
  - c) prevent or delay the functional deterioration of a person;
  - d) provide needed assistance and relief to the family and others who are providing care to a person;
  - e) assist a person with a disability to function as independently as possible;
  - f) eliminate or delay the need for a person's admission to a long term care facility or hospital;
  - g) maintain a person in the community pending placement in a long term care facility;
  - h) allow a terminally ill person to remain at home as long as possible; and/or
  - i) permit earlier discharge of a person from hospital or reduce the frequency of hospital re-admissions.
4. The District Health Authority is responsible to ensure that processes are in place to address concerns when an applicant is accepted to the program and there are serious reservations about safety, either for the individual requiring care or the home care service provider. The District Health Authority must:
  - a) set conditions it believes are necessary to make service arrangements workable;
  - b) ensure that any conditions for admission are clearly explained to the applicant (and/or their substitute decision maker if the applicant lacks capacity), involved family members, and involved others from the client's support network;

- c) ensure ongoing documentation of client needs and circumstances, factors affecting service arrangements, and all discussions and agreements with clients and supporters regarding service arrangements; and
  - d) ensure that the service arrangements are reviewed regularly.
5. The District Health Authority may reconsider providing or continuing the provision of home care services in circumstances which may include, but are not limited to circumstances where:
- a) there are serious reservations, based on a risk management assessment, about the safety and/or benefits of providing services to the applicant;
  - b) the required help is available from others who are willing and able to provide the applicant's care;
  - c) the applicant is unwilling to accept the assessment process or service plan, or to cooperate with plans for delivering services;
  - d) the applicant's safety between service visits cannot reasonably be assured because of inadequate support at home;
  - e) a life-threatening situation for the applicant or home care service provider staff exists and the program cannot guarantee delivery of the required services;
  - f) the services required cannot be safely provided because of the applicant's home situation/environment; or
  - g) the program has inadequate resources (personnel or financial) to serve the needs of the applicant.
6. The District Health Authority must develop process and procedures for situations where, due to safety concerns for the client, DHA staff, or service provider, it is considering either not providing home care services, withdrawing home care services or placing conditions on the provision of home care services. This process must address the following considerations:
- a) the right of the applicant to knowingly take risks;
  - b) an exploration of reasonable alternatives to provide service;
  - c) the advisability of a written agreement with the applicant;
  - d) an identification and definition of what home care is able to provide;
  - e) an identification of what the individual and informal supporters are responsible for;
  - f) clear explanation to the applicant (and/or their substitute decision maker), family members and supporters who are involved regarding any conditions or changes to conditions for providing service;
  - g) documenting the agreement and all relevant aspects of the case on an ongoing basis; close monitoring of the situation; and
  - h) alignment with the employee rights under the *Occupational Health & Safety Act (1996, c.7, s.1)*.

<b>Section: 2.0 CLIENT ACCESS TO SERVICE</b>	
<b>Policy: 2.5 Restrictions on Access to the Home Care Program</b>	
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<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

## **2.5. RESTRICTIONS ON ACCESS TO THE HOME CARE PROGRAM**

### **Definitions**

“Assisted living” is a living arrangement which is characterized by the following elements:

- a) individuals are able to direct their own care and reside in separate, self-contained units to which they control access; and
- b) some or all of the individual’s needs, related to activities of daily living, are met through services provided as an integral part of the person’s living arrangement.

“Home support services” include personal care, meal preparation, light housekeeping, and respite.

### **POLICY**

1. An applicant shall not be accepted to the home care program if:
  - a) the required services are the legislated or contractual responsibility of the applicant’s place of residence;
  - b) the required services are not services the home care program is authorized to provide;
  - c) the required services are the responsibility of a third party payer which may include insurance providers and federal, provincial, and/or municipal governments; or
  - d) the required services exceed the provincially established allowable service limit for home care.
2. The District Health Authority shall not provide home care services in an assisted living facility, when these are services provided by the operator as part of the assisted living arrangement. The contract specifying an operator’s responsibilities may be written or verbal. If the contract is verbal, the home care program shall determine what services have been agreed upon in exchange for the assisted living fee charged.
3. In circumstances where it is unclear whether the service required by the resident of an assisted living arrangement is the responsibility of the facility operator, the District Health Authority shall not unilaterally withdraw services that have been previously provided through home care, without consulting the parties concerned.

4. The District Health Authority shall not provide home support services to a resident of a facility licensed or approved by the Department of Health and Wellness or the Department of Community Services. For the purposes of this section, this includes the following long term care facilities: Nursing Homes, Homes for the Aged, Residential Care Facilities, Regional Rehabilitation Centers, Adult Regional Centers, Group Homes, Developmental Residences, Community Based Options, Small Options Homes, and Alternative Family Support Homes.
5. The District Health Authority shall not provide home care nursing services in a facility which is either licensed by or approved by the Department of Health and Wellness or the Department of Community Services under the *Homes for Special Care Act (R.S., c.203, s.1)* except as may be provided under Ministerial Order (see Appendix A) for the following:

Acute home care nursing services (see Section 9.2 of this manual), for the purpose of improving or stabilizing a medical or post-surgical condition and which are time limited and short term in duration, may be delivered in:

- facilities licensed by the Department of Health and Wellness or the Department of Community Services under the *Homes for Special Care Act (R.S., c.203, s.1)*; or
  - in facilities approved by the Department of Health and Wellness or the Department of Community Services under the Interim Standards for Community Based Options.
6. The District Health Authority is responsible to ensure that home care nursing services delivered in a facility licensed by or approved by the Department of Health and Wellness or the Department of Community Services are safe, effective, appropriate, and provided within available resources.

<b>Section: 2.0 CLIENT ACCESS TO SERVICE</b>
<b>Policy: 2.6 Priorities</b>

<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

## 2.6. PRIORITIES

### POLICY

1. The District Health Authority shall set priorities for home care service based on the client's assessed need and level of risk.
2. The District Health Authority shall determine need through an assessment process, which provides a comprehensive, multi-dimensional account of the individual's situation, including the person's functional abilities and home environment.
3. The District Health Authority will explore alternative ways of meeting the individual's needs as part of its assessment and care coordination process.
4. The District Health Authority must consider and balance the following criteria to determine the degree of need:
  - a) the more serious and immediate the consequences to the individual if service is not provided, the higher the priority; and
  - b) if more appropriate alternatives are available to the individual, the lower the priority.
5. The District Health Authority shall consider the relative cost effectiveness of other appropriate alternatives available to the individual.



<b>Section: 2.0 CLIENT ACCESS TO SERVICE</b>	
<b>Policy: 2.7 Referrals to Other Agencies if Unable to Meet Needs</b>	
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<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

**2.7. REFERRALS TO OTHER AGENCIES IF UNABLE TO MEET NEEDS**

**POLICY**

1. District Health Authorities must have a process in place to refer applicants where appropriate to an organization or another District Health Authority service when home care is unable, or inappropriate, to meet an applicant's needs.

<b>Section: 2.0 CLIENT ACCESS TO SERVICE</b>	
<b>Policy: 2.8 Non-Acceptance</b>	
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<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

## 2.8. *NON-ACCEPTANCE*

### **POLICY**

1. District Health Authorities must have a process in place to monitor all referrals and non-acceptance situations. The process must communicate, to the applicant (and/or their substitute decision maker), the reason(s) for the referral and/or non-acceptance of the applicant.
2. All referrals and non-acceptance situations must be documented.

<b>Section: 3.0 CONSENTS, CONFIDENTIALITY AND PRIVACY</b>	
<b>Policy: 3.1 Consents, Confidentiality and Privacy</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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### 3.1. CONSENTS, CONFIDENTIALITY AND PRIVACY

#### Definition

“Informed consent” is a process which involves educating a person about the nature, benefits, risks and alternatives which pertain to personal care, including health care decisions. The person must receive information about the nature of the proposed service, its expected benefits and the known common and serious risks, as well as alternative choices and likely consequences of accepting or refusing recommended service. In addition to receiving this information, the person must also be given the opportunity to ask and be given answers to any questions he or she might have.

“Personal directive” is a written document that sets out the wishes an individual may have with respect to personal care decisions, including health care decisions. A personal directive may also contain information related to the appointment of a delegate who can make a decision on behalf of the individual in the event that the individual lacks capacity to make a personal-care decision.

“Substitute decision maker” is an individual who can make health care decisions on behalf of a applicant/client who lacks capacity to make health care decisions. This individual may be appointed by the applicant/client through his/her personal directive or may be designated as a statutory decision maker in accordance with the *Personal Directives Act (2008, c.8, s.1)*.

#### POLICY

1. All information concerning an individual client is to be treated as confidential. District Health Authority staff are responsible to protect the privacy of individual clients with respect to any personal information about them in accordance with all applicable legislation, including but not limited to:

*Freedom of Information and Protection of Privacy Act (1993, c.5, s.1)*

*Health Protection Act (2004, c.4, s.1)*

*Hospitals Act (R.S., c.208, s.1)*

*Involuntary Psychiatric Treatment Act (2005, c.42, s.1)*

*Personal Directives Act (2008, c.8, s.1)*

*Personal Information International Disclosure Protection Act (2006, c.3, s.1)*

2. District Health Authority staff shall have authorized access to confidential information for program purposes only (i.e. on a “need to know” basis).
3. The District Health Authority must obtain and file as part of the clients’ record, informed written consent from the client or substitute decision maker as follows:
  - a) To obtain and access personal information from agencies, bodies and individuals involved in the client’s care, as may be necessary for the purposes of assessing eligibility and need; providing referral, services and for ongoing case management.
  - b) To share personal information about the client with agencies, bodies and individuals involved in the client’s care, as may be necessary for the purposes of assessing eligibility and need; providing referrals, services and for ongoing case management.
4. To obtain informed written consent, the District Health Authority must ensure that the client or substitute decision maker has capacity to consent, has full knowledge of the specific services for which the consent has been requested, and that those services are specified in the consent document signed by the client or substitute decision maker.
5. The District Health Authority must ensure that the processes used to obtain consent are compliant with the *Personal Directives Act (2008, c.8, s.1)*.
6. For consent to be considered valid the person must have capacity, it must be voluntary, it must be informed and it must be specific to the treatment/service and to the service provider who will be providing the service.
7. Where an individual has a personal directive, the District Health Authority must obtain a copy and communicate this to appropriate team members.
8. The District Health Authority must ensure that home care service providers obtain appropriate consents from the client or substitute decision maker prior to providing service.
9. The District Health Authority must have policies regarding client consent and the collection, use, disclosure, and retention of personal information, with consent or as otherwise specifically authorized in the applicable legislation, e.g.:
  - Freedom of Information and Protection of Privacy Act (1993, c.5, s.1)*
  - Health Protection Act (2004, c.4, s.1)*
  - Hospitals Act (R.S., c.208, s.1)*
  - Involuntary Psychiatric Treatment Act (2005, c.42, s.1)*
  - Personal Directives Act (2008, c.8, s.1)*
  - Personal Information International Disclosure Protection Act (2006, c.3, s.1)*

## GUIDELINES

1. Assessing capacity to consent is within the scope of practice of any health care provider proposing or delivering services to a person. It is assumed that all health care professionals conduct an assessment of a person's ability to consent to service as an element of his/her professional practice. A person is assumed to have capacity to consent unless there is contrary evidence that supports the person's incapacity. A person also possesses the right to refuse recommended service and to knowingly live at risk.
2. Capacity to consent relates to a person's ability to understand the nature of the home care services being proposed and to appreciate the consequences of accepting or not accepting the proposed services.
3. Capacity to consent implies varying levels of abilities on a variety of decision making tasks. To be considered legally capable of making a specific decision, a person must demonstrate that they understand the nature of the decision and have the ability to appreciate the consequences of making a choice or not making a choice. While a cognitive impairment may contribute to a person being unable to make specific health care decisions, this condition does not preclude an individual from making other decisions that may relate to personal care, including health care decisions. In other words, a person may lack the capacity to make some decisions but have the capacity to make other decisions.
4. The four elements of valid consent:
  - a) Must be given voluntarily, without undue influence, duress or coercion;
  - b) Must be given by a person who has capacity (and if not, their substitute decision maker) and this person must understand the nature, risk and benefits of the proposed service and understand that this applies to him/her;
  - c) Must be specific to the treatment/service and to the service provider who will be providing the service; and
  - d) Must be informed; Individuals must understand the consequences of their decision, lack of decision, or refusal to accept the services. They must have been given adequate information about the proposed service and its anticipated outcomes, as well as any significant risks and alternatives (if available).

<b>Section: 4.0 CLIENT RIGHTS AND RESPONSIBILITIES</b>	
<b>Policy: 4.1 Client Rights</b>	

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#### 4.1. CLIENT RIGHTS

##### Definition

“Continuing Care Assessor” is the District Health Authority staff person who completes an assessment of the applicant/client to determine program eligibility and need for home care services.

##### POLICY

1. The District Health Authority must establish written policies and procedures regarding the rights of clients. This includes the promotion and protection of each client’s right to receive necessary information, to be given reasonable choices and to be treated with dignity and autonomy.
2. The District Health Authority is required to ensure that processes are in place to:
  - a) make sure that clients understand their rights;
  - b) help clients exercise their rights; and
  - c) investigate and resolve complaints regarding a violation of client’s rights.
3. The District Health Authority is responsible for ensuring that the client, or the substitute decision maker, understands the consequences of decisions he/she makes and for documenting any discussion with the client or substitute decision maker in this regard.
4. If it is determined, in accordance with the *Personal Directives Act*, that a client’s capacity is in question, and the client is making a decision that could seriously compromise his/her health and/or safety, the Continuing Care Assessor is responsible to determine the appropriate substitute decision maker (see Section 3.1) and to communicate this concern to the substitute decision maker.
5. Clients and/or their substitute decision makers have the right to refuse service.
6. Clients have the right to knowingly live at risk.
7. Clients and/or their substitute decision makers have the right to fully participate in the assessment process.

8. Clients and/or their substitute decision makers have the right to choose whether a third party is present during the assessment process.
9. Clients have the right to participate in the service delivery and make personal choices within the parameters of services available.
10. Clients and/or their substitute decision makers have the right to access personal information about themselves gathered by District Health Authority staff and by service providers engaged by the District Health Authority to provide home care services.
11. Clients and/or their substitute decision makers have the right to appeal service plan decisions.
12. Clients have the right to receive safe, appropriate, and timely service.
13. Clients have the right to be treated with consideration, respect, and full recognition of their dignity and individuality.
14. Clients have the right to freedom from abuse, neglect or exploitation from all persons involved with the delivery of home care services.
15. Clients have the right to be assured of confidential treatment of their care records and that the privacy of their personal information is protected in accordance with applicable legislation.
16. Clients and/or their substitute decision makers, have a right to have their complaints regarding service delivery heard, reviewed and where possible, resolved.

## **GUIDELINES**

### **Advising Clients of Possible Consequences When Exercising Their Rights**

1. In some cases, exercising a right may affect the ability of the District Health Authority to serve a client's needs.
2. When explaining the potential consequences of exercising a particular right, the Continuing Care Assessor should provide as much information to the client as possible.

<b>Section: 4.0 CLIENT RIGHTS AND RESPONSIBILITIES</b>
<b>Policy: 4.2 Client Abuse</b>

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## 4.2. CLIENT ABUSE

### Definitions

“Abuse” is considered any activity that causes physical, mental, financial or emotional injury to a client. Abuse is a violation of a client’s civil and human rights.

### POLICY

1. District Health Authorities have a duty to protect clients from abuse by all persons involved in the delivery of home care services. A zero-tolerance approach to client abuse must be enforced without exception.
2. The District Health Authority shall develop appropriate policies and procedures to ensure a zero-tolerance approach to client abuse.
3. The District Health Authority must ensure they are in compliance with all applicable legislation and Department of Health policies related to abuse. These include, but are not limited to,
  - *Protection of Persons in Care Act ( 2004, c. 33, s. 1)*
  - *Adult Protection Act (R.S., c. 2, s. 1)*
  - *Criminal Code of Canada (R.S., 1985, c. C-46)*
  - Department of Health and Wellness Critical Incident Reporting Policy
  - District Health Authority policies



## **GUIDELINES**

### **Client abuse may be defined as:**

#### 1. Physical abuse:

- use of physical force that may result in bodily injury, physical pain, or impairment including, but not limited to, slapping, pinching, pushing, striking, shoving, shaking, choking, kicking, burning and other rough handling;
- force-feeding;
- inappropriate use of medication, including the administration, withholding or prescribing of medication for inappropriate purposes; and
- forced confinement.

#### 2. Emotional/psychological abuse:

- the infliction of anguish, pain or distress through verbal or non-verbal acts;
- verbal assaults including, but not limited to, yelling, swearing, threats, derogatory comments, humiliation, intimidation;
- denial of rights including, but not limited to, denying client participation with respect to his/her life; and
- social isolation including, but not limited to, giving the “silent treatment,” treating like a child/infant, isolating from family/friends/regular activities.

#### 3. Financial abuse:

- misuse of client’s funds, property or assets including, but not limited to;
  - forcing a client to sell his/her personal belongings or property;
  - stealing a client’s money, pension cheques, or possessions; and
- fraud, forgery, extortion.

#### 4. Sexual abuse:

- Molestation;
- Sexual assault; and
- Sexual harassment.

#### 5. Neglect:

- abandonment of the client by the caregiver; and
- failure or refusal to provide the necessities of life including, but not limited to, withholding of food/water, personal care or health care services, etc.

<b>Section: 4.0 CLIENT RIGHTS AND RESPONSIBILITIES</b>	
<b>Policy: 4.3 Client Responsibilities</b>	
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**4.3. CLIENT RESPONSIBILITIES**

**POLICY**

1. The District Health Authority will ensure that clients understand their responsibility to:
  - a) participate in developing and carrying out the service plan;
  - b) be available for service at the scheduled time, as agreed;
  - c) notify the District Health Authority and home care service providers of any changes that may affect the provision of service;
  - d) respect the rights of the service provider as set out in the *Occupational Health & Safety Act (1996, c.7, s.1)* and the *Nova Scotia Human Rights Act (R.S., c.214, s.1)* (e.g. freedom from abuse, exploitation, and racism);
  - e) maintain a safe working environment for the service provider;
  - f) use equipment, which is necessary for staff/client safety, in a safe and proper manner; and
  - g) have a backup contingency plan, in the event that home care services are unavailable.
  
2. In situations where clients do not carry out their responsibilities, the District Health Authority will take all reasonable steps to:
  - a) communicate client responsibilities, as indicated in Section 4.3.1 above to clients and staff;
  - b) eliminate or minimize factors, within its control, that contribute to inappropriate behaviour;
  - c) use restrictive actions only when all positive processes have failed;
  - d) integrate these actions into the plan of service as necessary; and
  - e) document the situation and actions taken.

<b>Section: 5.0 ASSESSMENT PROCESS</b>	
<b>Policy: 5.1 Assessment and Service Authorization Process</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

**5.1. ASSESSMENT AND SERVICE AUTHORIZATION PROCESS**

**POLICY**

1. The District Health Authority must ensure that an assessment and service authorization process is in place to make decisions regarding Continuing Care services and is congruent with the provincial SEAscape Procedures Manual.
2. The District Health Authority must seek to achieve consistency in the determination of a client’s need for service.
3. The assessment process must ensure the following critical elements:
  - a) the coordinated entry to Continuing Care services;
  - b) an equitable and consistent service across the District Health Authority;
  - c) a mechanism to monitor the assessment process; and
  - d) the use of consistent assessment tools.
4. The assessment and service authorization process must:
  - a) ensure that the assessment tools and related manuals approved by the Nova Scotia Department of Health and Wellness are used to conduct assessments;
  - b) review all assessment data to determine if an applicant/client meets all the eligibility and acceptance criteria;
  - c) evaluate the need for services and match the need with available resources as much as possible;
  - d) explore alternatives to meet identified needs, including referrals to other appropriate agencies and/or other District Health Authority services;
  - e) develop a service plan;
  - f) identify a person responsible to coordinate the service plan and establish reporting relationships with service providers engaged by the District Health Authority to provide home care services;
  - g) review the progress of clients at regular intervals to ensure that the services are still required and that they meet the needs of clients and their support network; and
  - h) ensure that assessment and service authorization decisions are communicated to the relevant parties.

5. Clients must be major participants in the assessment process, not simply the subjects of the assessment.

## **GUIDELINES**

Those involved in the assessment process as consented to by the client and/or substitute decision maker may include:

- the client and/or the substitute decision maker;
- the client's family, friends or other caregivers;
- other district home care staff;
- staff of service providers engaged by the District Health Authority to provide home care services;
- referral source;
- medical consultants;
- therapists, social workers or other professionals in the community; and
- other available persons with the knowledge or expertise that could contribute to the decision making process.

<b>Section: 5.0 ASSESSMENT PROCESS</b>	
<b>Policy: 5.2 Assessment Tool</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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## 5.2. ASSESSMENT TOOL

### POLICY

1. All assessments must be conducted using standard assessment tools, which have been approved by the Nova Scotia Department of Health and Wellness.

The approved standard assessment tools include:

- the RAI–Home Care tool;
  - the approved short form, paper format assessment;
  - other tools, as developed from time to time, and approved by the Nova Scotia Department of Health and Wellness.
2. All assessment and care coordination staff must complete training, provided by the Nova Scotia Department of Health and Wellness on the proper use of the approved assessment tools.

<b>Section: 5.0 ASSESSMENT PROCESS</b>	
<b>Policy: 5.3 Assessment Requirements</b>	
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**5.3. ASSESSMENT REQUIREMENTS**

**POLICY**

1. The District Health Authority must ensure that all applicants are assessed prior to the provision of home care services.
2. Risk factors will determine the priority for assessment.
3. Assessments for all home care services must be conducted in accordance with the current provincially approved assessment standards, as outlined in Section 5.2.1.

<b>Section: 5.0 ASSESSMENT PROCESS</b>	
<b>Policy: 5.4 Clients' Rights Regarding Assessments</b>	
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**5.4. CLIENTS' RIGHTS REGARDING ASSESSMENTS**

**POLICY**

1. Applicants/clients are major participants in the assessment process.
2. Continuing Care Assessors must ensure that applicants/clients, or their substitute decision makers, are informed of their rights prior to the assessment interview.
3. Continuing Care Assessors are responsible for advising applicants/clients, or the substitute decision makers, of any foreseeable consequences of their decisions.
4. Continuing Care Assessors must inform applicants/clients, or the substitute decision makers, of their rights regarding their personal health information.

**GUIDELINES**

1. In some cases, the exercise of a right might affect the ability of the program to serve client's needs. For example, if a person refuses to undergo any part of an assessment interview, it would be very difficult for the assessment process to determine the needs and services. Similarly, refusal to allow the Continuing Care Assessor to seek the professional opinion of a third party, such as a physician, might also impact the determination about needs and services. The Continuing Care Assessor is always responsible for ensuring that the applicant/client, or the substitute decision maker, understands the possible effects of exercising a particular right.
2. No applicant/client should be automatically refused admission to the program because he or she is unwilling to cooperate fully in the assessment process. A decision should be made on each case, based on available information.

3. During the assessment process all clients have the right to:
- a) have their views and desires recorded during the assessment interview;
  - b) choose whether a third party is present during the assessment interview;
  - c) a representative or translator if required for the assessment interview;
  - d) refuse to answer any question, or refuse to participate in part or all of the assessment;
  - e) be consulted before the views of third parties are sought, and to approve, restrict or deny such access;
  - f) be fully informed of the Continuing Care Assessors service decisions and participate in service planning; and
  - g) to restrict release of this information to third parties.



<b>Section: 5.0 ASSESSMENT PROCESS</b>	
<b>Policy: 5.5 Clients' Right to Appeal</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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**5.5. CLIENTS' RIGHT TO APPEAL**

**POLICY**

1. Clients and/or their substitute decision makers have the right to appeal home care assessment, service planning, and/or discharge decisions made by District Health Authority staff.
2. Clients, substitute decision makers, and/or their Enduring Power of Attorneys have the right to appeal fee determination decisions made by the District Health Authority staff.
3. Continuing Care Assessors must ensure that the client, or the substitute decision maker, is informed of the right to appeal and the process for appeal, of decisions about acceptance, assessment, service plan, fee determination or discharge.

<b>Section: 5.0 ASSESSMENT PROCESS</b>	
<b>Policy: 5.6 Appeal Process</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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## 5.6. APPEAL PROCESS

### POLICY

1. The District Health Authority must develop a policy and procedures that clearly outline the appeal process.
2. The District Health Authority must have two levels of appeal:
  - a) The first level of appeal is to the respective manager in the District Health Authority who is responsible for the appeal assessment. The person assessing the appeal at the first level must not have been involved with the initial assessment; and
  - b) The second level of appeal is to a committee structure determined by the District Health Authority.
3. Whenever assessment information is in question, the client must be reassessed.
4. The District Health Authority must conduct client appeals in a timely and expedient manner.
5. The committee must hear from representatives of the district assessment personnel and from the client and/or representative, and may invite opinions from others as appropriate.
6. The decision of the committee is final.

### GUIDELINES

1. In taking steps to ensure the completion of client appeals within a reasonable period of time, the District Health Authority may wish to consider developing guidelines related to appropriate time frames for the appeal process. As a general guide, the following time lines might be considered as appropriate examples for a client appeal process:
  - a) Completion of a review of the case, at the first level of appeal, within two weeks of receiving a formal appeal request.

- b) Providing the client and/or representative a written decision and reasons for the decision reached at the first level of appeal within 5 working days of completion of the review. In cases where the client elects to continue an appeal to the second level, a copy of the decision would be forwarded to the committee.
- c) Completion of the appeal review by the committee within two weeks of receiving the appeal request.
- d) Providing the client and/or representative, and the district staff who completed the first level of appeal, a written notification of the committee decision within 10 working days of the decision.

<b>Section: 6.0 CASE MANAGEMENT</b>	
<b>Policy: 6.1 Case Management</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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**6.1. CASE MANAGEMENT**

**Definitions**

“Case management” includes assessment, service planning, care coordination, and monitoring and evaluation of the effectiveness of the service plan. Case management is a collaborative, client-centred process that is continuous across provider and agency lines. Case management addresses the health and well being of clients, while promoting quality care and cost effective outcomes.

**POLICY**

1. The District Health Authority is required to provide case management for home care clients.

**GUIDELINES**

1. The Continuing Care Assessors role:
  - a) In collaboration with clients, the Continuing Care Assessor facilitates and coordinates services by linking clients with service providers and community resources;
  - b) The Continuing Care Assessor works with families, friends, other caregivers and communities associated with the client to facilitate access to timely and appropriate services;
  - c) The Continuing Care Assessor is familiar with the client’s goals and is involved in monitoring and ongoing reassessment; and
  - d) The Continuing Care Assessor uses assessment tools to collect and document information about individuals.
2. The purpose of case management is to develop an approach that improves access to coordinated and integrated health services that are client-centred, community based and that meet the client’s health needs.

3. Principles of case management:

- a) respects clients' dignity, responsibility, and self-determination;
- b) recognizes and responds to clients' and caregivers' needs and expectations;
- c) ensures clients are informed, are provided with options, and participate in making decisions;
- d) respects the role of families, other caregivers, substitute decision makers and community resources in planning and implementing care for clients;
- e) promotes easy access to timely and appropriate services;
- f) respects the principles of confidentiality (sharing of information should be directed by the client, on a need-to-know basis);
- g) protects the rights of others, as well as clients;
- h) promotes coordination of services through a multi-disciplinary team approach;
- i) fosters good communication, cooperation and collaboration among service providers, clients and communities;
- j) promotes early interaction aimed at identifying people at risk;
- k) emphasizes the support of independence and community-based living;
- l) promotes and provides opportunities for client education;
- m) supports staff strengths and skills to deal with complex home care issues; and
- n) promotes efficient, effective and equitable use of resources, focused on achieving positive health outcomes.

<b>Section: 7.0 SERVICE PLAN</b>	
<b>Policy: 7.1 Development of Service Plans</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

### 7.1. DEVELOPMENT OF SERVICE PLANS

#### POLICY

1. The District Health Authority must have established procedures for developing service plans for clients receiving home care services and they must be congruent with the provincial SEAScape Procedures Manual.
2. The service plan must specify:
  - a) the type and frequency of service the client requires based on an assessment and the Continuing Care Assessors recommendation;
  - b) the client-centered goals of the service to be achieved and where appropriate, within a designated timeframe;
  - c) goals that are individualized, measurable and achievable;
  - d) the date that service is authorized to start;
  - e) referrals made to other health care providers/agencies;
  - f) the role of the client in self-care;
  - g) services to be carried out by:
    - client's caregiver support network;
    - other organizations or agencies;
    - the home care program; and
    - any other approved services offered by the District Health Authority.
  - h) service review date.
3. The plan should include:
  - a) health promotion;
  - b) illness prevention;
  - c) education to promote self-care and independence;
  - d) transition/discharge plan, as appropriate; and
  - e) identification of any written agreements or risks.
4. The service plan must be updated on an ongoing basis to reflect changing needs, met or changed goals, altered service or support.

<b>Section: 7.0 SERVICE PLAN</b>	
<b>Policy: 7.2 Service Plan Participants</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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**7.2. SERVICE PLAN PARTICIPANTS**

**POLICY**

1. Clients and/or their substitute decision makers, and other caregivers/supporters, are participants in the development of the service plan.
2. Service plans are to be communicated to appropriate parties.

<b>Section: 7.0 SERVICE PLAN</b>	
<b>Policy: 7.3 Reassessment/ Revision of Service Plans</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

### **7.3. REASSESSMENT/REVISION OF SERVICE PLANS**

#### **POLICY**

1. The District Health Authority must have established procedures for changing or updating service plans and they must be congruent with the provincial SEAscape Procedures Manual.
2. After the initial assessment, a thorough review or reassessment of every client must be conducted at least once annually, to ensure the changing needs of the client are appropriately met.
3. Additional case reviews or reassessments must be conducted if the condition or situation of client changes.
4. All relevant information must be considered in conducting a review.
5. Reassessment must be conducted using an assessment tool approved by the Nova Scotia Department of Health and Wellness.
6. Consents must be reviewed and documented on an annual basis at a minimum.
7. Prior to making any major changes to client service plans, District Health Authority staff must notify clients and/or their substitute decision makers and explain the basis for the proposed changes.



<b>Section: 7.0 SERVICE PLAN</b>	
<b>Policy: 7.4 Authority and Requirements for Discharge</b>	
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<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

#### ***7.4. AUTHORITY AND REQUIREMENTS FOR DISCHARGE***

##### **POLICY**

1. When home care services are no longer appropriate or required, clients must be discharged from the program or have services discontinued.
2. Clients shall participate in planning for discharge from the program.
3. Discharge plans, referrals, and discharge data must be documented on the client record and congruent with the provincial SEAScape Procedures Manual.

<b>Section: 7.0 SERVICE PLAN</b>	
<b>Policy: 7.5 Re-Admissions</b>	
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**7.5. RE-ADMISSIONS**

**POLICY**

1. When a previously discharged client is re-admitted into the home care program for service, the decision for re-admission is based on the completion of a new assessment by a Continuing Care Assessor.

<b>Section: 8.0 CLIENT RECORDS</b>	
<b>Policy: 8.1 Client Records</b>	
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## 8.1. CLIENT RECORDS

### POLICY

1. The District Health Authority is required to maintain records on all clients receiving home care services.
2. The District Health Authority is responsible to ensure that client records are kept confidential and that the privacy of individual client information is protected.
3. The District Health Authority is responsible to develop district level policies and procedures that are congruent with provincial SEAScape procedures pertaining to client records.
4. The District Health Authority must make reasonable security arrangements for client records to protect against unauthorized access, collection, use, disclosure, or disposal of personal information.
5. Information storage methods must permit the ready retrieval and consolidation of client records stored in different formats, for the purpose of secure destruction, in accordance with established record retention schedules.
6. The District Health Authority must have policies regarding the collection, use, disclosure, and retention of health information with consent or as otherwise specifically authorized in the applicable legislation, e.g.:
  - Freedom of Information and Protection of Privacy Act (1993, c.5, s.1)*
  - Health Protection Act (2004, c.4, s.1)*
  - Hospitals Act (R.S., c.208, s.1)*
  - Involuntary Psychiatric Treatment Act (2005, c.42, s.1)*
  - Personal Directives Act (2008, c.8, s.1)*
  - Personal Information International Disclosure Protection Act (2006, c.3, s.1)*

7. The District Health Authority must develop written policies and procedures (that are congruent with provincial SEAscope procedures) indicating how the various forms and documentation are to be completed and used. This will help to promote quality and consistency in client records used for case management.

## **GUIDELINES**

1. Home care staff and service providers engaged by the District Health Authority to provide home care services should be familiar with standard charting requirements and applicable documentation standards, as per the requirements of their professional licensing bodies, the certification requirements for unlicensed providers, and their employers.
2. Appropriate client records will:
  - a) contain sufficient information to:
    - identify clients clearly;
    - identify functional deficits and unmet needs;
    - justify the reasons for service delivery; and
  - b) document the services authorized, service goals, and client progress.
3. An adequate client record will generally contain:
  - a) identifying data (e.g. surname, given names, birth date, Nova Scotia Health Services card number, address, etc.);
  - b) assessment form;
  - c) service plan, including goals and when appropriate, time frames;
  - d) records of medications, therapeutic treatments and care provided;
  - e) the reason for any decision made and documented;
  - f) physician's orders, where applicable;
  - g) progress notes, flow sheets;
  - h) record of action taken, if any, to arrange alternate care if the client is discharged; and
  - i) documentation of discharge or discontinuation of service, indicating the reason for discharge, circumstances of discharge and persons notified, if applicable.

The data listed above should be maintained in a manner that permits the ready retrieval and consolidation of all records on a client that are stored in different formats, e.g. paper records, electronic records, etc.

<b>Section: 9.0 TYPES OF CARE</b>	
<b>Policy: 9.1 Types of Care</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

**9.1. TYPES OF CARE**

**POLICY**

1. All District Health Authority home care programs must provide the following types of care:
  - Acute home care - (short term)
  - Chronic home care - (ongoing, supportive, maintenance, and/or rehabilitative care);
  - Palliative home care - (end-of-life care).

<b>Section: 9.0 TYPES OF CARE</b>	
<b>Policy: 9.2 Acute Home Care</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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## 9.2. ACUTE HOME CARE

### DEFINITION

“Acute” is an illness or condition of short duration and relatively severe course which is a pronounced deviation from the normal state of health of that individual.

“Medically stable” is a term used to describe an individual’s medical condition, which is not meant to be a diagnosis, but a general guide to the individual’s status as determined by several factors. This term is commonly used to denote a condition where an individual has a favorable prognosis or general outlook in terms of healing, recovery and any expected complications with a certain condition, disease or treatment. An individual with a stable medical condition may have health conditions that can be managed and stabilized with monitoring or minimal intervention and may require short term specialized/skilled nursing for acute episodes only.

### POLICY

1. This category identifies situations, other than palliative home care, in which the home care program provides a service or services that might otherwise be provided in a hospital. In many cases, the services will be provided to a person recently discharged from hospital.
2. Acute home care clients must have a primary need for immediate/urgent time limited intervention with a goal to improve and/or stabilize a medical or post surgical condition.
3. The applicant/client must be medically stable.
4. Acute home care services are only to be provided based on an order received from a physician.
5. The applicant/client requires nursing services alone, or in conjunction with home support services.
6. Once a client receiving acute home care has been stabilized, and if ongoing, indefinite home care involvement is indicated, the categorization of the client’s type of care is to be changed to chronic home care.

7. The District Health Authority is responsible to ensure that the medications and medical supplies, directly required for the treatment of the acute condition for which the individual is receiving Acute Home Care, are provided at no charge to the client for the duration of the Acute Home Care episode.
8. The District Health Authority cannot require a client to access personal insurance for the coverage of medications and medical supplies directly required for the treatment of the acute condition for which the individual is receiving Acute Home Care.

## **GUIDELINES**

1. A client's service plan will usually indicate a definite time frame for the provision of services.
2. The types of clients that receive acute home care should generally align with the standard for the acute home care client grouping developed by the Canadian Institute for Health Information.

<b>Section: 9.0 TYPES OF CARE</b>	
<b>Policy: 9.3 Chronic Home Care</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

### 9.3. CHRONIC HOME CARE

#### POLICY

1. This category identifies situations in which the home care program provides a service or services that are generally ongoing in nature and that have the objective of assisting the client to live successfully in the community. This applies when the focus of the care provided to the client is neither acute nor palliative, but is directed at supporting or maintaining the client at home. Clients may be considered to be receiving chronic care when:
  - a) home care services are provided on an indefinite basis for the primary purpose of assisting clients to remain in the community and/or to avoid admission to long-term care facilities; or
  - b) home care services are providing respite to the clients' caregivers.
2. Medical supplies used during a nursing visit to support the service plan of the individual receiving chronic home care, are provided at no direct charge to the individual. The individual and/or family are responsible for supplies used between nursing visits.
3. Medications for pre-existing or chronic conditions are the responsibility of the client and are not provided by the home care program.

#### GUIDELINES

1. The types of clients that receive chronic home care should generally align with the standards developed by the Canadian Institute for Health Information for one of the following home care client groupings:
  - Long-Term Supportive,
  - Maintenance, or
  - Rehabilitation.



<b>Section: 9.0 TYPES OF CARE</b>	
<b>Policy: 9.4 Palliative Home Care</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
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#### **9.4. PALLIATIVE HOME CARE**

##### **DEFINITION**

“Palliative home care” refers to home care services that provide active, compassionate care to the client who is terminally ill. It is a service made available to terminally ill persons and their supporters who have determined that treatment for cure or prolongation of life is no longer the primary goal.

##### **POLICY**

1. This category applies to clients who are dying and who have chosen to spend as much time as possible in their own homes. Clients may be considered “palliative” when:
  - a) their condition has been diagnosed by a physician as terminal with life expectancy of weeks or months;
 

The communication to a Continuing Care Assessor of a person’s palliative status, for the purpose of determining eligibility for palliative home care, may happen in a variety of ways including identification by a District level Palliative Care Team, a family physician, etc.
  - b) active treatment to prolong life is no longer the goal of care; and
  - c) the case management process has determined through assessment that the individual has “end stage” palliative care service needs.

##### **GUIDELINES**

There are three stages in the palliative process:

1. “Early” and “Intermediate” Stage Palliative Care – Individuals in the early and intermediate stage of the palliative process normally would be considered “stable”, where deterioration is proceeding at a slower pace, and minimal or occasional assistance is required due to terminal illness.

2. “End Stage” Palliative Care – The following parameters may be used to help determine whether terminally ill individuals are in the end stage of the palliative process and are dealing with end of life (dying) issues:
  - a) the time frame for the end stage may be measured in terms of days or weeks of dying. Time frames are difficult to determine however, and in some cases this end stage may be longer than a few weeks or as short as one or two days;
  - b) there are typically day-to-day changes with deterioration proceeding at a dramatic pace;
  - c) end stage may be characterized by:
    - increasing intensity of need;
    - increasing assistance required for physical and psychological need and family exhaustion; and/or
    - a requirement for additional interventions such as social work, pastoral care, and therapies;
  - d) there is documented clinical progression of disease, which may include a variety of symptoms.
3. The types of clients that receive palliative care would generally align with the standard for the End of Life home care client grouping developed by the Canadian Institute for Health Information. The typical prognosis for clients in this grouping would be a life expectancy of less than 6 months.

<b>Section: 10.0 HOME CARE SERVICES</b>	
<b>Policy: 10.1 Home Care Services</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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**10.1. HOME CARE SERVICES**

**POLICY**

1. All home care services must be provided in accordance with applicable legislation, policies and standards, including but not limited to the:
  - Co-ordinated Home Care Act (1990, c.6, s.1)*
  - Health Authorities Act (2000, c.6, s.1)*
  - Homemaker Services Act (R.S., c.201, s.1)*
  - Homes for Special Care Act (R.S., c.203, s.1)*
  - Personal Directives Act (2008, c.8, s.1)*
  - Home Care Policy Manual
  - Continuing Care Policy Manual
  - Standards for Quality Care, Edition #3.1.
  
2. The delivery of home care services should be in keeping with the Department of Health and Wellness’s Cultural Competence Guidelines for the Delivery of Primary Health Care in Nova Scotia.

<b>Section: 10.0</b>	<b>HOME CARE SERVICES</b>
<b>Policy: 10.2 Core Home Care Services</b>	

<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
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## ***10.2. CORE HOME CARE SERVICES***

### **Definition**

“Core home care services” are the services funded by the Department of Health and Wellness and administered and delivered by the District Health Authorities.

### **POLICY**

1. Every District Health Authority must offer the core home care services.
2. Core home care services include:
  - a) assessment (refer to Section 5.0);
  - b) case management and care coordination (refer to Section 6.0);
  - c) nursing services; and
  - d) home support services, that include personal care, meal preparation, light housekeeping, and respite.
3. Core home care services are provided through service providers approved by the Department of Health and Wellness to provide home care services.

<b>Section: 10.0 HOME CARE SERVICES</b>	
<b>Policy: 10.3 Nursing Services</b>	
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### **10.3. NURSING SERVICES**

#### **POLICY**

1. Home care nursing services include:
  - a) performing nursing assessments;
  - b) performing nursing treatments and procedures;
  - c) teaching and supervising self-care to clients receiving personal care or nursing services;
  - d) teaching personal care and nursing procedures to family members and other caregivers;
  - e) providing service for personal care or respite when the assessment process identifies that the condition of the client warrants provision of these services by a nurse;
  - f) teaching and supervising home support service providers who are providing personal care and performing delegated nursing tasks; and
  - g) initiation of referrals to other agencies and services as appropriate.
  
2. Home care nursing services must be delivered by providers who are members in good standing of either the College of Registered Nurses of Nova Scotia or the College of Licensed Practical Nurses of Nova Scotia.
  
3. Home care nursing service providers are required to deliver services in accordance with their scope of practice as defined by the regulatory body governing their profession and within their employer's scope of employment.
  
4. District Health Authorities shall ensure that the nursing supplies required during the visit by the home care nurse are available at no charge to the client.

<b>Section: 10.0</b>	<b>HOME CARE SERVICES</b>
<b>Policy: 10.4 Home Support Services</b>	

<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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#### **10.4. HOME SUPPORT SERVICES**

##### **Definitions**

“Direct supervision” is the direct observation of the services being delivered.

“Indirect supervision” is being available for report and consultation when service is being delivered; this supervision may or may not be on-site but is available, as defined by employer protocols.

“Light housekeeping” includes assisting with and/or teaching self-care techniques for instrumental activities of daily living in the areas of general household cleaning, laundry, and changing linen.

“Meal preparation” includes assisting with and/or teaching self-care techniques for instrumental activities of daily living in the areas of nutritional care, menu planning, and meal preparation.

“Personal care” includes assisting with or supervising activities of daily living in the areas of hygiene, toileting, dressing, feeding, and mobility.

“Respite” is any combination of services provided specifically for the purpose of giving relief to the family or other non-paid caregivers of a dependent person who lives at home. The objective of respite services through home care is to support the family environment by allowing primary caregivers time to attend to personal matters or to obtain needed rest and relief.

“Scope of employment” means the range of an employee’s duties and responsibilities as defined by the service provider in accordance with such employee’s level of competence as prescribed by the service provider.

“Scope of practice” means roles, functions, and accountabilities for which individuals are educated and authorized to perform as well as the limitations pursuant to which these services are provided. For members of a regulated profession, these roles, functions, and accountabilities and limitations are also defined by applicable legislation.

## **POLICY**

1. Home support services have four components:
  - a) personal care;
  - b) meal preparation;
  - c) light housekeeping; and
  - d) respite.
2. Meal preparation is provided to improve and/or maintain the nutritional status and general health of clients and every effort must be made to assist clients to become as self-reliant as possible in meal preparation and/or to access community based meal services, where available.
3. Respite services shall not be provided to relieve parents from routine childcare.
4. Home support services must be delivered by service providers who, at a minimum, meet the requirements established in the provincial Continuing Care Educational Requirements for Entry to Practice policy.
5. Home support service providers are required to act in accordance with existing scopes of practice and within their employer's scope of employment.
6. Clients may be eligible for both respite services and the Caregiver Benefit Program.
7. Home support service providers must be supervised by a practicing member of the College of Registered Nurses of Nova Scotia (CRNNS) or the College of Licensed Practical Nurses of Nova Scotia (CLPNNS). Supervision may be direct or indirect.
8. In cases where individuals have an assessed need for only meal preparation and/or light housekeeping services, District Health Authorities may only provide these services to those clients with an income which fits within Home Care Fee Category A.

## **GUIDELINES**

### *Respite Component*

1. In home care, respite means providing relief for short periods of time. Respite may be provided occasionally, or periodically on a regular basis. The frequency and duration of respite services will depend on the needs of caregivers, in addition to district resources and other options available for respite.
2. The need of caregivers for respite is determined through assessment and the respite care component incorporated into the client's service plan. At a minimum, respite care includes supervision of activities of daily living, but may also include other aspects of personal care or home making activities. The service provider in a respite situation is temporarily taking the place of the primary caregiver and provides the assistance that the dependent person needs.

<b>Section: 10.0 HOME CARE SERVICES</b>	
<b>Policy: 10.5 Additional Home Care Services</b>	
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### ***10.5. ADDITIONAL HOME CARE SERVICES***

#### **POLICY**

1. Where feasible, a District Health Authority can choose to offer additional home care services which can include:
  - therapies when available, i.e. physiotherapy and occupational therapy;
  - home maintenance; and
  - volunteer programs.
2. The District Health Authority is required to obtain prior approval from the Department of Health and Wellness before additional services can be offered through the home care program.
3. Where additional home care services are being offered, District Health Authorities are required to develop appropriate policies, guidelines and procedures governing the provision of these services.
4. Where a District Health Authority chooses to provide other services within the home care program, the District Health Authority is responsible for ensuring that the personnel providing these services either have or take training appropriate for the services being provided, and that the personnel work in accordance with their scope of employment and their employer's policies and procedures.



<b>Section: 11.0</b> <b>SERVICE PROVIDERS</b>
<b>Policy: 11.1 Continuing Care Assessors</b>

<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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***11.1. CONTINUING CARE ASSESSORS***

**POLICY**

1. The District Health Authority is responsible to ensure that Continuing Care Assessors possess the required skills and qualifications to perform the assessment and case management functions for the home care service.
  
2. The District Health Authority shall ensure that there are management personnel in place who are responsible for the selection and appropriate supervision of Continuing Care Assessor staff.

<b>Section: 11.0</b>	<b>SERVICE PROVIDERS</b>
<b>Policy: 11.2 Nursing Service Providers</b>	

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## ***11.2. NURSING SERVICE PROVIDERS***

### **POLICY**

1. District Health Authorities are responsible for ensuring that professional home care nursing services are delivered by:
  - a) Registered Nurses (RNs), who are enrolled as practicing members in good standing with the College of Registered Nurses of Nova Scotia (CRNNS); or
  - b) Licensed Practical Nurses (LPNs), who are enrolled as practicing members in good standing with the College of Licensed Practical Nurses of Nova Scotia (CLPNNS).

<b>Section: 11.0      SERVICE PROVIDERS</b>	
<b>Policy: 11.3 Home Support Service Providers</b>	
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### ***11.3. HOME SUPPORT SERVICE PROVIDERS***

#### **POLICY**

1. District Health Authorities are responsible to work with home support service providers approved and funded by the Department of Health and Wellness.

<b>Section: 11.0      SERVICE PROVIDERS</b>	
<b>Policy: 11.4 Volunteers</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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***11.4. VOLUNTEERS***

**POLICY**

1. Where a District Health Authority chooses to use volunteers within the home care program, the District Health Authority is responsible for ensuring that policies are in place to address responsibility for the appropriate screening of volunteers, the coordination of volunteer activities, the orientation of volunteers, and the training and supervision of volunteers.
2. The District Health Authority is responsible for ensuring that adequate supervision is provided for the volunteers.
3. Volunteers may perform those volunteer services designated by the District Health Authority.

<b>Section: 12.0</b>	<b>SPECIAL PROGRAMS</b>
<b>Policy: 12.1 Services to Status First Nations Persons Living on Reserve</b>	

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## ***12.1. SERVICES TO STATUS FIRST NATIONS PERSONS LIVING ON RESERVE***

### **BACKGROUND**

This policy has been developed by the Continuing Care Branch under the auspices of the Aboriginal Health Transformation Fund, in order to support a home care discharge planning process for registered First Nations persons who are living on Reserve. This represents one step in a broad, iterative and collaborative process involving the Nova Scotia Department of Health and Wellness, Federal Government Departments and First Nations communities to address home care policy issues.

### **POLICY**

1. District Health Authorities are required to provide the following home care services to registered First Nations persons who are living on Reserve:

#### **1.1. Home Care Discharge Planning Services in Hospital**

A Continuing Care Assessor shall complete a home care assessment on registered First Nations persons who are living on Reserve and who have been admitted to hospital. The home care assessment is completed for the purposes of identifying the individual's needs and to support his or her return home. The District Health Authority home care program will provide the First Nation Home and Community Care Program with the assessment information, service recommendations and other relevant information, as deemed appropriate.

#### **1.2. Acute Home Care Services on Reserve**

The acute home care category provides a service or services that might otherwise be provided in a hospital. In many cases, the services will be provided to a person recently discharged from hospital. Acute home care services are provided in accordance with the parameters established in Section 9.2 of this manual.

2. Only the following sections of the Nova Scotia Department of Health and Wellness Home Care Policy Manual are applicable, in whole or in part, to the services referenced in Section 12.1.1:
  - Section 2 - Client Access to Service
  - Section 3 - Consents, Confidentiality and Privacy
  - Section 5 - Assessment Process
  - Section 8 - Client Records
  - Section 9 - Types of Care

## **GUIDELINES**

1. In order to appropriately provide discharge planning and acute home care services on Reserves, it is recommended that District Health Authorities consider adopting the following approaches:
  - Formal documentation, through a Memorandum of Understanding, of any agreement with a First Nation band related to the sharing of services and/or provision of District Health Authority services to registered First Nations persons living on Reserve.
  - Establishment of mechanisms to appropriately manage the District Health Authority relationship with the First Nation Home and Community Care Programs in its area. Such mechanisms could include:
    - regular meetings to facilitate issue resolution and knowledge sharing.
    - establishing and maintaining communication protocols with respect to the First Nation Home and Community Care Program.
  - Taking steps to provide the District Health Authority staff, who are delivering the identified services, with appropriate training in cultural competency and cultural safety.
  - Having District Health Authority home care program personnel work with the First Nation Home and Community Care Program staff in their area, to facilitate and build professional relationships and to ensure mutual understanding of their respective programs.

<b>Section: 12.0 SPECIAL PROGRAMS</b>	
<b>Policy: 12.2 Quick Response Program in the Capital District Health Authority</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

## ***12.2. QUICK RESPONSE PROGRAM IN THE CAPITAL DISTRICT HEALTH AUTHORITY***

### **BACKGROUND**

This policy has been developed to address broad program requirements for the Quick Response Program currently operating out of the Capital District Health Authority.

### **POLICY**

1. The objective of the Quick Response Program is to provide prompt coordination and delivery of home care services to maintain clients in the Capital District in their place of residence in an effort to avoid hospitalization from the Emergency Department.
2. Under this program, clients must meet the following eligibility criteria:
  - Meets general eligibility criteria outlined in Section 2.3;
  - Lives within the geographic catchments area determined by Capital District Health Authority;
  - Is medically and psychiatrically stable, unlikely to deteriorate and is manageable without extensive investigations or consultations;
  - Is usually able to cope independently or has family/caregiver(s) who will provide the necessary supports to facilitate the Quick Response Program;
  - Is currently in the QEII or Dartmouth General Hospital emergency department;
  - Must be in need of services during an acute illness or condition that may be safely and effectively provided in the home;
  - Has an identified attending physician who is aware of and has agreed to follow the client in the community when nursing service is authorized;
  - Have a diagnosis and prognosis that suggests the client will be a short-term user of the Quick Response Program services (up to 5 days); and
  - Require nursing services or short-term home support services, short-term close medical surveillance, and support for the caregiver/family for the duration of the admission to the Quick Response Program (up to 5 days).

3. The maximum amount of services based on assessed unmet need that can be authorized under this program per client, is services for 24 hours/day for 5 days.
4. Once a client receiving services through the Quick Response Program has been in the program for 5 days, if ongoing home care involvement is required, the categorization of the client's type of care is to be changed to another type of home care as referenced in Section 9.1.



<b>Section: 12.0 SPECIAL PROGRAMS</b>	
<b>Policy: 12.3 Palliative Care Medication Coverage in Colchester East Hants Health Authority, Cumberland Health Authority, and Pictou County Health Authority</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

***12.3. PALLIATIVE CARE MEDICATION COVERAGE IN COLCHESTER EAST HANTS HEALTH AUTHORITY, CUMBERLAND HEALTH AUTHORITY, AND PICTOU COUNTY HEALTH AUTHORITY***

**BACKGROUND**

This policy has been developed to address specific requirements regarding eligibility for medication coverage under the Palliative Care Resources in the Home Program in Colchester East Hants Health Authority, Cumberland Health Authority, and Pictou County Health Authority. This Program was initially developed and implemented as a pilot project in 2000 and is still in operation today.

**POLICY**

1. Continuing Care Assessors will collaborate with the other palliative care team members, physicians, and provide linkages to other community resources.
2. Clients may access this program if they meet eligibility requirements as outlined in Section 9.4.1.
3. Under this program, in order for medications to be funded, the medications must:
  - a) be palliative-related;
  - b) prescribed by a physician;
  - c) not covered under the Seniors' Pharmacare Program, Family Pharmacare Program, or the client's private insurance; and
  - d) be approved by the respective District Health Authority.
4. Medications will only be covered for approximately 3 months or less.
5. Medications or replacement medications, for existing or chronic conditions, which are not directly related to the client's palliative condition, are not covered under this program.

<b>Section: 13.0</b>	<b>SERVICE LIMITS</b>
<b>Policy: 13.1 Service Limits</b>	

<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

### ***13.1. SERVICE LIMITS***

#### **POLICY**

1. The District Health Authority is required to comply with the maximum monthly home care service limits established by the Nova Scotia Department of Health and Wellness.
2. The maximum amount of home support hours per 28 day service plan which may be authorized is 100.
3. The maximum amount of home nursing visits per 28 day service plan which may be authorized is 60.
4. Monthly maximum service limits shall not apply in the following circumstances:
  - a) The client meets the palliative home care criteria as outlined in Section 9.4.1.
  - b) The client is on the waitlist for placement in a long term care facility funded by the Department of Health and Wellness and is being supported in the community because there is no suitable bed available within 100 kilometers of the applicant/client’s community of choice.
5. In “extraordinary circumstances” when clients only require home support services, the monthly maximum home support service limits may be waived, but the maximum amount of home support hours should not exceed 150 hours.
6. Where the application of service limits has been waived in “extraordinary circumstances”, the District Health Authority must document these exceptions.

<b>Section: 14.0</b>	<b>CLIENT FEES AND CHARGES</b>
<b>Policy: 14.1 Client Fees and Charges</b>	

<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

### ***14.1. CLIENT FEES AND CHARGES***

#### **POLICY**

1. District Health Authorities are required to apply home care fees and charges in accordance with the policy and procedures contained in this policy manual.
2. District Health Authorities shall charge hourly fees for home support services provided by a home support service provider, **except** for services provided to:
  - a) clients receiving palliative home care services;
  - b) clients whose income falls within the fee exempt category; and
  - c) clients receiving short term acute home care services.
    - i. Clients receiving chronic home care services prior to accessing acute services will still be required to pay for their chronic home care services. Any additional home support services required as a result of the acute condition will not be subject to fees.
3. Clients who are required to pay fees and who are receiving both home support services and home oxygen services, shall be assessed for the home oxygen fee first and any applicable hourly home support fees second. In no case, shall the combined total of the home support client fees and the home oxygen service fee exceed the Maximum Monthly Client Fee Charge for the client's income category.
4. District Health Authorities may not charge Nova Scotia residents for assessment and care coordination services, home care nursing services, or medications and supplies related to the delivery of acute home care nursing services.
5. An individual's requirement to pay home support client fees, the amount of fees to be charged, and the maximum monthly fee amount shall be identified during the assessment process. This determination shall be made using the Home Support Fee Determination Process and the current Home Care Fee Determination Tables as established by the Department of Health and Wellness.

6. Clients receiving home support services must be informed, as part of the assessment process, about any fees they will be required to pay and their right to appeal the application of fees.
7. Individuals who do not wish to provide income information, but who otherwise meet program eligibility criteria, may still be able to receive home support services. For the purposes of fee determination, eligible persons choosing not to disclose income information shall be deemed to be in the highest Client Income Category.
8. Client fees shall be reassessed annually, or on an as needed basis.
9. Clients shall pay any assessed home support client fees directly to the service provider.
10. Where a client does not pay applicable home support client fees and all reasonable efforts have been made to secure payment, the District Health Authority may authorize discontinuation of home support services. Any subsequent request from the individual for home support services shall be treated as a new referral and acceptance for service shall be conditional upon the individual's payment of any outstanding charges.

<b>Section: 14.0 CLIENT FEES AND CHARGES</b>	
<b>Policy: 14.2 Home Support Fee Determination Process</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

## ***14.2. HOME SUPPORT FEE DETERMINATION PROCESS***

### **POLICY**

1. District Health Authorities are required to follow provincially established criteria in determining client fees for home support services.

### **PROCESS**

#### 1. Information Required to Determine Client Fee Status

Fee determination is based on net household income and family size. When scheduling an assessment interview, the Continuing Care Assessor should advise the client or substitute decision maker to have the most recent Canada Revenue Agency Notice of Assessment or Income Tax Return available for fee determination purposes.

#### 2. Calculating Net Income and Family Size

Net income and family size are used in the determination of home support client fees. For the purposes of client fee determination, net family income and family size are calculated in accordance with the following criteria:

- a) for partnered relationships, the incomes of both partners are included and family size includes all children under the age of 19, who are living at home.
- b) for partnered relationships where one partner is a resident in long term care, the income retained by the spouse in the community is used to determine client fees. Family size includes all children under the age of 19, who are living at home.
- c) where the home support service recipient is a minor (i.e. under 19 years of age) living with the family, the parental income is used to determine income category and fees. Family unit size includes parents and all children under the age of 19, who are living at home.

- d) where the home support service recipient is a dependent adult (i.e., qualifies as wholly dependent by reason of mental or physical infirmity for Income Tax purposes), who is living with parents or other caregivers **and** who has no income, the parental/caregiver income is used to determine income category and fees. Family unit size includes parents/caregivers and all children under 19, who are living in the home.
- e) siblings or friends living together are not considered a core family unit and each individual is treated separately for the purposes of fee determination.

### 3. Verification of Income

The Continuing Care Assessor is required to verify income information for home care applicants/clients. For the purposes of income verification, the net income of all applicable individuals as identified on line 236 of the Federal Income Tax Return or in the Notice of Assessment provided by the Canada Revenue Agency shall be used.

If applicable, Department of Health and Wellness payments through the Caregiver Benefit Program should be excluded from net income for the purposes of determining home support fees.

### 4. Determination of Fees in Multi Client Households

Where more than one fee eligible client resides in the same household, the following applies.

- a) where the individual clients are part of the same core family unit (i.e. husband & wife, parent & dependant child) there is a single client fee charged per family unit.
- b) where the individual clients are not part of the same core family unit (e.g. friends or adult siblings sharing accommodation), then each individual is treated separately for the purposes of fee determination.

### 5. Information to be Forwarded to Service Provider for Fee Collection

Where home support client fees are applicable, the District Health Authority shall inform the appropriate service provider of the client's requirement to pay fees and the client's maximum monthly fee amount.

<b>Section: 14.0      CLIENT FEES AND CHARGES</b>	
<b>Policy: 14.3 Home Support Fees</b>	
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<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

**14.3. HOME SUPPORT FEES**

**POLICY**

1. See the Home Care Fee Determination Tables for current home support fees.
2. Fee paying clients who are receiving both home support services and home oxygen services, are assessed the home oxygen fee first and any applicable hourly home support fees second. In no case, shall the combined total of the home support client fees and the home oxygen service fee exceed the Maximum Monthly Client Fee Charge for the client’s income category.

<b>Section: 14.0      CLIENT FEES AND CHARGES</b>	
<b>Policy: 14.4 Appeal of Fee Assessment Decision</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

***14.4. APPEAL OF FEE ASSESSMENT DECISION***

**POLICY**

1. Clients have the right to appeal decisions related to application of home support client fees on the basis that payment of the fees will cause personal financial hardship. The client is required to provide sufficient information to support the appeal.
2. For clients appealing the application of home support client fees, the District Health Authority shall follow the Appeal Process for clients described in Section 5.6 of this manual.



<b>Section: 14.0      CLIENT FEES AND CHARGES</b>	
<b>Policy: 14.5 Charges to Temporary Residents</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
<b>Approved by:</b> Kevin McNamara, Deputy Minister, Department of Health and Wellness	
<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

#### ***14.5. CHARGES TO TEMPORARY RESIDENTS***

##### **POLICY**

1. District Health Authorities are required to charge out-of-country residents staying temporarily in the province the full cost of service, including administrative costs.
2. District Health Authorities are required to charge Canadian citizens who are not Nova Scotia residents for the cost of home care services in accordance with the following:
  - Charges shall be for all services, including assessment, care coordination, home support and nursing; and
  - The charge shall be for the direct cost of providing a unit of service, including all service costs but not administration costs.

<b>Section: 14.0</b>	<b>CLIENT FEES AND CHARGES</b>
<b>Policy: 14.6 Third Party Payers</b>	

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<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

## **14.6. THIRD PARTY PAYERS**

### **Definition**

A “third party payer” is an agency or program that is responsible for paying the costs of services provided to a client.

### **POLICY**

1. The Department of Health and Wellness is the payer of last resort for all home care services.
2. District Health Authorities are required to charge third parties as provided for under such mechanisms as, but not limited to, the *Department of Veterans Affairs Act* (R.S., 1985, c. V-1, s. 1; 2000, c. 34, s. 95(F)), *Workers Compensation Act* (1994-95, c.10, s.1), *Criminal Injuries Compensation Regulations* made under the *Victims' Rights and Services Act* (1989, c.14, s.1) and settlements under private insurance policies.
3. Third party payers shall be charged the full cost of all Continuing Care services provided to the client, depending on the third party benefit package.

### **GUIDELINES**

1. The major third party payers in Nova Scotia are:
  - Workers Compensation Board (WCB);
  - Veterans Affairs Canada (VAC);
  - Health Canada (First Nations and Inuit Health);
  - Indian and Northern Affairs Canada (INAC).

<b>Section: 15.0</b>	<b>HOME CARE STANDARDS</b>
<b>Policy: 15.1 Home Care Standards</b>	

<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

**15.1. HOME CARE STANDARDS**

**Definitions**

“Standard” is a required level of quality or attainment.

“Process” is a series of activities which are undertaken to achieve a specific goal.

“Outcome” is the result or impact of a program.

**POLICY**

1. District Health Authorities shall comply with standards established by the Nova Scotia Department of Health and Wellness pertaining to the delivery of home care services.
2. Referral, assessment and care coordination standards address the processes and outcomes of the referral, assessment, service planning, and care coordination/case management functions.
3. Program outcome standards address the intended results of the home care program.

<b>Section: 15.0 HOME CARE STANDARDS</b>
<b>Policy: 15.2 Referral, Assessment and Care Coordination Standards</b>

<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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## 15.2. REFERRAL, ASSESSMENT AND CARE COORDINATION STANDARDS

### Definition

“Applicant” is an individual who has agreed to a referral to Continuing Care and is being considered for an assessment.

Standards	Measure/Indicator	Methods
<b>1. Initial Screening and Referral</b>		
a) District Health Authorities provide access to referral services 7 days a week.	Evidence of 7 day a week referrals.	Review of SEAscape
b) All clients are entered into SEAscape.	SEAscape referral exists for every client referred.	Review of SEAscape.
c) The primary identifier for Continuing Care clients is the Nova Scotia Health Card Number	Each client is identified in SEAscape by their HCN.	Review of SEAscape.
d) The SEAscape screening process is used to support appropriate responses and timely responses to handling referrals, including: <ul style="list-style-type: none"> <li>pre-visit risk/priority assessment of applicant completed during screening process;</li> <li>the client or substitute decision maker is aware of and is in agreement with referral.</li> </ul>	Existence of written criteria, policies and procedures, e.g. Priority Assessment Tool utilized. Time between referral and assessment. SEAscape referral identifies client is aware of the referral.	Client file review to: <ul style="list-style-type: none"> <li>measure time between referral and assessment.</li> <li>confirm pre-visit risk/priority assessment of applicant completed</li> </ul>
e) Screening process collects information on: <ul style="list-style-type: none"> <li>the types of problems; and</li> <li>the urgency of need.</li> </ul>	Evidence in SEAscape.	Review of screening and referral records.
f) District Health Authorities assign and train staff for referral responsibilities.	Intake responsibilities are included in job description for intake staff. All staff undertaking intake responsibilities receive training, including SEAscape training.	Examine job descriptions. Interview staff. Evidence of staff participation in training.

Standards	Measure/Indicator	Methods
<b>2. Assessment and Service Planning</b>		
a) District Health Authorities assess all applicants prior to providing any core services, other than assessment and care coordination, to them.	Evidence of assessments conducted as required by policy.	Review of client records, including SEAscape.
b) All persons admitted to the program meet the criteria for provision of service as follows: <ul style="list-style-type: none"> <li>• the person meets program eligibility criteria;</li> <li>• the person requires care and support while living in the community; and</li> <li>• the services to be provided do not unnecessarily replace the assistance provided by the family or community.</li> </ul>	Evidence in assessment record.	Review of client records, including SEAscape.
c) The District Health Authority uses assessment tools approved and mandated by the Department of Health and Wellness.	Evidence of use of RAI-HC and/or other approved tools.	Review of client records, including SEAscape.
d) The District Health Authority obtains and documents informed consent from the client/substitute decision maker to provide service and/or to access or share personal information about the client.	Documentation that the client/substitute decision maker has consented to service. Written consent for access to or sharing of personal information.	Review of client records, including SEAscape.
e) Assessors are trained in use of the RAI-HC and other approved tools.	Assessors have completed training in RAI-HC and other approved tools.	Review training records.
f) The Assessor conducts the assessment in the applicant/client's home if possible and appropriate.	Rationale for assessments done elsewhere is documented in record.	Review of client records, including SEAscape.
g) The Assessor obtains and records all RAI-HC assessment items.	Completeness of assessment records. # of completed assessments (signed off)	Review of SEAscape.
h) The Assessor obtains and records the views of the client and other persons consulted during the assessment.	Evidence in assessment notes.	Review of client records, including SEAscape.

Standards	Measure/Indicator	Methods
<b>2. Assessment and Service Planning</b>		
i) Based on assessment information, information from other sources and on professional judgement, the Assessor records his/her own summary of the client's situation, including: <ul style="list-style-type: none"> <li>• the needs, preferences and strengths of the client, the potential for self-care, learning and motivation;</li> <li>• the needs and strengths of the client's family and support system, and their current and potential role in teaching, motivating and caring for the client; and</li> <li>• the need for assistance from home care and/or other agencies or programs.</li> </ul>	Evidence in assessment documentation in SEAscape.	Review of client records, including SEAscape.
j) The Assessor completes a service plan in SEAscape which is appropriate to needs of the individual client and which: <ul style="list-style-type: none"> <li>• maximizes client independence and autonomy;</li> <li>• contain objectives of service, which are as specific as possible, so that their accomplishment can be assessed; and</li> <li>• reflects all the Continuing Care services being received by the client and/or type and frequency of service to be provided.</li> </ul>	Service plan documented in SEAscape. Evidence that service plans: <ul style="list-style-type: none"> <li>• meet current needs,</li> <li>• promote independence,</li> <li>• mobilize and support informal supports,</li> <li>• do not unnecessarily replace existing supports</li> <li>• contain specific goals</li> <li>• identify services</li> </ul>	Review of SEAscape data.
k) The Assessor ensures that the client/substitute decision maker is aware of the service plan and the right to appeal service planning decisions.	Evidence that client has been made aware of service plan and right to appeal.	Review of client records, including SEAscape.
l) The District Health Authority has procedures in place to ensure that clients may appeal assessment and service authorization decisions.	Evidence of an appeal procedure.	Review of procedure.
m) District Health Authorities have procedures to ensure that all information concerning clients is kept confidential.	Existence of procedures.	Review of procedures. Interview of staff.

Standards	Measure/Indicator	Methods
<b>3. Care Coordination/Case Management</b>		
a) District Health Authorities have a process established for all admission, discharge and re-admission decisions.	Evidence that admission, discharge and re-admission decisions are documented in the client record.	Review of client records, including SEAscape.
b) Home care service delivery begins after the development of a service plan.	Evidence that service is not normally started until a service plan is developed.	Review of client records, including SEAscape.
c) After the initial assessment, a reassessment is conducted at least once annually and as warranted by the client's changing condition or situation. Each time the Continuing Care Assessor must reassess the client's capacity to provide consent.	Evidence of annual and as needed, RAI-HC assessment.	Review of client records, including SEAscape.
d) When a client is admitted to the program despite reservations about safety, the District Health Authority must: <ul style="list-style-type: none"> <li>• set appropriate conditions for the service;</li> <li>• ensure that the conditions are clearly explained to the client and to involved family members and supporters;</li> <li>• consider entering into a written agreement with the client; and</li> <li>• ensure the ongoing documentation of case particulars and all discussions and agreements with the client and/or supporters.</li> </ul>	Evidence that conditions are established and agreed to when needed. Evidence of complete documentation. Evidence of regular case reviews. Evidence that risks are mitigated.	Review of client records, including SEAscape.
e) Clients are discharged when service is no longer necessary or appropriate.	Evidence that: <ul style="list-style-type: none"> <li>• the client no longer has a need for home care.</li> <li>• the clients has been made inactive.</li> </ul>	Review of client records, including SEAscape.

<b>Section: 15.0 HOME CARE STANDARDS</b>
<b>Policy: 15.3 Home Care Program Outcome Standards</b>

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<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

**15.3. HOME CARE PROGRAM OUTCOME STANDARDS**

<b>Standard</b>	<b>Measure/Indicator</b>	<b>Methods</b>
<b>1. Maintaining Client Independence and Wellbeing</b>		
a) Individuals are assisted to maintain independence and well being at home.	<p>Functional abilities and strengths, needs and limitations are assessed and used in planning care.</p> <p>Clients are encouraged and supported to do what they can for themselves.</p> <p>Client’s rights to accept risks and to refuse services are respected.</p> <p>Clients are involved in defining needs, setting goals, developing and revising service plans.</p> <p>Goals that are set with clients contribute to well being and independence, and are achievable.</p> <p>Clients believe that home care:</p> <ul style="list-style-type: none"> <li>• helps maintain their independence and well being;</li> <li>• helps them and their supporters to manage;</li> <li>• informs and involves them in assessment and service planning;</li> <li>• allows them to influence service decisions; and</li> <li>• respects their privacy and treats them appropriately.</li> </ul> <p>All support is coordinated to achieve goals.</p> <p>All cases are reviewed when situations change and goals are amended as required.</p>	Program Evaluation



Standard	Measure/Indicator	Methods
<b>2. Delaying or Preventing Long Term Care Admission</b>		
a) Admission to institutional long term care is delayed or prevented.	Home Care provides appropriate care that delays or prevents admission to long term institutional care.	Program Evaluation
<b>3. Supporting People Waiting for Long Term Care Admission</b>		
a) Support is provided to people waiting for admission to long term care facilities.	Home care is provided to people awaiting placement.	Review SEAScape data.
<b>4. Prioritizing</b>		
a) The District Health Authority makes the best use of home care resources by serving people with the greatest need first.	Cases with high priority needs are not screened out, refused admission, offered unduly restricted service levels or discharged.	Program Evaluation

<b>Section: 16.0      REPORTING REQUIREMENTS</b>	
<b>Policy: 16.1 Reporting Requirements for District Health Authorities</b>	
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<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

***16.1. REPORTING REQUIREMENTS FOR DISTRICT HEALTH AUTHORITIES***

**POLICY**

1. District Health Authorities are required to comply with all performance measurement and reporting requirements as established by the Department of Health and Wellness.
2. District Health Authorities are required to comply with Department of Health and Wellness auditing processes intended to measure compliance with any home care policies and standards established by the Department of Health and Wellness.

<b>Section: 17.0 OCCUPATIONAL HEALTH &amp; SAFETY</b>	
<b>Policy: 17.1 Occupational Health &amp; Safety</b>	
<b>Effective date:</b> June 1, 2011	<b>Version:</b> Replaces 1997 HCNS Manual
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<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

***17.1. OCCUPATIONAL HEALTH & SAFETY***

**POLICY**

1. The District Health Authority is required to have policies and mechanisms in place to ensure the provision of a safe work environment for District home care staff and which comply with the requirements of the *Occupational Health and Safety Act (1996, c.7, s.1)*.
2. The District Health Authority is responsible to work with service providers to ensure home care services are compliant with all requirements under the *Occupational Health and Safety Act* and have policies and mechanisms in place to ensure the provision of a safe work environment for home care service provider staff.

<b>Section: 18.0</b>	<b>INCIDENT REPORTING</b>
<b>Policy: 18.1 Incident Reporting</b>	

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<b>Signature:</b> <i>Original signed by Kevin McNamara</i>	

***18.1. INCIDENT REPORTING***

**POLICY**

1. District Health Authorities are responsible to ensure that District home care programs and all service providers are compliant with the provisions of the Disclosure of Adverse Events Policy and Critical Incident Reporting Policy, established by the Department of Health and Wellness.

## APPENDIX A - MINISTERIAL ORDERS