LEAMINGTON

Mennonite Home

Retirement Residence

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

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

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

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

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

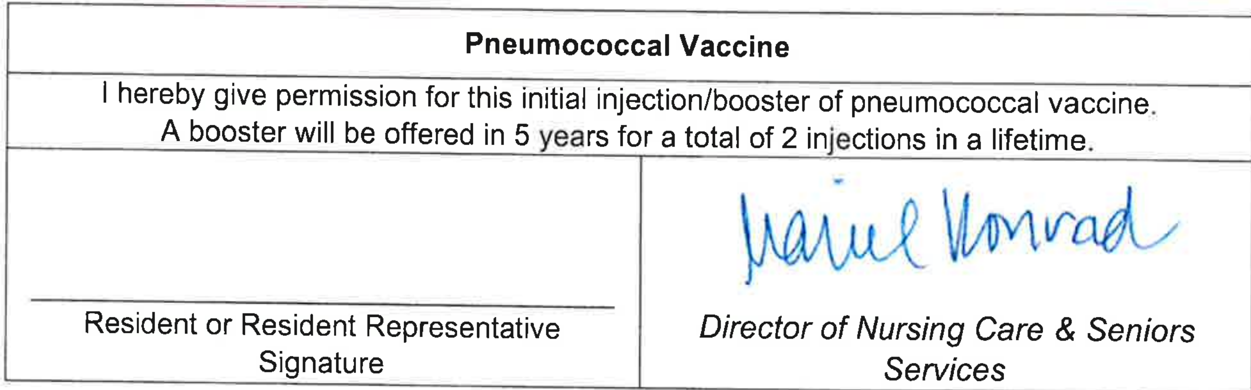
Jeff Konrad
Administrator

Mariel Konrad, RN
Director of Nursing Care & Seniors Services

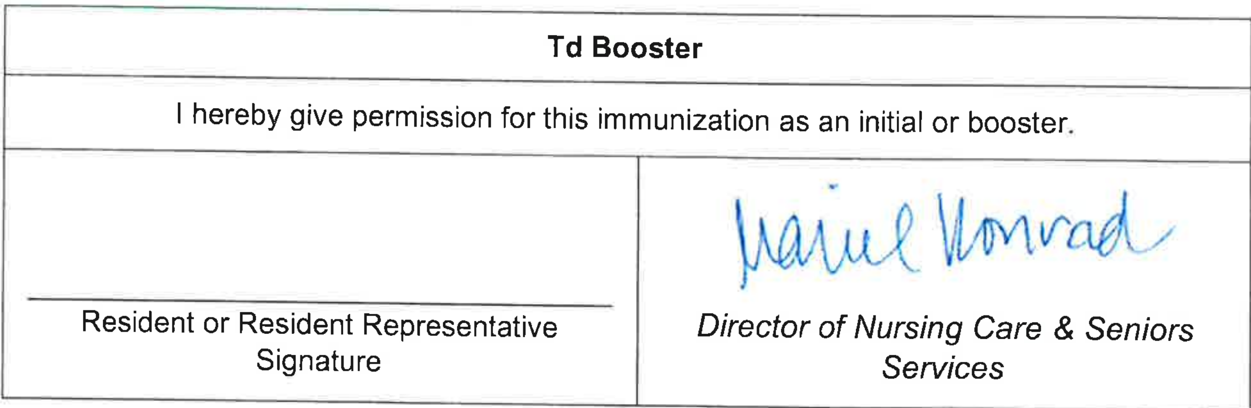
Leamington Mennonite Home

VACCINATION / IMMUNIZATION PERMISSION FORM

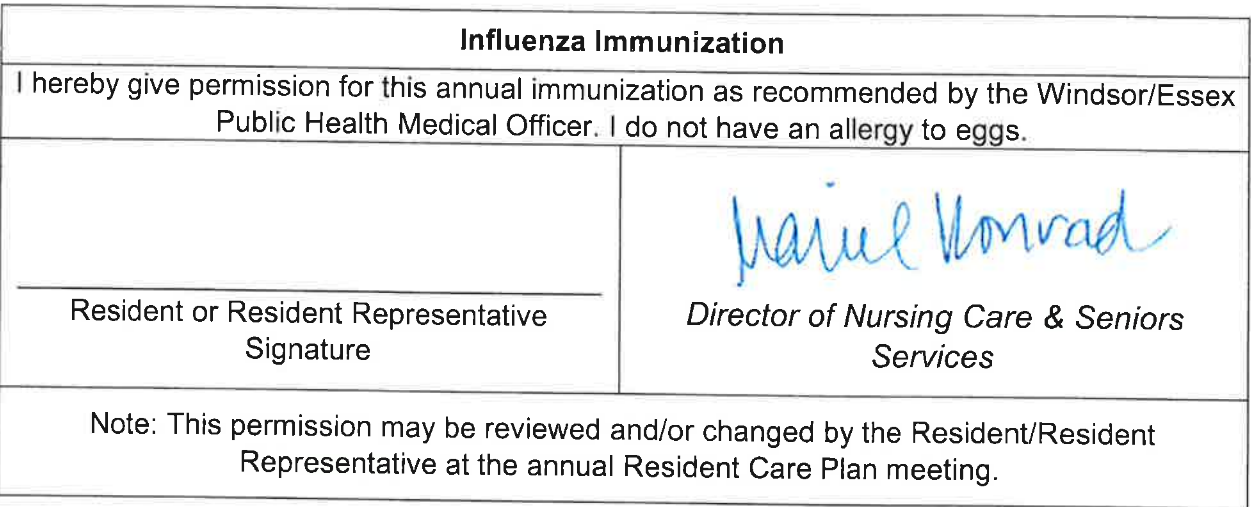
Resident Name: ______________________________ Room #: ________



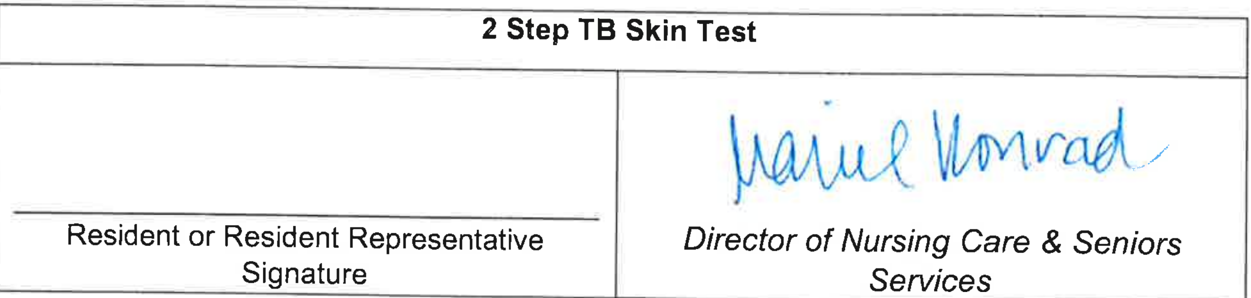
Pneumococcal Vaccine	
I hereby give permission for this initial injection/booster of pneumococcal vaccine. A booster will be offered in 5 years for a total of 2 injections in a lifetime.	
Resident or Resident Representative Signature	*Director of Nursing Care & Seniors Services*



Td Booster	
I hereby give permission for this immunization as an initial or booster.	
Resident or Resident Representative Signature	*Director of Nursing Care & Seniors Services*



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	*Director of Nursing Care & Seniors Services*
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	*Director of Nursing Care & Seniors Services*

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

CONSENT TO TREATMENT

With admission to the Leamington Mennonite Home Retirement Residence, the resident (______________________________) and/or resident representative/POA with resident permission (______________________________) hereby give(s) permission for all required medical and nursing treatment with the Leamington Mennonite Home Retirement Residence determining which Resident Home area is most appropriate for each resident's care and treatment.

Consent is hereby also given for the full release of all information, as required, for the medical treatment of the above-named resident. This release of information includes all physicians, specialists, nurse practitioners, and therapists providing assessment and/or treatment to the resident.

- ☐ I do not want my POA called for consent for medical treatments. ____initial
- ☐ I want my POA called for consent for medical treatments. ____initial

____________________________	__________________________
Resident Signature	Date
____________________________	__________________________
Resident Representative/POA	Date
____________________________	__________________________
Witness	Date

As of February 2017

Frequent Dispensing – Documentation/Consent/Notification Form

Patient Information

First Name:	Last Name:	OHIP No. or Date of Birth:

Pharmacist Assessment*

It is my professional opinion that the patient above requires a more frequent medication dispensing interval to help him/her achieve desired health outcomes, as he/she is incapable of managing his/her medication regimen as a result of a:

☐ Physical impairment Nature:	☐ Cognitive impairment Nature:	☐ Sensory impairment Nature:	☐ Complex medication regimen Details:

The dispensing regimen will be:

☐every 7 days ☐ every 14 days ☐every 28 days ☐Other:

**Regular assessment is required to verify the ongoing need for more frequent dispensing, and to determine if the patient is stabilized and capable of managing 100 day supplies*

The rationale/reason(s) for my assessment of the clinical or safety risks to the patient if larger quantities were dispensed, is/are:

Pharmacist's name (print)	OCP #:
Signature:	Date:

Pharmacy Information

Pharmacy Name:	Address:
Telephone	Fax

Patient/Agent Consent

I consent and authorize to have my medication(s) dispensed in reduced quantities from what was originally prescribed, as per the assessment, rationale and dispensing regimen outlined above.

I consent to have this form sent to the prescriber(s)

Date	Agent's Name (if applicable)
Patient's Signature	Agent's Signature (if applicable)

Prescriber Notification

Dear Prescriber: This notification is being sent to you to comply with regulations made under the Ontario Drug Benefit Act and policies under the Ontario Drug Benefit program, whereby I am required to notify you in writing with my determination and rationale noted above for your records.

Prescriber's Name	Date of Notification (DD/MM/YYYY):
Method of Notification: ☐ Fax:	☐ Other:

This documentation is valid for a period of 365 days.
It is required to be updated annually and, is to be maintained as part of the patient's permanent pharmacy health record.

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

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.