Application requirements based on category of applicant.

	Applicant Seeking Approval to construct a personal care home	Applicant Intending to Purchase Existing personal care home		Applicant seeking partnership status with existing home owner. (A partner is defined as a cooperator of the home not only a financial investor.)	Existing Home Owner Proposing		
		Existing Home Owners	New Applicant		Alterations	Bed Increases Extensions	Increased Level of Care
Application to Operate a Personal care home	T	T	T	T	T	T	T
Detailed Resume with copies of certificates attained	T		T	T			
Names of Contact Persons for References	T		T	T			
Certificate of Conduct (RNC/RCMP)	T		T	T			
National Building/Fire Code Long Form	T				T	T	
Buildings Accessibility Application for Building Design Registration	T				T	T	
Professionally drafted set of renovations/ construction drawings in triplicate. The plans must be stamped by a Certified Architect, Engineer or Professional Draftsperson	T				T	T	
Registration fees as required by the Buildings Accessibility or National Building/Fire Code Applications	T				T	T	

	Applicant Seeking Approval to construct a personal care home	Applicant Intending to Purchase Existing personal care home		Applicant seeking partnership status with existing home owner. A partner-ship defined as a cooperator of the home not only a financial investor.	Existing Home Owner Proposing		
		Existing Home Owners	New Applicant		Alterations	Bed Increases Extensions	Increased Level of Care
Approval in Principle from municipality, where applicable and/or a Preliminary Application to Develop Land	T				T	T	
Food Premises Application form and two sets of kitchen layout/design plans	T	T	T		If kitchen is part of renovations T	If kitchen is part of renovations T	
If an onsite water and sewage disposal service is proposed: **X Where the sewage flow is less than 4546 litres/day, a septic system design prepared by an Approved Designer** X **Where the sewage flow is exceeding 4546 litres/day, a septic system design prepared by a Professional Engineer**	T if applicable				Possibly if increased demand on systems T	Possibly if increased demand on systems T	

FORMS

The following forms are samples with the minimum information requirement.

Government Service Centre	Dietician		Community Health Nurse		Social Worker		Financial Assessor/Accounting Clerk		Placement Coordinator
					Home	Resident/Family	Home	Resident/Family	
Monitor Compliance with Policies: X Registration X Closure/Sale of personal care home and community care home X Building Design Standards X Fire and Life Safety Investigate complaints Education Liaise with home owner and other professionals	Monitor Compliance with Policies: X Nutrition and Food Services In service sessions Liaise with family, home owner, and other professionals Investigate complaints Approve and monitor nutritional supplements	Resident nutritional assessment, plan for care, education and counselling Educate owner and staff of individual plans for care Resident satisfaction Holistic needs met Liaise with physicians, dieticians (outside agencies), professional and support team members Respond to referrals Investigate complaints	Monitor Compliance with Policies: $ Services and Resident Rights X Levels of Care X Staffing X Admissions/ Transfers/ Discharges X Resident Care X Medications X Delegation of Nursing Tasks and Procedures X Sanitation and Infection Control X Resident Records X Benefits for Personal care home and community care home Residents X Complaints/ Incidents Resident plans for care with home owner Liaise with family, home owner, other professionals In service sessions Investigate complaints Approval of health supplies	Level of Care Monitoring health status Interview resident re: satisfaction In service sessions Holistic needs met Advance Health Care Directives Ongoing liaison re: placement process	Monitor Compliance with Policies: X Services and Resident Rights X Admissions/ Transfers/ Discharges X Financial X Trust Accounts Liaison with family, home owner, other professionals In service sessions Investigate complaints	Ongoing liaison re: placement process In service sessions Holistic needs met Advance Health Care Directives	Monitor Compliance with Policies: X Financial X Trust Accounts Financial Reporting Disburse monthly board and lodging and resident allowances for subsidized residents to home owner Disburse night security subsidies	Assessment re: initial financial subsidy and ongoing subsidy adjustments Liaise with income security, etc. Monitor trust accounts Authorization of drug cards, transportation and Inability to Pay Forms for financially eligible residents	Coordinate PCH placement process Maintain registry of PCH's Maintain current vacancies/wait list Coordinate admissions, transfers, discharges Liaise with home owner and Health & Community Services

Personal Care Home
Medical Assessment

Name: _____

Address: _____

Personal Care Home : _____

Consent for Release of Information

I hereby request and authorize a physician to provide the following information regarding my present health and medical history to the Regional Health Authority and/or the Licensee of the above named agency.

Date: _____ Signature: _____

To the Physician: This medical is required in compliance with the Personal Care Home Operational Standards. The above named is:

G applying to operate a personal care home
G a potential employee of a personal care home

On the basis of your records, medical history and physical exam, please provide the following information:

1. Has the applicant suffered ill health resulting in lost time from work in the past 3 years?
   Yes G No G
   Description of illness: _____

_____

2. Does the applicant have a history of any infection, disease or condition likely to be a hazard to ill or disabled persons? Yes G No G

Comments: _____

_____

_____

Personal Care Home
Medical Assessment
Page 2

3. Is the applicant physically and mentally able to perform the duties and responsibilities associated with providing personal care and homemaking services? Yes G No G
If "no", please comment: _____

_____

4. Is the applicant under medical supervision for any active or chronic illness?
Yes G No G Details: _____

_____

5. Does the applicant have a history of back problems? Yes G No G
Comments: _____

_____

6. Tuberculin Skin Test Result _____ mm

7. What is the last date of immunization for the following:
Diphtheria, Tetanus, Polio _____

8. Any other pertinent information: _____

_____

_____

Physician's Signature : _____ Date: _____

Physician's Name (print): _____

Physician's Address:_____

_____

_____

Personal Care Home
Pre Employment Tuberculin Skin Test

(This form is to be completed by the Community Health Nurse)

Please make an appointment with the local Community Health Nurse for a Tuberculin Skin Test (TST). Bring the result of your skin test to your family physician to be included with your medical report. For pre-employment two-step testing is recommended, not more frequently than every four years.

Name: _____ Maiden Name: _____

Date of Birth (Y/M/D): _____ Mother's Name: _____ Father's Name: _____

Address: _____ Telephone # _____

MCP # _____

Previous TST(s): Test _____ Date _____ _____ mm.
Test _____ Date _____ _____ mm.
Test _____ Date _____ _____ mm.

Date(s) of Previous BCG:
_____
_____

The above-named person has had a 5TU PPD Skin Test today, _____ and the result
(Date)
is _____ mm. and _____ and the result is _____ mm.
(Date)

_____
Signature of CHN

5 TU PPD test result	**Action**
Induration less than 10 mm	Repeat (for two step) in 7 days to 4 weeks
Induration greater than 10 mm (and no previous test within 6 months)	Chest x-ray (CXR)

If the initial 5TU PPD is <10 mm, a second test is to be performed seven days to four weeks after the original one to determine if there has been a booster effect, this is the two step process.

If the TU PPD is >10 mm and no history of a test in the past six months, a chest x-ray should be ordered. The CSR report should be returned to the Medical Officer of Health for interpretation.

NOTE: The Community Health Nurse will follow all persons with positive results

INSTRUCTIONS

1. Employee/Applicant must have the Tuberculin Test completed before going to a doctor and have the Pre-employment Medical form completed. This is necessary because the doctor needs the Tuberculin Skin Test results in order to complete the Medical Form.

2. This form must be completed in triplicate - original goes to the Doctor, one copy is retained by RHA and one copy is retained by the applicant.

Personal Care Home
Pledge of Confidentiality

This is to certify that I, _____, agree that any information obtained during the performance of my duties will remain strictly confidential and will not be discussed outside the personal care home.

Employee's Signature: _____

Witness' Signature: _____

Date (y/m/d): _____

Personal Care Home
Transfer Summary

Name: _____ MCP #:_____

Transferring from: _____ Transferring to: _____

Date of Birth (y/m/d): _____ Gender ___ Marital Status ____ Religion _____

PCH File #: _____ Drug Card #: _____ Expiry Date (y/m/d): **_____**

Next of Kin: _____ Phone #: _____

_____ Phone #: _____

Attending Physician(s): _____ Phone #: _____

_____ Phone #: _____

Reason for Transfer: _____

_____

_____

Health History (including assistance with ADLs and behaviour and special diet): _____

_____

_____

Medications:_____

_____

_____

_____

_____

_____

Allergies (Medications, Food, Environment, Other): **_____**

_____

_____

Personal Care Home
Transfer Summary

Page 2

Other Comments: _____

_____

_____

_____

_____

When transferring to another personal care home, hospital or nursing home, forward the following items with the resident:

- ! MCP Card
- ! Drug Card
- ! Medications
- ! Medical Assessment (if applicable)
- ! Personal money
- ! Financial Records (if necessary)
- ! Prosthetic Devices

Signature: _____ **Date (y/m/d):** _____

PCH - 5

Personal Care Home
Monthly Bed Status Report

Personal Care Home Name: _____Address: _____

Month Ended: _____ Approval Status (# of Beds): Level 1 _____ Level 2 _____

Please complete and submit monthly to the Health & Community Services Board in your region. Record all dates in year, month, day format

SUMMARY OF CHANGES DURING THE MONTH

Resident Name	Date of Admission	Date of Discharge	Reason for Discharge	Date of Death	Subsidized Beds		Unsubsidized Beds	Portable Subsidies
					Subsidy	Private pay		

END OF MONTH STATUS REPORT

	BED CAPACITY				BEDS OCCUPIED											BEDS VACANT			
	Fixed Subsidized Beds	Unsubsidized Beds	Respite Beds	Total Beds	Subsidized				Unsubsidized		Respite Beds				Total Beds	Subsidized Beds	Unsubsidized Beds	Respite Beds	Total Beds
					Male		Female		Male	Female	Male		Female						
					S	P	S	P	P	P	S	P	S	P					
End of Previous Month																			
End of This Month																			

Operator's Signature: _____ Date (y/m/d): _____PCH - 6

Personal Care Home
Monthly Bed Status Report

Instructions

This form is to be completed by the home owner at the end of each month and forwarded to the Regional Board.

On the top section of this form record the name and address of the personal care home and current month, and number of approved Level 1 and Level 2 beds.

Summary of Changes During the Month

- Record only changes which occurred during the month being reported
- Record, per line, the resident's name, and where applicable the admission date, discharge date and reason for discharge or date of death.
- If the resident is a permanent resident, check the column which matches the bed status and method of payment (e.g. subsidized bed but private pay).
- If the resident is a respite resident, note under comments
- If no change in resident population during the month, write no change across the section.

End of Month Status Report

End of Previous Month: Bring forward your totals from the "End of This Month" row for the previous month's report and record in the End of Previous Month row on this form.

End of This Month: **Bed Capacity:** Record the total number of approved beds under the applicable header (subsidized beds, unsubsidized beds,) and total the number of beds.

Beds Occupied: Record the number of males and females that were subsidized or private pay and occupying a designated type of bed (i.e. subsidized (fixed and portable), unsubsidized) and total the number of beds.

Beds Vacant: Record the number of beds available by type of bed (i.e. subsidized, unsubsidized, respite) and total the number of beds.

Comments/Concerns- Record any comments/concerns that need to be brought to the attention of the Regional Board regarding bed status.

Sign and date report.

Personal Care Home
Incident Report

Personal Care Home: _____

Address: _____

TYPE OF INCIDENT:

9 injury to resident 9 injury to staff 9 medication, please specify _____
9 damage to resident property 9 damage to staff property 9 other, please specify _____

Date and Time of Incident: _____

Location of Incident: _____

Name of Person(s) Involved in Incident: _____

Incident Witnessed By: _____

Incident Reported By: _____ **Incident Reported To:** _____

DESCRIPTION OF INCIDENT: (BE SPECIFIC, INCLUDE WHO, WHAT, WHEN, WHERE)

_____

_____

_____

_____

_____

_____

_____

ACTION TAKEN: _____

_____

_____

_____

Signature: _____ **Date (y/m/d):** _____

RECOMMENDATIONS/COMMENTS/ACTIONS: _____

_____

_____

_____

Signature: _____ **Date (y/m/d):** _____

VERBAL NOTIFICATION: (as appropriate)

Physician: _____ **Date (y/m/d):** _____

Operator: _____ **Date (y/m/d):** _____

Next of Kin: _____ **Date (y/m/d):** _____

Regional Board: _____ **Date (y/m/d):** _____

Other: _____ **Date (y/m/d):** _____

Instructions

An incident is defined as any happening not consistent with the routine care of a resident. It is not a normal or expected outcome of the care provided.

PCH: Record personal care home and community care home name.

Address: Record personal care home and community care home address.

Type of Incident: Check all categories that apply.

Date and Time of Incident: Indicate the date and time the incident occurred or was discovered.

Location of Incident: Indicate where the incident occurred.

Name of Person(s) Involved in Incident: Indicate who was involved (e.g. the resident, an employee, a family member, or visitor).

Incident Witnessed By: Indicate who witnessed the incident, including other residents, members of the general public, etc.

Incident Reported By: Who is reporting the event?

Incident Reported To: Who was advised of the incident occurring (e.g. operator, supervisor, etc.).

Description of Incident: Describe the facts about the incident.

Action Taken: Briefly outline what action was taken when the incident was discovered or occurred. Please sign the form here.

Recommendations/ Comments/Actions: To be completed and signed by the operator.

Verbal Notification: Indicate if you verbally notified anyone about the incident and the date the person was notified.

This is a confidential document

PERSONAL CARE HOME
Medication Administration Record

Resident's Name: _____ **Date of Birth (y/m/d):** _____

Medical Conditions: _____

Allergies: _____ **Physician:** _____

Month: _____

Medication, Dosage and Directions	Time	Day: 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

PCH-8

Chart Side	Notes Side	Injection Site Codes	
1. Initial Appropriate Box When Medication Given 2. Circle Initials When Medication Refused	3. State Reason for Refusal of Medication on Medication Notes Below 4. State Reason and Results for PRN Medication 5. Indicate Injection Site (Code)	1. Right Arm 2. Left Arm 3. Right Abdomen 4. Left Abdomen	5. Right Thigh 6. Left Thigh 7. Right Buttock 8. Left Buttock

Initials	Signature	Initials	Signature	Initials	Signature

Medication Notes

Date	Time Given	Medication and Dosage	Comments	Initials

PERSONAL CARE HOME
Medication Storage Audit

Personal Care Home: _____ Date (ymd): _____

Pharmacy: _____

	Yes	No
1. Security		
a. Is the medication cupboard/room/cart locked?		
b. Is the prepared medication tray/cart in the medication cupboard?		
c. Are the medications in a personal locked cupboard for residents who are self administering?		
2. Medication Storage		
a. Is the medication cupboard/room/cart neat and clean?		
b. Are the contents of the cupboard/room/cart properly separated, (i.e., orals from topicals)?		
c. Are the medication containers properly labelled, neat, and clear without defacing?		
d. Are medications kept in the original containers, bearing the original label with the prescription number, name of resident, prescribed dosage and expiry date?		
e. Are medications requiring refrigeration stored appropriately?		
f. Are discontinued or expired medications returned to the dispensing pharmacy?		
3. Medication System		
a. Are all medications prescribed by a physician, dentist, regional nurse or nurse practitioner?		
b. Are all resident medications (prescription and non-prescription) reviewed with the resident/family upon admission and a drug profile established in conjunction with the pharmacist?		
c. Is a Medication Administration Record kept on each resident and utilized according to policy?		
d. Upon transfer or discharge, is the resident's medication and detailed instructions taken with the resident?		
4. Staff Orientation/Education		
Are policies contained within the Operational Standards Manual reviewed by the operator with staff.		

Comments:

Pharmacist/Nurse: _____ Date (ymd): _____

Personal Care Home - SECURITY CHECKLIST

Personal Care Home Name: _____ **PCH - 10**

	YEAR _____ MONTH _____																														
Instructions: T If Okay X If attention require	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Exit doors are operating (physically open)																															
Exit lights are operating AC/DC (light bulbs)																															
Emergency lights are operating (test)																															
Fire alarm system operating (test light on) if applicable																															
Fire extinguishers operable (check gauge)																															
Fire hose operable (no water leaks) if applicable																															
Smoke barrier doors closed (no wedges holding doors)																															
Corridors, furnace room etc. free of garbage & obstacles																															
Outside stairs and steps (clear of ice & snow)																															
Basement area if applicable																															
Oxygen cylinders if applicable																															
Smoke room if applicable																															
Medication storage secured																															
Household cleaners storage secured																															
Bathrooms																															
Electrical, furnace and storage areas																															
Laundry rooms																															
Kitchen																															
Resident's Bedroom																															
Remarks Verified by Home Owner _____ Date _____																															

Personal Care Home
Diabetic Record

Resident's Name: _____ **File #:** _____

Physician: _____

Site Codes: 1. Right Arm 2. Left Arm 3. Right Abdomen 4. Left Abdomen
5. Right Thigh 6. Left Thigh 7. Right Buttock 8. Left Buttock

Blood				Medication Administration				
Date y/m/d	**Time**	**Chemstrip Results**	**Signature**	**Time**	**Type**	**Units**	**Site Code**	**Signature**

Personal Care Home
Request for Account Verification

Personal Care Home Name: _____

Resident's Name: _____

Admission Date (y/m/d): _____ **Discharge Date (y/m/d):** _____

		Resident Income										
Month	**Monthly Charge**	**OAS**	**CPP**	**VAC**	**Other**	**Total Income**	**Resident Allowance**	**Resident Contribution**	**Subsidy Required**	**Subsidy Received**	**Variance**	**Comments by Regional Board**
TOTALS												

Home Owner's Signature: _____ **Date (y/m/d)**: _____

Instructions

A form per resident is to be completed by the home owner if there is an incorrect payment by the Regional Board.

On the top section of this form record the personal care home/community care home name, resident's name, admission date and discharge date.

Month	-	Start with the first month for which there is an incorrect payment.
Monthly Charge	-	Record the total amount charged to the resident for the full month. If the resident is not in the home for the full month, the adjustment will be made when the account is being reviewed by the Regional Board.
Resident Income	-	Record the full amount of each cheque the resident receives. If the resident receives a pension in United States funds, write in the value of the cheque in Canadian Dollars.
Resident Allowance	-	Record the amount of the approved Resident Allowance.
Resident Contribution	-	Subtract the Resident Allowance from the total income to determine the resident's contribution.
Subsidy Required	-	Record the difference between the monthly charge and the resident's contribution.
Subsidy Received	-	Record the amount listed on the statement for that particular resident.
Variance	-	Record the difference between subsidy required and subsidy received.
Comments	-	Leave space for Regional Board comments.

Personal Care Home
Distribution of Resident Allowance

To be completed by the home owner and reviewed by Regional Board staff.

Name	Amount	Signature	Date

RHA Staff Signature: _____Date (y/m/d): _____

Personal Care Home
Subsidized Residents' Income - Quarterly Report

Personal Care Home: _____

Resident's Name	File Number	OAS	CPP	VAC	Other	No Income

NOTE: Failure to submit this report, fully completed, by February, May, August and November of each year will result in withholding of the cheque for the month in which the report is not received.

I hereby certify that the information contained in this report is complete and accurate.

Home Owner's Signature: _____ Date (y/m/d): _____

Personal Care Home
Subsidized Residents' Income - Quarterly Report

Page 2

Instructions

Personal Care Home	-	Record the personal care home
Resident Name	-	List all subsidized residents.
File Number	-	Record the file number which is listed on the statement received with the board and lodging cheque from the Regional Board.
OAS	-	Record the exact amount of the Old Age Security cheque received by the resident for the reporting month. If the resident did not receive Old Age Security, leave the space blank.
CPP	-	Record the exact amount of the Canada Pension cheque received by the resident for the reporting month. If the resident did not receive Canada Pension, leave the space blank.
VAC	-	Record the exact amount of the Veteran's Affairs Canada cheque received by the resident for the reporting month. If the resident did not receive a cheque, leave the space blank.
Other	-	Record other private pensions or income received by the resident from other sources (except the Regional Board).
No Income	-	Record a check mark in this space if the resident does not receive any income except the Board and Lodging Allowance and Resident Allowance received from the Regional Board.

Personal Care Home
Trust Account Agreement

This agreement provides authority for _____ to act as trustee for _____. It is agreed that _____ will accept responsibility for funds and valuables entrusted in care and that normal trust accounting guidelines will be followed in the day to day administration of the trust account.

This agreement also provides authority for _____ to retain all interest earned on the trust account as compensation for being trustee as agreed to below.

All Interest: Yes ____ No ____ , Other (Specify) _____

_____	_____	_____
Resident Name or Legal Representative (Print)	**Signature (Mark)**	**Date (y/m/d)**
_____	_____	_____
Witness (Print)	**Signature**	**Date (y/m/d)**
_____	_____	
RHA	**Name/Position (Print)**	

Personal Care Home

_____	_____
Signature	**Date (y/m/d)**

Personal Care Home
Record of Resident's Trust Account

Name: _____ **Monthly Income:** _____ **Source:** _____

	Deposits			Purchases				Balance	
Date	**Bank**	**Cash on Hand**	**Source of Deposit**	**Item**	**Cost**	**Money Given to Residents**	**Resident's Signature**	**Bank**	**Cash on Hand**

_____
Home Owner's Signature

PCH-16

Record of Resident's Trust Account

Page 2

Instructions

This form may be used when the home owner is managing a trust account.

On the top section of this form the resident's name, amount of monthly income and source of income (e.g., OAS) should be entered.

Columns:

Date: - Record date of transaction.

Deposits:
- Bank: Record the amount of money deposited in the bank.
- Cash on hand: Record the amount of money held by the home owner.

Source of Deposit - Indicate whether the funds are obtained from the Resident Allowance, pensions, gifts, etc.

Purchases - Record type of item purchased and cost.

Money Given to Resident - Record amount of money given directly to the resident.

Resident's Signature - Request the resident to sign and verify receipt of the amount of money indicated in the previous column.

Balance - Following each transaction (e.g. deposit, purchase, etc.), indicate the final balance in the resident's bank account or cash on hand.

Personal Care Home
Complaint Report

To be completed by staff. (Use other side if needed)

Name of Person Reporting: _____

Address: _____

Telephone: _____ **Date of Report (y/m/d):** _____

Time of Report: _____ **Report Taken By:** _____

Personal Care Home: _____

_____

Description of complaint (including all involved persons, date(s), etc.):

_____

_____

_____

_____

_____

Immediate action taken (including by whom and the date):

_____

_____

_____

_____

_____

Signature: _____ **Date (y/m/d):** _____

Recommendations/Comments/Actions:

_____

_____

_____

_____

_____

Signature: _____ **Date (ymd):** _____

Comments:

Release of Resident Information for Pharmacist

Client's Name: _____ File Number: _____

PCH Name: _____ Date of Admission: _____

Birthdate: _____ Height: _____ Weight: _____

Physician: _____ Telephone: _____

Health and Community Services Contact Name: _____

Phone Number: _____ Fax Number: _____

ASSESSMENT INFORMATION:

Allergies: _____

_____

_____

Medical Diagnosis: _____

_____

_____

Diet: _____

_____

_____

Medications: _____

_____

_____

Comments: _____

_____

_____

Method of Payment and Third Party Insurance Numbers (if applicable):

_____

_____

_____

Change: _____

_____

_____

Copy to: Health and Community Services Board / Home / Pharmacy.

Personal Care Home
Resident Care Sheet

Name of Resident: _____

Date		
Resident Needs Help With:	Yes	No
Bathing: tub		
shower		
sponge bath		
Shampoo		
Shave		
Clothes (taking on and off)		
Nail care		
Toilet (going to and from)		
Toilet (getting on and off)		
Diapers		
Walking		
Cane, walker or wheelchair		
Eating: feeding		
cutting food		

Add a new column and date each time there is a change.