Nova Scotia Department of Health and Wellness
Continuing Care Branch

Subject: **Facility Placement Policy**

Original Approved Date: March 28, 2002 Revised Date: January 24, 2011

Original signed by Keith Menzies

Approved By: _____

Keith Menzies, Executive Director, Continuing Care Branch

1.0 POLICY STATEMENT

The Nova Scotia Department of Health and Wellness (DOHW) is committed to providing fair, consistent and appropriate placement to the Long Term Care facilities that fall within the Department's mandate. The Department of Health and Wellness supports the objectives of the Facility Placement Policy within the framework of the Single Entry Access (SEA) Case Management Model.[1]

2.0 APPLICATION OF POLICY

The *Facility Placement Policy* applies to long term care facilities under the mandate of the Department of Health and Wellness participating in SEA.

Long term care facilities under the Department of Health and Wellness's mandate include:

- Licensed Nursing Homes or Homes for the Aged (hereinafter referred to as "nursing homes");
- Licensed Residential Care Facilities (RCF); and
- Community Based Options (CBO) - Small Options and Community Residences.

The *Facility Placement Policy* **does not apply** to long term care facilities under the jurisdiction of the Department of Community Services or to Designated Veterans Affairs Canada (VAC) beds in Nova Scotia long term care facilities. Veterans who apply for admission to non-VAC beds in Nova Scotia's long term care facilities are subject to the long term care Facility Placement Policy.

[1] Refer to the Department of Health SEA Case Management Model Manual February 1, 2002

3.0 PLACEMENT DECISIONS

3.1 Authority

The authority for reviewing and approving or declining applications for admission to Department of Health and Wellness long term care facilities shall rest with the Classification Officers, Department of Health and Wellness, Continuing Care Branch.

3.2 Key Responsibilities of the Classification Officer

- To ensure that all appropriate non-facility options have been exhausted before facility admission is considered and/or approved;
- To facilitate fairness and consistency in facility placement decisions;
- To request additional/specialized assessments be conducted on applicants where indicated and necessary to make the most appropriate service plan decision;
- To make a "Care Level Decision", ensuring that only those applicants who are determined to be eligible, as per provincial law or policy, are approved for admission to long term care facilities.

3.3 Placement Coordinator

The Placement Coordinator shall:

- Confirm that the client application is complete (i.e., there is a Care Level Decision and an accommodation rate) before placing the applicant on the wait list.
- Co-ordinate approved facility admissions with the applicant and facility;
- Manage the wait list on behalf of the Continuing Care Branch, Department of Health and Wellness; and
- Advise Care Coordinator when applicants are estimated to be within 90 days of placement.

3.4 The Care Coordinator

The Care Coordinator shall:

- Identify suitable applicants for long term care facility placement through the administration of a comprehensive assessment tool;
- Inform applicants of their responsibilities in the application process, including the financial application process;
- Record the applicant's preferred facility and inform the applicant of the *Facility Placement Policy* and process, including the administrative review mechanism;
- Confirm that care components of the application are complete, before bringing the application forward for eligibility determination.
- Bring placement recommendations to the Classification Officer for decision;

- Notify the Classification Officer of changes in status of applicants when such changes could lead to a change in the Classification Officer's decision.
- Coordinate home care and other non-facility services, including referrals to other services not offered through the Continuing Care Branch;
- Encourage applicant to contact/tour preferred facility and obtain additional facility specific information;
- Conduct reassessments for applicants on the waiting list, within 90 days prior to estimated admission to a long term care facility, and/or when there is a significant change in the applicant's condition or status; and
- Inform applicants of their responsibility to complete the Medical Status Report within 90 days prior to admission to a long term care facility.

4.0 WAIT LIST MANAGEMENT

4.1 Role of Placement Coordinator

On behalf of Continuing Care, the Placement Coordinator shall organize and manage the wait list for long term care placement according to predetermined criteria.

4.2 Entry to the Wait List

Except for Adults in Need of Protection, only fully eligible applicants shall have their names entered on the wait list. Fully eligible applicants include:

a) persons deemed eligible by a Classification Officer and who have agreed to financially contribute to their care as per the terms outlined by the Department of Health and Wellness.
b) existing residents, whose eligibility has been previously determined and, who have requested an inter-facility transfer (e.g., nursing home to nursing home).

Adults in Need of Protection may be approved and placed on the wait list by the Placement Coordinator prior to completion of the full assessment process or "Care Level Decision". The placement eligibility for these Adults in Need of Protection may be determined on a post-admission basis.

4.3 First Available Bed Provision

The guiding principle of the First Available Bed Provision is that the care needs of the applicant shall be addressed first and his or her placement preferences shall be pursued second.

For an applicant/resident who is subject to the First Available Bed provision, his or her name will be placed on the wait lists of all long term care facilities that are "suitable" to meet the applicant's care needs and that are within approximately 100 kilometers driving

distance from their "preferred community of residence". An applicant may request to be put on the waiting lists of suitable facilities beyond 100 kilometers of his or her "preferred community of residence".

A "suitable" placement is the offer of a long term care facility bed to an applicant where the characteristics of the available bed are matched to the care needs of the applicant, by the Placement Coordinator.

A "preferred community of residence" may be the applicant's current home community or another Nova Scotia community where the applicant prefers to live. For large amalgamated municipalities, such as the Cape Breton Regional Municipality, the preferred community of residence will be documented as the person's community within the larger Municipality (e.g. Glace Bay).

The First Available Bed Provision **applies** to any person who is:

- An Adult in Need of Protection awaiting placement. *Provincial legislation authorizes the placement of these clients in any available and appropriate facility in the province;*
- Placed in a facility as an Adult in Need of Protection or Community Variance which was outside 100 kilometers from their preferred community of residence;
- A medically discharged hospital patient awaiting placement;
- An existing resident of a Department of Health and Wellness long term care facility (currently residing in the facility or a hospital) who is reassessed as needing a different level of care that must be met at another Department of Health and Wellness licensed/approved long term care facility; and
- An existing resident of a Department of Community Services facility/community based option program, which includes Regional Rehabilitation Centers, Adult Residential Centers, Residential Care Facilities, Group Homes, Developmental Residences, Small Option Homes, and Alternative Family Support Homes. The resident must also be reassessed as needing a different level of care that can only be safely met at a Department of Health and Wellness licensed/approved long term care facility.

The First Available Bed Provision **does not apply** to an individual who is:

- A client living at home in the community and awaiting placement;
- An existing resident of a long term care facility who is seeking an inter-facility transfer to a similar long term care facility (i.e. nursing home to nursing home);
- An applicant returning "home" to their Long Term Care Facility after an extended hospital stay.
- An applicant requiring a different level of care that can be met at the same Long Term Care Site, except in cases where safety is a serious concern.
- An applicant whose family member is a resident of a Long Term Care Facility.
- An applicant requiring Peritoneal Dialysis.

- Applicant who is transferring out of Peter's Place or Aiseirigh House.

Exception to the First Available Bed Provision

Exceptions to the first available bed provision may be considered on a case by case basis where there are compelling circumstances and evidence of a significant impact on client care. The Director, Service and Business Support or designate will review and make decisions on requests for exceptions.

Individuals who are living at home in the community may wish to place their name on several facility wait lists or voluntarily subject themselves to the First Available Bed provision to expedite their placement.

4.4 Applicant's Preferences

At the time of assessment applicants shall be asked to indicate a preferred community of residence and to name one or more facilities to which they prefer to be admitted. Applicants shall be advised that they may change their stated preferences by contacting their Care Coordinator, who will then notify the Placement Coordinator on the clients' behalf.

The Placement Coordinator shall advise the Care Coordinator if the applicant has chosen a facility which cannot meet the identified care needs.

The applicant's preferences shall be recorded in the wait list management system. Where an applicant's preferred community of residence and preferred facility are outside the boundaries of the District in which he or she resides, the Placement Coordinator shall coordinate the placement with the preferred District.

If the applicant accepts a placement in a facility that is not their first choice, the applicant's name will remain on the wait list until they reach their preferred facility or until the applicant indicates to Continuing Care that they wish to remain at the facility.

A resident of a long term care facility may apply for an inter-facility request at any time. The resident will be entered on the wait list for the requested facility according to the date of the request.

4.5 Refusal and Deferral of a Placement Offer

Applicants shall have the right to refuse any offer of placement. Applicants who are subject to the First Available Bed provision and subsequently refuse to accept a "suitable" placement offer, shall have their names removed from the wait list. Applicants who are removed from the wait list may reapply at a later date.

Applicants waiting in the community, who voluntarily have their names placed on a facility's wait list may consider one of three options when they receive a placement offer:

1. Acceptance of placement offer;
2. Deferral for 90 days; or
3. Refusal of placement offer.

Under the deferral option, applicants can decide to temporarily remove their names from the Long Term Care wait list for a maximum of 90 days from the deferral decision date. Applicants can have their names reactivated on the wait list at their original care level decision date at any time within the 90 day period. Immediately following the end of the 90 day period, applicants' names will be reactivated on the wait list. Applicants will only be allowed to defer placement once, if an applicant refuses a second placement offer, the applicant will be removed from the wait list and may reapply at a later date. Applicants who choose to refuse the first placement offer will also be removed from the wait list and may reapply at a later date.

When an individual reapplies, the Care Coordinator will discuss the application process with the person to ensure that the individual understands that the application should only be made when the individual is prepared to accept a suitable placement offer.

4.6 Wait List Organization Criteria

The wait list shall be organized and managed in accordance with the following priority rankings. All first priority applicants will be placed before second priority applicants and second priority applicants before third priority applicants.

Priority 1

Adults in Need of Protection. These applicants:

- have been assessed by Adult Protection and have been determined to meet the criteria of an Adult in Need of Protection according to the *Adult Protection Act*.

If there is more than one Priority 1 applicant at any given time, they shall be organized on the wait list according to the urgency of need.

In the event an Adult in Need of Protection is placed in a facility outside 100 kilometers driving distance from their preferred community of residence, they will become a Priority 2 client until they are placed within approximately 100 kilometers driving distance from their preferred community of residence. After the client is placed within 100 kilometers from their preferred community of residence, their priority status will change to a Priority 3.

Priority 2

The following eight types of applicants are deemed to be Priority 2 status for placement:

Client Returning "home" to their Long Term Care Facility - The applicant:

- was a resident of a long term care facility who lost their bed, due to an extended hospital stay;
- is ready for hospital discharge and wishes to return to their original long term care facility; and
- has been assessed by Continuing Care to have a care level consistent with that provided by the applicant's preferred facility.

Applicant Requiring a Different Level of Care that can be met at the **same** Long Term Care Site (i.e., facility has both nursing home and residential care level beds)

- requires a different level of care that can be met by admission to another level of care located on the same site;
- wishes to continue living at the same site;
- has been assessed by Continuing Care to have a care level consistent with that provided by the applicant's preferred facility; and

In cases where safety is a serious concern, the First Available Bed Provision may be applied to residents in these facilities.

Applicant Requiring a Different Level of Care that can not be met at the same Long Term Care Site –The applicant:

- is an existing resident of a Department of Health and Wellness long term care facility (currently residing in the facility or a hospital); and
- has been reassessed as requiring a different level of care that can only be met at another Department of Health and Wellness licensed/approved long term care facility.

OR

- is an existing resident of a Department of Community Services facility/community based option program, which includes Regional Rehabilitation Centers, Adult Residential Centers, Residential Care Facilities, Group Homes, Developmental Residences, Small Option Homes, and Alternative Family Support Homes.
- resident may be currently residing in the facility/community based option program or a hospital; and
- has been reassessed as requiring a different level of care that can only be safely met at a Department of Health and Wellness licensed/approved long term care facility.

Applicant whose Family Member is a Resident of a Long Term Care Facility - The applicant:

- has a spouse, parent, sibling or dependent child who is living in a DOHW long term care facility;
- wants to live in the same location as the family member; and
- has been assessed by Continuing Care to have a care level consistent with that provided by the facility in which the family member resides.

Applicant Requiring Peritoneal Dialysis - The applicant:

- requires placement in a facility that has specially trained staff, an appropriate staffing complement and the physical environment to support the provision of peritoneal dialysis care.

Applicant who is transferring out of one of the following two facilities;

- Peter's Place
- Aiseirigh House

Applicants with an Approved Community Variance Request – The applicant:

- see Section 4.8 for more information

Client moving from a DOHW facility outside 100km of the client's preferred community of residence to a DOHW facility within 100km of a client's preferred community of residence.

- Applies to only clients placed through Community Variance or Adults in Need of Protection

With the exception of applicants with an approved Community Variance Request, Priority 2 applicants are organized on the wait list in chronological order in accordance with their "Care Level Decision" dates.

Priority 3

The following three types of applicants are deemed to be Priority 3 status for placement:

Applicant Waiting in the Community - The applicant:

- has been assessed by Continuing Care to have a care level consistent with that provided by a DOHW long term care facility; and
- is temporarily manageable in their current setting due to the presence of family supports or other system resources.

Applicant Waiting in Hospital - The applicant:

- has been medically discharged and cannot return home to the community with non-facility based Continuing Care services; and
- has been assessed by Continuing Care to have a care level consistent with that provided by a DOHW long term care facility.

Applicant Waiting for Transfer in a Long Term Care Facility - The applicant:

- is currently residing in a DOHW long term care facility; and
- has requested a transfer to another DOHW approved or licensed long term care facility which will provide the same level of care; and
- the client does not have outstanding bad debt in the facility in which they currently reside.

Priority 3 applicants are organized on the wait list in chronological order in accordance with their "Care Level Decision" dates, except as follows:

- applicants who are removed from the wait list, and subsequently reapply, are listed on the wait list system according to their most recent "Care Level Decision" date;
- residents who request a transfer to another DOHW facility after they have been placed, are positioned on the wait list according to the date that the Placement Coordinator is informed of the resident's transfer request;
- applicants who have received a "Care Level Decision" and subsequently become acutely ill, will not be considered for long term care placement or transferred until they are medically stable, have been reassessed, and, if warranted, undergo an eligibility review by a Classification Officer. If after the reassessment/review the applicant is deemed eligible, the original "Care Level Decision" date will be used as the wait list reference date.

4.7 Variance to the Wait List Ordering System - Applicants in Hospital

In exceptional circumstances, where a hospital in a District is unable to meet accepted standards of service provision because of a shortage of beds, application may be made to the Director, Service & Business Support for a temporary variance from the Continuing Care wait list policy.

This variance may be used to increase the priority ranking of long term care facility applicants waiting in the hospital. The rank order of applicants may be increased within the Priority 3 category, but they shall not be given a higher priority than existing Priority 1 and Priority 2 applicants.

4.8 Variance to the Wait List Ordering System - Applicants in Community

In exceptional circumstances, where an applicant is deemed to be in a high risk situation and his/her support system and District Health Authority have demonstrated reasonable effort to meet the needs of the applicant in the community, an application may be made to the Director, Service & Business Support or designate for a needs-based variance from the long term care wait list policy.

This variance may be used to increase the priority ranking of applicants waiting in the community. The rank order of applicants may be increased from Priority 3 to Priority 2, but they shall not be given a higher priority than existing Priority 1 applicants.

If a Community Variance is granted, the applicant and/or substitute decision maker should understand that the criteria for placement ahead of others *are based on risk*; preference is secondary. Therefore, clients will have Priority 2 status for placement and be put on the wait list for all "suitable" facilities in Nova Scotia. In the event the applicant is placed in a facility outside 100 kilometers driving distance from their preferred community of residence, they will remain a Priority 2 client until they are placed within approximately 100 kilometers driving distance from their preferred community of residence. After the client is placed within 100 kilometers from their preferred community of residence, their priority status will change to a Priority 3 as they await a transfer to their preferred facility.

Requests may be submitted using the Department of Health and Wellness Community Variance Request Form.

4.9 Adults in Need of Protection Placed Prior to Care Level Decision

The Placement Coordinator may place an Adult in Need of Protection prior to completion of the "Care Level Decision" from a Classification Officer. In these instances, a "Care Level Decision" shall be obtained post admission. These residents must also undergo the financial assessment process after they have been safely admitted to a facility.

4.10 Inter & Intra-Facility Nursing Home Transfers

Inter-facility transfer requests from residents who were admitted to a long term care facility before the advent of the long term care Facility Placement Policy or the policy of "Universal Classification" (February, 2001) and who have not undergone the full care level and financial assessment and eligibility processes must undergo the assessment and eligibility process before being placed on the wait list.

For residents who are transferring between facilities and who have already had a financial and a care assessment, the assessment and eligibility determination do not need to be conducted again unless the level of care has changed and the admitting facility is operating under an approved per diem schedule that varies by care level.

The assessment and eligibility determination processes are not required for residents who move within a home or for residents who return to their "held" bed in a facility after a stay at hospital, unless the level of care has changed and the home has Department of Health and Wellness designated Level 1 or Level 2 beds.

Long term care residents who lose their bed due to an extended stay in a hospital must undergo a care assessment and eligibility process before being placed in a facility.

4.11 Placement to Licensed Respite Beds

See *Facility Based Respite Policy* in the Continuing Care Long Term Care Policy Manual.

4.12 Placement to Residential Care Facilities (RCF)

Due to the distribution of RCF facilities across the province, some applicants will not have access to a RCF within 100 kilometers one-way driving distance of their home or preferred community of residence. Under certain conditions these applicants may be admitted to a nursing home.

Under the following exceptional circumstances, an applicant who has been approved for RCF placement, may be wait listed for or admitted to a nursing home.

Applicant Waiting in the Community:

- there are no DOHW licensed RCFs within 100 kilometers driving distance of the applicant's preferred community of residence.
- nursing homes with designated level 1 beds must be accessed if available within 100 kilometers of the applicant’s preferred community of residence. In the absence of level 1 beds, applicants can be wait listed for level 2 beds.

Applicant Waiting Placement in Hospital:

- every effort has been made to discharge the client home with appropriate home care and other community based supports.
- where hospital discharge is not possible, the applicant shall be required to put their name on the waiting lists of all suitable DOHW licensed RCFs that are within 100 kilometers driving distance of the applicant's preferred community of residence.

- where there are no DOHW licensed RCFs within the 100 kilometers, the applicant may be wait listed for nursing homes.
- nursing homes with designated level 1 beds must be accessed if available within 100 kilometers of the applicant's preferred community of residence. In the absence of level 1 beds, applicants can be wait listed for level 2 beds.

4.13 Out of Province Applications

See *Service Eligibility Policy* in the Continuing Care Long Term Care Policy Manual.

5.0 FACILITY ADMISSION PROCESS

5.1 Notification of Vacancy by Facility

The facility shall inform the Placement Coordinator of each vacancy by indicating the specifications of the vacancy, including but not limited to: private/semi/ward room, gender of roommate if applicable, etc. Regular bed vacancies are reported on the "Notice of Vacancy" form. Respite bed vacancies are reported on the "Respite Stay Admission Notification" form.

5.2 Response to Notification of Vacancy

Upon receipt of the notification of a vacancy, the Placement Coordinator shall send the long term care facility the completed assessment forms and summary of the "Care Level Decision" for the applicant who matches the facility's vacancy specifications and is closest to the top of the wait list for that facility.

5.3 Facility's Choice of Admissions

The facility shall advise the Continuing Care Placement Office of their acceptance or refusal of an application and agree to an admission date, if applicable.

The Department of Health and Wellness shall not normally schedule an admission to a licensed bed in the same day that the bed is vacated. With the agreement of the admitting facility, a booking may occur on the same day the bed is vacated.

The facility shall have the right to refuse an applicant if it can demonstrate that it does not have the resources to meet the applicant's care needs.

The facility shall inform the Placement Coordinator in writing of any decision to refuse placement and list the reasons for the refusal. Upon receipt of the refusal notification, the Placement Coordinator shall send the documentation for the next appropriate applicant on the wait list. The District Manager shall act in accordance with the Refusal Process.

Facilities shall not refuse an applicant on the basis of ethnicity, religion, language, or community of residence.

Facility refusals will be reviewed on a regular basis by the Department of Health and Wellness. Where there are concerns related the use of a facility's "right to refuse", the Department of Health and Wellness shall, in consultation with the facility, review the facility's history of refusals.

Department of Health and Wellness staff person who is responsible for inspecting the facility shall be involved in the review process.

5.4 Applicant Disagreement with Care Level Placement Decision

See *Service Decision Review Policy* in the Long Term Care Facility Policy Manual.

6.0 DISCHARGE OF RESIDENT

In the event a resident wishes to leave a facility in order to reside back in his/her community permanently, the facility, in consultation with a Continuing Care Coordinator and the resident (and/or their substitute decision maker if applicable), must ensure there is an appropriate discharge plan in place to support the resident in the community.

In the event a facility wishes to discharge a resident, the facility, in consultation with a Service Delivery Consultant, Continuing Care Coordinator, and the resident (and/or their substitute decision maker if applicable), must ensure there is an appropriate discharge plan in place to support the resident.

Facilities are responsible to ensure that residents have capacity to make decisions related to their personal care. If there is a reasonable basis to believe that the resident may or does lack the capacity to make this decision, then the facility should respond in accordance with the provisions outlined in the *Personal Directives Act*.

Once a resident is discharged from a facility to community, at a later date he/she may apply again for long term care admission. At that time, he/she will have to be reassessed to determine care needs. The resident will be considered a new admission and have a new care level decision date.

7.0 ACCOUNTABILITY

The Executive Director, Continuing Care Branch is responsible for ensuring compliance with this Policy.

8.0 MONITORING

The implementation, performance, and effectiveness of this Policy will be monitored by the Executive Director, Continuing Care Branch.

9.0 REFERENCES

Community Variance Request Form

10.0 ENQUIRES

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11.0 APPENDICES

Not applicable.