

WIISOKOTAATIWIN PROGRAM GUIDELINES



NETAAWGONEBIIK HEALTH SERVICES
HOME & COMMUNITY CARE
AND LONG-TERM CARE

807-226-2864

HOURS OF OPERATION
8:30 am - 4:30 pm
Monday - Friday

Disclaimer

This program booklet was developed as a guide to help those preparing for their Journey by the Naotkamegwanning Wiisokotaatiwin Program Leadership Committee.

Information presented is based on current resources and is not meant to endorse any particular listing.



Naotkamegwanning Wiisokotaatiwin Program
Leadership Committee
October 2014

Back Row (left to right): Jyles Copenace, Rachel Prince,
Shannon Anderson, Wilma Sletmoen, Maxine Crow

Front Row (left to right): Rose Skead, Lulu Kabestra,
Megan Cowley

MISSION STATEMENT

Wiisokotaatiwin will provide coordinated, comprehensive, person-centered and compassionate care to those who are very sick whose wish is to return home to Journey, while supporting individual beliefs and values.

VISION

To have available for Naotkamegwanning First Nation members, coordinated comprehensive services for those wishing to return home to Journey, maintaining use of individual traditions and spiritual beliefs.

TERMS OF REFERENCE

The Wiisokotaatiwin Program Team will facilitate the coordination of high-quality service to those who are very sick in our community by:

- Providing a forum to share and collaborate within the team
- Providing education and training to those involved in the person's care
- Providing bereavement and after care to families
- Creating partnerships with external linkages
- Maintaining communication with our networks

WIISOKOTAATIWIN PROGRAM PATH OF CARE FLOW CHART



WIISOKOTAATIWIN PROGRAM PATH OF CARE

1. Client Identification

Referrals for the Wiisokotaatiwin program may be received from all access points, including existing Naotkamegwanning Home and Community Care program (HCCP) clients, self or family, family physician, Health Centre or other medical clinics, hospital, or any other health care program.

A referral to the program is appropriate if:

- a) The client could benefit from the services of the program, and
- b) The client wishes to receive their care at home, and
- c) The client has an illness from which no recovery is expected, and
- d) The client has a PPS score of 60% or less with a prognosis of continuing decline to 0% within approximately 1year.

A Client Introduction pamphlet, a condensed version of this program guideline booklet, regarding the program will be made available to service providers and shared with the client and family. If translation is required and unavailable elsewhere, translation services are available from the community and may be requested by notifying the HCCP Coordinator.

2. Client Referral

Upon receiving consent from the client, a referral can be made to the Home and Community Care Program Coordinator (who is also the coordinator of the Wiisokotaatiwin program) by phone at (807) 226-2864 or by faxing the HCC Program referral form, specifying the Wiisokotaatiwin Program (fax number is on the form).

3. Comprehensive Assessment

Upon receiving a referral, the HCCP Coordinator visits the client, explains the program in detail, and conducts a comprehensive palliative care assessment, utilizing the HCCP Wiisokotaatiwin program assessment form.

- a) If the assessment occurs at home, it will be conducted in conjunction with the home care nurse and the family.
- b) If the client is in hospital, the assessment will be conducted in coordination with the palliative care nurse and/or other hospital staff and the family.

Consent is obtained from the client to share assessment information with the circle of care (see step 4).

4. Case Conference and Development of Care Plan

- a) Upon completion of the assessment, and with client consent, the HCCP Coordinator organizes and chairs a case conference with the client/family and invites the following members of the circle of care, as appropriate: home care nurse; personal support worker; physician; homemaker; WNHAC nurse practitioner; Community Health Nurse; Community Health Representative; CCAC care coordinator/ staff; LWDH discharge planner; palliative care nurse; cross-cultural coordinator; any other appropriate provider (ie: OT, PT, mental health, spiritual care provider, traditional healer); and anyone else the client wishes.
 - If client is at home, the conference will take place in the home or in the community; participants will attend case conference in person or with OTN connection.
 - If the client is in hospital, the case conference is planned and occurs several days before discharge. The HCCP Coordinator organizes and chairs the conference in conjunction with hospital discharge planner and appropriate hospital staff.

- b) A written plan of care will be developed and shared with all members of the circle of care, by means of the In-Home chart. In the event that care providers are unable to attend the meeting the HCCP Coordinator may also follow up with a phone call to communicate the care plan, if necessary. It may be determined that not all case conference participants are necessarily actively involved in the client's care at the present time, and/or it may be determined that other providers need to be included.

The plan will include goals of care; services to be provided; procurement and storage of medications, including traditional medicines if appropriate; and, equipment procurement; as well as a checklist of possible services designed to address all domains of care. This is to be referred to on an ongoing basis, ensuring clients are assessed for and offered services at the appropriate time.

The plan will also include information for family and staff on whom to contact if there are changes in health status, symptom crises, or questions regarding care occur. This can include but not be limited to CHCP, WNHAC, physicians, telemedicine services, and pain and symptom management coordination. If additional members are added to the circle of care, consent is obtained and the care plan is shared with them.

5. Coordinated Health Services Delivery

- a) Day-to-day communication between the circle-of-care is documented in the logbook placed in the clients home.
- b) The HCCP Coordinator is the client's care manager.
- c) Case conferences will be called as necessary; any member of the circle-of-care can call the HCCP Coordinator and request a case conference.

- d) Family and staff will be instructed to call HCCP Coordinator for answers to any questions regarding care, changes in health status, or symptom crises; and prior to taking client to emergency or hospital or given other specific instructions.

Family and staff will be made aware of whom to contact if the HCCP Coordinator is away from the community, on vacation, or sick. This support will be available on a 24/7 basis.

- e) Regular reassessments will be coordinated through the HCCP Coordinator and home care nurse. Adjustments to the care plan will be made as necessary and communicated to members of the circle of care through the In-Home chart, and other communication from the HCCP Coordinator if appropriate.
- f) HCCP Coordinator will call the discharge planner and/or the emergency department, based on type of hospital visit, when the HCCP Coordinator is aware that one of the Wiisokotaatiwin clients is on their way to hospital.
- g) The HCCP Coordinator will provide the LWDH care planner and WNHAC with a list of Wiisokotaatiwin Program clients, and the planner will notify the coordinator if any clients are admitted to hospital.
- h) If a client is transferred to hospital, the client will be requested to bring the In-Home chart to the hospital for hospital staff to refer to.
- If this is an Emergency Room visit, a note/fax will be placed in the In-Home chart regarding the presenting problem, the treatment, and any further plan.
 - If this is an admission, the HCCP Coordinator will be involved in discharge planning. A copy of the discharge form will be placed in the In-Home chart which will return home with the client.

6. Planning for Coming Home (The Passing):

Discussions with the client/family regarding their choices for care are initiated by the physician, or appropriate person, at a PPS score of 30% (or earlier if appropriate) and documented with the date in the In-Home chart.

- a) If a client is in hospital, a meeting with the client/family is initiated by the discharge planner and the HCCP Coordinator, involving the physician, and Merv Copenace if appropriate. The options for care and services available in hospital and at home are explained. If the decision is to go home, a case conference with the circle-of-care is initiated by the HCCP Coordinator to plan for care at home, including identifying what needs to be in place prior to discharge.
- b) If the client is at home, the HCCP Coordinator meets with the client/family to discuss “what it means to stay home”, and explains what services the program can offer. The decision to remain home initiates a case conference with the circle-of-care to revise the care plan.

In both cases, the care plan will include:

- Explanation of expected physical changes in a culturally sensitive and safe manner;
- Ensuring the family knows who to contact for support; and
- Involvement of a spiritual support person or a traditional healer/support person for client/family support and performance of ceremonies, as requested/required.

7. Client Has Passed:

The family is most involved and caregivers take direction from the family. If food and wood are required, the community will provide help with this. Financial support for the family, funeral, food and supplies, are available through the Naotkamegwanning Band Office if required.

8. Follow-up and Bereavement Support:

Traditional and cultural beliefs, values, and customs are honoured and respected.

Services from the Wiisokotaatiwin Program will continue after the passing, as appropriate:

- a) A follow-up bereavement visit from the HCCP Coordinator will occur to assess how the family is doing.
- b) If additional support is required, referrals can be made to the community mental health coordinator, family support/traditional advisor, elder support, KCA psychologist, WNHAC emotional wellness coordinator, or Thunder Bay community wellness team.
- c) HCCP Coordinator will ensure family has access to traditional support.
- d) A sharing circle for all members of the circle-of-care will take place, organized by the HCCP Coordinator, and led by both an Elder and a mental health professional.

9. File Closure:

Equipment is returned to the HCCP Coordinator and will arrange returns to appropriate agencies as required.

Each agency is responsible for maintaining and retrieving their own records.

WIISOKOTAATIWIN PROGRAM LIST OF SERVICES

HOME & COMMUNITY CARE PROGRAM

Program Coordinator 226-2864

Services provided are:

- Intake, assessments, monitoring and support of HCCP and Wiisokotaatiwin Program
- Case conferencing, client advocacy, care plan development and review
- Referral(s) to organizations/agencies
- Coordination of client discharge from hospital

Home Care Nurse 226-9665

Services provided are:

- Assistance for chronically and acutely ill clients to receive the care they need in their own community

Personal Support Workers 226-9665

Services provided are:

- Health monitoring, health teaching, personal care and meal preparation
- Bathing, grooming, basic foot care, skin care, dressing, medication assistance, toileting, vital signs, respite care

Home Maker 226-2864

Services provided are:

- Assistance with activities of daily living and non-medical care
- Home cleaning tasks, person care and meal preparation, housekeeping, laundry duties, personal care, assistance with hygiene, assistance with transferring and mobility, friendly visits, respite care

Home Support 226-2864

Services provided are:

- Minor home repair and exterior maintenance of client's home
- Installing grab bars and other minor home adaptations, seasonal yard maintenance, for example: grass cutting, snow removal, cutting and piling wood, clearing hazardous walkways, observing and reporting client/home safety concerns, and equipment malfunctions

NETAAWGONEBIIK HEALTH SERVICES

Administration 226-1026

Health Clerk/Reception 226-5383

Services provided are:

- Coordination and scheduling of medical appointments, as requested
- Coordination of doctor and nurse practitioner appointments, in community
- Maintenance of Winnipeg and Kenora appointment books
- Coordination of clinic prescription pickup

Community Health Nurse 226-5383

Services provided are:

- Provision of health care services through clinic visits
- Knowledge of individuals' general health by regular contact with community members
- Assistance with referrals to outside agencies, as requested
- Mandated Programs:
 - Immunization
 - Communicable Disease Program
 - Well Baby Program

****Walk-Ins if and when time permits****

Community Health Educator 226-5383 ext. 224

Services provided are:

- Identify, prioritize community needs on an ongoing basis
- Education and promotion of all health initiatives
- Home visits to all community members on a quarterly basis
- Coordination of Health related community activities

Mental Health Services 226-1026 ext. 222

Services provided are:

- Ongoing counselling to all family units and individuals
- Referrals to services on and off reserve, when appropriate
- Home and office visits to community members to provide support as needed

Elder Support Worker 226-1026

Services provided are:

- Support and services to Elders
- Transportation to town and cities

Family Support Worker 226-1026 ext. 248

Services provided are:

- Community based support and prevention services for children, youth, and families
- Family counselling services within the context of mental health

Circle of Hope and Healing 226-1026

Services provided are:

- Promotion of the involvement of natural and extended family systems
- Strategies to promote positive changes in lifestyle through traditions, customs, and language of Naotkamegwanning
- Respect for the customary way of life, including traditional

Community Wellness Worker 226-1026 ext. 240

Services provided are:

- Assistance to community members requesting traditional healing
- Quarterly sweat lodge ceremonies
- counselling services/referrals
- Transportation to appointments

Suicide Prevention/Black River Camp 226-1026 ext. 244

Services provided are:

- Culturally based activities for youth and Elders
- Black River Youth and Elder engagement camp

Community Transportation Services 226-5383

Services provided are:

- Medical Van: transportation to and from appointments in Kenora
- Alternate Distance Driver: transportation to and from Winnipeg appointments
- Dialysis Driver: transportation of dialysis patients to and from Kenora

IMPORTANT COMMUNITY SERVICES NUMBERS

- **Mino'Giizhigad Elder Centre 226-9665/226-2864**
- **Naotkamegwanning Housing Manager 226-2736**
- **Naotkamegwanning FN Administration 226-5411**
- **Naotkamegwanning Ontario Works 226-1092**
- **Naotkamegwanning EMS 226-2277**
Community has 911 system

COMMUNITY HEALTH CARE PROVIDERS

WAASEGIIZHIG NANAANDAWE'IYEWIGAMIG (WNHAC)

**Kenora Health Access Centre (807) 467-2666
212 4th Avenue S., Kenora**

Nurse Practitioner

Services provided are:

- Weekly clinic in community, broad range of health care services including assessment, diagnosis, and treatment
- Home visits can be arranged for Wiisokotaatiwin clients as required
- Available to respond to questions regarding care of family or staff

Mental Health & Emotional Services (in community or Kenora)

Services provided are:

- Emotional Wellness coordinator
- Traditional healing programs, access to Elders and traditional health services
- Diabetes education and foot care
- Health education and promotion—group education and issue-specific workshops in community

KENORA CHIEFS ADVISORY (807) 467-8144

3 - 115 Chipman St., Kenora

Services provided are:

- Psychologists
- Social Workers
- Mental Health team

LAKE OF THE WOODS DISTRICT HOSPITAL
(807) 468-9861
21 Sylvan St., Kenora

Palliative Care Coordinator: 468-9861 ext. 2339

Services provided are:

- Coordinate palliative care, see patients in hospital
- Referral by client's physician

Discharge Planning: 468-9861 ext. 2254

Services provided are:

- Provide consultation to any in/out patient at LWDH to assist with identification/coordination of services required for safe discharge
- Referral through any member of interdisciplinary health team or at patient/family request

NORTHWEST COMMUNITY CARE ACCESS CENTRE
(807) 467-4757
Suite 3 - 35 Wolsley St., Kenora

Robin Gould, Manager

- Through personal visits and regular check-ins, we help determine the right care and health supports for people and their families.

Services provided are:

- Nurses, occupational therapists, social workers, physiotherapists, speech therapists, and nutritionists
- Nursing service referrals need to be faxed in from physician or nurse practitioner. All other referrals can come from anyone (the client, family/caregiver, other community service programs)

JOHNSON'S PHARMACY
(807) 468-7412
116 Main Street S., Kenora

Services provided are:

- Accurate and timely prescription filling, including drug interactions, therapy duplication, correct dosing, and appropriate medication use and storage
- Available in person or by phone for direct patient inquiry or questions from family members
- Provide blister packaging of medication
- Member of patient's health care team

PAIN & SYMPTOM MANAGEMENT PROGRAM
1-800-625-5406

Marg Poling, Pain & Symptom Management Consultant

Services provided are:

- Expert advice, support, and resources to health care providers on all aspects of palliative care
 - Consulting on issues regarding a specific client
 - Information and education on palliative care
- *Services available Monday-Friday 8:30– 4:30****

TELEMEDICINE NURSE, HOSPICE PALLIATIVE CARE
St. Joseph's Care Group, Thunder Bay
(807) 343-2431 ext. 2511

Robin Cano, Telemedicine Nurse Consultant

Services provided are:

- Pain and symptom management
- Assistance discussing and completing advanced directives
- Client specific caregiver support and education
- Client specific allied health support and education

COMMUNITY HEALTH CARE PROFESSIONALS INC.
(807) 467-8393
201 - 115 Chipman St., Kenora

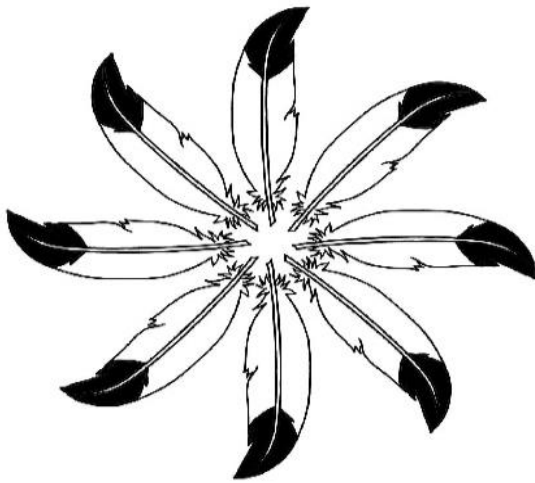
Vicki Barnes, General Manager

Services provided are:

- Deliver Home Care and Community Health nursing services in First Nation Communities, including Naothkamegwanning.
- All of the nurses receive cultural sensitivity training and are able to incorporate the needs of the community and clients into their nursing care, while maintaining all standards of the programs they service, as well as, the professional standards of nursing.
- Home care services are offered through the First Nation and Inuit Home & Community Care Program.
- Offer both Registered Nurses and Registered Practical Nurses depending on the needs of the clients they are providing services for.
- Nursing services include hands on nursing, on call nursing, program supervision, assistance with reports and supervision of unregulated health care providers.
- The team of professional nurses has a variety of skills and experiences to accommodate the communities and clients they service.

SHOPPER'S HOME HEALTH CARE
(807) 468-4128
605 4th St., Keewatin

BROWN'S FUNERAL HOME
(807) 468-8633
429 2nd Street S., Kenora



*Ojibway unity and harmony
with Mother Earth*