**The Salvation Army – William Booth Special Care Home**

**Admission and Discharge Policies and Procedures**

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# Admissions

**POLICY:**

WBSCH will comply with the RQHR Special Care Home Policies; Section 4 **Access to Services** (2016).

As a requirement in the Accreditation guidelines (19.4), the team delivers written and verbal safety information for residents and families about their role in promoting safety. WBSCH must ensure that safety information is presented to and reviewed with new residents and families.

**EQUIPMENT (forms):**

* Information regarding vacancy
* Admission Packet
* Communication Hand-Over

**PROCEDURE:**

* The day the room becomes vacant, WBSCH notifies SWADD electronically using the “information regarding vacancy” form
* SWADD will inform the Care Coordinator / designate regarding the next admission to WBSCH. Client admission documentation will be faxed or courier to WBSCH prior to admission.
* Prior to admission, the Care Coordinator / designate will complete communication hand-over (nurse-to-nurse) with transferring facility. Any special needs identified prior to admission (examples):
  + ARO status
  + Bariatric
  + Equipment (i.e.: mechanical lift; specialized seating; saskpole; etc)
  + Financial (i.e.: not in arrears)
  + Physician
  + Responsive behaviours (i.e.: resistive to care; wandering, etc)
  + Smoker / accepting of direction
  + Wounds
* The Care Coordinator / designate will complete the admission process (admission package for permanent resident).
  + PCC admission progress note
  + Complete photo identification
  + Safety Information Checklist
  + PCC care plan (within 8 hours)
    - activities of daily living
    - falls / safety
    - infection control (as required)
  + PICTURE care plan (post in room)
  + Complete TLR assessment
  + Complete FALLS Matrix Risk Assessment
  + MVLST (as required)
  + Admission Agreement forwarded to Reception
  + Financial Agreement forwarded to Reception
  + Complete PCC medical diagnosis
  + Complete PCC allergies
  + Complete dietary alert (as required)
  + Medications / Admission Checklist confirmed with Physician
  + Physician orders / Admission Checklist faxed to College Avenue Drugs
* **(Convalescent / RWGH)**: Notify Care Coordinator / designate when unable to obtain admitting orders from attending physician.

**Approval/Implementation/Evaluation Process**

Initial Implementation Date: August 18/97

Review Date: September 2016

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Consent To Treatment

**POLICY:**

All residents who are admitted into any of the WBSCH Programs / RWGH will sign an Admission Agreement. This agreement states the obligations of the Home to the resident and also the parameters in which care will be given.

The WBSCH recognizes the resident as an autonomous individual who requires respect for his/her rights and needs. The resident shall be given an opportunity to consent to treatment or personal care without suggestion of undue influence or coercion and without fear of reprisal, dependent on the impact to others, the resources of the home, and in compliance with the Admission Agreement.

WBSCH has posted the document “Commitment to Our Residents”. This document identifies roles and responsibilities of both the Home and the Resident.

**PROCEDURE:**

* An Admission Agreement is to be signed upon admission to WBSCH. The admitting nurse will ensure the Admission Agreement form is completed and given to Reception.
* Prior to beginning treatment the resident must either verbally or nonverbally agree to receiving care. This agreement may simply be a stated "yes", a bodily motion, or passivity / implied consent (particularly with regard to routine care).
* Residents are deemed by law to be capable of giving consent unless their legal capacity to give an authorization for treatment has been removed by legislation or by a court order. If so, their legal guardian must be informed of care being provided and in particular any "special care" being considered.
* If a resident refuses care this must be respected and should be documented. A care conference may be deemed necessary to discuss issues surrounding refusal.
* If a resident refuses care, attempts at a later time to secure consent may be helpful (i.e. returning 15 minutes later or asking a fellow staff member to make an attempt). Consistent refusals, leading to an unsafe situation, may require medical treatment / intervention. Health Care Manager / DOC to be notified.

**Approval/Implementation/Evaluation Process**

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Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Pronouncement Of Death

**POLICY:**

At WBSCH, when a death occurs and the death is expected, anticipated, and due to natural causes, the RN, RPN or LPN may pronounce the death. This policy is to provide guidelines which enables professional staff to pronounce death under specific circumstances (death is expected, anticipated, and due to natural causes).

For the purpose of this policy, the phrase “expected, anticipated and due to natural causes” shall be interpreted to mean:

* Advanced Directives has been established identifying that the resident is not to be resuscitated and that compassionate care / comfort measures is to be given.
* Death occurs after a period of illness from which there is no hope for recovery.
* The resident / client situation is such that it is reasonable to expect death may occur even in the routine day to day course of events.

This policy applies to death of residents / clients in the Long Term Care program and RWGH when the death is expected, anticipated, and due to natural causes.

The death of a client in a **temporary care program** (Convalescent and Respite) may **NOT** be expected, explained or appear to be from natural causes. The RN / RPN / LPN will pronounce death and **immediately** notify the physician of the death. The physician may give direction:

* for an **autopsy**. The funeral home must be notified of the request for autopsy. The funeral home will transport the body to the appropriate hospital for the autopsy.
* that the death is a **Coroner’s case**. In this situation the body cannot be moved. The physician is responsible to contact the Coroner (telephone 306-787-5541).

When death may be from an unnatural cause (i.e.: fall), the physician must be informed and request that the Coroner be notified.

When the death is unexpected, unexplained or appears to be from unnatural causes, the Health Care Manager / DOC must be notified as soon as possible.

**PROCEDURE:**

**ASSESSMENT:**

1. The nurse will assess for spontaneous respirations for one full minute.
2. The nurse will assess for apical heart rate for one full minute.
3. This assessment must be included in the progress notes / documentation.

**NOTIFICATION** (refer to Care After Death Checklist form)**:**

* The nurse will notify the family /designate at the time of death. If the nurse is unable to notify the family/designate, appropriate signage should be placed to indicate to visitors that they should check in at the Nursing Station before entering the room. An Angel decoration is located at the Nursing Desk / this can be hung on the door of the resident’s room. This will alert all staff a death has occurred.

1. **The nurse will notify the responsible physician as soon as possible. If the death occurs during the night the nurse may call in the AM. A MESSAGE WITH THE ANSWERING SERVICE IS NOT SUFFICIENT. THE NURSE MUST SPEAK WITH THE PHYSICIAN OR THE PHYSICIAN TAKING CALL.**
2. The Physician may order an autopsy. Obtaining permission from the NOK for an autopsy is the responsibility of the physician. An Autopsy requires a written consent using the RQHR Consent for Autopsy form (see **NOTE**).
3. If the family requests an autopsy, they are to be directed to speak with the Physician. An Autopsy requires a written consent using the RQHR Consent for Autopsy form (see **NOTE**).
4. The funeral home must be notified of the request for autopsy. The funeral home will transport body to appropriate hospital for the autopsy.
5. All lines, tubes, electrodes and appliances are to remain in place. Do not remove.
6. Once a nurse pronounces death, he/she may authorize removal of body to a funeral home, except in Coroner’s Case. The physician will designate who is a Coroner’s Case, and contact the Coroner (306-787-5541).
7. The nurse will notify the Health Care Manager / DOC during normal working hours but does not need to notify after hours unless clarification or support is needed, by either the family or staff member.
8. The Chaplain may be called in the event of a death if support is needed by the family. It is advisable to call prior to the death, if this is possible.

**NOTE**: When obtaining consent for Autopsy, the NOK who may authorize are list in order below. All expect the spouse must be at least eighteen years of age:

* Spouse (unless living separate immediately prior to the death or illness)
* Children of the person
* Either parent
* Brother or sister
* Any other NOK
  + - When permission is obtained from a person other than the person or persons listed highest on the hierarchical list, the reasons should be documented on the health record (RQHR)

**CARE OF THE BODY:**

**Note: for special cultural and religious customs please refer to Hospice Resource Manual 13.0**

1. Prepare Body
2. wash body; remove Sub Q lines, catheter, etc. Redress with disposable gown. Place incontinent product under body.
3. Autopsy, do not remove lines, catheter, tubing, etc.
4. When preparing the body always ensure dignity of the body is maintained during this procedure.

* The body may be kept on site for up to 6 hours, ensure door to room is closed and proper signage is placed on the door, (SEE NURSE AT DESK PRIOR TO ENTERING).

**DOCUMENTATION:**

* Documentation should include the following:
  + events leading up to death
  + assessment to determine death (respirations/pulse)
  + time of pronouncement of death
  + disposition of body
  + if autopsy requested, this should also be included in the Progress Notes.
* Physician to sign Discharge Summary Following Death form and all telephone medication orders not yet signed. If physician not on site at time of death:
  + Discharge Summary Following Death form is faxed to his / her office
  + Unsigned telephone medication med orders are faxed to his / her office, as per normal protocol for med orders.)
* Funeral Home to sign Release of Body Form, original to be left on chart.
* Notification of Discharge/Transfer/Death form to be sent to each dept.

**NOTE: The Infection Control measures / precautions must be documented and relayed to the Funeral Home when the body is transported (e.g.: VRE, MRSA, etc.)**

**Cultural Practices and Religious Beliefs Related to Dying and Respectful Care of the Body**

The following list gives a brief overview of some of the death and burial customs commonly practiced. The information is intended to broaden the awareness of staff so they can make dying residents and their families more comfortable.

The process of mourning and burial or cremation may be highly emotional to the family and friends of the dead person. It is important to take time to observe the wishes and traditions of different groups. Misunderstandings between health care professionals and families may result in unnecessary friction.

***Buddhism:***

For Buddhists, the most important consideration at the time of death relates to their state of mind as they believe in reincarnation of the soul and state of mind will influence their character at re-birth. The dying resident may seek quiet and privacy for meditation. They may be reluctant to use medications, as the goal at death is for the mind to be calm, hopeful and as clear as possible. There is no objection to blood transfusion, organ and tissue donation or post-mortems. No special rituals regarding body.

***Hinduism:***

Prefer to die at home and as close to mother earth as possible (on floor or ground). Holy water from the holy river of Ganges may be sprinkled on the body. A thread may be tied around the neck or wrist to bless the person. Symbols of blessing should not be removed. Important for family to wash body. Eldest son arranges funeral. There are no religious objections to post-mortems or organ or tissue donation.

***Judaism:***

A dying Jew may wish to hear or recite special psalms, particularly Psalm 23 (The Lord is my Shepherd) and the special prayer (The Shema). They may appreciate being able to hold the page on which it is written. Body must not be left unattended from death till burial. Soul leaves body from feet- do not stand at feet. Jews are opposed to most autopsies. All tissue, amputated limbs, hair, etc. must be buried with the body.

***Catholicism:***

* Revolves around the Christian theme that there is life after death.
* Anointing of the sick is often administered near the time of death, to bring spiritual and physical strength during an illness.
* Belief that baptism is necessary for salvation and those children of believers should be baptized.
* Salvation of unbaptized infants is possible.

***Lutheranism/Anglican:***

* Revolves around the Christian theme that there is life after death.
* Belief that baptism is necessary for salvation.
* A “Service of blessing” may be provided.
* Baptism is not done after the person has died.

***Jehovah’s Witnesses:***

* Revolves around the Christian theme that there is life after death.
* Request the use of non-blood medical alternatives.
* The Witnesses do not feel that the Bible comments directly on organ transplants; hence decisions regarding cornea, kidney, or other tissue transplants must be made by the individual Witness.

***Muslims:***

A dying Muslim may wish to lie or sit facing Mecca (northeast direction) and moving the bed to make this possible would be greatly appreciated. Usually a relative or Muslim priest whispers prayers from Koran to the dying. The dead person’s head should be bandaged to the lower jaw to ensure that the mouth is closed. Close the eyes. Hands should be put on the abdomen, right hand on top of left. Legs should be straightened. A spouse or relative of the same sex washes patient’s body. Muslims believe that their body belongs to God; therefore, the subject of organ/tissue donation should not be discussed unless the family initiates it.

***Sikhs:***

A dying Sikh will receive comfort from reciting hymns from Guru Granth Sahib – the Sikh holy book. A relative, priest or any Sikh present can recite hymns. The five traditional symbols that could cause distress if removed from dying person should be left with him.

* Kesh – long uncut hair of face and head.
* Kanga – hair comb (symbol of discipline).
* Kara – steel bangle on wrist (strength and unity).
* Kirpan – sword, worn as brooch (authority and justice).
* Kachha – special shorts (spiritual freedom).

Staff may prepare the body.

***Aboriginal First Nations/Métis:***

Death approached as another stage in the circle of life.

* Recognize the diversity among Aboriginal peoples. Spirituality, whether it is manifested in traditional First Nations ways or as mainstream Western religions, must be respected.
* Involve traditional healers and interpreters in care as appropriate. Healers, “Shamans” or “Medicine Men or Women” may be brought in to help with the transition between life and the afterworld.
* Treat ceremonial and spiritual items with respect. These include medicines in the form of teas, feathers, cloth, special stones, sweet grass, cedar or sage, and pipes.
* Women who have their menses do not come into contact with these items.
* Large extended family gathers when there is a health crisis demonstrating respect and support for dying and family members. The family should appoint a spokesperson.
* Generally have a high tolerance for pain so necessary to read non-verbal signs of pain.
* High sense of modesty; prefers someone of same sex to provide care.
* Common communication patterns to be aware of include: lack of eye contact during interaction, “yes” or “no” answers to questions, silence, indirect and subtle communication, storytelling and humour.
* Immediate family looks after the collection of the personal belongings of the deceased.

Source: RQHR Nursing Procedure, Death, Care of Body (2009).

**Approval/Implementation/Evaluation Process**

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Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Discharge Without Consent / Against Medical Advice

**POLICY:**

This policy is written to ensure a consistent procedure is followed when residents of WBSCH / RWGH request discharge without consent / against medical advice.

Residents have the right to refuse care to the extent permitted by law.

**PROCEDURE:**

* When a resident wishes to leave the facility against the advice of the attending physician or the Care Team, they will be asked to sign the form, Discharge Against Medical Advice (see attached).
* The Nurse will document the discussion held with the resident / responsible person (NOK / proxy). Documentation should contain that the resident / responsible person (NOK / proxy) was provided information on the risks and the possible effects / consequences of leaving the facility:
  + Progress note (point-click care)
  + Discharge Against Medical Advice form
* Should the resident / responsible person (NOK / proxy) refuse to sign the Discharge Against Medical Advice form, this refusal should also be documented along with the aforementioned.
* Signed Discharge Against Medical Advice form is to be retained in the WBSCH medical record (chart).
* The attending physician and Health Care Manager / DOC must be notified of the discharge without consent / against medical advice.

Sources: Program Guidelines for SCH (2013), 15.4 Resident Refusal of Care.

**Approval/Implementation/Evaluation Process**

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Review date: November 6, 2013

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Personal Property On Discharge

**POLICY:**

This policy is written to direct staff on the procedure to follow when a resident / client leaves this facility, and does not take all of his or her personal belongings with them.

**PROCEDURE:**

* Health Care Manager / DOC to contact the client / Executor / family member(s) / friend(s), and ask them to pick up the property left in the facility.
* If the client / Executor / family / friend are unable to come to the home in a timely manner, inform them the personal items will be packed for them and kept for a period of 7 days (basement).
* The personal property should be put in a box or bag, identified and placed in the basement storage area. Packaging should be witnessed by 2 people. Packing of belongings should also be documented in the chart.
* If the items are not picked up within 7 days, the DOC will send a registered letter to the client / Executor / family member / friend, stating that if the items are not collected within 30 days the Salvation Army will presume that the items are no longer wanted and they will be disposed of. The tracking number of the registered letter should be kept on file.
* Should a client / Executor / family member / friend pick up the articles, the “Personal Belongings” form must be signed. If items are left for the facility’s use, the family should state this on the belongings form, date and sign.

**Approval/Implementation/Evaluation Process**

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Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Communication Handover Process

**POLICY:**

Inter-facility communication (Nurse to Nurse) is vital when transferring care between facilities and caregivers.Communication breakdown during hand over of care between facilities and caregivers during transfer is a leading cause of sentinel and adverse events.

To mitigate the risk of adverse events a standard of practice has been developed within Regina Qu’Appelle Health Region with regard to both written and verbal communication upon transfer to and from facilities. The inter-facility communication standard of practice will be followed:

* To ensure a standard communication process is established and followed when transferring Residents between facilities
* To ensure that continuity of care is not compromised when transferring Residents between facilities
* To ensure vital information is conveyed from the sending nurse to the receiving nurse both verbally and in written form
* To mitigate the risk of adverse events

**EQUIPMENT (form)**:

* Transfer to Acute Care Package:
  + WBSCH Communication Hand-Over Record
  + SBAR (RQHR 1327)
  + Referral Information (NISS – RI – 142.8)
  + EMS Transfer Sheet – ARO History form
  + Identification wrist band

**PROCEDURE:**

The WBSCH COMMUNICATION HAND-OVER RECORD is to be used when sending / receiving a Resident to another facility (Acute Care / ER / LTC):

* To ER with anticipated return to WBSCH
* Return to WBSCH from ER
* Transfer between LTC / Acute Care

The WBSCH COMMUNICATION HAND-OVER RECORD is an internal document, and is **NOT** to be included in the information sent with the Resident. The WBSCH COMMUNICATION HAND-OVER RECORD is to remain at WBSCH and will be used to audit the communication (verbal / written) sent / received between facilities.

The completed WBSCH COMMUNICATION HAND-OVER RECORD is to be filed in the Resident’s medical record (chart), Consults section.

**Approval/Implementation/Evaluation Process**

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Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_