KELSEY TRAIL HEALTH REGION

Last Name First Name

DOB YMD ☐ Male ☐ Female

PHN CPI #

Physician

Supportive Care Admission Agreement

In this agreement the resident/responsible party will be called 'you'. The Facility will be called 'we'.

This legally binding agreement outlines the kind of care you can expect from us and the services we will provide. It also explains your responsibilities. If you have any questions or concerns about the contents of this agreement, please talk to us before signing it. Signing this agreement means you understand and agree to the terms of the agreement. Several of the terms used in this agreement are defined terms and the definitions appear on "Schedule B".

General Information and Care Responsibilities

1. We will provide services with consideration, respect, and dignity, which includes;
   - Privacy when you are receiving treatment
   - Attention to your personal needs
   - Opportunities to participate in religious, ethnic, political and community activities within available resources.

2. We will provide you with care, as needed, for your health, safety and well-being.

3. We will equip your room with basic furnishings, provide nourishment in accordance with The Canada Food Guide each day, provide clean linens and bedding, and will do personal laundry (excluding dry cleaning).

4. We will inform you of the general operating policies and procedures of our Facility as outlined in the Resident Handbook, a copy of which has been provided. Any suspected criminal activity that comes to our attention will be reported to the police.

5. KTHR reserves the right to transfer/relocate a resident to a different room if it is determined that a move to another location within the home is necessary for the safety, welfare and or health of a resident, staff or others. The LTC home will discuss transfer/relocation with the resident and /or responsible party. If the situation is urgent, contact with the responsible party will be made as soon as possible once the resident's care needs are met and explanations will be provided. Under these conditions, the LTC home accepts responsibility to move the resident's personal belongings to their new location.

Initials ☐

6. We encourage you to bring your clothing, small personal effects and furnishings to personalize your room (subject to available space). We are unable to accept any responsibility for items of significant financial value such as jewelry, artwork or other valuables. Personal effects and furnishings must not interfere with the ability of our staff to provide safe care. Electrical and safety checks are required on anything you bring to the Facility. We will remove or dispose of articles for sanitary or other good reasons and we will explain the problem with having such articles in the Facility with you before such items are disposed of, if possible.

7. For infection control, safety and security reasons we will inspect your room periodically.

SERVICE PROTOCOLS

1. We will work with you to develop a plan of care that meets your needs.

2. We will respect your wishes regarding the intensity of the level of intervention you have requested related to your medical management.

3. We will notify your doctor when your medical condition requires it or when you ask for medical attention.

4. You consent to having your name and room number appear in written listings that contain a list of residents of the facility in which you reside. We will have your photo- graph taken for identification and health care purposes.

5. If you require emergent medical care, we will arrange an appropriate and safe mode of transfer to hospital, and will do our best to notify your primary contact person.

6. We will provide medications, treatments and procedures ordered by your physician provided that they are consistent with the Facility's policies and appropriate for the staff's training, skill level and availability. Medications will be ordered from the pharmacy contracted by the Facility. No medications supplied by family or friends should be in your possession unless approved by medical personnel

7. We will inform you of our policy of least restraint. If it is necessary to implement the use of a restraint, we will discuss with you the type of restraint and the reason it is necessary.

8. Unless you specifically direct otherwise, we will disclose your registration information to Elections Canada and/or Elections Saskatchewan.

9. KTHR is neither responsible nor liable for the negligence of any third party

10. KTHR does not assume guardianship of the resident and is not responsible for any personal debts incurred.

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As the Resident you agree to:

1. Follow the Facility's policies and procedures as outlined in the Resident Handbook, a copy of which has been provided.

2. Pay the Facility's monthly or daily rate as established by *The Special-care Homes Rates and Regulations*. ***Note: Saskatchewan Health adjusts the rate of accommodation at the facility usually four (4) times per year.*** You will continue to be charged this fee, even when you are in hospital or away from the Facility.

3. Pay using the pre-authorized payment plan.

4. Label your clothing and personal effects according to specific Facility handbook.

5. Provide the Facility with one week's written notice should you decide to discharge yourself from the Facility.

6. Be under the care of a physician, who has privileges in the facility, and who will provide your medical attention and prescribe medications, treatments, and interventions as needed.

7. Provide the staff with the name of your primary contact person and your financially responsible person. If these people change, you must advise the Facility immediately.

8. Respect the privacy and confidentiality of other residents.

9. Make no unauthorized alterations or additions to the Facility.

10. Comply with all applicable federal and provincial laws and refrain from committing or assisting in the commission of any offence. As well as abiding by the policies, procedures, rules and regulations of KTHR, including infection control practices and outbreak management protocols.

11. Work with the facility administrator in the event that the facility can no longer meet your required needs. KTHR will assist you with arrangements for your discharge or transfer.

Initials 

Privacy

1. We are committed to keeping information relating to you confidential. This includes information related to your care and to your medical and personal affairs. However, your information, including your photograph, may need to be released, as necessary, to authorized personnel in order to:

- Identify you
- Assess your health status and care needs
- Plan and provide care to you
- Plan, develop, deliver, monitor or evaluate services that you require or have requested
- Monitor or transfer your ongoing care
- Contact your alternate decision maker
- Facilitate investigation of an offence

Your signature on this document provides us with your written permission to release your information for these purposes.

Dated this _____/_____/_____ in _____, _____.

Day Month Year (city/town) (Province)

KTHR Per: _____ _____

Signature for Facility

Signature Resident/Proxy/Personal Attorney/Personal Guardian/Nearest Relative Substitute Decision Maker

Long Term Care:

The parties agree that this Agreement will remain in effect from the date of admission to the date of discharge or death of the resident.

By signing below, you confirm that you have reviewed this Long Term Care Admission Agreement and agree to abide by its terms.

_____ _____

Signature of Resident/Substitute decision maker/POA Date

_____ _____

Signature on behalf of the facility Date

Temporary Care:

I wish to receive Temporary Care for _____

(Resident's Name)

from _____ to _____ and extension, if applicable, as mutually agreed upon.
I agree to abide by the conditions outlined in this agreement.

_____ _____

Signature of Applicant/Responsible Person Signature on behalf of the Facility

_____

Date

Policy – effective July 2015. Updated for Clarification May 2016

Special-care Home Resident Supply Charges

In Addition to the Income Tested Resident Charge

Group A – no charge to resident	**Group B – an additional charge to the resident at actual cost**	**Group C – incontinent supplies, a charge at actual cost to continue to resident**	**Group D – fully covered by supply charge- charged to resident(adjusted annually to increases in OAS/GIS)**
☐ Basic foot care provided by the facility ☐ 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 ☐ Facility-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 ☐ Intravenous therapy and medications ☐ Bubble packaging/compliance packaging for medications ☐ Infection control items such as disposable gloves, Hand sanitizer, etc.	☐ Transportation cost to and from destination 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 ☐ Post discharge charges to 3 days if bed is vacant ☐ Specialized foot care provided by podiatrist/other ☐ Nutritional supplement supplies if not clinically indicated	☐ Incontinent supplies(attends, colostomy, ileostomy supplies)	☐ 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, etc.

Current supply charge $21.25 per month- adjusted annually to increases in OAS/GI

Initials ☐

Schedule B - Definitions:

Nearest relative: means nearest relative as described in section 15 of The Health Care Directives and Substitute Health Care Decision Makers Act and, subject to a few exceptions, the person first described in the following clauses that is willing, available and has the capacity to make a health care decision:

a) The spouse or person with whom the person requiring treatment cohabits and has cohabited as a spouse in a relationship of some permanence;
b) An adult son or daughter;
c) A parent or legal custodian;
d) An adult brother or sister;
e) A grandparent;
f) An adult grandchild;
g) An adult uncle or aunt;
h) An adult nephew or niece.

Except with respect to adoptive relationships, the health care decision of a relative of the whole blood will be preferred to the health care decision of a relative of the same description of the half-blood; and the health care decision of the elder or eldest of two or more relatives listed above is preferred to the health care decision of the other or others of those relatives.

Personal attorney: means a person who is appointed to act for you under the terms of an Enduring Power of Attorney with respect to your personal affairs

Personal guardian: means a person appointed by the court pursuant to clause 14(1) (b) of The Adult Guardianship and Co-decision-making Act

Primary Contact Person: means the person designated by you or on your behalf as your primary contact person. We will notify your primary contact person in the event of any material change in your medical condition or other living circumstances. By signing this agreement you are authorizing us to share information with your primary contact person to the extent necessary to allow us to obtain direction, consent or authority from your proxy, personal guardian, property guardian, attorney, property attorney, the public guardian and trustee or your nearest relative as the case maybe.

Proxy: means a person appointed in a directive to make health care decisions for the person making the directive;

Substitute Decision Maker: means, in descending order of priority, the person designated as your proxy, your personal attorney, your personal guardian if your personal guardian has been granted the authority to make decisions respecting your health care, including decisions respecting admission to a health care facility or lastly, your nearest relative.

Consents

Last Name First Name

DOB YMD ☐ Male ☐ Female

PHN CPI #

Physician

Specific consent is required for the next seven items – please indicate "yes" or "no" and provide your signature:

1. I hereby consent for myself/or _____ to undergo any examinations, diagnostic tests, treatments and medications prescribed by my/his/her physician.
   Yes ☐ No ☐ _____
   (Signature)

2. Provide the Facility with an Advance Care Plan (Advance Directive) to instruct staff on your care and to advise us of any change to your directions.
   Yes ☐ No ☐ _____
   (Signature)

3. Provide a blood sample for testing if a staff member or volunteer or other resident is exposed to your blood or body fluids.
   Yes ☐ No ☐ _____
   (Signature)

4. I consent to the annual influenza immunization.
   Yes ☐ No ☐ _____
   (Signature)

5. I consent to the pneumococcal immunization if not previously given (handout available).
   Yes ☐ No ☐ _____
   (Signature)

6. I consent to the display within the facility, photographs of me taken at facility social and recreational events.
   Yes ☐ No ☐ _____
   (Signature)

7. I consent to be photographed and/or filmed /video-taped for activities and for pictures in the Resident Care Charts. I understand that the photograph, film/videotape can only be used for identification purposes of the Kelsey Trail Health Region. I also understand that the materials produced are the property of Kelsey Trail Health Region.
   Yes ☐ No ☐ _____
   (Signature)