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		Operational Procedure Number 5:01
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DEPARTMENT		Client Services
SUBJECT		Assessment /Reassessment Process
APPROVED BY (Signature)	**CHIEF EXECUTIVE OFFICER**	**Jennifer Hammond, RN, BScN**
APPROVED DATE		June 2009
REVIEWED BY (Title & Signature)		Anne Winacott Client Service Manager
REVIEW DATE		November 2017

OPERATIONAL PROCEDURE

Procedures

Personal Attendant Care Inc. must gather essential client information prior to commencement of service. Initial and continuous client assessments are important to establish care requirements and ensure Personal Attendant Care Inc. is providing safe, quality care to all clients.

Potential Eligibility for Services / Client "Direction of Care"

Upon receipt of the Referral and Application form the Intake Coordinator/Designate is responsible for:

- Contacting the applicant within three days to confirm receipt and determine potential eligibility completing the Referral Screening form;
- To apply for services the client must meet the following criteria:
    - Have a permanent disability;
    - Sixteen (16) years of age or older;
    - Require personal care (bathing, dressing, toileting etc.);
    - Able to direct own services.
- Entering the applicant's information in the scheduling software under the REF-SHORT note;
- Potentially eligible applicants are booked out with a Client Service Supervisor/Designate for a home assessment within 7-10 days;
- REF-SHORT note updated for status: Eligible, Ineligible, Hold (booked out for home assessment) per PAC Referral/Waitlist Process;
- If ineligible contact referring agency and refer to other agencies in the community;
- Completion of Service Plan based on information provided on Referral/Application and assessment package prepared and forwarded to the applicable Client Service Supervisor/Designate for home visit.

Initial Assessment

- Potentially eligible referral booked for an appointment to complete the initial assessment (approximately one (1) hour required);
- Upon completion of initial assessment:

Ineligible for PAC service:

1. Return file to office;
2. Update Ref-Short Note status as "Ineligible";
3. Scan Referral/Application form and Priority Screener and attach document in Gold Care;
4. Shred information in step 3.

Services available (immediate):

1. Priority rating at assessment (1 –immediate need) and current human resources available are used to determine;
2. Update Ref-Short note as "Eligible";
3. Admit to Expanded Wait List;
4. Admit to PAC Outreach program;
5. Daily Living services (provide regular schedule of consistent staff) entered and the admission portion of the Admission/Transition/Discharge form completed;
6. Forward file to Scheduler/designate to update any outstanding information in Gold Care, Service Plan, Priority code; Client Summaries on Network, mail the Service Plan/Medication List (2 copies) and communication letter (refer to Intake Assess & Reassess Check List for detailed list).

Services not available (wait-listed);

1. Priority rating at assessment (1 –immediate need) and current human resources available are used to determine;
2. Notify wait listed, assist to complete a community service partner referral;
3. Update Ref-Short note as "Eligible";
4. Admit to Expanded Wait List;
5. Follow up by Intake Coordinator / Designate every two months until potential client is admitted to PAC Outreach program. Note another home assessment may be required before admission;
6. Complete a Priority Screener to confirm if any change in status;
7. Assist to complete a community partner service referral.

Initial Assessment Continued

- Supervisors/designate will ask potential client to present their health card on their first visit to the client's home to protect against mistaken identity and confirm identifying information such as sex, date of birth, name, address and phone number are correctly documented on the Service Plan.
- Completion of Priority Screener for Services, including date and signature at commencement of assessment to confirm eligibility and service priority; if ineligible assist to complete applicable community partner service referral(s). Do not complete the rest of the assessment. Return file to office and refer to "Ineligible for PAC Service" on page 2 of this procedure;
- Client Service Supervisor or Designate to provide a Personal Attendant Care Inc. folder and review the following with each applicant at the time of the assessment:
    - Discuss is the individual able to establish a Contingency Plan and activate it when requested by Personal Attendant Care;
    - Is the individual able to cognitively understand Personal Attendant Care's Responsibility Statement, Consent and Authorization and develop their Service Plan;
    - Is the individual able to sign or direct appropriate person to sign if he or she is not physically able to sign;
    - A business card for the appropriate Client Service Supervisor;
    - Home Care Bill of Rights, 4 Moments for Hand Hygiene, 4 Safe Food Handling Practices Checklist, Fire Safety Tips, Home Safety Checklist (includes Fall Prevention tips), Take It Back (medication/sharps information);
    - Forms –Equipment Check, Client Progress Notes and Client Service Reports;
    - Development of Service Plan with potential client or designate;
    - Review ability to complete ADL's, ambulation and how they transfer;
    - Review of current and/or additional service requirements such as Respite, Physiotherapy, Occupational Therapist, Meals on Wheels), assist or make referrals to community partners;
    - Review, Date and Signature on the Authorization to Collect, Use and Release Personal Health Information (yellow copy remains in client folder);
    - Review Responsibilities Statement;
    - Confirm if they have an e-mail address to send bi-weekly schedule;
    - Complete, date and signature of List of Current Medications;
    - Health and Safety Inspection of home documented on the Risk and Safety Assessment Check. Risks/concerns identified are addressed with client/family prior to commencement of services (yellow copy remains in client folder);
    - Leave Client Folder in home, recommend to review and contact if any further questions or clarification required;
    - Inform client a follow up call will be conducted to notify when services will commence and the status on any referrals made on their behalf;
    - Inform client once commenced they will receive a completed Service Plan and Medication List (2 copies – 1 for home folder and 1 for their wallet). R

- Request they review and contact Client Service Supervisor with any errors or omissions;
- Return file to office and refer to "Services Available Immediate and/or Services Not Available" on page two of this procedure.

Re-assessment

The client Service Supervisors are responsible for completing re-assessments *annually* for each client:

- Supervisors/designate will ask client to present their health card on their first visit to the client's home to confirm correct with number on file;
- Completion of Priority Screener for Services, including date and signature at commencement of assessment to confirm still eligible and correct service priority;
- Client Service Supervisor or Designate to provide a Personal Attendant Care Inc. folder and review the following with each applicant at the time of the assessment:
    - A business card for the appropriate Client Service Supervisor;
    - Home Care Bill of Rights, 4 Moments for Hand Hygiene, 4 Safe Food Handling Practices Checklist, Fire Safety Tips, Home Safety Checklist (includes Fall Prevention tips), Take It Back (medication/sharps information);
    - Forms –Equipment Check, Client Progress Notes and Client Service Reports;
    - Discuss is the individual able to establish a Contingency Plan and activate it when requested by Personal Attendant Care;
    - Is the individual able to cognitively understand Personal Attendant Care's Responsibility Statement, Consent and Authorization and develop their Service Plan;
    - Is the individual able to sign or direct appropriate person to sign if he or she is not physically able to sign;
    - Assessment of current and/or additional service requirements (i.e. additional hours, Respite).
    - Review of current Service Plan and development / changes required to meet needs. Review ability to complete ADL's, ambulation and how they transfer;
    - Review, Date and Signature on the Authorization to Collect, Use and Release Personal Health Information (yellow copy remains in client folder);
    - Review Responsibilities Statement;
    - Complete, date and signature of List of Current Medications;
    - Health and Safety Inspection of home documented on the Risk and Safety Assessment Check. Risks/concerns identified are addressed with client/family prior to commencement of services (yellow copy remains in client folder);
    - Leave Client Folder in home, recommend to review and contact if any further questions or clarification required;
    - Inform client a follow up call will be conducted to notify when any additional services will commence with PAC, or the progress on any referrals made on their behalf i.e. other community partners for additional hours or Occupational Therapist etc.;

- Inform client they will receive a completed Service Plan and Medication List (2 copies – 1 for home folder and 1 for their wallet). Request they review and contact Client Service Supervisor with any errors or omissions;
- Return file to office- organize the client chart file and update information systems.

Respite

Respite care is defined as caregiver relief. Respite hours are a temporary service with personal support, assisting at medical appointments, homemaking, meal preparation and companionship provided to relieve the primary caregiver(s). Respite hours are available in a block of a minimum of 3 hours. Personal Attendant Care Inc. ensures each client/caregiver has equal access to the Respite care.

Primary caregiver is defined as the family member or other individual who is an informal provider of care and who is available to assist client with their personal care and homemaking tasks when other services are not available.

Personal Attendant Care will provide respite care for eligible clients within the available resources, financial and staffing. Respite care is defined as, temporary assistance with personal support, homemaking service and companionship as a result of clients' primary support person being unavailable to provide assistance and caregiver relief.

Personal Attendant Care Inc. provides Respite to:

- Help to reduce or alleviate stress on the client's primary caregiver, and help prevent caregiver burnout/fatigue;
- Allow the primary support person the opportunity to take care of his or her own needs;
- To aid in the client's ability to remain in their own home and or help prevent move to institutional care.

Eligibility for Respite:

- Current client;
- The client must direct their own care;
- Hours of care are within the time frame agreed upon between the organization and the caregiver;
- A maximum request of 3 hours per day for duration of no longer than a 2 week period per request;
- Respite services will be reevaluated at the completion of the 2 week period. There is no guarantee of extension;
- There is a maximum of 56 hours per year, per client;
- All respite service requests will be implemented on a first come, first serve basis; determined with in the financial parameters of the organization;
- Need for primary support person (care giver) relief has been identified in writing on the Respite Request Care form or e-mail from Supervisor to Schedulers/Customer Service;
- Respite hours are scheduled outside of the maximum allowable hours per month per client.

The Client Service Supervisor will:

- In consultation of the primary support person, establish the respite care. The care will be documented in the client's file and the information given to the attendant if the tasks differ from what is indicated on the Client Service Plan.
- If resources for respite care are not available to the client at the time of the request, the client may be offered an alternative time. If time does not coincide with the client's need the Client Service Supervisor will make a referral to the appropriate community agency.

Organizing Client File

Client files are organized using the following format:

- Documentation for the client file will be placed in a letter-sized brown file folder equipped with paper fasteners on either side of the file. All documentation will be placed in reverse chronological order.
- The client's name will be written on a label with surname followed by given name and the file is then placed in the Client File Room (files locked after hours).
- Forms placed on the right-hand side of the file as follows:
  - Personal Attendant Care Referral and Application Form;
  - Referral Screening Form;
  - Priority Screener for Services;
  - Risk and Safety Assessment Check;
  - Authorization to Collect, Use and Release Personal Health Information;
  - Responsibility Statement;
  - Service Plan.
- Forms/documents placed on the left-hand side of the file as follows:
  - CE CCAC Assessment Tool (if applicable);
  - Correspondence to and from client / family;
  - Correspondence to and from referral source;
  - E-mails;
  - Internal memos;
  - Ongoing written documentation;
  - Client / Worker Exemption;
  - Complaint Report;
  - Client Incident Report;
  - Potential Health and Safety Audit;
  - Client Survey;
  - Additional Client Care;
  - Client Admission/Transition/Discharge;
  - List of Current Medications;
  - Respite Care requests;
  - Client File Audit.

- Each client file is audited once per year to ensure being maintained in a standardized and consistent manner. The designated staff will audit on a monthly basis utilizing the Client File Audit Checklist Form.

- Any omissions and misplacement of items within the file are noted on the checklist and reviewed and adjusted accordingly by the Client Service Supervisor.
- The Client Service Manager and/or Chief Executive Office reviews and upon approval forwards to the designated personnel to maintain originals in the Client File, and updates the master File Audit spreadsheet.

Service Plan

The Client Service Supervisor will establish Service Plan in collaboration with the client and/or client's family and/or designate to provide safe and reliable pre-scheduled service for all clients. This will initially be completed at the commencement of services with Personal Attendant Care Inc. The Service Plan will be reviewed at the annual re-assessment and as the needs of the client change.

The Client Service Supervisors/designate are responsible for the following:

- Updating new or additional information to the Service Plan immediately. A copy will be mailed for the client's home folder, updated on network and copies placed in the client file, Client Service Plan Master Binder, and to all Personal Support Workers who provide regular service to client.

- The Service Plan will contain the following information:
  - Full Name
  - Client number
  - Phone number
  - Address
  - E-mail address
  - Directions
  - Access to home/lockbox code
  - Gender
  - Date of birth
  - Weight and height
  - Diagnosis and secondary diagnosis(s)
  - Lifeline/ Falls Risk;
  - Cultural Specific Needs;
  - Identify as indigenous, francophone, visible minority;
  - Primary and secondary languages
  - DNR (Do Not Resuscitate Order)
  - Lifeline
  - Allergies
  - Living arrangements and primary caregiver
  - Client Goals
  - Day/range/length/service description
  - Emergency and Contingency contact information

- Service information such as the day, range of time and length will be included. Specific client care will be noted. If requests from client differ greatly from the information on the Service Plan, the Client Service Supervisor must be notified.
- Clients specific care needs are documented under the following titles; Sensory/Communication, Mood and Behaviour, Infectious Disease, Pain, Mobility/Ambulation, Transfers/Equipment, Service Needs, Skin Integrity, Assistance required for ADL's.

- Service Plan identifies if a Risk and Safety Assessment Check has been completed and risks identified and any precautions required.
- If transferable skills are required they are identified and documented on the Transferrable Skills form, which identifies all transferable skills required to complete care, details provided if skill required and Personal Support Workers who have been trained to provide transferable skills will be listed.
- Both the client and the Client Service Supervisor will review the Service Plan at the time of the assessment/re-assessment.
- The Personal Support Workers are responsible to ensure they have Service Plans for all clients on their schedule.

Client Satisfaction Surveys

Annual surveys are completed to evaluate the service, the organization and the staff. The survey is designed to identify:

- Client expectations;
- Identify and monitor concerns;
- Monitor the quality of care received by clients;
- Provide feedback for administrative planning in order to initiate organizational improvements.

- In October of each year, a survey will be sent by regular mail and/or electronically to each client.
- All completed surveys will be confidential and returned to the attention of the Chief Executive Officer.
- If applicable, follow-up phone calls can be requested from the Chief Executive Officer.
- Review of surveys and results to be completed by Chief Executive Officer and reviewed by the Management team.
- A report of the results will be communicated to employees/clients via regular mail and/or e-mail.
- Chief Executive Officer will provide an overview of the survey results to the Board of Directors.

Attached Forms

Admission/Transition/Discharge	5(c)	Progress Notes	5(h)
Authorization to Collect Consent	5(e)	Referral and Application Form	5(a)
Client/Worker Exemption	5(o)	Referral Process Flow Chart	5(b)
Client File Audit Checklist	5(l)	Referral Screening Form	5(z)
Client Incident Report	4(p)	Respite Request	5(g)
Client Satisfaction Survey	5(p)	Responsibility Statement	5(q)
Client Service Report	5(i)	Risk and Safety Check	4(k)
Complaint Report	4(c)	Service Plan	5(d)
Equipment Check	4(d)	Transferrable Skills	5.1(j)
Potential Health and Safety Audit	4(i)		
Priority Screener for Services	5.1(h)		

Attached Documents

Home Care Bill of Rights	
Screening Tips Tools for New Referrals	5(a)
PAC Referral / Waitlist Process	5.1(i)
Intake Assess/ Reassess Check List	5.1(m)