PROGRAM SERVICE Delivery

5

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ABOUT THIS HANDBOOK

Purpose

Handbook 5 describes the service delivery process for home and community care clients.

The Handbook is intended for Health and Social Service Team Members responsible for the delivery of home and community care services in First Nations and Inuit communities.

Using this Handbook

This Handbook is a guide. It provides suggestions and possible approaches to delivering the essential services of the First Nations and Inuit Home and Community Care Program from the time a client is referred, assessed and admitted to the program to the planning and delivery of care to discharge planning. The Handbook also discusses, in general terms, the essential services of program reporting, monitoring and data collection. Further elaboration and detail on the last topics will be covered in Handbook 6 – Evaluation.

Many of the suggestions and ideas documented in the Handbook come from individuals with hands on experience in delivering home and community care services in First Nations and Inuit communities. *Select the suggestions in the Handbook that reflect the values of your community and that are the most appropriate for meeting your community's particular needs.*

Other Supporting Material and Useful Reference Tools

Earlier in 2000, a joint First Nations/Inuit/Health Canada Working Group oversaw the development of **Standards and Policies Template Manuals** for the First Nations and Inuit Home and Community Care Program. The Manuals are intended to serve as a resource for communities to develop their home and community care programs and to support service delivery. The content of the two manuals is summarized in Appendix A. The Manuals are available on the First Nations and Inuit Health Branch Web Site at the following address: **http://www.hc-sc.gc.ca/msb/fnihcc** and are available in CD-ROM and hard copy format through regional First Nations and Inuit Health Branch offices.

A **Bulletin Board** for the Home and Community Care Program has also been created and can be accessed through the First Nations and Inuit Health Branch Web Site. The Bulletin Board is intended to help facilitate in the sharing of program planning and development amongst programs, including feedback discussions regarding the barriers, challenges and successes experienced by the First Nations and Inuit Home and Community Care workers, leaders, regional and national representatives.

The Bulletin Board allows users to share information regarding their community based home care program and enables them to attach files to their messages so other users can download them, ask questions, and post tips and suggestions.

INTRODUCTION

Throughout the Handbook, reference is made to Vision, Philosophy and Mission Statements. These statements are the essence of what your Home and Community Care Program represents and generally guide decisions on home and community care service delivery. It is therefore recommended that the suggestions for service delivery outlined in this Handbook be applied within the context of your Program's Vision, Philosophy and Mission Statements.

For a successful program, it is important that the community leadership not only approve the Statements but truly understand and support them. They should also be communicated on a regular and ongoing basis to community members. If you have not developed Vision, Philosophy and Mission Statements for your program, please refer to Handbook 1 – Getting Started for examples.

Health care has changed dramatically in the past decade -- a trend that is likely to continue. Your Home and Community Care Program and service delivery process will need to remain flexible so that they are able to respond to these changes and to the changing needs of your community and its members.

The goal of Program Service Delivery is to allow clients to remain at home as long as possible. In order to achieve this, the necessary services to assist clients and families need to be provided in a safe, coordinated and efficient manner based on client need, while maximizing all resources.

Any person may request home and community care services. The request for service may come to the Home Care Nurse Coordinator from any number of sources, such as the person requesting the service, a family member, a community member, the doctor, community health or social service agencies, or outside agencies.

The decision to “admit” or “not to admit” may be an obvious one, however, most referrals will result in the need for a home visit and a detailed client assessment to determine the care needs and the most appropriate program or agency to care for those needs. It is important to complete the assessment in the home as many factors of the person’s home environment can influence his or her home care needs, e.g. is the home wheelchair accessible.

Preparations Prior to Home Visit

Prior to visiting the client, it is recommended that the Home Care Nurse Coordinator[1] (or the person in your community who will be responsible for carrying out client assessments) carry out the following preparatory work:

- Obtain relevant information about the referral such as doctor’s/other designated professional orders, acute care discharge summary, concerns from individuals, other professionals or community members.

1 For purposes of this Handbook, the title Home Care Nurse Coordinator refers to a registered nurse with training in client assessment and case management responsible for the management and coordination of the Home and Community Care Program. Titles and roles / responsibilities may vary between communities.

- Initiate client record forms by completing the basic information known from the referral. This may include: name, address, name of doctor, referral source, diagnosis, problems, etc. It is recommended that only the forms necessary to complete the client assessment process be taken to the client's home in order to reduce the amount of paperwork that is completed during the home visit. Examples of such forms may be the assessment form/tool, the care plan or home care contract, the client consent to treatment and sharing of information form, and the client rights form.
- Record the time and date of the referral and home visit in a log book or on referral sheets ***(refer to Appendix B for a sample)***, kept in the office. It is recommended that a record/file of all referrals be kept for legal purposes, whether the referral resulted in service provision or not, and the reason for non-admission to the program. Potential reasons for non-admission may include: individual referred to another (more appropriate) program; insufficient or untrained staff available to provide the service; or services cannot safely or adequately be provided in the home. This information will be useful for analytical purposes when looking at the need to increase staff, provide additional training, and/or to illustrate the number of admissions/non-admissions to the program.

- Contact the person requesting the service and/or a family member to arrange a convenient time for a home visit and to determine if there is a need for an interpreter or translation of documents. A family member or an informal care giver, such as a family friend or another community member, may need to be present at the home visit, particularly if the person will require long term and/or complex care. If the person is admitted to the program, the family member or informal care giver may be asked to assume certain responsibilities on behalf of the client such as assisting them with their care needs and acting as their advocate. The family member or informal care giver will also ensure that someone other than the Home and Community Care staff are available to assist the client or respond to emergency needs since home care services will not be available 24 hours/day, 7 days/week in most areas.
- Ensure that the nursing bag has all the necessary supplies in order to carry out a physical assessment of the client in the home. A recommended list of basic and supplementary medical supplies and equipment for home and community care is available in Appendix C.

The Home and Community Care Program will assist the client with things they cannot do themselves while promoting client independence and family involvement.

Conducting the Assessment Interview

While conducting the assessment interview, it is important to be aware of the cultural and traditionally accepted communication practices in each community. Any staff member who is not familiar with these practices should be provided with an orientation to the community and be encouraged to attend cultural awareness workshops. It is important to listen and learn the community's lines of communication and traditions.

A good rapport can be developed at this early time by conveying a sense of support and trust. The use of non-verbal cues may be another way to communicate respect and caring in a way that is more culturally appropriate. The body language of the client and the informal care giver can also tell you if they are comfortable with what is being said or asked. Experience and judgement will guide you on whether more time needs to be spent on establishing rapport and trust. What is important is that the client feels that they are respected and that the Home Care staff accepts them as they are.

Some time may need to be spent on explaining the philosophy, values and mission of the Home and Community Care Program of encouraging independence and involving family or others in the care plan. This will be especially important in areas where home care has traditionally been seen as a homemaking service and where services have been provided based on historical practice rather than on assessed need.

Time should be taken to explain the purpose of the client assessment, whether or not writing will be done during the assessment, and how the care plan will be jointly agreed upon. During this time, the client should be informed of his/her "rights" ***(refer to the Client Care Section of the Policies Template Manual for examples on Client Rights)*** and should be encouraged to ask questions at any time during the assessment process to ensure that what has been explained has, in fact, been understood. Using language that is easily understood and avoiding, where possible, the use of medical terms is a good idea. The services of an interpreter may be necessary in some cases.

The home care assessment is the key to successful home care services. This process sets the foundation for a positive and effective relationship between the client and informal care giver and the Home and Community Care staff. The average assessment visit will take between 60 and 90 minutes. It will take at least the same amount of time to do the preparatory work, charting, follow up visit and any referrals that may be necessary.

Completing the Assessment Tool

Completing the assessment tool should only be done after a good rapport has been established between the client/informal care giver and the Home Care Nurse Coordinator. Each Home Care Program should have an assessment tool that has been adopted for use by the Program. ***Sample assessment tools are available in Handbook 4.***

Questions should be understandable and open-ended whenever possible. A good way to ask a question is to start by saying "please tell me about ..."

The assessment tool should begin with all the relevant information about the client, such as name, address, next of kin, health number, band number or NIHB number (the latter is Inuit specific), language preference, doctor's name, name of pharmacy, diagnosis, medications and treatments, medical history as well as the client's ability to understand written instructions.

The tool should also identify the physical and functional conditions and needs, the living conditions of the client's home environment, the supports available to the client, the current problem(s) and any services being received. Information on completing a physical and functional assessment follows on page 10.

The Home Care Nurse Coordinator will need to do more than complete a form during this initial home visit. She will also need to observe the environment (e.g. access to home, stairs, running water, mold), examine relevant conditions (e.g. wounds, skin conditions, breathing problems), and review all medications currently taken by the client. In order to do a complete medication review, the Home Care Nurse Coordinator should ask the client to **show all the medications** (e.g. pills, creams, sleeping aids, liquid medication) that they are currently taking. Specifically, ask about any medications that the client might be "borrowing" from someone else as well as any non-prescription medications, vitamins and traditional remedies. When all medications have been gathered, the Home Care Nurse Coordinator should ask the client to tell her about when they take them. This may be a good time to check reading ability by asking them **to read** the instructions on the medication container.

A suggested acronym for a complete Physical Assessment is "M.O.R.E. S.E.N.S.E."

M **Mobility/Physical Abilities**

This will identify any movement or walking difficulty as well as any limited strength or transportation problems. You may ask "Do you go to church, to the community centre, hall, etc.? Do you own/drive a ski-doo or 4-wheeler?"

O **Oral/Dental Health**

Note dentures, if any and discuss any problems with chewing. Identify the client's dentist and the date of the last examination.

R **Respiration**

Determine any breathing difficulties or persistent cough. You may ask "Can you walk the distance equal to one block without trouble breathing?"

E **Eyes/Ears**

Ask client to describe what they have trouble seeing, e.g. numbers (at Bingo or on telephone). Identify their Eye Doctor and the date of their last examination. Ask if they wear glasses. Ask and observe any hearing difficulties and ask about whether or not client has/uses a hearing aid and how long they have had it. Also determine if the client understands how and when to obtain/change batteries.

S **Skin and Circulation**

Use questions and observation. Does the client identify any problems? Do you see any conditions, e.g. poor color, dryness, ulcers, etc.?

E **Elimination**

This can be a very sensitive area for clients to talk about so phrase the questions very carefully, e.g. “Would you say that you have any problem with your ....bladder or bowels?” (Use language that the client would understand).

N **Nutrition**

Ask the client “what” they eat. Determine if they have ever been advised to be on a “special” diet, what kind, etc. Discuss how groceries are obtained and any difficulties cooking. You may ask “Can you get to the store? Do you have enough to eat? Do you have access to traditional foods?”

S **Social Activities**

Ask client about visitors and their frequency – Who? When? What activities they do with them? What role do they play with children/grandchildren? Are children present in their home? How often? Determine activities that the client enjoys as well as any difficulty performing these activities or getting to them. Also enquire about skills/interests that the client may be willing to share.

E **Emotional Health**

Another very sensitive area. Ask client to share their feelings about a variety of things, e.g. their illness (ask what is the hardest thing about their illness), their family, their environment, sleeping, etc.

A complete Functional Assessment looks at all activities of daily living. An easy acronym for this may be “H.E.L.P.”.

H **Homemaking**

Identify any difficulties with housework, making meals, shopping and/or laundry.

E **Environment**

Look at/enquire about home renovations that are needed or ones that impact on the safety of the client or the care givers. Is there sewer and running water? Is wood required to heat?

L **Living Activities/Lifestyle**

Enquire about financial management, transportation. Is the client able to manage these activities or does she/he need help? Questions related to lifestyle issues such as addictions are relevant to ask in an assessment, however, direct questioning may or may not be appropriate. Each case should be looked at individually.

P **Personal Hygiene**

Ask client to describe their bathing/shampooing practices. Is help needed? Do they have difficulty dressing or undressing? Do they have difficulty getting in/out of the tub?

After carefully doing the Physical and Functional Assessments, summarize:

- the areas where assistance is required (client needs);
- the type of assistance required;
- who will do the assisting; and
- when the help will be given.

Admission

A person is admitted as a client to the Program when:

- the client assessment has been completed; and
- it has been determined that the person has a physical and/or functional need that is greater than what the family/informal care giver can meet; and
- the need can be met in a safe and affordable manner through the Home and Community Care Program.

Since the spiritual aspect of a person's life affects many areas, it is important to be sensitive to the client's beliefs during the entire assessment process. Both cultural and traditional customs and beliefs will influence how they will accept and comply with the proposed plan of care.

Non-Admission

A person should not be admitted to the Program when following the client assessment:

- it has been determined that the person and/or family can provide the needed services themselves (your Program Philosophy and Mission Statement of client independence and family involvement will help guide you in this decision); or
- it has been determined that the person's needs can best be met by another program or agency; or
- it has been determined that the person's needs cannot safely be provided in the home.

In the event of the latter two, the person should be referred to the appropriate agency/program and told that "if the needs change" the Home Care Nurse Coordinator should be contacted again and asked to reassess the situation. If there is no other appropriate service in or outside the community, this should be noted.

Prior to ending the assessment visit:

- inform the client whether he or she will be admitted or not admitted to the Home and Community Care Program. If further research needs to be carried out, inform the client when a decision will be made;
- review the identified needs/problems with the client and the informal care giver/family;
- clearly state the goals of care and tasks to be carried out ***(refer to the following section for more information on developing a care plan)***;
- agree on what the informal care giver is able to do in meeting the goals of care;
- agree on what the client can do;
- agree on what the Home and Community Care staff will do for the client;
- inform the client and the informal care giver/family when the service will begin, the duration of the service, and when the reassessment will occur;
- review any relevant policies and procedures related to the goals of care, e.g. care will only be provided with the client present and within a safe environment for the client and care provider;

- ask the client to sign a consent form for treatment and sharing of information, as needed with other professionals ***(refer to Client Care Section of Policies Template Manual for examples)*** as well as any other client forms (e.g. client contract, client bill of rights, worker bill of rights) if applicable; and
- ensure that the client and informal care giver know how to contact the Home Care Nurse Coordinator if needs change.

Developing a Client Care Plan

The client care plan is developed by the Home Care Nurse Coordinator with the client and informal care giver based on the needs identified during the client assessment process.

The purpose of the care plan is to document the health and/or functional needs/problems, the goals of care, how long the service is planned for, what the client and supports will do, what home care will do and what referrals are necessary. The care plan will also document any allergies, medications, treatments, special diet or special precautions that are specific to the client. ***Sample care plans are available in Handbook 4.***

The goals for care should be clearly stated, realistic, understood and agreed upon by the client, the family/informal care giver and the health and/or social service care provider. The goals of care should be supported by identifying and assigning the necessary tasks and services, when, how often and for how long the tasks will be carried out.

Example Goal

To teach client to administer insulin injections safely and as ordered and to understand the signs and symptoms of diabetic reactions.

Example Task

R.N. will visit daily and instruct client regarding signs and symptoms of diabetic reactions until client is able to explain them and will teach client to administer insulin, rotating and recording sites and will observe client doing self-administration until proficiency is achieved.

Example Goal

To teach client/informal care giver to change wound dressing, using clean technique.

Example Task

R.N. to cleanse left lower leg ulcer with normal saline and apply dry dressing daily until client/informal care giver demonstrates ability to do so then will continue to monitor progress weekly until healed.

In some communities, there may be standard definitions of care, e.g. cleaning may mean sweeping/washing floors, cleaning bathroom, wiping counters and removing garbage. Assist with a.m. care may mean assisting client to get dressed, wash, brush teeth and prepare breakfast. If these standard definitions are used, it saves time in doing assignments but it must be remembered that any deviation from these definitions has to be clearly stated such as cleaning and changing bed or assist with a.m. care and assist client with range of motion exercises.

The care plan is dynamic and will be updated frequently as the care needs are met or as the client's condition, treatments or medications change. The care plan should be readily available to anyone providing services.

When developing the care plan goals and tasks, you may want to use the opportunity to once again review the Program's Mission Statement, Philosophy and relevant policies and procedures with the client, family member/informal care giver and home care staff to ensure that expectations of services to be provided are clearly understood. For example:

Client - Inform client that staff will only do assigned tasks. If changes are needed or wanted, the client is asked to contact the Home Care Nurse Coordinator. Staff will encourage and work with client to learn ways to become independent or remain as independent as possible.

Informal care giver - Review informal care giver's responsibilities to ensure these are clearly understood. If responsibilities cannot be met, the informal care giver should arrange to have someone else provide the service or call the Home Care Nurse Coordinator to make alternate arrangements so that the client's care needs continue to be met.

Home Care staff - Review program policies and procedures relevant to the goals of care so these are clearly understood. Review other key policies and procedures related to the delivery of service on a regular basis ***(refer to Policies Template Manual for examples)***. For example:

- Confidentiality;
- Ethics and Employee Conduct (these will address important issues such as hand washing, e.g. with an approved solution or with soap and water, and when not to provide care as assigned, e.g. if client is not home or if there appears to be a risk to staff safety).

Collecting Client Data

To fully understand and be able to meet client care needs, client data must be collected from a variety of sources and kept on a client file. For reasons of confidentiality, it is recommended that policies be developed around access to and safe keeping of client files ***(refer to Policies Template Manual for examples)***. Client data includes:

Relevant Orders

All medication and treatment services must be accompanied by ***current, signed Physician's orders*** or other designated health care professionals (as approved by the health care system in each community). It is recommended that each community develop a policy stating the frequency of updating these orders as well as the accepted form, e.g. faxed copy, phone orders.

Discharge Summaries

When clients are discharged from facilities such as hospitals, it is necessary to have the following information in order to provide appropriate services:

- reason for admission;
- treatment/medication while in facility;
- physical/functional changes that have occurred as a result of current hospitalization;
- required treatments/medications to be continued at home;
- follow up appointments; and
- relevant orders for treatments/medications and medical supplies/equipment.

Transfer Reports

If a client is transferred back to the community from another program it is necessary to have the following information:

- services that were received;
- supports from informal care givers;
- reasons for transfer;
- current treatments/medications;
- current illnesses;
- current abilities; and
- contact person from transferring agency/program.

Case Management

Case management is a key element to managed care. Managed care is widely understood to mean the right care is provided by qualified and competent health team members at the right frequency and duration that will best support that person. It can be said that managed care goes beyond First Nations and Inuit home and community care services (with client consent) to link with other care and service providers outside the community. The goal of case management is to coordinate the multiple services a client may be receiving to ensure quality and consistency of those services regardless of who or what agency provides the care.

The Home Care Nurse Coordinator usually assumes the role of Case Manager. Case management can be achieved by establishing Health and Social Service Team meetings or multidisciplinary team meetings to ensure that the appropriate

linkages and referrals have been made, and by holding care (case) conferences to determine the best ways of meeting client care needs, involving staff and/or the family as appropriate.

Multidisciplinary team meetings are an important way to manage client care. For this reason, it is recommended that team meetings be held on a regular or as needed basis in order to review services provided to clients and avoid duplication. Team meetings can also be used to carry out anticipatory planning on program issues that may arise (e.g. elder abuse).

The composition of the team will vary by community but generally includes the Home Care Nurse Coordinator, Community Health Nurse, Social Services Director/Manager, Home Health Aide and the Community Health Representative. If a community has children with special needs requiring home care services, it will be important to ensure Child and Family Services staff are part of the team. Ultimately what is important is that:

- client care needs are met in a coordinated and comprehensive manner;
- relevant community agency staff involved with client care participate (this will help avoid one program off loading onto another); and
- client confidentiality be strictly adhered to during these meetings.

Because client information will be shared at the multi-disciplinary team meetings, it is recommended that community members not participate on this committee. A more appropriate way of involving community members and elders in the Program may be to establish a Community Member Advisory Committee who would meet regularly to:

- bring community concerns to the attention of the multidisciplinary team;
- receive information regarding policy changes and/or revisions; and
- advise the Health and Social Services Team about community reaction to new programs or new directions.

Care/Case Conferences are different from multidisciplinary team meetings and should also be held on a regular or as needed basis. These sessions may involve staff providing home and community care services only or can include family members as well (family conferences). The goal of these sessions is again to support client care needs. Front line staff, who often work in isolation, are important contributors at these meetings and should be encouraged to attend and participate. One way to encourage attendance is to make the meetings part of the front line worker's schedule of work. The Home Care Nurse Coordinator is likely the most appropriate person to chair the meetings if she is responsible for all care planning, coordinating and direction/supervision of staff.

Service Referrals will make sure that the client can pass from one health or social service to another without difficulty, and the information from one service will follow the client to the next service. Examples of service referrals may be:

- from one home care agency to another if the client moves;
- from one program to another if service needs change, e.g. from home care to mental health program; and
- consultation with specialist services such as those offered by a Diabetes Education Specialist.

It may be necessary to contact outside agencies/programs to inform them of new programs in your community. Communication and a good rapport with other agencies/ programs and an understanding between programs and agencies will improve referrals and linkages. Providing program and/or cultural awareness information will also improve chances of better uninterrupted/coordinated care for clients since outside agencies need to know:

- who to contact;
- what services are available; and
- how to arrange implementation of care or continuation of services.

Examples of referrals from outside services that may be required to support the community based activities and client needs include:

- experts in wound management;
- rehabilitation services;
- pharmacists; and
- nursing procedure experts.

All referrals should be written, dated and signed. The client must be aware and consent to all referrals. If a Consent to Treatment and Sharing of Information form is used, the client's signature is required. The Home Care Nurse Coordinator should ensure that the client understands and agrees to the referral.

Linkages with other programs and services are also important to establish. It is recommended that linkages be formalized in the form of written agreements between programs and/or between communities when linkages/referrals have been made. These agreements should clearly state what, when, how and by whom shared services will be provided.

SCHEDULE APPROPRIATE STAFF

Careful scheduling of staff will assist the Home Care Nurse Coordinator to:

- make the best use of limited resources to meet program service needs;
- validate time sheets and thus maintain accurate and complete records and statistics on amount of care provided; and
- be able to regularly contact and communicate with front line home care workers when needed.

When scheduling staff, you will need to take into account:

- the knowledge, skills and competencies and scope of practice of the home care worker to carry out the required tasks;
- the time required to carry out the tasks;
- the support available from family members or the informal care giver (identified in the assessment process); and
- the availability of staff.

Professional Development and Continuous Learning

Since home care needs are dynamic and ever changing, continual staff training and learning will be necessary. Therefore, it is recommended that ongoing training be planned for and included in program budget planning processes. While it may not be possible for all communities to have all staff classifications and/or fully trained and certified staff, other alternatives such as sharing trained workers with other communities or establishing linkages with outside agencies for expert support should be explored.

The advantages of having trained staff are numerous. Reasons include:

Client Safety - If the worker assigned to do the cleaning is trained/certified and the client needs assistance for transferring or toileting during the time the worker is cleaning, the client will be moved safely.

Liability - If staff are assigned to do certain tasks, there is an expectation that they are also registered, trained and qualified to do those tasks. If not, the Program or the Health Centre or Community Authorities may be held responsible. Each staff classification will have scope of practice standards which will clearly state what tasks or services they are qualified to perform.

Cost-Effectiveness - If staff members are trained and qualified to do a broad range of tasks, it is more cost-effective than having to hire/retain a large staff complement who may only be able to carry out limited activities.

Fairness - If a community has accepted that only trained staff members will provide services in the Home and Community Care Program and that family members will not be paid to provide care, there is a better acceptance if a trained worker is assigned.

Each person assigned to provide care is expected to be competent to do so otherwise the safety of the client is at risk, and the program places itself at risk of legal liability for any outcome of care.

One way to keep track of staff scheduling is to use a calendar for each client that shows:

- which staff member is assigned to the client;
- when the staff member is expected to arrive at the client's home; and
- the length of time the staff member is expected to stay in the client's home.

The calendar or schedule would be accompanied by the task list which identifies what activities the staff member is expected to perform. It is important that each staff member and client be given a copy of their schedule and task list.

For many home and community care clients, the home care staff are their only contact outside their home. For this reason, staff members should be encouraged to follow the schedule as closely as possible and to notify the client if they are going to be arriving at a different time. At the same time, clients should be encouraged to contact the home care worker or the Home Care Nurse Coordinator if they are not going to be at home at the time of the scheduled appointment. If phones are not in use, a note left on the door will suffice.

When care plan changes occur (for example, a client receiving only personal care assistance becomes more ill and requires nursing care or when friction arises between the client/informal care giver and the home care staff) it may be necessary to reassign and/or re-schedule staff. Should this occur, all those involved in the client's care, including the client, should be informed of the changes.

Part of the scheduling process includes allocating/assigning time for each task. This activity will:

- allow for better budget projections and adherence to set program budgets;
- ensure that services being provided are fair and consistent between clients; and
- meet statistical and reporting expectations identified by your Program.

An example of time allocation could be that meal preparation shall be one hour unless otherwise specified. A variation of this may be the length of time is takes to teach a hemiplegic client to do things for themselves vs. a client with unrestricted mobility. Also environmental factors that necessitate, for example, the need to haul water or wood may require additional time. It is recommended that any program standards developed in these types of areas have the political and administrative support/approval prior to implementation.

A final point on staff scheduling: replacing staff during vacation or sick leave may be very difficult in small home care programs. The urgency of the need for care of the client should be the deciding factor in whether the staff will be replaced for that client's care.

PROVIDE SERVICES AS DETERMINED IN CARE PLAN

When schedules and task lists are completed, the Home Care Nurse Coordinator will contact the assigned staff member and explain the care plan to ensure the staff member has a clear understanding of:

- the day(s)/time(s) the work is to be carried out;
- the specific tasks that need to be carried out;
- how much time has been allotted for the tasks;
- what, if any, special precautions need to be taken;
- what activities/self-care to encourage client to do;
- the role of the family member (or informal care giver) with the client's care; and
- the reporting requirements and method of reporting (e.g. oral reports that are phoned in or given at team meetings, written reports using established forms).

The client should be made aware of which staff member will be providing care, when it will be provided, and the expected duration. This can be done by either giving a copy of the task list and the schedule or a copy of the care plan to the client and/or family member, or by asking the staff member to take an extra copy to the client's home on their first visit. The information is best placed in a highly visible spot such as on the refrigerator door.

If treatments are assigned the staff member must follow the specific written orders. These orders are to be dated, signed and placed on the client's file. If medications are to be set out or monitored they too must have specific orders.

It is a good idea to regularly review your program standards, policies and procedures with staff prior to providing care, particularly those policies that deal with the following situations:

- when the client is not present in the home;
- when the client falls or injures him/herself;
- when the client or someone else in the home is abusing substances;
- when there are inadequate or no supplies for providing the service;
- when the client wants to discuss other clients or programs;
- if the client dies during care;
- if there is reason to believe that the client is home but the staff member is not able to enter the house;
- when the staff has reason to believe there is risk of harm to themselves or someone else in the home; and
- harassment.

When providing services, teaching independence should always be a priority for the home care worker. Maintaining independence, whenever possible, increases self-worth. One way of promoting independence is to encourage clients to reorder supplies and medications prior to depleting their supply.

COMPLETE CLIENT RECORDS AND PROGRAM REPORTING

Maintaining accurate, factual and complete client records is a legal requirement and a management responsibility.

As with all legal documents, pens must be used and all notes must be signed and dated. Most health agencies/facilities have developed acceptable abbreviation lists which can be used in all recordings. Only those approved and accepted by the community should appear on the written permanent client record.

Client records or files must be kept in a secure/locked area accessible by the Home and Community Care Program. Each community should determine who will have access to the client records as well as how this access will be achieved, bearing in mind that all data in the client record is strictly confidential. Refer to the Client Care Section of the Policies Template Manual for information on confidentiality of client records.

The Home Care Nurse Coordinator will ensure the client file is complete and that all the necessary data is recorded such as:

- relevant orders (from doctor or other designated health care professional) are signed and dated;
- a completed and signed client assessment;
- narrative notes recording phone calls, visits and any changes in client care needs;
- copies of care plan and/or assigned tasks;
- completed medication/treatment form;
- authorization form or transfer of function form; and
- client consent to treatment and sharing of information.

Staff members are also responsible for reporting on client care and should be fully informed of expectations in this area. It is recommended that staff members document such important information as:

- time spent with client -- one method is to have the client actually sign for the service when it is completed;
- any reasons that care was not provided such as client not home;
- travel mileage (if this is an allowable expense);
- any changes in the assigned schedule such as working for another staff member, client not home, or family staying with client or some other client care arrangement;
- reporting observations of changes in client's health status or supports; and
- Incident Reports or Unusual Occurrences -- these should be verbally reported to the supervisor as soon as possible followed by a written report.

It is recommended that copies of staff signatures/initials be kept on file (staff signature validation file).

In addition to the above, staff reporting responsibilities will vary depending on the staff classifications in each community, for instance:

- R.N. or L.P.N. providing home care services must record and sign all treatment and medications administered or observed. They must also record all relevant findings and communication with the clients and their supports as per provincial/territorial regulations. These can be recorded on nurse's notes which can be carried with them and turned into the Home Care Nurse Coordinator on a regular or weekly basis to be placed on the client's file.
- Home Health Aides have the most frequent contact with the client. They will be able to identify ongoing/additional needs or improvement in the client's condition which will be reported to their supervisor or the Home Care Nurse Coordinator. Monthly activities also need to be reported, such as home visits and attempted home visits, time and type of service provided.

While the broad program reporting requirements for the Program will be identified through the development of an information and evaluation framework, the following are examples of minimum reporting requirements used in established home care programs to inform program staff, leadership, community membership and the funding agency on the status of the Program:

- Reports of Client Service. This may include information on:
    - the number and type of clients referred to the program;
    - the number of admissions and discharges;
    - the type of care provided;
    - the number of hours of care required and provided; and
    - the frequency and length of hospitalization.
- Reports on Training, In-Services, Workshops, Classes held;
- Financial Reports; and
- Reports on Staffing. This may include information on: recruitment of nurses and other home care workers, number of trained workers providing service as well as the number of staff used by classification.

Program reporting requirements and data collection tools should take into consideration your community's evaluation questions with respect to program activities and outcomes, and the requirements from the funding agency. ***To assist with program reporting and data collection, sample data collection tools are available in Handbook 4, Appendix F.***

REASSESS CLIENT ON A REGULAR BASIS

At the time of the original assessment, a date for routine reassessment will be established and agreed upon. This date will depend upon client needs and condition. Both client and informal care giver/family will be aware that this is the date that the Home Care Nurse Coordinator will return to determine how the care plan goals have (or have not) been met and how well the client is managing. Both client and informal care giver/family will also be informed that if the client's needs change at any time before the scheduled reassessment date, the Home Care Nurse Coordinator should be notified.

Reasons for Reassessment

- additional service requests made by client/family to home care staff -- staff member will report these requests to the Home Care Nurse Coordinator who will then decide if reassessment is necessary to change the care plan in order to reflect a change in service;
- admission to or discharge from an acute care facility (e.g. hospital);
- change in occupants in client's home, e.g. if a healthy family member moves in with client and is capable of providing the service that Home Care has been providing;

As home care services are based on assessed needs, reassessments should be carried out regularly to ensure that the care provided continues to be responsive to the client's needs. At the same time when a need no longer exists, home care services should no longer be provided.

- change in availability of informal care giver, e.g. if the informal care giver is no longer available or able to do the tasks agreed upon, it may be necessary for Home Care to do more;
- treatments are no longer necessary, e.g., wound healed earlier than expected and therefore dressing changes are no longer required;
- client becoming independent due to successful learning and/or to improvement in health status; and
- when there are complaints/concerns/comments shared by client/family.

Revise Care Plan

After reassessment occurs, the process begins again with the necessary care plan changes stating:

- client/informal care giver and Home Care Nurse Coordinator agree on changes in the goals of treatment;
- service tasks will be revised as necessary;
- staff will be informed and new assignments will be given, possibly with new schedules;
- client record will contain all relevant information necessitating the changes; and
- a future date for reassessment will be set.

Discharge

Most agencies/facilities/programs have accepted that **Discharge Begins on Admission**. This means that plans should be started as soon as the client is admitted to a program to help them become independent of the program. In many cases, this will mean teaching the client/informal care giver to do tasks within their ability. It may also mean ordering special equipment or arranging home renovations through the housing department, e.g. wheelchair ramps. This is consistent with the Home Care philosophy of creating and maintaining independence.

It is for this reason that the following is discussed at the time of admission to the Program:

- stated goals of care;
- specific tasks assigned;
- timeframe in which services will be provided; and
- client/informal care giver responsibilities.

Clients are discharged when:

- services are no longer needed;
- services are no longer safe to provide in the home, e.g., client admitted to an acute care facility or long term care facility; and
- care needs exceed program budget ability (examine your policies to know program service limits due to budgets).

Program Monitoring

Program reporting and analysis will allow communities to monitor the changing health and social needs of the community and adapt services and programming in response to those needs.

The reports will form the basis for quality control which will show whether the services are meeting client needs and should be used to initiate planning for improving client care. Each community will develop their own method of measuring the quality of services provided.

One of the most common examples of a quality control measure is the use of chart audits. Chart audits can be done by a committee who will review the client records either randomly, alphabetically, or by client condition. If this control method is used, the terms must be very detailed to ensure that all audits are being conducted uniformly.

Random verification methods are also used in some communities. This is done by the Home Care Nurse Coordinator randomly contacting clients, on a regular basis to determine:

- if the service assigned was provided;
- if the staff member was there on time and for the time assigned; and
- if the care plan and service is still satisfactory.

Work is currently underway at the national level to identify the broad range of information needs for program monitoring and evaluation, and the management of service delivery and client care. Input will be obtained from First Nations, Inuit, regions and territories, to determine what type of information needs to be collected for the community, the tribal council/health alliance, the region and nationally. The outcome of this process will be documented in Handbook 6 - Evaluation.

Appendix A - Content Summaries: First Nations and Inuit Home and Community Care Standards and Policy Template Manuals

First Nations and Inuit Home and Community Care Standards Template Manual

This manual includes standards templates in six topic areas, as well as an introduction, reference list and glossary that are common to the Policies Template Manual. The introduction includes information and suggestions on how to use the manuals; definitions and benefits of standards, policies and procedures; background information about the First Nations and Inuit Home and Community Care Program, including roles and responsibilities for communities and government; and suggestions of future activities, including customizing the templates to better meet the needs of individual communities, and preparing for accreditation.

The six topic areas for the standards include the following:

Leadership

Standards templates are provided to support vital components of the Program's development and ongoing evolution: community needs assessment, vision, capacity building and resource and contract management.

Quality

The templates for quality standards focus on ongoing quality improvement in program development and the monitoring, evaluation and timely handling of risk issues.

Home and Community Care Services

This section focuses on accessible, appropriate, effective services; promoting continuity of these services; and the inclusion of health promotion, prevention and protection services. This section also addresses the importance of clients' rights and specifically addresses client participation and consent, ethical issues and confidentiality of clients and their information.

Environment

These standards address issues related to health and safety, including a focus on building and physical space, as well as equipment and materials, and disaster planning. A standard related to linkages and partnerships with other community programs and organizations is also included to promote a unified approach to services and community issues.

Human Resources

The human resources standards promote proactive and responsive human resources planning, as well as fair, timely and effective recruitment and retention initiatives. These standards also foster staff development through regular performance evaluation and education and training, and a positive working environment.

Information Management

These standards begin with a focus on assessment and planning for current and future information needs; then move to what is required to address these needs: collecting reliable, relevant data; providing easy access to those who need the information; analyzing and evaluating relevant indicators; promoting information exchange within and outside the community; effectively using the information for program changes and improvements; and maintaining information management systems that are secure and protect confidential data.

First Nations and Inuit Home and Community Care Policy Template Manual

This manual includes policies in eight topic areas, as well as the same introduction, reference and glossary that appear in the Standards Template Manual.

The eight topic areas include the following:

The Organization

These policies centre on the mission, vision, values, beliefs, goals and objectives that shape the Program and its services. Policies also address the organizational structure and the roles and responsibilities of clients and families, service providers, program management and the community and its leadership. Clear policies in these areas are fundamental to a sound, well-grounded Program.

Scope of Services

This section addresses clear policies concerning the range of services to be provided, model(s) for their delivery, access for all eligible community members to ensure people receive services based on predetermined criteria and need, and the processes for appeal regarding unfair, inequitable or inappropriate allocation of services.

Client Care

These policies focus on client rights, confidentiality and privacy of all client information, informed consent to treatment, and documentation to ensure that reliable, relevant information is collected.

Human Resources

This is the most extensive section of the manual, and covers a variety of human resources policies to ensure equitable practices, investment in staff development, and clear understanding of processes and protocols, all in an effort to promote positive recruitment and retention activities. Specifically, the scope of these policies ranges from topics of equal opportunity, ethics and human rights to recruitment, hiring, orientation; from the employment relationship, compensation and benefits to harassment and grievances; from conflict of interest to performance management and disciplinary process.

Quality

These policies encompass processes to monitor performance indicators, evaluate the efficiency and effectiveness of the Program, promote continuous improvement to the Program and reduce risk to clients, families, staff and the Program.

Operations

This section addresses policies for the various operational components of Program management, record management, communications and financial management, as well as the annual Program summary.

Health and Safety

These policies focus on health and safety areas including hazardous waste management, disaster response, fire and evacuation, negligence, client abuse, and infection control. As well, policies regarding incident reporting and liability protection are included here.

Clinical/Service Delivery

This is the only section that does not include a comprehensive range of policies. The four that are included are felt to be of significance for the Program's success: eligibility criteria, priority setting, resource allocation, and delayed admission. As well, a number of specific protocols have been identified, such as death in the home, doctor's order, first dose medications administration, general medications administration, universal precautions, and more detailed protocols regarding the refusal to provide services and related staff safety issues. These protocols were felt to be the most valuable to Program development and implementation at this point.

Appendix B - Sample Home Care Client Intake Log

Date: ____________________

Home Care Client Intake Log

Client Identifier:	Referral received:	Contact made or attempted dates:	Assessment complete:	Admission:	Discharge:	Referral to:	Comments:

Appendix C - Recommended List of Basic and Supplementary Medical Supplies and Equipment for the First Nations and Inuit Home and Community Care Program

The information in this appendix was generated from input received from established First Nations and Inuit home and community programs, Health Transition Fund home care pilot sites, home care nurses, and experts from provincial home care programs.

Access to medical supplies and equipment is an essential element in the delivery of home and community care services (ref: Home and Community Care Program Framework and Criteria). Each community, tribal council, alliance or regional association must therefore ensure that it has access to basic medical supplies and equipment to address the needs of the home care clients.

The following is a recommended list of basic and supplementary medical supplies and equipment broken down in three categories:

- the basic and supplementary supplies and equipment needed by the home care nurse to perform her/his duties during home visits;
- basic equipment to meet immediate and short term home care client needs; and
- high utilization items required in the care of home care clients (e.g. dressing supplies, diabetic supplies, incontinence supplies).

It should be noted that for all three categories, particularly in categories (2) and (3), the list of items should be validated against the community's case load requirements. While this may be difficult to do until communities have fully operational programs in place, it is recommended as an interim measure, that communities review the following data to validate its requirements against the recommended basic list of medical supplies and equipment:

- data collected through the community needs assessment process for the Home and Community Care Program;
- data on items purchased through the Drug Distribution Program; and
- medical supplies and equipment utilization data available from the Non-Insured Health Benefits Health Information Claims Processing System (this information can be obtained by contacting the Non-Insured Health Benefits unit in your region).

Basic and supplementary supplies and equipment needed by the home care nurse to perform her/his duties during home visits
(contents of the Home and Community Care Program Nursing Bag)

BASIC EQUIPMENT

1 dual head stethoscope

1 sphygmomanometer

- child cuff (if providing nursing care to any children)
- adult cuff
- obese cuff (if providing nursing care to larger clients)

1 bandage scissors

1 suture scissors

1 diagnostic set

- ophthalmoscope
- otoscope

1 electronic thermometer with probe covers

1 blood glucose meter

- test strips and control solution

1 tape measure

1 CPR mask

1 O2 sat monitor

1 pill cutter

1 clip remover

1 hemostat

1 forceps

Reference Material

- CPS Compendium of Drugs
- Drug Handbook
- Nursing Care Resource Materials

BASIC SUPPLIES

- disposable gloves - non sterile
- disposable latex gloves - sterile
- antiseptic hand gel or water less hand-washing towels
- abdominal pads
- gauze pads 2x2 and 4x4
- alcohol wipes
- telfa pads
- paper bags
- adrenalin kit and instructions (carry only with doctors orders – most clients who use it will have it prescribed at the time)
- sharps container
- non allergic tape (wide and narrow width)
- stretch kling various sizes
- hazardous waste container
- lubrication
- normal saline

Supplementary Equipment: (if case load requires it)

- lab work equipment if doing venipuncture
- velcro walking belt

Supplementary Supplies: (if case load requires it)

- syringes
  - insulin
  - 1 ml
  - 3 ml
  - 10 ml
- needles
  - 25 gauge, 5/8 inch
  - 21 gauge, 1.5 inch
- glucose for hypoglycemia
- disposable impervious aprons

Foot Care Supplies:

The following supplies are recommended only if home care nurse is certified in foot care and case load requires it (two sterile sets)

- nail nippers
- nail files
- diamond deb files
- blacks files
- spoon head probe
- stainless steel bowl (oval or kidney base which fits instruments)

Basic equipment to meet immediate and short term home care client needs: (loan cupboard items)

- wheelchair
- crutches
- walkers
- bath chairs
- commode
- bedpans
- canes
- raised toilet

High utilization items required in the care of home care clients:

Wound Care

- specialized dressings
- dry dressings
- adhesive bandages and tapes
- topical preparations

Incontinence Supplies

Diabetic Supplies

- blood glucose meter
- lancets
- insulin syringes
- insulin pens

Appendix D - Case Samples

Sample 1

A phone request is received by the Home Care Nurse Coordinator requesting home care services to allow a mother of a 3 year old child to go to college 3 days a week.

Since Home Care does not include babysitting or routine child care needs, this request for service is denied without an actual home visit/assessment being carried out. The Home Care Nurse Coordinator will, however, explain the program eligibility and will ask the mother to contact Child and Family Services (encouraging independence), or if this is not possible, she may offer to make a referral to Child and Family Services on behalf of the caller. Consent should be sought from the caller on any referrals made.

Under the above scenario, the caller will not be admitted as a client to the Home and Community Care Program.

Sample 2

A phone request is received by the Home Care Nurse Coordinator to immunize or provide a flu shot to an individual in the community. The Home Care Nurse Coordinator will explain the program criteria for admission and refer the client to the Community Health Program (Nurse).

Under the above scenario, the caller will not be admitted as a client to the Home and Community Care Program

Sample 3

The following is a referral for service from an outside agency.

The acute care facility (hospital) will contact the Home Care Nurse Coordinator for a client who has recently had a cholecystectomy (gallbladder surgery) and who will be returning home on the third day post operatively. The Home Care Nurse Coordinator will request a discharge summary stating specific medication and treatment orders, signed by the physician as well as prescriptions for supplies and medications, as needed. If distance and time allows, it is ideal for the Home Care Nurse Coordinator to visit the client in hospital, prior to discharge. She will discuss home care needs with the client and staff and will make home care arrangements in order to start the service as soon as the client returns home. This will result in a short term assessment and care plan. It is, however, advisable for the Home Care Nurse Coordinator to visit the client in their home as soon as possible after discharge to review/revise the assessment, needs and care plan.

The Home Care Nurse Coordinator will write the

Sample Care Plan

Date:	Need/Problem:
Goal:	
Task(s) Assigned:	
By Whom:	When Reassessment:
Nursing:	
Diagnosis:	

task/assignment stating:

- the order for treatment;
- what teaching is required and to whom;
- what is to be reported back to Home Care Nurse Coordinator; and
- frequency and allotted time for treatment (schedule).

This written task/assignment and schedule will be discussed with the health provider (e.g. nurse, LPN) assigned, e.g. change abd drsg. daily (10:00 10:30) -- cleanse wound with normal saline, apply telfa and dry drsg. Encourage client to learn to do the drsg. change teaching aseptic technique, supplies discarding procedure, and necessary reporting. Report progress to the Home Care Nurse Coordinator weekly (or daily if patient status is deteriorating), identifying healing progress and any additional concerns or needs.

Under this scenario, the client is admitted with short term care needs.

Sample 4

One of the biggest challenges to a Home and Community Program is a client with multiple needs and minimal supports. An example of this may be a client with diabetes (newly diagnosed), with limited vision, recent hospitalization for lower leg amputation -- returning home where he/she lives alone with very limited resources (human and financial) and poor housing conditions with no running water.

This client will need many services from many programs such as:

- **Home/Community Care**
    - Nursing to change dressings, to surgical area (amputation), to teach re: diabetes, transfers and diet.
    - Health Care Aide to assist with personal hygiene, homemaking, meal preparation and planning.
- **Social Services**

    To review financial needs, especially relating to diabetes (increased grocery costs and possible visual aides).
- **Housing**

    To repair any safety hazards and to build a ramp.
- **NIHB**

    Wheelchair or walker, medications, supplies and transportation services.
- **CNIB**

    Visual aides.

This type of case is a good example of the need for program linkages and multidisciplinary team meetings.