
Leading Practice Guidelines

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Final Draft

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Accessibility:

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Preamble

These guidelines have been developed to outline the current consensus on leading practice in service delivery. The expected outcomes should these guidelines be pursued by organizations:

- Increased quality of services
- Better consistency of services
- Better outcomes for people
- Shared vision and road map for service delivery
- Competent, stable, confident workforce
- Increased confidence in services

These guidelines rely upon the following principles and values:

- People are respected and treated with dignity;
- People belong, contribute and are included within their neighbourhood, communities and workplace;
- People exercise rights and responsibilities as outlined in current human rights code, law or convention;
- People receive responsive, timely personalized support;
- People have the supports to achieve overall wellbeing and fulfill their potential;
- People are seen, heard, known and valued;
- Families and support networks are valued and respected;
- People have choice & control and design lives of their choosing;
- People have the material and social capital to pursue and achieve their dreams and goals;
- People receive quality services defined and directed by the person that enables full inclusion and citizenship;
- People enjoy continuity and stability of services and supports.

Throughout this document, 'guideline' is used as a collective term to describe both the outcomes and the statements which sets out the systems and practices that should be present within organizations.

Not every guideline will apply to every service depending upon if the organization provides temporary or ongoing supports, residential, clinical, respite, or employment supports, etc.

The "What Does This Look Like" section explains what achieving the guideline looks like in practice.

These guidelines do not replace or remove the need to comply with other legislation, regulations, codes and policy which sets out requirements for the provision of services. Organizations should continue to follow existing legislative requirements and best practice guidance which applies to their particular service or sector, in addition to striving to provide services in alignment with these guidelines. The guidelines should be used to complement the relevant legislation and best practice to support organizations to ensure high quality care and continuous improvement.

Each guideline covers common elements in each outcome area. In order to provide high quality services and to deepen practice in any particular area, an organization must consider:

- **Expectations & Commitment** Do they have a statement of commitment and expectation that clearly outlines what they expect in their systems and practices?
- **Communication & Information** Have they given the required knowledge and tools to all stakeholders including people served, their families and support networks and staff?
- **Practice & Follow through** Is there a practice of follow through on stated expectations throughout the organization?
- **Measurement & Monitoring** Do they have a system of monitoring and measuring whether they are having the impact that was desired?

Please note: The guidelines are recommendations for practice. They do not stipulate or propose a single correct approach for delivering services or managing all situations. Decisions regarding specific services, support or clinical approaches require individualized considerations that are the ultimate shared responsibility of people served, their families and support network, service providers and professional health care providers. Leading practice guidelines can change over time as we learn and grow and thus will require ongoing attention and revision.

Definitions

Advance Care Planning - The process of dialog, knowledge sharing, and informed decision-making that needs to occur at any time when future or potential end-of-life treatment options and preferences are being considered or re-visited. The primary goal of Advance Care Planning is to seek consensus on care plans that reflect the best interests of the person.

Advance Care Plan - The form used to record medical intervention decisions reached through the Advance Care Planning discussions.

Behaviour support: A set of interventions developed to support people with challenging behaviour. These behavioural strategies are designed to improve an individual's quality of life, are functionally based and are integrated with person-centred planning. (Definitions from Community Living B.C. (CLBC) Behaviour Support and Safety Planning Policy, May 2012)

Behaviour support plan: An individualized, written document developed to support individuals who have challenging behaviour. It outlines specific behaviour support interventions, strategies and implementation requirements. It is a tool for all support networks to be consistent in the strategies they are using when dealing with challenging behaviour. (Definitions from Community Living B.C. (CLBC) Behaviour Support and Safety Planning Policy, May 2012)

Challenging behaviours include:

- **Difficult or Unconstructive Behaviour:** Impedes community acceptance or interferes with other behaviours and remains unchanged over time. It impedes community inclusion.
- **Serious Behaviours:** Interfere with learning and daily activities and the behaviours are likely to become severe if they are not addressed. Serious behaviours greatly concerns family members, support network members or staff. This behaviour may prevent individuals from participating in community activities.
- **Critical Behaviour or Unsafe Behaviour:** Is of such intensity, frequency, or duration that the physical safety of the individual or others is likely to be placed in serious jeopardy. (Definitions from Community Living B.C. (CLBC) Behaviour Support and Safety Planning Policy, May 2012)

Community Living disABILITY Services (CLDS) - services offered by the Province of Manitoba, Department of Families. More information can be found at <https://www.gov.mb.ca/fs/CLDS/index.html>

Crisis situation is defined as a circumstance where:

- Challenging behaviour places the person at immediate risk of harming himself or others or of causing property damage;
- Attempts to deescalate the situation have been ineffective; or
- The behaviour is new or unprecedented in its intensity such that the Behavior Support Plan (BSP) does not effectively address it.

Culture - is a word for the way different groups of people do things. Different groups may have different cultures. A culture is passed on to the next generation by teaching and modeling. People express their culture in the way they write, talk, dress or interact with others. Specific cultures have different music, cooking or religion.

Delegation of Function - is the extension of authority by a nurse or other regulated professional to an unregulated care provider who does not have the authority to perform the task as an assignment through their scope of employment.

Employment is defined as:

- Activity that is compensated at not less than provincial minimum and not less than the customary rate paid by the employer for the same or similar work performed by other individuals without disabilities;
- Occurs at an integrated location where the employee interacts with other persons who do not have disabilities to the same extent as others working the same or similar positions;
- Where the person receives the same benefits provided to other employees without disabilities in the same or similar positions;
- Presented, as appropriate, with opportunities for advancement that are similar to those offered to other employees who have similar positions

Family - Family is a word that can have many different meanings. People have many ways of defining a family and what being a part of a family means to them. For the purposes of these guidelines, family refers to people that the person supported acknowledges as being part of their family. When that is not known, it refers to people who are biologically or legally related to the person.

Functional Behavioural Assessment: An assessment that seeks to describe the behaviour, the environmental factors and setting events that predict the behaviour, and the function that the behaviour serves. Functions of behaviour may include communication, getting something, or avoiding something.

Health Care Directive

A self –initiated document that allows individuals to make health care preferences known in the event that they are unable to express them. In Manitoba, a Health Care Directive may indicate the type and degree of health care interventions the person prefers and/or may indicate the name(s) of a person(s) who has been delegated to make decisions (i.e. a "Proxy").

Home - refers to an emotional connection to a space. This space could be any dwelling where someone makes a home. The word home refers to more than a simple building and acknowledges that it is a place of warmth, comfort and sanctuary that goes beyond simple shelter.

Identity - refers to the way one understands or thinks about themselves. People may think about themselves in relation to their culture, religion, family connections, ethnicity, gender, sexuality, economic status, etc.

Intimate Personal Care –defined as activities of care of an intimate nature, associated with bodily functions and personal hygiene, which require direct or indirect contact with, or exposure of, the sexual parts of the body such as assistance with bathing, toileting, or dressing, etc.

Normalization - means making available to people with disabilities the same patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life.

Organization - service provider or agency which is funded through Community Living disABILITY Services (CLDS).

Over the Counter Medications - refer to those medications that can be purchased and used without prescription. These include such items as cough syrup, ibuprofen, etc.

People - typically when the term people or person is used, we are referring to people who receive services. Others are labeled as per their role such as staff, care providers, family, friends, support network member, etc.

Physical restraint is a holding technique, used by a person on another person, that restricts the latter's ability to move freely.

Psychotropic Medications - A psychotropic medication is any medication that alters the chemicals in the brain and consequently impacts a person's emotions and behaviours.

Psychotropic medications treat a variety of psychiatric conditions including depression, bipolar disorder, anxiety disorders, attention-deficit/hyperactivity disorder (ADHD), and psychosis.

Safety Plan: An individualized, written document designed to address situations where unsafe behaviour has the potential to harm the individual or those around them. The safety plan outlines the strategies and procedures to respond to the behaviours and reduce risk. Safety plans should only be developed as an adjunct to or in conjunction with an overarching Behaviour Support Plan.

(Definitions from Community Living B.C. (CLBC) Behaviour Support and Safety Planning Policy, May 2012)

Spirituality - refers to a variety of activities and experiences that have deeply personal meaning to someone and often involves a sense of connection to something bigger than oneself. Christina Puchalski, MD, Director of the George Washington Institute for Spirituality and Health defines spirituality as "the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred."

Staff - where the word staff is used in this document it includes all staff employed or contracted by a service provider (direct support, supervisory, management, administrative, executive). For the purposes of this document this would include foster providers and/or people contracted to provide a home share, employment or job coaches, clinical consultants, etc.

Substitute Decision Maker

A third party identified to participate in decision making on behalf of a person who lacks decision making capacity under the Vulnerable Persons Act. The task of a Substitute Decision Maker is to faithfully represent the known preferences and/or the interests of the person.

Support Network is defined to include the individual's family, friends and other natural supports, circle of support, or others chosen by the individual. An individual's support network includes involved family members and others as directed by the person.

While the following **Core Practice Guidelines** address areas of sound business practice, they are not meant to be an exhaustive and comprehensive resource regarding excellence in business operations.

For the purposes of these guidelines, we have focused solely on organizational or management processes and behaviours that are imperative specifically to best practice in supporting people funded through CLDS as opposed to the activities and standards that would be common to all organizations and businesses.

It is assumed that at minimum, organizations comply with any and all legal or legislative requirements, regulations, contractual obligations, rights of the person served, ethical business conduct, and fair, non-discriminatory employment practices.

Outcome Area: Core Practices

Governance & Management Practices

Guideline:

Mission, vision, & values for the organization have been identified and are used to guide decision making and the work of the organization.

The organization has a Board of Directors that is diverse and includes people who receive services and family representatives.

Management systems and core policies are defined, documented, communicated & monitored.

People receiving services and their families play meaningful leadership and decision making roles within the organization.

The organization regularly undertakes strategic planning to ensure that its mission and the expectations of people who receive services are translated into a plan of action that is shared and monitored.

What does this look like?

The organization has a mission, vision and values that promotes and maximizes personal outcomes, reflects leading practice, and is regularly reviewed. While each organization's mission, vision and values will be unique, the content should:

- Promote and enhance a positive, strength based image of people served;
- Shape services and supports around the needs, wishes and desires of people served and their communities;
- Reflect a social model of disability. This means we seek to change societal barriers to promote citizenship as opposed to changing people with disabilities;
- Protect, promote and enable people's rights, responsibilities and citizenship.

The organization has a Board of Director or governance structure that is:

- Accountable, ethical and transparent;
- Diverse and representative with expertise and perspectives in a variety of areas;
- Open, positive, and constructive;
- Free from conflict of interest;
- Concerned with the stability and continuity of services;
- Orientated and informed;

- Regularly updated on financial, human resources, service delivery, and legal issues.

The organization's management systems are clearly documented and defined, communicated and shared with staff and stakeholder. Organizational structure and processes promote continuity and succession planning and are monitored regularly to ensure that they function in the manner in which they are expected to.

Opportunity and support is provided to people served and their families to engage and participate in decision making and leadership forums within the organization. This may include (but is not limited to) participation on the Board of Directors, involvement with policy development and input into strategic planning.

Core policies and structures are in place to ensure the ethical, effective and efficient operation of the organization. These include (but are not limited to):

- Conflict of interest
- Ethical codes of conduct
- Prohibition of & reporting of wrongdoing
- Whistleblower policy
- Selection, structure, orientation and evaluation of the board of directors and its members
- Ethical research practices
- Confidentiality
- Communications/social media
- Fundraising

Strategic planning is undertaken regularly, involves people served and is shaped by their expectations. It takes into account financial and political realities, based on risk assessment and analysis of quality measurement results. The finished plan should be shared, communicated, measured and evaluated towards progress.

How would you know this is happening? (Evidence)

What you see in systems:

The organization's mission, vision and values is documented and widely shared. These use positive, rights-based language that enhance the image, outcomes and inclusion of people served.

Key policies, structures and systems are documented, communicated and monitored.

The organization has a strategic plan that is based on feedback from people served and other key stakeholders.

Members of the Board of Directors reflect major stakeholders and have a diversity of perspectives, background and expertise.

What you see in actions:

People receiving services and their families serve on committees, groups and forums within the organization in which they are able to shape and provide feedback on the operation of the organization.

People served, families and staff are aware of and speak positively about the governance and leadership structures in the organization.

Resources to support achieving guideline:

What's Worth Working For - John O'Brien - <http://thechp.syr.edu/wp-content/uploads/2013/10/whatsw.pdf>

Citizenship for all - accessible guide - Simon Duffy & Wendy Perez
<https://www.centreforwelfarereform.org/uploads/attachment/419/citizenship-for-all-an-accessible-guide.pdf>

Five Accomplishments - John O'Brien & Connie Lyle O'Brien
https://www.inclusionwa.org.au/download/O'Brien_Five_Accomplishments.pdf

Imagine Canada - Sector Source - <http://sectorsource.ca/>

Related Guidelines

- Quality Improvement
- Risk Management
- Financial Management
- Human Resources
- Supporting Choice and Control
- Informed Consent and Decision Making
- Supporting Inclusion & Community Participation

Outcome Area: Core Practices

Accessing, Using & Exiting Services

Guideline:

The organization has a transparent, timely and responsive process that people can use to access, use and exit services. This process, while consistent, is flexible enough to be shaped by the unique needs, wishes and circumstances of the person requiring services and their support network.

What does this look like?

The organization has a documented process that sets out the scope of service options, eligibility, and how prioritizing or access is determined. Key aspects of this process are:

- Information about the process to access services is readily available to people and their families in a format accessible to them.
- Service options are fully explained to people requesting service. Any limits or conditions of service, fees or costs, and how long they may have to wait are outlined. Information is shared in a manner and format that is both accessible and easily understood.
- Access to services is provided based on relative need and available resources.
- Possible timelines for responses and stages of the process are outlined.
- Service options and target population are shaped by the skills and expertise the organization possesses.
- The process outlines if wait lists are maintained and how they are managed.
- Service options are offered and delivered based upon information gathered from the person and their support network. Information is sought to better understand the person and their circumstances and includes information about their needs, strengths, risks, interests, wants, goals and scope of service requested. Collection is done in a culturally sensitive manner that takes into account the person's communication style and method.
- The organization has systems and staff with skills in place to determine what resources or services are required to meet the person's needs.

- The service provider actively advocates for service options that best meet the person's needs.
- Service planning is then shaped and directed by the person to the extent possible.
- Upon commencement of service, the organization ensures that people are told about their rights and responsibilities as a recipient of services as well as what they can expect from the organization. Input and information about funding and how resources will be used and/or allocated are provided.
- Identifies that if the organization cannot serve a person, they will immediately notify the person and help them to find another option.
- People living in a home are informed of the possibility of a new roommate and given the chance to meet them in advance of any move. Information is shared about the potential roommate, balancing the rights of privacy with the desire to choose whom they live with.
- People enjoy the security and continuity of home and/or supports and are not required to leave against their wishes unless there are compelling reasons. Each person is consulted in advance of any move and has access to an advocate if they wish to object.
- There is a clear process and transition plan for those exiting services. The organization collaborates with other organizations to support the transition and to meet the person's needs (as guided or consent to by the person).
- Information is provided on how to re-access services.
- If an individual is asked to leave the organization, they provide robust notice periods and make every effort to link the person with appropriate services.

Staff who are responsible for these processes are trained and knowledgeable about how to discover, collect and match people's goals and preference with available resources and supports.

How would you know this is happening? (Evidence)

What you see in systems:

An accessible document is available for those seeking services that explains how to access services and what to expect throughout that process.

Information is collected and used to make decisions about accessing and planning services.

Information is prepared and shared upon discharge to assist future service providers to support the person successfully (with the person's consent).

What you see in actions:

People or families seeking services receive clear information that helps them navigate the process.

People understand all possible options that they could access and are involved in all stages of service planning.

People are informed of changes that impact their services or home.

Resources to support achieving guideline:

Sample Intake Policy - [insert link when uploaded]

Sample Discharge Policy - [insert link when uploaded]

Sample Guide to Services - [insert link when uploaded]

Related Guidelines:

Informed Consent & Supported Decision Making

Person Centred Planning

Support Plan Documentation

Home

Outcome Area: Core Practices

Quality Measurement & Improvement

Guideline:

The organization has a commitment to continuous improvement that is evident by a system of soliciting feedback from key stakeholders, monitoring of key processes, outcomes and data, and analysis of what was learned leading to action. This system is shaped by the needs and expectations of people served.

What does this look like?

The organization has a quality measurement & improvement system that emphasizes the involvement, feedback and participation of people served, as well as family, friends, and advocates in monitoring and reviewing services and supports. Key features of this system are:

- Focuses on outcomes for people who use services and supports;
- Monitors its performance and learns from its mistakes;
- Indicators that monitor progress are established and used to assess whether organizational objectives are being met;
- Is communicated and shared with all levels of staff in the organization, people served and their support networks;
- Encourages continuous improvement;
- Decisions about quality improvement and priorities are based on feedback, data and evidence;
- Feedback is solicited from people who leave the organization;
- Includes a system of audits of key processes that are done regularly;
- Strives to meaningfully involve those people served that do not communicate in traditional ways.
- Data collection and monitoring should address:
 - Personal outcomes of people served
 - Financial
 - Risk management
 - Incident and accident review
 - Human resources
 - Technology
 - Health and safety
 - Strategic planning
 - Complaints and grievances

- Accessibility
- Demand for services

How would you know this is happening? (Evidence)

What you see in systems:

Documented quality and data systems are available that demonstrate measurement of impact of service on people along with key organizational systems.

Evidence of feedback systems are available showing that people served and their support networks are regularly engaged to help measure quality.

What you see in actions:

Staff, people receiving services and their families are aware of how quality is measured in the organization. They feel involved and valued as part of this process.

Resources to support achieving the guideline:

Sample Quality Improvement Program & Policy - [insert link when uploaded]

Accountability - CQL - Quality in Practice Guides - <https://www.c-q-l.org/resource-library/publications/cql-publications-for-free/quality-in-practice-guides/accountability>

Data Systems - CQL - Quality in Practice Guides - <https://www.c-q-l.org/resource-library/publications/cql-publications-for-free/quality-in-practice-guides/data-system>

Quality Enhancement Plan - CQL - Quality in Practice Guides - <https://www.c-q-l.org/resource-library/publications/cql-publications-for-free/quality-in-practice-guides/quality-enhancement-plan>

Related guidelines:

Risk Management

Supporting Choice & Control

Outcome Area: Core Practices

Human Resources

Guideline:

People receiving services have the opportunity and support to provide meaningful input into the hiring, training and performance feedback of their staff.

The organization seeks screens and hires staff that have the values, attitudes and skills to provide safe, respectful and personalized supports.

Staff possess and maintain the knowledge, skills and experience required to fulfill their roles. This includes information about the unique support needs and preferences of each person that they are responsible for supporting.

Staff are empowered to make decisions to maximize people's outcomes.

Management systems and decisions strengthen the continuity and consistency of support.

The organization clearly articulates its expectations of its employees and has strategies and systems in place to supervise, support and monitor whether these expectations are being fulfilled.

What does this look like?

The organization creates systems and opportunity for people and/or their families to have input into hiring, training and performance feedback for staff that work directly with them. As each organization may have unique employment circumstances and arrangements, it is important that people receiving services and their support network are informed of:

- The management, supervision and employment structures within the organization.
- The scope and/or any limitations of authority, decision making and opportunity for input available to people served surrounding human resources.
- The mechanisms that are available to share feedback or concerns regarding employee actions or inaction.
- The opportunities available to people for input regarding hiring or selection of staff along with any limitations that may result from features of the employment arrangement.

Staff are also clearly advised of the scope, limitations and opportunities that people they support have related to selection, training and performance feedback.

The organization conducts robust screening of all applicants, verifies qualifications and has systems in place to ensure that staff do not work alone with people until all screening is complete.

The organization ensures that staff receive competency-based orientation and training that provide them with the information they require to support people successfully. The orientation and training provided have these key features:

- Learning leads to the promotion and maximizing of personal outcomes for people supported;
- Staff gain a robust orientation to expectations and processes that enable them to successfully work alone;
- The training is regularly reviewed and evaluated;
- Staff development incorporates people served as important teachers and experts in service delivery;
- Training is evidence informed and based on accepted leading practice and expert professional consensus;
- Employee learning and development is ongoing throughout their time with the organization;
- There are strategies to ensure that there is a successful transfer of learning from theory to practice;
- Orientation includes the unique needs, routines, preferences and instructions of people to whom the staff will provide direct services
- The process of learning about people and how to support them is done in a manner that is sensitive to the person's right to direct what information is shared about them. Care is taken to actively request and involve the person in sharing information;
- Orientation and training to personal care routines is ideally completed following a period of time in which the staff and person supported can develop trust and rapport.

Management systems and decisions are focused on ensuring that Direct Support Professionals (DSPs) have enough supervision, support and information in order to provide consistent, personalized support. Systems need to empower DSPs to be able to provide support in the way that the person they are serving would prefer, while still providing enough supervision and monitoring to adequately ensure that high quality services are being provided consistently in diverse and separate geographic locations.

The organization focuses energy and resources on retaining and maintaining employees so that people served experience continuity of services and consistency of support. Wherever possible, the manner in which organizations assign and schedule DSPs should take into account the preferences and wishes of people served.

The organization has processes and practices for performance management that include supervision, coaching, and mentoring along with documented regular evaluations that relate to job function as well as personal outcomes for people supported. Concerns about performance are followed up promptly with a focus on supporting the development of employees to do the job successfully balanced with the requirement to provide consistently high quality services and supports.

People supported and families are actively solicited for performance feedback and processes are in place to follow up on concerns raised.

Where employees are placed in situations which may involve risk, there is an assessment of the level of risk and a safety plan developed to mitigate or reduce the risk.

The organization provides debriefing for staff after critical incidents, and psychological supports are available as needed.

Core human resources policies are available and in place that create a structure and system for staff. Policies outline the expectations, training, support, supervision and monitoring of staff that enable services to be delivered in a consistent manner that maximizes the outcomes of people served. Core policies would include:

- Job descriptions for all roles
- Recruitment process (including selection, screening and hiring process)
- Employee benefits and conditions of employment
- Harassment and workplace conflict
- Grievance and appeal
- Disciplinary action and dismissal
- Substance abuse/use
- Workplace Health and Safety policies
- Non-discriminatory practices
- Professional credentials/standards of practices
- Reasonable accommodation
- Supervision requirements
- Compensation structure & systems
- Use of Volunteers

How would you know this is happening? (Evidence)

What you see in systems:

Job Descriptions and core HR policies are in place and available to staff.

Orientation and training content and confirmation of completion is available.

Performance evaluations and/or corrective feedback documentation is available.

What you see in actions:

People and families report feeling included and involved in staff selection and training and feel confident that their input and feedback about staff performance is taken into account.

Staff have the information, knowledge, skills and tools to support people successfully. Staff are confident and empowered to provide flexible, personalized supports.

Resources to support achieving guideline:

Hay Group - Competencies - [insert link when uploaded]

Sample HR Policies - [link when uploaded]

University of Minnesota - Institute of Community Integration (Research & Training Centre) <https://cl.ici.umn.edu/our-work/direct-support-workforce>

CQL Quality in Practice Guides - Staff Hiring and Evaluation - <https://www.c-q-l.org/resource-library/publications/cql-publications-for-free/quality-in-practice-guides/staff-hiring-and-evaluation>

Related Guidelines:

Governance - Mission, Vision, Values

Risk Management

Intimate Personal Care Support

Outcome Area: Core Practices

Financial Management

Guideline:

The organization manages its financial resources in a way that promotes and enhances the outcomes of people served, complies with generally accepted accounting principles (GAAP) and ensures good stewardship of resources.

The organization advocates for and arranges appropriate funding to ensure that people's needs are met.

People supported have input into how their own funding is utilized and allocated.

What does this look like?

The organization organizes its financial systems to ensure ready access to available funds to enable spontaneous and flexible use that supports and enhances people's outcomes.

The organization identifies, advocates for and coordinates changes in funding to ensure that people's needs are being met. This is informed by feedback received from people supported, their families, staff and others involved in supporting the person. Objective data or information is also helpful in assessing whether people's outcomes are being impacted by the resources available.

As the ability to direct where funding is allocated or used may differ between service types or organizations, the organization takes steps to inform people receiving services and their support network of the mechanisms and opportunities that are available to have input and/or direct how their funding is utilized. Limitations to this input should be articulated at the beginning of service provision if at all possible.

In addition to GAAP, the organization complies with the Financial Reporting Requirements outlined by the Department of Families.

The organization has sound core financial policies in place and available to all stakeholders. These would include:

- Assignment of authority for necessary and regular financial actions and decisions, which may include delegation of some authority to staff leaders
- Policy statement on conflicts of interest
- Clear authority to spend funds, including approval, cheque signing, and payroll
- Clear assignment of authority to enter into contracts

- Clear responsibility for maintaining accurate financial records
- Process for creating and authorizing budgets and analyzing spending

How would you know this is happening? (Evidence)

What you see in systems:

Financial documentation is up to date and available that demonstrates sound practices and good stewardship.

Core financial policies are available to stakeholders.

What you see in actions:

Staff are confident and knowledgeable about their authority and limitations around spending organizational funds. They report that they can easily access funds within certain controls as needed to support people well.

People supported and/or their support network has confidence in the financial decisions made by the organization and report having input into how their own funding is utilized.

Resources to support achieving guideline:

Department of Families, Financial Reporting Requirements -
<https://www.gov.mb.ca/fs/about/pubs/frf.pdf>

CPA - Canada's Guide to Accounting Standards for Not-for-Profit Organizations in Canada
<https://www.cpacanada.ca/en/business-and-accounting-resources/financial-and-non-financial-reporting/not-for-profit-organizations/publications/accounting-standards-for-nfps-in-canada>

Sample financial policies - [insert link when uploaded]

Related Guidelines:

Financial Well Being
Accessing, Using & Exiting Services

Outcome Area: Core Practices

Risk Management

Guideline:

The organization has a risk management system that assesses, prevents, mitigates and responds to risk so that people supported have the opportunity for safe and healthy lifestyles without undue restrictions.

What does this look like?

Risk management systems balance the integrity of the organization with the rights and liberties of the person receiving services. Where risk is identified to a person, a formal review and due process is done to ensure that any strategies that are used to reduce that risk that might impact the person's rights or freedoms are wholly justified, temporary and there is a plan to reduce. These actions would be a last resort after all other strategies or supports were tried.

Staff are expected and empowered to report possible or actual risks without reprisal.

System of risk management that is in place includes:

- Assessment of risk in key areas such as financial, political, legal, ethical, personnel, safety & wellbeing of people
- Identification of plans for mitigating or reducing risk and how will the organization monitor results
- Compliance with relevant laws, legislation and contracts, mandatory requirements, licensing
- Protection against loss
- Insurance protection for people, property, liability, vehicles

Key Risk Management policies are in place and available. These would include:

- Legal assistance for personnel;
- Compliance with legislation/law;
- Investigating and review of critical incidents;
- Emergency measures (fire, missing person, severe weather/natural disasters, violent visitor, etc.);
- Communications and social media

How would you know this is happening? (Evidence)

What you see in systems:

Evidence of risk assessment, mitigation and reduction planning reported regularly to the Board of Directors.

Insurance policies are in place.

Key risk policies are available.

What you see in actions:

People supported are not restricted unduly without review and due process.

The Board of Directors and the leadership of the organization are aware of potential risks and have set plans in place to mitigate or eliminate them.

Staff are confident and competent to assess risk and know how to report them.

Resources to support achieving guideline:

Imagine Canada - Sector Source - <http://sectorsource.ca/managing-organization/risk-management/risk-management-basics>

Related Guidelines:

Dignity of Risk

Rights Restrictions & Due Process

Emergency Measures

Safety

Outcome Area – Well Being

Freedom from mistreatment, abuse, neglect and exploitation

Guideline:

The organization has robust policies, procedures and practices that defines, prohibits and prevents mistreatment, abuse, neglect, and exploitation including the requirement and process to report any concerns as defined within Manitoba law.

What does this look like?

- The organization has a policy and procedure that:
 - Defines & explicitly prohibits mistreatment, abuse, neglect and exploitation
 - Details the mandatory reporting process and the duty to report for all staff and volunteers
 - Outlines the relevant legislation and regulations that apply to the duty to report
 - Details how investigations will occur, who is responsible, and identifies standards for timely resolution
 - Outlines procedures to maintain safety and prevent further incidents from occurring while investigations are ongoing
 - Outlines preventative measures the organization takes to reduce situations of abuse.
 - Outlines required communication & follow up with the person receiving services and their substitute decision makers (if applicable) throughout the process (if possible) and upon resolution of the investigation. Follow up should acknowledge the harm done, the impact on the person and provide support (both informal and professional, if needed) to recover from the events.
- Staff receive information and training so that they are able to recognize mistreatment, abuse, neglect or exploitation, understand the requirement to report, how to do so and how to maintain safety for those involved. If responsible for conducting any level of investigation, staff should receive guidance and training on how to conduct effective, objective investigations.
- People receiving services and their family/support network, receive information about how to prevent and recognize mistreatment, abuse, neglect and exploitation and what to do when they experience or see something. They receive information on what to expect before, during and after an investigation including what communication or information they can (or cannot) expect to receive throughout the

process. Ideally, this information is shared at the beginning of services being provided and regularly throughout that relationship.

- The organization regularly reviews and learns from incidents of suspected/confirmed mistreatment, abuse, neglect or exploitation. Strategies to prevent further incidents are implemented as a result of this review.

How would you know this is happening? (Evidence)

What you see in systems:

Thorough, written policy and procedure on mistreatment, abuse, neglect and exploitation.

Orientation and training being delivered to staff/care providers recognizing and reporting suspected mistreatment, abuse, neglect or exploitation.

Training and information being provided to people served and their support networks on being safe and what to do when you aren't.

Data related to incidents of suspected/confirmed mistreatment, abuse, neglect or exploitation is maintained, analyzed with follow up articulated.

What you see in actions:

Staff/care providers can clearly articulate what to do if they see something that concerns them.

People who receive services feel safe and are confident about what they would do if they did not. People are safe from abuse, neglect, violence and preventable injury.

Families understand the reporting process and what information they would receive (or not receive) during and following an investigation.

People who receive services report that they received support and counselling (if they wanted it) following an occurrence of abuse, neglect or exploitation.

Resources to support achieving guideline:

Sample Abuse/Neglect/Exploitation Policy – [insert link when uploaded]

Sample Curriculum for Staff/Caregivers on reporting suspected abuse-- [insert link when uploaded]

Sample Curriculum/Information for people served on staying safe from abuse and what to do when they aren't – [insert link when uploaded]

Manitoba Vulnerable Persons Act – https://www.gov.mb.ca/fs/pwd/what_is_vpa.html

Reporting Requirements for Direct Service Providers:

https://www.gov.mb.ca/fs/pwd/pubs/spl_for_service_providers.pdf

Sample Information/Training packages:

<https://www.crimepreventionottawa.ca/en/initiatives/coda-booklet-on-disability-abuse>

https://www.nds.org.au/images/events/files/zt_guide_supervisors.pdf

Outcome Area: Wellbeing

Health Care Support

Guideline:

Organizations provide the support and assistance needed for each person to be as healthy as possible or desired and live a healthy lifestyle of their design. Support includes provision of information, assistance with accessing required health care providers, assistance with health advocacy, promotion of healthy choices, assistance with obtaining recommended and timely preventative health screening, and creating and maintaining systems and ability to respond to health emergencies.

What does this look like?

The organization has comprehensive systems and practices that provide individualized health care supports to each person. These will include:

Gather/Document/Plan

The organization collects and documents relevant health history, risk factors, conditions and health care needs of each person served. This is done preferably prior to the person being served by the organization and on an ongoing basis. This information may be collected from the person, their family, support network members, previous service providers, health care professionals or others as identified. This information is documented in a plan that is accessible to those that require it to support the person, with their consent.

The organization gathers and documents information from the person and those that support them, on what support the person requires to manage their health care, documents any specific wishes or preferences they have regarding health care and ensures that these instructions are available and known by all who require this information. This should also include supports the person may need to communicate effectively with health care professionals (augmentative communication, interpretation, support staff, etc.)

The organization ensures there is a system to collect health observations and notes on a daily basis. This system collects observations about symptom onset and details, minor illness occurrences and other relevant health information.

Access/Provide

People have access to and are assisted to maintain a relationship with a primary care physician or other suitably qualified health practitioner of their choice.

The organization has a system and practice that supports people to access their health care providers as needed. This may include arranging the logistics of setting up appointments, getting to and from, providing support during a health appointment, etc.

If the person requires support during health appointments, the organization will arrange that a qualified person who knows the person well, understands his/her health issues, and who can communicate with the primary health care provider, attends the appointment, documents what occurs and does appropriate follow up. This person may attend along with or instead of family/designated members of the person's support network.

The organization assists each person to obtain a thorough annual physical with their primary health care provider, along with other health screenings and treatments guided by the Canadian Consensus Guidelines on primary care for adults with intellectual and developmental disabilities (see resources) (e.g. 6 monthly dental check, annual influenza vaccinations, annual/biannual hearing and vision/eye health checks).

Medications should be reviewed annually by a doctor or pharmacist to be sure that they remain appropriate and the full list can be reviewed for contraindications.

The organization seeks out required support for people who may experience limitations to mobility or movement. This may include access to and input from physiotherapy and occupational therapy as required. Consultation required may include consultation on seating, night and daytime positioning systems, the use of equipment e.g. wheelchair, standing frames, orthotics, pressure relieving equipment etc.

Implement & Follow up

The organization has a system for tracking or monitoring health outcomes of recommendations made by a health care provider for assessments, treatment, and other services.

Routine monitoring or observations are done to prevent or ensure early detection of chronic or common health concerns for each person.

Communication

The organization manages communication and coordination between health care professionals and systems, communicating with physicians, dentists, and other health care providers as required.

The organization provides timely sharing of information with the person, substitute decision maker (SDM), family, support network and other organizations involved in supporting the person as appropriate and guided by the person. This information should be provided in a manner that is accessible to the recipient in order to facilitate full understanding.

The organization ensures that the person is supported to advocate or advocates on their behalf as needed when gaps or challenges occur in accessing quality health care.

The organization has a robust and thorough system to communicate changes in health care status, treatments, medications or instructions to all staff who need to be aware of this information.

Where organizations have limits to the types of health supports that they would provide or coordinate, this is communicated to the person, their SDM and their support network, whenever possible in advance of services starting.

People are encouraged and assisted to access appropriate health information and education in the community including information on:

- diet and nutrition
- the risks associated with smoking, alcohol and drug consumption
- exercise and physical activity
- other relevant health related topics important to and for the person.

Training

Staff receive high quality training and competency assessment in all aspects of the physical and psychological needs of the people being supported.

Staff receive training and information on universal precautions and infection control and there is evidence of effective infection prevention and control measures in place.

How would you know this is happening? (Evidence)

What you see in systems:

Written policies and procedures are available that outline the expectations of behaviour of staff as it relates to supporting health care.

People's records include documentation of relevant health history, risk factors, conditions and health care needs including the supports that they require to be as independent as possible in managing their own health care.

Staff training details expectations, behaviour and practices required to support people to be as healthy as possible. Records are maintained of competency and completion.

What you see in actions:

Staff have a good awareness of what is 'usual' for the person in terms of their health and wellbeing, and are able to identify and respond swiftly to indicators of changes in health status (physical or psychological/emotional and mental health).

Staff are aware of how an individual communicates their health needs, including indicators of discomfort, pain or distress – and are responsive to these communications.

People and their family/support network feel involved, informed and educated on what they need to do to be as healthy as possible and have access to supports required. This includes receiving training, support and opportunity to practice what to do in the case of a medical emergency.

Resources to support achieving guideline:

Canadian Consensus Guidelines on primary care for adults with intellectual and developmental disabilities: <http://ddprimarycare.surreyplace.ca/guidelines/>

Preventive Care Checklist for Adults with Developmental Disability:
<http://ddprimarycare.surreyplace.ca/tools-2/general-health/preventive-care-checklist/>

UN Convention on the Rights of Persons with Disabilities - Right to Health Care
<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-25-health.html>

Related Guidelines:

Meals and Nutrition

Sexual Health

Mental Health

End of Life Planning and Support

Aging & Dementia Support

Outcome Area: WellBeing

Clinical Services

Guideline:

Clinical services should be driven by the person and focus on interventions that help the person improve their quality of life through specific interventions and therapies.

Clinical Services delivery models and strategies are based on accepted practice in the field and incorporate current research, evidence-based practice, clinical practice guidelines and /or professional consensus.

Professionals licensed by their respective boards must practice under the confines of their license and provide a current license to their agency annually. All clinicians (contracted or hired) must hold active relevant professional licenses to provide services in the Province of Manitoba.

What does this look like?

The organization delivering clinical services has a clear, documented process for delivery of service in a strengths-based person centred, family supportive manner considering the following:

- Clinical services are based upon each person's needs, tolerance for activity, preferences, and abilities;
- Clinical services are required to be designed to support functional participation and self-advocacy in fulfilling roles with family, friends, and the person's preferred community;
- Informed consent is obtained before and at regular intervals throughout service to ensure that the person and their support network remain informed of the purposes, risks and possible outcomes of planned intervention. Consent can be withdrawn at any time;
- Interventions will be determined by the person, whether his or her preferences are expressed independently, with assistive devices or interpreted by others. Consideration of how the person's culture and age impact their goals is important;
- The clinician shall develop strategies to support activities of daily life addressing issues that impact the person's ability to lead the life they wish;

- The organization should integrate clinical strategies into daily life as guided by the person, SDM, family and support network;
- Clinicians actively involve the person's family and/or support network throughout service, according to the person's and/or family's wishes. Although the person supported is ultimately at the centre of service provision, clinicians recognize that family and/or other members of the support network play an important role in supporting the goals that are set;
- Clinicians recognize that there may be differing opinions amongst the person being supported and various members of the support network about which goals should be set and how services should proceed. In such situations, clinicians make every effort to understand those differing perspectives and explore how they may be reconciled. Should conflicting opinions be irreconcilable, clinicians prioritize the perspective of the person being supported, in alignment with their SDM for health, should they have one;
- Interventions are socially valid, with clear and specific outcomes that can be achieved within the time available. Goals are written in a manner that links the goal to the outcome for the person.

How would you know this is happening? (Evidence)

What you see in systems:

Written documentation is available to verify current professional licensing of all clinicians, ongoing continuing education and clinical supervision activities

Policies and procedures exist that outline a consistent, values based approach to service delivery.

Clinical documentation is respectful, functional and focused on socially valid goals shaped by the person.

What you see in actions:

Clinicians work collaboratively and respectfully with people served, their families and support networks.

People report positive experiences and outcomes as a result of clinical consultation.

Resources to support achieving guideline:

The College of Occupational Therapists of Manitoba - <https://cotm.ca/>

The Psychological Association of Manitoba - <https://www.cpmb.ca/>

Manitoba Physiotherapy Association - <https://mbphysio.org/>

College of Dietitians of Manitoba - <https://www.collegeofdietitiansmb.ca/>

College of Registered Nurses of Manitoba - <https://www.crnmb.ca/>

The College of Audiologists and Speech Language Pathologists of Manitoba -
<https://caslpm.ca/>

Related Guidelines:

Health Care Support

Informed Consent and Supported Decision Making

Outcome Area: Well Being

Medical Emergencies

Guideline:

The organization has a system of communication and information needed to respond to health emergencies. This includes ensuring the staff/caregivers have the knowledge and competence to respond and have access to health care information and plans for each person they support.

What does this look like?

The organization clearly explains its role and scope related to supporting medical emergencies as part of welcoming people into their services so that they are aware of what to expect and if there are any limitations to the service delivery. For example, some transportation, day or employment support services may have limitations to their scope of support related to health care. These must be clearly articulated so that the person and their family/support network are able to make informed decisions about how the service will meet their unique health care needs.

Where the organization is responsible for health care supports, proactive planning is recommended for people served who have conditions or illnesses that present a high potential to become a life-threatening situation or medical emergency.

Documentation of plans and expectations for staff should these situations occur assist them in confidently responding in a timely and knowledgeable manner leading to better outcomes.

Examples of conditions where proactive planning is recommended include (not exhaustive):

- Seizure disorder/epilepsy creating risk for prolonged seizures or status epilepticus;
- Neurological disorders requiring devices or implants such as shunts or vagal nerve stimulator that may have specific directions for use or require intervention if malfunction occurs;
- Cardiac conditions that create risk for heart attack or cardiac failure;
- Asthma or other respiratory disease creating risk for respiratory distress or failure;
- Diabetes creating risk for diabetic coma from very high or very low blood sugar;

- Risk for aspiration creating risk for aspiration pneumonia; acute respiratory distress or sepsis;
- Gastrointestinal disorders with history of severe constipation, impaction, bowel obstruction, rectal prolapse or gastric bleeding;
- Feeding tubes; address risk of tube displacement or blockage;
- Severe allergies that are known to result in anaphylactic shock or other severe, life threatening reaction;
- Bleeding risk related to diseases, disorders or anticoagulant therapy; and
- Other conditions based on health care professionals recommendations.

Proactive planning should include input from family members/support network members regarding the situation(s) under which a medical emergency may occur and the action steps that the person and/or his/her SDM desire to be taken in a medical emergency.

Training on what to do in specific medical emergencies should be extended to family and close friends (and where appropriate other personnel from other support agencies) to ensure all feel competent to respond when spending time with the person.

Plans should be created with family/support network in collaboration with the applicable members of the person's health care team (nurse, nurse practitioner, clinical pharmacist, general practitioner or specialist and clinical consultants). Ultimately what is created should be approved by and shared with the health care team (with the person's consent).

Protocols for what to do in emergencies should be written in clear, jargon-free language and include:

- A brief and simple description of the condition or illness with the most likely life-threatening complications that might occur.
- How those complications may appear to an observer.
- Step-by-step instructions regarding the actions to be taken by staff and/or others to intervene in the emergency, including criteria for when to call 911 directly.
- List of emergency contacts with phone numbers.
- If appropriate, reference to whether the person has an advanced care plan or other end of life instructions and where these are located.

Location of plans or health care information takes into account the various locations and contexts in which support is provided.

The organization provides training and instruction to staff related to responding to medical emergencies. This includes:

- The availability, content and location of health care information for each person served and the expectations of action during emergencies.
- When and how they contact emergency services, organizational leaders and the person's family/support network.
- Training on specific health care interventions as required (dependent on person's health and scope of service)

How would you know this is happening? (Evidence)

What you see in systems:

Documented plans on what to do in an emergency are in place for people with high risk health conditions.

Training and orientation documentation for staff on how to respond in medical emergencies and how to specifically support each person as required.

What you see in actions:

Staff are confident and knowledgeable about what is expected of them when a medical emergency occurs and know where to access required information specific to the person.

People receiving services and their family/support network have confidence that their support team has the knowledge and competence to manage emergency situations.

Resources to support achieving guideline:

Sample Health Care Emergency Plan: [insert link when uploaded]

E.R.I.K. - Emergency Response Information Kit

https://www.winnipeg.ca/fps/Public_Education/EMS_Presentations/E.R.I.K.stm

Related Guidelines:

End of Life Planning

Delegation of Nursing Tasks

Outcome Area: Well Being

Medication Support

Guideline:

Organizations that are responsible for medication support have systems and practice to ensure the safe and effective administration and management of medications. The organization provides education and support to people to be actively involved in decision making, management and administration of their medications as guided by their abilities and wishes.

What does this look like?

Organizations clearly communicate their role and scope of service related to medications to people and their family/support network prior to beginning service in order for the person to make an informed choice on whether the service will adequately support their unique health needs. For example, some transportation, day or employment support services may have limitations to their scope of support related to medication support.

The organization has policies and procedures that comply with all applicable Licensing requirements related to medication administration, documentation, storage and destruction. These should cover both prescribed and over the counter medication and treatments. The policies should also include:

- Maintenance of history of medication and immunizations;
- Processes to gain pharmacological review and advice on how medications may interact with one another and what common side effects could be expected. This should include an annual review of all medications (prescribed and over the counter);
- How side effects and health outcomes are monitored in order to assist health professionals to evaluate the effectiveness and impact of medications;
- Information and communication that will be provided to people served and their families/support network (as guided by the person) about medication options, purposes, side effects and changes. Each person is advised, as appropriate, about the side effects of prescribed medicines and is given access to information fact sheets provided with medicines. Each person is afforded the opportunity to consult the pharmacist or other appropriate independent healthcare professional about medicines prescribed as appropriate. Consent of the person and/or their Substitute Decision Maker should be the first step of providing medication support;

- How privacy will be respected and protected while provided medication support;
- Protocols related to handling or altering medications:
 - Some individuals may need to have oral medications altered, for example, tablets broken or crushed to aid administration or mixed with food or liquids (e.g. for use with a feeding tube). The alteration is intended to assist administration and ensure that individuals receive necessary medications. Always check with a pharmacist first before altering the form of medications as this practice may have unsafe consequences.
 - Some medications cannot be altered because this may reduce effectiveness, create a greater risk of toxicity or other harm, an unacceptable presentation to the individual in terms of taste or texture, make it difficult to ensure appropriate dosage and risk to work health and safety. Cross-contamination of medications is also a risk.
 - If an individual is having difficulty taking their medications, or they require an alteration to the standard dosage form, the individual might need alternative formulations or different medications instead. Staff administering medications should check with a pharmacist about which oral dose medications can and cannot be altered in form and any special conditions relating to the alteration or administration of specific medications.
 - Some medications e.g. antibiotics, are also not suitable for ingestion with yoghurt. Check with a pharmacist first if it is intended to use yoghurt to assist with ingestion.
 - Medications must be stored in the conditions indicated on the pharmacy label. E.g. Refrigeration, etc.
- Medication should not be hidden in food or liquid. Some people prefer or require medication to be placed in food to aid in swallowing however, this is done with their full knowledge and not designed to deceive;
- Process to ensure that medication supply is consistent and reliable including how to manage emergency after hours shortages;
- Reporting, follow up and review of all medication errors or incidents.

The organization provides staff with training and support to gain competence in all areas of medication support provided by the organization. These could include:

- "Seven rights and three checks" of Medication Administration
 - Seven Rights - right person, right medication, right route, right time, right dose, right reason, right documentation
 - Three Checks:
 - When the medications are retrieved from storage area
 - When the medications are prepared for administration
 - When the medications are being presented to the person for administration
 - Proper medication administration documentation
 - How to monitor for side effects and sensitivities resulting from medications
 - Purposes and common side effects of medication received by people served
 - Proper storage, recording, documentation, handling and destruction of medication
 - Emergency procedures for serious medication errors - key contact information (pharmacist, physician, poison control)

People served are provided education and support to gain skills needed to be as actively involved in their own medication decisions, management and administration.

How would you know this is happening? (Evidence)

What you see in systems:

Comprehensive policies that articulate scope of service in the area of medication support and practices expected

Training content and completion records

Medication records

Medication error data and quality review records

What you see in actions:

Staff are knowledgeable and confident in their skills and competence to fulfill expectations around medication support.

People served and their family/support network is aware of what they can expect from the organization related to medication support.

People served are involved, informed and aware of their medications and the reasons they take them and have been actively involved in their health care decisions to the extent that they are able and wish to be.

Resources to support achieving guideline:

Medication Management section of Residential Care Licensing Regulation - [insert link when uploaded]

Sample Medication Administration Policies: [insert link when uploaded]

Related Guideline:

Health Care Supports

Self Administration of Medications

Outcome Area: Well Being

Self Administration of Medication

Guideline:

The organization promotes and supports people to be actively involved in their health care decisions and medication management, including self-administration of medication if they wish and have the skills to do so with good health outcomes. The organization will assist the person and their support network to review their skills in this area and identify any potential risks. Education and support is offered to assist people to learn skills in this area.

What does this look like?

The organization has a policy and practice that outlines the expectations and parameters of supporting people to safely administer their own medications. The policy should expand on these key features:

- Following a risk assessment and assessment of skills, each person is encouraged to take responsibility for their own medication, in accordance with their wishes and preferences.
- Where there is uncertainty about an individual's ability to safely manage and administer their medication, a review of skills and risk is undertaken in consultation with a qualified health care professional, the person and their support network.
- As capacity may vary over time, a reassessment may be required if the person appears to be having difficulty in managing their medication.
- If a staff is concerned that an individual is having difficulty in managing and/or administering their medication they should discuss their concerns with the person and discuss the situation with their supervisor. These concerns should also be shared with the person's family and/or support network as guided by the person.
- All decisions made in relation to self-administration of medication, as well as the factors contributing to the decision should be recorded in the person's Support Plan.
- If the assessment concludes that an individual does not have the capacity to self-manage or administer their medication, strategies which will assist the individual to build their skills towards self-administration should be determined.

- Some individuals may require extra support with medication management for a period of time (e.g. returning home from hospital, during a short-term illness or injury), but may be able to transition back to self-management and administration.
- As a guide, a review of skills and risk should cover:
 - A clear indication that the person wants to administer their own medication
 - The person's ability to understand time and place
 - individual's capacity to understand:
 - how to get a prescription filled and checking processes
 - the purpose of the medication
 - instructions relating to medication administration
 - ability to read labels on packaging and identify the correct medications
 - the consequences of incorrect or missed doses and what to do if this happens
 - safe storage and disposal practices
 - side effects and what to do if these occur
 - Physical ability, including:
 - gross and fine motor dexterity
 - visual acuity
 - swallowing
 - communication
 - capacity to open packaging
 - The likelihood of incorrect administration occurring and the risk of harm this may cause the person or others
 - Any precaution that should be taken to prevent incorrect administration
 - If suitable and secure storage is available for medications
 - Understanding of safe storage requirements to protect others they live with
 - When and who to ask for help or a review of medications.
- Individuals may wish to administer only some of their medications and may request or require assistance with others.

- Some individuals may require only minimal reminding or prompting and are otherwise able to self-administer their medications. Others may require observation to ensure they are following instructions correctly.
- Some individuals will require only physical assistance with administration.
 - There are a wide range of practices which might be employed to support individuals who have capacity for self-administration but who have reduced physical capacity, such as:
 - providing safe storage:
 - taking medication in its container from the area where it is stored and hand the container to the individual
 - providing assistance with opening a medication container
 - removing medication from a container and placing it into another container or the individual's hand
 - assisting the individual to place the medication in their mouth
 - observing the individual to ensure they do not experience difficulty in administering their medication
 - assisting the individual to make a record of medication administration.
- Technology and environmental modifications can be used to support successful self-administration (i.e. timers, digital cues, colour coding, text reminders, etc.).

The organization trains appropriate staff to lead the development of a skills and risk review along with the person, their support network and health professionals.

How would you know this is happening? (Evidence)

What you see in systems:

Policy that provides guidance related to supporting self-administering of medication in a safe and respectful manner.

Training content and records of completion.

What you see in actions:

Designated staff feel confident and aware of the need to support active involvement of the person in health care decisions and medication management. They are aware of resources and information available to support skill development and know how to do a skills and risk review to assess what support people need to safely manage their medications.

People receive the support that they require to manage their medications along with the education and training to gain independence in this area, should they wish.

Resources to support achieving guideline:

Sample Self Administration Policy - [insert link when uploaded]

Sample Skills and Risk Review Form - [insert link when uploaded]

Related Guidelines:

Medication Support

Health Care Support

Outcome Area: Well Being

Training and Delegation of Nursing Function

Guideline:

The organization ensures that health care tasks that are performed by any staff are done with proper support and training from regulated health care providers. The organization has clearly identified their process for assessing health care activities, how they support staff to gain competency in approved health care interventions and any limitations to their scope of practice that may impact services.

What does this look like?

The organization has a policy and process that clearly outlines the expectations, procedures and behaviours required related to the provision of health care tasks by staff within the organization. The policy should include:

- How health care needs and required interventions are assessed and flagged prior to and throughout services being provided.
- The process to be followed when health care interventions required are assessed as being functions that a non-regulated care provider cannot do.
- How the organization will determine if the health care task is appropriate and safe for staff to conduct, what protocols, training and supervision would be required prior to performing the task and how the intervention would be monitored and evaluated. In determining this process, the organization should consider legislation and practice guidelines (linked under resources) that provide guidance on how and under what conditions unregulated health care providers would be authorized and safely able to perform certain health care tasks.
- How delegation of function is formally documented, where these documents are stored and who they are shared with (as guided by the person). This should include acknowledgment that delegation of function must always be person-specific and is not transferable to other people served or staff within the organization.
- If there are any health care functions that the organization will not support their staff to perform and how these thresholds will be shared with people served and their families/support network before and throughout service being delivered.

- How staff will maintain their competency to do delegated functions. This may include refresher training, requirement to perform the task at regular intervals and/or expiry of competency after a certain time period without practice or re-training.
- How the organization will ensure that staff assigned to work with a person have the skills and training to perform required health care tasks including an emergency plan if staff who are trained to perform a specific delegated function are not available.

The organization provides support, training and required equipment to staff performing health care tasks. Where delegation of function has occurred, this will mean support and training from a regulated health profession such as a nurse at a frequency and quantity that develops and maintains competency to perform the health care intervention.

Given that delegation is an individual process that is dictated by a unique risk assessment and depends upon the person's health status, the environment and the skills and support available to the unregulated care provider, there is no definitive list of tasks that are delegated or not. However, below is a list of things that, given the right circumstances, could be delegated and those items in which delegation would never be considered to unregulated care providers. The list below is provided only for general guidance and specific discussions should occur with nursing personnel and/or the College of Registered Nurses of Manitoba for clarity on specific situations.

Medication:

- Administration of an auto-injector (e.g. EpiPen)
- Administration of a metered dose inhaler with and without aerochamber and use of a nebulizer for aerosolized medication
- Administration of routine medication with a predictable outcome (training, not a delegation typically, unless is under the skin such as insulin)
- Administration of rescue medication (i.e. auto-injector, or sublingual/buccal, or intranasal medication or in some situations and with ongoing training and review - glucagon)

Nutrition:

- Administration of medication via an enteral tube into the stomach or jejunum
- Administration of nutrition via an enteral tube into the stomach or jejunum via pump or gravity or syringe push methods

- Nurses can generally delegate enteral tube replacement when the tube goes into the stomach and the person involved in the care is a constant care provider (i.e. shared care)
- Blood glucose checks using a blood glucose meter or other approved device

Elimination:

- Care of colostomy site, appliance, emptying, removal and reapplication
- Care of urostomy site appliance, emptying, removal and reapplication
- Clean intermittent catheterizing

Oxygen

- Administration of pre-set oxygen using cylinder tank or concentrator
- Oral and/or nasal suctioning

Neurological

- Vagal Nerve Stimulation care, management and support for use

Skin/Protection

- Minor wound care for dressing changes

How would you know this is happening? (Evidence)

What you see in systems:

A clear, comprehensive policy outlining the scope, thresholds and requirements related to performing health care tasks within the organization is available.

Training and competency records for specific health care tasks are available for all staff assigned to work with a person requiring health care tasks.

Documented plans on delegated functions for specific people who require these are available

What you see in actions:

Staff are clear on those tasks they are able to do and what falls outside their scope. They are confident and competent in those tasks that they are asked to perform.

Resources to support achieving guideline:

College of Registered Nurses of Manitoba - Practice Direction - Assignment & Delegation to Unregulated Care Providers:
https://www.crnmb.ca/uploads/document/document_file_40.pdf?t=1527775148

The Regulated health Professions Act -

<https://web2.gov.mb.ca/laws/statutes/2009/c01509e.php>

Sample Policy - Delegation of Nursing Function: [insert link when uploaded]

Related Guidelines:

Health Care Supports

Clinical Supports

Outcome Area – Well Being

Medication for Behaviour Support

Guideline:

The organization has a formal, rights based approach for the use of medication for behaviour support that ensures there is formal consent and review, monitoring and evaluation and required partnership with positive behaviour support strategies.

What does this look like?

The organization has a policy that outlines the values, expectations and parameters related to use of medication for behaviour support. This policy should include:

- Clear definitions and parameters related to psychotropic medication, chemical restraint and treatment of psychiatric conditions.
 - Psychotropic medication is any medication that alters the chemicals in the brain and consequently impacts a person's emotions and behaviours. Psychotropic medications treat a variety of psychiatric conditions including depression, bipolar disorder, anxiety disorders, attention-deficit/hyperactivity disorder (ADHD), and psychosis. They can also be used to modify someone's state in order to change their behaviour in the absence of a diagnosed psychiatric condition. At times, medications that have psychoactive effects but are not considered psychotropic medication can also be used to alter behaviour (i.e. anti-convulsants).
- Sets out requirements for:
 - Psychotropic medication in the absence of a psychiatric condition is only used following a Functional Assessment and in partnership with a positive Behaviour Support Plan (BSP) that may include changes to the environments, relationships, skill building opportunities, and the activities available to a person rather than targeting problem behaviours exclusively through medication.
 - Regular review by senior leadership of the organization, the prescribing physician along with the person and their support network. All opportunities to reduce or eliminate medication will be sought and evaluated with an aim to achieve a balance between the person's optimum quality of life and the use of medication as required. The review includes

an evaluation of whether the potential benefits of using the psychiatric medications outweigh the risks of not using these medications.

- Ongoing monitoring for impact, side effects and effectiveness to ensure that the desired outcomes are being achieved, changes can be evaluated objectively and accurate information is provided to the person, their support network and their prescribing physician.
 - People served and their families and SDMs are informed of the risks associated with medication for behaviour support prior to its implementation.
- Prohibits use of psychotropic medication when:
 - It is administered at a dose or frequency to intentionally limit behaviour without identifying an underlying anxiety, fear, severe emotional distress or other symptom of psychiatric or emotional disturbance that needs to be eased, managed or treated.
 - It is a substitute for adequate and meaningful support services
 - It is utilized in the absence of any positive behaviour support strategies

Staff are oriented and trained to understand the behaviour expected surrounding the usage of medications for behaviour support. They are aware of and understand the purpose of all medications that people they support are taking.

How would you know this is happening? (Evidence)

What you see in systems:

Clear, comprehensive policy is in place and shared with all stakeholders

Training or orientation records exist as evidence of staff knowledge

BSPs are in place wherever medications are being used to alter behaviour in the absence of a psychiatric diagnosis.

What you see in actions:

Staff are aware of and understand the medications that people they support are using and how they may impact behaviour. Staff are knowledgeable of the person's BSP and the plan to reduce medication over time.

People served and their support networks are aware of the purpose and reasons for medications that they take and how they relate to BSPs. People are supported to be

actively involved in decision making and planning surrounding their behaviour needs according to their wishes and abilities.

Resources to support achieving guideline

Sample Policy - Medication for Behaviour Support - [insert link when uploaded]

Psychotropic Medication Issues - Surrey Place

http://ddprimarycare.surreyplace.ca/wp-content/uploads/2018/03/Psychotropic_Med_issues.pdf

Auditing Psychotropic Medication Therapy

http://ddprimarycare.surreyplace.ca/wp-content/uploads/2018/03/Auditing_Psychotropic_Med.pdf

Related Guidelines

Medication Support

Positive Behavior Support

Behavior Support Plan

Outcome Area: Well Being

Positive Behaviour Support

Guideline:

The organization provides behavioural support to people served by the organization that promotes a positive approach. While a Behaviour Support Plan (BSP) may be required, medical, psychiatric, or environmental causes for the behaviour must be ruled out first.

The organization has clear, transparent and respectful practices of supporting people whose behaviour creates difficulties for them and others.

The organization uses an approach that integrates the following elements:

- Principles of normalization
- Social validity (or acceptable to the person the approach is used with)
- Protection of rights
- Principle of least intrusive first
- Commitment to positive behaviour support

What does this look like?

The organization has a policy on the provision of behavioural support to people served that promotes positive behaviour supports and details how interventions are implemented. This policy would include:

- A description of positive behaviour support that is provided by the organization
- The values, strategies and activities that are undertaken to support those whose behaviour creates difficulties for them.
- Positive behaviour support emphasizes the acquisition and maintenance of positive skills (e.g. building healthy relationships) to increase the person's quality of life--understanding that a natural reduction in other less positive behaviours will follow.
- Specifically, behaviour support identifies skills and capacities that contribute to a person's ability to experience success and satisfaction in a range of settings.
- Support includes all efforts to teach, strengthen, and expand positive behaviours. The focus of support is primarily on assisting and guiding the person toward opportunities to pursue the goals that genuinely represent what is most important to him/her.
- An important, but secondary consideration is to understand, anticipate, and prevent problem behaviours that have general and specific outcomes or

functions for the person. The usual function of problem behaviour becomes less useful when people are supported effectively and when those responsible for support are given sufficient information and guidance.

- Problem behaviour may be reduced or eliminated when a person is assisted to achieve desired goals in socially desirable ways. Effective support considers changes to the environments, relationships, and activities available to a person rather than exclusively targeting problem behaviour.
- The plan will focus on changing the person's environment, or it will seek to teach him/her new communication or coping skills, or it will try to give him/her more control over some aspect of his/her life, in the expectation that this kind of quality of life improvement will reduce his/her level of anxiety or frustration and thus reduce the frequency or intensity of the behaviour.

Where a person experiences repeated difficulty in managing their behaviour, a functional behavioural assessment is carried out by a suitably qualified professional in order to draw up a BSP to provide additional support in consultation with the person and support network.

- A BSP is a proactive plan that assists individuals to develop new skills and behaviours to replace challenging behaviours and assist individuals in accomplishing what they want to do.
- The plan must describe and define the target behaviour that the person wants to reduce or eliminate, and the strategies or activities that will be used to bring that about. This in turn will involve an outline of the desirable behaviours that will hopefully replace the undesirable ones, and the strategies for establishing or increasing these desirable behaviours. Behaviours that cause, or have the potential to cause injury to self or others are the priorities for the development of alternative behaviours. The plan must be sufficiently detailed that staff and the persons support network will, by reading it, understand the interventions and be able to implement them.
- While a professional behavioural consultant may be involved in developing the plan, it needs to be a collaborative plan that also includes the person, their family, staff and support network.

Discussions about behaviour support are conducted in a manner that honour and respect people's privacy and dignity and thus share details only with those whom need to know.

During implementation of the plan, high risk or unsafe behaviours may occur, thus a Safety Plan may be required. This Safety plan addresses how to de-escalate the dangerous behaviours while reducing risk of harm to the person and those around him. The plan may need to include an intrusive practice, so safeguards around its approval and review must be built in, and it can never stand alone as a means of controlling the person; it must be an adjunct to a positive BSP. If necessary, a temporary Safety Plan may be implemented while a BSP and functional behavioural assessment is being completed.

A Safety Plan details how staff would be supported during a crisis situation, when and how they would call for assistance, as well as debriefing that would occur with the person and staff involved following an incident.

As positive behavioural supports take time, if the person them self, or others are at risk, it may be necessary to adopt a restricted practice that limits the person's behaviour or their freedom of movement. However, even in this situation, positive behavioural supports will provide the framework for all interventions. The restrictive measure selected must always be the least intrusive of the strategies likely to succeed, temporary in nature, must be formally reviewed prior to implementation and regularly thereafter by organizational leadership, and its effectiveness must be monitored closely.

- Restrictive measures include:
 - restitution;
 - routine use of law enforcement as part of a BSP;
 - routine use of emergency hospitalization procedures as part of a BSP;
 - use of PRN psychotropic medications for behaviour control;
 - use of protective devices for behavioural purposes (e.g., helmets for head banging, mitts or gloves for hand biting);
 - use of bed rails;
 - use of a device and/or monitoring system that may impact the person's privacy or other rights;
 - use of any alarms to alert staff to a person's whereabouts;
 - Use of restraints - physical or chemical

- The following is a list of punitive measures that should never be part of a positive BSP. The organizations policy should clearly identify these as prohibited.

- Corporal punishment: The application of any painful stimuli to the body as a penalty for certain behaviours. This may include shocking, over-correction (enforced repetitive behaviour), pepper sauce, water in the face, or aversive sounds.
- Psychological or Verbal Abuse
- Restriction of Contact with Family or with Significant Others
- Denial of Basic Needs: Denial of food or drink, sleep, shelter, bedding or access to bathroom facilities. Fasting before a medical procedure is an obvious exception.
- Limiting of a Person's Mobility: Removal of crutches, glasses, hearing aids or wheelchair to limit mobility for the purposes of altering one's behaviour.
- Withholding Personal Funds for behaviour control
- Unauthorized Use of a Restrictive Measure (i.e. of a physical or chemical restraint)
- Secure Isolation/ Confinement Time-Out

The policy should articulate any limits or thresholds the organization has related to supporting people with unsafe behaviour so that people and their support networks can make an informed decision about whether the service is suitable for their unique needs.

People are encouraged to appropriately express their feelings and are helped by the organization to deal with issues that impact on their emotional wellbeing

Communications are clear, appropriate and positive and help people to understand their own behaviour and how to behave in a manner that is respectful of the rights of others and supports their development. Each person is consulted with and given an explanation regarding the effects of inappropriate behaviour and what is expected of them, in a manner consistent with their ability and capacity.

Specialist and/or therapeutic interventions are evidence based and implemented in accordance with professional codes of practice and with the informed consent of each person or persons acting on their behalf and reviewed as part of the person centred planning process.

The organization consults with former support staff and family and friends with the informed consent of each person, in order to learn how to best to assist the person to manage their behaviour.

Staff are:

- Trained in provision of positive behaviour support to people with disabilities.

- Trained to understand and to respond to behaviour and verbal and non-verbal communication that may indicate an issue or concern.
- Given all the relevant information required to assist them in supporting people with their behaviour. This includes access to and explanation of people's Support Plan, BSP or Safety Plan, as applicable.
- Trained in prevention and de-escalation to reduce the likelihood of unsafe situations and the need for restrictive procedures.
- Trained in respectful interactions and how to avoid confrontation.
- Trained in ways to manage reactive or aggressive behaviour in a non-violent, safe manner.

Where a person is served by more than one organization, the two service providers will collaborate and share information (as guided by the person) to ensure that a consistent, respectful approach is utilized by all services.

The organization regularly monitors and collects data and information on the service's approach to behaviour support. This information is reviewed and analyzed as part of the organizations quality improvement strategy.

How would you know this is happening? (Evidence)

What you see in systems:

Comprehensive, clear policy is in place, shared and practiced

Training records confirm staff are trained in a timely manner

Written BSPs are in place when needed and are positive, respectful and supportive

Written safety plans are in place when required.

Documented approvals are available for restrictive interventions.

What you see in actions:

Staff are confident and competent in delivering services in a positive and respectful manner even when someone's behaviour creates difficulties for them or others.

People and their families/support network provide feedback that they are satisfied with the support they gain surrounding their behaviour needs.

Resources to support achieving guideline:

Community Living BC's (CLBC) "Behaviour Support and Safety Planning – A Guide for Service providers" (Revised November 2016). [insert link when uploaded]

Consensus Guidelines - Care, Support and Treatment of People with Developmental Disability and Challenging Behavior - Ontario

<http://www.community-networks.ca/wp-content/uploads/2015/07/CNSC-O-Consensus-Guidelines-EN-F-08-19-16.pdf>

Sample Positive Behavior Support Policy - [insert link when uploaded]

Related Guidelines:

Behavior Support Plans

Medication for Behavior Support

Restraint - Physical

Documentation of Support Plans

Rights Restrictions & Due Process

Quality Improvement

Clinical Services

Outcome Area – Well Being

Behaviour Support Plans

Guideline:

When people require additional support related to behaviour that is unsafe or impacts their quality of life, the organization utilizes behaviour support plan as a positive, collaborative planning process that involves the person, their family/support network and staff who support them. This process includes an assessment and analysis of potential causes for behaviour (medical, psychiatric, environmental) along with an understanding of the function of the behaviour in the person's life.

What does this look like?

The organization has a formal, consistent process that guides the development and implementation of a Behaviour Support Plan (BSP) as needed by the person served. This process should include:

- A BSP is linked and integrated with the person's support plan.
- BSPs emphasize the development of positive behaviours and skill development that are likely to lead to the person's desired outcomes and lifestyle.
- Medical, environmental, or psychiatric causes for the behaviour are ruled out prior to implementing a BSP. Additional factors such as past traumatic events and possible history of abuse are considered.
- Given the frequency that negative behaviour results from frustration surrounding communication, behaviour support should include a focus on how the person communicates and what supports they may need to enhance their ability to express their needs and wishes.
- All BSPs are preceded by a thorough review of the behaviour such as a functional analysis of the behaviour (what purpose does the behaviour serve for the person, what they are trying to communicate). This should explore a clear description of the targeted behaviour, the circumstances and environment where it typically happens, what happens before, during and after and identifies an alternative positive behaviour or skill that would serve a similar function or purposes for the person. The assessment should also explore the ways in which the behaviour of concern interferes with the person's performance, participation, and progress towards their desired outcome and lifestyle.

- A BSP clearly shares strategies on how to support the development of the alternative positive behaviour or skill as well as how those around the person will respond should the targeted behaviour occur. Where triggers or cues for the behaviour are known, the BSP includes strategies to reduce the frequency or likelihood of these occurring.
- The BSP should focus on quality of life activities such as such as participation in pleasurable activities, opportunities for choice, building meaningful relationships, and inclusion in community activities.
- If the targeted behaviour includes high risk or unsafe behaviours, a Safety Plan may be required. This Safety Plan addresses how to de-escalate the dangerous behaviours while reducing risk of harm to the person and those around him. The plan may need to include a restrictive practice, so safeguards around its approval and review must be built in, and it can never stand alone as a means of controlling the person; it must be a in partnership with a positive BSP. If necessary, a temporary Safety Plan may be implemented while a BSP and functional behavioural assessment is being completed.
- There is a process for these strategies to be monitored and evaluated so that there can be an objective analysis of whether the BSP is achieving desired outcomes. The BSP should outline what success will look like in advance so that the plan can be evaluated against these outcomes. As guided by the person, these may include such things as: reduced need for crisis support, improved quality of life outcomes (be as specific as possible), decreased use of targeted behaviour and increased use of the positive alternative behaviour or skill.
- While a professional behavioural consultant may be involved in developing the plan, it needs be a collaborative plan that also includes the person, their family, staff and support network. Strategies and methods used in BSPs will be explained to the person.
- The BSP should identify additional training or competencies staff supporting the person should have in order to successfully implement the strategies or to maintain safety.

Staff are trained to understand, implement and participate in the evaluation of BSPs for the people they serve.

Where a person is served by more than one organization, the two service providers will collaborate and share information (as guided by the person) to ensure that a consistent, respectful and safe approach is utilized by all services.

How would you know this is happening? (Evidence)

What you see in systems:

BSPs are in place for people who require that level of support. They are respectful, positive and collaborative.

Training content includes understanding of behaviour, purpose and scope of BSPs and positive behaviour support.

What you see in actions:

Staff are confident and competent in understanding behaviour and utilize positive strategies for supporting people. They have access to and understand the unique BSPs for people they directly support.

People served and their family/support networks are aware of and involved in the development of their behaviour support plans.

Resources to support achieving guideline:

Community Living BC's (CLBC) "Behaviour Support and Safety Planning – A Guide for Service providers" (Revised November 2016). https://www.communitylivingbc.ca/wp-content/uploads/2018/04/BSSP_GUID_NOV_2016.pdf

Sample behavior support plan – [Insert link when uploaded]

Risk Assessment - Surrey Place - <http://ddprimarycare.surreyplace.ca/tools-2/mental-health/risk-assessment-tool-for-adults-with-dd/>

Related Guidelines:

Positive Behavior Support
Medication for Behavior Support

Outcome Area: Well Being

Personal Safety

Guideline:

The organization proactively prevents, identifies and responds to risks to the safety and wellbeing of people using services. Supports needed to be as safe as possible are integrated into each person's support plan. Information, training and opportunities to practice safety skills are provided to the person receiving services.

What does this look like?

Documented processes and practices (including training staff) are in place that describe systems for ensuring the environment where services are provided are safe, hygienic and clean. These include, but are not limited to:

- fire and other emergencies;
- safety and security;
- equipment, furniture, lighting and ventilation maintenance and management;
- appropriate physical accessibility;
- food safety and nutritional suitability;
- chemical use and storage;
- infection control – cleaning;
- occupational health and safety including incident, accident and hazard reporting.

There are records of regular monitoring of systems, for example, fire and emergency equipment, equipment maintenance and food safety.

People received safety education and training specific to the environments and conditions they encounter. This includes training, support and opportunities to practice what to do in an emergency (medical, fire, bad weather, etc.) - See Emergency Measures.

The organization provides information, training and skill development opportunities to people they support as needed to assist them to be safe in their community. This may include support in the areas of:

- using public transport
- negotiating roadways and traffic
- how to find their way around their community
- using and keeping their money safe and personal belongings while out
- recognizing dangerous situations

- public vs private
- good touching/bad touching
- what to do when bad weather occurs
- avoiding exploitation or bullying
- asking for help when needed
- staying calm when anxious
- using a cell phone to get help

Staff are trained and expected to be alert and respond to signs of significant deterioration in people's physical or mental health and wellbeing or risk of harm.

The organization listens to and takes people seriously if they have a concern about the protection and safety of themselves or others. The organization intervenes and ensures required reporting occurs and the person is safe, supported and assisted to gain additional help or treatment as needed.

The organization has processes in place for when people supported may go missing which dictates urgent action, including looking for the person and liaising with the police, other agencies and people who are important to them.

Staff are expected and trained to be alert for situations in which people supported may harm themselves or others. They are aware of their duty to protect the person and others and to take action to try to prevent harm. Support planning documentation includes information about risks for harm and the support that must be in place to reduce the harm.

The organization has a system of reporting, investigating and reviewing incidents, accidents and hazards which ensures that actions are identified and taken to avoid repetition of negative occurrences.

How would you know this is happening? (Evidence)

What you see in systems:

Training materials and completion records are available for staff and people supported

Incident or accident reports

Support Plan documentation includes information around safety. Where complex or significant safety concerns are present, the person has a specific Safety Plan.

What you see in actions:

People receive the supports, education and training to be as safe as possible while balancing their rights to make informed choice and have dignity of risk.

Staff have the knowledge, tools and training to know what to do when people's safety is at risk. This includes proactive identification, emergency intervention, and reporting of risks.

Resources to support achieving guideline:

ESCAPE-NOW: Effective Strategy-Based Curriculum for Abuse Prevention and Empowerment for Individuals with Developmental Disabilities-NOW(Khemka & Hickson, 2015) <https://www.tc.columbia.edu/oopd/escape-curriculum/>

Quality in Practice Guides - Safety - <https://www.c-q-l.org/resource-library/publications/cql-publications-for-free/quality-in-practice-guides/safety>

Risk Assessment - Surrey Place - <http://ddprimarycare.surreyplace.ca/tools-2/mental-health/risk-assessment-tool-for-adults-with-dd/>

Safety at Home and in the Community - Connectability - <https://connectability.ca/2018/04/25/safety-at-home-and-in-the-community/>

Related Guidelines:

Emergency Measures

Risk Management

Dignity of Risk

Freedom from mistreatment, abuse, neglect and exploitation

Positive Behavior Support

Support Plan Documentation

Outcome Area: Well Being

Creating Home

Guideline:

Where a home is provided as part of service, the organization helps the person choose and create a home in which they feel safe, secure, and comfortable. The home's location and environment facilitate independence, social inclusion and enhances the person's desired outcomes. The home creates a sense of belonging, control and sanctuary for the person.

What does this look like?

The organization supports each person served to create an environment, atmosphere and routines in their home that facilitates a sense of control, privacy, security and comfort. Important aspects of creating a home are:

- People served feel in control over what happens in their home and direct their routines and events on a daily basis. The organization expects and trains staff to support people in a manner that ensures they feel a sense of belonging and control in their home.
- People are supported and encouraged to invite family, friends, neighbours and others in their support network to their home. The organization supports this by teaching and showing hospitality to visitors in the home. The organization facilitates private spaces for people to visit if they wish and space is available.
- People feel safe in their home. They are not subject to abuse or mistreatment from roommates, staff or community members.
- People have access to their home using a key or other means accessible to them. They can access and use all common areas in their home along with a private space for themselves. Their bedroom can be locked by them with the understanding and explanation that staff may enter in an emergency.
- The organization helps people decorate and personalize their home and particularly their bedroom so that the home reflects their personality, wishes, interests and preferences.
- If people supported want to keep a pet, the organization makes an effort to support this wherever possible. This may be dependent upon available resources, building rules and the agreement of all sharing the home.
- The organization strives to serve people in integrated communities and homes. Places where people with diverse needs, strengths, abilities and interests live.

- The home is located as near as possible to individuals who are important to people and their known community in order to help retain natural connections. The location enables people to be an active member of the community if they choose. There is consideration for access to public transport and other amenities, distance from places they frequently go to work and have fun.
- People are able to unwind and rest in their home as they wish. There is space that is relaxed, welcoming, peaceful and free from avoidable and intrusive noise.
- The home blends into the surrounding community.
- The organization organizes their services and supports so that people gain a sense of permanence and history surrounding their home. People are not given cause to fear losing their home without significant reasons.
- The home is accessible and adapted to promote independence by meeting the specific needs of people living in the home. The environment is equipped where required with assistive technology, equipment and supports to enable the full capabilities of people. These may include:
 - Being equipped appropriately with hoisting, bathing, showering, changing and other mobility equipment people require.
 - Considering the person's individual sensory needs and how to meet them.
 - Keeping the person's needs in mind when purchasing household items or furniture - e.g. small jugs or containers for liquids so people can pour their own drinks, tables with central pedestals to allow ease for wheelchair users, etc.
 - Using technology to enable independence - e.g. voice activated or switch controlled functions such as turning on lights or opening doors.
- The home is well looked after, comfortable, clean, adequately lit, heated, cooled and ventilated depending upon the outside weather conditions. The home and its contents are maintained in good repair.
- The organization considers the number, age, needs, gender, gender identity, and gender expression when suggesting people share a home.
- The organization supports people to ensure they have access to transport that meets their needs and ensures ease of access to and from their home.

Staff of the organization are trained to understand and facilitate people's sense of control, independence and comfort in their home. They are expected and know how to bring forward concerns with safety, security or comfort within a home and look for ways to enable people's ability to use and take care of their home as independently as possible.

How would you know this is happening? (Evidence)

What you see in systems:

Maintenance records show both preventative and timely repair to homes.

Training content and completion records are available

What you see in actions:

People live in homes that are welcoming and comfortable. They have a key to their home. Their homes reflect their personalities and desired outcomes are adapted to meet their needs and maximize their independence. People clearly direct what happens in their home to the extent they wish.

Staff are competent and confident in their role in supporting people to develop a sense of home and create a hospitable and empowering atmosphere.

Resources to support achieving guideline:

Sample Home Audit - Values in Action - [insert link when uploaded]

Related Guidelines:

Accessibility

Personal Safety

Supporting Inclusion & Community Participation

Facilitating Relationships, Connection & Social Capital

Supporting Choice & Control

Outcome Area: Well Being

Fun & Recreation

Guideline:

When recreation & leisure supports are part of the scope of service:

The organization acknowledges, promotes and facilitates the important role of fun and recreation in people's life. The organization provides important logistical and planning supports to ensure that people have access to activities that they find fun, interesting and pleasurable.

What does this look like?

The organization actively seeks information and input from the person receiving services on their interests, hobbies, and activities that they find pleasurable. This information is captured in people's support plan to ensure that it is not lost or forgotten.

Where people's experiences of activities and hobbies have been limited, the organization will make efforts to create opportunities for the person to trial and experiment.

Where the person does not communicate in traditional ways, the organization will note non-verbal body language, facial expressions, vocalizations and other demonstrations of interest or dislike to try to interpret the persons' likes and dislikes. The organization will collaborate with the person's family, friends and other natural supports to discover and document activities that they prefer.

As fun activities are more meaningful when shared with friends and family, the organization will work with the person to look for opportunities to build relationships or share time with loved ones while doing the things they find fun and entertaining.

The organization will provide logistical support as needed so the person can engage in fun activities to the extent that they wish and their resources allow. This may include purchasing tickets, arranging rides, providing companion support, calling ahead to assess accessibility, providing guidance on required or appropriate dress, equipment or knowledge.

The organization maintains good knowledge and connections to local businesses and services available to support the person's interests and desired activities.

Staff are expected and trained to understand and acknowledge the importance of fun, how to discover and uncover what people find interesting and pleasurable and are

empowered and knowledgeable in providing the logistical support to enable these activities.

Each person has opportunities for recreation, travel and leisure within their means.

How would you know this is happening? (Evidence)

What you see in systems:

Support Plans contain information on what activities people find fun, interesting and pleasurable.

Training content and completion records.

What you see in actions:

People participate in desired fun activities with support as needed. These activities provide opportunity for building social connections and relationships.

Resources to support achieving guideline:

Ideas of fun activities to explore:

<https://www.bigthrillfactory.com/funforallages>

<https://www.thesimpledollar.com/100-things-to-do-during-a-money-free-weekend/>

Related Guidelines:

Facilitating Relationships, Connection and Social Capital

Support Plan Documentation

Communication

Outcome Area: Well Being

Financial Well Being

Guideline:

The organization provides required support to the person to gain, manage and utilize personal financial resources.

People can easily access their personal monies and control their own financial affairs in accordance with their wishes.

Where assistance is required and provided, that assistance is provided only to the extent the person requires and is shaped by the wishes, dreams and preferences of the person.

What does this look like?

The organization acknowledges the impact and prevalence of poverty for people living with disabilities and the significant role that having enough resources to meet your basic needs plays in quality of life.

The organization supports each person to maximize their income through meaningful employment whenever possible or available.

The organization is knowledgeable and adept at accessing other financial assistance programs that may be accessible to people served to increase their available resources or assistance.

The person and their family/support network are informed at the beginning of services of costs or fees that they are responsible for and those the organization covers through the person's Community Living disABILITY Services (CLDS) funding.

Organizations may provide assistance in managing finances when the person requires this. The assistance is provided in a manner that ensures the person maintains as much control over their money and personal affairs as possible. The assistance needed, who is responsible and how they will gain direction from the person, is documented in the person's Support Plan.

Where people need support to manage their financial affairs, who will support them is set out in an annual Financial Plan. Funds are accounted and managed as per the policy "Management of Personal Funds – CLDS"

If the organization takes responsibility for the funds of persons served, it implements written procedures that define:

- how the persons served will give informed consent for the expenditures of funds
- how the person will access their records
- how funds will be segregated and maintained for accounting purposes
- what safeguards are in place to ensure that funds are used for the designated and appropriate purposes
- how monthly reconciliation is provided to the persons served at least monthly
- how personal financial management is audited within the organization.

Even when the organization is not involved in supporting finances, but they become aware of concerns related to coercion or exploitation, they immediately report these concerns to the person's CLDS social worker or Substitute Decision Maker.

The person is supported to comply with reporting requirements dictated by provincial or federal governments such as reporting income, paying taxes, etc.

The person along with their family/support network is supported and encouraged to create an annual budget to outline their minimum basic needs and direct how they want this to be utilized.

The organization is knowledgeable and assists the person to understand their options to save their funds in a RDSP or other protected fund.

The organization provides support and advocacy as needed to assist the person to create, use and manage a bank account.

Staff receive training in supporting someone to manage their own personal finances, when and how it is appropriate to provide assistance and how to do so while still ensuring that the person maintains as much control as possible.

How would you know this is happening? (Evidence)

What you see in systems:

Where the organization is responsible for managing someone's finances, robust, transparent and up to date documentation is available.

Support plans contain information on the support required for someone to manage their finances.

What you see in actions:

At minimum, people have adequate resources to meet their basic needs. Preferably, people have access to discretionary funds through employment opportunities. Where that is not currently available, people are aware of and assisted to access financial assistance programs.

Staff are competent and confident in how to balance providing assistance when required to manage finances and enabling people to direct the use of their funds. They are aware of all reporting and recording requirements for financial accounting.

Resources to support achieving guideline:

Sample Financial Management processes - [insert link when uploaded]

Management of Personal Funds Policy - CLDS - [insert link when on government website or upload]

CLDS Personal Banking Information Sheet - [insert link when uploaded]

Employability Assistance for People with Disabilities -

<https://www.gov.mb.ca/wd/ites/vrmanual/index.html>

Employment and Income Assistance Program (EIA) for Persons with Disabilities

https://www.gov.mb.ca/fs/eia/eia_disability.html

Disability Trusts & Registered Disability Savings Plan -

https://www.gov.mb.ca/fs/eia/eia_rdsp.html

Rent Assist Program

https://www.gov.mb.ca/fs/eia/rent_assist.html

My Money Lessons - Florida

<https://www.myfloridacfo.com/mymoney/me/default.html>

UN Convention on the Rights of Persons with Disabilities - Right to adequate standard of living

<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-28-adequate-standard-of-living-and-social-protection.html>

Related Guidelines:

Employment and Meaningful Activity

Freedom from Abuse, Mistreatment, Neglect and Exploitation

Supporting Choice and Control

Outcome Area: Well Being

Meals & Nutrition

Guideline:

Where meals are provided or supported by the organization:

The organization works with the person to create healthy meals that the person enjoys. Meals and snacks meet people's cultural and dietary needs, beliefs and preferences. Meal times are nourishing to the body and spirit and whenever possible are relaxed, fun opportunities for social connection.

What does this look like?

The organization ensures that people served create or have input into meals, snacks and grocery shopping (if applicable). Where people live with others, the organization assists the group to collaborate and create a menu or meal that meets the needs and preferences of the majority.

Where people need help with eating and drinking, this is carried out in a dignified safe manner. Referrals to clinical specialists such as dietitian, feeding and swallowing specialists or occupational therapists are facilitated as needed to ensure the person is safe when eating and drinking.

If able people are supported to make their own meals, snacks and drinks, and can choose to grow, cook and eat their own food where possible.

Where health conditions dictate changes in diet, appropriate health care professionals are sought to provide direction and input. The person and their support network (provided consent is given) is informed of the recommendations of the health care provider, the consequences of ignoring the advice and is supported to implement their decision.

People's preferences, likes, dislikes, dietary needs and risks if any related to eating are documented in the person's Support Plan and staff are trained to safely provide appropriate support.

Food should be varied, adequate in amount and based upon nutritionally sound principles.

Where swallowing difficulties have led to the use of a gastrostomy or jejunostomy tube for nutrition, the organization seeks ways to provide opportunities to maintain comfort and pleasure through taste in ways that don't put them in risk.

Staff have nutritional training, meal preparation training and preferably food safety and handling training.

There are systems in place to ensure that food storage and best before dates are reviewed and remedied.

How would you know this is happening? (Evidence)

What you see in systems:

Support plans contain information about people's dietary preferences and needs, what support they require to safely eat and drink and their preferred mealtime atmosphere and experience.

Training content and completion records for staff training.

What you see in actions:

People and their families report access to nourishing, healthy food that they prefer. They are actively involved in planning what they eat and meals are pleasant, social experiences.

Resources to support achieving guideline:

Food Handler Certificate course information

<https://www.gov.mb.ca/health/publichealth/environmentalhealth/protection/foodsafes.html>

Related Guidelines:

Creating Home

Supporting Choice & Control

Supporting Culture, Language, Spirituality & Identity

Outcome Area: Well Being

Emergency Measures

Guideline:

The organization has comprehensive plans developed, maintained and communicated that guide staff and the people they support in the case of relevant emergencies.

What does this look like?

The organization has emergency plans in place for the type of emergencies that are most likely to occur in the geographic area where service is provided. These may include:

- flooding
- tornado
- fire
- missing person
- water contamination
- winter storm
- power failure
- violent visitor or intruder
- chemical spill
- bomb threat
- situations involving harm or violence, or the threat of harm or violence

The organization develops emergency plans that address:

- coordination with appropriate local, provincial, and federal governmental authorities;
- coordination with emergency responders;
- coordination and communication with people served;
- evacuation of people with mobility needs;
- accounting for the whereabouts of staff and people served; and
- alternative options for relocating people as needed.

Drills are conducted that are realistic and occur at different times. Drills provide opportunities to test the effectiveness of emergency plans, monitor skill acquisition and practice responses to emergencies.

Staff and people served are trained and informed of emergency plans. Families are informed about the plans and the contact they can expect during an emergency.

How would you know this is happening? (Evidence)

What you see in systems:

Written emergency plans are available.

There are up-to-date records of completion of emergency procedures, evacuation drills and training.

Required information and equipment is available and up to date.

What you see in actions:

People are aware of what to do in an emergency and feel confident that they will be safe.

Staff are confident and competent about their roles and responsibilities during an emergency.

Resources to support achieving guideline:

Emergency Preparedness Guide for People with Disabilities - Government of Canada - <https://www.getprepared.gc.ca/cnt/rsrscs/pblctns/pplwthdsblts/index-en.aspx>

Disability & Health Emergency Preparedness Tools and Resources - Centers for Disease Control and Prevention - <https://www.cdc.gov/ncbddd/disabilityandhealth/emergency-tools.html>

Sample Emergency Plans - [insert link when uploaded]

Related Guidelines:

Medical Emergencies
Personal Safety

Outcome Area: Well Being

Mental Health

Guideline:

The organization helps people with disabilities to gain timely access to mental health services, where appropriate. People receive enhanced support at times of acute distress in a manner that takes account of their particular needs and preferences.

People are encouraged to express their feelings and are helped by the organization to deal with issues that impact their emotional wellbeing.

What does this look like?

The organization strives to create and maintain environments that are positive, healthy and supportive. Staff work to build trusting relationships with people.

The organization is committed to supporting and advocating for high quality mental health supports for people served.

- The organization is aware of and acknowledges that people with an intellectual disability are much more likely than other members of the population to experience depression, anxiety and other mental illness.
- Despite knowledge of the prevalence of mental illness amongst people with intellectual disability, signs of mental illness are often missed.
- People with intellectual disability may have reduced capacity to participate in standard clinical assessment processes, which can make diagnosis very difficult and result in limited access to appropriate mental health care.
- If a person is displaying unusual behaviour that is causing them distress, the organization supports them to be assessed by relevant mental health professionals.
- Once a mental illness is recognized, clinicians may face challenges in determining the most appropriate treatment and carrying out the treatment. The organization has an important role in supporting the person to follow through on treatment recommendations and monitoring and documenting results.

The organization assesses and documents support that people require to maintain good mental health, strategies and treatment for episodic or chronic mental health concerns and planned emergency interventions in the event of acute concerns. Staff are trained and informed about each person's mental health support needs.

Staff have an awareness of what good mental health looks like for each individual and will develop strategies to support good mental wellbeing. They are trained to recognize, report and provide urgent support when people are struggling with poor mental health.

How would you know this is happening? (Evidence)

What you see in systems:

Support plans contain information and strategies for supporting mental health conditions.

What you see in actions:

People report that they are supported to access required mental health support and services. They experience staff as supportive, positive and calming.

Staff are competent and confident in their ability to support the unique mental health needs of each person or are aware when and how to obtain professional assistance.

Resources to support achieving guideline:

Related Guidelines:

Health Care Support
Positive Behavior Support

Outcome Area: Well Being

Sexual Health

Guideline:

The organization acknowledges that sexuality is an essential part of anyone's health, well-being, and identity. Loving relationships, which include sexual expression, are an integral component of a person's physical, emotional and mental well-being.

All individuals with intellectual disabilities have the same inalienable rights to life, liberty, and the pursuit of happiness as all other individuals. This includes the right to responsibly engage in interpersonal relationships, which include sexual expressions, where there is mutual consent.

Each person is supported on an individual basis and in a sensitive and appropriate way to gain knowledge, skills and information about sexual health and expression.

What does this look like?

The organization has policies and practices that give proactive guidance and direction to staff on how to support people to express their sexuality in healthy and positive ways. These include the following important aspects:

- Promote and protect the rights of people specifically the right to self-determination concerning relationships, sexual expressions and sexual health.
- Mutual sexual expression, which is private and between consenting adults, is a healthy and pleasurable expression of affection, bonding, and sexuality. Heterosexual, bisexual and homosexual expressions are matters of individual choice and will be equally supported.
- Inappropriate sexual behaviour may be due to a lack of knowledge or experience, an expression of medical condition or lack of any other meaningful activity. The organization supports the person to explore the root of the behaviour, understand the options for alternative ways to gain the same result and ensures the person is informed of any potential social or legal consequences of their actions. The organization seeks additional resources and expertise as needed to support the person.
- Masturbation is a normal, healthy expression of sexuality. At times, masturbation may not in itself be a sexual act. It may be a form of sensory stimulation that is readily accessible and usually pleasurable. Masturbation at

the appropriate time and place can be acceptable behaviour. Masturbation will be supported when expressed in a way which does not intrude on others and does not inflict self-harm.

- When a person with an intellectual disability becomes sexually active their parents or other support people may be anxious. This anxiety about the risks and the vulnerability of the person may or may not be warranted. Each situation needs to be assessed on its own merits.
- People need to be able to interact with others that they encounter day-to-day, and to be free to form close friendships or love relationships that they choose. Friendships and romantic relationships are a matter of personal preference. Staff will respect the personal choices and will only intervene when it is necessary for the person's safety. Heterosexual, bisexual and homosexual relationships will be supported equally.
- Some adults with intellectual disabilities may need support in recognizing opportunities and in developing skills and knowledge which enable them to develop loving relationships.
- The organization will help people understand the difference between public and private and reinforce that most sexual expression should occur in a personal, private space. Where appropriate to the scope of service, the organization will ensure that people have access to private space of their own.
- Any documentation in a Support Plan concerning sexual matters will be limited to issues of health, safety, and life quality. All communication and documentation will be: respectful of the person's dignity and self-determination, treated as confidential in nature, and stored and accessed only by those that need to be aware of this information. The organization avoids stigmatizing labels or terms for sexual behaviour.

People with intellectual disabilities have the same range of sexual desires and expressions as the rest of the community, however they may have had limited life experiences or social opportunities to learn about sexuality. The organization provides age and developmentally appropriate support and education that may include:

- Sexual rights & responsibilities
- Sexual health and development;
 - Proper names for body parts
- Safe and healthy relationships;
 - Social skills needed to develop and maintain healthy romantic relationships

- How to sense or understand their feelings
- Socially acceptable rules of sexual behaviour
 - Public vs private spaces
 - Consent - saying no, importance of getting a clear yes
- Prevention & Recognition of sexual abuse and exploitation -
 - Knowing when they don't feel safe
- Birth control and pregnancy prevention;
- Prevention of STDs and HIV/AIDS
 - Risks, means of transmission, and recommended precautions.

Education will be delivered in an accessible and personalized manner. If this includes group education, then strategies will be considered on how to continue support for skills learned outside of the class.

The organization considers recruiting people who received education and demonstrated leadership skills to be trained and hired as self-advocate peer mentors

The organization trains staff to be able to support people in healthy expressions of sexuality. Training should include:

- The myths and stereotypes about the sexuality of people with developmental disabilities
- Social and cultural barriers to sexual expression
- Promotion of positive attitudes towards appropriate sexual expression
- Proactive guidance to ensure that they take reasonable measures to provide protection while supporting residents in expressing, consenting and enhancing sexuality.
- Available resources such as printed information, audio-visual resources, trained staff, therapists and community resources
- Information about the specific needs of people they support regarding sexual expression and health.

How would you know this is happening? (Evidence)

What you see in systems:

Respectful Support Plan documentation is available

Policies related to supporting sexual health

Training Content and records

What you see in actions:

People feel well supported and respected in the area of sexual expression.

Staff talk in a positive, respectful manner and are aware of expectations, strategies and resources available to support people in the area of sexuality.

Resources to support achieving guideline:

Canadian Guidelines for Sexual Health - <http://sieccan.org/pdf/guidelines-eng.pdf>

Respectability Sexual Education Resources

<https://www.respectability.org/resources/sexual-education-resources/>

Related Guidelines:

Rights Promotion and Protection

Facilitating Relationships, Connection & Social Capital

Intimate Personal Care Support

Outcome Area: Well Being
Intimate Personal Care Support

Guideline:

The organization trains, assigns and supports staff so that intimate personal care is provided with sensitivity, privacy and dignity.

What does this look like?

The organization has policy and training that ensures that intimate, personal care is delivered as expected.

As part of support planning, the organization will discuss and discover the preferences of people being served related to intimate, personal care. This discussion or discovery may be informed by the person, their family/support network and/or observation of the person's comfort/discomfort, etc. The person's preferences will be documented in their Support Plan.

Where possible, the organization will schedule, assign and shape routines of staff so that intimate personal care is provided as preferred by the person. This may include preferences such as staff gender, strength of relationships, cultural or religious considerations, etc.

New staff will not, under normal circumstances, provide intimate personal care to people until a familiarity and trust has been established. As part of new staff's orientation, they will hear about how each person prefers to receive personal care. Wherever possible, this should come directly from the person.

Staff receive training on how to provide sensitive, dignified intimate care. This will include:

- Information on the context and risks related to providing intimate, personal care;
- How to provide support in a way that reinforces the person's positive body image and control over their own body;

- Ensures that staff give as much choice as possible about who assists and how it is done;
- Appropriate infection control practices such as use of gloves, cleaning up bodily fluids safely, etc.;
- Proper perineal care for both males and females
- Teach privacy by modeling privacy
- Make sure people dress, bathe and use the toilet in private:
 - Knock before entering a room.
 - Close doors and blinds.
 - Use towels or blankets to drape over the person when assisting with personal routines where the person's body may be exposed. This provides both warmth and privacy.
 - Add barriers between the person and staff. This can be accomplished by taking off and putting on one piece of clothing at a time, using a sponge or washcloth or using hand over hand assistance as opposed to direct contact.
- Ask permission to do or assist:
 - Always ask to see and always ask to touch. Do not proceed if the person declines assistance. Where refusal is a common experience, a discussion should occur with the person, their support network and staff to articulate how care will be provided or not and alternative strategies to try.
- Wait for consent:
 - Even if the person being supporting is non-verbal, allow them time to indicate with body language if this touch is okay.
 - If the person is showing discomfort or anxiety, stop and try to better understand how to make them more comfortable.
- Explain each step of any procedure (what you are doing and why):
 - Pair words with actions to teach respectful touch.
 - Remember to bring needed clothing for the person when moving from location to location (e.g. bedroom to bathroom).
 - Staff should position themselves to give as much privacy as possible, i.e. pull shower curtain partially, etc.

- Keep private subjects private:
 - Do not discuss a person's bodily functions, sexual habits or personal hygiene publicly; defer questions about private subjects to a private time and place; teach where and when certain subjects can be discussed. Staff should model this in their interactions.

- When two staff are required to provide intimate personal care, the attention is focused on the person receiving support and conversations that do not include the person do not occur.

How would you know this is happening? (Evidence)

What you see in systems:

People's support plans include information about their preferences on receiving intimate personal care.

Organizational policies are available.

Training content and records of completions are available.

What you see in actions:

People and their families report positive experiences in the area of intimate personal care.

Staff talk respectfully and knowledgeably about providing respectful and dignified support and are aware of the preferences of the people they support.

Resources to support achieving guideline:

Ethics of Touch - <http://diverse-city.com/product/the-ethics-of-touch/>

Sample Intimate Personal Care Support Policy - [insert link when uploaded]

Related Guidelines:

- Privacy
- Sexual Health
- Support Plan Documentation

Outcome Area – Well Being

Aging & Dementia Supports

Guideline:

Where appropriate, the organization has policies, procedures and practices that meet the needs of people as they age and are impacted by age related issues or dementia.

What does this look like?

The organization has a policy or statement on Aging in Place – or process for identifying thresholds of care that are shared with people and their families in advance of services being provided.

Staff receive training in the normal aging process, age related issues specific to the population that they serve, healthy aging, the potential signs and impact of dementia and other age related conditions.

People served and their families are supported to access information about healthy aging, age related illness and dementia as needed.

If dementia is present, emotional support and information is provided to roommates, friends and family of the individual as the disease progresses.

Screening occurs to establish baseline functioning and to identify changes in functioning as people age. In particular, this is important for those who experience increased risk for dementia such as people with Down Syndrome, history of head injuries or a family history of dementia.

Support is provided to address the environmental challenges to facilitate the person remaining in the community

Later life planning (retirement) and supports are provided when appropriate as directed by the person and their support network. This includes supports to participate in age-appropriate generic community retirement activities with non-disabled peers.

The organization seeks health and clinical supports to address the behavioural and psychological symptoms associated with dementia.

End of life planning and supports are provided (see end of life guideline).

How would you know this is happening? (Evidence)

What you see in systems:

Thorough, written policy on aging in place and/or thresholds of care along with a supportive, proactive discharge process is available.

Orientation and training being delivered to staff/care providers in the area of aging, age related dementia and support.

Written documentation for families on resources they can access related to aging and dementia.

Screening results are available for people of a certain age.

What you see in actions:

The person, their families and staff are clear on the commitment of the organization to support the person through the aging process and what needs to occur if that is not possible. This knowledge is acquired in advance of a crisis.

People are supported to retire as needed.

Staff have basic knowledge of warning signs and symptoms of age-related issues and dementia and are equipped with data and tools to inform the person's health care provider of changes they are experiencing.

Staff who are supporting someone with suspected or confirmed dementia have basic knowledge of how best to support the person given this diagnosis and are aware of resources available to learn more.

Resources to support achieving guideline:

[National Task Group on Intellectual Disabilities and Dementia Practices website](#)

On the above website you will find many helpful resources such as:

- Guidelines for Structuring Community Care and Supports for People with Intellectual Disabilities affected by Dementia
- The National Task Group on Intellectual Disabilities and Dementia Practices Consensus Recommendations for the Evaluation and Management of Dementia in Adults with Intellectual Disabilities
- Guidelines for Dementia-Related Health Advocacy for Adults With Intellectual Disability and Dementia: National Task Group on Intellectual Disabilities and Dementia Practices

NTG-EDSD – Screening tool for baseline and changes in functioning –
<https://aadmd.org/sites/default/files/NTG-EDSD-Final.pdf>

Aging Framework from MAC (<http://www.abilitiesmanitoba.org/wp-content/uploads/2015/01/Framework-Document-final-2.pdf>)

How to best support individuals with IDD as they become frail: An international consensus statement <https://onlinelibrary.wiley.com/doi/abs/10.1111/jar.12499>

List of Manitoba Provincial Trainers for NTG training - [insert link when uploaded]

Aging and Down Syndrome: A Health & Well Being Guide - The National Down Syndrome Society - <http://www.ndss.org/wp-content/uploads/2017/11/Aging-and-Down-Syndrome.pdf>

Outcome Area – Wellbeing

End of Life Planning and Grief Support

Guideline:

The organization ensures each person has had an opportunity to discuss their plans and wishes related to the end of their life. These discussions are recorded in the person's Support Plan and include their family, support network and others as directed by the person. Where appropriate an Advanced Care Plan is developed and formalized.

People with life threatening or life-limiting conditions and their families have access to palliative and end of life care, receive care and support which meets their physical, emotional, social and spiritual needs and respects their dignity.

What does this look like?

The organization has a process and practice of proactively supporting people to think and plan for their end of life. This planning and discussion can include family, friends, support network members, staff and others as guided by the person. This discussion ideally occurs in advance of significant illness, however the timing, pace and scope of the conversations must be directed by the person and their family. End of life planning can cover one or all of the following topic areas:

- Advanced Care Planning
- Personal property - wills or bequeathing
- Funeral planning

Advance Care Planning is the process of discussion, knowledge sharing, and informed decision-making that needs to occur at any time when future or potential end-of-life treatment options and preferences are being considered or re-visited. The primary goal of Advance Care Planning is to seek consensus on what care will be provided at the end of someone's life that reflect the best interests of the person.

An Advance Care Plan is the form used to record medical intervention decisions reached through the Advance Care Planning discussions. It can be completed where people, Substitute Decision Makers (SDMs) or health care professionals wish to define end of life care. An advanced care plan is different from a Health Care Directive.

A Health Care Directive is a self-initiated document that allows individuals to make health care preferences known in the event that they are unable to express them. In Manitoba, a Health Care Directive may indicate the type and degree of health care

interventions the person prefers and/or may indicate the name(s) of a person(s) who has been delegated to make decisions (i.e. a "Proxy").

In the absence of evidence to the contrary, a person who is 16 years of age or older is presumed to have the capacity to make a Health Care Directive. Generally speaking, a Health Care Directive is binding on health care professionals, unless the request for interventions is illegal or inconsistent with accepted standards of practice.

An adult who has a SDM appointed for health care decisions cannot create a Health Care Directive. Health Care Directives must, by definition, be self-directed, and are usually self-initiated, while an Advance Care Plan is generally initiated by a health care or support team.

While an Advance Care Plan must be consistent with any existing Health Care Directive, it does not replace it.

The organization ensures that documentation related to Advanced Care Plans or Health Care Directives is readily available in the case of an emergency.

While Advanced Care Planning is a formal document that sets out the levels of care and intervention that is preferred at someone's end of life, it is also important to talk about and document important routines, objects and people that bring comfort to the person.

End of life planning may also include helping the person and their family think about and plan for their personal property. The person may wish to make a will or simply informally bequeath a special item to a specific person. All such discussion must include the person's SDM, if applicable.

The person may identify wishes surrounding funeral planning. This may range from choice of music, religious readings or setting to seeking and paying for funeral expenses in advance.

Staff are aware of the wishes, preferences and directives of people they are supporting related to their end of life plans.

The organization strives to provide, facilitate and advocate for end of life care and support that is consistent with the person's expressed wishes. Where the person's wishes are not known, the organization is guided by family, support networks and by those that know the person well enough to help interpret what they would have wanted. Support and care may include consideration for:

- Ensuring the provision of clear, accessible and timely information to the person about their health
- Support from palliative care or hospice care
- Pain and symptom management
- Spiritual, cultural or family traditions
- Emotional or psychological support for the person
- Contacting and arranging visits for family and friends
- Supporting family, friends and others who care for the person with logistical and emotional needs

The organization ensures that people receive accurate and timely information and appropriate support to deal with critical events in their lives such as loss of people or pets in their lives. Grief supports are provided in an individualized manner that are tailored to the person's communication style and abilities.

Staff receive information and training on how to support someone through life threatening illness and death. This includes how to support people through grief and loss.

How would you know this is happening? (Evidence)

What you see in systems:

Support Plans document discussions about end of life topics

Advanced Care Plans or Health Care Directives are available for people, if applicable

Staff training records

What you see in actions:

People and their families experience sensitive, respectful, proactive support to explore their wishes surrounding end of life care.

Staff are knowledgeable and aware of people's end of life wishes.

People supported who experience losses report feeling supported and informed through the process.

Resources to support achieving guideline:

Advanced Care Planning Workbook - WRHA
<http://www.wrha.mb.ca/acp/files/Workbook.pdf>

Palliative Care in Manitoba -
https://www.gov.mb.ca/health/palliative_care.html#b

Compassionate Care Course for Support Workers -
<http://palliativemanitoba.ca/education/compassionate-care-course/>

Living Well: Using person centred thinking skills with people who have life limiting illness
- Helen Sanderson - <http://www.helensandersonassociates.co.uk/wp-content/uploads/2015/02/livingwell-hull.pdf>

Grief and Bereavement Resources - Connectability
<https://connectability.ca/2015/03/09/grief-and-bereavement-2/>

Related guidelines:

Aging & Dementia

Personal Financial Management

Health Care Support

Outcome Area: Rights & Responsibilities

Rights Protection and Promotion

Guideline:

The organization protects, promotes and enables people's rights.

What does this look like?

The organization clearly articulates its values and intention related to people's rights and this is widely shared with those receiving services, their families, staff/caregivers and the public.

People served and their support network (paid staff and family/friends) are taught about rights and responsibilities and the role that the organization has in facilitating them. This includes being good citizens, how choices and actions impact others, avoiding harm and respecting others and their property as well as exercising their rights in the community.

The organization regularly (at least annually) talks with the person and their support network about their rights, what they know about their rights, the extent to which any rights may be restricted, how these will be resolved or reviewed, and what support the person needs and wants to be able to exercise their rights.

People are supported to form advocacy organizations or join existing groups as they wish.

How would you know this is happening? (Evidence)

What you see in systems:

Written policy/procedure/statement on the organization's commitment to rights protection and promotion.

Information about people's rights and responsibilities is available, is clearly stated in ways in which people can understand, and is discussed regularly.

Documentation of the discussion/review/audit of the person's rights knowledge, restrictions, support needed and plans towards enabling full citizenship.

Training being delivered to people served about their rights and responsibilities and how to gain support for their specific needs in this area.

Training being delivered to staff/caregivers about the organization's commitment to the rights of the people served and their roles and responsibilities in protecting, promoting and facilitating full citizenship.

What you see in actions:

People are supported to exercise their rights. They receive and understand information about their rights, responsibilities and are supported to enact those rights. Stories of people exercising their civil rights, advocating against violations of their (or others) rights or demonstrations of 'good citizenship' are all evidence of this guideline in action.

The way in which staff and caregivers talk about people they support and what they do when confronted with rights violations or infringements provides evidence of this guideline in action. Their actions should be in compliance with legislation, organization policy and expectations and demonstrate a deep commitment to honour and promote people's human rights.

People receive an apology if things go wrong with their services or their human rights are not respected and the organization takes responsibility for its actions.

People are satisfied with the supports they are provided regarding exercising their rights and responsibilities.

People know what to do if their rights are violated.

Resources to support achieving guideline:

UN Convention on the Rights of Persons with Disabilities –

<https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx>

Canadian Charter of Rights & Freedoms - <https://www.canada.ca/en/canadian-heritage/services/how-rights-protected/guide-canadian-charter-rights-freedoms.html>

Canadian Human Rights Act - <http://laws-lois.justice.gc.ca/eng/acts/h-6/>

Manitoba Vulnerable Persons Act - https://www.gov.mb.ca/fs/pwd/what_is_vpa.html

Sample Rights Protection & Promotion Policy Statements - [insert link when uploaded]

Sample Rights Audit/Review Documentation - [insert link when uploaded]

Sample Rights Curriculum – [insert link when uploaded]

Related Guidelines:

Rights Restrictions & Due Process

Privacy

Complaints, Grievances & Appeals

Outcome Area: Rights & Responsibilities

Rights Restrictions & Due Process

Guideline:

The organization does not limit or restrict rights without due process and only in response to a health or safety concern.

What does this look like?

The organization has a policy that prohibits or limits restrictive practices and rights restrictions except under strict conditions. This policy must define restrictive practices and rights restrictions, require due process for any rights restrictions, ensure that such restrictions are time limited, have a reduction plan and what process must be followed and by whom. The policy clearly identifies those practices that would be prohibited completely, regardless of circumstances. Some practices that restrict people's rights or personal freedoms are completely prohibited. Others should only be temporary strategies in partnership with a positive behaviour support plan.

People served and their support network (paid staff and family/friends) are taught about what constitutes rights restrictions, restrictive practices and what process needs to occur when they are occurring or are being proposed. People are as involved as they can be in agreeing and reviewing any restriction to their independence, control and choice.

Positive Behaviour Support is provided before restrictions are implemented. Continued support and teaching continues even if restrictions are being utilized in order to reduce the need for these interventions in the future.

Due process is provided to the person when their rights restrictions are occurring or being proposed. Ideally, this would include a review of the proposed restriction, the justification and the plan for reduction by a third party or at minimum someone who is removed from direct service delivery. The person, their decision maker and others, if they wish, can participate in this review and validation process.

Restrictions are temporary and are proposed after all other less restrictive strategies have been tried. There must be a plan for reduction. Restrictions must be ended if no longer needed or ineffective to manage the risk (serious risk to their safety or welfare).

While restrictions may be utilized in the case of emergency in response to an immediate and urgent health or safety risk, these should not be used repetitively without following the rights restriction process including due process.

Where external regulation, systems or requirements impact on rights, the organization advocates and provides information (with the person) to the restricting authority to encourage relief from or changes to specific requirement. Should this not be successful, strategies to reduce the impact on the person should be utilized and ongoing advocacy continued.

Any measure taken by staff that impact what a person may wish to do provides for appropriate and effective safeguards to prevent abuse and respect the rights, will and preferences of the person with a disability. Any such measures taken by staff are free of any conflict of interest and undue influence, are proportional and tailored to each person's circumstances, apply for the shortest time possible, and are subject to regular review.

Restrictions are recorded in the person's personal plan and each use is monitored on an ongoing basis.

Staff are trained in the use of restrictive procedures and only use approved and agreed techniques.

Staff are trained in conciliation and de-escalation to reduce the likelihood of violence and the need for restrictive procedures.

Persons for whom medication has been prescribed for behaviour support have a Behaviour Support Plan in place that addresses the same behaviour for which the medication is given. Data is collected on behaviours for which medication is given and is regularly analyzed to assess the benefit of the medication.

How would you know this is happening? (Evidence)

What you see in systems:

Written policy and process on rights restrictions and how they are identified and reviewed.

Information about the process for identifying, reducing, restricting and reviewing rights restrictions is available, is clearly stated in ways in which people can understand, and is discussed regularly.

Documentation of the rights restrictions that have been reviewed and either approved or declined is available. This includes documentation related to least restrictive alternatives that have been attempted and evidence that the restriction has been put in place for a temporary period, as a last resort and there is a plan to reduce them.

Training and/or information is being delivered to staff/caregivers about how to identify, report and review and reduce rights restrictions.

What you see in actions:

People and their support network are knowledgeable or aware of rights restrictions in general and more specifically have experienced due process when their rights have been restricted.

Staff have a comprehensive understanding of what may constitute a rights violation and what to do when either learning about or planning to restrict people's rights.

Resources to support achieving guideline:

UN Declaration - Convention of the Rights of Persons with Disabilities

<https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx>

Canadian Charter of Rights & Freedoms - <https://www.canada.ca/en/canadian-heritage/services/how-rights-protected/guide-canadian-charter-rights-freedoms.html>

Canadian Human Rights Act - <http://laws-lois.justice.gc.ca/eng/acts/h-6/>

Manitoba Vulnerable Persons Act - https://www.gov.mb.ca/fs/pwd/what_is_vpa.html

Sample Rights Restriction Policy & Process - [insert link when uploaded]

Related Guidelines:

Rights Protection & Due Process

Privacy

Complaints, Grievances & Appeals

Outcome Area: Rights & Responsibilities

Privacy

Guideline:

The organization protects, promotes and enables people's right to privacy and dignity.

What does this look like?

The organization has policies and procedures that comply with applicable privacy regulation or legislation and that acknowledges that primary responsibility to the person to control their information and direct who it is shared with. This policy outlines exceptions when information may be shared without the person's consent or knowledge. The policy outlines any parameters or restrictions on information that should or should not be shared with family members of people served including the requirements for communication when family act as Substitute Decision Makers under the Vulnerable Persons Act (VPA).

The organization considers and strives to balance people's right to privacy with the need for record keeping as a requirement for accountability and good service delivery. The organization ensures that documentation is respectful, enhancing, and available to people.

People have access to private spaces within their home. Staff knock before entering people's home and bedrooms. People have the opportunity to have a key to their home. People have the opportunity to keep their belongings in a private space separate from others that no other person enters, uses or intrudes upon without their expressed permission.

People have the opportunities to be alone. When this is limited due to safety or health concerns this restriction is reviewed regularly and formally while the person is supported to gain skills in order to reduce the need for this support.

While privacy and dignity are respected at all times, particular attention is paid to:

- Receiving visitors
- Personal communications such as mail and telephone calls
- Expressions of intimacy and sexuality
- Communications with social workers, health care professionals and clinicians
- The provision of intimate and personal care and support

- Circumstances where confidential and/or sensitive information is being discussed

People are provided information on how to gain privacy in their workplace.

People's records are kept secure however the person has been provided information about their right to see these records and how to access them.

Privacy is not used as a reason for poor communication within or between service agencies that support the person.

Employees are trained in how to protect and honour people's right to privacy and to control information that pertains to them.

People, their families and decision makers receive information upon entering the organization's service about their policies on privacy, what control they have over information and what situations may lead to information being shared without their knowledge or consent.

People are supported to protect the information that they do not want to share inside or outside the organization.

How would you know this is happening? (Evidence)

What you see in systems:

Written policy/procedure/statement on the organization's commitment people's privacy is available.

Information about people's right to privacy is available, is clearly stated in ways in which people can understand, and is discussed regularly.

There is a system for storing and safeguarding information that ensures that people still have access to their own information (record keeping, file management).

What you see in actions:

People are aware that they can access and decide who sees their information along with any exceptions to this practice such as emergency situations, etc.

Staff are respectful and vigilant about protecting people's privacy without letting it impact communication and support especially when multiple organizations are involved.

Staff knock before entering people's space and ask before sharing information.

Families are clear on in advance when and how they can gain information about their loved ones and what restrictions there may be to this.

People are satisfied that their privacy and dignity are maintained.

Resources to support achieving guideline:

Manitoba Privacy Act - <https://web2.gov.mb.ca/laws/statutes/ccsm/p125e.php>

Personal Health Information Act (PHIA) -
<https://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php>

Freedom of Information and Protection of Privacy Act (FIPPA) -
<https://web2.gov.mb.ca/laws/statutes/ccsm/f175e.php>

Manitoba Ombudsman - <https://www.ombudsman.mb.ca/>

Related Guidelines:

Informed Consent & Supported Decision Making
Personal Care Support
Sexual Health

Outcome Area: Rights & Responsibilities

Complaints & Grievances

Guideline:

The organization has fair, accessible and accountable feedback, complaints and appeals processes.

What does this look like?

The organization has a documented complaints & grievance process that includes:

- Identification of how complaints should be communicated and to whom
- Timelines on expected responses to complaints
- The opportunity for people to contact and gain assistance from an independent advocate.
- Roles and responsibilities for board, management, staff, the person and their family throughout the process
- Feedback on services is actively solicited from people served and their family to help improve services.
- Feedback and complaints lead to improvements and outcomes that are communicated.
- Retaliation for filing a grievance or appealing a decision is strictly prohibited.
- Communication that can be expected when a complaint or grievance is shared.
- The annual review of complaints received to identify trends, quality improvement opportunities and accomplishments.

Information on the complaints procedure is available and explained to people and their support network in an accessible and appropriate format. The organization shares this information at the beginning of service and periodically throughout.

People are informed of and enabled to make a complaint outside of the organization if they wish.

Each person is encouraged and supported to express any concerns safely and is reassured that there are no adverse consequences for raising an issue of concern, whether informally or through the formal complaints procedure.

Staff are trained in how to recognize, support and enable people served (or their family) to submit a complaint or grievance and how to respond to concerns promptly, effectively, and objectively.

Staff are trained to understand behaviour that indicates an issue of concern or complaint that a person with a disability cannot communicate by other means. Such messages receive the same positive response as issues of concern and complaints raised by other means.

How would you know this is happening? (Evidence)

What you see in systems:

Comprehensive policy and procedure is documented and communicated.

Training content and completion records.

Tracking system of complaints/grievances and resolutions that is reviewed annually.

What you see in actions:

Concerns are addressed immediately at a local level and, where appropriate, without recourse to the formal complaints procedure, unless the person wishes otherwise.

Staff are knowledgeable about what to do when people or their families have a concern or complaint. Issue and concerns are dealt with in a timely fashion and if not resolved are forwarded respectfully and without retribution.

The complaints, appeals and feedback systems can be easily accessed by all people. People are satisfied with the management of complaints and feedback.

There is a culture of openness and transparency that welcomes feedback, the raising of concerns and the making of suggestions and complaints. These are seen as a valuable source of information and are used to make improvements in the service provided.

Resources to support achieving guideline:

Sample Grievance Policy & Process [insert when uploaded]

Related Guidelines:

Rights Protection & Promotion
Rights Restriction & Due Process
Advocacy
Supporting Choice and Control
Quality Improvement

Outcome Area: Rights & Responsibilities

Accessibility

Guideline:

Services are accessible and meet the specific accessibility needs of people served. The organization has a plan to remove or compensate for barriers that exist.

What does this look like?

The organization complies with or exceeds provincial and federal accessibility and building code requirements.

The organization assesses, documents and meets people's needs related to accessibility to ensure that they be as independent as possible and use environments, information and services without experiencing barriers.

Environments are accessible for all those who utilize them. All levels of buildings where services are provided and all common areas are accessible. If this is not currently available, there are efforts to mitigate the barrier this creates and to work towards creating full access.

In planning the location and use of space, the organization considers: accessibility, availability and affordability of public transportation, location of relevant community resources and the needs of people receiving services.

The organization has a process to identify the need for and request professional consultation for people who may benefit from therapeutic, adaptive, mobility, orthotic, prosthetic, communication, corrective and safety devices or other assistive devices. The organization supports the person (and family, support network if available) so that they are:

- involved in the selection of specific equipment or devices;
- provided the opportunity to try the equipment prior to purchase or selection; and
- trained on the use of specific equipment being provided.

The organization expects, trains and informs staff about how to support people's use of assistive devices and equipment. This includes information that specify the situation in which each is to be used and how to care for the equipment.

Equipment is maintained, in good repair and is readily available to the person who uses them throughout their daily schedule. A schedule of regular preventative maintenance is followed.

The organization works with community resources to help the person identify and make necessary physical adaptations to the person's home, workplace or other location where services are provided. These may include:

- ramps;
- lifts/elevators;
- porch or stair lifts;
- hydraulic, manual, or other electronic lifts/elevators incorporated into the building structure;
- roll-in showers;
- sink modification;
- bathtub modifications;
- toilet modifications;
- water faucet controls;
- floor urinal and bidet adaptations;
- turnaround space adaptations;
- widening of doorways/hallways;
- specialized accessibility/safety adaptations/additions;
- installation of specialized electronic and plumbing systems to accommodate medical equipment and supplies;
- handrails, grab-bars, door handle adaptations, trapeze and mobility track systems for home ceilings; or
- automatic door opener/doorbells
- voice, light, and /or motion-activated and electronic devices;
- modified switches, outlets or other structural controls for home devices;
- alarm, alert or signaling systems;
- fire safety adaptations;
- medically necessary air filtering devices;
- medically necessary heating/cooling adaptations; or
- glass substitutes for windows and doors or other structural safety modifications.

The organization provides information and supports to people in accessible formats. Written documentation or videos are adapted for the needs of people using them.

The organization helps community resources meet the accessibility needs of people using services through education and advocacy.

How would you know this is happening? (Evidence)

What you see in systems:

Support Plans articulate people's needs in the area of accessibility, how to use assistive devices, adaptations and accommodations, etc.

Information produced or shared by the organization is designed to maximize access and reduce barriers.

What you see in actions:

People have full access and use environments that have been adapted to maximize their independence and personal outcomes.

Staff are knowledgeable and aware of each person's need for accommodation, adaptation and access and is confident and competent in how to meet these needs. Where barriers exist, they are aware of the plan to reduce or eliminate the barrier.

Resources to support achieving guideline:

Accessibility for Manitobans Act - <http://www.accessibilitymb.ca/>
<http://web2.gov.mb.ca.proxy2.lib.umanitoba.ca/laws/statutes/ccsm/a001-7e.php>

The Accessibility for Manitobans Act - Customer Service Standard Regulation
<http://web2.gov.mb.ca/laws/regs/current/pdf-regs.php?reg=171/2015>

Barrier-Free Manitoba: <http://www.barrierfreemb.com/home>

Convention on the Rights of Persons with Disabilities - Right to Accessibility
<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-9-accessibility.html>

Related Guidelines:

Creating Home

Clinical Services

Health Care Support

Communication

Outcome Area: Rights & Responsibilities

Legal Support & Assistance

Guideline:

The organization strives to ensure that people receive the support they may require to uphold their right to recognition before the law and to exercise their legal capacity. This includes assistance to access legal advice and representation and to engage in legal proceedings.

What does this look like?

The organization has a process to identify and assist people to receive legal advice and representation when required.

People supported receive information and education on their rights.

Staff are trained and knowledgeable about people's rights and are aware of resources to access should people require legal assistance or advice.

When services are provided to a person through an arrangement with a court or criminal justice system, the organization provides information to the person's services concerning the relationship between the criminal justice entity and the organization. This ensures that they understand what information may be exchanged or shared and what role the organization will play related to any conditions of release they may be under.

How would you know this is happening? (Evidence)

What you see in systems:

Documentation of process on when and how staff would identify and assist someone to access legal assistance or advice is available.

Training content and records.

Rights training material for people served.

What you see in actions:

People experience support to gain representation and advice as needed to uphold their rights.

Staff are aware of the situations in which people may need and have the right to representation or advice from legal counsel.

Resources to support achieving guideline:

Legal aid services Lawyer Referral Program - <https://www.legalaid.mb.ca/>

Lawyer Referral Program - <http://www.communitylegal.mb.ca/programs/law-phone-in-and-lawyer-referralprogram/>

UN Convention on the Rights of Persons with Disabilities - Access to Justice
<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-13-access-to-justice.html>

Related Guidelines:

Rights Protection and Promotion
Communication

Outcome Area: Contribution & Growth

Supporting Lifelong Learning

Guideline:

Educational, training and growth opportunities are made available to each person that promotes their strengths, abilities and personal outcomes.

People are supported to develop and maintain independence, problem-solving, social and self-care skills appropriate to their age, ability and culture.

What does this look like?

The organization seeks to discover and document the areas in which the person supported would benefit from and wishes to enhance their skills, learning or educational qualifications.

Information is available for people, their families and support networks in an accessible format that assists them in understanding and outlines the range of education, recreation, leisure, cultural and community events available in their chosen community.

The organization works with government and community resources to facilitate access to longer term education and training opportunities to support people's personal outcomes and goals.

Staff are knowledgeable of educational and growth opportunities for people in their community that may align with the goals or interests of people they support.

Staff are knowledgeable on how to support people to develop and maintain independence, problem-solving, social and self-care skills.

The organization links with education providers in order to ensure that the particular needs of each person are identified and addressed.

How would you know this is happening? (Evidence)

What you see in systems:

Person Centred Planning and Support Plans document people's goals, needs and wishes in the area of education and learning.

Accessible information is available to people served, their families and staff to inform them about opportunities.

What you see in actions:

People are offered and supported to engage in lifelong learning.

Staff are aware and knowledgeable of the expectations and opportunities to support the skill development and learning goals of people they support.

Resources to support achieving guideline:

Employability Assistance for People with Disabilities -
<https://www.gov.mb.ca/wd/ites/vrmanual/index.html>

UN Convention on the Rights of Persons with Disabilities - Right to Education and Lifelong Learning -
<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-24-education.html>

Related Guidelines:

Employment and Meaningful Activity
Supporting Inclusion & Community Participation
Facilitating Relationships, Connection and Social Capital

Outcome Area: Contribution & Growth

Reciprocity & Contribution

Guideline:

The organization acknowledges, values and supports people's need to contribute to their community and develop mutually beneficial relationships and social roles that leverage their unique strengths and abilities.

The organization seeks formal and informal ways in which people supported can share their gifts and talents.

What does this look like?

The organization supports people to discover their gifts and talents and to find places, spaces and groups within their neighbourhood, community groups or geographic area where they can share and contribute.

Staff help people reciprocate friendly actions and overtures in order to nurture relationships.

Staff actively look for and offer opportunities for people served to play leadership roles within the organization.

The organization has a process to identify and match people supported who have the skills and desire to mentor others, with those that may benefit from mentorship.

Staff are expected, trained and supported to look for opportunities for people to contribute in meaningful ways.

How would you know this is happening? (Evidence)

What you see in systems:

Person Centred Planning and Support Plans document gifts, talents and skills as well as current and desired opportunities to contribute.

Organizational committees, boards and groups include people served on their membership.

What you see in actions:

People act as leaders, mentors and contributors in informal and formal capacities in the organization, their neighbourhoods and community groups. People have opportunities to give back to others in small and large ways.

Staff are aware and engaged in supporting people to contribute on a daily basis.

Resources to support achieving guideline:

Handbook for Inclusive Meetings - NASDDS - [insert link when uploaded]

Volunteer Manitoba - (Ideas for contribution and leadership)

https://www.volunteermanitoba.ca/volunteer_opportunities.php

Related Guidelines:

Facilitating Relationships, Connection & Social Capital

Outcome Area: Contribution & Growth

Employment & Meaningful Activity

Guideline:

The organization acknowledges, values and supports people to gain employment as directed by the person. When that is not the person's goal, the organization assists them to spend time in ways that are personally meaningful and fulfilling to them. Such activities should enhance and promote the person's defined outcomes and goals.

What does this look like?

Organizations providing support in the areas of employment and/or personal development clearly articulate the scope and purpose of services to assist people and their support networks to choose supports that best align with their goals and preferences. Where there are limitations to the types and range of services that they might provide, the organization clearly identifies these in advance of commencing services (i.e. medication support, health or personal care, etc.).

Where staff have a role in assisting people and their support networks to plan for the future, employment should always be the first consideration. If someone does not choose employment, the decision should be based on informed choice. Making an informed choice about employment is an individualized process and ideally this process begins when they are still in school. People all have unique histories and backgrounds and some people may have limited experiences and information to make a decision about employment.

The organization must work together with the person and their support network to determine and provide opportunities for activities that support making an informed choice about employment as well as what support they require to obtain it.

- **Discovery:** The first step in making an informed choice about employment starts with the discovery of people's skills, abilities and interest. This discovery process involves the person and others who are important to them in articulating meaningful life outcomes and preferences.
- **Experience:** If a person has no volunteer or employment history, then the person and support network should consider trying new discovery experiences in the community to determine interests, abilities, skills, and needs.

- Opportunity for Trial Work or Volunteering: The organization can also offer or provide the person with access to job exploration activities including volunteer work and/or trial work opportunities, if the person is interested.
- Information: The organization highlights the benefits of employment to the person along with any impacts on services or supports that may result from a change in employment status.

Depending upon the person's goals, abilities and preferences, they may choose from a range of available support services:

Employment focused supports include a range of services. The goal of employment services is to support individuals to increase their independence, productivity, and community integration by developing skills that will lead to competitive employment. Access to employment enables the person to engage in community life, control personal resources, increase self-sufficiency, and receive services in the community.

While supports are individualized and driven by the person's defined goals, all supports are focused on ultimately gaining employment.

The organization works with the person along with those that they choose, to identify a person centred employment support plan, along with the supports that they will require to achieve their goals. The plan articulates strategies to overcome barriers to employment and identifies any clinical, assistive technology and therapy supports necessary for the person to succeed in employment.

These supports may include:

- Job development, carving, restructuring & maintenance
- Job sampling or trial work experience
- Developing a résumé (written or visual) that identifies a person's relevant vocational experience.
- The organization supports people to explore and seek opportunity for career advancement through growth in wages, hours, experience, and promotions. People are provided the opportunity to participate in negotiating their work schedule, break/lunch times, and leave and medical benefits with their employer.
- A job coach may be provided to assist individuals with personal care needs in community employment settings when natural supports are not available. Services must be provided in a way that does not embarrass, disrespect, or restrict a person from making friendships and co-worker relationships.

- Natural/peer supports should be explored and encouraged to potentially fade the paid supports when natural supports are in place and stable.
- The organization may arrange for, provide, or teach the person on transportation supports, including the use of public transportation options;
- The organization assesses the need for and will arrange for required assistance needed for personal care and assistance with daily living (such as eating, toileting and personal hygiene);
- The organization coordinates, provides or facilitates health care needs such as medication administration, health care interventions and monitoring.
- Developing and/or identifying community based job opportunities that are in line with the person's skills and interests.
- Supporting the person in gaining the skills or knowledge to advocate for him/herself in the workplace.
- Educating the person and their staff on rights and responsibilities related to employment.
- Arranging for or providing benefits counseling where needed
- Facilitating/developing job accommodations and use of assistive technology such as communication devices.
- Assisting the person to gain and/or increase job seeking skills training, which include, but are not limited to interviewing skills, résumé writing, and work ethics training.
- Assisting employers with requests for reasonable accommodations, disability awareness training and workplace modifications or make referrals to appropriate agencies.
- Utilizing community employment resources;
- Maintaining ongoing communication with various levels of the company to assure satisfaction for both the person and the company;
- Assisting the person with the development of natural supports;
- Assisting the person to communicate and express his/her needs with co-workers;
- Advocating for the person to be integrated into the work culture, including attending job-related social functions, interacting with their non-disabled co-workers during lunch or break times as well as full access to employer designated dining or break areas;
- When a person elects to start his/her own business, the organization supports:
 - completing a market analysis of product/business viability;
 - assisting with and/or utilizing community resources to develop a business plan, a business infrastructure to sustain the business over time and marketing plans;

- assisting with obtaining a business license or incorporation documents and with completing any other business paperwork required by municipal or provincial codes;
- supporting the person to develop and implement a system for bookkeeping and records management; and
- providing effective on-the-job training and skill acquisition.

When employment is not an identified goal for the person, they may choose to gain services and supports focused on non-work related skill development and activities.

Personal development services – Such services are designed to develop, maintain and enhance an individual's personal care and social skills, emotional growth, physical development, and community skills. The main goals of such services are to create opportunities for personally meaningful activities and roles that maximize the person's outcomes and goals. Key features of such services are:

- Individualized supports for each person;
- Promotion of community membership and contribution;
- Use of human and social capital to decrease dependence on paid supports; and
- Provision of supports that are outcome-oriented and regularly monitored.

The organization ensures that each person's opinions and known preferences guide the choice and development of activities. Each person is an active participant in the activities they engage in and their actions and responses determine future plans.

Examples of activities may include participating in clubs, classes, or recreational activities in the community; learning new skills to become more independent; volunteering or membership in community groups

Organizations providing personal development focused supports may provide the following range of services:

- Creating individualized schedules that can be modified easily based on individual needs, preferences, and circumstances and that outline planned activities per day, week and month including date, time, location, and cost of the activity.
- Building activities to support the person's goals and outcomes, as appropriate.
- Assisting with skills application activities in typical community settings (e.g. banking or shopping).
- Providing supports for volunteer activities, offering information and coaching to community members to support the person's success.

- Identifying and connecting the person to community resources.
- Arranging or providing opportunities (time, information, materials, and other resources) to pursue age appropriate hobbies, recreation/leisure activities, and interests with other community members. The focus should be on supporting people in the most integrated environment possible.
- Providing opportunities for active individual choice-making during the day, including daily schedules, activities, skill building, and community participation.
- Providing information pertaining to individual rights and responsibilities in the community.
- Assisting in the development of self-advocacy skills.
- Providing support to the person to assume social roles that are valued by both the person and the community.
- Providing support to the person in becoming actively engaged in community sponsored activities specifically related to the person's (as compared to the organization's) interests.
- Assisting with budgeting to pay for adult education activities designed to promote personal growth, development, and community integration as guided by the person.
- Exploring and creating a diverse range of experiences (multi-sensory, sports, music, art, culinary, social, literature, drama, dance, nature, gardening, geo-caching,
- Arranging and assisting the person to participate in community classes. This may include arranging for natural or staff support while in class.
- Providing and training on transportation supports, including the use of public transportation options.
- The organization coordinates, provides or facilitates health care needs such as medication administration, health care interventions and monitoring.
- Addresses communication needs and supports, such as need for interpretation, support to use assistive devices, etc.
- Providing basic assistance needed for personal care and activities of daily living, such as eating, dressing, toileting, and personal hygiene.
- Assisting with the development of natural support networks that complement or replace paid supports through development of personal relationships/friendships with people who are not disabled and who have similar interests and preferences.
- Arranging access to age appropriate adult education opportunities available to the public (e.g. coursework or conferences with non-disabled peers).

While many of these services occur in organizations that are referred to as Day Services, meaningful activity and contribution is not limited to specific hours or days of the week and should be a focus for all service providers.

The organization ensures that staff are provided with training in how to facilitate employment and/or activities in ways that make them meaningful for the people involved.

The organization collaborates and partners with community and business organizations in order to leverage opportunities for the people they serve. Staff are knowledgeable about community resources.

Staff who are engaged in job development and supporting employment receive specific training and competency to fulfill these roles.

How would you know this is happening? (Evidence)

What you see in systems:

Organizational materials clearly articulate their purpose and scope of service in an accessible, easy to understand format and are available for people looking for service.

Support plans articulate specific employment or personal development supports that are provided to each person that maximize their desired life outcomes.

What you see in actions:

People are supported to gain employment if this is what they wish. Where that is not their preference, they are engaged in valued activities that enhance and promote their personal outcomes.

Staff are confident and competent in the skills required to support the person to gain employment and have the tools and information they need to provide a range of opportunities to people.

Staff are trained and practiced in helping people discover their gifts and talents, identify their goals and engage in activities that work towards achievement of their stated goals.

Resources to support achieving guideline:

Bridging to Adulthood - A Protocol for Transitioning Students with Exceptional Needs from School to Community

<https://www.edu.gov.mb.ca/k12/docs/policy/transition/>

Customized Employment Competency Model -

<https://www.dol.gov/odep/pdf/2011cecm.pdf>

Employability Assistance for People with Disabilities -

<https://www.gov.mb.ca/wd/ites/vrmanual/index.html>

UN Convention on the Rights of Persons with Disabilities - Right to Work and Employment

<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-27-work-and-employment.html>

Griffin-Hammis Associates, Inc (GHA): <http://www.griffinhammis.com/>

Marc Gold and Associates (MGA) :<http://www.marcgold.com/>

Association of People Supporting Employment (APSE): <http://apse.org/>

Institute for Community Inclusion – Job Search/Advancement

https://www.communityinclusion.org/topic.php?topic_id=3

Connectability - Employment Resources

<https://connectability.ca/2016/07/05/employment/>

CQL Employment Companion Guide - [insert link when uploaded]

Planning Transition Services for Youth with Disabilities - Inclusion Winnipeg

[insert link when uploaded]

Related Guidelines:

Supporting Inclusion & Community Participation

Supporting Lifelong Learning

Person Centred Planning

Support Plan Documentation

Fun & Recreation

Outcome Area – Inclusion

Supporting Inclusion and Community Participation

Guideline:

The organization supports the person to seek and pursue opportunities, experiences and activities that are available to all people.

The organization is proactive in identifying and facilitating opportunities for people to participate in their chosen community in real and meaningful ways. People are supported to use ordinary community settings at the same time and in similar ways to other people.

What does this look like?

The organization helps people, as necessary, to define their interests and capacities, often by helping them discover, try and evaluate a variety of new experiences.

The organization promotes valued roles for people by seeking and creating opportunities where they can:

- Share space and time in ordinary places with others from their community of choice who share similar interests, skills or passions;
- Act as good neighbours, co-workers, or classmates;
- Discover, connect with, navigate around and actively participate in their neighbourhood, workplace or community;
- Engage in positively regarded activities that enhance their image;
- Join and participate in community associations;
- Engage in cultural or political activities;
- Use community resources available to other people in your area or community;
- Exercise their rights, privileges, and responsibilities as full members of their community including forming or joining advocacy groups.

The organization provides people necessary assistance or facilitation to identify community settings, resources and activities, to get to and from places safely, and to participate effectively. Support is provided in a manner that works to enhance others' perception of the person.

The organization supports people to ensure they have access to transport that meets their needs and ensures ease of access outside their home.

The organization helps identify barriers that may reduce or restrict active community participation and helps to develop strategies to reduce and/or eliminate them.

People are supported to gain necessary skills to participate fully and positively in activities of their choice.

Staff are knowledgeable about community resources and activities and how to identify opportunities that are accessible for people.

Staff have been trained to facilitate social inclusion.

How would you know this is happening? (Evidence)

What you see in systems:

There is strong evidence and focus on inclusion and community participation within person centred planning and support plan documentation.

Staff training records and content

What you see in actions:

People spend time in ordinary places they chose with others who share interests, passions or skills. People are seen, known, welcomed, accepted, connected, cared for and valued in their neighbourhood, workplace and other places they spend time in. People participate in meaningful ways.

Staff are confident and competent in facilitating social inclusion and community participation for people they support.

Resources to support achieving guideline:

The Three Faces of Integration and Inclusion - by Dave Hingsburger - The International Journal for Direct Support Professionals

<http://www.vitacsls.org/UserFiles/uploads/files/sss%20vol%207%20issue%204%20-%20ENGLISH.pdf>

UN Convention on the Rights of Persons with Disabilities - Article 19 - Living independently and being Included in the Community -

<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-19-living-independently-and-being-included-in-the-community.html>

Related Guidelines:

Fun & Recreation

Creating Home

Employment & Meaningful Activity

Facilitating Relationships, Connection & Social Capital

Supporting Choice & Control

Supporting Choice, Language, Spirituality & Identity

Transportation

Outcome Area – Connection

Family Centred Supports

Guideline:

The organization, guided by the person served, views the person's family as a vital part of the person's support team and interacts with family members in ways that supports family unity, acknowledges the families expertise and importance and builds capacity of the family to nurture, love and support the person served.

What does this look like?

The organization demonstrates a commitment to supporting families, as guided by the person served, as part of the support team. This commitment could be formally established in a statement of commitment or philosophy and shared with people receiving services and their family members at the beginning of services. This commitment, whether formally documented or in embedded in practice includes these elements:

- Families are welcomed, listened to and kept informed. Notwithstanding this commitment, at times, the person served may choose to limit contact or request information not be shared with their family. These requests would be honoured.
- Families are involved in planning for the future as guided by the person.
- Recognizing that people served exist within the context of a family, support acknowledges family values, goals and dynamics. Where appropriate, information on accessing helpful resources is provided to the family to support family functioning.
- Families are aware of how to address concerns and what is expected from them when raising issues.
- The organization is committed to partnership with the family that is built on mutual respect and is characterized by open, honest, and respectful two way communication.

The organization works with the person to establish an optimal level of family involvement. Each person defines family differently, whether it be biological family, legal guardians, foster or adoptive families, extended family members, significant others, peers or other close friends. Organizations should work with the person to understand their definition of family in order for them to develop and sustain healthy, long term relationships.

The organization helps people maintain family contacts and continue relationships with parents, siblings, extended family members, and other family-like supports through regular contact and shared activities. This contact may not be pursued if it is unhealthy or unsafe or not desired by the person. This contact can be facilitated by:

- Supporting and facilitating regular communication with family members. Wherein person contact is not possible, telephone, web-based or electronic communication can be a good alternative.
- Assisting the person acknowledge special days or milestones for family members (i.e. birthdays, anniversaries)
- Understanding that separation from family or significant others can be difficult and support the person to grieve the loss of family connection
- Support the person to acknowledge and participate in events related to a family member's death
- Where families do not live close to the person, the organization assists the family with travel arrangements and/or supporting the person to travel to visit should they wish and are able to.

Where people have difficulties in communicating their wishes or making informed decisions, there is an obligation for organizations to work in close collaboration with the person's family and/or support network who can assist to ascertain the person's wishes and facilitate them in achieving a desired outcome.

The organization clearly outlines the extent to and any limitations there may be in the information and communication they may expect about their family member in advance of service beginning. This ensures that families are fully aware of what to expect and where they may not receive information.

Staff are trained and oriented to the expectations and values of the organization related to family involvement. Staff receive information and support on how to respond to concerns promptly and respectfully.

How would you know this is happening? (Evidence)

What you see in systems:

There is formal, written statement of commitment or philosophy outlining how families are viewed, supported and involved within the organization.

Information is available and shared prior to service for families on how they can expect to be involved and informed.

What you see in actions:

Staff are aware of and committed to the value of family, recognize their expertise, importance and behaviour in accordance with that commitment.

Families feel welcomed, listened to and informed.

People feel supported to maintain healthy, ongoing relationships with their family if they choose.

Resources to support achieving guideline:

Sample Family Centred Practice Statement of Commitment - [Insert link when uploaded]

Parent-Professional Relationships - https://plumtree.org.au/wp-content/uploads/Parent-Professional-Statement_v5.pdf

Related Guidelines:

Bridging & Supporting Relationships & Social Capital

Enlisting Natural Supports

Supporting Choice and Control

Outcome Area – Connection

Facilitating Relationships, Connection & Social Capital

Guideline:

The organization values, recognizes, understands and emphasizes the centrality of relationships in people's lives.

The organization provides focused, intentional support to establish, maintain and enhance relationships according to each person's wishes and preferences. Support focuses on facilitating participation, membership and friendship. Relationships ideally are voluntarily chosen and mutually valued.

What does this look like?

The organization expresses a commitment and focus on supporting people to create connection and belonging in their lives. This commitment, typically a formal written document, sets out expectations for staff behaviour and strategies to assist people in developing and maintaining relationships as they wish. This formal commitment or strategy may include:

- Outlining reasons why relationship, connection and social capital are important
 - Connection, belonging and intimacy is a key human need that we all share
 - People are safer when they are loved and belong
 - Loneliness reduces life span and quality of life
- Identifying the ways in which connection and relationship develop and what role the organization may play in facilitating these circumstances
 - People form relationships through shared interests and culture
 - People connect when they share the same space over and over again
 - Relationships form when there is invitation and mutual pleasure in each other's company and trust
- Outlining the strategies and support that the organization will provide to enhance connection:
 - Support to nurture, maintain or re-connect with friends
 - Explore and uncover people's interests so that activities and opportunities could be offered to connect with those that share similar interests
 - A wide range of activities are offered, encouraged, and facilitated that foster the formation and nurturing of relationships

- Flexible services that can meet the dynamic needs of evolving relationships
- Support as needed around the logistics of participation in friendships, association or membership (i.e. transportation, scheduling, payment, registration, gifts, etc.)
- Access to news, pop culture and information through radio, TV and whenever possible, Internet allows people to participate in conversations about current events, be aware of opportunities for connections and connect with others using electronic or online forums
- Support as needed to acknowledge, reciprocate and honour important days, milestones and achievements of friends as directed by the person.
- While some people may choose to spend time with people with disabilities, this is not imposed and, in fact, experiences and activities with a diverse range of people and communities are offered and encouraged
- Welcoming people's friends and assisting people to be hospitable and welcoming
- There are not restrictions on visitors except where the person directs or where conflicts occur related to safety or privacy of others that share the same space. Limits may be imposed during work or vocational type activities
- Support to acknowledge and support grief and loss and assist the person to remember and honour loved ones

People receive support, information and education around relationships. This may include:

- Differences between private and public spaces
- Differences between friends and romantic relationships
- Learning to recognize what the other person is feeling
- Conversation skills
- Hospitality
- Which environments, activities and context in which certain types of socializing may not be appropriate (i.e. work)
- Signs or risks that someone may not be a friend
- How to establish and maintain rapport with someone

Staff receive training and support to foster participation and the formation and nurturing of relationships. Staff are aware of and equipped to fulfill the organization's expressed expectations around supporting connection and friendships.

The organization measures and tracks the extent to which people are satisfied with the level of connection in their lives on an individual and organizational basis. They use this information to make decisions on how best to support people.

How would you know this is happening? (Evidence)

What you see in systems:

The organization has written statements, policies or strategies that outline expectations for organizational members regarding supporting friendships and connection.

Information is available about the extent to which people have participation, membership and friendship in their lives. This information is reviewed and used as part of the organization's quality improvement process.

What you see in actions:

Staff talk and act in a manner that consistently enhances and nurtures connection with those they support. It is clear that they know this is a central focus in all they do.

People are satisfied with the support they receive to maintain connections.

Resources to support achieving guideline:

Al Condeluci - <http://www.alcondeluci.com/>

iBelong website - <http://www.ibelong.ca/>

Sample Statement of Commitment - [insert link when uploaded]

Community Living BC, A guide for Self-Advocates Support Network –
<http://www.communitylivingbc.ca/wp-content/uploads/Support-Networks-A-Guide-for-Self-Advocates.pdf>

Related Guidelines:

Supporting Inclusion & Community Participation
Quality Improvement

Outcome Area – Connection

Enlisting Natural Supports

Guideline:

The organization is focused on assisting people to build and maintain a robust network of natural supports. While related to support to gain friendships and social connections, this activity intentionally focuses on soliciting and enlisting unpaid community members to use their unique gifts, experiences and connections to enhance both the life of the person supported and community members.

What does this look like?

The organization has a process and statement of commitment to assisting people to build support networks if they choose.

The organization provides assistance and where necessary facilitation to develop and maintain a natural support network as directed by the person. Ideally, this network should be one that:

- Is made up of people whom the person supported, trusts and has chosen;
- People participate voluntarily;
- Is mutually beneficial to all members and the person is supported to reciprocate assistance, kindness and support in unique and personal ways;
- Makes use of members' personal and social connections to make positive changes for the person;
- Focuses on strengths, talents and capabilities of all involved;
- Engages people in imagining and leveraging support for positive change in the person's life (as directed by them);
- Is diverse and well connected;
- Acts based on the will, preference and best interest of the person.

The organization provides clear, documented guidance to staff on how relationships between paid staff and people supported may grow and change into natural friendships along with any limitations to staff interactions or relationships. This is shared with people supported, families and staff as early as possible.

Staff received training on how to solicit, enlist and nurture natural supports for people they support. Where needed, staff are trained to facilitate support network interactions and activity.

Documentation and contact information for members of people's support networks is maintained and updated within the person's Support Plan.

How would you know this is happening? (Evidence)

What you see in systems:

There is evidence of robust support networks in person centred planning and support planning documentation

Staff training records

What you see in actions:

People and their families receive support, assistance and fellowship from a robust support network of trusted, engaged community members.

Staff understand the importance of support networks and focus on helping the person develop and nurture their activity.

Resources to support achieving Guideline:

<http://www.inclusion.com/circlesoffriends.html>

http://www.circlesnetwork.org.uk/index.asp?slevel=0z114z115&parent_id=115

Circle of Support 2015 - Manual for Getting Started - Resourcing Families - https://www.ric.org.au/assets/Uploads/70239/ufiles/Circles_of_Support_Manual_2015.pdf

Sample Policy/Process for Enlisting Natural Support - [insert link when uploaded]

Innovative Life Options – Resources

<http://www.innovativelifeoptions.ca/resourcesbylife.html>

Related Guidelines:

Supporting Choice & Control

Facilitating Relationships, Connection & Social Capital

Supporting Inclusion & Community Participation

Outcome Area: Voice

Supporting Choice and Control

Guideline:

The organization supports people to have choice and control over their services and life choices. People are actively asked for input and feedback. People are informed of relevant information and options in a manner that is understandable and accessible to their unique communication style. People's wishes and opinions are respected, listened to and acted on. When this is not possible, people are informed of the reasons why.

What does this look like?

The organization has a policy and statement of commitment in place to describe their systems for active promotion and support of each person's right to choice and control over their service and life decisions. This may include reference to:

- Stated commitment and expectation that people will be respected and listened to:
 - People are recognized as an expert in their own experiences, needs and wishes.
 - People are empowered and enabled to be as independent and as in control of their lives as they want to and can be.
 - Each person is listened to with care and respected by staff and the organization. Their views are taken into account in all decisions.
 - People receiving service are facilitated and empowered to exercise choice and control across a range of daily activities and to have their choices and decisions respected.
 - People are encouraged to work out a structure to their daily lives that best reflects their goals, activities, and needs and are assisted in doing so, if required.
 - Encouraging and welcoming people to serve in leadership or advisory roles within the organization.
 - People's right to refuse a recommended action or activity, where appropriate

- Providing information and options:
 - Providing support, information and advice in a format or language that is appropriate to the unique communication style of each person.
 - Information is provided at the earliest opportunity and as required thereafter to enable people to make choices and decisions.

- Providing information on options and support accessing services from alternative services when the organization cannot meet the person's needs or they wish an alternative option.
- Providing needed supports for choice and decision making:
 - Each person has a documented description of the supports they need and desire to make decisions and choices successfully. This includes identifying people's preferred communication methods, who they rely on to make decisions or ask advice from, and behaviour and body language that demonstrate pain, distress, or discomfort (when the person is unable to express these directly or clearly).
 - Active involvement of an advocate of the person's choice and/or their decision maker(s). Where people do not have this support, the organization will make ongoing and active efforts to assist them in developing supportive relationships.
 - Involving family members and significant others to assist with making choices and decisions, where appropriate.
 - Access to and/or information about equipment, aids or technology that increase independence, strengthen current skills, and support communication and decision making.
 - Assistive technology and communication supports are provided to facilitate contact with family and friends, as appropriate.
 - Providing information about how to access independent advocacy, support and advice when this is needed or requested.
- Active Solicitation for Feedback and Input:
 - People are consulted about and make decisions about the services and supports they receive and their views are actively and regularly sought by the organization.
 - Each person's means of expressing their preferences, choice and decision will be sought and shared to ensure that people are given the maximum opportunities to express their wishes, ideas and choices.
 - If people are unable to make their own decisions at any time, the views of those who know their wishes, such as their family, support network, independent advocate, formal or informal decision maker are sought and taken into account.

The organization provides training, guidance and supervision to staff to ensure that there is a robust understanding of the expectation and practice of supporting choice and control for people served within the organization.

Staff receive required instruction and information on each person's preferred method of communication, how they make decisions and choices and what support they require or wish in order to be successful.

The organization provides support and information to people served by the organization and their families/support network on the supports they can expect, training and skill development opportunities in the area of choice, decision making and self-advocacy and any limitations that may exist related to directing their services and support. This information is made available in an accessible format they can understand.

The organization monitors and evaluates whether people experience opportunities for choice and control, gain support to make decisions and feel in charge of their service and lives.

How would you know this is happening? (Evidence)

What you see in systems:

Written policy/statement of commitment and expectations related to people's right to make choices and control their support decisions

Training content and records of completion

Documentation reflects the involvement of people who use the service, staff, family members and other stakeholders

Documentation includes people's right to refuse a recommended action or activity.

What you see in actions:

Staff demonstrate an understanding of each person's right to choice and control in services and life decisions.

Feedback from people supported and their families indicate that they have been supported to exercise choice and control in service-delivery decision making, along with people's right to refuse a recommended action or activity without retribution or consequence.

Resources to support achieving guideline:

Manitoba Vulnerable Persons Act - https://www.gov.mb.ca/fs/pwd/what_is_vpa.html

The Essentials of Supporting Choice - The Council on Quality and Leadership: <https://c-q-l.org/resource-library/resource-library/all-resources/the-essentials-of-supporting-choice>

It's My Choice Toolkit - Inclusion Melbourne - <http://inclusion.melbourne/resources/choice/>

What's Worth Working For - John O'Brien - <http://thechp.syr.edu/wp-content/uploads/2013/10/whatsw.pdf>

Michael Bach (Canada) – Video "Speaking differently at Disability and Decision Making" <https://www.opensocietyfoundations.org/voices/looking-differently-disability-and-decision-making>

Sample Choice and Control Policy Statements - [insert link when uploaded]

Sample Curriculum for Strategies for Supporting Choice and Control

Related Guidelines:

Informed Consent & Decision Making

Enlisting Natural Support

Outcome Area: Voice

Informed Consent and Decision Making

Guideline:

The organization provides robust information, education and support to people served in order to facilitate decision making and informed consent that takes into account their learning and communication style and needs.

What does this look like?

The organization has a policy and statement of commitment in place on how and when they seek and gain informed consent from people they serve. This policy also identifies how they support people to make decisions. This may include reference to:

- Capacity to give consent and make decisions should be assumed. Everyone makes decisions – either big or small. Formal decision makers are asked to provide consent on the persons' behalf only in the specific areas that have been designated by the Vulnerable Person's Commissioner. People are supported to make their own decisions in all other areas.
- Supported Decision Making: Supported decision-making is a process by which a person who requires assistance can be supported in making his or her own decisions. Some key factors to supported decision making are:
 - The organization needs to learn how people make decisions and document what support they need to be successful. They may require such support as interpreter assistance, communication support, assistive technologies, and plain language translation.
 - People can make decisions that others may not agree with. A person can change their mind at any point.
 - Some people may need more support to make decisions such as involving family, or independent advocates. The supporter(s) solely explain(s) the issues, and may interpret the signs and preferences of the person to others based on their prior knowledge of and relationship to the individual.
 - The process and supports may include:
 - Helping a person access all information and options that are useful or necessary for a decision;

- Helping her or him weigh the potential consequences and the pros and cons of each option; explaining possible risks of proposed decisions;
 - Helping the person get advice from others that they rely on and trust;
 - Identifying if the person can trial their decision before deciding;
 - Assisting in communicating the decision to third parties;
 - Carrying the decision out, if applicable;
 - Supporting the person through the consequences of their decisions, assisting with learning and assessing whether they wish to change their decision over time.
- People's skills change over time so it's important to re-visit whether they continue to require the same level of support to make decisions and in what areas throughout their life.
- Formal consent:
 - For consent to be truly informed, the person must receive information in a manner that is understandable and accessible to them. Decision must be voluntary without threat or force.
 - Need to engage and listen to the person and give them information in a manner that has been adapted to their learning style, strengths and abilities.
 - Written consent is time limited, specific and described clearly in a way that the person can understand. There is clear system for documenting and storing these consents.

The organization trains, supports and supervises their staff to meet the expectations outlined in policy/statement and to provide **thoughtful, ethical** and **supportive** assistance to people receiving services to make decisions and give consent.

The organization provides information and education to people served and their families on when, how and why they will be asked for formal consent and/or to make decisions. Limitations or changes to how and who these decisions are made by are explained in a timely and accessible way.

The organization ensures that all research done within its services has received ethics approval. People are given clear and robust information about any research to decide if they wish to participate.

How would you know this is happening? (Evidence)

What you see in systems:

Clear policy on when and how informed consent will be sought from people served, how this will be documented and stored.

Training content and records of completion

Written information for people served and their family/support network about when and how they will be asked to make decisions and/or give formal consent.

Written consents are accessible and organized.

What you see in actions:

Staff know when and how they should be seeking formal consent from people, how to assist people to make decisions and how to document and communicate these decisions.

Feedback from people supported and their families indicate that they have been supported to make decisions in a structured way, know when and how they will be asked to give formal consent and what limitations there may be on their decision making authorities.

Resources to support achieving guideline:

Manitoba Vulnerable Persons Act - https://www.gov.mb.ca/fs/pwd/what_is_vpa.html

Community Living Manitoba - Agencies Guide to the VPA - [insert link once uploaded]

Community Living Manitoba - Families Guide to the VPA - [insert link once uploaded]

Community Living Manitoba - Personal Guide to the VPA - [insert link once uploaded]

It's My Choice Toolkit - Inclusion Melbourne -

<http://inclusion.melbourne/resources/choice/>

Sample Consent Policy Statements - [insert link when uploaded]

Sample Curriculum for Strategies for Supported Decision Making [insert link when uploaded]

Michael Bach (Canada) – Video "Speaking differently at Disability and Decision Making"

<https://www.opensocietyfoundations.org/voices/looking-differently-disability-and-decision-making>

Helen Sanderson Associates – Video "Decision Making Agreement" –
<http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/decision-making-agreement/>

The UC Davis MIND Institute (Medical Investigation of Neurodevelopmental Disorders)
– Video on supported decision making –<https://www.youtube.com/watch?v=i0jd-J9Lozs>

Supported Decision Making - Canadian Association for Community Living -
https://youtu.be/ZY69_BW8Y_o

Supported Decision making: <http://inclusion-international.org/supported-decision-making-dialogue-guide/>

Related Guidelines:

Supporting Choice and Control
Dignity of Risk
Privacy
Enlisting Natural Support

Outcome Area: Voice

Communication

Guideline:

The organization acknowledges and supports communication as a fundamental human right and as such, works actively to ensure that the person is provided required support to maximize their ability to communicate throughout their daily life.

What does this look like?

The organization offers or seeks (as needed) clinical services to assist in identifying the form of communication or method that works best for the person. This may include a range of options such as: speech therapy, use of sign language, printed symbols, switches, augmentative communication devices or use of computers.

The person, their family and support network are informed and educated on how to use any communication aids or devices appropriately and meaningfully.

The organization has a process to ensure that any devices and supports required by the person to communicate are available to them in all the settings and places they go throughout their day.

Staff act as active communication partners who value all communication, whether intentional or not and take the time to really listen and respond. They help others involved in the person's life to communicate with them through modeling and teaching.

While each person has unique needs, where possible, staff should try to create conditions to enable effective communication. This may involve:

- Face the person
- Speak (or sign) clearly and at a moderate pace and volume
- Use plain language, choosing words the person may likely be familiar with
- Minimize background noise and unnecessary distractions
- Considering the impacts of fatigue, pain, temperature, illness, medications or stress

Where people use unique and personalized gestures, noises and facial expressions to communicate, the organization works with the person and their support network to capture and document these along with their interpreted meaning. This documentation

is available to all those that interact with the person to facilitate understanding and relationships.

Staff need training on the importance of communication, how the people they work with communicate and what support they require. Training may need to be refreshed as technology assistance for communication changes regularly.

The organization trains staff to carefully clarify messages and check the extent of a person's comprehension, particularly in high-risk legal, financial, or medical situations.

How would you know this is happening? (Evidence)

What you see in systems:

The methods and the supports needed for the person to communicate effectively throughout their day are documented in Support Plans

Staff training and records

Clinical recommendations are available as needed

What you see in actions:

People have access to the supports needed to communicate to the best of their ability in all environments. Families and support networks are aware of and supported to use communication aids or devices.

Staff are confident and competent in their ability to support the communication needs of the people they serve.

Resources to support achieving guideline:

Communication: First Principles - Centre for Applied Disability Research -
<https://www.cadr.org.au/research-to-action-guides/communications-first-principles>

Convention on the Rights of Persons with Disabilities - Article 21 - Freedom of Expression and Opinion and Access to Information -
<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-21-freedom-of-expression-and-opinion-and-access-to-information.html>

Related Guidelines:

Facilitating Relationships, Connection and Social Capital

Health Care Support

Legal support & assistance

Informed Consent & Decision Making

Support Plan Documentation

Positive Behavior Support

Accessibility

Outcome Area: Voice

Supporting Culture, Language, Spirituality & Identity

Guideline:

The organization supports, promotes and protects people's connection with their culture and language, celebrates diversity and honours a person's identity. The organization supports people to develop and maintain their personal, gender, sexual, cultural, religious and spiritual identity. People are respected and valued regardless of their needs, ability, or mental health status.

The organization has clearly defined congruent set of values and principles and demonstrates behaviours, attitudes, policies, structures and practices that enable them to support people's wishes and practices that relate to their culture, language, spirituality and personal identity.

What does this look like?

The organization has formally committed to providing support and services in a manner that respects and promotes people's wishes related to their personal identity, culture and language.

In this policy or statement of commitment, the organization details the expectations that they have for staff and community partners to create and maintain an atmosphere and culture of inclusion and respect for diversity. The statement and practices may include:

- People with culturally and linguistically diverse backgrounds are assisted to maintain their cultural identity and connection to community if they wish to.
- Clear processes on how to respond to racism or discrimination.
- The organization maintains appropriate community linkages and collaborates to meet the cultural, spiritual and language needs of people.
- People and staff to learn about and celebrate different cultural beliefs. Discussions are led by employees to promote open discussions about different culture groups that may include spiritual beliefs, holidays, diet, clothing, attitudes towards disabilities, language, gender related issues, and aging related issues
- People are treated according to their self-identified gender, meaning that transgender and gender non-conforming people are given access to sleeping quarters, bathroom facilities, and services based on their stated gender, not their assigned sex at birth.

- Each person's preferences, their dietary requirements and cultural and religious beliefs are taken into account in relation to mealtimes and food provided.
- Supports and accommodations, such as transportation and easy-to-read materials should be provided as needed to facilitate the person's preferred participation in spiritual or cultural activities of her/his choice.
- Cultural or spiritual communities should be encouraged to build their capacity to support and welcome individuals with intellectual and/or developmental disabilities and their families, and should be assisted in such efforts.
- Information is sought and maintained about people's history, preferences and wishes related to their culture, language, spirituality and personal identity.

Strategies that may assist include:

- Use an interpreter, if needed
- Develop an understanding of the person's perception of disability – how does this person (or family or culture) perceive the disability
- Develop an understanding of the roles that religion and faith play in their life and in people's well-being
- Develop an understanding of the role of cultural traditions in the person's life
- Ask whether the person has had an opportunity to fully participate in their culture's practices and traditions and whether they wish to in the future
- Assist the person to identify, explore, communicate and participate in the spiritual practices of their choice. Spirituality is an important part of human experience that may be expressed either through religious practice or through other spiritual activities, which carry personal meaning and reflect the person's values.

Staff are provided with information and training to understand the organization's expectations of their role in supporting culture, language and identity.

People and their families are assisted to understand their roles in supporting the culture, identity and spiritual practices of other members of the community and organization.

How would you know this is happening? (Evidence)

What you see in systems:

Documented processes are in place that describe the system for maintaining and strengthening the cultural, spiritual and language connections of people served; for example, questions and information are asked and gathered about people's

preferences, culture, language, spiritual practices when they begin to received services and are maintained throughout. This information helps shape support and assistance.

When people or their family need the assistance of interpreters, there is a documented system for accessing this.

Content of training related to cultural competency is available along with evidence of completion by staff.

People's history, records of life experiences and achievements, school reports, photographs of meaningful and significant events and the names of significant people involved in the person's lives are available in a portable format (e.g. a life book) that the person could take with them when moving or changing service providers.

What you see in actions:

Staff respect the sexual orientation, gender identity, and gender expression of people served and their families.

Staff demonstrate an understanding of:

- cultural and linguistic diversity
- how and when to access an interpreter
- community linkages and/or partnerships with specific services that relate to people's culture, identity or spiritual practices.

Feedback from people served and their families indicates that they feel that their culture and identity is valued and promoted and that they are assisted to participate in cultural or spiritual practices as they wish.

Resources to support achieving guideline:

National Center for Cultural Competence - Georgetown University -
<https://nccc.georgetown.edu/>

Bridging Diversity Toolkit - Connectability -
<https://connectability.ca/2015/05/09/bridging-diversity-toolkit/>

Related Guidelines:

Supporting Choice & Control

Outcome Area: Voice

Person Centred Planning & Discovery

Guideline:

The organization uses creative, flexible and inclusive methods to identify a person's strengths, needs, goals and aspirations. The planning process is driven and guided by the person.

The plan is based on an exploration of the persons' desired personal outcomes and needs and the goals and activities that would lead to the attainment of those outcomes. A timeline to achieve these goals and the people that are needed to help are part of the plan.

A person centred planning process is conducted at least annually. This process feeds updates to the Support Plan. A person centred plan is developed with each person in advance or shortly (~3 months) after service begins.

The organization monitors and is accountable for the commitments made during the planning process.

What does this look like?

The organization has a consistent and documented process to ensure that planning with people served occurs. Essential features of this process include:

- Planning is a regular and ongoing activity that brings people together who love and support the person to help them:
 - Describe their desired future
 - Identify how they could achieve this desired future
 - Explore what's getting in the way and how to reduce or eliminate barriers
 - Identify who they need help from to make progress
 - Identify a personalized mix of paid and non-paid people, services and supports to achieve their desired outcomes.
 - Create a plan and get commitment from those they need
 - Evaluate, revise plan and repeat
- The process is driven by the person, includes whomever the person chooses (number and specific people) and the format, location and topics are as guided by the person. The use of person centred planning tools such as PATHS, MAPs,

Personal Outcome Measures, Person Centred Thinking Tools, etc., is offered to and directed by the person.

- The planning occurs in an accessible manner that is understandable to the person. The person has required communication support and any meetings associated with the planning process occur in the language they are most comfortable in (English, French, American Sign Language (ASL), use of symbols, etc.)
- The planning occurs within a safe space with ground rules that ensure positive, respectful and collaborative discussion among those that the person trusts.
- Ongoing planning acknowledges that the person can change their mind. There is direction on how and when the plan is revised and how this is communicated.
- When a person does not identify personal goals, desires or preferences, efforts are made to expose the person to new opportunities that are thought to be interesting, enjoyable and meaningful.
- There are a variety of tools and methods that can be used to assist planning and facilitate meaningful discussion. Such as:
 - Relationships/friendships
 - Reviewing what is working/not working,
 - Exploring specific aptitudes, skills, and abilities,
 - Walking through what is a good day/bad day for the person,
 - Talking about what is important to/important for the person,
 - Discuss what the person does and does not want in significant areas of life such as:
 - Learning/education
 - Employment/meaningful activities
 - Retirement
 - Fun
 - Health goals
 - Identify characteristics of people who support the person best.
 - Identify what people like and admire about the person.
 - Use relationship maps.
 - Use communication charts explaining communication style and best ways to communicate.

Staff are trained and competent in person centred planning and understand the expectations of follow up, evaluation and ongoing planning.

People receive the training and support they need to participate actively in the planning process to the extent that they are interested.

Follow up on actions committed to during planning is done consistently and in a timely fashion.

While a written support plan may be developed or updated following planning with the person, the support plan itself does not in and of itself shape or dictate the process. Updates to the support plan and any other required documentation is a likely action stemming from each planning session.

How would you know this is happening? (Evidence)

What you see in systems:

The organization has a written, consistent process on how it facilitates regular planning with people they support.

Written document is available that captures the planning process. These documents are live, dynamic plans that are referenced and updated regularly and shape the way that the organization provides services to people.

The plan is documented and shared as directed by the person.

There is evidence of follow up and progress on expressed plans of people served.

What you see in actions:

Staff within the organization use people's planning documentation as a road map for how they wish to be supported and what they want to achieve. They are accountable for the commitments made during the planning process and follow up to be sure that others are accountable for their part of the plan.

People supported along with their support network feel that the planning process is a powerful, empowering process that allows them to direct and plan how they wish to be supported, what they want to achieve and who they need help from to succeed.

The routine and tasks of the person, as supported by the organization, reflect the person's wishes and their person-centred plan.

Resources to support achieving guideline:

National Center on Advancing Person Centred Practices and Systems

<https://ncapps.acl.gov/Resources.html>

Improving the Quality of Person Centred Planning

<https://rtc.umn.edu/docs/pcpmanual1.pdf>

Person Centered Tools: <https://www.sdaus.com/tool-kit-templates-examples>

Michael Smull (Michael is the founder and Chair of the Learning Community for Person Centered Practices) videos on use of the tools:

- Important To and Important For: <https://www.youtube.com/watch?v=VDqERIxM4HM>
- What's Working and What's Not Working: <https://www.youtube.com/watch?v=QbTXp0wKFMQ>
- 4+1 Questions: <https://www.youtube.com/watch?v=KYzxYcMN7sE>
- Matching Support: <https://www.youtube.com/watch?v=QbTXp0wKFMQ>

Sample Policy/Process - Person Centred Planning - [insert link when uploaded]

Developing a Positive Personal Profile (Employment related Planning - [insert link when uploaded])

Related Guidelines:

Support Plan Documentation

Supporting Choice and Control

Quality Improvement

Outcome Area: Voice

Support Plan Documentation

Guideline:

The organization solicits and documents information from the person, their family and support and social network on the best way to support the person. This information is shared with those responsible for providing services so that they are equipped with and are guided by the wishes and needs of the person.

What does this look like?

The organization completes a personal or individual support plan for each person served that:

- Is built by and with the person, their family and support and social network
- Identifies the support needed by the person in a range of areas in order for them to be as independent and/or actively involved as possible.
- Captures the goals, preferences, needs, strengths, abilities, and wishes of the person on how best to support them going forward.
- Contains information that may have been received from health care providers, clinical consultants, etc., as guided by the person.
- Is informed by the results of person centred planning processes, personal outcome measure interviews and any specific assessments that the person may have received.
- Integrates information from other specific plans or protocols such as behaviour support plan, health care protocols, etc.
- Documents important historical milestones and events for the person so that key features of their story are not lost.
- For privacy or sharing purposes, the person may wish to break the document into specific areas or separate plans.
- Includes goals related to the person's preferences and routines of daily living.

People are consulted with and participate in the development of a comprehensive support plan, in consultation with their families and support network. The written personal plan is kept in their personal file. These are prepared before people begin receiving services or as soon as possible after service begins. People served or the Substitute Decision Maker, along with those they delegate, receive a copy of the plan and provides ongoing input to ensure it remains up to date.

Personal support plan should include details about the needs, strengths and supports needed in the area to be as independent or actively involved as possible. While topics are guided by the unique circumstances surrounding each person and the types of supports the organization is providing to the person, the support plan should consider the following areas (in no particular order):

- One Page Profile - summarizing major points of Support Plan
- History/Story
 - What is the person's story? What is the important history that shapes who the person is today?
 - Where did they live in the past? With whom?
 - Past struggles and joys that they want their support team to be aware of.
- Rights & Responsibilities
 - What awareness and knowledge does this person have of their rights and responsibilities?
 - What information and education do they need to enhance their knowledge and skills in this area?
 - Are any rights restricted? Why? What is the plan to eliminate or reduce this restriction? Include specific rights restriction review documentation if available.
- Decision Making
 - What support does this person need to make decisions, if any?
 - Who are the people who provide formal or informal support in this area?
- Self-Direction/Advocacy
 - How does the person express and advocate for themselves?
 - What support do they require to advocate?
 - Do they currently or want to in the future, access advocacy services or peer mentorship?
 - Name and contact information of advocate, if applicable.
 - Community resources used or needed.
- Relationships/Connection
 - Who is important to the person?
 - What is or where is the important information about these important people (i.e. contact information, birthdays, desired frequency of contact, etc.)?

- What support and assistance does the person need to develop or maintain relationships?
- Strategies to address barriers
- Community resources used or needed
- Inclusion
 - Does this person know or want to know their neighbours? Do they need support to interact or connect with them?
 - How does the person access and participate in their neighbourhood, preferred communities or city/town? What support do they need to do so?
 - What community groups, special interest communities or organizations does this person want to be involved in? Do they require support to do so?
 - Strategies to overcome barriers
- Employment/Meaningful Contribution
 - What are and how is this person being supported to achieve their employment goals?
 - If employment is not their goal, how do they wish to contribute and spend their time (e.g. volunteerism, healthy lifestyle activities, etc.)?
 - What community resources or supports does the person use or need in this area?
 - Strategies to address barriers.
- Education and lifelong learning
 - Goals, dreams and wishes
 - Community resources used or needed
 - Strategies to address barriers
 - Transportation/Getting Around
 - How does the person get around their community? Are there barriers?
 - What support do they require to successfully access transportation?
 - Strategies to address barriers
 - Community resources used or needed
- Financial/Material Wellbeing
 - Supports required to be as independent or actively involved
 - Income/Expenses - does the person have enough income to meet their needs, and if not, what strategies could increase or reduce the gap between their needs/desires and the availability of funds to meet those needs?
 - Status of financial planning/budgeting - who does what?

- Community resources used or needed
 - Strategies to address barriers
 - Communication/Language
 - How does this person communicate? What support do they require to maintain, enhance or initiate this?
 - What training or information do staff who support them require to understand, interpret or facilitate this communication?
 - Does the person use or want to use any assistive technology in order to enhance their ability to communicate.
 - Strategies to address barriers
 - Community resources used or needed
 - Fun & Recreation
 - What does the person like to do for fun, what do they not like to do
 - What support does the person require to participate in their preferred activities or to try new ones?
- Independent Living/Daily living
 - What support does the person need to get through their day?
 - How do they want that support to be provided?
 - How do they direct that support or communicate when they want changes to the way their day is going?
 - Does the person require personal or intimate care during bathing, dressing, toileting, or personal hygiene? How is this best done? Who, how and when do they prefer this is provided? What specific information or training do the staff providing this support require in order to do this respectfully and safely?
 - Does this person have any specific support needs to assist them to sleep well?
- Safety
 - What supports does the person require to be safe? What risks are present for the person?
 - Do they have information and skills to keep themselves safe from or to report if they are being mistreated, disrespected or hurt?
- Health and wellbeing
 - Acute and chronic health conditions
 - Allergies

- Medications and Treatments
 - Sensory needs
 - Mobility needs
 - Healthy lifestyle supports
 - Mental health supports
 - Counselling
 - Addictions support
 - Clinical supports (physiotherapy, occupational therapy, dietary, speech, nursing)
 - Food & Nutrition
 - How does this person communicate when they are not feeling well or in pain?
 - Reference or attach all health care protocols or plans (seizure or prn protocols)
 - Contact information for all members of the person's health care team
 - Community resources used or needed
 - Strategies to address barriers

- Support required to be as independent or actively involved in all above areas
 - Spirituality
 - What spiritual practices does this person engage in/want to engage in?
 - Religious communities or practices
 - Cultural ceremonies or events
 - Meditation, massage or other self-care activities
 - What brings the person comfort when they are sad, upset or experiencing grief?

- Positive Behaviour Support
 - Does the person require any specific support around behaviour that is unsafe or gets in the way of their ability to be successful at home or in the community?
 - What strategies or supports are helpful and under what circumstances?
 - Refer to or include any behaviour support plans and safety plans.

- Technology
 - Does the person use technology for fun or assistance?
 - What support does the person require to use or access this technology?
 - What information or training will those that support the person need about the technology?

- Legal
 - What supports does or would the person require to address legal issues?
 - Who would help or support if this becomes a need?
 - How would the person's rights be supported and protected?
 - What community resources would or could be accessed?

- End of life planning
 - Has or does the person wish to document their wishes for health care in advance of and arrangements following their death?
 - Does the person have or want to have a will or expression of wishes?
 - What support does the person need to execute these plans?
 - Where is required and relevant documentation kept in the event of serious illness or death?

- Support Team
 - Who are the key members of the person's support team both in and outside the organization? Include contact information for all (this may include key staff, managers, social workers, EIA worker, clinicians, Substitute Decision Maker, etc.).
 - Who are the members of the person's natural support network that could provide the required supports? Include contact information for all.
 - Are there specific roles and responsibilities that each fulfill in supporting this person successfully.

Each person has a copy of their support plan in an accessible format, if they wish.

Each person's personal plan is reviewed annually or more frequently if there is a change in needs or circumstances. The review of the plan is guided by the person and informed by the person's ongoing person centred planning process. While the person may not wish to involve everyone in this process, relevant changes to the support plan should be shared with those responsible for facilitating or implementing the support, with the person's consent.

The organization has a method to ensure that all staff who are responsible for supporting the person have access to and are familiar with their support plan. Staff receive orientation prior to working with the person on the best ways to support them. Staff are trained to understand the purpose and importance of support plans and their role in providing the supports outlined.

Depending upon the scope or type of support the organization provides to the person, the support plan may be broad or very focused (i.e. employment support only). Where

two (or more) organizations provide support to a person, it is imperative that there is collaboration and sharing to ensure that support is integrated. This is, however, guided by the person and there may be some information that they wish not to disclose to all service providers. When this happens, there needs to be discussion about any risks that this may create and a plan to mitigate or decrease these risks.

How would you know this is happening? (Evidence)

What you see in systems:

Each person has a written support plan that outlines the supports the person needs to be successful.

Training/orientation content and record of completion.

What you see in actions:

Staff are aware of and guided by the wishes, preferences and needs of the person as documented in a comprehensive, thorough and dynamic support plan.

People who the person relies on for support (either paid or unpaid) are aware of and committed to their role in helping the person be successful.

People receive the support they require and desire.

Resources to support achieving guideline:

Sample Support Plan - [insert link when uploaded]

One Page Profiles - Helen Sanderson

<http://helensandersonassociates.co.uk/person-centred-practice/one-page-profiles/>

Related Guidelines:

Person Centred Planning

Supporting Culture, Language, Spirituality & Identity

Personal Care Support

Outcome Area: Voice

Dignity of Risk

Guideline:

People are supported to make informed choices and decisions about the risks or consequences of potential decisions. They are encouraged to take positive risks which enhance their personal outcomes.

The organization has a process to thoughtfully and thoroughly anticipate possible risks, plan ahead, and promote a safe environment while increasing opportunities for people to participate more fully in the community.

The organization enhances the abilities of the person to keep safe by ensuring that he/she has knowledge of his/her rights, choices, and how his/her actions can influence others.

What does this look like?

The organization has a process, training and practices that promote dignity of risk.

The organization balances the right for people to make decisions and choices that may expose them to risk with the responsibility to take reasonable care to ensure that actions do not cause injury or harm to the person or others.

The organization supports the person by:

- helping the person acquire the skills necessary to identify the risks associated with individual choice as reasonable or unreasonable, acceptable or unacceptable
- Supporting the person to actively identify and assess the possible risks associated with a given choice including understanding the impact and consequences of risky and unsafe behaviour.
- Implement a plan involving suitable supports, resources, and practices to reduce the risk (to the individual, the organization, or the community at large) and maximize success in pursuit of a goal.
- Supporting and encouraging the person to connect with and discuss possible risks and options with family, friends, professionals or members of their support network.

Identified risks and the support needed to try to mitigate these risks are documented in a person's Support Plan and/or Safety Plan.

Staff are expected, empowered and trained to support people to make informed decisions about activities or behaviours that may expose them to risk. Staff have a good understanding of the process for identifying and reporting high levels of risk in a sensitive manner.

How would you know this is happening? (Evidence)

What you see in systems:

Identified risks and supports needed are documented in people's plans

Staff training content and records of completion

Incident report follow up documentation

What you see in actions:

People receive support to make informed decisions that balance their right to direct their own lives with protection from significant harm. Families and support networks are involved in helping the person as they choose.

Staff have the tools and information needed to guide people in their choices. They are knowledgeable about how and when to raise concerns about potential harm and risk.

Resources to support achieving guideline:

It's My Choice Toolkit - <http://inclusion.melbourne/resources/choice/>

CQL - Understanding Risk

<https://c-q-l.org/resource-library/resource-library/all-resources/understanding-risk>

Related Guidelines:

Informed Consent & Supported Decision Making

Supporting Choice & Control

Personal Safety

Risk Management