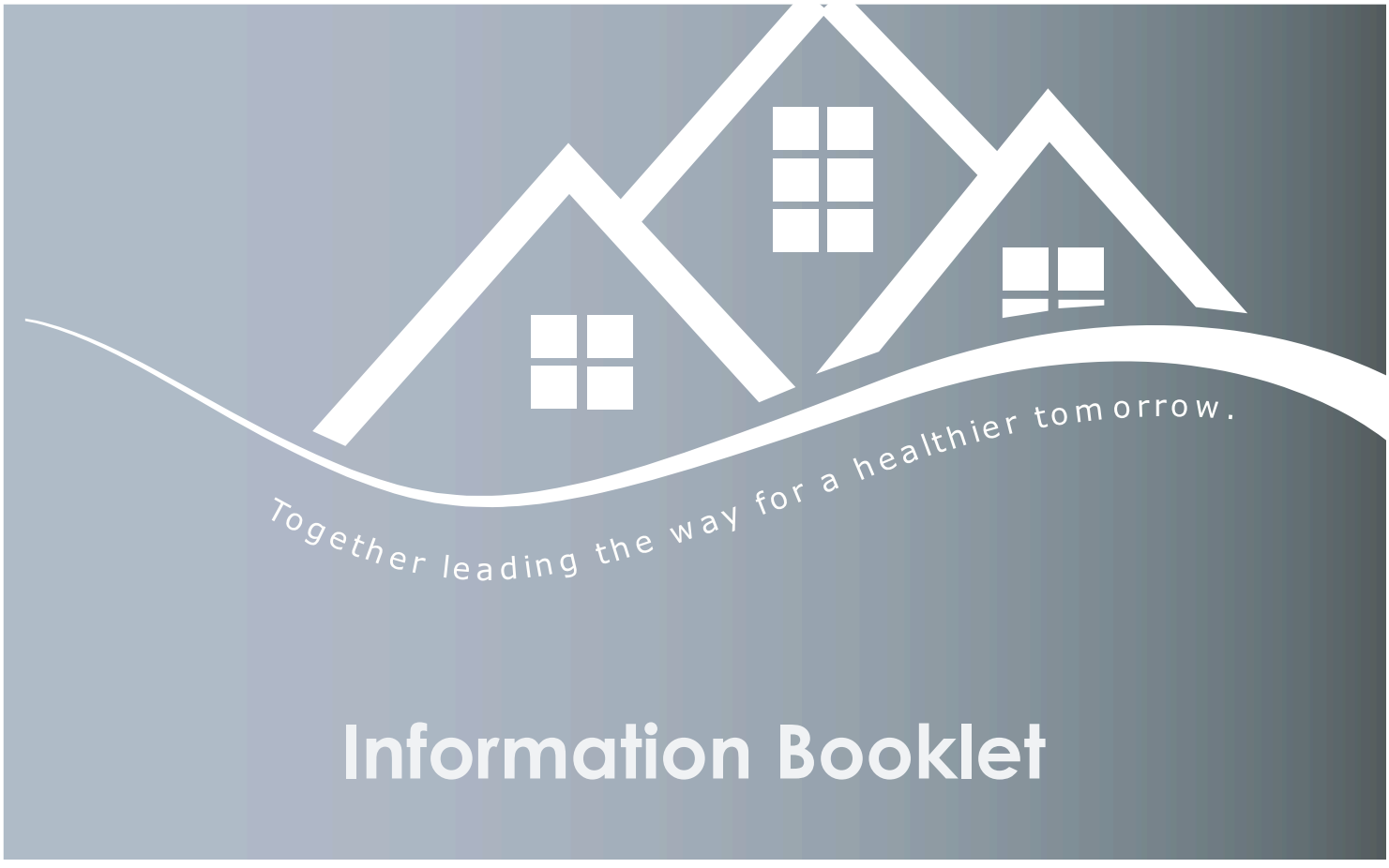
Interlake-Eastern
Regional Health Authority

# Home Care




## Information Booklet

## HOME CARE SERVICES

are available to individuals regardless of age, who require health services or assistance with activities of daily living to remain safely in their homes and require more assistance than available from existing supports and community.

Home Care services are intended to supplement the role of family/ informal support network and community resources in the provision of care in the community. The Home Care program was designed to be a support to individuals and family members.

## Referrals

Can be made by any person or professional. The person for whom the referral is being made needs to be aware and in agreement with the referral and assessment.

## Assessment

Once a referral is received, the Home Care Case Coordinator completes an assessment including information from you and your family.

Your personal health information may be shared with other members of the health care team to ensure safe and effective care.

## Eligibility

Your case coordinator will determine eligibility for services based on provincial criteria that includes:

1. You must be a Manitoba resident, registered with Manitoba Health.
2. You require health services or assistance with activities of daily living such as, bathing or help with medications.
3. You require services to stay in your home for as long as safely possible.
4. You require more assistance than family, friends and community resources can provide.

5. Your home environment is a safe place for home care staff to work (for example, entranceways are cleared of snow and ice, equipment is in good working condition and pets are controlled as needed).
6. A reliable back-up person must be available for those times when Home Care staff is not available.

## Your Rights

We believe you are an active participant in your health care. You have the right to:

- Be treated with respect and dignity
- Be informed about options for care and treatment and share in decision making about your care.
- Be informed about community resources that may assist in your care.
- Receive information about your Home Care services in a clear and understandable way.
- Be involved in making a care plan that is specific to your needs.
- Involve your family members or other people of your choosing in your care plan.
- Receive a copy of the Home Care Client Care Plan.
- Be informed of changes in your care plan in a timely manner.
- Refuse care and/or service.
- Complete a Health Care Directive if so desired.

## Care Plan

- The case coordinator will with you and your family, develop a plan of care to meet your individual assessed needs.
- Home care staff is required to follow the care plan and advise the case coordinator of any requests for changes or concerns raised about the care plan.

- Only the case coordinator can change the care plan. This is done in consultation with you and/or your family.

## Backup Plan

- You must identify two (2) contact persons who will be responsible for initiating a backup plan in the case where Home Care is unable to provide service as arranged (for instance, if there is bad weather or roads, or if Home Care staff is ill).

## Other Important Information

- Home Care services can be increased or decreased, discontinued or reinstated, depending on your needs, the availability of others to assist you, and availability of Home Care staff. If you become able to manage some aspects of your own care of you require increased assistance, please let your case coordinator know

so that Home Care services can be delivered in the most appropriate, efficient and economical way possible.
- Home Care services do not include driving to appointments or errands.
- Home Care staff work within the requirement of the Regional Safe Client Handling Injury Prevention program. This may require that you purchase certain equipment or complete home modifications to ensure your safety and for staff when you require assistance to move within your home.
- Costs associated with products and supplies that go beyond what the program provides will be the responsibility of the client.

## Home Care Services Include:

- personal care, for example: bathing or dressing
- health teaching
- referrals to other services as needed, for example: pharmacist, occupational therapist or Services to Seniors
- family respite, to give family caregivers short periods of relief
- respite care in a hospital or personal care home, so family caregivers can have a longer period of relief – there is a fee for this service
- equipment such as beds, commodes or mechanical lifts
- supplies, when required for care, for example: catheters or dressing supplies
- assessment for specialty services such as, Adult Day programs which allow you to enjoy social and recreational activities away from your home – there is a fee for this service

- Personal care home/ supportive housing assessments and applications at your request, and with the involvement of you and/or family. The case coordinator completes the application which is then reviewed by a panel of professionals from the Regional Health Authority who determines whether the application will be accepted.
- Self and family-managed care enables you or your family member to administer, recruit, retain, coordinate and supervise non-professional staff under contractual agreement with the Regional Health Authority – this in support of community living and autonomy.
- Other services as assessed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**For further information**

**or concerns about Home Care, please contact:**

**INTERLAKE-EASTERN REGIONAL HEALTH AUTHORITY**

**Home Care Administration**

**204-785-4876**

or

**Manitoba Health Appeal Board**

**866-744-3257**

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