CARE@HOME+

Information for patients, families and caregivers

Eastern York Region North Durham

EYRND ONTARIO HEALTH TEAM

CONNECTING CARE FOR CLIENTS, FAMILIES AND CAREGIVERS | EYRND.ca

What is Care@Home+?

Care@Home+ provides wrap around services at home to individuals with complex needs. These services are provided in partnership with South East Geriatric Outreach Team, LOFT (IPOP and Behavioural Support Services), CHATS (Community and Home Assistance to Seniors), and SE Health.

We will continue to support you until your goal (s) have been met and your condition is stable. Your home care services will continue to be coordinated through your primary nurse.

Your Care@Home+ team will:

- Work closely with members of your health care team
- Manage your home care services
- Connect with your family doctor or health care provider and specialists
- Identify services that may be beneficial for support at home, including nursing, physiotherapy, occupational therapy, speech language therapy, dietitian and personal support workers
- Connect you with community resources to support independent living

How does Care@Home+ work?

Before you begin this program, you must consent to pause your current home and community care services. Once confirmed, the transitions care lead and a member from the Care@Home+ team will virtually meet with you, your caregiver(s) and informal supports to create your initial home care plan for the first 72 hours.

This plan will be shared with everyone involved in your care. As the team gets to know you and your needs, a long range plan will be developed in collaboration with you and your caregiver(s) to meet your goals.

We will provide you and your caregiver(s) with a list of items you would need for your care at home and will support you with getting them.

When will my Care@Home+ start?

Your first home visit will be within 24 hours upon acceptance into the program.

What can I expect from Care@Home+?

Your Care@Home+ team will:

- Visit you within 24 hours upon acceptance into the program
- Check in with you daily for the first week
- Work with you, your caregiver(s) and your whole health care team to understand your health goals
- Support arranging for a visit with your primary care physician to inform him/her of the changes to your care plan
- Work with you to update your home care plan to help with your recovery
- Keep your doctor, nurse practitioner and Oak Valley Health updated on how you are doing to ensure you meet your health goals

How is care provided?

Care may be provided to you in the following ways:

- Home visits
- Telephone calls
- Virtual (like telemonitoring)

We will also work with other partners, like CHATS, and LOFT to ensure you have the supports you need like:

- Caregiver support
- Transportation (rides)
- Other community support services e.g. Meals on Wheels
- Specialized behavioural supports and outreach

What happens if I still need care once I have completed Care@Home+?

You and your Care@Home+ team will be talking often, together and with you, about the services you may need at the end of the program.

Two important points are:

- At approximately six weeks, you and your Care@Home+ team will meet with you and assess how you are doing with meeting your goals. Your home care plan will be updated with a focus on potentially adding additional services that you may need. This may include possibly adding another four weeks to your care with the Care@Home+ program to continue supporting your goals and needs. Your plan will be re-evaluated every four weeks.
- When your goals have been achieved and you are stable, we will communicate with home and community support services to begin reviewing and reinstating support services, and refer you to other out-patient programs and to community support services as needed.

What if I don't have a family doctor or nurse practitioner?

The Care@Home+ team will work with you to find you one.

What are my Rights?

As MSH Care@Home patient, you, your family and your caregiver(s) have the right to:

- Receive care in a courteous and respectful manner and be free from mental, physical and financial abuse
- Receive care in a manner that respects your dignity, privacy and promotes independence
- Receive care regardless of your ethnic, spiritual, language, lifestyle and cultural preferences
- Receive a clear explanation of the services you will receive and who will provide them
- Actively participate in care assessment/planning and determine your service requirements including any revision to your care plan
- Give or refuse consent to treatment of any service
- Express concerns about your care and decisions affecting your care without fear of retribution
- Be informed in writing how to express a concern regarding a service provider
- Confidentiality of your personal health record

Privacy and your health information

If you would like access to your personal health information, please call: **1-833-991-1969**

Patient Relations – complaints, concerns, compliments

Care@Home+ partners are committed to listening to patients and learning from your experiences. We believe that your feedback, whether it is a compliment or complaint, is an opportunity for us to learn and to improve the quality of care that we provide to our patients. If you have any compliments, comments, and/or concerns, please do not hesitate to speak with your primary nurse, a member of the health care team involved in your care, or contact us at:

1-833-991-1969

patientrelations@msh.on.ca

How do I contact my Care@Home+ team?

You can contact a member of the care team, **7 days a week, 24 hours at day at:**

1-833-991-1969

When you call this number, your call is answered by one of our coordinators who can:

- Answer questions about changes to or cancelling a visit
- Transfer you to a nurse to answer health-related questions
- Connect you with the Oak Valley Health Patient Relations office to share compliments, comments, and/or concerns about the program

Proud members of the EYRND Ontario Health Team

Oak Valley Health | LOFT | Health | CHATS Community & Home Assistance to Seniors | NEW UNIONVILLE HOME SOCIETY | Ontario Central Local Health Integration Network

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