Effective Date: June 14, 1989	TITLE: **ADMISSIONS**	POLICY NO. I-20
Review Date: *Interim Review: November 8, 2018*		PAGE 1 OF 2
Revision Date: June 22, 2017	SUBTITLE:	APPENDIX A, B, C

PREAMBLE

63 (1) of the Vulnerable Persons' Living with a Mental Disability Act (VPA) states that "A Substitute Decision Maker (SDM) for Personal Care who has the power to decide where a vulnerable person is to live under clause 57(2) (a) shall not place a vulnerable person in a developmental centre without first obtaining the approval of the court."

63 (6) of the VPA states that "The court may, by order, approve the placement of the vulnerable person to a developmental centre if it is satisfied that:

a) the applicant has made reasonable efforts to find a placement for the vulnerable person other than in a developmental centre, and no suitable alternative placement is available;
b) it is in the best interests of the vulnerable person to be placed in a developmental centre; and
c) there is a developmental centre willing to accept the vulnerable person."

Consideration of admission, readmission or interfacility transfer of an individual to a Developmental Centre will be guided by the Centre's ability to offer a progressive model of services and supports to allow the individual to reach or maintain his/her developmental potential through a personalized program to ensure that his/her needs are appropriately met.

Discharge planning for the individual must be discussed prior to admission to the Manitoba Developmental Centre (MDC).

OBJECTIVE

The admission or readmission to the MDC is in the best interest of the individual, and legal and administrative requirements are observed and documentation standards are met.

POLICY

Consistent with the VPA, the following policies for admission to a developmental centre will be followed:

1. The individual must have a SDM appointed for personal care. If no SDM:
   - 1.1 The Clinical Coordinator and the applicant determine that the individual is indeed:
     - a) a vulnerable person as defined by the Vulnerable Persons Living with a Mental Disability Act (VPA).
     - b) incapable of personal care
     - c) needs decisions made on his or her behalf to prevent the immediate danger of death, serious harm, or deterioration to the physical or mental health of the person.
   - 1.2 If that determination is made, the Clinical Coordinator assists the applicant in referring the person to the Vulnerable Persons' Commissioner for the appointment of an "emergency" SDM
2. The individual must be a vulnerable person as defined by the VPA. "*An adult living with a mental disability who is in need of assistance to meet his or her basic needs with regard to personal care or management of his or her property*". An adult is defined as being 18 years of age or older. Mental disability is defined by the VPA as "significantly impaired intellectual functioning existing concurrently with impaired adaptive behaviour and manifested prior to the age of 18 years".
3. The individual must have a documented diagnosis of Intellectual Disability (Intellectual Developmental Disorder) as per the DSM 5.
4. Requests for consideration for placement and provision of necessary documentation is facilitated by a regional Community Service Worker.
5. Consideration for placement at MDC includes an examination by members of the MDC Admissions Committee of necessary and satisfactory documentation. See Pre-Admission Checklist (A.95–Appendix A).
6. Where a recommendation for placement at MDC is precipitated by the clinical status (behavioural or medical) of an individual, MDC may conduct further independent medical or psychological assessment in addition to necessary documentation to confirm they have adequate supports required to allow the individual to reach his/her potential.

Effective Date: June 14, 1989	TITLE: **ADMISSIONS**	POLICY NO. I-20
Review Date: *Interim Review: November 8, 2018*		PAGE 2 OF 2
Revision Date: June 22, 2017	SUBTITLE:	APPENDIX A, B, C

7. An application to court for the prospective admission of a vulnerable person to MDC is facilitated when preceded by admission planning between MDC and those seeking admission and acceptance by MDC.
8. The acceptance of an individual at MDC does not mandate additional services or programs beyond the capacity of existing resources and priorities.
9. **Readmission Initiated By SDM**
   - 9.1 A SDM for Personal Care who has the power to decide where an individual is to live, and who has given consent for the individual to leave MDC and live elsewhere, may return the individual to MDC within six (6) months of discharge without court approval if the Centre is willing to accept the individual at that time.
   - 9.2 A request to return an individual to MDC within six (6) months of discharge will require MDC, in liaison with the SDM for Personal Care and community service providers, to determine the most appropriate course of action in the best interests of the individual to support his/her care, safety and lifestyle.
   - 9.3 The Clinical Coordinator will review with the Admissions Committee, finalize arrangements for return of the individual to the MDC and initiate an IP meeting to develop a plan of action for short term needs of the individual.
   - 9.4 After six (6) months of discharge, re-admission to MDC requires court approval in accordance with legislation, and is considered as in Section 1 of this policy.
10. **21 Day Respite**

Under the *Vulnerable Persons Living with a Mental Disability Act* (the Act), certain requirements must be met for a substitute decision maker to temporarily place a vulnerable person in a developmental centre for respite care.

The requirements that must be met are that:

- the substitute decision maker for personal care has been granted power under clause 57(2)(a) of the Act to decide where the vulnerable person is to live
- the purpose of the placement is to provide respite care for the vulnerable person
- the vulnerable person requires a level of care that is not readily available outside a developmental centre
- there is a developmental centre willing to accept the vulnerable person
- the temporary placement of a vulnerable person in a developmental centre does not exceed three weeks in a year

PROCEDURE:

1. The Clinical Coordinator will utilize the Pre Admission Checklist Form A.95 (See Appendix A) for the initial process of Admission.
2. The Residential Coordinator will utilize the Residential Area Admission Checklist Form CR.3 (see Appendix B) for preadmission/admission process.
3. These forms will be scanned into the resident's electronic health record once complete.

REFERENCES:

The Vulnerable Persons Living With A Mental Disability And Consequential Amendments Act
Council on Accreditation (COA) CA-GLS 15
Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5)
MDC Policy and Procedure VI-95 Consent for Health and Medical Treatment

PRE-ADMISSION CHECKLIST

Name of Potential Admission: _____

		Date Requested	Date Received
1.	**Documentation Required for Review by Admission Committee**		
	Letter of Request from Community Service Worker (CSW) with written support from (Community Living disABILITY Services (CLdS) Program Specialist confirming that all actions have been taken to arrange for alternate living arrangements and that admission to MDC is the last resort; must include referral name, date of birth and Personal Health Identification Number (PHIN)/Manitoba Health numbers.		
	Confirmation of Intellectual Disability Diagnosis prior to the age of 18		
	Confirmation of Substitute Decision Maker (SDM) status including current powers		
	Approval of SDM for support of admission		
	CSW report that includes: ▪ Goals for Admission ▪ Summary of incidents for past 12 months and interventions used in the community ▪ Medical diagnosis ▪ List of current medications; medication history ▪ List of placements ▪ Medical history ▪ Allergies ▪ Most recent Individual Plan ▪ Current Behaviour Support Plan/Safety Plan ▪ Other reports as requested by MDC (e.g. Day program report; specialist reports; recent psychological reports, etc.)		
2.	**Documentation Required <u>Prior</u> To Admission**		
	Commissioner approval for placement		
	Variance to SDM powers (if required) to include 52 (2) h i, ii, iii from CSW		
	Updated immunization record for Diphtheria, Tetanus, Pertussis, Polio, Tuberculosis, Antibody titres for MMR and Hepatitis B (antigen and antibody testing) and necessary immunization		
	Social History including education		
	Community physicians and dentists names including last known appointment		
	Manitoba Health transfer/referral form (MG-1832) if admitted from another health care facility		
	Social Insurance Number, Marital Status, Religion, Family Contact (names, contact numbers and frequency of contact)		
	Treaty number (if applicable)		
	Notification of communicable diseases (STD's; HIV)		
	Confirmation of funding is attached to the client for discharge planning		
	The Health Information Services Coordinator will fax consent to SDM for ID photo, collection and storage of DNA (use form ID Card Information) CR.93. Notify respective Residential Coordinator or designate when received.		
	If SDM for care is not Public Guardian and Trustee, written consent for routine medical treatments will be required; see MDC Policy VI-95 Consent for Health and Medical Treatment (Form CR.23a). Health Information Services Coordinator will initiate.		

3.	**Role of Clinical Coordinator**	**Date Requested**	**Date Received**
	a) Ensure any external requests regarding admission are directed to the individuals CSW.		
	b) Respond to CSW request for referral with email outlining initial documentation required for admission committee consideration. Email to include discharge planning expectations whereby the referring agency must be committed to a post-MDC placement and program with funding in place and guaranteed for return to community within two (2) years of admission or earlier if deemed appropriate by the treatment team.		
	c) Contact MDC Health Information Services to open an electronic health record with provided referral name, date of birth and PHIN/Manitoba Health numbers.		
	d) Schedule an Admission Committee meeting with potential Residential Coordinator's (RC)/Directors in attendance. Provide all scanned CSW reports via email to the stakeholders for review prior to the meeting.		
	e) Respond to CSW with email decision regarding Admission including list of other documentation required as well as final approval of admission contingent upon assessment by Clinical Psychologist and care team.		
	f) Once team assessment has occurred and deemed to meet criteria, arrange for completion of letter of "willingness of MDC to accept the individual" from the CEO; this letter is then faxed to the SDM for personal care (SDM will file a notice of application with the court for placement of the individual at MDC).		
	g) If required, complete paperwork from Vulnerable Persons' Commissioner Office (VPCO) for Temporary Placement and fax to SDM for personal care.		
	h) Arrange with CSW for delivery of five (5) days of clothing to be provided to MDC (for washing and tagging prior to admission re: bed bug policy); advise that a list of clothing and valuables and $100.00 spending money to accompany the individual upon admission. Notify respective area when five (5) days of clothing has been received. Residential area to process same.		
	i) Inform pertinent MDC care provider about the pending admission (Environmental Services, Financial Services, Nutrition and Food Services, Health Information Services (HIS), EMC, RC).		
	j) Discuss with CSW admission arrangements (time, method etc) note: morning on a Tuesday is optimal.		
	k) Complete MDC Admission Information Form Questionnaire in electronic health record.		
	l) Prompt HIS to provide area with file and change status to "Active" in electronic health record on the day of admission.		

RESIDENTIAL AREA PRE-ADMISSION CHECKLIST

Resident Name: _____ Admission Date: _____

1.	**Role of Clinical Coordinator**	**Date**	**Employee Signature**
	a) Assign Prime Nurse and PNA.		
	b) Make arrangements with interdisciplinary team members (including but not limited to RPN, Clinical Psychologist) to attend initial assessment for potential admission if required.		
	c) Consult with Nursing Outreach regarding any current protocols when consideration for placement involves the transfer of the individual from an acute health facility.		
	d) Initiate a preliminary Individual Plan in electronic health record. Ensure all current questionnaires are scheduled and used.		
	e) Medication prescription ordered/signed by the physician. Standard order sheet to be completed. Take orders to Pharmacy to be processed.		
	f) If applicable: Develop draft Behaviour Support Plan/Preventative Plans with Psychology and the Care Team. Required intrusive/restrictive interventions are to be ordered by the Doctor (Physician/Psychiatrist/Registered Doctoral Clinical Psychologist).		
	g) If applicable: Explanation of MDC Intrusive/Restrictive Policies given to Substitute Decision Maker (SDM), Community Service Worker (CSW) and the residents first primary contact. BSP to be sent to SDM for signing/approval.		
2.	**Immediate Action Plan Upon Admission by Nurse in Charge/designate**		
	a) Escorted to residential area with minimum 1:1 staff		
	b) Head-to-toe examination for any injuries by the nurse with another staff member present. Assessment and documentation of any physical abnormalities or distinguishing marks will be carried out. Photos will be taken of any abrasions, bruises, swelling apparent during the physical examination. Arrange for photos to be placed on CD and stored at Health Information Services (HIS). All findings to be documented in a progress note in the electronic health record.		
	c) Assign two (2) staff to help unpack clothing and valuables. All items are examined and handled in accordance with the bed bug prevention protocol (MDC Policy VII-20 Pest Control). The Clothing & Valuables Form CR.47 will be completed and clothing will be placed in MDC duffle bag and marked "new admission". Potentially dangerous items will be removed and placed in locked storage. Any items removed will be documented. All items not in use to be locked up. All valuables to be labeled.		
	d) Arrange diet with Nutrition and Food Services by forwarding an e-mail to Dietitian.		
	e) All personal medication to be taken to Pharmacy for disposal.		
	f) Confirm consent has been received prior to having resident photo taken for identification. Arrange creation of ID with Health Information Services.		
	g) Resident DNA and fingerprints taken for identification. Arrange with Administrative Support to access kit once consent has been received. Resident ID card is required to complete prints as there is a separate card with ID and areas for finger prints.		
	h) Nurse to perform a Mental Status Exam to assess for stability and potential immediate risk factors. Document in electronic health record.		
	i) Tour of residential area & introduction of staff.		

j) House Rules reviewed when assessed to be clinically stable, and if applicable.		
k) Residents' Bill of Rights & Responsibilities reviewed when assessed to be clinically stable, and if applicable		
l) Draft Behaviour Support Plan reviewed with resident when assessed to be clinically stable, and if applicable		
m) Document admission in progress note. Link to discharge/transfer focus.		

	Role of Nurse in Charge/designate	**Date**	**Employee Signature**
3.	a) Arrange for Admission physical at the Treatment Room within 2 working days. Advanced Care Plan questionnaire to be completed at that time.		
	b) Notify nursing Outreach if immunization record is not obtained as information can be accessed through "echart" or MIM5.		
	c) Complete baseline temperature, SPo2, weight, height, blood pressure and pulse.		
	d) Arrange for Mantou testing		
	e) Arrange for other immunization if required.		
	f) Further develop Behaviour Support Plan if applicable.		
	g) Complete questionnaires for further Care Guide Development (e.g. MDC Fam History V4, Fall Assessment, etc.).		
	h) Complete referrals for individual assessment needs (e.g. Dietitian, Psychiatry, Recreation).		
	i) Tour of Centre as a whole when assessed to be stable.		
	j) Arrange for appointment with Psychiatrist.		
	k) Clinical Psychologist to complete Clinical Psychological Assessment and Community Discharge Report.		
	l) Arrange for dental/vision assessments within 1 month after admission (or when assessed to be stable) if last appointment more than 6 months prior.		
	m) Arrange Individual Planning meeting within 4-6 weeks.		
	n) Continue to make changes to Care Guide as required.		
	o) Continue shift to shift documentation for a minimum of one (1) week.		
	p) E-mail cash ledger sheet to Systems Administrator to add resident's name.		
	q) Add resident's name to all other area documents as required (e.g. Residential Area Accountability Checklist N-75 or A-6, etc.).		
	r) Implement use of N-6 "Checklist for Resident Supervision/Observation" if warranted during early admission days.		

Forward Completed Checklist to Health Information Services for scanning.

_____ _____

Date Signature

SUBSTITUTE DECISION MAKER – PERSONAL CARE
CONSENT FORM

I.D. CARD INFORMATION

To: Manitoba Developmental Centre
Box 1190
Portage la Prairie MB R1N 3C6

I, _____, as the Substitute Decision Maker for personal care,

consent to having _____ relevant medical conditions stated on I.D. cards as well
Resident name
as having DNA hair samples, fingerprints and photograph taken to be kept on record at the Manitoba Developmental Centre in case of emergency identification purposes.

_____ _____
Substitute Decision Maker for personal care Date

_____ _____
Witness Date