Focus on Quality

Basic Care Training

Presented by the North Dakota Department of Health

June 27, 2007

Overview – Bruce Pritschet, Division Director

- Legislative Update
  - Darleen Bartz, PhD, APRN
    Health Resource Section Chief

    - 2007 Legislative Session Update
    Related to Basic Care Facilities

Overview – Bruce

- Resident Assessment and Care Planning
  - Lucille Torpen RN and Judi Johnson RN
    - Importance of Assessment first ...some situations where specific assessment required.
    - Some helpful examples of areas where assessments have been missed.

Overview- Bruce

- Care Planning
- What should be addressed in a care plan
- Individualizing a care plan.
- Timeframes and who is responsible

Overview - Bruce

- Next we will briefly review the survey process as it relates to the dietary department. -Cathy Myrvik RN & LRD and Kristen Hoyt LRD
- Review basic food safety principles and discuss examples. Preparation, sanitation, storage, & food safety.
- Discuss provision of prescribed diets.
- Discuss meeting the nutrition needs of residents.

Overview - Bruce

- Becky Humann RN with cover the storage and administration of resident medications.
- Delegation of medication administration and medication assistants

Overview - Bruce

- Next we will have Joan Coleman LSW (training coordinator for HF) presenting information on the Governing Body.
- Cover policies and procedures
- Hand hygiene
- Glove usage

Overview – Bruce con't

- Elopement
- Falls
- Abuse and Neglect
- Admission and Discharge
- Education programs

Overview - Bruce

- Life safety code and licensing rules – Monte Engel P.E.
- Fire drills and evacuation
- Construction types
- Evacuation index – overall facility score
- Use of the form – risk factors
- Dorrene Haugrud to discuss determining resident capabilities to exit

2007 Legislative Update

Presented by Darleen Bartz

Discuss the following Bills:

- HB 1004 – Demonstration Project on Voluntary Surveys during Construction
- HB 1488 – Changes to Survey Process
- SB 2109 – Changes to Moratorium

2007 Legislative Update

HB 1004 – Section 12.

- Demonstration Project for Voluntary Surveys During Major Construction or Renovation of Basic Care and Long-Term Care Facilities – Continuing Appropriation – Report to Legislative Council.
  - The department of health must design and implement a demonstration project through which the department offers a life safety survey process for basic care facilities and long term care facilities to access voluntarily during and at the conclusion of a construction project, renovation project, or construction and renovation project that costs more than three million dollars.

2007 Legislative Update

HB 1004 – Section 12.

- Facility must request participation in demonstration project
- Department may charge travel expenses including per deim
- Department must insure there is no conflict with federal requirements
- Project must be within 2007-2009 appropriation and staffing levels
- Department to report to legislative council by August 1, 2008

2007 Legislative Update

HB 1004 – Section 12.

- Actions taken include:
  - A meeting is being planned to receive input from stakeholders and to discuss factors the department to consider in designing and implementing this demonstration project.
  - Consultation with the Attorney General's office related what should be contained in a signed agreement/contract between the facility and the department should a facility is eligible and desires to participate in the project.
  - Plan to have the demonstration project designed and ready to implement as close to August 1, 2007 as possible
  - Plan to consider information that will need to be collected to report to legislative council before August 1, 2008.

2007 Legislative Update

- HB 1488 – Section 1 Amendment
  - 23-09.3-04. Department to establish standards – Licensing – Inspection – Survey – Prospective violation. The department shall establish standards for basic care facilities...The department shall implement a survey process for basic care facilities which for purposes of the life safety portions of the survey, all surveys must be announced; and which for purposes of the health portions of the survey, half the surveys shall be announced; and for which for purposes of complaints related to health and life safety, all surveys must be unannounced.

2007 Legislative Update

- HB 1488 (cont)
  - As part of the survey process, the department shall develop, in consultation with basic care facilities, and implement a two-tiered system of identifying areas of non-compliance with the health portions of the survey.
- Section 2. DoH Report to Legislative Council.
  - Before August 1, 2008, the DoH shall provide a report to legislative council regarding the impact, including whether the department will be recommending any legislative changed to the basic care survey process.

2007 Legislative Update

- HB 1488 - Actions taken:
  - HC approval received in June to go out to public hearing to remove Subsection 9 of Section 33-03-24.1-03 of the NDAC, relating to basic care facilities as follows:

    ~~9. The department will perform, as deemed necessary, unannounced onsite surveys to determine compliance with this chapter.~~

2007 Legislative Update

- HB 1488 - Actions taken
  - Developing a workgroup consisting of:
    - One Basic Care Facility Representative from each of the six Long Term Care Regions,
    - Other stakeholders; and
    - department staff.
  - To provide an opportunity for consultation with providers and discussion related to a two-tiered system of identifying non-compliance with the health portions of the survey prior to development of the system by the department.
  - The resultant changes to the survey process guidelines will be shared with Basic Care Providers prior to implementation.

2007 Legislative Update

SB 2109 – Section 1 Amendment

1. Basic care beds may not be added to the state's licensed bed capacity during the period between August 1, 2007 and July 31, 2009, except when:

   a. A nursing facility converts nursing facility beds to basic care; or

   b. An entity demonstrates to the state DoH and DHS that basic care services are not readily available within a designated area of the state or that existing basic care beds within a fifty-mile radius have need occupied at ninety percent or more for the previous twelve months.

2007 Legislative Update

SB 2109 (cont)

b. (cont) In determining whether basic care services are readily available if an additional license is issued, preference may be given to an entity that agrees to any participation program established by the DHS for individuals eligible for services under the medical assistance program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.].

c. If the state DoH and the DHS grant approval of new basic care beds to any entity, the approved entity shall license the beds within forty-eight months from the date of approval.

2007 Legislative Update

SB 2109 - Section 2 Amendment

1. Not withstanding sections 23-16-06 and 23-16-10, except when a facility reverts basic care beds to nursing facility beds, nursing facility beds may not be added to the state's licensed bed capacity between August 1, 2007, and July 31, 2009. A nursing facility may not convert licensed nursing bed capacity to basic care bed capacity or convert basic care beds back to nursing facility beds more than one time in a twelve-month period if the beds have been licensed as basic care.

2007 Legislative Update

SB 2109 – Section 3

- Legislative Study to include:
  - The state's long term care system including:
    - Capacity,
    - Geographical boundaries for determining capacity,
    - The need for home and community based services,
    - A methodology to determine need for more beds,
    - Access,
    - Workforce,
    - Reimbursement, and
    - Payment incentives.

Assessment and Care Planning

Presented by Judi Johnson
and Lucille Torpen

North Dakota Department of Health

June 27, 2007

Assessment

- A process to gather information about a person's life, functional abilities and needs in order to develop an individualized plan of care.

33-03-24.1-12.

1. An assessment is required for each resident within fourteen days of admission and as determined by an appropriately licensed professional thereafter, but no less frequently than quarterly.

2. The assessment must be completed in writing by an appropriately licensed professional.

The assessment must include:

a. A review of health, psychosocial, functional, nutritional, and activity status.

b. Personal care and other needs.

c. Health needs.

d. The capability of self-preservation

e. Specific social and activity interests.

Data collection

- Observation
- Obtain information
- Knowledge about the resident
- Understanding the resident's limitations and strengths

- Equally important is ongoing monitoring and assessment of residents, particularly when a resident returns from the hospital or when a resident experiences a change in condition.

Fall

- An unintentional change in position resulting in contact with the floor or other surface.

Fall assessment

- Identification of resident risk factors
  - Fall history
  - Mobility
  - Cognitive/functional ability
  - Sensory function
  - Medical conditions
  - Nutritional status
  - Medication regimen

Fall assessment

- Evaluation of environmental conditions related to falls.
- Collection of information from the resident as well as family members about the history of falling

Resident Behavior

- Wandering
- Elopement
- Resident to resident altercation

Wandering

- To move about with no destination or purpose; roam aimlessly

Assessment for wandering

- Medical conditions
- Cognitive function
- Functional mobility
- Life history
- Environment
- Emotional/psychological conditions
- Social considerations

Elopement

- when a resident who needs supervision, leaves the facility without staff awareness or supervision

Resident to resident altercations

- A verbal and/or physical confrontation between residents

Sleep assessment

- Normal sleep pattern
  - Medical conditions
  - Usual bedtime
  - Sleep aids, bedtime rituals
  - Environmental factors
  - Sleep disturbances

Sleep Problems

- Insomnia
- Sundowning

Urinary Elimination assessment

- Collection of data
  - Voiding patterns/habits
  - Environmental factors

Urinary incontinence risk factors

- Medications
- Immobility
- Inability to manage one's own toileting
- Medical conditions

Urinary Tract Infection

- The most common bacterial infection in the elderly
- Can cause incontinence
- Mental changes or confusion often are the only signs of a urinary tract infection

To avoid an infection

- Encourage adequate fluid intake
- Remind the resident to void regularly
- Stress the importance of wiping from front to back after urination

Bowel Elimination

- Assessment includes:
  - Usual bowel patterns
  - Recent changes/problems
  - Elimination aids

Bowel elimination risk factors

- Chronic laxative use
- Nerve damage
- Stress
- Functional damage
- Diarrhea
- Constipation

To prevent constipation

- Sufficient high fiber food and fluid
- Encourage exercise
- Review the resident's medication list

Assessment of diarrhea

- Monitor diarrhea episodes
- Assess for fecal impaction
- Monitor for dehydration
- Evaluate the diet
- Review the resident's medication list

Skin assessment

- Examination of the skin for:
  - redness
  - rash
  - blisters
  - open areas

Diabetic Care

- The physician will need to establish acceptable blood sugar level ranges for each resident
- Establish guidelines for low blood sugar
- Periodic foot care

Nail Care

- Establish a plan to ensure nail care is provided by facility staff or completed by the resident on a regular basis

Illness

- Establish guidelines for staff to notify the nurse when a resident is ill and what constitutes “ill”

Care Planning

- 33-03-24.1-12

  3. A care plan, based on the assessment and input from the resident or person with legal status to act on behalf of the resident, must be developed within twenty-one days of the admission date and consistently implemented in response to individual resident needs and strengths.

Care Planning

- 4. The care plan must be updated as needed, but no less than quarterly.

The Care Plan

- Is individualized
- Addresses the needs, strengths, and preference of the resident
- Builds on resident strengths
- Has measurable outcomes
- Must include the information necessary for staff to provide care for the resident
- Must reflect the current status of the resident

Break Time

Focus on Quality

FOOD & NUTRITION in Basic Care Facilities

North Dakota Department of Health

Presented by Kristen Hoyt, LRD and

Cathy Myrvik, RN, LRD

June 27, 2007

DIETARY SERVICES

We are all working towards the same goal:

To provide safe, nutritious food and an enjoyable dining experience for all residents in basic care facilities.

OBJECTIVES

- Review basic food safety principles and discuss examples.
- Discuss menus, prescribed diets, and meal service.
- Discuss meeting the nutritional needs of residents.

FOOD SAFETY

- 33-03-24.1-18. Dietary Services.
- “The facility must. . . Provide dietary services in conformance with the North Dakota sanitary requirements for food establishments.”
- North Dakota Requirements for Food and Beverage Establishments (The “RED BOOK”)

FOOD STORAGE

- Are refrigerated foods stored properly, covered, dated, and labeled?
  - Refrigerator temperatures should be 41 degrees Fahrenheit or below.
  - Cover and label foods (name) if taken out of their original packaging.
  - Date marking is especially important for food that is ready- to- eat and potentially hazardous.
  - Potentially hazardous food kept for more than 24 hours must be date-marked

FOOD STORAGE

- POTENTIALLY HAZARDOUS FOODS ARE GENERALLY:
  - Moist
  - Neutral or slightly acidic (ph 4.6 – 7.5)
  - High in protein content

FOOD STORAGE

Food Safety Concern:

- Ready-to-Eat Potentially Hazardous Foods:
  - if the package is OPEN the product must be used within seven days
  - if the package is NOT OPEN follow the product's manufacturer's recommendation, facility policy, or general food storage guidelines

FOOD PREPARATION

- Are foods properly thawed, cooked, and cooled?
- Are food contact surface and utensils cleaned to prevent cross contamination and foodborne illness?
- Are staff using gloves and washing hands properly?

FOOD PREPARATION

- THAWING METHODS
  - Refrigerator
  - Cool Running Water (70 degrees or lower)
  - Microwave (If it will be cooked immediately)
  - As part of the cooking process

FOOD PREPARATION

- COOKING TEMPERATURE GUIDE
  - **145° F/15 seconds** - raw shell eggs made to order for immediate service, pork, fish.
  - **155° F/15 seconds** - raw shell eggs for later service, all ground, injected meats.
  - **165° F/15 seconds** - poultry, stuffed meats, pasta, microwave foods, and all dishes with previous cooked ingredients.

FOOD SERVICE/SANITATION

- Holding Temperatures
  - **Hot Holding** - minimum 135 degrees Fahrenheit during tray service
  - **Cold Holding** - maximum 41 degrees Fahrenheit during tray service
    - Temperature Logs
    - Calibrate Thermometers

FOOD PREPARATION

- COOLING PROCEDURE
  - Cool from **135 to 70 degrees F** within first **2 hours** and from **70 to 40 degrees F** within **4 hours** (Total of 6 hours).
  - Cool to less than **40 degrees F** within **4 hours** if cooled from room temperature.

FOOD PREPARATION

- COOLING METHODS
  - Exchange hot pans for cool pans
  - Use shallow pans
  - Separate smaller portions
  - Use blast chiller or freezer
  - Ice water bath
  - Loosely cover
  - Allow air to circulate around pans

FOOD SERVICE/SANITATION

- TEMPERATURE CONTROL . . .

  is key to killing microorganisms that can cause foodborne illness . . . The minimum internal temperatures at which foodborne microorganisms are destroyed varies from product to product . . .

  - Cooking Temperatures

  However. . . cooking cannot destroy possible spores and toxins. Handling food safely before and after it is cooked will prevent microorganisms from producing these spores or toxins.

  - Holding Temperatures
  - Cooling Temperatures

FOOD SERVICE/SANITATION

- PERSONAL HYGIENE
  - Hand washing-When to wash your hands?
  - Before and after work
  - After smoking, eating, drinking, or using the toilet
  - Changing tasks, especially between working with raw foods and ready to eat foods
  - When changing gloves
  - Minimize bare hand contact

FOOD SERVICE/SANITATION

- PERSONAL HYGIENE
  - Hair Restraints
  - Jewelry
  - Aprons

FOOD SERVICE/SANITATION

- DISHMACHINES
- Know what type of machine you have
  - chemical sanitizing or hot water sanitizing
- Know the acceptable parameters for ensuring proper sanitization for each
  - gauges, temperature test strips, chemical test strips

FOOD SERVICE/SANITATION

- DISHMACHINES
- Educate staff about the importance of checking temperature gauges and/or checking chemical concentration.
- Have a back-up plan in place if the dishmachine is not properly sanitizing the dishes.
- Maintain temperature logs, chemical logs, and/or records from your service representative.

FOOD SERVICE/SANITATION

- THREE COMPARTMENT SINKS and SANITIZING SOLUTION BUCKETS
- Know what type of sanitizer you are using
  - chlorine, quaternary ammonia, etc.
- Check sanitizer concentration with the appropriate test strips
- Follow manufacturer's directions for correct concentration
- Food particles and soap may decrease sanitizing solution strength/concentration

DIETARY SERVICES

- Food is an integral aspect of daily life.
- Food and dining services are often viewed as a quality of life measure.
- Food is a source of comfort and fulfillment for residents.
- Food provides nutrition and promotes health and healing.

DIETARY SERVICES

- 33-03-24.1-18. Dietary Services
  - “The facility must meet the dietary needs of the residents . . . Dietary services must include:

DIETARY SERVICES

- A minimum of three meals a day.
  - Meals must be nutritious and well-balanced in accordance with the recommended dietary allowances of the Food & Nutrition Board of the National Research Council, National Academy of Sciences.

DIETARY SERVICES

- There must be no more than a fourteen-hour span between the evening meal and breakfast.
  - Example: If the evening meal is served at 5:30 p.m., breakfast cannot be served later than 7:30 a.m.

DIETARY SERVICES

- Snacks must be served between meals and in the evening.
- These snacks must be listed on the daily menu.
- Vending machines may not be the only source of snacks.

DIETARY SERVICES

- Dietary services must make provisions for prescribed diets, if the facility accepts or retains individuals in the need of such diets.
  - Menus for prescribed diets must be planned and reviewed as needed by a professional consistent with the ND Century Code, Chapter 43-44.

DIETARY SERVICES

- The menus of the food served must be kept for at least three months.

DIETARY SERVICES

- Foods must be prepared using methods that will conserve nutritive value, as well as enhance flavor and appearance.
- Food must be served at proper temperatures and in a form that will meet individual needs.

DIETARY SERVICES

- Meals must be served to all residents in a dining room, except for residents with a temporary illness.

NUTRITION

- Assessment
  - A thorough assessment is the foundation for providing optimal nutritional care
  - Many factors can affect a residents nutritional status

NUTRITION

- Assess
  - Weight
  - Intake
  - Hydration status
  - Elimination status
  - Lab values
  - Skin integrity

NUTRITION

- Interventions
  - Enhance foods to increase calories, protein, or fiber
  - Offer between meal supplements or meal replacements
  - Modify food texture or type
    - Soft foods, finger foods
  - Ensure proper serving sizes
    - Serving utensils
    - Recipes

NUTRITION

- Interventions
  - Offer assistance with meal set up and encourage intake
  - Provide specialized equipment
    - Plate guards, nosey cups, adaptive utensils
  - Determine food “likes and dislikes”
    - Honor these choices or offer substitutions

NUTRITION

- Interventions
- Engage resident in the meal time experience:
  - Have residents help plan the menu or plan special meals
  - Stimulate olfactory senses
    - Bake bread or cookies prior to meals
  - Create a “happy hour” to encourage increased fluid intake

NUTRITION

- Interventions
- Create a pleasant dining room environment by:
  - minimizing noise and distractions
  - Playing soft dinner music
  - Creating a homelike atmosphere
  - Serving attractive, appealing foods
    - garnishes
  - Seating residents to encourage conversation

Nutrition

- Monitor
- Continue to monitor factors that affect nutrition
- Continue to evaluate interventions
  - Are they being implemented as planned?
  - Are they being accepted by the resident?
  - Is the resident making progress towards the set goals?

SUMMARY

- Reviewed basic food safety principles and discuss examples.
- Discussed menus, prescribed diets, and meal service.
- Discussed meeting the nutritional needs of residents.

Thank You

MEDICATION STORAGE & ADMINISTRATION

Presented by

Becky Humann, RN BSN

North Dakota Department of Health

June 27, 2007

MEDICATION STORAGE & ADMINISTRATION

- Chapter 33-03-24.1-15

  Pharmacy & Medication Administration Services

MEDICATION STORAGE & ADMINISTRATION

- ". . . 2. The facility shall provide a secure area for medication storage consistent with Chapter 61-03-02."

MEDICATION STORAGE & ADMINISTRATION

- ". . . 4. All medications used . . . are administered or supervised by staff must be:

  a. Properly recorded

  b. Kept and stored in original containers and labeled consistently with state laws

  c. Properly administered."

MEDICATION STORAGE

- Definition

  Storage defined as “medications . . . stored in areas suitable to prevent unauthorized access and to ensure a proper environment for preservation of the medications . . . .”

  (Ch 61-03-02 ND Consulting Pharmacy Regs. for LTC Facilities, Skilled, Intermediate, and Basic Care)

MEDICATION STORAGE

- Security

  Unattended medication rooms/carts shall be locked

  Controlled substances are locked and accounted for (every shift change)

MEDICATION STORAGE

- Insulin Vials

  According September 2003 issue of Diabetic Care, Volume 26, Number 9, pages 2666-7 “How Long Should Insulin Be Used Once a Vial is Started?”

MEDICATION STORAGE

- Medications shall be kept and stored in original containers and labeled consistently with state laws

MEDICATION ADMINISTRATION

- Inhalers

  Proper sequence

  Wait 1 minute between “puffs”

MEDICATION ADMINISTRATION

- Oral Medications

Medication ranges (1-2 tabs and/or 0.5 mg -1 mg)

MEDICATION ADMINISTRATION

- Oral Medications

Medications ordered at specific times before meals (ac) or after meals (pc)

MEDICATION ADMINISTRATION

- Basic care facilities may employ . . . medication assistants (I, II, III)

MEDICATION ADMINISTRATION

- Medication assistant defined (Ch 54-01-03)

  an individual who has a current registration as an unlicensed assistive person (UAP),

  has had additional training in administration of medication,

  and possesses a current registration from the Board of Nursing as one of the following medications assistant I, II, III.

MEDICATION ADMINISTRATION

- Requirements for supervision as stated in Ch 54-07-05-04

  A licensed nurse who delegates med administration to a med assistant must provide supervision as follows. . .

MEDICATION ADMINISTRATION

Ch 54-07-05-04

- 3. In any other setting where the licensed nurse delegates the intervention of giving meds . . .

  the licensed nurse must establish in writing the process for providing the supervision in order to provide the recipient of the medication appropriate safeguards

MEDICATION ADMINISTRATION DELEGATION

- Delegation is defined as . . .

  “the authorization for the performance of selected nursing interventions from a licensed nurse to an unlicensed assistive person.”

(Ch ND Administrative Code Ch 54-01-03-01.16)

MEDICATION ADMINISTRATION DELEGATION (NDAC Ch 54-07-08)

- Specific Delegation of Medication Administration

A facility must . . .

MEDICATION ADMINISTRATION DELEGATION (NDAC Ch 54-07-08)

- Have organizational policies & procedures

- Educate staff regarding specific client's med administration (verbally & written) regarding:

MEDICATION ADMINISTRATION DELEGATION (NDAC Ch 54-07-08)

- Educate on . . .
  - Name of medication
  - Purpose of med
  - S/S of common side effects
  - Route
  - When to contact licensed nurse

MEDICATION ADMINISTRATION DELEGATION (NDAC Ch 54-07-08)

- Observe staff administering meds to a specific client until competency is verified

- Verify competency of staff

MEDICATION ADMINISTRATION DELEGATION (NDAC Ch 54-07-08)

Staff must know the 6 Rights of Medication Administration

MEDICATION ADMINISTRATION DELEGATION (NDAC Ch 54-07-08)

- Ensure staff know the name(s) of med(s) & common dosage

- Ensure staff know S/S of SE for each med

MEDICATION ADMINISTRATION DELEGATION (NDAC Ch 54-07-08)

- Staff need to know when to contact the licensed nurse

MEDICATION ADMINISTRATION DELEGATION (NDAC Ch 54-07-08)

- Ensure staff can properly administer meds (especially inhalers)

MEDICATION ADMINISTRATION DELEGATION (NDAC Ch 54-07-08)

- Staff documents the meds administered according to facility P/P

MEDICATION ADMINISTRATION DELEGATION (NDAC Ch 54-07-08)

- Facility staff must . . .
  - evaluate the client when med orders change
  - determine if staff need further instructions prior to implementing the med change

MEDICATION ADMINISTRATION OF PRNS BY MED ASSISTANTS

- Ch 54-07-05-10 Pro re nata (PRN) medications states

"1. The decision to administer PRN meds cannot be delegated in situations where an onsite assessment of the client is required prior to administration."

MEDICATION ADMINISTRATION OF PRNS BY MED ASSISTANTS

- “2. Some situations allow the administering of PRN med without directly involving the licensed nurse prior to administration.”

MEDICATION ADMINISTRATION OF PRNS BY MED ASSISTANTS

- “2a. The decision regarding whether an onsite assessment is required is at the discretion of the licensed nurse.”

MEDICATION ADMINISTRATION OF PRNS BY MED ASSISTANTS

- "2b. Written parameters specific to an individual client's care must be written by the licensed nurse . . .

  when an onsite assessment is not required prior to administration of the medication."

MEDICATION ADMINISTRATION OF PRNS BY MED ASSISTANTS

- These written parameters will . . .

  supplemental the MD's PRN order

  provide staff with guidelines that are specific re: PRN medication

MEDICATION ADMINISTRATION OF PRNS BY MED ASSISTANTS

- Must document the effectiveness of all PRN meds administered

MEDICATION ADMINISTRATION OF PRNS BY MED ASSISTANTS

- Licensed staff should review the times/responses of PRN medications administered.

CONCLUSION

- Medication rooms & carts must be secured at all times
- Label insulin vials w/ date upon opening. Keep up to 28 days

CONCLUSION

- Medication bottles and medication cards must be properly labeled.

- Ensure all medications are properly administered according to acceptable standards of practice (inhalers).

CONCLUSION

- Must follow MD orders regarding specific times for administration of some meds (ac or pc)

CONCLUSION

- All staff must promptly and accurately document the administration of all meds, including effectiveness of PRN meds.

CONCLUSION

- Facility P/P must delineate specific steps for staff to follow re: med administration.
- Facility‘s must verify the competency of medication aides.

CONCLUSION

- The decision to administer PRN meds cannot be delegated in situations where an licensed staff onsite “hands on” assessment is required prior to med administration.

Governing Body

Resident Health, Safety, and Security

Presented by Joan Coleman
North Dakota Department of Health
June 27, 2007

33-03-24.1-09. Governing Body

The Governing Body is *legally* responsible for:

- The quality of resident service;
- For resident health, safety, & security; and
- To ensure the overall operation of the facility is in compliance with all applicable federal, state, and local laws.

33-03-24.1-09. Governing Body

- The governing body is responsible for approval and implementation of effective resident care & administrative policies and procedures for the operation of the facility.

33-03-24.1-09. Governing Body

These policies and procedures must be:

- In writing
- Signed
- Dated
- Reviewed annually
- Revised as necessary

33-03-24.1-09. Governing Body

These policies and procedures shall address:

- All services provided by the facility to meet the needs of the residents . . .
  - What services do you offer?
  - What are the needs of your residents?

Policies & Procedures

Remember The Four Ds

Adapted from Maria Arellano, RN, BS

Policies & Procedures

Remember the Four Ds

Define your policies & procedures

Ensure they are:

- Realistic
- Up to date with current standards of practice

Adapted from Maria Arellano, RN, BS

Policies & Procedures

Remember the Four Ds

Develop your systems

- For how your programs will be carried out based on your policies & procedures
- Communicate your system to all staff who will be involved with carry them out

Adapted from Maria Arellano, RN, BS

Policies & Procedures

Remember the Four Ds

Deliver the care in the manner in which you say you will

- Observe staff in action
- Listen to staff interaction with residents
- Review resident records/documentation
- Interview staff & residents

Adapted from Maria Arellano, RN, BS

Policies & Procedures

Remember the Four Ds

Document

Make sure your documentation system is:

- Concise, yet thorough
- Efficient
- Consistent

Adapted from Maria Arellano, RN, BS

Hand Hygiene

Policy and Procedure

- Define
- Develop
- Deliver

Hand Hygiene

- Centers for Disease Control and Prevention (CDC) identifies handwashing as the single most effective way to prevent the transmission of disease

Hand Hygiene

Studies Done On Hand Hygiene In Hospitals

Year of Study	Adherence Rate	Hospital Area
1994 (1)	29%	General and ICU
1995 (2)	41%	General
1996 (3)	41%	ICU
1998 (4)	30%	General
2000 (5)	48%	General

Gould D, J hosp Infect 1994;28:15-30. 2. Larson E. J Hosp Infect 1995; 1995;30:88-106. 3. Slaughter S. Ann Intern Med 1996;3:360-365. 4. Watanakunakorn C, Infect Control Hosp Epidemiol 1998; 19:858-860. 5. Pittet D, Lancet 2000:356;1307 1312.

Hand Hygiene

Some Self-Reported Factors For Poor Hand Hygiene

- Handwashing agents cause irritation & dryness
- Sinks are inconveniently located/lack of sinks
- Lack of soap & paper towels
- Too busy/insufficient time
- Low risk of acquiring infection from patients

Adapted from Pittet D, Infect Control Epidemiol 2000;21:381-386

Hand Hygiene

Indication for Hand Hygiene

- When hands are visibly dirty, contaminated, or soiled, wash with soap & water
- If hands not visibly soiled, use soap & water **OR** an alcohol-based handrub for routinely decontaminating hands.

Guideline for Hand Hygiene in Health-care Settings. MMWR 2002; vol.51, no.RR-16.

Hand Hygiene

Recommended Hand Hygiene Techniques

- Handrubs
  - Apply to palm of one hand, rub hands together covering all surfaces until dry
  - Volume: based on manufacturer

Guideline for Hand Hygiene in Health-care Settings. MMWR 2002; vol.51, no.RR-16.

Hand Hygiene

Recommended Hand Hygiene Techniques

- Handwashing
  - Wet hands with water, apply soap, rub hands together for at least 20 seconds
  - Rinse & dry with disposable towel
  - Use disposable towel to turn off faucet

Guideline for Hand Hygiene in Health-care Settings. MMWR 2002; vol.51, no.RR-16.

Hand Hygiene

Before

- Resident contact
- Using gloves

After

- Contact with a resident's skin
- Contact with body fluids or excretions, non-intact skin, wound dressings
- Removing glove

Guideline for Hand Hygiene in Health-care Settings. MMWR 2002; vol.51, no.RR-16.

Glove Usage

- Should be used as an addition to, not as a substitute for handwashing
  - Provide a safety barrier that protects residents or food from skin-borne microorganisms
  - Contamination is still possible
  - Essential that gloves be used in combination with handwashing

Glove Usage

- Wear gloves when contact with blood or other potential infectious materials are possible
- Do not wear the same pair of gloves for the care of more than one resident
- Do not wash gloves
- Remove gloves after caring for a resident
- Wash hands after gloves are removed

Environmental Surfaces

- How often should you clean your hands after touching an environmental surface near a resident (i.e. bed stand, sink, etc.)
  1. Always
  2. Often
  3. Sometimes
  4. Never

Environmental Surfaces

- How long can cold & flu germs live outside the body, such as on doorknobs or computer keys?

James Steckelberg, MD ~ Infectious Disease Specialist at Mayo Clinic

Environmental Surfaces

- Length of time varies
- Suspected range is from a few seconds up to 48 hours (depending on the specific virus and type of surface)
- Flu viruses tend to live longer on surfaces than cold viruses
- Cold & flu viruses survive for longer periods on nonporous surfaces (plastic, metal, etc)
- Important to wash hands frequently or use alcohol-based hand sanitizer

Hand Hygiene

Performance Indicators

- Make improved hand hygiene a priority
- Monitor & record adherence to hand hygiene
- Provide feedback to workers about their performance

Guideline for Hand Hygiene in Health-care Settings. MMWR 2002; vol.51, no.RR-16.

Elopement

Policy and Procedure

- Define
- Develop
- Deliver
- Document

Elopement

- "Elopement" refers to the ability of a resident (who is not capable of protecting himself/herself from harm) to successfully *leave* the facility unsupervised and/or unnoticed and enter into harm's way.

Elopement

- All elopement policies & response plans need to be unique and written for the facility in which they are to be implemented.
  - Failure to do so places that facility at a higher risk for litigation regarding elopement incidents.

Elopement

- Elopement-related deaths create anguish for both families and the facility staff members
- Courts have quite harsh in ruling the facilities were neglectful in providing a safe environment
- Verdicts often results in millions of **$$$$** in compensation & punitive damages

Elopement

- Primary cause of elopement related deaths:
  - Being struck by a vehicle
  - Exposure to heat or cold
  - Drowning
- In majority of cases, resident had prior elopements
- Incidents of elopement occur in every state in all levels of care

Elopement

- Reminder - you are responsible for the residents who reside in your facility and therefore you need to have the *TOTAL* answer when an elopement occurs
  - Calling the police is not the total answer to an elopement

Elopement

Role of policy in elopement planning has two major and important functions:

- The first is to prevent elopements
- The second is to direct what actions are to be taken when an elopement does occur

Elopement

Policy and Procedure

Consider the following:

- Assessment
- Containment
- Elopement Incident

Elopement

Policy and Procedure (cont.)

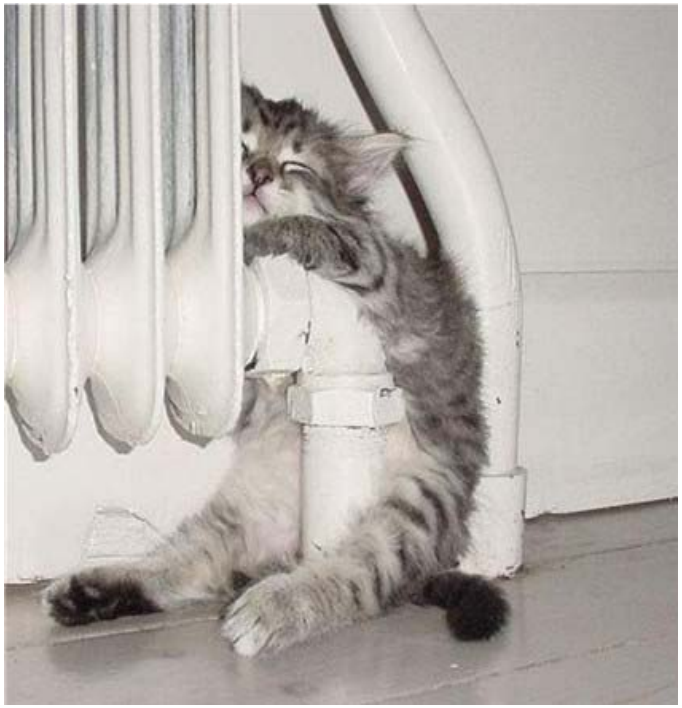
- Staff Training on Elopement
- Documentation & Reporting
- Investigation

Lunch

Falls

Policy and Procedure

- Define
- Develop
- Deliver
- Document



Falls

- Falls are the leading cause of injury related death for both females and males age 75-plus

Falls
Prevention Policy & Procedure

Purpose

- To provide a safe environment for residents
- To reduce falls
- Implement appropriate fall prevention strategies

Falls
Prevention Policy & Procedure (cont.)

Procedure

- Assess residents at risk for falls
- Implementing fall prevention strategies for residents at risk for falls
- Documentation

Post Fall

Policy & Procedure

Purpose

- To assure residents are assessed for possible injuries (including if a head injury has occurred or is suspected)
- To ensure proper treatment
- To notify appropriate persons
- To decrease future risks for falls
- Documentation

Prevention of Falls

Potential Solutions

Refer to the handout titled Potential Solutions for Prevention of Falls

Abuse & Neglect

Policy and Procedure

- Define
- Develop
- Deliver
- Document

Abuse & Neglect Policy and Procedure

Develop and Implement Policies & Procedures to:

- Protect vulnerable residents from abuse, neglect, and misappropriation of resident property from staff
- Protect vulnerable residents from aggressive/assaulting residents

Abuse & Neglect
Policy and Procedure

Refer to the handout titled Key Components of Abuse, Neglect, & Misappropriation of Resident Property Policy & Procedures

Abuse & Neglect Policy and Procedure

- A Concern at the National Level

Convicted Registered Sex Offenders

- Working as employees among vulnerable residents
- Residing in health care facilities with vulnerable resident

Abuse & Neglect Policy and Procedure

Statistics

- Advocacy groups identified as many as 800 registered, convicted sex offenders residing in LTC & Assisted Living Facilities across the country

- Since the 1990's (of the known cases) – resident sex offenders have committed two dozen rapes, murder & other crimes

Abuse & Neglect Policy and Procedure

Statistics (cont.)

- In several states, new laws requiring mandatory employee-background checks revealed hundreds of ex-felons and sex offenders working as nursing home staff
- A number of widely publicized incidents have prompted states to enact “vulnerable citizens” laws to protect residents

Government Accountability Office and TF – Managed Risk Firm

Abuse & Neglect Policy and Procedure

Resident Safety Considerations

- Do you have P/P in place for checking registered sex offenders (employees & residents)
- Familiarize yourself with individual state & U.S. Dept. of Justice websites

Abuse & Neglect Policy and Procedure

Resident Safety Considerations

- Reminder – No listings existed prior to 1990, when first registration laws were enacted
- Ask before a staff is hired or a resident is admitted if he/she has been convicted of a sexual offense
  - Employee application form
  - Admission form

Admission & Discharge

Policy and Procedure

- Define
- Develop
- Deliver
- Document

Admission & Discharge Policy and Procedure

- Admission Policy is very important as you must meet the needs of the residents you admit and retain in your facility
  - What type of care & services can you provide?
  - What policies & procedures do you have in place?
  - What is your staffing?
  - Has your staff received adequate education/training?

Admission & Discharge Policy and Procedure

Areas To Consider

- The resident's ability. He/she is (independent, needs reminders, needs supervision, needs minimal assistance, needs moderate assistance, needs extensive assistance, etc)

Admission & Discharge Policy and Procedure

Areas To Consider (continued)

- The resident is experiencing or at risk for incontinence of bowel &/or bladder, falls, pressure sores, aggressive/violent behaviors, elopement, weight loss, dehydration, etc.

33-03-24.1-11 Education Programs

33-03-24.1-11 Education Programs

- The facility shall *design*, *implement*, and *document* educational programs to orient new employees & develop and improve employees' skills to carry out their job descriptions

33-03-24.1-11 Education Programs

On an *annual* basis, *all* employees shall receive in-service training in at least:

- Fire & accident prevention
- Mental & physical health needs of the residents, including behavior problems
- Prevention & control of infections, including universal precautions
- Resident Rights

33-03-24.1-11 Education Programs

- Administrator shall attend at least twelve continuing education hours per year relating to care & services for residents
- Staff responsible for food preparation shall attend a minimum of two dietary educational programs per year
- Staff responsible for activities shall attend a minimum of two activity-related educational programs per year

BASIC CARE

Life Safety Code

and

Licensing Rules

Monte Engel, PE

Mgr., Building Stds./LSC

Division of Health Facilities

North Dakota Department of Health

Licensing Rules

- North Dakota Administrative Code

  Chapter 33-03-24.1

  Licensing Rules for Basic Care Facilities in North Dakota

- Section 33-03-24.1-10 Fire safety

Licensing Rules

- 33-03-24.1-10 (1)
- Life Safety Code
  - 1988 edition
  - Chapter 21, Residential Board and Care Occupancy
  - Slow evacuation capability
  - Or a greater level of fire safety

Licensing Rules

- 33-03-24.1-10 (2)
- Fire drills
  - Monthly
  - Twelve (12) per year
  - Alternating with all workshifts
  - Complete evacuation once per year

Licensing Rules

- 33-03-24.1-10 (3)
- Fire evacuation plans
  - Posted in a conspicuous place

Licensing Rules

- 33-03-24.1-10 (4)
- Fire drill records
  - Dates, times, duration
  - Names of staff and residents
  - Description of drill
  - Escape path
  - Call to fire department

Licensing Rules

- 33-03-24.1-10 (5)
- New admissions
  - Fire drill walk-through within five (5) days

Licensing Rules

- 33-03-24.1-10 (6)
- Variation
  - Waivers must be approved by the department

Licensing Rules

- **33-03-24.1-10 (7)**
- **Greater level of fire safety**
  - **Meet the fire drill requirements of that occupancy classification**
  - **Twelve (12) licensed basic care facilities are located in health care occupancies.**

Life Safety Code

- The requirements of Chapter 21 are based on two main concepts:

  a) Larger buildings, which are more difficult to evacuate, require more built-in fire protection than smaller buildings.

Life Safety Code

- The requirements of Chapter 21 are based on two main concepts:

b) People who are more difficult to evacuate require more built-in building fire protection than people who are easier to evacuate.

Life Safety Code

- Section 21-2
- **Small facilities**
  - **Sleeping accommodations for not more than 16 residents.**
  - **Sixteen (16) basic care facilities are small facilities. Eleven (11) of these are located in health care.**

Life Safety Code

- Section 21-3
- **Large Facilities**
  - **Sleeping accommodations for more than 16 residents.**
  - **Thirty-nine (39) licensed basic care facilities are large facilities.**

Life Safety Code

- Section 21-4

- Suitability of an apartment building to house a board and care occupancy.

Life Safety Code

- Residential Board and Care Occupancy
- Definition:

  A building used to provide lodging, boarding, and personal care services for four (4) or more residents.

Life Safety Code

- Residential Board and Care Occupancy
- Example:

  A group housing arrangement for physically or mentally handicapped persons who normally may attend school or church in the community, or otherwise use community facilities.

Life Safety Code

- Residential Board and Care Occupancy
- Example:

  A group housing arrangement for physically or mentally handicapped persons who are undergoing training in preparation for independent living, paid employment or other activities.

Life Safety Code

- Residential Board and Care Occupancy

- Example:

  A group housing arrangement for the elderly that provides personal care services but that does not provide nursing care.

Life Safety Code

- Residential Board and Care Occupancy

- Example:

  Facilities for social rehabilitation, alcoholism, drug abuse, or mental health problems that contain a group housing arrangement and personal care.

Life Safety Code

- Evacuation capability

- The ability of the occupants, residents, and staff as a group to either evacuate the building or relocate from the point of occupancy to a point of safety.

Life Safety Code

- Evacuation capability

- **Prompt**

  Equivalent to the capability of the general population.

Life Safety Code

- Evacuation capability

- **Slow**

Capability of the group to move to a point of safety in a timely manner, with some residents requiring assistance from staff.

Life Safety Code

- Evacuation capability

- **Impractical**

A group, even with staff assistance, that cannot reliably move to a point of safety in a timely manner.

Life Safety Code

- Minimum construction requirements

- This chapter requires evacuation only to a point of safety, and therefore, the residents will frequently remain inside the building during a fire emergency.

Life Safety Code

- The width of corridors shall not be less than 44 inches. Corridors must be maintained free and clear of impediments to exiting.

- **Storage of items in corridors is not permitted. All items in corridors must be in use.**

Life Safety Code

- Any room, or suite of rooms, in excess of 2,000 square feet shall be provided with at least two exit doors remote from each other.

- Travel within a room or suite or living unit to a corridor door shall not exceed 75 feet.

Life Safety Code

- From any corridor door, exits shall be accessible in at least two directions.

- It shall not be necessary to travel more than 100 feet from the door of any room to reach the nearest exit.

Life Safety Code

- Not less than two exits shall be accessible from every floor.

- **Exits must be paved with asphalt or concrete from the building to a public way such as a parking lot or street.**

Life Safety Code

- The means of egress shall be lighted. Lights must be provided in all corridors and exits.

- **Exterior exit discharge from the building must also have emergency lighting.**

Life Safety Code

- Emergency lighting shall be provided in all buildings with more than 25 rooms.

- **Battery powered emergency lighting units must be tested monthly for 30 seconds and annually for 90 minutes.**

Life Safety Code

- Means of egress shall be marked with exit signs.

- **Both bulbs must be functional to provide the necessary back up in times of need.**

Life Safety Code

- Vertical openings such as stairways, elevator hoistways, dumbwaiters, shafts, etc. shall be enclosed with fire rated construction and self-closing fire doors.
- **Doors must close and latch, with no gaps between the door and frame.**

Life Safety Code

- Hazardous areas shall be separated from other areas by 1 hour fire rated construction with self-closing fire doors or equipped with a sprinkler system.

- **Doors are required to be self-closing and positively latching.**

Life Safety Code

- Interior wall and ceiling finish shall be Class A or Class B.
- **Wood paneling.**
- Interior floor finish shall be Class I or Class II.
- **Carpet.**

Life Safety Code

- A manual fire alarm system shall be provided.

- Initiation of the fire alarm system:
  - Manual means
  - Automatic sprinkler system
  - Smoke detection system

Life Safety Code

- An annunciator panel connected to the fire alarm system shall be provided.
- Occupant notification shall be provided automatically, without delay.
- Fire department notification by telephone or other means.

Life Safety Code

- **A smoke detector must be located above the fire alarm panel.**
- **The fire alarm circuit must have a locking device.**
- **The fire alarm panel must be locked.**

Life Safety Code

- Each sleeping room shall be provided with a single station smoke detector connected to the electrical service.

- Exception for existing facilities with a corridor smoke detection system.

Life Safety Code

- All corridors and common spaces shall be provided with smoke detectors connected to the fire alarm system and audible in all sleeping areas.

- Detectors may be omitted from common spaces in buildings protected by a sprinkler system.

Life Safety Code

- Where an automatic sprinkler is installed, it must comply with NFPA 13, NFPA 13D or NFPA 13R.

- Sprinklers may be omitted in closets not over 24 square feet and bathrooms not over 55 square feet.

Life Safety Code

- Portable fire extinguishers shall be provided near hazardous areas.

- **Portable extinguishers must be checked monthly and serviced annually.**

Life Safety Code

- Sleeping rooms and other rooms shall be separated from corridors and other common areas by fire barriers.

- These corridor walls must have a fire rating of not less than 1 hour.

Life Safety Code

- In existing buildings the corridor wall shall have a fire rating of not less than 20 minutes.

- With a sprinkler system, no fire rating is required – corridor walls must resist the passage of smoke.

Life Safety Code

- Doors in the corridor walls must have a fire rating of 20 minutes.
- Existing 1¾ inch solid bonded wood core doors are acceptable.
- With a sprinkler system, no fire rating is required – doors must resist the passage of smoke.

Life Safety Code

- There shall be no louvers, transfer grilles, operable transoms, or other air passages penetrating the corridor walls and doors except properly installed heating and utility installations.

Life Safety Code

- Doors in corridor walls shall be self-closing or automatic closing.

- Doors in walls separating sleeping rooms from corridors shall be automatic closing.

Life Safety Code

- Doors to sleeping rooms that have occupant control locks restricted to the occupants or staff may be self-closing.

- With a sprinkler system, doors, other than doors to hazardous areas, vertical openings, and exit enclosures are not required to be self-closing or automatic closing.

Life Safety Code

- **Corridor doors must close and latch.**
- **Doors cannot be held open by chocks, wastebaskets, bricks, blocks, beds, etc.**
- **Limit gaps between the door and frame.**

Life Safety Code

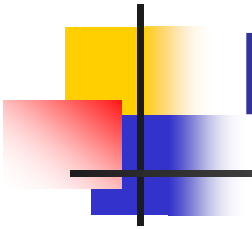
- Every sleeping room floor shall be divided into at least two smoke compartments.

- The maximum travel distance from a sleeping room corridor door to a smoke barrier shall not exceed 150 feet.

Life Safety Code

- With a sprinkler system, smoke barriers are not required.

- Smoke barriers are not required where the aggregate corridor length on each floor is not more than 150 feet.



Break

Evacuation Difficulty Index

Monte Engel

Manager

Building Standards/Life Safety Code

Division of Health Facilities

Department of Health

Licensing Rules

- North Dakota Administrative Code

  Chapter 33-03-24.1

  Licensing Rules for Basic Care Facilities in North Dakota

- Section 33-03-24.1-10 Fire safety

Licensing Rules

- 33-03-24.1-10 (1)
- Life Safety Code
  - 1988 edition
  - Chapter 21, Residential Board and Care Occupancy
  - Slow evacuation capability
  - Or a greater level of fire safety

Life Safety Code

- Chapter 21, Residential Board and Care Occupancy

- Evacuation capability
  - ☑ Prompt
  - ☑ Slow
  - ☐ Impractical

Life Safety Code

- **Evacuation capability**
- Prompt

Equivalent to the capability of the general population.

Life Safety Code

- **Evacuation capability**
- Slow

Capability of the group to move to a point of safety in a timely manner, with some residents requiring assistance from staff.

Evacuation Capability

- NFPA 101M

  Manual on Alternative Approaches to Life Safety

  1988 edition

- Chapter 5

  A Procedure for Determining Evacuation Capability

Evacuation Capability

- **STEP 1**

For each resident, complete one copy of Worksheet 5-1, Worksheet for Rating Residents.

Evacuation Capability

- **STEP 2**

For each facility complete one copy of Worksheet 5-2, Worksheet for Calculating Evacuation Difficulty Score (E-Score).

Evacuation Capability

- **STEP 3**

Determine evacuation difficulty using the E-Score from Step 2.

Step 1

- Rating of residents should be based on commonly observed examples of poor performance.
- Ratings should be based on consultation with someone who has observed the resident on a daily basis.

Step 1

- All persons naturally tend to be less capable on some days, and the ratings should be based on examples of resident performance on a typically “bad” day. Ratings should not be based on rare instances of poor performance.

Risk Factors

- **I. Risk of Resistance.**

  There is a reasonable possibility that, during an emergency evacuation, the resident may resist leaving the facility.

Risk Factors

- **I. Risk of Resistance.**

Unless there is specific evidence that resistance may occur, the resident should be rated as “minimal risk.”

Risk Factors

- **I. Risk of Resistance.**

Specific evidence of resistance means that staff have been required to use some physical force in the past.

Resistance may be active or passive.

Risk Factors

- **I. Risk of Resistance.**

- a) Minimal Risk.

  There is no specific evidence to suggest that the resident may resist an evacuation.

Risk Factors

- **I. Risk of Resistance.**

- b) Risk of Mild Resistance.

  There is specific evidence that the resident may mildly resist leaving the facility.

Risk Factors

- **I. Risk of Resistance.**

- c) Risk of Strong Resistance.

  The resident may offer resistance that requires the full attention of one or more staff members.

Risk Factors

- **II. Impaired Mobility.**

  The resident is physically limited in his or her ability to leave the facility.

Risk Factors

- **II. Impaired Mobility.**

The resident is rated according to how easily he or she can leave, given the presence of physical barriers such as stairs, ability to get out of bed or chairs, etc.

Risk Factors

- **II. Impaired Mobility.**

The resident should be given credit for being able to use devices that aid in movement such as wheelchairs and walkers.

Risk Factors

- **II. Impaired Mobility.**

- a) Self-Starting.

  The resident is physically able to start and complete an evacuation without physical assistance.

Risk Factors

- **II. Impaired Mobility.**

- b) Slow.

  The resident cannot prepare to leave and then travel from the room to an exit in 90 seconds.

Risk Factors

- **II. Impaired Mobility.**

- c) Needs Limited Assistance.

  The resident may require some initial or intermittent assistance, but can accomplish most of the evacuation without assistance.

Risk Factors

- **II. Impaired Mobility.**

- d) Needs Full Assistance.

  The resident may require physical assistance from a staff member during most of the evacuation.

Risk Factors

- **II. Impaired Mobility.**

- d) Very Slow.

  The resident cannot prepare to leave and then travel from the room to an exit in 150 seconds.

Risk Factors

- **III. Impaired Consciousness.**

The resident could experience a partial or total loss of consciousness during a fire emergency.

Risk Factors

- **III. Impaired Consciousness.**

The resident has experienced some temporary impairment of consciousness of short duration six or more times during the preceding three months.

Risk Factors

- **III. Impaired Consciousness.**

Do not count episodes where the loss of consciousness was the result of a temporary medical problem.

Risk Factors

- **III. Impaired Consciousness.**

- a) No Significant Risk.

  Not subject to loss of consciousness or fewer than six episodes during the preceding three months.

Risk Factors

- **III. Impaired Consciousness.**

- b) Partially Impaired.

  Had at least six episodes in the preceding three months – resident was able to participate somewhat.

Risk Factors

- **III. Impaired Consciousness.**

- b) Partially Impaired.

Examples: mild seizures
dizzy spells
intoxication

Risk Factors

- **III. Impaired Consciousness.**

- c) Totally Impaired.

  Had at least six episodes in the preceding three months – resident requires full assistance from staff.

Risk Factors

- **III. Impaired Consciousness.**
- c) Totally Impaired.

Examples: severe seizures
fainting spells
intoxication

Risk Factors

- **IV. Need for Extra Help.**

There is specific evidence that more than one staff member may be needed to evacuate the resident.

Risk Factors

- **IV. Need for Extra Help.**

Two or more persons have been previously needed to assist the resident. The resident could need assistance from two persons in a real fire emergency.

Risk Factors

- **IV. Need for Extra Help.**

- a) Needs One Staff Member.

  The resident does not need help from two or more persons in a fire emergency.

Risk Factors

- **IV. Need for Extra Help.**

- b) Needs Limited Assistance from Two Staff Members.

  Requires some initial or intermittent assistance from two persons.

Risk Factors

- **IV. Need for Extra Help.**

- c) Needs Full Assistance from Two Staff Members.

  Requires assistance from two persons during most of the evacuation.

Risk Factors

- **V. Response to Instructions.**

The resident's ability to receive, comprehend and follow through with simple instructions.

Risk Factors

- **V. Response to Instructions.**

Residents should be rated on their responses to staff members whose directions they are least likely to follow.

Risk Factors

- **V. Response to Instructions.**

- a) Follows Instructions.

  The resident can usually receive, comprehend, remember and follow simple instructions.

Risk Factors

- **V. Response to Instructions.**

- b) Requires Supervision.

  The resident is generally capable of following instructions, but is not dependable.

Risk Factors

- **V. Response to Instructions.**

- b) Requires Supervision.

  May need to be guided, reminded, reassured, or accompanied during the evacuation.

Risk Factors

- **V. Response to Instructions.**

- b) Requires Supervision.

  Does not require the exclusive attention of a staff member.

Risk Factors

- **V. Response to Instructions.**

- b) Requires Supervision.

  This category includes elderly persons with dementia.

Risk Factors

- **V. Response to Instructions.**

- c) Requires Considerable Attention or May Not Respond.

  The resident may fail to receive, understand or follow through with instructions.

Risk Factors

- **V. Response to Instructions.**

- c) Requires Considerable Attention or May Not Respond.

  Resident may not respond to instructions or general guidance.

Risk Factors

- **V. Response to Instructions.**

- c) Requires Considerable Attention or May Not Respond.

  May require most of the attention of a staff member during the evacuation.

Risk Factors

- **VI. Waking Response to Alarm.**

- Response Probable, unless:

  a) There is no alarm system meeting the Life Safety Code or the alarm is not very loud in the resident's room.

Risk Factors

- **VI. Waking Response to Alarm.**

- Response Probable, unless:

  b) Medication take at night is different or increased over that take during waking hours.

Risk Factors

- **VI. Waking Response to Alarm.**

- Response Probable, unless:

  c) Hearing impairment or resident removes hearing aid when sleeping.

Risk Factors

- **VI. Waking Response to Alarm.**
- Response Probable, unless:

d) Resident is a sound sleeper.

Risk Factors

- **VI. Waking Response to Alarm.**

- a) Response probable.

  None of the four conditions is true for the resident.

Risk Factors

- **VI. Waking Response to Alarm.**

- b) Response not Probable.

  One or more of the conditions is true for the resident.

Risk Factors

- **VII. Response to Fire Drills**

Resident's ability to leave the building as demonstrated by the resident's performance during fire drills.

Risk Factors

- **VII. Response to Fire Drills**

The resident's ability to make decisions - does not relate to mobility.

Risk Factors

- **VII. Response to Fire Drills**

Resident must be trained or instructed in the desired task.

Resident must demonstrate the desired response in at least three of the last four fire drills.

Risk Factors

- **VII. Response to Fire Drills**

If skill has not been tested in four fire drills, resident must demonstrate the desired response during the last two fire drills.

Risk Factors

- **VII. Response to Fire Drills**

Any resident who has not been trained using fire drills must be given the higher scores.

Risk Factors

- **VII. Response to Fire Drills**

- a) Initiates and Completes Evacuation Promptly.

  Ability to start and complete the evacuation without unnecessary delay.

Risk Factors

- **VII. Response to Fire Drills**

- b) Chooses and Completes Back-up Strategy.

  Ability to select an alternative means of escape if the primary route is blocked.

Risk Factors

- **VII. Response to Fire Drills**

- c) Stays at Designated Location.

  Resident will stay at a designated safe location during fire drills.

Step 2

- **Finding the Staff Shift Score**

- Alarm Effectiveness

  Whether smoke detector-activated alarm devices are loud enough to dependably alert staff.

Step 2

- **Finding the Staff Shift Score**

- Alarm Effectiveness

  a) Assured.

  b) Not Assured.

Step 2

- **Finding the Staff Shift Score**

- Staff Availability

  Whether there are circumstances when staff may be less able to respond or may be delayed.

Step 2

- **Finding the Staff Shift Score**

- Staff Availability

  a) Standby or Asleep.

  b) Immediately Available.

  c) Immediately Available and Close by.

Step 2

- **Finding the Staff Shift Score**

- a) Standby or Asleep.

  Staff does not have specific duties to assure an immediate response, but otherwise available.

Step 2

- **Finding the Staff Shift Score**

- b) Immediately Available.

  Staff is required to be available for immediate assistance, but is not in close proximity.

Step 2

- **Finding the Staff Shift Score**

- c) Immediately Available and Close by.

  Meets conditions for b) and is in close proximity.

Step 3

- **Calculation of E-Score**

$$\frac{\text{Resident Score} \times \text{Vertical Distance}}{\text{Staff Score}} = \text{E-Score}$$

Step 3

- **Level of Evacuation Difficulty**

≤ 1.5	**Prompt**
>1.5 ≤5.0	**Slow**
>5.0	**Impractical**

Dorrene Haugrud

- Discussion on how to integrate the resident evacuation score with the assessment and care plan to determine the resident's ability for self preservation.

Thank You!!!

Questions!!!