Program Guidelines for Special Care Homes

Revised July 2021

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Introduction:

The *Facility Designation Regulations, s. 17 (2)(3)*, require that all special-care homes and other designated facilities (i.e. hospitals, health centres, community beds) that provide long-term care shall offer long-term care in accordance with the *Program Guidelines for Special-care Homes.*

The *Program Guidelines for Special-care Homes* July 2021 replaces all former versions, including those published in 2013 and 2016.

The *Program Guidelines for Special-care Homes* are considered the minimum standards of care in special-care homes and are intended to provide a means for internal and external review to ensure good quality of care and guide continuous quality improvement.

While the *Program Guidelines for Special-care Homes* is an integral part of the requirements regarding the operation and provision of quality care, the Saskatchewan Health Authority is responsible for the observance of, and compliance with, other regulatory requirements and policies pertaining to the delivery of long-term care services.

Compliance with these guidelines will be assessed at regular intervals through a variety of mechanisms including resident and family experience surveys, monitoring of quality indicators, senior leadership tours, resident chart and home/facility audits and on-site compliance reviews. Additional compliance measures may be introduced as required to measure and monitor performance and compliance.

The *Program Guidelines for Special-care Homes* consists of three sections: 1) standards that form the basis for delivery of safe and quality care, 2) recommended operational policies, and 3) requirements set out in other legislation.

Philosophy:

Special-care homes and other facilities providing long-term care services in Saskatchewan, shall offer long-stay (permanent) and/or short stay care in a home that strives to provide resident-family centred care in a home-like setting.

Resident-family centred care is an approach to providing respectful, compassionate, culturally safe and competent care in a home-like setting. Care provided is responsive to the values, cultural backgrounds, beliefs and preferences of the residents and their family members. When staff work collaboratively with the resident, the resident is encouraged to make decisions affecting his/her care, feel included, and encouraged to participate in the activities offered.

Definitions and Interpretations:

The interpretations contained in this document are intended for use with the *Program Guidelines for Special-care Homes.*

Adult Day Program - A program where residents are provided with support for social and recreational activities and assistance with activities of daily living during a defined period and defined number of days per week. Basic services shall include snacks and a balanced lunch or supper meal, personal care (baths, nail care, etc.) nursing care and social and recreational care (rest periods, exercise, etc.). Typically the resident resides in their own home and this program provides caregiver relief.

Advance Care Planning/Health Care Directive - Instructions given by a person pursuant to the *Health Care Directives and Substitute Health Care Decision Makers Act* that deal with the person's health care decisions, with the appointment of a proxy or with both. A directive takes effect when the person making the directive does not have the capacity to make a health care decision respecting a proposed treatment.

Care Plan - A written or electronic document developed by the multi-disciplinary team that includes a resident's assessed unmet health care needs, goals and interventions to address their needs.

Convalescent Care - The provision of an additional period of recuperative time following surgery or serious illness intended to provide the person with the opportunity for recovery of health and independence in order to return safely to their community setting.

Discharge Abstract Database (DAD) - A national database maintained by the Canadian Institute for Health Information (CIHI) that captures administrative, clinical and demographic information on hospital discharges (including deaths, sign-outs, and transfers). For information on requirements for reporting to DAD please refer to the DAD Abstracting Manual and the Canadian Coding Standards for ICD-10-CA and CCI.

Emergency Respite Care - Offers a temporary period of care to persons who normally reside at home and for whom there is a sudden and unplanned breakdown in the support network.

Enduring Power of Attorney - A legal document that appoints another person to make financial and legal decisions on behalf of a resident and meets the requirements of the *Power of Attorney Act.*

Health Care Organizations - Includes an affiliate or a prescribed person that receives funding from the Saskatchewan Health Authority to provide services.

Long Stay Care - A service for persons who require 24-hour nursing care and supervision for an indefinite period of time. There is generally no expectation of discharge to the community, except in the case of long stay temporary care requiring an extended restorative treatment/recovery period in excess of three (3) months. These beds are often referred to as permanent placement beds.

Night Care - A planned period of temporary care at night to persons who normally reside at home, and who are dependent on family/community members for intermittent or continuous care. This may be offered as emergency temporary care to persons who normally reside at home, and for whom there is a sudden and unplanned breakdown in the support network.

Nursing Procedures - Nursing procedures that are taught as part of the nursing education programs for registered nurses, registered psychiatric nurses, and licensed practical nurses, where students acquire both the knowledge and clinical practice needed to perform competently.

Palliative and End of Life Care - Is an approach that improves the quality of life of families and residents facing a life-threatening illness, through the prevention and relief of suffering by early assessment and treatment of pain and other problems including, physical, psychosocial and spiritual.

Rehabilitative Care - Restoration following disease, illness, or injury to the highest possible level of function. In addition to medical care, access to physiotherapy, occupational therapy, speech language therapy and other therapies whose main objective is to restore function and return to the community.

Resident - An individual that resides in a home, providing long-term care services, for the purpose of long stay care or temporary care.

Resident/Family Partnerships/Councils - A group of residents and family members from the same home, whom meet on a regular basis to improve the quality of life of the residents and identify and address concerns.

Respite Care - Offers a planned period of temporary care to persons who normally reside at home and who are dependent on family members in the community for intermittent or continuous care.

Responsible Person – A person legally authorized to act on behalf of the resident. Should a responsible person not be specified then the nearest relative should be considered as the person that will act on behalf of the resident. Nearest relative is interpreted to be legal spouse/common law partner, son or daughter, parent, brother or sister, grandparent, grandchild, uncle or aunt, nephew or niece.

Responsive Behaviors - When a person with dementia is responding to an unmet need which may include positive and negative, frustrating, stimulating or confusing interactions in his or her environment. The reasons or triggers for these challenging behaviors may be external, social, physical or personal in their environment.

Restraint - Any measure, including pharmacological, environmental, mechanical or physical, that is used with the intention of protecting a resident from self-harm or harming others.

Short Stay Care - The provision of care that occurs for a short time period including, but not limited to palliative, respite, convalescent and rehabilitative care.

Special-care Homes - A designated facility that provides personal or nursing care to individuals who reside in the home on a temporary or permanent basis. The home may provide any of the following types of care: convalescent care; rehabilitation services; palliative care; respite care; and day programming. Special-care homes are operated by the Saskatchewan Health Authority or by a provider that has a contract with the Saskatchewan Health Authority. Special-care homes may be referred to as "homes" in the *Program Guidelines for Special-care Homes*.

Special-Care Home System (SCHS) - Is a web-based system maintained by Ministry of Health that records the admissions and discharges for the homes' residents and supports provision of income information to proceed with the income-testing process.

Section I: Standards

This section outlines minimum standards that special-care homes are expected to meet.

1.1.0 ADMINISTRATION

1.1.1 Eligibility and Placement:

a) Eligibility for long-term care is available to:

i. Applicants who hold a valid Saskatchewan Health Services Card;

ii. Where the applicant and, where applicable, his/her spouse is in the process of establishing permanent residence in Saskatchewan and have applied for and qualify for a Saskatchewan Health Services Card. There is no residency requirement to move into a special-care home in Saskatchewan; or,

iii. The applicant is a resident of Manitoba or Alberta in a border area where the Ministry of Health has approved a contractual arrangement.

b) Eligibility shall include:

i. Completion of an assessment process approved by the Ministry of Health that determines the client needs; and,

ii. An attestation that all community and/or home-based services have been explored and do not appropriately meet the client's needs.

c) Placement shall consider:

i. Level of need and the risk of the resident's current living arrangement;

ii. Placement in or near the home community whenever possible;

iii. Option to remain in the community until there is a bed in the home of choice; and,

iv. Prioritized placement in the same home for married/common-law couples.

Further Clarification:

Individuals requiring long-term care that are not Canadian citizens or permanent residents and do not qualify for a Saskatchewan Health Services Card will be charged the full cost of care until they are eligible for a Saskatchewan Health Services Card.

1.1.2 Coordinated Access:

Residents shall move in through a process coordinated through the Saskatchewan Health Authority (SHA).

Further Clarification:

a) Residents shall be prioritized based on greatest assessed need and those living at greatest risk.

b) Appropriate services shall be offered using a case management approach.

c) Residents shall be placed in homes that can safely manage their care needs.

d) Special-care homes shall not deny admission to individuals that smoke.

1.1.3 Appeal Process:

The SHA shall establish an appeals process that allows residents the right to appeal eligibility for placement in long-term care, and designation of end-stage palliative care status upon move-in. Appeals must be responded to in writing within 60 days of receipt.

Further Clarification:

a) Appeals must be heard by individuals not involved in the original decision; and,

b) Decisions must include viable options to assist clients in remaining in their home community when possible.

1.1.4 Move In Agreement:

Special-care homes shall have a move in/financial agreement that includes the rights and responsibilities of both the resident and the home.

At minimum, the agreement shall include resident charges, additional charges, roles and responsibilities of resident and home, process for collecting accounts in arrears, appeals processes, protection of personal health information and concern handling processes.

If amendments to the move in agreement are required, any changes made to the agreement must be made on the original document and signed by both parties.

1.1.5 Consent:

Each special-care home shall have a consent policy that sets out consent for move-in/end-of-service from the home and consent for all treatment and procedures.

Further Clarification:

a) Resident's consent is to be documented in the resident's chart.

b) Consent is to be confirmed prior to each treatment and/or procedure.

c) Residents have the right to accept or reject any health care interventions.

1.1.6 Resident Transfers:

Transfers between homes will be facilitated through the SHA and each home shall have a consistent transfer policy. There shall be a consistent process for the transfer of residents from one home to another home, and from the home to the hospital or other health care facility.

Further Clarification:

a) Transfer to another home:

   i. If a resident has been offered a bed in a home that is not their home of choice, they will be given the option to transfer to the home of their choice when a bed becomes available in the home of choice;

   ii. The resident/responsible person shall be notified in advance and arrangements made for the transfer of the resident and their belongings, if the bed in the home of choice is accepted by the resident;

   iii. The resident/responsible person shall be consulted regarding mode of transportation. If an ambulance is required due to the care needs or condition of the resident, the resident/responsible person is to be informed if ambulance fees will be the responsibility of the resident; and,

   v. The sending home is to notify the receiving home with transfer timelines and care plan needs prior to sending resident.

b) Transfer to hospital or other health care centre:

   i. It is the expectation that the resident will continue to maintain their room in the home until such time it is deemed that the resident will be unable to return to the home. During a resident's absence the room shall not be used for the accommodation of another resident without consulting the resident/responsible person;

   ii. If the resident/responsible person requests a transfer to a hospital or other health care centre for care/treatment, they shall be supported with the transfer and the attending physician or registered nurse (nurse practitioner) shall be notified;

   iii. When appropriate the responsible person shall be notified immediately of the need to transfer a resident to hospital or other health care centre;

   iv. If an ambulance is deemed to be the preferred method of transfer, the resident/responsible person is to be informed of the mode of transfer and if ambulance fees will be the responsibility of the resident; and,

   v. The sending home is to notify the hospital or other health care centre of transfer timelines and changes in care needs prior to sending resident.

c) Transfer for medical or other health related appointments:

   i. The resident/responsible person shall be consulted regarding mode of transportation;

   ii. Where the resident requires an individual to accompany them to their appointment the responsible person shall be contacted and accompany the resident, unless the physician or RN/NP has ordered a care provider to accompany the resident; and,

   iii. The sending home to call receiving home/facility with transfer timelines.

A communication process to ensure residents arrive and leave facilities safely shall include, but not be limited to:

a) When a resident is being transferred **to** a home from another facility (hospital, health centre, another home, etc.), the home shall ensure that specific details about expected arrival time and transportation are received from the transferring home/facility.

   i. If a resident does not arrive at the home at the anticipated time, the transferring home/facility will be contacted to confirm the transfer has occurred. If the resident is not located, the emergency preparedness procedure for a "Missing Resident" shall be activated.

b) When a resident is being transferred **from** a home to another home/facility (hospital, health centre, another home, etc.), the home shall provide specific details about expected arrival time and transportation to the receiving home/facility.

   i. If the home does not receive confirmation of the resident's arrival at the receiving home/facility at the anticipated time, the home shall contact the receiving home/facility to ensure the resident's arrival. If the resident is not located, the emergency preparedness procedure for a "Missing Resident" shall be activated.

c) Documentation of the communication plan will be completed on the resident chart.

1.1.7 End of Service:

Where a long-stay care resident returns to the community, the home shall facilitate the transition by working with community partners (such as home care, physio, day programs, etc.) to meet the resident's care needs in the community.

Further Clarification:

1) Where a resident had been transferred to a hospital or health centre, they shall not be discharged from the home, as the home will hold the bed for the resident, until the home is advised that the resident will not be returning to the home.
    i. Where the resident does not return to the home from a hospital visit, the discharge date becomes the day the resident was transferred to the hospital. This is specific to requirements under *The Vital Statistics Act* and *Regulations*, and does not affect the home's ability to continue to collect fees for a bed being held, where the resident has been transferred to a hospital or health center.
2) Where a resident chooses to return to the community, the home must include in their documentation on the resident's care record:
    i. The current status of the resident;
    ii. Counselling and alternative care options discussed to meet current care requirements of the resident; and,
    iii. If relevant, note that the resident/responsible person elected to self-discharge against medical advice.

1.1.8 Referral to Another Home due to Resident's Care Needs:

Special-care homes shall have a process to facilitate the transfer of a resident to an alternate home when a resident's care needs exceed the capabilities of the current home.

Further Clarification:

This transfer process shall include, but not be limited to:

a) Resident placement in homes that have the appropriate environment to safely and adequately accommodate their care needs resulting in quality outcomes, while maintaining resident quality of life;

b) Consultation with other programs and services to determine appropriate placement options should the resident's care needs exceed the services offered by the home;

c) Timely assessment and transfer of residents at risk that have care needs beyond the scope of the resident's current home;

d) Provision of safe and adequate care in the current home temporarily where there is no home immediately available to accept the resident transfer; and,

e) Timely notification of the resident and the responsible person where there is the potential for transfer so they can participate in the transfer as appropriate.

1.1.9 Resident Abuse:

Special-care homes shall provide an environment that is free from all forms of abuse and shall have a policy that defines abuse and includes processes for reporting, investigating, and follow up.

Further Clarification:

The policy shall:

a) Indicate that abuse, in any form, is unacceptable and will not be tolerated, as well as strategies to mitigate and eliminate the risk of resident abuse;

b) Validate that any instance of abuse is subject to reporting as per *The Saskatchewan Critical Incident Reporting Guideline, 2004* as outlined in *The Critical Incident Regulations, 2016;*

c) All employees shall be trained and responsible for promptly reporting any and all evidence or suspicion of abuse;

d) Have clear processes outlined to support reporting, investigating, and follow up, including communication with family members; and,

e) Indicate that instances of criminal abuse shall be reported to law enforcement agencies.

1.1.10 Resident Trust Account and Safekeeping of Valuables:

Special-care homes shall safeguard resident trust accounts and valuables and have a policy and procedure concerning how breeches are investigated and concluded.

Further Clarification:

a) Where a home accepts the responsibility of safekeeping of resident's valuables and/or having resident's petty cash entrusted to their home, it shall be directed and administered consistently to ensure security and accurate record keeping.

b) Residents and responsible persons can access their valuables and record of transactions when requested.

1.1.11 Resident and Family Councils:

Special-care homes shall have resident and family councils to ensure residents and families have a voice in the operation and activities of the home.

a) At a minimum, resident and family council includes residents, family members and designated staff members;

b) Councils shall meet at least once annually;

c) Meeting notes shall be documented and available for review; and,

d) All homes shall have mechanisms to thoughtfully consider and respond to all recommendations from the council.

1.1.12 Resident Rights and Responsibilities:

Special-care homes shall respect the legal rights of every resident in so far as they are competent and capable of looking after their own affairs as is embodied in *The Saskatchewan Human Rights Code* and *The Canadian Charter of Rights and Freedoms*.

Special-care homes shall:

a) Ensure resident rights and responsibilities are known and protected by informing each resident/responsible person of his/her inherent rights and responsibilities upon moving into the home;

b) Post the residents rights and responsibilities in a public accessible manner within the home; and,

c) Assist residents to exercise their rights without fear of retribution, including their right to express their cultural and gender identity and to receive visitors in a respectful manner.

Further Clarification:

Communication of resident rights and responsibilities shall be clearly documented including, as appropriate, in the move-in agreement.

1.1.13 Special-care Home Rights and Responsibilities:

Special-care homes shall:

a) Establish rights and responsibilities of their home in collaboration with the SHA;

b) Follow the SHA policy requirements;

c) Inform each resident/responsible person of the home's rights and responsibilities upon moving into the home; and,

d) Post the home's rights and responsibilities in a publicly accessible manner within the home.

Further Clarification:

Communication of the home's rights and responsibilities shall be clearly documented including, as appropriate, in the move-in agreement.

1.1.14 Use of Video Technology:

Where video technology is used by the home or residents, homes shall have a policy that guides its use and safeguard personal information and personal health information in accordance with *The Freedom of Information and Protection of Privacy Act* (FOIP), *The Local Authority Freedom of Information and Protection of Privacy Act* (LA FOIP) and *The Health Information Protection Act* (HIPA).

Further Clarification:

a) The policy shall include the appropriate use of video surveillance, including: video cameras, closed circuit cameras, still frame cameras, digital cameras, and time-lapse cameras that enables continuous or periodic recording (videotapes, photographs, or digital images), viewing, or monitoring of public areas.

b) The policy shall include the use of the equipment/system, including location of recording equipment, which personnel are authorized to operate the system, and hours that surveillance will be in effect.

c) The policy shall include who is authorized to view the video, and a log should be kept of all instances of access to, reasons for access, and the use of the video.

d) Signage must advise that video surveillance is taking place, rationale for surveillance, how video will be used, and who to contact if there are questions and concerns. If, sound is recorded note that as well.

e) The policy shall address video technology for both clinical and non-clinical purposes, as well as video surveillance/calling in a resident's room.

f) The policy shall stipulate that personal equipment of staff members i.e. personal cellphone must not be used to record patients' health information due to a lack of security.

g) The policy shall note how long the videos are will be retained, as well as how they are accessed, stored, disclosed, and disposed of.

h) The policy shall be incorporated into the employee training and orientation programs, so they are able to comply with the policy while performing their duties and job functions in relation to the surveillance system.

i) A privacy impact assessment (PIA) and consultations with relevant stakeholders should be undertaken before any video surveillance takes place.

1.1.15 Health Care Directives and Substitute Health Care Decision Makers:

The Health Care Directives and Substitute Health Care Decision Makers Act

Special-care homes shall support residents to develop health care directives, and where a health care directive is established and the individual can no longer communicate their medical care wishes, their directive shall be respected.

Further Clarification:

a) During move-in, the special-care home shall provide information about health care directives to the client and support them to develop a health care directive if requested.

b) The special-care home shall request a copy of the health care directive, if it exists, and file it in the resident's medical record.

c) The existence of a health care directive does not replace a resident's right to make their own decisions when they are capable of doing so.

d) If the resident has no health care directive, is no longer capable of developing a health care directive, and has not appointed a health proxy, *The Health Care Directives and Substitute Health Care Decision Maker's Act* shall be referred to, and followed to determine the appropriate decision maker for health-related decisions.

e) The health care directive shall be reviewed, at least annually (at annual care conference), and as required, and a new directive completed if warranted.

f) A copy of the health care directive shall accompany the resident being admitted to an acute care hospital/treatment centre.

1.1.16 Trusteeship:

Adult Guardianship and Co-decision Making Act

The Powers of Attorney Act, 2002

A special-care home accepts the responsibility of trusteeship when receiving funds from the Public Guardian, OAS, Indigenous Services Canada, or Social Services on behalf of a resident for the purpose of paying the monthly resident fee, other incurred charges, and comfort funds.

Further Clarification:

These funds shall be directed and administered consistently ensuring:

a) Funds are deposited in a banking institution and the account is designated a trust account;

b) The trustee does not have access to the resident's personal bank account or property, except for the purposes as directed by the resident;

c) Receipts are provided to the resident/responsible person;

d) The special-care home holds liability insurance that covers losses related to special-care home staff members' dealings with trust accounts, or staff members are bonded;

e) The trust account is maintained in accordance with good accounting practices;

f) The trust account is audited annually and reported as a part of the audited financial statement with respect to the operations of the home;

g) Any returns, reports and information respecting the operation of the trust account requested by the Ministry of Health shall be provided;

h) The disclosure of the status of the trust account shall be provided on the written request of the resident/responsible person;

i) The trustee's authority to act for the resident ceases upon death of the resident;

j) A procedure to deal with the payment of interest on resident trust account funds is established;

k) Upon move-in, resident/responsible person is informed on how trust account is managed;

l) All records and documentation pertaining to the general resident trust account is kept on file for at least seven years; and,

m) Residents or their POA/Guardian sign for all cash received by the trustee on behalf of the resident.

An arrangement between Public Guardian, OAS, Indigenous Services Canada, or Social Services and a special-care home to administer benefits for a specific resident is not a Power of Attorney. Funds are simply in trust to cover the resident's day-to-day expenses. The difference between a trustee, Power of Attorney and Personal or Property Guardian is described below:

a) A Trustee is an individual person or member of a board given control or powers of administration of another person's property in trust with a legal obligation to administer it solely for the purposes specified.

b) A Power of Attorney is a legal document where one person gives another person the authority to act on his or her behalf respecting specified personal, property or financial matters. Special-care homes are not eligible to be appointed as Power of Attorney for residents.

c) A Personal or Property Guardian is appointed in a case where a person is lacking capacity to appoint a Power of Attorney. A Personal Guardian has authority to make certain specified personal decisions, for example, decisions relating to where the person will reside, on behalf of the person. A Property Guardian has authority to make certain specified property decisions relating to the person's estate on behalf of the person. Special-care homes are not eligible to be appointed as Personal or Property Guardians for residents.

1.1.17 Power of Attorney and Guardianship:

Powers of Attorney Act, 2002

The Adult Guardianship and Co-decision-making Act

No person shall act as a power of attorney if the person's occupation or business involves providing personal care or health care services to the resident of the special-care home unless the court appoints such a person.

Further Clarification:

The following shall be considered when establishing a policy:

a) In situations where the individual resident is deemed to be incompetent, it may be necessary to have a property guardian appointed. If there is an existing power of attorney then a property guardian is not required. For further information, inquiries should be directed to the Office of the Public Guardian and Trustee at: 100-1871 Smith Street, Regina, Saskatchewan, S4P 4W4, or telephone (306) 787-5424.

b) Power of Attorney and guardianship ceases on the death of the resident; and,

c) An official agreement between Employment and Social Development Canada and a special-care home to administer Old Age Security and/or Canada Pension Plan benefits for a specific resident is not a Power of Attorney. Funds are simply in trust to cover the resident's day-to-day expenses.

1.2.0 CHARGES

Residents of special-care homes and those receiving long-term care services in another facility (who have been assessed and qualify for long-term care), shall be subject to fees as set by the Ministry of Health. The Ministry of Health sets fees through various mechanisms including regulations and policy.

1.2.1 Long-term Care:

The Special-care Homes Rates Regulations sets out the process for determining the income-tested resident charge that shall be applied to residents residing in a publicly subsidized designated home (i.e. a long-term care bed in a facility designated as a Special-Care Home, Hospital or Health Centre), and residents that have qualified for long-term care services and are receiving care in an acute care or health centre bed waiting for placement in a home.

Further Clarification:

a) All information related to income-testing shall be provided to residents/responsible persons when preparing for move-in or at the time of move-in. Forms are available on-line by logging into the Special-care Home System https://www.schs.health.gov.sk.ca and choose the tab "Forms and Information" on the menu to the left.

b) Move-in and End-of-Service Documentation:

   i. The Special-care Home System Admission/Discharge form shall be completed electronically. (Refer to the Special-care Home System Manual for guidelines for completion of the forms and the requirements for reporting to the Special-care Home System).

   ii. Where residents qualify for long-term care services, but are receiving services in an acute care bed, documentation is required on both the Special-care Home System as well as in the Discharge Abstract Database (DAD).

c) Income-testing Guidelines:

   i. Resident charges are based on annual income plus any earned interest. Personal assets such as land, houses and bank accounts are not taken into account in determining the charge. Ministry of Health, utilizing the formula(s) outlined in *The Special-care Homes Rates Regulations*, determines the income-tested resident charge.

   ii. For married residents, the resident and spouse's income is combined, divided equally, and then the formula as outlined in the regulations is applied. Married residents who live in separate dwellings for reasons beyond their control may choose to complete an Optional Designation Form for the purpose of determining the resident charge. With this designation, only the resident's income is considered. This designation is also available to common-law couples. This option is only of benefit in situations where the spouse in the community has higher income than the resident.

iii. The resident is required to provide income information when preparing for move-in, annually, and if income changes in order to calculate the income-tested resident charge. The rate is set at the minimum charge for up to two months until income testing is complete, at which time retroactive fees as a result of income testing will also be charged. When income information is not provided the maximum resident charge is applied and is refundable only to the start of the year in which income information was provided.

iv. Each quarter, income-tested charges may be adjusted based on increases provided in OAS/GIS as announced by the federal government.

v. A resident/responsible person may request a recalculation of the resident charge by submitting a written request to the Ministry of Health along with supporting documentation when the resident has had a significant change in financial circumstances since the residents monthly charge was last calculated, or the difference between the annual reported income and the annual net income of the resident or the resident's spouse is one per cent or more.

vi. If there is a change in the resident charge as a result of a recalculation, the revised charge would become effective the first day of the month for which the resident's income changed, but not beyond the most recent annual review period.

vii. At end of service there is flexibility to charge up to 3 days following the date of discharge.

d) Appeal Process:

Where residents/responsible persons disagree with the initial calculation or any re-calculation they shall direct their concerns in writing to:

Ministry of Health
Drug Plan and Extended Benefits
Income Assessment Unit
System and Client Support Services
3475 Albert Street
REGINA SK S4S 6X6
306-787-5023 (Regina)
306-787-3543 (Regina)
1-800-667-4884 (toll-free)
306-787-8679 (fax)
dpeb@health.gov.sk.ca

1.2.1.1 Residents Under 18 Years:

Residents under 18 years of age shall not be charged a monthly resident fee except in the following cases:

a) The resident is permanently committed to the care of the Minister of Social Services under *The Child and Family Services Act;* or,

b) A third party is liable for the cost of the resident's care.

Further Clarification:

a) A resident is deemed to be under the age of 18 years for the entire calendar month in which he or she turns 18 years of age.

b) The Ministry of Health will pay the minimum resident fee for residents under the age of 18, except when paid by the Ministry of Social Services or a third party.

c) With the consent of the parent or legal guardian the home shall provide to the Ministry of Health the following information:

   i. Home/community where the client will be residing;

   ii. Name of client;

   iii. Parents/legal guardian name and address;

   iii. Date of birth and health services number; and,

   v. Date accepted for placement.

1.2.1.2 Other Payers Responsible for the Resident Charge:

Where applicable the monthly resident fee shall be collected from responsible third parties.

Further Clarification:

Workers Compensation Board (WCB)

a) A resident's monthly charge is full cost of care if covered by compensation paid pursuant to the *Workers Compensations Act, 2013;*

b) The Saskatchewan Health Authority and their homes shall work directly with the WCB when determining monthly payment;

c) Income-testing is not required by the Ministry of Health, when WCB are responsible for payment; and,

d) Charges for other medical supplies must be coordinated with the WCB.

Saskatchewan Government Insurance (SGI)

a) Where SGI is responsible for the monthly charge; the residents monthly charge shall be the resident's income-tested resident charge; and,

b) Based on the *Automobile Accident and Insurance Act*, residents will typically be billed directly and be reimbursed by SGI; however, on a case by case basis SGI may have alternate billing arrangements.

First Nations

a) The Ministry of Social Services will pay the monthly minimum resident fee and personal living allowance for First Nations residents under the age of 65 years if the resident is eligible for provincial assistance and if they normally resided off reserve prior to move-in. Note hospital stays off reserve do not constitute residency off reserve;

b) Indigenous Services Canada (ISC) will pay the monthly minimum resident fee and personal living allowance for First Nations residents under the age of 65 years if the resident is eligible for federally funded social assistance and if normally residing on reserve prior to moving into the special-care home. Individuals who typically live on-reserve, who are off-reserve for the purpose of obtaining care not available on-reserve, continue to be considered a reserve resident and continue to be eligible for funding through the Assisted Living program, assuming that all eligibility criteria is met through the Social Programs National Manual and they do not exceed Type I or II care as described in the Social Programs National Manual.

   Social Programs National Manual Care Types

   Type I care - This level of care identifies a person who is ambulant or independently mobile, who has decreased physical or mental faculties, and who primarily requires supervision or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition. A person recognized as Level I would not normally be admitted to a residential care facility.

   Type II care - This level of care identifies a person with a relatively stabile (physical or mental) chronic disease or functional disability, who having reached the apparent limit of his/her recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital, but who requires availability of personal care on a 24-hour basis, with medical and professional nursing supervision and provision for meeting psycho-social needs. The period of time during which care is required may consist of a number of months or years.

   *** Type I and Type II care are defined in the federal ISC classification system and are not associated with any provincial classification.**

1.2.1.3 Accounts in Arrears:

All special-care homes shall establish a procedure for the collection of monthly resident charges and other charges for residents receiving long-term care services that includes the collection of charges that are in arrears.

Further Clarification:

a) During the move in process, residents and their family will be advised of all monthly fees and applicable deadlines to pay these fees.
b) As soon as a payment is missed without prior notification, a designated staff member will discuss payment options with the resident and/or their responsible person to bring the account up to date.
c) When a resident is 30 days late with paying their monthly fees, a designated staff member will contact the office of the Public Trustee to explore options for changing the resident's power of attorney or appointing the public trustee to oversee the resident's financial matters.

1.2.2 Short Stay Care:

All individuals requiring short stay care must sign a move-in/financial agreement that, at minimum, includes:

a) Type of care (respite, convalescence, rehabilitative, or palliative);

b) Proposed length of stay;

c) Discharge plan;

d) Charge for stay and any other fees and charges;

e) Rights and responsibilities of the home and the resident; and,

f) Any other information the home deems relevant.

1.2.2.1 Respite Care:

The respite care fee to be charged is the minimum income tested resident charge for the days that the client occupied a respite care bed for less than a full calendar month (calculated to be 30.4 days).

Further Clarification:

a) Eligibility for respite care is based upon assessed need and availability of resources. A short stay agreement must include the length of stay, procedure to request extensions of stay or early discharge and the fees charged.

b) Clients will be charged the respite resident charge for the first 60 consecutive days.

c) Where a client has been reassessed as requiring continued respite care beyond 60 days, the client will be charged the income-tested fee as directed in *The Special-care Homes Rates Regulations*.

1.2.2.2 Adult Day Program/Night Care:

Adult day and night care programs shall charge a provincially consistent fee set by the Ministry of Health.

Further Clarification:

a) The fee will be adjusted annually based on changes to the Old Age Security and Guaranteed Income Supplement (OAS/GIS) pensions.

b) Participants of adult day programs or night care programs will be notified one month in advance of any fee increase.

c) Where transportation is provided for an additional fee, the fee should be affordable for individuals on limited income.

1.2.2.3 Convalescent Care:

Clients will not be charged for convalescent care of 30 days or less.

When a client requires convalescent care for more than 30 days and less than 90 days, the client will be charged the minimum monthly resident fee for those days.

When a client requires convalescent care beyond 90 days, the client will pay the income-tested fee going forward.

Further Clarification:

Eligibility for convalescent care is based upon assessed need and availability of resources. A short stay agreement that details the length of stay, the charges for the entire period or extension of stay or early discharge is required.

1.2.2.4 Refusal to Leave Short Stay Care:

A client that refuses to leave a short stay care bed when they are no longer authorized to occupy that bed will be charged the full cost of care going forward.

Further Clarification:

Special-care homes shall ensure that all options for discharge from temporary care have been explored and provided to the resident/responsible person with the goal of finding a care setting appropriate to the needs of the client while supporting the transition including:

a) Charging full cost of care shall be considered the last resort;

b) The full cost of care must only be implemented three days after issuing written notice of the change in charges; and,

c) Homes will consider cancelling the full cost of care charges once appropriate action towards leaving the temporary care bed has been implemented.

1.2.3 No Charge Services:

1.2.3.1 End-Stage Palliative Care:

Clients admitted to long-term care for the purpose of receiving management of acute palliative symptoms or end-stage palliative care will not pay a monthly resident fee, nor supply charges as indicated in Standard 2.8 Supply Charges.

Further Clarification:

a) Clients assessed as early/intermediate palliative shall pay a monthly resident fee as directed in *The Special-care Homes Rates Regulations.*

b) Current long-term care residents that become end-stage palliative or require management of acute palliative symptoms will continue to pay the income-tested resident fee.

End stage palliative care shall be determined using a combination of:

a) The standardized assessment tool in addition to the Palliative Performance Scale developed by the Victoria Hospice Society and Capital Region Home Nursing Care in British Columbia[1];

b) A physician diagnosis as terminal with life expectancy of weeks or months, active treatment to prolong life is no longer the goal; and,

c) Professional physical assessment and documented clinical progression of disease.

Other Benefits:

i. The cost of oxygen and corresponding equipment prescribed by a physician may be covered by Saskatchewan Aids to Independent Living for individuals designated as "end stage" palliative; and,

ii. Physicians may designate individuals as palliative (any stage) and recommend them for full coverage of benefit drugs under the Saskatchewan Prescription Drug Plan.

1.2.3.2 Active Rehabilitation Services:

Clients admitted for active rehabilitation services in designated rehabilitation facilities will not pay a monthly resident fee.

1.2.4 Supply Charges:

Permanent long-term care residents shall be charged an additional monthly supply charge established by the Ministry of Health for select supplies, not specifically covered by the income-tested resident fee.

Further Clarification:

a) The supply charge will be adjusted annually based on changes to the Old Age Security and Guaranteed Income Supplement (OAS/GIS).

b) Residents/responsible persons will be notified of any increase one month in advance.

c) Homes and other facilities are not to charge a handling fee to residents for any supplies.

d) Supplies identified in Group A and Group B will apply to short stay clients; however, short stay clients will not be charged the monthly supply fee.

Standardized Monthly Special-care Home Resident Supply Charge In Addition to the Income Tested Resident Charge – updated June 2021		
Group A – no charge to resident	**Group B – an additional charge to the resident at actual cost**	**Group C – items included in the supply charge (adjusted annually in alignment with increases in OAS/GIS)**
• Basic foot care provided by the home • Nutritional supplement supplies if clinically indicated • Safety Engineered Sharps Devices (SESDs) • Storage fees • Identification bracelets/photos • Name plate on resident's door • Labelling of resident belongings including clothing, dentures, eyeglasses, etc. • Monitoring alarm systems including bed, chair, room and wandering alarms • Home-owned equipment including Broda chairs, wheelchairs, walkers, sheepskins, slings, turning sheets, specialty mattresses, etc. (any equipment that is reusable from resident to resident) • Specialized equipment deemed medically necessary by the care team for the resident, for example equipment for intravenous therapy, nutritional supplements, wound vac machine, catheter, catheter supplies, etc. • Wound care supplies • Bubble packaging/compliance packaging for medications • Infection control items such as disposable gloves, Isogel, etc.	• Incontinent supplies (attends, colostomy, ileostomy supplies) • Transportation to home of choice • Cable television • Private telephone service • Barber/hairdressing service • Wandering alert bracelet • Specialized equipment as requested by the resident/family member • Oxygen equipment • Non-reusable hip protectors • Specialized foot care provided by podiatrist/other • Nutritional supplement supplies if not clinically indicated • Prescribed medications • Charges for cost related to participation in extracurricular social events as organized by the home	• Personal hygiene items such as toothpaste, toothbrushes, denture cleaning supplies, denture adhesive, mouthwash, cotton tip applicators, shampoo, conditioner, hand soap, body cleansers, basic lotion, baby oil, body powder, Peri-wash, lubricating gel, deodorant, etc.

*cpap, bipap, and mechanical insufflation-exsufflation device (cough-assist) equipment is available to qualifying residents through the SAIL program.

1.2.5 Summary of Charges: (effective March 2020)

Types of Service	Includes	Resident Charge	Additional Policy Context
Long Term Care	Permanent LTC residents	Income-tested charge rate as set out in *The Special-care Homes Rates Regulations, 2011*.	The rate upon move in is set at the minimum charge for up to 2 months until income testing is complete. Failure to provide income information will result in maximum resident charge. Flexibility to charge up to 3 days following the date of discharge.
	Individuals in hospital that are assessed and qualify for LTC.	Income-tested charge as set out in *The Special-care Homes Rates Regulations, 2011*.	Individuals start to pay the resident income tested charge once approved and qualify for LTC while awaiting placement.
	Existing LTC residents that become end-stage palliative.	Income-tested charge as set out in *The Special-care Homes Rates Regulations, 2011*.	Existing special care home residents continue to pay their income tested resident charge once they are deemed end stage palliative.
	Admissions from the community for long stay assessment of 90 days or greater.	Clients will pay the minimum monthly resident charge for the first 90 days and then the income tested charge for stays beyond 90 days.	
	Residents under 18 years.	No charge to the resident.	The Ministry pays the minimum monthly resident charge on the child's behalf until the month of the child's 18th birthday unless the child is permanently committed to the care of the Minister of Social Services or a third party is responsible for the cost of the care.
Short Stay Care	Respite Care	Clients pay the minimum monthly resident charge prorated on a daily basis for the first 60 consecutive days.	Ministry determines the charge as set out in *The Program Guidelines for Special-care Homes* as follows: Minimum monthly charge divided by 30.4 days = Daily Respite Charge
	Adult Day Program	Daily charge determined by the Ministry as set out in *The Program Guidelines for Special-care Homes*.	
	Night Care	Daily charge determined by the Ministry as set out in *The Program Guidelines for Special-care Homes.*	
	Convalescence (period of additional recuperation) in a special-care home,	For the first 30 days – no charge;	

	designated acute care beds or other residential facilities as well as short stay assessment transition and temporary placement programs.	For stays between 31-90 days – minimum monthly resident charge; and, For stays beyond 90 days – client to be assessed for long stay care and hence pay the income tested charge.	
	Penalty for refusal to leave short-stay care.	Residents pay full cost of care after 3 days written notice. Full cost of care equates to $250/day.	
No Charge Services	Admission for palliative care end-stage or management of acute palliative symptoms.	No fee to the resident.	As set out in *The Special-care Homes Rates Regulations, 2011.* A person who is admitted for the purpose of receiving acute care management of symptoms related to palliative care or end stage palliative care is not required to pay a resident's monthly charge. Stays longer than 60 days will be reassessed to ensure the client continues to meet palliative care criteria.
	Active rehab services in designated rehab facility i.e. Geriatric, post-stroke, post hip/knee, etc.	No charge to residents.	
	Provincial Dementia Assessment Units (Wascana Rehab Centre and Parkridge Centre)	No charge. Residents continue to pay their income tested resident charge at their home facility except when: • client has been discharged from their former special-care home and is in Assessment Unit and is targeted for a different special-care home following assessment; and, • when client is admitted from the community and if during the DAU stay, it's determined LTC placement is required and is awaiting same, they will be charged the LTC fee similar to those awaiting transfer from hospital.	

1.3.0 CARE STANDARDS

1.3.1 Clinical Assessments:

All residents moving into special-care homes for long-stay care shall have an assessment completed using an assessment instrument approved by the Ministry. The information obtained from the assessment shall inform the resident's care plan. Assessment information shall be provided to the Ministry in a format approved by the Ministry.

Further Clarification:

a) All long-stay residents, shall have an assessment:
   - on the fourth day after moving in;
   - when there is significant change in the status of the resident; and,
   - quarterly.

b) The care of short-stay care clients is guided by their home care assessment.

1.3.2 Care Plans:

Special-care homes shall ensure that each resident has an appropriate comprehensive and individualized care plan developed upon arrival in collaboration with a multidisciplinary team; the resident and their most responsible person shall be included in the care plan development.

Further Clarification:

a) Using the outcomes from the assessment, the care plan must address the resident's physical, psychological, spiritual, cultural and social needs and corresponding goals.

b) In conjunction with the assessment, the care plan must be developed within four days of arrival and reviewed quarterly or when there is a change in health status.

c) The care plan shall include an annual care conference with the interdisciplinary team and the resident and/or their responsible person.

d) All care staff involved with the resident's care, the resident and their responsible person must have access to the care plan.

1.3.3 Personal Care:

Special-care homes shall provide residents with personal care that is consistent with the care plan to support quality outcomes through the promotion of health, safety, independence, and comfort considering the individual rights of each resident within the inherent limitations of a group living situation.

Further Clarification:

At a minimum all special-care homes must provide for:

a) Psychosocial needs in the care plan including goals and objectives to support the resident's emotional needs, spiritual and cultural beliefs;

b) Basic personal hygiene as outlined in the care plan for each resident;

c) Minimum of one bath or shower per week, with additional baths and/or showers based on resident care plan in consultation with resident and/or responsible person;

d) Daily mouth care including cleaning of dentures/teeth;

e) Assistance for residents to use dentures, and sensory aids i.e. eyeglasses, hearing aids, etc.;

f) Assistance for resident/responsible person to access appropriate medical, dental, podiatry, optical, and auditory services when required and/or requested by the resident/responsible person;

g) Bladder and bowel management to respect and support the individual needs of residents;

h) Options for residents to participate in recreation activities of their choice; and,

i) Resident opportunities to mobilize independently as much as possible.

1.3.4 Living at Risk:

Special-care homes shall recognize residents' right to live at risk when they choose to do so.

Further Clarification:

Where a resident chooses to live at risk, a risk management agreement must be in place between the home and the resident/most responsible person. The risk management agreement shall:

a) Clearly outline the agreed upon risk and that all parties have agreed;

b) Be signed and dated by the resident or most responsible person;

c) Be documented in the care plan;

d) Be kept in the resident's record with documentation that the risks were reviewed with the resident; and,

e) Be reviewed yearly at an interdisciplinary care conference or more frequently as required.

1.3.5 Falls Prevention and Injury Reduction Program:

Special-care homes shall have a Falls Prevention and Management Program that fosters resident independence and quality of life while mitigating risk for the residents and staff. The program should reduce the incidence of residents' falls and mitigate risks of falls through a resident focused, team approach.

Further Clarification:

The program objectives shall include:

a) Improving and maintaining a resident's optimal functional level and quality of life;

b) Identifying and reducing or eliminating biological, behavioural, social and environmental risk factors for residents;

c) Reducing the frequency of falls; and,

d) Reducing the severity of injuries from fails.

The program's activities shall include:

a) Best practice interventions for residents who have fallen;

b) Monitoring and tracking trends related to resident falls;

c) Team training;

d) Communication and effective care planning;

e) Post fall huddles, including risk assessment; and,

f) Yearly program evaluations.

1.3.6 Restraints:

Special-care homes shall only restrain residents (environmental, chemical or physical restraints) as a last resort, when there is an identified risk of injury to self and/or others and all other alternatives have proven ineffective.

Further Clarification:

Homes shall have strategies, policies, and procedures in place to reduce the use of all restraints, frequent assessments of all restraints, and staff training on use of all types of restraints. These should be evaluated yearly to ensure best practices are being followed.

Use of restraints must be maintained in accordance with accepted professional standards and practice, and shall include, but not be limited to:

a) All less intrusive interventions have been trialed and the outcomes documented;

b) Initial (within 24 hours) and on-going regular comprehensive assessments of the resident, as well as the outcomes of the restraint use, are documented including rational for using the restraint;

c) Use of the restraint is evaluated at quarterly or more frequently;

d) There is a written physician's or nurse practitioner's order for the restraint;

e) Discussion with the resident and most responsible person about the rational for use of the restraint, their involvement in the decision to use a restraint, and written consent is signed;

f) Resident-specific orientation and training based on the care plan for care providers that will be providing care for a specific restrained resident; and,

g) When chemical restraints are ordered, a medication review by a physician or nurse practitioner and the multidisciplinary team must occur at a minimum of once a month to ensure the appropriateness of the medications prescribed. Virtual meeting options may be used.

h) Restraint use should not be a deterrent when accepting new residents.

1.3.7 Skin Integrity and Wound Care:

Special-care homes shall provide skin and wound care to preserve residents' skin integrity, prevent pressure injuries, promote comfort and mobility, and prevent infection.

Further Clarification:

Special-care homes shall have a skin care and wound management policy/procedure that includes education for all staff regarding pressure injury prevention and best practice.

The purpose of skin care and wound management policy or procedure is to:

a) Reduce and mitigate the overall incidence of pressure injuries;

b) Reduce risk factors that contribute to the development of pressure injuries;

c) Monitor the incidence and severity of pressure injuries;

d) Promote an optimal level of resident function, comfort and quality of life; and,

e) Monitor and evaluate resident outcomes.

1.3.8 Pain Management:

Special-care homes shall establish a policy/procedure to assess and manage residents' pain on a regular (at least daily) basis to facilitate residents' optimal comfort, dignity and quality of life.

Further Clarification:

Pain is individualized and subjective; therefore, the resident's self-report of pain is the most reliable gauge of the experience. If a resident is unable to communicate, the family or caregiver may provide input.

Components of pain assessment include:

a) History and physical assessment;

b) Functional assessment;

c) Psychosocial assessment;

d) Multidimensional assessment; and,

e) Recognizes and reports resident verbalizations and behaviors.

Pain management procedures shall focus on:

a) Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired;

b) Strategies to manage pain including non-pharmacologic interventions, equipment;

c) Supplies, devices and assistive aids, and comfort care measures;

d) Monitoring of residents' responses to and the effectiveness of the pain management strategies; and,

e) Team training, communication and effective care planning.

1.3.9 Managing Responsive Behaviors:

Special-care homes shall appropriately document and manage responsive behaviours in accordance with the care plan.

Further Clarification:

Responsive behaviour management shall include:

a) Assessment/reassessment quarterly, or more frequently when behaviours change, to ensure interventions are reaching the recommended outcome;

b) Specific safety precautions are implemented and evaluated based on the assessment and professional consultations with specialists in the care and treatment of responsive behaviors;

c) Residents/responsible persons participate in the care planning and are advised of the rationale for the safety precautions implemented;

d) Safety precautions should be communicated to all staff that provide hands on care and to individuals who have interactions with residents on a regular basis; and,

e) Resident-specific orientation and training for care providers.

1.3.10 End-of-Life Care:

Special-care homes shall offer a palliative approach to end-of-life care. Palliation includes the provision of active, compassionate care to a terminally ill resident where it has been determined that treatment for cure or prolongation of life is no longer the primary object of the care being provided.

Further Clarification:

Palliative care for all residents at end-of-life shall include:

a) Discussion with the resident/family about any aspect of the dying process;

b) Respecting and following residents' health care directives; and,

c) Pain assessments, management, and relief are provided as required.

Palliative care for residents designated as palliative upon move in shall include:

a) Procedures for move in - specific to palliative care, including an agreement;

b) Review of the resident's health care directive, if available;

c) Procedures for end of service, including SCHS entry;

d) Pain and other symptom assessments, management and relief as required; and,

e) Application of palliative care charges as outlined in the charges section of *The Program Guidelines for Special-care Homes*.

1.3.11 Nutrition and Hydration:

Special-care homes shall ensure that all residents have their nutritional and hydration needs assessed upon move in and when indicated; and they are offered appropriate nutrients and fluid intake based on their assessed needs and preferences.

Further Clarification:

The home will:

a) Develop a menu plan in accordance with Canada's Food Guide, in consultation with a registered dietitian, and with resident input, and review it annually or more often as required;

b) Complete and document weights upon move in and, at a minimum monthly thereafter for each resident;

c) Assess the nutritional status of all residents upon move in and review dietary needs quarterly, and whenever the assessment triggers a need or the physician or nurse practitioner and/or nursing assessment indicates a need;

d) Where a resident has been identified as dehydrated or at risk of becoming dehydrated keep an accurate record of intake and output of fluid along with a plan for ensuring the resident is receiving sufficient fluids. This may not apply to residents at end-of-life, whose care should be guided by their care plan;

e) Where a resident has been identified as a nutritional risk keep an accurate recording of food intake, including all meals, snacks and liquid consumed over a 24-hour period;

f) A registered dietitian shall review all special diets ordered or changed by the physician or nurse practitioner, as well as establish corresponding menu plans;

g) Orientate all direct care and dietary staff participating in the residents' care and meal assistance regarding each resident's menu plan and feeding method, and the importance of monitoring their food and fluid intake;

h) Annually evaluate resident satisfaction with the food services and dining environment, and document quality improvement actions;

i) Ensure at least one staff member working in the kitchen when food is being prepared or served has successfully completed a course in food sanitation approved by a public health officer; and,

j) Train staff members in the basic principles of safe food handling, sanitation, special diets and food presentation.

Meal and snack service shall consider:

a) The time that meals, including at least three meals each day will be served; with special consideration given to clients requesting relaxed breakfasts;

b) The times that nutritious snacks will be offered;

c) The portion sizes, for each food served in accordance with the approved menu;

d) Allowances for individual food preferences as well as cultural, religious or ethnic preferences of residents within available resources;

e) Provision of texture-modified foods to a resident only after an assessment that includes consultation with a registered dietitian, has occurred; and,

f) Records of menus are kept on file for at least three months.

1.3.12 Therapeutic Nutritional Products:

Therapeutic nutritional products shall be offered to residents as recommended by a physician, nurse practitioner or registered dietitian.

Further Clarification:

The therapeutic nutritional products policy shall include:

a) Accurate documentation of consumption of therapeutic nutritional products;

b) Where therapeutic nutritional products have been ordered by the physician, nurse practitioner or registered dietitian, the resident will not be responsible for the cost of the product or equipment; and,

c) Where nutritional products are being consumed, but have not been clinically indicated, the resident is responsible for the cost of the product.

1.3.13 Residents with Dysphagia:

Resident-specific safe diet and dining assistance instructions shall be provided for residents with dysphagia.

Further Clarification:

Residents with dysphagia shall:

a) Have an assessment by a speech language pathologist, dietitian, or other health professional that has completed specialized training in dysphagia assessment. The assessment shall be completed in a timely manner based on client need and include the identification of the appropriate diet and dining assistance;

b) Be reassessed within six (6) months; and,

c) Be supported by staff with training and education related to appropriate diet, positioning, and other techniques as documented by the health professional completing the assessment.

1.3.14 Tube Feeding:

Tube feedings will be provided as ordered by a physician or other appropriate health care provider in consultation with a registered dietitian.

Further Clarification:

Tube feeding shall include:

a) Involvement of the resident and responsible person in the decision to initiate tube feeding;

b) The feeding tube be inserted by a physician or other appropriate health care professional; and,

c) No charge for tube feeding products or supplies to the resident.

1.3.15 Food Safety:

Special-care homes shall ensure safe food handling in compliance with *The Food Safety Regulations* and accompanying Public Eating Establishment Standards.

Further Clarification:

a) Special-care homes, with a capacity of more than 20 residents, are required to be licensed to operate (the food service) by the SHA. The licensing process is initiated by contacting a Public Health Inspection Manager.

b) Special-care homes, with 20 or less residents, are to arrange for regular inspections with a public health inspector.

c) Inspection frequencies will be determined by a public health inspector based on factors associated with the operation of the home such as type and variety of food served, extent of food handling, clientele and history of poor compliance.

1.3.16 Medication Management:

Special-care homes shall ensure residents receive safe, reliable and cost-efficient drug management services that comply with *The Housing and Special-care Homes Regulations* and are administered by persons practising within their scope of practice.

Further Clarification:

Safe medication management includes:

a) Safe and effective distribution and administration of residents' medications following industry and professional practices including documentation;

b) Continuing education programs for staff administering medications and providing care;

c) Medication reconciliation to review all residents' medication profiles upon move in or transfer;

d) Multidisciplinary medication review process whenever resident circumstances indicate a need for review and at regular intervals not exceeding three months; with more frequent reviews for residents prescribed medications that may have adverse effects;

e) Process to address concerns related to resident medication;

f) Review process for all medication incidents that did or could have had a negative outcome for the resident to provide recommendations to prevent future occurrences;

g) Regular review of the medication room/s and medication cart/s storage to ensure the security of both and the safe access by only authorized staff;

h) All medications are to be kept in locked cabinets. Medications requiring refrigeration shall be kept in a locked refrigeration unit or located in a locked medication room accessible only to authorized staff. If the refrigeration unit is used for storing foods, the medication shall be kept in a marked locked tray or container that is not removable;

i) Each resident medication package or container must have a clear and adequate label applied by the issuing pharmacy including prescription number, resident's name, prescribing physician or nurse practitioner, administration directions, date of issue and pharmacy name. Soiled or damaged labels shall be returned to the pharmacy for re-labelling;

j) Controlled drugs and substances (e.g. narcotics) must be stored in a double locked system. Medication carts should be stored in a locked medication room/cupboard when not in use. Confirmation of stock must be documented and signed by two professional staff members at the end of every shift; and,

k) Access to pharmacist/s to support medication management program.

Medication management for resident end of service includes:

a) Handling of medications for residents that are leaving the special-care home to transfer to another home, to return to their own home or for short-term absences;

b) Management of medications following the death of a resident;

c) Management of medications for respite or short-term clients, including return of resident's own medications to resident or their most responsible person upon end of service; and,

d) Management of unused medication including narcotics and controlled drugs remaining in the special-care home following discontinuance, resident transfer, end of service, or death in accordance with pharmaceutical regulations.

Medication management for retained medication stock includes:

a) Identification of over the counter medications that will be kept in stock;

b) Pharmacy availability for medications that may be ordered on an urgent basis;

c) An accurate record of supply medications kept, which is regularly reviewed; and,

d) Documentation of use of medications, including who ordered the medication, the resident receiving the medication and the reason this supply was used.

1.3.17 Intravenous Therapy:

Special-care homes providing intravenous hydration or drug intravenous therapy shall ensure there are policy/procedures to ensure safe resident care.

Further Clarification:

The intravenous therapy policy/procedure shall include, but is not limited to:

a) There must be professional staff to monitor the intravenous therapy as directed by the nurse in charge, and no less than hourly;

b) The home must ensure the staff has the skills to competently perform the task;

c) All intravenous therapy is ordered by a physician or a nurse practitioner; and,

d) The resident or their responsible person has consented to the therapy.

1.3.18 Purposeful Rounding:

Special-care homes shall implement purposeful rounding - the timed, planned intervention of healthcare staff in order to address common elements of care, typically by means of a regular bedside round that proactively seeks to identify and meet residents' fundamental care needs and psychological safety.

Further Clarification:

Purposeful rounding must include:

a) Asking the resident the 4 Ps where appropriate:
   - **P**ain: presence of pain and pain management.
   - **P**ersonal needs: including use of bathroom.
   - **P**ositioning: check comfort and air mattress inflation, if being used.
   - **P**lace: place essential items within reach.

b) Scan for hazards:
   - Are there any fall hazards in the room?
   - Is the temperature of the room okay? Does the resident need blankets?
   - Is all of the resident's medical equipment working? (Ex. bed alarm plugged in, oxygen or cpap/bipap machines)

c) Before leaving:
   - Ask "Is there anything else I can do for you?"
   - Mention that you will be back in one hour to check again.
   - If necessary, document the round on the patient's chart.

d) Policies and procedures for the Purposeful Rounding Program are monitored and evaluated at least yearly by the continuous quality improvement plan.

1.3.19 Resident Care Records:

Special-care homes shall ensure every resident has a standardized resident care record starting upon move in and maintained up-to-date for the duration of the stay in compliance with *The Housing and Special-care Homes Regulations*.

Further Clarification:

The resident care record shall at minimum:

a) Be kept confidential and securely stored;

b) Be available based on the requirements of the *Heath Information Protection Act* to the resident/responsible person/s where requested;

c) Document unusual events immediately after occurrence. The care provider who observed an event or attended to the resident should complete the recording in an accurate and legible manner that meets charting requirements;

d) Record information in chronological order. If an entry is made out of chronological sequence, a notation should be made to that effect (i.e. in the nursing/progress notes, the writer should record the current date and time of documentation and then record the date and time of when the event/actions had originally occurred; an arrow may be placed indicating where the entry should be placed within the sequence). All notations should be dated and signed by the writer;

e) Keep use of abbreviations to a minimum. Only those abbreviations generally accepted as standard for the nursing and medical professions and approved by the home should be used;

f) Where flow sheets are used, do not record on the progress notes unless something unusual has happened, or a change in the client's health status has occurred; and,

g) Be uniform throughout the resident care program. No individual should, on his or her own initiative, add or omit items, which are not in accordance with the home's policies or practices.

Corrections of entries in resident care records:

a) Written Copy – The writer should note "incorrect entry" and initial beside the incorrect entry. The newly documented page with correct information should be labeled as "corrected copy" and placed in front of the original page.

b) Electronic Documentation – Electronic document entries should have accessible audit trail which captures date, time and person for every entry.

The resident care record shall include:

a) Resident information;

b) Contact information for the person legally authorized to act on behalf of the resident (most responsible person), and contact information for any person to be consulted and/or notified regarding the resident activities and needs, if different;

c) Move-in/readmission documentation, including the move-in/financial agreement;

d) Documentation of the resident leaving and returning related to move-in, end-of -service, transfers and other outings;

e) Health care directive;

f) Consents;

g) History, physical examinations and other related records;

h) Assessments;

i) Resident Assessment;

j) Resident specific care plan;

k) Physician/Nurse Practitioner/Pharmacist orders;

l) Physician and other professional consultation progress notes;

m) Nursing documentation/progress notes;

n) Medication and treatment records;

o) Reports from lab, x-rays and other diagnostic tests;

p) Rehabilitation and restorative therapy records;

q) Social service documentation;

r) Activity documentation; and,

s) Nutrition services documentation.

1.3.20 Death of a Resident:

Special-care homes shall have a policy regarding pronouncing resident death, certifying death, notifying the most responsible person, and legal documentation.

Further Clarification:

The statutory requirements with respect to pronouncement and certification of death are as follows:

Pronouncement:	There is no legal requirement that death be pronounced by a physician. This can be addressed in the policy.
Certification:	There is a legal requirement that death must be certified by a physician or by a Coroner; this duty cannot be delegated. A physician or Coroner must sign the death certificate. There is no legal requirement that the physician must view the body before signing the death certificate. If the physician does not view the body, he/she must be satisfied as to a natural cause of death according to good medical practice and judgement.
Moving a Body:	There is no legal requirement that a physician must see a body before it may be moved; **however, if the death falls under** *The Coroners Act* the body may NOT be moved until the Coroner authorizes it.

The policy should address:

a) Who will pronounce death (professional staff recommended);

b) Who will notify the physician/nurse practitioner and when this will occur;

c) Who will notify the most responsible person and when this will occur;

d) Paper documentation required;

e) Who will complete the Registration of Death Form;

f) Who will ensure the Certificate of Death is signed by the physician;

g) Who will notify the funeral home and provide them with documentation;

h) Who is authorized to order removal of the body to the funeral home;

i) Instances where the family chooses to transport the body on their own from the special-care home to the funeral home. Anyone can transport a deceased body provided they are not receiving payment for it. The death certificate should be signed prior to transport as it is required for a burial permit;

j) A process to phone the transplant program (Regina 1-306-766-6477 and Saskatoon 1-306-655-5054) when a resident has died and indicated an interest in organ and tissue donation on their advance care directive. The tissue coordinator will co-ordinate final consent and transportation of the body;

k) The process to be followed when a resident's most responsible persons are not available to be notified; and,

l) The removal of the deceased resident's belongings by family or other responsible persons.

1.3.21 Resuscitative Services:

Resuscitative services shall be available to all residents of special-care homes at minimum by calling 911 if in accordance with the resident's advance care directive; no home shall have a home-wide no CPR policy.

Further Clarification:

The home shall identify:

a) The procedures staff are to follow in situations where a resident/responsible person requests resuscitative measures as part of a health care directive, including details of whether staff are to call 911 and allow emergency personnel to initiate resuscitation, staff are to perform CPR as directed by 911, or staff will independently perform CPR;

b) Requests for resuscitative services may come directly from the resident/responsible person or via a health care directive;

c) All residents shall continue to receive medically necessary care and treatment for the purpose of comfort, safety, dignity and well-being when they have stated they do not desire resuscitative measures as part of a health care directive; and,

d) Procedures for a resident/responsible person to revise, renew, rescind or cancel requests for resuscitative services.

1.4.0 SUPPORTIVE SERVICES

1.4.1 Accessing Professional Services:

Special-care homes shall facilitate residents' access to other health professionals (dentists, social worker, etc.) as required to meet the needs of each resident.

Further Clarification:

The process shall include:

a) Advising residents/responsible persons that other health professional services are available;

b) Informing residents/responsible persons of the process for referral to other health professional services not covered or partially covered by Saskatchewan Health;

c) Identifying the process for travelling to other health professional services not covered or partially covered by Saskatchewan Health, detailing who is responsible to transfer the resident;

d) Informing residents/responsible persons that the resident is responsible for all uninsured costs of the service and the actual cost of any special requirements, modifications or treatments; and,

e) Informing residents/responsible persons of other health professional service options when requested or when indicated on the client assessment.

1.4.2 Therapy Services:

Special-care homes shall facilitate residents' access to therapy services based on need identified through the assessment process and documented in the resident care plan.

Further Clarification:

Services shall include:

a) Physical therapy, occupational therapy, respiratory therapy and speech language pathology as identified in the care plan; and,
b) Where residents request therapy services that are not identified in the assessment process or specified in the care plan, they shall be assisted in accessing these services through:
    i. Informing residents/responsible persons of the process for accessing therapy services not provided in the home;
    ii. Identifying the process for travelling to access therapy services not provided in the home; and,
    iii. Informing residents/most responsible persons that the resident is responsible for all uninsured costs of the service.

1.4.3 Diagnostic Services:

Special-care homes shall facilitate residents' access to diagnostic services to meet their needs including laboratory, diagnostic imaging, or other services as indicated.

Further Clarification:

The process shall include:

a) The identification of the procedure for accessing these services;
b) The identification of the method of transportation if the service is offered off site and who will cover the costs of transporting the resident;
c) The guidelines to determine if the resident must be accompanied to the service and if they require a care provider to ensure their care and safety while out of the home. If the ordering physician/nurse practitioner or nurse in charge determines that a care provider or family member must accompany the resident, and a family member is not available, the resident will not be charged for the cost of an attendant to accompany them to the appointment; and,
d) The process to contact family or other responsible persons based on the resident's preference to inform them of the diagnostics and to discuss options for transportation.

1.4.4 Recreational Services:

Each special-care home shall offer recreational activities designed in consultation with residents/responsible persons to meet the social and recreational needs, and interests and capabilities of each resident, and enhance the quality of each resident's life.

Further Clarification:

Each home shall:

a) Plan, co-ordinate and evaluate the recreation program within the home;
b) Provide adequate space for the recreation program in the home that is accessible to all residents and is available at all reasonable times;
c) Offer activities to match resident desires and capabilities;
d) Document resident preferences and participation in recreation activities on the resident's care plan;
e) Post the recreation program to provide families and other community members the opportunity to participate with the residents; and,
f) Evaluate the program on a routine basis, at least annually, to ensure it is a resident centred program (considers the individual needs of the residents).

1.4.5 Environmental Services:

Special-care homes shall provide environmental services to ensure the home is a clean, safe and comfortable environment.

Further Clarification:

Environmental services shall:

a) Identify the importance of good housekeeping for resident quality of life and for the prevention and control of infectious diseases and incidents that could result in illness or injury to residents, visitors and staff;
b) Include all areas within all the buildings on the property;
c) Provide initial and on-going training of employees responsible for environmental services including the importance of good hand-washing;
d) Include the development and maintenance of procedure manuals that are accessible to all environmental services staff for reference;
e) Include a process for the selection and evaluation of cleaning supplies and techniques;
f) Describe the provision of appropriate equipment and supplies for effective cleaning; and,
g) Include a procedure for evaluating environmental services.

1.4.6 Laundry Services:

Special-care homes shall provide laundry services for residents.

Further Clarification:

Laundry services shall:

a) Ensure repair needs of linen and personal clothing are identified, and repaired through an established process;
b) Identify services that will be provided by the laundry department that may include:
   i. Types of personal laundry that will be accepted;
   ii. Repair of personal laundry; and,
   iii. Labelling of personal items.
c) Include the selection and evaluation of laundry supplies and techniques considering the importance of infection control, allergies and sensitivities;
d) Include the development and maintenance of procedure manuals that are accessible to all laundry staff;
e) Include initial and on-going training of employees responsible for laundry duties; and,
f) Allow for the provision of appropriate equipment and supplies for effective cleaning of linen, lifting slings and personal items.

1.5.0 SAFETY

1.5.1 Infection Prevention and Control:

Special-care homes shall monitor, reduce and/or control the spread of infectious organisms to residents, staff and visitors through the surveillance, identification, prevention, control, and reporting of infections and shall establish an infection prevention and control policy.

Further Clarification:

The policy shall:

a) Be developed in cooperation with an Infection Control Committee/Medical Health Officer/Infection Control Practitioner and be in alignment with the Ministry of Health Communicable Disease Control Manual;

b) Identify staff education related to the infection control program including regular on-going training for effective hand washing;

c) Identify personal protective equipment required including reasonable supply on hand, and the use, care and maintenance plan for the equipment;

d) Include a process to inform residents and others coming to the home of the infection control program and their responsibility in prevention, control and reporting;

e) Staff education regarding the importance of immunization and how to access immunization services;

f) Include a plan to review and revise the Infection Control Program; and,

g) Follow Ministry of Health and Public Health orders, regulations and guidelines related to outbreak management.

1.5.2 Biological Waste Management:

Special-care homes shall have a procedure to ensure the safe handling, packing, labeling, transportation and disposal of biomedical waste that complies with SHA infection control policies; and, any federal, provincial and municipal requirements.

Further Clarification:

The biological waste management procedure shall include special precautions required due to the waste being infectious or potentially infectious, containing sharps, or cytotoxic.

1.5.3 Outbreak Management:

All special-care homes shall report, investigate and control communicable diseases in accordance with the requirements of the Communicable Disease Control Manual.

Further Clarification:

None

1.5.4 Pandemic Preparedness:

Special-care homes shall have a pandemic preparedness plan.

Further Clarification:

The pandemic preparedness plan shall include:

a) Infection control protocols;

b) Outbreak management protocols;

c) Access to personal protective equipment; and,

d) Staffing and resource plans.

1.5.5 Emergency Preparedness:

Special-care homes shall establish an emergency preparedness plan and ensure that all staff are aware of and prepared for their roles and responsibilities in the event of an emergency.

Further Clarification:

The plan shall:

a) Ensure all employees know the location of the emergency preparedness manual and receive initial orientation in emergency preparedness and ongoing training in accordance with SHA policy;

b) Ensure all employees are familiar with standard emergency codes and the procedures to be followed in his/her area, including:

   i. Fire (Code Red);

   ii. Violent Incident (Code White);

   iii. Missing Resident (Code Yellow);

   iv. Evacuation (Code Green);

   v. Disaster (Code Orange);

   vi. Bomb Threat (Code Black);

   vii. Hazardous Material Incident (Code Brown);

   viii. Hostage Taking (Code Purple);

   ix. Cardiac Arrest (Code Blue);

   x. Hospital Over Capacity (Code Burgundy) as applicable;

   xi. Active Assailant/Shooter (Code Silver);

c) In addition employees should be aware of procedures associated with:

   i. Severe weather plan; and,

   ii. Service disruption plan.

1.5.6 Fire Safety:

Special-care homes shall have a fire safety plan, including fire inspections, that meets all national, provincial and municipal requirements.

Further Clarification:

The plan shall include:

a) Code Red procedures including evacuation of residents, visitors and employees;

b) Designation of a person in charge in the event of a Code Red;

c) Employee communication plan for site-specific Code Red procedures including requirements of the local fire department;

d) Ongoing fire training for staff with regular updates; and,

e) Frequency of fire alarm tests and drills with records kept of all tests, exercises and attendance.

1.5.7 Design and Aesthetics:

Special-care homes shall create a cheerful and home-like environment to meet resident care needs, assure their quality of life, and to provide a healthy work environment for employees.

Further Clarification:

a) Comfortable room temperature (20-25 degrees Celsius), as determined with resident input, shall be maintained;

b) Regular building monitoring to detect safety issues, such as loose flooring, and address noted issues in a timely manner shall take place;

c) Any plans to renovate must be done in compliance with regulatory requirements, including but not limited to: the Ministry of Health Capital Asset Planning Process, building codes, infection control, fire safety and occupational health and safety;

d) Renovation plans should be prepared in consultation with, and consideration given to, resident and family council input; and,

e) There must be a process to follow when residents/responsible persons desire to make changes to the resident rooms, which is communicated to all residents/responsible persons.

1.5.8 Water Temperature:

The temperature of water in hot water holding tanks and at points of use shall be maintained at an appropriate temperature for the intended use.

Further Clarification:

The following recommendations shall be considered:

a) The hot water tank temperature must be maintained at the temperature required to assist in the prevention of legionella;

b) Water temperature be controlled at the point of use where residents have access;

c) The implementation of a protocol for testing and documenting water temperature in bathtubs prior to residents entering the tub;

d) Water temperature requirements for laundry be identified;

e) All water temperature-controlling devices are monitored and documented on a routine basis; and,

f) The home shall follow all SHA policies on water temperature testing, monitoring and recording.

1.6.0 STAFFING

1.6.1 Staffing Requirements:

Special-care homes shall meet the staffing requirements set out in *The Housing and Special-care Homes Regulations.* Homes shall provide nursing and personal care using a staff mix of care providers including registered nurses, registered psychiatric nurses, licensed practical nurses, continuing care aides (CCA) and other suitably trained staff to provide quality resident care that meets the assessed care needs of the residents.

Further Clarification:

The Housing and Special-care Homes Regulations s.4 states:

(1) The care of the guests is to be carried out by or under the direction of a registered nurse or registered psychiatric nurse and supervision by the guest's personal physician or a nurse practitioner.

(2) Every home shall employ at least one full-time registered nurse or registered psychiatric nurse.

(3) Nursing care by a registered nurse or a registered psychiatric nurse shall be provided on a 24-hour basis.

In addition to these regulatory requirements, homes shall:

a) Demonstrate that quality outcomes, quality of care needs and the quality of life needs of residents are considered priority when staffing;

b) Stipulate that nursing care is provided by a RN or RPN on a 24-hour basis. This is interpreted to be a minimum of eight (8) hours a day five (5) days per week on-site with a RN/RPN on call when not in the home;

c) Ensure that CCAs are under the supervision of a professional nurse;

d) Direct that individuals newly hired to work in the CCA role that have not yet completed an SHA recognized training program, must do so within two (2) years of initial employment. In the interim, they must have the skills to perform the job requirements;

e) Incorporate a process to determine the safest and most effective staffing mix of health care providers to meet the needs of the residents; and,

f) Include a plan to change staffing mix as required based on residents needs, the evaluation process and/or the competence of the staff.

1.6.2 Regulated Professionals:

Special-care homes shall ensure that each LPN, RN, RPN, NP, physician, or other regulated professional shall be licensed to practice with their professional regulatory body and that they practice in accordance with the requirements of their professional body.

Further Clarification:

None.

1.6.3 Medical Coverage/Physician Services:

Homes shall provide medical coverage in a manner consistent with *The Housing and Special-Care Homes Regulations.*

Further Clarification:

All residents shall be under the care of a physician; however, homes may engage nurse practitioners to provide clinical services to residents within the scope of a nurse practitioner and in collaboration with a resident's physician.

A physician shall be designated for the provision of medical care and treatment for each resident by:

i. The resident or responsible person, and if this fails; and,

ii. The special-care home responsible for the care.

An examination by the physician or NP must be completed and documented:

i. Upon move in;

ii. Where a nursing assessment indicates that the resident's condition requires attention by a physician or NP; and,

iii. Not less than once every year.

Medical coverage shall include, but is not be limited to:

i. The arrangement for a physician or NP to be on call and available to receive calls at all times;

ii. The examination upon move in and annually shall be a comprehensive assessment specific to the resident's age and medical condition, and be documented on the resident care record;

iii. The inclusion of the physician or NP as part of the care team in the annual care conference;

iv. The use of virtual technology when appropriate to provide care;

v. The completion of a medication review in collaboration with the resident and care team every three months or more frequently based on the resident assessment;

vi. The requirement that the physician or NP provide notifications related to communicable disease outbreaks, participate in critical incident investigations and any other regulatory reporting requirements;

vii. The requirement that the physician or NP perform only treatments and/or procedures approved by the special-care home in the special-care home, and compatible with the competencies of the attending staff; and,

viii. The requirement of the physician or NP to notify the special-care home when not available to attend to the resident/s and indicate the name and contact information of the alternate physician that will take over the care in the interim.

1.6.4 Specialty Practice Procedures/Registered Nurse Clinical Protocols:

Special-care homes shall describe specialty practice procedures and regulated nurse clinical protocols required by the home and implement them in accordance with criteria developed by the Saskatchewan Registered Nurses Association (SRNA); Registered Psychiatric Nurses Association (RPNAS) and the Saskatchewan Association of Licensed Practical Nurses (SALPN).

Further Clarification:

Specialty practice procedures and clinical protocols shall be developed based on the following principles:

a) Regulated health care providers are expected to carry out specific approved specialty practice procedures, for which they are trained and competent to safely perform;

b) Staff trained in specialty practice procedures and clinical protocols, but have not performed these procedures for some time, must achieve competency in the procedure and protocols prior to performing them;

c) Equipment and supplies to safely and effectively carry out the specialty practice procedures and clinical protocols identified will be available;

d) There should be a process for physicians and other health care professionals to request new clinical protocols to be considered and incorporated;

e) All relevant staff must be aware of the specialty practice procedures and clinical protocols that have been approved; and,

f) Specialty practice procedures and clinical protocols should be evaluated periodically.

1.7.0 QUALITY AND REPORTING

1.7.1 Quality Management and Quality Improvement:

Special-care homes shall implement a quality management program that incorporates elements of the Saskatchewan Healthcare Management System to monitor and improve the quality of its services.

Further Clarification:

The program shall include, but not be restricted to:

a) Monitoring the quality of care/services, including quality indicators, and using this data to improve services;

b) Completing resident and family satisfaction surveys at regular intervals as requested by the Ministry of Health;

c) Reviewing trends based on documented resident and others concerns expressed through the Client Concern Handling Process and through reportable incident reports;

d) Monitoring client outcomes in comparison to evidence-based best practices;

e) Evaluating quality improvement strategies and modify based on outcomes;

f) Ensuring staff training strategies are identified that respond to the changing resident needs and health care trends; and,

g) Participating in the accreditation process.

1.7.2 Concern Handling:

Special-care homes shall have a documented process to ensure that residents/responsible persons/employees, and any other person having a concern related to the care a resident is receiving, have the opportunity to report the concern, and receive a response in a timely manner, without fear of retribution.

Further Clarification:

The process shall include:

a) The process to follow when a resident/responsible person, family, employee, friend, and/or others have a concern;

b) A communication plan to ensure the process is communicated to staff and explained on move-in to the resident/responsible person, friends and family;

c) A statement that all concerns expressed will be reviewed and a response will be provided, in a timely manner;

d) Concerns should be addressed and escalated according to the following:

First-level Attempt

i. First attempt to resolve the concern should be by front-line staff. If resolution is not possible, it is referred to the most appropriate supervisor or manager.

ii. If the direct supervisor is not successful at resolving the concern, the concern should be escalated to the home's management and/or the director of long-term care if necessary.

Second-level Review

i. If the above has been unsuccessful, and the complainant is still unsatisfied, a second-level review is completed within 30 days. The concern is raised with the most appropriate health authority manager, who will investigate the complaint or possibly arrange for an independent secondary review of the issue. Typically, the result of this review would be considered the final decision on the part of the health authority.

ii. At any time, residents or family members can contact the Ombudsman for assistance in working through a concern. It is typically only after this second-level review from the health authority that the Ombudsman would be contacted.

e) The procedure must include:

   i. A review of all relevant information.

   ii. The review is free from bias or reasonable perceptions of bias.

   iii. Handled in a timely fashion (within a maximum of a 30 day period). Every effort should be made to resolve concerns at the point of service in real time. Progress and possible delays (with reason for delay) need to be communicated to all parties involved in the concern, while respecting confidentiality.

   iv. Be documented, tracked and monitored.

   v. Include a clear explanation to those who raised the concern, or have been involved in the process of any decision, as to how the decision was made and general action taken, taking into consideration confidentiality and consent.

   vi. Involve those who raised the concern in the process.

   vii. A process for implementation of the recommendations as a result of the review.

   viii. Information advising how to access the second-level review process if the initial resolution is unsatisfactory and the issue remains unresolved.

   ix. Not include concerns of a clinical decision made by a regulated healthcare professional, which should be referred to the appropriate regulatory body for review.

f) Residents and family members must be advised that, at any point, the home or the resident/responsible person can contact the Quality of Care Coordinator, Patient Advocate or Client Representative and include them in the concern process.

g) Residents/responsible person, family members, and employees need to be informed of the Ombudsman and their role, including:

   i. A procedure that permits residents to communicate in private with the Ombudsman.

   ii. A procedure to inform residents of their right to communicate with the Ombudsman, and the services provided by, and the contact information for the Ombudsman.

1.7.3 Critical Incident Reporting:

All incidents that have the potential to, or have affected the health and safety of a resident, staff, visitor and/or other person in the special-care home shall be investigated and reported in accordance with legislated requirements.

Further Clarification:

Further specific information is available in Section 3, 1.3 Incident Investigation and Reporting.

1.7.4 Reporting:

Special-care homes shall report the following to the Ministry of Health:

a) All move-ins, transfers and discharges as prescribed by the Ministry;

b) Any changes to incorrect move-in information previously provided to the Ministry;

c) Where residents provide their annual reported income to the home it shall be provided to the Ministry of Health for the purpose of setting the income-tested charge;

d) Any changes to resident income will be reported immediately to ensure a timely change to the income-tested resident charge;

e) Total bed counts identifying the number of permanent placement beds and the number of temporary care beds used for respite care, convalescent care or other short stays;

f) Ongoing changes made on a permanent basis to long-term care bed numbers as approved by the Ministry of Health; and,

g) Other information as required by the Ministry of Health.

Homes shall report data to CIHI as directed by the Ministry of Health.

Further Clarification:

None

Section II: Recommended Operational Policies

Special-care homes are encouraged to establish policies and procedures on the following topics that build on the standards outlined in Section I and reflect best practice.

2.1.0 ADMINISTRATION

2.1.1 Resident Handbook:

A detailed written document should be available to prospective residents, their families or responsible person, and the public about the home and the services provided. This information shall be provided to each resident or their responsible person.

Further Clarification:

The following outline is provided to assist in developing a resident information handbook.

a) Home contact information and business hours;

b) Assessment/move-in process;

c) Resident charges;

d) Resident rooms and furnishings;

e) Personal belongings (identification and safekeeping);

f) Resident care team, including direct contact for family;

g) Resident care provided;

h) Medical/emergency services;

i) Food and nutrition services, including permitted outside food;

j) Religious services;

k) If the home is operated under sectarian auspices, how are clergy of other faiths to visit residents and conduct religious services;

l) Visiting hours and expectations;

m) Activity/recreation program;

n) Library services and reading/video materials available;

o) Mail Service;

p) Transportation available and fees charged;

q) Alcoholic beverages rules;

r) Smoking/vaping rules;

s) Fire safety measures;

t) Safety provisions, including lifts and exit alarms;

u) Volunteer services;

v) Family support group/resident council; and,

w) Process for addressing resident/family concerns.

2.1.2 Resident Outings:

Special-care homes shall have a policy that outlines the process and procedures to follow when a resident leaves the home for an outing. The procedure shall document the outing and required follow up if the resident does not return as planned.

Further Clarification:

The following elements are recommended for consideration:

a) The resident/responsible person shall be asked to sign a resident outing sheet that includes the resident's name, date, time of departure, expected time of return, and the name, signature and phone number of the person responsible for the resident during the outing;

b) In the event that a resident/responsible person does not sign a resident outing sheet and/or give information on the outing, this must be documented in the resident's care record;

c) Administration of medication during the outing through the use of medication separated into small envelopes or containers in accordance with restrictions based on applicable legislation. Each envelope or container should be labelled with the resident's name, medication name, and time it should be administered as well as any side effects that could be experienced with directions should this happen; and,

d) Protocol for staff to follow if the resident does not return to the home at the designated time, including:

   i. Contacting the responsible person that took the resident on the outing;

   ii. Contacting next-of-kin; and,

   iii. Initiating code yellow (missing resident).

2.1.3 Smoking and Vaping Products:

Special-care homes shall not deny admission to individuals that smoke. Homes shall establish policies regarding smoking and vaping products, including specific safety precautions if required for the resident to safely smoke.

Further Clarification:

The following elements are recommended for consideration:

a) Review of the smoking/vaping policy during the move in procedure with the resident/responsible persons, and inclusion of information regarding smoking/vaping rules in the resident handbook;

b) Homes that allow the option of smoking/vaping **inside** the building must provide a separate enclosed ventilated place in accordance with *The Provincial Health Authority Act* and *The Tobacco and Vapor Products Control Regulations*;

   i. A separate enclosed ventilated place in a home must be set aside exclusively as a smoking room or room in which vapour products may be used or consumed with signage posted on the room identifying it as a "smoking/vaping room for residents only;"

   ii. Smoking/vaping room must have a door that closes automatically and seals to prevent smoke/vapour from escaping into other parts of the home;

   iii. The door must be kept closed at all times except when opened to permit entry or exit from the room;

   iv. Smoking/vaping room must have ventilation system that provides a continuous supply of fresh air into the designated room and prevents recirculation of air from the designated smoking/vaping room to any other part of the home;

   v. Ventilation must be capable of replacing the air volume into the designated smoking/vaping room at least 12 times per hour and exhausts the air from the designated smoking/vaping room directly to the exterior of the home;

   vi. Combustible materials, such as carpets, books, magazines and other paper products should be restricted from this area;

   vii. Provide ashtrays designed to keep unattended smoldering cigarettes from falling on the floor or furniture and empty ashtrays after each smoking period into a metal receptacle that is kept in a location acceptable to the Chief Fire Official; and,

   viii. Install an ABC fire extinguisher at or near the entrance to the room.

c) Refillable cigarette lighters or fuel should not be permitted in the home;

d) Restriction of residents on oxygen from smoking/vaping or entering the designated smoking/vaping areas while oxygen is flowing. Oxygen flow must be shut-off and oxygen removed by staff prior to allowing admittance to smoking/vaping areas;

e) Initial assessment of the resident's ability to manage smoking/vaping safely to ensure their safety and that of others prior to planning the smoking/vaping opportunities. The assessment shall be done on an on-going basis with the changes made to the smoking/vaping plan as indicated; and,

f) Where residents are deemed as at risk through the assessment process, consideration shall be given to:

   i. Offering nicotine replacement therapy;

   ii. Wearing fire retardant aprons;

   ii. Supervision by a responsible person while smoking/vaping;

   iii. Restriction of blankets and cushions accompanying residents when smoking/vaping in wheelchairs; and,

   iv. Keeping smoking/vaping products out of resident's reach.

2.1.4 Alcohol in the Home:

Special-care homes shall have a policy regarding the consumption of alcoholic beverages in the home that is in compliance with the *Alcohol and Gaming Regulation Act, 1997*.

Further Clarification:

When alcohol consumption is occurring the following elements are recommended for consideration:

a) A thorough review with individual residents upon move in and during the quarterly multidisciplinary medication review to ensure they are aware of contraindications based on their prescribed medications or medical conditions. Any contraindications and risks to the resident should be discussed with the resident/responsible person to inform their right to decide whether to consume alcohol;

b) A home is considered a private residence, making it permissible for residents to have or consume liquor responsibly. Liquor kept in the home needs to be securely stored. A resident may store liquor in their room if it is securely stored;

c) Residents at risk, should have their alcohol labeled and kept secured at the nursing station;

d) In common areas of congregation (e.g. those that may be accessible to the public) a liquor permit must be obtained for each instance in which alcohol will be sold; and,

e) Inquiries in this regard should be directed to: Saskatchewan Liquor and Gaming Authority, P.O. Box 5054, Regina, Saskatchewan, S4P 3M3, or phone (306) 787-5563. Information and application forms can also be found on the Saskatchewan Liquor and Gaming Authority Website at https://www.slga.com/.

2.1.5 Pets in the Home:

Special-care homes shall have a policy regarding pets in the home on a permanent basis or for short-term visits.

Further Clarification:

Where pets reside or visit the home, the following elements are recommended for consideration:

a) Consultation with residents or the responsible person;

b) Consultation with staff including the staff member responsible for infection control;

c) Review of local bylaws and/or legislation to establish compliance;

d) The procedure to be followed when determining the type and number of pets allowed;

e) The approval process for visiting pets;

f) The procedure for caring for the pet/s including regular veterinary checks, immunization, grooming, exercise as needed, feeding and watering, as well as any additional care needed for the particular type of pet;

g) A list of responsible persons to attend to the pet on a routine basis and during each shift;

h) The procedure to be followed when a resident or staff member has been diagnosed with an allergy to the pet;

i) The procedure to be followed if it is determined the pet is not suitable for the environment;

j) A plan for signage on resident rooms who do not wish a pet to visit their room;

k) Prior to move-in residents/responsible person are to be informed of the pet policy; and,

l) Pets will not be allowed in the food preparation and dining areas.

2.1.6 Cannabis in the Home:

Special-care homes shall have a policy on medical and recreational cannabis use.

Further Clarification:

Regarding medical cannabis, the following elements are recommended for consideration:

a) The review of the cannabis policy with the resident/responsible persons on move-in;

b) Residents will sign a copy of the policy to include in their clinical record to indicate the resident understands the content of the policy;

c) Storage of resident's medical cannabis (i.e. medication cart), how it will be administered/accessed (i.e. smoking, edibles, etc.), who is responsible for administering (i.e. staff or resident self-administering), and how it is documented on the medication administration record;

d) Medical cannabis shall be ordered by a physician, purchased through a licensed cannabis dispensary, and other obligations of Health Canada;

e) If a resident is smoking medical cannabis, smoking rules of the home must be followed (i.e. designated smoking areas);

f) Initial and on-going assessment of the resident's ability to manage smoking safely to ensure their safety and that of others;

g) Where residents are not able to safely manage smoking medical cannabis, a discussion with the resident/responsible person and the prescribing physician to consider alternatives; and,

h) Any suspected illegal activity will be reported to the prescribing physician, and the police.

Regarding recreational cannabis, the following elements are recommended for consideration:

a) Reference to the legal use of recreational cannabis i.e. age, amount, etc.;

b) Resident consumes/smokes recreation cannabis at own risk;

c) If resident is smoking cannabis, smoking rules of the home must be followed (i.e. designated smoking areas);

d) Recreational cannabis (all forms) must be securely stored in the resident's room and out of sight;

e) The SHA/home is not responsible for lost or stolen cannabis;

f) Any suspected illegal activity will be reported to the police; and,

g) Implications if resident's behavior negatively impacts other residents and/or staff safety when using recreational cannabis.

2.1.7 Research and Education:

When research or the clinical training of health professionals will be conducted within the home, the home shall have a policy to ensure residents' rights and privacy are respected, and that researchers and students are aware of applicable safety and care protocols.

Further Clarification:

The following elements are recommended for consideration:

a) Requirement for a signed agreement or letter of understanding with the outside agency and/or organizations (e.g. medical/nursing colleges, etc.) requesting to conduct research or provide educational opportunities to define areas of responsibility of the persons/organization and its personnel, as well as areas of responsibility of the home and its staff;

b) Whether an ethics committee has approved the research;

c) Respect for resident privacy requirements;

d) The process to ensure the resident/responsible person is advised of their right to choose whether or not to participate in such programs including documentation of consent or denial;

e) The resident/responsible person must have the option to review their decision at any time; and,

f) Educational agreements where the home is to be a clinical site shall include, but not be limited to:

   i. The orientation plan for students including the staff safety program;

   ii. The supervisory responsibilities of those in charge of the clinical placements;

   iii. Written details of procedures the students will be expected and allowed to perform; and,

   iv. The process for documentation on the care record.

2.2.0 SUPPORTIVE SERVICES

2.2.1 Spiritual and Cultural Services:

Special-care homes shall establish policy to support residents to access spiritual and cultural services of their preference either within the home or by utilizing community resources.

Further Clarification:

The following elements are recommended for consideration:

a) Recognizing a resident's spiritual and cultural observances, practices and affiliations while also respecting the rights of other residents;

b) Respecting resident preference for participation in spiritual and cultural services in the home or in the community and ensuring this is documented in the care plan;

c) Recognizing that resident attendance at spiritual and cultural services is voluntary;

d) Utilizing space within the home for spiritual and cultural services, should space be available and be conducive to worship free from interruptions; and,

e) Offering residents assistance with accessing spiritual and cultural services of choice.

2.2.2 Volunteers:

Where a volunteer services program is incorporated into the home, policy shall be established with attention to legal liability, insurance protection, and expenses related to volunteer services.

Further Clarification:

The following elements are recommended for consideration:

a) Orientation/training of volunteers;

b) Mechanism to screen volunteers dependent on the volunteer's role in the home and the level of contact with residents;

c) Criminal record/vulnerable sector checks of all volunteers prior to commencing volunteerism; and,

d) Defined scope of volunteer activities within the home.

2.2.3 Privately Hired Care:

Homes shall have a procedure to allow for a resident/responsible person to hire private care if desired.

Further Clarification:

The following elements are recommended for consideration:

a) An agreement indicating who is responsible for the payment of the service;

b) Collaboration between the home and the privately hired care to ensure care meets both the resident's and the home's needs;

c) Privately hired care provider be advised of, and agree to comply with all policies and procedures of the home including reporting and charting requirements and the administration of medication;

d) Orientation of privately hired care provider, including the safety program and the safe operation of equipment that the privately hired care provider will be required to use;

e) Confirmation of private care provider liability insurance including workers compensation coverage and current practicing membership, if a regulated provider;

f) Privately hired care provider is responsible to the resident/responsible person;

g) Detailed documentation of all functions that the privately hired care provider will perform and that these functions are within their scope of practice; and,

h) The home should check with their insurance provider to ensure they are in compliance.

3.0 SAFETY

2.3.1 Employee Immunization:

In consultation with the SHA Medical Health Officer or public health services, an employee immunization policy shall be established (including affiliates/contracted homes) to assist in the prevention of the transmission of communicable/vaccine preventable diseases.

Further Clarification:

The following elements are recommended for consideration:

a) Provision of information to employees regarding how to access immunizations;

b) The requirement to maintain accurate records of employee immunization, medical examinations and tests carried out pursuant to the policy, and retain these records as per employer policy after he/she ceases to be an employee;

c) Identification of immunization requirements for employees in consultation with the SHA Medical Health Officer. Recommended immunization requirements have been determined by the Provincial Medical Health Officers. The following list should be considered when establishing requirements:

   i. Influenza;

   ii. Diphtheria and Tetanus Toxoid;

   iii. Polio;

   iv. Measles;

   v. Rubella;

   vi. Hepatitis B; and,

   vii. New vaccines as discussed with the SHA Medical Health Officer.

d) The requirement that all persons accepting employment in the special-care home shall be requested to show evidence of current immunization to meet the above requirements;

e) The requirement that persons accepting employment with no history of adequate immunization against the identified vaccine preventable diseases shall be offered immunization as recommended by the SHA Medical Health Officer;

f) In situations where an employee refuses immunization with no medical reason, the special-care home should consult with the SHA Senior Management Team and Human Resources/Labour Relations;

g) All Healthcare workers (including physicians, students, volunteers, contractors, etc.) that are required to be in resident care areas are encouraged to be vaccinated yearly against influenza; and,

h) It is recommended that all long-term care employees and regular volunteers have two-step tuberculin testing completed at the time of hire as per the Canadian TB Standards.

Where an employer offers immunization at the place of employment the required process to offer immunization shall include, but not be limited to:

a) A protocol relating to specialty practice procedure requiring additional training;
b) The appropriate environment exists to support the LPN/RN trained in the specialty practice;
c) The standards of conduct, competencies, proficiency, and the manner and method of the specialty practice set out by the Saskatchewan Registered Nurses Association and the Saskatchewan Association of Licensed Practical Nurses; and,
d) A process to assist in identifying how the supply of publicly funded vaccine must be requested through the SHA.

2.3.2 Preventative Maintenance and Repair:

A preventative maintenance and repair program for all buildings and equipment shall be established.

Further Clarification:

The following elements are recommended for consideration:

a) Documentation of all equipment and buildings;

b) Identification of the responsibilities for maintenance and repair of buildings and equipment including resident owned and loaned equipment;

c) The procedure to ensure that equipment and buildings are maintained as per instructions and recommended maintenance schedule;

d) The process for employees to identify and initiate equipment and building maintenance and repair needs;

e) The process to document maintenance and repairs;

f) The requirement to follow infection prevention and control policies; and,

g) Evaluation of the preventative maintenance and repair program.

2.4.0 STAFFING

2.4.1 Staff Orientation:

Each home shall have orientation policies and procedures for new staff.

Further Clarification:

The following elements are recommended for consideration:

a) Orientation, including documentation that all employees have a working knowledge of the *Program Guidelines for Special-care Homes* and how to access the guidelines;

b) Orientation, that is specific to the job descriptions and addresses all relevant areas;

c) A detailed outline for each area of orientation, both general and job specific;

d) Safety training related to WHIMIS and appropriate responses to violence;

e) Verification that employees understand and can apply the information provided;

f) Permanent documentation that each employee has successfully completed the orientation program prior to working independently; and,

g) Identification of a plan to review and revise the orientation programs on a regular basis, or whenever there is a change in circumstances.

2.4.2 Staff Development:

All homes shall have policies regarding on-going education and training for staff.

Further Clarification:

The following elements are recommended for consideration:

a) Staff development programs that are evidence-based and support the scope of practice and required competencies of all staff;

b) A method to verify that employees understand and are applying the information provided;

c) Documentation of education and training attended by staff; and,

d) Programs are reviewed and revised on a regular basis, or whenever there is a change in circumstances.

Section III: Legislative Requirements and/or General Information

While the *Program Guidelines for Special-care Homes* is an integral part of the requirements regarding the operation and provision of quality care, special-care homes shall comply with all relevant legislation.

This section references select legislative requirements and is not meant to be an exclusive list of requirements.

This section also includes reference to other programs and services that may be of benefit to residents of special-care homes.

3.1.1 Retention of Records:

The Health Information Protection Act

The Income Tax Act

Resident records shall be kept for a minimum of seven (7) years after the date of discharge for all adults and for children until the child reaches 18 years of age, plus two (2) years.

Further Clarification:

a) Where concerns related to the particular resident have been identified, all records relevant to the case should be maintained until it is clear that the concerns have been resolved; and,

b) When in doubt about whether a particular document or record should be destroyed, the home's solicitor should be consulted.

3.1.2 Disclosure of Health Information:

The Health Information Protection Act

As a trustee under *The Health Information and Protection Act*, special-care homes must keep residents' health information in a secure place, treat residents' health information as confidential, and protect residents' health information from loss and unauthorized access.

Further Clarification:

Residents' health information may be shared with others under the following circumstances:

a) The resident provides consent to share information;

b) The resident has designated a family member or close friend to be made aware of their health information;

c) The resident's health information needs to be shared with another healthcare provider to provide optimal care to the resident; and,

d) The Ministry of Health, coroner or any other person designated by the Minister of Health requests access.

3.1.3 Incident Reviews Investigation and Reporting:

The Provincial Health Authority Act

The Occupational Health and Safety Act, 1993

The Public Health Act

Saskatchewan Critical Incident Reporting Guideline, 2004

The Occupational Health and Safety Regulations, 1996

The Disease Control Regulations

All incidents that have the potential to, or have affected the health and safety of a resident, staff, visitor and/or other person in the special-care home shall be investigated and reported in accordance with legislated requirements.

Further Clarification:

The incident review process shall include:

a) Recommended changes to prevent the reoccurrence of similar incidents;

b) Retention of incident reports for a minimum of seven years;

c) Documentation of de-identified concerns on the provincial Client Concern Handling System Database; and,

d) Respect for resident confidentiality.

The process to review, investigate and report incidents shall be based on regulatory requirements including, but not limited to:

a) Critical incidents shall be investigated and reported on in accordance with the Saskatchewan Critical Incident Reporting Guidelines, 2004 and *The Provincial Health Authority Act,* s.58. Contact Ministry of Health provincial quality of care coordinators at (306) 787-6992 or 787-0935.

b) Incidents related to infection with a Category I or Category II Communicable Disease shall be reported to the local Medical Health Officer (MHO) in accordance with *The Public Health Act, 1994*, *The Disease Control Regulations*, and *The Communicable Disease Control Manual*. Health care providers are required to report to the local MHO as soon after forming an opinion of infection with a Category I or Category II Communicable Disease regarding both known and suspected cases. Contact Ministry of Health, Population Health Branch for additional information at (306) 787-8847.

c) Incidents that affect an employee shall be reported in accordance with *The Occupational Health and Safety Act, 1993* and its regulations. Contact Labour Relations and Workplace Safety Division for additional information:

Regina

300-1870 Albert Street
REGINA SK S4P 4W1

Telephone: 1-800-567-7233
Toll free in Saskatchewan
Regina: (306) 787-7404
Fax: (306) 787-2208

Saskatoon

122-3rd Avenue North
SASKATOON SK S7K 2H6

Telephone: 1-800-667-5023
Toll free in Saskatchewan
Saskatoon: (306) 933-5052
Fax: (306) 933-7339

3.1.4 Income Security and Assistance Programs:

Old Age Security Pension

Guaranteed Income Supplement

Canada Pension Plan (CPP) Retirement Pension

Veterans Affairs Canada

Saskatchewan Aids to Independent Living (SAIL)

Provide information to residents/responsible persons to assist in accessing income security benefits and assistance programs.

Further Clarification:

Residents/responsible persons shall be advised of the following financial assistance programs:

a) Old Age Security:

The Old Age Security (OAS) pension is a monthly payment available to most Canadians aged 65 or older. Seniors are automatically enrolled when they turn 65.

b) Guaranteed Income Supplement:

The Guaranteed Income Supplement (GIS) is a monthly benefit for low-income seniors already receiving OAS. Eligible seniors are automatically enrolled.

c) Seniors Income Plan:

The Seniors Income Plan provides additional funds to senior citizens who have minimal income other than OAS and GIS. Seniors, whose incomes are below the designated levels, will automatically receive the Seniors Income Plan (SIP) benefit as part of their OAS/GIS payment. For additional information contact:

Ministry of Social Services
Seniors Income Plan
2nd Floor, 2125 Scarth Street
REGINA SK S4P 2H8
Phone: (306) 787-2681 or toll-free: 1-800-667-7161

d) Canada Pension Plan:

The Canada Pension Plan (CPP) is a monthly benefit for people who have contributed to CPP. Application may be made if:

i. The applicant is at least 65; or,

ii. The applicant is at least 60 and meets the earning requirements.

Additional information and applications forms for OAS, GIS and CPP are available by calling toll free 1-800-277-9914 or by accessing the website at http://www.esdc.gc.ca/en/cpp/oas/index.page.

e) Additional Assistance:

i. Veterans Benefits:

Veteran's benefits through Veteran's Affairs Canada are case specific. If an individual identifies him/herself as a Veteran or believes that they have service that would qualify them for Veterans benefits, contact should be made with the nearest Veterans Affairs Canada Office.

Regina Office	Saskatoon Office
108-1783 Hamilton Street REGINA SK S4P 2B6 Phone toll-free: 1-866-522-2122	101-22nd Street East SASKATOON SK S7K 0E1 Phone toll-free: 1-866-522-2122

ii. Saskatchewan Income Support (SIS):

The Ministry of Social Services provides financial and health benefits to individuals who lack the resources to meet their basic living requirements. For additional information on SIS call 1-866-221-5200.

iii. Supplementary Health Services Coverage:

Residents who are experiencing difficulty in covering the cost of health care services (e.g. dental services, drugs, medical supplies/appliances, optical services, chiropractic services and emergency medical transportation costs) may be eligible for supplementary Health Services coverage provided they meet the following criteria:

- The resident is 65 years of age or older;
- The resident is receiving benefits from the SIP; and,
- The resident is receiving Level 3 or 4 care in a special-care home.

If a resident meets the above criteria, the special-care home will complete a Health Coverage Advice form indicating a request for Supplementary Health Services coverage and submit it to:

Ministry of Social Services
Seniors Income Plan
2nd Floor, 2125 Scarth Street
REGINA SK S4P 2H8
Phone: (306) 787-2681 or toll-free: 1-800-667-7161
Fax: (306) 787-2134

iv. Saskatchewan Aids to Independent Living (SAIL) Benefits:

This program facilitates the independence of persons with permanent physical disabilities and those with select chronic conditions by providing an extensive range of benefits. Some benefits are particularly relevant to institutional supportive services including home oxygen and mobility devices.

For more information on SAIL benefits, refer to the following website at https://www.saskatchewan.ca/residents/health/accessing-health-care-services/health-services-for-people-with-disabilities/sail or contact:

Ministry of Health
Drug Plan and Extended Benefits Branch
3475 Albert Street
REGINA SK S4S 6X6
Phone: 306-787-7121Third Party Agency:

In special circumstances, a third party agency may be obligated to provide for the full cost of care of a resident, which includes all expenses incurred by the home in maintaining the resident in institutional supportive care.

3.1.5 Prescription Drug Plan:

The Prescriptions Drugs Act

Resident shall be charged for prescription drugs in accordance with the Saskatchewan Drug Plan, the Saskatchewan Seniors' Drug Plan, and any other Saskatchewan drug plan program or policy.

Further Clarification:

Where a home enters into contracts with a pharmacy for prescription drug services residents shall be afforded the lowest possible additional charge for medication/pharmacy services.

In accordance with the Provincial Supply Charge Policy, residents shall not pay for compliance packaging for medications.

Any contract entered into between a special-care home and a pharmacy shall ensure that residents have full access to the range of benefits under the Saskatchewan Drug Plan, including those related to dispensing maintenance medications (i.e. single dispensing fee for 100-day supply eligible medications).

3.1.6 Saskatchewan Aids to Independent Living (SAIL):

Saskatchewan Aids to Independent Living (SAIL)

Special-care homes will assist resident to access SAIL equipment, services and other programs as required.

Further Clarification:

Information regarding SAIL can be found on the web site (link above) or by contacting the program directly at:

SAIL Program
3475 Albert Street
REGINA SK S4S 6X6
Telephone: (306) 787-7121

When a resident dies or no longer requires the SAIL equipment, it must be returned to SAIL. Call SAIL at 306-664-6646 to arrange to have the equipment picked up.

3.1.7 Occupational Health Committee:

The Occupational Health and Safety Act, 1993

The Occupational Health and Safety Regulations, 1996

Each special-care home shall establish an occupational health committee as directed by *The Occupational Health and Safety Act, 1993*.