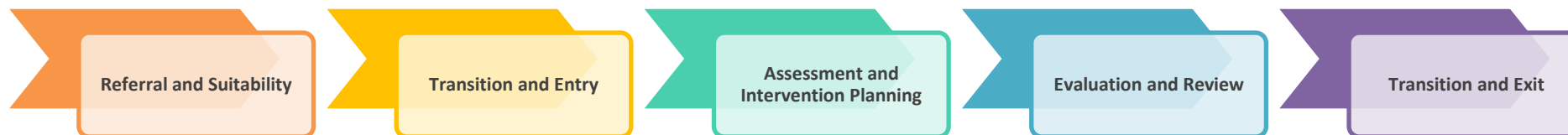


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Residential Care and Transition Services – Residential Care



Referral and Suitability	Transition and Entry	Assessment and Intervention Planning	Evaluation and Review		Transition and Exit
<ul style="list-style-type: none"> SPM complete CTARS Initial Referral Register Generate/reactivate Client Profile in CTARS, set hierarchy to Referral Commence <i>CTARS Referral Record Form</i> Assessment process – may include further meeting/discussion and information gathering Recommendation – provided to SPM for approval in <i>CTARS Referral Record Form</i> Outcome provided to persons requesting services and recorded on CTARS If referral not accepted, deactivate CTARS Client Profile. If referral accepted, change CTARS Client Profile hierarchy to relevant Unit Send FS IP RCaTS RES Working with MC/FS IP RCaTS RES Working with ITIS to CSO and CSSC Team Leader. 	<ul style="list-style-type: none"> Complete visual transition planning and actions Develop Individual Activity Planner Enter medication and create CTARS Medication Chart Enter information into CTARS Client Profile as follows: <ul style="list-style-type: none"> Basic profile Critical contacts IR email contacts Critical medication information Positive Behavior Support Plan/Safety Plan FS FORM RCaTS Welcome Kit Checklist MC Privacy Brochure MC Feedback and Complaints Brochure FS FORM RCaTS Welcome Booklet (relevant to the program model) Complete Entry Questionnaire for under 12 or 12 years and over. Review and update Pool Safety Plan FS FORM RCaTS Emergency and Fire Safety Management Plan House Meeting in 2 days of entry 	<p>Within first 2 weeks of entry:</p> <ul style="list-style-type: none"> Conduct and set schedule of Reference Person Meetings Conduct House Meeting to re-set house expectations and establish new group dynamics Set Initial Critical Goals in Client Profile (inc. GBI, medication, family, school, behavioural supports, etc.) Begin Therapeutic Assessment Report (TAR) and CANS Assessment <p>Within first month of entry:</p> <ul style="list-style-type: none"> Complete initial TAR Review/update Goals to reflect recommendations from TAR Complete Client Profile information Book Departmental Case File Review Activity Risk Assessment Log <p>Within first 3 months of entry:</p> <ul style="list-style-type: none"> Cultural Support Plan developed 	<p>Reporting and ongoing assessment</p> <ul style="list-style-type: none"> Monthly Data Analysis Report (DAR) provided to the Dept. in the first week of the month Monthly Goals Progress update, provided to the Dept. via Goals Report with DAR Monthly Positive Behaviour Support Plan and Safety Plan Review Monthly Stakeholder Meetings – completion of minutes to be provided to stakeholder group Fortnightly MC Team Meetings – complete CTARS MC Team Meeting Minutes (CTL/SRCW) 6 monthly review of TAR Ongoing uploads of External Reports and documents to CTARS Internal Case Consults, as needed Critical document reviews, as needed Activity Risk Assessment Log Cultural Support Plan reviewed every 6 months, in line with the TAR <p>Data entry</p> <ul style="list-style-type: none"> Shift Log (AM, PM, Sleep Disturbance) – completed by RCW/ SRCW Behaviour Log – completed by RCW/ SRCW Medication Log – completed by RCW/ SRCW Activity Log – as per Planner Incident Log – completed by RCW/SRCW/AC/CTL/SPM Specialty Forms – assigned by CTL for a period of time to gather unique information <p>High frequency reviews</p> <ul style="list-style-type: none"> Daily review of Incident Log Draft Daily processing of Incident Register Weekly Reference Person meeting (may inc. psychoeducation) – record on Activity Log Regular review of Medication Logs Produce Data Charts, as needed Produce ad hoc reports, as needed 		<ul style="list-style-type: none"> Commence/complete transition planning and actions Produce Exit Summary for the Dept. (Goals Report with all goals) Provide current Behaviour Support Risk Plan and Safety Plan to the Dept. Deactivate Medication Charts Enter exit data into CTARS Client Profile/advise Business Support Team Deactivate CTARS Client Profile

Approved By: Regional Director, Residential Care and Transition Services

Approval Date	12 Sep 2022	Implementation Date	16 Sep 2022	Review Date	12 Sep 2024
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