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COMMUNITY LIVING TEAM

The community living team delivers both residential and day supports to individuals with developmental disabilities and their families. We adhere to the policies and procedures of the Clements Centre Society that meet the standards of both CARF and Community Living BC. As appropriate our residential services also adhere to the standards outlined by Community Care Facilities Licensing through the Community Care & Assisted Living Act.

5.1 ELIGIBILITY

Principle: All programs and services provided by CCS have entrance criteria that must be met in order for service to be delivered. Referrals are accepted from CLBC as well as directly from individuals with independent funding.

5.1.1 Entrance Criteria

Procedure:
CCS supports individuals and their families who:

- Live in the Cowichan Valley–Saltair to Malahat, west to Nitinat, including Thetis and Kuper Islands.
- Meet individual program/funding criteria.

For individuals eligible for service from Community Living BC (CLBC), CLBC is responsible for determining eligibility and priority.

Order of acceptance of any person awaiting service will be based on the date of referral, entrance criteria, urgency of placement, and ability of the program to meet the needs of the individual. The Program Director is responsible for acceptance decisions.

A Community Living client:
- must be 19 years of age and older for adult services
- must be 6-18 years of age for children’s services
- must be diagnosed with a developmental disability
- may have secondary mental health diagnosis needs such as psychosis, bipolar affective
- may have a physical disability

Specific Program Admission Criteria

- Residential: An individual’s needs will be considered within the scope of the needs and existing residents, the home’s physical limitations, and available staffing.
- Children and Family Support Program: An individual’s needs will be considered within the scope of the needs of existing participants, the facility’s physical limitations, travel limitation, and available staffing.
• Adult Day Services: Individual needs will be considered within the scope of the needs of existing participants, the facility’s physical limitations, and available staffing.

- Supported Employment program is best suited for individuals who:
  - Have a vocational goal and demonstrate the skills that indicate he/she may be able to attain their stated vocational goals within a three-year period.
  - Are independently mobile with or without aids, and self-administer their own medications.

- Semi-Independent Living is best suited for individuals who:
  - Either live independently or who have the desire to do so.
  - Are able to be left on their own for periods of time.
  - Are able to administer their own medications.
  - Are able to use transportation with or without the help of another person.
  - Are able to manage the activities of daily living with minimal assistance from non-professional, in-home support staff.
  - Are able to attend a day program.

- Activation/Leisure is best suited for individuals who are:
  - Independently mobile with or without aids.
  - Able to toilet independently.
  - Interested in pursuing recreational and leisure activities both on-site and community based.

- Lunch on Clements is best suited for individuals who are:
  - Independently mobile with or without aids.
  - Able to toilet independently.
  - Still interested in training to develop skills in a cafeteria-style program.

- South Cowichan is best suited for individuals who are:
  - Independently mobile with or without aids.
  - Able to toilet independently.
  - Interested in pursuing recreational and leisure activities both on site and in community.
  - Living within the South Cowichan area.

5.1.2 Ineligibility

If an individual is not eligible for service, staff may:
• Explain the reasons they have not met the criteria.
• Refer the individual back to CLBC staff.
• Offer information about other programs or services that may be suitable.

CCS will identify reasons why individuals have not met entrance criteria, and strategically plan to identify gaps and means of filling those gaps.
5.1.3 Referral Process

Procedure:
The referral process consists of the following:

1. Initial Site Visit
   • CLBC staff and manager discuss waitlist priority regarding potential placement.
   • Manager arranges an appointment with the individual and their family/caregiver to
     arrange an orientation.
   • General information is exchanged during this and other exploratory visits.

2. Decision to Accept Service
   • Manager notifies CLBC of the individual’s decision to receive service.
   • The individual completes Clements Society’s Intake Form.

3. Transition
   • The individual, parents/caregiver, CLBC staff, manager (and executive director if
     appropriate) meet to discuss transition issues and develop a transition plan.
   • The individual, their family and manager may arrange a transition schedule that includes
     visits (may include overnight/weekend visits when a residential placement is being
     considered).
   • Manager will identify and ensure that any specific staff training needed to support the
     individual is arranged.
   • Wherever possible, and with the consent of the individual, previous and current service
     plans, assessment and any other information required to provide suitable care will be
     shared with CCS staff.

4. Emergency Placements
   • There are sometimes unavoidable situations where an individual must be quickly moved
     into one of the homes/programs, not allowing sufficient time to implement a Transition
     Plan. In this event an individual profile and any other available information should be
     provided prior to placement.

5.1.4 Intake and Orientation

Once an individual has chosen to receive service, a staff member will open a client file and
provide a thorough orientation to the program including safety measures and emergency
procedures. Staff is required to provide each individual with an orientation package (including
handbook), complete the Emergency Information Sheet and review each item on the orientation
checklist.

5.1.5 Exit Criteria

Individuals are exited from the program when:
• They request to be exited
Section 5 – Community Living

- Their goals have been met
- They no longer meet the criteria of the program
- Their needs can be better met by another service or agency
- They move out of the Cowichan Valley
- They are not making a sincere attempt to participate in their program

Once it has been decided that the individual will be exited, the manager will ensure that the following are completed as appropriate:
- File Closure Summary to the CLBC with copy to the Individual’s file.
- Personalized letter to the individual, copy to the individual’s file.
- Satisfaction Survey to the individual.

CLBC requires that a person’s residence remains available to them for up to 4 months following their move, to accommodate for temporary medical, legal or personal absence.

5.1.6 Follow-Up

Follow up information is used to assess the quality of CCS services. Clients will be contacted by telephone or mail for a brief follow-up interview six months following their exit. Survey result will be included in the data collection for CCS’s annual outcomes report.

5.2 SERVICE DELIVERY

Information Management

Principle:
Each individual who receives services will have a secure file in which information is managed.

Procedure:

5.2.1 Client Files

Once an individual is accepted into one of CCS’s programs, a client file is opened. Client files will include all forms listed on the Individual’s File Checklist.

CCS has policies and procedures in place to ensure that all client files are maintained in a confidential and secure manner. Please refer to CCS’s Confidentiality Policy for more information.

5.2.2 Record Keeping Guidelines

1. All documentation must be accurate and should be substantiated. Record facts and observations.
2. Be objective. All opinions should be clearly identified as opinions.
3. All entries must be made in pen or be typewritten.
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4. All entries must be clearly dated and signed.
5. All corrections of error must be stroked out with a single line and clearly initialled. Do not use white-out.
6. Entries must be made in chronological order.
7. Never complete charts or records for someone else.
8. Reserve red ink for changes in medication or important medical issues.
9. Forward all documents to the manager prior to distribution to the individual/CLBC etc.

Communication Logs: Entries are made on a daily basis and include the following information:
- Program related items
- Meetings, workshops, appointments (also written on the office calendar)
- CCS business
- References to information in Personal or medical Logs (seizure charts, progress notes, OT notes, Nurse’s notes, etc.)
- Work related information and inquiries
- All information that needs to be passed on to other staff

Personal Logs: Entries are to be written at the end of each shift, and include the following information:
- Health (i.e. medical information/appointments/illness or concerns).
- Behavioural information (i.e. verbal or non-verbal expressions of feeling, wishes, or desires / possible indicators of emotional/physical well-being/positive and negative responses to events or situations)
- Program (day program feedback/progress with IPP and PSP goals)
- Activities (leisure/social/family contact)
- Comments/Other information (other contacts/communication from parents/pertinent information related to the individual)

Personal and/or Medical files must also contain the following information:
- Service Plans (PSP, ISP, SP etc.)
- Personal Inventories
- Emergency information/photograph
- Healthcare information sheets
- Weight Charts (taken monthly)
- Program Information (IPP’s, contracts)
- Financial Information (banking records, clothing receipts, warranties)
- Incident Reports
- Assessments
- Guardianship and Decision Making (TSDM) information
- The identification of any individual who is restricted or prohibited from accessing the individual and or may pose a risk to the health, safety or dignity of the person in care

Residential:
- Behaviour Support Plans (if applicable)
- HCP’s
Section 5 – Community Living

- Oral HCP’s
- Nutrition Plans
- Bathing Protocols

For updating and archive information please refer to the document entitled: Record Keeping Summary

5.2.3 Service Planning

Principle: CCS services are driven by the identified needs, desires, and dreams of the individuals and families. Unless specified in the service plan, individuals supported by CCS Community Living Services require constant supervision.

Procedure:
Service Plans will:
- Be driven by the individual or their representative
- Occur within 6 months of intake
- Include participation of persons chosen by the individual
- Reflect CCS’s Vision, Mission, Values, and Principles
- Be based on individual strengths, abilities, needs, preferences, and cultural background
- Include the areas of home, social networks and community involvement, health, education and work
- Identify risks/barriers to goals and the supports needed to lower those risks/barriers
- Have clearly stated, measurable goals
- Include action plans to reach those goals
- Be reviewed and updated on a regular basis

Adult care regulations require additional plans for individuals served by a licensed facility:
- A plan for the residents health care, including nutrition, falls and any self-medication
- A plan for the residents oral health care
- A plan for the residents recreation and leisure activities
- A behavioural and safety plan as appropriate

These care plans must:
- Be completed within six weeks of the resident’s admission to the facility
- Be reviewed on a regular basis and modified according to the current needs and abilities of the resident
- Be accessible at all times to the staff who provide direct care to the resident
- Include assessments and prevention planning as appropriate

A licensee must encourage residents to participate in the development and review of their care plans. Other participants may include health care providers, therapists, family, friends, and staff. For more information see Community Care and Assisted Living Act.
5.2.4 Food and Nutrition Monitoring

In addition to a nutrition plan for each individual, each of the residences will develop and maintain a rotating menu. The menu will include meals and snacks that are nutritious and based on the Canada Food Guide.

Community Support Workers will be encouraged to maintain certification in safe food handling and will be offered ongoing education regarding assisted eating techniques as appropriate.

Manager or designate will conduct regular (annual at minimum) reviews of nutrition plans for each resident. Those reviews will:

- Use the “Meals and More” Nutrition Care Plan Checklist within 30 days of admission and annually.
- Use the “Meals and More” Menu Checklist as appropriate
- Monitor weight goals and monthly weight charts for each individual

If there are concerns resulting from the assessment or if the person in care experiences a significant weight change, the manager or designate will consult with HSCL or the physician as appropriate.

5.2.5 Quality Assurance

**Principle:** Community Living Services have established outcomes based on deliverables outlined in program contracts.

**Procedure:** CCS collects information to assure quality client centred services through the development of performance indicators and outcomes measurements. (See also Section 2). In the performance of their duties, staff collects information regarding both program and individual outcomes to determine efficiency, effectiveness and satisfaction. The program director compiles this information and submits it according to requirements.
## 5.2.6 RECORD KEEPING SUMMARY

<table>
<thead>
<tr>
<th>Document name</th>
<th>How Often Document is Updated</th>
<th>Details</th>
<th>How Long Document is Kept in Individual’s File</th>
<th>What Happens to the Document When it Leaves Individual’s File</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral or Application Form</td>
<td>N/A</td>
<td>Usually faxed to CCS by CLBC</td>
<td>As long as CCS maintains the file</td>
<td>Archived</td>
</tr>
<tr>
<td>Confirmation of Service</td>
<td>N/A</td>
<td>Completed by each program if individual is supported by more than one</td>
<td>As long as CCS maintains the file</td>
<td>Archived</td>
</tr>
<tr>
<td>Intake Form</td>
<td>N/A</td>
<td>Completed only once for each individual</td>
<td>As long as CCS maintains the file</td>
<td>Archived</td>
</tr>
<tr>
<td>Documentation (reports/letters) from Support Professionals</td>
<td>N/A</td>
<td>Ensure individual has copies if applicable</td>
<td>Until replaced with another, more recent report</td>
<td>Archived</td>
</tr>
<tr>
<td>Weekly Schedule</td>
<td>As Needed</td>
<td>An overview of individual’s schedule</td>
<td>Until updated</td>
<td>Shredded (retain most recent)</td>
</tr>
<tr>
<td>Monthly Schedule for Children’s Family Support</td>
<td>As Needed</td>
<td>An overview of individual’s schedule</td>
<td>Until updated</td>
<td>Shredded (retain most recent)</td>
</tr>
<tr>
<td>Critical Incident Reports</td>
<td>As Needed</td>
<td>For more information see Health and Safety Policies</td>
<td>One year</td>
<td>Archived</td>
</tr>
<tr>
<td>Internal Incident Reports</td>
<td>As Needed</td>
<td>For more information see Health and Safety Policies</td>
<td>One year</td>
<td>Archived</td>
</tr>
<tr>
<td>Contact Notes</td>
<td>Daily maximum, Weekly minimum</td>
<td>Refer to the record keeping guidelines</td>
<td>One year</td>
<td>Archived</td>
</tr>
</tbody>
</table>
### Section 5 – Community Living

<table>
<thead>
<tr>
<th>Document name</th>
<th>How Often Document is Updated</th>
<th>Details</th>
<th>How Long Document is Kept in Individual’s File</th>
<th>What Happens to the Document When it Leaves Individual’s File</th>
</tr>
</thead>
<tbody>
<tr>
<td>Release of Information Form(s)</td>
<td>Every six months minimum or as appropriate</td>
<td>Refer to CCS’s confidentiality policy</td>
<td>One year</td>
<td>Archived</td>
</tr>
<tr>
<td>Personal Service Plan or Self Directed Plan</td>
<td>Annually or as requested</td>
<td>Refer to My Plan package for review process. Copies to individual, CLBC, and file.</td>
<td>Until updated</td>
<td>Archived</td>
</tr>
<tr>
<td>Program Placement Rationale</td>
<td>Annually (as appropriate)</td>
<td>Refer to Supported Employment and LOC program information</td>
<td>Until updated</td>
<td>Archived</td>
</tr>
<tr>
<td>Emergency Information Form</td>
<td>Annually</td>
<td></td>
<td>Until updated</td>
<td>Shredded (retain most recent)</td>
</tr>
<tr>
<td>*Orientation Checklist *Participant Responsibilities *Confidentiality</td>
<td>Annually</td>
<td>Review information each individual received with initial orientation</td>
<td>Until updated</td>
<td>Shredded (retain most recent)</td>
</tr>
<tr>
<td>Health Care Plans Including: Oral, Nutrition, Safety, Transfer of Function</td>
<td>Annually</td>
<td>Completed in conjunction with HSCL staff</td>
<td>Until updated</td>
<td>Shredded (retain most recent)</td>
</tr>
<tr>
<td>Medication Administration Record Sheets (MARS)</td>
<td>Annually</td>
<td></td>
<td>One year</td>
<td>Archived</td>
</tr>
<tr>
<td>Personal Inventory (residential)</td>
<td>Annually</td>
<td>Compare to prior year inventory</td>
<td>Until updated</td>
<td>Archived</td>
</tr>
</tbody>
</table>
Financial Procedures

5.2.7 Banking - Residential

**Principle:** Individuals are encouraged to be involved in their own banking as much as possible. Employees provide assistance only as needed.

**Procedures:**

- A banking record is maintained for each individual. All deposits, withdrawals, service charges and interest are recorded.
- Include as much detail as possible (what the withdrawn money will be used for, which cheque was deposited, etc).
- Check the shift routines for individual banking days, levels of support required and further details.
- Individuals withdraw money from the bank based on need, some have regular weekly spending, and others keep spending money ‘on hand’.
- The amount of the withdrawal is recorded in Bank Record ledgers.
- Some individuals have money that goes into their wallets (a minimal amount, based on individual need, usually about $20 but no more than the individual is likely to spend or is able to manage independently).
- Purchases made from cash in an individual’s wallet do not have to be recorded if they are spending their money independently.
- Remaining money from the withdrawal is placed into a pouch in a locked cabinet. This is recorded in the ledger as “from bank” and the line and page number from this ledger entered into the Bank Record ledgers for that transaction.
- Receipts should be initialled and the page and line number written on them.
- Details of each transaction should be clear and include special purchases (i.e. weekly spending and new shoes).
- Major expenditures (over $20) should be from the pouch and receipts provided.

**Monitoring:**

- Client funds are counted at least weekly and errors documented in the house log.
- Managers will seek to resolve any errors. Any unresolved discrepancies are reported as an internal incident and accurate balances recorded in the ledger.
- Bank statements are reviewed by the manager or designated staff for errors or omissions.
- Statement balance and Bank Record balance should reconcile.
- Client funds are also regularly monitored by community care facilities licensing staff and agency accounting department.

5.2.8 Petty Cash - Residential

- Petty Cash is replenish-able each month.
- Cheque is made payable to Manager or Person in Charge.
- Cheque is to be cashed and money placed in petty cash box/wallet in locked cabinet.
- Full time day/evening or PIC staff will have access to petty cash.
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- Petty cash ledger sheets are kept for records – all transactions require an entry.
- All staff must obtain permission from their Manager or Person in Charge before using cash for their own meals or for any purchases over $10.
- If staff is not expected to return with change and receipt, immediately place a note in wallet listing the amount taken, use of funds, date, name, and signature of staff.
- Each person using petty cash is responsible to submit receipt, change, and to record transaction on ledger sheet.
- All purchases require receipts. Write category number on receipt and initial. Ensure date, item purchased, and amount is listed.
- Use of petty cash for staff meals requires approval of the team leader in all circumstances. Please refer to section of the collective agreement.
- Record purchases immediately on ledger sheet, allocate expenses, balance to cash, and initial.
- Number all notes/receipts per column “A” on Petty Cash ledger sheet submitted to admin.
- Verify amount on ledger with cash in wallet
- Manager or PIC will sign and submit reconciled ledger pages and receipts for reimbursement. Transfer balance to new page when page(s) submitted.

5.2.9 Client Travel Expenses

When planning client holidays, a detailed memo needs to be submitted to the Manager. These memos will then be forwarded to the Program Director for information. Please include the following:
- Name of the client and support staff taking the vacation
- Dates, destination, itinerary
- Travel costs & arrangements (van, ferry, air, extra private vehicles, cab fares, transit, etc.)
- Meal costs for the client
- Meal costs for the staff (based on Collective Agreement)
- Client miscellaneous expenses (i.e. spending money)
- Accommodation costs

Direct payment from individual to staff should be avoided as much as possible. If it becomes necessary for staff to pay for individual expenses then submit for re-imbursement – staff should submit those expenses on an expense sheet. Individuals can then reimburse the organization rather than the staff person directly.

Other Procedures

5.2.10 Vacations & Out of Town Trips

- Clements Centre recognizes the value of annual vacations for people served by its programs.
- Employees are encouraged, where appropriate, to plan out of town activities with individuals.
Section 5 – Community Living

- Employees are not obligated to accompany individuals on annual vacations. If staff choose to do so it is strictly on a volunteer basis.
- Employees accompanying individuals will be paid for regularly scheduled shifts only.
- When possible, individuals will be offered choice of volunteer staff to invite on vacations.
- Required levels of support will be at the discretion of the manager.
- While on vacation, employees will not be expected to pay transportation or lodging costs.
- Costs for activities and meals will be at the discretion of the manager.
- A written list of staff and individuals involved must be left at the facility.
- CLBC should be notified if the trip is out of province.
- The manager, with the knowledge of the program director, must approve authorization for major out of town activities and events.

5.2.11 Outings / Activities

Employees shall actively encourage the involvement of each individual in their community. Responsibility for duties is to be organized in a fashion that ensures time for activities. Cooperation and teamwork are essential to distribute an even workload amongst employees. When planning outings/activities, consider the individual and their needs, interests, spiritual beliefs, physical and emotional health in response to environment, service plan goals, personal finances, and educational opportunities. As a safeguard to both the individual and staff, minimize or avoid potential situations that could be open to speculation that the individual is being exploited (i.e. taking an individual for lengthy visits to the employee’s home on a regular basis while on duty).

5.2.12 General Information for Key Workers

Under the direction of their Program Manager, Community Support Workers may be assigned key worker responsibilities for an individual. Key workers assume the primary responsibility for a particular individual including their health, finances, and day-to-day activities. The key workers also participate in the preparation and updating of the individual’s service, health care, nutrition, and other plans. The key worker is to oversee all the listed responsibilities and delegate some responsibility to other team members. However, the overall responsibility to ensure that duties are completed remains with the key worker. Line work is to be divided amongst all clients, not specifically with the individuals staff have been assigned to as key worker.

- Monitor health, safety and well-being
- Medical appointments
- Record keeping
- Completing forms, registration, updates, reports
- Setting up, initiating and reviewing individualized plans and IPP’s
- Review and ensure financial records are in order
- Financial planning
- Ongoing activities of interest
- Vacations
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- Planning for special occasions
- Clothing needs
- Personal inventory
- Organize files
- Liaison with other agencies as required by Manager
- Act as an advocate/encourage people to advocate for themselves
- Support individuals to be involved with their family and friends and develop new relationships
- Provide opportunity for building social networks, include a meaningful contribution to the community
- Provide opportunity for daily learning, further education and skill development
- Teach rights and responsibilities

5.2.13 Person In Charge – PIC

The following shall guide the practice concerning the PIC:

- PIC must be appointed by the Program Manager, before their absence.
- Dates of PIC appointment should be communicated to payroll via the manager.
- PIC is expected to accomplish significant principal duties of the Program Manager, otherwise the PIC need not be appointed.
- PIC is appointed only when the Program Manager is away for more than 1 week.
- PIC rates will be effective from the first day the Program Supervisor is away.
- PIC position and rates will only be effective for shifts that are Monday to Friday.
- PIC shifts are preferably day shifts.

5.2.14 Duty Worker

Duty Worker Responsibilities:

- Contact on the emergency contact list, after the house manager
- Sit on the Hiring Committee
- Contact for the employee check-in
- Act as Community Living BC contact person for any queries, referrals, meetings etc. where the department should be represented
- Other duties as directed by the Program Director

Duty worker is not an on-call position. Please follow “Emergency Contact List’ for serious or life threatening situations posted at all residential sites.
Health Care

5.2.15 Access to Health Care

Principle: Individuals living in homes operated by CCS shall have access to all necessary health care.

Procedures:
- Generic services and full use of community health care resources should be utilized.
- Whenever possible, individuals should make their own appointments with the medical professional of their choice, preferably after work/day program.
- All medical and dental appointments are recorded in the individuals file. Employees will ensure that appointments are recorded and upcoming appointments are marked on the calendar.
- All medical and dental appointments are recorded in the individuals file.
- Individuals should have a regular dental check-up every six months or as directed by dentist, and a complete physical examination by a doctor annually.
- A dental or health treatment record will accompany the individual for the health care professional to complete.
- Employees must ensure that the appropriate information accompanies the individuals to the physician in order for the physician to provide treatment.
- When appropriate, key workers or other designated staff should accompany individuals to their appointment and make notes of any recommendations, suggestions, etc.

Surgery: The manager / key worker should:
- Consult with the doctor and/or nurse to obtain accurate information regarding the medical procedure recommended.
- Discuss the procedure with the individual and provide as much information as possible.
- Contact the parent/guardian and CLBC staff to explain surgical requirements.
- Obtain the appropriate consents.
- Notify the Program Director and document in the individual’s file.
- Complete the appropriate incident reports.

5.2.16 Guidelines for Bathing and Personal Care

Principle: In collaboration with the adult, their family and support network, appropriate guidelines will be developed and documented in individual personal care plans.

Procedures:
The Community Care and Assisted Living Act include guidelines intended to assist adult community living services staff and contracted service providers to support an individual with a developmental disabilities; when requests are made for privacy, when bathing, or when providing assistance with other personal care activities that may involve risk to the individual.
Each care plan will acknowledge the individual’s personal preferences, clearly address identified risks, include any personal care issues (real or potential) that require additional safeguards and document the measures that will be undertaken to minimize those risks and promote safe bathing and personal care practices for the individual. The plan will also identify any equipment requirements, training needs or reassessment schedules needed to manage any identified risks. For more information please refer to the Community Care and Assisted Living Act.

5.2.17 Hospital Admission

Principle: To plan for the safety and security of individuals who require hospitalization, Clements Centre collaborates with hospital staff.

Procedures:  
The manager is responsible for informing CCS Program Director, CLBC, Licensing, and the HSCL nurse, where applicable, of all hospital admissions.  
− The manager contacts the hospital social worker for the unit in situations where there will be a requirement for staffing exceptional to the existing levels. The social worker will be informed of the person’s care requirements for activities of daily living i.e. mealtime assistance, toileting, grooming, mobility, and exceptional needs i.e. behavioural issues, monitoring requirements, communication, safety concerns (inability to call for assistance, specific medical support need etc.).
− The patient is assessed to establish the need for care facility staff members to stay with the patient by the unit manager or unit social worker in conjunction with the group home manager.
− Hospital staff members complete the form “Authorization for Staff to Support Adults with Developmental Disabilities”. She/he notifies the group home manager who then arranges the care required. Nursing staff members document the presence of group home caregivers in the progress notes.
− If families are available and wish to be on site for a portion of the day, and are able to provide the activities of daily living support, this may be taken into consideration as part of the staffing plan.
− Upon discharge, the home manager sends the completed form and the number of hours of care staff provided, to CCS administration for re-imbursement.

Behavioural Support Strategies and Guidelines

5.2.18 Guidelines for Responding to Challenging Behaviours

Principle: Clements Centre staff use behavioural supports that are positive, respectful, individualized and least restrictive.

Procedures:  
• CCS has adopted CLBC guidelines for the use of Behavioural Techniques.
• Attempt to identify the environment antecedents and communicative functions of the behaviour.
• Avoid subjective and negative assumptions about behaviours.
Avoid inadvertently encouraging the behaviour by continually commenting on the behaviour to the individual or telling the individual not to do it.

Encourage any approximation of a positive behaviour.

Record any incident, including as much information about antecedents, what behaviour occurred, outcomes and recommendations for future reference.

When the intent is to reduce dangerous behaviours, the method used shall be specified in a formal, systematic, and written Behavioural Support and Safety Plan.

Process for the use of a Behavioural Support Plan:

1. Identify the need for a behavioural Support Plan or Crisis Prevention Strategy.
   - It is often difficult to determine the causes for a person exhibiting challenging behaviour. It is imperative, firstly, to ensure that it is not a result of physical health problems. For this reason, a full medical and medication review must be initiated by the Manager prior to the institution of any behaviour management intervention. Secondly, behaviour must always be viewed as a form of communication (e.g. “I don’t want to be here” or “I don’t like my roommates”). A review of an individual’s overall life situation must be initiated by the Manager before a behavioural plan is put into place.
   - Individuals with a history of suicide attempts or threats, will have written plans to guide support.

2. Using CCS’s template, develop a plan with:
   - the individual
   - their representative (if applicable)
   - their family (if the individual wishes)
   - their key worker (and other staff if applicable)
   - CLBC staff
   - Behavioural Consultant (if appropriate)
   - Physician (if appropriate)

   For the purposes of identifying protocols for various behavioural techniques, there are three levels of interventions identified and outlined in the Community Care & Assisted Living Act.

3. Obtain required authorization. When supporting children, this authorization must be from the family/guardian.
4. Distribute the plan with a copy to the client, the client’s file, the Program Director, and the family, with individuals consent.
5. Arrange monitoring methods and regular, planned reviews.
6. Arrange staff training as required.
5.2.19 Guidelines concerning Sexuality

Principle: CCS recognizes that all persons have the right to full expression of their sexuality.

Procedures:

- The CCS affirms that sexuality should be viewed in the total context of human relationships. These include gender identity, friendships, self-esteem, body image and awareness, emotion and spiritual development, and social behaviours expressing love, affecting and physical desires.
- All persons served by the CCS will be treated as unique individuals in the context of their sexuality. All such persons have the right to love and be loved and to develop a variety of friendships and emotional relationships with others.
- The CCS will promote appropriate socio-sexual interactions through ongoing training programs in both residential and vocational services.
- CCS staff will serve as appropriate role models through their behaviour, attitudes and guidance while on the job. CCS staff will be responsible for supporting individuals to develop healthy and appropriate expressions of their sexuality.
- Under no circumstances should any CCS staff restrict or regulate any individual for behaviours that express their sexuality, unless the behaviour contravenes legal restrictions, public mores or the best interest of the individual. These best interests would include health, safety, security, and societal acceptance.
- Under no circumstances should the personal feelings, moral standards, values, or beliefs of any CCS staff be involved in counselling individuals regarding the appropriateness of their sexual expression or desires. Specifically, no individual shall be advised to alter or dissuaded from expressing their sexual orientation, gender identity, choice of partner, or environment of expression, unless the health, safety, security or societal acceptance of the individual is thereby put at risk.

5.2.20 Guidelines Concerning the Use of Alcohol (for those receiving services)

Principle: The Clements Centre Society promotes a healthy lifestyle for the people served in its programs, including issues surrounding the consumption of alcohol.

Procedures: All CCS staff is reminded that personal choice in this matter is paramount. However, because of issues relating to health, safety, and liability, the following guidelines are suggested:

- Persons receiving services should be encouraged to consider alternatives to alcohol consumption, and such alternatives should be provided in social situations.
- Staff should be aware of, and prepared to intercede in, situations where peer pressure may unduly influence individuals who may prefer not to consume alcohol.
- Staff should be aware of the cumulative effects of consuming alcohol and personal medications, and advise persons receiving services of any risk to the individual from such behaviour.
Section 5 – Community Living

- Where a situation exists that a person receiving services is obviously impaired by the consumption of alcohol, staff must take measures to ensure that person’s safety and security, without restricting the person’s human rights.
- If substance abuse is suspected, staff should attempt to arrange a referral to the appropriate counselling service.
- Staff should educate persons receiving service about the laws and regulations governing alcohol possession and consumption.

5.2.21 Guidelines concerning displays of affection

**Principle:** Clements Centre Society promotes interactions between staff and clients, which convey empathy and caring.

**Procedures:**

- Interactions should be authentic, natural and initiated by the individual. They should also be comfortable for both staff and for the individuals they support.
- Consideration should be given to the individual’s age, physical and emotional maturity.
- Interactions should be individualized; specific guidelines for touch may also be referenced and clearly outlined in individual service or care plans as appropriate.
- Expressions of affection between staff and individuals supported should never be sexual in nature, or likely to be perceived by observers as sexual in nature.
- A plan for dealing with the issue of expressions of affection should be discussed among the larger working team if there are areas of ambiguity or discomfort.
- All incidents involving the initiation of sexual touch will be reported to the manager to ensure adequate planning to address the issue and protect the individuals involved.
5.2.22 VIOLENCE IN THE WORKPLACE – RISK ASSESSMENT

The following questions should be used to determine the risk of violence that staff may be subject to in their worksite. The Supervisor is responsible for answering these questions in writing, preparing crisis prevention strategies, and ensuring that all staff within the site (regular and casual) understands the information and the protocol.

1. Does this person have a history of aggressive behaviours?
   (a) No - There is little risk of injury from violence associated with working with this individual. Prevention should be exercised by ensuring choices are provided and treating the individual with dignity and respect.
   (b) Yes - Go to 2 (Prepare Crisis Prevention Strategies)

2. Has the behaviour been recent?
   (a) No - There is little risk of injury from violence associated with working with this individual. Care should be taken to inform new staff of the individual’s history and circumstances around their aggressive behaviours. Staff should also be apprised of the methods that were used to eradicate the behaviour.
   (b) Yes - There is a risk of injury from violence or aggressive behaviour that is associated with working with this individual or in this worksite. Staff should be apprised as to the level of risk (low, moderate, high) and of the items outlined below: (Crisis Prevention Training is recommended).

3. Provide a description of the behaviour.
   What is the staff person likely to expect? e.g. striking, grabbing, biting, hair pulling, kicking,….

4. How often does the behaviour occur?
   e.g. daily, weekly, monthly, or?

5. Describe the warning signs?
   e.g. wringing hands, red face, raised voice or does the behaviour come seemingly unprovoked?

6. When is the behaviour likely to occur? Things to consider:
   (a) menstrual cycles
   (b) changes in routines (i.e. new work situation)
   (c) change in plans (i.e. outing cancelled)
   (d) when required to do a specific task (i.e. hygiene routines)
   (e) a particular time of day

7. Who is it likely to happen to? i.e.: Does the individual target particular people?
   (a) people of small/large stature
   (b) people of a specific group (i.e.: age/race)
   (c) members of the opposite/same sex
   (d) specific staff members
   (e) the staff or person in closest proximity
   (f) or ____________________________
VIOLENCE IN THE WORKPLACE – RISK ASSESSMENT

8. Where is the behaviour likely to occur?  
   e.g. home, parents home, work, specific rooms, in the community, specific situations.

9. Why does the behaviour occur?  (identify specific triggers)  
   (a) communication  
   (b) frustration  
   (c) transition

10. What is the appropriate response from staff when there are warning signs that an aggressive incident may ensure?  
    Is there any way a staff person can avoid the escalation of behaviour?

DURING AND AFTER THE INCIDENT:

11. What should the staff do to keep themselves and others safe?

12. Is it necessary or advisable to call the Police or Ambulance?

13. Once everyone is calm, how should the staff deal with the client?

14. Who should be contacted and when?

5.2.23 MEDICATION

Practice:  CCS will provide staff with an orientation and training on the storage, distribution and administration of medications.

Procedure:  Medications will be stored, distributed and administered according to procedures.

Medication Refills
Pharmacy prepares MARS & blister packs for regular medications each month. Staff is responsible to pick these up on the last 2 or 3 days of each month.  
Administer medications to one client at a time.  
Compare each new & old blister pack and MAR’s for:
   • Name of individual  
   • Medication name  
   • Concentration (i.e.: how much medication in pill, ml of liquid, etc.)  
   • Dose (i.e.: quantity person is to receive 1 tab, 2 tabs, 30 mls., etc.)

➢ If either MARS or blister packs are different clarify any differences with pharmacist before placing the blister packs in the med rack.
➢ Once the MARS and blister packs are determined accurate place blister pack into appropriate coloured geri-card, complete administration times in MARS and d/c appropriate medication, and then onto individual’s med rack.
Changes in Orders & New Orders

• When the doctor changes medication orders or makes new orders, ask him to phone the pharmacist or write a prescription (attending staff must submit to Pharmasave).
• Upon receiving the new or changed medication, the staff must add the new label to the individual’s MARS & insert the blister pack into the appropriate coloured geri-card and place in the individual’s med rack. D/C old medications from prescription (Rx.) date.
• Double check the doctor’s order & medication label. *If different, do not administer:* clarify with the pharmacist. Inform manager.
• Double check that the MARS does not contradict doctors instructions (i.e. allergies). *If there is a contraindication Do not administer.* Contact the pharmacist and request that the pharmacist get clarification from the prescribing physician. Inform manager.
• Do not place labels for new or changed medications over existing entries on MARS. If necessary, start a fresh MARS. Extra sheets are available from pharmacy & should be kept in MARS book.
• Do not alter directions, add or remove medications to the MARS, this is done exclusively by the pharmacy. They will provide new labels.
• When a new medication is ordered, draw a straight line from the start of the MARS to the current date & enter an “0” for ordered.

Adverse Reactions

When a new medication is ordered:

• Review the medication information sheets provided by pharmacist or www.healthlinkbc.ca and provide to staff for their review.
• Monitor the individual closely for the first 24 hours after starting a new medication for signs of reaction.
• If a severe or anaphylactic reaction occurs, call an ambulance immediately.
• For any other drug reaction or potential drug reaction, the pharmacist should be notified immediately. The interaction will be treated in accordance to the pharmacist’s orders. If the reaction is noted after business hours, contact the 24 hour HealthLink BC support by calling 811.
• As soon as possible, arrange for an appointment with the individual’s physician.
• Complete appropriate documentation.

Additional information:

• Most allergic reactions occur within hours to two weeks after taking the medication and most people react to medications to which they have been exposed in the past. This process is called "sensitization."
• Symptoms of adverse reactions are often the same as a drug allergy and may include:
  - Rashes, bruising, and bleeding problems
  - Difficulty breathing
  - Nausea/vomiting
  - Constipation or diarrhea
  - Lowered blood pressure, resulting in headache, dizziness, ringing in the ears, and blurred vision
  - Confusion or sleepiness
One of the most severe allergic reactions is anaphylaxis (an-a-fi-LAK-sis). Symptoms of anaphylaxis include hives, facial or throat swelling, wheezing, light-headedness, vomiting and shock.

Most anaphylactic reactions occur within one hour of taking a medication or receiving an injection of the medication, but sometimes the reaction may start several hours later. Anaphylaxis can result in death, so it is important to seek immediate medical attention.

**Discarded Medications**

All unused medications are returned to Pharmasave at the end of each for return. Record all meds returned to the Pharmacy—record staff name, date, which meds, how many and reason. Some reasons for return may include discontinuation, expiry date has passed, missed or refused meds, and contaminated meds or individual is no longer served by a particular program.

**Stop Orders**

Inform the pharmacy when:
- Medication has been completed.
- Doctor indicates individual discontinue the medication.
- Enter a ‘D’ on MARS and draw a single line through MARS to the end of the month.
- Pharmasave will then remove Information from the individual’s MARS for the following month.

**PROCEDURES FOR DISPENSING AND ADMINISTRATION**

**Dispensing and Administration**
- Dispense medications for **ONE INDIVIDUAL AT A TIME**
- Dispense medication from blister pack directly into med cup &/or remove treatment from cabinet.
- Enter a dot on the MARS to indicate medication has been dispensed.
- Do not leave medication unattended. Once dispensed do not put medication down.
- Never leave medication cabinet open and unattended.
- When administering make sure the meds are ingested before signing MARS.
- Inform doctor & pharmacy of any allergic/ adverse reactions.
- **Do not** sign for meds that another person has administered
- **Do not** prepare meds for another person on shift to administer.

**Individuals Self-Administration of Medications**
- Individuals must be supervised and assisted by an employee throughout the procedure.
- Employee to mark “other” on the MARS.
- Complete reverse side of MARS.

**Outings**

1. Dispense med into labelled envelope with
   - Name
   - meds enclosed, concentration, dosage
   - time & date to be administered
   - staff signature
   - contact phone number
2. Seal the envelope.
3. Chart MARS with appropriate notation then initial.
4. If med is not administered this is to be documented on back of MARS, in personal log & in
medication log.

**Home visits/ Vacations**

If staff is accompanying:
- Take the entire med pack & MARS with the individual; dispense, administer & sign according to procedure.
- Ensure that the extra meds are on hand in case of emergency (3 day supply).

If no staff is accompanying:
- **Package meds into labeled bottles or envelopes as described above & give to the person responsible for administering.**
- Chart MARS with appropriate notation.

**PRN’S (as needed)**
- Always know why a PRN has been prescribed; PRN’s must have protocols written by HSCL and signed by GP.
- Pharmacy is to be informed of all PRNs & will indicate such on MARS.
- **Record administration of PRNs on the front & back of MARS as well as in the individual’s personal or medical log. Ensure that med, date, & time, reason & results are recorded.**
- Check how often PRN may be administered & the time & date of last administration.
- Pre-packaged PRNs carried on a regular basis for the individual which have been dispensed and not administered (with expiry date, name of individual, med, dosage & instructions and date dispensed, will be returned to med cabinet at end of outings.
- All discontinued or expired PRN’s will be returned to pharmacy within 30 days.

**Recording Medications**
- Initials used to sign for medications on front of MARS must be accompanied by written signature (including first initial & last name on back of MARS
- White out is not allowed, if an error is made, place a single line through it, write error your initial, record in detail on back of MARS.
- Utilize the chart notations on the lower right hand corner of the MARS & make a note on back of MARS and the personal logs to explain.

**Missed/ Vomited Medications & Administration of Wrong Medications**
Med times may be varied by 1 hour to accompany meals or bedtime, unless specifically stated otherwise (i.e.: 1 hour before meals or 2 hours after meals).

- **FORGETTING TO GIVE MEDICATION OR NOT FOLLOWING PROCEDURE IS NOT ACCEPTABLE**

If a medication is missed or vomited use your judgement (i.e.: missed foot powder vs. missed anticonvulsant), THEN:
- Phone Pharmacy or Hospital for further instructions.
- Document on MARS using chart notation.
- Document in personal log.
- File a Medication Incident Report or if missed med results in hospitalization, file a Critical Incident Report and inform manager.
- Follow Emergency Procedures if necessary.
- If a wrong med is administered to the wrong person, follow steps above.
Refused Medications

- Explain to the individual what the med is and what it is for.
- Offer the med again in 15-minute intervals for 1 hour.
- Follow procedure for missed medication.
- Place in envelope & label for return to Pharmasave at end of month.
- Document on MAR’s.

Contaminated Medications

- If a med has been dropped on the floor, or has become wet, or is destroyed, replace it with the one for the last day of the month from the blister pack.
- Advise Pharmasave & they will replace the med.
- File a medication incident report.
- Follow the recording procedure for missed medication.
- Place contaminated med in envelope and label.
- If you don’t have access to a replacement, use your judgement. (Consider the effect of giving a contaminated med vs. not giving any medication at all)

Medications at Vocational Sites

- When an individual must take medication at their day program & is unable to self medicate, it is the responsibility of the day program staff to administer meds.
- All medication must be clearly labelled. A separate envelope/container must be provided for each medication.
- All errors/missed meds must be documented & reported to the residential service provider.

Admission to Hospital

- On a resident’s admission to hospital contact the manager.
- Take MARS to hospital with resident.
- On the resident’s admission to hospital the blister packs will be reversed in the holder.
- File a Critical Incident Report.

PROCEDURES FOR TRAINING AND EDUCATION

- CCS staff will be provided with a thorough orientation on the storage, distribution and administration of medications that meets industry standards.
- Training specific to the needs of individuals served will be provided on an as-needed basis.
- Training will be offered in response to Medication Error Incident Reports as appropriate.

PROCEDURES FOR MEDICATION MONITORING

Manager or designate will regularly (monthly at minimum) conduct a medication review that includes the following:

- MARS (signature on reverse accompanies initials)
- Medication error reports
- PRN usage (see more below)

Any concerns arising from the review will be brought to the attention of the program director for planning.

PRN Review Procedure

- Check and count PRN medications (tablet and pill forms) during monthly medication review
- Record numbers on Medication Administration Records (MARs) labels for each individual
- Compare present and previous month; compare to actual PRN usage
• Report discrepancies between recorded usage and actual count on internal “medication incident report” forms as PRN shortage.
• Report discrepancies in any medications containing controlled substances (such as codeine or morphine) on internal “medication incident report”, inform Manager and provide copy to Program Director.

**Medication Safety Committee**

CCS Residential Managers attend Medication Safety Committee meetings at least annually to monitor medications.

The Medication Safety Committee members include:

- The distributing Pharmacist
- Representation from Health Services for Community Living
- Managers of the 3 residential programs

Minutes and inspection records are maintained by each residential facility.

The committee will establish and review:

- Policies and procedures for the safe and effective storage, handling and administration of medication
- Training and orientation programs for staff members who store, handle or administer medications
- Policies and procedures for immediate response to and reporting of medication errors and adverse reactions to medications
- Liaison/communication between all parties

**AUDIT:** MARS

- Incident Reports – Medication and Critical
- Medication Safety Committee Minutes and Inspection Reports
- Orientation agendas and attendance lists
- Training Records

---

Supporting Legislation:
Community Care Facilities Licensing Act
Ministry for Children and Family Development – Community Support Services Policy Manual
To: Community Living British Columbia

From: CCS Community Living Services

Date:

This is to confirm that ____________________________ has chosen to participate in CCS Community Living Services.

Please forward written information that is necessary to develop an individualized community based plan. All information is kept confidential as outlined in CCS’s Confidentiality Policy. The information requested is:

- Service Plan
- Health and Safety concerns
- Any additional supports to help meet the challenges or needs are to be taken into consideration (medical, physical, emotional or behavioural)
- Any other information necessary for developing an individualized service plan.

Name: ____________________________ D.O.B. (M/D/Y): __________

I give my consent for the Community Living British Columbia staff to share the above information about me with:

CCS Community Living Services

Signature: ____________________________

Date: ____________________________

Witness: ____________________________
CL2 Individual File Checklist

Name: ____________________________________________________________

Date Referral Received: ____________________________________________

Date File Opened: _________________________________________________

Program Name: __________________________________________________

Annual Review Date: ______________________________________________

Sections 1 – 2: When opening a file, please initial to acknowledge that the following forms are completed and included in the file. Sections 3 – 6: Please initial as completed.

Open File

Section 1
_______ Referral or Application Form
_______ Confirmation of Service / Request for Information
_______ Intake Form(s)
_______ Client Orientation Checklist
_______ Participant Responsibilities
_______ Understanding Confidentiality
_______ Program Placement Rationale (if applicable)

Section 2
_______ Client Profile / Emergency Information Sheet
_______ Consent to Release Information
_______ Weekly Schedule

Section 3
_______ Self Directed Plan Review
_______ Self Directed Service Plan(s)

Section 4
_______ Contact Notes & Correspondence

Section 5
_______ Reports / Plans (Behaviour Support, Health Care, Nutrition, MAR, CIR, etc.)

Section 6
_______ Program Specific Information

Closed File (to be placed in section 2)
_______ Closing Form and Letter
_______ Exit Survey

____________________________________         ___________________
CCS Staff Signature      Date
Section 5 – Community Living

CL3 Client Orientation Checklist
Please initial to acknowledge that you have explained to the individual the following, and file in the individual’s file.

General Orientation Folder

__________CCS Handbook
__________Vision / Mission / Values / Principles
__________Connector
__________Board of Directors/Managers List
__________CCS Historical Timelines and History
__________Website

Adult Services Orientation

__________Community Living Services Handbook
__________Your Rights Book
__________Participant Responsibilities

Tour of Clements St. Building

__________Emergency Exits
__________Fire Extinguishers
__________Emergency Procedures
__________Introductions to Staff and Programs
__________Washrooms
__________Telephone
__________Regular Business Hours
__________Mail Room

Tour of Other Sites (if applicable)

__________Campbell
__________Ryall
__________Marchmont
__________SouthEnd
CL4    File Closure Summary

Date: __________________________________________
Name: __________________________________________
Program: __________________________________________

Reason for Closure:

☐ Goals have been met
☐ Individual has moved from catchment area
☐ Individual has chosen to leave the program
☐ Individual’s needs would be better met by another service
☐ Individual’s attendance in this program poses a health or safety risk that cannot be accommodated
☐ Individual no longer meets entry criteria
☐ Other __________________________________________

Additional information:

☐ Notification of file closure was provided in the form of a personalized letter addressed to the individual with a copy to client file and CLBC.

☐ Individual was offered the opportunity to participate in a Satisfaction Survey.

______________________________________________
Signature of Program Staff
Date:

Name:
Address:

Dear ______________________,

This letter is to inform you that, after talking with you, your Program file has been closed. (Personal comments here).

I have informed your Facilitator at the Community Living British Columbia office of your exit from the program. If, in the future, you wish to reopen your Program file, please contact your CLBC Facilitator.

The staff has enjoyed working with you and wish you luck in the future. Please remember, you may always use the Program as a resource.

At Clements Centre Society we work to provide the best possible service to everyone. Your feedback helps to ensure that our services are the best they can be. Could you please fill out the survey that we have included with your exit letter at your earliest convenience? There is also a stamped envelope, so returning the survey will not cost you anything. You may also drop it off at the CCS building if that would be more convenient. Your opinions will be used to assess and improve our programs.

Sincerely,

Name:
Position:

cc: CLBC Facilitator
### My Self Directed Service Plan

**My Name Is:**

**Attending:**

**Date:**

<table>
<thead>
<tr>
<th>My Goals:</th>
<th>I am good at (strengths, abilities, skills):</th>
<th>What is in the way of my goals (barriers) and/or what risks are there to my health, safety, lifestyle?</th>
<th>What needs to be done so I can reach my goals and/or lower the risks (methods, strategies, or accommodations):</th>
<th>Who will support me? (supports)</th>
<th>How will we know if I have reached this goal?</th>
<th>When and how often will we review?</th>
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<tbody>
<tr>
<td>HOME (How I live and would like to live): Personal satisfaction with current home Future living plans Personal satisfaction with supports and activities within the home Skills that would be helpful to maintain or increase independence at home i.e. budgeting, shopping, handling emergencies, personal care Financial/legal matters Guardianship/Committee ship Culture</td>
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<td>MY PERSONAL AND SOCIAL LIFE: Personal satisfaction with social networks Important social contacts Communication at home, work and in community Maintain or build relationships Culture</td>
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### Section 5 – Community Living

| GETTING INVOLVED in the Community: |  |  |  |
| --------------------------------- |  |  |  |
| Personal satisfaction with community involvement |  |  |  |
| Hobbies or person interests |  |  |  |
| Leisure, recreational, spiritual interests |  |  |  |
| Transportation |  |  |  |
| Culture |  |  |  |

| HEALTH: |  |  |  |
| -------- |  |  |  |
| Personal satisfaction with health and health supports |  |  |  |
| Any physical or mental health care issues |  |  |  |
| Current health care supports |  |  |  |
| Culture |  |  |  |

| WHAT ABOUT WORK/EDUCATION: |  |  |  |
| -------------------------- |  |  |  |
| Personal satisfaction with education, work |  |  |  |
| Interests and skills |  |  |  |
| Future career plans, Skills to be learned |  |  |  |
| Culture |  |  |  |

| MY PLAN IS EASY TO UNDERSTAND. |  |  |  |
| ------------------------------- |  |  |  |
| For me |  |  |  |
| For people supporting me to reach my goals |  |  |  |
| I have reviewed information about my rights, confidentiality, and complaints. |  |  |  |

I understand and accept this plan: ________________________________

Date: __________________________
## BEHAVIOURAL SUPPORT PLAN

<table>
<thead>
<tr>
<th>GOAL desired outcome</th>
<th>DESCRIPTION OF BEHAVIOUR</th>
<th>ANTECEDENT (A list of the preceding events/situations/triggers typically observed prior to the target behaviour)</th>
<th>ESCALATING BEHAVIOURS (A complete description of the behaviour at various stages)</th>
<th>STRATEGIES (A detailed description of strategies/proven methods of redirection. Document in order from least restrictive)</th>
<th>AUTHORIZATION</th>
<th>REVIEW DATE (Plans must be reviewed and revised at least annually)</th>
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Individual: ____________________________  Date: ____________________________
CL8 Understanding Confidentiality

CCS keeps records about individuals and families, and the services and supports provided. It is important that each person/family understands this and how files and information is kept confidential and shared.

I understand that:
1. A file in my name will be kept for the services that CCS provides to me. This file is locked for my protection.
2. I can ask to see my file at any time and a time for this will be arranged within five working days.
3. All CCS staff and volunteers have signed a confidentiality agreement – they must keep my information private.
4. If I have concerns about the privacy of my information, I can follow conflict resolution steps.
5. CCS staff will share information between programs on a need to know basis. This means that staff will only share and discuss information that is necessary to provide you service.
6. I can choose what information I would like talked about in my planning meeting. There may be very private topics that I do not want to discuss with the whole group. I can choose to discuss this private information with only the people I choose.
7. There are times when staff must share information:
   • When there is a court order or written policy.
   • When staff have to protect the health, safety and well-being of me or someone else.

____________________________________________________________________
Participant Signature                                           Date
____________________________________________________________________
Representative Signature                                    Date

I have explained this form to the best of my ability.

____________________________________________________________________
Staff Signature                                                     Date
### CL9 Weekly Schedule

<table>
<thead>
<tr>
<th></th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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<tbody>
<tr>
<td><strong>Morning</strong></td>
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<td><strong>Lunch</strong></td>
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<td><strong>Afternoon</strong></td>
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<tr>
<td><strong>Supper</strong></td>
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<td><strong>Evening</strong></td>
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<td>GOAL:</td>
<td>PROGRESS:</td>
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### Section 5 – Community Living

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<th>GOAL:</th>
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<th>PROGRESS:</th>
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</table>
CL11  Consent to Release Information

With your consent the Clements Centre Society will only release information:

➢ That we wrote
➢ To the people who you choose

I, _________________________________  D.O.B (M/D/Y): ____________

Give my consent for Clements Centre Society staff to share the following information:

______________________________________________________________________________
______________________________________________________________________________

(Type of report or specific information)

only to:

______________________________________________________________________________
______________________________________________________________________________

(Agency and/or person who will receive the information)

Effective from: (date) _______________________ to ___________________________

Client Signature: _______________________________________________________________

or

Representative’s Signature: _______________________________________________________

Date: _________________________________________________________________________

Staff Acknowledgement: I have explained this form and its meaning to the best of my ability.

Staff Signature: _______________________________ Date: __________________________
Section 5 – Community Living

R1 Residential Intake Form

Name: ___________________________________  Date of Birth: ________________________
Personal Health No. ___________________________  S.I.N.: ___________________
Family/Caregiver Home Address: ____________________________________________________
________________________________________  Phone Number: ______________
Primary Contact Person: ___________________________________  Relationship: _______________
Phone Number: _____________________________  Address:  __________________

Alternate Contact Person: ___________________________________  Relationship: _______________
Phone Number: _____________________________  Address:  __________________
________________________________________________________________________
________________________________________________________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone</th>
<th>Fax</th>
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</thead>
<tbody>
<tr>
<td>CLBC Staff:</td>
<td></td>
<td></td>
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<tr>
<td>Family/Advocate:</td>
<td></td>
<td></td>
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<tr>
<td>Physician:</td>
<td></td>
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<tr>
<td>Dentist:</td>
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<tr>
<td>Psychiatrist</td>
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<tr>
<td>Specialist (specify):</td>
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<tr>
<td>Physio/Occup Therapist</td>
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<tr>
<td>Counsellor:</td>
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<td>Financial Assist. Worker:</td>
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<tr>
<td>Day Program:</td>
<td></td>
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<tr>
<td>HSCL Nurse:</td>
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<tr>
<td>DDMHST Contact:</td>
<td></td>
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<tr>
<td>Probation Officer:</td>
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<tr>
<td>OTHER:</td>
<td></td>
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</tbody>
</table>

Is or has there been any involvement with the POLICE? ______ Describe: ________________________

REASON FOR ADMISSION:

________________________________________________________________________

TRANSITION PLANS: (If known)

________________________________________________________________________
Section 5 – Community Living

Date of Transition:

______________________________________________________________________

Transition Address:

______________________________________________________________________

Reason for Transition:

______________________________________________________________________

**ADMISSION:** (Please complete as much as possible prior to admission)

**GENERAL HEALTH HISTORY:**

DIAGNOSIS: ____________________________________________________________________

ALLERGIES: ____________________________________________________________________

Health Care Plan attached: Yes No

MEDICATIONS: (Special consideration i.e., w/juice, yogurt, etc.)

HEALTH CARE ISSUES/MEDICAL CONCERNS: (epileptic, diabetic, cardiovascular diseases, etc.)

SPECIAL CONSIDERATIONS/TREATMENTS:

Protocol attached: Yes No

Seizure History:

Seizure Precautions:

Last T.B. Test (skin or chest x-ray) ___________ positive ___________ negative ___________

Last Hep B Test ___________ positive ___________ negative ___________

Doctor: _____________________________ Last Appointment: ____________

Psychiatric Concerns:

________________________________________________________________________

________________________________________________________________________

CCS practices UNIVERSAL PRECAUTIONS – are there any known communicable diseases that we should be informed of to protect the health and safety of all residents and staff?

________________________________________________________________________

________________________________________________________________________

**BEHAVIOURAL ISSUES:**

(wandering, depression, aggression, noisy, self-injurious, obsessive, sexually inappropriate, SUICIDAL, etc.)

Describe behaviour, triggers, and support measures utilized: (include behaviours that may be exhibited and have been proven to be a concern for yourself or others)

________________________________________________________________________

________________________________________________________________________

**CRISIS INTERVENTION PLAN:** Attached Yes No

**MOBILITY AIDS/SPECIAL EQUIPMENT:** (wheelchair, braces, helmet)

________________________________________________________________________
### NUTRITION:

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<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Dysphasia:</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Health Care Plan or Meal Guidelines:</td>
<td>□</td>
<td>□</td>
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</tbody>
</table>

**Diet:** (high fibre, low fat, food texture (if not regular), cup up, minced, pureed, high protein, low sodium, gluten free, etc.)

**Specify:**

**Fluids Preferred:**
- Tea ______
- Coffee ______
- Milk ______
- Other ________________

**Food Likes:**

______________________________

**Food dislikes:**

______________________________

**Food Allergies:**

______________________________

**Special Diet:**

______________________________

**Other:** (i.e., coughing/choking during meals:)

______________________________

### PERSONAL CARE:

**Independent or needs assistance with:**

______________________________

**Toileting (any concerns?):**

______________________________

**Bladder Function:**
- continent □
- incontinent □

**Bowel Function:**
- continent □
- incontinent □
- diarrhea □
- ostomy □
- bowel routine □
- catheterization □

**Elimination Routine:**
- regular toileting every _____ hours
- Incontinent pads

**Other:**
- day □
- night □

**Sleeping Habits:** (usual bedtime, sleep disturbances, wake-up time, etc.)

______________________________

**Lifts and Transfers:**
- independent □
- one person pivot □
- two person lift □
- sliding board □
- mechanical lift □
- other □
### POSITIONING:

<table>
<thead>
<tr>
<th>In bed:</th>
<th>Pressure mattress required:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of bed raised to:</td>
<td>°</td>
<td>at all times</td>
<td>during meals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In chair:</th>
<th>During meals:</th>
<th>Other:</th>
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</thead>
</table>

### HYGIENE:

<table>
<thead>
<tr>
<th></th>
<th>With help</th>
<th>With reminders/prompting</th>
<th>Independently</th>
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<tbody>
<tr>
<td>Teeth brushing</td>
<td></td>
<td></td>
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<tr>
<td>Hair combing</td>
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<td>Dressing</td>
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<tr>
<td>Bathing/showering</td>
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<tr>
<td>Shaving</td>
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<tr>
<td>Menstruation care</td>
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<tr>
<td>Other</td>
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<tr>
<td>Dentures</td>
<td>Upper</td>
<td>Lower</td>
<td>None</td>
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</tbody>
</table>

### COMMUNICATION

Are there specific or unique ways that the individual uses to express him/herself?

- [ ] Verbal
- [ ] Non-Verbal
- [ ] Sign Language
- [ ] Other

Specifics:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

### SELF CARE

<table>
<thead>
<tr>
<th></th>
<th>With help/prompts</th>
<th>Independently</th>
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<tbody>
<tr>
<td>Meal preparation</td>
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<td>Housekeeping</td>
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<tr>
<td>Shopping</td>
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<tr>
<td>Telephone</td>
<td></td>
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<tr>
<td>Passenger in car</td>
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<tr>
<td>Public transit use</td>
<td></td>
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</tr>
<tr>
<td>Eating</td>
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</table>

Additional Comments:

____________________________________________________________________________
____________________________________________________________________________

### RECREATIONAL/LEISURE:

(What does the individual like to do with their free time? (TV, crafts, walks, gardening, etc.)

Likes: _________________________________________________________________________
______________________________________________________________________________
Section 5 – Community Living

Dislikes: ________________________________________________________________________________
______________________________________________________________________________

SENSORY:

Vision Impaired: yes □ no □
Glasses: yes □ no □
Contacts: yes □ no □

Hearing Impaired: yes □ no □
Aids: yes □ no □
Right ear: yes □ no □

Olfactory: yes □ no □
Explain: ___________________________________

Tactile: yes □ no □
Explain: ___________________________________

SKILLS AND ACTIVITIES:

Likes: ________________________________________________________________________________
______________________________________________________________________________

Dislikes: ________________________________________________________________________________
______________________________________________________________________________

SAFETY CONCERNS:

Traffic Awareness: ______________________________________________________________________

Interpersonal: _______________________________________________________________________

Personal: ___________________________________________________________________________

Other: ______________________________________________________________________________

WORK/EMPLOYMENT HISTORY:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

FRIENDS AND SPECIAL PEOPLE:

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone</th>
<th>Fax/or E-mail</th>
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</table>
Section 5 – Community Living

GOALS/DREAMS:

___________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________

OTHER COMMENTS/ISSUES/CONCERNS:

____________________________________________________
____________________________________________________
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____________________________________________________

Request for Service and Information Release Form

I, _____________________________________________, consent to

• The release of confidential information to Clements Centre Staff for the purpose of optimal health care and service.
• Clements Centre staff offering first aid as necessary
• Clements Centre staff arranging medical care as necessary
• Clements Centre staff arranging transport to hospital as necessary

Signature of
Parent/Guardian/Caregiver _____________________________________________

Witnessed by:   ______________________________________________

Title:    ______________________________________________

Date:    _____________________________________________
R2 Profile Sheet (including emergency contacts)

(Attach photo here)

Name: __________________________  S.I.N.: ________________________
Admission Date: ________________  M.S.P.: ________________________
Date of Birth: _________________  Band #: ________________________
Height: ___________  Sex: _________  Status #: ______________________
Hair: _____________  Eyes: ________  B.C.I.D.: ______________________

Religion: ______________________

Diagnosis/Disabilities: _____________________________________________________

Doctor: ________________ Tel#:______________  Glasses: ____________
Dentist: ________________ Tel#:______________  Dentures: __________
Optometrist: _______________ Tel#:______________  Other: ____________
CLBC Staff: _______________ Tel#:______________  Allergies: __________
Other: ________________ Tel#:______________

Contact Person:  Alternate Contact:
__________________________  __________________________
__________________________  __________________________
________  Tel #:____________  _______ Tel #:______________
### R3 Dental Treatment Record

<table>
<thead>
<tr>
<th><strong>CLIENT NAME:</strong></th>
<th>___________________________</th>
<th><strong>DATE:</strong></th>
<th>___________________________</th>
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</thead>
<tbody>
<tr>
<td><strong>STAFF ACCOMPANYING CLIENT:</strong></td>
<td>___________________________</td>
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<tr>
<td><strong>DENTIST:</strong></td>
<td>___________________________</td>
<td><strong>HYGIENIST:</strong></td>
<td>___________________________</td>
</tr>
<tr>
<td><strong>SEDATION USED:</strong></td>
<td>□ NONE □ PRN □ General Anaesthetic □ IV</td>
<td></td>
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<tr>
<td><strong>LOCATION OF TREATMENT:</strong></td>
<td>□ IN HOME □ DENTAL OFFICE □ HOSPITAL □ OTHER</td>
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</tr>
<tr>
<td><strong>TREATMENT COMPLETED:</strong></td>
<td>______________________________________________________________________________________</td>
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<tr>
<td><strong>TREATMENT NEEDED:</strong></td>
<td>______________________________________________________________________________________</td>
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<tr>
<td><strong>NEXT APPOINTMENT DATE:</strong></td>
<td>___________________________</td>
<td><strong>TIME:</strong></td>
<td>___________________________</td>
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<td>___________________________</td>
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<tr>
<td><strong>FOLLOW-UP INSTRUCTIONS</strong></td>
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<tr>
<td><em>(Give detailed instructions for group home staff, i.e. care for gingival surgery, extraction, root canal, oral hygiene, etc.)</em></td>
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<td>______________________________________________________________________________________</td>
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<tr>
<td><strong>PRESCRIPTION GIVEN:</strong></td>
<td>□ YES □ NO</td>
<td></td>
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<tr>
<td>Dentist Signature:</td>
<td>___________________________</td>
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</tbody>
</table>

**Please be specific for dental personnel and group home staff, i.e. 25 (upper left first molar) filling, root canal. If more space is required, use the back of this page.**
R4  Medical Appointment Information Sheet

To be completed by Staff:

Individual’s Name: ___________________________  Date: ________________

Physician: ___________________________  Accompanied by: ___________________________

Reason for Appointment: _________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

To be Completed by Doctor:

RESULTS OF OFFICE VISIT:

Diagnosis: ________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Medications (prescribed or changed): __________________________________________
________________________________________________________________________

TREATMENT REQUIRED: __________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Blood Work: ___________________________  Urinalysis: ___________________________

X-Rays: ________________________________  E.C.G.: _____________________________

Other: ______________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Follow Up Visit?: ________________________________

Physician’s Signature: ___________________________  Date: ________________

Signature of Attending Staff: ________________________________________________

Signature of Manager: ______________________________________________________
### R5 Medical Appointment Summary

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason for Visit:</th>
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<tbody>
<tr>
<td></td>
<td>Treatment:</td>
</tr>
<tr>
<td>Date:</td>
<td>Reason for Visit:</td>
</tr>
<tr>
<td></td>
<td>Treatment:</td>
</tr>
<tr>
<td>Date:</td>
<td>Reason for Visit:</td>
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<td></td>
<td>Treatment:</td>
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<tr>
<td>Date:</td>
<td>Reason for Visit:</td>
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<tr>
<td></td>
<td>Treatment:</td>
</tr>
<tr>
<td>Date:</td>
<td>Reason for Visit:</td>
</tr>
</tbody>
</table>
## R6 WEIGHT CHART

<table>
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<tr>
<th>Year</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
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</table>
R7 MEDICATION LOG

Name: ___________________________________________ Date: ___________________________________

INDIVIDUAL PROGRAM PLAN
Goal:
Rationale:
Objective:
Long Term Goal:
Short Term Goal:
Procedure:
Measurement:

Name: ________________________________________ Date of Birth: ____________________________________
Drug Allergies: ________________________________ Blood / Liver Problems: __________________________
Food Allergies: ________________________________ Other: __________________________________________
Adverse Drug Reactions: ________________________

PLEASE LIST THE MOST CURRENT MEDICATIONS FIRST, INCLUDING PRESCRIPTIONS

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Reason for Treatment</th>
<th>Date Started</th>
<th>Date Stopped</th>
<th>Reason for Discontinuation</th>
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<tbody>
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R.8 MEDICATION - INTERNAL INCIDENT REPORT

*Critical Incident Forms MUST be completed if medical intervention is required

CLIENT NAME: ___________________________ PROGRAM: ___________________________

DATE OF INCIDENT: ___________ TIME: __________ LOCATION: ____________________________

DATE INCIDENT WAS NOTED: ______________________ TIME: __________________________________

TYPE OF INCIDENT  Check as many that are applicable:

☐ incorrect medication  ☐ incorrect dose administered  ☐ incorrect route of method
☐ medication given at wrong time  ☐ missed medication  ☐ dropped/refused medication
☐ dispensing error  ☐ documentation error  ☐ prn shortage
☐ other, please specify ____________________________________________________________________

NAME OF MEDICATION: __________________________________________________________________

COMMENTS: ____________________________________________________________________________
_______________________________________________________________________________________

STAFF ON SHIFT AT TIME OF INCIDENT: ____________________________________________________

DESCRIPTION

Describe in detail what happened:
______________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Observations:
__________________________________________________________________________________________
__________________________________________________________________________________________

Pharmacist recommendation/action taken:
__________________________________________________________________________________________

WHO WAS NOTIFIED?  Check as many as are applicable:

<table>
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<th>Date/time</th>
<th>Name</th>
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<td>☐ Manager/Duty Worker:</td>
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Name: ☐ Pharmacist: ☐ Physician:

Other: __________________________________________________________________________________

FACILITY FOLLOW UP: ______________________________________________________________________
_______________________________________________________________________________________

Name of person reporting incident: ___________________________ Date: ______________________
Manager’s Initials: ___________________________

January 2003
R.10 DATA COLLECTION

Name: ________________________________ Data Collection Period: ________________________________

Month: ________________________________ Year: ________ Key worker: ________________________________

| GOALS | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|-------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 1.    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 2.    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 3.    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 4.    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 5.    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 6.    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 7.    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 8.    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 9.    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 10    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 11    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

*Please initial the chart each time the event has occurred*
R.12 SAMPLE INDIVIDUAL LOG

Index

- Photo/Info Page
- Family info/personal contacts
- Guardianship/Representation Agreement
- Protocols/Current Medications
- Health Care Plan (HCP)
- Seizure Records
- Vitals
- Areas of Concern
- Medical Appointment Sheets
  - Doctor – scheduled
  - Doctor – hospital/emergency
  - Dentist
  - Seating
  - Specialist
  - Misc.
- Daily documentation
- Community Program Plans/Program Specifics
- Personal Service Plans
- Current Progress Reports (CLBC quarterly reports)
- Outcomes
- Financial Information
  - Location of files
- Personal Inventory
- Nutrition Plan & Nutritionist Assessment
- Eating Assessments
  - Dysphagia Specialist Report
  - HSCL Occupational Therapist meal Review/Report
  - Positioning Report
- Weight Charts
- OT/PT notes
- Nursing notes
- Oral health care plan
- Other Assessments (as relevant to the individual)
  - Audiology
  - Speech/Language
  - Misc.
- Critical Incident Reports
- History
- Consent (Release of Information)
### Day Shift (0700-1500hrs)

**Health**
- Bath □
- Dental Hygiene □
- Shave □
- Finger/toe nails trimmed □
- Range of Motion/Physio □
- Breakfast □
- Lunch □
- Fluids (amt) ______

**Bowel Charts**
- (on Day ______)  Refer to additional charting__________

A. **Client/Staff health concerns:**

B. **Medical appointment required? Yes □ date booked ______ □ No □ explain □**

C. **Ongoing concerns:**
- Improved □
- Same □
- Deteriorated □

D. **Appointments:**

E. **Activities:**

F. **Incidents - type (see reports) ________**

G. **Behavioural Observations/Concerns:**

---

### Evening Shift (1500-2300hrs)

**Health**
- Bath □
- Dental Hygiene □
- Shave □
- Finger/toe nails trimmed □
- Range of Motion □
- Dinner □
- Fluids □ (amt) ______

**Bowel Charts**
- (on Day ______)  Refer to additional charting__________

**Client/Staff health concerns:**

**Medical appointment required? Yes □ date booked ______ □ No □ explain □**

D. **Ongoing concerns:**
- Improved □
- Same □
- Deteriorated □

E. **Appointments:**

F. **Activities:**

G. **Incidents - type (see reports) ________**

H. **Behavioural Observations/Concerns:**
Night Shift (2300 – 0700hrs)

Washroom visits (#) _______; Bowel Charts □ (on Day ______); Incontinent □
Health Comments/Concerns: ___________________________________________________

Medical appointment required? Yes □ No □
explain ________________________________

Behavioural Comments/Concerns: ________________________________________________

Incidents - type (see reports) ____________

IPP Totals: Community_______ IPP#1_______ IPP#2_______

Staff Initial: ________________________________
R.14  ASSESSMENT AND REPAIR REPORT

TYPE OF EQUIPMENT: ____________________ OWNED BY: ____________________

ASSESSED / REPAIRED BY: ____________________ DATE: ________________

REASON FOR APPOINTMENT: _________________________________________

________________________________________________________________________

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TO BE COMPLETED BY SERVICE PROVIDER

REPAIRS DONE:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

RECOMMENDATIONS:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

RETURN VISIT? ____________________

SIGNATURE: ____________________ DATE: ____________________

TO BE COMPLETED BY ATTENDING STAFF

ADDITIONAL INFORMATION:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

STAFF SIGNATURE: ____________________

MANAGER’S SIGNATURE: ____________________
Section 5 – Community Living

R.15 HOSPITAL ADMISSIONS – AUTHORIZATION FOR STAFF SUPPORT

Authorization for Staff to Support Adults with Development Disabilities

To be completed by Group Home Manager, VIHA Unit Manager and VIHA Social Worker

Client Name:

Date of Birth: 

☐ Medical / Surgical Procedure  ☐ Emergency Service
☐ Other (Specify) 

The Group Home staffing is required for the following reasons:

Group Home Name: (Please print)

Phone Number: 

This service is APPROVED for the period of: ___________________________ (dates)

Hours of service approved per day: ___________________________ UNIT: ________________

Extension approved for the period of: ___________________________

Authorized Signatures

Group Home Manager: 

Phone: 

VIHA Unit Manager: 

Phone: 

VIHA Social Worker: 

Phone: 

Invoicing Information: Invoices will not be paid unless ALL DOCUMENTATION IS COMPLETE.

Group Home Manager to submit a copy of the invoice and the form to the Provider Hospital’s Health Record Department. Fax numbers: (Area Code 250 when dialing long distance)

Victoria General Hospital 727-4114 Royal Jubilee Hospital 370-8550
Lady Minto (Saltspring Island) 538-4007 Nanaimo Regional General Hospital 755-7659
Cowichan District Hospital 709-3006 Campbell River Hospital 266-7089
West Coast General Hospital 724-8510 Saanich Peninsula Hospital 662-7525

VERIFICATION SECTION FOR HEALTH RECORD DEPARTMENT

Dates of Stay: 

Documentation of support provided: ____Yes ________number of hours per day.

Unable to confirm by reviewing chart: __________________________

Health Records: Name ___________________________ Contact Number ___________________________

Please forward this completed form to ROB CRISP – Director, Rehabilitation Services, Vancouver Island Health Authority, Victoria General Hospital, 1 Hospital Way, Victoria, BC V8Z 6R5 PHONE: (250) 727-4117.

Director / Designate Signature ___________________________ Date ___________________________

Contact Diane Knippshild @ 250-709-3000 ext. 4244 for electronic version of this document Rev.: 14 January 2009

ORIGINAL FORM – Group Home to retain for submission
UNIT to keep a copy of form on file.
Process for Authorization And Documentation for Staff to Support Adults with Developmental Disabilities (Complex Care Patients)

Planned or Emergency Admission

Patient is assessed to establish need for group home staff to stay with patient by:
- Unit Manager
- Unit Social Worker
- Group home Manager
Form “Authorization for Staff to Support Adults with Developmental Disabilities” to be completed, approved and signed.

APPROVAL will only be given for up to 6 hours / day to a maximum of 4 days.
Upon Approval, the Group Home Manager arranges the care required.

The Unit Social Worker and the Unit Manager must re-assess client for support required greater than 4 days. Any extensions of the approved hours must be approved and initialed by the Unit Manager and the Social Worker. Hours that are billed and not approved will not be paid.

Unit staff must document the presence of group home caregiver on the Progress notes.

Upon patient discharge, the Group Home Manager submits an invoice and the approved Authorization form to the Hospital’s Health Records Department where the patient was admitted.

Health Records provides verification of service & LOS (length of stay).

Health Records completes the authorization form and forwards the form and invoice to the Director with signing authority for cost center.

Director or designate signs invoice and send to Accounts Payable Department.

Accounts Payable Department reimburses the Care facility.

Rob Crisp, Director,
Rehabilitation Services
c/o Victoria General Hospital
Administrative office
1 Hospital Way
Victoria, BC V8Z 6R5
Fax: 250-727-4106

REV.: 01-Feb-07; 05-Nov-07; 14-Jan-09
Clients with Developmental Disabilities

Planned Admission to Hospital:

- Group Home Manger will determine through Information, the unit where the client will be admitted.
- **Group Home** Manager contacts the Social Worker for the Unit via their pager or through switchboard in situations where there will be the requirement for staffing exceptional to existing staffing levels.

  VGH: 370-8000 or
  RJH: 370-4212 or
  Saanich Peninsula: 652-3911

- Discuss the requirement by Ministry of Children and Family Development, Community Living Services, to have the form: **Staffing Requirement to Support Client with Developmental Disability completed. See appendix.**
  Give the social worker a copy of the form. (Though the form requests completion from the Patient Care Coordinator, the hospital staff and CLS staff concur that completion by the social worker is appropriate.) Clinical Coordinator has alerted all social staff to the requirement.
- Inform the social worker about the client’s care requirements for activities of daily living i.e. mealtime assistance, toileting, grooming, mobility; and exception needs i.e. behavioural issues (screaming, aggression, wandering etc.), monitoring requirements, augmentative and alternative communication issues etc. Highlight safety concerns e.g. inability to pull a cord to call for help, dysphagia etc.
- **Omit this sentence:** (The social worker is aware of nursing levels and liaisons with the units) Together, the Patient Care Manager, social worker, and Group Home Manager, determines the requirement for staff assistance while the client is in the hospital.
- If families are available and wish to be on site for a portion of the day, and are able to provide the activities of daily living support, that may be taken into consideration as part of the staffing plan.
- The form is faxed directly from the Social Worker to Community Living Services. Request a copy of the form for our accounting records.

Emergency Admissions to Hospital:

- Determine, through Information, the Unit where the client is being admitted.
- Request the social worker contact you as soon as possible.
- Manager/staff exercise judgment based on the needs of the client re: staff coverage while in hospital and ensure adequate support from the group home is arranged.
- Proceed as above.
Clients with Developmental Disabilities

Staff Role while supporting client in hospital:
- Hospital staff performs the acute care roles
- Group Home staff performs the regular activities of daily living support that are part of their job description within the home.
- Exceptions may be negotiated with the nurse/staff in the best interest of the client. For example, the nurse may oversee the **group home staff member** administering the **client’s routine** medications when the client will not accept the meds from a stranger.

Exceptional Considerations:

The hospitals have a **Patient Care Coordinator** that deals with more global issues. They may be **contacted** through the switchboard.

Example 1: Two clients are in hospital at the same time and having them in the same room would save staff hours, the patient care coordinator would be contacted to assist with making these arrangements.

Example 2: Our client becomes agitated with noise and may scream. A request could be made through the patient care coordinator to have access to the grief room to decrease stimulation.

---

_Process approved April 12, 2002_

*Kim Gibson: Clinical Coordinator, Social Worker Services, Capital Health Region*

*Herdis Cowden: Patient Care Coordinator, Capital Health Region*

*John Davies: Social Worker, MCFD, Community Living Services.*

*Karen Van Rheenen: Manager, Kardel Consulting Services Inc.*

*Terry Hartley: Nurse Manager, Kardel Consulting Services Inc.*
Section 5 – Community Living

D.1 Intake Form

Name: ________________________________ D.O.B. (M/D/Y): __________________________

Personal Health No.: _____________________ SIN (optional): __________________________

Family/Caregiver Home Address: _________________________________________________
________________________________________ Phone Number: _____________________

Primary Contact Person: _______________________ Relationship: __________________
Phone Number: _____________________________ Address: __________________________

Alternate Contact Person: _______________________ Relationship: __________________
Phone Number: _____________________________ Address: __________________________

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<td>Physician:</td>
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<td>Specialist (specify):</td>
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<td>Day Program:</td>
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REASON FOR REFERRAL:
______________________________________________________________________________
______________________________________________________________________________

TRANSITION PLANS: (if known)
______________________________________________________________________________
______________________________________________________________________________

Signature of CLBC Staff: _________________________________________________________

Date of Transition:  _____________________________________________________________

Transition Address:  _____________________________________________________________

Reason for Transition:  ___________________________________________________________

ADMISSION: (Please complete as much as possible prior to admission)

GENERAL HEALTH HISTORY:
______________________________________________________________________________

DIAGNOSIS:
______________________________________________________________________________

ALLERGIES:
______________________________________________________________________________

Health Care Plan attached: Yes No

MEDICATIONS: (special consideration i.e., w/juice, yogurt, etc.)
______________________________________________________________________________
HEALTH CARE ISSUES/MEDICAL CONCERNS: (epileptic, diabetic, cardiovascular diseases, etc.)

SPECIAL CONSIDERATIONS/TREATMENTS:

Protocol attached: Yes No

Seizure History:

Seizure Precautions:

Last T.B. Test (skin or chest x-ray) positive negative
Last Hep B Test positive negative

CCS practices UNIVERSAL PRECAUTIONS – are there any known communicable diseases that we should be informed of to protect the health and safety of all residents and staff?

BEHAVIOURAL ISSUES:
(wandering, depression, aggression, noisy, self-injurious, obsessive, sexually inappropriate, SUICIDAL, etc.)
Describe behaviour, triggers, and support measures utilized: (include behaviours that may be exhibited and have been proven to be a concern for yourself or others)

CRISIS INTERVENTION PLAN: Attached Yes No

MOBILITY AIDS/SPECIAL EQUIPMENT: (wheelchair, braces, helmet)
Section 5 – Community Living

NUTRITION:

Dysphasia: Yes No
Health Care Plan or Meal Guidelines: Yes No

Diet: (high fibre, low fat, food texture (if not regular), cup up, minced, pureed, high protein, low sodium, gluten free, etc.)

Specify: ____________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

Fluids Preferred: Tea _____ Coffee _____ Milk _____ Other ________________

Food Allergies:
__________________________________________________________
__________________________________________________________
__________________________________________________________

Other: (i.e., coughing/choking during meals)
__________________________________________________________

COMMUNICATION

Are there specific or unique ways that the individual uses to express him/herself?

_____ Verbal _____ Non-Verbal _____ Sign Language _____ Other

Specifics:
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

OTHER

COMMENTS/ISSUES/CONCERN:
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
I ___________________________ would like to join CCS Day Programs. The Community Living staff will support me to reach my goals in my Self Directed Plan. I understand that I have to do my part to reach my goals.

I am responsible for:

1. Respecting myself and others around me. I understand that CCS promotes a safe and healthy environment for everyone.

2. Speaking up for myself. I understand that staff will encourage me to do this. I must remember that I have a voice.

3. Telling staff if I am unable to attend my day program. This can be done by telephone, by email or in person.

4. Keeping in contact with the staff. I understand that if there has been no contact from me in three appointed days, staff will report to CLBC and I may have to leave for 3 or more appointments.

5. Arriving prepared for the planned events. This may include having money, lunch, or proper clothing with me.

6. Working on the goals that I have set myself in my Self Directed Plan. I understand that I can change my goals as my life changes.

7. I will be supported to solve problems using the steps outlined in Conflict Resolution as described.

______________________________________________________________________________
Participant Signature                                                      Date

______________________________________________________________________________
Representative Signature                                               Date
(if applicable)

I have explained this form to the best of my ability.

______________________________________________________________________________
Staff Signature                                                                Date
D.3 CLIENT PROFILE / EMERGENCY INFORMATION SHEET

Name: ________________________________________________________________

Date: _______________ Person completing form: ______________________________

Identifying features: ________________________________

Height: ____________________________ Individual’s
Weight: ____________________________ Photo
Diagnosis: ____________________________ Here
Hair Colour: ____________________________
Eye Colour: ____________________________
Other: ________________________________
Other names used: _______________________

Address: ___________________________________________________________________

Phone: _______________________________ email: ______________________________

D.O.B. (M/D/Y) ___/___/___ Age: ______ B.C. Care card # _______________________
B.C.I.D.# ______________________________

#1 Emergency Contact: ____________________________ Relationship:__________________
Phone #: __________________ Work: _______________ Cell/Pager: _________________

#2 Emergency Contact: ____________________________ Relationship:__________________
Phone #: __________________ Work: _______________ Cell/Pager: _________________

#3 Emergency Contact: ____________________________ Relationship:__________________
Phone #: __________________ Work: _______________ Cell/Pager: _________________

By signing page two of this form you will give Clements Centre staff consent to:
[ ] Apply first aid if necessary
[ ] Arrange transport to hospital as necessary
Dependants: _____________________________________________________________
Medications: ____________________________________________________________
When Administered: __________________________ By Whom: _______________________
Allergies: __________________________________________________________________________________
Reaction to allergens: __________________________________________________________________________
Seizures: Yes No (Circle one)  Description of Seizures: ________________________________
Physician’s Name: ___________________________ Clinic: ____________________________
Phone: ______________________________________
Dentist: ___________________________ Phone: ____________________________
Specialist: ___________________________ Phone: ____________________________
Method of Communication: ____________________________
______________________________________________________________________________
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______________________________________________________________________________
______________________________________________________________________________
CLBC staff: ___________________________ Phone: ____________________________
Hours: 8:30 AM - 4:30 PM   After Hours Emergency Phone: 310-1234

Additional Information/Precautions: _____________________________________________
______________________________________________________________________________
______________________________________________________________________________
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Signed: ___________________________
Date: ____________________________
## D.4 PARTICIPANT CONTACT NOTES

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### D.5 MEDICATION SIGNATURE SHEET

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D6 INDIVIDUALIZED FUNDING CONTRACT

(name)

(address) (phone)

RE:
(individual’s name)

The Clements Centre Society (CCS) looks forward to providing services to your family and wishes to outline some of the policies and procedures.

CCS provides day program services based on the goals identified in an individualized service plan. Our staff supports each individual to develop a service plan with their family/caregivers and others in their support network.

Rate of pay and Billing Schedules
There is a fee for service with the following rates of pay:

- Full Day (typically 8:30am – 3:30pm) = $75.00 per diem

Families will be invoiced monthly per an agreed schedule.

Termination of Service
- Payment obligation is based on the hours agreed upon, not on the actual hours of attendance.
- Either party is required to give at least 2 weeks written notice if they wish to terminate or significantly alter the frequency of service.
- Failure to provide sufficient notice will result in being invoiced for 30 days of agreement.
- Failure to pay invoice within 30 days will result in a termination of services.

Concerns and Complaints
Should you have any concerns about the service, a complaint process is available to you. Discuss your concern with any CCS staff, they can attempt to resolve the issue and/or help you file a formal complaint.

Agreement
Beginning on ________________ I agree to enrol ______________________ in the day program services offered by Clements Centre Society for _______ days each week.

Signature: ___________________________ Date: ___________________________
### C.1  REFERRAL FOR SERVICE – CHILDREN’S FAMILY SUPPORT PROGRAM

All referrals are through Ministry for Children and Family Development

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<thead>
<tr>
<th>Date:_________________________________</th>
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<tbody>
<tr>
<td>Child’s Name:_________________________</td>
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<tr>
<td>Parent/Guardian:_______________________</td>
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<td>Phone: (H):_________________ (W):________</td>
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<td>E-mail address:_______________________</td>
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<tr>
<td>Program(s) Requested (please circle): Youth Day / R.A.P / Evening Group</td>
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<td>Days of the Week you want to attend the Program: M T W Th F</td>
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<td>Comments:________________________________________________________________________________</td>
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☐ Fax to CFSP Coordinator at 746-1636
CONFIRMATION OF SERVICE / REQUEST FOR INFORMATION
CHILDREN’S FAMILY SUPPORT PROGRAM

To: Ministry of Children and Family Development

From: CCS Children’s Family Support Program

Date:

This is to confirm that ______________________________________________ has chosen to participate in our Children’s Family Support ______________________________________ Program.

Please forward written information that is necessary to develop an individualized community based plan. All information is kept confidential as outlined in CCS’s Confidentiality Policy. The information requested is:

- ✅ Individualized Service Plan or a copy of the Individual Education Plan
- ✅ Health and Safety Concerns
- ✅ Any challenges that will need to be taken into consideration (medical, physical, emotional or behavioural)
- ✅ Any other information necessary for enhancing the success of this child in the Children’s Family Support Program

Parent/Guardian Name: _____________________________________________

I give my consent for the Ministry of Children and Family Development to share the above information about my child with

- ☐ CCS Children’s Family Support Services

Signature: ______________________________________________________

Date: ______________________________

Witness: ______________________________________________________
C.3 INDIVIDUAL FILE CHECKLIST – CHILDREN’S FAMILY SUPPORT PROGRAM

Name: ________________________________________________________________

Date Referral Received: ________________________________________________

Date File Opened: ______________________________________________________

Annual Review Date: ____________________________________________________

Open File

_____ Referral Form

_____ Confirmation of Service

_____ Client Profile

_____ Orientation Checklist

_____ Service Plan

_____ Reports/Assessments/Other Communication

Closed File

_____ Closing Letter

_____ Exit Survey

_____ Follow Up Telephone Call (3 months)
C.4 ORIENTATION CHECKLIST – CHILDREN’S FAMILY SUPPORT PROGRAM

Please initial to acknowledge that you have explained to the individual the following and file in the individual’s file.

**General Orientation Folder**

- _____ CCS Handbook
- _____ Vision/Mission/Values/Principles
- _____ Connector
- _____ Board of Directors/Managers List
- _____ CCS historical timelines and history
- _____ Website

**Tour of Clements Centre Building**

- _____ Emergency Exits
- _____ Fire Extinguishers
- _____ Emergency Procedures
- _____ Introduction to Staff
- _____ Washrooms
- _____ Regular Business Hours
- _____ Coordinator’s Office
C.5  FILE CLOSURE SUMMARY – CHILDREN’S FAMILY SUPPORT PROGRAM

Date:

Name:

Reason for Closure:

- Family has moved away from catchment area
- Family has chosen to leave the program
- Child poses a health or safety risk that cannot be accommodated in the program
- Family has not accessed program for 2 months
- Child has graduated from the program (has turn 19 years of age)
- Other ____________________________________________________________

Additional Information:

- Notification of file closure was provided in the form of a personalized letter addressed to the family with a copy sent to MCFD.

- Family was offered the opportunity to participate in a Satisfaction Survey.

_______________________________________________
Signature of Program Coordinator
Dear _________________________,

This letter is to inform you that, after talking with you, your Children’s Family Support Program file has been closed. (Personal comments here).

I have informed the Ministry of Children and Family Development of your exit from the program. If, in the future, you wish to re-open your file please contact your CLBC Facilitator.

The CFS team has enjoyed working with you and wish you the best of luck in the future. Please remember that you may always use the program as a resource.

At the Clements Centre Society we work to provide the best possible services to everyone. Your feedback helps to ensure that our services are the best they can be. Could you please fill out the survey we have included with your exit letter at your earliest convenience? There is also a stamped envelope so returning the survey will not cost you anything. You may also drop it off at the Clements Centre building if that would be more convenient. Your opinions will be used to assess and improve our programs.

Sincerely,

Name
Coordinator, Children’s Family Support Program

cc: MCFD
SILP.1 INTAKE - SEMI INDEPENDENT LIVING

Date: _____________________

Name: ________________________

I currently live (i.e. apartment, house, basement suite, group home, other):

_________________________________________________________________________

I would like to live (i.e. alone, with friend(s), with my family, with another family, other):

_________________________________________________________________________

During the day I: ____________________________________________________________

I would like to (i.e. work, volunteer, day program, etc.): _________________________

Please indicate in which areas you will require support with details, if possible:

Transportation: _______________________________________________________________

Money management: ___________________________________________________________

Banking: __________________________________________________________________

Medication Management: ______________________________________________________

Appointments (making, attending): _____________________________________________

Nutrition / Meal Planning: _____________________________________________________

Meal Prep / Cooking: __________________________________________________________________

Grocery Shopping: ____________________________________________________________

General Errands: ______________________________________________________________

Housekeeping: __________________________________________________________________

Laundry: ___________________________________________________________________

Personal Safety: _______________________________________________________________

Home Safety: __________________________________________________________________

Personal Care: __________________________________________________________________

Time Management: __________________________________________________________________

Recreation / Socialization: __________________________________________________________________

Additional Comments
SE.1 INTAKE FORM

Job Coach: _____________________________  Date: ________________

A. Personal Information:
   Name: _______________________________

Ministry Staff:
   Facilitator: __________________________
   EAW: ________________________________

B. Client Information:
   Do you have a resume?  _____ Yes  _____ No
   Are you working right now? _________
   If the answer is no, how long since your last job? ________________

   Present/Last Employer:
   Name: ____________________________________________________________
   Supervisor: _________________________________________________________
   Address: ____________________________________________________________
   Phone: _____________________________________________________________

   How long have you worked there? ______________________________________
   Reason for Leaving: _________________________________________________

   Longest job you’ve worked at: _________________________________________
   How Long? __________________________________
   Supervisor: ______________________________
   Address: ________________________________
   Phone: _________________________________

   Shortest job you’ve worked at: _________________________________________
   How long? __________________________________
   Supervisor: ______________________________
   Address: ________________________________
   Phone: _________________________________
Clements Centre Society Operations Manual

Section 5 – Community Living

Favorite past job: _____________________________________________________________
Why? ______________________________________________________________________

Worst past job: _______________________________________________________________
Why? ______________________________________________________________________

What is the perfect job? _______________________________________________________
____________________________________________________________________________

What are the most important things to you when looking for a job? _________________
____________________________________________________________________________

Where do you see yourself working? (I.e. inside/outside, non-smoking, quiet, noisy)____
____________________________________________________________________________

What is your level of education and have you taken any other classes: ________________
____________________________________________________________________________

Have you taken training in any other areas? ________________________________________
____________________________________________________________________________

What areas do you need support in before starting work?

_____ I want to find out more about my career choices.
_____ I want support looking for work.
_____ I want to learn how to look for work.
_____ I want to know what kinds of jobs are out there.
_____ I want support choosing what job is right for me.
_____ I want to learn about how to keep a job.
_____ I want support choosing my strengths and weaknesses.
_____ I want to learn more about self-confidence.
_____ I want support with how to set my goals and make good decisions.
_____ I want more education or training.
_____ I want more hands-on work experience.
_____ I want to learn more about reading, writing, and/or speaking.
_____ I want to learn about work habits and skills.
Section 5 – Community Living

Is there any other support you want from the Supported Employment Program?  
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Tell me about any personal health problems that might get in the way of work (i.e.: bad reactions to medications, allergies, etc.)?  
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What type of transportation do you use?  My Car_____ Parent/Caregiver Car_____ 
Bus____ Bike____ Taxi____ Walk____ Other___________

Do you feel you have anything stopping you from getting a job?  
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What strengths do you have that you could use on the job:  
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Is there anything about you that might get in the way of keeping a job?  
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Hours that you can work:  
____ Days (9-5) _____ Nights _____ Full time _____ Part time 
_____ Shifts with flex days off _____ Weekends off _______ Hours per day

Would where you live now in any way affect your sleep if you were to work shifts?  
_____ Yes _____ No

Do you have any problems sleeping? _____ Yes _____ No

If yes please explain ____________________________________________________________
________________________________________________________________________

How would you feed yourself when you are at work?
________________________________________________________________________
Section 5 – Community Living

If you have children or dependants, what things could be done to help with their care while you are at work? _____________________________________________________________
________________________________________________________________________
________________________________________________________________________
How much money do you get each month? _________________________________
Where does your money come from? _________________________________
Hobbies and interests: ___________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Would you be able to come to Supported Employment on a regular basis? ___Yes ___No
Who are your important support people? (i.e.: family or friends)______________
________________________________________________________________________
________________________________________________________________________
Do you have any more information that has not already been discussed?
________________________________________________________________________
________________________________________________________________________
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### SE.2 CAREER ACTION PLAN

<table>
<thead>
<tr>
<th>Planning Participants:</th>
<th>Strengths</th>
<th>Wishes</th>
<th>Goals</th>
<th>Barriers</th>
<th>Action Plan</th>
<th>Who is Responsible</th>
<th>When?</th>
<th>Outcome?</th>
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<tr>
<td>Community Leisure Options:</td>
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<td>Social Life/Family Relationships:</td>
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<td>Unique Needs:</td>
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<td>Ongoing Support:</td>
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<td>Long Term Financial:</td>
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<td>DREAMS!</td>
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SE.3 PROGRAM PLACEMENT RATIONALE AND AGREEMENT

Individual: _______________________________   Date: __________________

Main Service Plan Goals (from I.P.P./P.S.P or equivalent):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Program Recommendation: Support ______
Preparation _____
*Training for Employment______
**Employment______

Rationale for recommendation:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

It is understood and agreed that this placement reflects the individual’s goals as defined through a Personal Service Plan and is addressed within his/her Support, Preparation or Training Plan.

_________________________________________  ________________________________________
Client Signature   Date

_________________________________________  ________________________________________
Service Provider   Date

_________________________________________  ________________________________________
Parent/Caregiver (Subject to client desire)   Date

_________________________________________  ________________________________________
CLBC Staff   Date

* Training (Employment Standards Act applies, Training Plan must be in place)
** Employment (Employment Standards Act applies, All requirements of the act must be in place)
I ___________________________ would like the services of the Supported Employment Program. I want to learn work search skills and to find Work Experience, Volunteer Experience, and/or Employment with the assistance of the Supported Employment Program.

With the help of the Supported Employment Program, I will put together a Vocational Action Plan with short term goals of my choice which will help me reach my long term goal.

The Supported Employment Program will support me in working towards and reaching these goals. I understand that I have to do my part in reaching my goals.

I AGREE:

- To attend scheduled meetings. I will let the Supported Employment Program know if I cannot come to an appointment.
- To attend work shifts as scheduled. I will let my employer and the Supported Employment Program know if I am not able to attend scheduled shifts.
- To work on my goals, which are goals I choose, in my vocational Action Plan. If I think any goals need to be changed I will follow up on changing them.
- To follow expected rules when ending a Work Experience, Employment or Volunteer placement.
- To be as independent as possible. I am the person who will make the decisions about what I want.

If I do not follow this agreement a meeting will be held to look at why I am not following this agreement. Supported Employment and I will then work together to decide what the steps will be for me to be successful in this program.

I HAVE READ AND I UNDERSTAND THIS AGREEMENT

Participant ___________________________  Witness ___________________________  Date ___________________________
## SE.5 VOCATIONAL ACTION PLAN

<table>
<thead>
<tr>
<th>Participant’s Name:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Vocational Goal:**

| Short Term Goals (to achieve vocational goal) | Strengths | Barriers | Intervention | Who is Responsible | Evaluation Method & Review Date |
|-----------------------------------------------|-----------|----------|--------------|--------------------|---------------------------------
|                                               |           |          |              |                    |                                  |
|                                               |           |          |              |                    |                                  |
|                                               |           |          |              |                    |                                  |

Participant Signature: ____________________________________________ Date: ____________________________

5/24/12
### SE.6 WORK SEARCH FORM

<table>
<thead>
<tr>
<th>Date</th>
<th>Talked to/Position</th>
<th>Business Name</th>
<th>Phone Number</th>
<th>Telephone Call</th>
<th>In Person</th>
<th>Results</th>
<th>Follow-up Date</th>
<th>Done Yes/No</th>
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