COMMUNITY LIVING
Lanark County

Inspiring Possibilities

SUPPORT POLICIES AND PROCEDURES

(A)

June 2019

Contents

SUPPORT POLICIES AND PROCEDURES

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PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

Supports and services provided by the Association shall be designed specifically for each person through person centred planning. Supports will be designed to reinforce the Associations Vision, Mission and Values and Beliefs.

Mission
"Community Living Association (Lanark County), is a charitable organization accountable to a community based membership and is dedicated to supporting individuals with intellectual disabilities to live a quality life in a state of dignity, with the opportunity to participate fully in their community and to contribute and benefit from societal engagement."

Vision
All Individuals regardless of abilities are treated with respect and dignity, have opportunities for personal development to fulfill their dreams and participate fully in their community.

PROCEDURES:

Values and Beliefs

Respect:
All individuals are valued and appreciated and are treated respectfully and fairly.

Dignity:
All individuals have inherent worth and are respected for their ability and not judged by their disabilities.

Caring:
We ensure that all individuals receive recognition and live in a state of respect and dignity.

Responsibility:
All individuals have rights and obligations and are entitled to the benefits of citizenship and are responsible for the obligations of citizenship.

Inclusion:

Individuals are accepted and included in the meaningful activities, rites and the fabric of families, groups, institutions and communities.

Team/Family:
We value the strength of team and family and recognize the benefit of the collective and the obligation of the individual to contribute to the health and well-being of their co-worker, team and family.

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PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

Supports and services provided by the Association shall be designed specifically for each person through person centered planning. All supports will be individualized to meet each person's individual goals, needs and wishes.

PROCEDURES:

1. The person shall be involved in all planning and decisions regarding the person's needs or wishes.
2. All planning, support and decision making shall focus on and be accountable to the person. The person shall be supported to direct the process.
3. An integral component of the individual support shall be the facilitation and fostering of an ongoing support network involving family, friends and others, as decided by the person (or the family in the case of a child).
4. In the case of adults, the person shall be encouraged and supported to involve family, friends and others as they may wish, in the planning process.
5. Planning and support shall be committed to connecting people to all aspects of the community in the most natural way possible.
6. Planning and support shall be an ongoing process, responding to the ever-changing needs and wishes of the person being supported.
7. Planning and support meetings or get-togethers shall be held as often as needed at a time and location of the person's choosing and shall be recorded in a manner that is meaningful and respectful.

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CATEGORY: GENERAL	
POLICY # A1.03 – INDIVIDUAL SUPPORT PLAN	
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APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

An individualized "Individual Support Plan" shall be developed for each person being supported by the Association, in order to clarify the required supports and the responsibilities to provide those supports in order for a person to achieve personal goals.

PROCEDURES:

1. The development of the Individual Support Plan shall come out of a person centred planning process.
2. The Individual Support Plan shall:
    i. Summarize the person's desired goals and plans.
    ii. Outline the strategies to reach the above goals and plans.
    iii. Outline the commitments made by the various members of the support group, including the Association and other identified community organizations, to help the person achieve the goals and plans.
    iv. Contain time lines in which all agree to meet their commitments to the person.
3. The Association shall ensure that there is a dispute solving mechanism available to solve any concerns that might arise out of the agreement.
4. The Individual Support Plan shall be reviewed and updated as required on at least an annual basis, although changes to the agreement may be made at any time through mutual determination.
5. The Individual Support Plan is a working document and must be continually referenced to ensure both Association accountability and relevance to the person.
6. The Individual Support Plan shall be developed and recorded in a manner that is clear and understood by all parties (e.g. Braille, audio-visual, symbols etc.).

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: GENERAL	
POLICY # A1.04 – ACCESS TO ASSOCIATION SUPPORTS	
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PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

Access to Association supports will be made through the Lanark County Pressures and Priorities Committee or the "single point of access" as identified by the Ministry of Community and Social Services.

PROCEDURES:

1. The procedures that will be followed shall be as defined by the Lanark County Pressures and Priorities Committee or the "single point of access" as identified by the Ministry of Community and Social Services.
2. Those individuals who are served exclusively through Passport funding, are excluded from this policy.
3. The following documents will be completed at intake to determine the supports that are required and the service's ability to deliver said supports:
    i. Application for Services Intake
    ii. Risk Assessment
    iii. Skills and Competency
    iv. Quality of Life
4. When an individual has been approved to receive supports from the Association, the individual and his/her support network shall receive an orientation to the Association's mission statement, service principles and the rights statement and package.

SUPPORT POLICIES AND PROCEDURES	
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POLICY # A1.05 – FAMILY INVOLVEMENT	
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AUTHORIZATION: Executive Director	

POLICY:

The Association shall honour and support every person's relationship with family.

PROCEDURES:

1. The Association shall support and encourage people supported to stay connected and involved with their family members.
2. The Association shall encourage people supported to involve their family members in planning strategies for their life.
3. The Association shall encourage family members to become members of the Association.

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POLICY # A1.06 – CODE OF ETHICS	
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APPROVAL DATE: 10.07.2011	**REVISION DATE:**
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AUTHORIZATION: Executive Director	

POLICY:

Employees of the Association shall be expected to abide by an approved Association Code of Ethics which shall be circulated to all employees.

PROCEDURES:

1. The Code of Ethics will be found in the Associations Human Resources Policy Section D5.01.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: GENERAL	
POLICY # A1.07 – RESIDENTIAL SERVICE CONTRACT	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

All Individuals and family members or legal guardian served and supported by the Association in a residential home shall sign a service contract that clearly defines the responsibilities and commitments of the person, family members or decision makers and the Association.

PROCEDURES:

1. When an Individual or family requests services, the Association shall clearly outline its philosophy and support delivery methodology so that decision makers can make an informed decision.
2. The Association shall clearly outline its requirements regarding supports and involvement from family members or decision makers.
    i. The Association recognizes that family and natural relationships are integral to an Individual's quality of life and encourages family involvement in all facets of the Individual's life.
    ii. The family member and Individual agree that all finances shall be controlled by the Individual, if they are competent, and that the family shall allow the Association or its representative to assist the Individual to prudently manage their finances.
    iii. The Individual or designated decision maker shall agree to meet the financial obligations required to support the Individual in the home and as outlined in the Service Contract.
    iv. The Individual or designated decision maker shall agree to allow the Association representative to attend all medical, clinical and other appointments if the agency deems it appropriate and necessary to provide supports and services.
3. The Individual and designated decision maker shall agree to abide by the operating rules of the home.
4. The Individual and designated decision maker acknowledge that other people live in the home and that they need to respect the needs and rights of all Individuals.
5. The Individual and decision maker acknowledge and respect that the Association must abide by regulations that may limit them from meeting certain service and support requests that conflict with these regulations.
6. The Individual and designated decision maker recognize and respect that the Association has limited resources that must be allocated equitably amongst the people that it supports in the home.
7. The Association will abide by the philosophy that group homes are peoples' homes and that they are entitled to all rights and privileges normally associated with living in one's home.
8. The Association commitments to supporting the individuals with excellent person centered supports within the allocated resources and the limitation of group living environments.

SUPPORT POLICIES AND PROCEDURES	
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PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure appropriate sleeping accommodation for each person living in Association operated accommodation.

PROCEDURES:

1. The Association will ensure each person living in a group home will have their own bedroom.
2. The person's bedroom will have at least the following.
    a. a bed of appropriate size
    b. a suitable mattress
    c. bedding appropriate for the weather
    d. Appropriate individual furniture and clothing storage
    e. S=sufficient space to keep their personal possessions and to pursue hobbies and interests without unwanted intrusion form others.
    f. an exterior window and window coverings.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: GENERAL	
POLICY # A1.09 – DAILY RECORDS OF ACCOUNTABILITY	
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APPROVAL DATE: 10.07.2011	**REVISION DATE:**
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AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that there is a process where employees are accountable to the people for whom the Association works.

PROCEDURES:

1. Every person the Association works will have an individual plan on file that reinforces the support the person requires and wishes.
2. All staff are accountable to ensure that the plan is an active document and is followed and checked at least monthly.
3. Each Individual supported will have goals identified in their Individual Support Plan and who is responsible in ensuring the support happens.
4. It is the manager's responsibility to monitor and ensure all documentation is up to date and followed.
5. The Association will follow the Rights policy in ensuring supports are appropriate and that we are accountable to the people we work for.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: GENERAL	
POLICY # A1.10 – PETS AND SERVICE ANIMALS	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

It is the policy of Community Living Association (Lanark County) that people supported have the right to own pets. It is the role of Community Living Association (Lanark County) employees to assist the person supported to access information on the responsibilities associated with pet ownership, including the care and cost involved.

PROCEDURES:

1. Where an individual want to acquire a pet, every effort will be made to acknowledge, support, and pursue that interest. In doing so, staff members of the Association will fulfill the following functions:
    i. Listen to the individual who is expressing an interest in pet ownership and acknowledge that such interest has been heard.
    ii. Explore that interest in greater detail with the person, supporting a process of understanding the nature of the interest and the context within which it is expressed.
    iii. Counsel the individual in a supportive manner to ensure that he/she is fully aware of the responsibilities and the costs associated with owning a pet.
    iv. Ensure that the individuals interest in pets is reflected in his/her Personal Plan and that the goals articulated in the plan deal with the issue.
    v. Collaborate with the individual to consider the implications of pet ownership on others, particularly those who may share living space with that person.
    vi. Support the individual to pursue his/her interest as necessary and appropriate.
    vii. Support the person supported to acquire appropriate vaccinations and health maintenance for the pet.
2. In some instances, this right may be constrained by circumstances. Individuals who receive support from the Association Residential Services will need to be aware of the needs and interests of others who share their home. Those particular situations may prevent an individual from acquiring a pet. In group living arrangements, co-habitation obligates individuals to compromise on interests and priorities out of respect for housemates. For example, consideration for a housemate who is allergic to cats could, and should, prevent a resident from acquiring a cat.
3. In the event that a person supported requires a service animal, staff of the Association will assist the person to access the following and any other resources as are required for the health and welfare of the person.
    i. Support the person to contact CNIB and other resources required.
    ii. Support the person to gather all information required to assist the Individual in making an informed decision on owning a service animal.
    iii. Support the person to acquire appropriate vaccination and health services for the service animal.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: GENERAL	
POLICY # A1.11 – RECREATION & LEISURE FUND & FUNDRAISING	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.08.2012	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.08.2012	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

Employees have demonstrated a willingness and eagerness to assist in developing additional resources to enhance service delivery in their services. The association encourages and applauds these initiatives. It is recognized that funds raised under the banner of Community Living Association and through the efforts of employees, volunteers and the Individuals we support.
The Recreational and Leisure Fund is for the expressed purpose of enhancing services to the Individuals we work for.

PROCEDURES:

1. All fundraising must be approved by the Executive Director
2. All cash donations must be administered by the corporate office to comply with the appropriate donor stewardship and CR guidelines.
3. The association will set up a Recreation and Leisure Fund bank account for each location at a local bank for the expressed purpose of maintaining funds.
4. There will be three signing authorities for each account; an employee, an Individual we support, and a manager.
5. Expenditures from the fund shall be decided upon by the team and Individuals we work for.
6. The team shall seek approval of the manager for expenditures in excess of $200.00
7. Staff shall keep an up to date ledger and will reconcile the account monthly through AIMS.
8. The manager shall review and sign off on the account monthly.
9. Employees shall not keep more than $100.00 on site at any time.
10. Employees shall not borrow from the fund for personal use.
11. Funds may be used for:
    a. Emergency supports of Individuals
    b. Program supplies
    c. Social events
    d. Support of Individuals
    e. Equipment and furnishings
    f. Special requests recommended by the team and approved by the manager.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.01 – PERSONAL NEEDS ALLOWANCE	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.05.2007	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.15.2006	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that all people for whom it works maintain the appropriate personal needs allowance from the Ontario Disability Support Program (ODSP) cheque.

PROCEDURES:

1. The ODSP cheque is deposited directly into the person's bank account.
2. The person pays the appropriate room and board as per the requirements and limitations of the ODSP.
3. The remaining amount (personal needs allowance) remains under control of the person for whom the Association works.
4. The Association shall assist the person in banking as required and in accordance with Association policies and procedures.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.02 – ASSISTANCE WITH PERSONAL FINANCE	
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APPROVAL DATE: 10.07.2011	**REVISION DATE:**
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AUTHORIZATION: Executive Director	

POLICY:

The Association shall offer assistance with personal finances to those people for whom it works who request or require it, to assist them in achieving and maintaining financial security as part of their endeavor to establish a desired healthy lifestyle.

PROCEDURES:

1. Each person's financial affairs shall be kept in strict confidence as per policy on confidentiality.
2. Financial support requests that are identified by the person or personal support network shall be addressed within the Individual Support Plan as well as through a written request that shall be placed in the person's central file.
3. All personal financial support arrangements are to be time limited and reviewed at least annually as part of the person's personal support planning process.
4. Efforts should always be given to find the person generic or natural financial support arrangements (e.g. bank personnel, community counseling financial services etc.).
5. The Association or its employees shall not act as trustees of a person's financial affairs.
6. The Association employees shall not be co-signers or have joint or shared accounts with persons supported by the Association.
7. The PIN numbers, which access a person's bank account, are not to be known to Association support employees. If the person needs another person to have this information it should be someone from the personal support network.
8. To ensure accountability, an independent financial audit (required by the Ministry of Children, Community and Social Services) shall be completed annually by the Association's financial department; this independent review shall include a report to the Board of Directors.
9. Money exchanges between people served or supported and Association employees should be avoided whenever possible. If for some personal reason, such a transaction must occur, it should be witnessed and proper receipts issued to verify the transaction.
10. At the discretion of the person supported the staff shall assist with a monthly reconciliation of personal finances (using AIMS) and once completed the form shall be reviewed by the Manager.
11. The person's PIN money within a home shall be reconciled daily and shall be recorded in AIMS.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.03 – PERSONAL SUPPORT IN HOME	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
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AUTHORIZATION: Executive Director	

POLICY:

The Association shall provide personal support in a person's own home in order to help the person maintain, or regain, as much independence in living as possible.

PROCEDURES:

1. The Association shall provide personal support in the private home of people for whom it works:
    i. With the consent of the person.
    ii. Only when other more appropriate sources cannot provide the support.
    iii. Only if the person requires the support to manage his or her home and property.
2. The support provided shall be as stipulated in the Individual Service Contract.
3. All support shall be provided with the aim of developing independence so that the person, if appropriate, will eventually manage without Association support.
4. Staff shall respect the autonomy of the person for whom they work and recognize at all times that they are a "visitor" in someone's home.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.04 – WILLS	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
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AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that all persons over the age of eighteen are informed about the importance of having a current will in order to ensure the smooth transition/distribution of property after death.

PROCEDURES:

1. A record of whether or not a person has a will shall be noted on the personal file.
2. Each person for whom the Association works shall be informed about the importance of having a will and the purpose of having a will.
3. Such discussion will involve the family at upon the request of the person supported.
4. A record of such discussion will be recorded and maintained in the personal file.
5. When necessary staff shall assist each person in obtaining the services of a lawyer or other legal practitioner as required.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.05 – EMERGENCY FUNDS	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.15.2007	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.15.2007	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall maintain an emergency fund for the use of people for whom it works.

PROCEDURES:

1. An emergency fund shall be maintained in an account separate from the Operating Account so that it may accrue in value from year to year.
2. A person for whom the Association works shall have access to the fund in the event of a financial crisis in his/her life.
3. The request shall be made to the appropriate Manager.
4. The Manager shall review the request to determine if it is an emergency and if relief is available from other resources.
5. A maximum of $500 may be accessed
6. There will be an expectation that the money granted will be repaid.
7. If the Manager agrees that it is an appropriate request, the request shall be made in writing, and will include a schedule of re-payment.
8. If it a request for which there can be no repayment, the Executive Director shall approve the request. Once approved a memo shall be sent to the Manager of Finance and Administration to issue a cheque and establish a tracking system for repayment etc.
9. All details of the request shall be kept in the person's file.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.06 – DUTIES AND RESPONSIBILITIES	
PAGE: 1 of 1	**REFERENCES:**
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AUTHORIZATION: Executive Director	

POLICY:

Staff are tasked to complete duties and responsibilities as identified for each service location. A checklist shall be developed and implemented for each Association operated support location.

PROCEDURES:

1. Duties and responsibilities will be completed at the time specified on the Duties and Responsibilities checklist, at least once every shift.
2. The date of the inspection must be written at the top of each itemized column on the form.
3. At the time of completion employees will initial the specific item on the checklist.
4. All employees will ensure the inspection and checklist is completed before leaving their shift.
5. Noncompliance to the identified duties and responsibilities may result in disciplinary action.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.07 – BEHAVIOURAL SUPPORT	
PAGE: 1 of 2	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
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AUTHORIZATION: Executive Director	

POLICY:

The Association may ensure the development and/or implementation of behavioural support plans and strategies that are in the sole interest of the person for whom the Association works.

PROCEDURES:

1. The person supported will be referred to a Behavioural Consultant or Psychologist.
2. A behavioural plan will be approved by a psychologist before implementation.
3. This plan may include:
    i. Involvement of professional psychiatric or psychological assistance.
    ii. Identification of back-up strategies for employees.
    iii. Involvement of medical and/or hospital employees.
    iv. Identification of managers to be notified immediately in case of altercations.
    v. Identification of an advocate (parent, other family member, friend, etc.) and procedure for notifying the advocate when required.
    vi. Identification of employee supports.
4. An Individual Support Plan will be developed for each person with a challenging behaviour, Identification of all PRN medications is required with clear strategies and protocol for use of medication.
5. Review and sign off of all Behaviour Support Plans is required by each employee working with that person annually.
6. Students and volunteers are not permitted to take part in any behaviour Intervention strategies.
7. All Behaviour Support Plans will have guidelines for consent as to who the plan can be shared with outside of Association staff. The Association will have a signed consent form to share information with external sources and placed in the Individual's personal file.
8. All Behaviour Support Plans will be reviewed by a third party review committee (refer to policy # A2.08).
9. Behavioural Support Plans will be developed with the involvement of the person with a challenging behaviour and/or where applicable, the persons acting on behalf of the Individual with a challenging behaviour, and the plan will have documentation of their involvement.
10. The Individual with a challenging behaviour and/or where applicable, the persons acting on behalf of the Individual with a challenging behaviour, will provide consent to the behaviour support plan and the strategies that it outlines.
11. The Behaviour Support Plan will include provisions from clinicians(s) who approved the plan, for the eventual fading out or elimination of intrusive behavioural interventions which may be outlined in the behavioural support plan.
12. Where Behavioural Support Plans do not identify when to notify the contact person of the Individual with challenging behaviours the Association shall ensure that there is an attached

document to the Behaviour Support Plan identifying when to contact the persons acting on behalf of the Individual with a challenging behaviour to notify them of:

i. Regular updates and progress of the plan.
ii. Notification of intrusive behavioural interventions.
iii. Notice of crisis situations.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.08 – SUPPORTING INDIVIDUALS WITH CHALLENGING BEHAVIOURS	
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APPROVAL DATE: 10.07.2011	**REVISION DATE:**
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AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that the development and implementation of Behavioural Support Plans to support Individuals with challenging behaviours will ensure the safety and security of the Individuals in the least intrusive manner.

DEFINITIONS:

Challenging Behaviour is defined as a behaviour that is aggressive or injurious to self or to others or that cause property damage or both and that limits the ability of the person with developmental disabilities to participate in daily life activities and in the community or to learn new skills or that is any combination of the above.

Prescribed Mediation, as an example of an intrusive procedure or action in Ontario regulation 299/10 is medication that is prescribed to assist the person in calming themselves with a clearly defined protocol developed by a physician as to when to administer the medication and how it is to be monitored and reviewed.

PROCEDURES:

1. The Association will ensure that all Individuals receiving behavioural supports identified in a behavioural support plan due to challenging behaviours will have access to a third party review committee to complete an annual review of the Behavioural Support Plan.
2. The review committee's membership consists of:
    - 1 – Behavioural Science Technician
    - 1 – Psychometrist
    - 1 – Behavioural Development Program Coordinator
    - 1 – Psychologist
3. The Review Committee's membership's role and responsibilities are to ensure the Behaviour Support plans are:
    i. Ethical and appropriate to the person's needs and assessments results based on professional guidelines are best practices.
    ii. In compliance with the ministry's requirements outlined in the regulation to the services and supports to Promote the Social Inclusion of Persons with a Developmental Disability, 2008 and the policy directives.
4. The Review Committee shall include the involvement of a clinician with expertise in supporting adults with a developmental disability who have challenging behaviours.
5. The Review Committee will review all current behaviour support plans annually. A copy of the review will be sent back to the Individual and attached to their current Behaviour Support Plan.

Supports Provided by More than One Agency

1. When supports are shared between two agencies a memorandum of understanding "Supporting Individuals with Challenging Behaviours" will be developed with defined roles and responsibilities of both agencies. The agreement shall identify consistent strategies to ensure adherence to the behaviour support plan for the Individual.

Crisis Situations

1. If an Individual with challenging behaviours experiences three crisis situations within a twelve-month period, the Association shall investigate the potential causes of the behaviour and factors that may have led to the crisis situations. The investigation may lead to a functional assessment of the Individual and the development of a behaviour support plan for the Individual.

Use of Prescribed Medication

1. The Association shall ensure that all medication prescribed to the person with a challenging behaviour is reviewed by the prescribing physician. The physician's findings and recommendations shall be included in the regular review of the Individual's behaviour support plan.
2. All medication received resulting from the following a Behaviour Support Plan will be charted with results to the effects at intervals of:
    i. 30 minutes
    ii. 60 minutes
    iii. 2 hours.
3. Charting is to be reviewed with the Behaviourist quarterly.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.09 – SUPPORTING INDIVIDUALS WITH CHALLENGING BEHAVIOURS – SECURE ISOLATION	
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APPROVAL DATE: 10.07.2011	**REVISION DATE:**
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AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that the development and/or implementation of behavioural support plans to support Individuals with challenging behaviours ensures the safety and security of the Individuals in the least intrusive manner.

PROCEDURES:

1. If secure isolation/confinement time out due to challenging behaviour is identified in the Positive Behaviour Support Plans, periodic monitoring of every 1-2 minutes will be written into the plan with clear guidelines and protocols.
2. Positive Behaviour Support Plans shall identify the duration of the time that the person may spend in the secure isolation/time out area, any extension periods, and the total/maximum amount of time the person may spend in the secure area.
3. Documentation shall be kept for each time an Individual is in secure isolation, these records will be reviewed monthly to bi-monthly with the clinicians overseeing the plan. Trend analysis will be completed on an ongoing basis.
4. Debriefing will be conducted among all staff who were involved in the restraint or secure isolation/confinement time-out.
5. Employees will ensure debriefing occurs with all Individuals who were in the vicinity and witnessed the restraint. Documentation of the debriefing will be logged into the Association's AIMS database.
6. The employee on duty shall notify the Supervisor or Manager who oversees the behaviour support plan of a restraint or secured isolation/confinement time out.
7. The debriefing process is conducted with the Individual who was restrained or in secure isolation/confinement time out as soon as he/she is able to participate and to the extent that he/she is willing to participate. The debriefing will be structured to accommodate the person's psychological an emotional needs and cognitive capacity.
8. The debriefing process will be conducted within a reasonable time period of three business days after the restraint or secure isolation/confinement time out is carried out (including crisis situations). When circumstances do not permit a debriefing process to be conducted within a reasonable time period the debriefing process should be conducted as soon as possible. A record must be kept of the circumstances that preventing the debriefing process from being conducted within the reasonable time period.
9. Employees on duty shall inform other staff members of coming on duty to support the Individual of the restraint or secure isolation/confinement time out.
10. A serious occurrence report will be filled with the Ministry of Children, Community and Social Services when appropriate as per the serious occurrence reporting procedures.

Use of Restraint or Secure Isolation/Confinement Time Out General.
Restraint and secure isolation/confinement time out and prescribed medications are used in some situations with adults with developmental disabilities who have challenging behaviours to address their behaviour. The directive is aimed at ensuring a person's safety and well being during the use of a restraint, secure isolation/confinement time out, or with prescribed medication.

1. The Association shall ensure that the use of physical restraints, mechanical restraints and secure isolation time is stopped when there may be a risk that the restraint itself will endanger the health or safety of the Individual who is being restrained; or the supporting staff person(s) have assessed the Individual and situation and have determined that there is no longer clear and imminent risk that they Individual will injure his/herself or others.

Use of Restraint or Secure Isolation/Confinement Time Out Rooms
Where secure isolation/confinement time out is recommended to be used to address a person's challenging behaviour as part of their behaviour support plan are followed:

1. The Association shall ensure that all policies and procedure reflecting challenging behaviours and secure isolation are followed.
2. The Association shall ensure that its fire escape plan includes provisions for escape from a secure isolation/confinement time out room in the event of an emergency.
3. If the secure isolation/confinement time out has a lock on the door to prevent person from leaving the room the service shall ensure that the lock can be easily released from the outside in the event of an emergency.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.10 – SUPPORTING INDIVIDUALS WITH CHALLENGING BEHAVIOURS – VIDEO MONITORING PROTOCOL	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.2013	**REVISION DATE: 01.07.2019**
PROCEDURE APPROVAL DATE: 10.2013	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

All video monitoring must be approved by the Executive Director, the Individual being monitored and/or persons acting on their behalf prior to video monitoring is installed.

PROCEDURES:

1. Clear guidelines for when and how the video monitoring is utilized will be developed specific to the Individual and identified in the Behaviour Support Plan.
2. The following must be included in the video monitoring protocol:
    i. Purpose/outcome of the monitoring.
    ii. When the monitor can be used and cannot be used.
    iii. Tracking expectations of the monitor
    iv. Review and documentation of the information collected.
    v. Consent of the Individual and/or persons acting on their behalf.
    vi. Consent as to whom the data may be shared with.
    vii. When the monitor can and cannot be used.
    viii. Rights restrictions if applicable. Means to address restrictions or purpose behind restrictions.
    ix. How the long the monitoring system will be utilized.
    x. Outcomes of monitoring

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.11 – SUPPORTING INDIVIDUALS WITH CHALLENGING BEHAVIOURS – STAFF TRAINING	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.2013	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.2013	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall provide training to employees supporting persons with challenging behaviours where applicable.

PROCEDURES:

1. Employees shall complete a non-violent physical crisis intervention training course before working alone with Individuals with challenging behaviours.
2. Employees will complete refresher courses as prescribed by the service provider of the course.
3. Employees will have an orientation to all behaviour support plans before working alone in the service. Orientation will be part of the original site orientation package.
4. Employees shall complete at minimum an annual review and sign off of behaviour support plans. Review dates to be forwarded for inclusion in the employee's personnel file.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.12 – AFTER HOURS EMERGENCY SUPPORT	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that there is after hour emergency supports available at all times.

PROCEDURES:

1. The Association shall maintain a system that ensures after hour emergency supports are available at all times.
2. Emergency supports shall be accessed through the on call telephone number.
3. Employees are only to contact emergency support personnel when their regular Manager is not available; such as after regular working hours.
4. After regular working hours the emergency support personnel shall be contacted whenever a decision maker is required, even if an employee feels the need to talk to his/her regular Manager.
5. The decision to contact the regular Manager shall be made by the emergency support personnel.
6. Employees are to contact the On Call Manager only when necessary and not if the situation can wait until regular working hours when the regular Manager can be contacted.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.13– STAFFING COMPLEMENT – DAY SERVICES	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 03.13.2019	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 03.13.2019	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

Each day service will have the appropriate staffing to deliver ongoing supports and services to the people that we work for.

PROCEDURES:

1. Management will continually review the staffing requirements necessary to deliver programs and services to the Individuals supported at the day service. The review will include:
    i. Appropriate ratios for the activities that day (internal and external supports)
    ii. Risk Assessments/Medical Protocols
    iii. Appropriate complement of Facilitator 1's and Facilitator 2's and, when applicable, volunteers.
    iv. Students/volunteers are not to be considered in ratios at any given time.
    v. When in service those staff members with a 1:1 assignment, are to participate in supports when safe to do so.
    vi. Staff and management will identify any staffing shortages and utilize on call lists when it is felt necessary to properly and safely deliver programs and supports.
2. Staffing Ratio Guidelines - General
    i. The manager shall determine staffing ratio's based on activity, risk, competencies and events.
    ii. Minimal staffing ratios with high competent individuals within the CSS for internal programming shall be 12 to 1.
    iii. In general, staff should never be left alone in the facility in case of an emergency.
    iv. During lunch or other risky activities, ratio will be determined based on risk and staff assigned to specifically supervise those individuals deemed at risk.
    v. Designated staff should be aware of the risk factors and trained to respond to the potential emergency.

Planned activities and programs shall be delayed until the service is able to meet the staffing ratio requirement.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.14 – TEAM HUDDLES – DAY SERVICES	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 03.13.2019	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 03.13.2019	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

The Association's day services will hold a start of shift team huddle in order to address supports and services for the day.

PROCEDURE:

1. Teams will huddle for a maximum of 10 minutes prior to start of shift supports in order to address the supports and services for the shift.
2. The Team Lead or a designated staff (assigned by the service Manager) will host the team huddle.
3. All staff on shift must attend team huddle (no exceptions).
4. The team huddle agenda will consist of the following:
    i. Review the shift's schedule
    ii. Challenges/changes required to supports
    iii. Adequate staffing available at key points in the schedule (transportation, meals, etc.).
    iv. Team assignments for the day and timelines
    v. Reports, information and supplies available
    vi. Necessary follow-ups for current shift/next shift
5. At shift change, it is imperative that the designated staff lead brief arriving staff of any issues/concerns that may affect their supports. The day's designated staff lead will hold a shift hand off meeting, briefing the next shift of what has transpired that day and any expectations that may affect the afternoon shift.
6. Any new information that was not addressed in the team huddle and that will affect the shift's supports will be identified on a white board displayed prominently within staff's office. The whiteboard will be used exclusively to capture changes/important information for that shift's supports.

Example:

- Team Huddle transpires
- Group Home pick up
- Group Home staff identifies change in supports for Individual and provides documentation.
- Staff member returns and writes change on the whiteboard and provides documentation to designated staff lead for documenting (AIMS, Risks and Caution's binder).
- Designated staff lead ensures all staff are alerted to change in support.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.15 – TEAM MEETINGS– DAY SERVICES	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 03.13.2019	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 03.13.2019	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

In order to best support individuals, monthly team meetings will be held. The meetings will address issues that affect supports for individuals as well as ongoing operations of the service.

PROTOCOL:

1. The Manager will call monthly for each service.
2. The agenda will include at minimum the following standing items:
    i. Priority Case Management (changes to supports including updated assessments and behaviour support plans) – Facilitator 1's/Team Leads
    ii. Individual Goals and Objectives Update – Facilitator 1's/Team Leads
    iii. Operations – Pressures and Priorities - Manager
    iv. Health and Safety (responsibility of Health and Safety representative)
    v. Operational Dashboard – Manager
    vi. Budget – Manager
    vii. Recreation and Leisure Accounting - Manager

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.16 – INTERAGENCY/ INTERNAL COMMUNICATION – DAY SERVICES	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 03.13.2019	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 03.13.2019	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

In order to best support the individuals between group home (the Association's or another agency) and day supports, consistent communication must occur.

PROTOCOL

1. A Memo of Understanding (see next page) between home and day supports will be created and reviewed at minimum annually. Any updates to the means of communicating pertinent support information will be updated immediately.
2. Pertinent information will not be left to being communicated verbally.
3. The Memo of Understanding (next page) will be created by the Association and contain at least the following:
    a. Means of communication will be in the following formats:
        i. Communication book – reviewed and written in daily (or as required) with consent of the individual supported.
            i. The page is to be dated with a subject line.
            ii. Request for signature acting as a read receipt.
        ii. Email – Should the Individual not provide consent for a communication book, email correspondence will be utilized in keeping with confidentiality best practices (i.e. use of initials). The subject line of the email will identify the person's initials and the reason for the communication.
        iii. The content of the email will be to the point and in keeping with the 5 W's.
            i. Who – are you referring to
            ii. What – is the subject/request.
            iii. When – is it pertinent or timelines/deadline for response.
            iv. Where – if necessary add places
            v. Why – you are emailing

MEMORANDUM OF UNDERSTANDING
SHARED SERVICES

Community Living Association, Lanark County

SERVICE LOCATION: _____
and

_____
Partner Agency/Service

Shared Supports for: _____

Date: _____ (renewed annually)

Community Living Association, Lanark County and _____ (partner agency/service) combined provide services for the Individual listed above.

As part of these services the two parties agree to:

- Share and update all pertinent information in order to support the above named Individual effectively and safely.
- Participate fully in any medical/clinical and planning meetings as required.
- Ensure that all medical and clinical assessments/ information is shared in a timely fashion.
- Communicate via an agreed upon format (book or email) as set out in CLA policies.
- Ensure that all financial requests for PIN/special event funds are received within a reasonable period of time.
- Ensure that all food/medication arrives in a format that allows for ease of use i.e. Individuals that require food that is pureed arrive with food in the correct consistency for consumption.
    - Where applicable, provides three additional meals (freezer ready) should the meal not be provided in the proper consistency on any given day.
- Other:
    - _____

- _____
- _____
- _____

SIGNATURES

On behalf of Community Living Association, Lanark County:

_____	_____	_____
Signature	Name (please print)	Date

On behalf of partner Agency/Service:

_____	_____	_____
Signature	Name (please print)	Date

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.17 – ADVANCED END OF LIFE CARE PLANNING, DO NOT RESUSCITATE ORDERS (DNR), & EXPECTED DEATH IN HOME PROTOCOL (EDITH)	
PAGE: 1 of 7	**REFERENCES:**
APPROVAL DATE: 10.2019	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.2019	**REVISION DATE:**
AUTHORIZATION: Executive Director	

PURPOSE / SCOPE:

To respect the autonomy, wishes, values, and beliefs of the individuals we support and to ensure staff know how to process and implement advance care planning.

DEFINITIONS:

"**Advance Care Directives"**: An Advance Care Directive is most often a document, written while the individual is well and able to make decisions, in which they state their wishes for medical or non-medical care, just in case the individual becomes unable to speak for themselves at some time in the future.

"**Advance Care Planning**": The process of reflection and communication where individuals consider what sort of treatment they may want at the end of life. It includes the deliberation and communication of wishes, values and beliefs between the individual, their loved ones, their substitute decision-maker and their healthcare provider(s) about end-of-life care.

"**Certifying Death**": The legal process of attesting to the fact, cause, and manner of someone's death, in writing, on the form prescribed by the local authority (i.e. complete the Medical Certificate of Death).

"**Do Not Resuscitate Order (DNR)**": An order to withhold resuscitation at the end of life. Only healthcare providers can issue DNRs.

"**Do Not Resuscitate Confirmation (DNR-C) Form**": A form to direct the practice of first responders in situations where a DNR is part of an individual's treatment plan. The Form must be completed and signed by a healthcare provider. When this form is issued, a paramedic or firefighter will not initiate basic or advanced CPR but will provide necessary comfort measures.

"**Power of Attorney**": A power of attorney is a legal document that gives someone (called an "attorney" or "proxy") the right to make decisions for another individual if that individual is no longer able to look after matters on their own.

"**Pronouncing Death**": Pronouncing a death means issuing an opinion that life has ceased based on a physical assessment of the patient.

"**Resuscitation**": An invasive and immediate lifesaving treatment that is administered to a client who has a sudden unexpected cardiac or respiratory arrest. It may include basic cardiac life support involving the application of artificial ventilation (such as mouth-to-mouth resuscitation and bagging) and chest compression. It may also include advanced cardiac life support, such as intubation and the application of a defibrillator.

"**Substitute decision-maker**": Someone who makes healthcare decisions on behalf of a patient if they are incapable of healthcare decision-making. The *Health Care Consent Act, 1996*, sets out a hierarchy of people who may give or refuse consent on behalf of an incapable individual, as well as additional requirements that must be met in order for an individual to be eligible to act as substitute decision-maker.

POLICY:

People we support are entitled to plan how they want to receive end of life care. The Association (within the financial abilities (e.g. costs of staffing, changes to environment, etc.) will respect the autonomy, wishes, values, and beliefs of the people it supports and/or of their loved ones and their substitute decision makers in order to assist with respectful end of life care when it is supported by a medical opinion or expressed in advance directives.

The Association staff and management is not part of the decision-making process regarding advance care planning, except for referring to resources. Advance care planning is conducted between the individual, their loved ones, their substitute decision-maker and their healthcare provider(s). Management will review all DNRs and Advance Care Directives before they are implemented in order to ensure that all information is clear, concise and within the abilities of the association to implement the wishes.

In Ontario, there is no legal definition of who is able to pronounce death. In cases where death was expected, nurses (Nurse Practitioners (NP), Registered Nurses (RN) and Registered Practical Nurses (RPN)) can pronounce death. However, only Medical Doctors (MD) and NPs (in specific circumstances) can certify death. In cases where death is unexpected, only an MD can pronounce and certify death.

APPLICABLE LEGISLATION, STANDARDS, AND RESOURCES:

- *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* – https://laws-lois.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html
- *Coroners Act* – https://www.ontario.ca/laws/statute/90c37#BK6
- *Health Care Consent Act, 1996* – https://www.ontario.ca/laws/statute/96h02?search=health+care+consent+act
- *Personal Health Information Protection Act, 2004* – https://www.ontario.ca/laws/statute/04p03
- "Do Not Resuscitate Confirmation Form" Ministry of Health and Long-Term Care, Form Number: 014-4519-45 (Edition 2008/01) – http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ENV=WWE&NO=014-4519-45
- Advance Care Planning – https://d3n8a8pro7vhmx.cloudfront.net/dwdcanada/pages/3905/attachments/original/1558106674/20190507_ACP-Ontario.pdf?1558106674

- Advance Care Planning – Speak Up: https://www.advancecareplanning.ca/

PROCEDURE:

ADVANCE CARE PLANNING AND DIRECTIVES

It is never too early for primary healthcare providers (MDs or NPs) to discuss advance care planning with their patients. As part of routine care, primary healthcare providers are encouraged to discuss with their patients: the importance and the benefits of advance care planning and choosing a substitute decision-maker (by way of a power of attorney for care or other); the importance of documenting and disseminating Advance Care Directives to their loved ones, substitute decision-maker, and their healthcare provider(s); and, the importance of reviewing Advance Care Directives throughout one's life. Primary healthcare providers can assist their patients in creating an Advance Care Directive, which contemplates their wishes, values and beliefs regarding end-of-life care, which may or may not contain a DNR. For those directives containing a DNR, please refer to the following section of this policy.

Advance Care Directives do not constitute consent. Consent must always be given by the individual if that individual is capable or from the incapable person's substitute decision-maker. Advance Care plans or directives can help guide a substitute decision-maker in making decisions on behalf of an incapable individual. Moreover, an individual can always change their mind regarding an Advance Care Directive.

Although the Association staff may accompany an individual to their appointment with a healthcare provider in which advance care planning is discussed, they are not to be involved in the decision-making process regarding Advanced Care Directive. The decision is to be made by the individual or their substitute decision-maker.

Whenever the Association receives an Advance Care Directive for an individual it supports, a copy of the Advance Care Directive will be placed in that person's personal file, as well as in their "Care Plan Binder" and the Service Manager will be notified. A scanned copy of the advance care directive will also be uploaded to the server.

It is the responsibility of the Service Manager and Team Lead to ensure that all staff on shift (including casual on-call staff) are aware of the Advance Care Directive and familiarize themselves with it. If the Advance Care Directive contains a DNR, please refer to the following section of this policy.

DO NOT RESUSCITATE ORDERS – RESIDENTIAL PROGRAM

Where, after discussing the option of a DNR, the primary healthcare provider issues a DNR for an individual supported in a residential program by the Association as part of that person's treatment plan or Advanced Care Directive, a DNR-C Form may also be completed by that healthcare provider. As with Advance Care Directives, the Association staff do not participate in the decision-making process regarding DNRs.

Whenever the Association receives signed copies of a DNR-C Form for an individual it supports, a copy of the form will be placed in that person's personal file and the Service Manager will be notified. A scanned copy of the form will also be uploaded to the server and another copy will be put in a sheet protector and placed in the front of the "Care Plan Binder" for easy access by all staff.

It is the responsibility of the Service Manager and Team Lead to ensure that all staff on shift (including casual on-call staff) are aware of the DNR-C Form and of the protocols that should be followed if that person stops breathing or presents without a pulse.

In the event the person who has a DNR-C Form on file stops breathing or their heart stops beating while they are in the care of the Association, the following procedures must be followed:

1. Call 911
2. Call the Palliative Care Team (if applicable).
3. Conduct a breathing assessment and check responsiveness but DO NOT INITIATE CPR.
4. If it is clear that the individual is deceased, do not move the body or anything else in the room.
5. If two staff members are available, one must wait for the first responders at the front door with the DNR-C Form, which is to be presented to the first responders as soon as they enter the building.
6. Inform first responders that although the individual has a DNR, the death was unexpected so it is our policy to call first responders.
7. First responders will conduct an assessment and, if the individual is deceased, they will contact the police who will then call the coroner to certify death.
8. Contact the service manager or on-call staff immediately. The manager will coordinate with the police to notify the family.
9. A Serious Occurrence report must be completed.
10. The manager will arrange for debriefing and counselling support for the staff, as needed.

<u>DYING AT HOME - EXPECTED DEATH IN HOME PROTOCOL (EDITH)</u>

The Expected Death in the Home Protocol (EDITH) supports end of life care in the home and an individual's expressed wishes for no resuscitation when their heart stops beating or they stop breathing.

Expected death is the natural and inevitable end to an irreversible illness. Death is recognized as an expected outcome. Supportive and sensitive communication should have taken place between all those involved, and an Advance Care Directive should be in place as an end-of-life plan.

The EDITH Protocol supports the development of an Advance Care Directive to identify the approach for pronouncement and certification of death in the home to allow for the timely removal of the body. The primary healthcare provider (MD or NP) agrees to make arrangements to complete the Medical Certificate

of Death (MCOD) within 24 hours. This reduces the stress for the family when death occurs and supports healthcare providers to care for end of life patients in the community setting.

Use of the EDITH form does not replace the partial completion of the MCOD or the DNR-C Form. The use of the EDITH protocol will reduce the inappropriate use of Emergency Services such as Police, EMS, Fire and the Coroner.

If there are challenges obtaining the information to support an EDITH there should be an escalation of the issue to the Association management, who will notify the rest of the team, as appropriate.

A. Completion of the End of Life Care Plan and the EDITH Protocol

An individual, along with their loved ones and/or their substitute decision-maker, may request that the Association assist them with a plan to die at home. Upon consultation with the Executive Director and, if it is within existing resources (e.g. financial, human resources), the Association will support the implementation of the EDITH Protocol by following these steps.

1. The Service Manager will notify the Executive Director whenever an EDITH protocol is being proposed before it is put in place. The Service Manager will notify the Executive Director of any staff who finds themselves in a conflict of interests with this protocol on moral or ethical grounds.
2. The Service Manager, following authorization from the Executive Director, will notify the Team Lead, who will be responsible for contacting the local Community Care Access Centre (CCAC) to access the Complex Care Team (Palliative Care team). The Team Lead will be the primary contact for the Association with the Complex Care Team.
3. The Palliative Care Team will compile (with input from the family and staff) an individualized End of Life Care Plan, including Advanced Care Directives, indicating that the patient has an expressed wish for no resuscitation when their heart stops beating or they stop breathing. The individualized End of Life Care Plan will outline the following:
    i. The person's wishes, values and beliefs regarding end-of-life care;
    ii. The Association staff's roles and responsibilities – i.e. whom to call when the individual is experiencing a medical issue and ensuring that staff follow the Advanced Care Directives.
    iii. Direction from the primary healthcare provider regarding which secondary medical conditions will be treated – i.e. pneumonia, urinary tract infections, and seizures.
    iv. Direction from the primary healthcare provider on how and where medical conditions are to be treated – i.e. oral medications vs. intravenous treatment, treatment at home vs. hospital emergency department;
    v. Who to call when death occurs and in particular not to call 911.
    vi. The family and/or substitute decision-maker's preferences regarding notification in the event of death or imminent death.

4. Unless there is already a plan for certification and pronouncement of death in the patient's file, the Team Lead will consult with the individual's primary healthcare provider (MD or NP) and a palliative care physician to confirm the appropriateness of the EDITH protocol in the circumstances and to confirm roles. The primary healthcare provider is responsible for initiating a partial Medical Certificate of Death.
5. For individuals that wish to access Medical Assistance in Dying (MAID), the Team Lead, along with the individual's healthcare team, will support a seamless individualized process that will be complimentary to EDITH.
6. The CCAC will undertake all arrangements required under the EDITH protocol, including:
    i. Ensuring there is a plan for pronouncement and certification of death by contacting the primary healthcare provider;
    ii. Confirming with the individual and their family or substitute decision-maker that the funeral home has been contacted and is aware of the completion of the plan for EDITH;
    iii. Documenting the plan for pronouncement and certification of death and the funeral home information on the EDITH form and signing and dating it.
    iv. Notifying members of the care team by removing and sending them the pink copy of the EDITH form.
    v. Ensuring the original copy of the EDITH form remains in the home for the Association staff.
7. The EDITH protocol will include any DNR directives.
8. The Service Manager or designate will arrange for support and education around palliative care issues and will be provided to staff/management as needed or requested.

B. Pronouncement and Certification of Death

In accordance with the Ontario *Coroners' Act*, where a person dies while a resident in a supported group living residence or an intensive support residence under the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008*, the person in charge of the home or the palliative nurse shall immediately give notice of the death to a coroner, and the coroner shall investigate the circumstances of the death and, if as a result of the investigation he or she is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body.

When death occurs, the Association staff will:

1. Follow the EDITH protocol and call the primary healthcare provider (MD or NP – whichever one is indicated in the plan) to pronounce death;
2. Notify the Team Lead and Service Manager (or the On-call Manager for after hour support);
3. Notify the family and other staff members (if they are not in attendance) according to the expressed wishes of the deceased individual as documented in the End of Life Care Plan;
4. Ensure all members of the End of Life Care Team are aware that death has occurred;

5. Complete an incident report before the end of their shift and submit through the AIMS. Management will complete a Serious Occurrence Report and submit it through the appropriate channels and within the appropriate timelines as directed by the Ministry of Children, Community and Social Services.

If the MD attends to pronounce death, they will sign the Medical Certificate of Death at that time. If the NP attends to pronounce death, the MD (or Coroner) will sign the Medical Certificate of Death within 24 hours of death at the funeral. Currently, in Ontario all MAID deaths are to be reported to the Coroner.

In the case of Coroner involvement, the body must remain in the home until the Coroner speaks to the primary healthcare provider and authorizes release of the body. In those cases, the coroner will contact the funeral home to arrange the removal of the person's body in keeping with the individual's or family/substitute decision maker's wishes.

After the individual passes away, debriefing will be provided to all members of the staff team through either the Association's Employee Assistance Program, Palliative Care Services or any other appropriate resource

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: PERSONAL SUPPORT	
POLICY # A2.18 – SHARED SERVICES	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.2019	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.2019	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY

When an individual receives supports from two or more service locations (both internally and externally) a person-centred memorandum of understanding must be in place prior to receiving service. The memorandum must include copies of all medical and clinical assessments that may affect/direct supports. The memorandum must be updated at a minimum annually, or whenever supports are revised.

PROCEDURE

1. Upon entry into service, the F1 or Team Lead will meet with the individual and the other support team (i.e. residential lead agency) to determine supports while in service.
2. The F1 or Team Lead will utilize the memorandum template to develop a person-centred memorandum for the individual and will have the other service (i.e. residential lead agency) review and sign off on content.
3. The F1 or Team Lead will enter all pertinent information into AIMS (Internal Notification feature) and upload said memorandum and any assessments into the individual's file.
4. Individuals must not start service until proper medical and clinical assessments are received.
5. All risk and cautions will be added to the Risk and Cautions binder.
6. An internal notification is to be sent in AIMS to all applicable staff and management.
7. Within one week, all staff must acknowledge via signature having and read and understood the memorandum.
8. Whenever supports are revised (i.e. new assessments), the memorandum is to be updated and the revised memorandum, along with any supporting documentation, will be uploaded in the individual's server file, followed by revisions in AIMS and in the Risk and Cautions binder.
9. The Individual must not return to service until such time as revised medical and clinical assessments have been received.
10. A new internal notification is to be sent in AIMS to all applicable staff and management.
11. All staff must acknowledge having read and understood the revised memorandum.

COMMUNITY LIVING
Association (Lanark County)
Inspiring Possibilities

MEMORANDUM OF UNDERSTANDING
SHARED SERVICES

Community Living Association, Lanark County

SERVICE LOCATION: _____

and

_____

Partner Agency/Service

Shared Supports for: _____

Date: _____ (renewed annually)

Community Living Association, Lanark County and _____ (partner agency/service) combined provide services for the Individual listed above.

As part of these services the two parties agree to:

- Share and update all pertinent information in order to support the above named Individual effectively and safely.
- Participate fully in any medical/clinical and planning meetings as required.
- Ensure that all medical and clinical assessments/ information is shared in a timely fashion.
- Communicate via an agreed upon format (book or email) as set out in CLA policies.
- Ensure that all financial requests for PIN/special event funds are received within a reasonable period of time.
- Ensure that all food/medication arrives in a format that allows for ease of use i.e. Individuals that require food that is pureed arrive with food in the correct consistency for consumption.
    - Where applicable, provides three additional meals (freezer ready) should the meal not be provided in the proper consistency on any given day.
- Other:
    - _____
    - _____

- _____
- _____

SIGNATURES

On behalf of Community Living Association, Lanark County:

_____	_____	_____
Signature	Name (please print)	Date

On behalf of partner Agency/Service:

_____	_____	_____
Signature	Name (please print)	Date

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: USE OF EXTERNAL SUPPORT CONTRACTORS	
POLICY # A3.01 – RATIONALE AND GUIDELINES FOR THE USE OF EXTERNAL AGENCIES	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 06.18.2018	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 06.18.2018	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

The Association will use an OPR as a last resort when CLA or other DS sector publicly funded organizations cannot provide the supports required by the person. CLA will ensure that the mission and values support philosophies are complementary.

PROCEDURES:

1. CLA will use a private operator only when it cannot provide the service and supports themselves due to the lack of resources or lack of competencies to support the person in a safe and secure manner.
2. CLA in consultation with stakeholders will determine the services and supports required in the best interest of the Individual.
3. The OPR has the Staff expertise and other related resources to support the individuals in an effective manner that is consistent with CLA's requirements and goals.
4. The OPR has a positive corporate reputation and a proven record of successfully supporting individuals with an intellectual disability.
5. The OPR has complementary Mission, Values and Programmatic Philosophies.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: USE OF EXTERNAL SUPPORT CONTRACTORS	
POLICY # A3.02 – CALL FOR PROPOSALS FOR THE USE OF EXTERNAL AGENCIES (OPRS)	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 06.18.2018	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 06.18.2018	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

CLA will ensure that that OPRs will ~~are able to~~ meet minimum programmatic and business standards.

PROCEDURES:

1. Private Operators subcontracting business or individual supports from CLA shall respond to a call for proposals and submit an Expression of Interest.
2. The Call for Proposal will include:
    i. All of elements in the Expression of Interest
    ii. Description of Physical Asset/Residence.
    iii. Statement to the effect: As soon as a contract is awarded, the OPR or Private Operator is considered an extension of CLA and is subject to all the pertinent regulations that CLA is bond to.
3. Call for Proposal(s) will be individualized reflecting the specific services and supports required for the person supported.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: USE OF EXTERNAL SUPPORT CONTRACTORS	
POLICY # A3.03 – RATIONALE AND GUIDELINES FOR THE USE OF EXTERNAL AGENCIES	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 06.18.2018	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 06.18.2018	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

CLA will ensure that that OPRs will meet minimum programmatic and business standards.

PROCEDURES:

1. Private Operators subcontracting business or individual supports from CLA shall respond to a call for proposals and submit an Expression of Interest.
2. The Expression of Interest shall include the following:
    a. A brief confidential description of the Service and Supports required.
    b. Provide the reason for the OPR's interest
    c. Agency Description
        i. Organizational Mission and Philosophy
        ii. Programs and Supports
        iii. Organizational History
        iv. Confidential Financial Profile – 2 years of audited statements
        v. Attach promotional material if it is available
    d. Proposed Support Plan which will include the following:
        i. A Person centered program based on the "Clinically Informed Person Centered Plan"
        ii. All supports and services included in the plan and daily support of the person.
        iii. Identified community based program and supports.
        iv. Identified the provisions to connect to family and natural supports.
    e. Staffing: A detailed description and schedule of staffing resources, including
        i. Staffing resources designated to ongoing residential care;
        ii. Enhanced staffing requirements for the initial transitional period.
        iii. Staffing resources to facilitate travel to community-based day programming and/or regular social/recreational activities.
        iv. Identify support staff, and provide information regarding background, education and qualifications.
    f. Financial Data
        i. Provide a detailed budget for the transition period
        ii. If relevant provide a detailed annual budget inclusive of transition cost.
        iii. If relevant provide a projected budget for year 2 of the plan.
        Note: the budget must identify all cost items:
        i.e. – Staffing costs, benefits, Supplies, Food, Transportation, Clothing, etc**.**
    g. References
        i. Provide 2 references from families or decision makers of individuals you have supported within the past 2 years.
        ii. Provide 2 references from agencies that have utilized your services.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: USE OF EXTERNAL SUPPORT CONTRACTORS	
POLICY # A3.04– INTERVIEWS OF OPR PRINCIPALS AND STAFF TEAM	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 06.18.2018	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 06.18.2018	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

CLA shall ensure that there is a fit with the OPRs principals and with the assigned staff team.

PROCEDURES:

1. Once the best proposal(s) is selected, CLA will conduct an interview with the OPR.
2. Invested Stakeholders shall be invited to review the proposal and to participate in the interview process.
3. Interview shall explore in more detail the elements of the proposal and clarify any issues or other points in the proposal that may need to be clarified.
4. The interview is to be used to determine the fit between the family or decision maker and the OPR.
5. At an appropriate time and before the contract is signed, family, the individuals shall meet and interview the principal members of the staff team.
6. CLA will have the final decision to engage with the OPR.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: USE OF EXTERNAL SUPPORT CONTRACTORS	
POLICY # A3.05 – SITE VISIT	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 06.18.2018	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 06.18.2018	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

Preamble: As soon as a contract is awarded, the OPR or Private Operator is considered an extension of CLA and is subject to all the pertinent regulations that CLA is bond to, as cited in the Request for Proposals.

CLA shall ensure that the site is safe and secure and appropriate for the proposed supports and services.

PROCEDURES:

1. CLA staff shall ensure the following for the site:
    i. Cleanliness and tidiness – the site/home is clean and tidy and well organized.
    ii. Clearly identified duties and responsibilities in regards to cleanliness.
    iii. Maintenance – that the site is well maintained and regular and periodic maintenance is good.
    iv. Maintenance Records are up to date on equipment and regular maintenance for the home/site.
    v. Vehicles are well maintained and there is record for regular maintenance.
    vi. Documented Health and Safety checks are conducted by staff and that the site in adhering to MOL regulations.
    vii. Hazardous material is clearly labeled and stored appropriately.
    viii. Evidence of emergency preparedness and evacuation procedures.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: USE OF EXTERNAL SUPPORT CONTRACTORS	
POLICY # A3.06 – COMPLIANCE REVIEW	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 06.18.2018	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 06.18.2018	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

Preamble: As soon as a contract is awarded, the OPR or Private Operator is considered an extension of CLA and is subject to all the pertinent regulations that CLA is subject to.

CLA shall ensure that the Private Operator meets or exceeds Regulations 299/10 Quality Assurance Measures (QAM)

PROCEDURES:

1. CLA shall request and review the OPR's Policy and Procedures in regard to Service and Supports. The OPR will clearly demonstrate that it has policies and procedures that address the Regulations.
2. CLA shall review Staff Records – specifically overall education and training, Annual reviews and certification, CRC, First Aid, CPR, training in physical restraints.
   CLA will pay attention to the staff that will be working with the individual that it supports. These checks shall include a reference check.
   Review documentation for training and education in regard to the specific needs of the individual.
3. Individual Records (refer to regulations to identify specific regulations.
4. Overall records and documentation
5. Site inspection

If the OPR cannot meet or fulfill regulations, they will be provided 48 hours to respond to the assessment and to take corrective action.

The OPR may have already had a Compliance review completed by another organization. In which case that organization can provide proof of compliance and CLA shall follow up with the Agency that conducted the review.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: USE OF EXTERNAL SUPPORT CONTRACTORS	
POLICY # A3.07 – INDIVIDUAL TRIAL VISIT & STAY	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 06.18.2018	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 06.18.2018	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

Whenever possible the individual supported should have input into the decision of where they are going to live. CLA will continue to provide Individuals the experiences to allow for informed decision making.

PROCEDURES:

1. The individual will be provided minimally 24 to 48 hour stay at the home or to participate in programs and Day Services to determine as to whether the individual, the agency and the proposed staff team is compatible.
2. During the trial visit, the agency will provide similar supports and activities as the ones that they are contemplating for on-going supports.
3. Once the visit is complete the family, the individual, and an agency representative shall decide if this placement is a good fit.
4. Ultimately CLA will have the final say in the OPR placement.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: USE OF EXTERNAL SUPPORT CONTRACTORS	
POLICY # A3.08 – AWARDING OF CONTRACT	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 06.18.2018	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 06.18.2018	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

The contract for services shall ensure that the Private Operator can provide quality service and supports that meet or exceed regulations and that fulfill the goals and objectives of CLA, in consultation with ~~of~~ the major stakeholders.

PROCEDURES:

The contract shall be awarded only when the OPR has met the following conditions:

1. They have successfully completed the proposal and interview stages.
2. Successful reference checks with current users of the services.
3. Successful reference checks with other organizations in the DS Sector.
4. Proof of organizational and financial stability.
5. Successful completion of QAM review
6. Successful completion of trial visit and/or stay.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: USE OF EXTERNAL SUPPORT CONTRACTORS	
POLICY # A3.09 – REVIEWS AND VISITS	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 06.18.2018	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 06.18.2018	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

CLA shall ensure consistent quality delivery of service and supports in compliance with the contract, support plan goals and Ontario Regulations 299/10. (QAM)

PROCEDURES:

1. CLA will formally review the contract annually and request proof of QAM compliance, Support Plan goal achievement and other as may be required.
2. CLA shall conduct 6 visits per year- these will be on site visits and 1 visit will be unannounced. During these visits CLA will do all the site visits checks, MARS sheet and check on journal notes, conduct financial banks statement check, check on all medical contacts.
3. CLA will meet with family or with the individual independent of the Private Operator and ascertain satisfaction with services and ensure the safety of the individual.
4. If there are areas of concerns the OPR will be given written request to correct the situation within 3 days
5. If the individual is deemed to be at risk or the visits uncovers any abuse, the individual shall be removed from the private operator immediately.
6. The stakeholders shall implement any recommendations resulting from these reviews or visits to improve planning and supports for the individual.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: USE OF EXTERNAL SUPPORT CONTRACTORS	
POLICY # A3.10 – VETTING PROCESS FOR THE USE OF EXTERNAL AGENCIES (OPRs)	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 06.18.2018	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 06.18.2018	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

The contract for services shall ensure that the Private Operator can provide quality service and supports that meet or exceed regulations and that fulfill the goals and objectives of CLA, in consultation with the major stakeholders.

PROCEDURES:

1. Call for Proposals (Policy 9.02)
2. Expression of Interest submitted (Policy 9.03)
3. Interviews conducted with preferred proposals (Policy 9.04)
4. Site Visit (Policy 9.05 & Policy 9.06)
5. Trial Visit (Policy 9.07)
6. Contract Awarded (Policy 9.08)

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.01 – APPROPRIATE HEALTH & MEDICAL SUPPORTS	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that all people for whom it works have access to appropriate health and medical services so that they can make informed choices about their health and that they have access to appropriate medical services.

PROCEDURES:

1. Each person shall have a personal physician.
2. Each person shall have a personal dentist.
3. Each person shall have an annual physical check-up.
4. In the event that the personal physician refers a person to specialists, the Association shall ensure that such referral occurs in a timely manner and that appointments are maintained.
5. In the event of an emergency, appropriate help shall be obtained (see policy on Emergencies).
6. All medical appointments or professional appointments shall be documented on the Medical Contact form. This form will accompany each person to all medical appointments.
7. All medical appointments will be discussed with the person supported before the appointment; the person supported will have the opportunity to sign the medical contact form. In the event that a person refused medical treatment as prescribed by a medical doctor or specialist every effort shall be made to provide the person with additional information for informed choice.
8. An incident report form will be completed and the manager notified immediately for all refusals for medical treatment by a medical doctor or specialist.
    i. A meeting will be held with the person and their significant others or advocates implementing a plan of action for follow up.
    ii. The outcome of the follow up will be documented in the person's file notes.
9. Documentation of the outcome of the appointment will be summarized after each appointment. All follow up will be documented and arrangements made for such follow up.
10. All medical recommendations and medical professional orders will be followed by all staff supporting the people the Association works for.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.02 – SAFE TRANSPORTATION	
PAGE: 1 of 1	**REFERENCES:** Vehicle Circle Check Form
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10..07.2011	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that transportation provided to people for whom it works shall be done so in the safest possible manner.

PROCEDURES:

1. Employees driving Association vehicles shall have a Class G permanent driver's license.
2. Prior to operating an Association vehicle, a Vehicle Circle Check shall be completed using the Vehicle Circle Check Form.
3. The driver and all passengers shall be seat belted before the vehicle is placed in motion.
4. All wheelchairs shall be secured before the vehicle is placed in motion.
5. All articles shall be safely stowed or secured before the vehicle is placed in motion.
6. A cell phone shall be carried on all trips.
7. The driver shall not operate the cell phone while operating the vehicle.
8. Appropriate insurance shall be in effect for all vehicles, Association or staff owned.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.03 – PERSONAL HEALTH & SAFETY	
PAGE: 1 of 5	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10..07.2011	**REVISION DATE: 11.05.2013**
AUTHORIZATION: Executive Director	

POLICY:

The Association recognizes people's rights to self-determination and control over their own decisions and actions. The Association shall try to ensure that people are free to exercise their rights and that they meet their responsibilities as citizens of their communities The Association also recognizes that in certain situations, persons may require assistance in decision making and support in order to maintain their health and safety (as well as the health and safety of others) and their community responsibilities.

PROCEDURES:

Personal Health of People Supported by the Association

1. The Association, through its supports and services, shall ensure people supported have access to public health information that will assist the person to make informed choices.
2. It is the responsibility of Association employees to teach or to arrange for training on health topics that pertain to the health interests and needs of people supported.
3. When outside professional support is required, assistance shall be provided in accessing that support (e.g. doctors, hospitals, dentists, etc.) and assisting the person to obtain it in a timely fashion.
4. The Association shall develop personal health and safety protocols for each person who requires them. This shall be done with the assistance and knowledge of the person, kept in a known place and all employees supporting the person shall be made aware of the existence of such protocols.

Maintaining Home Cleanliness

1. Procedures regarding home cleanliness apply to all persons that the Association supports residentially with the exception of those persons who reside with their families, with associate families and in home-sharing arrangements.
2. It is the responsibility of Association employees to teach the people they support about the importance and benefits of maintaining a safe and healthy living environment, with specific reference to the following issues:
    i. Fulfilling their responsibilities as citizens;
    ii. Showing respect for their housemates, support employees and guests
    iii. Compliance with the Landlord and Tenant Act and the individual Tenancy Agreement (where applicable) as well as the Support Agreement with the Association as it relates to standards of cleanliness;
    iv. Outlining the benefits/losses of maintaining a clean/unkempt home with respect to how this affects their image, self-esteem, the perception of others, their opportunities for acceptance and inclusion, their health and safety, etc.
3. It shall be the responsibility of all employees and support network to develop instructional methods designed to assist the people they support to learn how to complete all standard

household maintenance chores, with a goal of helping people become as independent as possible in fulfilling such chores or assist them to access these services via other generic or paid services.

4. For people who are unable to perform household chores independently for reasons directly related to the nature of their disability, it is the responsibility of employees to access generic community services to assist. In the absence of such service the employees shall provide direct assistance as required to complete such tasks to ensure the living arrangement meets acceptable societal levels of cleanliness as part of their assigned responsibilities.
5. With respect to the exterior condition of the living arrangement (lawns, gardens, driveways, condition of physical property), it is expected that employees shall support people to maintain their property in ways that are in keeping with the standard of their community and neighbourhood.
6. It is the responsibility of the Managers to design and implement a process to ensure that all living arrangements that fall under their direct support are maintained in ways that are consistent with the intent and scope of this policy in consideration of the wishes of the person.

Protocols for Agitated and Violent Behaviour

1. The Association shall take every reasonable precaution in the circumstances to protect the health and safety of both persons' supported and the employees who are involved with incidents of aggressive behaviour.
2. Recognizing the uniqueness of each person and the need for flexibility in responding to each situation, the Association provides the following statements of principles and policy objectives which are intended to provide information, guidance and to set overall limits but are not meant to be rigidly interpreted.
    i. The Association recognizes and appreciates the burdens of stress and anxiety that are placed upon employees who deal with aggressive behaviour, especially in circumstances where an employee feels a sense of isolation from colleagues and management. In addition to the normal processes of program review and monitoring, senior employees shall take every reasonable action to support and sustain the efforts of employees in such situations.
    ii. The Association recognizes that the presence of aggressiveness may be part of a person's disability and may be a primary reason for which the person or family seeks support; therefore, a person's receipt of the Association's supports shall not be made contingent upon "appropriate behaviour".
    iii. The Association recognizes that a fundamental employee's responsibility is the support and enhancement of the legal and human rights of persons served or supported. Nevertheless, it is necessary at times to make judgments in the interest of safety on the spur of the moment which may temporarily limit those rights. No employees shall be disciplined for taking such action in the responsible performance of duties. It is recognized that the responsibility for the planning and delivery of support to individuals with the potential to be aggressive rests with the employee's team and others involved in the person's support. Senior employees shall support, encourage and collaborate with employee teams in every possible way to resolve safety and programming issues in the most appropriate way.

3. The Association recognizes the value of programs, which are known to be effective in correcting aggressive behaviour. However, the following conditioning techniques are defined as aversive and are unacceptable under any conditions:
    i. Systematic infliction of physical pain, illness, physical and/or emotional trauma.
    ii. Dehumanization of the person.
    iii. Techniques inappropriate for the age of the person.
    iv. Treatment out of proportion with the target behaviour.
    v. Procedures which are normally unacceptable for persons without a disability and, in particular social segregation, social isolation, verbal abuse, a sustained systematic program of electric shock, mechanical restraint, water/lemon juice spray, and noxious stimulation (taste, smell, noise).
4. It is also recognized that some Individuals or employees may have personal objections to participating in programs, which establish and maintain extraordinary limits for a person. Such employees shall be supported to express these objections in a way that is both private and free from fear of discipline or other reprisal. Such employees are encouraged to bring such concerns directly to the Manager who shall treat the matter as privileged and confidential.
5. The Association's view is that aggressive personal behaviour can be the result of faulty learning processes, and that such behaviour has a communicative function. All employees should understand that aggressive behaviour is not always an expression of anger or hostility toward others and consequently cannot be predicted. Therefore, measures to assess a person's potential to aggress are inappropriate and could result in unfair labeling. The Aggressive behaviour may be the only indicator that the person is upset, unhappy, feeling ill, etc. As such, it can be a symptom of any underlying issue or cause, which needs to be discovered and understood. The persistence of such behaviour may be the result of our failure to understand the message that is being communicated.
6. The proper role of support to individuals who engage in such behaviour is to stand beside the person and to offer support in an empathetic and unconditional way. As it stands in direct contradiction to the principles and policy objectives outlined in this statement, the Association does not encourage the involvement of the police in situations where persons supported act out aggressively.
7. Some types of behavior described as aggressive which are experienced by employees can be a reaction to inappropriate action by employees towards a person, particularly in situations where employees may be attempting to assert control over the person. It should be understood that for the purpose of interpreting this policy such behaviour, or situations where individuals are reacting to inappropriate actions by others toward them, is not aggression.
8. The Association employees shall ensure that, as much as possible, support workers and people being supported are compatible with each other. Compatibility among people who spend a great deal of time together under demanding circumstances helps to ensure mutual acceptance and understanding, thereby reducing the likelihood of aggressive behaviour occurring.

Policy Objectives

1. Whenever possible the Association shall ensure that appropriate staff training in the prevention of behavioural crises and the provision of specialized support to persons with aggressive behaviour is provided to any employee assigned to work with such people, and the Association shall endeavor to make such training available to all employees.
2. The Association shall arrange to provide for external professional consultation to respond to a pattern of aggressive behaviour as required.
3. The normal practice shall be to avoid scheduling employees who have not yet received specialized training, to work alone with people who have the potential to behave aggressively.
4. The Association shall provide arrangements for back-up systems in particular where employees typically work alone.
5. Where there is a known risk of working with a person with aggressive behaviour, the Association shall give priority consideration to requests for reassignment from employees who are experiencing special circumstances, such as pregnancy.
6. Association employees are expected to appreciate at all times:
    i. the unconscionable and destructive effects of the labeling of people;
    ii. the importance of the promotion of positive images of people with a disability;
    iii. the importance of the protection of people's privacy and the confidentiality of personal information.

    Association employees therefore shall not support any program or other intervention, the object or result which labels, stigmatizes, or otherwise set apart people served or supported by the Association.
7. Notwithstanding the above, the Association shall ensure that there is full disclosure of relevant information, concerning a person served or supported, to all employees assigned to work directly with that person.

Procedures for Supporting People with Known Agitated or Violent Behaviour

1. If a person is known to express violent behaviour, a plan shall be developed that is specific to the person's unique situation.
2. This plan may include:
    i. Involvement of professional psychiatric assistance.
    ii. Identification of back-up strategies for employees.
    iii. Involvement of medical and/or hospital employees.
    iv. Identification of managers to be notified immediately in case of altercations.
    v. Identification of an advocate (parent, other family member, friend, etc.) and procedure for notifying the advocate when required.
    vi. Identification of employee supports.

Consideration for Employees who are Experiencing Concern for Their Safety

1. At the beginning of the shift, an employee shall make sure s/he is aware of the backup system and the backup resources and how to contact them

2. If an employee has not had specific training, the Manager shall be approached with a request for such training as soon as it is offered.
3. If an employee requires additional assistance or advice about how to handle aggressive behaviour, it shall be taken up with the Manager. Through established processes, it should be possible to arrange for program advice and assistance in organizing and planning around the person's specific needs.
4. If an employee is experiencing special circumstances, such as pregnancy, when tolerance for such risk is reduced, the employee may ask to be rescheduled or reassigned until circumstances are back to normal.
5. In the event that the employee is injured s/he shall call for back up and seek medical attention. The injury shall be reported immediately to the supervisor in order that the required report to Worker's Compensation can be filed.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.04 – MEDICAL EMERGENCIES	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10..07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that all people it supports have access to appropriate medical emergency services.

PROCEDURES:

1. In the event that medical emergency assistance is required, 911 will be called.
2. Unless there is a DNR or other Advance Care Directive providing otherwise, First Aid shall be administered until first responders arrive. First Aid will include monitoring the person's airway, breathing and circulation along with other life-threatening injuries. Vital signs shall be monitored until first responders arrive and every effort shall be made to ensure the individual is safe and comfortable.
3. If possible, the individual in an emergency shall be accompanied to hospital. If not possible, the Manager shall be notified and someone shall be sent to the hospital as soon as possible.
4. The following information shall be sent with the individual to the hospital:
    i. Information Summary Sheet;
    ii. Medical Record of Contact;
    iii. List of current medications.
5. All relevant information pertaining to the medical emergency shall be documented in the person's file and the appropriate reports shall be completed. (e.g. Incident Report).
6. The Manager shall be notified immediately. If the Manager is not available, the On-Call Manager shall be notified immediately.
7. Should the incident occur at a day service and the individual is supported in a residential setting, the individual's residential staff will be contacted immediately and the Manager will determine if and when supports will be handed off to residential supports.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.05 – CONSENT TO TREATMENT	
PAGE: 1 of 2	**REFERENCES: Health Care Consent Act 1996**
APPROVAL DATE: 01.14.2008	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 01.14.2008	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

Regulated health practitioners providing treatment to people for whom the Association works must ensure that they meet the legislated requirements for obtaining informed consent as defined by the *Health Care Consent Act, 1996*.

Employees of the Association shall identify a list of potential Substitute Decision Makers (SDM) as defined by the Health Care Consent Act, 1996.

Under no circumstance shall employees of the Association provide consent for treatment on behalf of people for whom the Association works.

PROCEDURES:

1. Every person for whom the Association works shall have on file a list of persons who have agreed to act as substitute-decision-makers (SDM). The person for whom the Association works shall be involved in the process of determining the SDM. Such a list shall be in the person's file and Information Summary.
2. The Association shall endeavor to obtain at least three persons as SDMs and in doing so shall contact all potential SDMs in order to rank them (See Section 20 of the *Health Care Consent Act, 1996* – attached).
3. An SDM means a person who is authorized under Section 20 of the *Health Care Consent Act, 1966* to give or refuse consent to treatment on behalf of a person who is incapable with respect to the treatment (See Section 20 of the *Health Care Consent Act, 1966* attached).
4. The Manager of all the residences at which the person in question resides shall be responsible for ensuring that the list of SDMs is established and reviewed on no less than an annual basis.
5. The health care practitioner (doctor) shall be the authority and the responsibility that determines if the person for whom the Association works is capable or incapable of making an informed consent with respect to the treatment. An employee of the Association may provide information to assist the health care practitioner to make such a determination but shall not make the determination.
6. In the event that a health care practitioner requires urgent/immediate consent for treatment. The Association employee shall provide the names and contact information of the SDMs.
7. It is the responsibility of the health care practitioner to contact the SDM, although an Association employee may assist with the contact if requested to do so.
8. All discussions with respect to the consent for treatment shall be between the health care practitioner and the SDM.
9. A similar process shall be used when the treatment is not of an urgent/immediate manner.

10. This policy and these procedures shall apply: to persons who live in Association operated homes; to persons who live in Family Home situations; and to people who live on their own but are supported by the Association in some other manner.
11. For persons who live in homes operated by other agencies, the Association shall share this policy and these procedures with that agency with the encouragement that such persons also have SDMs identified.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.06 – RISK ASSESSMENT	
PAGE: 1 of 1	**REFERENCES: Risk Assessment Form**
APPROVAL DATE: 01.14.2008	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 01.14.2008	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

In order to provide the best possible support to its clients, the Association shall ensure that a risk assessment is completed for each individual and employees shall ensure that all precautions are taken to respect the risks outlined.

PROCEDURES:

1. A risk assessment shall be completed for each individual supported by the Association as soon as the Association's formal involvement with the individual commences.
2. The risk assessment shall be reviewed and updated as information changes and no less than on an annual basis.
3. The Risk Assessment Form shall be used to complete the risk assessment.
4. It shall be the responsibility of the Manager of the program to ensure that changes and updates are completed as required.
5. Every employee working for an individual shall read, be familiar with and follow all information on the Risk Assessment Form of the individual supported.
6. Information contained in the risk assessment shall be treated as confidential and shared only with employees who need to know about the information in order to provide appropriate support.
7. Language used in the risk assessment shall be respectful and clear.

Day Services Support

1. A Risk and Cautions binder will be developed and maintained by the Team Lead.
2. The Risk and Cautions binder will be organized as follows:
    i. By individual (last name, first name)
        a. Allergies
        b. Assessments
        c. Behavioural
        d. Medical
2. The Risk and Cautions binder will be updated as new information becomes available (i.e. change in food preparation) and staff will be notified immediately (team huddle and whiteboard).
3. New risks or revisions to risks will be flagged via AIMS as must reads for all staff.
4. The Risk and Cautions binder will be reviewed at each team meeting, identifying any new information and any areas of concern.
5. The Risk and Cautions binder will be reviewed and signed off by all new staff, students and volunteers (as required).

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.07 – POLICE ASSISTANCE	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

For issues of safety and security not covered by other policies and procedures, the appropriate police service shall be contacted.

PROCEDURES:

1. Various policies and procedures cover when the police shall be contacted.
2. If in doubt about calling the police, employees shall contact the Manager or On Call Manager.
3. If a Manager cannot be contacted and/or if it is an emergency requiring immediate action the employee shall contact the appropriate police service.
4. If contacting police without first contacting the Manager, ensure that the Manager is aware of the contact as soon as possible.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.08 – EMERGENCY PREPAREDNESS PLAN	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall develop and maintain an Emergency Preparedness Plan (consistent with supports provided) that addresses emergencies inside Association premises and outside Association premises which would also address continuity of operation.

PROCEDURES:

1. All services will have an Emergency Preparedness Plan (consistent with supports provided) posted at all exits to the service areas.
2. Plans will include:
    i. list of what should be in an emergency kit:
        a. Flashlight and batteries
        b. Radio and batteries or crank radio
        c. Spare batteries (for radio, flashlight, assistive devices, etc.)
        d. First aid kit
        e. Telephone that can work during a power disruption
        f. Candles and matches/lighter
        g. Extra car keys and cash
        h. Important papers (identification)
        i. Non-perishable food and bottled water
        j. Manual can opener
        k. Clothing and footwear
        l. Blankets or sleeping bags
        m. Toilet paper and other personal items
        n. Medication
        o. Medic Alert® bracelet or identification
        p. Backpack/duffle bag
        q. Whistle (to attract attention if needed)
        r. Playing cards
    ii. a list of people in the service and emergency contact information
    iii. a meeting place designated in the event of an evacuation
    iv. a list of all emergency contact numbers the location of the emergency kit
    v. identified home floor plan and service floor plan

3. People living in Independent Living environments will be provided information on what they need to do in an emergency situation. People will be assisted to complete their own emergency kit and contact list.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.09 – BATHING	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that appropriate physical safeguards and bathing practices are in place to address the dignity, protection and safety of persons for whom the Association works while bathing or being bathed.

PROCEDURES:

1. The dignity and self-esteem of the person shall be ensured.
2. Documentation shall include the person's personal preferences regarding bathing and bathing skills according to the level of care and supervision required.
3. Each person's privacy shall be respected by ensuring the person is appropriately covered during and after bathing.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.10 – MINIMUM AND MAXIMUM TEMPERATURES IN ASSOCIATION HOMES	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that minimum and maximum temperatures are kept at a minimum of 20 degrees Celsius from October 1st to May 31st of each year, the Association will also ensure that each environment will have a minimum of one cooling room with a humidex level set below 35 degrees Celsius.

PROCEDURES:

1. The Association will ensure the environment of a group home or family home is kept at a minimum of 20 degrees Celsius from October 1st, to May 31st of each year.
2. The Association will ensure that each environment will have a minimum of one cooling room with a humidex level set below 35 degrees Celsius.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.11 – WATER TEMPERATURE	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The staff of the Association will ensure water temperature is monitored for people whom the Association works that do not demonstrate the ability to recognize hot and cold on their own. The Association shall safeguard people who live in or use Association buildings from injury due to scalding from excessive water temperatures.

PROCEDURES:

1. The Association shall ensure all regulators are on all main hot water tanks are in good working order in all Association operated homes. Regulators will be monitored to ensure the temperature is maintained at no more than 49 degrees Celsius.
2. The Association will ensure inspection of water temperature is monitored and tested to ensure the water from taps is no hotter than 49 degrees Celsius on a daily basis.
    a. A hot water tap is to be run for one minute before using a digital thermometer to check the scald guard is working and the water temperature from the tap is no hotter than 49 degrees Celsius.
    b. The Association will document the information on the duties and responsibilities checklist on a daily basis.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.12 – SELF ADMINISTRATION OF MEDICATION	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall support people to self-medicate when a person asked to do so or when a person has the ability to self-medicate. The self-medication procedure will be adhered to by the person supported and ultimately the staff providing the support will be held accountable until such time the person supported has completed self-medication standards as outlined in the person's self-medication program.

PROCEDURES:

1. Staff will monitor the person's medication on a daily basis, until such time as the person supported has successfully completed all self-administration steps in their individual self-medication program.
2. The person supported will obtain a supply of medications as required from pharmacist.
3. The staff will ensure the person supported has all Dr.'s orders filed in the medication section of person's file. Written doctor's orders are required.
4. Calendar/modified MAR/checklist will be implemented specific to individual's needs to be checked by individual and monitored by support worker.
5. There will be no self-administration of medication without a specific program that will be written for self-administration of medications.
6. Personal medication must be locked up.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.13 – FOOD & NUTRITION	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that when it provides meals, they are nutritious and reflect the culture and diversity of the people it supports and are in compliance with Canada's Food Guide.

PROCEDURES:

1. Menus will be designed to meet the needs of the people living in the home.
2. The people living in the home will participate in menu planning. They will be involved in the decisions about what types of food they eat and how they like it prepared.
3. Menus will be reviewed by a dietician on a semi-annual basis.
4. Staff will adhere to all dietary recommendations/orders by a medical doctor.
5. All food restrictions will be honoured and food preparations (such as puree) will be followed.
6. Staff will be trained by a medical professional on the various consistencies required for food consumption as needed.
7. Staffing numbers during meal times will be consistent with the needs of the individuals supported.

Day Services Cooking Programs/Lunches

1. Menus will be designed to meet the needs of the individuals attending the program and will be based on Canada's Food Guide.
2. Staff will adhere to all dietary recommendations/orders by a medical doctor.
3. All food preparation will be closely monitored and food/drink will not remain unmonitored on counters.
4. All food restrictions will be honoured and food preparations (such as puree) will be followed.
5. All food that requires restrictions must be prepared by the individual's residential home program.
    i. If staff have to prepare an individual's food, all dietary recommendations/restrictions will be followed.
    ii. Staff will be trained by a medical professional on the various consistencies required for food consumption as needed.
6. Staff will closely monitor individuals with restrictions during meal times.
7. Staffing numbers during meal times will be consistent with the needs of the individuals supported.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.14 – MISSING PERSONS	
PAGE: 1 of 4	**REFERENCES:**
APPROVAL DATE: 03.31.2018	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 03.31.2018	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

Community Living Association, Lanark County is committed to a person centered approach to service delivery, and recognizes that many people who use our services are able to go about their daily lives very independently while others may need varying levels of support and/or supervision. In accordance with this, each person will be afforded dignity and respect by recognizing their individuality, their personal abilities and their support and supervision requirements within the day or residential service and the wider community. The risk of an individual going missing is considered on an individual basis as part of the person's individual support plan and risk assessment.

PURPOSE:

The purpose of this policy is to set out the procedure to be taken if someone is suspected and/or confirmed to be missing or absent without explanation while being supported by Community Living Association, Lanark County. The policy does not address supervision levels or prevention strategies as these are decided on an individual basis in response to the person s needs and wishes and as part of their individual support plan.

POLICY SCOPE

This policy applies to all staff employed by Community Living Association, Lanark County, including those contracted for services, volunteers, the people who use our supports and their families/carers.

CORE PRINCIPLE UNDERPINNING THE POLICY

1. The balancing of rights and risk.
2. Each person s right to independence and freedom of movement both within and outside of the day or residential service and the wider community is respected.
3. Unnecessary restrictions are not placed on a person's right to freedom of movement.
4. Staff are responsible for promoting an active and flexible approach to managing potential dangers in order to minimize restrictions and promote independence.
5. Staff should support people to be as independent as possible based on their individual support and supervision requirements and personal wishes.

DEFINITION OF A 'MISSING PERSON'

A person is considered missing when they are absent from the place where they ought to be and their whereabouts is unknown.

CONFIRMING IF A PERSON IS MISSING

1. Staff must take the following steps to confirm whether the person is missing:
    i. A person goes missing from their day or residential service.
    ii. Check the person's support plan, file notes or other relevant sources to see if the person is at a prearranged meeting or appointment. Ask other people at the day or residential service whether the person has told anyone where they were going.
    iii. If there is no record of this information inform the manager or Team Lead of the day or residential service, who then becomes the coordinator of the search.
2. Inform all persons in the immediate vicinity.
3. Send a staff member to cover the main exits of the service/home.
4. A full search of the buildings and grounds should be organized immediately.

AN INDIVIDUAL GOES MISSING ON AN OUTING

1. Search the immediate area
2. Seek assistance from bystanders and police if the person is at risk if on their own.
3. Notify manager and staff at the day or residential.

AN INDIVIDUAL DOES NOT ARRIVE TO THEIR DAY SERVICE

1. Contact the person's place of residence to enquire as to their whereabouts.
2. If no response, contact their usual mode of transport to find out if the person was picked up or dropped off.

AN INDIVIDUAL DOES NOT RETURN TO THEIR RESIDENTIAL SERVICE AT THE EXPECTED TIME

1. Contact the place where the person was last known to be and make enquiries regarding their whereabouts.
2. If necessary, contact their usual mode of transport to find out if the person was picked up or dropped off If the missed person is not found and no explanation is forthcoming then the person is confirmed as 'missing'.

NB: The length of time between a person being missed' and being confirmed as a missing person' should be decided on an individual basis. For example, if the missed person is known to be at increased risk of harm if unsupervised then they should be confirmed as missing immediately. Staff should seek guidance from their manager with respect to this and if in doubt should always confirm the person as missing sooner rather than later.

1. If a person is confirmed as missing:
    i. The Manager or Team Lead becomes the Search Coordinator.

ii. The Search Coordinator calls all available staff including those in other areas for inclusion in a search party.
iii. The Search Coordinator coordinates the members of the search party and designates areas to be searched.
iv. The Search Coordinator informs the Executive Director of the missing person.
v. An extended search should take place.
vi. The Search Coordinator should stay behind in the day or residential area and remain contactable by phone.
vii. Depending on individual circumstances the search party may require any or all of the following:
    a. A fully charged flash light in the case of a person going missing after dark
    b. Warm blanket or silver rescue sheet
    c. Drinking water
    d. First aid kit

2. The Search Coordinator should inform police and provide them with a completed missing persons' identification form from AIMS including a photograph of the Individual.
3. Reporting and Informing
    i. The Executive Director or Search Coordinator (when delegated by the Executive Director) must inform the missing person's family/guardian/next of kin and keep them updated.
    ii. The Manager (Search Coordinator) or Executive Director must inform the missing person's family/guardian/next of kin and keep them updated.
    iii. The Executive Director or designate will complete all reporting documentation required by the Ministry of Children, Community and Social Services.

WHEN THE INDIVIDUAL IS FOUND

1. The Search Coordinator should be informed immediately.
2. The Search Coordinator must then inform:
    i. All members of the search party.
    ii. The Executive Director.
    iii. The person's family/guardian/next of kin (when delegated by the Executive Director).
    iv. Police, if the person was not found by them.
    v. All relevant staff.
3. The Individual should be medically assessed by a medical practitioner if necessary.
4. If further medical referral or transfer to hospital is indicated this should be arranged and the person's family/guardian/next of kin informed.
5. An Incident report should be completed.
6. A serious occurrence report will be completed by the Executive Director or his/her designate.
7. Debriefing involving all relevant staff, the person and their family if indicated should occur as soon as possible after the event
8. A full review of the incident should be conducted in consultation with the person and their family if indicated.
9. Any contributing factors should be addressed and a risk management plan developed.

i. If the person is deemed to be at on-going risk of wandering or going missing an individualized response plan should also be developed and placed in the persons support plan.
ii. All persons involved in supporting the person must be familiar with their individualized response plan.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.15 – CONTROLLED ACTS	
PAGE: 1 of 2	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall comply with all legislation pertaining to the administration of controlled health procedures.

PROCEDURES:

1. Staff of the Association will adhere to all regulations regarding controlled acts as outlined in Section 27. (1) of the Regulated Health Professions Act 1991.
2. Staff shall not perform a controlled act set out in subsection (2) in the course to providing health care services to an individual unless,
    i. the person is a member authorized by a health profession Act to perform the controlled act; or
    ii. the performance of the controlled act has been delegated to the person by a member described in clause (a). 1991, c. 18, s. 27 (1); 1998, c. 18, Sched. G, s. 6.

CONTROLLED ACTS

A "controlled act" is any one of the following done with respect to an individual:

1. Communicating to the Individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the Individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
    i. beyond the external ear canal,
    ii. beyond the point in the nasal passages where they normally narrow,
    iii. beyond the larynx,
    iv. beyond the opening of the urethra,
    v. beyond the labia majora,
    vi. beyond the anal verge, or
    vii. into an artificial opening into the body.

7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.
8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response. 1991, c. 18, s. 27 (2); 2007, c. 10, Sched. L, s. 32.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: HEALTH AND WELL BEING	
POLICY # A4.16 – OXYGEN THERAPY IN RESIDENTIAL HOMES	
PAGE: 1 of 3	**REFERENCES:**
APPROVAL DATE: 11.2019	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 11.2019	**REVISION DATE:**
AUTHORIZATION: Executive Director	

Policy: Home oxygen therapy is commonly used for in residential settings. Oxygen therapy involves breathing air that contains more oxygen than normal air from a cylinder or machine. It may be prescribed for people who have a condition that causes low oxygen levels in the blood. When an Individual requires the use of oxygen therapy. Home oxygen therapy can be given via:

- tube positioned under the nose (nasal cannula)
- face mask placed over the nose and mouth
- mask attached to an opening in the throat (tracheostomy)

Oxygen is delivered via the tube or mask from a cylinder, concentrator or ventilator machine.

It is the financial responsibility of the Individual to obtain, maintain and service the oxygen equipment; in accordance with the manufacturer's recommendations. Prior to initiation of treatment, a registered respiratory technologist or qualified representative of the supplier must visit the facility and instruct the Individual and appropriate staff members in the operation and maintenance of the unit. This instructional session shall include the appropriate safety precautions to be followed.

Procedure: Where oxygen therapy is prescribed the Team Lead and Manager will meet with the respiratory therapist to develop protocols for use of oxygen therapy. A binder will be developed with the following but not limited to information:

- Monitoring of the person using the oxygen including how and frequency.
- Administration of oxygen. This should include:
    - flow rate
    - frequency
    - duration of use
    - prescriber's details.

  Check these each time to make sure you're administering the oxygen correctly.
- If the person self-administers the oxygen, you need to have assessed the risks. Keep a copy of the risk assessment in their care plan binder.
- Make sure the tubing and masks are clean and in good condition. Replace them when needed. Only use them for the person they were prescribed for.
- Individual risk assessments should include information about the potential dangers of having oxygen in the care home.

The Team Lead and Manager must ensure that:

- The equipment is CSA (Canadian Standards Association) approved.
- The name, address, telephone number and person's name of the installer must be provided.
- Proof in writing that the person who fills the cylinders has been given the proper training by the installer. Also, that written instructions have been left at the home.
- Proof that the fire department has been notified in writing of the installation.
- All staff will be trained in the use of oxygen and the corresponding therapy and will sign off on said training. A copy of the training will be forwarded to the main office for inclusion in each staff's personnel file.
- All manufacturers guidelines are followed for storage and use including, but not limited to the following guidelines:
    - Use
        - Ensure staff are trained and competent to manage home oxygen therapy. Staff must be competent and have appropriate training. They must be able to order, check storage, administer and monitor the effects of oxygen.
    - Storage

      Follow the manufacturer's advice on how to store oxygen. Store oxygen cylinders:
        - Securely to prevent the cylinder from falling away from areas that would block escape routes or fire exits
        - In well-ventilated areas
        - Away from heat and light sources
        - In an area that is not used to store any other flammable materials
        - Away from combustible material (such as paper, cardboard, curtains)
        - So that they are not covered by items of clothing
        - Store oxygen concentrators upright. Plug them directly into the mains. Do not use an extension lead.
        - Place statutory hazard notices in areas where you store oxygen. This includes the person's bedroom.
        - Oxygen cylinders have an expiry date. Check the dates regularly to make sure you don't use out of date cylinders.
        - Return equipment to the oxygen supplier if it is no longer in use or out of date.
        - If you hold supplies of oxygen for emergency use, you need appropriate equipment and storage.
    - Safety

      Follow the manufacturer's safety advice, including but not limited to:
        - Oxygen can be a **dangerous fire hazard**. Take adequate precautions while oxygen is being used.
        - Inform the fire department of the use of oxygen in the home and where it can be found.

- Do not allow people to smoke including electronic cigarettes, where oxygen is being used.
- Keep oxygen at least two metres away from flames or heat sources.
- Do not use flammable liquids, such as paint thinners or aerosols, near oxygen.
- Do not attempt to lubricate the oxygen equipment.
- Do not use petroleum based products, such as Vaseline® or Vicks®, near oxygen.
- Do not use electronic devices (phones, laptops) in the vicinity of the oxygen.
- Make sure that fire alarms and smoke detectors are working.
- Keep a fire extinguisher within easy reach of anyone using oxygen.

o Preventative Maintenance

- Ensure that all manufacturer's guidelines are followed and recorded for the maintenance of the oxygen, masks and tubing.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: RESTRICTIONS	
POLICY # A5.01 – ABUSE/NEGLECT	
PAGE: 1 of 5	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

The Association is committed to providing a safe, nurturing and respectful environment that promotes the rights of persons for whom it works. There is zero tolerance of abuse or neglect of any kind. Any alleged, suspected or witnessed abuse will be reported to the local authorities in compliance with Ontario Regulation 299/10, it is noted that the person's consent is not required. Abuse happens when a person or group of people use their power (authority, control or influence) to cause or create a significant likelihood of harm to a person. The following are types of abuse: emotional abuse; verbal abuse; financial or material exploitation; neglect; professional malpractice; civic and human rights abuse; sexual abuse; or physical abuse. Any person supported where abuse of that person has been alleged, suspected or witnessed will be supported, in a way that works for the person. Everyone within the Association must be empowered to make complaints without fear of consequences. All incidents of alleged abuse will be reported. Any staff member accused of abuse will be held accountable.

DEFINITION:

"Abuse" means action or behaviour that causes or is likely to cause physical injury or psychological harm or both to a person with a developmental disability, or results or is likely to result in significant loss or destruction of his or her property. ("mauvais traitements") Abuse also includes any and all physical, sexual, emotional, verbal and financial abuse. Types of abuse include:

Physical abuse, which may include:

i. hitting
ii. pushing
iii. kicking
iv. rough handling
v. using an object or weapon to hurt someone

Neglect, which may include:

i. not giving proper food, clothing or hygiene
ii. not taking care of health and safety needs
iii. wrong use of medication

Sexual abuse, which may include:

i. touching someone's sexual body parts or forcing them to do something of a sexual nature they do not want to do
ii. forcing someone to have sex when they do not want to

iii. making someone watch pictures or videos that make them uncomfortable
iv. making offensive sexual comments and jokes and saying things that hurt someone or make them uncomfortable

Emotional abuse, which may include:

i. bullying
ii. creating fear or scaring people
iii. keeping someone away from their friends and family
iv. not giving people privacy

Verbal abuse, which may include:

i. making comments on things like race and gender
ii. threatening people
iii. using abusive language or swearing

Financial abuse, which may include:

i. stealing or taking someone's money by forcing or tricking them
ii. using someone's money without asking them
iii. forcing someone to sign documents to give their money to someone else
iv. making changes to someone's financial documents
v. asking someone to steal or claim money that does not belong to them

INDICATORS OF ABUSE:

Physical Abuse

Some of the indicators of physical abuse are: signs of new injuries when old injuries have not yet healed; unexplained and unusual burns, cuts, bites, blisters/bruises, broken bones or bald spots on head in unusual or clustered patterns; unusual imprints on the skin from the instrument used to inflict abuse (such as the round pattern of a stove burner etc.); and injuries inconsistent with the description of cause

Neglect

Some of the indicators of neglect are: poor hygiene; dirty, torn clothes worn every day; insufficient clothing; bug infestation in the person's clothes or body; unattended medical or dental needs; and underweight or overweight (when not associated with the primary disability).

Sexual Abuse

Some of the indicators of sexual abuse are: existence of sexually transmitted diseases or pregnancy; stained, torn and/or bloody underclothes; bruised or swollen genitalia/anal area; sore throat (which may be due to pressure applied to the throat through choking or forced oral sex); pain while walking or sitting (with evasive or illogical explanation); semen around the mouth, genitals or on clothing; unusual or offensive odor; and a significant change in sexual behavior or attitude

Emotional
Some of the indicators of emotional abuse are: extreme, unusual behavior (aggression, compliance, withdrawal); high level of anxiety/fear of returning to a particular place; attempted suicide; and lack of attachment to parents or other caregiver.

Financial
Some of the indicators of financial abuse are: person has no money, when they have just been paid or received a payment. Documentation is not balanced or there are consistent inaccuracies with no explanation.

PREAMBLE:

People's disabilities can often make them vulnerable. This vulnerability could be countered by the meaningful involvement of family, friends and community friends. The design and delivery of programs and services should minimize the vulnerability of individuals by ensuring that employees who provide support demonstrate competency in terms of appropriate practices using training/teaching programs which are permitted and promoted by the Association. Appropriate use of psychotropic medications, Behavior management, and medical and physical care practices, with an understanding of how such practices could contribute to or result in the abuse of individuals who are vulnerable.

If someone says that they have been abused, staff see abuse happening, staff thinks that abuse might be happening or someone else reports abuse, the Association will report all accusations of abuse to the authorities immediately upon notification.

PROCEDURES:

1. All staff hired by the Association and volunteers shall complete a Criminal reference checks to work with people that are vulnerable.
2. All incidents, allegations or suspicions of abuse toward a person supported, whether by an Association employee or by another person, shall be immediately reported to Police.
3. The immediate manager or manger designate shall be notified of the incident. A written follow-up will be completed using the Association reporting forms.
4. Support will be given to the person reporting abuse to seek medical assistance as required, set up counseling and ensure they are informed of all their rights. Staff will inform and educate on the process of reporting abuse.
5. Supports will be given to a person we support who has been accused of an alleged assault, ensuing information is given around all rights and that education is given around steps taken through the process alleged abuse.
6. The Manager will report the incident to the Executive Director.
7. The staff will obtain consent from the person support to notify any persons acting on behalf of them. i.e.: family or substitute decision maker. The guardian may give consent for medical treatment if required. It is noted that the guardian family member or a person that may inform

8. the abuser will not be contacted if there is suspicion or notification they may be the abuser. All staff will seek advice from their manager on the immediate actions.
9. All staff will ask for guidance from manger regarding the safety and security of the individual making the allegations of the person by providing supports including but not limited to the following:
    i. Assist the person to be comfortable in a private confidential setting suitable to the person.
    ii. **Employees will not ask any direct questions.**
    iii. Remain calm take all statements seriously
    iv. Use all communication and language ensuring consideration of the cognitive ability of the person.
    v. Listen non judgmentally leaving time for the person to process and reflect on what is being alleged using resources, tools and individual communication aides such as pictures either drawn by the person or pointed to by the person.
    vi. Document all statements
    vii. Gather information without leading avoid all yes no questions or questions that may suggest an answer. Yes, no questions or questions that lead to a specific response will invalidate the allegation.
    viii. Inform the person you may not be able to keep the information confidential or private.
    ix. Ask the person if there is anyone else they would like to be a part of this process
    x. A medical examination with a written report and follow up on all recommendations of the attending physician.
    xi. If the abuse has just happened encourage the person to go to hospital right away, not to shower/bath, change clothes or comb hair.
10. A serious occurrence will be completed and forwarded to the Ministry of Community and Social Services.
11. The Executive Director shall ensure the person abused has received the appropriate support and follow up.
12. The Manager will ensure the person who has been abused has given consent before any family members or another person acting on that person's behalf about the abuse, is told an thing about the accusation/situation.
13. There will be no internal investigations until such time as the authorities have conducted and completed their investigation.
14. The Association shall ensure that all people supported by the Association shall receive the support, training and assistance necessary to take action in identification and prevention of abuse and neglect. People shall be taught in the "language" they understand. All board, employees, volunteers and caregivers of the Association shall be oriented to this policy and procedures and have an annual review of said policies.
15. In the event that a staff/employee of the Association is accused of abuse, such employee will be suspended with pay until such time the investigation is completed.
16. In the event that a staff employee is charged with an abuse, such employee will be suspended without pay until such time as a court case is determined and a verdict is found. If said employee is found guilty by law, such employee will be dismissed.
17. All Association employees will be trained on how to document an accusation of abuse.

18. In the event that an Association volunteer is accused of abuse, such volunteer support will be ended. In the event the external investigation determine the volunteer is not to be charged the Association reserves the right to reassign or end the volunteer supports
19. If a person requests support, assistance shall be given. It may be necessary to explain
20. What the person's rights are and what type of assistance as available, and to provide the appropriate help to receive the necessary supports.
21. The Association will review the effectiveness of the abuse policy and procedure to determine the effectiveness and make changes if necessary to ensure abuse to people whom are vulnerable stops.
22. The attached protocol on reporting Abuse shall be adhered to at all times.

EXECUTIVE DIRECTOR ANNUAL SIGN OFF

_____ _____

Tony Pacheco Date

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: RESTRICTIONS	
POLICY # A5.02 – USE OF AVERSIVE AND INTRUSIVE PRACTICES	
PAGE: 1 of 2	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall not tolerate the use of aversive conditioning techniques and intrusive practices.

DEFINITION:

Techniques which have one or more of the following characteristics are defined as aversive:

1. systematic infliction of physical pain, illness, physical and/or emotional trauma;
2. dehumanization of the person;
3. techniques inappropriate to the age of the person;
4. treatment or consequences out of proportion to the target behaviour;
5. procedures which are normally unacceptable for non-disabled people and in particular:
    i. systematic or prolonged social segregation or social isolation;
    ii. verbal abuse,
    iii. a program of electric shock or mechanical restraint,
    iv. the use of tranquilizing drugs as a form of restraint,
    v. water or lemon juice spray, and/or other noxious stimulation (taste, smell, or noise).
    vi. removal of a person's privileges or rights

PROCEDURES:

1. The use of aversive conditioning techniques by Association employees, other Association paid service providers, students, or volunteers shall be considered cause for disciplinary action, up to and including termination of employment
2. The Association shall advocate against any aversive conditioning techniques practiced by other services in the community.
3. The Association shall not refer people to other organizations the Association knows or suspects the practicing of aversive conditioning techniques.
4. Association employees shall not engage in implementing or carrying out intrusive interventions with a person supported unless it is for health/safety or life/death reasons (e.g. moving someone out of the path of a speeding car, jumping from a bridge, hospitalization without consent).
5. Physical intervention shall be considered as a last resort and shall only be used by employees to intervene on behalf of the person to ensure care, health and safety to the persons and those around the person.
    i. An intervention of this kind shall be maintained only as long as safety requires it and for a period of no longer than two months.
    ii. Approved methods of physical intervention shall only be employed by qualified employees assigned to support the person.

iii. All incidents that involve physical restraint shall be documented and kept on file with a copy immediately sent to the Executive Director.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: RESTRICTIONS	
POLICY # A5.03 – PHYSICAL RESTRAINTS	
PAGE: 1 of 2	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

Use of physical force to constrain or control the behaviour of a person for whom the Association works shall not be tolerated under normal conditions of support. Even with the consent of the person for whom the Association works, use of physical force by employees to control or restrain a person is considered by the Association to be a form of abuse and may result in disciplinary action up to and including termination of employment, except under the conditions described below.
It is recognized that under extreme conditions, physical intervention may be necessary to save lives or prevent serious injury.
It is further recognized that carefully controlled use of restraint may be the least intrusive option available for some people during episodes of violent behaviour. **The following apply to extreme conditions only, and then only after less intrusive options have been exhausted.**

PROCEDURES:

The following procedures are intended to set limits, give guidance and otherwise support the Association's employees when dealing with challenging or extreme behaviours. "Extreme behaviour" is generally understood to mean behaviour that poses a danger to oneself or others and/or behaviour that so seriously deviates from social norms as to place the person in conflict with the law or at risk of severe consequences. Failure to control such behaviour implies consequences for the person that ought to be avoided even if the means of doing so involves a compromise of one's civil rights and freedoms.

1. Physical restraint may be carried out only if there is a clear and imminent risk of, or for the purpose of preventing a person from physically injuring or further physically injuring himself or herself or others.
2. Physical restraint may never be carried out for the purpose of punishing a person.
3. Physical restraint may be carried out only after is a determined that less intrusive interventions would be ineffective in preventing the person from physically injuring himself or herself or others.
4. Only direct support staff members who have received training in Non-Violent Crisis Prevention Intervention (CPI) may carry out physical restraint.
5. When physical restraint is carried out, it must be carried out using the least amount of force that is necessary to restrict the person's ability to move freely.
6. During physical restraint, the person's condition must be continually monitored and assessed.
7. Physical restraint must be stopped upon the earlier of the following:
    i. When there is no longer a clear and imminent risk that the person will injure himself or herself or others.
    ii. When there is a risk that the physical restraint itself will endanger the health and safety of the person.
8. Within 48 hours following a physical restraint, a debriefing process shall be conducted among the staff members who were involved in the restraint.

9. Within 48 hours following a physical restraint, a debriefing process shall be conducted among the staff members who were involved in the restraint and the person who was restrained. This process must be structured to accommodate the person's psychological and emotional needs.
10. All incidents that involve the use of physical restraint shall be documented using the Unusual Occurrence Reporting Format and reported to the Ministry of Community and Social Services according to its protocol.
11. Definition of "physical restraint" means using a holding technique to restrict a person's ability to move freely, and "physically restrain" has a corresponding meaning.
12. Generally, physical restraint is used in connection with an approved behavioural plan or program.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: REPORTS	
POLICY # A6.01 – SERIOUS OCCURENCES	
PAGE: 1 of 3	**REFERENCES:** **Reporting to MCCSS Process** **Reporting Timelines/Occurrence Levels** **Serious Occurrence Process**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY

All Serious Occurrences shall be reported to the appropriate Manager and to the Executive Director immediately after the occurrence.

In accordance with the Ministry of Children, Community and Social Services (MCCSS) requirements, certain types of Serious Occurrences (as defined by the Ministry in Appendix B attached to this policy) shall be reported to the Ministry by the Executive Director or designate within 1 to 24 hours of becoming aware of the occurrence and depending on the seriousness of the occurrence.

DEFINITIONS

Serious Occurrence Reporting is a process that:

- Allows service providers to manage incidents as they occur, make records of the incidents and monitor actions taken in response to incidents in order to prevent or mitigate further incidents; and
- Supports MCCSS in monitoring and overseeing service providers in the delivery of services.
- The reporting process to MCCSS is provided in Appendix A.

A **Serious Occurrence** ("SO") is an incident that:

- Requires or may require intervention and/or investigation by a service provider, MCCSS, and/other applicable parties (such as the police); and
- Falls within one or more of the following SO categories (see appendices A & B for definitions and reporting timelines):
    1. Death;
    2. Serious injury;
    3. Serious illness;
    4. Serious individual action;
    5. Restrictive intervention;
    6. Alleged, witnessed or suspected abuse or mistreatment;
    7. Error or omission;
    8. Serious complaint; and
    9. Disturbance, service disruption, emergency or disaster.

- Based on the type of incident, a SO is designated as either a Level 1 or a Level 2. The level indicates the timeframe in which the SO must be reported to MCCSS:
    1. *Level 1 SO*: MCCSS must be notified immediately and a SOR must be submitted within 1 hour of the SO.
    2. *Level 2 SO*: A SOR must be submitted as soon as possible but no later than 24 hours after the SO.

A **Serious Occurrence Report** ("SOR") is the official record used to report information about SOs to MCCSS.

PROCEDURES

Internal Reporting Protocol

- Employees are encouraged to discuss with each other the circumstances of any unusual or extraordinary occurrences that have transpired during their shift and, in particular, serious occurrences that involve:
    - death,
    - serious injury,
    - serious illness,
    - serious individual action,
    - restrictive intervention,
    - alleged, witnessed or suspected abuse, errors or omissions (i.e. medication),
    - serious complaints,
    - disturbance, service disruption, emergency or disaster.

  Notwithstanding this, each employee is responsible for being aware of their reporting obligations and to determine when a Serious Occurrence must be reported under this policy.
- All Serious Occurrences as per the definitions listed above, shall immediately be reported verbally to the appropriate Manager (or On-Call Manager/Team Lead if after hours) who will report to the Executive Director immediately thereafter.
- The employees must complete a written report in AIMs using the reporting software which shall follow the verbal report.
- All employees who witness or have knowledge of such occurrences shall complete separate reports in AIMS. Written reports shall be directed to the appropriate Manager and the Executive Director prior to the completion of the employee's work period.
- The Executive Director or designate is tasked to complete the Serious Occurrence Report (SOR) with the Ministry in the timelines dictated by the occurrence.

Training, Updates, Review

The Association will provide training to all staff regarding the Serious Occurrence policy and procedures upon hire and annually thereafter.

The Association will review and update the Serious Occurrence policy annually and conduct a review and analysis of all SORs for each calendar year. The annual review will:

- Identify issues, trends and/or patterns; and
- Detail actions planned or undertaken in response to any issues or concerning trends and patterns uncovered through the annual review and analysis.

The Association will maintain a record of the annual review and analysis, which is to be made available to MCCSS upon request. Any significant issues or concerning trends/patterns that arise from the review and analysis of SORs must be communicated to the service provider's designated MCCSS contact(s), and the communication must include strategies to address the identified issues or concerning trends/patterns.

Confidentiality

The Association will maintain the confidentiality of all individual's information in accordance with policy A8.03.

REPORTING TO MCCSS PROCESS

STEPS	ACTION
1. Attend to the incident and individuals involved in the incident	• Upon becoming aware of an incident, staff shall attend to the incident and any immediate health or safety needs of individual(s) involved in the incident. • Staff will report the occurrence to the Manager, who will alert the Executive Director.
2. Determine if the incident meets the definition of a SO	• The Executive Director or designate will evaluate the incident against the criteria within the guidelines, applicable MCCSS legislation/policy and CLA's internal SO reporting policy to determine whether the incident is a SO.
3. Determine the category for reporting	• Once an incident is identified as a SO, the Executive Director or designate will determine which category or categories the SO should be reported under.
4. Determine the timeline for reporting	• Once the SO category or categories have been identified, the Executive Director or designate will determine which time frame the SO must be reported to MCCSS under (either Level 1 or Level 2).
5. Initial notification to MCCSS about Level 1 SOs	• The Executive Director or designate must immediately notify MCCSS about Level 1 SOs. The initial notification should be a brief description of the incident, including: o The type of incident (e.g. death, serious injury, serious illness, etc.); o The approximate date and time of the incident; o The approximate number of individuals involved; o Whether any of the Individuals involved have immediate health or safety needs, and what the service provider is doing to address these needs; o Who has been notified about the incident; o Whether any initial actions have been taken by the Association in response to the incident; and o Whether the incident has garnered media attention or is expected to garner media attention.
6. Submit an initial SOR to MCCSS	• Level 1 Serious Occurrences o Submit a SOR within 1 hour of becoming aware of the SO or deeming the incident to be a SO. • Level 2 Serious Occurrences o Submit a SOR as soon as possible but no later than 24 hours of becoming aware of the SO or deeming the incident to be a SO. • All SORs are to be submitted through the SOR-RL online tool. • Initial SORs must include, at a minimum: o The service provider's site information (for service providers that have multiple site locations, select the site that is submitting the SOR); o The date and time of the SO;

STEPS	ACTION
	○ The date and time of becoming aware of the SO/deeming the incident to be a SO (if different from date and time of the SO); ○ Individuals involved; ○ The SO category or categories; ○ A description of the SO and any necessary further details (i.e. explanation if SOR was submitted outside required reporting timelines); ○ Who has been notified about the incident; ○ Whether any initial actions have been taken by the service provider in response to the incident; ○ Whether the incident resulted in any media attention, and whether the service provider expects there to be any media attention in the future; ○ Whether the initial SOR is expected to be the only/last report submitted for the SO; ○ Individual's views / perspectives; ○ Supporting document that are directly relevant to the SO; ○ Executive Director of designate sign-off
7. MCCSS initial response to the SOR	• Once MCCSS has received the initial SOR from the service provider, MCCSS will review the submission and may contact the service provider to: ○ Seek clarification of any information submitted; ○ Request information submitted to be corrected, including having the service provider change the SO category selected if it is not correct or remove any unnecessary personal information; ○ Request additional information about the SO; and/or ○ Request or direct that additional action to be taken by the service provider, including enforcement action.
8. Provide updates (where applicable)	• Until MCCSS deems that no further action is required from the service provider with respect to the SO, service providers are required to provide updates as new information becomes available about the SO and no later than 7 business days after submitting the initial SOR. • Updates are required at a minimum every 7 business days thereafter until MCCSS deems that no further action is required from the service provider. • MCCSS may request updates at any time.
9. Determining when no further action is required	• MCCSS will review each SOR to determine when no further action is required from the service provider with respect to the SO, which includes checking that the service provider: ○ Filled out all required fields; ○ Made all required notifications; ○ Has undertaken all further action or follow-up, as requested; and ○ Met all SOR requirements.

APPENDIX B

CATEGORY-SPECIFIC REPORTING REQUIREMENTS

For additional details refer to the Ministry of Children, Community and Social Services Serious Occurrence Reporting Guidelines, 2019

CATEGORY	DESCRIPTOR	**LEVEL 1** Immediately notify MCCSS and submit a SOR within 1 hour of becoming aware of the SO or deeming the incident to be a SO.	**LEVEL 2** Submit a SOR as soon as possible but no later than 24 hours of becoming aware of the SO or deeming the incident to be a SO.
DEATH	Where the death of an individual occurs while receiving a service: a. Suicide b. Violence/homicide c. Accidental (choking, falling object, fire, MVA, poisoning, etc.) d. Known illness or other natural cause e. Unknown cause (at the time of reporting)	All deaths	
SERIOUS INJURY	Where an individual receiving a service incurs a serious injury which requires unscheduled medical attention from a regulated health professional and/or unplanned hospitalization: f. Accidental (i.e. choking, falling object, fire, MVA, poisoning, etc.) g. Aggressive behaviour (i.e. physical altercation) h. Self-harm (including injuries sustained during a suicide attempt) i. Unknown cause (at the time of reporting) j. During a physical restraint, mechanical restraint, or placement in a secure de-escalation room k. Other (specify)	• A life-threatening injury • An injury caused by a service provider or; • An injury requiring emergency medical services.	All other serious injury SOs
SERIOUS ILLNESS	Where an individual receiving a service incurs a serious illness or has an existing serious illness which requires unscheduled medical attention from a regulated health professional and/or unplanned hospitalization: l. Mental health (i.e. individual taken to hospital due to mental health concerns)	• A life-threatening illness; or • An illness requiring emergency medical services	All other serious illness SOs

CATEGORY	DESCRIPTOR	LEVEL 1 Immediately notify MCCSS and submit a SOR within 1 hour of becoming aware of the SO or deeming the incident to be a SO.	LEVEL 2 Submit a SOR as soon as possible but no later than 24 hours of becoming aware of the SO or deeming the incident to be a SO.
	m. Communicable disease n. Other disease, illness or infection o. Unknown cause (at the time of reporting)		
SERIOUS INDIVIDUAL ACTION	**Suicidal behaviour**: Where an individual receiving a service attempts suicide, utters a suicidal threat of a serious nature or utters a suicidal threat that results in the individual being placed on suicide watch: p. Attempt q. Threat that results in placement on suicide watch	Suicidal behaviour: Threat to the health and safety of the individual or immediate risk of harm to the individual.	All other serious individual action SOs
	Alleged, witnessed, or suspected assault: Where an individual receiving a service is assaulted or is accused of assaulting someone: r. Individual on individual s. Individual on staff t. Individual on other (specify)	Any assault that results in serious injury to the individual or service provider staff	

	Contraband/safety risk: Where an individual receiving a service is suspected to be, or is discovered to be, in possession of a substance or object that:
	• is prohibited by legislation or policies and procedures,
	• has the potential to cause injury or death, and/or
	• is deemed by the service provider to be a significant danger or concern.
	  • Weapons
	  • Narcotics/illegal substances
	  • Fire setting (including arson)
	  • Other items that pose a threat
		Contraband /safety risk:
		• has the potential to cause injury or death
		• is being actively investigated by police and/or MCCSS
		• Resulted in the use of lockdown/searches	

CATEGORY	DESCRIPTOR	LEVEL 1 Immediately notify MCCSS and submit a SOR within 1 hour of becoming aware of the SO or deeming the incident to be a SO.	LEVEL 2 Submit a SOR as soon as possible but no later than 24 hours of becoming aware of the SO or deeming the incident to be a SO.
	Inappropriate/unauthorized use of information technology (IT): Where an individual receiving a service uses IT in an inappropriate and/or unauthorized way that: • has or could result in criminal charges, and/or • is or could be a threat to the health, safety or well-being of the individual, other individuals or the public.	The information technology usage results in or could result in criminal charges, the usage is tied to engagement in prostitution or human trafficking, or the usage is a threat to public safety.	

	Unusual, suspicious or unauthorized individual absence: Where an individual receiving a service is discovered to be absent, and their absence is unauthorized, or the individual is missing/absent without permission, which includes an individual who is missing/absent without permission or is missing/absent under unusual or suspicious circumstances., which includes:
	• An individual who is missing/absent without permission or is missing/absent under unusual or suspicious circumstances.
	  • Escape lawful custody
	  • Unlawfully at large
	  • Missing/absent without permission or under suspicious circumstances
		The absence poses a serious concern about the individuals' immediate safety or poses a serious concern about the individual's immediate safety or poses a serious public safety concern.	

	Serious charges: Where an individual receiving a service incurs serious charges.	New charges that represent a significant individual or public safety concern.	
	Relinquishment of care/threat of relinquishment of care: Where the family/primary caregiver of an adult with a disability receiving a service relinquishes care of the individual, the family/primary caregiver of an adult with a developmental disability receiving a service threatens to relinquish care, or another individual (e.g. a staff, volunteer, etc.) suspects that relinquishment of care may occur.	Relinquishment of care by family/primary caregivers has been fulfilled.	

CATEGORY	DESCRIPTOR	LEVEL 1 Immediately notify MCCSS and submit a SOR within 1 hour of becoming aware of the SO or deeming the incident to be a SO.	LEVEL 2 Submit a SOR as soon as possible but no later than 24 hours of becoming aware of the SO or deeming the incident to be a SO.

RESTRICTIVE INTERVENTION	**Physical restraint**: Where a physical restraint is used on an adult with a developmental disability who is receiving a service in circumstances where:
	• The physical restraint was used with an adult with a developmental disability to address a crisis when positive interventions have proven to be ineffective, where:
	  • A person with a developmental disability is displaying challenging behaviour that is new or more intense than behaviour that has been displayed in the past and the person lacks a behaviour support plan that would address the behaviour, or the behaviour intervention strategies that are outlined in the person's behaviour support plan do not effectively address the challenging behaviour,
	  • The challenging behaviour places the person at immediate risk of harming themselves or others or causing property damage, and
	  • Attempts to de-escalate the situation have been ineffective.
	• The physical restraint was used with an adult with a developmental disability who was displaying challenging behaviour (either as part of the person's behaviour support plan or in a crisis) and the physical restraint resulted in the injury to the individual who was restrained, and/or the staff person(s) who employed the use of the physical restraint, and/or anyone else in the vicinity where the physical restraint took place; or
	• The physical restraint was used with an adult with a developmental disability who was displaying challenging behaviour (either as part of the person's behaviour
		Any restrictive intervention that:
		• Contravenes MCCSS legislation, regulations and/or policy;
		• Resulted in physical impairment/injury and/or emotional harm of the individual;
		• Resulted in treatment by a regulated health professional, requiring emergency medical services; or
		• Was administered by an unauthorized person.
			All other serious restrictive intervention SOs

CATEGORY	DESCRIPTOR	LEVEL 1 Immediately notify MCCSS and submit a SOR within 1 hour of becoming aware of the SO or deeming the incident to be a SO.	LEVEL 2 Submit a SOR as soon as possible but no later than 24 hours of becoming aware of the SO or deeming the incident to be a SO.
	support plan or in a crisis situation) and the physical restraint resulted in an allegation of abuse.		
	Mechanical restraint: Where a mechanical restraint is used on an adult with a developmental disability contrary to the individual's behaviour support plan, the provisions of Ontario Regulation 299 under the SIPDDA and/or the policy directives (2.0 – Supporting People with Challenging Behaviour) under the SIPDDA. **Secure de-escalation (or secure isolation/confinement time-out)**: Where an individual receiving a service is placed in a secure de-escalation (or secure isolation/confinement time-out) room. Any placement in such settings is to be reported as a SO.		

ABUSE OR MISTREATMENT	• Where there are allegations of abuse or mistreatment (witnessed or otherwise), or suspected abuse or mistreatment of an individual receiving a service which occurred, or is alleged to have occurred, while the individual was receiving a service; or
	• Where there are new allegations of historical abuse or neglect of a child or young person receiving a service.
	  • Physical abuse
	  • Emotional harm
	  • Neglect
	  • Exploitation
	  • Sexual abuse
		Any allegations of, witnessed or suspected abuse or mistreatment where:
		• There is an immediate threat to the health, safety or well-being of the individual or others;
		• A current service provider staff, volunteer, etc. is implicated in the alleged, witnessed or suspected abuse or mistreatment of an individual; or
		• The individual is receiving threats or harassment from a human trafficker.
			All other alleged, witnessed or suspected abuse or mistreatment SOs.

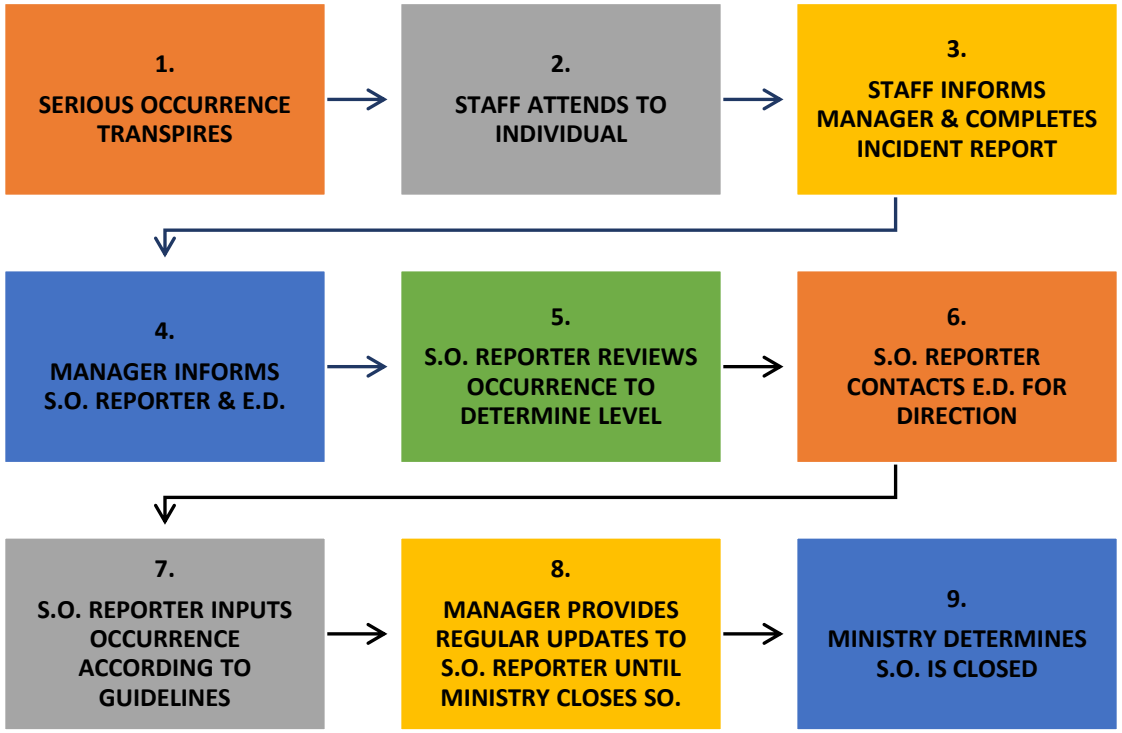
ERROR OR OMISSION	**Medication errors**: Where there is a medication error involving the prescribing, transcribing, dispensing, administration and/or distribution of medication(s) to an individual receiving a service.	There is a medication error involving the prescribing, transcribing, dispensing, administration and/or	All other error and omission SOs

CATEGORY	DESCRIPTOR	LEVEL 1 Immediately notify MCCSS and submit a SOR within 1 hour of becoming aware of the SO or deeming the incident to be a SO.	LEVEL 2 Submit a SOR as soon as possible but no later than 24 hours of becoming aware of the SO or deeming the incident to be a SO.
		distribution of medication(s) to an individual receiving a service.	
	Privacy breach: Where there is a breach or a potential breach of privacy and/or confidentiality, including any instance/suspected instance when personal information of an individual who is receiving a service has been collected, used, stolen, lost or disclosed without authority that results in serious harm or risk of serious harm to the individual and/or others.	The individual has been seriously harmed or is at risk of serious harm as a result of a breach of personal information or the breach contravenes the YCJA.	

SERIOUS COMPLAINT	• Where a complaint is made by or on behalf of an individual who is receiving a service regarding the alleged violation of their rights (e.g. under the *Canadian Human Rights Act*, *Canadian Charter of Rights and Freedoms*, Ontario *Human Rights Code*, CYFSA, etc.).
	• Where a complaint is made by or on behalf of an individual receiving a service regarding a violation of their privacy rights (i.e. improper collection, use or disclosure of the individual's personal information).
	• Where a complaint is made by or about an individual who is receiving a service that the service provider considers to be of a serious nature.
	• Where a complaint is made about the operational, physical or safety standards of the services received by an individual.
	  • Rights-based complaint (privacy or human rights)
	  • Service-related complaint (operational, physical environment, safety standards)
	  • Complaint about an individual receive in a service
	  • Other (specify)
		The complaint is about a service provider staff; director or owner being charged or arrested for a crime that may affect or has affected an individual or Individuals receiving a service.	All other serious complaints SOs

CATEGORY	DESCRIPTOR	LEVEL 1 Immediately notify MCCSS and submit a SOR within 1 hour of becoming aware of the SO or deeming the incident to be a SO.	LEVEL 2 Submit a SOR as soon as possible but no later than 24 hours of becoming aware of the SO or deeming the incident to be a SO.
DISTURBANCE, SERVICE DISRUPTION, EMERGENCY OR DISASTER	Where the disturbance, service disruption, emergency or disaster occurs on the service provider premises or in the case of residential care, the place where residential care is provided, or within close proximity of where the service is provided, and it interferes with the service provider or foster parents' ability to provide routine services. • Adverse water quality • Fire • Flood • Natural disaster • Power outage (i.e. that causes a significant disruption) • Gas leak • Carbon monoxide • Abduction • Infection outbreak (where public health officials are involved) • Riot • Stand-off • Hostage taking • External threat (i.e. bomb threat, hacking, etc.) • Other (specify)	• The Continuity of Operations Plan (COOP) or business continuity plan was activated in response to an incident that threatened the health or safety of individuals or others; • The incident is or was perceived to be a significant danger to or concern of the community; • There was/is a site evacuation because of this incident; • There was/is a site lockdown because of this incident; or • Police intervention or assistance was/is required.	All other disturbance, service disruption, emergency or disaster Serious Occurrences.

Serious Occurrence Process



SUPPORT POLICIES AND PROCEDURES	
CATEGORY: REPORTS	
POLICY # A6.02 – INCIDENT OR UNUSUAL OCCURENCES	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

All unusual incidents or occurrences affecting people for whom we work shall be recorded.

PROCEDURES:

1. An unusual incident or occurrence shall be defined as something that occurs that is out of the ordinary, such as medication error, falling, minor injuries, hitting an employee, etc.
2. If an employee is unsure if an incident or occurrence falls in this category, it should be reported and the Manager shall indicate if it is an unnecessary report.
3. The employee shall complete in full the Incident/Unusual Occurrence Report as soon after the incident or occurrence as possible.
4. The completed form shall be forwarded electronically to the Manager who shall acknowledge the report and take any necessary action as a result of the incident or occurrence.
5. The Manager shall electronically forward the incident to the Executive Director who shall review it, and take appropriate action, analyze any emerging trends and maintain it in an annual file.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: REPORTS	
POLICY # A6.03 – COMPLIANCE	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

As an agency funded under the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008*, the Association shall obtain and maintain compliance as established by the Ministry of Children, Community and Social Services.

PROCEDURES:

1. All the appropriate managers are to ensure all compliance is followed and all documentation is on file.
2. A compliance checklist will be kept in each service and staff will receive orientation on their role in ensuring compliance with regulations and laws.
3. All staff, of the Association will cooperate with Ministry designate and or staff in the completion of compliance checks.
4. All recommendations in order to be in compliance will be addressed as agreed upon at time of compliance checks within the specified deadlines.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: SATISFACTION	
POLICY # A7.01 – RIGHTS	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Board of Directors	

POLICY:

The Association shall develop, implement and maintain a Rights process that is person focused, known to all employees and people for whom the Association works and is as neutral as possible.

PROCEDURES:

1. All Association staff and people supported shall participate in Rights Training at least on an annual basis.
2. The Association shall establish a Rights Committee in line with the Association's Rights Respect and Responsibilities Training Package.
3. If there is a rights infringement the association will follow the complaints process as laid out in the Rights Respect and Responsibilities training package.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: SATISFACTION	
POLICY # A7.02 – PERSONAL SATISFACTION	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association is in the business of supporting people to experience a quality of life of their choice as citizens of their community. Personal satisfaction ensures that the supports being provided to people are consistent with the Association's Goal and Vision and in fact do assist the person to attain this quality of life and the desired lifestyle.

PROCEDURES:

Personal satisfaction is measured on two levels: satisfaction of the person's life in general and satisfaction of the person with the service or supports provided by the Association.

1. **Personal Satisfaction with his/her Life**
   i. Formally: As part of a yearly review of the person's service planning/agreement process, a review of the person's lifestyle plan shall be discussed with the person and/or support network to determine if the person is enjoying the lifestyle identified for themselves (personal outcomes). Adjustments to the lifestyle plan shall be made so that supports (support agreements) can be re-tailored to help achieve newly identified needs
   ii. Informally: On an ongoing basis, support employees shall "check-in" with the person and their support network to see if they are satisfied with the overall direction with their life and personal lifestyle. This shall be recorded on the person's file.

2. **Association's Support and Service**
   i. Regular and at least annual contact by the appropriate support employee shall be made with the person and personal support network, and family if appropriate to ensure that the Association is responding to its commitment as outlined in the Personal Support Agreement.
   ii. A personal satisfaction process shall be conducted on no less than an annual basis to ensure that the person is satisfied with the Association's responses to his/her needs.
   iii. Internal and external audits of the Association's service and support practices shall be conducted on a regular basis using appropriate measurement tools and processes.

3. **Dissatisfaction**
   If there is dissatisfaction identified or expressed in any of the above, the person supported needs to be encouraged and supported to use the Complaints Policy and Procedure.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: SATISFACTION	
POLICY # A7.03 – COMPLAINTS/FEEDBACK PROCESS	
PAGE: 1 of 3	**REFERENCES:** **COMPLAINT FORM**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that all people receiving support, persons acting on their behalf of Individuals supported and the public have the right and are aware of the right to express complaints or grievances about any Association service or support.

PROCEDURES:

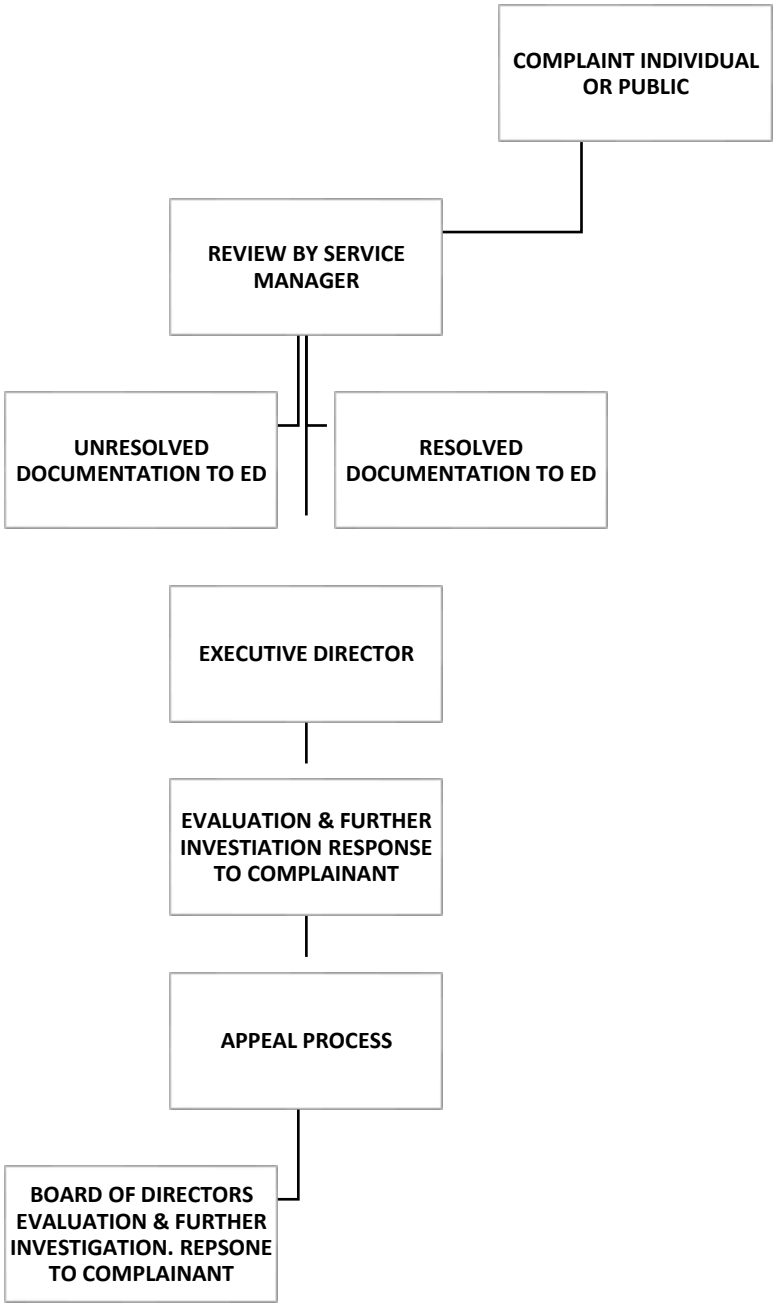
1. The person supported (family or their representative) will be made aware of their right to express a complaint regarding the association's services and supports to the association at any time. Such a right will be addressed with the Individuals at time of intake and with mandatory annual training.
2. The public shall be made aware of our complaint/feedback process through the Association website and its official publications.
3. The person has the right to ask and expect whatever assistance is required to make such a complaint.
4. The person supported (family or their representative) shall present (in written or other form) the details of the complaint to the appropriate employee who shall in turn explain the complaint process.
    i. Employees shall document all facts about the complaint and send a copy to the person making the complaint and to the Executive Director. Roles and responsibility of the Individual submitting the complaint will be reviewed.
    ii. The appropriate employee shall meet with the person making the complaint (and a representative(s) of his/her choice if so desired) in an attempt to address the complaint to the satisfaction of the person supported. This meeting shall occur within seven business days of receipt of the complaint.
    iii. If the complaint is resolved at this level, all documentation shall be forwarded to the Executive Director, who shall review the situation, and meet within seven business days with the person supported (and a representative(s) of his/her choice) and the appropriate employee.
    iv. If the issue is not resolved at this level, all documentation shall be forwarded to the Executive Director, who shall review the situation, and meet within seven business days with the person supported (and a representative(s) of his/her choice) and the appropriate employee.

v. If the issue is still not resolved, the Executive Director shall inform the President of the Board of the situation (maintaining confidentiality). The Board shall appoint an advisor or working group to work towards a resolution. The Board will appoint an employee who shall assist the person supported to seek outside assistance (mediator, adult protective service worker, etc.) to work toward a resolution of the issue.

vi. All documentation of the complaint/feedback process will be kept in the Individual's file that made the complaint and kept on file at the Association's main office.

5. During steps one through six (above) of the complaint process the Executive Director will review documentation and the investigation process to ensure it is free of any conflict of interest.
6. Roles and responsibilities of each person involved in receiving complaints/feedback, documentation, investigation, resolving and providing notification or confirmation with the Individuals who submitted the complaint/feedback will be reviewed with the Manager of the service at step one (above) of the complaint process.
7. The Executive Director, unless the complaint involves him/her, shall keep the Board apprised of the progress of their directives regarding the complaint process from step five (above) onward.
8. If the nature of the complaint involves the Executive Director, the complaint will be forwarded to the Board President. The Board of Directors will respond within one month of the initial complaint.
    i. The Board shall appoint an advisor or working group to review the specific complaint.
    ii. The Board, at their discretion, will call in the Individuals to hear their complaint in person.
    iii. The Board shall document their findings and respond to the Individual in writing and/or in person within the month's timeframe of the initial complaint.
9. Role of the Board of Directors
    i. The Board shall have the authority to refer the issue to proper authorities if deemed necessary and/or to resolve issues if it is within their policy framework.
    ii. It is the Board's responsibility to review all complaints in #4 (steps iv-vi) and all steps in #8. The Board will review the evidence objectively and recommend mediation and/or arbitration, if appropriate, and respond back to the Individuals within the thirty-day period.
10. The Manager of the service supports the Individual who has filed a complaint and/or the Executive Director will ensure the complaint/feedback process is free of any coercion or intimidation of bias, either before, during, or after the review process.
11. All complaints/feedback shall be serious until evidence demonstrates that it may be frivolous or unsubstantiated. If the complaint is deemed frivolous, the association, its representatives shall meet with the plaintiff to explain their findings.
12. Based on the nature of the complaint/feedback brought forward, the Association will follow the Ministry of Children, Community and Social Services Serious Occurrences Reporting process where applicable.
13. If the complaint submitted is one of abuse, the Association's policy on Abuse/Neglect (A4.01) shall come into effect and the foregoing procedures shall be negated.

Complaint Feedback Process



COMMUNITY LIVING
Association (Lanark County)
Inspiring Possibilities

COMPLAINT FORM

This form has been created for Individuals who wish to file a complaint in regards to the support and services provided by Community Living Association, Lanark County.
Please fill out the form to the best of your abilities. Forms that contain vulgar language or are of a harassing nature as defined by the Occupational Health and Safety Act will not be accepted.
All information shall be handled in accordance with the Freedom of Information and Protection and Privacy Act.

Personal Information

Name	
Current Date	
Address *	
Phone Number *	
Service Location	

*You are not required to fill out these sections. The information is collected only for follow up on complaints, and will not be used for other purposes.

Complaint Information

Please explain your complaint with as much detail as possible including specific dates, locations and individuals involved when possible.

If you have a specific resolution you would like to have occur as a result of this complaint (such as increased services, an apology, or additional actions) please provide the information below.

Please note, that by signing this document you are confirming that the information you provided is true to the best of your knowledge.

Name: _____ (PLEASE PRINT)

Signature: _____

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: SATISFACTION	
POLICY # A7.04 – INVESTIGATIONS (INTERNAL/EXTERNAL)	
PAGE: 1 of 5	**REFERENCES:** **COMPLAINT FORM**
APPROVAL DATE: 10.2019	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.2019	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY

The Association is committed to ensuring that all investigations are conducted in a fair, impartial, thorough, thoughtful manner and in compliance with all applicable laws within Ontario.

PURPOSE

The purpose of this policy is to provide guidance for conducting investigations of serious occurrences (as defined by Policy # A5.01), complex issues, alleged workplace misconduct or other violations of the Association's policies, rules and standards of conduct. Investigations must ensure that events are deconstructed, understood, and documented according to what occurred. The form of Investigations may vary on a case by case basis, having regard to the individual circumstances at hand.

APPLICABILITY

This policy applies to all staff, students, and volunteers of the Association and the individuals it supports.

RESPONSIBILITY

Where appropriate, the Association will promptly initiate an investigation into serious occurrences, complex issues, possible workplace misconduct and/or violation of its policies in proportionality with the subject matter of the situation. The Executive Director or designate will have primary responsibility for investigating complaints relating to employee misconduct. In certain situations, the Executive Director may retain a third party investigator for purposes of conducting an investigation. The third party investigator must be experienced and competent to conduct the investigation and must be neutral and impartial.

SITUATIONS TO BE INVESTIGATED

The following list, while not exhaustive, provides examples of the types of situations that the Association will investigate:

1. a Serious Occurrence, as defined by Policy # A5.01
2. a complex occurrence
3. an employee workplace issue
4. where there is a need for transparency
5. where there is a request from the board or from the Ministry of Children, Community and Social Services.

EXCEPTION FOR ABUSE

In accordance with O Reg 299/10 of SIPDDA and the Association's Policy # A4.01, where the Association suspects any alleged, suspected or witnessed incidents of abuse of a person with a developmental disability may constitute a criminal offence, the Association shall:

1. immediately report the alleged, suspected or witnessed incident of abuse to the local authorities; and
2. not initiate an internal investigation before the authorities have completed their investigation.

PRIVACY AND CONFIDENTIALITY

The investigator will inform the parties that the ongoing investigation will be handled on a need-to-know basis; however, if information is learned that requires personnel or legal action, there is a potential that disclosure of this information may occur in the process.

Investigations will comply with all applicable privacy legislation and privacy and confidentiality obligations under the Association's funding agreement under the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act*, 2008, SO 2008, c 14.

INVESTIGATIVE FRAMEWORK

The Association will make all reasonable efforts to initiate an investigation into situations and conclude the investigation in a timely fashion, as appropriate.

INVESTIGATIVE TASKS

The following steps should be undertaken, as appropriate, for the particular investigation:

STEP	ACTION
1	Assess the situation and/or complaint to establish the investigative framework, namely the scope, objectives and the timelines and to selecting the appropriate investigator with regards to the circumstances.
2	Prepare for and conduct witness interviews of relevant witnesses, including the complainant and the subject of the investigation. Where conducting interviews would not be proportional to the situation under investigation, obtain statements from all parties, in writing, if possible/appropriate. Secure any publicly available reports from police or other agencies concerning the reporting (if applicable and appropriate/proportional to the circumstances).
3	Take photographs/video of any injury or damage (if applicable, appropriate and proportional to the circumstances).
4	Preserve all evidence, and secure the evidence in a locked location. Document all evidence obtained. The investigator will be responsible for maintaining the chain of custody for the evidence.
5	Determine if there is a potential for risk reoccurrence. If there is a potential, take all measures appropriate to protect staff, students, volunteers and individuals supported by the Association and property.
6	Complete an investigation report, appropriate to the circumstances, which includes a summary of relevant and necessary information, including findings.

DOCUMENTATION OF FINDINGS

Based on the investigation, the investigator should determine whether the situation was substantiated, unsubstantiated or inconclusive. This determination should be documented in writing and made part of the investigative report. The determinations are as follows:

- **Substantiated:** Where a violation of the Association's policies or workplace misconduct is found to have occurred, the subject of the investigation should be notified of the finding and of the specific or corrective actions to be taken. The subject of the investigation's Manager will also be notified if appropriate. No details about the nature or extent of disciplinary or corrective actions will be disclosed to the complainant or witnesses unless there is a compelling reason to do so (e.g., personal safety).

- **Unsubstantiated**: In this situation, the complainant and the subject of the investigation should be notified that the Association investigated the allegation(s) and found that the evidence did not support the claim.

- **Inconclusive**. In some cases, the evidence may not conclusively indicate whether the situation was substantiated or unsubstantiated. If such a situation occurs, the notification to the complainant and the subject of the investigation should state that Association completed a thorough investigation but has been unable to establish the truth or falsity of the situation. The Association will take appropriate steps to ensure that the individuals involved understand the requirements of the Association's policies, and that the Association will monitor the situation to ensure compliance in the future.

RETENTION OF INVESTIGATIVE RECORDS

Unless advised otherwise, the Association will retain records relative to an investigation for the greater of a period of seven years or the minimum retention period required by law.

RELEASE OF INVESTIGATIVE RECORDS

The Association will not release any investigative files, including interviews and findings, unless authorized by the Executive Director or designate, a statutory requirement or a court order (i.e. subpoena).

SAMPLE INTERVIEW QUESTIONS

COMPLAINANT

- What happened?
- What was the date, time and duration of the incident or behaviour?
- How many times did this happen?
- Where did it happen?
- How did it happen?
- Did anyone else see it happen? Who? What did they say? What did they do?
- Was there physical contact? Describe it. Demonstrate it.
- What did you do in response to the incident or behaviour?
- What did you say in response to the incident or behaviour?
- How did the subject of the allegation react to your response?
- Did you report this to anyone in management? To whom? When? What they say and/or do?
- Did you tell anyone about the incident or behaviour? Who? What did they say and/or do?
- Do you know whether the subject of the allegation has been involved in any other incidents?
- Do you know why the incident or behaviour occurred?
- Do you know anyone else who can shed light on this incident?

- Is there anything else you want to tell me that I haven't asked you?

WITNESSES

- What did you witness?
- What was the date, time and duration of the incident or behaviour you witnessed?
- Where did it happen?
- Who was involved?
- What did each person do and say?
- Did anyone else see it happen? Who?
- What did you do after witnessing the incident or behaviour?
- Did you say anything to the parties involved in response to what you witnessed?
- How did the complainant and the subject of the allegation react to your response?
- Did you report this to anyone in management? To whom? When? What they say and/or do?
- Did you tell anyone about the incident or behaviour? Who?
- Do you know why the incident or behaviour occurred?
- Do you know anyone else who can shed light on this incident?
- Is there anything else you want to tell me that I haven't asked you?

SUBJECT OF THE COMPLAINT

- What happened?
- If the subject denies that the incident occurred, ask:
- Is there any reason anyone would invent or lie about the incident?
- Where were you when the alleged incident occurred?
- Do you have any witnesses who can corroborate your whereabouts at the time of the incident?
- If the subject doesn't deny that the incident occurred, ask:
- When and where did this happen?
- What were the circumstances leading up to the incident?
- Who else was involved?
- What is your connection to the complainant?
- Are you aware of any other complaints by this person?
- Recount the dialogue that occurred in order of what was said.
- What did the complainant do or say?
- Is there any evidence to support your account of what happened?
- Is there anyone else we should talk to who had knowledge of the incident or the circumstances surrounding it?
- Have you talked to anyone about the incident? Who? What did you tell them?

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: RECORDS	
POLICY # A8.01 – PERSONAL FILES	
PAGE: 1 of 3	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association will maintain accurate, current, complete and confidential information for each individual supported. This personal and confidential information will be housed in a web-based case management software program (AIMs) or in a secure file housed on CLA's server as appropriate. Any documents that should be kept in its original form will be housed in a secure and locked file within the residence or service.

The Association will keep a record for each individual supported by the Association, which will include at minimum the individual's (1) application for developmental services and supports; (2) supports intensity scale needs assessment; and (3) individual support plan.

PROCEDURES:

1. **Personal Information – Original Form**
    i. Any personal information that must be kept in its original form will be maintained in a secure, filing cabinet in each service location. Filing cabinets will be locked at all times unless people are accessing the files. Keys to the filing cabinet will be kept in a secure locked key box.
    ii. All information shared with any person outside the Association will follow the Policy A7.04 Personal Information Privacy for the People the Association works for and staff (Policy A7.04 found on the CLA website).
    iii. When the individual is no longer supported by the Association, the appropriate Manager shall arrange for the appropriate storage of the files in the Association's central file storage.
    iv. An individual's files shall be retained for a minimum of seven (7) years, as legislated under Regulation 299/10 under the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008*.
    v. An individual's personal information in its original form will accompany the individual when they are no longer supported by the Association or, in the event of death, will be provided to their family or substitute decision-maker. A list of personal information supplied to the family or substitute decision-maker will be developed, signed and placed in the electronic file system.

1. **AIMS – Case Management Software/Association Server**
    i. Access to personal information shall be in accordance with the Association's other Support and Service Policies on "Confidentiality" (A8.03) and "Release of Information" (A8.02).
    ii. Personal information shall only be available to the individual supported and to those directly involved with the individual (e.g. support staff, Manager, Executive Director).

iii. The individual always has access to their personal information but they may be required to make an appointment to do so.
iv. Access and maintenance of personal information shall be the responsibility of the Manager or designate and/or other persons designated by the Executive Director.
v. Each individual supported by the Association shall have one main profile located in AIMS, with scanned documentation housed on the Association secured server. These files shall contain all information relevant to the Association's provision of supports and services.
    a. Content of personal files must comply with the Ministry of Children, Community and Social Services requirements under Regulation 299/10 to the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008*. (i.e. serious incidents reports)
    b. In cases where an individual no longer requires the support of the Association, documentation will be moved to a dormant file on AIMS and within the Association's secure server. The file will include a document indicating:
        i. Details of circumstances for discontinuing supports;
        ii. Closure of financial issues; and
        iii. Disbursement of personal property, checklist signed by individuals, their family or substitute decision maker.

4. **Review, Access to/Removal of Personal Files, Records and Information in Files.**

i. All personal files are the property of the Association and the Association agrees to treat all individuals and their files with respect:
    a. Any personal information collected with the use of technology must be maintained in accordance with PIPEDA (Policy A8.07).
    b. Any personal health information must be maintained in accordance with PHIPA (Policy # A8.08).
ii. No file, record or information contained in such can be photocopied or removed without the permission of the individual and the appropriate Manager.
iii. Access to an individual's information by their family shall only be permitted if:
    a. The individual supported is under the age of 18 years; or
    b. The individual supported is over the age of 18 years and:
        i. Has given written consent/permission,
        ii. Signed a Release of Information Form, or The parent has guardianship of the individual.
iv. Upon consideration by the Executive Director, an individual or advocate can request to have certain information in the file sealed but not destroyed.
v. An individual can have instructions or comments put in the file if they disagree with information contained in the file, but such information shall not be removed.
vi. Files, records and information shall be disposed of as follows:

a. Personal files shall be reviewed annually to determine any records to be either kept in the central office record's storage or destroyed as per the policy and procedures;
b. Hard copy records to be destroyed must be summarized, scanned and then shredded and only with the authorization of the appropriate Manager. and certain information (as indicated in Central Office Storage below) is only to be shredded, with Manager's approval, after being summarized and placed in central record storage at the main office;
c. Electronic files will be purged from the various services and placed in an electronic dormant storage system for inactive files.

UPON INTAKE

i. Ensure all information above is entered/uploaded in AIMS/CLA secure server.
ii. Ensure all risk and cautions are placed in the Risk and Cautions binder and are clearly identified in AIMS.

CENTRAL OFFICE STORAGE

ANNUALLY (May of each year)

i. Place the following scanned documents into a past year's file on the server:
    a. Bank statements
    b. Medical records of contact,
    c. MAR sheets and
    d. Annual sign offs, etc.

UPON DEATH OF AN INDIVIDUAL:

i. Remove personal information in its original form, from residence or service;
ii. Place documents in a manila envelope;
iii. Seal and label (with marker) as follows:
    a. Last name, first name, date of death (MM, DD, YYYY) (i.e. Smith, John, 11.12.2018)
iv. Include the following information:
    a. All personal identification
    b. Copy of Death Certificate
    c. Will
    d. Funeral arrangements
    e. Correspondence with family members
    f. Disbursement of personal effects
v. Transport file to main office to be placed in central storage (files are not to remain in vehicles over extended periods of time during transport).
vi. Administration will remove old files and shred according to policy.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: RECORDS	
POLICY # A8.02 – RELEASE OF INFORMATION	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

People supported by the Association have the right to expect personal information, whether in written or verbal form, to be treated with respect and in the strictest confidence and any release of such information shall be so noted in signed releases.

PROCEDURES:

1. Written authorization to release specific information is required prior to the release of any information, particularly if it is in written form, to an individual or agency outside the Association. (see attached form)
2. Each instance for which written information is requested requires separate authorization. The authorization for release must give the time frame in which the release is to be in effect and the specific information being released.
3. Authorization to release information is given by adults (over eighteen) and by the parent or legal guardian in the case of a child.
4. Consent given for any purpose must be informed consent. That is the individual giving consent must understand to the greatest extent possible what information is being released/obtained, to whom and why. The person shall be encouraged to discuss the request with family and supportive friends
5. Written authorization to share information with Association employees is not required, but such information should be treated with respect, and restricted to information that is considered “need to know” and to employees with a “need to know”.
6. Information released to other agencies/individuals, particularly if it is in written form, must be carefully screened to ensure that “third party” information (information about another person that may be contained in the original documents), is not included.
7. Written authorization to release relevant information is not required to release to:
    i. a public hospital where the person is being treated
    ii. an attending physician or dentist
    iii. a coroner or medical examiner
    iv. a court or officer of the court
8. This policy and the procedures shall also apply to photographs taken for the purpose of advertisement or other Association sanctioned reasons.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: RECORDS	
POLICY # A8.03 – CONFIDENTIALITY	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY:

The Association respects the right of people it supports and their families to privacy and confidentiality and all employees and volunteers involved with the Association shall commit to such in writing.

PROCEDURES:

1. Anyone who has contact with the person supported (Association employee, volunteers, students, members of the Board of Directors and other paid service providers) shall sign an oath of confidentiality (see attached form) upon commencing their association with the Association. Breach of this oath shall result in disciplinary action or requested resignation.
2. All records shall be maintained in a secure fashion in accordance with the relevant policies and procedures.
3. Any time a person supported is photographed, recorded or otherwise identified for purposes of publicity, the permission of the person supported (or parent or guardian in the case of a minor) shall first be obtained in writing.
4. In the situation where the Association provides individual funding in order for the person to purchase support, the Association shall support the individual to develop an Affirmation of Confidentiality for the person providing the support.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: RECORDS	
POLICY # A8.04 – PERSONAL FINANCES	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

An Individual's personal finances should not be supervised or controlled by staff, with the exceptions listed below:

i. If the person is deemed to need assistance to administer their own finances and does not have a trustworthy personal advisory, they will be referred to the Public Guardian and Trustee (PG&T), or

ii. Staff will act as an advisor and assist in control of the finances as outlined in the policy Support Policies and Procedures A2.02.

PROCEDURES

1. Team Leads or Facilitator 1's shall consult with the Individuals regarding a third party advisor or counsellor.
2. If the Team Lead or Facilitator 1 deems the Individual as incompetent to handle their own finances, they will discuss their conclusion with the manager and determine the best course of action for the Individual.
3. The Individual shall be referred to PG&T:
    i. If there are financial assets over $5,000.
    ii. If there is a conflict with the association's philosophy of person centered service delivery.
    iii. If there is a risk of conflict between the Individual and the staff.
    iv. If there is a risk for potential liability for staff involvement.
4. Staff will act as an advisory or assist in the management of finances:
    i. If the financial assets are under $5,000.
    ii. If there is not a conflict with the association's philosophy. People we support shall always have control and/or be involved in decisions regarding their personal finances.
    iii. If it is deemed by management that the PG&T controls are excessive and encumbers the Individual's lifestyle and right to choose.
5. All financial records and activities shall be kept within the guidelines and controls outlined in the corresponding policies.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: RECORDS	
POLICY # A8.05 – GUIDELINES FOR SUPERVISION & MANAGING INDIVIDUAL'S MONEY	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The association and its staff are accountable to ensure proper administration of the Individual's finances.

PROCEDURES:

1. Budgeting: Team Leads and Facilitator 1's shall assist the Individual to develop an annual budget as part of the annual ISP.
2. Individual's money must be kept in a chequing account.
3. All accounts will be under the Individual's name and the staff if approved by management be the second signing authority to verify signatures and transactions.
4. Bank statements, cheques, personal finances are reconciled monthly,
5. Managers will review and sign off the bank and financial reconciliation and Individual budgets monthly.
6. The following amounts shall be kept in trust for the Individual on site:
    a. Group Homes – no more than $200 per Individual (exception: amount may increase due to special occasions or events).
    b. Day Services – Generally discouraged but if necessary due to financial illiteracy or competence, nor more than $100 per Individual shall be kept on site (exception when day service manages monthly finances please refer to group home protocols).
7. Staff shall keep an update financial ledger and accurate account of spending money.
8. Lead Hands and Facilitator 1's shall do monthly budgets and statements for the Individual.
9. Employees shall not access money without the consent of the Individual that they support.
10. Any discrepancies shall be investigated by the person who has found the error. In the case of group home error, the error will be reported to the Team Lead via email, the Team Lead will report the discrepancy to the manager, if the discrepancy cannot be reconciled. In the day services, the error will be reported to the manager.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: RECORDS	
POLICY # A8.06 – FINANCIAL ACCOUNTABILITY TO PEOPLE SUPPORTED	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY

The association will ensure the finances of people supported shall be safe and secure. The staff supporting people with their finances will ensure the documentation of all funds.

PROCEDURES

1. Philosophy
   i. Individuals have the right to manage their own finances.
   ii. Individuals have the right to make decisions regarding their personal spending.
   iii. Individuals have the right and responsibility to plan for their future security.
   iv. The association has a responsibility to ensure that the Individual is informed of these rights and responsibilities.
   v. The association has the responsibility to assess the Individual's ability to manage their own personal finances.
   vi. The association has the responsibility to ensure that an Individual's assets are secure and used appropriately.

2. Team Leads and Facilitator 1's
   i. Ensures that Individuals are aware of their financial rights and responsibilities.
   ii. Ensures that Individuals can make informed decisions regarding their finances.
   iii. If a CLA employee deems the person to need assistance to manage their finances they will recommend the following choices:
   iv. The Individual select someone who is capable and willing to manage their finances.
   v. The Individual can choose to elect the Public Guardian and Trustee oversee their finances.
   vi. The Individual elects to have CLA manage their finances.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: RECORDS	
POLICY # A8.07 – PERSONAL INFORMATION PRIVACY FOR INDIVIDUALS SUPPORTED	
PAGE: 1 of 2	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall ensure that all people receiving support will only be used for purposes outlined in the following procedure. For the purposes of this policy and applicable legislation (Canada's federal Personal Information Privacy and Electronic Documents Act) the Executive Director is responsible for ensuring compliance with this policy and such legislation.

PROCEDURES:

5. Personal information provided to Community Living Association – (Lanark County) will only be used for the following purposes:
    a. To confirm the identity of the individuals receiving support.
    b. To determine the qualifications and eligibility of individuals to receive support.
    c. To fulfill legislated reporting requirements (such as but not limited to, ODSP, CPP, EI, Income Tax).
    d. To protect Community Living Association (Lanark County), the individuals receiving support.
    e. Staff having knowledge of the Individual's support requirements.

CONSENT

Community Living Association obtains the consent from those persons about to receive supports (to collect, store, use and exchange or disclose personal information for the above stated purposes) at the time the individual first joins Community Living through the acceptance of the service. Those individuals already receiving support will grant this consent through the publication, distribution and acceptance of this privacy policy.

COLLECTION OF INFORMATION

Community Living collects only that personal information necessary to achieve the purposes set out above, from and about individuals receiving support or about to receive support using only open, fair and lawful means.

USE, DISCLOSURE AND RETENTION OF INFORMATION

Community Living Association (Lanark County) only uses the individual's personal information for the above stated purposes unless, if for another separate purpose, separate explicit consent is obtained from the individual or unless required or allowed by law. If an individual's personal information is disclosed or exchanged with another party, such as another service provider, Community Living Association (Lanark

County) will ensure that such party accepts and will comply with the provisions of this policy and will complete a release of information form for a specified period. Community Living Association (Lanark County) will retain an individual's personal information as long as necessary to achieve the stated purposes and to comply with legislation and regulations regarding records retention. When information is no longer required to be kept, Community Living Association (Lanark County) will destroy paper files and purge electronic files in a secure way that will eliminate the possibility of information contained in such files ever being accessible to anyone else.

ACCURACY

Community Living Association ((Lanark County) will undertake its best efforts to maintain the accuracy and currency of all personal information contained in its files and will update such information promptly when advised by the individual of a change, or when Community Living (Lanark County) otherwise learns of a change.

SAFEGUARDS

Community Living Association (Lanark County) will store the personal information files of those receiving support, both paper and electronic, in files which only authorized personnel have access. The storage area will be locked filing cabinets and computer files protected by passwords. All employees and volunteers of Community Living Association (Lanark County) sign an Oath of Confidentiality on gaining employment in which they acknowledge their duties subject to this policy and subject to related legislation. Also, all members of the Board of Directors sign a similar oath.

OPENNESS

This policy is publicly posted and accessible via Community Living Association Lanark County's Internet website and paper copies are available on request to the Privacy Officer.

INDIVIDUAL ACCESS

Upon the receipt of reasonable notice, Individuals receiving support may view the paper and electronic files maintained by the Association with their own personal information. The individual may review the information contained in such files and comment on its accuracy, identify items of information not correct or not current and make specific suggestion or request for their proper revision. The individual has the right to a copy of all documents contained in the files. At no time will documents be removed from a file without the written consent of the person of whom the file belongs.

COMPLIANCE

Those receiving support may contact the Privacy Officer with questions, suggestions or opinions with regard to the Associations compliance with this policy and relevant legislation.

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: RECORDS	
POLICY # A8.08 – PERSONAL HEALTH INFORMATION OF SUPPORTED INDIVIDUALS	
PAGE: 1 of 6	**REFERENCES:**
APPROVAL DATE: 10.2019	**REVISION DATE:**
PROCEDURE APPROVAL DATE: 10.2019	**REVISION DATE:**
AUTHORIZATION: Executive Director	

POLICY

As a health information custodian under the Personal Health Information Protection Act, 2004 ("PHIPA"), the Association is responsible for personal health information under its control and custody and is committed to a high standard of privacy for their information practices in accordance with PHIPA.

All personal health information contained in supported individuals' records under the control or custody of the Association shall be regarded as confidential and available only to authorized users. Subject to specific limitations and exceptions, supported individuals (or their substitute decision maker(s)) may access their own personal health information contained in records under the custody or control of the Association following the process outlined in this policy, in conjunction with Policy # A8.02.

PURPOSE

To establish guidelines for the collection, use and disclosure of personal health information to protect the rights and privacy of individuals supported by the Association while facilitating optimal supports and services in compliance with provincial and federal legislation. The protection of privacy will not be utilized as a barrier to the provision of services and supports.

APPLICABILITY

This policy applies to the Association and all affiliates, including employees, students, volunteers, contract staff, directors and other persons who act of provide services on behalf of the Association.

DEFINITIONS

"agent", in relation to a health information custodian, means a person that, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian, and not the agent's own purposes, whether or not the agent has the authority to bind the custodian, whether or not the agent is employed by the custodian and whether or not the agent is being remunerated;

"collect", in relation to personal health information, means to gather, acquire, receive or obtain the information by any means from any source, and "collection" has a corresponding meaning;

"disclose", in relation to personal health information in the custody or under the control of a health information custodian or a person, means to make the information available or to release it to another

health information custodian or to another person, but does not include to use the information, and "disclosure" has a corresponding meaning;

"health information custodian" refers to an organization or an agent who has custody or control of personal health information as a result of or in connection with performing the organization's powers or duties. The Association is responsible for the personal health information of the individuals it supports and so are their employees as their agents;

"identifying information" means information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual;

1. "personal health information", subject to certain exceptions, means identifying information about an individual in oral or recorded form, if the information,
2. relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,
3. relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,
4. is a plan of service within the meaning of the Home Care and Community Services Act, 1994 for the individual,
5. relates to payments or eligibility for health care in respect of the individual
6. relates to the donation by the individual of any body part or bodily substance,
7. is the individual's health number, or
8. identifies an individual's substitute decision maker;

"record" means a record of information in any form or in any medium, whether in written, printed, photographic or electronic form or otherwise, but does not include a computer program or other mechanism that can produce a record;

"substitute decision maker", in relation to an individual, means a person who is authorized under PHIPA to consent on behalf of the individual to the collection, use or disclosure of personal health information about the individual;

"use", in relation to personal health information in the custody or under the control of a health information custodian or a person, means to view, handle or otherwise deal with the information.

PROCEDURE

Accountability for Personal Health Information

The Association is responsible for personal information under its custody and control and has designated individuals (a Privacy Director, Manager and Privacy Office staff) who are accountable for compliance at all Association sites.

The Association is not responsible for personal health information that is kept in a supported individual's home under the individual's control. The individual is fully responsible that their personal health information remains confidential when they have control of the documents.

Identifying Purposes for the Collection, Use and Disclosure of Personal Health Information

Persons collecting personal health information will explain to the individual who is the subject of the information, their substitute decision maker or a person who is authorized under PHIPA, the purpose(s) for which the information is being collected, subject to applicable federal and provincial laws.

The primary purposes for collection, use and disclosure of personal health information of individuals supported by the Association include, but are not limited to:

- Making decisions about the types of services required;
- Providing appropriate services and supports;
- Communicating with other service providers and agents
- Monitoring the provision of services and evaluating the response to the services provided;
- Administering quality control and risk management programs;
- Providing payment for health care, services or products;
- Billing and accounting purposes; and
- Meeting legal, and regulatory requirements

Consent for the Collection, Use, and Disclosure of Personal Health Information

Consent with respect to the collection, use or disclosure of personal health information about an individual may be express or implied. Consent must be express where:

- the Association makes the disclosure to a person that is not a health information custodian; or
- the Association makes the disclosure to another health information custodian and the disclosure is not for the purposes of providing health care or assisting in providing health care.

Where express consent is required, the Association will seek the written authorization of the supported individual in accordance with Policy # A8.02.

1. Who may Consent:

If the individual is at least 16 years of age and capable of consenting to the collection, use or disclosure of the information:

- the individual, or
- any person who is capable of consenting, whom the individual has authorized in writing to act on his or her behalf and who, if a natural person, is at least 16 years of age.

Except for specific circumstances provided by PHIPA, if the individual is a child who is less than 16 years of age, a parent of the child or a children's aid society or other person who is lawfully entitled to give or refuse consent in the place of the parent.

If the individual is incapable of consenting to the collection, use or disclosure of the information, a substitute decision maker or a person who is authorized under PHIPA to consent.

If the individual is deceased, the deceased's estate trustee or the person who has assumed responsibility for the administration of the deceased's estate, if the estate does not have an estate trustee.

A person whom a provincial or federal law authorizes or requires to act on behalf of the individual.

2. Capacity to Consent:

A resident is capable of consenting to the collection, use or disclosure of personal health information if the individual is able,

- to understand the information that is relevant to deciding whether to consent to the collection, use or disclosure, as the case may be; and
- to appreciate the reasonably foreseeable consequences of giving, not giving, withholding or withdrawing the consent.

Supported individuals, or their substitute decision maker(s), have the right to withdraw consent at any time, unless the collection, use or sharing is required or permitted by law.

<u>Limiting Collection of Personal Health Information</u>

The personal health information collected will be limited to that which is necessary for the purposes identified by the Association, or as otherwise permitted by law.

Limiting Use, Disclosure, and Retention of Personal Health Information

Personal health information may be used only for the purposes for which it was collected, except with the consent of supported individuals or as required by law.

The personal health information is retained only as long as necessary, and it is securely destroyed in accordance with applicable legislation and Association policies.

Ensuring Accuracy of Personal Health Information

The Association will make every effort to ensure the information it holds is accurate, complete and up-to-date. Supported individuals have the right to challenge the accuracy of the information.

The Association will not routinely update personal health information, unless such a process is necessary to fulfill the purposes for which the information was collected.

Ensuring Safeguards for Personal Health Information

The Association applies security safeguards appropriate to the sensitivity of personal health information to aim to protect it against loss, theft, unauthorized access, disclosure, copying, use, or modification, regardless of its format.

Protection may include physical measures (i.e., locked filing cabinets and restricted access), organizational measures (limiting access on a "need-to-know" basis), and technological measures (use of passwords, encryption and audits).

New staff and affiliates are required to complete privacy and confidentiality training and sign a confidentiality agreement as a condition of employment or affiliation. Contracted agents are bound to privacy and confidentiality as a condition of the contract.

Openness About Personal Health Information Policies and Practices

The Association makes information about their privacy policies and practices available on its website at https://www.clalanark.com/policies-and-procedures. Information provided includes:

- contact information for the Association's Privacy Director, Manager and Privacy Office, to which complaints or inquiries can be forwarded;
- the means of gaining access to personal health information held by the Association;
- a description of the type of personal health information held by the Association, including a general explanation of its use, and common examples of how the information may be shared.

Individual Access to Own Personal Health Information

Upon request, within a reasonable time and at a reasonable cost, an individual will be informed of the existence of their personal health information and will be given access to it. In order to receive access to one's own service records, a written request must be made to the Privacy Director, Manager and Privacy Office staff or delegate. Individuals can challenge its accuracy and completeness and have it amended as appropriate.

Exceptions to providing access will be limited and specific. This may include information that is prohibitively costly to provide, refers to other individuals, cannot be disclosed for legal, security or proprietary reasons, and/or is subject to solicitor-client or litigation privilege.

An individual must provide sufficient information to permit the Association to identify the existence of personal health information, including details of third-party recipients, as the case may be.

Challenging Compliance with the Association's Privacy Policies and Practices

An individual will be able to challenge the Association's compliance with the Association's policies and privacy law to the Privacy Director, Manager and Privacy Office staff. The Association has procedures in place to receive and respond to complaints or inquiries about their policies and practices relating to the handling of personal health information (Policy # A7.03). The Association will investigate all complaints in accordance with its Investigations Policy (XX). If a complaint is substantiated, the Association will take appropriate measures, including, if necessary, amending their policies and practices.

Moreover, complaints under PHIPA can be made in writing to the Information and Privacy Commissioner of Ontario at:

Information and Privacy Commissioner of Ontario
2 Bloor Street East, Suite 1400
Toronto, Ontario M4W 1A8

SUPPORT POLICIES AND PROCEDURES	
CATEGORY: RECORDS	
POLICY # A8.09 – PERSONAL PROPERTY	
PAGE: 1 of 1	**REFERENCES:**
APPROVAL DATE: 10.07.2011	**REVISION DATE: 10.05.2017**
PROCEDURE APPROVAL DATE: 10.07.2011	**REVISION DATE: 10.05.2017** **01.07.2019**
AUTHORIZATION: Executive Director	

POLICY:

The Association shall respect the personal property of the people for whom it works.

PROCEDURES:

1. All personal property owned by a person supported living in a residential family home or group home will have a personal belongings inventory completed and reviewed at least annually. The inventory will be updated as needed when the person supported purchases or is given a new item.
2. Written operating instructions and or warranties of equipment or items owned by the person supported will be kept in the person's personal file.
3. People supported will be given assistance in the operation of any equipment or items if required or requested.
4. All equipment, items and personal belongings will be maintained in good working order and or condition as recommended by the manufacture.