Community Living Toronto's

Partnership with Families

IN THE DELIVERY OF

Services and Supports

Equity, Diversity and Inclusion Statement

Community Living Toronto aspires to a culture where equity and inclusion are naturally occurring, and diversity is embraced as a source of learning and pride.

Community Living Toronto aims for equity through the fair and respectful treatment of all people — staff and individuals served. This will be achieved through an intentional and respectful focus on, and recognition of, everyone's unique qualities and attributes and creation of inclusive environments where all individuals feel respected, accepted and valued.

We believe that supporting and engaging diversity of age, gender identity, sexual orientation, physical or intellectual ability, ethnicity, religion and Indigenous heritage is integral to the services we provide.

As an employer of choice, Community Living Toronto is committed to attracting and retaining a diverse workforce, building and strengthening partnerships, and fostering an environment free of discrimination and harassment.

We will work to ensure that the concepts of equity, diversity and inclusion are understood and barriers are eliminated, so that the EDI (equity, diversity, and inclusion) culture is reflected and celebrated throughout the organization.

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MISSION

fosters inclusive communities by supporting the rights and choices of people with an intellectual disability.

VISION

A society where everyone belongs. A society where everyone is valued.

VALUES

Outline of Family Partnerships in the Delivery of Services and Supports

In 1948, a group of parents who shared a common vision came together to challenge the status quo for their children who had an intellectual disability.

Working in partnership with families and collaborating with parents/caregivers is at the root of the community living movement and is an integral part of Community Living Toronto's history.

This guide will clarify the roles and responsibilities of CLTO (the agency), families and caregivers in the provision of services and supports and to establish mutual expectations of the agency and family/caregiver that will help to ensure integrity, effective communication and outcomes based services/supports. This framework is aligned with the vision, mission and values of CLTO.

Community Living Toronto has adopted a model of services/supports whereby the professionals involved with the supported person collaborate with their support team, the individual in service and their family/caregiver. We believe that it is only when all parties work together with a common understanding of purpose that the highest quality of personal outcomes can be achieved.

This guide shall be reviewed by all parties annually.

Provision of Services and Supports

- CLTO shall facilitate person-directed planning/plans of care with the individual in service, their family/caregiver and circle of support, as appropriate. CLTO will monitor the personal outcomes of goals set through these processes.
- CLTO will supervise, train and support staff in the use of individualized support strategies for the individual in service.
- CLTO shall monitor quality of life through achievement of personal outcomes as well as the mental/physical health of individuals in service, according to our agency's policies/procedures, and consistent with Ministry guidelines and regulatory requirements.
- CLTO will develop appropriate behaviour support protocols as required.
- CLTO shall facilitate the provision of community-based, medical, psychological, behaviour and psychiatric supports to the best of the agency's ability to do so.
- Behaviour Support Consultants shall monitor and oversee behaviour support plans, where required.
- CLTO shall monitor progress with respect to support strategies that have been developed.

Contact Information by Role

To provide families/caregivers with the opportunity to discuss specific services and supports with the leadership or clinical team members, a list specific to the location will be provided.

The list will include the following persons/positions, as appropriate (The family/caregiver/Substitute Decision Maker responsible for signing documents must be identified on the list.) :

- **Person Supported**
- **Substitute Decision Makers and Powers of Attorney With Signing Authority**
  e.g. for treatment decisions, consents, etc.
- **Primary Worker/Service Coordinator**
  The first point of contact for families/caregivers
- **Program Supervisor**
  e.g. support issues, feedback and/or complaints/concerns shall be directed to the Program Supervisor
- **Program Manager**
  If resolution of an issue directed to the Program Supervisor is not agreed upon or the matter has not been attended to within 48 hours, Program Manager should be notified by the family/caregiver
- **Senior Manager/ Service Stream Director**
  If resolution of an issue directed to the Program Supervisor or Manager is not agreed upon or the matter has not been attended to within in a timely manner, the Senior Manager/Service Stream Director as applicable should be notified by the family/caregiver
- **Behaviour Services Consultant**
  Any questions to the staff from families/caregivers pertaining to treatment shall be redirected to the Behaviour Services Consultant for discussion. Behaviour Services Consultants shall be responsible for the development of appropriate behavioural interventions with oversight being provided by the Clinical Supervisor and the Manager of Clinical Supports
- **Clinical Supervisor**
  If a resolution of an issue related to clinical services — which has been directed to the Behaviour Services Consultant is not agreed upon or the matter has not been attended to within 48 hours, the Manager of Clinical Supports will be notified by the family/caregiver
- **Other (Name & Role)**
  e.g. Lead Care Coordinator, Social Worker, and Lead, Health & Wellness Services

Communication

Effective and respectful communication is fundamental to the partnership between the agency and the family/caregiver.

CLTO staff adhere to a Code of Conduct and the expectation of a high level of professionalism at all times. Similarly, it is expected that families/caregivers conduct themselves in a respectful manner with all members of the support team. Any instances of abusive, threatening or harassing language or intimidation and/or the destruction of agency property will not be tolerated.

We intend to ensure potential disputes are dealt with and resolved at the lowest possible level, but can be escalated to the next dispute resolution level if required. We are committed to working through issues as they emerge as per the agency's policy on managing complaints and our "We Want to Hear from You" form available at CLTO locations and on our website.

Designated times shall be arranged between the service coordinator and the family/caregiver to provide regular updates that may include overall health, well-being, activities sleeping patterns, behaviour, support and treatment, focused on strengths and progress. These times are to be arranged with the program in advance to ensure operational needs are met.

Families/caregivers are encouraged to be active members of an individual's support network and at the direction of the individual can be notified of important events such as medical appointments, so that you may attend and support.

Should they be unable to attend medical appointments, they shall be advised of all recommendations through the designated point of contact. Prior to implementing any recommended treatment options, consent must be acquired from the individual. In instances where an individual does not have capacity to consent, a subsequent decision maker will be requested to provide consent.

Adults in service may not consent to have their medical information shared with their family/caregiver. In this case, families will not be informed of any medical information.

At the family/caregiver's request, a schedule of monthly activities shall be sent to the family via email and available to them at the location or as determined by mutual agreement between the program and the family at the Plan of Care/Person Directed Plan meeting.

Visits

Regular visits with family members/ caregivers are encouraged, either at the family/caregiver home or at the site where the individual receives supports/ services.

On-site visits will also take into consideration the needs of other individuals in the program. The time of visits will be determined based on the needs of the program as a whole.

During the time of on-site visits, regular routines and any programs in place shall continue to be followed by staff in order to maintain consistency.

Dates and times for on-site and home visits or outings are to be scheduled in advance to enable planning for health or behaviour support needs and for scheduling.

To ensure that the person supported is able to take full advantage of recreational, social and skill building opportunities, the frequency and duration of visits with family/ caregivers shall be discussed and planned. This will be documented and a copy provided to the family/ caregiver and kept on-site.

If a planned visit must be postponed for any reason, the service coordinator or the Program Supervisor shall contact the family/caregiver as soon as possible to discuss alternatives.

The family/caregiver agrees to provide ample notice to the Program Supervisor in the event of any scheduling changes occur to avoid any scheduling conflicts. Any issues or concerns that occur on weekends, should the Program Supervisor not be scheduled to work, the problem can be addressed by staff on-site. If a resolution is unable to be reached, the staff and/or family/caregiver can follow up with the Program Supervisor on the next business day. An on call system is in place for coverage of weekends and holidays for urgent matters.

Staff are required to ensure a consistent medication regime for individuals, which must also be followed during home visits. This consistency is also critical to the individual's health and well-being. The family/caregiver will be required to complete and sign an ***Absence from Service Medication Information Form*** prior to all home visits as per CLTO policies and procedures.

Medical Appointments/ Treatment

CLTO recognizes and supports the right of families/caregivers, when the individual's consent is given, to participate in medical treatment decisions for their family member, based on medical advice from a licensed physician.

In order to maximize efficiency and safety and to minimize any miscommunication that could lead to error, CLTO will adhere to the following practices at all times:

- CLTO staff attends all medical appointments in order to both provide and receive input about medical status and any recommendations for treatment.
- The ***CLTO Healthcare Provider Form*** is to be completed in full and signed by the respective Licensed Health care Professional for inclusion in the case file.
- The signed ***Medical/Dental Record Form*** and guidelines for treatment are to be in the possession of CLTO before medical treatment is administered to ensure consistency and clarity of the staff team as per CLTO policies and procedures and relevant legislation.
- The family/caregiver will advise the Program Supervisor of the details of any upcoming appointments that have been made by them for the individual.

Operational Considerations

Any concerns or questions about operational issues at the site (e.g. safety, staffing) can be discussed directly with the Program Supervisor.

In the event of a crisis or emergency situation, CLTO will call for Emergency Services and contact the family/caregiver as soon as the immediate crisis/emergency has been resolved. It is understood by both parties that the family/caregiver will contact CLTO as soon as possible if there is an immediate risk to the individual, themselves or others.

Should the family/caregiver believe that an operational issue/concern is not able to be resolved through discussion with the Program Supervisor, the matter will be redirected to the attention of the Program Manager or to the Service Stream Director as per the CLTO Complaints Policy. A copy of the "We want to hear from you" information pamphlet shall be provided to the family/caregiver. In following the Complaints Policy please allow a response time of 48 hours for appropriate follow up.

FINANCES

An **Annual Personal Budget Plan** will be established for each individual for standard expenses (e.g. haircuts, outings, discretionary spending, etc.). Those involved in developing personal budget plans may include the individual caregiver, family members, the appropriate Program Supervisor and the primary Support Worker. This will involve identifying and agreeing on a monthly budget that includes all sources of income and regular expenses. The Annual Personal Budget Plan will be signed by the individual and/or family member. The Program Manager will sign only if the individual and/or family member is unable to do so. Where appropriate, a representative from the Office of the Public Guardian and Trustee may be involved.

Bank accounts will be established for individuals at a bank that is reasonably close to where they live. All bank account holders will receive monthly bank statements that list all transactions.

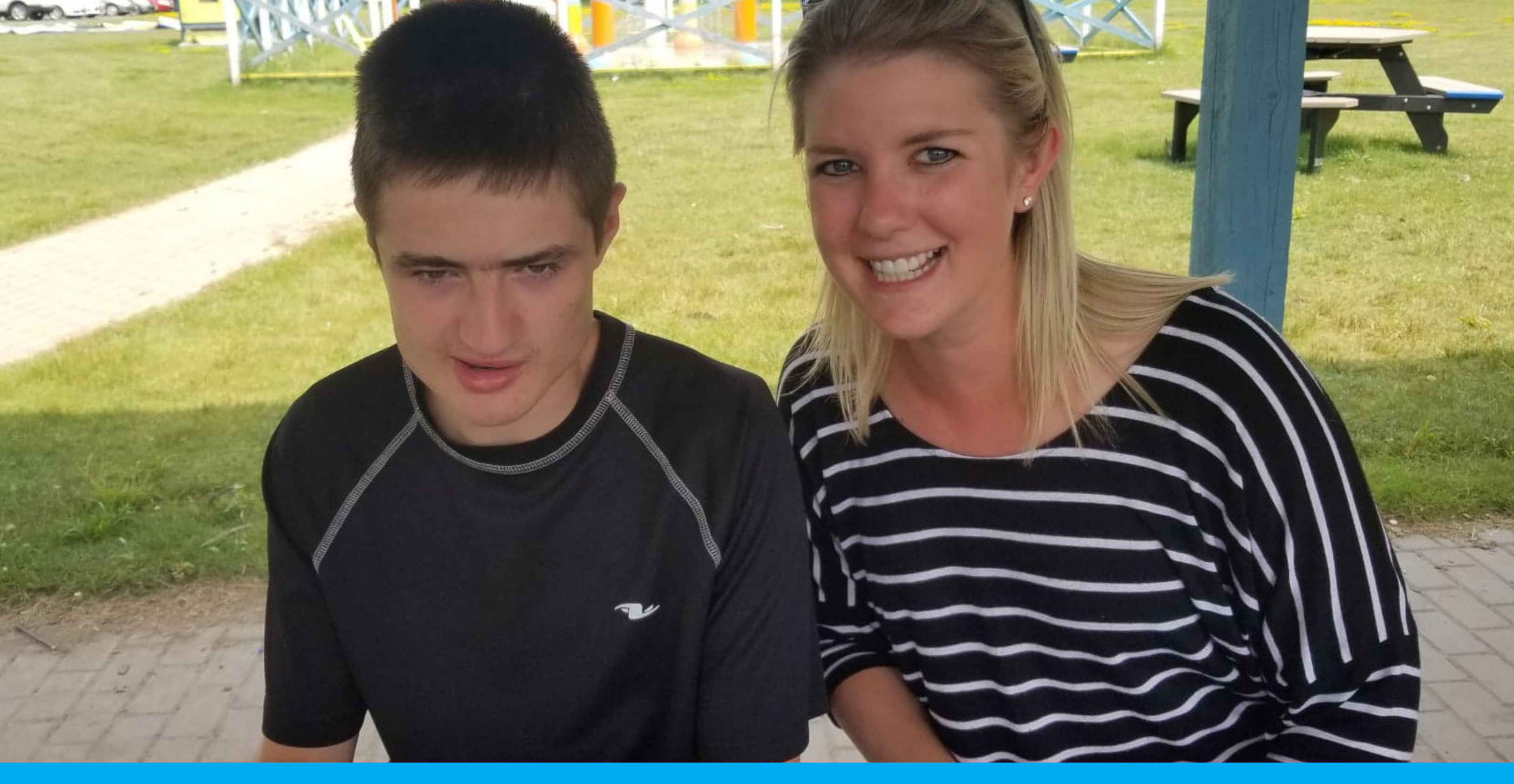
Appropriate daily cash withdrawal limits will be established.

The use of debit cards for major purchases over $100 and for the purpose of replenishing cash on hand must be pre-approved by the Program Supervisor.

Any monies forwarded to the program staff from the family or Public Guardian and Trustee for the individual's use will be administered according to the agency's policy.

Any questions regarding finances of an individual are to be directed to the Program Supervisor.

In Children's Services, the parent(s) or the guardian are responsible for clothing and all medical expenses including medication, unless otherwise specified.



Interdisciplinary Services

All individuals experiencing changing needs while receiving support from Community Living Toronto will have access to clinical services from CLTO's interdisciplinary team.

The interdisciplinary team is comprised of Transition Services, Health and Wellness Services, Behavior Services and Social Work. These services are provided on a consultative basis and can be accessed through an integrated referral form completed by the individual's support staff/team. The interdisciplinary team will work collaboratively with the person supported, the operational team at CLTO, and the person's support network for any assessment and recommendations required and will obtain any additional consent for treatment decisions as needed.

Community Living Toronto operates within the context of the Bio-Psycho-Social Model of supports where individuals, family members/caregivers, the support team and professionals share information and work collaboratively to provide support and expertise. Each component of the model is as outlined:

- **Biological** – physiology (a review of medical history, medication, etc.)
- **Psychological** – emotions and behaviours (a review of previous behavioural interventions, psychiatric medication, mental health supports, etc.)
- **Social** – socio-economic, socio-environmental, cultural factors (a review of relationships, stakeholders, ethnicity, religion, etc.)

All the above components are critical elements of this collaborative process. Input from the family/caregiver regarding treatment recommendations is important to the interdisciplinary team and shall be considered prior to the implementation of any interventions. Each element of the process is essential to the individual's treatment and therefore it will not be an option for the family/caregiver to select or reject one element of treatment over another. The family/caregiver can bring any concerns regarding elements of this process to the attention of the interdisciplinary team. Should the family/caregiver have concerns about recommendations, those concerns shall be redirected

to the most appropriate member of the interdisciplinary team for discussion, clarification, or review. During these discussions (in person/ telephone/videoconference), the family/caregiver shall have the opportunity to ask questions about the risks/benefits of any treatment before consenting to the assessment and implementation of interventions. Treatment decisions will not be made without a scheduled meeting when all parties of the treatment team are able to attend to ensure consistency and clarity for all involved. Once interventions are implemented, staff shall be trained and directed to carry them out as per protocol until such time that a formal change has been approved by the team.

If medical and/or psychiatric support is required, questions or concerns about the medication treatment plan may be addressed with the person's supported primary Physician or Psychiatrist (if applicable) at which time changes to the treatment plan may be recommended. It is strongly encouraged that the family/caregiver attend these appointments in order to have their questions or concerns addressed effectively as staff are not able to provide answers on behalf of an attending physician. It is understood that the status of the treatment shall be reviewed regularly by the interdisciplinary team on the basis of the objective evidence presented. It is on that basis that recommendations for changes to the treatment plan are made. Interventions proposed by members of the Interdisciplinary Team are based on accepted standards of evidence-based practice.

BEHAVIOUR SUPPORT PROTOCOLS

If required, behavioural support plans/protocols shall be developed by Behaviour Services.

Some of the behaviour protocols are developed to ensure the safety of the individual and the staff while others are developed with a focus to teach alternative behaviours to the behaviours of concern. The behaviour strategies are written with input from the entire support team as well as the family/caregiver and reviewed by Behaviour Services. Consent will be received from the family prior to implementation and will be formally reviewed by the Interdisciplinary Team every six months. The members of the support team shall be fully trained in the use of the behavioural support plans/ protocols. CLTO leadership and staff are responsible for carrying out the protocols correctly and consistently.

To maximize safety and consistency, the behaviour support plans and protocols are to be followed at all times, including on visits with the family. The family/caregiver agrees that they will not intervene or hinder the implementation of any protocol, including crisis intervention. Should the individual meet criteria to receive a Behavioural PRN (on an as needed basis), it is understood that CLTO staff will follow the crisis protocol as written without interference.

CRISIS MANAGEMENT

If required, a crisis response plan may be developed as part of the overall behaviour support plan.

However, if it is determined that CLTO cannot safely support the individual due to a crisis situation (e.g., medical, behaviour, mental health crisis), staff may seek the support of a local hospital or other appropriate service provider for assessment and treatment and will work collaboratively to facilitate a transition back to the site once the situation has been stabilized.

INTERDISCIPLINARY REVIEW COMMITTEE (IRC)

Community Living Toronto has developed a committee of which one of its functions is the review of complex clinical situations.

The IRC is an interdisciplinary group of external allied health professionals who meet monthly with the goal of supporting clinicians in providing high-quality health services to persons supported at CLTO. In addition, the IRC also conducts a yearly adherence to Quality Assurance Measures on all Behaviour Support Plans developed and implemented within CLTO. The committee is intended to be a supportive and constructive process that provides an opportunity for discussion and collaboration on challenging clinical scenarios. The Committee is made up of approximately 6-8 members including a psychiatrist, psychologist, behaviour analyst, social worker, registered nurse, and pharmacist. Should a case be brought forward for review the process includes an approximately one hour in length meeting which is comprised of a brief presentation, discussion, and provision of feedback. Following the review, detailed recommendations are provided in writing and may include support from a committee member. Examples of cases brought forward to the IRC could include an unusual increase in aggression or self-injury, requests for resources potentially unknown to the team, an individual at risk for loss of housing, education sessions for staff members at CLTO and many other situations that may benefit from these allied health professionals.

CHANGING NEEDS AND TRANSITIONS

CLTO has an intake and transition planning process for any individual who is entering CLTO's Supported Living and Specialized Resource Home services for the first time, as well as for any individual who is making an internal move within the agency's supported living programs. This process will be followed for all transitions due to aging out of children's services or as it relates to changing needs and choice.

CLTO recognizes and respects the importance of stability of supports for adults and will endeavor to provide continuity in living situations. However, it is acknowledged that individual's needs may change, and individuals may require a change in living situation.

Where necessary and in consultation with both the Interdisciplinary and Operational teams, CLTO will propose alternative supported living environments that are better suited for the individual, in terms of both safety and comfort. CLTO supports individuals throughout the City of Toronto. In the event that another placement is needed due to changing needs, the agency may explore other areas of Toronto than where the individual is currently residing to better meet their needs.

If it is determined that the person's support needs cannot adequately be met at their current home, the support team shall meet with the individual and/or family/caregiver to review any concerns together before any decisions are made. CLTO will make their best effort to find a suitable location internally that will meet the needs of the person supported, should this not be feasible, CLTO, the person supported, and their support network will work collaboratively to explore options outside of CLTO. This can include community supports, other developmental sector agencies outside of CLTO, and healthcare partners such as long-term care.

CHILDREN'S SERVICES

CLTO supports children within placements up until their 18th birthday within the Specialized Resource Homes. Prior to their 18th birthday, children residing within supported living settings would be referred to adult services through Developmental Services Ontario — Toronto, for possible placement options. The family/caregiver will work with the placing agency, such as Lumenus, and Children's Aid Societies, etc. in these circumstances to locate a suitable adult living environment, with the assistance of CLTO, as appropriate.

Should a persons needs exceed the ability and/or expertise of CLTO in order to continue to provide effective and safe supports, the placing agency will work with the family/caregiver to find the most appropriate support environment to meet their needs, including agencies external of CLTO.

Medications

In order to maximize safety, medication (including PRN) may not be administered by the staff unless it is accordance with the directive of the consulting licensed health care professional as per CLTO's policies and procedures.

Any recommendations and/or changes to the individual's medication regimen shall be reviewed by the family/caregiver, for people under 18 years of age. Changes will be implemented upon authorization and direction from the consulting Physician.

CLTO shall ensure that the individual's medications are regularly reviewed by the appropriate licensed health care professional involved (e.g. General Practitioner and/or Psychiatrist). Any decisions made regarding treatment will be made as a result of discussion between the physician or health care professional, the individual, family/caregiver and the immediate support team.

It is imperative to the individual's well-being to maintain consistency in support plans including medication and behaviour strategies. Medication regimens and behaviour plans must be followed through as per the recommendation of the physician/health care professional and support team.

NON-PRESCRIPTION MEDICATIONS

Non-prescription medications/treatments shall include, but are not limited to, over the counter medications/treatments such as pain relievers, laxatives, vitamins and herbal and/or naturopathic remedies and supplements.

In order to ensure safety and consistency, it is critical to the individual's health and well-being that any non-prescription medications are first reviewed by the family doctor and/or psychiatrist prior to administering them. A prescription will need to be obtained from a licensed physician prior to administration as per CLTO's policies and procedures as well as Ministry guidelines and legislated requirements. CLTO staff shall not administer any non-prescription medications without a clear guideline for use and have been approved by the physician.

Acceptable Physician's orders will include:

- A copy of the prescribing physician's prescription
- A signed Healthcare Provider Visit Form
- A confirmation order from the pharmacy
- Medications cannot be discontinued without a physician's order.

Community Living Toronto has partnered with Seamless Care Pharmacy to provide our individuals with excellent pharmacy services and care. Seamless Care is a family-owned business, who have focussed their care on individuals with developmental disabilities. Their clinical pharmacists and staff provide medication reviews, administer injections, and offer 24/7 after hours services, so that the CLTO support team is always able to connect with them when necessary. Information on Seamless Care pharmacy, including the necessary consent forms, will be reviewed during the intake process to facilitate access to their services.

Contingency Planning

It is acknowledged that there may be circumstances under which CLTO is unable to provide a safe environment for an individual and the support team, or to attain the critical cooperative working relations with a family/caregiver, despite the best efforts to achieve this.

Under such circumstances, CLTO shall work with the family/caregiver or the placing agency (children's) to find an alternative arrangement for the provision of needed supports and services.

Items that are critical to each individual's support plan are to be followed by all participants at all times. Failure to do so may jeopardize CLTO's ability to provide optimal services and supports. Families/caregivers play a vital role in the decision making process and are a valued member of the team. CLTO is committed to the goal of ensuring. the best possible care for individuals receiving service so that we can continue to foster inclusive communities by supporting their rights and choices.

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Join Us!

Donate

Your generous support will help us create a future where every person with an intellectual disability has the opportunity to realize their goals and dreams.

Volunteer

Share your time and skills to create stronger communities!

Join Our Team

Check out the great opportunities posted on our website.

Become a Member

Advocate, support and enable our vision by supporting the rights and choices of people with an intellectual disability.

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