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Quality Assurance Regulations

Effective Date: __ February 27, 2013 ___ **Policy #:** __ PR-QAR__

Revision Date: ___April 12, 2013___

Scope:
All officers, directors, employees and volunteers of New Leaf: Living and Learning Together Inc.

Rationale:
Policies and procedures must comply with Ministry of Community and Social Services' policies and regulations.

Policy Statement:
The Agency will establish policies and procedures in respect to its quality assurance measures and shall follow the policies and procedures and ensure that its staff members, volunteers and members of its board of directors follow them, to the degree that is appropriate given the role of the staff member, volunteer and board member; and shall ensure that the policies and procedures are in writing, and dated and reflect the agency's most current practice.
This shall include, but shall not be limited to, the development of a mission statement that promotes social inclusion, and principles of service delivery that promote individualized approaches to supporting persons with developmental disabilities. The agency shall ensure that all individuals within the scope of this policy receive an initial orientation to the mission statement and principles of service delivery and that the same receive refreshers and reviews as per the quality assurance regulations.

References:
Bill 77 and accompanying regulations

ADMISSIONS - ADULTS

EFFECTIVE DATE: ____March 23, 2009_______ POLICY #: _PR-01______

REVISION DATE: ____July 11, 2011_______

SCOPE:
All persons referred as potential candidates for service at New Leaf, employees, community partners, MCSS.

RATIONALE:
The current access system dictates how priorities are assessed, and how referrals for vacancies are processed.

POLICY STATEMENT:
New Leaf works within the current access and intake mechanisms established in each region of service. Where possible, preference will be given to the person representing the highest risk of those names forwarded. New Leaf will also assess suitability of each individual and will ensure that each person taken into service is most likely to succeed while in service and that others in the home should not experience decreased quality of life as a result.

REFERENCES:
MCSS Memorandum: Developmental Services Vacancies and Waitlists (January 15, 2008)

ADMISSIONS - ADULTS

GENERAL

The choice of one's place of residency, employment and recreational activities is one of the major decisions of adult life. Accordingly, it is important that any person moving into one of the homes or programs operated by New Leaf does so voluntarily and only after he/she has been given an indication as to what such a decision entails. Therefore, each candidate should have an opportunity to visit the home or participate in the program or activity before the decision is mate.

Recognizing that people living together in a home form a community, the opinions of existing residents will be sought in regard to the admission of new residents, as will input from the Residential and Day Services supervisors.

INTAKE CRITERIA AND PROCEDURE

The front line service co-ordination function for this agency is performed by the Director of Residential and Day Services.

In accordance with the MCSS policy direction (Bill77 – Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008) and the Regional Developmental Services Ontario (DSO – Toronto and DSO- Central East Region), all referrals for core services will be processed through the Central Access point.

DISCHARGE PROCEDURES

EFFECTIVE DATE: ____March 23, 2009______ POLICY #: ___PR-02________

REVISION DATE: ________________________

SCOPE:
Any persons receiving support from New Leaf.

RATIONALE:
New Leaf management, a client's family or the client themselves may decide that they no longer wish to receive service, or appropriate service cannot be provided by New Leaf.

POLICY STATEMENT:
New Leaf has no legal obligation to deny discharge if a client or their family requests it. New Leaf does not have a legal obligation to continue to provide service if the agency feels that the service is no longer appropriate. New Leaf recognized the moral obligation to help pursue alternative arrangements and ensure the person moves to a safe and appropriate service/location.

REFERENCES:
New Leaf policy – Case Files

DISCHARGE PROCEDURES

GENERAL

When a person is being discharged:

* A discharge report needs to be completed detailing the reasons for discharge. This report must be complete with signatures from all relevant stakeholders.
* After the above form has been completed, all files on an individual must be put into manila envelopes and forwarded to the appropriate manager for archiving. The MCSS supervisor is to be contacted.

CRITERIA

A person will leave the program when:

* A recommendation is made from the management for:
  a) transfer to a facility better suited to meet the client’s needs.
  b) other living accommodations or program(s) have been secured;
* An individual is unable/unwilling to fulfill the financial and/or program obligations;
* If a resident leaves on his/her own accord, it is the responsibility of the staff to contact appropriate support for the individual.
* Medical or behavioural conditions become too severe for the staffing or structure of the program to adequately deal with; temporary or permanent alternative placements will be sought.
* An individual dies.

When a person has left a program, a discharge report will be completed and placed in the person’s completed file.

FOLLOW UP PROCEDURE

Contact will be maintained by New Leaf for a maximum period of 6 months.

A copy of all follow-up contact will be maintained on file.

APPEAL PROCEDURE POLICY – FAMILY / CLIENT

PROCEDURE:

1. Applicant / client or agent has 5 business days in which he/she can submit an appeal.

2. Appeal will be made to the Program Manager or Director

3. Applicant/client space will be kept open if appeal procedure is exercised. MCSS Program Supervisor will be informed of the appeal process with respect to established 10 day time line to declare vacancies and a 30 day expectation to fill existing vacancies.

4. The Appeal Committee (Manager, Director and Executive Director) will meet within 10 business days to discuss the appeal, form a decision concerning the appeal and notify the applicant within 48 hours of the decision.

5. If the applicant / client or their agent is not satisfied with the Committee's decision, appeal can be made to the local access mechanism or committee for review.

6. New Leaf is not bound by the recommendations of the committee.

COMPLAINT / FEEDBACK PROCEDURES POLICY

EFFECTIVE DATE: ____January 3, 2012__ **POLICY #: PR-03**

REVISION DATE: ____January 17, 2012___

SCOPE:
Individuals receiving supports, families, advocates, interested public. (This policy does not deal with staff/management relations issues or grievances which have established procedures in the Collective Agreement.)

RATIONALE:
In an effort to provide quality services that are responsive to individuals needs, New Leaf will provide a complaint / feedback process to those who wish to submit a complaint or provide feedback and will provide a response to the complaint / feedback that is timely and free of any coercion, intimidation or bias.

POLICY STATEMENT:
New Leaf encourages people receiving services, their parents, guardians, advocates or other interested persons in the community to freely and openly discuss any concerns about the services and supports provided by the agency.

New Leaf shall take all complaints seriously, and review and investigate all matters. New Leaf is not, however, expected to attempt to resolve complaints that it may determine to be frivolous or vexatious.

New Leaf will endeavor to respond to all complaints in a timely manner. There will be no coercion, intimidation or bias before, during or afterward toward any individual who brings forward a complaint or grievance.

New Leaf will assist an individual to communicate their complaint in a manner that takes into consideration their particular abilities and communication needs or preferences. Where assistive augmentative communication systems are required, New Leaf will do its best to assist the individual to access these alternate communication systems.

New Leaf will keep a record of all complaints received and shall review these complaints annually to ensure best practices are being maintained at all times.

New Leaf shall formally review the complaints procedure on an annual basis and make revisions as required.

New Leaf shall provide a copy of the complaints / feedback policy and procedures to all individuals receiving support, their families and / or their advocates.

This policy will also be placed on the agency web site for all interested parties to review.

DEFINITIONS:
"Complaint" is an expression of dissatisfaction related to the services and/or supports that are provided by New Leaf. A complaint may be expressed by a person with a developmental disability who is receiving services and supports from New Leaf, a person acting on their behalf, or by the general public, regarding the services and supports that are provided. A complaint may be made formally (such as a letter written to the agency) or informally (such as a verbal complaint expressed to a staff person).

"Feedback" may be positive or negative (including complaints) and is related to the services and/or supports provided by New Leaf. Feedback may be solicited (such as information and comments collected through a satisfaction survey or a comment box) or unsolicited (such as a letter from a person or family member about the services and supports that New Leaf provides). Feedback may be formal (like the survey or letter noted above) or informal (such as a verbal complaint expressed to a staff person).

Note: This policy and procedure relates to general complaints and feedback about services and supports offered by New Leaf.

This policy does not replace the policies and procedures on Serious Occurrence Reporting (PR-18), Abuse Reporting (PR-16) or Harassment Reporting (HR-09) but serves to enhance the above noted policies.

REFERENCES: The Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008, Ontario's Regulation on Quality Assurance measures, MCSS Policy Directives For Service Agencies, and New Leaf Policies PR-18, PR-16, HR-09

COMPLAINT / FEEDBACK PROCEDURES

Procedure:

* Any person who receives support or other interested party who believes he or she has a justifiable complaint and would like specific action taken to resolve a situation should first discuss the matter with the appropriate Manager.

* Should a satisfactory resolution fail to be reached through informal discussion with the employee / Manager, the person should be directed or referred to the appropriate Director.

* The Director will discuss the matter with the person and attempt to resolve the situation. Should the matter remain unresolved, the individual will be advised to follow the formal complaint process.

* If the person wishes to proceed with a formal complaint he/she should notify the Director of their intention. The Director will ensure that any assistance necessary is provided to the person in preparing and submitting concerns through the levels of the complaint process.

* At this stage the person must outline their concerns in writing, including:
  - A description of the problem/concern
  - Attempts made to resolve the problem
  - Their proposed solution or specific action requested.

* Similarly, the Director will document:
  - The problem/concern
  - The facts surrounding the matter
  - The attempts made to resolve the situation, and
  - Any suggested solution to the problem.

* Both reports will be forwarded to the Executive Director of New Leaf: Living and Learning Together Inc. within 7 days of agreement to proceed with the complaint.

* The Executive Director will review the documentation and situation with the Director and the person individually. The Executive Director may wish to meet with both parties together to discuss the situation and attempt to resolve the situation.

* Within 7 days of having received written documentation, the Executive Director shall inform both parties of his or her decision, or shall confirm the solution arrived at, both verbally and in writing.

* If the problem remains unresolved or if the person is dissatisfied with the response, the matter may be referred to the Board of Directors through the Executive Director.

* The Executive Director shall prepare a report containing:

- His/her perception of the problem
- The facts he/she has obtained
- The documentation of the person and the Director
- The attempts made to resolve the problem
- The suggested solution to the problem
- Any recommendations for preventing further occurrences of the problem.

* This report is submitted to the President of the Board of Directors. The President may delegate this matter to another individual or individual(s). The President or delegated individual(s) will review the documentation and may invite presentations from relevant parties as appropriate. A response shall be provided in writing within 7 days of having received all documentation and presentations.

The decision of the President or individual(s) delegated by the President shall be binding. Should the person feel that the matter is unresolved to their satisfaction they will be informed of other appropriate avenues to pursue.

CLIENT RECORDS AND FILE MANAGEMENT

EFFECTIVE DATE: _____March 23, 2009______ POLICY #: __PR-04________

REVISION DATE: _____July 11, 2011______

SCOPE:
All clients receiving service at New Leaf and the staff responsible.

RATIONALE:
New Leaf is obligated as a condition of funding, to gather and maintain records on persons accessing services. This information is accessible by the Ministry of Community and Social Services and other governmental bodies. The Agency is further obligated to collect information relevant to ensure the provision of the best possible services and supports to the people who access our services.

POLICY:
New Leaf will collect and maintain in a confidential manner, information on the persons accessing Agency supports and services. This information may include financial, medical, family and other personal information necessary for the Agency to monitor individual and program outcomes. Except for information required by the funding Ministry(s), or otherwise required under law, New Leaf will not share personal information with a third party unless we have received the written consent to do so from the individual or their designate.

CLIENT RECORDS AND FILE MANAGEMENT

GENERAL:

1) Each year, an annual person centred planning meeting is conducted and results in a Person Centred Plan or an Individual Support Agreement (ISA). This meeting is to be person centred with the objective of assisting the individual to identify goals, objectives and dreams.
The meeting is to include the people closest and important to the individual. The individual must be supported to direct the process as much as possible.
This meeting will review the past goals and objectives from all areas with information gleaned from past monthly and quarterly reports and other relevant information. The team will then set goals for the coming 12 months. Goals must be specific and have person(s) assigned responsibility to monitor outcomes.
At this meeting ensure that the client history section is updated. A medical synopsis is to be updated at this time and will include all medication changes. This will ensure a current, running medication history is always readily accessible. Include dates and significant outcomes from all medical and specialist appointments. Include a summary of medical incident reports.

Process:

1) Once the current Annual ISA Report has been created, the prior annual reports are ready for archiving.
2) Current goals and objectives are reviewed and reported on monthly report. Monthly reports are filed in relevant sections of the binder.
3) Goals and objectives are reviewed quarterly. This will be a more detailed analysis relative to the monthly report. This would normally involve discussion with the resident and team members working toward the identified outcome.

Following the completion of the Annual ISA Report, the previous year's monthly and quarterly reports will be given to the Manager for destruction. Past Annual Reports are to be archived.

Note: formal reports and assessments are to be kept on file and not destroyed. They may be archived at the discretions of the Manger. Serious Occurrence Reports must be retained and are not to be destroyed. Financial information is to be included as part of the Annual ISA Report.

Resident's Permanent File:

1) Synopsis of history – current (old histories to be destroyed)
2) Medical synopsis, reports, assessments
3) Annual ISA Report including behavioural and financial summary information.
4) Serious Occurrence reports.

Resident records are to be kept for 7 years after the last entry or 7 years after the death of a resident.

Retention of Other Records:

Financial and tax related information to be retained for 7 years.
Client menus to be retained for 7 years.
Records of Fire Drills to be retained for 3 years.
Records of inspections (fire, health, equipment, furnace etc) to be retained for 3 years.
Small Water Works records to be retained for 15 years
Personnel Records to be retained for 7 years.

FAMILY INVOLVEMENT POLICY

EFFECTIVE DATE: ___March 23, 2009______ POLICY #: PR-05_________

REVISION DATE: ______________________

SCOPE:
Immediate and/or extended members of a client's family and advocates.

RATIONALE:
Many people supported by New Leaf have family members or advocates who have been and continue to be actively involved in the lives of people receiving services.

POLICY STATEMENT:
New Leaf will encourage and facilitate the continued development of healthy family connections. New Leaf will endeavor to be responsive to the needs and wishes of family members, as indicated by the individual receiving support or their designate.

REFERENCES:
Person Centred Planning Principles

FAMILY INVOLVEMENT POLICY – GENERAL

New Leaf encourages families and advocates to be actively involved in the lives of the People we support. New Leaf will seek to maintain, as appropriate, open lines of communication with family members. The degree and nature of the contact will be directed by the wishes of the person receiving services or their designate. New Leaf will seek to inform families and advocates of any significant event or development in the individual's life in a timely fashion.

New Leaf will involve family members, advocates and others identified by the person supported at each annual Person Centred Planning meeting.

All identified family members, advocates and friends of New Leaf's residents will be invited to the agency's annual events and also to outings and events that occur in the context of their home and community if they so desire.

Families will be informed of changes related to New Leaf's structure, significant changes related top operations and each time a serious occurrence is reported to MCSS related to their family members.

New Leaf will respect our adult residents' right to privacy in all interactions with families and other stakeholders. New Leaf cannot share information that has not been consented to by the individual or their substitute decision maker.

CONSENT TO TREATMENT POLICY

EFFECTIVE DATE: ____March 23, 2009_________ POLICY #: __PR-06_____

REVISION DATE: ____July 11, 2011_______

SCOPE:
All people receiving services from New Leaf, staff, Board members and volunteers of New Leaf, Public Guardian and Trustee, family members

RATIONALE:
The agency will support the individual to consent to and obtain necessary medical treatment.

POLICY STATEMENT:
A person receiving service at New Leaf who is unable to provide informed consent to treatment will have an identified list that describes, in order of priority, those persons who are legally authorized to provide consent to treatment.
Should a person refuse to obtain, or accept the medical recommendations from a qualified medical practitioner this information will be documented as a medical incident report. All reasonable action will be taken to assist the individual to make appropriate and informed decisions regarding their health care. Where an individual is incapable of giving informed medical consent, the legal medical substitute decision maker will be contacted to provide the required consent.

REFERENCES:
Health Care Consent Act – Ontario

CONSENT TO TREATMENT POLICY

GENERAL:
There are two ways to determine whether or not a person is capable of giving their own consent to treatment.

In the first instance, the attending physician will make that determination upon examination. If the physician believes the person is not capable of providing their own consent, they will refer to the substitute decision maker list and obtain consent starting with the first person on the list and moving downward if that person is unavailable / unable. The Public Guardian and Trustee is the consent giver of final resort.

In the second instance, a person may already be deemed incapable by a capacity assessor and those people must have consent provided by the specified party(ies). This may either be a designated family member or the Office of the Public Guardian and Trustee.

At no time, will anyone employed by or acting on behalf of New Leaf provide consent for anyone receiving service at New Leaf.

TRUSTEESHIP (CLIENT)

EFFECTIVE DATE: ___March 23, 2009______ POLICY # _PR-07________

REVISION DATE: _______________________

SCOPE:
Those formally appointed as trustee for a disabled person.

RATIONALE:
Adults (18years of age +) with disabilities may not be able to make sound decisions regarding finances, personal assets and/or estates. In this case it is necessary to have a formally appointed trustee in place to manage any assets associated with that person. A trustee can be a family member or a representative from the Office of the Public Guardian and Trustee (Ontario).

POLICY STATEMENT:
Trustees are appointed with the singular responsibility of ensuring careful and sustainable finance and asset management for an identified person with disabilities.

REFERENCES:
Office of the Public Guardian and Trustee (OPGT) – (Ministry of the Attorney General), Ontario Disability Support Plan (ODSP), New Leaf Finance Policy

TRUSTEESHIP (CLIENT) - GENERAL

There are two significant areas where a trustee may be appointed for a person's finances:

1) A capacity assessor may deem a person to be incapable of managing funds and will appoint the OPGT or a family member as trustee for finance. In this case all purchases and expenditures are vetted through the trustee and the client must request, or have an advocate request funds on their behalf. Only those expenditures deemed to be appropriate will have funds provided for those purchases. New Leaf, as advocate, will maintain constant contact and reporting of client needs with appointed trustees to ensure that all client needs are met within the scope of prudent and responsible financial management. New Leaf's employees, volunteers and Board will not act as trustee for any client except in the case outlined below (#2).
2) ODSP may appoint the client, a family member or New Leaf as trustee related to funds provided by this office. Where New Leaf is established as trustee for ODSP, it will ensure that sound and strict internal controls are in place as outlined in New Leaf's Finance Policy. Where the client or family member is established as trustee, New Leaf will work with these parties to ensure, as much as is possible, that sound financial practices are consistently employed and the client does not suffer undue financial hardship.

CLIENT HEALTH CARE

EFFECTIVE DATE: ____March 23, 2009______ POLICY #: ___PR-08_______

REVISION DATE: _____January 13, 2014_________

SCOPE:
All persons receiving service at New Leaf.

RATIONALE:
Supports and services for maintaining optimal health, both mental and physical are critical to contributing to the overall well being of the people we support.

POLICY STATEMENT:
All New Leaf residents must have their health concerns addressed by an appropriate medical professional in a timely fashion.
New Leaf will ensure that each person supported is provided with relevant information regarding their health, and will be supported to make informed choices about this health.

REFERENCES:
Ontario Disability Support Plan (ODSP), New Leaf Client Rights Policy, Ministry of Health and Long Term Care

CLIENT HEALTH CARE

GENERAL:

All New Leaf residents will have access to a family doctor and will see that doctor for a formal physical once per year. Any additional physical health concerns are to be addressed expediently.

OHIP provides for eye examinations for people with disabilities to be carried out once every two years. These examinations are paid for by OHIP and must be provided to the residents.

ODSP provides coverage for dental care and pharmaceuticals. All New Leaf residents will have access to a dentist and visit at the frequency allowed under those benefits. More frequent visits may be arranged as needed.

Any additional supports required for the overall well-being of clients will be provided as expediently as possible. These supports include but are not limited to:
Psychiatrist, Psychologist, Occupational Therapist, Speech Language Pathologist, Behaviour Therapist, Chiropodist, Massage Therapist and Emergency Medical Services (EMS). All additional supports are recorded on a Medical Incident Report, Medical Report, and/or an Incident Report. Use of EMS must be reported to the Manager, and in consultation with the Director of Services, report the use of EMS to the individual’s primary contact, and where required, submit a Serious Occurrence Report within 24 hours.

New Leaf will endeavour to ensure that individuals and/or their advocate are provided with current health information as relevant to their situation.
Health care concerns and development will be addressed in the person’s ISA (see PR-09 Health Monitoring section).

Regulated Health Professions Acts (1991)

New Leaf is committed to ensuring that employees provide the highest quality care to the individuals they support. Under Ontario law, certain acts, referred to as “controlled acts,” may only be performed by authorized healthcare professionals. However, under appropriate circumstances, these acts may be taught or delegated to others. Teaching controlled acts that are considered Acts of Daily living under the RHPA can result in a

higher quality of life and the opportunity for individuals to live in their community instead of an institution.

1. Controlled acts are defined as acts that could cause harm if performed by those who do not have the knowledge, skill and judgment to perform them and are set by the Health Professions Act, 1991 (RHPA).

2. Only regulated professionals who are authorized to perform a particular controlled act and are members of a regulated body can teach or delegate that controlled act to unregulated care providers as outlined in the RHPA.

3. The RHPA outlines certain exemptions in section 29 where persons may perform controlled acts if they are delegated or done in the course of

a) rendering first aid;
b) fulfilling the requirements of becoming a member of a health profession;
c) treating a member of one's own household;
d) **assisting a person with his or her routine activities of living (ADL)** and the act is set out in paragraph 5 or 6 of subsection 27 (2).

4. A controlled act remains controlled even when it is considered an Act of Daily Living.

5. ADL must still be taught by a professional this is authorized to perform the controlled act.

6. If a controlled act that cannot be defined as an ADL as per the RHPA must be delegated. True delegation is something that should take place as a last resort and is for a limited period of time. Delegation is a transfer of authority to perform the act and the nurse holds liability for the actions of the UCP. New Leaf will not enter into delegation agreements. If the ADL cannot be taught the procedure must only be performed by an authorized professional.

7. The competence of staff performing a controlled act that has been taught must be monitored and documented on a regular basis. The monitoring parameters are individualized to the act and the client. Monitoring can take the form of direct monitoring or indirect monitoring.

MEDICATION MONITORING, ADMINISTRATION AND MANAGEMENT POLICY

Effective Date: __September 25, 2009_____ Policy#:__PR-09___

Revision Date: ___April 12, 2013 __

SCOPE:
All staff and volunteers who provide direct care to service recipients at New Leaf and who may have occasion to support clients in the management and monitoring of their medication.

RATIONALE:
Staff and volunteers at New Leaf are entrusted to provide the highest quality of support possible to individuals in service. One of the most critical responsibilities entrusted to staff in supporting individuals is the management and monitoring of their medications ensuring that this is done appropriately and that the highest priority is placed on individuals' safety and well being.

This policy clearly defines the appropriate approach and procedures for the management and monitoring of medication with, and on behalf of, each individual in service. It also serves as a reminder to all who provide direct care to be meticulous and vigilant in the fulfilment of their responsibilities in this area.

The New Leaf programs and services listed below will adhere to this policy framework with assumption that all persons in service require the intense level of staff involvement as articulated in the policy. We accept and expect that under certain circumstances, a person in service who is educated by staff and other stakeholders and demonstrates the ability to be more independent in managing and monitoring their personal medications, will require a reduction in staff support as detailed in the policy. Program and service areas where this policy is in effect are as follows:

1. Residential Services
2. Day Services
3. Safe Bed Supports

In situations where staff oversight is not required to be as intense as detailed in the policy, the individual's support plan must clearly articulate where, how and why staff may not be required to follow the policy as written. Any time this circumstance occurs, the Program Manager must have approved, in writing that deviation from this policy has been shown to be a safe practice.

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POLICY STATEMENT:

1. The assurance of the client's health and safety shall be the primary concern in administration, monitoring and storage of medications.
2. A client shall have the right to regular medication reviews by his/her physicians and efforts should be made to reduce unnecessary medications through consultation with the client's physician. The client and their family are to be educated and encouraged to be involved in decisions related to medications.
3. Every effort will be made to increase each client's and the client's families' understanding of the medications they are prescribed.
4. All staff will have a sound understanding of the medications they are responsible for administering.
5. An up to date list of each resident's current medication should be made available to any healthcare practitioner from whom a resident receives consultation and/or treatment.
6. Staff must have successfully completed the medication training, and demonstrated a basic knowledge of medications, administration procedures and documentation at a given program before they may administer medication at that program.

STAFF TRAINING

SmartMeds Medication Monitoring and Management Training is given to each new full / Part time or relief staff member by a SmartMeds Representative or the designated senior staff for health matters relating to the residents (e.g. medication, seizures, respiratory problems, medical routines, communicable diseases, general health practices etc.). At the end of the 1 hr training, each staff will obtain a certificate stating that they are now qualified to dispense medication. To assure best practices further training for new staff is required.
Training for new staff consists of the following;

1) A one hour SmartMeds in house training, facilitated by a SmartMeds Representative;
2) The supervisor or person in charge will provide a thorough and detailed history of each clients' unique medical and/or psychiatric needs;
3) New staff will observe medication being dispensed and administered by *qualified staff persons on three separate occasions;
4) New staff will dispense and administer medications on three separate occasions while being observed by *qualified staff;
5) New staff will have to successfully complete the above two steps before dispensing and administering medication as *qualified staff;

*(staff who have completed medication training and are designated by the Program Manager)

Refreshers for SmartMeds medication training will be conducted annually.

MEDICATION STORAGE:

All medications must be safely stored and supervised in accordance with applicable legislation.

Procedure:

a) Keep medication locked at all times with the keys in the possession of a designated staff member.
b) Maintain Store Flex Bins (blue bins) in the medication cabinet or in a designated area.
c) Ensure that the supply of medication currently being used is finished before starting the next package.
d) Monitor expiry dates on a regular basis (monthly), especially PRN's, narcotics, and treatments.

MEDICATION PASS:

All medications administered are listed on the individual's MAR Sheet. Adhering to administration and documentation procedures ensures each individual receives the correct medication. Only staff trained in the SmartMeds Medication Monitoring and Management training can administer and dispense medications to individuals supported at New Leaf, and according to the specified standards of administration and documentation. When an individual expresses an interest in managing their own medication dispensation, the agency will ensure that the individual is provided with the education and training to safely and appropriately administer the medication. Verification of competency will be sought from the individual's primary health care provider and/or primary contact, where indicated.

Procedure:

1. Locate the first individual's MAR sheet and sealed package strip.
2. Identify the individual by using the MAR sheet picture or picture on the store flex bin.
3. Ensure the individual is ready to take medication.
4. Working in pairs, one staff will read the MAR sheet for the names of medications to be given, the dose, and whether or not a drug holiday is in effect. The second staff will confirm the information on the sealed med cup/package strip for each pass.
5. Open each strip pack at the perforation and pour contents into medication cup.
6. Check the identity of the individual before giving the medication, and remain with the individual until the medication is taken. Medication should be administered to an individual in pairs (administrator and witness), unless only one staff member is on shift during that medication dispensation time.
7. Initial the MAR sheet to indicate that the medication has been given and use the appropriate code if the dose is omitted.
8. If a medication that has already been poured is refused, it is to be placed in the medication disposal bin and the appropriate notation made on the MAR sheet. Medications should never be placed back into the container.
9. Both the administrator and the witness sign the "Dispensation of Daily Medication" form which is to be affixed to the front of the MAR binder each day.
10. Proceed to the next individual and continue until all medication for the medication pass is given.

Do not leave medication unattended unless all cabinets are securely locked.

NARCOTICS:

A 'Resident Narcotic/Controlled Drug Count' form must be used to monitor all PRN narcotic medication administration and shift counts.

Procedure:

1. A count of all narcotics, Lorazepam and other benzodiazepines that may potentially be abused, which are administered to residents, should be done daily and a record initialed by the Supervisor or designate. First count is to be completed at the end of shift and recorded on the Resident's Narcotic/Controlled Drug Count form.
2. Narcotics **must** be double locked. This means that narcotics are always kept locked in the medication cupboard as the first lock, and the office door kept is locked as the secondary lock.
3. Whenever a PRN narcotic is administered, staff must document the following information on the Resident's Narcotic/Controlled Drug Count Form: date, time, quantity administered, quantity remaining, dosage, and staff initials.
4. When the last dose of PRN Narcotic or Controlled drug has been administered, the Resident's Narcotic/Controlled Drug Count form must be removed from the MAR binder and kept on file with each Residential manager.

Any loss or suspected theft of any narcotic is to be immediately reported to the Residential Manager, Director of Services or the on call manager (after hours).

PRN MEDICATIONS:

Administer the right drug to the right person in the right dosage at the right time using the right method of administration.

All PRN* medications must be documented on the MAR sheet and Dispensation of Daily Medication and must include the following information (For OTC medications, see separate from). All behavioural PRN must be documented on a PRN Monitoring Sheet accompanying by the ABC monitoring sheet or Incident report. PRN medication can be very effective when dealing with difficult behaviours and other intermittent medical issues. It is critical that staff follow the guidelines set forth in the PRN Protocol written for each individual that details at what point a PRN should be given. Generally, a PRN should be given in order to **avoid** a behavioural incident and should **not** be given as a result of a behavioural incident unless further incidents are imminent. All efforts to council, redirect, relocate individual, provide them with what they need, engaging different staff, ruling out underlying physical maladies etc. should be tried before administering PRN medication. Staff should **never** administer a PRN in order to sedate a client where there is **no threat** of a behavioural incident pending.

(* PRN is medication which is prescribed or over the counter (OTC) which may be administered to a resident on an as needed basis.)

1. All PRN medications must be authorized by a physician in writing.
2. All PRN medications must be reviewed by the attending physician every six months.
3. PRN monitoring form (attached) must be used and must include:
   a. Resident's name
   b. Medication name/dosage, date and time.
   c. The condition(s) for which the medication is to be given should be clearly stated.

When PRN medications are given to a resident, documentation must be made in the daily communication book for all staff to be informed. The documentation must reflect a determination as to whether or not the medication was effective and what alternative interventions might be tried for future reoccurrences.

INJECTIONS:

Injections will be administered by a licensed practitioner and in compliance with legal and regulatory requirements. Where regular injections are required for diabetes management a client will be supported by staff to effectively self administer the treatment. Where New Leaf staff are required to administer insulin injections, they may do so only after receiving training from a qualified registered nurse.

MASTER SIGNATURE LIST:

A 'Master Signature List' is maintained by the home to identify the initials of staff members who are allowed to chart on MAR sheets, and Drug record books.

Procedure:

1. All staff employed in the home enters their full name, initials (written exactly as they will be used in documentation) and signature on the 'Master Signature List'.
2. New staff members add their name to the list upon completion of medication training.
3. The residential managers keep all original completed documents, a copy to remain in the MAR book.
4. New Leaf retains all original 'Master Signatures Lists' for at least 20 years.

HOURS OF ADMINISTRATION:

New Leaf has established standard hours of administration for medication to be given. These standard times as approved by SmartMeds pharmacy are typically: 0800, 1200, 1700, and 2100 hrs.

Procedure:

1. Determine standard hours of administration of medications, for the following directions:
   a. DAILY = Once Daily
   b. BID = Twice Daily
   c. TID = Three Times Daily
   d. QID = Four Times Daily
   e. HS = Bedtime
   f. Q4H = Every 4 Hours
   g. Q6H = Every 6 Hours
   h. Q8H = Every 8 Hours
   i. Q12H = Every 12 Hours
   j. AC = Before Meals
   k. PC = After Meals
   l. CC = With Meals
   For oral antibiotic administration (if different from standard times)
   m. DAILY = Once Daily
   n. BID = Twice Daily
   o. TID = Three Times Daily
   p. QID = Four Times Daily

2. For Topical medications:

   q. DAILY = Once Daily
   r. BID = Twice Daily
   s. TID = Three Times Daily
   t. QID = Four Times Daily
   u. Q SHIFT = Each Shift
   v. HS = Bedtime
3. If the physician intends the medication to be given at a time other than the standard administration time, this must be included in the order.

4. Alternate Day dosing: Pharmacy will determine the start date on alternate day dosing unless otherwise stated on the "Physician Order" form.

5. In the case of the pharmacist recognizing a drug-drug interaction, they will decide the appropriate time for the administration of that particular medication and inform the registered staff at the home either verbally or through the clinical consult.

6. Medications to be given once a week or twice weekly: Unless otherwise stated pharmacy will determine the days in which these medications should be given using the pharmacist's professional judgment.

DRUG RECORD BOOK:

Procedure: How to document the ordering and receiving of medications from the pharmacy in the Drug Record Book **(DRB).**

Where: Each residential home has a DRB containing the Drug Record Book sheets. Extra Drug Record Book sheets are located in the forms box.

What: You will need a DRB Sheet to complete this procedure. You may also use this form to order supplies from the pharmacy such as lancets, sharps containers, forms, etc. The DRB is a communication tool between staff and the pharmacy. It also facilitates communication between staff on different shifts with regards to orders placed with the pharmacy and any med changes that may have occurred.

How:

1. The law states that the following information needs to be recorded in the Drug Record Book for any new or reordered drug requested or received in the home.
    a. The date the drug is ordered
    b. The signature of the person placing the new order
    c. The name, strength, and quantity of the drug
    d. The name of the home from which the drug is ordered
    e. The name of the resident for whom the drug is prescribed, where applicable
    f. The prescription number for re-orders
    g. The date the drug is received.
    h. The signature of the person receiving the drug in the home.
2. Entries in the DRB must be signed and dated.
3. Fax both the DRB sheet to the pharmacy with the new Physician Order (if the physician has not already done so).
4. All medications will arrive with the Received **(pink)** and Re-order **(yellow)** labels either stuck on the medication container or together with the strip pack
5. When the new order is received by the staff at the home, the Received **(pink)** label is peeled off and placed directly below the request on the DRB form. The staff member will sign and date the transaction.

6. When re-ordering any medication check the current MAR to ensure the medication is active.

7. Peel off the Re-order **(yellow)** label and place it onto a blank space on the DRB sheet.
8. Then fax the DRB sheet containing the Re-order label **(yellow)** to the pharmacy.
9. When the order is received, place the Received **(pink)** label directly below the corresponding Re-order **(yellow)** that was initially faxed to the pharmacy.
10. Sign and date the transaction
11. All full DRB sheets must be kept on record for at least 2 years and should be archived by each homes residential manager.

NEW PHYSICIAN ORDERS:

Procedure: How to process a new Physicians order

Pharmacy can only accept written orders on a physicians order form, six month review, or doctor's telephone orders.

How:

1. For individuals returning to the home with prescription from their physicians or specialists, the staff needs to fax the prescription to SmartMeds pharmacy.
2. The new order must include the drug name, strength, dosage form, quantity, prescription duration, directions for administration, doctors name, and if applicable where the drug should be applied (topical, eye drop etc.).
3. If a medication is put on hold, the Physicians Order must specify on which date the hold will be initiated. This way the change on the MAR will correspond with the replacement pack.
4. Whenever there is an order change or a new order during the week and it affects the strip pack, the pharmacy will send the replacement pack and a replacement pack label, and Drug Record Book labels (Received/Re-order).
5. The replacement pack is a strip package containing medications reflecting the order change to carry on until the next pack start date. On receiving the replacement pack, the old pack must be put in the medication disposal bin and the new replacement pack should be placed in the individuals storage bin.
6. For all New Physicians Orders, the change will always start from the next full day, unless otherwise noted by the SmartMeds Pharmacy. A Surplus Medication form must be attached.

RECEIVING WEEKLY MEDICATIONS:

Procedure: How to receive weekly strip packages.

Where/When: All weekly deliveries will arrive at each home on a designated day and time.

What: Each individual's medication gets packed in a strip pack which contains seven days supply of medication. The strip pack is divided by the day of the week and sub divided by the times of administration. The first and last pack in the strip lists the

summary of the medications, identifying each drug by Generic and Brand Name, the strength, and total quantity of each medication strip.

Each strip package would have the following printed on it

- Name of Individual
- Strip number (1 of 1, 1 of 2…)
- Name of residence
- Day and date of administration
- Time of administration
- Name of the medication
- Strength of the medication
- Description of the medication (colour and shape of pill)
- Quantity of each medication
- Name of Pharmacy
- Administration times (e.g. Breakfast 0800, Lunch 1200, Dinner 1700, Bedtime 2100)
- Total # of pills per package

How:

1. On a designated day the home will receive each individual's weekly medication.
2. The strips are arranged in a secure SmartMeds Pharmacy bag.
3. The supervisor on duty (or person in charge) must make certain that each strip corresponds to the individual's MAR to ensure the medications are correct and ready to start for the first designated pass. Staff must also compare the old MAR sheet(s) to the new MAR sheet(s) to ensure that any changes or updates were captured.
4. Note in the Drug Record Book if packages are missing and contact the on-call pharmacy immediately.
5. Replacement packs for order changes, newly prescribed medications or re-ordered items will also arrive with this delivery but in a separate bag. Follow the DRB procedure for receiving these medications.

Day Services:

1. SmartMeds will continue to package the weekly medications in the individual's strip.
2. If an individual attends a day program, it is the responsibility of each home's staff to organize med transfers to Day Services.

RECEIVING DAILY MEDICATIONS:

All medications received into the home are checked for accuracy and their receipt recorded in the Drug Record Book

Procedure:

1. When a residence is scheduled for a delivery outside of the regular weekly delivery.
2. The delivery driver will hand staff the medications which will come in a paper bag identifying the name of the home.
3. Staff are to check the number of bags they are signing for is correct and then initial and print their name on the Receiving Daily Medications Form.

4. Staff then checks all medications received for accuracy of individuals name, medication, dosage, and directions.

5. Using the received labels from the delivered medications match them up with the new orders or re-orders on the Drug Record Book, sign and date. If the quantity received differs from what was ordered, note in the drug record book.
6. Read all communication sheets that may be attached to any orders (e.g. clinical consultation).
7. Contact pharmacy if medication looks different in any way.
8. If medication received has not been ordered (it is not recorded in the Drug Record Book), investigate further before documenting receipt of the order.
9. Staff are to complete any necessary Medication Change Forms, update the MARS as necessary, and inform Shift Supervisors and the Residential Manager of any medication changes.

TRANSCRIBING PHYSICIANS ORDERS TO MAR SHEETS:

All physician orders are transcribed accurately and completely to the MAR sheet

Procedure :

1. Adding New Orders:

a. Include name and strength of medication, dosage, route if other than oral, full directions, and duration of treatment if specified, date of the order, and start date.

b. Add time of administration in the hour's column. (Use the standard hour form to pre-determine what pharmacy will choose).

c. Draw a vertical line to indicate the start of the first dose.

d. If medication is to be administered on anything other than a daily basis, score out the boxes for the days the medication is to be omitted.

e. If the medication is to be administered on an infrequent basis (weekly or monthly) highlight or draw a square around the box for the day(s) of administration.

* Staff must complete a Medication Change Form and inform their Supervisor and the Residential Manager of any medication changes.

2. Discontinuing Orders

a. Place an "X" through the entire box containing the medication order to be discontinued.

b. Draw a vertical line after the last dose.

c. Write D/C and then date and initial after the last dose given.

* Staff must complete a Medication Change Form and inform their Supervisor and the Residential Manager of any medication changes.

3. Changing Orders

a. Any change in a medication order is considered to be a new order.

b. Discontinue existing order.
c. Write the new order in the next available space on the MAR.

* Staff must complete a Medication Change Form and inform their Supervisor and the Residential Manager of any medication changes.

4. Important

a. It is the responsibility of the staff member transcribing the new order to fax the order to the pharmacy.
b. It is the responsibility of the staff member transcribing the discontinued order to remove all discontinued medications from the med cart or other storage areas.
c. It is the responsibility of the staff member transcribing the changed order to order a new supply of medication if required or remove surplus medication from storage areas.
d. Transcribe all medication orders on both the current MAR and the following months MAR if it has been received in the home.

MEDICATIONS FOR DISPOSAL/SHARP CONTAINERS PICK-UP:

All medications which become surplus due to discontinuation or refusal, change in order or expiry, are destroyed according to applicable legislation.

Procedure:

1. All surplus and discontinued medications are to be placed in the bin designated for medications for disposal.
2. SmartMeds and New Leaf have agreed upon a monthly pick up date.
3. If a residence requires a sharps container (either new or re-order), it is to be ordered via the Drug Record Book.
4. Full sharps containers will be picked up along with med destruction on the prearranged designated day.

MEDICATION ERRORS:

Each of the following constitutes a medication error:

a. Missed or forgotten medication (exceeding one hour either before or after the designated dosage time).
b. Administering the wrong medication or an incorrect amount of medication.
c. Administering a medication at the wrong time.
d. Administering medication to the wrong person.
e. Client refusal
f. An error in procedure or documentation.
g. A found pill.

Procedure:

In the event of a medication error, of types (a) through (d), staff will follow the procedures in the order provided:

a. In case of potential health risk, staff will seek medical advice (i.e. Poison Control, local Emergency Department, On-call SmartMeds pharmacy).
b. Immediately contact the Residential Manager and/or the Manager On-Call (905)955-9511
c. Document using the correct code on the Medication Administration Record.
d. Complete a Medication Error Report. All completed Medication Error Reports must include the name of the staff(s) that apparently made the error.

- In the event of an error in procedure or documentation, or in the case of a found pill, staff will deal with the error beginning at step (c), above.

- A found pill is an error for the obvious reason that we have apparently failed to ensure that a supported person has ingested his medication. This may be impossible to determine who may have been at fault. This is not important. Staff are to complete a Medication Error Report.

- Errors in procedure and documentation are to be understood as follows:
  An error in procedure occurs whenever a person deviates from the step by step protocol for administering medication, as set forth in this policy.
  An error in documentation has occurred if it is discovered that a medication was given but not initialled as having been given, or that the appropriate status was not entered.
  An error in documentation has occurred if it is discovered that a medication was initialed as given, but was not administered.

MEDICATION REFUSAL:

All residents of New Leaf have the right to refuse medication. Where a physician has determined that medication is necessary for the health and safety of a client, administration should take place in accordance with the principle of the least restrictive alternative.

1. Individualized counseling
2. Have alternative staff attempt to administer
3. Try again within one hour

RESIDENT ILLNESS

When a resident vomits after taking a prescribed medication, the staff should attempt to determine how much, if any, of the medication was emitted. With this information, the staff member should then first contact the pharmacy, family physician, medical consultant or nearest hospital for direction with regard to the procedures to follow (i.e., whether or not to administer additional medication, signs/symptoms to be observed). Staff are to document on a Medical Incident Report.

RESIDENT MEDICATION WHILE ABSENT FROM SERVICE

All medication leaving a New Leaf residence must be contained in the pharmacy labeled pack with enough medication for the length of stay plus an additional 24 hour supply.
The Daily Medication Chart While Absent form must be read, signed and sent with the medication.
Ask the person signing for medication if they have any questions, concerns or require clarification.

FOOD SERVICES POLICY

EFFECTIVE DATE: __March 23, 2009_________ POLICY #: __PR-10_______

REVISION DATE: _____July 11, 2011_________

SCOPE:
All staff, volunteers and residents of New Leaf

POLICY STATEMENT:
People receiving support at New Leaf will be provided with healthy, high quality foods and will be involved in menu planning and preparation of meals. Dietary issues will be dealt with based on individual needs/wants and menus and supplies will be adjusted accordingly.

REFERENCES:
Canada Food Guide, Bill 77 and accompanying regulations

FOOD SERVICES POLICY

GENERAL:

Interesting, nutritious and appetizing menus are designed and distributed weekly. As each home receives a copy it provides staff and residents with complete information regarding daily breakfast, lunch, dinner and evening snack for a designated week. All general food orders are filled according to the menus and all pertinent ingredients and supplies for each meal are made available and prepared for pick up on a designated day at the Farm's storeroom.

Individual meal preparation guidelines are made available, if necessary, on the menus. Each residence has several cookbooks available. Meals are composed around the Canada Food Guide and provide all essential nutrients. Fresh produce is used as much as possible. Daily menus can be switched as long as the food items originally ordered are used.

Where possible, when a home makes individual plans for dining out, the Manager of Purchasing should be advised ahead of time. This will avoid any unnecessary or surplus supplies.

Supplies are more than adequate and it is the agencies policy to make sure that each resident is provided with satisfying, ample and healthy meals. It is also in the interest of the client and the agency to encourage and provide a healthy lifestyle, which includes food consumption in moderation. Residents and staff should work together and watch for over-eating. This includes eating and/or snacking when outside the home.

Clients should be encouraged to be actively involved in menu planning, securing supplies and preparation of meals. Menus are to be kept on file for twelve months and must be reviewed by a dietician twice per year. Menu plans shall reflect the diversity of the various cultures and religions of the people being served.

RESIDENT'S RIGHTS

EFFECTIVE DATE: ____March 23, 2009________ POLICY #: __PR-11________

REVISION DATE: __April 12, 2013________

SCOPE:
All people receiving service at New Leaf.

RATIONALE:
All Canadians have rights identified under the Canada Charter of Rights and Freedoms regardless of gender, age, ethnicity, orientation and ability.

POLICY STATEMENT:
People receiving service at New Leaf, like any other person in Canada, have rights as outlined in the Charter of Rights and Freedoms.

REFERENCES:
Canadian Charter of Rights and Freedoms.

RESIDENT'S RIGHTS

SPECIFICALLY:

1. A resident has the right to be protected from physical or emotional abuse. Any physical abuse by a staff person is absolutely forbidden, and failure to adhere to this policy will result in immediate dismissal.

2. A resident has the right to privacy. Each resident should possess space where he/she may keep their personal items.

3. A resident has the right to decorate his personal living area as he/she chooses. Staff should encourage and give guidance to ensure the décor of the person's living area is appropriate.

4. A resident should be addressed with respect at all times and proper names of the person should be used.

5. A resident should have an opportunity to voice a grievance with a staff member and the Manager of the program. A resident is entitled to voice a grievance in meetings with the staff and can request the services of an advocate.

6. A resident should have access to all information such as any records/files pertaining to them, sexual counseling, personal hygiene, and daily living routines. This information may or may not necessarily be provided by residential staff, but the staff should be willing to help the individual to obtain the relevant information.

7. A resident has the right and should be encouraged to vote.

8. A resident has the right to send and receive mail without censorship.

9. A resident has the right to receive visitors and make telephone calls.

10. A resident has the right to have a personal bank account. Instructions on how to go to the bank, open an account, deposit and withdraw money should be given where possible to each resident.

11. A resident has the right to religious freedom and practices.

12. A resident has the right to demand and receive prompt medical/dental care and treatment.

13. A resident has the right to refuse any treatment inappropriate to his/her well being including behaviour management procedures, medications, or counseling services, or medical services that are recommended by a legally qualified medical practitioner or other health professional Any refusal of treatment must be documented on a Medical Incident Report and reviewed by the Residential Manager, Director of Services, and communicated to the individual's primary contact. All efforts will be made to educate and counsel the individual where treatment is deemed in the individual's best interest and welfare.

14. A resident has the right to choose their clothing and personal possessions.

15. A resident has the right to receive legal services.

16. A resident has the right to be informed of, and receive community educational services appropriate to his/her needs.

17. A resident has the right to leave an accommodation setting which he/she feels does not meet his/her personal needs. Staff should be prepared to offer advice and support to the resident and inform relatives/advocates and the police (if required) of the resident's departure.

18. A resident has the right to refuse foods of his/her choice and should be involved in menu planning.

19. A resident has the right to obtain the assistance of an advocate of his/her choice.

20. A resident has the right to pursue leisure activities.

21. A resident has the right to be involved in their community as they choose, subject to recognized community standards, laws and mores.

COMPLAINTS PROCEDURE

New Leaf will ensure that all individuals receiving support and their families and/or advocates are aware of their right to express complaints about any services or supports they receive from the agency and to seek remedy.

Procedure:

- Discuss the complaint with your direct support staff. This person will usually be able to answer most of your questions or concerns. If the issue remains unresolved, then you will request to speak to the Manager. at this point it is advisable that you put your complaint in writing. One of your support staff will be able to assist you if required.
- If your direct support staff is unable to provide the assistance you require, contact, in person, the Manger. The Manager will respond in a timely fashion and recorded actions taken to resolve the complaint. If the issue remains unresolved, the Manager will present the written complaint to the appropriate Program Director. If the issue remains unresolved, the Program Director will present the written complaint to the Executive Director.
- The Executive Director is available to meet with anyone who does not feel that his or her concerns have been adequately responded to. The Executive Director will pursue the necessary steps and respond in writing, in a timely fashion, regarding actions taken to resolve the complaint.
- Should the issues remain unresolved; the Executive Director will encourage the complainant to approach another external advocacy group, such as the Area Rights Commission, or an Adult Protective Service Worker.
- Once the complaint has been resolved the written complaint and resolution will be placed in your confidential file.

You are encouraged to ask for help at any point in this complaint process should you wish, from your primary counselor or any other advocate of your choice.

Family members and/or advocates should express complaints to the Program Manager; Director or Executive Director.

RESIDENT RESPONSIBILITY

EFFECTIVE DATE: ____March 23, 2009_________ POLICY #: _PR-12________

REVISION DATE: _________________________

SCOPE:
All clients residing at New Leaf.

RATIONALE:
As in any cooperative living situation, everyone is expected to contribute, to the extent of their ability, to upkeep of the home, show respect for property and safety / well being of others and conduct themselves as appropriately as possible in all situations.

REFERENCES:
New Leaf Resident's Rights Policy

RESIDENT RESPONSIBILITY

GENERAL:

1. Residents should be responsible for the cleanliness of their own bedrooms.

2. Residents should (where possible) share in household duties, such as meal preparation, cleaning, etc. as an appropriate stage in life skills training.

3. Residents should show respect for the property and privacy of others.

4. Residents should be responsible for demonstrating appropriate behaviour, both in residence and the community.

5. Residents should be responsible for informing residential staff of their whereabouts when absent from the residential program for extended periods of time.

INDIVIDUAL SERVICE AGREEMENT (I.S.A.) SERVICE SUPPORT PLAN

EFFECTIVE DATE: ____March 23, 2009______ POLICY #: __PR-13________

REVISION DATE: ________________________

SCOPE:
All clients receiving service at New Leaf, responsible staff, families and other stakeholders.

RATIONALE:
ISA planning is a process of setting goals for individuals with specific needs and defining steps for achieving these goals. The approach is based on the premise that, given appropriate opportunities, each individual is capable of change and positive growth throughout his or her life. In the ISA this is contractually outlined.

POLICY STATEMENT:
The agency's policy on ISA's will be to follow as closely as possible the concept and the format as laid out in the discussion and guidelines that follow.

REFERENCES:
New Leaf policy.

INDIVIDUAL SERVICE AGREEMENT (ISA) SERVICE SUPPORT PLAN

GENERAL

In the Person Centred planning process and contractual agreement, the client, his/her family and key service providers work together to ensure that the individual's needs are met. Working as a team, they begin a careful consideration of all aspects of the individual's development and environmental circumstances. The team selects overall goals and specific objectives, decides on methods to achieve them, and designates responsibility and target dates. The team's decisions are clearly and concisely recorded in a written plan of action; the individual program plan and individual service agreement.

GUIDELINES

The ISA should include (inter alia)

* Involvement in meaningful daily and weekly routines, schedules and activities which involve the home, and work environment community as well as events of personal or public significance.
* Progressive normal life experiences.
* Respect and consideration for the wishes and choices of the person as well as his/her right to self determination.
* Life in a social world that includes friendship and meaningful involvement with others.
* Access to financial assistance and sheltered or competitive employment.
* Environments where all activities are modeled on those available to the mainstream of society.
* any medical, physical or psychiatric needs.

RESIDENT PRIVATE SPACE

EFFECTIVE DATE: _____March 23, 2009_____ POLICY #: ____PR-14_____

REVISION DATE: __April 5, 2011______________________

SCOPE:
All persons receiving residential services at New Leaf.

RATIONALE:
It has been determined conclusively that much that causes dissension, upset and other dysfunctions is precipitated by the forced proximity (however necessary) to others who may experience similar anxieties or dysfunctions.

POLICY STATEMENT:
The right to privacy, individual personal needs, idiosyncrasies and limitations (physical or otherwise) and the dignity of the individual will be the determining factors in the organization and furnishing of each individual's private room.
Admission to their privacy space, except in cases of emergency, will be at the invitation of the resident. The exceptions are: where a resident does not respond to knocking on the door or a vocal request and in order to ensure their well being, or where danger is suspected – entry is permitted.

RESIDENT PRIVATE SPACE

GENERAL:

It is the policy of New Leaf Inc. that all residential clients will be provided with a private individual bedroom in the residence in which they dwell. Every such bedroom will have adequate closet space for storage of clothing and personal possessions. Appropriate bedroom furniture and bedding in good condition will be provided.

Each room will be decorated tastefully (paint and/or wallpaper, window blinds and/or curtains, lamps and wall decorations). Where possible the individual resident will be involved in the choosing of furnishings and other room appointments.

If requested by a client, their room will be equipped with a door lock, the key for which will be in the possession of the particular resident (a master key for all bed rooms will be kept by staff for emergencies).

SERVICE REVIEW PROCESS (CLIENT)

EFFECTIVE DATE: ___March 23, 2009________ POLICY #: _PR-15_______

REVISION DATE: ________________________

SCOPE:
All persons receiving service at New Leaf, employees and community partners

RATIONALE:
Current services may cease to be adequate to support a persons' needs for a variety of reasons. They may have behavioural, medical or psychiatric needs that New Leaf is unable to support. In these circumstances, alternative supports may be sought.

POLICY STATEMENT:
New Leaf will commit to providing supports to all residents and in circumstances where this is no longer possible, will access service resolution mechanisms in the appropriate region.

GENERAL:
Both the Toronto and Central East regions provide Service Review Committees made up of community partners related to all service areas including: developmental services, mental health, respite services and behaviour management services and long term care. Should New Leaf determine that it can no longer meet a client's needs, New Leaf management will engage in the service review process within the appropriate region.

REPORTING AND MANAGING ABUSE AND SUSPECTED ABUSE

EFFECTIVE DATE: _____March 23, 2009______ POLICY #: __PR-16______

REVISION DATE: _____September 6, 2011_____

SCOPE:
All employees, volunteers and stakeholders providing service to clients of the agency.

RATIONALE:
New Leaf is committed to the belief that each person that we support is a citizen with all the rights, dignity and prerogatives of a citizen of Canada. As such, each person should be able to expect to receive supports needed without fear of abuse in any form. Therefore, each staff and volunteer shares in the responsibility for creating and maintaining an environment free from abuse.

REFERENCES:
"Protecting Our Clients", Canadian Charter of Rights and Freedoms

REPORTING AND MANAGING ABUSE AND SUSPECTED ABUSE - GENERAL

Client Abuse includes:

a) The infliction of physical harm upon a client;
b) The sexual molestation or sexual exploitation of a client;
c) The failure to provide a client with required medical treatment and/or meet basic needs.
d) The infliction of severe emotional harm upon a client.
e) Financial misappropriation.
f) Verbal threats, insults and demeaning language

The laws that apply to the conduct of all citizens apply to staff and volunteer involvement in the lives of the people we support, in their homes, places of employment, and places of learning.

Given that these individuals come to us for support on a voluntary basis with a sense of trust in our intent, the Agency considers abuse, whether sexual, physical, psychological, verbal or abuse through omission abhorrent when perpetrated against a vulnerable person by an individual who is employed to, among other things, safeguard the dignity of the individual.

This agency considers any form of abuse or neglect unacceptable and will not tolerate staff or volunteers committing such acts. Any allegation related to such action will be immediately investigated. It shall be standard procedure that any act of criminal abuse shall be reported to the police.

The Agency reserves the right to lay criminal charges when warranted.

All staff, volunteers, and stakeholders must understand that individuals that we support are entitled to the same protection under the law that applies to all citizens of Canada. The Agency therefore has a duty to support and defend the rights of these persons under the law. Any criminal act or civil tort which is proven to have been committed against a person we support by a staff or volunteer is a betrayal of confidence so serious in nature that a single incident is grounds for immediate dismissal without requirement for progressive discipline.

Any staff or volunteer found guilty of an act of abuse or neglect through commission or omission will be dismissed.

All incidents or allegations of client abuse or neglect, whether by agency staff or others, shall be reported immediately to a Manager or Director.
Where there is suspicion that any suspected or witnessed incident of abuse may constitute a criminal offence, New Leaf shall immediately report to the police the alleged, suspected or witnessed incident of abuse; and New Leaf staff shall not conduct an internal investigation before the police have completed their investigation. When a staff member has opted to directly contact police to report alleged criminal abuse, they must immediately thereafter notify a Manager or Director.
The Executive Director or designate shall be promptly informed of all allegations of abuse or suspected abuse.
Failure to make reports shall not be tolerated by New Leaf and will lead to disciplinary action which may include dismissal.

Note: The police must be notified even when the victim does not want them to be notified.

The resident/client involved must give their consent before notifying any other persons or parties, provided the individual is capable of giving consent. If the resident/client involved has a person acting on their behalf, that is court ordered, the persons consent would not be required. If the resident/client has a person acting on their behalf, that is not court ordered, consent from the person would be required, if the person is capable of giving consent.
Any action taken or not taken by New Leaf with respect to such occurrences shall be subject to review by the victim, and/or with the family provided the consent of the victim has been obtained.

PROTOCOL:

New Leaf will report to the police, all allegations of abuse. The police will be contacted to conduct the investigation where the initial report suggests abuse has occurred.

In such a case staff must not conduct any investigation or discuss the facts of the incident with the individual in order not to contaminate the information.

If the police are involved, New Leaf will make every effort to ensure ongoing sharing of information to enable New Leaf staff to support the individual and other staff. It is the

intent of this process to conclude the investigation in a timely and efficient manner and to do so with the least disruption to the operation of individual's lives and the Agency as possible.

If an individual requires aids to facilitate communication, these shall be made available.

When requested by the alleged victim, a person whom he/she trusts will be allowed to support the person during the investigating process. Under no circumstances shall this person conduct the interview. Provision must also be made that this individual does not "contaminate" the evidence by coaching or leading the individual through the investigation process.

If a medical examination is required as part of the investigation, this shall be carried out by a physician knowledgeable about abuse and in a manner that is not distressful for the individual. Information about the individual's special needs and/or handicap shall be given to the physician.

PROCEDURE:

To assure that all incidents are managed in a fashion which respects the rights of all involved and ensures that the principle of innocence until proven guilty is upheld, the following will occur:

- the alleged abuser will be removed from client contact immediately to ensure protection for both alleged victim and accused;

- the alleged abuser will not resume duties until completion of the investigation by appropriate external and/or New Leaf authorities and New Leaf is satisfied that the matter is resolved;

- should charges be laid against the staff alleged to have committed an offence they will either:
    - work in an administrative capacity with no client responsibility, or
    - not work and receive pay until resolution, or
    - not work without pay until resolution.

Individuals found guilty of abusing a client will be terminated from employment with New Leaf.

USE OF FORCE AND RESTRAINT

EFFECTIVE DATE: ____March 23, 2009________ POLICY #: ____PR-17______

REVISION DATE: _________________________

SCOPE:
All staff and volunteers providing service to clients of New Leaf.

POLICY STATEMENT:
The general rule is that physical restraint is forbidden except in exceptional circumstances described below. The least invasive approaches to dealing with problematic behaviours must always be employed prior to use of physical restraint.

REFERENCES:
Bill 77 and accompanying regulations Reg. 272 of RRO 1990, amended 2006.

USE OF FORCE AND RESTRAINT

DEFINITION:
Physical restraint for the purposes of this policy means using a holding technique to restrict the individual's ability to move freely. For greater certainty, physical restraint does not include restriction of movement, physical redirection or physical prompting, if the restriction of movement, physical redirection or physical prompting is brief, gentle and part of a documented and approved behaviour teaching program.

GENERAL:

It is recognized, however, that under extreme conditions, physical intervention may be necessary to save life, prevent serious injury and/or to protect oneself or others. It is further recognized that carefully controlled use of force may be the least intrusive option available for some individuals during episodes of violent behaviour. The following apply to extreme conditions only and then only after less intrusive options have been exhausted:

* Physical restraint may be carried out only if there is a clear and imminent risk that the individual will physically injure or further physically injure himself/herself or others.

* Physical restraint of a resident may never be carried out for the purpose of punishing the person.

* Physical restraint of an individual can only be carried out by staff trained and certified in non-violent crisis intervention techniques, and the specific techniques to be employed.

* The amount of force used must be the least amount required in order to deliver the required treatment, and must be stopped upon the earlier of the following:
a) when there is no longer a clear and imminent risk that the person will injure themselves or others
b) when there is a risk that the physical restraint itself will endanger the health or safety of the individual.

PROTOCOL:

All incidents that involve the use of physical force must be documented using the serious occurrence reporting procedure before leaving shift, and be verbally reported to the Executive Director, or designate (managers serve as designates) before leaving shift.

The Executive Director or designate will ensure that a copy of the report is provided to MCSS, and the parent or guardian has been verbally informed within 24 hours. The President of the Board, or designate, will be notified of all incidents of restraint.

Use of physical force to control individuals we support will not be tolerated under normal conditions of service operation. Use of physical force by employees to control or restrain individuals we support, except under the conditions described in this policy statement, is considered by the Agency to be a form of abuse and may result in disciplinary action up to and including termination of employment.

INTERVENING ON BEHALF OF A PERSON'S SAFETY AND WELL-BEING

Intervention strategies sanctioned by the organization are those taught by the National Crisis Prevention and Intervention Institute. An employee is advised to allow behaviour to run its natural course, using redirection techniques and verbal interventions only.

Verbal Intervention
Verbal intervention is respectful, dignified and courteous and reduces anxiety. Any verbal intervention provided which is or may be considered disrespectful or abusive or increases a person's anxiety is not condoned by the organization and may be just cause for disciplinary action.

Physical Intervention
Physical intervention is defined as the use of physical assistance, hand-over-hand techniques, and assisting with personal matters such as lifting, repositioning, etc. Such interventions are permitted and often required.

Physical Restraint
As indicated above, physical restraint is forbidden except under extreme conditions and only after less intrusive options have been exhausted.

Immediately following a situation where physical restraint has been deemed necessary an employee must:
- complete an Incident Report detailing the circumstances leading to the use of restraint, a description of the restraint technique used, length of time the person was restrained, outcome of the incident and required follow up before leaving the shift.
- notify the Executive Director or designate of the incident before leaving shift (after hours notify the on-call manager).
- the Executive Director, or designate, is required to forward a copy of the report to MCSS within 24 hours of the incident.
- within 24 hours provide a parent, guardian, or the participant's emergency contact with a copy of the report.

All incidents of restraint must be followed by a debriefing process amongst the staff involved, and also between the staff and the individual restrained. The debriefing session(s) must occur within 48 hours of the incident and must be documented.

Training and Orientation
* All direct care staff will be trained and certified in non-violent crisis intervention within 45 days of commencement of employment. All staff must have their certification renewed at least every 12 months.
* All staff will ensure that they have read the agency's policy on restraint.
* At the employee's annual performance appraisal, the employee's understanding and application of the subject matter described in these documents will be assessed and recorded.

REPORTING OF SERIOUS OCCURRENCES

EFFECTIVE DATE: ____March 23, 2009_______ POLICY #: _____PR-18___

REVISION DATE: ___April 5, 2011______________________

SCOPE:
All employees and volunteers providing service to clients of the agency

RATIONALE:
The Ministry of Community and Social Services (MCSS) has directed and defined occurrences involving clients in an agencies' service that are deemed to be of a nature serious enough to warrant direct reporting to them.

POLICY STATEMENT:
New Leaf will ensure that staff comply with the Ministry of Community and Social Services requirements and procedures related to the reporting and handling of all serious occurrences.

REFERENCES:
Bill 77 and accompanying regulations, MCSS Policy Directive (July 2008)

REPORTING OF SERIOUS OCCURRENCE - PROCEDURES

If a Serious Occurrence has occurred or a staff member/volunteer suspect an incident may be a Serous Occurrence, they are to contact their Manager or the on-call manager, who in turn will report the incident to the appropriate Director and/or Executive Director.

The Manager, in consultation with the Program Director will report the incident to the clients' family verbally and to the MCSS, in writing, within twenty-four (24) hours of the incident occurring. A Serious Occurrence Report is warranted when the incident occurred while the client was in service at any New Leaf site, or in the community in the care of a New Leaf representative.

The MCSS and MCYS have provided eight categories of serious occurrences to be reported by the service provider to the ministry. Please note that the examples supplied in each category are meant for illustrative purposes only and do no constitute an exhaustive list of incidents considered a serious occurrence.

1. Any **death** of a client which occurs while participating in a service, including all clients receiving community-based support services that are funded or licensed by the MCSS and/or MCYS.

2. Any **serious injury** to a client which occurs while participating in a service. A factor to consider in deciding if an injury should be reported as a serious occurrence is whether professional medical treatment (eg. doctor or dentist) is required, not in-house first aid. Serious injuries include:
   - an injury caused by the service provider (eg., lack of or inadequate staff supervision, neglect/unsafe equipment, improper/lack of staff training, medication error resulting in injury).
   - a serious accidental injury (eg., sports injury, fall, burn, etc).
   - a serious non-accidental injury (eg., suicide attempt, self-inflicted or unexplained injury.

3. Any **alleged abuse or mistreatment** of a client which occurs while participating in a service (eg., allegations of abuse against staff, foster parents or other foster family members, volunteers, temporary caregivers, police/court staff while young persons are in custody, drivers providing client transportation. This category **does not** include reports of historical abuse divulged by the client that did not occur while the client was participating in a service.

4. Any situation where a **client is missing** in accordance with ministry requirements for applicable program sectors and any applicable legislative requirements; otherwise, where the service provider considers the matter to be serious.

   SORs may include clients missing for less than the prescribed ministry requirement where their absence is considered serious by the service provider. A child in the care of a CAS or a residential program who has been missing for 24 hours or more must be reported to the police, and the ministry if appropriate. In child care centres, the reporting of a missing child to the police must be immediate.

   All SORS should describe whether the client poses a serious risk to themselves or others, any attempts made to locate the client, prior client history of leaving without permission, client's state of mind before leaving, precipitating events, etc.

   The service provider must advise the ministry once the client has returned, regardless of the date/time, via telephone or e-mail message.

5. Any **disaster on the premises** where a service is provided, that interferes with daily routines (eg., fire, flood, power outage, gas leak, carbon monoxide, infectious disease – where public health officials are involved, lockdown, etc.).

6. Any complaint about the **operational, physical or safety standards** of the service that is considered serious by the service provider including reports of adverse water quality. Other examples include reports of lead exceedence, hazardous/ dangerous substances (poisons, flammables), medication error (not resulting in medical treatment), missing or stolen files, neighbor complaint about noise or physical appearance of the property (only where municipal authorities are involved), etc.

7. Any **complaint** made by or about a client, or any other serious occurrence involving a client that is considered by the service provider to be of a serious nature, for example:
   * Police involvement with a client (client charged by police)
   * Serious assault by client against staff, peers or community member
   * Serious assault by non-caregiver against client (eg. friend, another client, stranger).

* Hospitalization (excluding regularly occurring doctor visits related to an ongoing medical problem and any medical ailment occurring as part of the aging process), (eg., medical ailment, suicidal ideation, drug or alcohol overdose).
* Inappropriate disciplinary techniques (eg., excessive, non-sanctioned)
* Complaints arising from sexual contact between clients

8. Any use of a **physical restraint** of a client in a residence licensed as a children's residence under the *Child and Family Services Act* or in a residential program funded under the *Bill 77 and accompanying regulations* that provides group living supports to adults with developmental disabilities, that results in a) no injury, b) injury, c) allegation of abuse. **The use of physical restraints is not permitted in programs covered by the *Day Nurseries Act*.**

   The SOR must describe the type of physical restraint used, use of less intrusive interventions before physical restraint, client and staff debriefing, legal status of the client, duration of the physical restraint, names of all parties notified, if the use of physical restraint resulted in a) no injury, b) injury, c) allegation of abuse.

   When more than one physical restraint is used with a client in a 24-hour period, one SOR may be submitted, describing the physical restraints used in the 24-hour period. Likewise, when physical restraint is used on more than one day in a 7-day period, one Inquiry Report (IR) may be submitted, describing all incidents.

The Program Director or Executive Director will contact other parties as required including police and coroner.

Reporting of Serious Occurrences shall be in compliance with the MCSS directive "Serious Occurrence Reporting Procedures".

Effective January 16, 2006, the MCSS implemented an Enhanced Serious Occurrence Reporting Procedure. In addition to the current Serious Occurrence Reporting Procedure, Enhanced Serious Occurrence Reporting Procedures are to be followed when emergency services (police, fire, ambulance) are used in response to a significant incident and/or the incident is likely to result in significant public or media attention.

In these circumstances the Manager, in consultation with the Program Director or Executive Director, will ensure that the MCSS's early alert system is notified within one hour of determining that the incident was, in fact, an Enhanced Serious Occurrence.

Management staff will direct all correspondences relative to the Serious Occurrences Reporting process, and must ensure that they have read and are aware of the MCSS **Serious Occurrence Reporting Procedures for Service Providers** and all MCSS policy directives and updates relative to Serious Occurrence Reporting.

RESIDENT SUPERVISION / MISSING PERSON (RESIDENT)

EFFECTIVE DATE: ____March 23, 2009 _____ POLICY #: ____PR-19_______

REVISION DATE: ____May 5, 2009__________

SCOPE:
All employees and volunteers at New Leaf, family, friends and other stakeholders who may be responsible for a client's well being.

RATIONALE:
New Leaf is responsible for vulnerable individuals in our care. This policy addresses staff responsibility to know the whereabouts of persons in their care, and to follow proper procedures in the event that a person in care goes missing.

POLICY STATEMENT:
Staff on duty must be aware of the whereabouts of individuals in their care, and must take action to ensure that missing persons are located as soon as possible.

RESIDENT SUPERVISION

The following relates to persons who reside in 24-hour group living settings:

It is the responsibility of the staff on shift to at all times know the whereabouts of the individuals who reside at the home. It is understood that the amount and degree of direct supervision required will depend upon the skills and needs of the individual supported. Staff members working in these programs are responsible to ensure that they are familiar with the individuals and their specific needs and skills.

The above notwithstanding, it is understood that the individuals who reside in our residences access our services on a voluntary basis. It is understood that the individuals we support are exposed to the same risks that other members of the community are exposed to by virtue of living, working and playing in the community. Therefore this policy statement does not restrict a person's right to access their community without direct staff supervision.

For some individuals who we support, (due to the degree of disability, behavioural concerns, skill level or potential risk to the public), it would pose an unacceptable risk for them to be unsupervised outside of the home. **Staff must be aware of the where abouts of these individuals at all times**. **These persons will be considered missing immediately upon staff becoming aware of their absence.** There should be no delay in initiating the search and find protocols below.

In the case of a resident who has unsupervised access outside of the home he/she will be considered missing when they are unaccounted for after two hours of the expected time of arrival/return at the residence or program destination point.

SEARCH AND FIND

If suspicion of disappearance is evident, the staff on duty will do the following:

- Check the individual's last known place of whereabouts
- Question persons there about the missing person's departure in regard to his/her mood, mode of transportation, verbal remarks on departure, and indications of his/her destination.

If no success arises from this check, the staff on duty will then organize a brief search of the immediate area of known places of interest to the individual.

Check all areas o the house ie: every room! Check the grounds. In the case of the Farm residence, check all outbuildings. Walk down the lane and look up and down the road (do not walk up the road, just look and see if you can see the person). Walk back to the house calling the person's name loudly.

If unsuccessful the staff on duty will contact the manager on-call.

Obtain the person's emergency file, which always has an updated photo and write down the person's name, height, hair and eye colour, weight, complexion, type and colour of clothing he/she was wearing.

Call a member of management staff.

If, after one (1) hour of searching (less than one hour in the case of a very vulnerable individual, an individual who may pose a potential threat to harm themselves or others, or extreme weather), the person cannot be located, call the police. Tell them who you are, the steps and measures you have taken; give them the physical description you have written down. Usually the police will come to the particular residence. Show the picture in the emergency file and provide a complete physical description, including the clothing the missing person was wearing.

If a resident becomes missing during an outing do not leave the area, he/she may return. if possible, send someone to search the area and bring him/her back. If not quickly located, call the police (or security personnel if at a mall or theme park) and ask for their assistance in locating the missing person. If the missing person is not located in one (1) hour of informing the police or security personnel call the on-call hone at 905-955-9511.

The missing individual's next of kin will be notified by the manger on-call. If unsuccessful in locating the missing person the manager will contact the Executive Director, and a Serious Occurrence Report will be filed with MCSS.

FOLLOW UP

The staff involved/on duty are required to complete a fully detailed incident report. The staff member on duty is responsible to ensure that all relevant information related to the search is passed on to replacement staff and the next shift.

It is at the discretion of the on-call manager as to whether staff then on duty will remain on duty until the situation is resolved.

If the missing person is located the staff on duty will contact all parties involved in the search to apprise them of the situation.

New Leaf: Living and Learning Together Inc.
Program Related Policies

MEALS AND SUPERVISION

EFFECTIVE DATE: ___June 8, 2012 __ **POLICY # __PR-19-A __**

REVISION DATE: _________________

SCOPE:
All employees and residents of New Leaf.

RATIONALE:
Some of the individuals receiving support at New Leaf have challenges related to eating that pose a potential health risk. It is incumbent upon staff and management at New Leaf to closely monitor food preparation and consumption to ensure a safe and comfortable environment is maintained at all times.

POLICY STATEMENT:
Special dietary, behavioural or medical precautions and procedures where they exist will be clearly documented in the individual's Support Plan, and staff will be made aware of such precautions and procedures.

Staff will ensure that **ALL** residents are supported to eat food in a safe manner, whether or not they have an identified special precaution or procedure.

Food is not to be consumed while walking or engaging in other activities. To minimize the risk of accidental choking, residents are encouraged to consume food while sitting at a table.

Staff will assist and instruct residents to eat slowly and to chew their food thoroughly.

Staff will supervise closely **ALL** residents during meal times or at any time food is being prepared, presented or consumed.

Residents will be discouraged from taking food into their bedrooms.

Some individuals require enhanced supervision due to psychological and behavioural difficulties related to food consumption, hording, gorging and choking. Staff will ensure that such individuals are closely monitored at all times, and that behavioural and safety protocols are followed as indicated.

All incidents of concern related to food consumption must be reported to the Program Manager.

ON-CALL POLICY

EFFECTIVE DATE: ______March 23, 2009 ___ POLICY #: _____PR-20______

REVISION DATE: _______________________

SCOPE:
All employees and volunteers of New Leaf.

POLICY STATEMENT:
New Leaf has appointed managers available to assist front line staff with emergencies every day of the year.

GENERAL:

New Leaf provides twenty-four hour back up to staff by having a Manager on-call each day and night of the year. The schedule for on call duties will be created a year in advance and any changes to that schedule will be reported to the Program Director. The on-call Manager should be contacted when a legitimate emergency occurs that staff need to report or if there is guidance required. The on-call Manager does not act as a schedule coordinator and should not be contacted regarding staffing issues unless every attempt has been made to solve the problem in consultation with the Supervisor (or person in charge) either within the program or between programs.

Please be sure to contact the on-call Manager if you need support and/or are dealing with a **Serious Occurrence, allegations of abuse, neglect, fire, police contact, a significant change in a resident's medical status (including hospitalization), resident death or a situation occurring in the community that may have the potential to be misconstrued by the public.** There are certainly other circumstances that may reasonably warrant contacting the on-call Manager and you are asked to use your best judgment in these circumstances.

DEATH OF AN INDIVIDUAL RECEIVING SUPPORT

EFFECTIVE DATE: ____March 23, 2009 _____ POLICY #: __PR-21_________

REVISION DATE: ________________________

SCOPE:
All staff/volunteers providing service to clients at New Leaf.

RATIONALE:
The death of a client requires efficient and multi faceted action on behalf of those charged with oversight of the process.

POLICY STATEMENT:
If an individual receiving support from New Leaf dies, the actions of staff shall be dictated by the procedure.

DEATH OF AN INDIVIDUAL RECEIVING SUPPORT

GENERAL:

Procedure:
In the event of death, the following people shall:

Executive Director or designate shall:
- notify individual’s family
- notify other Directors
- notify MCSS area office
- act as a spokesperson for New Leaf
- notify the President of the Board of Directors
- complete a Serious Occurrence form for the Ministry
- prepare a press release, if necessary

Manager or designate shall:
- carry out directions of the Executive Director
- notify individual’s bank so their accounts can be closed (if applicable)
- notify all pertinent employees
- notify insurance company (if applicable)
- notify individual’s workplace/program area
- ensure other individuals involved are informed and supported as they require
- arrange for grief counseling for employees and individuals who receive support, as needed
- notify individual’s ODSP worker or Public Guardian and Trustee (if applicable)
- ensure that all other pertinent individuals are notified
- make funeral arrangements if required by the family
- notify family physician
- follow directives in the individual’s will, if applicable
- place obituary in paper (if required)
- support family of individual in a way directed by the Executive Director
- secure a copy of the autopsy results (if necessary)
- write a detailed report of the serious occurrence as it unfolds and submit to the Executive Director when the occurrence concludes

Immediate Supervisor shall:
- support other individuals receiving support as their needs dictate
- do a complete final inventory of the person's belongings
- close log book and case file where individual was supported and forward to central files

Staff shall:
- upon discovering the death of an individual, contact emergency personnel
- contact immediate supervisor and/or on-call manager

BEHAVIOURAL POLICIES

EFFECTIVE DATE: _March 23, 2009_______ POLICY #: _PR-22_________

REVISION DATE: _____January 10, 2014________

SCOPE:
All employees and volunteers of New Leaf.

RATIONALE:
New Leaf will provide a rural setting where the emphasis will be on cooperative, family style relationships of unlimited duration. New Leaf will only employ Positive Behavioural Supports to affect change to improve the quality of life for the people we support. New Leaf believes that through the competent and skilled use of Positive Behavioural Supports, all individuals, including those with complex challenges, can make meaningful progress toward their goals. Positive Behavioural Support offers a process for designing individualized approaches to support individuals experiencing behavioural difficulties. Positive Behavioural Support incorporates functional behavioural assessment and leads to positive behavioural intervention plans that are proactive, educational and functional in nature.

POLICY STATEMENT:
New Leaf's ethical principles include;
* Respect for the individual's personal values, beliefs, desires abilities, cultural practices, and social context.
* Protection of the individual's rights, freedoms and dignity.
* Adherence to the least intrusive/restrictive model.
* Use of empirically-validated procedures whenever possible.
* Services must be consistent with the laws and regulatory requirements of Ontario.
* Individuals should be informed about the nature and scope of Applied Behaviour Analysis and Positive Behaviour Supports with respect to the services that could be recommended.
* All staff should recognize the limits of their expertise. If the problem encountered is beyond the expertise of the practitioner, then the practitioner should help the individual find the appropriate services.
* Volunteers are not permitted to implement Behaviour Support Plans unless they have been trained in the procedures and are supervised by trained, qualified staff.

REFERENCES:

Bill 77 and accompanying regulations, Standards of Best Practice for Behaviour Analysts in Ontario – Ontario Association for Behaviour Analysis Standards Development Task Force, 1998.

BEHAVIOURAL POLICIES

- New Leaf will provide staff with training in Positive Behavioural Supports including, but not limited to the following:
    1. Defining behaviour
    2. Data collection and analysis
    3. Functional assessment
    4. Program implementation
    5. Identification of Antecedents, Behaviours and Consequences (ABC)
    6. Rights, choice and other ethical considerations
    7. The history of Applied Behaviour Analysis and Positive Behavioural Supports

- All agency staff shall ascribe and adhere to a number of basic assumptions about behaviour. These include:
    1. Problem behaviour serves a function
    2. Positive strategies are effective in addressing the most challenging behaviour
    3. When positive behaviour intervention strategies fail, additional functional assessment strategies are required to develop more effective strategies
    4. Features of the environmental context affect behaviour
    5. Reduction of problem behaviour is an important, but not the sole, outcome of successful intervention; effective PBS results in improvements in quality of life, acquisition of valued skills, and access to valued activities.

- All staff shall understand the legal and regulatory requirements related to assessment and intervention regarding challenging behaviour and behaviour change strategies. This includes:
    1. Requirements of Bill 77 and the Quality Assurance Regulations 299/10 with respect to PBS
    2. The purpose of human rights and other oversight committees regarding behaviour change
    3. Provincial/agency regulations and requirements

- All individuals supported by New Leaf will have an Individual Support Plan that

is developed in conjunction with the individual, his/her support network, primary contact and identified significant others. The support plan will be formally reviewed at least twice annually and more frequently as indicated.
A formal behavioural plan will be developed as indicated to either teach appropriate skills or decrease inappropriate behaviours as identified through the Individual Support Plan process. All behavioural plans must contain the following 11 key elements:

1. Collaborative team-based decision making
2. Person centered decision making
3. Self determination
4. Functional assessment of behaviour and functionally derived interventions
5. Identification of outcomes that enhance quality of life and are valued by the individual, their families and the community
6. Strategies that are acceptable in inclusive community settings
7. Strategies that teach useful and valued skills
8. Strategies that are evidence based, and socially and empirically valid to achieve desired outcomes that are at least as effective and efficient as the problem behaviour
9. Techniques that do not cause pain or humiliation or deprive the individual of basic needs
10. Constructive and respectful multi-component intervention plans that emphasize antecedent interventions, instruction in pro-social behaviours, and environmental modification
11. Ongoing measurement of impact.

- Before implementing a behavioural support plan a thorough assessment will be conducted in accordance with the bio-Psycho-Social model. The individual's biological, medical, past history, and developmental factors should be addressed and considered prior to, or concurrent with, the behavioural assessment. Behaviour(s) of concern need to be clearly defined and measurable, selected with the individual (where feasible), and be of relevance to improving the individual's well-being and quality of life. An analysis of behaviour-environment interactions should be conducted typically using descriptive and functional analyses to identify possible setting events and discriminative stimuli controlling the occurrence of the behaviour, and reinforcers maintaining the behaviour. The contextual, social, and cultural aspects of the behaviour also should be considered. Based on the information gathered in the assessment, hypotheses should be

generated that (a) describe the possible functional relationship between the behaviour(s) of concern and environmental, biological, and historical variables (as relevant), and (b) lead to intervention recommendations.

- Assessment may include picture or video recording to create effective Behaviour Support Plans. New Leaf will ensure that the recorded material will be kept confidential, respect the privacy and dignity of all individuals, and only shared with pre-approved professionals for whom the individual or their primary contact has given consent. The recordings will only be used as means to better provide professional care/treatment.

- In accordance with the agency policy on restraint - physical restraint will be used only as a last resort and only where an individual's behaviour is likely to result in imminent danger to self or others.
  Where the use of contingent physical restraint has been used with an individual more than 3 times in a 12 month period a formal behavioural assessment must be initiated.

- "Behaviour Support Plan" means a document that is based on a written functional assessment of the person that considers historical and current, biological and medical, psychological, social and environmental factors (a bio-psycho-social model) of the person with a developmental disability that outlines intervention strategies designed to focus on the development of positive behaviour, communication and adaptive skills. A Behavior Support Plan will be implemented for any member with challenging behaviour;

- "Intrusive Behaviour Intervention" means a procedure or action taken on a person in order to address the person's challenging behaviour, when the person is at risk of harming themself or others or causing property damage. Intrusive Measures are:

1. Physical restraint, including a holding technique to restrict the ability of the person to move freely, but does not include the restriction of movement, physical redirection or physical prompting if the restriction of movement, physical redirection or physical prompting is brief, gentle and part of a behaviour teaching program. During a physical restraint staff will monitor the member's breathing to ensure there are no signs of distress. In the event that there are signs of distress, the restraint will be terminated immediately. The maximum amount of time a member will be in physical restraint will be no more than 30 minutes. The

Behavior Support Plan will outline the maximum time the member can be in a physical restraint. If an additional period of time is required, staff will proceed with the restraint and the Residential Manager will be informed of the incidents. A Serious Occurrence will be submitted to the Ministry within 24 hours of the incident only if a crisis intervention and de-briefing will occur as well. A Serious Occurrence does not require a report if the restraint is identified in the BSP. The individuals primary contact person will be notified on each use of a physical restraint in a crisis situation.

2. Mechanical restraint, which is a means of controlling behaviour that involves the use of devices and equipment to restrict movement, but does not include any restraint or device,

    i) that is worn most of the time to prevent personal injury, such as a helmet to prevent head injury resulting from seizures or a device to safely transport a person in a motor vehicle,

    ii) that helps to position balance, such as straps to hold a person upright in a wheelchair, or

    iii) that is prescribed by a physician to aid in medical treatment, such as straps used to prevent a person from removing an intravenous tube.

3. Secure isolation or confinement time out in a designated, secure space that is used to separate or isolate the person from others and which the person is not voluntarily able to leave.

    i) When isolation or any confinement measure is used supporting staff will monitor the member's behaviors every 5 minutes or as outlined in their individual behavioral management approaches. All staff will ensure that all corresponding documentation is completed and reviewed by the Residential Manager and the clinical team on a monthly basis. The individual will remain in the secure isolation or confinement time area for a designated period of time as outlined in their behavioral management approach. In the event that the individual is required to remain in the area for a longer period of time the Residential Manager and/or Director of Services will immediately be informed of the incident.

4. Prescribed medication to assist the person in calming themself, with a clearly defined behavioral management approach reviewed and approved by a physician as to when to administer the medication and how it is to be monitored and reviewed. ***The PRN medication may also be used for a one time visit to a physician, or visit to a hospital emergency room, and is required to be included***

in the Behaviour Support Plan. When a PRN is administered the individual will be monitored to ensure their safety and well-being, as well as the effectiveness of the PRN .

The staff member who administered the PRN to the resident is responsible to monitor that resident every 15 minutes for a 90 minute period. Staff will acknowledge this responsibility, including a signature, on the eDocuments system as they are completing their report. In the event that this staff member must transfer the responsibility to another staff member, the administrating staff member is responsible to ensure that their relief is aware of:

a) What medication was given and when
b) The time period for PRN monitoring (start and end times)
c) How to monitor the resident during the PRN monitoring session
d) What actions to take if there is an emergency
e) How to transfer responsibility to another person, if required

PRN Monitoring is completed every 15 minutes for a 90 minute period. It consists of the following:

<u>Pulse Check</u>- Check the individual's skin on their face and neck. Skin should be pink (for Caucasian individuals), warm and dry, which suggests proper circulation.

<u>Eye Movement</u>- Check that the person is responsive and they can follow you with their eyes. If the person is asleep there is no need to perform this check.

<u>Respiration</u>- Check that the person is breathing. If the person is awake and moving around, there is no need to perform a physical check. If the person is asleep or appears lethargic, check the rate, rhythm and depth of their breathing. Adults should breathe between 10-20 times per minute, with an even rhythm.

No additional paperwork related to the PRN monitoring (15-minute interval checks) is required, unless the check is abnormal or an emergency arises. In the event of a medical emergency staff are to call 911 immediately for assistance, then notify the on-call manager at the earliest convenience.

5. It is recognized that intrusive measures always carry risk and therefore all staff will work to minimize that risk. When any intrusive measure is used all supporting staff will monitor the individual's health and well-being throughout, and after, it's use.

6. When an intrusive measure is used supporting staff will complete the necessary documentation as per the individuals Behavioural Support Plan, as well as an incident report and inform the Supervisor or Manager. The corresponding data

and incident report will be reviewed by the by the Clinical Liaison Manager, Behaviour Therapist and/or Clinician, as well as the Director of Services.

7. When an intrusive is proposed and the individual is their own guardian they will be asked for permission to share with a family contact when the measures are used. If consent is given, there needs to be a signed consent form. If the individual is not their own guardian then the designated contact will be informed whenever an intrusive measure is utilized as outlined in their Behaviour Support Plan. Where a Behaviour Support Plan indicates that each use of intrusive behaviour support need not be communicated to the contact person, regular monthly updates will be provided and documented.

- New Leaf adheres to the least intrusive/restrictive model therefore all formal behavioural support plans must be approved, and employ the use of intrusive behaviour supports will only be approved after it has been demonstrated that least intrusive/restrictive approaches have been considered. Any such program must be signed by a psychologist, a psychological associate, a physician, a psychiatrist or behaviour analyst certified by the Behaviour Analyst Certification Board (the plan must be closely monitored and revised as indicated).
- No Behavioural Support Plan or program will be developed without active participation at some level with the individual concerned.
- Individuals will be involved in selection of goals and skills to be developed.
- Behavioural Support Plans and programs must be presented to the individual in plain language in order for consent to be valid.
- Individuals may call for a review of the Behavioural Support Plan or program at any time.

- All staff shall understand that data based decision making is a fundamental element of Positive Behavioural Supports, and that measuring behaviour is a critical component of behavioural assessment and support. This includes:
  1. Using data systems that are appropriate for target behaviours, including:
     a) Frequency
     b) Duration
     c) Latency
     d) Interval recording
     e) Time sampling

   f) permanent product recording
2. Developing data collection plans that include:
   a) The measurement system to be used
   b) Schedule for measuring behaviour during relevant times and contexts, including baseline data
   c) Manageable strategies for sampling behaviour for measurement purposes
   d) How, when, and if the inter-observer agreement checks will be conducted
   e) How and when procedural integrity checks will be conducted
   f) Data collection recording forms
   g) How raw data will be converted to a standardized format (e.g. rate, percent)
   h) Use of criterion to determine when to make changes in the instructional phase

- All staff shall understand the importance of multi-element assessments including:
  1. Person Centered Planning
  2. Quality of Life
  3. Environmental/ecology
  4. Setting events
  5. Antecedents and consequences
  6. Social Skills/Communications/Social Networks
  7. Curricular/instructional needs (e.g., learning style)
  8. Health/biophysical

- All comprehensive assessments shall result in information that has focus upon at lease these following areas:
  1. Lifestyle
  2. Preferences and interests
  3. Communication/social abilities and needs
  4. Ecology
  5. health and safety
  6. Problem routines
  7. Variables promoting and reinforcing problem behaviour:
     a) preferences/reinforcers
     b) antecedents setting events potential replacement behaviour
  8. Function(s) of behaviour
  9. Potential replacement behaviours

- A behavioural intervention shall be proactive and expected outcomes will be of benefit to the individual. The intervention must be based on the sound assessment data, and use empirically validated procedures. It must follow the least restrictive/intrusive model and consent for treatment must be obtained from the individual or the substitute decision-maker, according to existing provincial statutes and standards of professional practice. A formal behavioural support plan should be written by someone with sufficient expertise and the individual (and other relevant parties) should be involved in the development of the plans as much as possible. At the minimum, a behavioural support plan should include (a) clear definition(s) of the behaviour(s) of concern, (be) meaningful, relevant, and feasible behavioural objectives, (c) clear description of the intervention, including descriptions of generalization and maintenance procedures (as relevant), (d) delineation and evaluation of the responsibilities and actions of the people involved in the design, implementation, and monitoring of the intervention(s), and (e) description of an objective evaluation system based on observable and measurable outcomes to monitor the effects of the intervention.

NEW LEAF: LIVING AND LEARNING TOGETHER INC.
BEHAVIOUR REVIEW COMMITTEE – Terms of Reference
June 5, 2012

The purpose of the Behaviour Review Committee is to provide third party review and recommendations regarding the use of intrusive support strategies (including psychotropic medications). Intrusive support strategies are understood not to include emergency procedures (i.e. physical restraint). However, where physical restraints are used on a person supported three or more times in a 12-month period, the Behaviour Review Committee must be apprised of the situation and the Clinical Liaison Manager must undertake measures to develop a formal behavioural support plan and strategies. Also, when any non-positive based strategy is utilized in an effort to decelerate the frequency, intensity or duration of a challenging behaviour the Behaviour Review Committee must be apprised of the situation and the Clinical Liaison Manager must undertake measures to develop a formal behavioural support plan and strategies.

Intrusive Support Strategies are defined as:

1) Physical restraint, including a holding technique to restrict the ability of the person with a developmental disability to move freely, but does not include the restriction of movement, physical redirection or physical prompting if the restriction of movement, physical redirection or physical prompting is brief, gentle and part of a behaviour teaching program.
2) Mechanical restraint, which is a means of controlling behaviour that involves the use of devices and equipment to restrict movement, but does not include any restraint or device,
    - That is worn most of the time to prevent personal injury, such as a helmet to prevent head injury resulting from seizures or a devise to safely transport a person in a motor vehicle.
    - That helps to position balance, such as straps to hold a person upright in a wheelchair, or
    - That is prescribed by a physician to aid in medical treatment, such as straps used to separate or isolate the person from removing an intravenous tube.
3) Secure isolation or confinement time out in a designed, secure space that is used to separate or isolate the person from others and which the person is not voluntarily able to leave.
4) Prescribed medication to assist the person in calming themselves, with a clearly defined protocol developed by a physician as to when to administer the medication and how it is to be monitored and reviewed.

In providing its review, the Behavioural Review Committee may consider whether:

- The strategies are consistent with the person's human rights.

- The strategies subject a person to actual or perceived abuse or neglect.
- The strategies focus sufficiently on positive change for the person as opposed to simply eliminating undesirable behaviour(s).
- Appropriate assessment, including a functional analysis, has been completed.
- The strategies are based on reasonable and validated procedures.
- Whether the procedures can be carried out in a manner that does not compromise the person's dignity.
- The strategies are the least intrusive procedures necessary to accomplish the desired outcomes.
- The strategies help meet the needs of the person supported and not merely the needs of New Leaf and/or its employees.
- On-going use of intrusive support strategies is justified given the data available.
- Appropriate consents, approvals and documentation have been obtained.
- To the extent that it is possible, the person supported and/or their family or guardian has been involved in the planning, development and approval of the behaviour support plan.
- Appropriate training and supervision is in place to carry out the interventions safely and effectively.
- Intervention protocols (including protocols for the administration of P.R.N. medications) are appropriately and clearly written so that employees can understand how to provide the support.
- All plans and intervention strategies comply with New Leaf Behavioural policies.

Notwithstanding the role of the Behaviour Liaison Manager in the development and monitoring of behavioural plans, the Behavioural Review Committee does not provide behavioural support strategies, nor does it develop a behavioural support plan or treatment plan; however, it may recommend that alternate or additional support or treatment options be developed.

The Behaviour Review Committee must provide monitoring of the on-going use of intrusive support strategies at least every three months and monitoring of the on-going use of psychotropic medication at least annually.

The Behaviour Review Committee will provide written feedback of its findings to those responsible for developing the support strategies, including clinicians, and to the person

supported for inclusion in their permanent file. The Committee will provide minutes of each meeting to the Executive Director

The Behaviour Review Committee members must become familiar with New Leaf Behavioural Policies, PART III of the MCSS Quality Assurance Measures with Respect to Service agencies, Behaviour Intervention Strategies; MCSS Policy Directives related to supporting people with challenging behaviours.

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MEMBERSHIP:

New Leaf Director of Services
New Leaf Training Coordinator & Clinical Liaison
2 informed persons not employed by New Leaf of whom at least 1 is a clinician with expertise in supporting adults with a developmental disability who have challenging behaviours.

ADMINISTRATIVE SUPPORT:

The New Leaf Executive Assistant or designate will provide administrative support to the committee and will record and disseminate minutes, and coordinate the scheduling of meetings and meeting rooms.

Sexuality Policy

EFFECTIVE DATE: ___July 27, 2011 ____ **POLICY #**: __PR-23 ____

REVISION DATE: ____________________

SCOPE:
All employees of New Leaf.

RATIONALE:
It is incumbent upon New Leaf to set out clear guidelines for our staff that will ensure the protection and right of the adults we support in relation to their pursuit and expression of personal relationships and healthy sexuality.

The purpose of this policy is to ensure a coherent and consistent approach is applied when dealing with adults receiving services and supporting their personal relationships and sexuality within the agency. It seeks to ensure a proper balance between an individual's rights, their physical and emotional safety, and the rights and responsibilities of others including New Leaf staff.

POLICY STATEMENT:
New Leaf recognizes the significance of intimate personal relationships and of sexual expression for all people. It is the policy of New Leaf to promote the rights of adults within our programmes to develop and enjoy the personal and/or sexual relationships of their choice.

These rights include, but are not limited to the following:
* The right to have opportunities to love and be loved and to engage in consenting relationships, whether sexual or not
* The right to education and information about their own bodies
* The right to education and information about personal relationships and sexuality presented in a manner appropriate to their individual needs
* The right NOT to be sexually exploited
* The right to opportunities to develop legally acceptable relationships
* The right to information and help with contraception and the maintenance of sexual health
* The right to develop consenting intimate relationships

* The right to have their sexual orientation respected
* The right to be treated with respect and dignity
* The right to information and advice about the responsibilities of parenthood, and support when deciding whether to become a parent or not
* Adults within our programmes have sexual feelings, needs and identities and have the right to privacy and sexual expression

When enabling people to exercise any of these rights, New Leaf recognizes the need for planned, multi-disciplinary approaches, properly discussed and recorded.

Nothing in this policy shall be construed as removing any statutory rights or obligations.

CONFIDENTIALITY AND PRIVACY:

Adults with disabilities are entitled to confidentiality regarding all aspects of their relationships and sexuality, unless there is evidence of abuse or significant concern about the possibility of abuse. Information will not be shared without their consent, unless there are issues of personal safety. In that case, they must always be told that confidentiality cannot be maintained.

Personal and sexual relationships and individual expressions of sexuality require access to private space, which must be offered and respected. In residential establishments, public and private areas should be clearly identified. Day programs are, by definition, public places in their entirety.

SEXUALITY EDUCATION AND TRAINING:

* New Leaf abides by the principles that all adults with disabilities or with mental health needs and all staff working with them should be provided with education and training in all areas of sexuality.
* Individuals served by New Leaf who may require education in sexuality as identified by themselves, their families or primary support workers will be instructed, as needed and as specified in an Individual Service Plan.
* New Leaf will determine the need for and seek as appropriate the resources of other professionals including a socio-sexual consultant, physician, and/or therapist to develop or provide instruction to individuals and staff requiring education on sexuality.

PROCEDURES: POLICY GUIDELINES

1. Sexuality, Abuse and Education

All people have the option and right to obtain accurate, current and factual education
regarding relationships and sexuality. The denial of sexual education to people with disabilities has contributed to abuse and misinterpretation of behaviour.
New Leaf will provide classes, which address not only sexual relationships, but also relationships of all kinds. Subjects covered will include interpersonal skills – including but not limited to communication, decision-making, assertiveness, and refusal skills – sexual health and hygiene, and information related to sexuality and specific disabilities. Classes will also include education to help decrease the risk of victimization and abuse

and reduce the risk of unwanted pregnancy and disease. Classes will work to increase the understanding of people with disabilities regarding pro-social and pro-sexual behaviour in order to educate them about actions that can be misinterpreted as behaviour with a criminal intent. Additional resources and services will be accessed when necessary.

2. <u>Consent</u>

Any relationship, including a sexual relationship, must be consensual; that is, it must involve the willing participation of those in the relationship. A person's ability to understand the nature of sexual activity and the implications or consequences of that activity is a key component of consent. Due to the varying levels of cognitive ability, as well as the fact that people with disabilities have been denied sex education and have had few typical opportunities for a range of social and sexual activities, questions may arise concerning ability to give informed consent in social/sexual situations.

New Leaf will address the issue of relationship consent through education and training within the curriculum to both people receiving and providing services. Additional resources and services will be accessed when necessary.

3. <u>Sexual Orientation:</u>

People have the right to be in consensual relationships of choice with those of the same or opposite gender. Although sexual orientation is often subject of divergent attitudes, all individuals need to be able to discover and express who they are free from external pressures, prejudices and discrimination. Regardless of orientation or gender, everyone has a right to intimacy within a consensual relationship.

New Leaf will provide education through the curriculum and direct support for the expression of sexuality within a consensual relationship regardless of orientation. Additional resources and services will be accessed when necessary.

4. <u>Masturbation and Self-Stimulation:</u>

Masturbation is a natural sexual exploration of one's own body that is acceptable when done in a safe, private place. An understanding of privacy, appropriateness, and gentleness is essential. Although people with disabilities are often misinformed about masturbation, and have been punished for practicing this form of sexual expression, everyone is entitled to an atmosphere of comfort and calm regarding this private sexual behaviour.

5. Sexual Contact including Sexual Intercourse

Sexual contact and intercourse – defined as any physical contact between people that involves genital contact, or contact with breasts or buttocks, including oral, anal and vaginal sex – is a right of consenting adults regardless of sexual orientation, creed, colour or disability. A sexually intimate relationship is recognized as an exciting and fulfilling time, and a significant developmental and lifestyle marker. With this experience comes the obligation to make responsible decisions.

New Leaf will provide education and support through the curriculum to support healthy, consensual sexual contact. Additional resources and services will be access when necessary.

New Leaf will provide education regarding the importance of pregnancy prevention, and support the birth control method of choice for individuals through accessing medical and/or family planning services.

All those who are sexually active are at risk for Sexually Transmitted Infections (STI) and have the right to education, information and resources to protect themselves. New Leaf will provide education on STIs, condoms and safe-sex products.

New Leaf will provide education through the curriculum regarding sexuality and relationships to help people undertake safe and healthy decisions regarding the long term partnerships in their lives. Additional resources and services will be accessed if necessary.

6. Abuse, Harassment and Exploitation

Everyone has a right to be free from abuse, coercion, exploitation and harassment. People with disabilities are recognized as one of the most victimized group in society, with those providing care the primary abusers. People with disabilities must be made aware of their rights to a safe place to live and to be supported by respectful New Leaf staff. They must also learn how to understand and report abuse.

New Leaf will provide education and support through the curriculum to the people we support and to New Leaf staff to address potential abuse, harassment and exploitation. Additional resources and services will be accessed if necessary.

7. <u>Staff-Individual Contact/Boundaries</u>

Touch and informal conversation may be easily misinterpreted by the people directly involved and/or observers. Understanding physical and emotional boundaries helps to ensure that people will develop and maintain effective relationships. This understanding also helps people recognize potentially unsafe contact and avoid behaviour that may be misinterpreted.

People providing services will model socially acceptable touch and speech in every situation. Sexual contact between those providing and those receiving services is prohibited at all times. New Leaf will provide education and support through curriculum. Additional resources and services will be accessed if necessary.

8. Privacy

Everyone is entitled to privacy regarding their body and their personal space. This is critical to their mental and emotional well-being; and for understanding and maintaining safe and healthy distance from others.

New Leaf will provide education within the curriculum and direct staff support to ensure privacy.

9. Sexual Self-Advocacy

Everyone has the right to advocate for themselves in areas that impact their lives. Relationships and intimacy are two critical areas in which people have the right to speak for themselves to get their needs met.

New Leaf will support an individual's right and need to speak for themselves concerning these subjects in any situation. Education will be provided through the curriculum; support will be provided through New Leaf and direct service staff. Additional resources and services will be accessed if necessary.

10. Guardianship

Guardianship may be necessary when a person cannot make safe, responsible decisions on their own. Effective guardianship involves the participation of the person to the

highest degree possible when decisions are being made about the person's life or well-being.

New Leaf supports people in securing competent and responsive guardians to help them make informed decisions if this becomes necessary to ensure the health and safety of the individual.

BATHING SAFETY POLICY

EFFECTIVE DATE: ___March 6, 2010_ **POLICY #: PR-24**

REVISION DATE: ____April 12, 2013__

SCOPE:
All employees, volunteers and residents of New Leaf.

RATIONALE:
To ensure the safety of all New Leaf residents by prevention of scalding from hot water.

POLICY STATEMENT:
1. All residential programs at New Leaf are equipped with Thermostatic Water Control Valves. These valves monitor the flow of hot and cold water, controlling the temperature. The maximum hot water temperature should not be higher than 113° F (45° C), nor lower than 104°F (40°C).
Staff records the temperature nightly, documenting on a Nightly Check List. The following steps are to be taken when testing water temperature:
   - Turn on nearest hot water tap
   - Let water run until hot (minimum 2 minutes)
   - Place digital food probe thermometer under running water until highest temperature is reached. Once highest temperature is reached, leave thermometer under running water as control valve may activate and decrease the temperature.
   - If temperature reads 113 degrees F (45 degrees C) or higher, please call the on-call Manager, and discontinue bathing/showering until maintenance arrives.
   - Temperatures lower than 104 degrees F (40 degrees C) can be reported to maintenance the following day.

2. A person diagnosed as having epilepsy shall be supervised while bathing or swimming. When employee coverage and/or resident privacy conflict with the provisions of such supervision, the person should shower using a hand held shower attachment while seated in a free draining tub. Employees will be within hearing distance of the person while they are bathing and/or showering.

PETS AND SERVICE ANIMALS

EFFECTIVE DATE: ___ August 10, 2011 ___ POLICY # ___PR-25 __

REVISION DATE: _____________________

SCOPE:
All employees, volunteers and residents of New Leaf: Living and Learning Together Inc.

RATIONALE:
To ensure that any pets or service animals on New Leaf property are managed safely.

POLICY STATEMENT:
It is the policy of New Leaf: Living and Learning Together Inc. that individuals receiving support have the right to own pets. It is the role of New Leaf: Living and Learning Together Inc. employees to counsel individuals on the responsibilities associated with pet ownership, including the care and cost involved.

PROCEDURE:
Where an individual resident wants to acquire a pet, every effort will be made to acknowledge, support, and pursue that interest. In doing so, staff members of New Leaf: Living and Learning Together Inc. will fulfill the following functions:

* Listen to the individual who is expressing an interest in pet ownership and acknowledge that such interest has been heard.
* Explore that interest in greater detail with the person, supporting a process of understanding the nature of the interest and the context within which it is expressed.
* Counsel the individual in a supportive manner to ensure that he/she is fully aware of the responsibilities and the costs associated with owning a pet.
* Ensure that the individual's interest in pets is reflected in his/her Personal Plan and that the goals articulated in the plan deal with the issue.
* Collaborate with the individual to consider the implications of pet ownership on others, particularly those who may share living space with that person.
* Support the individual to pursue his/her interest as necessary and appropriate.

In some instances, this right may be constrained by circumstances. Individuals who receive support from New Leaf: Living and Learning Together Inc., will need to be aware

of the needs and interests of others who share their home. Those particular situations may prevent an individual from acquiring a pet. In group living arrangements, co-habitation obligates individuals to compromise on interests and priorities out of respect for housemates. For example, consideration for a housemate who is allergic to cats could, and should, prevent a resident from acquiring a cat.

Where there is evidence that a pet is not receiving proper care and/or is causing significant property damage and/or hygiene issues, the animal may be removed from New Leaf owned property.

* Where a pet is kept at a group home it must have up to date vaccinations and immunizations as indicated by local health regulations and an updated file of vaccinations and immunizations must be kept on site.

* New Leaf will make every attempt to accommodate the needs of individuals who employ service animals to assist in their adaptive functioning.

Standard Operating Procedure (SOP) Tracker System
Policy and Procedures

EFFECTIVE DATE: __ June 1, 2013 _____ **POLICY #: __ PR -26___**

REVISION DATE: ____________________

SCOPE:
All New Leaf staff, students, volunteers and Agency Staff (Collectively called staff members or employees)

POLICY STATEMENT:
Staff members will be provided with the most up to date memos, protocols and other communications in the most efficient way possible. New Leaf will endeavour to simplify the process of identifying unread documents and to ensure employees have real time information on any unread documents.

GENERAL:
New Leaf utilizes software called "SOP Tracker" to manage documents agency-wide. Employees are given unique login information, leading to a personalized dashboard on the SOP Tracker web interface. From this dashboard, employees are able to easily identify all assigned and unread documents. Employees will read the documents and indicate acknowledgement. Users have the ability to review all active documents at any time.

FIRST TIME USE:

1. On first use, employees will navigate to https://www.soptracker.com/newleaf/login (don't forget the "s" in https://)
2. Click on "Forgot Password"
3. Enter username: "firstnamelastname" for example, Jim Smith would be "jimsmith"
4. SOP Tracker will email you a temporary password (may take 10 minutes)
5. Employee will login with temporary password and immediately change their password. New Leaf does not have the ability to see the new, changed password. To change a password:
    a. Once logged in, click on your name on the top right of the screen
    b. Enter your new password in the "Password" field
    c. Re-enter your new password in the "Password (again)" field
    d. Note that passwords must be **at least 8 characters long with at least 1 capital letter and at least 1 number.**
6. Employee will immediately report to their Residential Manager if they are not able to successfully change their password or login. If employees are not able to setup their email accounts successfully, they should contact the Residential Manager during business hours to have a password manually reset.

DAILY PROCEDURE:

1. Employees will navigate to https://www.soptracker.com/newleaf/login at the beginning of each shift.
    a. Employees must read and acknowledge each document under the **Pending SOPs** category before their shift each day.
    b. Assigned documents are not limited to the home in which the employee is working that day. Employees must read all assigned SOPs, regardless of work location, unless approved by the Residential Manager.

2. Once documents have been read, employee must:
    a. Click the corresponding check box under the "read" column.
    b. **Click "Complete,"** near the bottom of the "Pending SOPs" section.
    c. Note that the employee will be prompted for his/her password once again
3. All documents that have been read appear under the heading "Previously Read SOPs." These documents remain for as long as they are active.

ASSIGNMENT OF DOCUMENTS TO EMPLOYEES:

1. Each employee is assigned to read documents associated with all sites at which they work. This assignment process is completed by management.
    a. Only documents relevant to each employee will appear under the "Pending SOPs" section for any given employee.
2. Any employee who has not been assigned the appropriate documents, or who has been assigned documents for a program at which they do not work, must inform their Residential Manager so that the error may be promptly corrected.

ADDITIONAL FEATURES:

1. All employees have access to all agency documents. To review any active document from any program, including New Leaf general documents and Day Service documents, users can:
    a. Click on the "All SOPs" tab, located at the top right
    b. Navigate to the desired program, either by scrolling down or clicking on the corresponding program name.

SECURITY:

1. All employees must **change their password** during the first use of SOP Tracker
2. Login difficulties arising at any time must be reported to the Residential Manager by phone or email immediately.
3. Employees must change their passwords monthly.
4. Employees must ensure that passwords are at least 8 characters long, include at least one capital letter, include at least one number.
5. Employees must not share their passwords and must ensure that they protect their personal passwords when entering them on the computer.

6. Documents are not permitted to be printed, except where they need to be added to the program's protocol binder or memo board.
7. Documents are not permitted to be viewed by anyone other than the employee who is logged in to SOP Tracker.

HARD COPIES OF DOCUMENTS:

1. Shift Supervisors must still maintain hard copies of all memos, protocols, PRN protocols, plans of care, BSPs, meeting minutes, JHSC minutes, and any other documents.
    a. Hard copy signoff pages are no longer required for the above documents
    b. This process will assist in the event of a power outage, server outage or other unforeseen circumstance.
    c. In the event of a prolonged outage, defined as more than 3 days, the Shift Supervisors or designates will attached paper signoff sheets to all active documents.
2. Shift Supervisors must ensure that the memo board, protocol binder and other documents accurately reflect the content that is posted on SOP Tracker.
    a. The content on SOP Tracker should be regarded as accurate and up to date.

INFORMATION COLLECTED:

1. New Leaf will store and access information associated with each employee's use of SOP Tracker and the documents associated with that use. This includes who, what, where, when and how information was accessed.
    a. New Leaf does not have access to a user's password once it is changed

EXTENUATING CIRCUMSTANCES:

1. If there is an extenuating circumstance where an employee is not able to read all assigned documents before starting a shift, the employee must:
    a. If during regular business hours: Telephone the Residential Manager to explain
    b. If outside regular business hours: Email the Residential Manager to explain
    c. If outside regular business hours and email access is not available: Explain the issue to the Shift Supervisor or designate, who will report to the Residential Manager during the next business day

AGENCY STAFF:

1. Agency staff do not have login access to SOP Tracker. They should read hard copies of all agency documents before starting their shifts.
2. Agency staff will date, print and sign their names on the back of all documents
3. The Shift Supervisor will ensure that agency staff members comply with this directive