Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé	**REGIONAL** Applicable to all WRHA governed sites and facilities (including hospitals and personal care homes), and all funded hospitals and personal care homes. All other funded entities are excluded unless set out within a particular Service Purchase Agreement.		Level: 1
POLICY	Policy Name: **Personal Care Home Bed Cancellation**	Policy Number: 110.130.080	Page 1 of 4
	Approval Signature: *Original signed by Tara-Lee Procter*	Section: CLINICAL / PROGRAM SERVICES	
	Date: September 2023	Supercedes: February 2014	

1.0 PURPOSE:

1.1 To define the collaborative process under which a personal care home (PCH) bed shall be cancelled when a Resident is in hospital and their Care Plan and ongoing care needs exceed the care that can be safely managed in their PCH.

1.2 To promote appropriate and effective use of PCH beds.

2.0 DEFINITIONS:

2.1 Care Plan: A document that outlines the care to be provided to the Resident that includes their individual physical, social and emotional needs. Care Plans provide guidance to the Resident's Health Care Team so they can effectively care for and meet the needs of the Resident. The Care Plan is developed collaboratively with the Resident and/or their family and it is informed by ongoing comprehensive assessments of the Resident's needs. The Care Plan is communicated with appropriate Health Care Team members, including Caregivers as appropriate.

2.2 Chronic Care: Chronic Care provides specialized care to individuals who have long-term, complex medical conditions or disabilities that require medical intervention, skilled care, and access to resources not available in the community or PCH.

2.3 Continuing Care Operations Leader: Provides operational expertise and leadership in the areas of Resident-centred care, patient flow, client relations management, education and research. The Continuing Care Operations Leader engages in collaborative planning and coordination with Continuing Care, Community and Hospital partners regarding service delivery processes.

2.4 Health Care Team: May include the Resident's nurses, nurse managers, physician or nurse practitioner, health care aides, allied health professionals, and support staff.

2.5 Hospital Leave: The period of time a Resident is absent from the PCH for the purpose of obtaining treatment in hospital.

2.6 Long Term Care (LTC) Access and Complex Care Manager: Manager responsible for overseeing the delivery, planning and evaluation of services provided to clients by the Long Term Care (LTC) Access Centre.

2.7 Long Term Care (LTC) Access Coordinator/Navigator: The person responsible for coordinating and completing the assessment application for LTC placement.

2.8 Patient Flow Contact: A member of the Health Care Team in hospital whose role is dedicated to management/leadership functions which support organizational patient flow policies and practices.

2.9 Resident: Any individual, patient, client, or Resident living in a long term care facility.

2.10 Residential/Authorized Daily Charge: The daily fee paid by the Resident directly to the PCH as determined by Manitoba Health.

2.11 Special Needs Behaviour Unit: Specialized units for PCH Residents with severe responsive behaviours secondary to a previously diagnosed cognitive disease or disorder which put themselves or others at risk.

2.12 Special Needs Unit: A secure unit serving Residents with more intensive care needs which may include, but are not limited to, individuals with cognitive disease or disorder exhibiting moderate responsive behaviours impacting their ability to fit safely within the regular PCH environment.

2.13 Substitute Decision Maker (SDM): An identified third party who participates in decision making on behalf of an individual who lacks capacity. The task of a Substitute Decision Maker is to faithfully represent the known preferences, or if the preferences are not known, the interest of the individual lacking capacity. Link to full policy: https://policies.wrha.mb.ca/policy/415/regional/3080/110-000-005-informed-consent-for-procedures-treatments-and-investigations.pdf

3.0 **POLICY:**

3.1 The Resident shall return to the PCH, once treatment in hospital is complete and the Resident's Care Plan and ongoing care needs can be safely managed at the PCH.

3.2 There shall be ongoing communication and consultation between a designated Health Care Team member in hospital and a designated Health Care Team member at the PCH, at a minimum of every 21 days during the Hospital Leave.

3.3 The PCH social worker or designate shall advise the Resident or SDM that they are responsible to continue to pay the Residential/Authorized Daily Charge to the PCH during the Resident's hospital admission.

3.4 For Residents receiving Employment and Income Assistance benefits from the Government of Canada to pay their Residential/Authorized Daily Charge, approval shall be received from the Department of Families to extend payment past the initial 21-day period.

3.4.1 The PCH social worker or designate shall be responsible for notifying the Department of Families of the Resident's hospital admission and any need for extension of payment.

3.5 The PCH bed shall not be cancelled without consultation between the designated Health Care Team member at the PCH, the Hospital Patient Flow Contact, the LTC Access and Complex Care Manager, Continuing Care Operations Leader, the Resident and/ or SDM and any other agency involved in the Resident's care.

3.6 The PCH bed shall be cancelled when the Resident's Care Plan developed by the hospital Health Care Team and their ongoing care needs exceed the care that can be safely provided in the PCH.

4.0 **PROCEDURE:**

4.1 If at any time during the Hospital Leave, the Resident's Health Care Team at the PCH has concerns that the Resident's health condition, new functional baseline, and Care Plan developed at the hospital cannot be safely managed at the pre-admission level of care, there shall be a collaborative discussion between the designated Health Care Team member of the PCH, Hospital Patient Flow Contact or designate, the LTC Access and Complex Care Manager and Continuing Care Operations Leader to obtain information related to the Resident's current Care Plan and trajectory of care.

4.1.1 The PCH social worker or designate and Hospital Patient Flow contact or designate will work collaboratively to inform the Resident and their SDM about the Resident's current Care Plan, ongoing care needs, and possible outcomes.

4.2 In the course of the collaborative discussion referenced in 4.1:

4.2.1 If it is determined that the Resident's Care Plan developed at the hospital and their ongoing care needs can be safely managed at the PCH, the designated Health Care Team member of the PCH, Hospital Patient Flow Contact or designate, and the LTC Access and Complex Care Manager shall discuss the potential date that the Resident will return to the PCH.

4.2.2 The Resident shall return to the PCH when acute care treatment is complete and there are no anticipated changes to the Care Plan.

4.2.3 If it is determined that the Resident's Care Plan developed at the hospital and their ongoing care needs exceed the care that can be safely managed in the PCH, the LTC Access and Complex Care Manager shall confirm the date the PCH bed shall be cancelled in consultation with the PCH Social worker or designate and Hospital Patient Flow Contact or designate.

4.2.4 The PCH social worker or designate shall communicate to the Resident and/or their SDM the rationale and decision to cancel the PCH bed.

4.3 The Hospital Patient Flow Contact or designate shall facilitate a consult, for the Resident whose PCH bed has been cancelled, to the LTC Coordinator/Navigator when the Resident no longer requires treatment in an acute care environment and is ready for disposition planning.

4.3.1 LTC Coordinator/Navigator shall reassess the Resident's level of care and eligibility for LTC placement (e.g., Chronic Care, Special Needs Unit, Special Needs Behavior Unit, another PCH).

5.0 **REFERENCES**:

5.1 Employment and Income Assistance Programs, Entrepreneurship, Training and Trade Policy #20.1.5 Rates for Participants in Personal Care Homes During a Temporary Absence from Placement https://www.gov.mb.ca/fs/eia_manual/20.html#2015

5.2 Manitoba Health. Application/Assessment for Long Term Care (2007).

5.3 Manitoba Health Policy HCS 205.7 Personal Care Homes Admission and Separation (2012).

5.4 Residential Charges Rate Table - Personal Care Services | Health | Province of Manitoba (gov.mb.ca)

Policy Contact:

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