# Approved Private Service Homes Program

## Proprietor's Reference Manual

*"One person caring about another represents life's greatest value."*

*Jim Rohn*

*Saskatchewan.ca* | October 2013

Saskatchewan

*"I am a caregiver because I care."*

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# SECTION 1: INTRODUCTION

***"Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn a life around."***

Leo Buscaglia

## A. Purpose of Approved Private-service Home (APSH) Program Proprietor's Reference Manual

- The manual serves as a reference guide for you as an APSH proprietor. It defines your roles and responsibilities as well as those of the Ministry of Social Services. Specifics regarding program requirements, regulations, and policies are provided.
- It is impossible to cover each and every situation or issue that will arise in your daily life.
- It is anticipated that common sense, your acquired skill set, compassion, and respect of yourself and your residents will be your most valuable assets as you provide care for residents in your home.
- The manual is reviewed and updated by a committee of Ministry staff and representatives of the Saskatchewan Approved Private Homes (SAPH) Inc. from across the province. This occurs approximately once every 5 years when reprints of the manual are required.
- If you require further information or have any questions, please contact your Community Services Worker (CSW) or the nearest Ministry office.

## B. Ministry of Social Services

### Ministry Overview:

The Ministry of Social Services invests in positive outcomes for people in areas of income support, child and family services, supports for persons witti disabilities, and affordable housing. We work with citizens as they build better lives for themselves through economic independence, strong families and strong community organizations.

### 1. Ministry of Social Services

Income Assistance and Disability Services (IADS) is the division of the Ministry of Social Services responsible for income assistance and disability programs throughout the province. Ministry staff that you will work with most closely fall into two branches of IADS:

a) Income Assistance Service Delivery;
b) Community Living Service Delivery.

- Staff in the Income Assistance Service Delivery (IASD) branch are responsible for delivering the Saskatchewan Assistance Program (SAP) and the Saskatchewan Assured Income for Disability Program (SAID).

- Staff in the Community Living Service Delivery (CLSD) branch provide case management services for clients with intellectual disabilities.
- You will have one or more CLSD staff assigned to your home. Your primary contact will be your Community Services Worker (CSW). Each resident in your APSH may also have an Income Assistance Worker (SAP) or an Assured Income Specialist (SAID).

**2. Vision**

The Ministry aligns with government's vision for a secure and prosperous Saskatchewan, leading the country in economic and population growth, while providing opportunity for a high quality of life for all.

**3. Mission Statement**

We protect Saskatchewan's vulnerable people and support their inclusion in the province's prosperity.

**4. Values**

CLSD is guided by the values of the Saskatchewan community. We believe:

- each person is unique and has equal, intrinsic worth;
- each person has the right to be treated with dignity and respect;
- each person has the right and responsibility to make informed choices, to identify risks, and to participate freely in decisions that affect them;
- each person has the right to access opportunities for learning and development;
- each person has the right to partlcipate fully in the life of the community, to make meaningful contrlbutlons, and to value others for their individual diversity;
- each person has the right to develop and nurture positive personal relationships with family, friends, and other members of the community; and,
- each person has the right to participate in the life of their cultural community.

***"A person cannot be satisfied or peaceful without their own approval; I have mine."***

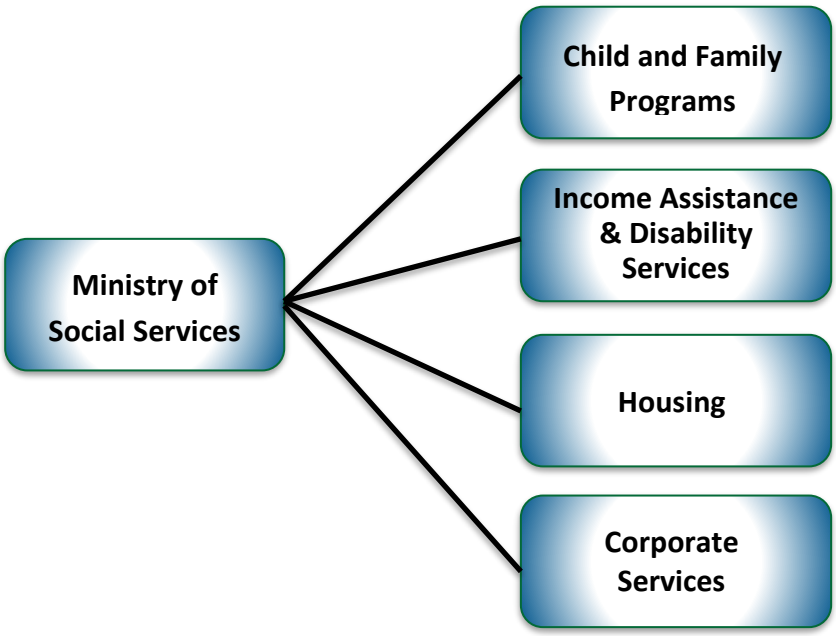
**5. Principles**

- Persons with developmental disabilities must be surrounded by supportive, self-sustaining communities.
- Families must be recognized and supported for their pivotal role ensuring that the needs of their members have been appropriately met.
- Services should be provided as close to home as possible, recognize the importance of families, significant others, and a supportive community, while respecting individual choices.
- Resource development should be based on the needs of individuals, and facilitated through collaborative partnerships and a comprehensive case management process.
- Services should be supportive of growth, development, and independence, while meeting the needs of individuals in such a way that barriers are removed, but not so much or so little as to set them further apart from the community.
- Service provision must respect choices and focus on individualized supports.
- Families, caregivers, and communities must recognize the right of individuals to make informed choices and facilitate this by utilizing mechanisms such as supported decision making.
- Development is a lifelong process and all individuals are capable of continued growth and learning. We must assist families and communities in removing barriers to achieving this.
- Generic services such as education, housing, and employment must be available, accessible, and Inclusive of individuals with disabilities.

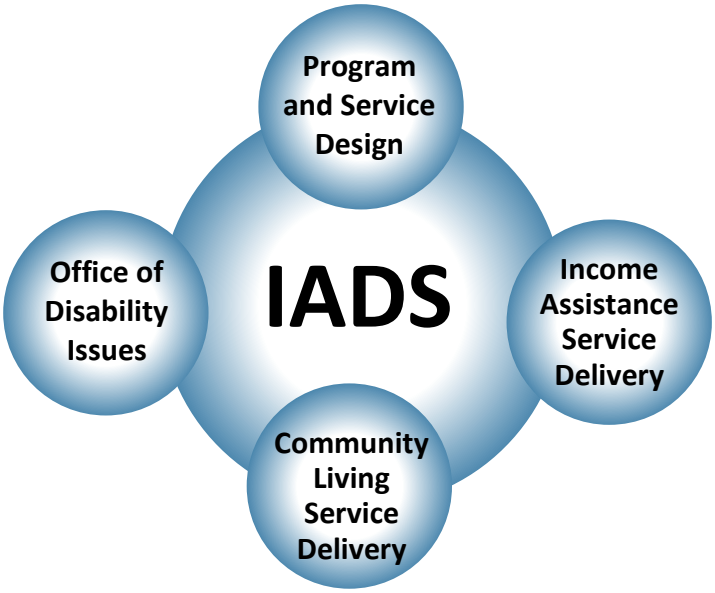
***"To improve and grow — that's our goal."***

## Ministry of Social Services
## Structure and Organizational Charts

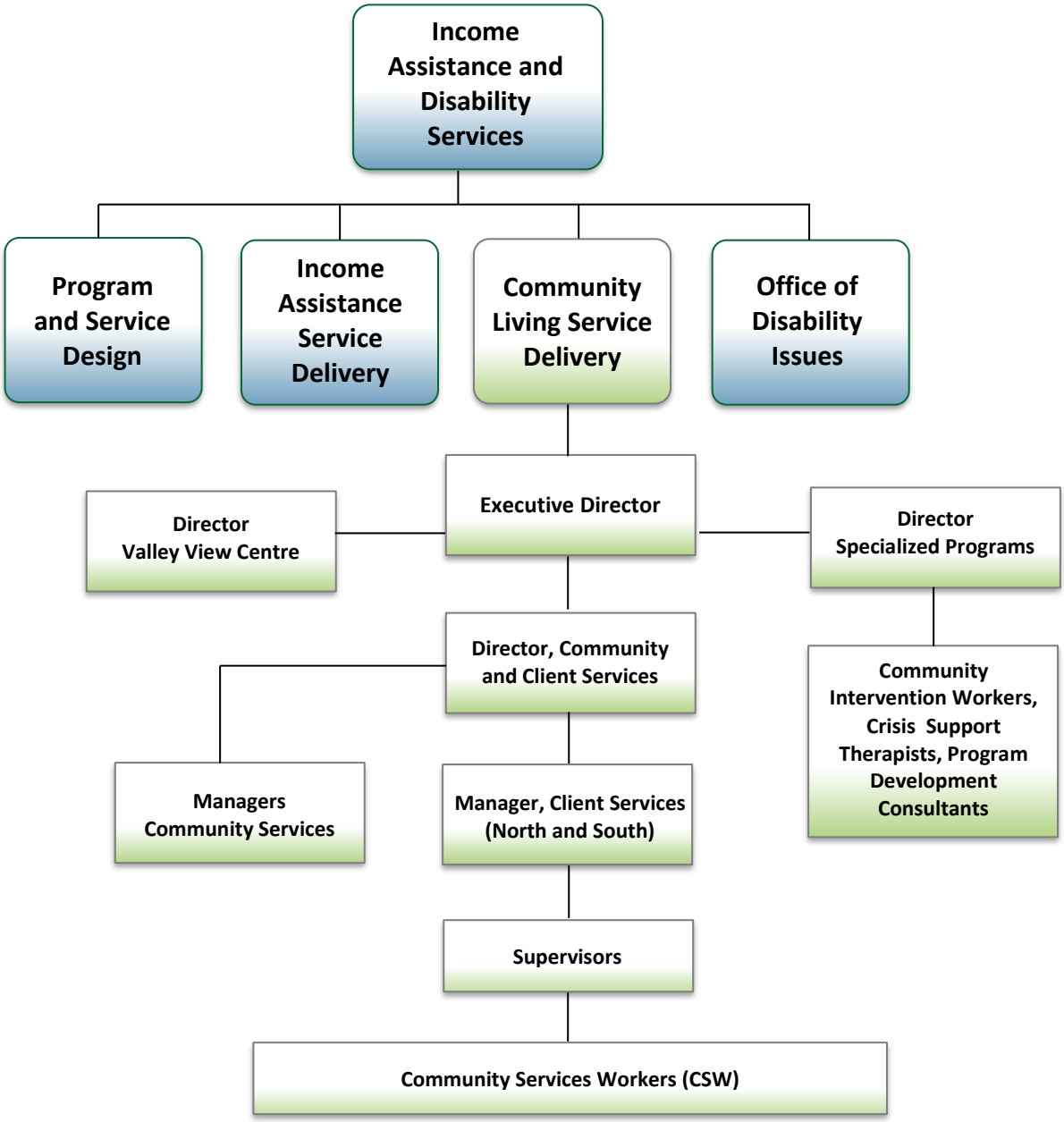
**1. Ministry of Social Services Divisions**




**2. Income Assistance & Disability Services (IADS) Branches**



## 3. Community Living Service Delivery (CLSD) Organizational Chart



## C. The Approved Private-service Home (APSH) Program

### 1. Purpose

- The purpose of the APSH program is to provide a supportive family living environment for individuals with intellectual disabilities. Some individuals may also have physical disabilities. Homes enable residents to experience family living in a community setting with the opportunity to develop social, recreational, and living skills according to their ability.
- APSHs are an adult resource. An individual must be at least 18 years old to be placed in an APSH and must be a client of CLSD.
- Every APSH in Saskatchewan is certified under *The Residential Seivices Act* and the Private-Service Homes Regulations. Copies of these documents are available for information and review purposes in Section 17. You are encouraged to read these documents. The following information provides a quick reference to some key sections of the *Act* and Regulations.

### 2. Definition

As defined in Section 2(e) of the *Act*, a "private-service home" means an unincorporated facility that provides lodging, supervision, personal care, or individual programming to residents in need of such services.

In the Act and Regulations:

- "proprietor" means a person who operates an APSH;
- "resident" means a persbn who resides in an APSH for the purpose of receiving lodging, supervision, personal care, and program planning;
- "officers of the Department'' means designated employees of the Ministry of Social Services.

### 3. Issuance of Certificates

Section 6 (1 and 2) of the *Act* indicate that certificates of approval can only be issued for a period of up to one year. Certificates are issued on the basis of:

- need for the private-service home:
- a home being "of benefit to persons who may be resident;"
- the operation of the home is in the "public interest;"
- the home meets all the requirements of the "regulations."

### 4. The Regulations

The Regulations outline:

- the certification process;
- the physical standards which the home needs to meet;
- the services provided to residents;
- the duties of the proprietor.

## D. History of the Approved Private-service Home Program (APSH)

The APSH program was introduced in 1969 as an alternative to institutional settings for people with intellectual disabilities and/or mental illness. Some individuals also had physical disabilities. The goal was to provide family-like residential placements in the community.

- Standards were developed regarding the number of residents allowed to live in the home, the physical requirements of the home, and payment guidelines.
- In 1987, the Ministry of Social Services began certifying APSHs under *The Residential Services Act* and the Private-Service Homes Regulations. This legislation ensures that all APSHs in the province meet a consistent set of standards.
- Today, the APSH program provides inclusive community-based residential services to approximately 500 people with intellectual disabilities across the province. The key strengths of the program are the emphasis on a family setting and the focus on community inclusion.

# SECTION 2: SASKATCHEWAN APPROVED PRIVATE HOMES INC. (SAPH INC.)

***"It is rewarding to know that I have played a part in bettering the everyday lives of my residents."***

Saskatchewan Approved Private Homes Inc. (SAPH Inc.) is an umbrella organization that represents all Approved Private-service Homes (APSH) in Saskatchewan. We have a provincial body with regional associations. Each region has a local executive and members who provide information to the provincial executive on matters that pertain to caregivers throughout the province.

We seek to build cooperative relationships with our certification bodies, as well as with relevant members in civic positions and the Saskatchewan Government.

We provide information, education, and support for caregivers. We work in close cooperation with the appropriate agencies in seeking solutions to problems concerning mentally ill, physically disabled, intellectually challenged, and senior populations.

We lobby provincial and municipal boards, councils, commissions, and committees on existing acts, regulations, bylaws, and policies affecting APSHs. We collaborate with many of these offices and committees on the development of legislation, bylaws, acts, and policies. As stakeholders, who will be ultimately affected by these decisions, it is vital that we participate and are consulted about all issues concerning APSHs.

The Provincial board holds meetings in alternating regions and invites all APSH proprietors to attend when we come to your area. At these meetings, we discuss regional issues, talk about impending changes, and bring forth training initiatives and events throughout the province.

Being a member of your local and provincial associations provides you with the opportunity to form a network with other operators who truly understand your issues. We share concerns, receive support, and often find humour in our daily stressors. The value of having and maintaining that network cannot be overstated.

We welcome you to our association and urge you to contact your CSW to find out who you can call in your region for more informatlon.

Please be sure to consent to the release of your name and address to both SAPH Inc. and your local association in order that we may send you our newsletter and announcements.

The website for SAPH Inc. is ***www.saph.ca***.

***"I am offended when someone calls me a landlady; I am a caregiver."***

# SECTION 3: APPROVAL/CERTIFICATION PROCESS

***"Having an Approved Private-service Home is my vocation."***

## A. Selecting and Approving an Approved Private-service Home (APSH):

There are three main considerations in selecting and approving a home:

- regional need for home;
- personal suitability;
- home suitability.

### 1. Regional Need:

- Resource needs for homes vary from region to region. Sometimes home studies are deferred or delayed if there are existing homes with vacancies or awaiting placements. At other times, recruitment initiatives are undertaken because of urgent needs.
- You are encouraged to discuss the situation in your community with your CSW.

### 2. Personal Suitability:

Among the many factors taken into account to determine proprietor suitability are physical and mental health status, relevant experiences, motivation, reliability, age, family circumstances, expectations, reference checks, and a criminal record check, including a vulnerable sector check.

### 3. Home Suitability:

- An APSH must be a family home. The house must be your principal residence and you must live there on a full-time basis. A variety of structural and safety requirements must be met. In addition, zoning approval from the municipality may be required.
- The Private-service Homes Regulations define the physical requirements for the home. During the certification process, your CSW will review both The Private-service Homes Regulations and *The Residential Services Act* with you. **You must be willing to comply with this legislation.** In summary, the regulations define the physical requirements of the home which must:
  - pass health, fire, and municipal building standards;
  - be open at all reasonable times for visits from Ministry staff;
  - provide adequate space for privacy, sleeping, and recreation;
  - be equipped with adequate furnishings for each resident: and,
  - be equipped with adequate washroom facilities.
- You must provide for the basic needs of each resident including food, shelter, clothing, safety, social relationships, and privacy. You must be willing to help provide support and care to individuals placed in your home and act as a trustee and advocate as appropriate.

- New homes are usually approved for one to three residents depending upon the proprietor's experience level. Increases in capacity are based on regional needs and are determined by the CSW, in consultatioh with you. An APSH can be certified for a maximum of five spaces.

To qualify for residential occupancy under the National Building Code, the total number of occupants in your home cannot exceed ten. This includes you, family members, residents, and any others living in your home.

## B. Procedure for Certification:

### 1. Process:

- A CSW will be assigned to complete a home study involving you and all members of your household. The home study process usually takes 3 to 6 months and involves a series of home visits and interviews in addition to the collection of the following documentation:
  - application form;
  - floor plan of entire house;
  - criminal record checks, including vulnerable sector checks, for each adult in the home;
  - reference checks;
  - health Inspection report;
  - fire inspection report;
  - zoning and permit approval (as applicable);
  - individual and family statements.

- Any costs incurred during the home study process are your responsibility. Costs may include:
  - fees for record checks;
  - fees for inspections;
  - fees for water testing (for rural homes not on a municipal water line);
  - costs to address deficiencies noted on fire and health inspections.

- During the home study process, the CSW will review with you the contents of this manual and applicable policies, procedures, and standards.

- You are encouraged to ask questions and seek clarification throughout the process.

**2. Insurance Coverage:**

- You are encouraged to contact your insurance carrier regarding comprehensive insurance coverage for your home. Tell your insurance agent that you "operate a care home" and your agent will assist with the correct policy. It may be called "Liability Insurance Home Care Services" by one agent or "Insurance Programs for Special Care Homes" by another agent. These policies should include Property & Liability Coverage.
- You can choose which policy best suits your purpose but insurance is required.
- The CSW will need to state that you carry home and liability insurance in the home study report.
- While relatively minor damage may not be a great source of concern to you, most assuredly a total loss of your home as a result of a willful or criminal act of a resident would be a major financial blow, and none of it covered by insurance.
- Having recognized this, SAPH has been able to arrange an insurance policy that will provide this coverage by adding an Extended Property Damage Insurance endorsement that would apply to every member of SAPH. This coverage would be effective on a $500 deductible basis, up to $500,000 per occurrence upon the denial of your own individual home coverage. The premium for this extended coverage wlil be paid by SAPH.
- The Insuring Agreement reads as follows:

  *"To pay all claims for direct loss or damage to property owned by or in the care, custody or control of the approved private home, where such loss or damage is caused by the criminal or willful act of a resident for whom the approved care provider is responsible. Insurance provided hereby shall be concurrent in form to that carried by the approved private home provider and shall apply where such claim for loss or damage is not valid or collectible under the approved private home providers personal insurance policy, due solely to a 'definition of insured' clause."*

- You may contact SAPH Inc. for further information regarding insurance.

**3. Home Study Report:**

- The CSW will prepare a comprehensive home study report once all the required information and documentation has been gathered. The report will recommend whether or not you should be certified as an APSH proprietor along with the number of individuals that can be placed in your home.
- You will review the home study report and sign it before the CSW submits it to the Regional Supervisor for review. The Regional Supervisor then forwards the home study report to senior management for final approval and issuance of the APSH certificate. The certificate authorizes you to operate an APSH in Saskatchewan.

In the province of Saskatchewan, you must be **certified** to provide both care and accommodation to an adult who is not a relative.

4. **Approved Private Service Home (APSH) Agreement:**

   - Prior to the placement of an individual in your home, you will need to sign the APSH Agreement with the Ministry. This service agreement outlines your responsibilities as an APSH proprietor. You are encouraged to review your APSH Agreement regularly and ask your CSW for further information if you have questions or concerns.

## C. Annual Reviews:

- APSH certificates are valid for 12-month periods and must be renewed on an annual basis. Well in advance of your certificate expiry date, you should contact your CSW to begin the annual review process.

- The annual review process consists of the following:

  - Fire Inspection (the cost of the inspection is determined by each municipality and is your responsibility);

  - Home Visit by the CSW to:

    - tour the home;
    - complete the APSH Annual Review Report with you;
    - review the APSH Agreement;
    - review client records and financial files;
    - review policies and information pertaining to the APSH program as appropriate;
    - discuss any questions or concerns you may have.

  - In addition to the above, the CSW will complete interviews privately with the residents living in your home. For individuals who are unable to respond verbally, interviews may be held with family members or day program staff.

  - Once all applicable information has been gathered, the CSW will review the results with you and you will sign the Annual Review Report. If all is in order, a new certificate will be issued by the Ministry.

  - In certain situations, the Ministry may not be able to issue a new 12-month certificate. For example, the fire inspection may be delayed or there may be deficiencies that need to be addressed. In such cases, the Ministry may issue a short-term conditional certificate in order to give you time to address outstanding items. It is crucial that deficiencies are resolved as quickly as possible.

  - Conditional certificates must not exceed 6 months. You cannot operate an APSH without a valid certificate in Saskatchewan. The Ministry has no authority to issue payments to you if you are not certified to operate an APSH.

***"I feel it was a gift to have been chosen to provide a home for people with special needs and different abilities."***

## D. Challenges and Rewards:

- When you become an APSH proprietor you begin an intense learning experience. Much of this learning will be on the job training. The challenge of creating a family unit with a group of strangers with a variety of disabilities is not a decision to be taken lightly. However, most proprietors who are seriously interested in helping others will succeed. To be successful you will require:
  - a sense of humour;
  - patience and understanding;
  - tile ability to use sound judgement but not be Judgmental;
  - the abllity to respect and value diversity.
- Having a household of residents each with their own personalities and needs can be challenging. Some challenges may come from the community and family members or other parts of the service delivery system.
- Challenges identified by proprietors include:
  - lack of personal privacy for self and family;
  - hard to get away for outings and holidays;
  - lack of complete lnformafion about residents;
  - unappreciative residents;
  - lack of support from professional staff;
  - amount of work involved;
  - relationship with resident's family;
  - resident's benavior support rteeds;
  - lack of activities and programs for residents;
  - getting residents out of the house and keeping them busy;
  - tragic events such as deaths;
  - difficulty in finding suitable and affordable relief help.

***"There can be challenges but we always end our day laughing."***

- Along with the challenges the APSH proprietor may face, there are rewards to be found.
- Proprietors have identified the following rewards experienced in their work:
  - knowing that you have contributed to positive change in residents;
  - learning from other people;
  - seeing personal growth and self improvement;
  - being able to stay home with family;
  - learning about disability issues;
  - earning an income;
  - enjoying good times with residents;
  - receiving thanks and appreciation;
  - being part of a team effort;
  - creating a family feeling and home atmosphere;
  - deep emotional satisfaction;
  - greater respect for diversity;
  - advocacy;
  - acceptance and awareness of others;
  - promoting inclusive communities;
  - seeing residents improve and grow.

*"Sharing life's triumphs and failures with my residents brings us close in heart."*

# SECTION 4: ROLES AND RESPONSIBILITIES

*"The people I care for know that I will be there for them."*

## A. Your Roles and Responsibilities as a Proprietor:

### I. General Expectations:

- The Ministry of Social Services has four main expectations of you as an APSH proprietor:
  - to provide a supervised supportive residence in the community:
  - to provide a family atmosphere;
  - to provide quality of life activities in the home;
  - to assist residents to access quality of life activities in the community.
- The residents in your home need to feel and be:
  - safe and secure;
  - accepted, respected, and understood by others;
  - free to express themselves without fear of criticism or punishment.
- By living in an APSH, residents are given the opportunity to gain independence in several ways such as learning homemaking skills, life skills and personal hygiene skills. Best of all, this learning lakes place within a family setting.
- Your role primarily is to provide support for the resident in your home. It is important to give support and guidance to the resident as a "whole person". This means you must consider the resident's need for:
  - physical (bodily) support;
  - cognitive (thinking) support;
  - social (companionship) support;
  - emotional (feeling) support;
  - spiritual (religious) support;
  - recreational support;
  - advocacy support.
- There is a need to promote independence. Residents in your home may need support in some areas but not others. Some may require supervision, some may require reminders, and some may require physical assistance. Each resident is an individual. Do not assume that all residents have similar abilities or needs. It is important to refer to the information you are given about a resident so that you know whether he/she requires encouragement, occasional prompts, supervision, or actual assistance.

*"Living together and respecting one another."*

**2. Physical Support:**

A resident may need help with:

- eating, bathing, dressing, grooming;
- taklng part in hobbies;
- taking medications;
- bowel and bladder care;
- exercising (See the Physical Activity section).

**3. Cognitive Support:**

Encourage residents to use their mind by:

- helping them remember events that occurred in the past and encouraging discussion about their experiences;
- giving the opportunity to make choices whenever possible, such as what to wear and what to do;
- encouraging and assisting in recreational activities e.g., puzzles, cards, crafts, hobbies, and reading;
- engaglng and encouraging participation in conversation about current events and topics of interest;
- providing explanations and respectful ongoing communication.

**4. Social Support:**

The resident needs to be able to be with and talk to other people. Some people like to visit more than others, but most people enjoy some companionship. You can encourage socializing by:

- encouraging the residents to use the common living area to enjoy board games, puzzles, cards, coffee or tea;
- asking family, friends and volunteers to visit residents;
- encouraging the resident's family to participate in resident activities;
- encouraging the residents to take part in community activities;
- ensuring residents eat together with the family.

**5. Emotional Support:**

Everyone needs to be able to express their feelings in order to reduce stress or to share enjoyment of life. You can help residents express their feelings by:

- listening when they talk;
- acknowledging various communication styles;
- taking seriously what they say;
- asking what is troubling them if they appear to be upset;
- sharing their happy events.

*"We enjoy having a good talk one-on-one."*

6. **Spiritual & Cultural Support:**

   - Many residents have spiritual and cultural beliefs that are important to them. You do not have to share those beliefs and customs but you must respect the resident's right to have those beliefs and practice them. You can help residents practice their spiritual beliefs and customs by:
     - celebrating culturally significant events;
     - respecting special dietary considerations;
     - allowing them to take part in customs that are important to them;
     - giving them privacy and respect when they worship;
     - helping to arrange for them to attend religious services and cultural events;
     - offering to contact a representative from their place of worship to visit;
     - assisting with spiritual and cultural activities if residents request it and you are comfortable doing so;
     - respecting their choices.
   - Be aware of how your own views may influence the residents in your home.
   - You may contact Multi-Faith Saskatchewan for further information at ***www.multifaithsask.org***.

7. **Recreational Support:**

   - Every person needs to have fun and enjoy life. You can help residents to have fun by:
     - assisting them to attend activities in the community;
     - offering fun activities in your home;
     - encouraging them to choose a broad range of leisure and recreational activities.
   - While the resident is responsible for recreation and related transportation costs, you may be required to assist in arranging or providing transportation.
   - Contact your CSW for activities available in your region.

8. **Advocacy Support:**

   Some residents may face challenges in their daily lives that they are unable to resolve on their own. You may need to act as an advocate for your residents. An advocate is someone who speaks on behalf of another person, who champions for a cause, and is a supporter and defender.

**Key Responsibilities:**

1. **Home Atmosphere:**

- The atmosphere in an APSH is to be warm and family-like. This means residents will receive genuine and appropriate attention from your family. Your family will also assist residents in daily living activities where appropriate, and encourage residents to develop self-help and social skills.
- Residents will have access to the common areas of the family home.
- Residents are **not** to be segregated In specific areas of the home.

2. **Home Safety:**

***Fire Prevention***

- Ensure your smoke alarms, fire extinguishers, and emergency lights are always in good working order and your furnace is regularly inspected.
- Smoking indoors is discouraged. Some municipalities enforce bylaws that prohibit smoking In APSHs while others allow for a designated smoking area. **Smoking is never allowed in bedrooms**.

***Co-Detectors***

You must have co-detectors appropriately located in your home. Ensure your co-detectors are always in good working order.

***First Aid Kit***

- You need to have a First Aid Kit in your home.
- You may purchase a pre-packaged kit or assemble your own.
- See the Health and Safety section for a list of items that make up a basic first aid kit.

***Infection Control***

- Good housekeeping practices along with frequent and thorough hand washing by all members of your household are important in preventing transmission of bacteria and viruses.
- Should your CSW be concerned about possible health risks in your home, a public health inspection may be requested.
- See the Health and Safety section for tips on hand washing, household cleaning, and laundry.

***Mattresses***

- Mattresses must be clean and In good condition.
- Mattress care can be particularly challenging when residents are incontinent of bowel or bladder.
- Washable mattress covers are a good investment.
- See the Health and Safety section for tips on mattress care.

3. **Meals:**

- You are responsible to provide a nourishing well-balanced diet consisting of three meals a day plus snacks. Nourishing lunches are to be provided for residents attending school, day programs, or competitive employment.
- The sharing of food is of great cultural significance. Meals are often a time of celebration and bonding. A feeling of belonging comes from sharing a meal together.
- Serve meals in a family atmosphere. It is expected that residents will eat with you and your family. Residents should not have a segregated eating area.
- Residents should not eat meals in their bedrooms except during periods of severe illness.
- Accommodate special dietary needs e.g., vegetarian, etc.
- Accommodate religious dietary requirements.
- Accommodate medically-related dietary needs e.g., diabetic diet.
- Accommodate special dietary needs due to food allergies and food intolerances eg. gluten-free.
- Whlle residents must never be forced to eat or drink, they can be offered a variety of healthy food choices.
- Food Is not to be used as a reward or a punishment,
- See the Nutrition and Food Safety section for information regarding the Canada Food Guide, meal planning and related topics.

4. **Food Safety:**

- Precautions must be taken to prevent food borne illness. This means food must be kept at safe temperatures. Kitchen surfaces, dishes, and cutlery must be clean and sanitized.
- See the Nutrition and Food Safety section for further information.

5. **Pets:**

- Ensure your pet's vaccinations are kept up-to-date.
- Keep your pet's food and water dishes clean.
- Pets and pet foods may transmit harmful bacteria such as salmonella. Always wash your hands after handling pets, their food, and their dishes. Encourage your residents to do so as well.

6. **Physical Activity:**

- Daily exercise is an important part of healthy living.
- Encourage your residents to be as physically active as possible, while respecting their choices.
- Individualized exercise programs for residents with physical disabilities should be part of their person-centered plans. Exercise programs are typically developed by physiotherapists or other qualified specialists.

- Assist your residents to participate in fun activities such as swimming, bowling, dancing, and Special Olympics.
- Contact your CSW for activities available in your community.
- See the Physical Activity section for further inforrnation.

**7. Clothing:**

- Ensure your residents have an adequate amount of neat, clean, fashionable, age and gender appropriate clothing and footwear.
- Ensure the clothing is appropriate to the season.
- Encourage residents to select their daily clothing, dress appropriately, wear clothing appropriate for the occasion, select and purchase their clothing as independently as possible, and maintain (launder, clean, mend) their clothing as independently as possible,
- Adequate closet and drawer space must be provided for each resident's clothing.

**8. Hygiene and Grooming:**

- Help your residents to exercise maximum independence in health, hygiene, and grooming practices including: bathing, use of deodorant, brushing teeth, shampooing, washing, combing and brushing hair, shaving, and care of toenails and fingernails.
- Ensure the safety of your residents while they are bathing/showering.
- Some residents cannot determine a safe water temperature. To prevent the risk of scalds, you need to keep your household water temperature setting at a safe level. You also need to check the temperature of the water before the resident steps into the bath or shower.
- As a further safety precaution, you may install a "scald guard" faucet. Your local plumbing company can provide further information.
- Some residents are at risk of slipping and falling. To decrease this risk, you may need to install such things as safety bars, and non-slip mats.
- Even though independence is encouraged, some residents may require your constant attention while they are in the bath tub or shower.
- Ensure each resident has their own toiletry items.
- Encourage residents to use denture(s), eyeglasses, hearing aids, etc. as appropriate.
- Residents who are incontinent of bowel and/or bladder often require additional support to maintain hygiene.
- Supervision and physical assistance may be required to ensure residents complete a regular health, hygiene, and grooming routine. Other residents in the home are not to be responsible for performing personal care for co-residents.

## 9. Medication:

### *Right Medication*

Make sure that you are giving the resident the right medication. Look at the medication record and check to see that the pills on the record are the same as the pills you are giving.

### *Right Person*

Make sure that you are giving the medication to the right person.

### *Right Amount (Dose)*

Check to make sure that the amount (number of pills) and the dose (how many milligrams) of the medication on the packaging is the same as the amount and dose that are written on the medication record.

### *Right Time*

Make sure that you give the medication to the resident at the time prescribed e.g., morning, bedtime. etc.

### *Right Method*

Check to see what route the medication is given e.g., by mouth, eye drops, nose spray, etc.

### *Medication Safety*

- Most residents require some supervision and assistance when taking medications.
- Changes to the recommended dosage of medicatlons can be made only under the direction of the resident's physician in writing.
- Over the counter or non-prescription medications must also be preauthorized by the resident's physician e.g., cough medicine, aspirin, antihistamines, etc. This authorization should be in writing.
- All vitamins, minerals, health supplements, herbal remedies, and so on must also be preauthorized by the resident's physician.
- As of March 4, 2011, qualified pharmacists have prescriptive authority which means they may prescribe certain medications in certain circumstances e.g., providing prescription refills during the physician's absence.
- All medications, including non-prescription medications, and the personal medication of the proprietor and family members must be kept in a locked cupboard.
- Ensure that residents are taking their medications in the manner stated on the medication label.
- All expired or unused medications must be disposed of by returning them to a pharmacy.
- **It is recommended that resident prescriptions be filled in Bubble/Blister Packs. This helps prevent medication errors, but you must always be vigilant.**

- There may be residents who are able to manage their own medication with support from you. This will be determined on an individual basis in consultation with your CSW. These medications must also be kept in a locked box or cupboard.

***Disposal of Sharps***

Some residents may have diabetes and require insulin injections. Do not attempt to recap used needles (sharps). Place sharps in an approved puncture-proof container. Approved containers can be purchased through participating health districts and pharmacies. Do not overfill the container. Store the container in an area that isn't accessible to children or others who may not be able to protect themselves from injury. Dispose of the sharps container at a designated drop-off site. Contact your local health region or the Saskatchewan Pharmaceutical Association for specific drop-off locations.

***Side Effects of Medication***

Residents often experience side effects from their medications. Side effects can range from mild to severe reactions.

| Side Effect | Suggestions |
|---|---|
| **Eyes sensitive to strong light or sunlight** | Wear sunglasses or hat; avoid prolonged exposure. |
| **Dryness of the lips and/or mouth** | Increase fluid intake; rinse mouth often with water; keep hard candy or gum available. |
| **Occasional upset stomach** | Drink small amount of clear soda water or milk; eat dry saltines or toast. **Do not take antacids without doctor's permission.** |
| **Mild difficulty urinating** | Let water run in bathroom; run warm water over hands if possible. |
| **Occasional dizziness** | Get up slowly from sitting or lying down position. |
| **Mild drowsiness** | Take a brief rest period during the day; consult physician about switching daytime medications to bedtime. |
| **Dryness of skin** | Use mild shampoo and soap; use hand and body lotion after each bath; wear seasonal protective clothing. |
| **Mild sunburn** | Use calamine or other soothing lotions; always use sun screen. |

***Severe Side Effect Reactions*** — call the resident's doctor for any of the following side effects:

| | |
|---|---|
| Blurred vision | Drooling |
| Difficulty swallowing | Body tremors or spasms |
| Diarrhea | Severe constipation |
| Muscle rigidity/stiffness | Anxiety or excitement |
| Rash | Skin discoloration |
| Sexual difficulty | Involuntary movements |
| Drinking excessive fluids | Swelling of throat and tongue |

***Medical Abbreviations***

| | | | |
|---|---|---|---|
| **o.d.** | once daily | **b.i.d.** | two times a day |
| **t.i.d.** | three times a day | **q.i.d.** | four times a day |
| **a.c.** | before meals | **p.c.** | after meals |
| **b\p** | blood pressure | **t.p.r.** | temperature, pulse, respiration |
| **h.s.** | bed time | **caps** | capsules |
| **elix.** | elixir | **fld** | fluid |
| **gm** | gram | **gr** | grain |
| **gtt** | drop | **q.h.** | every hour |
| **oz** | ounce | **q.2.h.** | every two hours |
| **q.3.h.** | every three hours | **q.4.h.** | every four hours |
| **SS** | half | **cc** | cubic centimeter |
| **ml** | millilitre | **P.R.N.** | to give as necessary |

## 10. Medical Services

- You need to know about the type of health coverage held by the residents placed in your home.
- In addition to the Saskatchewan Health Benefits all residents of the province receive, residents who qualify for SAP or SAID are eligible for additional coverage under the Supplementary Health Program. Such residents will receive a letter advising that they have been approved for Supplementary Health Benefits.
- Some residents placed in your home may have treaty status and have coverage provided by the Federal Government. Health Canada. First Nations and Inuit Health branches can provide details regarding the Supplementary Health Benefits which those residents have. You may need prior approval for medical services. Contact Health Canada, First Nations and Inuit Health at ***www.hc.sc.gc.ca*** for further information.
- Residents need to present their Saskatchewan Health Card and the letter when accessing services. If the letter is not presented, the service provider needs to be advised verbally that the resident has supplemental Health coverage. The service provider can verify the coverage on-line using the resident's Saskatchewan Health Card number.
- For details regarding the Supplementary Health Program, call 1-800-667-7766 or visit Saskatchewan Health's website at ***http://www.health.gov.sk.ca/supplementary-health***.
- Ensure residents in your home have annual physical and dental examinations and eye examinations every two years or more frequently depending upon age and individual circumstances.
- When a resident's behavior, disposition, or general functioning changes suddenly, it is important to consult with the resident's physician.

- Keep a record of medical appointments for each resident and make notes regarding any health concerns in the resident file.
- Prior to making any arrangements for medical equipment such as walkers etc., please contact your CSW as there may be cost implications or there may be benefits that cover these items.
- If any resident in your home is found to be suffering from an infectious or communicable disease, serious illness, injury, or is admitted to a hospital or Mental Health Centre, notify your CSW following the steps outlined in the Serious Incident Reporting Flowchart. See the Serious Incident Reporting section for further information.

**11. Consent for Medical Treatment**

- You **DO NOT** have the legal authority to consent to medical or dental treatment for residents and neither does the CSW. Residents are not in the care of the Ministry and the Minister is not the legal guardian.
- If a personal guardian has been appointed through the legal system to make health care decisions, the personal guardian would have the authority to consent to medical treatment.
- "Personal Guardian" is defined as someone appointed pursuant to *The Adult Guardianship and Co-decision-making Act* who has the authority to make health care decisions for a dependent adult and who acts in accordance with the authority granted pursuant to the *Act.*
- *The Adult Guardianship and Co-decision-making Act* defines "personal guardian'' as a person appointed by court order.
- *The Health Care Directives and Substitute Health Care Decision Makers Act* provides for the nearest relative to consent to medical treatment when an individual lacks the capacity to consent themselves. Section 15 of this legislation outlines the list of persons who constitute a ''nearest relative".
- 15(1) Subject to Subsections 2 and 3, a nearest relative is, with respect to a person requiring treatment mentioned in Section 16, the person first described in the following clauses who is willing, available and has the capacity to make a health care decision:
  - the spouse or person with whom the person requiring treatment cohabits and has cohabited as a spouse in a relationship of some permanence;
  - an adult son or daughter;
  - a parent or legal custodian;
  - an adult brother or sister;
  - a grandparent;
  - an adult grandchild;
  - an adult uncle or aunt: and;
  - an adult nephew or niece.

- Subsection 16(4) provides that where there is no nearest relative or where the nearest relative cannot be found and the person lacks the capacity to make a health care decision, a treatment provider may provide treatment in a manner and to the extent that is reasonably necessary and in the best interests of the person without receiving a health decision from the nearest relative, if the treatment provider believes that the proposed treatment is needed and another treatment provider agrees in writing that the proposed treatment is needed.
- "Treatment provider" is defined as a person authorized by law to provide treatment.
- *The Health Care Directives and Substitute Health Care Decision Makers Act* provides liability protection in Section 22. It states that no action lies against a treatment provider acting in good faith and in accordance with Subsection 16(4). A treatment provider cannot be sued if two physicians decide that the treatment is in the interests of the patient and they make that decision in good faith.
- Therefore, the District Health Boards should be looking to the nearest relative to execute consents or two treatment providers when obtaining consent for an individual who lacks the capacity to give informed consent.
- There has been significant controversy and confusion around the consent issue with vulnerable adults. There are times when CSW and proprietor believe that a resident has the capacity to provide his/her own consent. The doctor must be satisfied of capacity before treating the resident. The doctor has to make that judgement call. You or your CSW can try and convince the doctor that the resident has the capacity to consent, but ultimately the doctor must make that assessment in relation to treatment.
- There have been times when medical professionals have requested that the CSW or the proprietor sign consent on behalf of residents. **CSWs and proprietors DO NOT have the legal authority to consent to any medical treatment, nor can they sign any kind of advance health care directive such as Do Not Resuscitate (DNR) orders.**
- You may need to advocate on behalf of your residents in order to arrange for appropriate medical treatment. Contact your CSW if you encounter any issues. A referral may be made to a Saskatchewan Association for Community Living (SACL) advocate. Concerns can also be expressed to the Health Region's Quality of Care Coordinator.

**12. Confidentiality:**

- Personal information about the residents in your home is confidential and is only shared on a "need-to-know" basis. For example, it is appropriate to share the resident's medical care needs with respite providers and members of the resident's support team.
- If you have any questions about confidentiality, contact your CSW.

**13. Budgeting:**

- You will often need to assist and supervise residents with their money.
- Typically, you will become the trustee for the resident's Saskatchewan Assistance Program (SAP) or Saskatchewan Assured Income for Disability (SAID) benefits.
- You will assist residents with banking and may need to assist residents to open bank accounts if they don't have them prior to moving into your home.
- You will be responsible for keeping financial records and receipts.
- See the Financial section for further information.

**14. Person-Centred Planning:**

- Person-Centred Planning refers to the planning of co-ordinated services and supports that assist the resident to realize his/her goals, dreams, and aspirations to enhance development and quality of life.
- You are an important team member in the person-centred planning process and are expected to participate in meetings to establish the personal plan for each of your residents. See the Comprehensive Personal Planning and Support Policy (CPP&SP) section for further information.

**15. Individual Responsibility:**

Encourage residents to make their beds, put their clothing away, keep their rooms tidy, and assist with household chores and meal preparation to the best of their ability. Besides helping residents become more independent, these tasks promote a sense of belonging, of confidence, self-pride, and achievement.

**16. Learning Events:**

- Ongoing learning is important. You are expected to participate in a variety of educational opportunities such as presentations, workshops, policy reviews, and self-study.
- While some educational events are specified as mandatory, the expectation is that you will attend all events that are offered by the Ministry.
- In addition, you are encouraged to attend educational events that are of personal interest and applicable to your role as an APSH proprietor.
- You are encouraged to join SAPH Inc. and your local association in order to keep informed. The provincial and local associations often provide educational events for their members.
- Contact your CSW for further information.

**17. Absences from the Home:**

- You are responsible for the residents placed in your home. Even if the residents have day programs, you need to be available and able to respond in case of emergency.
- It is your responsibility to ensure that an alternate care provider is available during periods that you are not - whether due to employment outside the home, vacation, illness, or any other reason.
- Alternate care providers must be at least 18 years old and mature and responsible enough to provide the level of support required by your residents.
- Alternate care providers must clearly understand the support needs of your residents. Be sure the client profile information is shared and a list of emergency contacts is provided.
- While resident independence is encouraged, not all residents can be home alone without supervision. Some may not be safe alone for even a few minutes while others may be capable of being alone for several hours.
- The decision to leave a resident at home unsupervised is made on a case-by-case basis by you, your CSW, and your resident. **A safety plan must be clearly agreed upon and understood by all parties.**
- **Residents are never to be left unsupervised overnight.**
- More independent residents are not to be left in charge of other residents in the home.
- You must inform your CSW of your alternate care arrangements.

**18. Record Keeping - Resident's File**

- You are required to keep organized records for each resident in your home.
- Standardized client files are available from your CSW and are to accompany the resident upon a move.
- The resident file contains the following documents: client profile, individual information, progress notes, medical records, emergency management plan, family contacts, and financial accounting record.
- Progress notes will include significant changes, behaviors, and events in the resident's life.
- Additional information kept in the resident's file Includes:
  - person-centred plans;
  - meeting minutes;
  - reports;
  - any other pertinent documentation that applies to the resident.
- The CSW will review the resident files during visits to your home. It Is important to keep resident files up-to-date.
- If you keep computer records, you must make paper copies available for review, back-up your data, and protect confidentiality.

**19. Reporting:**

- All serious incidents must be reported to your CSW. See the Serious Incident Reporting section for further information,
- In addition to serious inddents, all significant events that occur with your residents or in your home must be reported to your CSW. Examples of such events include:
  - changes in resident behavior;
  - behavioral outbursts;
  - illness;
  - changes in physical, emotional or cognitive functioning;
  - vacations;
  - resplte plans and so on.
- The Service Agreement that you sign with the Ministry stipulates that you will notify the Ministry of any changes In your home situation that differ from the home situation described in your Home Study.
- Criminal record checks are required for your children aged 18 years or older, who reside in your home.
- Criminal record checks are required for any adult moving into your home who is not a client placed by Ministry staff.

**20. Assisting With Funeral Arrangements:**

- You may be asked to assist in making funeral arrangements in the unfortunate event that one of your residents passes away.
- Your assistance will most likely be requested in cases where the resident has no next-of-kin.
- Your CSW can provide support through this process.
- Do not sign any funeral contracts as you may be held financially responsible.
- SAP and SAID funded clients are eligible for funeral cost funding. Contact their Income Assistance Worker or Assured Income Specialist prior to making any funeral arrangements.

**B. Roles and Responsibilities of Resident's Family and Friends:**

**1. Role:**

- Family is an important part of the resident's life. The love and support shown by family is essential to the resident's well-being and sense of belonging.
- Family connections and regular contacts are encouraged. Residents may require your assistance to maintain contact with family through phone calls, letters, cards, emails, and visits.

- Friendships are also an important part of the resident's life and are to be encouraged and supported. Your assistance may be required to maintain the resident's connections with friends.

**2. Responsibility:**

- Family members and friends of residents are to be respectful to you, your home, your privacy and that of the other residents in your home.
- While visits and phone calls are encouraged, family members and friends of residents are expected to be courteous in establishing mutually agreeable times for such contact.
- Some family members may wish to take responsibility for the resident's medical care and/or act as trustee but ordinarily, these are your responsibilities as an APSH proprietor.
- If concerns or conflicts arise with your resident's family members or friends, contact your CSW for assistance.

## C. Roles and Responsibilities of Ministry of Social Services Staff:

**Community Services Worker (CSWs)**

- Provide case management services, information, and support;
- Case management is the coordination of services for individuals who have ongoing support needs in areas such as housing, employment, social relationships, and community participation. Specific tasks include:
- assessment;
- case planning;
- implementation of plans;
- regular review of needs and supports;
- Provide a file for each resident that contains the following documents:
  - Client Profile;
  - Individual Information Sheet;
  - Progress Notes;
  - Medical Records;
  - Emergency Management Plan;
  - Family Contacts;
  - Financial Accounting Record.
- Provide referrals to appropriate community agencies and other professionals;
- Participate in the development of person-centred plans;
- Conduct regular home visits during the year;
- Schedule annual home reviews to coincide with the certification of your home;

- Liaise with Saskatchewan Assistance Program (SAP) staff and Saskatchewan Assured Income for Disability (SAID) staff who administer financial services and assist in nomination for Supplementary Health Services;
- Liaise with the appropriate funding source for First Nations residents;
- Liaise with The Office of the Public Guardian and Trustee;
- Liaise with the resident's support network e.g., day program staff;
- Advocate on behalf of residents;
- Liaise with other professionals who may be involved with you and your residents.

**Consultants, Program Development (PDCs)**

Provide consultation, assessment, training and program strategies, including behavioural intervention strategies.

**Community Intervention Workers (CIWs)**

Develop, implement, and coordinate specialized supports for individuals with complex needs and the service providers who support these individuals.

**Crisis Support Therapists (CSTs)**

Deliver crisis prevention workshops, crisis support outreach services, and develop intervention plans for individuals in crisis.

**Supervisors**

Manage and direct resources within the region and supervise case management.

**D. Day Programs and Employment:**

- Most residents are involved in activities throughout the day. Day programs may include centre-based programs, community-based programs, supported employment programs or educational programs.
- As a proprietor, you play an important role in supporting the residents in your home with the choices they make. As opportunities arise regarding employment, it is important that you support your residents to maximize their independence and potential. An increasing number of options are arising to enhance employment opportunities for persons with disabilities. You are an important member of the team in ensuring these opportunities are a success. You can contribute to this success by providing support, encouragement, flexibility, and accommodation.

**E. Independent Living:**

- The goal of some residents Is to live independently in their own homes.
- You can assist residents to prepare for independent living by teaching life skills in your home such as cooking, cleaning, budgeting etc.

## F. Retirement For Residents:

Residents have the right and opportunity to make choices about their retirement years. Your role is to encourage residents to remain active and participate in the seniors programs and activities offered in your area, respecting the resident's abilities and preferences. Some residents may choose to be less active than others.

## G. The Rights of Proprietors:

- The right to be treated with dignity, respect, and fairness.
- The right to enjoy some family privacy.
- The right to accept or decline a prospective client for placement.
- The right to be safe.
- The right to have full disclosure regarding a prospective client's history.
- The right to receive 30 days written notice or financial compensation in lieu of notice from a resident who wants to move.
- The right to give 30 days written notice to a resident you wish to leave your home.
- The right to have rules to be followed in your home such as meal times, quiet times, and residents advising you of their whereabouts and when they plan to return to the home.
- The right to voice your concerns.

## H. The Rights of Individuals with Intellectual Disabilities:

**People First Saskatoon**, a group of people labeled with intellectual disabilities, made a list of their basic rights. They would like everyone to understand and respect these rights.

**My rights:**

- the right to be accepted and respected for who I am and not who they want me to be;
- the freedom to do what I want — to go for coffee with my friends;
- the right to be in a relationship — to date or marry who I want;
- the right to control what happens to my body — who does my personal care;
- the right to have Information about what is going on and to know what my choices are;
- the right to make my own decisions and to speak on behalf of myself;
- the rigtit to make choices, whether or not they are right or wrong;
- the right to be heard;
- the right to have doctors, social workers, support workers, and everyone else explain things to me in language I understand;
- the right to know what my medications are and the side effects;
- the right to equal protection of the laws and to phone the police and be listened to;
- the right to see a lawyer or other advisor;

- the right to have enough money to buy good food, have a place to live, decent clothes and entertainment;
- the right to proper medical care;
- the right to be educated and have job training;
- the right to apply for a job and be taken seriously:
- the right to safe working and living conditions;
- the right to ask the government for what we want;
- the right to be happy and accepted by others;
- the right to live where I want and with who I want.

There are advocacy groups in the province that individuals with intellectual disabilities and their care providers can join.

## I. Human Rights:

### What are human rights?

- The term human rights includes a wide variety of basic rights.
- Human rights are rights that people have because they are necessary to preserve the integrity and dignity of human life.
- All people throughout the world have these human rights simply by virtue of being human. They are not earned or acquired through who we are or what we do.
- Human rights are often put into categories such as:
  - *equality rights* – the right to have equal access to and benefit from employment, services, education, and housing; includes the right to have different needs recognized and provided for;
  - *legal rights* – includes the right not to have one's liberty restricted arbitrarily, the right to fair hearings, etc.;
  - *social rights* – the right to adequate shelter, clothing, food, health care, and education;
  - *democratic rights*— includes the right to vote.

**Human rights and the law**

- Not all human rights are equal and protected by Canadian law. Some human rights are protected at all times, such as the right to be free from slavery or torture. Other human rights are subject to limitations, such as the right to freedom of opinion, information, and expression.
- Canada and Saskatchewan have passed laws which are intended to protect peoples' rights. The two laws that you might hear about most often are:

    - *The Saskatchewan Human Rights Code* (Website: ***saskatchewanhumanrights.ca/learn/the-human-rights-code***) which provides for the legal protection of certain human rights. It protects fundamental freedoms such as freedom of conscience, religion, expression, and association, and freedom from arbitrary arrest and detention. It also protects equality rights, which means that people must not be discriminated against in areas necessary to maintain life with dignity; housing, employment, public services, education, and contracts. The *Code* applies to the actions of the Government of Saskatchewan and to all individuals and corporations (business, companies, etc.) falling under provincial jurisdiction.

    - *The Canadian Charter of Rights and Freedoms* (Website: ***https://www.justice.gc.ca/eng/csj-sjc/rfc-dlc/ccrf-ccdl/***) which oulines the rights and freedoms that all Canadians are entitled to and which cannot be taken away except under specific conditions. It guarantees fundamental freedoms, democratic rights, mobility rights, legal rights, equality rights, and minority language educational rights. Among the legal rights are the right to life, liberty, and security of the person and protection against cruel and unusual punishment and treatment. The *Charter* applies to the governments of Canada and the provinces and requires these governments to ensure that their laws and policies do not breach these rights as guaranteed under the *Charter*.

- There are also international agreements and covenants which attempt to set standards for the protection of human rights of all peoples. Two of the ones we hear most about are:

    - The United Nations' *Universal Declaration of Human Rights* (1948) is a statement of ideals, principles. and standards which sets out those human rights and fundamental freedoms to which all people are (or should be) entitled without discrimination.
    - The Convention on the Rights of Persons with Disabilities (Canada signed in 2007) promotes, protects and ensures the full and equal enjoyment of all human and fundamental freedoms by all persons with disabilittes and promotes respect for their inherent dignity.

**What is your role in protecting human rights?**

- We cannot rely on the law alone to protect human rights. We all have a shared responsibility to make this happen.
- You will help protect the rights of residents in your home. You can also help residents to understand the responsibilities associated with these rights.

## J. Supported Decision-Making:

- Supported decision making is one way you can assist residents in exercislng their rights.
- Supported decision making is a process of acting with an individual to discover their values, interests, talents, and gifts in order to support them to choose how they want to live their lives.
- This definition is based on the right and ability of all people to make decisions, to be self-determining and to be supported in expressing these rights. This means that whether an individual has a disability or not they have the fundamental right to make decisions and to have those decisions respected.
- These rights are affirmed for all citizens in *The Canadian Charter of Rights and Freedoms*. Just as important as the right to make decisions is the idea that decision making is about the values, dreams, goals and wishes of the person you support.
- This decision making process must support their vision for themselves. The individual must be the centre of the decision-making process.
- It is your role to assist residents through the problem-solving process — to weigh the positive and negative aspects of a decision, and assist residents to consult with those people they would like to include in their decision-making. Examples of decisions that you may assist the resident in your home in making may range from daily decisions (e.g., what to wear, activities) to significant life decisions (e.g., community employment, retirement).
- See the CPP & SP section for information regarding supported decision-making *(Appendix B).*

# SECTION 5: FINANCIAL

*"We make a living by what we get, but we make a life by what we give."*

Norman MacEwan

## A. Daily Living Support Assessment (DLSA):

### 1. DLSA:

- The amount you are paid to provide support to residents in your home is determined by the DLSA. The DLSA is an assessment tool that determines the level of care payments for adults residing in APSHs. The DLSA has been used to determine payments since 1997.
- The DLSA measures the amount of support your residents require in three areas:
  - Dependence;
  - Behavior;
  - Health.
- DLSA payments range from Level 1 to Level 5 with .5 increments. A resident assessed at level one would typically be very independent and require minimal support. The lowest monthly payment would be received. A resident assessed at Level 5 would require constant care and supervision and/or have extremely high support needs. The highest monthly payment would be received.
- CSWs are trained in administering the DLSA to ensure consistency, reliability, and validity. Assessments are approved by the Supervisor. Assessments at level 4 and higher are reviewed by the Supervisor and approved by designated senior management staff.
- Contact your CSW for information regarding current DLSA level of care rates.

### 2. Things To Consider When Preparing For a DLSA:

- Prepare for the assessment meeting (review notes, have applicable documentation handy, think carefully about all the types of support provided to the resident).
- Provide as much detail as possible when describing what you do - the more detail, the better.
- Be accurate with the information about the supports you provide:
  - Do not minimize the supports you provide to paint a "rosy" picture;
  - Do not minimize the supports you provide because you have come to accept the supports as "normal" or "no big deal" or "not important".
- Be prepared to provide information about frequency e.g., how often do you need to do something?
- Be prepared to provide information about duration e.g., how long does it take you to support the resident to do something?

- Be prepared to provide real-life examples of the supports you provide.
- If there are supports that weren't discussed during the assessment interview, tell your CSW about them so the information can be added. The CSW should ask about this before concluding the assessment interview.
- If you think of additional information after the assessment interview is over, call your CSW as soon as possible to say you've got more information that needs to be added to the assessment.
- The DLSA is NOT about belittling or demeaning the resident. It is about accurately and thoroughly describing all the things you need to do to help the resident with dally life.

**3. Benchmark Rate:**

- You will receive two cheques per month. One cheque includes the benchmark payment of $410,00 plus the resident's personal funds and the other is the level of care payment.
- Residents who are employed will pay a maximum of $410 per month to you out of their own earnings. This maximum amount is referred to as the "benchmark rate." The exact amount will be determined by the resident's financial worker and depends upon how much money the resident has earned for the month. The remainder of the level of care payment for the resident will be paid by the Ministry of Social Services.
- The purpose of the benchmark rate is to provide incentive for residents who are competitively employed.
- Residents who have inheritances will also pay the benchmark rate directly to you with the balance of the level of care payment paid by the Ministry of Social Services.

**4. Initial Placement:**

- When a resident moves from another APSH into your home, the already established DLSA level of care will remain in effect.
- When a new resident, who has no previous DLSA, moves into your home, an estimated level of care minus .5 will be paid for up to the first three months of placement. The DLSA will be administered after the resident has been in your home for 8-12 weeks as you should have an accurate sense of the support requirements by this time. If the DLSA level of care is higher than the estimate, you will be reimbursed for the difference retroactive to the date of placement. If the DLSA level of care is lower than the estimate, the decreased payment will take effect the first of the month following the date of assessment.

***"Sharing a life and living to share."***

5. **DLSA Reviews:**

- A resident's DLSA should be reviewed whenever significant change occurs in the resident's health, behavior, or dependence support needs. Reviews can be triggered by either increased or decreased support needs. You may request a DLSA review or your CSW may decide a review is required. You must notify your CSW, in writing, if you wish to have a review done for one of your residents. If you've identified the need for a DLSA review during your annual home review, this is noted on page 1 of the review document and serves as written notice.
- **A review may result in either a higher or a lower level of care rating with the corresponding payment adjustment. The level may also stay the same with no change in payment.**
- Payment increases are retroactive to the date of the reassessment.
- Payment decreases lake effect the first day of the month following the date of the reassessment.

6. **DLSA Appeals:**

- You may question or appeal a DLSA rating. If you have a concern, follow these steps:
  - Contact your CSW who will attempt to resolve the concern with you;
  - If the issue is not resolved, submit your reasons for requesting an appeal in writing to the Supervisor within 45 calendar days of the date the DLSA was completed. The supervisor will review the DLSA and if necessary arrange to have the assessment re-administered.
  - If the issue is not resolved af this level, the Supervisor will refer the matter to a designated senior manager. The designated senior manager will review the existing documentation to determine the accuracy of the ratings. The decision made at this level is final.

## B. Funding Sources:

- Your residents may receive funds from sources such as:
  - The Ministry of Social Services:
    - Saskatchewan Assistance Program (SAP);
    - Saskatchewan Assured Income for Disability (SAID).
  - Old Age Security and Guaranteed Income Supplement;
  - The Office of the Public Guardian and Trustee;
  - Aboriginal Affairs and Northern Development Canada (AANDC) or First Nations Bands.
- Some residents may receive income directly from employment, CPP, insurance settlements, or estates.

### 1. Saskatchewan Assistance Program (SAP):

- Some residents living in APSHs are funded by SAP and will have an Income Assistance Worker. Most of these residents are assigned to the centralized caseload in Saskatoon (1-800-361-4381).
- SAP fUnds the DLSA level of care (which includes the benchmark rate of $410) and also provides the following:
  - Personal Living Allowance for the resident (covers clothing and personal items such as toothbrushes, grooming supplies etc.);
  - Approved Home Activity Allowance for the resident (to assist with costs of community activities);
  - Transportation funding (set kilometer rate for transportation to day programs and medical appointments);
  - Plan 3 Supplementary Health Coverage nomination.
  - SAP may also provide funding for special needs
  - SAP payments are usually made in advance (at the beginning of the month).
  - Contact your resident's Income Assistance Worker for further information.

### 2. Saskatchewan Assured Income for Disability (SAID):

- Many residents living in APSHs are funded through the SAID program. SAID is an income support program for people with significant and enduring disabilities. It is an alternative to SAP.
- SAID has its own cheque format and requires less reporting so that people with disabilities do not need to reconfirm their disabilities every year.
- Residents enrolled in SAID have an assigned Assured Income Specialist.
- Contact your resident's Assured Income Specialist for further information.

3. **Seniors Income Plan:**

   The Seniors Income Plan provides senior citizens with the financial assistance required to meet their basic needs. A monthly supplement is provided to seniors who have little or no income other than the federal Old Age Security pension and Guaranteed Income Supplement. For more information, call 1-800-667-7161.

4. **Old Age Security (OAS) Pension and Guaranteed Income Supplement (GIS):**

   - When residents reach age 65, their primary funding source is the Old Age Security pension and Guaranteed Income Supplement. Some residents may have support needs in excess of their pension resources, and are thus eligible for supplemental funding from SAP or SAID.
   - The OAS pension is a monthly benefit payable to all persons 65 years of age or over.
   - Residents need to apply to receive the OAS pension and will likely require your help to do so. Residents should apply at least 6 months in advance of their 65th birthday.
   - Consult with your CSW and the resident's financial worker on an ongoing basis to ensure there is no disruption in funding.
   - The GIS is an income-tested monthly benefit payable to an OAS pensioner who has a limited income apart from the OAS pension.
   - Application must be made to receive the GIS. In about March or Aprll of each year, an OAS pensioner must submit a statement of his/her earnings or income from other sources in order to receive the GIS. If this statement ls not submitted, the GIS is stopped.
   - For more information, call Service Canada at 1-800-277-9914.

5. **The Office of the Public Guardian and Trustee:**

   - The Office of the Public Guardian and Trustee is part of the Ministry of Justice and Attorney General. The Office of the Public Guardian and Trustee administers the property of persons who are deemed legally incompetent to handle their own estates.
   - Funds come to the Office of the Public Guardian and Trustee from estates, insurance policies, OAS, etc. If the resident's funds run out, or are not sufficient to meet his/her needs, the Office of the Public Guardian and Trustee may apply for SAP or SAID on behalf of the resident.
   - If your resident's funds are administered by the Office of the Public Guardian and Trustee, a Trust Officer wlll be assigned.
   - The Office of the Public Guardian and Trustee is located in Regina. The phone number is 1-877-787-5424.

**6. Aboriginal Affairs and Northern Development Canada (AANDC) and First Nations Bands:**

Individuals placed in your home who have Treaty Status may be funded through AANDC or their Band. Funding mirrors the amount that would be paid through SAP or SAID.

**7. Residents who are "Self-Payers":**

- The term "self-payer" is used to describe a resident who has his or her own funds and who makes payment directly to you.
- Residents who are employed, will be responsible for paying you up to a maximum of $410 per month (the benchmark rate). The remainder of the DLSA level of care payment is paid by the Ministry of Social Services.
- A small number of residents may have insurance settlements or estate funds. In most cases, these funds are administered by a legally recognized court-appointed trustee or the Office of the Public Guardian and Trustee. The resident or his/her Trustee will pay you the benchmark rate of $410 with the remainder of the DLSA level of care rate paid by the Ministry of Social Services.
- A resident may manage his/her own OAS/GIS/SIP funds, although in most cases, a financial trustee is appointed. The resident or his/her trustee will pay you the full DLSA level of care rate. If the resident's funds are insufficient to cover the DLSA level of care rate and personal needs, an application to SAP or SAID for supplemental funding will be necessary.

## C. Trusteeship:

**1. Trusteeship:**

- You will often be appointed as a trustee for your resident's SAP or SAID funds if the resident is incapable of managing those funds independently. Funds typically include the Personal Living Allowance, the Approved Home Activity Allowance, and transportation funding.
- This trusteeship agreement is with the Ministry of Social Services and it does not apply to other funds such as G.S.T. credit cheques although you may still need to assist the resident with managing those funds.
- There may be separate trustee agreements you need to sign with other funders such as the Office of the Public Guardian and Trustee.
- In some cases, a resident's famlly may be appointed as trustee.
- A trustee is responsible for the administration of the resident's money in the best interests of lhe resident.
- You must keep records of and account for the resident's funds. Use the "Financial Accounting Record" and keep this up-to-date on your resident's file. Your records will include:

- All funds managed on behalf of the resident (Personal Living Allowance, Approved Home Activity Allowance, G.S.T., etc.);
- How funds are spent with receipts kept on file;
- Bank transactions (deposits and withdrawals);
- All cash given directly to the resident for spending money.

- Your CSW may review the resident's financial records at any time and a financial review is also part of the annual review process.
- The funding agency may ask to review the resident's financial records on a regular basis.
- Keep your records organized and up-to-date with the applicable receipts attached.
- Good record-keeping practices protect you in cases where concerns are raised about the use of resident funds.
- Each funding agency has a specific trustee agreement that you are required to sign. Ensure you are fully aware of the agency's requirements. Share a copy of the trustee agreement with the resident's bank.
- If a resident moves from your home, keep copies of the financial records.
- Contact the specific funding agency for further information.

Keep financial records for seven (7) years.

**2. Guidelines for the Personal Living Allowance:**

- The Personal Living Allowance is intended to cover the resident's personal clothing costs and personal items such as grooming and hygiene products. Other appropriate uses lnclude: spending money for outings and treats, saving up to buy desired items, saving up to go on a holiday.
- The Personal Living Allowance is not to be used toward any of your general household maintenance costs, household expenses such as groceries, home insurance, utflities, etc.

**3. Guidelines for the Approved Home Activity Allowance:**

- The Approved Home Activity Allowance is intended to support resident participation in community activities. Residents are encouraged to explore new interests and make choices about communiiy activities they would like to experience.
- The Approved Home Activity Allowance is often used for tickets to sporting events, movies, art and craft classes, membership fees, dances, and so on.
- Keep track of how allowance is spent along with applicable receipts in the resident file.

4. **Guidelines for Receipts:**

   Receipts must be kept for all maJor purchases. It is not necessary to keep receipts for small incidental purchases such as coffee, pop, etc.

5. **Guidelines for Reward Points:**

   If you make purchases using a resident's funds at establishments that offer reward points, be sure the points collected are used to benefit the resident. Ideally, the resident should have a reward card issued in his or her name.

6. **Conflict of interest:**

   - As a paid service provider or relative of a service provider, it would be considered a conflict of interest to:
     - Accept gifts from a resident with an estimated total value greater than $100 in a year;
     - Accept personal property or personal possessions from a resident or from anyone on behalf of a resident as payment for care an accommodation in the home;
     - Accept gifts or bequests provided in a resident's will unless:
       - the proprietor is a licensed charity; or
       - the will was executed prior to the resident being admitted to the home.
   - If a paid service provider or relative of a service provider receive a gift they should notify the resident's supporter or family member and record the following information:
     - The date of receipt of the gift;
     - The name of the person who received the gift;
     - The amount or estimated value of the gift;
     - The name of the person contacted to advise of receipt of the gift.

**D. Income Tax for Residents:**

- Income tax forms must be completed for the residents in your home. Completion of the income tax return determines eligibility for the GST rebate for individuals 19 years of age and older (as of December 31st). If you cannot assist the resident in completing the form, there are usually volunteers available who can be contacted through Canada Revenue Agency.
- T5's are issued by the Ministry of Social Services.

## E. Income Tax for Proprietors:

- Be sure to identify the funding source if payment comes through a trustee.
- Payments you receive from the province of Saskatchewan or an agent of the province are not considered to be taxable income.
- Payments you receive from a "self-paying" resident are considered to be taxable income.
- Contact Canada Review Agency for further lnformation.

## F. Absences/Moves from the Home:

### 1. Temporary Absences:

- When a resident is away from your home for a short period of time e.g., visiting family or on a holiday, you continue to receive the monthly DLSA level of care payment. Payments will be made for up to 30 days.
- Your resident will likely require some spending money while away. It is recommended that you discuss this with the family to ensure an adequate and affordable amount is agreed upon.
- In rare situations, the resident's family may request remuneration for lodging and care. You are not obligated to make payment to the family when the visit is at the family's request. Contact your CSW for assistance if this becomes an issue.
- When and resident is unexpectedly absent from your home as in the case of hospitalization and the resident is expected to return to your home, full rates will be paid for the first 30 days. Half-rates will be paid for days 31-60.

### 2. Permanent Moves:

- You must provide your CSW with a minimum of 30 days written notice if you wish to terminate the placement of a resident in your home. The preference is that notice is given on the first of the month.
- Since you are paid for the month in advance, if you terminate the placement of a resident without giving 30 days notice, you will be in an overpayment position and will have to pay back funds to the Ministry of Social Services.
- A resident may choose to move from your home. The resident must provide you with 30 days written notice. The resident's CSW will assist the resident as required to provide this notice.
- If the resident leaves your home suddenly without giving the required notice, you may be eligible for 30 days pay in lteu of notice or pay until the vacancy is occupied, whichever comes first. This also applies if a resident dies in your home.
- See the Transitions section for further information regarding resident moves.

# SECTION 6: RESPITE

***"Those who bring sunshine into the lives of others cannot keep it from themselves."***

Sir James M. Barrie

**1. Respite is Important:**

- Your work as an APSH proprietor can be very demanding, so regular use of respite is strongly recommended.
- You are responsible for arranging your own respite services including emergency respite. It is recommended you have at least 2 or 3 people you can call upon to provide respite.
- Respite providers must be mature, responsible people that are at least 18 years of age and are capable of providing the level of care and supervision required by your residents.
- Make sure you give the respite provider all necessary information required to care for your residents including: emergency contact numbers, medications, schedules, dietary requirements, etc.
- Respite providers must also have an understanding of the policies governing the APSH program including: CPP&SP, APSH Program Abuse Policy, and the APSH Program Violence Policy.
- You must inform your CSW of your respite arrangements.
- If you are having difficulty finding respite providers, your CSW may be aware of other APSH proprietors in your area who provide respite. Your CSW may also be aware of other respite options in your community.

When you are the one providing respite in your home, do not exceed your certified capacity.

**2. Built-In Respite Pay:**

- Respite pay is included in your DLSA level of care based upon 21 days of respite per year
- To calculate how much per day you might pay to a respite provider, the example below reflects the calculation steps using a DLSA level 3.0 at $1230.00 per month.

**a) Calculation of Monthly Respite Per Diem Rate:**

DLSA Level x 12 months 365 days x 1.75 = monthly respite per diem rate
Example: $1230 (DLSA Level) x 12 months ÷ 365 days x 1.75 = $70.77

**b) Calculation of Care Amount:**

DLSA Level minus the monthly respite per diem rate = total care amount
Example: $1230 (DLSA Level) - $70.77 = $1159.23

**c) Calculation of Respite Per Diem:**

Total care amount ÷ 30 days per month = respite per diem payout
Example: $1159.23 ÷ 30 = $38.64

- Based on this example, you would pay the respite provider $38.64 per day to care for the client while you're away.
- The DLSA rate of $1230 is used in the example for demonstration purposes only. Please check with your CSW for current DLSA rates.
- The daily rate calculation is a suggested rate only. You may pay your respite provider an amount that is negotiated by mutual agreement.

**3. APSH Program Respite Subsidy:**

***AMOUNT:***

- In addition to the built-in respite pay, you are eligible for up to 21 days per year of respite subsidy at $30 per day for each resident residing in your home who has an intellectual disability and for whom you receive a DLSA level of care payment from the Ministry.
- The APSH subsidy is also paid for residents funded by AANDC, OAS/GIS, employment earnings, or inheritances.
- The APSH respite subsidy provides a maximum of $630 per fiscal year per resident. A fiscal year starts on April 1st and ends on March 31st of the following year.
- Regardless of when a resident moves into your home, you are eligible to receive the respite subsidy for that resident.
- The APSH respite subsidy cannot be paid to a co-licensee or your spouse.
- Respite provision of three hours or more in a 24 hour period is considered to be one day of respite.
- Reimbursement will not be made for less than one day of respite.

***PROCESS:***

- Enjoy your time away - you have earned it!
- Pay your respite provider.
- Complete the APSH Respite Subsidy Reimbursement form located in the Forms section of this manual. Complete all applicable sections and be sure to obtain the signature of your respite provider on the appropriate signing line.
- Submit the original signed reimbursement form to your CSW.
- You should submit your reimbursement form as soon as possible after paying your respite provider.
- A cut-off date is identified near the end of each fiscal year. You must submit your reimbursement forms by the cut-off date or you will not be reimbursed.
- If your respite use happens to occur close to the cut-off date, you may submit your reimbursement form in advance as long as you've obtained the signature of your respite provider on the form.
- You should receive reimbursement within 90 days of submission.

***"I enjoy the freedom of not working outside the home 9 - 5. "***

# SECTION 7: TRANSITIONS

***"Families are the people who greet us in the morning to start the day and the ones who wish us goodnight when we go to sleep."***

***"Families are the people who love us no matter what we do or do not do."***

## A. Client Profile Information:

- It is crucial that you receive current and accurate information about residents who are living in or placed in your home.
- Detailed client information is available from your CSW and Is included in the Client Profile.
- It is your responsibility to ask for this information if it is not offered. It is also your responsibility to assist the CSW in updating the Client Profile on an ongoing basis especially when the resident is leaving your home. This helps other proprietors to benefit from your knowledge. insights. and experiences in working With a particular resident.

## B. How Placements Occur:

- CSWs are responsible for the placement of individuals in APSHs following the process described in the Comprehensive Personal Planning and Support Policy (CPP&SP).
- When an individual requires placement, the CSW will consider the individual's support needs and identify potential placement optlons. Whenever possible, the individual will be able to visit several homes and make a choice about where he or she would like to live.
- When you are asked to consider an individual for placement in your home, you will:
  - discuss the indlvidual's support needs with the CSW;
  - meet the individual and have the individual tour your home and meet your family;
  - consider how the individual will get along with any other residents in your home.
- Whenever possible, severaJ visits to your home by the individual are recommended.
- The CSW will assist in arranging pre-placement visits. There is no payment made for these visits.
- The CSW is available to answer any questions you may have about the individual.
- Just as the indtvidual has the right to choose where to live, you have the right to choose whether or not to proceed with a placement. If you feel the prospective resident is not a good match for your home, inform the CSW immediately in order that the CSW can explore alternative placements.
- There will be no repercussions should you decide not to proceed with a placement.

- If you decide to proceed with the placement, a mutually-agreeable move-in date will be determined.
- The CSW will meet with you to review the Client Profile document in detail.
- If the individual is moving into your home from another APSH, it is recommended that both you and the former proprietor meet to share information. The resident must give consent to the release of this information, as appropriate.
- Financial arrangements need to be organized prior to the placement. You wlll be required to sign the Trustee Form and the resident's Move Form.
- When the lndividtial moves into your home, you will have frequent contact with the CSW to discuss the resident's progress and identify and resolve any adjustment issues.
- If you feel that the resident does not fit in your home, let your CSW know immediately so that arrangements can be made for a transition to an alternate placement. A minimum of 30 days notice is required.
- If a particular resident does not work out in you home, this does not mean you have failed. Even with careful transition planning, unanticipated reactions may occur.

## C. Resident Leaving Your APSH:

### 1. Resident is Choosing to Move:

- Residents have the right to choose where they want to live. If a resident chooses to move away from your home, you are to respect that decision and be a part of the transition to his/her new home in a positive and supportive way. This support may include: assisting the resident to pack belongings, providing information to the new home proprietor, and participating in transition planning as described in the CPP&SP.
- The following are some of the most common reasons why residents may choose to move from your home:
  - they want a change/want to live in a different home;
  - they are unhappy with specific circumstances that cannot be resolved;
  - they are in conflict with you, your family, or other residents in your home, and the conflict cannot be resolved;
  - they wish to move to independent living;
  - they wish to return to live with family or move closer to family.

***"It is rewarding to hear my residents say:***

***'I love staying here. This is my home'."***

***NOTICE:***

Residents must provide you with a minimum of 30 days written notice. Some residents may not be able to provide written notice or may not understand the concept of ''giving notice," In such cases, it may be the CSW or a family member who provides the notice.

***WHAT TO DO:***

- Discuss the resident's request to move with your CSW.
- Participate in transition planning as described in the CPP&SP.
- Update the resident's banking and financial information in preparation for the change in trusteeship.
- Provide the CSW with the resident's updated file information prior to the move.
- Ensure all funds and personal effects belonging to the resident go with the resident when he/she moves.

***WHAT YOU ARE PAID:***

- You will receive full payment during the 30 day notice period, unless the resident moves prior to the 30 day period and the space is filled by someone new.
- If the resident moves without providing 30 days notice, you will receive payment in lieu of notice for up to 30 days subsequent to the date of departure or until the vacancy is filled, whichever occurs sooner.

**2. Resident is Moving at Your Request:**

- You may decide that a resident's placement in your home cannot continue. This decision may be a difficult one for you to make. Discuss this with your CSW who may be able to provide you and your resident with support through the transition.
- There are many reasons why you may ask a resident to leave your home. The following are some of the most common:
  - behaviour challenges that cannot be resolved;
  - refusal to respect house rules;
  - conflict with other residents that cannot be resolved;
  - safety issues such as smoking;
  - increasing physical, medical, or mental health support needs;
  - conflict with relatives or friends that cannot be resolved;
  - drinking/substance abuse.

***NOTICE:***

You must provide a minimum of 30 days written notice to both the resident and the CSW.

***WHAT TO DO:***

- Participate in transition planning as described in the CPP&SP.
- Update the resident's file information.
- Update the resident's banking and financial information in preparation for the change in trusteeship.
- Provide the CSW with the resident's updated file information prior to the move.
- Ensure all funds and personal effects belonging to the resident go with the resident when he/she moves.

***WHAT YOU ARE PAID:***

- You will receive full payment during the 30 day notice period.
- If you arrange to have a resident move from your home without providing 30 days written notice, payment is cancelled from the day of discharge and you will have to repay the Ministry all funds you have received past the date of discharge.
- If there is just cause as determined by the Ministry, for the discharge of a resident without 30 days notice, payment may be continued for 30 days or until the vacancy is filled, whichever occurs sooner.

**3. Resident is Moving With Cause:**

- A decision may be made to move a resident from your home. This decision is never made arbitrarily but is arrived at after applying the principles of due fairness to all parties.
- The following are some of the most common reasons why a resident may be moved from your home:
  - the resident's support needs have increased and can no longer be met in the home e.g., a move to a nursing facility is required;
  - required supports are not provided;
  - negative interactions that cannot be resolved;
  - abuse allegations.

***NOTICE:***

The CSW will provide you with a minimum of 30 days notice unless the resident's safety or well-being is at risk.

***WHAT TO DO:***

Update and provide all file, banking and financial information to the CSW along with the resident's funds and personal effects.

***WHAT YOU ARE PAID:***

You will receive full payment during the 30 day notice period. If a resident is removed from your home without notice due to an abuse allegation, payment may continue for up to 30 days pending the results of the review process.

**D. Renovating Your Home:**

- Inform your CSW of your plans to do structural home renovations.
- Contact your municipality to obtain a building permit for major renovations as you will need to ensure that the renovations meet current National Building Code (NBC) requirements.
- Provide your CSW with a new floor plan if the renovations alter the original layout or the home.

**E. Selling Your Existing Home:**

- If you wish to sell your existing home but continue operating an APSH in a new home, you must ensure the new home meets all zoning, fire, health and NBC requirements **before** you move in.
- Inform your CSW of your plans well in advance in order that all the required inspections of the new home can be completed **prior** to the move date.
- Your old home must be decertified before a certificate can be Issued for the new one.

**F. Retirement:**

- While there is no mandatory retirement age for APSH proprietors, as you age, you need to think about a retirement plan. The plan may include a period of downsizing before you achieve full retirement.
- A discussion about retirement will occur during each annual review. Your csw will ask you about your nealth and your ongoing ability to provide the care and support required by all your residents.
- If you make the decision to retire and you have residents who have Jived with you for many years, it is recommended that you provide as much notice as possible in order to facilitate positive transitions for your residents.

### *G. Closing Your Home - Decertification:*

- When you no longer wish to operate an APSH, contact your CSW to discuss transition planning for your residents.
- A minimum of 30 days notice is required but the more notice you can provide, the better, especially if you have several residents in your home,
- If you are selling your home, you cannot advertise it for sale as an APSH.
- Once the residents in your home have moved to new placements, you will receive an official Notification of Decertification which cancels your APSH certificate and terminates your service agreement with the Ministry.

***"I've given 28 years of loving care and thoroughly enjoyed it."***

# SECTION 8: EMERGENCIES

***"Impossible situations can become possible miracles."***

Robert H. Schuller

A variety of emergency situations may occur involving the residents in your home. The most common emergencies include:

- missing resident;
- aggressive behavior;
- medical emergency;
- death of a resident in your home;
- allegations of abuse;
- emergency/natural disaster.

Be proactive - plan ahead and be prepared as much as possible.

**A. Missing Resident:**

The resident has not arrived home at the expected time and you don't know where s/he is.

***WHAT TO DO:***

- Contact any service providers your resident is involved with (e.g., day program staff) to find out if they have any information.
- Be prepared to provide a description of the resident (clothing, glasses, height, hair and eye colour, medic alert, etc.)
- Be prepared to provide medical information if applicable (e.g., resident has diabetes).
- Call city transit if the resident takes public transportation. The dispatcher will alert the bus drivers to keep an eye out for the resident. A resident may not return home on time due to a missed bus or getting on the wrong bus.
- Call Crisis Support Services if available in your community.
- Call the pollce/RCMP to report the resident is missing.
- Notify your CSW as soon as reasonable.
- Only leave your home to search for the resident if there is someone else available to stay behind. Be sure you can be reached by cell phone in case the resident, the police or the hospital try to contact you.
- Log the time you noted the resident as missing along with the time various parties were notified.
- Log the time the resident returns home and the circumstances of the return.
- Notify any parties that may still be searching for the resident.
- Discuss the incident with your CSW to identify any actions required to decrease the possibility of a reoccurrence.

**B. Aggressive Behavior:**

The resident is displaying aggressive behavior and there is a reasonable chance that you or other residents may be hurt or damage may be done to your property.

***WHAT TO DO:***

- Do your best to remain calm.
- Use a calm, firm, and reassuring tone of voice.
- Use the techniques for responding to dangerous or harmful behavior that you learned from the CPP&SP, the APSH Program Violence Policy, and the Emergency Management Guidelines.
- Use the techniques outlined in the resident's Behavior Support Plan and Emergency Management Plan as applicable.
- Never escalate the behavior by yelling or reacting aggressively yourself.
- **If the aggression continues and harm is likely, remove yourself and others from the immediate area and call 911 or the RCMP/City Police for emergency assistance.**
- You may choose to call after-hours crisis support services as available in your area.
- Once the situation has de-escalated and it is safe to do so, contact your CSW.
- See the APSH Program Violence Policy section for details regarding reporting and documentation.

**C. Medical Emergency - In the Home:**

Your resident requires medical attention due to a serious injury or sudden, acute illness e.g., suspected heart attack, stroke, or loss of consciousness.

***WHAT TO DO:***

- Call 911 and follow the directions provided until the ambulance arrives.
- Have the resident's medical information readily available (Individual Critical Information Sheet).
- Provide First Aid or CPR as appllcable until help arrives.
- Ensure the resident has a Medic Alert identifier, if applicable.
- Report the incident to your CSW as soon as it is safe to do so.
- Document the incident in the resident's file.

## D. Medical Emergency - Away from Home?

Your resident is on a community outing without you and becomes ill.

***WHAT TO DO:***

- In the majority of cases, your resident will either tell someone to contact you, or the contact information will be found on the resident's person. Ensure your residents carry your contact information with them when they go on outings without you.
- Ensure the resident carries a Medic Alert identifier if applicable.
- Depending upon the situation, you may be informed by your local hospital that the resident is receiving emergency care and you need to provide tile necessary medical history and go to the hospital as soon as possible.
- If it is someone from the community calling to tell you the resident appears ill, you will need to assess the situation to determine whether:
  - the resident needs emergency medical attention
  - the resident needs to see his or her doctor;
  - the resident needs to return home to rest and then make the appropriate arrangements accordingly.
- If you are not sure whether or not the resident needs to be seen by a doctor immediately, call your local hospital or the doctor's office, or the Health Help Line and describe the symptoms and follow the direction you are given.
- Report the incident to your CSW as soon as it is safe to do so.
- Document the incident in the resident's file.

## E. Death of a Resident in your Home:

- A resident passes away in your home.

***WHAT TO DO:***

- Call 911 and follow the directions you are given.
- Contact your CSW to report the death. Your CSW will support and assist you through this traumatic event.
- The police and coroner will attend the scene of death.
- Provide information to the police and coroner as requested and follow their direction.
- Take care of yourself by seeking support as required e.g., Crisis Support Services may be available in your community.

**F. Allegations of Abuse:**

See the Abuse Policy section for details.

**G. Emergency Preparedness:**

An emergency/natural disaster occurs in your community (e.g.; tornado, flood, wildfire, etc.)

***WHAT TO DO:***

- Know the risks and have an emergency plan prepared in advance.
- Be prepared to take care of yourself and your household members for a minimum of 72 hours.
- Have an emergency kit.
- See the Government of Canada website @***www.getprepared.gc.ca*** for detailed information on emergency preparedness or call 1-800-622-6232.

Keep an up-to-date individual Critical Information Sheet filed in the back of ths manual for each of the residents in your home. This will give you quick access to the key information you or your alternate caregiver will need in a crisis situation.

# SECTION 9: SERIOUS INCIDENT REPORTING

## Serious Incident Reporting (SIR) APSH Flow Chart

**Serious Incidents must be reported to your Community Services Worker.**

▼

**Serious incidents include: (see definitions on following page)**

1. Abuse Allegations
2. Threat to Health and Safety
3. Death
4. Disruption of Services

▼

**REPORTING PROCESS**

| By Whom | To Whom | When |
|---|---|---|
| You (or your alternate care provider) ▶ | Community Services Worker<br>• If Community Services Worker (or cover-off) not available, contact the Regional Supervisor or cover-off.<br>• If Regional Supervisor or cover-off is not available, contact the Regional Manager or cover-off. | Immediately |
| | | **If incident occurs after hours or on a weekend:**<br>Leave a voice mail for the Community Services Worker and follow-up with a second phone call on the next working day to ensure the Community Services Worker received the message. |

## Serious Incident Reporting (SIR) Definitions

1. **Abuse Allegations**

   - **Allegations of Physical Abuse** – Any act that causes or has potential to cause physical injury, including but not limited to infliction of bodily pain by one or more instances of striking, shoving, slapping, pinching, choking or kicking. May include the use of restraining tecilniques outside of *Comprehensive Personal Planning and Support Policy* guidelines.

   - **Allegations of Sexual Abuse** – Any form of exploitative sexual behaviour or unwanted sexual touch including but not limited to harassment or acts of sexual assault.

   - **Allegations of Emotional Abuse** – Acts or omissions that cause or could cause emotional pain including but not limited to: acts or omissions that one disrespectful, rejecting, intimidating, criticizing, threatening or harassing. Also includes verbal or written expressions and yelling, screaming and swearing at others.

   - **Allegations of Neglect** – Failure to provide or make available the necessary supports that may result in physical or emotional harm or loss to the resident or their estate, including but not limited to: food, clothing, shelter, hygiene, medical care and support or supervision appropriate to the resident's age, development or situation. May be caused by an action or a failure to act and may not be intentional.

   - **Allegations of Property Abuse** – Misuse of a resident's funds or assets, including but not limited to unauthorized use of bank accounts or denial of personal possessions.

   - **Allegatlons of Medication Abuse** – Non-compliance with policies and procedures relatlng to medication administration, including but not limited to withholding medication, over-medication, inappropriate use of medication, repeated medication errors.

   - **Allegations of Denial of Opportunity** – Unreasonable denial of opportunity, or intentional withholding of access to available opportunity or choices to meet needs for economic, spiritual, mental or personal growth and satisfaction.

2. **Threat to Health and Safety**

   - **Unexpected Illness** – any illness that requires the resident to be admitted to the hospital.
   - **Disease Outbreak** – an outbreak of a communicable disease, or any occurrence of a reportable disease in a residence or program. An outbreak is the occurrence of a disease beyond the normally expected incident level.
   - **Fall** – any fall where the resident requires emergency care by a physician or transfer to a hospital.
   - **Motor Vehicle Accident** – any motor vehicle accident where injuries occur to a resident while in the care or supervision of a service provider.
   - **Other Injury** – any other injury to a resident that requires emergency transfer to hospital or emergency care by a physician (burns, scalds, medication error, etc.)
     **Note:** This category also includes resident to resident physical aggression or sexual assault, as well as resident to proprietor aggression.
   - **Poisoning** – any ingestion of a poisonous substance by a resident in a residence or program.
   - **Missing/Wandering Person** – any unscheduled or unexplained absence of a resident from a residence or program.
   - **Suicide Attempt** – any attempt by a resident to take his/her own life.

3. **Death**

   - **Unexpected Death** – any unforeseen death of a resident in a residence or program.
   - **Expected Death** – any death due to natural causes of a resident in a resldence or program.
   - **Suicide** – any death of a resident by suicide.

4. **Disruption of Services** – any service disruption that affects the delivery of services to residents (e.g., fire, flood, labour actions).

# SECTION 10: APSH PROGRAM ABUSE POLICY

APRIL 1, 2010

**STATEMENT OF POLICY:**

The Ministry of Social Services and Saskatchewan Approved Private Homes Inc. (SAPH Inc.) are committed to ensuring that all individuals with disabillties residing in Approved Private-service Homes licensed under ***The Residential Services Act*** *(www.publications.gov.sk.ca/details.cfm?p=823)* are provided with an environment which is free from abuse.

**PURPOSE:**

It is the purpose of this policy to:

- Define physical abuse, sexual abuse, emotional abuse, neglect, property abuse, medication abuse, and denial of opportunity.
- Describe the procedure that proprietors and Ministry of Social Services staff shall follow in reporting and responding to allegations, disclosures or observations of abuse.[1]
- Describe responsibilities, procedures and review process in cases of alleged abuse.
- Ensure the involvement of legal authorities whenever warranted.

**STATEMENT OF PRINCIPLES:**

- Abuse in any form shall not be tolerated.
- The rights of individuals under the *Canadian Charter of Rights and Freedoms* http://laws.justice.gc.ca/en/charter and other Canadian law shall not be denied.
- It is recognized that an allegation of abuse against a proprietor and/or a member of his/her family creates a situation of trauma for the proprietor and the alleged victim alike.
- The resident's and proprietor's dignity will be respected through a process for responding to and reviewing allegations of abuse that is timely, fair, humane, objective and complete.

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[1] This policy does not apply to situations in which the alleged offender is a resident.

**DEFINITIONS:**

**Physical Abuse:** Any act that causes or has potential to cause physical injury including but not limited to infliction of bodily pain by one or more instances of striking, shoving, slapping, pinching, choking or kicking. May include the use of restraining techniques outside of *Comprehensive Personal Planning and Support Policy guidelines*.[2]

**Sexual Abuse:** Any form of exploitative sexual behaviour or unwanted sexual touch including but not limited to harassment or acts of sexual assault.

**Emotional Abuse:** Acts or omissions that cause or could cause emotional pain including but not limited to acts or omissions that ate disrespectful, rejecting, intimidating, criticising, threatening or harassing. Also includes verbal or written expressions, and yelling, screaming and swearing at others.

**Neglect:** Failure to provide or make available the necessary supports that may result in physical or emotional harm or loss to the resident or their estate, including but not limited to food, clothing, shelter, hygiene, medical care, and support or supervision appropriate to the resident's age, development, or situation. May be caused by an action or a failure to act, and may or may not be intentional.

**Property Abuse:** Misuse of a resident's funds or assets, inciuding but not limited to unauthorized use of bank accounts or denial of personal possessions. For example, taking away an individual's radio because he didn't clean his room is property abuse.

**Medication Abuse:** Non-compliance with policies and procedures relating to medication administration, including but not limited to withholding medication, over-medication, inappropriate use of medication, or repeated medication errors.

**Denial of Opportunity:** Unreasonable denial of opportunity or intentional withholding of access to available opportunity or choices to meet needs for economic, spiritual, mental or personal growth and satisfaction.

**Resident:** Person who resides in an Approved Private-service Home for the purpose of receiving lodging. supervision, personal care and planning support.

**Proprietor:** Person who operates a certified Approved Private-service Home (APSH).

**Alleged Perpetrator:** Person identified as having committed or participated in an act of abuse toward a resident.

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[2] While a physician or psychiatrist may prescribe a physical or mechanical restraint, or a family or other person may request that a physical/mechanical restraint be used, approval from Community Living Service Deliver (CLSD) is required for use of restrictive procedures in a Ministry licensed APSH.

**PREVENTION:**

There are several things that proprietors can do to help reduce the risk of an allegation of abuse being lodged against them. These include:

3. Being very familiar with, and following, the guidelines for acceptable/unacceptable ways of supporting and interacting with residents. This includes the *Comprehensive Personal Planning and Support Policy*, as well as this policy on abuse.
4. Being familiar with acceptable ways to respond to emergency situations where a resident may become physically aggressive (Appendix A, Emergency Management Guidelines).
5. Being aware of the indicators of abuse and neglect and immediately reporting these to the resident's Community Services Worker if observed (Appendix B, Indicators of Abuse and Neglect).
6. Recording in detail on the resident file and immediately reporting to the Community Services Worker:
    - any significant changes in the resident's behaviour or health condition.
    - bruises, scratches, wounds, sores, bumps, infections, etc. resulting from accidental injury, self-injury or any difficult to explain circumstance, and where witnessed, the orlgin.

***NOTE:*** If the resident's Community Services Worker is not immediately available, ask to speak to an available worker or supervisor. If after hours, leave a voice mail; follow-up with a second call as soon as the office is open.

5. Acknowledging when you are not able to cope with the challenges a resident is presenting, and asking the Community Services Worker to assist in resolving the issue.

**REPORTING PROCEDURES**

1. Any proprietor who observes or becomes aware of abuse of a resident who is a client of the Ministry of Social Services shall immediately report the occurrence to the resident's Community Services Worker[3].

***NOTE:*** If the resident's Community Services Worker is not immediately available, the proprietor is to ask to speak to an available worker or supervisor. If after hours, the proprietor may leave a voice mail message and then follow-up with a second call as soon as the office is open.

2. The Community Services Worker will immediately inform the Regional Supervisor of the allegation.

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[3] Where the resident who is the alleged victim is a client of Mental Health, the proprietor will report the allegation to the Community Services Worker for their home and to the resident's mental health case manager or contact. The community services worker for the home will ask the mental health case manager to undertake any actions which directly involve the resident. These include: informing the police or the allegation as appropriate; ensuring the safety of the resident, which may include removing the resident from the home when necessary; and contact with the family or next-of-kin as appropriate.

The mental health case manager will also be invited to participate with ministry personnel in all other aspects of the response to the allegation.

3. Action will be taken by the Ministry of Social Services in response to all allegations of abuse regarding residents living in APSHs.

4. A Community Services Worker may receive a report involving an APSH proprietor of an allegation from a third party (i.e. someone ***other than***: the alleged victim, the person to whom a disclosure was made, or the person observing or suspecting the abuse). In these situations, the Community Services Worker shall confirm with the alleged victim, or the person to whom the disclosure was made or the person who directly observed or suspected abuse, that he/she has made a complaint of abuse.

   In confirming an allegation, the Community Services Worker shall **only** attempt to verify with the original source that a complaint of abuse has been made. The Community Services Worker shall **not** attempt at this point to determine whether or not the abuse actually occurred.

5. The Community Services Worker receiving an allegation of physical or sexual abuse shall inform the police of the allegation as soon as possible but in no case more than 24-hours after the allegation has been made, **unless** there is substantial reason to question the credibility of the allegation.[4] In such cases, the Community Services Worker will consult with the regional supervisor to determine an appropriate course of action.

   The police may also be called in other instances (i.e. an allegation of another type of abuse such as property abuse) if deemed warranted. The police shall be requested to conduct their investigation independent from any investigation that may be done by the Ministry.

6. A medical examination will be requested in situations of alleged physical or sexual abuse, or whenever relevant physical evidence may be present. The resident wlll be encouraged to see a physician immediately. Where possible, the examination is to be conducted within 24-hours of the time of the alleged incident. All steps shall be taken to preserve any evidence related to the allegation.

7. In the event that the alleged victim of physical/sexual abuse or neglect is a person under the age of 16 years, the Community Services Worker will ensure that the nearest office of Child and Family Services of the Ministry of Social Services is contacted, as required under *The Child and Family Services Act.*

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[4] Substantial reason to question the circumstantial credibility of an allegation applies only in exceptional circumstances, such as: 1) the resident has made the same allegation several times before and it has already been dealt with appropriately according to policy; or 2) the details surrounding the allegation make it impossible to have occurred (e.g. the alleged perpetrator is someone the individual has never met.)

Circumstantial credibility refers to the facts and circumstances of the incident and not the personal characteristics of the alleged victim or alleged perpetrator.

Situations where the person receiving the complaint may have difficulty believing that the alleged perpetrator could have done this action and do not meet the test of substantial reason to question the credibility of the allegation.

8. The Community Services Worker may contact family or next-of-kin with the resident's agreement to advise them of the incident in general terms. This contact is to be made at the point in the process as is most appropriate to the specific situation.

   If a Guardianship Order exists, review of that document is required to determine what, if any, authority there is to disclose the information to the guardian.

   As per *The Freedom of Information Act* Section 29(2)(i), the Community Services Worker may disclose without consent with the purpose of complying with an act. For example, the *Private-service Homes Regulations* Section 30 requires that next-of-kin are to be informed in cases of serious illness or injury,

   If the Community Services Worker is unable to determine the intentions of the resident, they should weigh the participant's right to privacy with sharing information if in the participant's best interest and where disclosure of the information is in accordance with any legal obligations of the Mtnistry.

   The Ministry may wish to seek independent legal advice in complex situations.

   The process used and the circumstances of the decision reached will be documented in the alleged victim's Ministry file. The Community Services Worker is required to Immediately record the exact questions asked and the exact words and gestures of the resident's response to questions regarding agreement for disclosure.

**ADVISING THE PROPRIETOR OF THE ALLEGATION:**

Where the proprietor or someone associated with the proprietor[5] is the alleged perpetrator, the Community Services Worker will advise the proprietor within 24-hours that a complaint has been received and that an investigation/review is being conducted. This may be either a police investigation and/or a Ministry review.

Where the safety of the resident or the integrity of the police investigation may be jeopardized, there is no notice given to the proprietor before beginning the investigation. If residents must be removed from the home, the Community Services Worker will advise the proprietor of the removal.

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[5] Someone associated with the proprietor refers to:

- A family member or friend of the proprietor, or other person who because of his/her relationship with the proprietor, has contact with the resident.
- An individual service provider paid by the proprietor to provide supports to the resident.

  *Note: Where the alleged perpetrator is an individual service provider, some reporting, investigative and disciplinary actions specific to the alleged perpetrator as contained in the APSH Program Abuse Policy may not be appropriate.*

**ACTIONS WITH RESPECT TO RESIDENTS:**

**The Ministry of Social Services has the responsibility to ensure the safety and well-being of Ministry clients who are alleged to have been abused or neglected, as is within the power of the Ministry to do so.**

Upon receiving an allegation of abuse, the Community Services Worker will, in consultation with his/her supervisor, assess the risk/safety of the resident who is the alleged victim as well as the other residents of the home. The Community Services Worker and Regional Supervisor may consult with the police and/or the Manager, Community Services and the Program Consultant, Assessment Design and Accountability on this matter. Ministry managers may consult with legal counsel as required.

The alleged victim/other residents may be removed from the home where:

- the alleged victim shows obvious medical evidence of abuse.
- the alleged perpetrator is still in/associated with the home.
- the proprietor is very distraught about the allegation and unable to continue to provide care.
- the resident is afraid/would prefer not to return to the home.
- there are concerns about the ongoing safety of the alleged victim and the other residents in the home environment.

**REVIEW:**

A review shall be conducted by the Ministry:

1. In all situations where there has been an allegation of abuse.
2. Where there have been repeated complaints of inappropriate service or unsatisfactory interactions with residents.

**A. Process:**

The following process applies to any review conducted by the Ministry.

1. The review will be conducted by a Community Services Worker or other Ministry representative, as determined by the Regional Supervisor or his/her designate.

2. The Ministry review will be completed within **30 days** of the initial allegation and the proprietor will be notified of the results, unless the review is unavoidably delayed by a police investigation. When the Ministry review process is delayed by a police investigation, the Community Services Worker will advise the proprietor of the delay and provide updates as appropriate.

3. The Ministry review will be discussed with the police **prior** to being initiated, to ensure that the review will not jeopardize any further investigation or criminal proceedings. The police will also be consulted during the review before the Ministry shares any information, reports or documents with the proprietor, to ensure that sharing this information will not jeopardize the police investigation.

4. As the outcome of the Ministry review may include decisions about the Certificate of Approval, all reviews shall be conducted respecting the rights of the proprietor, This means that the proprietor has:
    - the right to be treated fairly
    - the rlght to be heard before any final decision is made.
5. The Ministry review may consist of interviews with the residents of the home, the complainant and/or any other individuals who have information relevant to the allegation.
6. After the necessary information has been gathered (through interviews, etc.), the Ministry representatives will meet with the proprietor and explain any concerns. The proprietor will be advised he/she is welcome to have someone present with them during any interviews or meetings. A letter summarizing the concerns discussed during the meeting will be sent to the proprietor.
7. The proprietor will be given adequate time to prepare a response to the concerns. The proprietor can provide his/her response in writing or can meet with the Ministry representatives. i.e. Community Services Worker, Regional Supervisor, in person.
8. The Ministry representatives will review all the information in consultation with the Manager, Community Services and the Program Consultant, Assessment Design and Accountability. A sincere effort will be made to understand the issues and seek clarification when confused by the information provided by any party.

**B. Decision/Outcome:**

The Ministry representatives, who have heard all of the evidence and the response of the proprietor, will make the decision about how to address the issue of the complaint in consultation with the Manager, Community Services and the Program Consultant, Assessment Design and Accountability.

Where the allegation of abuse has been substantiated, or where the proprietor's interacHons with residents have been found to be unsatisfactory rather than clearly abusive, a written decision will define the strategy to address the issue of the complaint. This may include:

1. Development of a strategy to prevent further occurrences of unsatisfactory interactions with residents.
2. Outline of training in which the proprietor will participate.
3. Counselling – where the proprietor's interactions with residents are found to be unsatisfactory yet the actions are not clearly abusive, the Community Services Worker shall bring the matter to the attention of the proprietor. Documentation detailing what was discussed, when and with whom will be placed on the proprietor's Ministry file.

4. Written reprimand – where counselling has been ineffective but where termination of the Certificate of Approval is not warranted, the proprietor will be formally advised by means of a letter of the consequences of further instances of unsatisfactory interactions. A copy of this letter will be retained on the proprletor's Ministry file.

5. Decisions about the Certificate of Approval, which may include:
   - Continuation of Certificate
   - Continuation with conditions
   - Decertification

   The proprietor will be informed of the decision in wrlting and the reasons for the decision.

   The proprietor will be advised of the mechanism for appealing the decision and the time frame for requesting an appeal (30 days from receipt of the letter advising of the declsion).

**APPEAL:**

1. If the proprietor wishes to appeal a decision affecting his/her Certificate of Approval, the proprietor will request the appeal, in writing, to the Communlty Services Worker assigned to their home, within 30 days of receiving the letter from the Ministry advising of the decision.
2. The appeal wm be heard within 30 days of receiving the letter from the proprietor requesting the appeal.
3. The proprietor will be advised he/she is welcome to have someone present wlth them during any appeal interviews or meetings involving the proprietor.
4. The appeal will be heard by a Ministry representative designated by the Community Living Service Delivery Executive Director. The Ministry representative will have had no previous involvement in the decision regarding the case.[6]
5. The appeal of the decision will be heard with the proprietor present. The person hearing the appeal may request additional information if clarification is required. The appeal may be adjourned for up to 14 days to allow for information gathering,
6, Should the proprietor fail to attend the appeal hearing, it will be rescheduled. If the proprietor fails to appear a second time, the person hearing the appeal may declare the appeal abandoned and not proceed.
7. A decision will be made by the person hearing the appeal. It will be conveyed in writing to the proprietor, with reasons for the decision provided, within 14 days of the appeal hearing. This decision from the Ministry is final unless further application is made to an applicable authority.

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[6] The person hearing the appeal shall be unbiased. For example, he/she cannot have a financial interest in the matter or a personal or professional relationship with the appellant. The person hearing the appeal must have sufficient independence to be able to decide the case on its own merits. The facts and circumstances of each case must be considered. The person hearing the appeal cannot be bound by predetermined guidelines which prevent any flexibility in the decision-making process.

**DOCUMENTATION:**

Ministry staff involved in responding to the allegation will document all activity according to Section 8.2 of the Ministry of Social Services, Income Assistance and Disability Services Division: *Protocol for the Investigation of Abuse and Neglect Involving Adults with Intellectual Disabilities*.

The proprietor Will keep a file containing all written correspondence related to the allegation. The proprietor should also make notes of all conversations and activities related to the allegation and keep these notes in this file until the matter is resolved.

**CONFIDENTIALITY:**

All information obtained during the course of a review shall be treated as confidential and the discussion of such information is limited to only those directly involved with the case.

# APPENDIX A

**Emergency Management Guidelines**[7]

This document has been adapted from Willis and LaVigna's 1985 publication entitled *Emergency Management Guidelines* (originally published by the Institute for Applied Behaviour Analysis, Los Angeles, California). Efforts have been taken to remove techniques from this work which may potentially be misapplied, or which involve undignified treatment of participants[8] (e.g. ridicule, humiliation, physical containment).

***Please note that the suggested strategies are only examples, not an entire listing of all possible strategies that may be appropriate.***

## I. INTRODUCTION

**Why use emergency management guidelines?**

i. to manage dangerous behaviours in a positive, dignified and constructive way.

ii. to provide new techniques where none existed before, as there may be situations in which workers simply do not know what to do short of using highly restrictive procedures such as restraint or segregation to deal with dangerous behaviours.

These guidelines:

- offer a few suggestions, not the universe of possible positive techniques,
- suggest that there **are** ways to survive emergencies.
- offer positive, preventive and constructive ways of dealing with dangerous behaviours.
- describe a continuum of less to more involved or intrusive interventions.
- do not imply because of the "less to more restrictive" order of presentation, that this order must be followed in the case of a behavioural emergency (some behaviours can escalate to a crisis in seconds).
- suggest that the techniques should be used in a way, "(a) that is not more restrictive or intrusive than is necessary to prohibit the individual from inflicting harm on him/herself others; and (b) that is applied no longer than necessary to prevent or contain the dangerous behaviour." (Willis & LaVigna, 1985, p.2).

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[7] The terms "**him"** and "**her"** have been used interchangeably throughout this text to avoid sexual bias.

[8] The term "participant" is used to refer to the individual with an intellectual disability who is receiving support.

## II. POSITIVE PROGRAMMING:

Positive programming teaches more effective and socially acceptable ways of getting one's needs met and of coping with the realities of the physical and interpersonal environments in which the person must act and interact. In other words, positive programming teaches participants how to have their needs met and to cope with people and events in their life in the most acceptable manner. The first emphasis of interventions designed to manage dangerous behaviours (e.g. aggression and property destruction) must be to provide positive programming that develops the individual's communication, vocational, recreational, social, community and coping skills. Within this context, we can take steps toward reducing the individual's behaviour problems.

As the person learns more effective daily living and coping skills, behaviour problems occur less often, if at all. Positive programming emphasizes the importance of providing frequent contingent praise and constructive assistance for appropriate interactions with other participants and workers. Attention should be provided frequently in non-contingent social interactions (e.g. offering attention solely for the reason of giving individual attention). Frequent interactions among workers and participants are effective in preventing or lessening the frequency and Intensity of many occurrences of aggression as well as other undesired behaviours.

There are four common variations on positive programming:

1. ***Teaching a new behaviour or class of behaviours***. For example, an introverted, withdrawn person may benefit from assertiveness and social skills training. The participant who displays a variety of assaultive and self-injurious behaviours may be involved in counselling to help learn new ways of coping with fear of confrontations about misbehaviour.

2. ***Substituting a more socially appropriate behaviour***. For example, you may replace self-stimulatory behaviour with appropriate toy play.

3. ***Assigning meaning to behaviour***. This involves responding to a typical behaviour as though it were an attempt to communicate. For example, a person typically begins lightly pounding the table prior to displaying aggressions; the worker responds to the light pounding as a communication that the participant wishes a break from work.

4. ***Substituting a communicative means***. Rather than addressing the dangerous behaviour directly, it may be useful to substitute a communicative means. The use or indication of this method will be implicated by a functional analysis. It is quite common for a participant's desperate attempt at communication to be labelled as a maladaptive behaviour. For example, a participant who all of a sudden throws his work across the room fifteen minutes into each session may be described as "aggressive, uncooperative, and unmanageable", if no one considered that he might just be saying "I am tired of doing this task", but lacked the means to communicate this feeling in an appropriate way. The worker might teach the participant to hold up a coloured card to indicate that he wishes a break.

## III. SURFACE MANAGEMENT STRATEGIES FOR BEHAVIOUR PROBLEMS

Even when we provide positive constructive programming, the people with whom we work sometimes continue to display dangerous behaviours. Surface management strategies are designed to influence behaviour until positive programming can have the opportunity to affect a change. Surface management strategies should not be construed as treatment, but merely as short term techniques.

Most dangerous behaviours are either cued by events or situations in the environment (i.e. antecedents and/or occur in a typical or predictable behavioural chain. Surface management strategies manipulate either the antecedet/precipitating events or interrupt the chain of the dangerous behaviour(s),

This first category of surface management strategies involves eliminating precipitating events or antecedent control strategies. The second category involves interrupting the behavioural chain.

### 1. Eliminating Precipitating Events

#### *a) Remove seductive objects*

Objects, events and materials in the environment can serve as cues for someone to act in a certain way. For example, leaving a filled ash tray on the counter is a cue or invitation for someone who tends to steal and eat cigarette butts to display a dangerous behaviour.

By removing seductive objects, dangerous behaviours are likely to be eliminated, or at least to be reduced in frequency and therefore the need for worker intervention is reduced as welt

#### *b) Relocate People*

As we observe daily, some people just don't get along with others. At the table they may touch, push, grab or pull at each other, or they may attack others as soon as they come in close proximity. By attempting to keep people in different locations, potentially dangerous situations may be avoided while in the meantime, positive programming interventions are beginning to take effect.

#### *c) Remove unnecessary demands and requests*

People sometimes react angrily with assault and property destruction when they are presented with demands or are pursued for compliance. In such situations, the removal or lessening of demands/requests is likely to reduce many dangerous behaviour episodes.

When individuals do react to requests with dangerous behaviours, it Is important to be sensitive to their emotional and physical state; under conditions where they are extremely upset, frustrated, etc., it may be advisable **not** to issue demands requiring compliance at that time.

A participant may also be sensitive to particular demands given in a particular way. This being the case, it is advisable to temporarily eliminate the request and to find a better way to approach the person. It is possible that the person does not fully understand the request, or that he is afraid of doing the task incorrectly because it is too difficult. For example, instead of requesting "you go over there and pick that chair up right now", try saying, "when you've calmed down I'll help you put the chair back where it was."

If you find an effective way of making requests of a person who is upset, share that approach with others.

Generally, the word "No" is a cue for anxiety or anger in many of us. Rather than using the words ''No", "Don't" or "Stop" when you wish a participant to stop an activity or when he wishes to do an inappropriate activity, offer him a cholce of alternative activities, suggest a different course of action or rephrase your response eliminating the anxiety-inducing terms/words.

***d) Change the location and time of activities***

Certain people may exhibit dangerous behaviours reliably in certain situations and at select times. For example, hitting may occur in the dining room but not in the living room or tantrums might occur only at shift changes but not any other time.

By changing the location and/or time of activities, the dangerous behaviours may not present themselves. Examples:

- If a participant tantrums at shift change, maybe she could be involved in a stimulating outside activity at this time to prevent an outburst for attention.
- With a participant who assaults others when woken abruptly, an approach would be to try letting him wake up in a more gradual way to prevent the assaults.

***e) Rearrange the environment***

Many specific behaviour problems are tied to specific arrangements of furniture in select situations. For example, a participant may yell, scream and hit others only when sitting in a specific chair that is pointed in a specific direction. By changing the chair and the participant's position, it is possible to eliminate many outbursts without a structured behavioural intervention.

***f) Eliminate events which cue the behaviour***

If you have identified a stable relationship between the occurrence of an event and the occurrence of a dangerous behaviour, eliminate the event (e.g. avoid saying the Word "No" if it leads to agitation, instead give the person alternative behaviours to do).

## 2. Interrupting the Behavioural Chain

Some dangerous problem behaviours are frequently part of a chain or a sequence of events that progresses from less to more severe (e.g, assaultive behaviour such as hitting others, may begin with verbal protests, whining and crying, and so on). It may be possible to prevent assaultive behaviour by eliminating the early events in the behavioural chain.

Strategies which may help to interrupt the behavioural chain include:

### *a) Facilitating communication*

Many of the people with whom we work either lack entirely the skills needed to communicate desires, anger, frustration, and wants, or these skills are not firmly developed. Efforts lo assist them to express themselves may effectively reduce the likelihood that severe problems will appear.

When people begin to show signs of agitation and frustration, or when they show the early signs of escalating to more severe behaviours, every effort should be taken to determine their problems and to encourage them to express themselves. Specific questions might include: 'What do you want? Do you have a problem? Do you need help? What is wrong? Can you show me where it hurts? How are you feeling?"

To assist individuals to express themselves at the time, a combination of adapted communication (such as Amer-lnd gestural code, if needed), ''active listening'' and "best guessing'' techniques is useful. Remember to keep your language simple - the fewer words, the better.

***Examples:***

- A participant who is observed to be agitated or upset could be asked on paper what is wrong and given an opportunity to write out a response.
- A participant is pacing and appears anxious; the worker might respond by saying "I know you're upset about _____, let's try to figure out what to do".
- A participant is screaming and banging her head, and you know that she is about to have her period. One reaction might be "I know you don't feel good. Your stomach is hurting. I'm sorry. Would you like to lay down?"
- A participant is fighting with a peer and has a scratch on her face. She continues to grab and pull at anyone and anything around her. Try redirecting her attention and de-escalating the situation by saying "you have a scratch on your face. I bet that hurts. Let me help you. Let's put some cream on it".

### *b) Proximity Control*

We might observe that someone is less llkely, if at all, to display dangerous behaviours when a worker is present or in close proximity. Under such situations, simply moving closer to the person while he appears to become agitated may be sufficient to prevent a full blown episode. One may even place their arm on the person's shoulder or sit down with him in close proximity while at the table, just to let the person know you are there.

**CAUTION:** When some individuals are about to display dangerous behaviour, proximity of workers may serve to intensify the behavior. Be sure to know as much as possible about individual response patterns.

Proximity control lets participants know:

(1) that you are aware of what they are doing; and,
(2) that you are there physically to support them.

### *c) Inject humour*

Sometlmes when participants appear sad or grim just before displaying dangerous behaviours, you may be able to prevent a problem from occurring or escalating by making a playful or humorous comment.

Caution needs to be exercised since such a method might be wrongly construed as ridicule or sarcasm, or simply not be understood by the individual.

If you do use humour, it must be at a level that the participant understands. Figurative comments which require the listener to listen to either voice tone or apply dual meanings to words are obviously inappropriate. Silly humour is often the most effective (e.g. silly humorous faces, ridiculous comments). A common humorous technique is the "you better not smile" technique: while doing something humorous, you might say to the person ''Now, don't smile" or "I thought I saw you start to smile".

**Following the use of injecting humour, it is important that the participant have the opportunity to communicate what was bothering him or at least be given emotional support.**

### *d) Instructional control*

Quite often people are willing to change their behaviour when given the instruction to do so. Instructions can be used to divert a person to more appropriate activities or to stop ongoing activities. Some examples include:

i. A person who masturbates indiscriminately might be asked to go to the washroom to masturbate.

ii. Telling a person who is about to hit others or one's self, "hands down".

iii. Telling a person who is agitated and escalating towards aggression to “leave the room", or to "help me move this chair" (or some other helpful task that diverts their attention). This technique is particularly useful for someone who derives pleasure out of helping others.

iv. Telling the person who is running toward the street to "stop".

**Detailed examples:**

1. John often hits others and causes severe injury. Assessment shows that he initiates requested activities whenever he is asked. One day while at his home, he was running to hit another person. The worker in the area was too far away to prevent contact. The worker remembered John's tendency to follow instruction and said "John, please take out the garbage.'' John slows his run and walks to begin the task.

2. Mary often picks up inedible objects and puts them into her mouth to eat. If one tries to take them out forcibly, she will become upset and begin pinching others. Asking her to ''throw it in the garbage" can avoid dangerous behaviour.

### *e) Facilitated relaxation*

If the person continues to be upset, agitated, self-abusive or destructive when other methods have been attempted, instructions to relax may be used to help the person learn the process of relaxing.

**Please note that the following process must be one of encouragement, not forced compliance. Your voice tone must be calm and convey emotional support.**

Possible steps include:

- Acknowledging that the person is upset: "I know you are upset." "You are angry about _____".
- Ask the person to calm down: "Relax" and "take a deep breath'', demonstrate how to raise the arms over head and take a deep breath.

3. If these relaxation steps are not effective in de-escalating the situation, the person should be asked to go to a place to "gain control". The place should be away from the others and disturbances (e.g. a quiet part of the house). Once in this area the person should be asked to sit or lie down and get comfortable. Assist the person to get comfortable and possibly ask them to loosen clothing and place their arms in a resting position at sides or in lap. These positions should be identified to the participant as resting positions.

- Ask the person to relax selected parts of the body (e.g. large muscle groups such as legs, arms, shoulders and neck).
- Another idea is to ask the person to shake hands and fingers, as shaking will lead to fatigue and relaxation. Helpful statements include ''limp like a rag doll", "float like a feather".

- Provide instruction in activities to promote relaxation such as deep breathing and muscular tensing and relaxing.
- Once the person has achieved a relaxed state for about two to five minutes, she may be asked "Are you calm?" If she seems calm, encourage her to stretch her arms over her head and get up; if not calm, take a few more minutes to relax.

**THIS TECHNIQUE IS NOT DESIGNED AS A PUNISHMENT SUCH AS TIME OUT, RATHER AS A TECHNIQUE TO PREVENT ESCALATION TO SERIOUS BEHAVIOURS AND TO INTERVENE TO PREVENT FURTHER DANGEROUS BEHAVIOURS.**

### *f) Stimulus change*

If instructional control methods, communication, and relaxation methods are not effective and if dangerous behaviour continues, "stimulus change" may be attempted.

This strategy involves presentation of an unexpected event or alteration of stimulus conditions in an effort to stop a behaviour or temporarily manage it. This procedure has the effect of decreasing all behavior, including the target behaviour. The momentary response is temporary.

This method is useful when a person is in the process of attacking, when aggressive acts are imminent or when serious behaviour is occurring in an unending chain.

Examples of this technique include: worker turning up or down the volume of the music, asking another participant to dance, asking other participants to jump up and down, giving a ridiculous instruction, turning out the lights in the room, going completely limp when being assaulted or dropping to the ground and playing dead, having everyone suddenly lie down on the floor, etc,

**VERY IMPORTANT: Specific stimulus control techniques are only effective 1 or 2 times before the participant "gets wise" to the technique. Once the technique has been used, new methods must be devised.**

## IV. GEOGRAPHICAL CONTAINMENT

This procedure Involves the use of the immediate environment to minimtze or eliminate the consequences of assaultive/destructive behaviour. One purpose is to reduce or eliminate the need for physical contact with the person.

Geographical containment should only be used when other procedures described previously have hot been effective. It is an emergency procedure used to eliminate and/or reduce dangerous behaviour.

Geographical containment procedures should be accompanied by positive methods described above such as facilitating communication, active listening, instructional control and facilitated relaxation.

**Examples:**

- The participant rushes toward a worker with her hands in the air intent on hitting someone, and the worker asks "What is wrong? What do you want?" while positioning herself behind a table or chair. The worker continues to talk to the participant while ensuring that the table\chair remains between them.
- A participant becomes angry and frustrated and strikes out at others, and a worker asks her to go into a quiet area where she can relax and be away from the other participants and where the worker can help her regain control.

For more examples. refer lo Willis & LaVtgna. 1985, p. 13.

## V. INDIVIDUALIZED EMERGENCY MANAGEMENT PLAN

An individualized emergency management plan is a procedure or set of guidellnes for applying Emergency Management Guideline methods for a specific person. The plan will include:

- an operational definition of the targeted dangerous behaviour(s) which the participant displays
- a description of antecedent conditions which might cue the dangerous behaviour(s)
- a description of the behaviours that often occur right before the dangerous behaviour(s)
- a description of prescribed Emergency Management Guideline techniques, in order from least through most intrusive, for dealing with the dangerous behaviour in a positive, preventative and constructive way.

lndividualized emergency management plans must be reviewed monthly.

**ADAPTED EMERGENCY MANAGEMENT GUIDELINES – EMERGENCY MANAGEMENT PLAN**

PARTICIPANT NAME: _____

DATE OF PROCEDURE: _____

Operational Definition of Dangerous Behaviour:

_____

_____

_____

Antecedent Conditions:

_____

_____

_____

Participant Behavioural Warning Signs:

_____

_____

_____

Adapted Emergency Management Plan Techniques (in order from less to more involved or intrusive). Include name of technique and how you would use it:

_____

_____

_____

_____

_____

*This document is located in the Forms section (Form 1824) at the back of the manual.*

## EXAMPLES OF DANGEROUS BEHAVIOURS

| CATEGORY | DANGEROUS BEHAVIOUR | NOT DANGEROUS BEHAVIOUR |
|---|---|---|
| **Self-injurious Behaviour** | • Banging forehead on wall or floor causing bruising.<br>• Scratching neck, causing bleeding.<br>• Putting inedible objects in mouth (e.g. coloured paper, cigarette butts). | • Lightly slapping one's head causing no damage or injury.<br>• Excessive rubbing of skin with no bleeding/bruising.<br>• Sucking a pen cap while writing a letter. |
| **Assaultive Behaviour** | • Punching another person in the face.<br>• Kicking another person in the leg.<br>• Pinching another person on the arm. | • Patting another person on the arm or back.<br>• Moving someone's feet out of the way with your feet.<br>• Tapping someone on the shoulder. |
| **Property Damage** | • Throwing a chair across the room.<br>• Ripping a sleeve off one's shirt in anger.<br>• Breaking a window with one's fist. | • Accidentally knocking a chair to the ground.<br>• Removing clothing too quickly causing a button to fall off.<br>• Pounding a table when upset, causing no damage. |

# APPENDIX B

**Indicators of Abuse and Neglect**

## 1. INDICATORS OF PHYSICAL ABUSE

| PHYSICAL INDICATORS | BEHAVIORAL INDICATORS |
|---|---|
| • verbal report of abuse<br>• unusual lacerations, bruises, burns (cigarette or scalding water), bites, ulcers, welts, skin discoloration<br>• unexplained or inconsistent explanation of injuries<br>• frequent absences from school or workplace and returns with bruises and/or injuries which are healing<br>• failure to thrive with no satisfactory medical explanation<br>• imprints on skin potentially caused by an instrument<br>• symmetrical grip marks, evidence of shaking of physlcally restraining a person<br>• injury to scalp from hair pulling<br>• dental injuries<br>• eye injuries<br>• fractures and dislocations<br>• nightmares and sleep disturbances | • reluctance to go home or to another specific environment<br>• behavioural extremes such as aggression, withdrawal, defiance, passivity<br>• acting out, attention getting or delinquent behavlours<br>• frightened of physical or social contact<br>• self-abusive or destructive acts including substance abuse, mutilation, property damage<br>• sudden inability or unwillingness to perform typical daily functions and social skills<br>• regression to more infantile behaviour |

## 2. INDICATORS OF SEXUAL ABUSE

| PHYSICAL INDICATORS | BEHAVIORAL INDICATORS |
|---|---|
| • verbal report of sexual abuse<br>• existence of sexually transmitted disease<br>• pregnancy<br>• stained, torn or bloody underclothes<br>• trauma or bruising to breasts, buttocks, lower abdomen, thighs, genital or anal areas<br>• foreign bodies in the genital, anal or urethral openings<br>• pain or itching in the genital area or throat; difficulty going to the bathroom or swallowing<br>• enlarged vaginal opening or redness and swelling in the genital area, infections or discharge<br>• recurring physical ailments and complaints (i.e., frequent stomach aches, persistent sore throats, vomiting)<br>• eating disorders, refusal to eat or eating constantly<br>• evidence of bribery, trickery, coerclon in a personal relationship<br>• nightmares and sleep disturbance | • significant change ln level of sexual activity, sexual behaviour or attitude<br>• persistent and inappropriate sexual play for an individual's age and developmental level<br>• excessive masturbation<br>• simulated sexual acts with peers or sexual attention to pets and animals<br>• compulsive sexual behaviour (i.e. grabbing breasts or genitals, indiscriminately removing clothes)<br>• sudden change in feelings about a particular person or place<br>• running away, refusing to return<br>• lack of attachment to parents or other caregivers<br>• withdrawal into fantasy life or some type of dissociative state<br>• regressive toileting and personal grooming skills<br>• low self-esteem, excessive critical perception of self<br>• extreme or fanatic attention to hygienic needs<br>• suicidal preoccupations or gestures |

### 3. INDICATORS OF EMOTIONAL ABUSE AND NEGLECT

| PHYSICAL INDICATORS | BEHAVIORAL INDICATORS |
|---|---|
| • verbal report of emotional abuse or conditions of neglect<br>• recurring physical ailments and complaints<br>• untreated health conditions<br>• eating disorders<br>• self-inflicted injuries<br>• lack of proper clothing<br>• loss of weight, or failure to marntain a healthy weight<br>• fatigue, irritability, difference in alertness<br>• Inadequate or no lunch<br>• recurring depressive symptoms enuresis<br>• constant apologies, even when not at fault | • significant confusion about reality of personal situation (i.e. fantasizing, rote reversal)<br>• poor peer relations; name-calling, swearing, intense teasing<br>• oblivious to risks and hazards<br>• deterioration in social skills<br>• low self-esteem, critical of self<br>• running away, reluctance to go home<br>• Unprecedented use of drugs or alcohol |

***For more information see:***

The Vocational and Rehabilitatton Research Institute, Sexual Assault Manual: A Manual for the Mentally and Physically Challenged and their Support Persons, V.R.R.I.: Calgary, 1987;

Roeher Institute, No More Victims, Reeher Institute: North York, 1992 and Charlene Senn, Vulnerable: Sexual Abuse and People With An Intellectual Handicap, Roeher Institute: North York, 1988.

# SECTION 11: APSH PROGRAM VIOLENCE POLICY

**Effective Date: April 1, 2005**

**Revised: June 30, 2011**

The Approved Private-service Home Program Violence Policy Is a companion document to the Approved Private-service Home Program Abuse Policy.

**TABLE OF CONTENTS**

**PREAMBLE:**

This policy is intended to support approved private-service home (APSH) proprietors to prevent and minimize the risk of violence and abusive behaviour toward proprietors or others living in their approved private-service homes. It is recognized that while violent and abusive behaviour is not accept-able, incidents may occur. This policy describes the role and responsibility of Ministry of Social Services staff and approved private service-home proprietor in minimizing the risk of violent and/or abusive behaviour as is reasonably practicable and ensuring the safety and welfare of all in the home.

This policy was developed by Community Living Division, Saskatchewan Ministry of Social Services between 1999/2003 in conjunction with a working committee of Saskatchewan Approved Private Homes Inc., Saskatchewan Ministry of Social Services and Saskatchewan Approved Private Homes Inc. are committed to ensuring that all individuals with disabilities, proprietors and their families residing together in homes certified under *The Residential Services Act* are provided with an environment which is free from violence and abusive behaviour.

**PRINCIPLES**

- Proprietors and others associated with the APSH (e.g members of the proprietor's family, co-residents) reporting or coming forward with information about incidents of violence and/or abuse shall do so without fear of retaliation or adverse consequences to themselves.
- In the event of a report of violence and/or abusive behavior, the proprietor and Ministry of Social Services staff shall take appropriate steps as necessary to minimize the risk to individuals involved.
- Decisions and actions following an incident of violence and/or abusive behaviour will endeavour to meet the needs of the resident who engaged in the violent and/or abusive behaviour in the best possible way without denying the rights of others.
- Resident's and proprietor's rights and dignity will be respected through a process for responding to and reviewing incidents of violence that is timely, fair, humane, objective, and complete.

**2. DEFINITIONS**

***a. Violence:*** The attempted, threatened, or actual conduct of a person that causes, or is likely to cause, injury and includes any threatening statement or behaviour that gives an individual reasonable cause to believe that he/she is at risk of injury.

***b. Abuse:*** For the purposes of this document, refers to any one or more of the following:

***(1) Emotional abuse:*** Acts or omissions that cause or could cause emotional pain, including but not limited to, acts or omissions that are disrespectful, rejecting, intimidating, criticizing, threatening, or harassing. This also includes verbal or written expressions, and yelling, screaming, and swearing at others.

***(2) Physical Abuse:*** Any act that causes or has potential to cause physical injury, including but not limited to, infliction of bodily pain by one or more instances of striking, shoving, slapping, pinching, choking, or kicking. This may include the use of restraining techniques outside of *Comprehensive Personal Planning and Support Policy* guidelines.

***(3) Sexual Abuse:*** Any form of exploitative sexual behaviour or unwanted sexual touch Including harassment or acts of sexual assault.

***(4) Property Abuse:*** Deliberate damage lo property of others.

***c. Practicable:*** Possible given current knowledge, technology, and invention.

***d. Reasonably Practicable:*** Practicable unless the person who Is responsible for the action can show that the cost in lime, trouble, and money necessary to carry out the action outweighs any benefits of that action.

***e. Training:*** Means to give information/explanation to an individual with respect to a particular subject matter and requires a practical demonstration that the individual has applied knowledge or skill related to the subject matter.

***f. Behaviour Support Plan:*** Component of a resident's personal plan that identifies all of the strategies in place with respect to any violence and/or abusive behaviour that the resident displays.

***g. Emergency Management Plan:*** Reactive Strategies as the part of a resident's behaviour support plan that describes what to do when an incident of violence and/or abusive behaviour seems likely, how to prevent escalation, and what steps to take should an incident occur.

**h.** ***Resident:*** A person who resides in an approved private-service home for the purpose of receiving lodging, supervision, or personal care and planning support.

***i. Proprietor:*** A person(s) who operates an Approved Private-service Home.

## 3. PREVENTION

To reduce the risk of violent and/or abusive behaviour in their homes, proprietors will:

a. Be aware of and familiar with appropriate ways to respond to emergency situations where a resident may become physically aggressive. Refer to the *Comprehensive Personal Planning and Support Policy*; Reactlve Strategies),

b. Follow the guidelines contained in the *Comprehensive Personal Planning and Support Policy* as well as the *Approved Private-service Home Program Abuse Policy*.

c. Participate in appropriate training to prevent, recognize, and appropriately respond to incidents of violence and/or abusive behaviour.

d. Record in detail and report to the Community Services Worker (CSW) significant changes in the resident's behaviour or health condition and any incidents of violence and/or abusive behaviour.

e. Participate in the Person-Centered Planning Process to develop a Person-Centered Plan for resident(s).

f. Work with Ministry staff to develop a behaviour support plan for individuals who display violent and/or abusive behaviour. This plan includes, at minimum:
    - appropriate interventions to assist residents to learn more effective and socially acceptable ways of meeting their needs (i.e. skill acquisition programs and/or behavioural interventions),
    - an emergency management plan.

g. Recognize stress levels and know how to prevent your stress from triggering a situation that increases the risk of resident violence and/or abusive behaviour.

h. Know limits with respect to the kinds of violent and/or abusive behaviour you are able to manage in your home and accept only people whose behaviour falls within these limits. Saying "no" to a placement suggested by a CSW will not jeopardize further placements in your home.

i. When a resident leaves your home, provide the file and all detailed information about that resident's violent behaviour, if any, to the CSW to assist future caregivers in preparing to provide supports to the resident.

To support proprietors in reducing the risk of violent and/or abusive behaviour in the home, the CSW will:

a. Provide comprehensive information to the proprietor, as part of the placement decision process, on:
    - known risk(s) presented by the individual with respect to potential for violent and/or abusive behavior;
    - any known previous violent and/or abusive behavior;
    - what training is available to the proprietor that would assist in successfully supporting the individual.

b. Assist the proprietor to assess compatibility of the individual with those currently in the proprietor's home.

c. Plan and implement a process for transition into the home that is appropriate to the needs of both the individual and the proprietor.

d. Participate in the Person-Centered Plannlng process to develop Person-Centered Plans for APSH residents.

e. Work with the proprietor to develop a behaviour support plan for individuals who display violent and/or abusive behaviour. This plan includes, at minimum:
    - Appropriate interventions to assist residents to learn more effective and socially acceptable ways of meeting their needs (i.e. skill acquisition programs and/or behavioural interventions).
    - An emergency management plan.

f. Ensure that appropriate training is available where and when deemed necessary to provide the proprietor with the knowledge and skills to carry out the behaviour support plans.

## 4. TRAINING

Prior to accepting into their home resfdent(s) with a history of violent and/or abusive behaviour (DLSA Level IV or V on aggressive, destructive, or sexual behavlour), proprietors will have received:

a. Level I training;

b. training on how to understand and address behavioural issues in an ethical and positive way;

c. training on how to prevent, recognize, and appropriately respond to incidents of violence and/or abusive behavior;

d. specific training on the strategies included in the resident's behavioural support plan.

## 5. RESPONSIBILITIES:

### Immediate Actions and Reporting

This section describes the procedures to be followed ln responding to, reporting, and following up incidents of violence and/or abusive behaviour.

**Immediate Actions:**

Follow the steps as outlined in the resident's emergency management plan. Where there is no emergency management plan because the resident has no history of violence and\or abusive behaviour, the proprietor will:

- Take the necessary steps to ensure the immediate safety of yourself and others in the home. Remain calm and do not mirror the behaviour of the violent individual or involve other residents.
- Do those things that you think may calm the individual and avoid dotng what may escalate the behaviour.
- If harm to people is likely then remove yourself and others from the situation if safe to do so until assistance arrives.
- If the situation is to the point of endangerment of your person or those in your home and there is no resolution, call 911 or the local RCMP/City Police Detachment.
- Be familiar with the Emergency Management Guidelines.
- Following the incident, discuss future prevention plans with your CSW.

**Reporting:**

- Document in the resident's file any incidents of violent and/or abusive behaviour by the resident.
- Report the matter to the resident's CSW at the earliest opportunity, where the violence and/or abusive behaviour is of a serious nature and/or is occurring repetitively and/or the frequency of the behaviour has increased.

- Where there is substantiation that the person who was violent/abusive intended to and was responsible to know the intent to harm, the incident will be reported to the police by the proprietor or by the resident's CSW.

- Discussion will occur between the APSH proprietor and the CSW regarding the decision to refer to the police. This discussion will need to take into account and balance the severity of the incident with the capacity of the individual to understand his/her actions and the potential consequences. Emphasis needs to be placed on the severity of the situation since the police will not likely follow up on minor matters. It may be appropriate to involve the police in the discussion/determination of whether this resident in this situation could have formed the intent to harm.

  We need to ensure that residents receive due process and come into contact with the consequences/responsibilities of their actions especially when they have caused serious injury to others.

- The decision to refer to the Police/Criminal Justice System may also need to be discussed with the victim. The CSW and the APSH proprietor need to ascertain if the victim wishes to proceed with this reporting since they will likely be interviewed and have to give a statement to police authorities. The individual's wishes and consent needs to be considered.

## 6. REVIEW

All reported incidents of violence and/or abusive behaviour will be reviewed with the proprietor by the CSW wlthin 3 working days of receiving the report. The review will address:

- the circumstances surrounding the incident;
- any addttional precautions to be taken to minimize the risk of reoccurrence;
- whether the behavioural support plan needs modifying and the plan to do this;
- the requirement of the development of a behaviour support plan if none exists.

A summary of the review will be noted in the chronological recordings on the resident's CLSD file.

## 7. DOCUMENTATION

- All written documentation of incidents of violent and/or abusive behaviour will be kept both in the proprietor's and Ministry's files on that resident.

- Documentation related to incidents of violent and/or abusive behaviour will contain only information stated in terms that are respectful of the resident's dignity.

# SECTION 12: Comprehensive Personal Planning and Support Policy (CPP&SP)

## TABLE OF CONTENTS



*February 4, 2005*

# SECTION I: APPLICATION AND IMPLEMENTATION OF POLICY

## INTRODUCTION

This policy applies to:

**Approved Private-service Home (APSH) Proprietors**
**Community Living Division (CLD)**
- Regional Supervisor
- Commurity Service Worker
- Program Development Consultant
- Valley View Centre Staff

**Community-Based Organizations (CBOs)**
**Individual Service Providers**

## APPROVED PRIVATE-SERVICE HOME PROPRIETORS

***Responsibility***

APSH Proprietors in providing day-to-day supports to the individuals under their care shall abide by the policies contained in this document.

***Interpretation***

CLD staff will ensure that all APSH Proprietors are familiar with this document and include the document as part of the orientation process.

## COMMUNITY LIVING DIVISION

***Responsibility***

CLD staff shall abide by the policies contained in this document.

Within CLD, a number of staff interact closely with CBOs, APSH proprietors and individual service providers that provide supports to participants with intellectual disabilities. When these supports are observed by CLD staff as not consistent with the policies outlined in this document, the staff shall:

- Bring concerns to the attention of the CBO, APSH proprietor or Individual service provider, and gather pertinent information.
- Inform the Regional Supervisor in writing; the Regional Supervisor will provide support as necessary.
- Document concerns in the appropriate file within seven working days.
- Following a review of concerns with the CBO, APSH proprietor or individual service provider, a plan will be developed to address the issue.
- Staff shall keep the Regional Supervisor informed and the Regional Supervisor has final responsibility to ensure the issue is dealth with.

The actions (on the previous page) are not meant to preclude any relevant legislation or government policies, such as Section 16 (1)(2) of *The Child and Family Services Act*, *The Participant Abuse Policy, CLD's Policy/Protocol for the Investigation of Abuse and Neglect Involving Adults with Mental Disabilities*, and the *APSH Program Participant Abuse Policy*.

Various community staff positions within CLD have different responsibilities with respect to this policy.

## Regional Supervisor

### *Responsibility*

Regional Supervisors are responsible for the orientation of new staff, and are often involved in program-related consultations with staff and community service providers. The Regional Supervisor has the responsibility of ensuring contract compliance of the CBOs in their region, and ensuring policy compliance of APSH operators and individual service providers in their region.

### *Interpretation*

Regional Supervisors shall orient staff to the policies of this document. This document shall be included in the orientation package for each new staff member. The policies outlined shall serve as a guideline for Regional Supervisors in all program-related consultations, recommendations, and decisions.

## Community Service Workers

### *Responsibility*

In the context of case management, Community Service Workers will observe practices, respond to requests for assistance and provide guidance resulting from the implementation of person-centred planning processes.

### *Interpretation*

When asked for assistance in program or planning areas, Community Service Workers have a dual responsibility:

- to determine what methods are presently in use and provide feedback on the appropriateness of these in relation to the policies of this document; and
- to uphold the policies in the offering of any suggestions with respect to personal planning, decision-making and behaviour support interventions and skill development interventions.

The details of such consultation, as well as the follow-up plan, must be documented in the participant's file.

Community Service Workers will ensure that APSH proprietors and individual service providers are familiar with and follow the policies in this document.

## Program Development Consultants

***Responsibility***

Program Development Consultants shall follow the policies as outlined in this document.

***Interpretation***

Program Development Consultants provide leadership and support in the design and implementation of developmental/behavioural programs. This work occurs in the context of consultation with service providers, families, and CLD staff.

## Valley View Centre Staff

***Responsibility***

In the provision of personal supports to people with intellectual disabilities, Valley View Centre (VVC) staff shall abide by the policies contained within this document.

***Interpretation***

All staff of VVC will be familiar with the policies contained within this document. Other VVC policies regarding the provision of personal supports to people with intellectual disabilities will be consistent with the policies contained within this document.

## COMMUNITY-BASED ORGANIZATIONS

***Responsibility***

As part of their contractual obligation to the Ministry of Social Services, CBOs will implement the policies contained within this document.

CBOs may have existing policies thal meet the spirit and intent of the policies in this document. In this case CLD and the CBO may agree that there is no need to re-draft CBO policies to exactly mirror the policies in this document.

***Interpretation***

CBOs will ensure that all staff and board members are familiar with the policies related to this document. CBOs will also include the policies related to this document as part of the orientation process for all new staff members.

This document recognizes the unique position of the Early Childhood Intervention Program (ECIP) regarding the nature of their relationship to families. While ECIP staff is guided by these policies in the design aud delivery of supports to families, it is the family that makes the final decision about the support offered to their children.

## Individual Service Providers

***Responsibility***

Individuals providing CLD-funded individual support services for participants shall abide by the policies contained in this document.

***Interpretation***

CLD staff will ensure that all individual service providers are familiar with this document and include this document as part of their orientation process.

# SECTION 2: PROTECTION OF PERSONAL AND HEALTH INFORMATION

This policy recognizes that the protection of personal and health information is governed by the following pieces of legislation:

- *Freedom of Information and Protection of Privacy Act*
- *The Health Information and Protection Act*

Accordingly, staff, agencies and service providers will be guided by the following principles:

- Where it is not reasonably practicable to obtain consent from the participant, the sharing of personal informatlon may only be made for the provision of health or social services to the participant and only if the disclosure of personal information will clearly benefit the health or well-being of the participant.
- Personal information will only be disclosed when the person to whom the informntion is to be disclosed agrees to use the information only for the purpose for which it is being disclosed, and not to make a further disclosure of the information.
- Personal information will only be disclosed for the purpose of arranging, assessing the need for, providing, continuing, or supporting the provision of, a service requested or required by the participant.
- Policies and procedures will be in place to restrict the disclosure of personal information to those persons who require the information to carry out a purpose for which the information was collected.
- All parties shall have in place and shall follow reasonable security policies and procedures.

## SECTION 3: DEFINITIONS

| | |
|---|---|
| **Aversive procedures:** | Stimuli or activities applied in response to behaviour that the participant perceives as physically or psychologically painful or harmful |
| **Challenging behaviour:** | Behaviour that others may may find disruptive, unusual and/or offensive but is not a threat to the physical well-being ofothers |
| **Comprehensive Behaviour Support:** | A four-component support strategy that aims to facilitate comprehensive lifestyle changes through the application of ecological changes, positive programming, focused support and reactive strategies |
| **Core group:** | The group of people who know and care about the participant and are committed to supporting her[1] (the participant decides who constitutes this core group) |
| **Dangerous or harmful behaviour:** | Any attempted or actual conduct of a person that causes, or presents an immediate risk of, bodily hurt |
| **Ecology:** | The relationship between individuals and other individuals, and between individuals and their environments |
| **Key person:** | Person designated by the participant and the core group as the fixed point of responsibility for identified actions |
| **Participant:** | Individual who receives direct services from the organization or service provider |
| **Person-centred planning:** | Refers to the planning of co-ordinated supports that assist the participant to realize her goals, dreams and aspirations to enhance her development and quality of life.<br><br>When working with children, Person-centred planning refers to the planning process around the family as well as the planning process around the child. |
| **Policy:** | A formalized course of action required meeting a specific standard |
| **Principle:** | A fundamental truth, law, doctrine or motivating force |
| **Procedure:** | Method and manner by which the policy isimplemented |
| **Service provider:** | Any individual, agency or organization that is under contract to the Ministry of Social Services, CLSD to provide supports to individuals with intellectual disabilities |
| **Standard:** | A level of excellence or attainment regarded as a measure of adequacy |
| **Supports:** | "Resources and strategies that aim to promote the development, education, interests and personal well-being of a person and that enhance individual functioning […] services are one type of support provided by professional and agencies" (AAMR, 2002, p. 15) |
| **Supported decision-making:** | "A process of acting with an individual to discover their values, interests, talents and gifts in order to support them to choose the way they want to live their life" (Bodnar & Coflin, in press) |

[1] For ease of reading, the pronouns *she* and *her* refer to participants of either gender.

# SECTION 4: PROGRAM POLICY

## PRINCIPLES

- Actions reflect the equal worth of all people.
- Each person has unique and shared intellectual, spiritual, social and physical needs.
- All interactions convey respect for the value and gifts of each participant.
- The participant is provided the choice of varied opportunities for optimal learning and growth.
- Opportunities for each parcipant are consistent with the range of what is available to and experienced by others in their community.
- Optimum learning, growth and change take place in enriched environments with people who respect and value the participant.

## HUMAN RIGHTS AND ETHICAL CONSIDERATIONS

This section addresses the protection of the particiipant's rights and responsibility of the service providers to support her in an ethical and respectful manner.

**POLICY I: All supports provided shall recognize the participant's rights and reflect ethical practices.**

***Considerations:***

Protection of the participant's rights, as outlined in the *Canadian Charter of Rights and Freedoms, the United Nations Convention on the Rights of the Child (1990)*, the *Saskatchewan Human Rights Code* and criminal and civil law is of utmost priority. Appendix A contains a brief description of the legislation that addresses human rights issues.

Practices are considered ethical when they respect the participant's human rights and dignity, and are consistent with the policies, considerations and appendices contained within this document.

**POLICY 2: Service providers shall interact with participants in a supportive and respectful way.**

***Considerations:***

Recognition and acceptance of a participant's preferences, decisions, strengths and differences is essential. A service provider's written and verbal communications with the participant and others shall reflect this support and respect.

**POLJCY 3: Participants shall be provided with the support that the need to make decisions.**

***Considerations:***

Participants have the right to make their own decisions.

Where assistance is required, a supported decision-making process (such as the one described in Appendix B) will be used to assist participants in making decisions.

When legal consent is required and the participant is unable (does not have the capacity) to provide that consent, a supported decision-making process may need to be supplemented through one of the following:

- financial decisions made by an appointed Trustee under *The Public Trustee's Act;*
- health care decisions made under Section 16 of *The Health Care Directives and Substitute Health Care Decision Makers Act;*
- personal or property decisions made under *The Adult Guardianship and Co-decision-making Act* where that authority has been granted to the guardian or co-decision-maker.

Guardians and co-decision-makers may use a supported decision-maklng process to reach a decision on matters within their authority.

Family consent is required for children under the age of 16 years.

**POLICY 4: Any act or omission that causes a participant to experience physical, emotional, sexual harm, loss of individual rights or the misuse of their personal property shall be prohibited.**

***Considerations:***

Service providers are aware of what actions constitute abuse and neglect and are aware of their responsibility for their own behavior as well as that of their peers in ensuring people are treated with dignity and respect.

Appendix F contains additional relevant information:

- a list and description of the abuse policies applicable to CLD and services funded by CLD — these policies define abuse and describe responsibilities with respect to the prevention of and response to allegations of abuse;
- a list and description of prohibited actions.

**POLICY 5: Procedures perceived by a participant to be aversive shall not be used with that participant.**

***Considerations:***

Aversive procedures are stimuli or activities, applied in response to a behaviour that the participant perceives as physically or psychologically painful or harmful.

Any response to a participant's behaviour has the potential of being perceived by the participant as aversive, even interventions generally considered positive. A determination needs to be made regarding whether the participant perceives a procedure or event as aversive. Assessing the individual's reaction to the procedure or event may assist in making this determination.

Appendix F contains additional relevant information:

- a list and description of the abuse policies applicable to CLD and services funded by CLD — these policies define abuse and describe responsibilities with respect to the prevention of and response to allegations of abuse;
- a list and description of prohibited actions.

## PERSON-CENTRED PLANNING

This section addresses person-centred planning. Person-centred planning is a process through which all aspects of the participant's life are considered. The participant determines what is meaningful to her. Decisions may range from day-to-day concerns such as what to have for breakfast to larger, more encompassing decisions such as where to live and work. The participant has the right to decide and direct the process (see Policy 3 and Appendix B). The service provider has the responsibility to respect participants' decisions and to provide support.

**POLICY 6: A person-centred planning process shall be used as a means of supporting the participant in deciding and planning her goals and supports required.**

***Considerations:***

The participant is the centre of all activity.

- plans, decisions, actions and supports are guided by and reflect the vision of the participant.
- options are authentic and within the realm of the participant's understanding.

Accountability for all actions is to the participant.

- Accountability is facilitated by clearly written objectives, plans, responsibilities and time frames.
- The environment in which a participant lives is designed, moulded and shaped to fit the needs of the participant. Planning is supported by complete and accurate information.
- Information relevant to the participant is helpful planning for appropriate supports. This information may include assessment/analysis of the participant's lifestyle preferences, sensory-motor, cognitive and communicative abilities and medical, social and emotional needs.

Planning is an ongoing process with regular reviews to ensure the provision of appropriate supports. These reviews must occur at least once every two years.

A person-centred planning process shall be used to support the participant when moving to a different home.

Appendix C contains a planning protocol that may be used when planning with a participant to move to a different home (this appendix is an update to a prior document entitled "Comprehensive Planning Process: Protocol and Standards," September 1997). This protocol may be adapted for other situations that require intensive planning.

**POLICY 7: The person-centred planning process shall involve the participant and a core group of people who know and care about the participant and are committed to supporting her.**

***Considerations***

The participant decides who constitutes the core group (refer to policy 3 and Appendix B). Advocates and/or people with specific expertise may be consulted or involved as requested.

The planning process encompasses all aspects of the participant's life, including but not limited to home, school or work, leisure and recreation, cultural and spiritual needs.

**POLICY 8: The person-centred planning process shall identify the roles and responsibilities of those providing support to the participant in achieving her goals.**

***Considerations***

A key person is designated as the fixed point of responsibility to oversee this process and to co-ordinate the efforts of all.

**POLICY 9: The person-centred plan shall be documented.**

***Considerations***

The participant's decisions, goals and supports required are written, including a start date, review date, target date and persons responsible to assist and/or provide support.

Reviews and updates will be documented. The participant will decide who receives a copy of the documented plan in whole or in part. If a comprehensive behaviour support plan is in place, it will be documented in the participant's person-centred plan.

# COMPREHENSIVE BEHAVIOUR SUPPORT

This section addresses support strategies to modify or affect a participant's ongoing challenging behaviour or dangerous or harmful behaviours, the use of medication to affect behaviour, and documentation requirements.

**Support Strategies for Ongoing Challenging Behaviours and/or Ongoing Dangerous or Harmful Behaviours**

## POLICY 10: Comprehensive Behaviour Support shall be used when designing support strategies to affect a participant's challenging behaviour, or dangerous or harmful behaviour.

***Considerations***

Comprehensive Behaviour Support is a support strategy that addresses four components:

- Ecological changes
- Positive programming
- Focused support
- Reactive strategies

Comprehensive Behaviour Support is described in detail in Appendix D.

The objective of Comprehensive Behaviour Support is to facilitate lifestyle changes rather than solely reducing the frequency, duration or intensity of challenging behaviours. Support strategies may be considered successful when the participant is able to engage meaningfully in a variety of home, school, community and work settings (where she may have been previously excluded due to the challenging behaviour), and when relationships are nurturing, caring and reciprocal.

Strategies addressing the components of Comprehensive Behaviour Support are based upon thorough objective assessment of the factors influencing a participant's behaviour (refer to Policy 11)

The Core Group is responsible to ensure that:

- a Comprehensive Behaviour Support plan is developed;
- time lines are set for the development and implementation of the Comprehensive Behaviour Support plan; and
- an individual with expertise in Comprehensive Behaviour Support is involved in the development of the Comprehensive Behaviour Support Plan.

Strategies are developed and implemented in the spirit of collaboration, not control or coercion.

The participant's preferences, decisions, input and suggestions are respected and incorporated into the Comprehensive Behaviour Support plan through the supported decision-making process (see Appendix B). The participant is involved through discussion, observation, and assessment.

## POLICY 11: Comprehensive Behaviour Support strategies shall be based upon the analysis of objective and thorough assessment information.

***Considerations:***

There are three general assessment categories:

- Lifestyle preferences
- Clinical issues
- Functional analysis

The nature, order and use of the assessment methods contained in these three categories are addressed in Appendix E.

Assessment methods must be objective. Objectivity is improved when information is gathered by observing behaviour rather than relying upon subjective opinions or feelings.

The assessment process requires a team approach involving the participant, the core group, other individuals who know the participant well, an individual with expertise in behaviour analysis, and in some circumstances professionals with specific clinical knowledge, (e.g., medical doctor, psychologist). The core group, including an individual with expertise in behavioural analysis, will decide which assessment methods are used as well as the order in which they are used.

An individual skilled in behavioural analysis will analyse assessment information in order to develop a hypothesis that explains the occurrence of the challenging behaviour. The quality of the assessment information obtained and the expertise of those who analyse the information influence the accuracy of any hypothesis. This hypothesis leads to the development of appropriate support strategies.

**POLICY 12: Comprehensive Behaviour Support strategies shall be documented in a *Comprehensive Behaviour Support Plan*.**

***Considerations:***

The *Comprehensive Behaviour Support Plan* shall include:

- a description of the assessment process and the assessment results (see Appendix E)
- a record of the process used with the participant to determine her preferences, decisions, input and suggestions (refer to Appendix B.)
- a description of the Comprehensive Behaviour Support plan that includes the strategies to be used in each of the four components: ecological changes, positive programming, focused support and reactive strategies
- the date, the names of those who drafted the document, and the locations in which the Comprehensive Behaviour Support plan is used
- plans for the documentation of the occurrence of ongoing challenging and/or ongoing dangerous or harmful behaviours
- plans for ongoing evaluation of the strategy
- plans for withdrawing the strategy
- results of the strategy

Documentation will be stored and maintained in ways that respect the participant's privacy and dignity.

## USE OF MEDICATION TO AFFECT BEHAVIOUR

**POLICY 13: The use of medication intended to affect challenging behaviour is a component of, not a substitute for, Comprehensive Behaviour Support and shall be carefully planned and strictly monitored.**

***Considerations:***

This policy also applies when medication is prescribed by a physician for a psychiatric disorder. Use of the medication is guided by a protocol that is outlined in Appendix G. The protocol acts as a safeguard against ineffective or unnecessary treatment, potential health risks, and harmful side effects.

## DANGEROUS OR HARMFUL BEHAVIOURS THAT HAVE NOT OCCURRED BEFORE

### POLICY 14: Service providers shall have an established policy for addressing participants' new behaviours that are dangerous or harmful to self, others or animals.

***Considerations:***

The policy will focus on prevention and contain specific methods for preventing the occurrence of the dangerous or harmful behaviour. Appendix D describes appropriate responses to dangerous or harmful behaviours.

Responses must not include mechanical restraint.

Upon the occurrence of a new dangerous or harmful behaviour the core group will determine whether a Comprehensive Behaviour Support plan needs to be developed in order to prevent future occurrences of the behaviour.

Appendix H contains guidelines for the development of a policy for addressing participants' new behaviours that are dangerous or harmful to self, others or animals.

Policies established by service providers will be compatible with the policies in this document.

### POLICY 15: Dangerous or harmful behaviours that have not occurred before shall be documented.

***Considerations:***

The purpose of documentation is to aid in the development of a Comprehensive Behaviour Support Plan.

Appendix H contains documentation guidelines.

# APPENDIX A

## Legislation

### Canadian Charter of Rights and Freedoms

A copy of the ***Canadian Charter of Rights and Freedoms*** is available from your local Member of Parliament office.

The Canadian Charter provides the protection under the following categories:

- Fundamental freedoms
- Democratic rights
- The right to live and seek employment anywhere in Canada
- Legal rights
- Equality rights for all individuals
- Official languages of Canada
- Minority language education rights
- Native people's rights

Some of the rights and freedoms in the Charter include:

- Freedom of conscience and religion
- Freedom of thought, belief, opinion and expression
- Freedom of peaceful assembly
- Freedom of association
- The right to vote
- The right not to be subjected to any cruel or unusual punishment
- The right to the equal protection and equal benefit of the law without discrimination

### Saskatchewan Human Rights Code

A copy of the Saskatchewan Human Rights Code is available from the Saskatchewan Human Rights Commission.

An objective of the Code is "to further public policy in Saskatchewan that every person is free and equal in dignity and rights and to discourage and eliminate discrimination."

The Code includes the Bill of Rights and the Prohibition of Discriminatory Practices.

The Bill of Rights includes:

- The right to freedom of conscience
- The right to free expression
- The right to free association
- The right to freedom from arbitrary imprisonment
- The right to elections
- The right to engage in occupations

The Prohibitions of Discriminatory Practices include:

- Discrimination in the purchase of property
- Discrimination in occupancy of housing accommodation
- Discrimination in places to which public is admitted
- Discrimination in education
- Discrimination in employment

## United Nations Convention on the Rights of the Child

A copy of the ***United Nations Convention on the Rights of the Child*** is available from the Children's Advocate.

This Convention states "State Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind. In all actions concerning children, the best interests of the child shall be a primary consideration."

In addition to the rights outlined for all children, the Convention has made additional provisions under Article 23 for children with disabilities. These provisions include:

- Recognition that a mentally or physically disabled child should enjoy a full and decent life in conditions which ensure dignity, promote self reliance and facilitate the child's active participation in the community
- Recognition of the right of the disabled child to special care based on the child's condition, the circumstances of the parents or others caring for the child and the available resources
- Recognizing the special needs of a disabled child, assistance shall be designed to ensure that the child has effective access to and receives education, training, health care, rehabilitation services, preparation for employment and recreation opportunities to achieve the fullest possible social integration and individual development

# APPENDIX B

## Supported Decision-making[1]

### Background

Supported Decision-making is about respecting the fundamental right of all Canadians to be self-determinant. The right to make decisions is stipulated in the Canadian Charter of Rights and Freedoms in Section 2 and Section 15 and applies to all Canadians.

Traditionally, people with disabilities have been provided with few opportunities to be self-determining. They have been receivers rather than determiners of services. From this traditional perspective, people with disabilities have been viewed as being incompetent because of the nature of their disability. Because Supported Decision-making is built from the perspective of the Canadian Charter of Rights and Freedoms, it supports the notion that all people are competent and that we must work towards ensuring that the ways we support people are also competent.

### The Supported Decision-making Framework

Based on the Canadian Charter of Rights and Freedoms, the framework for Supported Decision-making consists of three components:

### Principles

Principles are the context from which we support people to make decisions. These principles are "non-negotiable" and encompass and extend those stated in the Canadian Charter of Rights and Freedoms.

1. All humans have a "will." The human will is the inner drive to choose or determine how you live.
2. Each person has the right to self-determination: the right to make decisions.
3. We have a duty to respect the decisions that other people make and help them achieve their dreams.
4. Decision-making is a fundamental human right. It is guaranteed in the Canadian Charter of Rights and Freedoms and in Canadian and provincial/territorial human rights laws.
5. A person's right to make decision is not limited or removed by disability.
6. The right to make decisions includes the right to have the support needed to make decisions and to let others know about them.
7. In Supported Decision-making, the individual is the centre of the decision-making process.

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1. With the permission of the author, this information is summarized from Supported Decision Making Workbook (Bodnar & Coflin, 2001); see also Appendix I: Reference Materials)

## Relationships

Making decisions is based upon the relationships we have with others, i.e., those who are important to us, who help us, and most importantly, and those whom we trust. Supported decision-making reflects the concept of interdependence in relationships rather than dependence. Therefore, it recognises that decision-making is something we do with the help and support of others. It is something that we do not do alone. Relationships can be viewed from two perspectives:

**The participant** - this perspective refers to how the person provides information about themselves to their supporters, including their personal history, their skills and abilities, likes and dislikes and goals and dreams.

**The supporters** - this perspective refers to those who support someone to make decisions. It may mean collecting information, determining options, interpreting decisions and providing advice and consultation. It does not necessarily mean that advice will be followed. The perspective of the supporter must be to respect the values of the participant, respect the right of that participant to make decisions and to dream, plan and work toward the empowerment of the participant.

## The Decision-making Process

Based on the Principles and Relationships, decision-making follows a generic process that we all use:

1. Determine what decision needs to be made. What does the person want?
2. List the possible options. There is usually more than one way of getting what the person wants.
3. Get any information needed to make the decision.
4. Consider the pros and cons of each choice.
5. Make a decision.
6. Look at what happened. Is it what the person wanted? If not, why not?
7. What is the next decision? Begin the process again.

The participant and the supporters together decide what the process will look like, including what decisions require support, how the team is called together, what to do when emergency decisions are required, how disagreements will be handled and what decisions must involve other people.

Supported Decision-making is a process of supporting people with disabilities to be self-determining - of ensuring that their rights are respected. It empowers people to assume their citizenship rights and respects their right to dream, plan and be heard. To be effective, supported decision-making requires a foundation of the right people, trust amongst all involved and a strong commitment to the principles, values and process.

# APPENDIX C

## Planning Protocol for Moving to a Different Home

### Purpose

The purpose of this protocol is to establish a systematic planning process for all participants moving to a different home. Within the protocol all the activities necessary to support the participant's successful transition to another living arrangement are identified, co-ordinated and implemented. The participant is the central focus of planning and her participation is critical. The processes outlined in this document are based on the principles of Person Centred Planning and supported decision-making. The planning guidelines that follow are designed to facilitate, not hinder the realization of a meaningful life for the participant.

### Overview

The planning protocol establishes standards for effective planning with participants. It outlines the tasks and issues critical to a successful move, provides a protocol for addressing these in a systematic and co-ordinated fashion and identifies roles and responsibilities of the various key players.

### Application

The planning process is to be implemented whenever a participant is moving to a different home. The process is initiated whenever there is a request or a need for a new service or change in existing service. The process described below applies to any type of residential move.
It is the responsibility of each core group member involved in planning to be familiar with the protocol outlined in this document and to assume the responsibilities that pertain to him or her.

### General Planning Processes

1. Initiation of Planning
2. Initial Meeting
3. Notice of First Planning Meeting
4. Development of a Support Profile
5. Implementation
6. Transition
7. Follow-up

## 1. Initiation of Planning

Planning is initiated when there is a request or a need for a change in the current home or a request for a different home. The participant, family members, present service providers or Community Services Workers may make a request or identify the need for a change in service. The participant's Community Service Worker will be made aware of the request or need, and is responsible to organize the initial meeting. It is the responsibility of the Community Service Worker to assemble at the initial meeting, those individuals currently involved in providing supports to the participant.

## 2. Initial Meeting

The group of individuals assembled for the initial meeting is responsible to:

### a. Identify an Appropriate Person to Help the Participant Prepare for her First Planning Meeting

Prior to the scheduling the first planning meeting, the identified person will meet with the participant to discuss the planning and to determine the participant's wishes. An appropriate level of support must be provided so that the participant has the opportunity to discuss her wishes and other matters, including:

- the purpose of the first planning meeting and what will take place;
- who the participant wants to include as members of her core group and who will participate in the planning process;
- what she would like to have discussed at the first planning meeting;
- where the participant would like the first planning meeting to take place.

### b. Identify Members of the Core Group

The core group will engage in the planning process and function as a planning team to arrange appropriate supports for the participant. The core group consists of those identified below, unless the participant has objected to their participation:

- The participant
- Family member(s)
- Those requested by the participant
- Community Living Division Community Service Worker
- Those providing program support currently or in the future, where appropriate
- Current primary service providers (as appropriate)
- Future service provider (if known and as appropriate)
- Others with specific expertise as requested by core group members
- Comprehensive

**c. Identify Information Required for the First Planning Meeting**

The group will determine relevant information required for planning, and will determine responsibilities and timelines for compilation, collection and distribution of planning information. Those preparing reports and sharing information will ensure that the participant (or her guardian) has agreed to the sharing of each of these reports. If the participant refuses, the reports are not shared. Relevant information will include:

- A description of the participant's functional abilities, quality-of-life activities, daily routines, current Person-centred Plan and her Comprehensive Behaviour Support Plan, as appropriate
- A report describing family involvement, if the family will not be present at the initial planning meeting

If the participant has a history of challenging behaviours a report will be prepared following the guidelines for Confidential Client Information Reports (CCIR). The CCIR guidelines can be obtained from a Community Living Division Program Development Consultant or Valley View Centre Behaviour Therapy Co-ordinator.

**d. Identify Key Person**

The Key Person is the fixed point of responsibility that oversees the planning process, co-ordinates the efforts of all, and ensures that all actions are carried out as agreed upon by the team. Any member of the core group (see #2b.) can fill the role of the Key Person, and the Key Person may change, when appropriate, throughout the planning process.

At this initial meeting a Key Person is identified to ensure the planning processes identified above are completed following the timelines agreed by the core group. This person is also responsible to co-ordinate the first planning meeting.

**3. Notice of First Planning Meeting**

The Key Person is responsible to ensure that core group members identified at the initial meeting are informed of the initiation of planning, the date for the first planning meeting and any responsibilities that have been assigned to them, with the appropriate timelines. At this time, core group members will be requested to identify other people with specific expertise (e.g., psychiatrist, community physician) who should be invited to the first planning meeting.

At the first planning meeting, the Key Person will ensure that the following items are included on the agenda:

- explanation of the process of comprehensive planning;
- explanation of the role of the Key Person;
- discussion of the principles of effective planning;
- clarification of any information contained in the reports distributed prior to the meeting.

## 4. Development of a Support Profile

The development of a support profile is initiated at the first planning meeting. Discussion during this meeting and all subsequent meetings will be conducted in a manner that centres on the participant and is respectful of her wishes and dignity. The objective of planning is to determine the participant's vision of a meaningful life, program support requirements and appropriate financial arrangements. The following items provide a useful guideline for identifying and co-ordinating supports necessary to ensure the participant's successful transition to her new home setting.

### a. Participant's Vision of a Meaningful Life

One of the first steps in planning is determining what the participant sees as a meaningful life (e.g., where or with whom the participant wants to live, how she would like to spend her leisure time and how she might wish to be involved in community life).

If the participant is unable to talk about her vision, the members of the planning team who know the participant well may assist in identifying the kinds of people, experiences, and activities to which the participant reacts positively or negatively. This process may help to create a picture of the opportunities that would contribute to a satisfying lifestyle for the participant. A strategy needs to be established that provides the participant with opportunities to engage in a broad range of life experiences. Her reactions to such experiences may be helpful in the modification of plans in the future.

### b. Program Supports

Program supports that enable the participant to live a meaningful lifestyle are identified. Such program supports may include:

- providing an appropriate living arrangement that accommodates a participant's level of independence, required supports, preference for roommates, need for respite, etc.;
- determining what the participant's typical day might look like;
- making community connections and maintaining ongoing personal relationships;
- identifying what medical supports are required (including the administration of medications, specialized procedures and follow-up);
- providing specialized equipment;
- accessing required behavioural supports;
- accessing required mental health supports;
- providing other opportunities required to assist the participant in realizing her vision.

### c. Financial Arrangements

Financial arrangements are identified, including any new funding sources required:

- INAC (Indigenous and Northern Affairs Canada)
- OAS (Old Age Security)
- SAP (Saskatchewan Assistance Program)
- EI (Employment Insurance)
- EAPD (Employability Assistance for Persons with Disabilities)
- GIS (Guaranteed Income Supplement)
- Worker's Compensation
- Canada Pension Plan
- Self
- Trusteeship

Financial arrangements are identified for associated costs:

- Transportation
- Special needs
- Transition

## 5. Implementation

Upon consideration of the participant's vision of a meaningful life and supports required, a decision will be made regarding:

- whether the existing resource can be modified to meet the participant's needs and preferences;
- whether applications will be made to existing community services which meet the participant's needs and reflect her preferences (these are to be specified with options if any);
- whether a new resource needs to be developed to meet the participant's needs and preferences (the person responsible for exploring the development of such resources will be identified at the planning meeting).

If a move is required the Key Person will identify actions, assign tasks and ensure that those tasks are carried out. The required actions include:

- Establishing liaison with the Community Service Worker in the district where applications are being made or where resource development is being explored
- Completing and submitting application forms along with necessary supplementary reports and information
- Presenting application information an agency Admission Committee meeting by appropriate core group members
- Updating the planning team on the status of applications/resource development
- Determining medical supports and resources required to meet needs, including consent for medical procedures

- Informing or updating the PDC who may become involved
- Determining behavioural supports:
  - strategies to be implemented prior to move, with responsibility assigned;
  - assessment of the need for the development of a comprehensive behavioural support plan;
  - initial follow-up by current program support person or immediate transfer to another community resource person.

Throughout the planning process, the Key Person is responsible for ensuring that the participant's vision for a meaningful life is being fulfilled.

**6. Transition**

When the participant moves to an existing resource or a new resource the core group will identify the transition process that would best meet the needs of the participant. The core group will also identify who is responsible for carrying out each of the various tasks. The following issues will be addressed:

- Whether visits to her current home by people supporting the participant in her new home are necessary, and who is responsible for co-ordinating the visits
- What support the current service provider may provide after the participant moves to her new home and how this will happen
- What the process will be to provide necessary information about the participant and her required supports to the new service provider
- What the process will be to help the participant become familiar with her new home
- How the participant will be prepared for leaving her current home (including when and who is responsible for the details of the arrangements)
- What special equipment is required
- What medications are required
- How clothing and personal items are arranged for both during visits and the eventual move
- What behavioural supports are required, including:
  - strategies to be implemented prior to move, with responsibility assigned;
  - assessment of the need for the development of a comprehensive behavioural support plan;
  - initial follow-up by current program support person or immediate transfer to another community resource person;
  - referral for PDC services, if no already in place, and if deemed to be required.

## 7. Follow-up

Once the participant has moved to her new home a Person-centred Planning meeting will be convened within six weeks. The Person-centred Plan will reflect the participant's needs and desires in her new environment. The Key Person co-ordinates this meeting. The core group members will change once a move has occurred. The core group will consist of those identified below, unless the participant has objected to their involvement:

- Participant
- Family member(s)
- Those requested by the participant
- Key Person
- Community Living Division Community Service Worker
- Program support person
- Primary service provider
- Others with specific expertise as requested by core group members

The role of Key Person is transferred at the first Person-centred Planning meeting in her home. The new Key Person is identified by the participant and her core group and becomes the fixed point of responsibility for future planning and co-ordination of supports. Transfer arrangements include:

- forwarding to the Community Living Division Community Service Worker the participant's Community Living Division file containing current chronological recordings, program information, correspondence, medical information, assessments, social history, Person-centred Plans, applications, etc.;
- transfer of program support.

# APPENDIX D

## Comprehensive Behaviour Support

The objective of Comprehensive Behaviour Support is to facilitate meaningful lifestyle changes rather than to solely reduce the frequency, duration or intensity of challenging and/or dangerous or harmful behaviours. Although challenging and/or dangerous or harmful behaviours are regarded seriously, they are not the primary focus of the support strategy. One must look beyond the behaviour itself and focus upon teaching new behaviours and creating an environment where the participant feels accepted by, and important to, those who live and work with her. Support strategies may be considered successful when the participant is able to participate meaningfully in a variety of home, school, community and work settings (where she may have been previously excluded due to the challenging behaviour) and when relationships are nurturing, caring and mutually gratifying. This array of outcomes is not likely to be produced by any one strategy; rather what is required is a Comprehensive Behaviour Support plan with multiple components.

To address the full range of outcome requirements, support plans may include strategies in each of the four components of Comprehensive Behaviour Support:

1. Ecological changes
2. Positive programming
3. Focused support
4. Reactive strategies

When designing a Comprehensive Behaviour Support plan, one considers the patterns and routines of the participant's daily life, her interactions with others, her preferences and her dislikes. Support strategies may be used to reduce stress, deprivation and fear, or to increase those things that enrich the participant's life, compliment other preferred activities, and engage her interest. An effective and ethical Comprehensive Behaviour Support plan assists the participant in building a meaningful life.

One may indirectly affect the occurrence of challenging and/or dangerous or harmful behaviours by making changes to the participant's environment (i.e. ecological changes) or by teaching new adaptive skills through positive programming. Because ecological changes and positive programming may take time to work, there are instances when the challenging and/or dangerous or harmful behaviour itself is targeted for change or reduction by using focused support strategies. When the challenging and/or dangerous or harmful behaviour presents imminent danger to the participant or others, reactive strategies may be needed to ensure safety.

Reactive strategies alone do not constitute a Comprehensive Behaviour Support Plan.

## Ecological Changes

Behaviours occur within a context and often are a function of a person's physical, interpersonal and programmatic environment. The events in and the characteristics of a participant's environment (i.e. the ecological context for behaviour) are important areas of analysis that provide information that may be used in developing a support plan. Ecological changes attempt to smooth the fit between the person and her environment by modifying or enhancing the environment. Strategies that seek to modify or adapt the ecology of the participants are usually the most important part of a support plan.

Ecological change support strategies involve applying planned environmental changes that are expected to produce eventual changes in behaviour (e.g., changing the setting in which activities occur, changing the number and quality of interactions, changing the instructional methods being used, attempting to understand what the person is communicating through her behaviour, changing instructional goals, and removing or controlling environmental pollutants such as noise or crowding). The effectiveness of ecological change strategies is influenced by the quality of information obtained during the assessment process.

## Positive Programming

Positive programming involves assisting the participant to develop new skills and competencies that will assist her in better coping with her environment. There are four common variations of Positive Programming:

1. Teaching a new behaviour or class of behaviours
   (e.g., a person who is introverted or withdrawn may benefit from learning assertiveness and social skills)
2. Substituting a more socially appropriate behavior
   (e.g., replacing inappropriate touch with appropriate handshaking)
3. Assigning meaning to behavior
   (e.g., for a person who typically begins lightly pounding the table prior to displaying dangerous or harmful behaviour and caregivers respond to the light pounding as communication that the person wishes a break from work)
4. Substituting a communicative means
   (e.g., it is quite common for a person's attempt at communication to be labelled as a dangerous or harmful behaviour, for example, throwing work supplies across the room may be described as dangerous or harmful behaviour, when that person may simply lack the communicative means to say "I don't know how to do this")

By developing new skills and competencies, the participant may be less reliant on challenging and/or dangerous or harmful behaviours as a means to cope with her environment. These new skills and competencies targeted for development may have little apparent relationship to the challenging and/or dangerous or harmful behaviours that may be occurring.

The methods commonly used to increase skills and competencies may include:

- Positive reinforcement
- Shaping
- Chaining
- Stimulus Control
- Modelling
- Verbal prompts or instructions
- Fading
- Physical prompts or assistance

For detailed information on the above methods, please refer to the publications noted in the Reference Materials section of this document (Appendix I).

## Focused Support

Ecological changes may take time to arrange. Positive programming may require some time before new skills and competencies are mastered. There also may be instances when ecological changes and positive programming strategies are unable to sufficiently modify (i.e., change or reduce) the occurrence of challenging and/or dangerous or harmful behaviours. In these circumstances it may be necessary to target the behaviour directly for change or reduction by the application of focused support strategies. The purposes of focused support strategies is to produce the most rapid effects possible, to reduce the risks associated with the behaviour, and to reduce the need for reactive strategies. The application of focused support must be preceded by a thorough analysis of the factors influencing the challenging and/or dangerous or harmful behaviour (refer to policy 12 and Appendix E).

Focused support strategies are commonly derived from behavioural theory. As with positive programming strategies, focused support is rooted in positive reinforcement. Strategies may include:

- modelling or demonstrating desired, alternative or incompatible behaviours;
- positively reinforcing desired, alternative or incompatible behaviours (i.e., Differential Reinforcement);
- modifying the antecedents (the set of circumstances immediately preceding the behaviour that may serve to cue the behaviour) to the behavior;
- modifying the consequence (the set of circumstances immediately following the behaviour that may serve to reinforce or motivate the behaviour) of the behavior;
- teaching the participant to monitor and manage her own behaviour (i.e., Self-Management or Self-Monitoring).

For detailed information on the above methods, please refer to the publications noted in the Reference Materials section of this document (Appendix I). Focused support interventions may also involve methods outside behavioural theory that require other professional opinions such as counselling, medication adjustments and diet changes.

## Reactive Strategies[1]

Ecological changes, positive programming and focused support do not describe what to do when behaviour occurs; they are proactive, not reactive. Reactive strategies address episodes of dangerous or harmful challenging behaviour with the least amount of risk of injury to the participant, service providers and others in the environment. Reactive strategies do not produce changes in the future, but rather keep people safe in the here and now and/or reduce the harmful impact of the participant's behaviour. Reactive strategies may include active listening, stimulus change and crisis intervention

The following responses offer ways to manage dangerous or harmful behaviour that are positive, preventative, dignified and constructive. These guidelines describe a continuum of less to more involved or intrusive responses. It is not to be implied that because of the less to more restrictive order of presentation, this order must be followed in the case of an emergency involving potentially harmful behaviour. Rather, the responses should be used in such a way that is not more restrictive or intrusive than is necessary to prevent the participant from harming herself or others and that is applied no longer than necessary to prevent or contain the dangerous or harmful behaviour.

### A. Positive Approaches

The first emphasis of responses designed to manage dangerous or harmful behaviour is to provide positive programming that develops the individual's communication, vocational, recreational, social, community and coping-skills. Within this context, we can take steps toward reducing dangerous or harmful behaviour. As a participant learns more effective daily living and coping-skills, dangerous or harmful behaviours tend to occur less often, if at all.

Positive programming teaches more effective and socially acceptable ways of getting one's needs met and of coping with the realities of the physical and interpersonal environments in which the person must act and interact. Positive programming teaches people how to have their needs met and cope with people and events in their life in the most acceptable manner.

Positive programming emphasizes the importance of providing frequent positive feedback and constructive assistance. Attention is provided frequently in non-contingent social interactions, i.e., offering attention solely for the reason of giving individual attention. Frequent positive interactions among people are effective in preventing or lessening the frequency and intensity of many occurrences of dangerous or harmful behaviours.

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1. This information also appears in the Violence and/or Abusive Behaviour Toward Workers Policy Guidelines (pp R1-R11) and the Approved Private Service Home Abuse Policy (pp 10-22). It has been adapted from Willis, T., & LaVigna, G. (1985). Emergency Management Guidelines. Los Angeles, California: Institute for Applied Behavior Analysis.

## B. Surface Management Responses for Dangerous or Harmful Behaviour

Surface management strategies are designed to influence behaviour until positive programming can have the opportunity to affect change. Surface management responses are short-term techniques.

Many dangerous or harmful behaviours are either cued by events or situations in the environment (i.e., antecedents) and/or occur in a typical or predictable behavioural chain. Surface management responses manipulate either the antecedent/precipitating events or interrupt the chain of the dangerous or harmful behaviour.

The first category of surface management strategies is eliminating precipitating events or antecedent control strategies; the second is interrupting the behavioural chain.

### 1. Eliminating Precipitating Events

a) Remove seductive objects

Objects, events and materials in the environment can serve as cues for someone to act in a certain way, i.e., by removing seductive objects, dangerous or harmful behaviours are likely to be eliminated, or at least to be reduced in frequency.

b) Relocate people

- Some people just don't get along with others; at the table they may touch, push, grab or pull at each other, or they may attack others as soon as they come in close proximity.
- By attempting to keep people in different locations, potentially dangerous situations may be avoided, while in the mean time, positive approaches are beginning to take effect.

c) Remove unnecessary demands and requests

- People sometimes react with dangerous or harmful behaviour when they are presented with demands or are pursued for compliance; in these situations the removal or lessening of demands/requests is likely to reduce many potentially dangerous situations.
- When individuals do react to requests with dangerous or harmful behaviours, it is important to be sensitive to their emotional or physical state; under conditions where they are extremely upset or frustrated it may be advisable not to issue demands requiring compliance at that time.
- A person may also be sensitive to particular demands given in a particular way; it would therefore be advisable to temporarily eliminate the request, and to find a better way to approach the person.
- It may also be possible the person does not understand the request or that they are afraid of doing the task incorrectly because it is too difficult.
- If you find an effective way of making requests of a person without upsetting them, share that approach with others.

- Generally the word “no” is a cue for anxiety or anger in many of us; offer the participant a choice of alternative activities; suggest a different course of action or rephrase your response eliminating the anxiety inducing words.

d) Change the location and time of activities

Certain people may exhibit dangerous or harmful behaviours reliably in certain situations and at select times, e.g., hitting may occur only in the dining room, tantrums may occur only at shift changes but not at any other time; by changing the location or time of activities, the dangerous or harmful behaviours may not present themselves, e.g., with a person who assaults others when she is awakened abruptly, try letting her wake up in a more gradual way to prevent the assaults.

e) Rearrange the environment

Some dangerous or harmful behaviours are tied to specific arrangements of furniture in select situations, e.g., a person may hit others only when she sits in a specific chair that is pointed in a specific direction; by changing the chair and her position, it is possible to eliminate the dangerous or harmful behavior.

f) Eliminate events that cue the behaviour

If you have identified a stable relationship between the occurrence of an event and the occurrence of the dangerous or harmful behaviour, eliminate the event.

**2. Interrupting the behavioural chain**

Some dangerous or harmful behaviours are frequently part of a chain or a sequence of events that progresses from less to more severe, e.g., hitting others may begin with verbal protests and crying. It may be possible to prevent dangerous or harmful behaviour by eliminating the early events in the behavioural chain.

a) Facilitating communication

- Efforts to help people communicate effectively may reduce the likelihood that dangerous or harmful behaviours will appear.
- When people begin to show signs of agitation or frustration, or when they show the early signs of escalating to more severe behaviours, every effort should be taken to determine their problem, to encourage to express themselves.
- Specific questions might include: “what do you want”, “do you have a problem?” and “do you need help?”
- To assist an individual to express themself at the time, a combination of adapted communication, active listening, and best guessing techniques is useful.
- Keep your language simple — the fewer words the better.

b) Proximity control

- We might observe that someone is less likely, if at all, to display dangerous or harmful behaviour when a service provider is present or in close proximity; under such situations, simply moving closer to the person when they appear upset may be sufficient to prevent a full-blown episode.
- Proximity control lets the person know that you are aware of what they are doing and that you are there physically to support them.

c) Inject humour

- We may be able to prevent a problem from occurring or escalating by making a playful or humorous comment to a person who appears grim, sad, or agitated.
- Following the use of injecting humour, it is important that the person have the opportunity to communicate what was bothering them and/or be given emotional support.

d) Instructional control

- Often, people are willing to change their behaviour when given the instruction to do so; instructions can be used to divert a person to more appropriate activities or to stop ongoing activities, e.g., telling a person who is about to hit others or one's self "hands down", or telling a person who is agitated and escalating towards aggression to "leave the room", or to "help me move these pillows", or some other task to divert attention.
- This technique is useful for someone who derives pleasure out of helping others.

e) Facilitated relaxation

- If the person continues to be upset, agitated, self-abusive or destructive when other methods have been attempted, instructions to relax may be used to help the person learn the process of relaxing.
- The process must be one of encouragement, not forced compliance.

f) Stimulus change

- This strategy involves presentation of an unexpected event or alteration of stimulus conditions in an effort to temporarily manage a behaviour or stop it.
- This method is useful when a person is in the process of attacking, when aggressive acts are imminent, when serious behaviour is occurring in an unending chain, e.g. turn up or down the volume of music, ask another participant to dance, giving a ridiculous instruction, going completely limp when being assaulted or dropping to the floor and playing dead.
- Stimulus control techniques are only effective once or twice.

**C. Geographical Containment**

Geographical containment involves the use of physical features in the immediate environment to prevent harm and to minimize or eliminate the consequences of dangerous or harmful behaviour. The purpose is to reduce or eliminate the need for physical contact with the person. Techniques include placing objects between you and the person exhibiting harmful or dangerous behaviour. Removing all others from the immediate environment and calling for help should protect the safety of others.

**D. Evasion**

Evasion includes a variety of techniques and manoeuvres that serve to deflect blows and kicks and generally staying out of harms way.

**E. Emergency Physical Containment**

Emergency physical containment involves non-demeaning physical contact between a service provider and a participant displaying dangerous or harmful behaviour. The physical contact involves only the minimally sufficient contact to briefly stop or prevent the participant or resident from causing serious injury or death to another person or herself. Emergency physical containment is not used to prevent or stop property damage. Emergency physical containment is used only when less intrusive methods (above) have been attempted but have not de-escalated the dangerous or harmful behaviour. Physical contact must not be painful for the participant, have the potential to injure or be used to punish. Physical contact must be brief as possible and be removed as soon as possible.

# APPENDIX E

## Behavioural Assessment

A goal of assessment is to bring clarity and understanding to otherwise chaotic and confusing situations. We seldom reach this goal by focusing on a diagnostic label or the form of the behaviour. Assessment examines all aspects of the participant's life by addressing three main areas: lifestyle preferences, clinical issues and functional analysis.

Assessment precedes the development of a Comprehensive Behaviour Support plan. A comprehensive behavioural assessment process will determine the kind of life the participant wants to live, those things that are meaningful to her and the supports she needs to enjoy a meaningful life.

The assessment process requires a team approach involving the participant, the core group, other individuals who know the participant well, an individual with expertise in behaviour analysis, and in some circumstances professionals with specific clinical knowledge (e.g., medical doctor, psychologist).

The assessment process begins with determining the lifestyle the participant wants to live. Often, constructing a meaningful lifestyle results in the development of environments where the challenging behaviour is reduced or accommodated. Assessment of lifestyle preferences often yields the information required to design a Comprehensive Behaviour Support plan. In those instances where the challenging behaviour continues to interfere with the individual's quality of life, assessment needs to expand to investigate clinical issues, as well as a more detailed functional analysis of the challenging behaviour.

The information from the comprehensive assessment is used to develop a system of support that melds medical, architectural, behavioural and educational variables to create effective environments.

The core group, including an individual with expertise in behavioural analysis, will decide which assessment methods are used as well as the order in which they are used (e.g., in some instances the assessment of lifestyle preferences alone is sufficient to develop a Comprehensive Behaviour Support Plan; in other circumstances the team may decide to assess lifestyle preferences and clinical issues and perform a functional analysis simultaneously).

Lifestyle preferences, clinical issues and functional analysis are described below.

### Lifestyle Preferences

The assessment of lifestyle preferences determines how a participant wants to live her life. From this information, efforts are made to design physical spaces, activity routines, learning opportunities and social interactions in which the participant will succeed.

Information gathering is done through interviews with the participant, observation of the participant across different settings and personal interviews with the family members and direct service providers. Assessment leads to the development of a vision for the participant's future and the identification of critical features of effective support. Lifestyle preference assessment determines the things that work for the participant and the things that should be avoided.

When determining the critical features of support, one will examine the following:

- physical features of the living setting;
- living alone or with others;
- physical location of the home;
- nature of staffing support required;
- activity routines and patterns;
- degree of community participation and social networks;
- sleeping and eating routines;
- strong preferences and dislikes of the participant;
- instructional and behavioural strategies likely to be effective (or not effective).

**Clinical Issues**

Clinical assessment investigates the possible influence of neurological, medical or psychiatric variables on the challenging behaviour. Typically this type of assessment requires consultation with professionals who have expertise in these areas.

Examples of issues that may be detected or explained by clinical assessment:

- cognitive processing difficulties;
- brain injury;
- learning disabilities;
- illness;
- ongoing medical conditions;
- acute psychiatric conditions (e.g., reactive depression);
- chronic psychiatric conditions (e.g., schizophrenia);
- sensory or communication pathology (e.g., hearing or sight disabilities).

**Functional Analysis**

Functional analysis involves the systematic assessment of the variables that set the occasion for the occurrence or non-occurrence of challenging behaviours and the consequences that maintain those behaviours. This assessment defines the events in the environment that reliably predict and maintain challenging behaviours. Behaviour is assessed through interviews, rating scales, direct observations, and systematic, experimental analysis of situations.

A thorough functional analysis includes a determination of:

- possible influence of psychiatric, neurological, medical or other organic factors on the challenging behaviour (done through consultation with professionals);
- antecedent conditions that may cue the behavior;
- consequent conditions that may reinforce or reward the behavior;
- elements in the environment or ecology that may be linked to the behavior;
- frequency, duration and intensity of the behavior;
- history of this challenging behaviour in the participant's life.

## Documentation of Assessment Information

Upon completion of behavioural assessment, the information gathered will be documented. The following items should be addressed in the documentation of the assessment:

1. **Description of the challenging behaviour**

   Clearly describe in objective terms the challenging behaviour being addressed.

2. **Assessment process**

   Briefly describe how information was collected, e.g., through interviews, file searches, observation, and formal assessment tools.

3. **Record of the information/data collected**

   In summary form, document the information obtained with each assessment method.

4. **Analysis of data collected**

   In summary form discuss any patterns or trends that emerged through analysis of the data. Discuss any conclusions discovered regarding the meaning or function of the presenting behaviour of concern. A hypothesis that explains the occurrence of the challenging behaviour should be developed (refer to policy 10).

5. **Further information required**

   If the assessment information gathered was insufficient in order to explain the occurrence of the challenging behaviour, further assessment may be recommended.

# APPENDIX F

## Abuse

## Section I: Abuse Policies, Protocols & Procedures

The following policies, with the exception of the ***Provincial Child Abuse Protocol***, were developed through collaborative processes involving Community Living Division, Ministry of Social Services, Saskatchewan Association of Rehabilitation Centres, Saskatchewan Association for Community Living, Early Childhood Intervention Program Saskatchewan Incorporated, and Saskatchewan Approved Private Homes Incorporated.

1. Community Living Division's ***Policy/Protocol for the Investigation of Abuse and Neglect Involving Adults with Mental Disabilities*** (October 1995)

   This policy applies to all staff of Community Living Division and is to be followed when there are allegations of abuse/neglect involving adults with intellectual disabilities.

2. ***The Participant Abuse Policy*** (October 1995)

   This policy applies to all staff, Board members, and volunteers of Community-Based Organizations funded by the Ministry of Social Services that provide services to individuals with intellectual disabilities. The abuse policy is to be followed when there are allegations of abuse or neglect involving individuals with intellectual disabilities who receive services from the organization.

3. ***Approved Private Service Home Program Abuse Policy*** (May 1999)

   This policy applies to all Approved Private Service Home operators who are licensed by Community Living Division under ***The Residential Services Act***. It is to be followed when there are allegations of abuse or neglect of individuals residing in approved homes.

4. ***The Provincial Child Abuse Protocol*** (December 1990)

   This protocol is part of ***The Child and Family Services Act*** passed by the Saskatchewan Legislature in 1989 (proclaimed on December 1, 1990). Community Living Division staff, Early Childhood Intervention Program staff and Approved Private Service Home proprietors will follow this protocol when allegations of abuse or neglect of a child under the age of 16 years occur.

Other avenues for information on abuse include:

- ***The Occupational Health and Safety Act*** and Regulations.
- Saskatchewan Human Rights Commission
- Office of the Children's Advocate
- Provincial Ombudsman
- Saskatchewan Association for Community Living

## Section II: Prohibited Actions

The following actions are prohibited because they infringe upon the participant's basic human rights and dignity:

### 1. Abuse[1]

| | |
|---|---|
| Physical Abuse: | inflicting bodily pain by one or more instances of striking, shoving, slapping, pinching, choking or kicking |
| Sexual Abuse: | any form of unwanted or exploitative sexual behaviour including harassment or acts of assault. |
| Emotional Abuse: | inflicting emotional pain through verbal or written expressions of intimidation, humiliation, ridicule, contempt or hatred (includes yelling, swearing or screaming at others) |
| Property Abuse: | misusing a participant's funds or assets without consent, including unauthorized use of bank accounts or denial of personal possessions |
| Medication Abuse: | non-compliance with policies and procedures relating to medication administration, including withholding medication or over-medication, inappropriate use of medication, or failure to facilitate access to health services |
| Denial of Opportunity: | unreasonable denial of opportunity for economic advancement or intentional withholding of access to available opportunity to meet needs for spiritual, mental or personal growth and satisfaction |
| Neglect: | failure to provide the necessary care, assistance, guidance or attention which results in physical or emotional harm or loss to the adult or their estate (may be caused by an action or a failure to act, and may or may not be intentional) |

1. These definitions of abuse are found in the abuse policies of organizations funded through Community Living Division.

**2. Pain and Deprivation:**

| | |
|---|---|
| Physical Pain: | stimuli or activities that may result in physical pain include but are not limited to ammonia spray, electric shock, water spray to the face, pinches and deep muscle squeezes |
| Psychological Pain: | stimuli or activities that may result in psychological pain include but are not limited to verbal abuse, including the ongoing use of stigmatizing language, and outwardly aggressive interactions, including tone of voice and body posture |
| Deprivation: | stimuli or activities that may result in deprivation include but are not limited to withholding, withdrawing, or delaying visitation or private communication with family and friends, adequate sleep, shelter, bedding, bathroom facilities and food or drink or prolonged periods of isolation and seclusion |

**3. Withholding of Basic Rights**

This category includes any action that interferes with a participant's basic rights, as listed below (some of these examples might meet the criteria for neglect or denial of opportunity, and would therefore be considered abuse):

- The right to be treated with dignity and respect
- The right to protection against exploitation and demeaning treatment
- The right to practice her religion
- The right to a personal living area including private bed, bedding and space for personal property
- The right to a nutritionally sound diet, balanced over each 24 hour period and available during at least three eating periods which are spaced throughout the normal waking hours (N.B., withholding of food as a behaviour intervention strategy is prohibited; this prohibition does not imply that individuals should in any way be forced to consume meals which have been offered and refused)
- The opportunity to spend time out of doors each week
- Access to water and bathroom facilities at frequent intervals
- Opportunity and free time to meet with staff, visitors, friends, relatives, advocate, etc. in private, including telephone conversations and letter writing

- The right to reasonable use of personal possessions such as tobacco, cigarettes, toys, books, radios, toiletries, mail and jewellery and the right to control access to those possessions
- Access to an adequate allowance of neat, clean and seasonable clothing from which the participant may select items appropriate to the activities she may be engaged in
- Optimal independence in health, hygiene and grooming practices
- The right to possess, control and access legitimate earnings and allowances
- Access to normal environmental and social contacts
- The right not to experience prolonged withholding of necessary treatment programs as a consequence of behaviour (including removal from or withdrawn opportunity to attend day programs, speech therapy, occupational therapy, physiotherapy, recreation, etc.)

**4. Aversive Procedures**

Aversive procedures are those stimuli or activities that are applied in response to a participant's behaviour that she perceives as physically or psychologically painful or harmful.

Any response by a service provider to a participant's behaviour has the potential of being experienced by the participant as aversive, even interventions generally considered positive. A determination needs to be made regarding whether the participant sees any procedure or event as aversive. This determination can be made by assessing the individual's reaction to the procedure or event.

# APPENDIX G

## Medication Protocol

When medication is considered/prescribed as a behavioural support, a medication protocol incorporates the following guidelines:

1. Prior to a decision to pursue the use of medication to address behavioural issues:
    - All effort is made to rule out possible medical causes of the behavior.
    - The core group shall evaluate the appropriateness and effectiveness of all positive strategies which have been implemented.

2. The decision to pursue the use of medication as a behavioural support is made by the participant and their core group.

3. The core group will identify a key person who will contact the physician and who will support the participant during all medical interviews, appointments and/or assessments.

4. The core group will ensure that a baseline of the challenging behaviours has been completed. The baseline includes but is not limited to:
    - description of the behavior;
    - the antecedents leading to the behavior;
    - the frequency, duration and locations of occurrences of the behavior;
    - the consequences of the behaviour and follow-up;
    - a comprehensive analysis of antecedents, consequences and relevant ecological or environmental events.

5. The key person will ensure that a comprehensive report containing all relevant behavioural information is submitted to the physician at least one week prior to the individual's initial appointment. Relevant behavioural information includes:
    - baseline information;
    - history of behavioural pattern and interventions to date;
    - reports of any formal behavioural and/or psychological assessment (e.g., Motivation assessment scale, needs analysis, communication functions of behavior, Reiss screen).

6. Upon receipt of a prescription for the use of the medication to affect challenging, dangerous or harmful behaviour, the key person will ensure that the following information is obtained from the physician or pharmacist:

    - What specific behavioural changes will be observed as a result of taking this medication?
    - How quickly will changes be evident, i.e. days, weeks, months?
    - How much change in the behaviour can be expected?
    - If anticipated changes in behaviour do not occur, what steps should be taken?
    - How frequently will the medication be reviewed and what information will the physician need to adequately assess the effectiveness of the medication?
    - If adverse effects or drug reactions occur, what steps should staff take and how should these be documented?
    - Does the medication interact with certain foods? If so, which foods and what dietary precautions should be taken?
    - Can the medication safely be crushed if the participant has trouble swallowing?
    - Should the medication be taken with or without food?
    - What time(s) of day should the medication be taken?
    - What procedure should be followed if a dose of the medication is missed?
    - When the behaviour has decreased significantly and is stable, what steps can be taken to decrease the dosage of the medication?

7. The key person shall ensure that the participant is informed of the effects and side effects of all prescribed medications.

8. The core group will ensure that all relevant, appropriate, positive strategies continue to be implemented during the entire period that the participant requires medication as a behavioural support.

9. The core group will evaluate the appropriateness and effectiveness of all positive strategies implemented during the period that the participant requires medication as a behavioural support.

10. The key person will ensure ongoing documentation and review of all medications and necessary changes (i.e., Dosage, type, time, etc.) and incorporate this information into the individual's plan.

11. The key person will ensure that all Service Providers working with the participant are notified of the medication intervention and will provide the Service Provider with a written plan for safe and effective administration of the medication.

# APPENDIX H

## Emergency Response Policy Guidelines

There may be times when participants exhibit behaviours they have never exhibited before that present a danger to themselves and/or others. In an effort to protect these individuals and others around them, an emergency response policy offers guidelines of how to respond when these situations arise.

The Emergency Response Policy will:

- Provide direction to service providers according to the crisis cycle which is a model of escalation of behaviour
- Offer substantive approaches when a potential danger exists, presented in a hierarchy of increasing intrusiveness or restrictiveness, with the least intrusive/restrictive presented first (Least restrictive/intrusive is a procedure that is not more restrictive or intrusive than is necessary to prohibit the participant from inflicting harm to herself or others and applied no longer than necessary to prevent or contain the dangerous behaviour. Suggested responses to dangerous or harmful behaviours are outlined in Appendix D of this document.)
- Direct service providers not to approach a participant exhibiting dangerous/harmful behaviour alone, unless not to do so would put others at risk
- Direct service providers to remove others from the situation, if possible
- Outline techniques (calm, non threatening approach, reducing stimuli, stay out of individual's personal space)
- Direct service providers to protect herself and/or others if needed using the least restrictive response
- Direct service providers to report the participant's signs of escalating behaviour to the Supervisor and document information as soon as possible
- Direct service providers on when and how to access help within their organization or from other community support services

The emergency response policy will address the reporting protocol service providers are required to follow. The documentation should contain, but not be limited to the following information:

- name of the participant;
- date of the incident;
- time of the incident;
- place (location) of the incident;
- the antecedents of the incident;
- the reactive strategies and responses used by service providers (listed in order from the least intrusive to the most intrusive);
- an exact description of the action taken by service providers;
- witnesses to or others involved in the incident;
- the outcome of the responses demonstrated by service providers;
- the follow up plans (immediate and long-term).

The emergency response policy will address the requirement for service providers to develop a Comprehensive Behaviour Support plan with the participant (see Appendix D).

# APPENDIX I

## Reference Materials


Bambara, L. & Knoster, T. (1998). Innovations Designing Positive Behavior Support Plans. Washington, D.C.: AAMR.

This book is number 13 in the Innovations series published by the AAMR. Bambara and Knoster present positive and comprehensive behaviour support methodologies from definitions to practical case examples. This book is an excellent companion reference to the Comprehensive Personal Planning and Support Policy.

Bodnar, F., & Coflin, J. (2001). Supported Decision Making Workbook.

This manual presents supported decision-making as it applies to people with disabilities in Canada. Written in easily understood plain language, the manual provides a framework for both understanding and implementing Supported Decision-making. *A Trainer's Guide* is included with each of its five chapters.

Carr, E.G., Levin, I., McConnachie, G., Carlson, J.I., Kemp, D.C., & Smith, C.E. (1994). Communication-based intervention for problem behavior: A user guide for producing positive change. Baltimore, MD: Paul H. Brookes Publishing Co.

Carr et al. describe communication-based interventions for people with severe challenging behaviours. Their approach is designed to reduce challenging behaviour by teaching communication strategies. Challenging behaviour is viewed as having a function for the participant. Intervention focuses on education, not simply behaviour reduction. Lifestyle changes are presented as the ultimate goal of intervention.

Donnellan, A.M., LaVigna, G.W., Negri-Shoultz, N.N., & Fassbender, L.L. (1988). Progress without punishment: Effective approaches for learners with behavior problems. New York, NY: Teachers College Press.

This book presents a non-aversive technology in a practical format for service providers who work directly with individuals with serious behaviour challenges. It includes an overview of positive programming options as well as non-aversive behavioural and instructional techniques that lead to long-term behaviour change.

LaVigna, G.W., & Donnellan, A.M. (1986). Alternatives to punishment: Solving behavior problems with non-aversive strategies. New York, NY: Irvington Publishers, Inc.

This book provides comprehensive treatment alternatives to punishment in dealing with challenging behaviour. It describes effective non-aversive technology for supporting those with even the most severe behaviour challenges. Legal, administrative, ethical and procedural issues are presented. Also included are problem scenarios, support strategies, and research data.

Lovett, H. (1996). Learning to listen: Positive approaches with difficult behavior. Baltimore, MD: Paul H. Brookes Publishing Co.

This book presents a positive framework for understanding behaviour. Lovett encourages the reader to move from rehabilitation to accommodation, and from control to collaboration. He discusses the importance of listening empathetically and trusting the power of relationships.

O'Neil, R.E., Horner, R.H., Albin, R.W., Sprague, J.R., Storey, K., & Newton, J.S. (1997). Functional assessment and program development for problem behavior: A practical handbook. Pacific Grove, California: Brooks/Cole Publishing Co.

This handbook presents approaches for analyzing challenging behaviours and developing support strategies. Their approach is rooted in the believe that effective behavioural support should not only reduce challenging behaviours, but should increase the opportunities for learning new skills, social inclusion, access to meaningful activities, and participation in their community. Examples of forms and procedures that have proven useful in school, work and home settings are included.

Reid, D. & Parsons, M. (2003). Positive Behavior Support Training Curriculum. Washington, D.C.: AAMR.

Dennis Reid and Marsha Parsons present a positive behaviour support curriculum for supervisors and direct staff. This comprehensive curriculum contains 15 modules in the direct support edition and an additional 10 modules in the supervisory edition. Some of the topics include dignity, defining behaviour, functional skills, role of environment, program implementation, role of choice, data analysis, and staff performance analysis.

Willis, T. & LaVigna, G. (1999). Emergency Management and Reactive Strategies Within a Nonaversive Framework. Los Angeles, Ca.: IABA.

Pioneers in the field of non-aversive behavioural support, Thom Willis and Gary LaVigna present non-aversive emergency management strategies in a lecture format over a series of eight videotapes. This state of the art package includes a manual, study guide and references.

# SECTION 13: HEALTH & SAFETY

1. Contents of the First Aid Kit
2. Handwashing Tips
3. Housekeeping Tips
4. Mattress Care Tips
5. Bathing Procedure

***"I love the role of providing excellent care and nutrition and organizing a home."***

1. **Contents of the First Aid Kit:**

   Amounts or quantities of the following supplies and equipment should be adequate for the expected emergencies and contained in a well-marked container:

   - Antiseptic – wound solution or antiseptic swabs
   - Bandage – adhesive strips and hypoallergenic adhesive tape
   - Bandage – triangular, 100 centimetre folded, and safety pins
   - Dressing – sterile and wrapped gauze pads and compresses, various sizes including abdominal pad size
   - Dressing – self-adherent-roller, various sizes
   - Pad with shield or tape for eye
   - Soap
   - Disposable latex or vinyl gloves
   - Pocket mask with disposable one-way rebreathe valves
   - Scissors, bandage

***"Home is where I feel safe."***

2. **Handwashing Tips:**

   - Practice frequent and thorough handwashing with soap and water. Assist your residents to do the same. This is key to preventing transmission of bacteria and viruses.

   - The Ministry of Health describes thorough handwashing as follows:

     1. Wet hands;
     2. Soap hands for 20 seconds;
     3. Rinse;
     4. Turn off taps with paper towel (or clean hand towel).

   - At minimum, hands should be washed upon entering the home, before and after direct physical contact with others, before preparing, serving, or eating food, after using the washroom, after wiping your nose, coughing, or sneezing, and after contact with blood, body fluids, secretions, or contaminated objects.

   - Remember to cough or sneeze into the crook of your elbow and teach your residents to do so as well if tissue and immediate handwashing facilities aren't available.

   - Cloth towels should not be shared. Using paper towels in the bathroom is one way to ensure residents do not share each others towels. Paper towel can also be used to turn off taps and tum door knobs to prevent recontamination of clean hands.

**3. Housekeeping Tips:**

- Regular and thorough home cleaning minimizes the number of mfcro-organisms found on surfaces throughout the home. Clean bathroom and kitchen surfaces with disinfectant. Change towels and bedding at least weekly and immediately upon soiling. Dust and vacuum at least weekly. Wipe down things like remote controls, telephones, light switches. and door knobs with disinfectant wipes.
- Wash soiled laundry as soon as possible. The hot cycles of the washer and dryer are usually adequate to clean soiled laundry. You can sanitize your washer by running the empty machine through a complete cycle using a commercial disinfectant on a regular basis and immediately after coming into contact With soiled laundry.
- Household bleach is an economical sanitizer. To prepare a sanitizing solution, use one teaspoon of bleach to three cups of water (5 ml. of bleach to 750 mL of water).
- You are encouraged to use gloves when there is a possibility of contact with feces, blood, urine, vomits or other bodily fluids.
- Contaminated items such as dressings, bandages, soiled adult incontinence products, and feminine hygiene products are to be placed In a plastic bag, sealed, and placed ih the trash.

**4. Mattress Care Tips:**

- Mattresses must be clean and in good condition.
- Washable mattress covers are a good investment.
- Vacuum your mattress regularly to remove dust. dander, and dust particles.
- For residents who are incontinent of bowel and/or bladder, use a waterproof protective mattress cover. Special pads that are machine washable and dryable are also available for purchase.
- If a mattress does become soiled, absorb as much moisture as possible using cloth or paper towels.
- Use upholstery shampoo, enzymatic cleaner or the suds from a mild detergent to clean the mattress surface. Never saturate the mattress as this may cause mold growth.
- Dry the mattress outdoors in the sunshine or indoors With a fan. The drying process may take a full day.
- Commercial urine removal products are available.
- Professional mattress

cle

aning companies may be available in some communities.

***"Happiness is seeing my residents' faces light up whenI say "welcome home".***

5. **Bathing Procedure** – See the following Bathing Procedure Health Alert.

| Saskatchewan Ministry of Health, Saskatchewan Regional Health Authorities & Saskatchewan Cancer Agency<br>**Working Together for Safer Care** | File Number<br>06/07-03<br>Updated Apr 2008 |
|---|---|

# ALERT Recommendation to Prevent Water Burns of Adults, Children and Infants

## Issue:

Saskatchewan Health has been advised of the following recommendations arising from root cause analyses performed following reported critical incidents in which a client was burned in scalding water in a tub bath. This alert is intended to replace the original Issue Alert on preventing water burns in adult patients/clients/residents that was distributed in September 2006. **It has been improved to include safe water temperature recommendations for bathing children and infants.**

## Recommendations:

1) That all facilities and health services (including home care) providing tub baths implement a protocol of testing and documenting water temperature to ensure temperature is within safe limits prior to each resident/client/patient entering water. Further, ensure that staff are educated about the protocol and that the protocol is posted in every tub room.

   ***Example protocol:*** Fill tub, test water by putting hand and floating thermometer in tub water, read temperature, ensure that the temperature is within safe limit and document client, temperature and time on log (sample attached) kept in the tub room.

   ADULTS: maximum bath water temperature: 39°C (102.2°F)
   CHILDREN: maximum bath water temperature: 37°C (98.6°F)
   INFANTS: maximum bath water temperature: 36°C (96.8°F)

2) That all staff are trained in bathing procedures, including use of equipment.
3) That all facilities ensure ongoing maintenance, including documentation of all water temperature control equipment and tubs, and that there is a policy and procedure in place to respond to malfunctioning equipment.

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*Alerts are released by Saskatchewan Health following the review of at least one critical incident of this type reported to the ministry. The intent of an Alert is to recommend initiatives that will improve the safety of patients who may be cared for under similar circumstances.*

*A critical incident is defined as a serious adverse health event including, but not limited to, the actual or potential loss of life, limb or function related to a health service provided by, or a program operated by, a regional health authority or health care organization.*

*Recommendations are intended to support the development of best practices and to act as a basic framework for modification so that the end result is a good fit within your Regional Health Authority and Health Care Organization. To assist you, when able, we will share RHA policies or initiatives that been developed.*

## References:


The Hospital for Sick Children, University of Toronto. *Safe Kids Canada: How to protect your child from scalds and burns*. Retrieved April 2, 2008 from the Safe Kids Canada website: http://www.sickkids.ca/SKCForParents/section.asp?s=Safety%2BInformation%2by%2BTopic&sID=10774&ss=Scalds%2BBurns&ssID=11337

The Raising Children Network, Australia. Safe Bath Temperature. Retrieved April 2, 2008 from the Raising Children Network website: http//raisingchildren.net.au/articles/safe_water_temperature.html

# Water Temperature Log

**Location of Tub: _____**

**Maximum Water Temperature - ADULTS 39°C (102.2°F)**
**Maximum Water Temperature - CHILDREN 37°C (98.6°F)**
**Maximum Water Temperature - INFANTS 36°C (96.8°F)**

| Date | Time | Temperature | Client | Staff Initials |
|---|---|---|---|---|
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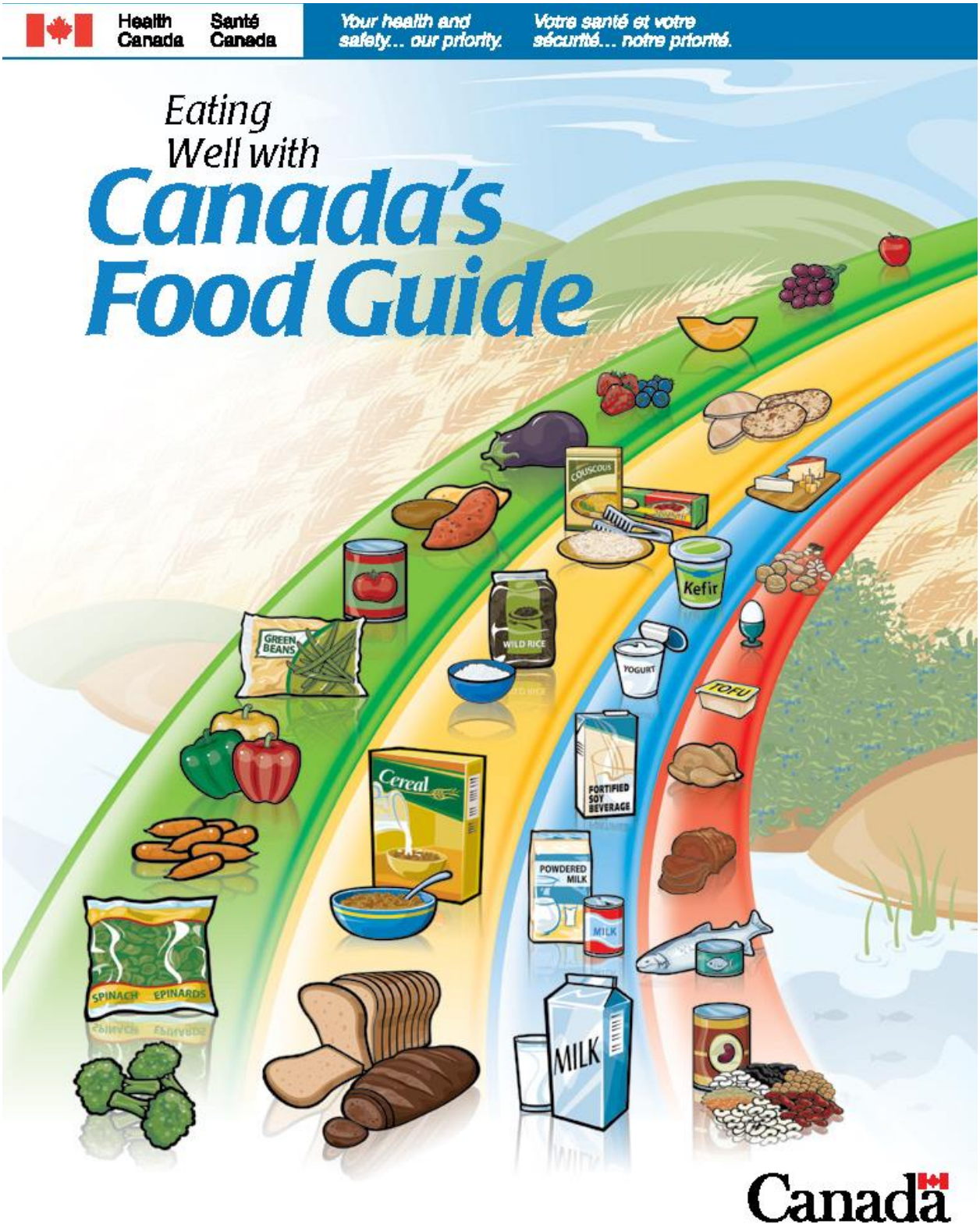
File Number: 06/07-03
Updated April 2008

## SECTION 14: NUTRITION & FOOD SAFETY

1. Canada's Food Guide and Canada's Food Guide First Nations, Inuit, and Métis
2. Menu Checklist
3. Nutrition Facts Table
4. Nutrition Coordinator Course
5. Food Safety
6. Protecting Yourself and Your Family from Salmonella

***"I like the contentment of all sitting around the table sharing a meal and conversation".***

## 1. Canada's Food Guide and Canada's Food Guide First Nations, Inuit, and Métis



## Recommended Number of Food Guide Servings per Day

| | Children | | | Teens | | Adults | | | |
|---|---|---|---|---|---|---|---|---|---|
| Age in Years | 2-3 | 4-8 | 9-13 | 14-18 | | 19-50 | | 51+ | |
| Sex | Girls and Boys | | | Females | Males | Females | Males | Females | Males |
| Vegetables and Fruit | 4 | 5 | 6 | 7 | 8 | 7-8 | 8-10 | 7 | 7 |
| Grain Products | 3 | 4 | 6 | 6 | 7 | 6-7 | 8 | 6 | 7 |
| Milk and Alternatives | 2 | 2 | 3-4 | 3-4 | 3-4 | 2 | 2 | 3 | 3 |
| Meat and Alternatives | 1 | 1 | 1-2 | 2 | 3 | 2 | 3 | 2 | 3 |

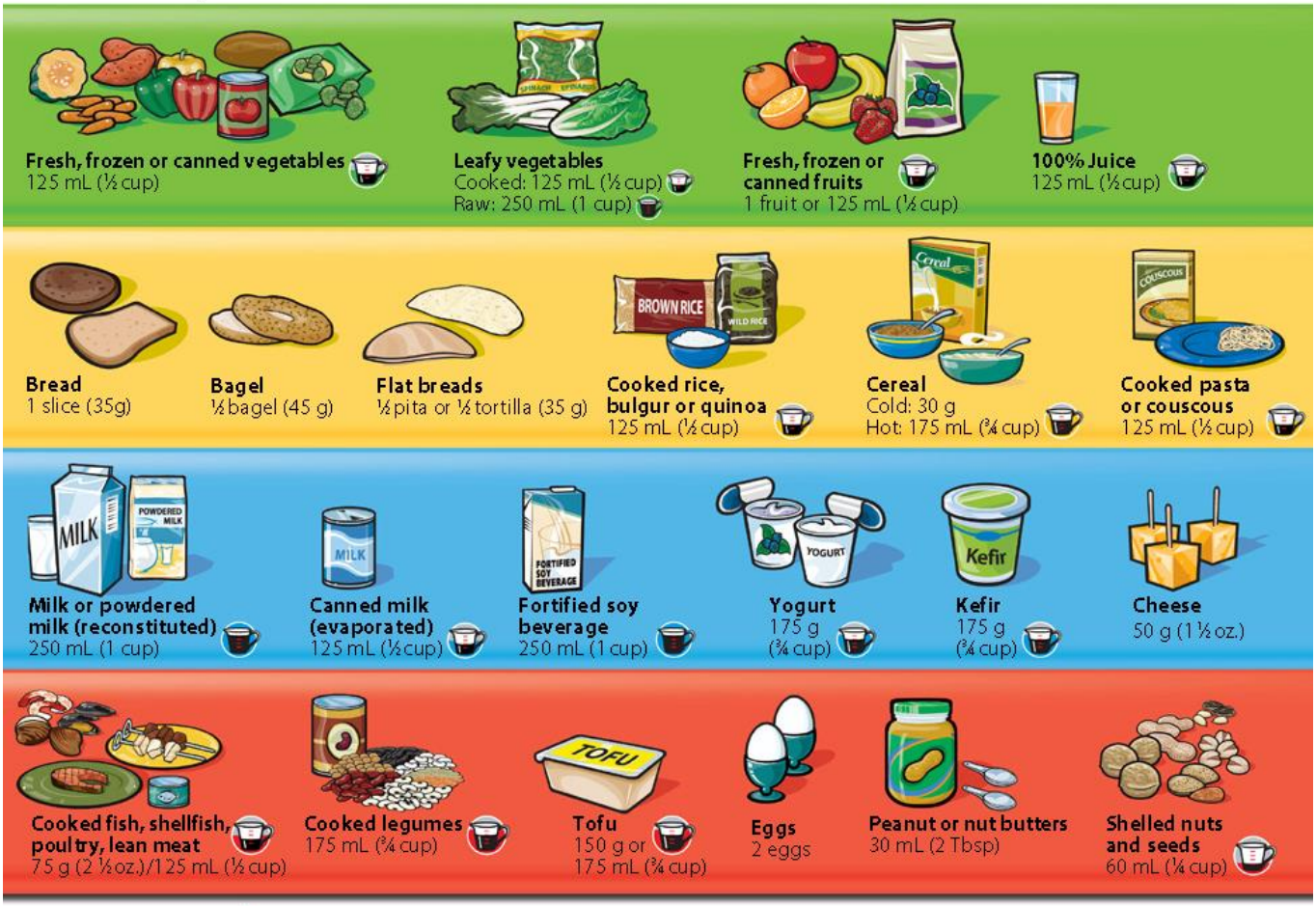
The chart above shows how many Food Guide Servings you need from each of the four food groups every day.

**Having the amount and type of food recommended and following the tips in *Canada's Food Guide* will help:**

- Meet your needs for vitamins, minerals and other nutrients.
- Reduce your risk of obesity, type 2 diabetes, heart disease, certain types of cancer and osteoporosis.
- Contribute to your overall health and vitality.

## What is One Food Guide Serving?

*Look at the examples below.*




### Oils and Fats

- Include a small amount – 30 to 45 mL (2 to 3 Tbsp) – of unsaturated fat each day. This includes oil used for cooking, salad dressings, margarine and mayonnaise.
- Use vegetable oils such as canola, olive and soybean.
- Choose soft margarines that are low in saturated and trans fats.
- Limit butter, hard margarine, lard and shortening.

## *Make each Food Guide Serving count…*
***wherever you are – at home, at school, at work or when eating out!***

- **Eat at least one dark green and one orange vegetable each day.**
  - Go for dark green vegetables such as broccoli, romaine lettuce and spinach.
  - Go for orange vegetables such as carrots, sweet potatoes and winter squash.
- **Choose vegetables and fruit prepared with little or no added fat, sugar or salt.**
  - Enjoy vegetables steamed, baked or stir-fried instead of deep-fried.
- **Have vegetables and fruit more often than juice.**

- **Make at least half of your grain products whole grain each day.**
  - Eat a variety of whole grains such as barley, brown rice, oats, quinoa and wild rice.
  - Enjoy whole grain breads, oatmeal or whole wheat pasta.
- **Choose grain products that are lower in fat, sugar or salt.**
  - Compare the Nutrition Facts table on labels to make wise choices.
  - Enjoy the true taste of grain products. When adding sauces or spreads, use small amounts.

- **Drink skim, 1%, or 2% milk each day.**
  - Have 500 mL (2 cups) of milk every day for adequate vitamin D.
  - Drink fortified soy beverages if you do not drink milk.
- **Select lower fat milk alternatives.**
  - Compare the Nutrition Facts table on yogurts or cheeses to make wise choices.

- **Have meat alternatives such as beans, lentils and tofu often.**
- **Eat at least two Food Guide Servings of fish each week.***
  - Choose fish such as char, herring, mackerel, salmon, sardines and trout.
- **Select lean meat and alternatives prepared with little or no added fat or salt.**
  - Trim the visible fat from meats. Remove the skin on poultry.
  - Use cooking methods such as roasting, baking or poaching that require little or no added fat.
  - If you eat luncheon meats, sausages or prepackaged meats, choose those lower in salt (sodium) and fat.



* Health Canada provides advice for limiting exposure to mercury from certain types of fish. Refer to www.healthcanada.gc.ca for the latest information.

## *Advice for different ages and stages…*

### Children

Following *Canada's Food Guide* helps children grow and thrive.

Young children have small appetites and need calories for growth and development.

- Serve small nutritious meals and snacks each day.
- Do not restrict nutritious foods because of their fat content. Offer a variety of foods from the four food groups.
- Most of all… be a good role model.

### Women of childbearing age

All women who could become pregnant and those who are pregnant or breastfeeding need a multivitamin containing **folic acid** every day. Pregnant women need to ensure that their multivitamin also contains **iron**. A health care professional can help you find the multivitamin that's right for you.

Pregnant and breastfeeding women need more calories. Include an extra 2 to 3 Food Guide Servings each day.

**Here are two examples:**

- Have fruit and yogurt for a snack, or
- Have an extra slice of toast at breakfast and an extra glass of milk at supper.

### Men and women over 50

The need for **vitamin D** increases after the age of 50.

In addition to following *Canada's Food Guide*, everyone over the age of 50 should take a daily vitamin D supplement of 10 µg (400 IU).

## *How do I count Food Guide Servings in a meal?*

**Here is an example:**

| Vegetable and beef stir-fry with rice, a glass of milk and an apple for dessert | | |
|---|---|---|
| 250 mL (1 cup) mixed broccoli, carrot and sweet red pepper | = | 2 **Vegetables and Fruit** Food Guide Servings |
| 75 g (2 ½ oz.) lean beef | = | 1 **Meat and Alternatives** Food Guide Serving |
| 250 mL (1 cup) brown rice | = | 2 **Grain Products** Food Guide Servings |
| 5 mL (1 tsp) canola oil | = | part of your **Oils and Fats** intake for the day |
| 250 mL (1 cup) 1% milk | = | 1 **Milk and Alternatives** Food Guide Serving |
| 1 apple | = | 1 **Vegetables and Fruit** Food Guide Serving |

# *Eat well and be active today and every day!*

## The benefits of eating well and being active include:

- Better overall health.
- Lower risk of disease.
- A healthy body weight.
- Feeling and looking better.
- More energy.
- Stronger muscles and bones.

## Be active

To be active every day is a step towards better health and a healthy body weight.

It is recommended that adults accumulate at least 2 ½ hours of moderate to vigorous physical activity each week and that children and youth accumulate at least 60 minutes per day. You don't have to do it all at once. Choose a variety of activities spread throughout the week.

***Start slowly and build up.***

## Eat well

Another important step towards better health and a healthy body weight is to follow *Canada's Food Guide* by:

- Eating the recommended amount and type of food each day.
- Limiting foods and beverages high in calories, fat, sugar or salt (sodium) such as cakes and pastries, chocolate and candies, cookies and granola bars, doughnuts and muffins, ice cream and frozen desserts, french fries, potato chips, nachos and other salty snacks, alcohol, fruit flavoured drinks, soft drinks, sports and energy drinks, and sweetened hot or cold drinks.

## Read the label

- Compare the Nutrition Facts table on food labels to choose products that contain less fat, saturated fat, trans fat, sugar and sodium.
- Keep in mind that the calories and nutrients listed are for the amount of food found at the top of the Nutrition Facts table.

**Nutrition Facts**

Per 0 mL (0 g)

| Amount | % Daily Value |
|---|---|
| **Calories** 0 | |
| **Fat** 0 g | **0 %** |
| Saturated 0 g + Trans 0 g | **0 %** |
| **Cholesterol** 0 mg | |
| **Sodium** 0 mg | **0 %** |
| **Carbohydrate** 0 g | **0 %** |
| Fibre 0 g | **0 %** |
| Sugars 0 g | |
| **Protein** 0 g | |

| | | | |
|---|---|---|---|
| Vitamin A | 0 % | Vitamin C | 0 % |
| Calcium | 0 % | Iron | 0 % |

## Limit trans fat

When a Nutrition Facts table is not available, ask for nutrition information to choose foods lower in trans and saturated fats.

## Take a step today...

- ✓ Have breakfast every day. It may help control your hunger later in the day.
- ✓ Walk wherever you can – get off the bus early, use the stairs.
- ✓ Benefit from eating vegetables and fruit at all meals and as snacks.
- ✓ Spend less time being inactive such as watching TV or playing computer games.
- ✓ Request nutrition information about menu items when eating out to help you make healthier choices.
- ✓ Enjoy eating with family and friends!
- ✓ Take time to eat and savour every bite!

***For more information, interactive tools, or additional copies visit Canada's Food Guide on-line at:***
***www.healthcanada.gc.ca/foodguide***

***or contact:***

Publications
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**TTY:** 1-800-267-1245

Également disponible en français sous le titre :
Bien manger avec le Guide alimentaire canadien

This publication can be made available on request on diskette, large print, audio-cassette and braille.

 HC Pub.: 4651 Cat.: H164-38/1-2011E-PDF ISBN: 978-1-100-19255-0

Health Canada Santé Canada

*Your health and safety… our priority.* *Votre santé et votre sécurité… notre priorité.*

*Eating Well with*

# Canada's Food Guide

## *First Nations, Inuit and Métis*


Canada

## How to use Canada's Food Guide

**The Food Guide shows how many servings to choose from each food group every day and how much food makes a serving.**

1. Find your age and sex group in the chart below.
2. Follow down the column to the number of servings you need for each of the four food groups every day.
3. Look at the examples of the amount of food that counts as one serving. For instance, 125 mL (1/2 cup) of carrots is one serving in the Vegetables and Fruit food group.

### What is one Food Guide Serving?

Look at the examples below.

### Eating Well Every Day

Canada's Food Guide describes healthy eating for Canadians two years of age or older.

Choosing the amount and type of food recommended in Canada's Food Guide will help:

- children and teens grow and thrive
- meet your needs for vitamins, minerals and other nutrients
- lower your risk of obesity, type 2 diabetes, heart disease, certain types of cancer and osteoporosis (weak and brittle bones).

| | Recommended Number of Food Guide Servings per day | | | |
|---|---|---|---|---|
| | Children 2–3 years old | Children 4–13 years old | Teens and Adults (Females) | Teens and Adults (Males) |
| **Vegetables and Fruit** Fresh, frozen and canned. | 4 | 5–6 | 7–8 | 7–10 |
| **Grain Products** | 3 | 4–6 | 6–7 | 7–8 |
| **Milk and Alternatives** | 2 | 2–4 | Teens 3–4<br>Adults (19–50 years) 2<br>Adults (51+ years) 3 | Teens 3–4<br>Adults (19–50 years) 2<br>Adults (51+ years) 3 |
| **Meat and Alternatives** | 1 | 1–2 | 2 | 3 |

**Eat at least one dark green and one orange vegetable each day. Choose vegetables and fruit prepared with little or no added fat, sugar or salt. Have vegetables and fruit more often than juice.**

Dark green and orange vegetables 125 mL (1/2 cup)


Other vegetables 125 mL (1/2 cup)

Leafy vegetables and wild plants cooked 125 mL (1/2 cup) raw 250 mL (1 cup)

Berries 125 mL (1/2 cup)

Fruit 1 fruit or 125 mL (1/2 cup)

100% Juice 125 mL (1/2 cup)

**Make at least half of your grain products whole grain each day. Choose grain products that are lower in fat, sugar or salt.**

Bread 1 slice (35 g)

Bannock 35 g (2" x 2" x 1")

Cold cereal 30 g (see food package)

Hot cereal 175 mL (3/4 cup)

Cooked pasta 125 mL (1/2 cup)


Cooked rice White, brown, wild 125 mL (1/2 cup)

**Drink 500 mL (2 cups) of skim, 1% or 2% milk each day. Select lower fat milk alternatives. Drink fortified soy beverages if you do not drink milk.**



Milk Powdered milk, mixed 250 mL (1 cup)

Fortified soy beverage 250 mL (1 cup)


Canned milk (evaporated) 125 mL (1/2 cup)

Yogurt 175 g (3/4 cup)

Cheese 50 g (1 1/2 oz.)

**Have meat alternatives such as beans, lentils and tofu often. Eat at least two Food Guide Servings of fish each week.* Select lean meat and alternatives prepared with little or no added fat or salt.**

Traditional meats and wild game 75 g cooked (2 1/2 oz)/125 mL (1/2 cup)

Fish and shellfish 75 g cooked (2 1/2 oz)/125 mL (1/2 cup)

Lean meat and poultry 75 g cooked (2 1/2 oz)/125 mL (1/2 cup)

Eggs 2 eggs


Beans – cooked 175 mL (3/4 cup)

Peanut butter 30 mL (2 Tbsp)

### When cooking or adding fat to food:


- Most of the time, use vegetable oils with unsaturated fats. These include canola, olive and soybean oils.
- Aim for a small amount (2 to 3 tablespoons or about 30–45 mL) each day. This amount includes oil used for cooking, salad dressings, margarine and mayonnaise.
- Traditional fats that are liquid at room temperature, such as seal and whale oil, or ooligan grease, also contain unsaturated fats. They can be used as all or part of the 2–3 tablespoons of unsaturated fats recommended per day.
- Choose soft margarines that are low in saturated and trans fats.
- Limit butter, hard margarine, lard, shortening and bacon fat.

*Health Canada provides advice for limiting exposure to mercury from certain types of fish. Refer to www.healthcanada.gc.ca for the latest information. Consult local, provincial or territorial governments for information about eating locally caught fish.

## Respect your body... Your choices matter

Following Canada's Food Guide and limiting foods and drinks which contain a lot of calories, fat, sugar or salt are important ways to respect your body. Examples of foods and drinks to limit are:

- pop
- fruit flavoured drinks
- sweet drinks made from crystals
- sports and energy drinks
- candy and chocolate
- cakes, pastries, doughnuts and muffins
- granola bars and cookies
- ice cream and frozen desserts
- potato chips
- nachos and other salty snacks
- french fries
- alcohol

## People who do not eat or drink milk products must plan carefully to make sure they get enough nutrients.

The traditional foods pictured here are examples of how people got, and continue to get, nutrients found in milk products. Since traditional foods are not eaten as much as in the past, people may not get these nutrients in the amounts needed for health.

People who do not eat or drink milk products need more individual advice from a health care provider.


## Women of childbearing age

All women who could become pregnant, and pregnant and breastfeeding women, need a multivitamin with **folic acid** every day. Pregnant women should make sure that their multivitamin also contains **iron**. A health care provider can help you find the multivitamin that is right for you.

When pregnant and breastfeeding, women need to eat a little more. They should include an extra 2 to 3 Food Guide Servings from any of the food groups each day.

For example:

- have dry meat or fish and a small piece of bannock for a snack, or
- have an extra slice of toast at breakfast and an extra piece of cheese at lunch.

## Women and men over the age of 50

The need for **vitamin D** increases after the age of 50.

In addition to following Canada's Food Guide, men and women over the age of 50 should take a daily vitamin D supplement of 10 µg (400 IU).

## For strong body, mind and spirit, be active every day.

**This guide is based on *Eating Well with Canada's Food Guide*.**

For more information, interactive tools or additional copies visit Canada's Food Guide at: **www.healthcanada.gc.ca/foodguide**

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This publication can be made available on request on diskette, large print, audio-cassette and braille.

## 2. Menu Checklist

| Menu Criteria | Yes | No |
|---|---|---|
| **Breakfast –** Servings from 3 food groups are offered.<br>☐ Vegetables and fruit<br>☐ Grain products<br>☐ Milk and alternatives<br>☐ Meat and alternatives | | |
| **Morning Snack –** Servings of vegetables or fruit plus 1 other food group is offered.<br>☑ Vegetables and fruit<br>☐ Milk and alternatives<br>☐ Meat and alternatives | | |
| **Lunch –** Servings from all 4 food groups are offered.<br>☑ Vegetables and fruit<br>☑ Grain products<br>☑ Vegetables and fruit<br>☑ Vegetables and fruit | | |
| **Afternoon Snack –** Servings of vegetables or fruit plus 1 other food group is offered.<br>☑ Vegetables and fruit<br>☐ Grain products<br>☐ Milk and alternatives<br>☐ Meat and alternatives | | |
| **Supper –** Servings from all 4 food groups are offered.<br>☑ Vegetables and fruit<br>☑ Grain products<br>☑ Milk and alternatives<br>☑ Meat and alternatives | | |
| **Milk and alternatives are offered at least twice a day.** | | |
| **If <u>juice</u> is offered:**<br>• It is 100% unsweetened juice.<br>• It is offered no more than 3 times per week. | | |
| **Foods to limit, if offered:**<br>• Appear on the menu no more than a total of 3 times per week.<br>• Are in addition to the recommended food groups.<br><br>***Foods to limit include cakes, pastries, doughnuts, cookies and granola bars, ice cream and frozen desserts, french fries, potato chips, nachos and other salty snacks, fruit flavoured drinks, soft drinks, sweetened hot/cold drinks.*** | | |

## 3. Nutrition Facts Table

Health Canada Santé Canada

*Your health and safety… our priority.* *Votre santé et votre sécurité… notre priorité.*

# Using the Nutrition Facts Table: % Daily Value

## How to CHOOSE

The Nutrition Facts table gives you information on calories and 13 core nutrients. Use the amount of food and the % Daily Value (% DV) to choose healthier food products.

**Follow these three steps:**

### 1 LOOK at the amount of food

Nutrition Facts are based on a specific amount of food (also known as the serving size). Compare this to the amount you actually eat.

### 2 READ the % DV

The % DV helps you see if a specific amount of food has a little or a lot of a nutrient.

5% DV or less is **a LITTLE**
15% DV or more is **a LOT**
} This applies to all nutrients.

Yogurt

**Nutrition Facts**
Per 3/4 cup (175 g)

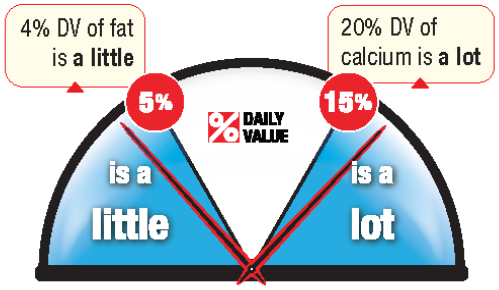
| Amount | % Daily Value |
|---|---|
| **Calories** 160 | |
| **Fat** 2.5 g | **4** % |
| Saturated 1.5 g + Trans 0 g | **8** % |
| **Cholesterol** 10 mg | |
| **Sodium** 75 mg | **3** % |
| **Carbohydrate** 25 g | **8** % |
| Fibre 0 g | **0** % |
| Sugars 24 g | |
| **Protein** 8 g | |

| | | | |
|---|---|---|---|
| Vitamin A | 2 % | Vitamin C | 0 % |
| Calcium | 20 % | Iron | 0 % |

### 3 CHOOSE

Make a better choice for you. Here are some nutrients you may want…

| less of | more of |
|---|---|
| • Fat | • Fibre |
| • Saturated and trans fats | • Vitamin A |
| • Sodium | • Calcium |
| | • Iron |




**Here is an example of how to choose:**
You are at the grocery store looking at yogurt. The small container (175 g) of yogurt you pick has **a little** fat (4% DV) and **a lot** of calcium (20% DV) – this is a better choice if you are trying to eat less fat and more calcium as part of a healthy lifestyle!


Également disponible en français sous le titre : Utilisez le tableau de la valeur nutritive : % de la valeur quotidienne.

HC Pub.: 100539
Cat.: H164-127/2011E-PDF
ISBN: 978-1-100-19881-1

Canada

## How to COMPARE

Use the amount of food and the % Daily Value (% DV) to compare and choose healthier food products.

**Follow these three steps:**

### 1 LOOK at the amounts of food

Compare the amounts of food (also known as the serving sizes) in the Nutrition Facts tables.

**Cracker A** has 9 crackers and weighs 23 grams.

**Cracker B** has 4 crackers and weighs 20 grams.

Because the weights are similar, you can compare these Nutrition Facts tables.

**Cracker A**

| Nutrition Facts | |
|---|---|
| Per 9 crackers (23 g) | |
| **Amount** | **% Daily Value** |
| **Calories** 90 | |
| **Fat** 4.5 g | **7** % |
| Saturated 2.5 g + Trans 0 g | **13** % |
| **Cholesterol** 0 mg | |
| **Sodium** 280 mg | **12** % |
| **Carbohydrate** 12 g | **4** % |
| Fibre 1 g | **4** % |
| Sugars 0 g | |
| **Protein** 3 g | |
| Vitamin A 0 % | Vitamin C 0 % |
| Calcium 2 % | Iron 8 % |

**Cracker B**

| Nutrition Facts | |
|---|---|
| Per 4 crackers (20 g) | |
| **Amount** | **% Daily Value** |
| **Calories** 90 | |
| **Fat** 2 g | **3** % |
| Saturated 0.3 g + Trans 0 g | **2** % |
| **Cholesterol** 0 mg | |
| **Sodium** 90 mg | **4** % |
| **Carbohydrate** 15 g | **5** % |
| Fibre 3 g | **12** % |
| Sugars 1 g | |
| **Protein** 2 g | |
| Vitamin A 0 % | Vitamin C 0 % |
| Calcium 2 % | Iron 8 % |

### 2 READ the % DVs

Since you are comparing crackers, you may want to look at the % DVs for saturated and trans fats, sodium and fibre.

**Cracker A** has 13% DV for saturated and trans fats, 12% DV for sodium and 4% DV for fibre.

**Cracker B** has 2% DV for saturated and trans fats, 4% DV for sodium and 12% DV for fibre.

**Remember: 5% DV or less is a little** and **15% DV or more is a lot.** This applies to all nutrients.

**Did you know?**
You may be able to compare products that don't have similar amounts of food.

For example, you could compare the % DVs of a bagel (90 g) to the % DVs of 2 slices of bread (70 g) because you would most likely eat either amount of food at one meal.

### 3 CHOOSE

In this case, **Cracker B** would be a better choice if you are trying to eat less saturated and trans fats, less sodium and more fibre as part of a healthy lifestyle.

Use the Nutrition Facts table and *Eating Well with Canada's Food Guide* to make healthier food choices.

% DAILY VALUE healthycanadians.gc.ca/dailyvalue

## 4. Nutrition Coordinator Course

This is a self study course, offered on-line by the North West College, developed by the Public Health Nutritionists of Saskatchewan for people working primarily in school and daycare settings. It provides an understanding of basic nutrition, menu planning, budgeting, purchasing and food production. There are no prerequisites for this class.

For course information, visit www.northwestcollege.ca or telephone: 306-937-5100.

## 5. Food Safety

- Keep cold food cold and hot food hot to avoid bacteria growth that causes illness. Avoid the "temperature danger zone" which is between 4 and 60 degrees Celsius (40 and 140 degrees Fahrenheit). Bacteria will grow quickly between these temperatures. Your fridge must be set at 4 degrees Celsius or lower. Your freezer must be set at -18 Celsius or lower.
- Refrigerate leftovers within two hours. Speed cooling time by using shallow pans or ice baths (placing a container of food into a larger container of sink filled with ice), cutting items into small portions, portioning food into small containers, or stirring the food frequenty.
- Dishes and cutlery are to be washed, rinsed and sanitized. Using a dishwasher with a sanitizing cycle is the best method. If you wash your dishes by hand, wash the dishes in one sink, rinse under running water and sanitize in a second compartment or container that contains a mixture of chlorine bleach and water – 1 teaspoon (or 5 ml) bleach to 3 cups (or 740 ml) water.
- Wash fresh fruits and vegetables.
- Keep kitchen surfaces clean and sanitized.
- Prevent cross-contamination by using separate plates and utensils for raw and cooked meats and fish.
- Do not serve residents unpasteurized milk.
- Do not serve residents home-canned non-pickled meat or vegetables. Improperly processed canned meats and vegetables may cause food borne illness.
- You are encouraged to take a Safe Food Handling course offered by your local Public Health office.
- The Health Canada website provides numerous food safety tips at: www.hc-sc.qc.ca.

## 6. Protecting Yourself and Your Family from Salmonella

*(Taken from May 2010 factsheet produced by The Ministry of Saskatchewan Health)*

*Salmonella* is a bacteria that may cause a food borne illnesses called salmonellosis. Symptoms of salmonellosis include: diarrhea, fever, chills, nausea, vomiting, abdominal pain and headache starting six to 72 hours after exposure to a *Salmonella* contaminated product. The symptoms usually last four to seven days and most persons recover without any treatment. The elderly, infants, pregnant women and persons with impaired immune systems may experience more severe symptoms requiring medical treatment.

Persons may become infected with *Salmonella* bacteria by consuming food derived from infected animals or consuming food contaminated by feces of infected humans or animals. Food sources include contaminated raw/undercooked eggs or egg products, raw milk/milk products, contaminated water, meat/meat products, poultry/poultry products and contaminated produce.

Handling infected animals (including pets) and/or their environments may also lead to *Salmonella* infection. Domestic and wild animals, including poultry, swine, cattle, rodents and pets such as iguanas, tortoises, turtles, cats, dogs, hamsters and hedgehogs have been found to be implicated in salmonellosis cases.

Infected persons may transmit the infection to others (fecal-oral transmission) for several days to several weeks after the onset of symptoms.

Cases of salmonellosis are reported in Saskatchewan throughout the year; however, the number of cases usually increase during certain times of the year such as Thanksgiving and Christmas.

### Q. How can I protect myself and my family from salmonellosis?

Wash your hands or the hands of family members requiring assistance, after participating in any activity that results in contamination of the hands, e.g. handling live animals, their droppings or anything in an environment where the animals have been. If you are unable to wash your hands right away, use a hand sanitizer until you are able to wash your hands with soap and water.

Handle food safely:

- wash your hands before, during and after handling raw food;
- wash fresh fruit and vegetables before eating them;
- keep cold food cold at 4°C (40°F) or lower;
- keep hot food hot at 60°C (140°F) or higher;
- keep frozen food at -18°C (0°F) or lower;
- thaw food safely:
  - in the refrigerator at 4°C (40°F) or lower;
  - completely submerged in cold running water;
  - in a microwave oven only when the food will be immediately subjected to a cooking process; or
  - as part of the cooking process.

- when thawing raw meat, poultry or fish in a refrigerated unit, place the food in a container that will collect any liquids that may be produced as the product thaws. This container should be placed on the lowest shelf of the refrigerator to prevent the raw liquids from contaminating other foods below.
- after handling raw meat, poultry and fish, ensure all food contact surfaces are washed, rinsed and sanitized. A mild sanitizing solution can be made by adding 1 tsp (5ml) bleach to 3 cups (750 ml) water;
- never place cooked food on the same plate that was used for raw meat, poultry or fish;
- refrigerate leftovers within two hours. **Cooling time may be reduced by**:
  - using shallow pans or ice baths (placing the container of food in a larger container or sink filled with ice);
  - cutting large items into smaller portions;
  - proportioning large quantities of food into smaller containers; or
  - stirring the food frequently
- remove the stuffing from the poultry cavity.
- thoroughly cook meat, poultry and fish; using a probe thermometer ensure the following internal temperatures are reached:
  - 60°C (140°F) or above for rare beef steaks and roasts;
  - 63°C (145°F) or above for eggs (if prepared for immediate service); medium rare beef, lamb and veal steaks and roasts;
  - 68°C (155°F) or above for game farm meat products;
  - 70°C (158°F)or above for fish;
  - 71°C (160°F) or above for ground beef/pork/lamb/veal; food made with ground beef/pork/lamb/veal, e.g. sausages, meatballs; pork chops, ribs and roasts;
  - 74°C (165°F) or above for ground chicken/turkey; food made with ground chicken/turkey or mixtures containing poultry, meat, fish, or eggs; chicken and turkey breasts, legs, thighs and wings; stuffing (inside a carcass); stuffed pasta; hot dogs; leftovers; egg dishes (if not prepared as specified above); and stuffed fish; or
  - 82°C (180°F) or above for chicken and turkey, whole bird*.

    ** Insert the thermometer in the thickest part of the inner thigh or breast without touching the bone.*
- do not consume unpasteurized milk or milk products;
- avoid cross contamination – keep uncooked food products separate from ready-to-eat foods;
- use food before the “Best Before Dates”; and
- maintain your kitchen in a clean and hygienic manner free of insects or rodents.

**Q. Are there additional precautions I should take when handling turkeys?**

If you follow the safe food handling practices outlined above, you will prevent or minimize the risk of contracting salmonellosis and other food borne illnesses.

**Q. Are there additional precautions I should take when handling raw eggs?**

*Salmonella enteritidis* is a strain of *salmonella* bacteria frequently isolated in humans. In North America, studies have shown that eating raw eggs, cracked eggs or poorly washed eggs increases the risk of acquiring *Salmonella entertidas* infection.

To prevent illness or transmission of *Salmonella*, keep eggs refrigerated, cook eggs until yolks are firm, and thoroughly cook foods containing eggs. Consider using commercially pasteurized egg products for recipes such as eggs benedict, Caesar salad dressing and hollandaise sauce.

**Q. What precautions can I take when handling pets and frozen pet food?**

Not only can *Salmonella* infection be transmitted through animals, it can also be transmitted through pet food. Frozen baby mice are sometimes fed to pet lizards, snakes or other reptiles. These frozen mice may be contaminated with enteric bacteria and viruses. Children, the elderly, and individuals with immunodeficiency are particularly at risk for *Salmonella* infection. They should avoid handling the frozen rodents used as reptile food or the reptiles. It is recommended that children five years and under should not handle either reptiles or frozen rodents used as reptile food.

After handling reptiles or frozen rodents used as reptile food, individuals should thoroughly wash their hands with soap and water and use a disinfectant to thoroughly clean any surfaces that have been in contact with frozen rodents.

Be sure to wash your hands with warm, soapy water for 20 seconds before and after handling pet food (including frozen pet treats) and feeding dishes. Frequent and thorough hand washing keeps pet foods from being contaminated with bacteria and other microorganisms that may be present on our hands and prevents the spread of contamination from pet food to yourself or your family.

Pets such as dogs, cats, snakes, reptiles have bacteria in their mouths and these microbes can be spread to the pet food and water bowls. Clean pet food dishes and water bowls after every meal. If the food is left in the dish and not cleaned properly, it creates an ideal environment for bacteria to grow and spread to other pets and household members.

Moist food should be refrigerated promptly or discarded. Pet food and treats should be stored in dedicated containers in a cool dry location. Always wash and dry pet food storage containers before refilling them with new food.

**Q. What should I do if I have been exposed to possible sources of contamination such as live animals or frozen pet food and experience persistent or sever symptoms?**

Because many different illnesses cause the same symptoms as salmonellosis, the only way to diagnosis it is through laboratory tests on the stools of infected people. Further testing can be conducted to determine the appropriate antibiotic to use in treatment.

**Q. Are there precautions I should take while travelling?**

Every year thousands of Canadians travel to countries with poor sanitation where some travelers contract Salmonellosis or other illnesses. Laboratory confirmed cases of diarrheal illness in returning Canadian travelers reported to Public Health Agency of Canada (PHAC) have led to several international investigations. Safe travel information can be obtained from a travel clinic or visiting the PHAC's website: http://www.phac- aspc.gc.ca/tmp-pmv/well-way_bon-depart- eng.php.

For more information on this fact sheet, contact the health region office. http://www.saskatchewan.ca/residents/health/un derstanding-the-health-care-system/saskatchewan-health-regions/regional- public-health-inspectors

## SECTION 15: PHYSICAL ACTIVITY

1. Physical Activity Guidelines

2. For Adults 18 – 64 Years

3. For Adults 65 Years and Older

Refer to the Blue Cross website www.push2play.ca. While these activities are designed for children, some of the games may be adapted for adults.

***"It's a good feeling when you look in the mirror at night and are satisfied with who you are and what you have done with the day".***

# Canadian Physical Activity Guidelines

**FOR ADULTS -** 18 – 64 YEARS

## Guidelines

To achieve health benefits, adults aged 18-64 years should accumulate at least 150 minutes of moderate- to vigorous-intensity aerobic physical activity per week, in bouts of 10 minutes or more.

It is also beneficial to add muscle and bone strengthening activities using major muscle groups, at least 2 days per week.

More physical activity provides greater health benefits.

### Let's Talk Intensity!

Moderate-intensity physical activities will cause adults to sweat a little and to breathe harder. Activities like:

- Brisk walking
- Bike riding

Vigorous-intensity physical activities will cause adults to sweat and be 'out of breath'. Activities like:

- Jogging
- Cross-country skiing

### Being active for at least **150 minutes** per week can help reduce the risk of:

- Premature death
- Heart disease
- Stroke
- High blood pressure
- Certain types of cancer
- Type 2 diabetes
- Osteoporosis
- Overweight and obesity

And can lead to improved:

- Fitness
- Strength
- Mental health (morale and self–esteem)

### Pick a time. Pick a place. Make a plan and move more!

- ☑ Join a weekday community running or walking group.
- ☑ Go for a brisk walk around the block after dinner.
- ☑ Take a dance class after work.
- ☑ Bike or walk to work every day.
- ☑ Rake the lawn, and then offer to do the same for a neighbour.
- ☑ Train for and participate in a run or walk for charity!
- ☑ Take up a favourite sport again or try a new sport.
- ☑ Be active with the family on the weekend!

***Now is the time. Walk, run, or wheel, and embrace life.***

PARTICIPACTION

CSEP | SCPE
THE GOLD STANDARD IN EXERCISE SCIENCE AND PERSONAL TRAINING

www.csep.ca/guidelines

# Canadian Physical Activity Guidelines

## FOR OLDER ADULTS - 65 YEARS & OLDER

## Guidelines

To achieve health benefits, and improve functional abilities, adults aged 65 years and older should accumulate at least 150 minutes of moderate- to vigorous-intensity aerobic physical activity per week, in bouts of 10 minutes or more.

It is also beneficial to add muscle and bone strengthening activities using major muscle groups, at least 2 days per week.

Those with poor mobility should perform physical activities to enhance balance and prevent falls.

More physical activity provides greater health benefits.

### Let's Talk Intensity!

Moderate-intensity physical activities will cause older adults to sweat a little and to breathe harder. Activities like:

- Brisk walking
- Bicycling

Vigorous-intensity physical activities will cause older adults to sweat and be 'out of breath'. Activities like:

- Cross-country skiing
- Swimming

### Being active for at least **150 minutes** per week can help reduce the risk of:

- Chronic disease (such as high blood pressure and heart disease) and,
- Premature death

And also help to:

- Maintain functional independence
- Maintain mobility
- Improve fitness
- Improve or maintain body weight
- Maintain bone health and,
- Maintain mental health and feel better

### Pick a time. Pick a place. Make a plan and move more!

- ☑ Join a community urban poling or mall walking group.
- ☑ Go for a brisk walk around the block after lunch.
- ☑ Take a dance class in the afternoon.
- ☑ Train for and participate in a run or walk for charity!
- ☑ Take up a favourite sport again.
- ☑ Be active with the family! Plan to have "active reunions".
- ☑ Go for a nature hike on the weekend.
- ☑ Take the dog for a walk after dinner.

***Now is the time. Walk, run, or wheel, and embrace life.***

PARTICIPACTION

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www.csep.ca/guidelines

# Approved Private-service Home Agreement

**Confidential**

THIS AGREEMENT MADE in duplicate, the DD day of MONTH A.D. YYYY.

**BETWEEN:**

THE PROVINCE OF SASKATCHEWAN, as represented by the Minister of

Social Services or designate

(hereinafter referred to as ***"Ministry of Social Services"***)

**AND:** _____

(hereinafter referred to as the ***"Proprietor"***)

residing at _____

in the Province of Saskatchewan.

**WHEREAS:**

Further to Section 28(c) of *The Private-service Homes Regulations* pursuant to *The Residential Services Act*, the Proprietor agrees to:

i. Conduct the business of an Approved Private-service Home in a way that conforms to the information provided in The Approved Private-service Home Proprietor's Manual and *The Private-service Homes Regulations*;

ii. Maintain the home situation identified in the Home Study document completed as part of the initial certification process, recognizing that any significant changes will require the written consent of the Ministry of Social Services or could result in the termination of the Certificate of Approval;

iii. Notify the Ministry of Social Services of any changes in the Proprietor's home situation that differ from the home situation described in the Home Study document;

iv. Participate in the planning, implementation and review of all programs for residents who are receiving services in the Approved Private-service Home;

v. Consult the Ministry of Social Services prior to implementing any strategies that attempt to alter a resident's inappropriate behaviour;

vi. Not be, nor hold the Approved Private-service Home to be, an agent of The Government of Saskatchewan. The Minister of Social Services shall not be liable for any action taken or omitted by the Approved Private-service Home or its Proprietor.

Failure to comply with the above items (i, ii, iii, iv, v, or vi) by the Proprietor will constitute a breach of this Agreement which may cause the Ministry of Social Services to revoke or suspend the Certificate of Approval in accordance with Section 10 (a) and/or 10(b) of *The Residential Services Act*.

The Ministry of Social Services agrees to conduct business within the framework of Ministry standards and guidelines.

The designate of the Ministry of Social Services located at #205, 110 Ominica Street West, Moose Jaw, Saskatchewan, shall administer this Agreement.

This Approved Private-service Home Agreement shall remain in force as long as the Proprietor is in receipt of a current annual certificate from the Ministry of Social Services.

**SIGNED, SEALED, AND DELIVERED:**

| | | |
|---|---|---|
| Minister or Designate | Witness | Date |
| Applicant | Witness | Date |
| Applicant | Witness | Date |

## SECTION 17: LEGISLATION

1. The Private-service Homes Regulations
2. The Residential Services Act

# *The Private-service Homes Regulations*

*being*

Chapter R-21.2 Reg 2 as amended by
Saskatchewan Regulation 75/88.

**NOTE:**

**This consolidation is not official. Amendments have been incorporated for convenience of reference and the original statutes and regulations should be consulted for all purposes of interpretation and application of the law. In order to preserve the integrity of the original statutes and regulations, errors that may have appeared are reproduced in this consolidation.**

# Table of Contents

# CHAPTER R-21.2 REG 2

*The Residential Services Act*

## TITLE AND INTERPRETATION

**Title**

**1** These regulations may be cited as *The Private-service Homes Regulations*.

**Interpretation**

**2** In these regulations:

(a) **"Act"** means *The Residential Services Act*;

(b) **"approved private-service home"** means a private-service home in respect of which a valid and subsisting certificate of approval is issued;

(c) **"Fire Commissioner"** means Fire Commissioner as defined in *The Fire Prevention Act, 1980*;

(d) **"local assistant to the Fire Commissioner"** means local assistant as defined in *The Fire Prevention Act, 1980*;

(e) **"proprietor"** means a person who operates an approved private-service home.

21 Mar 86 cR-21.2 Reg 2 s2.

## CERTIFICATE OF APPROVAL

**Eligibility**

**3** To be eligible for a certificate of approval, each applicant shall submit to the department:

(a) a letter from the medical health officer, as defined in *The Health Services Act*, for the area stating that the private-service home meets required health standards;

(b) a letter of approval from the local assistant to the Fire Commission advising that the structure, equipment and maintenance of the private-service home are satisfactory;

(c) a description of the type of program that the private-service home is to offer, including the mechanisms available to ensure visiting privileges and security and privacy of the residents; and

(d) a floor plan of the entire home specifying what bedrooms are to be used by the residents and what bedrooms are to be used by the applicant and his family.

21 Mar 86 cR-21.2 Reg 2 s3.

**Inspection required**

**4** No certificate of approval is to be issued to a private-service home until an officer of the department has conducted a physical standards inspection and a program standards inspection and has indicated to the department that the home meets the standards prescribed in these regulations.

21 Mar 86 cR-21.2 Reg 2 s4.

**Duty to provide information**

**5** The proprietor shall supply the minister with any information that he may require.

21 Mar 86 cR-21.2 Reg 2 s5.

**Form of certificate of approval**

**6** Every certificate of approval issued is to state:

(a) the name and location of the private-service home;

(b) the rated bed capacity of the private-service home; and

(c) any other matter the minister considers advisable.

21 Mar 86 cR-21.2 Reg 2 s6.

**Renewal**

**7** When a person wishes to renew a certificate of approval, he shall submit the material specified in section 3 three months prior to the date that the current certificate of approval expires.

21 Mar 86 cR-21.2 Reg 2 s7.

**Termination**

**8** A certificate of approval terminates immediately:

(a) on any change in the location or ownership of the private-service home; or

(b) on any significant change in the program, as outlined in the initial application for the certificate, offered in the private-service home, unless notice of the intended change has been submitted to the minister and his prior written approval for the change has been given.

21 Mar 86 cR-21.2 Reg 2 s8.

**Inspections**

**9**(1) An officer of the department shall visit and inspect, at least annually, every private-service home to determine whether the home is continuing to comply with the Act and these regulations and shall furnish the minister with a report of his findings.

(2) Every private-service home is subject to:

(a) an annual inspection by the local assistant to the Fire Commissioner; and

(b) a health inspection on the request of an officer of the department.

21 Mar 86 cR-21.2 Reg 2 s9.

## STANDARDS

**Required designated areas**

**10** The areas of the private-service home designated in the application for a certificate of approval as areas for lounging, dining, indoor recreation, sleeping, bathing, food preparation and storage are to be used only for those purposes unless otherwise approved by the minister.

21 Mar 86 cR-21.2 Reg 2 s10.

**Sleeping accommodation**

**11** Each approved private-service home is to provide sleeping accommodation for its residents as follows:

(a) each bedroom floor is to be not more than 1.22 metres below the level of the ground surrounding the main or ground floor level;

(b) no basement is to be used for sleeping accommodation unless, in the opinion of the local fire and health departments, it does not constitute a fire or health hazard;

(c) each bedroom is to have a minimum of seven square metres per resident or, where more than one resident is accommodated in a bedroom, 4.6 square metres per resident;

(d) each resident is to have his own bed of a size and type suitable to his age, with a clean mattress and with bedding appropriate to the weather conditions and climate;

(e) not more than two adults or four children are to be accommodated in one bedroom;

(f) if any resident has serious difficulty negotiating stairways, he is not to be placed in a bedroom above or below the ground floor level;

(g) each bedroom is to have at least one mirror, at least one outside window that may be opened for fresh air and adequate ventilation, lighting and heating.

21 Mar 86 cR-21.2 Reg 2 s11.

**Bedroom furnishing**

**12** Each approved private-service home is to provide each resident, in his bedroom, with:

(a) a clothes closet or wardrobe space, individual drawer space and at least one chair;

(b) space to store personal items such as dentifrices, cosmetics, towels and soap; and

(c) furnishings of reasonable quality as compared with the standards of other housing accommodation in the community, which quality is not to differ greatly from the other furnishings in the home.

21 Mar 86 cR-21.2 Reg 2 s12.

**Washing facilities**

**13**(1) Subject to subsection (2), each approved private-service home is to have at least:

(a) one wash basin with hot and cold water and one flush toilet for every five residents or fraction thereof; and

(b) one bath tub, or shower, with hot and cold water for every 10 residents, including the members of the family, and any other people who live in the home, or fraction thereof.

(2) Subsection (1) does not apply in any case where the approved private-service home is a farm house or is located in northern Saskatchewan and alternative toilet and bathing accommodation is available to the resident.

21 Mar 86 cR-21.2 Reg 2 s13.

**Number of residents**

**14** The number of residents in any approved private-service home is not to exceed the rated bed capacity of the home as approved at the time the certificate of approval is issued.

21 Mar 86 cR-21.2 Reg 2 s14.

**Smoke alarm system**

**15** Each approved private-service home is to be equipped, on each level of the facility, with a smoke alarm that is:

(a) of a type approved by the Fire Commissioner; and

(b) interconnected with all other smoke alarms in the facility.

23 Sep 88 SR 75/88 s3.

**Exits**

**16** All exit doors in the approved private-service home are to be equipped only with hardware that does not require special knowledge to unlock the door from the inside.

21 Mar 86 cR-21.2 Reg 2 s16; 23 Sep 88 SR 75/88 s4.

**Safety equipment**

**17** Each approved private-service home is to provide night-lights, non-skid stair treads, non-skid bath mats and handrails on stairways or in bathrooms if, in the opinion of the minister, they are required for the safety of the residents.

21 Mar 86 cR-21.2 Reg 2 s17.

**Meals**

**18**(1) Each approved private-service home is to provide residents with a nutritionally balanced diet, as set out in the *Canada Food Guide*, to be served in a family-type eating space appropriate to the residents' program.

(2) All food is to be properly refrigerated.

21 Mar 86 cR-21.2 Reg 2 s18.

**Day-room**

**19** Each approved private-service home is to have a day-room for lounging of not less than 13.5 square metres with approximately 1.86 square metres of floor space per person who resides in the home where the residents may play table games, watch television and enjoy a social life.

21 Mar 86 cR-21.2 Reg 2 s19.

**Study space**

**20** Each approved private-service home that provides a program of study is to provide adequate facilities for the purposes of study by the residents involved in the program.

21 Mar 86 cR-21.2 Reg 2 s20.

**Yard**

**21** Each approved private-service home is to provide some outside yard or lawn space with appropriate seating.

21 Mar 86 cR-21.2 Reg 2 s21.

**Accessibility**

**22** Any approved private-service home that accommodates residents who are physically handicapped is to have elements built into the home to allow entrance to and egress from the living areas, buildings and grounds by those residents.

21 Mar 86 cR-21.2 Reg 2 s22.

## SERVICE TO RESIDENTS

**Admission**

**23**(1) Before a person to whom or in respect of whom the department is providing financial assistance is admitted to an approved private-service home, the proprietor shall obtain the approval of the minister for that admission.

(2) On receipt of a request pursuant to subsection (1), the officer or other person, as the case may be, shall determine whether the proprietor is capable of providing the necessary lodging, supervision, personal care or individual programming that the resident requires.

21 Mar 86 cR-21.2 Reg 2 s23.

**Change in resident's condition**

**24**(1) The proprietor shall notify the minister of any negative change in the mental, physical or behavioural condition of any resident of the approved private-service home.

(2) Within 30 days of notification pursuant to subsection (1), the minister shall make an assessment of the resident's condition and, if it is determined that:

(a) the proprietor is no longer capable of providing the necessary lodging, supervision, personal care or individual programming to the residents; or

(b) the home no longer meets the needs of its residents;

arrangements may be made for the residents to be transferred to a place that is able to meet their needs.

21 Mar 86 cR-21.2 Reg 2 s24.

**Infectious diseases**

**25** The proprietor shall, when he finds or suspects any person who lives in the home to be suffering from an infectious or communicable disease, immediately notify the minister.

21 Mar 86 cR-21.2 Reg 2 s25.

**Absent proprietor**

**26** Prior to the proprietor absenting himself from the approved private-service home, he shall consult the minister so that alternate arrangements can be assessed.

21 Mar 86 cR-21.2 Reg 2 s26.

**Removal of resident**

**27** When the proprietor wishes to permanently remove a resident or his trustee from the approved private-service home, he shall give the resident one month's written notice of his intention.

21 Mar 86 cR-21.2 Reg 2 s27.

## DUTIES OF PROPRIETORS

**Agreement**

**28** The minister may require any proprietor to enter into an agreement respecting the following activities:

(a) the duties of the proprietor with respect to his providing supervision, personal care or individual programming of the resident;

(b) the records that the proprietor shall keep of the individual programming for each resident; and

(c) any other terms respecting the standards for the granting of a certificate of approval.

21 Mar 86 cR-21.2 Reg 2 s28.

**Personal records of residents**

**29** The proprietor shall cause all records of residents to be kept in locked containers and only the proprietor, the person to whom the record relates or his agent, and persons authorized by the minister are to have access to those records.

21 Mar 86 cR-21.2 Reg 2 s29.

**Medical treatment**

**30** With respect to the treatment of any injury to any resident, the proprietor shall provide only emergency first-aid and, in all cases of serious illness or injury to any resident, the operator shall, as soon as possible, cause:

(a) a physician to be called; and

(b) the parent, guardian or next of kin of the resident to be notified.

21 Mar 86 cR-21.2 Reg 2 s30.

**Medication**

**31**(1) Subject to section 30, the proprietor shall ensure that all medication and medical treatment is to be given to residents only as authorized by a physician.

(2) Each proprietor is to provide a lockable medicine cabinet in which medications are to be locked when not in use.

21 Mar 86 cR-21.2 Reg 2 s31.

## GENERAL

**Inspection of approved private-service homes**

**32** Each proprietor shall ensure that his approved private-service home is open at all reasonable times for inspection and examination by:

(a) any public health official; or

(b) any representative of the Fire Commissioner;

who may inspect the home and make any inquiries about the home and its proprietor as he may consider necessary for the purposes of these regulations.

21 Mar 86 cR-21.2 Reg 2 s32.

**Proprietor to operate one home**

**33** A proprietor may operate only one approved private-service home at a time.

21 Mar 86 cR-21.2 Reg 2 s33.

**Return of certificate**

**34** On the revocation of a certificate of approval or a certificate of approval otherwise becoming invalid, the proprietor shall, on the request of the minister, return the certificate of approval to the minister.

21 Mar 86 cR-21.2 Reg 2 s34.

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# *The Residential Services Act*

*being*

Chapter R-21.2* of the *Statutes of Saskatchewan, 1984-85-86* (effective June 19, 1985) as amended by the *Statutes of Saskatchewan*, 1986, c.5; 1989-90, c.8; 1996, c.28; 1997, c.47; 2000, c.50; 2002, c.R-8.2; and 2017, c.P-30.3.

***NOTE:** Pursuant to subsection 33(1) of *The Interpretation Act, 1995*, the Consequential Amendment sections, schedules and/or tables within this Act have been removed. Upon coming into force, the consequential amendments contained in those sections became part of the enactment(s) that they amend, and have thereby been incorporated into the corresponding Acts. Please refer to the Separate Chapter to obtain consequential amendment details and specifics.

# Table of Contents

# CHAPTER R-21.2

## An Act respecting Facilities that Provide Certain Residential Services

### TITLE AND INTERPRETATION

**Short title**

1 This Act may be cited as *The Residential Services Act*.

**Interpretation**

2 In this Act:

(a) "**certificate of approval**" means a certificate issued pursuant to section 6;

(b) "**department**" means the department over which the minister presides;

(c) "**licence**" means a licence issued pursuant to section 6;

(d) "**minister**" means the member of the Executive Council to whom for the time being the administration of this Act is assigned;

(e) "**private-service home**" means an unincorporated facility that provides lodging, supervision, personal care or individual programming to residents in need of such services;

(f) "**program**" means a plan of individual intervention or provision of safe shelter and appropriate counselling to residents in need;

(g) "**resident**" means a person who resides in a residential-service facility or in a private-service home;

(h) "**residential-service facility**" means a facility incorporated pursuant to *The Non-profit Corporations Act*, *The Co-operatives Act* or a private Act of the Legislature that provides lodging, supervision, personal care or individual programming for persons who:

(i) by reason of need, age or disability or for any other reason are unable to care fully for themselves;

(ii) require safe shelter and counselling appropriate to their circumstances; or

(iii) where a corporation, other than a co-operative, conducts or operates the facility, are not members of the management of the facility;

but does not include day-care centres, approved homes as defined in *The Mental Health Act*, facilities designated as special-care homes pursuant to *The Provincial Health Authority Act*, or other homes or facilities under the jurisdiction of any other department or agency of the Government of Saskatchewan.

1984-85-86, c.R-21.2, s.2; 1989-90, c.8, s.2; 2002, c.R-8.2, s.122; 2017, cP-30.3, s.11-1.

## LICENSING

**Licence, certificate required**

3(1) No person shall conduct or operate or hold himself out as conducting or operating a residential-service facility for the care and accommodation of three or more persons unless he holds a valid and subsisting licence.

(2) No person shall conduct or operate or hold himself out as conducting or operating an approved private-service home for the care or accommodation of or individual programming for five or less persons unless he holds a valid and subsisting certificate of approval.

1984-85-86, c.R-21.2, s.3; 1989-90, c.8, s.2.

**Prohibition**

4 No person other than a person who holds a valid and subsisting licence or certificate of approval shall hold himself out as conducting or operating a residential-service facility or an approved private-service home.

1984-85-86, c.R-21.2, s.4.

**Form of application**

5 Every application for a licence or a certificate of approval is to be made to the minister on a form provided by the department.

1984-85-86, c.R-21.2, s.5.

**Issuance of licence, certificate**

6(1) On receipt of an application for a licence or a certificate of approval, the minister may issue a licence or certificate of approval if he is satisfied that:

(a) there is a need for the operation of a residential-service facility or private-service home of the kind mentioned in the application;

(b) the residential-service facility or private-service home will be of benefit to persons who may be resident in that facility;

(c) the operation of that residential-service facility or private-service home is in the public interest; and

(d) the applicant for a licence or a certificate of approval and the residential-service facility or private-service home in respect of which the application is made meet all the requirements of the regulations in respect of the licence or certificate of approval applied for.

(2) A licence or certificate of approval may be issued for a period of up to one year.

1984-85-86, c.R-21.2, s.6.

**Conditional licence, certificate**

7(1) Subject to subsection (2), the minister may issue a conditional licence or a conditional certificate of approval to any residential-service facility or private-service home that does not comply with any provision of this Act or the regulations for a period not exceeding six months to allow that facility or home time to comply with that provision.

(2) No conditional licence or conditional certificate of approval is to be issued pursuant to subsection (1) where the immediate health and safety of the residents of the residential-service facility or private-service home are at risk because of the non-compliance with this Act or the regulations.

1984-85, c.R-21.2, s.7.

**Fee**

8 The fee payable for a licence or certificate of approval is the amount prescribed in the regulations.

1984-85-86, c.R-21.2, s.8.

**Display of licence, certificate**

9 Every person who holds a licence or certificate of approval shall display that licence or certificate, to the satisfaction of the minister, in a conspicuous place on the premises in respect of which the licence or certificate is issued.

1984-85-86, c.R-21.2, s.9.

**Revocation or suspension**

10 The minister may revoke or suspend a licence or certificate of approval where:

(a) the licensee of the residential-service facility or the proprietor of the private-service home or any employee or agent of the licensee or proprietor contravenes any provision of this Act or the regulations; or

(b) in the opinion of the minister, the premises in respect of which the licence or certificate of approval is issued have become unsuitable for use as a residential-service facility or private-service home.

1984-85-86, c.R-21.2, s.10.

## ENFORCEMENT

**Inspection**

11 Every residential-service facility or private-service home in respect of which a licence or certificate of approval is issued is to be open at all reasonable times to visitation and inspection by any person authorized in writing by the minister and that person may:

(a) examine any part of the premises;

(b) call for and examine all records relating to the operation of the facility or home; and

(c) make any inquiry with respect to any matter pertaining to the facility or home that he considers necessary or advisable.

1984-85-86, c.R-21.2, s.11.

**Officers**

12 The minister may appoint members of the staff of the department to be officers for the purpose of enforcing this Act and the regulations.

1984-85-86, c.R-21.2, s.12.

## TAXATION

**Exemption from taxation**

13 Where a residential-service facility is operated in accordance with this Act and is operated by a municipal, church or charitable organization or a non-profit corporation, the real property and buildings in respect of that residential-service facility are exempt from taxation, except local improvement taxes and special charges.

1984-85-86, c.R-21.2, s.13.

## OFFENCES AND PENALTY

**Obstruction**

14 No person shall prevent or obstruct or attempt to prevent or obstruct entry and inspection by any person authorized under this Act.

1984-85-86, c.R-21.2, s.14.

**Provision of information**

15 No person shall refuse to furnish information required to be furnished under this Act or furnish any false information respecting the purpose for which any premises are used.

1984-85-86, c.R-21.2, s.15.

**Operator's prohibition**

16 No person who operates a residential-service facility or an approved private-service home or has an interest in the operation of a residential-service facility or an approved private-service home shall, without the consent of the minister, bring an indigent person, or cause an indigent person to be brought, into Saskatchewan or encourage, by advertisement or otherwise, the entry of any indigent person into Saskatchewan.

1984-85-86, c.R-21.2, s.16.

**Penalty**

17 Every person who contravenes any provision of this Act or the regulations is guilty of an offence and liable on summary conviction to a fine of not more than $200.

1984-85-86, c.R-21.2, s.17.

**Injunction, etc.**

18 Where the minister reasonably believes that a person is acting or is about to act in contravention of section 3 or 4, that act may, in addition to any other penalty provided for, be restrained by action in Her Majesty's Court of Queen's Bench for Saskatchewan at the instance of the minister, and the court may grant an injunction, interim injunction or any other relief that it considers just.

1984-85-86, c.R-21.2, s.18.

## GENERAL

**Exemption**

19 The minister may, where he considers it to be in the public interest, exempt any residential-service facility or private-service home, in whole or in part, from the operation of any provision of this Act or the regulations.

1984-85-86, c.R-21.2, s.19.

**Powers of minister**

20(1) The minister may:

(a) subject to subsection (2), make grants to any person, corporation, organization or other body for the purpose of assisting in the purchase, construction or maintenance of any residential-service facility; and

(b) enter into agreements with any person, agency, organization, association, institution or body inside or outside Saskatchewan for the provision of any services or facilities with respect to persons who by reason of need, age, disability or otherwise are unable to care for themselves fully or who require safe shelter and counselling services, including agreements by which the minister is obligated to make payments.

(2) The minister shall obtain the approval of the Lieutenant Governor in Council before making any grant pursuant to clause (1)(a) that is in excess of $50,000.

(3) The minister may:

(a) plan, develop, supervise or operate any residential-service facility; and

(b) require any residential-service facility or approved private-service home to enter into an agreement with him respecting, subject to any regulations:

(i) the services and programs to be provided by the facility or home;

(ii) the maximum number of residents of the facility or home;

(iii) the use of grant money or fees paid by or on behalf of residents who receive financial assistance from the department; and

(iv) the manner in which the facility or home will be accountable for the terms of the agreement.

1984-85-86, c.R-21.2, s.20; 1996, c.28, s.16; 1997, c.47, s.2.

21 **Repealed.** 2000, c.50, s.23.

**Appropriation**

22 Sums required for the purposes of this Act are to be paid out of moneys appropriated by the Legislature for the purpose.

1984-85-86, c.R-21.2, s.22.

**Regulations**

23 For the purpose of carrying out this Act according to its intent, the Lieutenant Governor in Council may make regulations:

(a) governing the conditions under which grants may be made under this Act, the amount of those grants and the manner of making application for those grants;

(b) governing the construction, operation and maintenance of residential-service facilities or private-service homes;

(c) governing the licensing and inspection of residential-service facilities and the standards and rules of admittance to them;

(d) governing the approval and inspection of private-service homes and the standards and rules of admittance to them;

(e) defining the types of services that are to be available to residents and prescribing the maximum number of residents that may be accommodated or cared for in each type of service;

(f) respecting charges to be made by any person for accommodation or care provided to residents;

(g) governing the type of program that is to be offered in the residential-service facilities or approved private-service homes;

(h) prescribing the standards with respect to:

(i) buildings to be used as residential-service facilities or approved private-service homes;

(ii) the safeguarding of the health of residents; and

(iii) the general care of residents;

(i) prescribing the conditions that every person seeking admission to a residential-service facility or an approved private-service home is to comply with;

(j) prescribing the books and records to be kept and the reports to be submitted by every person who holds a licence or certificate of approval;

(k) providing for any other matter or thing required or authorized by this Act to be prescribed in the regulations.

1984-85-86, c.R-21.2, s.23; 1986, c.5, s.12.

**Transitional; continuance of certain licences and certificates**

24(1) A licence issued pursuant to *The Housing and Special-care Homes Act* or a certificate of approval issued pursuant to *The Mental Health Act* continues to be valid from December 31, 1985 for a period not exceeding 12 months to enable the facilities or homes affected by this Act to qualify for licensing or approval pursuant to this Act.

(2) Notwithstanding clause 2(h), where a licence was issued pursuant to *The Housing and Special-care Homes Act* prior to January 1, 1982 and since that date to individuals operating a privately-owned home, the home does not have to meet the requirement of being incorporated unless there is a change in ownership of that home after the date the regulations made pursuant to this Act come into force.

1984-85-86, c.R-21.2, s.24.

25 **Dispensed.** This section makes consequential amendments to another Act. The amendments have been incorporated into the corresponding Act.

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## SECTION 18: DEFINITIONS

***"I enjoy the feeling of being appreciated".***

| | |
|---|---|
| Abuse | See: Abuse Policy Section |
| Activities of Daily Living | Activities that include eating, bathing, dressing, grooming and participating in social and recreational activities. |
| ADHD | Attention Deficit Hyperactivity Disorder |
| APSH Agreement (Service Agreement) | A written agreement between you and the Ministry of Social Services signed when your home is approved. |
| Assessment | The determination of a resident's capabilities and support/care needs. |
| Authorized capacity | The maximum number of residents permitted to be in an APSH as stated on the certificate. |
| Bubble Pack (Blister Pack) | A card with individual punch-out "bubble" sections which contain pills that must be administered to the resident at the prescribed times. |
| CBO | Community-based Organization |
| Certificate | The document you receive from the Ministry of Social Services that authorizes you to operate an Approved Private-service Home. |
| Certification Process | The process you go through to obtain an APSH certificate. |
| Community Living Service Delivery (CLSD) | A branch of the Income Assistance and Disability Services (IADS) Division of the Ministry of Social Services |
| Condition | A requirement that you must meet in order to receive and maintain an APSH certificate. |
| Diagnosis | The identification of the nature of an illness or other problem by examination of symptoms. |
| Daily Living Support Assessment (DLSA) | An assessment tool for determining the levels of support required by a resident. |

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| Dual Diagnosis | Refers to the presence of more than one distinct disorder. When used in reference to somebody with an intellectual disability, it most often means that the person has both the intellectual disability and a co-occurring mental health disorder. |
| Fire Code | Standards for fire safety pursuant to: the National Building Code of Canada; the National Fire Code of Canada; the *Uniform Building and Accessibility Standards Act*; and, the Saskatchewan Fire Code Regulations. |
| Fire Inspector | A person that is approved by the Provincial, Regional or Municipal Fire Departments to conduct fire inspections. |
| Health Care Professional | A person who has been educated, trained and licensed in a particular field of health care and who has the right to call themselves a member of the profession and to practice what they have learned. |
| Home Review | An annual visit for certification purposes and/or a process to review problems in the home. |
| Office of the Public Guardian and Trustee | An appointed representative of the Government of Saskatchewan who administers the funds for an individual who is declared mentally incompetent and unable to manage their own finances. |
| Person-centred Plan (PCP) | The plan of co-ordinated supports that assist the resident to realize his or her goals, dreams and aspirations to enhance his or her development and quality of life. |
| Proprietor | The person certified to operate an APSH. |
| Reassessment (DLSA) | A review of a resident's abilities and care needs done after an initial assessment. |
| Resident | An individual placed in an APSH by the Ministry of Social Services. |
| SACL | Saskatchewan Association for Community Living |
| SAPH Inc. | Saskatchewan Approved Private Homes Inc. |
| SARC | Saskatchewan Association of Rehabilitation Centres |
| Trustee | Someone who manages the financial affairs of another person. |

## SECTION 19: DIRECTORY

***"I prop my residents up until they can reach out and grasp all they can from life".***

### Community Living Service Delivery Offices:

#### Northeast Region

**PRINCE ALBERT OFFICE**
McIntosh Building
7th Floor, 800 Central Avenue
Prince Albert, SK S6V 6G1
Telephone: (306) 953-2668
Toll Free: 1-866-719-6164

Melfort – (306) 752-6288
Nipawin – (306) 862-1704
La Ronge – (306) 425-4357

#### Southeast Region

**YORKTON OFFICE**
72 Smith Street East
Yorkton, SK S3N 2Y4
Telephone: (306) 786-1300
Toll Free: 1-877-786-3280

Estevan – (306) 637-4550
Weyburn – (306) 848-2421

#### Northwest Region

**NORTH BATTLEFORD OFFICE**
122 – 1146 102nd Street
North Battleford, SK S9A 1E9
Telephone – (306) 446-7929
Toll Free – 1-877-993-9911

Meadow Lake – (306) 236-7501
Lloydminster – (306) 825-6468

#### Southwest Region

**REGINA OFFICE**
5th Floor – 2045 Broad Street
Regina, SK S4P 3T7
Telepone – (306) 787-3848

**MOOSE JAW OFFICE**
1st Floor – 36 Athabasca Street West
Moose Jaw, SK S6H 6V2
Telephone – (306) 694-3800

Swift Current – (306) 778-8219

#### Centre Region

**SASKATOON OFFICE**
122 3rd Avenue North
Saskatoon, SK S7K 2H6
Telephone – (306) 933-6300
Rosetown – (306) 882-5400

## General Resources Directory:

| | |
|---|---|
| Aboriginal Affairs & Northern Development Canada (AANDC) Regional Office (Saskatchewan)<br>Phone: 1-800-567-9604<br>*www.aandc-aandc.gc.ca* | Contact AANDC to inquire about your resident's treaty number if he/she is a Status Indian.<br>If your resident receives funding from Aboriginal Affairs, please contact your CSW before calling AANDC to discuss funding issues. |
| Alzheimer Society of Saskatchewan Inc.<br>Phone: 1-800-263-3367<br>*www.alzheimer.ca/saskatchewan* | The Provincial Alzheimer Society provides support to people living with Alzheimer's disease, their care providers, families, and friends. |
| Camp Easter Seal - Watcous c/o Saskatchewan Abilities Council - Saskatoon<br>Phone: 1-306-653-1694<br>*www.abilifiescouncil.sk.ca* | Many camps are designed for people with intellectual disabilities, physical disabilities, and for those who have medical needs such as diabetes, hemophilia, cystic fibrosis, or are on dialysis. It is open to people from age six to adult. |
| Camp Thunderbird - Candle Lake c/o Valley View Centre, Moose Jaw<br>Phone: 1-306-694-3115 | This camp provides adults with intellectual disabilities an opportunity to enjoy camping and outdoor pursuits (nature hikes, bus rides, fishing, cookouts, tent outings, campfires, sing-a-longs, and featured special events). |
| Canada Pension Plan/Old Age Security<br>Phone: 1-800-277-9914<br>*www.servicecanada.gc.ca* | Contact this federal government agency to apply for your resident's Old Age Security funds. You should complete the application before your resident reaches the age of 65. Please contact your resident's CSW for further assistance. |
| GST Refunds<br>Canada Revenue Agency<br>Phone: 1-800-959-1953<br>*www.cra.gc.ca* | Residents who receive financial assistance are entitled to receive a GST refund. For more information please contact Canada Revenue Agency. |
| Healthline<br>Phone: 1-877-800-0002<br>*www.health.gov.sk.ca/healthllne* | Healthline is a free, confidential 24-hour health advice telephone line, staffed by registered nurses. Healthltne is NOT for emergency situations. |
| Health Registration Branch<br>Phone: 1-800-667-7551<br>*www.health.gov.sk.ca* | Contact this provincial government branch to change information (address) on your resident's health card or to apply for a health card. |

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| Hearing Aid Plan<br><br>Phone: Please refer to the white pages of your phone book. | Hearing assessments, hearing aid fittings, hearing aid repairs, and in service upon request.<br><br>There are mobile clinics located in several rural communities and regional offices In urban centres. |
| Health Canada<br><br>First Nations & Inuit Health Branch - Non-Insured Health Benefits<br><br>Phone: 1-306-780-5449<br>*www.hc-sc.gc.ca* | Contact this unit to ensure your resident's medical needs and medications will be covered under their present health coverage. |
| Information Services Corporation (Vital Statistics)<br><br>Phone: 1-866-275-4721<br>*www.isc.ca/vitalstats* | Birth, death, and marriage certificates, and name changes. |
| Legal Aid<br><br>Phone: 1-877-424-1902<br>*www.justice.gov.sk.ca* | Legal Aid handles only criminal (depending on the severity of the offence) and family matters (divorce, maintenance, custody, separation, etc.). Legal Aid does not handle civil cases (lawsuits). A person's level of income is a factor in determining whether or not an individual will qualify for the services of a Legal Aid lawyer. |
| Office of the Public Guardian and Trustee – Regina<br><br>Phone: 1-306-787-5424<br>*www.justice.gov.sk.ca/pgt/* | The Public Trustee administers the property of individuals who are declared legally incompetent to handle their own finances. They are responsible for the funds from estates, insurance policies, gifts, old age supplements, and the Saskatchewan Assistance Plan. |
| Paraplegia Program<br>Phone: 1-888-345-0850<br><br>*www.health.gov.sk.ca/aids-speclal-benefit-program* | Patients must be referred by a specialist in rehabilitation medicine for benefits such as incontinence management, dressing supplies, specialized rehabilitation equipment, financial assistance for ramps, wheelchair lifts and vehicle hand controls. |
| Prescription Drug Plan<br><br>Phone: 1-800-667-7581<br>*www.health.gov.sk.ca* | Contact the provincial Drug Plan to ensure your resident's medications are covered under his/her present health coverage. |
| Saskatchewan Aids to Independent Living (SAIL)<br><br>Phone: 1-888-345-0850<br>*www.health.gov.sk.ca/aids-special-benefit-prosaphgram* | This program provides benefits for people with long-term disabilities. The program is designed to assist people in leading more independent and active life styles. |

| | |
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| Saskatchewan Approved Private Homes Inc. (SAPH Inc.)<br><br>Phone: Please refer to your local association for the current phone number or ask your CSW.<br>*www.saph.ca* | Saskatchewan Approved Private Homes Inc. is an association of APSH proprietors who meet regularly to discuss and share information about homes, regulations, fees, government amendments, etc. |
| Saskatchewan Association for Community LiVing (SACL)<br><br>Phone:<br>1-306-790-5680 (Regina)<br>1-306-955-3344 (Saskatoon)<br>1-306-763-5605 (Prince Albert)<br>*www.sacl.org* | This agency provides a variety of services including advocacy and educational services. They have an excellent library on various topics such as autism, sexuality, and human rights. |
| Saskatchewan Drug Information Services<br><br>Phone: 1-800-665-3784<br>*www.druginfo/ask.ca* | This service promotes responsible use of medications and supplements information and advice provided by physicians and pharmacists.<br><br>Staff are available to answer questions about prescription and over-the-counter drugs as well as herbal products. |
| Saskatchewan Deaf and Hard of Hearing Services<br><br>Phone:<br>1-800-667-6575 (Saskatoon)<br>1-800-565-3323 (Regina)<br>*www.sdhhs.com* | This agency promotes independence by providing services to enhance quality of life. They provide vocational and personal counseling, and a hearihg aid battery discount program. |
| Special Olympics<br><br>Phone:<br>1-888-307-6226 (Provincial)<br>1-306-780-9247 (Provincial)<br>*www.specialolympics.sk.ca* | Special Olympics provides a variety of sports for people with intellectual and physical disabilities. Fees vary with each sport. |
| Supplementary Health Program for Social Assistance Recipients<br><br>(Plan Coverage Information)<br>Phone: 1-800-266-0695<br>*www.health.gov.sk.ca/low-income-support* | Residents who receive social assistance may be eligible for special health coverage through this program. |

## SECTION 20: FORMS

***"Families are the people we trust to be there for us in both joy and sorrow".***

1. Individual Information Sheet

2 . Incident Report

3. APSH Respite Subsidy Reimbursement

4. Forms for Resident Files:

   - APSH Client Profile
   - APSH Individual Information Sheet
   - APSH Progress Notes
   - APSH Medical Records
   - APSH Emergency Management Plan
   - APSH Family Contacts
   - APSH Financial Accounting Record

# Individual Information Sheet

Approved Private-service Home Program

**Confidential**

**NAME:** _____

**ADDRESS:** _____

**BIRTH DATE**: _____

**PHN:** _____

**TREATY NUMBER:** _____

**BANK:** _____ **BRANCH:** _____ **ACCOUNT #:** _____

***Family Contact:***

Name: Address: Telephone:

_____

_____

_____

***Day Program:***

Contact Person:

Name: _____

Address: _____

Telephone: _____

***Medical Information:***

Diagnosis:

Allergies:

Medications:

***Family Doctor:***

Name: _____

Address: _____

Telephone: _____ After Hours Number: _____

***Dentist Doctor:***

Name: _____

Address: _____

Telephone: _____ After Hours Number: _____

## Individual Information Sheet

**Confidential**

***Optometrist:***

Name: _____

Address: _____

Telephone: _____ After Hours Number: _____

***Community Living Service Delivery Contact Person:*** _____

***Community Living Service Delivery Emergency Contact Protocol:*** _____

_____

***Other Important Information:*** _____

_____

_____

# Incident Report

*Purpose: This form is to be used to record objective information regarding violent and/or abusive behavior(s).*

**GENERAL:**

Resident's Name:_____ Proprietor's Name:_____

Date: (d/m/y) _____ Time of Incident: _____ am/pm

**BEHAVIOR:**

Duration of Behavior(s):_____ Location of Incident: _____

Severity of Behavior(s):

| | | | | |
|---|---|---|---|---|
| **5** (severe - needed to call the police) | **4** | **3** | **2** | **1** (mild - handled incident on own) |

Type of Behavior(s): *(circle all that apply)*

| | | |
|---|---|---|
| bitten self/others | shouted/yelled/screamed | slammed doors |
| destroyed objects/property | kicked walls/doors/objects | threatening gestures |
| kicked others | thrown objects | spat |
| paced | pushed | scratched |
| struck | | |

Other behaviors: (*specify)*

_____



Saskatchewan

**DETAILS OF INCIDENT:**

What was taking place just prior to the incident:

Describe the actual incident:

Who was Present:

What was the cause for the incident: (*include medical and/or non medical reason)*

Describe the follow up or action taken:

Signature: _____ Signature _____

APSH Proprietor CLSD CSW

# Respite Subsidy Reimbursement

Community Living Service Delivery (CLSD)
Approved Private-service Home

**PLEASE SUBMIT COMPLETED FORM TO COMMUNITY SERVICES WORKER**

| | |
|---|---|
| **APSH Proprietor** (print full name of APSH Proprietor): | |
| **Mailing Address:** | **City:** |
| **Postal Code:** | **Telephone:** |

| | | |
|---|---|---|
| **Client Name** | **# of Days of Respite** | **Dates:** |
| **Client Name** | **# of Days of Respite** | **Dates:** |
| **Client Name** | **# of Days of Respite** | **Dates:** |
| **Client Name** | **# of Days of Respite** | **Dates:** |
| **Client Name** | **# of Days of Respite** | **Dates:** |
| **Name of Respite Provider** | **First Name** | **Last Name** |

**Total Days** _____ **X $30.00 per day = TOTAL INVOICE AMOUNT $**_____

**Phone Number of Respite Provider** (_____) _____ - _____ **Signature of Provider:** _____

**I hereby certify that the above is a correct and true statement and that expenditures were incurred for the provision of respite services.**

**Date:** _____ _____
**Signature of APSH Proprietor**

**Verified by:**

_____ **Date:** _____
**Signature of Community Services**

**Worker Approved by:**

_____ **Date:** _____
**Signature of Supervisor**

| **For Office Use Only** | | | | | | |
|---|---|---|---|---|---|---|
| **Supplier #** | | **Supplier Site** | | **Goods Rec'd date** | | |
| **Invoice #** | | | **Invoice Date** | | **Invoice Rec'd date** | |
| **Entity** | **Program** | **Org** | **Natural Account** | **Location** | **Project** | **AMOUNT** |
| 036 | 68139 | 261400 | 570090 | | 000000 | |
| | | | | | | |
| **Description:** | | | | | **Total** | |

Certified Correct: _____



Saskatchewan

# Client Profile

Confidential

Approved Private-service Home Program

## CLIENT PROFILE FOR INDIVIDUALS REFERRED TO COMMUNITY RESIDENTIAL RESOURCES

**PERSONAL INFORMATION:** Date: _____

1. Name: _____
2. Date of Birth: _____ Birth Place: _____
3. Social Insurance Number: _____
4. Personal Hospitalization Number: _____
5. Treaty Number: _____
6. Racial Origin: _____
7. Religious Affiliation: _____
8. Languages Spoken: _____
9. Marital Status: _____
10. Regional Community Services Worker: _____ Ph#: _____
11. Next-of-kin: _____
12. Family Involvement: (frequency and type of contact): _____
13. Program Involvement:

Name: _____

Address: _____

Contact Person: _____

Hours of Work: _____ Type of Transportation: _____

14. Personal Program in Place: ☐ Yes ☐ No

Review Date: _____

15. Has *Daily Living Support Assessment* been completed? _____ Date: _____

**Brief History:** (Include diagnosis, brief description of issues such as placement history/difficulties/medical/behavioural problems relevant to the specific individual's care needs.)

Where did individual last reside? _____

Reason for move? _____

_____

**SOCIAL SKILLS AND INTERPERSONAL RELATIONSHIPS:**

1. How does the individual interact with others in:
   a. One-to-one situations?

   b. A group situation?

2. Describe individual's personality, general attitude and motivation.

3. Describe individual's ability to express feelings/emotions.

4. How does individual perceive him/herself?

5. What social or recreational activities is the individual involved in (with others and independently)? Does he/she require encouragement to become involved? Does he/she require transportation?

6. What are other interests and hobbies?

**COMMUNICATION**

1. Languages: (Please check)
   a. Spoken ☐ American Sign Language ☐ Amerind ☐
   b. Understood: English ☐ French ☐ Cree ☐ Other ☐ _____

2. Comment on the individual's ability to communicate. Does he/she:
   a. Initiate conversations?
   b. Make needs known verbally?
   c. Respond appropriately?
   d. Speak clearly?
   e. Ability to read?
   f. Ability to write?

**SPIRITUAL:**

1. Does he/she attend church services? Explain frequency, transportation arrangements:

2. Is he/she involved in programs/activities of spiritual nature? Explain:

3. Does he/she currently receive or desire to have visits from clergy, elder?

**SMOKING**

1. If the individual smokes or uses snuff, specify and comment on the schedule/amount.

_____

2. Is he/she responsible with matches/lighter? _____
3. Does he/she require supervision while smoking? _____
4. Does individual use alcohol or drugs? _____

If yes . . . How often? _____

List other information. _____

_____

**FINANCIAL STATUS:**

1. What are this individual's sources of income?

☐ Independent
☐ Indian & Northern Affairs Canada
☐ Saskatchewan Assistance Program Case Worker: _____
☐ Public Guardian and Trustee of Saskatchewan
☐ Child Care

2. Is the Office Public Guardian and Trustee of Saskatchewan involved? If yes:

Name: _____ Phone: _____

Address: _____

3. Payment:
Maintenance: _____ Transportation: _____ Clothing: _____
Comforts: _____ Special Needs: _____

Payment Total: _____

4. a. Does the individual have the concept of the value of money? Yes ☐ No ☐

b. Comment on his/her budgeting skills.

c. Comment on the amount of money the individual is capable of handling on a daily or weekly basis.

**5.** Individual presently uses:

Name of Bank: _____ Name of Branch: _____ Account #: _____

Comment on the amount of assistance required, if he/she is not independent in this area.

Comments:

**WORK**

1. Describe past employment.

2. Describe present work situation.

3. Is the individual employed competitively in the community? If so, provide description of same.

☐ Yes ☐ No

Comments:

**EDUCATION**

1. Discuss any educational program he/she has been involved in.

2. Does the individual have any short and/or long term educational goals?

3. What are the individual's short and long term plans?

**MENTAL/EMOTIONAL/PSYCHOLOGICAL STATUS**

1. Provide a brief psychiatric history of individual including **all** psychiatric diagnosis.

2. Is the individual oriented to:

Time ☐ Person ☐ Place ☐

Explain:

3. Does he/she appear to experience confusion or disorientation at particular times or under particular situations?

Explain:

4. Is his/her judgment adequate for personal safety?

5. Does the individual appear to experience psychiatric symptoms such as:

a. Delusions? _____ If so, what is the content or nature?

Do the delusions interfere with or influence any aspect of daily functioning?

Explain:

What interventions are effective in assisting individual to deal with his/her delusions?

b. Hallucinations? _____ If so, what is the nature of these symptoms?

Do the hallucinations interfere with or influence any aspect of daily functioning?

Explain:

6. Describe other psychiatric symptoms that are evident.

7. Does the individual have insight into his/her disability?

8. Comment on the individual's:
   a. Problem solving ability.
   b. Short and long term memory.
   c. Ability to concentrate and follow through on tasks.

9. What are "stressful" situations for this individual?

10. How does he/she react to stressful situations?

11. a. Does the individual display any unusual, inappropriate or impulsive behaviours?

    Explain:

    b. Comment on interventions/strategies that are utilized to deal with these.

12. a. Does the individual currently display any inappropriate sexual or verbal or physical aggressive behaviour?

    ☐ Yes ☐ No

    Explain:

    b. Comment on any particular situations that appear to trigger aggressive episodes or inappropriate behaviours.

    c. What strategies/interventions are effective in minimizing and/or dealing with aggressive or inappropriate behaviours?

13. List Psychological Assessments/Interventions.

**ACTIVITIES OF DAILY LIVING:**

Is the individual independent/dependent in carrying out the following activities of daily living? Please indicate by checking the appropriate response: Independent, Requires Assistance, Requires Prompting, Currently Not Doing. Please comment on the specific type of assistance required.

| | Independent | Requires Assistance | Requires Prompting | Currently Not Doing |
|---|---|---|---|---|
| 1. Personal hygiene/grooming: | | | | |
| a) shampooing hair | | | | |
| b) combing hair | | | | |
| c) brushing teeth | | | | |
| d) shaving face/legs, etc. | | | | |
| e) use of deodorant | | | | |
| f) menstrual care | | | | |
| g) cutting toe/finger nails | | | | |
| h) dressing/undressing | | | | |
| i) wardrobe coordination | | | | |
| j) appropriate dress for climate/season | | | | |
| Comments: | | | | |

| | Independent | Requires Assistance | Requires Prompting | Currently Not Doing |
|---|---|---|---|---|
| 2. Meals and related skills: | | | | |
| a) eating and drinking assistance | | | | |
| b) table setting | | | | |
| c) after-meal cleanup | | | | |
| d) menu planning | | | | |
| e) grocery shopping | | | | |
| f) dining skills | | | | |
| Further explain the above if needed: | | | | |

| | Independent | Requires Assistance | Requires Prompting | Currently Not Doing |
|---|---|---|---|---|
| 3. Homemaking: | | | | |
| a) use of appliances | | | | |
| b) cleaning/maintenance of appliances | | | | |
| c) bed making | | | | |
| d) sweeping/mopping | | | | |
| e) scrubbing floors | | | | |
| f) dusting | | | | |
| g) doing laundry | | | | |
| h) ironing | | | | |
| i) cleaning bathroom | | | | |
| j) care of personal living space | | | | |
| k) care of clothing | | | | |
| Further explain the above if needed: | | | | |

| | Independent | Requires Assistance | Requires Prompting | Currently Not Doing |
|---|---|---|---|---|
| 4. Transportation: | | | | |
| a) public transportation | | | | |
| b) special transportation | | | | |
| c) driving ability | | | | |
| d) traffic safety inside & outside of vehicle, i.e.: seat belt, walking across street | | | | |
| Further explain the above if needed: | | | | |

| | Independent | Requires Assistance | Requires Prompting | Currently Not Doing |
|---|---|---|---|---|
| 5. Other skills: | | | | |
| a) using telephone | | | | |
| b) knowledge of emergency procedures | | | | |
| c) ability to tell time | | | | |
| d) shopping | | | | |
| Further explain the above if needed: | | | | |

6. What is the individual's bathing schedule?

7. Bowel and bladder control:

   (a) Is the individual continent of urine? ☐ Yes ☐ No

   (b) Is the individual continent of bowel? ☐ Yes ☐ No
   Please describe kinds of laxatives used and frequency, if required:

   (c) What is his/her toileting schedule?

   (d) Explain assistance needed?

   (e) Does he/she have a catheter or use Attends? ☐ Yes ☐ No
   Explain:

   (f) What is individual's usual bowel pattern?

8. Nutrition

   (a) Is individual able to feed self? ☐ Yes ☐ No
   Explain assistance required.

   (b) Must individual be supervised while eating?

   (c) Present diet:

   (d) Known food likes/dislikes:

   (e) Any known food allergies/intolerances or any dietary restrictions.

**MEDICAL PERSONNEL**

Physician:
Name: _____ Phone: _____
Address: _____
Dates: Last visit: _____ Next visit: _____
Results: _____
_____
Any current doctor's orders that may be relevant? _____
Date of last complete physical? _____ Results _____
_____

Dentist:
Name: _____ Phone: _____
Address: _____
Dates: Last visit: _____ Next visit: _____
Results: _____
_____
Does individual wear dentures ☐ Yes ☐ No
If yes: name of Denturist: _____

Optometrist:
Name: _____ Phone: _____
Address: _____
Dates: Last visit: _____ Next visit: _____
Results: _____
_____
Does he/she wear glasses ☐ Yes ☐ No
Does he/she have glasses ☐ Yes ☐ No

Psychiatrist:
Name: _____ Phone: _____
Address: _____
Dates: Last visit: _____ Next visit: _____
Results: _____
_____

Other Medical Personnel:
Name: _____ Phone: _____
Address: _____
Dates: Last visit: _____ Next visit: _____
Results: _____
_____

Program Development Consultant Involvement: ☐ Yes ☐ No
Name: _____ Phone: _____
Address: _____

Other: (i.e.) physio/occupation therapy
Name: _____ Phone: _____
Address: _____

**MEDICATIONS** (drug, dosage, when taken and why)

1. List all medications the individual is currently taking and whether regular blood work is required.

Is blood work required? ☐ Yes ☐ No If yes, how often?

2. Comment on recent medication changes and/or particular medications that have been found to be very beneficial and/or ineffective for individual.

**AMBULATION**

1. Is the individual independent in walking?

2. Indicate any aides that are used to assist with ambulation, with explanation if needed.

3. Does the individual wander?

4. Has the individual ever utilized the services of a chiropodist? ☐ Yes ☐ No

If yes, date of last appointment:

What foot care did he/she receive at that time?

**SLEEP AND REST**

Does individual:

1. Require nighttime medication to sleep? ☐ Yes ☐ No
2. Sleep through the night? ☐ Yes ☐ No
If no, explain:
3. Have rest periods during the day? ☐ Yes ☐ No
4. What is his/her usual bedtime?

**PHYSICAL**

1. Individual's height _____, current weight: _____.
2. List active physical problems.

Epilepsy ☐ Yes ☐ No Describe type and frequency:

Diabetes ☐ Yes ☐ No

Other:

3. List any allergies.

4. Past illnesses, hospitalizations and surgery (date, location)

5. Does individual have a communicable disease?

6. Is there a hearing impairment? If yes, to what extent: mild-severe.

a. Does he/she wear a hearing aid? ☐ Yes ☐ No
b. Can he/she wear a hearing aid? ☐ Yes ☐ No ☐ Unknown
c. Can he/she care for a hearing aid? ☐ Yes ☐ No ☐ Unknown
d. Date of last hearing examination, (if known) and by whom?

Findings of examination:

7. Authorization for consent for medical treatment:

Name: _____

Relationship: _____ Phone: _____

Address: _____

8. Information Source: File: _____ Other: _____

The information has been collected in good faith by the Community Services worker. It must be acknowledged that there are some aspects of the individual's life and support needs that may not be known by the Community Living Service Delivery staff.

_____
Community Services Worker
Community Living Service Delivery

_____
Caregiver

_____
Other

Date: _____

# Individual Information Sheet

Approved Private-service Home Program

**Confidential**

**NAME:** _____

**ADDRESS:** _____

**BIRTH DATE**: _____

**PHN:** _____

**TREATY NUMBER:** _____

**BANK:** _____ **BRANCH:** _____ **ACCOUNT #:** _____

***Family Contact:***

Name: Address: Telephone:

_____

_____

_____

***Day Program:***

Contact Person:

Name: _____

Address: _____

Telephone: _____

***Medical Information:***

Diagnosis:

Allergies:

Medications:

***Family Doctor:***

Name: _____

Address: _____

Telephone: _____ After Hours Number: _____

***Dentist Doctor:***

Name: _____

Address: _____

Telephone: _____ After Hours Number: _____

## Individual Information Sheet

**Confidential**

***Optometrist:***

Name: _____

Address: _____

Telephone: _____ After Hours Number: _____

***Community Living Service Delivery Contact Person:*** _____

***Community Living Service Delivery Emergency Contact Protocol:*** _____

_____

***Other Important Information:*** _____

_____

_____

# Progress Notes

Aproved Private-service Home Program

**Confidential**

**Approved Private-service Home Proprietor:** _____

**Resident:** _____

| DATE | INFORMATION/INCIDENT |
|---|---|
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# Medical Records

Approved Private-service Home Program

**Confidential**

**NAME:** _____

**APSH PROPRIETOR:** _____

| DATE | MEDICAL PERSONNEL | RESULTS OF APPOINTMENT |
|---|---|---|
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# Emergency Management Plan

Approved Private-service Home Program

**Confidential**

**PARTICIPANT NAME:** _____

**DATE OF PROCEDURE:** _____

**Operational Definition of Dangerous Behaviour:**

_____

_____

_____

**Antecedent Conditions:**

_____

_____

_____

**Participant Behavioural Warning Signs:**

_____

_____

_____

**Adapted Emergency Management Plan Techniques (in order from less to more involved or intrusive): Include name of technique and how you would use it.**

_____

_____

_____

_____

_____

# Family Contacts

Approved Private-service Home Program

**Confidential**

**NAME:** _____

**APSH PROPRIETOR:** _____

| DATE | WITH WHOM | TYPE OF CONTACT & RESULTS (Phone call, visit, etc.) |
|---|---|---|
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# Financial Accounting Record

Approved Private-service Home Program

**Confidential**

**NAME:** _____

**BANK:** _____ **BRANCH:** _____ **ACCOUNT #:** _____

**APSH PROPRIETOR:** _____

| DATE | DESCRIPTION | CREDIT | DEBIT | BALANCE |
|---|---|---|---|---|
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