PURPOSE

The Individualized Support policy is based on the Transitional Services provision under Manitoba Regulation 484/88 R (Residential Care Facilities Licensing Regulation). This regulation stipulates that the licensee providing transitional or residential care services shall:

- maintain adequate personnel for the supervision, assistance or counselling of the residents and for other requirements of the facility; and
- provide on-site supervision at the times and in the manner stipulated by the supervising agency.

The purpose of the Individualized Support policy is to provide a process for Residential Care Facility operators or licensees to seek approval from the Regional Office to individualize the level of support provided to residents with mental disabilities based on their unique needs and preferences.

Individualized Support provides persons living in Residential Care Facilities with the opportunity to:

- remain at home even though the care provider is not at home; and
- gradually progress to a more independent lifestyle without having to move to a new home.

DEFINITIONS

"Residential Care Facility" refers to a home that is licensed to provide care, supervision and support as well as room and board, to adults with a disability or disorder which precludes them from living independently. Residential Care Facilities include Home Share and Shift-Staffed homes (refer to Residential Service Options - Section C88.1).

"supervising agency" means the government department, agency or individual responsible for the overall supervision and treatment planning for a resident. The supervising agency for the Community Living disABILITY Services program is the Regional Office of the Department of Families represented through the Community Service Worker.

"transitional services" means supportive services to individuals with a disability or disorder, who currently or potentially are capable of undertaking activities of daily living independently, but who temporarily need supervision, assistance or counselling.

POLICY

Where an individual living in a Residential Care Facility is requesting increased independence, or where an individual moving to a Residential Care Facility requires Individualized Support, it is important that an appropriate process occurs to ensure that:

- when an individual remains at home without supervision it is because they desire such independence or have responded favourably to similar experiences in the past;
- the individual is able to cope with the demands that independence places upon them;
- the individual's potential for success is fostered and risk to them is minimized;
- a plan is developed which outlines the level of independence and support required, how the individual is to be prepared and the gradual steps towards increased independence; and
- following implementation the plan is reviewed on an ongoing basis to ensure the individual's needs for support, assistance and independence are assessed regularly and plans adjusted accordingly.

PROCESS

DEVELOPMENT OF AN INDIVIDUALIZED SUPPORT PLAN

Planning for a reduction in the level of support provided to an individual may occur as a component of the Individual Planning process (refer to Section C66). The process may be initiated by any one of the planning participants, however, the decision to recommend a particular level of support will be made by the planning team.

The planning team, including the individual, is responsible for determining the individual's needs and arranging for supports required. The Community Service Worker is designated as having the primary responsibility and accountability for ensuring that the process followed is in accordance with governing policies, regulations and established procedures. This would include following policy on Individual Planning (refer to Section C66) and policies outlined in the Residential Care Licensing Manual, (see Transitional Services - Appendix K). The Community Service Worker is responsible for circulating policies and procedures specific to Individualized Support to all team members.

Knowing the Individual

The team must determine whether or not the individual requires a change in the level of support he/she is receiving and specify the level of independence which is appropriate. All team members must have an understanding of the individual's preferences, needs, and abilities related to being home without supervision, and ensure that the individual wants such independence or has responded favourably to similar experiences in the past.

Goal and Action Planning

The planning team needs to identify the supports and resources required by the individual, while home without supervision. Planning must occur in order to:

- determine how to prepare the individual for greater independence;
- identify the steps toward increased independence; and
- outline the details regarding the provision of support.

The results of such initial planning are to be documented by the Community Service Worker and distributed to the planning team participants. This documentation is in the form of a separate summary (refer to Appendix A). Where the individual has the necessary skills for independence at specific times and does not require preparation, the Community Service Worker will proceed with seeking approval for individualized support, as described under Implementation.

IMPLEMENTATION

Provision of Individualized Support

Following preparation but before the individual remains at home without supervision, a meeting of planning participants should occur to:

- ensure that the individual has been adequately prepared;
- ensure that supports and resources required are available; and
- decide whether or not to proceed.

Supporting documentation (refer to Appendix A) must accompany the written request from the Community Service Worker to the Program Manager seeking approval to provide Individualized Support (refer to Appendix B).

The care provider must receive approval from the Program Manager prior to providing Individualized Support and leaving the individual at home without supervision. The care provider must ensure that adequate support be provided for other residents whose needs may differ from the individual identified as requiring Individualized Support.

Evaluation and Ongoing Planning

The initial review of the plan should occur 4 to 6 weeks following the onset of the individual being home without supervision, and subsequently as determined by the team according to the individual's needs. The purpose of these reviews are to: assess how the individual is coping; determine the adequacy of current arrangements, assistance, and support provided; change the plan according to the needs of the individual; determine whether or not further independence is possible and desired by the individual; and specify the level of independence appropriate to the individual.

Changes to the Individualized Support Plan as a result of these reviews, are to be documented by the Community Service Worker and distributed to the planning team participants. Such documentation may be in the form of a separate summary (refer to Appendix A). Where there are no changes to the Individualized Support Plan, the results of these reviews are to be documented in case notes.

Once established, the level of support provided to the individual, must be reviewed in conjunction with the Community Service Worker's yearly contact to evaluate the individual's satisfaction with his/her plan. The results of these discussions are to be documented in case notes.

Cancellation of Approval

Where the planning team determines that individualized support no longer is appropriate for the individual, the care provider will resume responsibility for 24-hour supervision. The Community Service Worker is responsible for notifying the Program Manager who forwards a formal letter to the care provider cancelling the approval to provide individualized support. The care provider is responsible for returning the original approved document to the Regional Office (refer to sample letter, Appendix C).