Team Name: Home Care Leadership Team Team Lead: Regional Director Home Care Approved by: Executive Director-East	Reference Number: CLI.5411.PL.003 Program Area: Home Care Policy Section: Service Delivery
Issue Date: April 19, 2016 Review Date: Revision Date: February 10, 2017	Subject: Client Level of Risk

POLICY SUBJECT:
Client Level of Risk

PURPOSE:
To identify a client's risk level that will be used as a factor in determining:

- Client's need for placement into a care facility or entering or remaining in hospital when the specialized services of the hospital are not required, or risk of premature readmission to the hospital if the client is returned home without Home Care (HC) services;
- Clients who require services (also known as "essential services") during times when caregiver resources are unavailable or limited;
- Frequency of client contact to manage client's risk factors;
- Client care requirements and interventions to decrease client's level of risk.

BOARD POLICY REFERENCE:
Executive Limitation (EL-01) Global Executive Restraint & Risk Management
Executive Limitation (EL-02) Treatment of Clients

POLICY:
In compliance with the Brian Sinclair Inquest (March 2015), Southern Health Santé-Sud HC program recognizes that by virtue of compromised health status and/or functional abilities all HC clients have some degree of vulnerability. Identifying and communicating a client's level of risk for an adverse event and implementing preventative measures to minimize risk(s) is important to client safety. Using a standardized clinical assessment tool, all clients admitted to the HC program will be screened for level of risk, associated risk factors and preventative measures identified for implementation to assist in risk reduction. This information will be entered on the HC program Procura Disaster Planning Registry and communicated to all relevant service providers by means of the client's individual care plan. Subsequent screening will occur on an annual basis and/or if the client's health status changes.

DEFINITIONS:

***Caregiver*:** A person who is providing care because of a prior relationship with a client. A caregiver may be a biological family member or "family by choice" (e.g. friends, partners, neighbors).

***Contact*:** Can be telephone or in person. All contact must be documented on Client Interdisciplinary Progress Notes.

Essential Services:

Services which if absent for a period of time will result in harm to the client or caregiver. Determination of what is essential is made on a case by case basis e.g. wound care, tube feeding, post op care, respite for high complex needs, medication management or meals for dependent clients with diabetes would be considered more essential than, baths, dressing, etc.. Essential services are usually defined more precisely and the frequency determined when resources are stretched e.g. during work stoppages, natural disasters. Families are called upon to assist in the care of their family members where possible.

***Family*:** A spouse or common law partner of the client; a biological or adoptive family member (parent, son, daughter, sibling, grandparent, grandchild, great grandparent, great grandchild, aunt, uncle, niece, nephew, cousin, step-parent), guardian, a spouse or a common law partner of any of those persons.

High Risk: Client is considered at high risk if service is not provided (e.g. Palliative Care, diabetic management, ventilator dependent, post stroke); Client cannot modify task independently (e.g. Severe mobility issues, severe chronic illness, dementia/cognitive issues); Client may or may not have short term access to third party support (e.g. aging/fragile spouse, no family support).

Low Risk: Client is at low risk if service not provided for 3 to 7 days (e.g. non-essential service); Client may or may not be able to modify the task.

Medium Risk: Client may be at risk if service not provided for a short period (2 – 3 days);Client may or may not be able to modify the task; Client may or may not have short term access to third party support (e.g. family/friends will experience undue hardship if service not provided for an extended period of time).

***Risk*:** The possibility of injury. Persons are at risk and in need of HC services when they meet the general eligibility criteria for HC.

IMPORTANT POINTS TO CONSIDER:

- The first 30 days post hospital discharge represents a period of transition and is associated with a 60% increase in the odds of a client experiencing an adverse event. This is an important variable to consider when evaluating a client's level of risk.

- Screening tools assist in identifying clients and caregivers who are most at risk.

PROCEDURE:

Case Coordinator (CC) will:

1. Review client eligibility for service.
2. Complete HC client assessment and determine client care needs.
3. Determine client's level of risk using the Risk Assessment Tool for Home Care Clients (CLI.5411.PL.003.FORM.01) in combination with Coordinator's own professional judgment. For example: A client's situation appears to fall in the Medium Risk category according to the definition, but the CC, using additional information and his/her own professional judgment, has determined the client is a Low Risk client. The client will be identified as Low Risk with rationale documented in the comment section of the Risk Assessment Tool and in the Interdisciplinary Progress Notes.
4. Document client level of risk e.g. high, medium or low in the:
   - Procura "*Disaster Planning" box* (located on the Procura "*General"* page, right corner, under "*Reference Numbers"*);

- Client Care Plan (Prior to the Fall Risk and Braden Scale Scores) and/or on the Nursing Service Request Form - Special Instructions Section as appropriate;
- Client Interdisciplinary Progress Notes.

5. Determine interventions/activities and frequency of such to decrease risk and document in:
   - Procura *Client Care Plan* and/or Nursing Service Request Special Instructions Section;
   - Client Interdisciplinary Progress Notes.
6. Complete and document client reassessments including re-evaluation of level of risk regularly as per need and degree of risk (see guideline below) and at a minimum annually and/or as client's health status changes.

Frequency of Client Contact Guideline

Frequency of contact with the client varies depending on level of risk. Regardless of degree of risk, predictable changes in services (reduction, increase or discontinuation), should guide the timing of contact. In general, contact should be as stated below:

- High Risk – at least every 3 months and/or when family/others alert Coordinator to changes.
- Medium Risk – every 4 to 6 months and/or when family/others alert Coordinator to changes.
- Low Risk – every 6 to 12 months and/or when family/others alert Coordinator re: changes.

Annual in-person assessment is an expectation of the Program to review the client and family's status and evaluate the effectiveness of the interventions identified.

SUPPORTING DOCUMENTS:

CLI.5411.PL.003.FORM.01 Risk Assessment Tool for Home Care Clients

REFERENCES:

Canadian Patient Safety Institute (2013). *Safety at Home*

Winnipeg Regional Health Authority (Sept 2009) Home Care Program- *Clients Level of Risk Guidelines*