LEAMINGTON

Mennonite Home

Long Term Care

MEDICAL & PERSONAL CARE FORMS

Residents first – through faith-based commitment, compassion, and community.

Leamington Mennonite Home

PERSONAL BELONGINGS & FURNITURE AGREEMENT

Resident Name: _____

I acknowledge and agree as follows:

(a) Prior to any furnishing(s) being brought to the Home, I will consult with the Director of Care to ensure that any item placed in the resident room is safe for resident and staff use and will not impede resident care in any way.

(b) I will ensure that any approved items will be delivered to the Home between Monday and Friday from of 8:30am to 3:30pm and that the Home will be advised in advance of the date of delivery. I understand and agree to abide by this guideline.

(c) I will not hang pictures, shelving, or other decorative items on the walls of the room. Any approved item will be installed by the Home's maintenance staff.

(d) Painting, wallpapering, carpeting, etc. of the room is prohibited.

(e) The safety of the resident and staff are paramount. Space and room layout may impact significantly upon safety. Any articles found in the room that are deemed to be unsafe or in contravention of the Home's policies, will be removed in consultation with the resident and/or resident representative.

(f) If the resident's condition deteriorates, I agree that it may be necessary to rearrange or remove furniture to facilitate safety in the operation of mechanical lifts.

_____ _____

Resident Representative Date of Admission

_____

Relationship to Resident

Leamington Mennonite Home

PERSONAL BELONGINGS WAIVER FORM

The Leamington Mennonite Home respects the personal belongings of each of its residents. The Home makes every effort to provide a safe and secure environment for every resident and his/her property.

The Leamington Mennonite Home does not, however, take responsibility for the deterioration and/or breakage of belongings caused by personal use by the resident. The Home also does not take responsibility for personal articles lost and/or misplaced by the resident. This includes, but is not limited to eyeglasses, dentures, hearing aids, walkers, wheelchairs, or any other personal belongings of the resident.

The resident and / or resident representative hereby agrees not to hold the Leamington Mennonite Home responsible for the deterioration, loss and/or resident misappropriation of his/her personal belongings.

I understand and agree that I am responsible for deterioration and/or breakage of my personal belongings.

_____ _____

Resident and / or Resident Representative Date

As of January 1, 2011

Leamington Mennonite Home

PERSONAL BELONGINGS LOG

Resident: _____ Admit Date: _____

Room: _____

ITEM	DESCRIPTION
Jewelry	
Watch(es)	
Glasses	
Hearing Aide	
Purse/Wallet	
Other	

Registered Staff Signature: _____ Date: _____

Resident/Rep. Signature: _____ Date: _____

As of January 1, 2011

Leamington Mennonite Home

ELECTRICAL ASSURANCE TEST

Attention: Maintenance Staff

Resident Name: _____ Room #: _____

Date: _____

ITEM	INSPECTOR	DATE	APPROVED?
☐ Television			Yes ☐ No ☐
☐ Clock			Yes ☐ No ☐
☐ Radio / Tape Recorder			Yes ☐ No ☐
☐ Lamp			Yes ☐ No ☐
☐ Shaver			Yes ☐ No ☐
☐ VCR			Yes ☐ No ☐
☐ Power Bars / Cheater Plugs			Yes ☐ No ☐
Other ☐ _____			Yes ☐ No ☐
. ☐ _____			Yes ☐ No ☐
. ☐ _____			Yes ☐ No ☐
. ☐ _____			Yes ☐ No ☐

Notes: _____

_____

_____

_____

_____

As of June 9, 2015

Privacy and Security: The Collection, Use, and Sharing of Your Personal Health Information

How We Protect Your Privacy

We handle and protect your personal health information in accordance with Ontario's *Personal Health Information Protection Act, 2004* (PHIPA) and any other laws that we are required to follow. We provide training, follow established policies, and take other steps to ensure that our staff and anyone else acting on our behalf protects your privacy.

Collection, Use, and Disclosure of Personal Health Information

Your request for care from us implies consent for our collection, use, and disclosure of your personal health information for the following purposes:

- to provide and assist in the provision of health care to you through our services, programs, and facilities;
- to get payment for health care and any related goods and services provided to you, including from OHIP, your private insurer, WSIB, and others as necessary;
- to plan, administer, and manage the operation of our services, programs, and facilities;
- to manage risk and improve the quality and safety of our services and programs;
- to educate or train our agents to provide health care;
- to conduct research activities as approved by a research ethics board;
- to comply with legal and regulatory requirements; and,
- to fulfill other purposes that are permitted or required by law.

From time to time, we may communicate about your care with your other health care providers, including collecting, using, and disclosing your personal health information through electronic medical information systems (sometimes called electronic health records, eHealth records, electronic medical records, etc.). If you would like more information about the electronic medical information systems we use, please speak with our Privacy Contact.

Any uses of your personal health information other than those mentioned above would require your express consent.

Unless you tell us not to, we share your assessment information with other health service providers who will provide you with support, now, and in the future.

Sharing Your PHI

We use a secure electronic system to share your health information with other health service providers. This allows them to view the information they need to provide you with the services for your needs.

If you have agreed to share your Personal Health Information, the information in your assessment will be used to:

- Provide health support and services based on your needs.
- Make sure your providers have the most up-to-date and complete record of your history and needs.
- Help us see where there might be gaps or overlaps so we can provide services where they are most needed.
- Make sure everyone is getting the right support and services.

Privacy & Security of Your Information

The personal health Information collected belongs to you. The privacy and protection of your PHI is a priority. We only collect the health information we need in order to determine your service and support needs. This information cannot be used for any other purposes without your permission.

- Your health information is kept in a secure place.
- Your health information will only be viewed by authorized people who deliver your services.
- All health service providers have signed contracts to keep your information confidential.
- When a person views your information, it is recorded in a log. This log is reviewed regularly to make sure there has been no unauthorized access to your information.
- Information is stored and/or disposed of according to the law.
- We will investigate any suspected breach or unauthorized access to your personal health information.

Your Privacy Choices

Your Rights and Choices
Please speak to your usual care provider or our Privacy Officer, if you want to:

See your own assessment: You can request a copy of your assessment at any time.

Correct your own Assessments: You can ask to have information in your assessment corrected or updated.

Opt Out: You may choose not to share your assessment information with other health service providers. You may also choose to have your basic personal information (like name, phone number, city) blocked from health care workers who view the IAR.

By choosing to share information with other Health Service Providers, residents are:

- Ensuring relevant information is reviewed by other Health Service Provider's to provide the best possible care/treatment.
- Avoiding potential duplication of information and extended time frames in receiving care.
- Streaming a needed referral for care and services from another Health Service Providers.

By choosing not to share information with other Health Service Providers, residents are:

- Perhaps withholding relevant and important Personal Health information that would expedite services and treatment.
- Potentially creating duplication for assessments and health status tests.
- Possibly prolonging access to needed services and treatment.

Issues or concerns

To choose to withhold your consent to share your assessment information or your basic identifying information, contact our Privacy Officer.

If you would like to know more about how your personal health information is handled and shared with our partner organizations, feel free to ask our Privacy Officer. They will be happy to answer any questions that you might have.

Leamington Mennonite Home:
Privacy Officer

(519) 326-6109 ext.236

The Privacy Commissioner
If you have any issues or concerns about how your health information is
being handled, you have the right to contact the
Information and Privacy Commissioner of Ontario at:

2 Bloor Street East Suite 1400 Toronto,
ON M4W 1A8
Telephone: 1 (416) 326-3333
or 1 (800) 387-0073
Online: http://www.ipc.on.ca

LEAMINGTON MENNONITE HOME

Long Term Care Home

Consent Directive to Sharing Personal Health Information and Assessment Data

The Leamington Mennonite Home strives to provide all residents with health care services that meet individual resident needs and enable residents to seek appropriate services from organizations across the province. In doing so, our Home may need to share your Personal Health Information and Assessment Data via fax, or an electronic sharing system, with other health service providers, who need to review this data in order to provide services to you.

You have the right to withhold or withdraw your consent to share your Personal Health Information at any time.

We may need to share your Health Assessment with other health service providers, who will need to review it in order to provide services to you. Do you consent to the sharing of your Personal Health Information and Assessment(s)?		
☐ Yes, I consent	☐ No, I don't consent	To the sharing of the **Personal Health Information** collected by the Leamington Mennonite Home. I understand my choice will be applied to the sharing of the **Integrated Assessment Record and/or all other assessments** with health service providers via fax or an electronic sharing system, and will be effective within 7 business days. Note: This consent does *not* apply to the copies of my assessments that other health service providers have already received.
☐ Yes, I consent	☐ No, I don't consent	To the sharing of **all my previous assessments, collected by the Leamington Mennonite Home**, I understand my choice will be applied to the sharing of **all assessments collected by the Leamington Mennonite Home** with other health service providers and will be effective within 7 business days. Note: This consent does *not* apply to the copies of my assessments that other health service providers have already received.

Name: _____

Signature: _____ **Date:** _____ (MM DD YYYY)

Substitute Decision-Maker (if applicable):

Name: _____ **Date of Birth:** _____ (MM DD YYYY)

Signature: _____ **Date:** _____ (MM DD YYYY)

Resident Information (information are collected for patient identification) The fields below are used for the purposes of identifying the individual who is consenting so that their Consent can be properly managed.

Name: **Date of Birth:** (MM DD YYYY)

Telephone No: **Address: The Leamington Mennonite Home**
35 Pickwick Dr., Leamington , ON N8H 4T5

An electronic sharing system is used to share your Assessment Data with other health service providers, who need to review the assessment data in order to provide services to you. If you wish to consent or withhold your consent to the sharing of all your assessments in the electronic sharing system, please contact the support centre by calling Telephone: 1-(855)-585-5279.

Please refer to the poster for additional information regarding the collection, use and disclosure of your Personal Health Information.

PROJECT AMPLIFI

Integrating Ontario

St. Joseph's Healthcare Hamilton (SJHH) completed a pilot project that enabled the sharing of resident health information between St. Joseph's Villa Long-Term Care home in Dundas, Ontario and the hospital. The pilot demonstrated value for residents and health care providers, and resulted in funding to expand health information exchange across the province. SJHH has been tasked to lead **Project AMPLIFI** by the Ministry of Health and Ministry of Long-Term Care.

Our Vision

To improve the continuity of care for Long-Term Care residents by streamlining transitions between care institutions, leading to safer care for Ontarians, and more efficient workflows for providers.

AMPLIFI

Benefits to LTCH Residents & Staff

When a resident is discharged to the hospital **Project AMPLIFI** allows LTC staff to digitally send summary of care information (such as allergies, medications, problem lists, immunizations, etc.) to the hospital.

This exchange reduces paper documentation exchange and provides hospital staff a more accurate clinical history.

When the resident returns from the hospital, **Project AMPLIFI** allows LTC staff to immediately view an electronic summary of the resident's care during their hospital stay (including medications, imaging and lab results, consult notes, discharge summaries).

The electronic summary decreases the need to phone/fax the hospital, preventing transcription errors, providing more time to care for residents, and with the ultimate goal of reducing hospital readmissions.

Project AMPLIFI Partners

Ontario
Ministry of Health
Ministry of Long-Term Care

St. Joseph's Healthcare Hamilton

PointClickCare

Epic Cerner MEDITECH

Contact Us

If you have any questions, please don't hesitate to reach out to us via email at **projectamplifi@stjoes.ca**

Under PHIPA, personal health information is collected, stored, and shared in a way that protects the confidentiality of that information, and the privacy of individuals. If you have questions about privacy, please email projectamplifi@stjoes.ca.

Leamington Mennonite Home

PERSONAL CARE DECISION FORM
ADVANCE CARE PLANNING

Resident Name: _____ Room #: _____

It is my understanding that at all times, any appropriate intervention will be explained to me and that informed consent (mine or that of my Substitute Decision Maker/Power of Attorney for Personal Care), is required in all non-emergency situations. In the event of an emergency situation in which I am unable to discuss any current plan of treatment options, I understand that the attending health care providers will follow these Advanced Directives. I also understand that this decision will be reviewed annually, and/or as requested by myself or my Substitute Decision Maker/Power of Attorney for Personal Care.

This documentation is to:	**This discussion was held with:**
☐ Create a new Advance Care Plan ☐ Review existing Advance Care Plan	☐ Resident ☐ SDM/POA Name: _____

Reason for this discussion/review:

- ☐ Admission
- ☐ Readmission
- ☐ Change in Condition Alert
- ☐ Resident or Family Request
- ☐ Other

Was an Advance Care Plan created or change made as a result of this discussion?

- ☐ No
  - ☐ Resident declined conversation
  - ☐ Resident/SDM not available at this time
  - ☐ SDM declined conversation
- ☐ Yes

Describe the Key Aspects of the discussion:

_____

_____

_____

_____

Staff or Healthcare Provider leading discussion

Name: _____ Title: _____

Signature: _____ Date: _____

Advance Directive Orders in Place:

☐ **Level 1 – Interventions of the highest level. Transfer to Acute Care with CPR**

I wish to be transferred to hospital for all available assessment and treatment interventions deemed appropriate by the attending physician, including **Cardiopulmonary Resuscitation (CPR)**. Emergency interventions in this level of care are aimed at prolonging life and include advanced life support.

☐ **Level 2 – Interventions of a Higher Level of Care. Transfer to Acute Care without CPR**
I do not wish to receive Cardiopulmonary Resuscitation (CPR), but I do wish to be transferred to hospital for all other assessment and treatment interventions deemed appropriate by the attending physician. Emergency interventions in this level of care are aimed at prolonging life up to, but not including, CPR or advanced life support.

☐ **Level 3 – comfort Care at a higher level without CPR**
I wish to remain in the Home with supportive care aimed at providing comfort, symptom relief, and pain control. I would like to be offered any investigative tests/assessments that can be done in the Home as well as tests done as an outpatient at a hospital. Treatment recommendations resulting from investigations will be discussed and decided on at that time.

☐ **Level 4 – Comfort Care Only without CPR**
I wish to receive palliative care provided in the Home with supportive care aimed at providing comfort, symptom relief, and pain control. I would like to be offered any basic investigative tests/assessments that can be done in the Home. Treatment recommendations resulting from investigations will be discussed and decided on at that time.

I, _____, believe that _____, who is
(Name of SDM/POA) (Name of Resident)
incapable of providing consent would in his/her present condition consent to the plan of care noted in the Advance Directive Record of Decision below. This most closely corresponds with his/her prior capable wishes or if not known to me, is in his/her best interest.

The Health Care Professional must discuss the plan of treatment that reflects the clients expressed wishes with the individual or the incapable person's Substitute Decision Maker/Power of Attorney for Personal Care, prior to completing the following Advance Directive Record of Decision and documenting in the chart.

Advance Directive Record of Decision

Level (check one)	Date and Time (00:00)	Signature of Resident/SDM/POA (check one)	Signature of Health Care Professional
☐ 1 ☐ 2 ☐ 3 ☐ 4	_____ DD/MM/YYYY Time:	☐ Resident ☐ SDM/POA	

This document is the property of the named individual and a copy must accompany that individual as he/she moves through the health care system.

Leamington Mennonite Home

COPY MUST BE GIVEN TO RESIDENT / SDM

SCHEDULE B

Dear Resident and/or Family,

As you are aware, the Leamington Mennonite Home always strives to ensure the health and safety of our residents.

Our Home therefore encourages every resident to receive from the Home the following vaccinations as offered on the Ministry of Health website and skin test at no cost:

- A one-time injection of the **pneumococcal vaccine** and a **booster** will be offered in 5 years for a total of 2 injections in a lifetime.
- A yearly influenza vaccination
- Td booster if not given in the last 10 years; if unknown history of immunizations, it is recommended
- 2-step TB skin test done upon admission unless it has been done within the last year
  Resident that has been previously exposed to TB or has had a positive test will not receive the skin test. They will be assessed by the Physician and may require an x-ray.

The **Pneumococcal Vaccine** is to prevent bacteria illnesses. Pneumococcal disease is a leading cause of death, pneumonia, and meningitis in the elderly. It especially effects those with chronic lung and/or heart disease.

The **Td Booster** is to protect against Tetanus and Diphtheria. Both Tetanus and Diphtheria are infections caused by bacteria that can be very serious and life-threatening.

The **Influenza Vaccine** is recommended by the Public Health Unit for **all** residents and staff in long term care facilities on a yearly basis to combat the **flu virus**. (Note: those with an allergy to eggs are excluded). **Influenza** affects many frail elderly, especially in an environment where the virus has the potential to spread from resident-to-resident. It can lead to severe respiratory complications.

We encourage you, as a resident or resident representative, to provide the required approval for these vaccines by signing the enclosed forms.

Dr. R. Holloway
Physician/Medical Director

Jeff Konrad
Administrator

Cheryl Alice, RN
Director of Nursing & Personal Care

Leamington Mennonite Home

VACCINATION / IMMUNIZATION PERMISSION FORM

Resident Name: _____ Room #: _____

Pneumococcal Vaccine	
I hereby give permission for this initial injection/booster of pneumococcal vaccine. A booster will be offered in 5 years for a total of 2 injections in a lifetime.	
_____ Resident or Resident Representative Signature	L Coppola, RN. Infection Control Officer

Td Booster	
I hereby give permission for this immunization as an initial or booster.	
_____ Resident or Resident Representative Signature	L Coppola, RN. Infection Control Officer

Influenza Immunization	
I hereby give permission for this annual immunization as recommended by the Windsor/Essex Public Health Medical Officer. I do not have an allergy to eggs.	
_____ Resident or Resident Representative Signature	L Coppola, RN. Infection Control Officer
Note: This permission may be reviewed and/or changed by the Resident/Resident Representative at the annual Resident Care Plan meeting.	

2 Step TB Skin Test	
_____ Resident or Resident Representative Signature	L Coppola, RN. Infection Control Officer

COVID-19 Immunization	
I hereby give permission for this immunization and applicable boosters as recommended by the Windsor/Essex Public Health Medical Officer.	
_____ Resident or Resident Representative Signature	L Coppola, RN. Infection Control Officer
Note: This permission may be reviewed and/or changed by the Resident/Resident Representative at the annual Resident Care Plan meeting.	

Ministry of Health
Version 6.0 – September 8, 2022

Ontario

COVID-19 Vaccine Consent and Notice Form

Patient information

By completing this form, I am indicating my desire to receive a COVID-19 vaccine and subsequent recommended doses for which I may be eligible. I acknowledge that I have had the opportunity to ask questions regarding the vaccine I am receiving and have had them answered to my satisfaction.

Last Name	First Name	Middle Name	Health Card Number
Street Address	**City**	**Province**	**Postal Code**
35 PICKWICK DR.	LEAMINGTON	ONTARIO	N8H 4T5
Home Phone	**Mobile Phone**	**Email**	
519 326 6109			
Sex		**Age (years)**	**Date of Birth (DD/MM/YYYY)**
☐ Male ☐ Female ☐ Prefer not to answer			
Primary Care Clinician (Family Physician/Pediatrician or Nurse Practitioner)			
DR. HOLLOWAY			

Notice of Collection, Use and Disclosure of Personal Health Information

The personal health information is being collected for the purpose of providing care to you and creating a clinical record for you, and because it supports the Government of Ontario's ability to plan for, and prevent the spread of, COVID-19. Your personal health information, as described in the *COVID-19 Vaccination Reporting Act*, will be stored in a health record system under the custody and control of the Ministry of Health. This information will be used and disclosed for these purposes, as well as other purposes authorized and required by law. For example,

- It will be disclosed to the Chief Medical Officer of Health and Ontario public health units where the disclosure is necessary for a purpose of the *Health Protection and Promotion Act*.
- It may be disclosed, as part of your provincial electronic health record, to health care providers who are providing care to you.

I understand that I may restrict the disclosure of my personal health information for treatment purposes at any time by emailing vaccine@ontario.ca.

Ontario

Consent for Communication and Research

You may be contacted by a hospital, local public health unit, or the Ministry of Health for purposes related to the COVID-19 vaccine (for example, to remind you of follow up appointments and to provide you with a record of immunization). If you consent to receiving these follow up communications by email, please indicate this using the box below.

☐ I consent to receiving follow-up communications:
☐ by SMS/text: _____ ☐ by email: _____

You also have the option of consenting to be contacted about participation in COVID-19 related research studies/surveys. If you consent to be contacted, personal health information may be used to determine which studies may be relevant to you and your name and contact information will be disclosed to researchers. Consenting to be contacted about research studies does not mean you have consented to participate in the research itself. Participating in research is voluntary. You may refuse to consent to be contacted about research studies without impacting your eligibility to receive the COVID-19 vaccine.

☐ I consent to be contacted about COVID-19 related research studies after receiving a COVID-19 vaccine:
☐ by email: _____
☐ by SMS/text: _____ ☐ by Phone: _____
☐ by mail: _____
_____

I understand that I may withdraw this consent to be contacted for follow-up communications or research studies at any time by emailing vaccine@ontario.ca.

Printed Name	Signature	Date of Signature (DD/MM/YYYY)

If signing for someone other than yourself, indicate your relationship to that other person:

_____

☐ If signing for someone other than myself, I confirm that I have the legal authority to provide consent for the individual that is to receive the COVID-19 vaccine (i.e. you are a parent, legal guardian, or substitute decision maker)

Leamington Mennonite Home

COPY MUST BE GIVEN TO RESIDENT / SDM

RECORD OF CONSENT TO TREATMENT DISCUSSION

Resident _____ Substitute Decision Maker (SDM) _____

Recording Health Practitioner _____ Date _____

This form is a summary record of a discussion between a health practitioner and a resident or SDM about consent to proposed treatment in a long-term care home. The health practitioner will fill out this form while he/she discusses the treatment with the resident or SDM, or immediately after. The resident or SDM must receive a copy of the completed consent form and will have the opportunity to ask questions during the consent process.

Consent must be informed and relate to the proposed treatment. The consent decision must be voluntary, without coercion or pressure. A health practitioner must not obtain consent through fraud or misrepresentation (he or she must provide accurate and unbiased information).

1. Name and Description of Treatment

Comprehensive Long Term Care, including all medical and nursing treatment under the direction of the Home physician, and assistance with all activities of daily living as required by the resident. – Yes ☐

Schedule A – Personal Care Decision Form – Yes ☐

Schedule B – Annual Influenza Vaccination – Yes ☐

Schedule C – Consent for Medication Administration During Mealtimes – Yes ☐

2. Capacity with Respect to Treatment

The practitioner determined that the resident is able to understand the information that is relevant to making a decision about the treatment, and appreciates the consequences of a decision or lack of decision **OR** – Yes ☐

The practitioner determined that the resident is not capable of giving consent to treatment – Yes ☐

3. Additional Requirements for Consent

The resident or SDM understands that he or she may refuse to consent to the treatment – Yes ☐

The resident or SDM had an opportunity to ask questions and received satisfactory answers – Yes ☐

The resident or SDM had sufficient time to make an informed decision about consent – Yes ☐

The resident or SDM understands that he or she may revoke this consent at any time – Yes ☐

4. Required Wording about Coercion

The Home must set out section 83 of the Long-Term Care Homes Act, 2007 in any document containing a consent or directive with respect to treatment.

Coercion prohibited

83. (1) Every licensee of a long-term care home shall ensure that no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because,

(a) a document has not been signed;

(b) an agreement has been voided; or

(c) a consent or directive with respect to treatment or care has been given, not given, withdrawn, or revoked. 2007, c. 8, s. 83 (1).

5. Informed Consent to Treatment

The resident ☐ and/or substitute decision maker ☐ has received and understands the Long Term Care treatment information as outlined in Section 1 (Name and Description of Treatment), has had an opportunity to ask questions and request additional information, and consents to the described treatment plan as described by the Registered Staff.

6. Resident or SDM Acknowledgement

I (the resident or SDM) participated in the consent discussion summarized on this form, on the date set out on the top of the form.

Signature of Resident or SDM

Witness Signature

Name of Witness (print)

Leamington Mennonite Home

CONSENT FOR MEDICATION ADMINISTRATION DURING MEALTIMES

Date:_____

Resident Name: _____

Resident Representative: _____

I / We request that medications ordered by the Physician for the hours of 0800, 1200 and 1700 hrs be administered during mealtimes.

_____ _____

Resident / Resident Representative Signature Date

Leamington Mennonite Home

PHYSICIAN CARE

Dr. Randy Holloway is the attending Home Physician and provides medical care on a 24-hour basis to all residents. Dr. Holloway maintains a regular weekly schedule and is available for consultation with resident families/resident representatives as required.

In order for Dr. Holloway to assume full medical responsibility of care for the resident, signature of approval is required by the resident or resident representative. This signature also approves the release of appropriate records in the event of resident hospitalization or specialist care.

_____

Resident or Resident Representative – Power of Attorney

_____

Date

As of January 1, 2011

Leamington Mennonite Home

EARLY BEDTIME ROUTINE CONSENT

Resident Name: _____

AM Routine

Our Home requires POA and/or Resident Representative consent for an early morning resident routine prior to 6:00am if the following applies:

- ☐ Resident is an early-riser
- ☐ Resident has early morning behaviours requiring supervision and care
- ☐ Resident is awake and requires early morning product change with consent given to dressing the resident for the day and made comfortable to resume sleeping until rising for breakfast

_____ _____

POA Signature Date

No, please provide regular rising time for my resident (6:00am and on).

_____ _____

POA Signature Date

PM Routine

If it is your preference that your resident has an early bedtime (6:30pm) please sign in the appropriate spot below.

Yes, we request an early bedtime for our resident (6:30pm)

_____ _____

POA Signature Date

No, please provide regular bedtime care for our resident (7:00pm and on).

_____ _____

POA Signature Date

Leamington Mennonite Home

COPY MUST BE GIVEN TO RESIDENT / SDM

SCHEDULE B

Dear Resident and/or Family,

As you are aware, the Leamington Mennonite Home always strives to ensure the health and safety of our residents.

Our Home therefore encourages every resident to receive from the Home the following vaccinations as offered on the Ministry of Health website and skin test at no cost:

- A one-time injection of the **pneumococcal vaccine** and a **booster** will be offered in 5 years for a total of 2 injections in a lifetime.
- A yearly influenza vaccination
- Td booster if not given in the last 10 years; if unknown history of immunizations, it is recommended
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We encourage you, as a resident or resident representative, to provide the required approval for these vaccines by signing the enclosed forms.

Dr. R. Holloway
Physician/Medical Director

Jeff Konrad
Administrator

Cheryl Alice, RN
Director of Nursing & Personal Care

Leamington Mennonite Home

VACCINATION / IMMUNIZATION PERMISSION FORM

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I hereby give permission for this immunization and applicable boosters as recommended by the Windsor/Essex Public Health Medical Officer.	
_____ Resident or Resident Representative Signature	L Coppola, RN. Infection Control Officer
Note: This permission may be reviewed and/or changed by the Resident/Resident Representative at the annual Resident Care Plan meeting.	

LEAMINGTON MENNONITE HOME

Emergency Department Visits for Seniors Living in Long-Term Care Settings

The Leamington Mennonite Home is dedicated to making sure that every resident remains comfortable and receives the best care possible, this includes avoiding unnecessary visits to the hospital. Our Registered Staff have many resources to use that can assist in diagnosing and treating residents in the home. This helps to maintain consistent care and comfort for each resident.

Transfers to the emergency department can pose significant health risks and make for an uncomfortable experience:

- Advanced age and cognitive impairment or dementia contribute to the complexity of their health care needs.
- Emergency departments are an unfamiliar place and staff are not familiar with their health situation, making them particularly vulnerable.
- Ambulances are usually involved in transporting LTC residents to and from the hospital. Ambulance services constitute an additional cost to the cost of receiving care.
- Waiting for transportation once a resident's care is completed can delay their return home.
- Time Spent in the emergency department Is longer for seniors who Live in LTC facilities.
- Visits to the Emergency Department have been associated with increased risk of new acute infection among the elderly population in general.
- In addition, the long exposure to an unfamiliar place may be particularly distressing for older seniors, many of whom also suffer from cognitive impairment. Increased agitation may also lead to the resident being physically or chemically restrained while in hospital.

Prior to deciding to send a resident to the hospital, the Registered Staff will discuss the situation with our Director of Care and the physician to determine if the resident can be treated at the home. There are certain situations that have been outlined to direct staff to send immediately. Registered Staff will also update and include family in decision making.

If you have any questions, please feel free to ask Registered Staff.

LEAMINGTON
Mennonite Home

Physiotherapy Consent to Treatment

I hereby give consent to an initial assessment, follow-up reassessments, and treatments for the purpose of my rehabilitation as the therapist deems appropriate. I authorize treatment to be administered by appropriate support personnel under the discretion of the therapist.

I hereby consent to treatments as prescribed and indicated on the treatment plan that may include any or all of the following:

- Modalities (e.g. Heat/ice, ultrasound therapy, transcutaneous electrical nerve stimulation (TENS) therapy, etc.)
- Exercise (e.g. Gait training, balance training, range of motion, strengthening, etc.)
- Other treatments that the physiotherapist deems appropriate

I acknowledge that it is customary to experience some discomfort during and/or following treatments. I acknowledge that the services provided may be funded through the Ministry of Health and provided at no cost to me. I understand that I will be informed of any services that fall outside of what is funded, and provided with costs and options to purchase additional services if I choose.

Consent to Collect & Disclose Personal Information

I understand that the therapist requires an accurate record of the resident's current and past medical history, date of birth, health card number, and physician. I hereby give consent for the therapist to review all resident medical records relevant to my care in accordance with privacy guidelines and to release the findings of the assessment and subsequent treatment to the Director of Nursing & Personal Care (DOC) and any other healthcare professional at or outside of the facility involved in my care. I understand the assessment and reassessment information will be used by the Leamington Mennonite Home to determine best practices and ensure quality of services.

Client Name: _____ Date of Birth: _____

Health Card Number and Version Code: _____

☐ Client is a veteran. Veteran Affairs K Number of Case #: _____

Client Signature: _____ Date: _____

OR

Name of Substitute Decision Maker/Power of Attorney: _____

Signature: _____ Date: _____

Email Address: _____

**By providing my email address I hereby authorize the Leamington Mennonite Home Physiotherapy Team to contact me via email.*

Leamington Mennonite Home & Apartments

35 Pickwick Drive, Leamington, ON N8H 4T5
Phone: 519-326-6109 Fax: 519-326-3595
www.mennonitehome.ca

Hello Resident Family Members,

LMH is happy to announce that we will be able to offer onsite dental hygiene services to our residents in both the Long Term Care Facility and Retirement Residence. The company is Go Smile Oral Healthcare Services. Their introduction letter follows below.

The price point can range from $180 to just over $300 - it's all dependent on each individual's needs and what they have done. They have the same pricing as a regular dental office and use the regulated fee guide for pricing. They accept insurance as well and will submit on the resident's behalf and can do Pre Determinations to their insurance company as well if there are financial concerns. They do require full payment from POA once they have received their Post Treatment and invoice (email or mail). They will submit to insurance and they will directly be reimbursed according to their plan.

If you would like to register your resident to start receiving oral hygiene service, please contact Kris Lowes via email (kris@mennonitehome.ca). I will email you the registration form and once returned, will forward it on to Go Smile, along with a list of medications and the medical questionnaire that a member of our Registered Staff will complete.

With thanks,

Jeff Konrad
Administrator

Go Smile Oral Healthcare Services

Hello and Welcome to Go Smile!

We are collaborating with your care facility, the **Leamington Mennonite Home,** to create practical and compassionate access to oral healthcare for your residents. We aim to have between 5-8 patients per dental hygiene clinic. As for frequency, we try to come back every 4 months to the facility for our dental hygiene clinics. How we do this is we contact our facility first, confirm a date(s), update charts with you and then start calling POAs to set up the schedule.

We offer a wide array of dental hygiene therapies to our clients. Full exams, scaling, polish, fluoride, cavity arrest therapies, denture cleaning, intraoral pictures, referrals to specialists or dentists upon request, and we work closely with a mobile denturist as well. Each hygiene appointment is specialized for each individual's needs and we always work with the client on how they are feeling that day.

Rachel S.

Office Manager

Dufour Dental Hygiene

GoSmile Mobile Oral Healthcare Services

GoSmile.ca

Go Smile

Client Registration

Patient Information

Name:

Date of Birth

Facility Name:

Room number:

Care Decisions

Name:

Relationship to Patient:

Phone number:

Email:

Address:

Postal code:

Financial Contact

Name:

Relationship to Patient:

Phone number:

Email:

Address:

Postal code:

Consent for Dental Hygiene Services

☐ I consent to dental hygiene assessment and cleaning incuding fluoride

☐ I would like to be notified of additional care recommendations

Insurance

Insurance Carrier:

Group Number:

Individual Number:

☐ **PRIVACY**: The information collected is required to enable us to provide you with the best possible oral healthcare. All information is strictly confrdential and is protected by the Personal Information protection and Electronic Documents act (PIPEDA). The registered dental hygienist will explain any questions that you do not understand.

☐ **TREATMENT/HEALTH CONSULTATION:** I understand that all necessary will be explained to me and give my consent for treatment as indicated above. I consent to allow Go Smile to access mylthe patient's medical history as it may pertain to the requested services. I also authorize the release of information to third party insurance carriers, payors and to my medical doctor or other healthcare providers if necessary.

☐ **PAYMENT:** I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependants.

☐ **E-MAIL**: I consent to receive correspondence via email including follow up care recommendations, confrrmation of appointments, reminders and information about upcoming clinics or community involvement events

Client/Guardian Signature:

Date:

Leamington Mennonite Home

EVACUATION INFORMATION

Resident Name: _____

Family Member Name: _____

1. In case of an emergency evacuation, I wish to have my family member, _____ (name of resident) at the Leamington Mennonite Home and Apartments transferred to our family.

   _____ Yes _____ No

2. If yes, the following contact person and address should be identified in the Home plan as the place of transfer:

   Name: _____

   Relationship to Resident: _____

   Address: _____

   _____

   Phone Numbers:

   Home: _____

   Work: _____

   Mobile: _____

   Are you able to provide transportation for your family member?

   _____ Yes _____ No

3. If you do not feel that your family member is capable of joining you or a member of your family, please answer NO to question #1. In this case, your loved one will be transferred to a designated evacuation site in case of an emergency.

_____

Signature of Family Member

As of January 1, 2011

Leamington Mennonite Home

RESIDENT PHOTO USE CONSENT FORM

I **UNDERSTAND** that photographs and/or video and/or audio recordings of me may be circulated widely and that, if posted on the MennoniteHome.com website and published in either the HomeFront Chatter or the Resident Newsletter, they will be available to the public.

I further understand that the Leamington Mennonite Home has no control over, and is not responsible for, the use or misuse of materials on its website and/or publications (HomeFront Chatter and Resident Newsletter), including my photograph and/or video and/or audio recordings of me. **Please check the box below that applies to you.**

FOR THE PURPOSE STATED ABOVE, I CONSENT to be photographed and/or to be video and/or audio recorded by the Leamington Mennonite Home or its authorized representatives.

☐ **I ALLOW** the Leamington Mennonite Home or its representatives to use, reproduce, publish, transmit, distribute, broadcast and display any photograph and/or video and/or audio recording that contain my image and/or voice along with my name in any Mennonite Home publication, multimedia production, video, CD-ROM, DVD, display, advertisement and/or on the Leamington Mennonite Home's website or other social medial web sites without further notice or my approval of finished photographs and/or video and/or audio recordings.

☐ **I DO NOT ALLOW** the Leamington Mennonite Home or its representatives to use, reproduce, publish, transmit, distribute, broadcast and display any photograph and/or video and/or audio recording that contain my image and/or voice along with my name in any Mennonite Home publication, multimedia production, video, CD-ROM, DVD, display, advertisement and/or on the Leamington Mennonite Home's website or other social medial web sites without further notice or my approval of finished photographs and/or video and/or audio recordings.

_____

Resident First and Last Name (Print)

_____

Resident or Applicable POA Signature

_____

Date

***Protecting Your Privacy:** In accordance with Section 39(2) of the Freedom of Information and Protection of Privacy Act (1990), personal information including images and recordings in connection with this form is collected under the authority of the Leamington Mennonite Home and will be used for promoting, publicizing, or explaining the Leamington Mennonite Home and its activities and for administrative, educational or research purposes. If you have any questions about the collection of personal information by the Leamington Mennonite Home as referenced on this form, please contact our Administrator.