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SUBSECTION:	EFFECTIVE: JANUARY 1, 2013

Intent

To describe health authorities' responsibilities in planning and delivering publicly subsidized residential care services.

Policy

Health authorities must plan and deliver publicly subsidized residential care services to clients as part of their established care plans, provided as:

- short-term residential care services including:
 - respite care;
 - convalescent care;
 - residential hospice palliative care;
 - for other purposes determined appropriate by a health authority to meet the unique needs of the client, or
- long-term residential care services.

Health authorities must:

- ensure that residential care services are delivered in compliance with the Residential Care Regulation;
- establish local service delivery models that will provide clients with access to residential care services within their community or within accessible distance to their community;
- authorize and manage access to residential care services either on a long-term or short-term basis by:
 - informing clients and their caregivers of the process for managing the waitlist and admission;
 - establishing a plan with clients and their families/caregivers to assist them to remain safely at home with support services where required until they are admitted to a residential care service;
 - providing information about their residential care services, including care philosophy, services, programs, facility descriptions, contact information and photographs that are available to the public, and to other health authorities;
 - determining the client's needs using assessment criteria, clinical judgement and best evidence, identifying the appropriate service for those needs, and facilitating access to residential care services where appropriate; and

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- ensuring that a client's capacity to provide informed consent to facility admission has been assessed, and that the client has consented in writing to be admitted to a residential care facility.

Definitions

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

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

long-term residential care services are services provided to clients admitted to a residential care facility on a permanent basis.

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

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

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

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

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residential care services provide a secure supervised physical environment, accommodation and care to clients who cannot have their care needs met at home or in an assisted living residence.

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

respite care is a short-term residential care service for the purpose of allowing the client's principle caregiver a period of relief, or to provide the client with an period of supported care to increase independence.

short-term residential care services are facility-based services provided on a short-term basis (usually less than three months) and include convalescent care, residential hospice palliative care and respite care.

References

Community Care and Assisted Living Act
 Director of Licensing Standard of Practice Number: 01/08/2006
Health Care (Consent) and Care Facility (Admission) Act
Hospital Act
Patient Care Quality Review Board Act
 Residential Care Regulation

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SUBSECTION:	EFFECTIVE: OCTOBER 15, 2012

Intent

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

Policy

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

Short-Term Residential Care Services

Short-term residential care services may include:

- respite care;
- convalescent care; or
- residential hospice palliative care.

Service Needs Determination

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

- has been assessed as requiring short-term residential care services (see Policy 2.D, Assessment);
- has agreed to pay the applicable daily rate (see Policy 7.C.1, Short-Term Residential Care Services Rates); and
- has agreed to vacate the residential care facility at the end of the agreed upon period of short-term residential care.

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SUBSECTION:	EFFECTIVE: OCTOBER 15, 2012

Intent

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

Policy

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

Service Needs Determination

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

- has been assessed as having 24-hour professional nursing supervision and care needs that cannot be adequately met in the client's home or by housing and health services;
- is at significant risk by remaining in their current living environment, and the degree of risk is not manageable within available community resources and services;
- has an urgent need for residential care services;
- has been investigated and treated for medical causes of disability and dependency that may have been remedial;
- has a caregiver living with unacceptable risk to their well-being, no longer able to provide care and support, or there is no caregiver available to the client;
- will accept the first appropriate bed where the client's preferred facility or location could not be accommodated on admission;
- has consented to admission to the facility, and has agreed to occupy the bed within 48 hours of notification of the availability of the bed, unless alternate arrangements are approved by the health authority; and
- has agreed to pay the assessed client rate (see Policy 7.B, Income-Based Client Rates) and any additional charges, as set out in Policy 6.F, Benefits and Allowable Charges.

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Client Characteristics for Long-Term Residential Care Services Options

Clients eligible for long-term residential care services include those who:

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

Reference

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

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SUBSECTION:	EFFECTIVE: OCTOBER 15, 2012

Intent

To describe health authorities' responsibilities in managing timely access to both short-term and long-term residential care services.

Policy

Health authorities must coordinate access to all residential care services consistent with the following:

- give priority for service to clients who have been assessed as having the highest care needs and/or the highest levels of risk; and
- determine which clients will have priority for admission to an available residential care bed, where assessment of need and urgency are equal; and

Health authorities must facilitate access to long-term residential care services consistent with the following requirements:

- manage access to residential care services and transfers of clients between residential care facilities, based on the preference of the client and the available resources in the community;
- ensure that a client has the opportunity to identify a preferred facility or location;
- manage, in an equitable manner, a client's transfer to a preferred facility where a client's request for a preferred facility cannot be met on admission;
- admit couples to the same facility where both members of a couple meet the eligibility criteria for residential care services, and when desired by the couple;
- develop a consultation process with a service provider to determine whether a residential care facility is appropriate for the needs of the client, and/or how the facility can address the needs of the client, where the service provider has requested that the placement decision be reviewed. This does not constitute an authority for a service provider to accept or reject specific clients. A client's specific diagnosis or a client's history of colonization or infection with a multiple antibiotic resistant organism is not, in itself, grounds to request a review of a placement decision; and

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- monitor continuously the status of clients approved and waiting for admission to residential care services including;
 - an increase in the availability and flexibility of community health supports and home support services;
 - a care plan that meets the needs of the client while waiting for placement; and
 - preparation and information regarding placement in residential care services.

Veterans Priority Access Beds

Veterans Affairs Canada priority access beds are beds designated by the Ministry and Veterans Affairs Canada for veterans who are eligible for a residential facility as set out in this manual and under the *Veterans Affairs Act*.

Health authorities must:

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

Eligibility for Federal Benefits

Veterans Affairs Canada will:

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

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Veterans' Priority Access Bed Waitlist

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

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

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

Non Resident Admissions

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

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

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

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Client Transfers between Health Authorities

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

The health authority where the client currently resides must contact the receiving health authority responsible for the facility or location requested and must:

- provide the most recent assessment to the receiving health authority;
- determine whether the client meets the access criteria for the residential care service requested; and
- provide the receiving health authority with full documentation to support the request.

The receiving health authority is required to:

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

Temporary Absences

A client may be temporarily absent from a residential care facility:

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

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

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

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

Reference

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

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SUBSECTION: 1 SUPPORTING SPOUSES WITH DIFFERING CARE NEEDS	EFFECTIVE: OCTOBER 15, 2012

Intent

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

Policy

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

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

Definitions

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

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

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

Reasonable Arrangements

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

Reasonable arrangements may include:

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

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SUBSECTION: 1 SUPPORTING SPOUSES WITH DIFFERING CARE NEEDS	EFFECTIVE: OCTOBER15, 2012

- identifying transportation options that may assist a non-driving spouse to visit the long-term care facility;
- identifying opportunities for accommodation for the non-eligible spouse in a nearby independent housing unit, apartment block, or other housing accommodation;
- considering any opportunities for co-location in a campus of care setting;
- considering any opportunities for co-location in an assisted living unit (see Policy 5.B.1 Assisted Living Services, Service Needs Determination).

Co-locating in a Residential Care Facility

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

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

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

Planning Meeting

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

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

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

Admission Agreement

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

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

The conditions of an existing admission agreement for the non-eligible spouse may be removed in the event that the non-eligible spouse is assessed to require residential care services. When this occurs, the spouse becomes a permanent resident of the facility and will not be subject to the first appropriate bed policy.

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SECTION: E ASSESSMENT	PAGE: 1 OF 1
SUBSECTION:	EFFECTIVE: OCTOBER 15, 2012

Intent

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

Policy

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

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

Reference

Residential Care Regulation

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SECTION: F BENEFITS AND ALLOWABLE CHARGES	PAGE: 1 OF 5
SUBSECTION:	EFFECTIVE: JANUARY 1, 2016

Intent

To clarify the benefits and chargeable items for clients receiving publicly subsidized residential care services.

Policy

Health authorities must ensure that service providers:

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

Definitions

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

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

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

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

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

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

Benefits Include:

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

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

Chargeable Items May Include:

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

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

PharmaCare

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

Special Services

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

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

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

References

Community Care and Assisted Living Act

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Continuing Care Act
Hospital Insurance Act
Residential Care Regulation
Wheelchair Policy Interpretation Guide, Ministry of Health, 2016

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SUBSECTION: 1 BASIC WHEELCHAIR BENEFIT	EFFECTIVE: JANUARY 1, 2016

Intent

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

Policy

Health authorities must ensure that service providers:

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

Definitions

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

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

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

Modified basic wheelchair is a basic wheelchair with appropriate adjustments, modifications and upgrades to cushion, armrests, and/or back, and excludes all physical (frame) and permanent alterations to the basic wheelchair. Modifications must be non-

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permanent so that the attributes of the basic wheelchair remain available for the next client who uses the wheelchair.

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

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

Wheelchair Benefits Include:

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

Chargeable Wheelchair Items May Include:

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

References

Wheelchair Policy Interpretation Guide, Ministry of Health, 2016

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SECTION: G CLIENT FUNDS AND BELONGINGS	PAGE: 1 OF 2
SUBSECTION:	EFFECTIVE: OCTOBER 15, 2012

Intent

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

Policy

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

Client Personal Needs Funds

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

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

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

Client Belongings

Health authorities must ensure service providers:

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

Reference

Residential Care Regulation Section Part 6

CHAPTER: 6 RESIDENTIAL CARE SERVICES	NUMBER: 6.G
SECTION: G CLIENT FUNDS AND BELONGINGS	PAGE: 2 OF 2
SUBSECTION:	EFFECTIVE: OCTOBER 15, 2012

Conflict of Interest

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

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

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

References

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

Hospital Act (Part 1, section 41)

CHAPTER: 6 RESIDENTIAL CARE SERVICES	NUMBER: 6.H
SECTION: H RESIDENT AND FAMILY COUNCILS	PAGE: 1 OF 1
SUBSECTION:	EFFECTIVE: OCTOBER 15, 2012

Intent

To describe health authorities' responsibilities to ensure that resident/family councils are encouraged and supported.

Policy

Health authorities must support the development of resident/family councils to promote the interests of clients and support the on-going role of family caregivers in residential care facilities by:

- providing meeting space, staff liaison and access to common information on the roles of councils and tools to develop or operate a council;
- identifying communication channels and encouraging collaborative relationships between staff, families and volunteers;
- providing information to assist the resident/family councils in functioning effectively and supporting a respectful and encouraging environment; and
- encouraging opportunities for resident/family councils to participate in regional education and networking opportunities.

Reference

Residential Care Regulation

CHAPTER: 6	RESIDENTIAL CARE SERVICES	NUMBER: 6.1
SECTION: I	RESIDENTS' BILL OF RIGHTS / PATIENTS' BILL OF RIGHTS	PAGE: 1 OF 1
SUBSECTION:		EFFECTIVE: OCTOBER 15, 2012

Intent

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

Policy

Health authorities must ensure that:

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

References

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

CHAPTER: 6 RESIDENTIAL CARE SERVICES	NUMBER: 6.J
SECTION: J MOVEMENT OF CLIENTS – CLOSURES OR RENOVATIONS	PAGE: 1 OF 2
SUBSECTION:	EFFECTIVE: APRIL 1, 2015

Intent

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

Policy

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

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

CHAPTER: 6 RESIDENTIAL CARE SERVICES	NUMBER: 6.J
SECTION: J MOVEMENT OF CLIENTS – CLOSURES OR RENOVATIONS	PAGE: 2 OF 2
SUBSECTION:	EFFECTIVE: APRIL 1, 2015

Health Authority Process

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

- a process for working with clients to provide opportunities for a care conference with health authority and facility staff, and to develop an individual placement plan;
- timely communication with the client, and an opportunity for follow up discussion of questions and concerns;
- a reasonable time frame for the client to plan for the relocation;
- a process to assess the client's needs and evaluate the suitability of their facility preferences; and
- a process to communicate the client's current clinical and special clinical needs to staff in the receiving facility.

Moving Costs

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

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

Retention of Benefits

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

Reference

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

CHAPTER: 6 RESIDENTIAL CARE SERVICES	NUMBER: 6.K
SECTION: K LARGE-SCALE STAFF REPLACEMENTS	PAGE: 1 OF 1
SUBSECTION:	EFFECTIVE: APRIL 1, 2015

Intent

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

Policy

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

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

Health Authority Process

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

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