COMMUNITY LIVING DURHAM NORTH

HEALTH AND SAFETY OF SUPPORTED PERSONS

Policy No: B-9 (Service Delivery) Effective Date: Dec. 13, 2008

Rationale:

To guide staff and help them to ensure that people are supported to be safe and to obtain the best possible health care.

Policy Statement:

Community Living Durham North supports people to be conscious of their safety and to maintain the best possible physical and mental health.

Senior staff will implement and maintain a comprehensive set of protocols to ensure the consistent use of best practices across all of the agency's service areas.

Approved by: _____ Date: _____
for Board of Directors

COMMUNITY LIVING DURHAM NORTH

HEALTH AND SAFETY OF SUPPORTED PERSONS

Procedure No: B-9-1 Effective Date: June 30, 2011

General Procedures for Promoting Healthy Lifestyles

- Staff will encourage and facilitate a range of non-sedentary leisure and recreational activities appropriate to each supported person.

- Staff will encourage and facilitate healthy and socially acceptable levels of personal care and appearance.

- Staff will be familiar with the Canada Food Guide and, in group homes, will ensure that good nutrition is maintained. Menus must also recognize the cultural and religious diversity of people served.

- People receiving residential support must have a Family Physician and a Dentist, and appointments with these professionals must be scheduled at least annually. Where appropriate, people who do not receive residential support will be encouraged to access routine health care on the same frequency.

- Vision Care is more complicated. For people under 20, and over 65, OHIP covers an annual eye exam and people should be supported to take advantage of this benefit. People between 20 and 64, who are eligible for ODSP, have coverage for a vision exam every two years, and again they should be supported to take advantage of this benefit. The rare supported person, between 20 and 64, who is not on ODSP, may qualify for OHIP coverage if he has a medical condition that puts him in special need of regular eye examinations. Failing such a special need, he or she should have an exam every two years at his own expense, or as a "Personal Needs" (agency) expenditure.

- Beyond the above-mentioned check-ups, staff will ensure that people supported residentially also receive the medical attention that they require, and that medical advice is effectively acted upon. In addition, staff will document family history and ensure that preventative health measures occur, as required.

- Staff will encourage and facilitate the maintenance of appropriate vaccination levels.

- The agency provides formal, mandatory training in the following areas:

    - Medication Administration
    - First Aid and CPR

- Approved behavioural intervention techniques

In the case of the latter two, a certificate is provided and must be kept current through annual refreshers.

- External resources will also be periodically accessed to meet other identified training needs (e.g. seating and positioning, epilepsy, the aging process, etc.).

Procedure No: B-9-2 Effective Date: Dec. 13, 2008
Maintaining Necessary Levels of Support

- Staff ratios in each program are designed with the support needs of each person in mind. For some people, the absence of this level of support constitutes an immediate health and safety risk. Therefore, the number of staff on a particular shift cannot be reduced without managerial approval.

- If a shortage does occur around shift change, two staff will be held accountable: the staff who did not arrive to work on time, and the staff who left prior to the arrival of his or her replacement. The staff who is required to stay late will of course be compensated (potentially at overtime rates) and, once a Manager has been notified, will be relieved as expeditiously as possible. Where programs do not operate on the basis of rotating shifts (e.g. the S.I.L. program), parallel situations may sometimes arise and staff will be expected to conduct themselves in accordance with the spirit of this protocol.

Procedure No: B-9-3 Effective Date: Dec. 13, 2008
Supporting People who have Seizures

- Every person supported by CLDN must have a Personal Support Plan and if he or she experiences seizure activity this fact must be a major highlight within the plan. The person may be at considerable risk while bathing or swimming and the Support Plan will detail the special protocols that are in place to mitigate that risk. The person's seizures may also be atypical in some way (e.g. they may last longer than would be considered normal or safe in another person) and this sort of person specific detail must also be included.

- Staff observing a seizure must complete a *Seizure Activity Chart* (C-15) and bring it to the attention of the Team Leader/Program Manager. Monitoring the frequency and severity of seizure activity is an important aspect of health care, and the physician is dependent on our observations and documentation.

- CLDN employees will be able to recognize epileptic seizures, will have a general understanding of their nature, and will be able to make accurate observations. This basic grounding may come from annual, mandatory first aid training. On an as needed basis, the agency may also access other external resources, such as Epilepsy Ontario, for training or training materials.

- The following basic information should be well known to people in the helping professions. However, be aware that it is general, non-specific information and may be contradicted in spots by a person's individual Support Plan:

    - There are different kinds of seizures. The two main types are called Tonic-Clonic seizures (formerly Grand Mal) and Absence seizures (formerly Petit Mal). Absence seizures are typically slight twitching spells or "blackouts" where the person stares into space for a few seconds and loses touch with his surroundings. He may or may not lose his balance. A Tonic-Clonic seizure is more generalized; the person collapses and usually twitches violently in some or all parts of his body. Although it is often dramatic, the seizure is painless and the person is usually unconscious. It should not last longer than 1 ½ minutes (typically) and the person does not need medical care (typically).

    - When someone begins to have a seizure, keep calm. You cannot stop it; the seizure must run its course. You are required to document the seizure. Know where to find the *Seizure Activity Chart*. Call for help if you need someone to check the time or get a pen. You will record the duration of the seizure. Also, observe if it is partial (localized in one part of the body), generalized, or both (i.e. sometimes a partial or localized seizure develops into a more generalized one).

    - If the person is on the floor or in her bed, loosen clothing and protect her head – without restraining. IMPORTANT: Be careful to protect yourself, as people are not in control of their movements. If the person is in her wheelchair, loosen clothing, leave lap strap fastened and remove tray. Again, try to protect the person's head, without restraining. Hold onto the wheelchair as it could tip during a severe tonic-clonic seizure.

    - Do <u>not</u> put anything in the person's mouth.

    - If there is anything in the area that could injure the person, remove it if possible.

    - After the seizure, turn the person onto his or her left side. This recovery position allows for postural drainage. The person should be allowed to rest or sleep, if so inclined. Monitor for further difficulties.

    - An emergency situation arises (typically) when a seizure lasts longer than 1½ minutes. An ambulance should be called and a Manager immediately notified.

Staff should accompany the person to the hospital taking their medical information with them.

Procedure No: B-9-4	Effective Date: January 31, 2014
Routine Practices	Last Revision/Review: Jan. 30, 2017

Routine Practices

- Community Living Durham North requires all staff to use Routine Practices to protect themselves and others against communicable diseases. The idea behind Routine Practices is that all people are potential carriers of any number of infectious germs. Neither individual staff nor the agency's management will always be aware of the presence of a communicable disease or infection, so it is necessary to always exercise this basic level of caution.

- It is important for all staff to understand how Communicable Diseases can be spread or passed from one person to another:

  - Direct or indirect contact – Contact transmission from hands (direct) or objects (indirect).
  - Droplet Route – Droplet transmission can be generated when a person talks, coughs or sneezes.
  - Airborne Route – Airborne transmission occurs when airborne particles remain suspended in the air or travel on air currents and are then inhaled by others.

- Routine Practices include:

  - Hand Hygiene – Hand hygiene may be performed using alcohol based hand rub or soap and running water. If using soap and water, hands should be washed for 15 seconds. After washing hands, pat hands dry with paper towel and use paper towel to turn off water. (Refer to Program Information Binder – Section Six – Infection Control Pandemic Plan– Hand washing poster.) Follow the four moments of hand washing: clean your hands immediately after entering a work site, clean your hands prior to any procedure, clean your hands immediately after an exposure risk to body fluids, clean your hands prior to leaving a work site.

  - Gloves – Hands must be cleaned prior to putting on gloves. Gloves must be worn when assisting people with direct care such as bathing, assisting with incontinence supplies, or washing and changing clothing. Gloves must be worn when there is a risk of hand contact with blood, body fluids, secretions, excretions, non-intact skin, mucous membranes or contaminates surfaces or objects. Wear gloves when handling laundry contaminated with blood or body fluids. Gloves must be removed immediately after use and perform hand hygiene after removing gloves.

In addition, cover all open skin lesions (cuts, nicks, scrapes, wounds, etc.) with a bandage prior to putting on a glove.

- Cough or sneeze into your sleeve (elbow), then wash your hands to ensure that germs are not passed on to co-workers or supported people.

- Use disposable paper products (e.g. Kleenex and disposable paper towels) instead of cloth towels which spread germs.

- Environmental and Equipment Cleaning – This is performed to remove micro-organisms from an object or surface. When cleaning, start with the cleanest areas and finish with the most contaminated. For example, when cleaning a bathroom, start at the sink and counter, then clean the tub/shower, then finish cleaning with the toilet. Proper cleaning products need to be used to ensure disinfecting occurs. Refer to the agency cleaning list on the server located under *Agency Wide\Health and Safety\Cleaning List* and refer to the Program Information Binder – Section #3 – Program Information and Maintenance – *Safe and Effective Use of Bleach* document.

- When a specific risk factor is identified staff should observe Routine Practices even more rigorously. Beyond that, CLDN's management and the agency's Joint Health and Safety Committee will determine the appropriate protocol to be put in place. The additional precautions that <u>may</u> be implemented are:

  - Gowns – Wear a long-sleeved gown if contamination of skin or clothing is anticipated. Gowns should be worn in situations where contact occurs with diarrhea, a known or suspected infection, or uncontained drainage. Gowns must be removed prior to leaving a person's bedroom or bathroom to prevent cross contamination from room to room.

  - N95 Masks/Eye Protection or Face Shield – Masks need to be worn when there is a risk of airborne transmission. All staff must wear a proper fit-tested mask. Please refer to Policy C-9-10 Respiratory Protection Program. Eye Protection or Face Shields need to be worn where there is a risk of splashing or droplet transmission.

Proper Sequence for Putting on Personal Protective Equipment (PPE)	Proper Sequence for Taking off Personal Protective Equipment (PPE)
1. Perform Hand Hygiene	1. Remove Gloves
2. Put on Gown	2. Remove Gown
3. Put on Mask	3. Perform Hand Hygiene
4. Put on Eye Protection	4. Remove Eye Protection
5. Put on Gloves	5. Remove Mask
	6. Perform Hand Hygiene

Procedure No: B-9-5	Effective Date: September 2, 2009
Hepatitis B	Last Revision/Review: Sep 1/14

- Hepatitis B is a virus that causes inflammation of the liver. It is contagious, and because of its historic presence in large-scale residential institutions there is a relatively high incidence among people who have developmental disabilities.

- Someone who is not a carrier may be susceptible to the disease. If, in consultation with his physician, an employee or a supported person opts for vaccination, the agency will cover the cost of the Hepatitis B serum.

- During the intake process, people applying for services other than group living will be advised that this benefit is available to them.

- It is not a cause for alarm if someone who lives in a group home, or who works there, is known to be a carrier of Hepatitis B. Casual contact poses no risk.

- However, some basic precautions are necessary. The virus can only be spread if infected body fluids (i.e. blood, semen and rarely saliva) pass into another body, either directly into the blood stream through an open wound, or through a break in the mucosal surface, e.g. the lining of the mouth. Therefore:

  - Wear latex, protective gloves when assisting the person to brush his or her teeth, or when performing any personal care/first aid where an open sore or bleeding is present. Dispose into a bag and place in the garbage.

  - Keep toothbrush, razor, scissors and other personal toiletry items separate. The person who is a carrier should not share these items with others.

  - Nor should the person prepare food for others if he has open sores on his hands.

Procedure No: B-9-6	Effective Date: Dec. 13, 2008
Routine Precautions concerning CMV	

- CMV (Cytomegolovirus) is another virus that is transmitted through body fluids, e.g. blood, semen, breast milk, etc.

- There are two circumstances in which CMV infection can pose a serious risk. First, if you are pregnant, in which case it is the fetus that is at risk. Secondly, if your immune system has been compromised by an organ transplant, hemodialysis, cancer or AIDS.

- The first mentioned risk, to the fetus, is the more common, and there is only a danger if you become infected while pregnant. Many people, perhaps most, already have the virus, without becoming carriers and without being ill. If you do have the virus before you become pregnant the baby is not at risk.

- If someone in your workplace has CMV the following basic precautions should be observed:

  - Wash hands carefully after contact with any body fluids or secretions;

  - Wear latex, protective gloves when performing first aid where an open sore or bleeding is present. Dispose into a bag and place in the garbage.

- Most important, be familiar with all of the Support Plans within the home where you work. And, because of the special risk to pregnant women, you are advised, if CMV is present in your workplace, to consult your physician if you are pregnant or planning to become pregnant in the near future. Also, inform your Program Manager.

Procedure No: B-9-7	Effective Date: June 30, 2011
Accessing Professional Health Care for Supported Persons	Last Revision/Review: Sep 15/13

- The Team Leader and the entire residential support team are responsible to ensure that each person supported residentially has regular – annual – medical and dental check-ups.

- All staff must be alert to the person's state of health and all staff share

  responsibility for ensuring that each person receives appropriate care as he or she may require it.

- It is the responsibility of staff to provide people with basic public health information and to present it in a plain language format that may help the person to make informed choices about their health.

- To the fullest possible extent, each person must have the opportunity to participate in accessing his or her health care.

- Prior to an appointment, staff should prepare the person by discussing the reasons for the visit and what the person might expect in terms of treatment or testing.

- The person should be encouraged to be bathed and well groomed.

- If a person needs particular kinds of support to make the visit successful, these supports or considerations must be detailed in his or her Personal Support Plan.

- Staff will bring the person's Health Binder to the appointment for reference.

- If appropriate, staff will accompany the person into the doctor's office to facilitate communication, present pertinent information and advocate for treatment. If medication is prescribed staff should ask (or make sure they know the answer to) these questions:

  - The purpose and desired effect of the drug?
  - Its response time?
  - Any unwanted effects?
  - Possible interactions with other drugs?
  - Special administration and storage instructions?
  - Is it a narcotic?

- Following the appointment, staff must create a new Service Activity in AIMS. Pertinent clinical details are also recorded in AIMS via the Medical tab -> Clinical tab -> Add New.

- If the visit results in a prescription, staff must ensure that the pharmacy provides a copy of it. This copy of the prescription will be attached to the *Physician's Orders form* and added to the person's Health Profile Binder.

- New prescriptions and medication changes or discontinuations are also recorded in the AIMS Medication section.

- If a Behavioural Support PRN is prescribed, it will be necessary to inform/remind the doctor that the group home requires a written standing order that includes the name of drug, purpose, circumstances in which to administer and general instructions. This Behavioural Support PRN Guideline is typically written by staff and signed by the physician.

- Upon returning from the visit, staff should make the person comfortable and ensure that any prescriptions are promptly delivered to his/her preferred pharmacy so the prescription can be filled. See B-11-2 *Ordering and Receiving Medications.*

- Staff will make a notation in the Program Calendar alerting all other staff to any medication changes and to the existence of any new clinical notes in AIMS.

- The normal and desired level of family involvement, for the particular person and his/her family, should be kept in mind throughout. This might suggest involving a family member in the actual appointment, or it may be more appropriate for staff, or the individual, to relay events after the fact, or not at all.

- If a person refuses to obtain or accept medical services recommended by a health care professional, staff will document the refusal in the person's AIMS Clinical

section and also record the event, i.e. the conversation, in an AIMS Service Activity.

Procedure No: B-9-8	Effective Date: June 30, 2011
CPR and First Aid	Last Revision/Review: Sep 15/13

- Training in First Aid and CPR is mandatory and certification must be renewed every three years. The training addresses both Child and Adult CPR.

- Staff must be alert to where and with whom they are working and they must be familiar with people's Support Plans. Child CPR might the appropriate procedure for some children who access the Respite Home and even for some very slight adults.

- Any situation requiring the administration of CPR procedures is extremely serious. An ambulance should be called immediately and a Manager notified at the first opportunity. The staff accompanying the person to the hospital will bring his or her medical information. An AIMS *Incident Report* must be completed as soon as possible.

- A fully stocked and properly marked First Aid Kit is kept at each program location. Its precise location within the home or program is pointed out to each new hire during his or her site orientation (and this step in the orientation process is an entry on the *Site Orientation Checklist* - form H3c). It is an expectation that staff know the location of the First Aid Kit in their work place.

- The Team Leader will ensure that the contents of the First Aid Kit are checked each month in reference to the *First Aid Kit Contents Checklist* (form D-10). The Team Leader will also ensure that any missing or depleted items are replenished, as needed. Note that a First Aid manual is included in the Kit.
- In this connection, parallel responsibilities reside in the Joint Health and Safety Committee. The Site representative checks First Aid boxes every month. Designated committee members also perform regular, rotating site inspections and the First Aid box is checked again during these visits.

- Staff are required to be familiar with the contents of the First Aid manual and, in an emergency, it is expected that staff will respond immediately and provide first aid.

Procedure No: B-9-9	Effective Date: Dec. 13, 2008
Missing Persons Protocol	Last Revision/Review: Jun. 15/17

- All people receiving service are supported to obtain a government issued Ontario Photo I.D which includes the person's name and contact information. Some people

will carry this identification on their person. For those who need assistance, staff will ensure that these cards are taken with the person when engaging in community events.

- If a person is unable to independently navigate the community this fact must be made clear in his/her Support Plan Agreement B-25 and also in the Support Information document - B-10. Where such a person is missing, he or she must be presumed lost.

- If this occurs in the community, one staff will assume responsibility for implementing the search procedures and proceed as follows:

  - Search the vicinity where the person was last seen and areas close by.

  - Contact security personnel in places where they exist (i.e. sports arenas) and provide a detailed description.

  - Notify the police within 5 to 30 minutes if unable to locate the person, and provide a detailed description. In making the determination as to timing, consider the person's:

    - safety skills (i.e. road crossing);
    - ability to communicate;
    - physical and cognitive abilities.

- Implement our Emergency Response protocol (Policy B-15) and contact managerial personnel. Inform the staff receiving the call that you require the AIMS Missing Persons page; i.e. a recent photograph and a detailed physical description. It should be determined during the call where this material will be delivered.

  Note: It is not our practice to take this kind of written record on outings, because of the risk of loss. Exceptions are out of town trips and vacations of several days duration as it may not be so easy in such cases to access the material left at home.

- Should a person disappear from their home proceed as follows:

  - Search all rooms of the house
  - Search the grounds and nearby roads
  - Contact the police and provide a detailed description
  - Implement our Emergency Response protocol.

- As soon as opportunity presents, staff should complete an AIMS *Incident Report* relating the events.

- Notwithstanding all of the above, some people who live in group homes are well oriented to their community and may also be left in their home without supervision. Where this is so, their Personal Support Plans will detail as precisely as possible the degree of independence that they can safely enjoy, and will establish benchmarks for determining when the individual is lost or at risk.

- Other services (i.e. day services, Respite, Youth Group, etc.) will follow these general guidelines while recognizing that they support a greater diversity of people and must follow the lead of families or residential programs in assessing levels of independence and measuring risk. People in the SIL program are able to access the community independently, so assessing whether someone is missing is based more on knowledge of the person, his habits, schedule, etc.

Procedure No: B-9-10	Effective Date: June 30, 2011
Overnight Safety Checks	Last Revision/Review: Sep 29/15

- Overnight Awake staff in group homes will ensure that people are safe during the night by conducting safety checks. The frequency (typically four) and the precise times of these checks will be determined from time to time by the Program Manager.

- Awake staff will look in on each person in the home to ensure their well being. Every effort must be made to minimize the intrusiveness of this practice. Flashlights, for example, must not be used.

- Awake staff will then report having completed each safety check by sending an e-mail to monitoringstation@cldn.ca. In the event of technical difficulties, the monitoring station's Blackberry can be contacted at 289-385-3168.

- The Monitoring Station enters the time of each e-mail on a spreadsheet located at *Agency Wide / People Who Live At / Monitoring Station / O/N Check-In Log.*

- Late or missed e-mails are reported by the Monitoring Station to the HR department and to the Program Manager.

- From time to time, Overnight Asleep staff may face unusual circumstances that require them to remain awake, or that simply make it impossible for them to sleep. If an Asleep staff is actively engaged in this way for two or more hours between midnight and 7:00 a.m., the shift will be considered to be "Awake," from the beginning of the active engagement through to the end of the shift. To trigger this situation, the staff must contact the Manager-on-call by calling 905-721-7199.

- This is a pager number that will not take you directly to the Manager. You will get a recorded voice message that will prompt you to:

  - Punch the number into the key pad of the phone you're calling from;
  - Press the # key and hang up.

- When the page is returned, the O/N Staff will make a brief verbal report and he or she must then remain awake for the duration of the shift, perform safety checks, as detailed above, and confirm them with emails at 12, 2, 4 and 6 to monitoringstation@cldn.ca.

- Staff are required to do daily hot water checks at each bath tub or shower unit. In homes that have overnight staff, this task is generally assigned to them. First, it is necessary to run hot water for a full two minutes. Then, using the special thermometer available for this purpose, a reading is taken at each tub or shower unit and recorded in the *Monthly Program Task Checklist*. If the reading is more than 49 degrees C a second reading must be taken one hour later. If that reading is also over 49 degrees C, the staff will post notice at the bath tub and make a notation in the program calendar to alert staff to the fact that the water is excessively hot. Then, without further delay, an email must be sent to the Manager of IT and Maintenance and to the Program Manager; these managerial personnel will then be responsible for resolving the situation promptly. The notice posted about unsafe temperature readings will of course be removed as soon as the problem is corrected.

- Bath or shower water that can be accessed by a vulnerable person, must not exceed 49 degrees C. As a rule of thumb, this is the temperature at which your hand will remain comfortable (warm but not hot) after holding it under the tap for 10 seconds.

- Most recently acquired group homes have an industrial regulator mounted on the hot water tank. A different kind of control mechanism (positemps), can be installed by any plumber, and they are placed immediately behind the tap, faucet or shower head.

- Water temperature safety is actually a complex issue, and it is important that staff do not take it upon themselves to alter the settings on hot water tanks or on the regulators that are mounted above some tanks. First, water cools as it moves through the hot water line. So, when one outlet (tub or shower) is close to the hot water tank, and another is relatively far away, it might be difficult to maintain a comfortable warmth in one without raising the temperature too high in the other. Then, it is important to know if, and where, positemps have been installed. If a home has an industrial regulator mounted on the hot water tank and a positemp has been installed behind the tub's faucet, it will probably be impossible to avoid a cold bath.

- CLDN employs or purchases the services of someone with technical expertise to perform regular checks on a variety of equipment. This person or service will regularly visit each of our group homes and take temperature readings at multiple outlets. If a reading exceeds 49 degrees C, the appropriate adjustment will be made at once. Where a temperature reading falls below the comfort zone and is too cold, more analysis or a second visit may be necessary - the issue might be overuse; i.e. the supply of hot water is running down. Taking a reading at every outlet will make it possible to interpret unexpected results and to identify problems like a counter-productive positemp valve.

- The temperature in dishwashers is not a concern because CLDN only purchases dishwashers that have a self-heating capability. According to the local public health department, dishwashers must reach a temperature of at least 82 degrees Celsius to properly sanitize dishes.

Procedure No: B-9-12	Effective Date: June 12, 2009
Bathing – Manual Temperature Checks	Last Revision/Review: Jun. 15/17
Regulated Health Professions Act	

- Unless an individual has demonstrated competence in self testing the temperature of his shower or bath water, staff must always double check the water temperature to guard against scalding.

- Do not assist a vulnerable person into the tub while it is still filling. Help the person in only when the tub is filled to the desirable level and the taps have been turned off. This eliminates any risk posed by toilets being flushed or washing machines being used, elsewhere in the home.

- The necessary level of supervision required by each person, based on her ability to regulate water temperature, her general level of independence, risks posed by seizure activity and any other factor relevant to bathing must be addressed in her Personal Support Plan.

Procedure No: B-9-13	Effective Date: July 2, 2009
Regulated Health Professions Act	Last Revision/Review: Oct. 13/16

- This Act identifies interventions or medical procedures that are invasive, that have potentially adverse outcomes, and that require special skills. According to the act, inserting a finger, hand or instrument beyond a person's external ear canal, the opening of the urethra, the labia majora, the anal verge or any artificial opening on the body is a controlled act. In more practical terms, suppositories, enemas, injections and inhalations are all controlled acts (note that handing a person a pill cup into which you've put a previously dispensed dose of medication is not a controlled act).

- Controlled acts fall into different categories. In the case of some, the authority to perform the act is strictly limited to the health care professionals - the doctors, dentists and nurses, for example - who are trained to perform them.

- A second kind of "controlled act" can be provided by an unregulated care provider if the care provider is:

  - Treating a member of his or her household, or
  - Assisting a person with routine activities of daily living.

- Providing the assistance in consultation with a health care professional. For example, a physician prescribing medication via suppository, for a child, will probably not provide the mother with formal training, but he is nevertheless deeming her to be competent, while reminding her, probably, to read the instructions on the label.

- Finally, a third kind of controlled act is one that can be provided by an unregulated person only if he/she has been properly trained to perform it by the appropriate health care professional. In this case, the health care professional is, in effect, delegating their authority to perform the act.

- A case in point is the administration of insulin injections. Before doing this, the employee must be trained directly by the health care professional, and must be trained in the context of the specific supported person. For this "delegation" to occur, the procedure must be routine in the sense that the need for the procedure, the supported person's response to it, and the outcome from it, have become well established over time and are predictable.

  Note that a controlled act that has been delegated can easily cease to be routine – for example, the supported person becomes ill. In that case the "controlled act" may be elevated to one that can only be performed by a regulated health care professional.

- Community Living Durham North can access multiple agencies in order to obtain the specialized training that it needs, from time to time, in order to assist people with complex care needs. Chief among these are VON Select, St. Elizabeth Nursing Services and the local Community Care Access Centre.

- CLDN employees receive medication administration training and our training package is periodically reviewed by a health care professional to ensure excellence and to comply with the *Regulated Health Professions Act.*

Procedure No: B-9-14 Effective Date: February 3, 2010

The Issue of Consent in the Health Care Context

- In the absence of a court appointed Substitute Decision Maker (and this kind of formal provision is rare), supported people confront each medical issue in their life fully able (in a legal sense) to direct their own care and to give or withhold consent.

- Where a physician is involved, he or she is legally required to make a case-specific judgment concerning the person's ability to understand information about the presenting medical condition and about different treatment options, including the refusal of treatment. The same person might be found capable, on a given day, to consent to a relatively simple procedure, and incapable, on a different date, when facing a more complicated issue.

- If the person is found to be incapable, in a particular circumstance, then the physician must turn to family members, and family members are rank ordered by

the Act in such a way that spouses take precedence over parents, parents over siblings, and so forth.

- In no case will CLDN provide consent. It is illegal under the Substitute Decisions Act for any service provider agency to assume decision making authority. We can only help to put the physician in contact with the family member(s).

- In the absence of family members, the physician's remaining option is to contact the Office of the Public Guardian and Trustee. CLDN can again facilitate this contact (i.e. provide a phone number) but it is the responsibility of the physician to make the contact.

Procedure No: B-9-15	Effective Date: February 3, 2010
Protocol with Lakeridge Health	Last Revision/Review: Sep. 1/14

- When someone is admitted to hospital, it is important that CLDN's involvement and the role of its staff be understood by the health care professionals in the hospital. Because CLDN has no status under the Substitute Decisions Act, there is a risk that we will be left entirely outside of the communication loop, and this will obviously make it difficult or impossible for staff to advocate for supported people who have been hospitalized.

- For this reason, we have entered into a protocol with Lakeridge Health. Prior to the person's hospitalization, he/she, or the family member acting as Substitute Decision Maker, will be asked to sign a form called "*Consent to Disclose Personal Health Information.*" The form can be emailed to the parent and the signed form can be emailed back to us in pdf format.

- The form "*Consent to Disclose Personal Health Information*" is included as C-12 in CLDN's bank of forms, but it is equally a Lakeridge Health form, and in fact it bears the logo of Lakeridge Health.

- Managers and/or Team Leaders should ask the person/family to sign-off on the occasion of each new admission. Partially completed forms kept in each person's *Health Profile Binder* will expedite this process. All staff must know where to access these forms in the binder.

- Together with the consent form, CLDN staff will deliver to the hospital a copy of the person's B-10 *Support Information* and AIMS *Health Profile*.

- The hospital has indicated that they will hold these forms at the local Nursing Station and they will add to it a sign-in sheet for the use of visiting CLDN staff.

- Staff who are visiting a supported person should go first to the Nursing Station to sign–in. Your signature will be the equivalent of a CLDN name tag. It will authorize hospital staff to share information with you; it will also make them more open to you in your efforts to advocate for the person.

- When signing in, ask for a treatment update and offer to clarify any support issues that might have arisen since staff last visited.

- The protocol might vary slightly in some specialized units like the Crisis Unit at Lakeridge Health Oshawa where they are particular about visit schedules and require a phone call in advance. A similar protocol has been negotiated with Markham Stouffville Hospital but we have obviously not done this with every out-of-region hospital to which a supported person might conceivably be transferred. However, every hospital is conscious of privacy issues and we will always need to obtain a signed consent. For Markham Stouffville Hospital and all other hospitals Form *C-12a Consent to Disclose Personal Health Information* can be used.

- Consistent with Procedure B-9-17 (below), staff must understand that in the hospital context they are visitors. We can help by providing background information and, as we would with family members, we can help assist at meal time, go for a walk with a person on the ward, help with hair brushing, etc. But we are not hospital employees; we cannot administer medication, even if asked to do so, and we cannot provide full personal care to people.

- Minor concerns that you have about the care provided to the person must be expressed immediately at the Nursing Station.

- If care and treatment concerns are not resolved by the acting nursing team, or if you have a serious complaint and are not comfortable addressing it yourself, then consult with a Program Manager, On-call Manager or Director. Complaints must be timely, so do not wait on your own Manager; any manager or director can help bring the matter quickly to the attention of the hospital's *Patient Care Manager*.

Procedure No: B-9-16	Effective Date: June 30, 2011
When People are Hospitalized	Last Revision/Review: Sep. 1/14

- When people are hospitalized, group home staff will make every effort to visit them and to make their stay in hospital more enjoyable or tolerable.

- However, staff must respect the fact that we are not mandated or funded to support people during their hospitalization. That mandate, and the funds to do the job, has been given to hospitals. Therefore:

  - The needs of people in the group home must be given priority, and visits

    to the person in hospital will occur whenever opportunity presents and/or flex time arises;

  - Managers cannot authorize additional shifts, or overtime, or lieu time in order to make hospital visits happen.

- The thrust of this protocol is not to minimize visits; indeed, we should visit as often as possible, inside of the aforementioned limitations. We need to share with

hospital staff important information like health cautions of which we're aware. We also need to advocate for the person. But our visits should be just that – visits; not prolonged stays or shifts designed to supplement the hospital's staffing resources.

- Barring exceptional circumstances, overnight visits will not take place. No CLDN group home is equipped with two staff on the overnight shift so visits are not possible during this shift.

- Family members may take issue with this protocol and suggest that it puts their relative at risk. Families should be reassured that we will visit as often as possible. Also, they need to be informed that hospital budgets recognize a category of patient called constant care patients and that money is set aside for them. Hospitals also have pools of PSW staff on which they can draw. Staff dealing with this issue should involve a Manager or Director. The hospital needs to be encouraged to use its own human and financial resources and a Manager or Director can put them in touch with the appropriate hospital personnel.

- Bearing this Policy/Procedure in mind, managers and staff teams need to be proactive and develop an individualized "hospitalization protocol" for each person residing in the home. In developing this protocol, a few of the questions one should ask are: What is the nature and level of the person's need? In a very few cases, it will be necessary to suggest to the hospital that they involve their custodial staff during the overnight. What is the level of the family's involvement? In many cases, this policy should be provided to families, and they should be specifically informed of what our visiting schedule is likely to be, during the hospitalization. Given that CLDN staff do not work shifts in the hospital, how can we best keep ourselves, and the family, apprised of the person's progress? The answer might be that the last CLDN visitor to leave the hospital contacts the On-call Manager with an update. This would enable the manager to contact the family, if he/she is aware that the family member would appreciate such a call.

- Individual managers and the entire management team need to be alert when people are hospitalized and ensure that these protocols are adjusted as circumstances change. The flow of information is obviously much more critical if the person hospitalized is seriously ill.

- Exceptions to this protocol – i.e. to the rule that CLDN does not "staff" hospitals - can only be authorized on a "one off basis," by a Director.

Approved by: _____ Date: _____
CEO