

Policies & Procedures

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# Abuse

I. **POLICY GUIDELINES**

Residents are to be free from verbal, sexual, physical, and emotional/mental abuse; neglect; self abuse/self-neglect; medical neglect; misappropriation of resident property; corporal punishment; and involuntary seclusion at all times.

The facility has developed a system for identifying, investigating, preventing, and reporting any incident or suspected incident of any type of abuse.

It is the responsibility of employees to promptly report to facility management any incident or suspected incident of neglect or resident abuse from other residents, staff, family, or visitors including injuries of an unknown source and theft or misappropriation of resident property.

Staff are state mandated reporters and “Covered Individuals” (per Elder Justice Act) and must comply with state regulations regarding reporting suspected abuse and with federal regulations regarding reporting any reasonable suspicion of a crime against a resident or other individual receiving care by the facility.

All reports of resident verbal, sexual, physical, and mental abuse; corporal punishment; involuntary seclusion; neglect; or misappropriation of resident property are promptly and thoroughly investigated by facility management.

**II. DEFINITIONS**

Abuse is defined as the willful infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm, pain, or mental anguish; or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Abuse may be resident-to-resident, staff-to-resident, or visitor-to-resident.

Verbal abuse is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families regardless of their age, ability to comprehend, or disability. Examples include, but are not limited to, threats of harm or saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

Sexual abuse is defined as, sexual contact with a person without their consent or with any person incapable of giving consent. It includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

Physical abuse is defined as non-accidental use of physical force that may result in bodily injury, physical pain, or impairment. Examples include, but are not limited to, hitting, slapping, pinching, kicking, as well as controlling behavior through corporal punishment.

Involuntary seclusion is defined as separation of a resident from other residents or from his or her room, or confinement to his or her room (with or without roommates) against the resident’s will or the will of the resident’s legal representative. (Note: Short-term or emergency separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident’s needs. Also, if a resident resides in a secured unit that prevents residents from free movement throughout the facility due to cognitive impairment, placement on the unit is not considered involuntary seclusion, as long as care and services are provided in accordance with the assessment of resident’s needs [and family wishes] and not for staff convenience).

Mental abuse is defined as infliction of anguish, pain, or distress through verbal or non-verbal acts. Examples include, but are not limited to, humiliation, harassment, and threats of punishment or withholding of treatment or services.

Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. May be intentional such as withholding or omitting care or unintentional where the caregiver should have known that care was needed, but it was not provided.

Misappropriation of Property is defined as the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident’s belongings or money without the resident’s consent. Examples include, but are not limited to, stealing cash or property; misuse of checks, credit cards, or accounts; forgery of a signature; identity theft.

**III. PROCEDURAL COMPONENTS**

A. Prevention

1. At the time of admission, each resident and responsible party is informed of the resident’s rights and the facility’s zero tolerance for any form of abuse

a. A zero tolerance policy of abuse, neglect, mistreatment, and misappropriation, along with reporting directions, is posted in the facility or given to the resident upon admission and each employee at orientation

b. Residents’ Rights remain posted in the facility at all times

2. The facility will not knowingly employ any individual convicted of resident abuse, misappropriation of resident property, or reported abuse as noted by licensure boards or registries. Prior to a new employee starting a work schedule, the facility:

a. Obtains reference checks in accordance with Human Resources policy

b. Obtains a national criminal background check

i. If the potential employee has been found guilty of, or pled nolo contendre to, abuse or assault, he/she is not hired

ii. A query from the Nurse Aid Registry is completed on all certified nursing assistants (CNAs) in each state where the CNA has previously worked

c. Checks the national sex offender Web site (www.nsopr.gov) as a preliminary screen prior to receipt of background check information

d. Obtains a copy of licensing, certification, and registration and verifies authenticity

e. Submits drug screen, if feasible, in accordance with Human Resources policy

f. Conducts tour with prospective employee and observes interactions with residents and other staff members

g. Evaluates prospective employee for personality traits of a competent and customer-oriented caregiver

3. Resident Rights and Abuse Prevention Training for all employees is conducted during orientation and at least annually and includes review of:

a. Mission, vision, corporate values, and code of ethical conduct

b. Definitions of abuse including:

i. Abuse

ii. Verbal abuse

iii. Sexual abuse

iv. Physical abuse

v. Involuntary seclusion

vi. Mental abuse

vii. Neglect

viii. Misappropriation of property

c. Resident Rights

i. Facility abuse prevention activities

d. Abuse and Neglect policy and criteria for assessing risk factors such as:

i. Characteristics of residents that have the potential to trigger an abusive incident

ii. Employees who are working or living in stressful situations who may have less tolerance for residents who are difficult to manage

e. Management of aggressive behavior

f. Conflict resolution, stress management, and signs of burnout

g. Appropriate care delivery and treatment interventions for residents with sensory deficits

h. Availability of mental health services

i. Annual review of duty to report and reporting process in accordance with the applicable state/federal rules, and review of the mandated reporter requirements

i. Though the specific state language varies, a mandated reporter is usually any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency

ii. Per the Elder Justice Act, and if applicable to the organization, reporting to the U.S. Department of Health and Human Services and locally identified law enforcement agency(s) any reasonable suspicion of a crime against a resident or other individual receiving care in the facility. If there is suspicion of a crime and serious bodily injury has occurred, a report must be made immediately, but no later than two hours after forming the suspicion. If there is suspicion of a crime without bodily injury, a report must be made no later than 24 hours after forming the suspicion

j. Leadership training for managers on their duty to address abuse and neglect allegations

4. Signed acknowledgments by the employee are maintained noting in-service attendance, understanding of the policy, and agreement to report immediately

5. Signed acknowledgements are obtained annually from owners, operators, managers, agents, and contractors that they have been informed of the Elder Justice Act and its consequences and agree to abide by their obligations under the Act (if applicable to the organization)

6. To the extent possible, assignments are consistent so that the resident is familiar and comfortable with his or her caregiver, and the assigned employee is knowledgeable about the resident

7. The facility obtains written affirmation of no observation/knowledge of abuse or neglect in the organization from employees annually and upon employee exit interview when possible

B. Intervention

1. Upon receiving reports of physical or sexual abuse, the facility Administrator is immediately notified to arrange for the examination of the resident

2. The physical examination is conducted by an appropriately trained/licensed professional (attending physician, emergency room physician)

a. The time, date, and person completing the examination is recorded in the resident record

b. If injury is involved, the police are to be notified

3. The facility staff conduct post-allegation, 72-hour monitoring and documentation

4. Sexual abuse can mean penetration, verbal harassment, or physical contact without penetration

a. If penetration has occurred:

i. Do not bathe the resident or allow her/him to shower

ii. Do not have the resident change their clothing or wash the resident’s clothing or linens

iii. Do not take items from the area in which the incident occurred

iv. Contact the police immediately

v. Arrange for examination in emergency room

vi. Contact liability insurance agent, insurance carrier, or legal counsel

5. If verbal or mental abuse has been determined to be unintentional but inappropriate, refer the employee for counseling

6. If theft has occurred, determine item missing and its value and whether item was lost or stolen

7. If neglect is suspected, a determination is made as to what services were not provided and what physical harm, mental anguish, mental illness, or deterioration in the resident’s mental or physical condition resulted. Also, neglect is evaluated as a result of indifference, carelessness, or deliberate negligence

C. Reporting

1. The Administrator is promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after normal working hours, the Administrator is called at home or paged

2. The Administrator notifies the following of a suspected abuse incident:

a. State licensing/certification agency

b. Local ombudsman

c. Resident’s legal representative of record (via telephone)

d. Adult Protective Services

e. Law enforcement officials

f. Resident’s attending physician (via telephone)

3. Notices to regulatory and state agencies are submitted per requirements (fax, e-mail, special carrier, U.S. mail, or by telephone). The notice includes at a minimum:

a. Name of resident

b. Room number

c. Type of abuse alleged (i.e., verbal, physical, sexual, neglect, etc., and whether abuse was resident to resident, staff to resident, or visitor to resident)

d. Date and time the alleged incident occurred

e. Names of all persons involved in the incident

f. What immediate action was taken by the facility

4. A completed copy of the Abuse Report and written summaries of witness interviews, if any, are provided to the Administrator per facility and state guidelines

5. A log is maintained regarding any reporting of a suspected crime to residents under the Elder Abuse Act including (a) date and time of call, (b) person to whom allegation were reported, and (c) detail of information provided

6. A social services consultant is available to monitor the resident’s emotions concerning the incident as well as the resident’s reaction to his/her involvement with the investigation. The social services representative writes a summary of his/her findings and forwards it to the Administrator

D. Investigation

1. Residents and staff are to be protected during incident investigations by ensuring:

a. Reports are made without fear of retaliation

b. Anonymous reports are investigated

c. The Administrator (and corporate leaders, if applicable) is/are immediately informed

d. A resident who is allegedly mistreated by another resident is removed from contact with that resident during the investigation

e. In conjunction with the attending physician, the resident’s care approaches and placement that is best for his or her safety is determined

f. Accused employees are removed from resident contact immediately and may be suspended from duty until the results of the investigation are reviewed

g. Employees’ rights to due process are maintained

h. Any individual accused and not employed by the facility is denied access to the resident or may be required to have access with supervision only

i. Follow-up counseling for victims of abuse and neglect is conducted

2. When an incident or suspected incident occurs, the Administrator or designee investigates the allegation

3. The individual conducting the investigation, at a minimum:

a. Reviews the completed resident abuse report

b. Reviews the resident’s record to determine events leading up to the incident

c. Interviews the persons reporting the incident

d. Interviews any witnesses to the incident

e. Interviews the resident (if appropriate)

f. Contacts the resident’s attending physician to determine the current mental status of the resident

g. Interviews the resident’s roommate, family members, and visitors

h. Interviews other residents to whom the accused employee provides care or services

i. Interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident

j. Reviews all events leading up to the alleged incident

k. Maintains confidentiality and cooperates with all state agency investigations

l. Updates the Administrator daily on progress of the investigation (when the Administrator is not conducting the investigation)

4. General guidelines for interviewing that are to be incorporated in an investigation include:

a. Explaining the purpose and confidentiality of the interview thoroughly to each person involved

b. Conducting interviews separately and in a private location

c. Informing the interviewee, if he or she discloses information that may be self-incriminating, of his/her rights to terminate the interview until such time as he or she may choose to be represented by legal counsel

d. Witness reports are documented in writing by the investigator and are signed and dated by both the interviewer and witness. The employee should not be asked to write the statement. A copy of each report is attached to the Abuse Investigation Report Form

5. Review of the personnel records of the suspected or accused employees

6. The ombudsman is notified that an investigation is being conducted

a. The ombudsman is invited to participate in the process. If the ombudsman declines, a notation is made in the investigation report

7. The Administrator keeps the resident and his/her representative informed of the progress of the investigation

8. When the investigation is completed, the Administrator informs the resident and his/her representative of the results and corrective active taken

9. Should the investigation reveal that abuse occurred, the Administrator reports the findings to the local police department, the ombudsman, the state licensing agency, and others as may be required by state, federal, and local laws within the required time frame

10. The Administrator provides a written report of the results of the investigation and action taken to the state survey agency within the required time frame

# Active Shooter

I. **INTRODUCTION**

It is the policy of this facility to provide a protocol to be implemented when an individual or individuals appear to be actively engaged in using a firearm(s) to harm or attempt to harm people anywhere on the facility campus.

An active shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated area. In most cases, active shooters use firearms, and there is no pattern or method to their selections of victims.

II. **PROCEDURES**

1. All employees identifying an active shooter situation:

a. Call 911 (with a landline or a cell phone) and state, “This is [facility name]. We have an active shooter(s) on the premises—gunshots fired. I am located at [your exact location]”

b. Evacuate residents, visitors, and staff, if safe to do so

c. Notify the Charge Nurse and the Director of Plant Services (or Maintenance Duty Officer). The Charge Nurse and the Director of Plant Services follow procedures as required in the “All Hazards Planning and Resource Manual”

2. According to the succession of command, the Incident Commander is identified and notified of the incident. An incident command post is set up as soon as possible when it can be done safely, per the “All Hazards Planning and Resource Manual.” Available staff supplies the Incident Commander with a list of residents or staff known to be in the area of the incident.

3. The Incident Commander:

a. Assesses the situation

b. Instructs staff to secure at-risk areas (if not already completed)

c. Reports the following information to the dispatcher to relay to local law enforcement:

i. Number of shooters

ii. Number of victims or potential victims

iii. Exact location of the shooter(s)

iv. Type and number of weapons possibly in the possession of the shooter(s)

d. Uses the facility’s mass notification system to make appropriate announcements to residents and staff

4. If an active shooter(s) enters the area where you are:

a. Try to remain calm

b. If safely able to evacuate, do so. Report to the facility’s maintenance building or other reunification location designated by the Incident Commander

c. If you are unable to get out safely, hide. Lock doors, turn off lights, silence cell-phone ringers, and remain quiet

d. If you cannot lock doors (as is the case in resident rooms), close doors and use beds, furniture, and other objects to barricade doors. If using beds to barricade doors, make sure wheels on the bed are locked

e. If there is no possibility of escaping or hiding and only as a last resort when your life is in imminent danger, make a personal choice to attempt to overpower the shooter(s) (using surprise, aggression, and speed)

5. If you are located a distance from the active shooter(s) (e.g., on a different unit or floor) and cannot evacuate:

a. Try to remain calm

b. Warn other staff, visitors, and residents to take immediate shelter; assist residents when possible

c. Lock and barricade doors or windows (to unit, if possible; to resident rooms; and to the room in which you are located), turn off lights, close blinds; block windows, turn off radios and other devices that emit sound, keep out of sight, and take adequate cover/protection (e.g., behind concrete walls, thick desks, or filing cabinets), and silence cell phones

d. For all employees with access to a landline or a cell phone, call 911 and state, “This is [facility name]. We have an active shooter on the premises—gunshots fired. I am located at [your exact location]”

6. If you are in an exterior area and encounter an active shooter(s):

a. Try to remain calm

b. Move away from the active shooter(s) or the sound of gunshot(s) and/or explosions(s)

c. Look for appropriate locations for cover/protection (e.g., brick walls, retaining walls, parked vehicles, etc.)

d. Call 911 (with a landline or a cell phone) and state: “This is [facility name]. We have an active shooter on the premises—gunshots fired. I am located at [your exact location]”

7. When law enforcement arrives, expect the officers to:

a. Immediately engage or contain the active shooter(s)

b. Identify threats, such as improvised explosive devices

c. Identify victims in order to facilitate medical care, interviews, and counseling

d. Investigate

8. For employees who are able to evacuate the facility, regroup at the facility’s maintenance building (or other area/reunification location designated by the Incident Commander) when it is safe.

9. Law enforcement officers responding to an active shooter incident are trained to proceed immediately to the area where shots were last heard in order to stop the shooting as quickly as possible. The first responding officers may be in teams; they may be dressed in normal patrol uniforms, or they may be wearing external ballistic vests and Kevlar® helmets or other tactical gear. The officers may be armed with rifles, shotguns, and/or other types of guns. The first officers to arrive at the scene do not stop to help injured persons; expect rescue teams to follow the initial officers.

10. Do exactly as law enforcement officers instruct. The first responding officers are focused on stopping the active shooter(s) and creating a safe environment for medical assistance to be brought in to aid the injured.

11. Know how to react when law enforcement officers arrive at your location:

a. Remain calm and follow officers’ instructions

b. Put down any items in your hands (e.g., bags, jackets, etc.)

c. Immediately raise your hands and spread your fingers

d. Keep your hands visible at all times

e. Avoid making any quick movement(s) towards officers, such as attempting to hold on to them for safety

f. Avoid pointing, screaming, and/or yelling

g. Do not stop to ask officers for help or direction when evacuating—simply proceed in the direction where officers are entering the area

12. Facility staff, visitors, and residents are kept away from the area(s) where the incident is occurring until the situation is fully resolved.

13. After the incident occurs, the facility’s “Crisis Communications Policy” is activated; this policy stipulates (among other things) that the Executive Director or, in his/her absence, the Director of Financial Services or another department head, if so designated by the Executive Director, functions as the communications coordinator during a crisis.

14. Administration provides appropriate resources to employees to address psychological and other trauma resulting from the incident.

III. **TRAINING**

1. The facility provides training to staff and residents

a. Management’s responsibilities in the facility’s active shooter/armed intruder plan

b. Employee responsibilities in the facility’s active shooter/armed intruder plan

c. Types of events (PHASE® and CAVE®)

d. The safety action plan

i. Get out

ii. Hide out

iii. Keep out

iv. Take out

e. Evacuation and reunification

i. Reunification site

ii. Employee accountability checks

f. Recovery

i. Crime scene management

ii. Role in investigations

1) Facility investigations

2) Criminal investigations

3) Media

# Admissions

I. **POLICY GUIDELINES**

The facility strives to promote resident safety. Residents whose identified needs can be met through the facility’s scope of service are eligible for admission.

The facility strives to maintain processes that promote ease in a resident’s transition to the assisted living setting. The admission procedure outlines organized approaches to the admission process.

The admission process applies to all residents without regard to race, color, creed, national origin, age, sex, religion, handicap, ancestry, marital status, or veteran’s status.

II. **DEFINITION**

Assisted living means a residential living arrangement for persons who are ambulatory or independently mobile but may require assistance with some activities of daily living, medication administration, and/or nutritional services. Assisted living does not provide skilled nursing care.

III. **PROCEDURAL COMPONENTS**

It is the responsibility of the Administrator to communicate the expectation that facility staff adhere to established admission protocols when screening and admitting residents.

The facility admits only those residents whose clinical needs can be adequately provided by the scope of services offered by the facility through its staff, in accordance with its license and other state and federal regulations.

A. Pre-admission Process

1. Prospective residents will be assessed for appropriateness of admission through a review of their physical, psychosocial, and behavioral status. General information regarding these functions is documented on the facility’s pre-admission screening form

2. The primary care physician provides a documented health assessment and statement indicating that the prospective resident is appropriate for admission to the assisted living setting as defined by the established admission criteria. This documentation is reviewed as a component of the pre-admission screening

3. An introductory interview is conducted by the facility’s Admissions Coordinator. The interview should include, when possible, the prospective resident’s family and/or other responsible parties. Discussion should include the expectations of the resident and family, a review of the prospective resident’s physician statement, a review of the resident’s needs, and the ability of the facility to meet those needs and expectations based on its scope of care

4. Financial information is gathered by the Admissions Coordinator and/or business office staff to ensure that the resident is able to meet the financial requirements of the facility

5. All pre-admission screening information is reviewed by the Administrator or designee. Residents who are appropriate candidates are referred to the admissions team for review. Consultation with other disciplines may be utilized to verify that resident needs can be provided within the facility’s scope of care

6. The final decision for a resident’s admission is accomplished collaboratively by the Administrator, the Admissions Coordinator, Resident Services Coordinator, and other members of the team

7. When the candidate is deemed appropriate for admission, he or she is notified of this in writing or by telephone along with determination of a date of admission, room location, and payment dates. If a bed is not available, the candidate is notified of placement on the facility’s waiting list

8. If the applicant does not desire to be admitted within 30 days from initial application or if a change in condition has occurred, the prospective resident is reassessed to determine continued appropriateness for placement

9. A pre-admission orientation day may be scheduled to simplify the day of admission and promote the building of rapport between the resident/family and the facility staff. Topics may include:

a. **I**NTRODUCTION/overview of the facility

b. Tour of the facility

c. Aging and associated risks/expectations management information

d. Validation of application information

e. Overview of admission day

f. Things the resident may bring and should not bring to the facility

g. Resident responsibility for personal property

h. Expectations relating to a resident’s transitional period

B. Admission Process

1. Upon admission, the resident applicant and the resident’s responsible party complete, sign, and/or review the following:

a. Resident application

b. Admission agreement

c. Other consents/authorization/releases

i. Immunization

ii. Photographs

iii. Release of record information

iv. Do not resuscitate form

v. Miscellaneous releases

vi. Activities

vii. Resident property

viii. Hair care

d. Acknowledgement of Receipt of Information including:

i. Resident rights

ii. Advanced directives

iii. Restraint policy, if applicable

iv. Discharge and bed reserve

v. Resident handbook

e. Completed physician’s report

f. Emergency data sheet

g. Tuberculosis (TB) test results

h. Name of dentist

i. Name of pharmacy

j. Medical insurance information

k. Emergency contact numbers

l. Copies of Advance Directive and Durable Power of Attorney

m. Negotiated/shared risk agreement, if applicable

2. Upon admission, the resident applicant and the responsible party may be provided an arbitration/mediation agreement, if appropriate per state statute

a. Components of an effective agreement include:

i. Presented as separate document from the admission agreement or in a distinctive font from other admission agreement language

ii. Signed acknowledgement of explanation of arbitration/mediation language to resident and/or legal representative

iii. Time provided for resident and/or legal representative to ask questions or to consult with others before signature is obtained

iv. Not presented as a “take it or leave it” basis for admission to facility

v. Terms are clear and demonstrate “fairness” to both parties

vi. Reviewed by legal counsel to assure compliance with state law

3. A variety of resident assessment screenings are conducted by facility staff at the time of admission, to include:

a. Level of care assessment

b. Physical assessment including vital signs, height, and weight

c. Allergies

d. Activity status

e. Functional ability including vision, hearing, speech, and mobility

f. Bathing needs

g. Pain

h. Dietary needs

i. Social history

j. Life story/history including interests, hobbies, family structure, religious practices, preferences for activities, music, entertainment, and typical daily routine and schedule

k. Medication administration needs, including self-administration assessment, if indicated

l. Cognitive function

m. Behavioral function

n. Safety assessment

o. Focused risk assessments for:

i. Fall risk

ii. Elopement risk

iii. Skin integrity risk and inspection

4. Medications are provided by the designated pharmacy in accordance with the physician’s orders

5. Facial photographs for use in medication administration are taken after consent has been obtained

C. Resident Service Plan

1. Information from the pre-admission and admission assessments and screenings serve as the basis for the development of the resident’s service plan. The service plan is developed by the staff of the various departments including dietary services, activities, clinical staff, and administration

2. The resident, family, and/or responsible parties are invited to participate in the development of the service plan. Their attendance or lack of attendance is documented

D. Orientation

1. Before and or at the time of admission, the resident receives orientation to the environment, processes, and the facility. If the resident is incapable of comprehending the content of the orientation and his or her rights, the resident’s responsible party is provided with the orientation information

2. Written record of orientation is maintained in the resident’s record

3. Orientation topics include:

a. INTRODUCTION/overview of the facility

i. Culture and history of the organization

ii. Facility layout

iii. Role of the staff

iv. Role of the attending physician

v. Facility level of care

b. Tour of the facility

c. Aging and associated risk/expectations management information

d. Resident’s rights

e. Financial management to include trust funds

f. Facility policies

i. Visitor procedures and sign-in

ii. Smoking

iii. Resident responsibility for personal property

g. Activities program including calendar of events

h. Social services

i. Transportation services

j. Dining options

k. Safety orientation including:

i. Exits and lighting

ii. Fire safety

iii. Disaster plan including evacuation procedures

iv. Security plan

v. Alarms

l. Mail services

m. Emergency response, including 911, and lack of medical care in assisted living

n. Use of staff notification systems such as call lights

o. Process for initiating work requests

p. Housekeeping schedules and laundry

q. Other procedures and information as needed

E. Reassessments

1. Periodic reassessments are conducted to verify the resident’s condition and to determine if the resident meets continued stay criteria. Reassessments include the components identified under the admission process

2. Reassessments are conducted at least annually and with any change in resident condition

3. Service plans are updated at a minimum every six months and with a change in resident condition

F. Family/Responsible Party Involvement

1. During all assessments and resident service plan meetings, the family and/or responsible parties are invited and encouraged to provide input and become familiar with the facility’s processes for managing specific resident needs

2. Notices regarding upcoming scheduled planning meetings are provided in advance of all meetings. Attendance at meetings is documented

3. Identified risks may be addressed through shared risk agreements when indicated. These will include:

a. Purpose of the agreement

b. Details regarding the assessed risk and possible consequences

c. Explanation of the risk to the resident and/or responsible party

d. Suggested alternatives, if applicable

e. The facility’s methods of managing the risk

f. The limitations of the facility regarding aging in place and future expectations

g. The resident and/or responsible party and facility representative’s signed acknowledgement of the plan

F. Discharge

4. When the resident’s needs exceed the ability of the facility to safely provide care to the resident (as determined by the facility’s admission and discharge criteria and in association with the primary care physician’s involvement) or when the resident’s needs exceed the scope of care the facility is licensed to provide, discharge planning is initiated. Plans for discharging the resident involve the resident and family/responsible party and an interdisciplinary team

# Suicide Risk Screening Tool

Preadmission:

Prior to move-in, the referral source if applicable, should be asked about any history of suicide attempts, violence, and criminal and domestic violence. If the potential resident is in acute care setting, information about his/her psychosocial and psychiatric history should be obtained from the medical record, practitioners, and family.

The following screening questions are appropriate if the potential resident is alert, oriented, and able to answer questions. These questions should be asked prior to moving into the Community

Begin with screening questions that address the resident’s feelings about living

1. How is your life going overall?
2. Are there any particular life stressors that are troubling you now?

If the potential resident does not identify any issues of concern, then no further questions are required. If either of the above two screening questions elicit answers about the potential resident’s state of mind that indicate that he/she may be at risk, ask the following suicide assessment questions:

1. Is death something you thought about recently?
2. Have you ever reached a point in which you had thoughts about harming yourself?
	1. If there has been a recent attempt to harm him or herself, obtain further details and notify the resident’s current health care provider and request a written medical clearance indicating that the resident is no longer a suicide risk.
	2. If the resident does not receive written medical clearance indicating he/she is no longer a suicide risk the Executive Director (ED) and/or Director of Resident Services (DRS) or Our House Manager (OHM) will consult with the V.P Clinical Services at the Home Office before accepting resident into the Community.

If the potential resident answers no to both questions 3 and 4, then no further questions are required. If he/she answers in the affirmative either question 3 and 4, continue with the remaining suicide risk assessment questions:

1. Have you any recent thoughts of hurting yourself now?
2. Do you have any plans to hurt yourself now?
3. Do you intend to act on your thoughts?

If a potential resident is being considered for admission answers in the affirmative to any of the questions from 5-7, this person would not be eligible to move into the Community at this time. The person and his or her family should be immediately referred to the hospital emergency department on a voluntary for a psychiatric evaluation. If the person refuses to be taken voluntarily, the appropriate steps should be taken for involuntary commitment to ensure the safety of the person if there is actual intent. The potential resident may be considered for future residency in the Community after receiving appropriate care and treatment and has written medical clearance indicating that he or she is no longer a suicide risk

Screening questions were adapted and modified from the Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors. American Psychiatric Association Steering Committee on Practice Guidelines, 2003.

**Suicide Screening Precaution**

1. Any statements from a resident regarding self harm or suicide must be taken seriously. If a resident verbalizes suicidal ideation by stating he wants to harm or kill himself, do not leave the resident alone.
2. Notify the wellness nurse or Director of Assisted Living (DRS). The nurse or DRS will assess the situation. If the situation occurs on the evening shift, overnight, or on a weekend, the manager on duty will notify the Executive Director (ED) and/or DRS.
3. If at any time the situation escalates and the resident becomes actively suicidal, or you are not sure what he/she may do, call 911 immediately so resident can be evaluated and transferred to an acute care facility.
4. Try to redirect the resident to other subjects. Inspect the immediate environment for sharp objects, medications and toxic substances that are in plain sight. Remove any items in the resident’s immediate environment that could be used to inflict harm to him/herself. This includes but is not limited to letter openers, long telephone cords, scissors, pins, tacks, medications, and toxic substances.
5. Notify the family and attending physician regarding the resident’s suicide ideation and/ or suicide attempt. If the resident is being treated by a mental health provider, also notify provider.
	1. Ask the family to become actively involved in resident’s safety. This may include providing a short term 24 hr. companion until a safety plan is formulated.
	2. If the family is not able or willing to provide a 24hr companion, the Community may need to provide this for resident as a temporary safety measure.
6. A detailed note of all observations, actions taken and communication should be included in the resident’s care notes.
	1. The DRS or designee will update the resident Focus/Interventions in MOVEN to include suicide ideation and what interventions are put into place (i.e. 24hr companion, checking on resident at certain times of the day, activities, etc.).
7. The DRS or ED will notify the Sr. VP, Community Operations, VP, Clinical Services and Director of Risk Management if there has been a suicide attempt.
8. The DRS will debrief staff members, including a review of the policy and whether the policy was followed. This debriefing should include lessons learned and if system improvements are required.
9. If the resident was sent out and returns to the Community, the resident must be followed actively by a mental health provider:
	1. Resident may not return to the Community without a written medical clearance indicating he/she is no longer a suicide risk.
	2. The DRS or OH Manager will supervise and ensure orders are received from the resident’s mental health provider regarding ongoing resident observations and evaluations regarding changes in mental status before returning to the Community.
		1. These orders will then be communicated to all participating associates such as the LVN and personal care staff.
	3. The DRS or OH Manager will ensure Focus Areas and Interventions are properly updated in MOVEN upon acceptance back into the Community.
10. The DRS and OH manager will ensure that staff training on managing residents who express suicidal ideation and or suicide attempts will be provided on an ongoing and annual basis.
11. Indications that a resident may need to be transferred out of the Community include but are not limited to:
	1. Continued expressions of suicidal intent with a thought out plan or statements for execution.
	2. Hoarding of medications.
	3. Refusal/inability to take psychiatric related medications.
	4. Continued attempts to hurt themselves.
	5. Violent behavior or statements.
	6. If you are in doubt as to the acuity of the situation, contact 911 immediately

# Complaints / Grievances

I. **POLICY GUIDELINES**

Individuals receiving services have a grievance/complaint procedure available to them without fear of threat or reprisal in any form.

The facility maintains a simplified process for the resident and/or resident’s family to express complaints, problems, hazards, and concerns.

The facility’s goal is to provide prompt resolution of a resident grievance regarding an alleged violation of resident rights.

All resident/family/legal representative complaints and grievances are investigated, addressed, and evaluated as a potential opportunity for improvement.

All staff members are expected to participate in resolving resident concerns and to resolve issues immediately whenever possible.

II. **DEFINITIONS**

A grievance is a formal or informal written or verbal complaint that is made by a resident or a resident’s representative when an issue cannot be resolved promptly by staff present. A complaint or concern that is received in writing by the resident and/or responsible party is considered a grievance.

A complaint is a concern that is verbally communicated to a staff member that can be resolved promptly, on the spot, by staff.

III. **PROCEDURAL COMPONENTS**

A. Rights

1. Residents are informed both orally and in writing upon admission about what rights and responsibilities he or she has, including:

a. The right to raise a concern when he or she believes his or her rights or the provision of his or her care has been compromised

b. The right to voice grievances without discrimination or reprisal and have the facility respond to those grievances promptly

B. Complaints

1. The Administrator designates an individual as the “Complaint Officer” for the facility and includes this information in staff education and resident admission information

2. The complaint-handling process includes the following steps:

a. All complaints are documented on the facility’s complaint form and forwarded to the designated complaint officer for resolution

b. A plan of action is developed, implemented, and communicated to the resident and/or responsible party within five days

c. The initial attempt at resolution may focus on assessment of the dimensions of performance, since many complaints arise from these issues. Performance dimensions may include availability, timeliness, continuity, safety, efficiency, and respect/dignity

d. Follow-up for resolution occurs within one week of communicating the action plan to the resident

e. The facility revises the plan of action, if needed, and continues to follow up with the resident until the concern is resolved

3. The Complaint Officer maintains a complaint log that includes:

a. Date complaint received

b. Resident name and/or person initiating complaint

c. Type of complaint

d. Department manager responsible for action plan

e. Date action plan communicated to resident

f. Date of follow-up with resident

g. Outcome

4. Complaints are tracked and trended and reviewed at Quality Improvement/Risk Management meetings

C. Grievances

1. Upon admission, the resident and/or the resident’s responsible party is provided written information on how to file a grievance or complaint

2. The grievance form is signed by the resident or the person filing the grievance or complaint on behalf of the resident

3. If the complaint or grievance involves details of the resident’s care and has been raised by anyone other than the resident, compliance with confidentiality policies is maintained. Authorization from the resident or the resident’s legal representative is required before discussing healthcare information

4. The Administrator designates an individual responsible for receiving grievances and posts this information for resident/family information

5. The Administrator or Director of Nursing (or their designee) conducts a formal investigation of all grievances. The scope of the investigation should include:

a. Assessing the resident’s plan of care and progress toward goals

b. Evaluating the functions of each member of the healthcare term as functions relate to the resident’s concern

c. Providing guidance and interpretation regarding policy and the standard of care

d. Conveyance of information compassionately and in accordance with facility practices

e. Facilitating a coordinated response

f. Verifying that pertinent communication to the resident is conveyed accurately and in a timely manner

6. The investigation and report includes:

a. The date and time the incident took place

b. The circumstances surrounding the incident

c. The location of the incident

d. The names of any witnesses and their account of the issue

e. The resident’s account of the issue

f. The employee’s account of the issue

g. Interviews of any other individuals involved (e.g., family members, visitors, employee’s supervisor, etc.)

h. Recommendations for corrective action

7. An investigation file is retained in a secured location in the Administrator’s office

8. The facility goal is to respond to the grievance within 10 days. This does not require that the investigation and plan of action be completed, but at a minimum, a progress report should be provided. A final response is provided in writing to the grievant, along with a summary of resolution

9. External agencies are contacted if the resident is not satisfied with the results of the investigation, which may include the local ombudsman’s office and/or state survey and certification agency

10. The organization reports grievances as well as actions taken to external regulatory and/or accrediting agencies to the extent required by law, regulation, and/or accreditation requirements

11. The Administrator, Risk Manager, and Director of Nursing are notified of any written grievances and consideration given to notification of the insurance agent or legal counsel (if a potential claim or litigation is expected)

12. A grievance log for tracking and trending of data is maintained

13. Data regarding grievances and action plan summaries are presented to the Quality Improvement/Risk Management Committee

# Confidentiality

I. **POLICY GUIDELINES**

The resident has the right to privacy, confidential care, and protection of health information.

Healthcare professionals have a duty to protect each resident’s healthcare information and privacy.

Violations of the resident’s rights undermine the public’s confidence in healthcare organizations.

Federal and state laws define specific measures that must be undertaken to preserve a resident’s personal health information.

II. **DEFINITIONS**

Health Insurance Portability and Accountability Act of 1996 (HIPAA) is an act that requires, among other things, the adoption of standards, including standards for protecting the privacy of individually identifiable health information. The privacy provisions of the federal law apply to health information created or maintained by healthcare providers who engage in certain electronic transactions, health plans, and healthcare clearinghouses.

Protected Health Information (PHI) is individually identifiable health information transmitted by or maintained in electronic media or transmitted or maintained in any other form or medium.

Secure Area means a location that is not accessible to the general public.

Breach of Confidentiality is a disclosure of private information to a third party without the resident’s consent or a court order. Disclosure can be oral or written; by telephone or fax; or electronic, for example, via e-mail.

III. **PROCEDURAL COMPONENTS**

A. Disclosure of Personal Health Information

1. A resident’s health information can only be disclosed:

a. When it will be used to carry out treatment, payment, or healthcare operations, except for research information unrelated to treatment

b. When the resident or substitute decision-maker has consented and it is necessary for a lawful purpose

c. Where it is required by law

d. For use by coroners

e. When it enables the Department of Health and Human Services to investigate or determine the covered entity’s (CE) compliance with HIPAA regulations

2. Only the minimum amount of PHI necessary to accomplish the allowed purpose may be disclosed

B. Release of Information

1. The resident’s right to authorize release of medical records is codified in many state statutes. These statutes state that medical records are confidential and cannot be disclosed, except in specifically provided circumstances. The extent of the resident’s right to access varies from state to state. All releases are in compliance with state and federal laws

2. Generally, the authority to release medical information is granted to:

a. The resident (if a competent adult or emancipated minor)

b. The resident’s legally-designated surrogate decision maker

c. A legal guardian

d. The Administrator or executor of the resident’s estate, if the resident is deceased

3. The following guidelines are followed when releasing records:

a. Records may only be released upon written authorization of the resident

b. The person or entity receiving records and date of release is documented

c. Originals are not to be released unless originals are specifically ordered by a court of law

d. Records that are involved in potentially or actively litigious situations are separated from other medical records and maintained in a secured area

e. Release of records should not be denied for non-payment of the resident’s bill

f. Procedures should be developed for managing subpoena and court orders

4. Elements of the release of information form should include:

a. Resident’s name and identifying information

b. Address of the healthcare professional or institution directed to release the information

c. Description of the information to be released

d. Identity of the party to be furnished the information

e. Language authorizing release of information

f. Signature of resident or authorized individual

g. Time period for which release remains valid

h. Language to reflect any state or federal laws that add other elements, such as specifying the reasons for disclosure or situations in which the authorization, may be revoked

C. Mandatory Disclosure

1. Medical information must be disclosed without resident authorization if the disclosure is compelled by:

a. Court order

b. Subpoena

c. Lawful search warrant

d. Notice to appear

e. Some situations and diseases require reporting

i. The facility should verify the requirements specific to its population and maintain a list that is readily accessible to staff. These may include:

(a.) Communicable diseases (i.e., reporting acquired immunodeficiency syndrome [AIDS] cases to the local health officer)

(b.) Child or elder abuse

(c.) Domestic violence

(d.) Acute poisoning by controlled substances

(e.) Medical examiner’s reports

(f.) Duty to warn (preventing harm to self or others)

(g.) Gunshot and knife wounds to be reported as required by applicable statutes or ordinances

D. Storage of Resident/Medical Records

1. All records are secured in areas that are not accessible to anyone other than employees

2. Special storage needs are designated for records containing information relating to:

a. Substance abuse

b. Psychiatric illness

c. Human immunodeficiency virus (HIV) testing

d. Employee health

E. Conversations in the Healthcare/Resident Care Setting

1. All staff are to exercise caution in the discussion of any personal health matters with residents, physicians, and other healthcare professionals

2. Sensitivity is required when discussing resident matters on the telephone or in person within hearing distance of others so that conversations are not overheard

F. E-mail and Technology

1. E-mail communication may be protected by:

a. Turning off computer screens or logging off when staff is not in immediate attendance

b. Double-checking the address of the recipient is correct prior to sending

c. Providing all employees with computer passwords, login, and user identification and requiring that they not be shared

d. Not permitting staff to e-mail PHI that has a potential for breaching the resident’s confidentiality

e. Securing the storage of all hard drives and computer disk files

f. Maintaining a secure configuration of the system (intranet and extranet)

g. Installing and configuring wireless network connections in a manner that protects system access

G. Voice Messaging

1. The use of voice messages is confirmed directly with the resident/family prior to using this method of communication. The resident or name of family member providing confirmation is to be documented in the resident record

2. The name of the facility and the name of the person that is being contacted may be left in the voice message provided the resident/family has consented to communication by voice messaging

3. Messages should not contain any health information such as tests, current condition, or other personal matters

4. Messages should not include any details regarding billing information

H. Faxing

1. The use of a fax for PHI is permitted only when delivery by regular mail does not meet time-sensitive needs of the sender or recipient.

2. When PHI information is transmitted by fax, the following measures must be taken:

a. Faxing to mail rooms is not permitted

b. A confidentiality statement is included on the fax cover sheet

i. Example of this language includes:

This facsimile is intended only for the use of the named addressee and may contain information that is confidential or privileged. If you are not the intended recipient, or you are not the employee responsible for delivering the facsimile for the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this facsimile is strictly prohibited. If you have received this facsimile in error, please notify the sender immediately

c. Other cover sheet information is to include:

i. Name of the intended recipient

ii. Business affiliation

iii. Telephone number

iv. Fax number

v. Number of pages contained in the transmission

d. Fax confirmation sheets are attached to and maintained with all faxed materials

e. Receipt of information acknowledgment is requested (e.g., call after receipt)

f. A hard copy is sent to follow electronic results

g. Faxing is not permitted for records or information that requires additional confidentiality measures including:

i. Substance abuse

ii. Mental health treatment

iii. Psychiatric residents

iv. HIV testing

I. Receiving Faxes

1. Employees are to take steps to minimize the possibility that received faxes are viewed or received by someone else, including:

a. Machines that receive faxes that include PHI are located in secured areas that are not accessible by anyone other than facility staff

b. If an employee receives a fax on a machine that is not secure, the recipient immediately advises the sender that the receiving fax machine should not be used for the transmission of any further information

c. Employees are to promptly remove incoming faxes and deliver them to the proper recipient

d. If a fax is received and the facility is not the intended recipient, the employee immediately notifies the sender and destroy the faxed material

e. The facility staff notifies entities that routinely send faxes if there is a change to the fax number

f. If information is received that contains sensitive PHI, the sender is advised that the facility is not permitted to accept such information by fax transmission

J. Employee Compliance

1. All staff are educated on confidentiality, the facility confidentiality policy, and requirements of regulations and laws including HIPAA

2. All staff are educated on both verbal and written release issues

3. Specific staff are designated and trained to handle all releases

4. Confidentiality agreements are required from vendors if applicable because of access to personal health information

5. All employees are required to sign a confidentiality statement (confidentiality policy acknowledgement) form at the time of hire

a. Confidentiality statements are signed by all employees whenever the confidentiality policy is revised

6. Employee confidentiality statements include the following elements:

a. Information that is considered confidential

b. Acknowledgement of receipt of facility confidentiality policy

c. Acknowledgment of legal and ethical responsibility to protect privacy, confidentiality, and security of all medical records and PHI, including resident identity

d. Agreement that computer passwords and other security codes are not shared

e. Agreement to abide by the policy

f. Understanding of consequences of failing to abide by the policy including possible criminal liability under the HIPAA regulations for intention and/or malicious release of PHI

K. Enforcement

1. Employees who do not comply with the confidentiality policy are subject to disciplinary action. Depending on the facts and circumstances of each case, and in accordance with any applicable collective bargaining agreements, the facility may reprimand, suspend, dismiss, or refer for criminal prosecution any employee who fails to comply with this policy

# Contracts

I. **POLICY GUIDELINES**

In order to protect the facility’s assets and minimize risks, the facility develops written contracts with providers of professional services, construction, goods and/or supplies and may participate in affiliation agreements, joint ventures, property leases, and other service agreements.

Since contracts are legally binding, they are to be written clearly, be concise and understandable, and contain all terms.

Maintaining adequate and current contracts is an effective risk reduction strategy.

II. **DEFINITION**

A contract is a binding agreement between two or more persons or parties that must be individually tailored to meet the objectives of the parties. Through the terms delineated in the contract, the process to carry out expectations and the consequences of not meeting those expectations are identified. Contracts should be reviewed by legal counsel to ensure the inclusion of key elements to maximize contract enforceability

III. **PROCEDURAL COMPONENTS**

A. Contract Renewal System

1. A routine and coordinated process that is triggered prior to the expiration date of contracts (a “tickler” system) is established to promote annual review of all contracts

a. Contracts with automatic renewal dates are reviewed annually to:

i. Verify the terms of the contract remain accurate and adequate for the services required

ii. Obtain a current certificate of insurance

b. Contracts with specified termination dates, considered the best way to protect the interests of both parties are reviewed 90 days prior to the termination date to determine if renewal is necessary

2. A checklist system is developed that delineates all components that should be addressed when developing or renewing contracts. This checklist serves as a guide to promoting complete contracts

3. A person is designated responsibility for the maintenance of current contracts

B. Storage and Contents

1. Contracts are stored in a centralized area in a secure, fireproof file with access limited to authorized personnel

2. A current copy of the certificate of insurance is attached to the agreement

C. Contract Development and Renewal

1. All contracts are signed by the designated authorized person

2. Contracts are reviewed and evaluated by legal counsel prior to final signature

3. Contracts contain the following elements:

a. The effective and termination dates of the agreement

b. Description of product or services

c. Representations and warranties

d. Insurance provisions and requirement to provide vender Certificate of Insurance (COI)

e. Hold harmless/indemnification clause with defined scope

f. Professional liability insurance access to books and records by the parties (if appropriate)

g. Dispute resolution process

h. Any licensing and certification requirements

i. Confidentiality clause (if access to confidential information)

j. Agreement to comply with laws, rules, and regulations

k. Defined process for amending the contract

l. Remedies for nonperformance

m. Signatures with dates of each authorized agent

n. Termination provisions

4. Temporary staffing contracts should also define the following elements:

a. Job description

b. Qualifications of staff

c. Competency and skills assessment

d. Screening responsibility, including:

i. Criminal background checks

ii. License, certification, and education verification

iii. Reference checks

iv. Drug testing

v. Sexual abuse registration checks

e. Orientation

f. Expectation for performance reviews

# Disaster & Evacuation Program

I. **POLICY GUIDELINES**

The facility strives to promote resident safety and to protect resident rights and dignity.

The facility Disaster and Evacuation Plan provides for an organized and comprehensive approach to operations in the event of a natural disaster, such as a hurricane, flood, tornado, or severe weather, which may affect the well being of residents and staff. This plan includes procedures for response to both internal and external disaster situations that may affect residents, visitors, and employees. It is intended to act as a guide, since the facts of an event may require a different response.

II. **DEFINITIONS**

Disaster: The Joint Commission defines a disaster as a natural or man-made event that causes any of the following:

• Significant disruption of the environment of care (e.g., damage to the facility from a tornado or earthquake)

• Significant disruption of care and treatment (e.g., loss of utilities due to floods or emergencies within the organization)

• Sudden, significantly changed, or increased demands for the organization’s services (e.g., a bioterrorist attack, building collapse, or plane crash in the community)

Internal Disaster: A fire, explosion, flooding, bomb threat, etc. that threatens the safety of persons within the facility and necessitates evacuation. These events are usually localized to the building and cause a disruption of services or destruction in some form.

External Disaster: Tornado, flood, explosion, disbursement of hazardous airborne particles or poisonous gases, or other event that threatens the safety of persons within the facility and necessitates evacuation. These events may impact the infrastructure of the community or beyond.

Partial Evacuation: Evacuation in which residents are not required to leave the premises but may be brought into hallways or other designated areas during the event such as a severe weather situation. In the event of a controlled/contained fire, residents may only require evacuation beyond the fire doors to a wing or other area.

Total Evacuation: Residents are removed from the building and relocated to area shelters.

Immediate Evacuation: Requires the immediate, prompt departure from the facility.

Urgent Evacuation: Allows for a quick but orderly departure from the facility. Residents are dispersed from the affected facility to the receiving facilities, but time may permit notification of families who are local and can accept the resident into their care on a temporary basis.

Strategic National Stockpile (SNS): Augments local supplies of critical medical items. The SNS is managed by the Centers for Disease Control and Prevention (CDC) and contains large quantities of medicines, antidotes, and medical supplies needed to respond to a wide range of expected problems or scenarios, including attacks using nerve, chemical, and biological agents.

National Response Framework (NRF): Formerly called the National Response Plan, the NRF presents the guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies from the smallest incident to the largest catastrophe. The Framework establishes a comprehensive, national, all-hazards approach to domestic incident response.

National Incident Management System (NIMS): Developed by the Federal Emergency Management Agency (FEMA), NIMS provides a systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work seamlessly to prevent, protect against, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life and property and harm to the environment. For more information go to www.fema.gov/emergency/nims/

Incident Command System (ICS): A standardized, on-scene, all-hazards incident management approach that allows for the integration of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, enables a coordinated response among various jurisdictions and functional agencies, both public and private and establishes common processes for planning and managing resources. For more information go to www.fema.gov/emergency/nims/

III. **PROCEDURAL COMPONENTS**

PART 1: **DISASTER PREPARATION**

A. Disaster Plan

1. A disaster plan is continuously maintained and annually reviewed. This plan is developed and approved at the facility level; however, assistance and input is provided by:

a. The local Department of Health

b. The local Emergency Medical Response providers/coordinators

c. Local, county, and state law enforcement agencies

d. Environmental Protection Agency (EPA)

e. FEMA, including NIMS and ICS structure

f. National Fire Protection Association (NFPA)

g. The Occupational Safety and Health Administration (OSHA)

2. The local emergency management agency’s plan for disasters is reviewed as a component of the facility’s annual planning process and serves to define the local emergency agency’s role during disasters. Input from other emergency and health agencies obtained to ensure the facility meets the disaster preparedness provisions of other organizations within the locality. It is the expectation that other departments and community resources assist in planning as well as during emergencies and may provide assistance with assets that are unable to be obtained due to an unforeseen circumstance. It is the role of the facility to conduct operations and to accomplish the goal of safety for the residents

3. Current contact information for the above listed agencies is obtained during the planning process and remain readily accessible at the facility and up-to-date

4. An internal calling tree has been established as part of the planning process and is updated at least quarterly by management. This information is maintained in a secure, designated, and readily accessible area (which may be with the disaster supplies)

5. The evacuation component of the disaster plan addresses evacuation and placement of non-ambulatory and cognitively impaired residents in a multi-level facility

B. Hazard Vulnerability Assessment

1. A thorough Hazard Vulnerability Assessment (HVA) is conducted to determine what events or incidents may negatively impact operations. The goal of the HVA is to identify as many potential threats as possible to adequately anticipate and prepare to manage a crisis or disaster

2. Local Emergency Management officials should be involved in analyzing possible hazards and vulnerabilities for the geographic location that could impact the facility such as proximity to structures and operations (nuclear plants, refineries, pipelines, military installations, airports, sewage treatment plants, dams, prisons, busy roadways, railroads, wooded areas, bodies water, gas lines, etc.)

C. Shelters

1. Shelter agreements are developed with facilities (“receiving facility”) that are able to accommodate the receipt of residents. The disaster plan includes the name of receiving facility, the contact person, the address, and the phone number

2. Depending on the geographic location of the facility, a secondary shelter in another locality—even one that is several hours away—should be considered in the event of a community-wide disaster

3. Legal counsel reviews the shelter agreements to evaluate the facility’s exposure to liability and include any Good Samaritan language, when appropriate and permissible by state regulations, to limit the liability of those who are voluntarily sheltering residents

4. Other components of the agreement may include:

a. After evacuation, staff members from the affected (or “sending”) facility are allocated, when possible, to the receiving facility. Staff are then under the leadership of the receiving facility

b. The sheltering facility agrees to grant temporary employment to the sending facility’s employees. As soon as possible, the sending facility agrees to provide the receiving facility with all pertinent staff information including certification and licensure

c. Employees remain on the payroll of the affected facility, which will continue normal insurance and worker’s compensation coverage until other arrangements are made

d. Residents maintain their current admitting physician unless the physician transfers the care of the resident to another physician in the receiving facility’s community

e. Transferring residents are accompanied by a resident evacuation tracking log, which lists all pertinent contact information. Resident medical information (contents listed below) also accompanies residents

f. If time permits, additional medical records are transferred to the receiving facility

g. At the time of relocation back to the original facility, a copy of pertinent medical record information accompanies each resident and is made available to the attending physician

h. Biomedical equipment is disbursed from the affected facility and initially accepted by the receiving facility. The receiving facility may catalog the equipment and conduct safety checks when time permits. Equipment is returned to the sending facility with the return of residents

i. Pharmaceuticals arrive with the residents but are subject to review by the receiving facility

j. Once the sending facility resumes normal operations, the receiving facility agrees to return any residents or equipment to the sending facility

D. Transportation

1. Transportation agreements are developed as part of the planning process. These address what occurs when residents need to be transported from the facility to a shelter or other facility and the extent of the available services

2. Methods of communication, including alternate mechanisms in the event of power loss or downed phone lines, are addressed in the agreement

3. The transportation service is provided with information regarding shelters with which the facility has arrangements and the facility’s communication process regarding where to deliver residents

4. For each transportation agency, vital information is kept readily available including:

a. Name of agency

b. Type of transportation

c. Contact person

d. Address

e. Phone

f. Response time

g. Resources for transfers, including number of residents who can be accommodated in a given timeframe

5. Depending on the geographic location of the facility, a secondary transportation agreement should be considered with a company that is in a distant locality and can be utilized in the event of a community-wide disaster that places a heavy demand on local transportation

E. Emergency Communications Systems

1. The preparedness process includes the primary emergency communication system that will be used in the event of a disaster

2. Backup emergency communication systems that are used in the event the primary system is inoperable are determined along with a list as to the order in which these systems are used

3. Other communication details obtained and maintained include:

a. Local hospital’s alternate method of communication

b. Cell phones

c. Satellite phones

d. Two-way radios, with designated channels

e. Amateur wave radios, including local clubs and methods of initiating contact

f. Web site

g. Regional maps

F. Media/Public Communications

1. Communication with media should be addressed at the time of a disaster. Factors considered when releasing information should balance:

a. Protection of the privacy, health, and welfare of residents

b. Addressing the public’s need for information and reassurance

c. Improving the flow of accurate information

2. The contact numbers to be used for communicating with the media are determined during the planning procedures with a list maintained in the disaster supply container and as an addendum to the disaster plan. This includes methods of pre-identifying media personnel to be contacted through the facility’s Public Information Officer (PIO) or Incident Commander (IC)

3. Media information guides should include:

a. Requesting that the public be advised not to come to the scene

b. Methods of apprising them of the situation

c. Anticipated “next steps”

d. Coordination of messages to residents, physicians, and staff

e. Mechanisms for communicating the events to the general population

f. Coordination of messages for handling the “worried well” (volunteers, separate locations, family members)

4. When information cannot be released, the release should be refused with an explanation. If delays are encountered, the media should be so advised

G. Disaster Supplies for Building

1. A continual supply of emergency equipment is maintained in quantities that can accommodate the needs of the census and building size. The supplies are maintained in a clearly designated location to which all staff have become familiarized

2. These supplies include:

a. Facility map, with location of all shut-off valves (water, gas, electric)

b. Resident evacuation tracking sheet

c. Fire extinguishers

d. Flashlights

e. Potable water supply

f. Ladders

g. Batteries

h. Extension cords

i. Mops, sponges, and buckets

j. Large trash bags

k. Heavy duty and plastic gloves

l. Transistor radio

m. Packing tape, string, and scissors

n. Contact numbers for emergency agencies, suppliers, and media

H. Census

1. An ongoing census of all residents is maintained and located where it can be easily accessed during an emergency. This includes:

a. A list of names with room or unit numbers

b. Primary medical problems

c. Emergency contact information

d. Ambulatory status (conditions which might prevent them from self-evacuating or self-propelling)

e. Log showing who is presently in the facility and out of the facility

I. Resident Information

1. A resident emergency information packet is maintained for each resident and located where it is readily accessible. This packet may be maintained in a plastic bag labeled with the resident’s name on the outside and located in the disaster supplies container

2. The resident emergency information packet should include:

a. Data sheet with identifying information and emergency contacts

b. Allergies

c. Medical conditions

d. Current medications

e. Resuscitation instructions

f. Power of attorney and/or advance directive

3. Routine updates (at a minimum, annually or with any changes) are required to ensure accurate information. A quarterly update coordinated with family may assist in maintaining accurate information. Other triggers for an update include:

a. Any significant change in a resident’s condition

b. Change in medication regimen

c. Hospitalization

d. Knowledge of changes in the family such as a death, illness, or relocation

4. In association with gathering contact information, the facility should address with the family or responsible party what arrangements may be made in the event of an evacuation where there is time for their assistance. This should include specific instructions for precisely how and where a resident would be evacuated by the family. If there is no next-of-kin or another reliable contact in the state, make plans that assume the resident will be evacuated with all facility residents, even in the event of a planned evacuation

J. Inventory of Residents’ Room/Apartments

1. An inventory is made of each resident’s household and personal contents after admission. This should be filed in the resident’s medical record and should include:

a. Prescribed and over-the-counter medications

b. Jewelry and other valuable objects (residents should be notified as part of the disaster plan orientation at admission that if a temporary move or evacuation is indicated, heavy items have to stay, no matter what their value)

K. An Emergency-Items Checklist

1. Separate from the inventory, each resident is provided with a checklist of essential items to have available in case of evacuation or a temporary move-out, time permitting. The following should be included:

a. Three to four sets of clothes

b. Underwear and socks

c. Comfortable shoes

d. Eyeglasses

e. Hearing aides

f. Dental supplies

g. Pillow, bed linens, and blanket (consider the possibility that the resident may be sleeping on a cot)

h. Any medical supplies used by the resident

i. Identification such as state identification, passport, or driver’s license

j. Important papers and documents such as insurance policies, checkbooks, and bank passbooks (or a list of where these are kept)

k. List of all contacts including family, doctors, dentist, pharmacist, church, or temple

l. Multiple tags and fasteners with name clearly and largely written

m. Sturdy bags large enough to hold all the above

2. This emergency checklist should be located in a designated area in the resident’s room or unit so staff and the resident can pack in a few minutes, without wasting time to ponder what is needed

L. Equipment

1. The facility maintains equipment inventories with plans for use during internal or external disasters. This includes a plan for managing equipment and ensuring movement during an evacuation. Supply resources are also identified

2. Resources for provision of sharing equipment across the region (e.g., personal protective equipment, decontamination systems, etc.) are also included. Contact information of vendors and suppliers shall be readily available

M. Essential Goods and Services

1. The disaster information lists (as addendums) shall include how essential goods and services such as food, water, and electricity is delivered to residents in the facility in the event of a disaster that interrupts services but does not require evacuation. A process for coordinating the request for delivery of additional supplies (e.g., laundry) is determined during the planning process

2. Mechanisms to secure a backup generator are made

3. Names and contact numbers of medical suppliers to obtain additional needs during an emergency are maintained

N. Pharmaceuticals

1. Arrangements and methods for accessing additional pharmaceutical supplies, locally or regionally, are determined and designated on the contact information sheets

2. The facility has determined a process for dispensing the medication to the facility staff and the residents. This includes a request process or form for the medication and supplies and a method of documentation receipt

O. Strategic National Stockpile

1. Availability, access, and delivery of the federal government’s SNS are determined during preparedness preparation. Contact information as well as the location and resources of supplies of critical medical items is obtained and included in the disaster supply information list

P. Routine review

1. Periodic review of the disaster plan is conducted and may be most effectively accomplished following each disaster drill. In order to ensure its accuracy, the plan should be reviewed at a minimum of every six months, as well as any time there is a change in the agency contracts, agreements, contact information, or services

Q. Contact Information Sheets

1. All of the above vital contact information is documented, kept up-to-date, and kept in both a designated primary location within the facility as well as in the disaster supply container

PART 2: **ACTIVATION OF DISASTER PLAN**

In conjunction with local, county, and state emergency management, the facility continually monitors and communicates in the event of actual or pending disaster

A. Incident Command System

1. It is the responsibility of the highest-ranking staff person on duty to declare a situation a disaster and to activate the facility’s disaster and evacuation plan. This may be the Administrator or designee in accordance with the organizational chart. This person assumes the role of IC

2. In situations of pending or actual disaster, the Administrator is contacted as soon as safely possible and is involved in decision making

3. Contact information for the Administrator or designee remains at the facility, easily accessible, and up-to-date

4. The IC should:

a. Establish a Command Center. Information and ongoing assessments are coordinated through this Command Center

b. Initiate and maintain communication with all agencies that are involved with local disasters

c. Obtain and verify the current census

d. Conduct an initial needs assessment. Depending on current on-site inventory, a preliminary determination of additional resources is made. The IC will then initiate and maintain contact with the following:

i. Designated shelters as defined in agreements. Expectations regarding the number of anticipated evacuees are provided along with an updated transportation plan and timeframe estimate

ii. Transportation agencies

iii. Suppliers of essential goods

iv. Equipment suppliers and resources

v. Pharmaceutical suppliers

e. Determine when and whether a partial or total evacuation is in order

f. Determine adequacy of destination in the event of a total evacuation

g. Initiate communication between the sending and receiving facilities

h. Coordinate (or appoint a coordinator for) resident transportation

i. Coordinate (or appoint a coordinator for) deployment of support equipment

j. Provide for staffing during transportation and relocation at the receiving facility

k. Assign a designee to oversee transportation of the disaster

l. Maintain a Resident Evaluation Tracking Log, including documentation of notification of physician and family members (other components listed below)

m. Provide staff with direction that promotes an orderly evacuation

n. Activate the Emergency Communications Systems in accordance with the preparedness plan

o. Coordinate Media/Public Communications for release of public information

B. Local health jurisdictions; local and regional emergency medical services (ambulance services/emergency medical services [EMS]); and local, county, and state law enforcement agencies

1. It is the responsibility of the Public Safety Agency to request a Disaster Declaration from the appropriate local government

2. The IC maintains contact with:

a. The Public Safety Agency

b. The local Department of Health

c. The local emergency response coordinator

d. Local law enforcement

e. Other relevant community agencies that may assist with evaluation of the situation and provide resources

3. The IC shall provide these agencies with a preliminary assessment, including:

a. An early assessment of needs

b. The number of residents present and impacted

c. Condition of the residents

d. Expectations regarding evacuation

e. Preliminary expectations regarding available and needed resources

f. Preliminary extent of damages

4. Other organizations are contacted that may be able to assist during emergencies and may provide assistance with assets that are unable to be obtained due to an unforeseen circumstance. These agencies may include:

a. EPA

b. FEMA

c. NFPA

d. OSHA

C. Internal Communication and Lines of Authority

1. Department supervisors/managers report immediately to the IC

2. The facility’s calling tree is initiated by each department manager. Each manager is responsible to call people in his/her own department

D. Contact List

1. Contact information is obtained for each agency or for services that may be needed. This information is maintained as an attachment to this plan as well as in the disaster supplies container. Contact information should be included for:

a. County/Local Emergency Management Agency

b. Public Safety Agency

c. County/Local Emergency Operations Center

d. County/Local EMS

e. Local hospitals

f. Department of Health Services (DHS)

g. Poison Control Center

h. Local media (newspaper, television, radio, etc.)

PART 3: **EVACUATION**

1. When the scope of a disaster exceeds the facility’s ability to maintain a safe environment of care for its residents, evacuation may be indicated

2. While state and local governments can order evacuations of the population or segments of the population during a disaster or emergency, the Administrator often has the responsibility for deciding whether to evacuate the residents or to shelter in place. In deciding whether or not to evacuate the following should be taken into consideration:

a. Evacuating too soon may place residents at needless risk if the disaster does not materialize

b. Evacuating at the same time as the general public may increase residents’ risk if traffic congestion and other road complications increase travel time

c. Evacuation too late increases risk if residents do not arrival at their destination before a disaster strikes

3. The facility notifies the State Health Division about their change in status when an evacuation or disruption of services exists

4. A local health officer should be contacted to assist in assessment of public health impacts

5. The leadership of the public safety agencies responding to the evacuation and disaster seeks, when indicated, a Disaster Declaration from the appropriate political jurisdiction

6. Non-ambulance methods of evacuation may be used when feasible and time permitting to alleviate the local burden on the emergency transportation system

A. Partial Evacuation

1. In the event of fire or other internal disaster, all residents and personnel are relocated from immediate danger to a safer section of the building, behind fire doors, or to a predetermined immediate external location

2. Moving is conducted initially behind fire doors on the same floor. If those areas become dangerous, residents and personnel are moved to lower floors or to the outside of the building

3. Moving is performed in a systematic fashion by moving all residents and personnel closest to the danger first

4. Fire doors are kept closed as much as possible when relocating residents from sections to other sections

B. Total Evacuation

1. In the event of a total evacuation, residents are moved by transportation service in accordance with agreement as well as by facility van(s) and private cars to a temporary location as designated by the shelter agreement. Residents should be dressed appropriately for weather conditions when possible

2. Residents are cared for in the designated locations until the facility can be reoccupied or until residents can be transferred to other facilities in the area

3. If time permits:

a. Kitchen employees should move all undamaged food to a designated location

b. The charge person or designee evacuates the medication, treatment carts, and the narcotic boxes

c. The medical records staff evacuates the resident charts

d. A designated person evacuates all undamaged incontinence products

e. The evacuation route is pre-determined by the situation and revised as needed depending on the event, such as fire location

4. When total evacuation has been completed, it is the responsibility of the Administrator, IC, or designee to account for the presence of all residents and staff. He/she must take a resident roster before leaving the building to use in accounting for residents

5. The department manager or person in charge of each department is responsible for accounting for all staff on duty and reporting such to the IC

C. Sending Facility Responsibilities

1. As soon as evacuation is being considered, the receiving facility is notified with the number and types of residents expected to be transferred. Verification is made that the receiving facility can accept the number of residents requiring evacuation and transfer

2. The sending facility carries out any measures to decrease census when possible. For example, if family members agree to temporarily have resident return home, this should be considered

3. The Resident Evacuation Tracking Log is used to document all residents who are evacuated, including:

a. Resident’s name

b. Notification of resident’s family and physician, when it is safe to do so

c. Medical records that are sent with resident

d. Belongings and valuable sent with resident

e. Medications and any equipment sent with resident

f. Method of transportation, including gurney, wheelchair, and walker

g. Confirmation at receiving facility of the above, including confirmation of resident identification

h. Time of departure and time of arrival

4. The resident emergency information packets, with content noted above, is sent with the residents

5. Staff accompany residents to the receiving facility whenever possible. Also, when it is feasible to do so and as outlined in the shelter agreement, staff of the sending facility may care for staff at the receiving facility

6. Medications and any necessary equipment are sent with residents when possible

7. Resident care and safety is the responsibility of the sending facility during the evacuation and transportation process

D. Receiving Facility

1. The receiving facility carries out any measures possible to decrease their census on a temporary basis to accommodate the influx of residents. This may include temporarily relocating residents to their family’s homes. This consideration should be included in the shelter agreement

2. The receiving facility attempts to secure additional equipment, staff, and resources to care for arriving residents

3. The receiving facility maintains a tracking log for all residents received. This should include notification to the family and physician of the resident’s relocation

4. The receiving facility should agree to assume leadership for the staff who are remaining from the sending facility

5. Should the receiving facility have fewer beds than required for the arriving residents, the applicable healthcare department or agency is notified

PART 4: **RECOVERY PHASE**

1. Following a disaster, the IC and/or Administrator, in conjunction with relevant local resources and competent authorities, such as the DHS:

a. Determine when safe re-entry into facility may commence

b. Photograph all areas of the building prior to reconstruction or repair

c. Notify staff and participating agencies regarding return to normal operations, including:

i. Department of Health

ii. Police

iii. Fire Department

iv. Department of Public Health

v. Emergency Management Coordinator

vi. Ambulance service

vii. Other relevant local agencies that provide clearance, such as the building department

d. Conduct a facility inspection of all utilities, communications, structures, and supplies, promoting a safe environment prior to any re-entry of residents. This includes:

i. Utilities

(a) Gas

(b) Electric

(c) Water

ii. Plumber

iii. Security personnel and locksmith

iv. Structural engineers

v. Carpenters

vi. Exterminator

vii. Data processing backup

viii. Food services

e. Implement a returning resident process that provides for a gradual, pre-planned, and safe return to normal operations

PART 5: DISASTER DRILLS

A. Disaster Committee

1. A disaster committee is formed that includes representatives from leadership, risk management, clinical services, security, physical plant, and administration

2. The committee establishes the drill schedule and coordinators, as well as decisions regarding the ramifications of the drills, such as their effect on existing residents, costs, and the extent of community involvement

3. The committee coordinates the drill process with the Resident Council. Periodic forums that include expert representatives of local agencies may be brought in to speak on the process of evacuating a city, a region, or the facility

B. Schedule

1. Disaster drills are conducted semi-annually. At least one involves a wide-scale, horizontal, and vertical evacuation

2. Meetings regarding drills or discussion (table-top simulated drills) are not be substituted for actual drills

C. Scope

1. A wide-scale, horizontal and vertical evacuation is conducted to provide an assessment for the facility (and community, when possible). Outside providers, such as transportation companies and fire department, are to be involved and provide assistance with communications and evacuation

2. Residents are notified in advance to minimize anxiety regarding displacement and to assist in reducing stress and fear. When possible, families should be invited

D. Scenario

1. Each drill should vary so that staff and residents are exposed to a variety of scenarios and that as many aspects of the plan as possible are tested

2. The committee should choose a disaster scenario that is relevant to the facility and addresses its vulnerability, with a goal of identifying areas for improvement. Scenarios should also assess whether residents know where they should go after leaving their rooms or units, after leaving the building, and where congregation locations are

3. Scenarios may include:

a. Utility loss (electric or water), such as that resulting from severe storm or earthquake, and include community power outage

b. Loss of facility’s communication

c. Total evacuation

d. Inability of staff to reach facility

e. Events that typically affect the community in a wide-scale manner, such as floods, tornados, earthquakes, and fires

f. Events that require immediate response, such as fire and evacuation to a pre-designated areas within the facility or grounds

g. Safe area relocations, such as with a tornado watch (low floor, middle of building, away from windows or glass)

E. Participation

1. Community-wide drills should involve:

a. Staff

b. The designated shelter

c. Designated transportation agency

d. Local emergency services

e. Fire and police departments

f. Media

g. Local healthcare facilities

h. Food services and suppliers

i. Other community resources as relevant

F. Notifying Participants

2. Community services and other entities, such as the news media, should be notified about the drill to give them time to prepare and to keep them informed

G. Executing the Drill

1. An established scenario is determined and scripted by the committee. At the time of the drill, the event announcement should be made along with a designated start time. The drill should be carried out in accordance with the script with initiation of the communication system and other components of the drill as indicated by the scenario

2. Specifically designated observers who may or may not be facility staff should record the events. Videotaping or taking pictures of the drill for future training purposes should be considered

H. Critiquing the Drill

1. Immediately following the drill, a discussion with the participants is conducted in order to obtain their comments and concerns. Issues for identification by the team should include:

a. Problems that emerged during the drill

b. Aspect of the plans that were successful

c. Areas for improvement

d. Input from non-facility participants should be obtained

e. Residents should be included in the discussion to provide information regarding aspects that raised concerns or worked well for them

2. Discussion at this meeting is documented so that corrective action plans can be developed

3. A compilation of this feedback should be used to modify the plan

PART 6: EDUCATION

1. All staff are orientated to the Disaster Plan at the time of initial hire. In associated with fire/safety education, annual disaster education is provided and noted on the mandatory education calendar

2. Ongoing education is conducted any time the Disaster Plan is modified

3. Education includes:

a. Communication procedures

b. Staff member roles and responsibilities

c. Location of the command center

d. Designated IC role

e. Location of disaster supplies

f. Location of resident emergency information packets and information contained in packets

g. Location of contact information for all agencies and resources

h. Facility and grounds layout and gathering locations

i. Methods for conducting needs assessment following initiation of the plan

j. Evacuation carries:

i. One-person carries

(a) Hip carry

(b) Cradle drop

ii. Two-person carries

(a) Swing carry

(b) Extremity carry

iii. Mattress slides

4. All residents receive information about disaster procedures at the time of admission. Updates may be coordinated with the timing of the resident’s annual assessment and service plan review, since the family may be present at this time

# Documentation

I. **POLICY GUIDELINES**

The facility maintains a complete, ongoing, and organized resident record on each resident from the time of admission until termination of the resident’s stay at the facility.

The purpose of the resident record is to provide a view of the resident’s identifying information, health history, and status and to provide communication among practitioners.

The resident record complies with federal law, state law, professional standards of practice, and facility policy.

II. **DEFINITION**

The legal medical record includes individually identifiable data, in any medium, collected and directly used in documenting healthcare and health status. This includes the open record, the thinned record, and the closed medical record. In an assisted living setting, the resident’s medical record may be a component of the resident record.

The required content of the resident record for each resident in an assisted living facility is variable per state regulatory requirements. The resident record should include medical and other personal information and care notes.

A. General Guidelines

1. A complete, timely, and accurate resident record is created and maintained for each resident

2. The resident’s record provides complete documentation of the services provided to an individual. The resident record should also contain sufficient information to identify the resident and include information relating to health history, screenings, service plan, emergency contacts, physician orders if applicable, consents, and care notes.

3. A separate financial record is maintained for each resident including a copy of the signed admission agreement and other signed financial documents

4. Only authorized individuals may make entries in the resident record

5. Every entry in a resident record needs to be legible, complete, and is authenticated and dated by the person responsible for ordering, providing, or evaluating the service in a prompt manner. Any corrections to the resident record are made by authorized persons

B. Contents

1. The resident’s record includes:

a. Pre-admission screening process that identifies:

i. The needs of the prospective resident

ii. The ability of the facility to care for the resident (reflects how the resident meets admission criteria)

b. Admission/readmission assessment that identifies:

i. Complete medical history and physical, diagnosis, and treatment plan

ii. Admission health history and review of systems

iii. Orientation to facility, room, and call light

iv. Risk assessments specific to the population, including:

(a) Skin assessment and risk score using scale (such as Braden scale, Norton Skin Assessment)

(b) Elopement risk assessment

(c) Fall risk assessment

(d) Pain assessment

(e) Nutrition risk (dehydration risk, malnutrition risk, swallowing problem, special diet)

(f) Psychosocial and spiritual status (cognitive, emotional, social, psychological, and spiritual). This may include:

(1) Depression screen

(2) Cognitive assessment such as global deterioration scale, Functional Assessment Staging Test (FAST), Brief Cognitive Rating Scale (BCRS), or mini-mental status exam

(3) Mental illness/mental retardation screen (Pre-admission Screening and annual Resident Review [PASARR])

(g) Cultural needs

(h) Functional status

(i) Oral health assessment

(j) Advance directive procedures, living will, and durable power of attorney (DPA) for healthcare

(k) Allergies to food and medications

(l) Medication orders including name, dosage, route, and frequency

v. Care notes, including

(a) Weights

(b) Elimination, including constipation, urinary incontinence, and bowel and bladder training for special care residents

(c) Vital signs

(d) Intake and output

(e) Dietary intake, appetite, special diet

(f) Bowel and bladder function

(g) Activities of daily living (ADLs), including ambulation, level of self care, bathing, and dressing

(h) Participation in formalized, group, and individual activities

(i) Social services

(j) Contracted services provided (such as rehabilitation, respiratory therapy, nursing)

(k) Consultants: podiatrist, dentist, ophthalmologist, psychiatrist/psychologist, pharmacist, etc.)

vi. Medications, including:

(a) Routine medications and treatments

(b) PRN (pro re nata, or as needed) use medications

(c) Resident self-administration of medication, including assessment to self-administer

(d) The reason, if medications are not given as ordered

(e) For PRN medications, why the medications were given and their effectiveness

vii. Resident Care/Service Plan

(a) Plan should be complete, accurate, and reflect services as planned

(b) Plan should document resident and family attendance at care conferences

viii. Reassessment whenever there is a significant change in status

ix. Routine skin checks and daily treatments if applicable

x. Reassessment of pain and pain management effectiveness

xi. Other progress reports or notes that reflect care rendered, including:

(a) Diabetic care and blood glucose testing

(b) Behavior monitoring including:

(1) Behavior tracking flow sheets

(2) Consents for use of psychoactive medications

(3) Abnormal Involuntary Movement Scale (AIMS) test, Dyskinesia Identification System, Condensed User Scale (DISCUS)

(c) Use of physical restraint if applicable including:

(1) Use of least restrictive device

(2) Consents

(3) Care of resident while restrained (check and release every two hours) and reduction attempts

(4) Use of side rails

(d) Emergency transfer notes

xii. Discharge summary that summarizes the course of stay, response to care, reason for discharge, and discharge disposition

C. Documentation Standards

1. The standards for documentation conform to current standards and include:

a. A process to secure documents to the chart

b. Defined allowable ink colors, no pencil

c. Legible entries

d. Timely entries (as soon as possible after the event or observation is made)

i. An entry should never be made in advance

ii. It is unethical and illegal to pre-date or back-date an entry

e. Process for making a late entry, addendum, or clarification note:

i. State the entry is a late entry

ii. Document current date and time

iii. Write addendum and state reason for addendum, referring to original entry

f. Use of only approved and acceptable abbreviations

g. No skipped lines or blank spaces

i. Narrative documentation should have a line drawn from the end of the entry to the signature of the individual making the notation (if there is any empty space between the note and signature)

h. Completion of all fields on flow sheets, assessment tools, and other checklists

i. Documentation of consent/informed consent as required, including:

i. Consent to treat

ii. Consent to photograph

iii. Consent for physical or chemical restraints

j. Documentation of all notification to family and physicians, including date and time (noting whenever a message is left on answering machine to return call)

k. Resident and family education, ethical issues, or non-compliance including:

i. Assessment of the resident and family barriers to education, preferred learning style, and needs

ii. Documentation of risks, benefits, and alternatives to recommended treatments

iii. Inclusion of a “managed risk agreement” to document issues of non-compliance

l. Standards for errors:

i. Do not use Liquid Paper®/Wite-Out®, do not obliterate entries

ii. Draw a single line through the entry, ensuring the inaccurate entry is legible

iii. Write “error” above the entry to be changed, initial, and date

iv. Document the correct information in the appropriate location

v. Avoid references to blame, accusations, arguments, staffing issues, etc.

vi. Use of factual terminology that is specific and objective

vii. In recording comments by residents and families, use quotes when possible

viii. No reference in the resident record that an incident report has been completed

ix. Information pertaining to the event to include:

(a) An objective description of the event

(b) The absence or presence of visible injury

(c) Notification of supervisor (if applicable), physician, and resident’s legal representative

(d) Measures taken to prevent re-occurrence

(e) Follow-up documentation on resident condition

(1) A minimum of daily for three days or until any injury is resolved

2. Skin breakdown or wound photography should not be conducted

3. Countersignature when indicated

D. Thinning the Resident Record

1. The resident record may require thinning on a regular basis

2. A secure location for all records is provided

3. When a record is thinned, the current record has a notation on the cover indicating that the record has been thinned, along with the most recent date of thinning

4. All resident assessments completed within the previous 15 months are maintained in the resident’s active record, after which point they may be stored in the records department in an easily retrievable location or format

5. Other documents that remain in the current resident record include:

a. Advance directive information

b. Admission data sheet

c. Emergency contact information

E. Record Retention

1. Resident records should be maintained for seven years beyond discharge of the resident, unless a different retention period is mandated by state/federal or fiscal regulations

2. Documentation of each resident’s name, Social Security number, date of birth, date of admission and discharge, and name and address of guardian, if any, are permanently maintained

F. Record Release

1. All records of residents are confidential

2. Records are stored in a safe and secure manner

3. Records are the property of the facility and cannot be reviewed by outside sources unless authorized by the resident or his/her legal representative in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines

4. A release of records consent form must be signed by the resident or legal representative before the records are released

5. Resident and/or legal representative has the right to review his/her record on request upon completion of the release of records consent form

a. Facility representative should be present at the time of any record review

G. Audit

1. Periodic audits should be conducted for completion and accuracy

2. Aggregate statistics and findings should be reported to the Quality Assurance/Risk Management (QA/RM) Committee

H. Destruction of Resident Records

1. In order to preserve the confidentiality of resident information, records are destroyed in a manner that preserves confidentiality, such as shredding

a. A shredder is used and documentation of destruction is maintained

b. A list of chart file numbers and resident identifiers are permanently maintained along with the date and certificate of destruction

# Elopement

I. **POLICY GUIDELINES**

The facility strives to promote resident safety and protect the rights and dignity of the residents.

The facility maintains a process to assess all residents for risk for elopement, implement prevention strategies for those identified as an elopement risk, institute measures for resident identification at the time of admission, and conduct a missing resident procedure.

II. **DEFINTIONS**

Elopement is the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter into harm’s way.

Wandering refers to a cognitively-impaired resident’s ability to move about inside the facility aimlessly and without an appreciation of personal safety needs and who may enter into a dangerous situation.

Elopers are differentiated from wanderers by their purposeful, overt, and often repeated attempts to leave the facility and premises. About 80 percent of elopements involve residents known to be chronic wanderers with prior elopements.

Note: Claims statistics show that nearly half of elopement cases and associated accidents occur within the first 48 hours of nursing home admission.

III. **PROCEDURAL COMPONENTS**

A. Assessment

1. An elopement risk assessment is completed on all residents on admission, quarterly, and upon change of condition. The initial resident assessment should be conducted within eight hours of admission

2. A facility-approved risk assessment tool (or scoring system) is utilized

a. The assessment is based on various risk factors that may precipitate an elopement event

b. The risk score includes a defined parameter which, when reached, indicates an increased risk and prompts prevention strategies, as described below

3. The risk assessment addresses the resident’s mobility and psychological, behavioral, physical, and cognitive functions. Specific risk factors include:

a. An involuntary admission

b. A history of wandering prior to admission or finding the resident “lost” in the facility after admission

c. Problems noted in the resident’s adjustment to the facility (such as stating a desire to go home, looking for children, attempting to attend functions that are based on a past schedule)

d. A change in the resident’s mental status

e. Interference with prevention strategies, including an expressed displeasure with a wander bracelet or an attempt to remove it

f. Behavior problems, including those where the resident is not easily redirected or managed when he or she is agitated or aggressive

g. Actual wandering behaviors, including:

i. Shadowing (following staff or another resident)

ii. Self-stimulatory (wandering due to boredom or lack of activity)

iii. Akathisia (motor restlessness characterized by pacing, standing and sitting, or rocking back and forth, which may be caused by psychotropic and antidepressant medications)

iv. Exit-seeking (resident is intent on leaving the unit or facility, looking for exits, and hovering at exits waiting for the opportunity to leave with someone or pushing on a door)

B. Prevention

1. Interventions that may be used for residents identified as high risk for elopement include:

a. Frequent monitoring of the resident’s whereabouts to assure he or she remains in the facility (e.g., every one-half hour check)

b. Promoting activities that are in full view of staff members

c. Alternative activities to maintain the interest level of the wanderer

d. Implementation of wander bracelet or other electronic alert systems

e. Transfer to a more suitable or more secured facility, if necessary

f. Notification of physician for changes in behavior, such as increasing insistence or attempts to leave

g. Environmental controls such as:

i. The physical plant is secured to minimize the risk of elopement through:

(a.) Functional alarm system for egresses and stairwells

(b.) Interior courtyards

(c.) Safety locks or keypad entry that restrict access to dangerous areas

(d.) Restricted window openings

(e.) Elevator controls

(f.) Fenced perimeters

(g.) Camouflaged doors and doorknobs

ii. Adaptation of the environment with way-finding cues and landmarks

(a.) Brightly lit, uncluttered paths with many rest areas (indoors/outdoors)

(b.) Decorations that provide positive distractions and also act as deterrents

2. Additional resident and family involvement and education

3. Verification of control systems

a. If an electronic surveillance system is in place, door alarms are added to the daily preventative checklist

b. Door alarm codes are changed routinely

c. Each resident alert device is checked daily and functioning documented on the Treatment Administration Record

d. A sign-in/out system is implemented, which requires responsible parties to sign the resident out when leaving and noting an expected return time

e. Creation of a lost person profile for each resident at risk

i. Two close-up photographs of each resident are taken on the day of admission

(a.) The photographs are for identification purposes only

(b.) One photograph is to be maintained in the resident’s Medical Record and the other in his or her Medication Administration Record

(c.) Written consent for photographs is obtained

(d.) Photographs are updated as required to reflect changes in a resident’s appearance

4. Prevention strategies are listed on each resident’s service plan

5. Periodic evaluation of the resident service plan and effectiveness of prevention strategies are conducted in accordance with facility policy

C. Intervention

1. Responding to an actual elopement

a. It is the responsibility of all staff, regardless of the department they work in, to respond to activated door alarms and to return residents to their units

b. Any resident who leaves his/her assigned unit unaccompanied should be approached according to accepted guidelines as follows:

i. Approach in a calm and reassuring manner

ii. Have one individual approach the resident. Discourage large numbers of staff around the resident

iii. Avoid arguing with the resident. DO NOT say “You can’t” or “You have to”

iv. Avoid touching the resident if possible

c. Restraints are not to be used as the primary solution; rather, diversionary activities should be encouraged to prevent reoccurrence

d. The family and physician are notified of the incident, and notification documented in the resident’s record

e. If the resident is placed on increased supervision, safety checks are documented in the resident record each shift for the duration of the increased supervision

2. When a resident is determined to be missing:

a. The time that the resident is/was determined missing is noted

b. The staff members assigned to the unit where the resident resides verify that the resident has not been signed out

c. The staff notify the Administrator that a resident is missing

d. Staff members, in accordance with the facility’s search team plan, conduct a thorough search to locate the resident. If the resident is not located, proceed with the following:

i. Staff members search the entire facility and grounds. Prior to beginning the search, the resident’s photograph is viewed by all staff involved in the search

(a.) All areas of the building, grounds, and neighboring streets are to be systematically searched when a resident is missing or has eloped

(b.) The Administrator assigns each staff member a sector when searching for a resident to minimize overlapping or overlooking of an area

(c.) When conducting a search, it is important to look under beds and furniture, in closets, under desks, and behind doors. When conducting a search in storage rooms, look behind boxes, in boxes, and on shelves. A resident who has eloped may be frightened and may be hiding. Being thorough in the search is of extreme importance

(d.) When finished searching a sector, report back to Administrator for further instructions

ii. If the resident has not been found after a period of ten minutes, the Administrator or designee calls the police and reports the resident missing

iii. When the police arrive the Administrator provides the officer with a picture and other pertinent information such as:

(a.) What the resident was wearing

(b.) How the resident was ambulating, i.e., with a cane, walker, etc.

(c.) The resident’s cognitive status, i.e., confused, alert

(d.) Information as to where resident may be going, if known

(e.) A resident profile, which includes the resident’s previous address and family’s address, is available in the resident’s chart for this purpose

iv. The Administrator notifies the family and attending physician if the resident is not found in the facility or on the grounds

3. When a resident has been found:

a. The Administrator notifies all staff that the resident has been found

b. The resident is examined for injuries

c. The attending physician is notified of the resident’s status

d. The resident’s responsible person is contacted and informed of his/her status

e. The resident service plan is updated

i. Consider implementing additional measures such as the addition of a wander bracelet if not in current use and 15-minute safety checks

ii. If the resident is placed on increased supervision, safety checks are documented in the resident record each shift for the duration of the increased supervision

f. Complete a Missing Resident form and require that all staff present involved sign the form. Forward to the Administrator/Risk Management Coordinator

g. Report the incident to the state authorities as required

D. Documentation

1. Document in the resident record all elopement attempts and events, including objective and factual statements regarding:

a. Circumstances and precipitating factors

b. Interventions utilized to return the resident to the unit

c. The resident’s response to the interventions

d. Results of reassessment upon the resident’s return and the condition of the resident

e. Care rendered

f. Notification of police, physician, and family

g. Physician orders following notification

h. Additional prevention strategies implemented

2. Complete an Incident Report and forward the report to the Administrator/Risk Management Coordinator

3. Do not record the Incident Report in the resident’s record

4. Document resident/family education about additional prevention strategies

E. Elopement Drills

1. Conduct elopement drills on a regular basis, such as quarterly (at a minimum semi-annually)

2. Utilize results for staff education

3. Documentation of elopement drills (and actual elopements) may be noted on the forms attached to this procedure (see attachment 1, 2, and 3)

F. Education

1. Family education should be conducted on admission or at any time the resident is identified as a high risk for elopement

2. Staff training at orientation and during annual in-services is provided, including the risk factors for elopement

3. Elopement prevention strategies are reviewed with all staff, including the method and frequency of assessing prevention effectiveness

G. Risk Management Review

1. Based on compiled incident report data, a periodic trend summary should be provided and discussed at the Quality Management/Risk Management Committee meetings

2. Data should include:

a. The number of residents identified as at risk for elopement

b. The number of elopement attempts

c. The number of events

d. Outcome severity

**Elopement**

Attachment 1

Elopement Drill or Post-Elopement Follow-up Report

Elopement Drill: Actual Elopement: Date:

Missing Resident Name:

Staff Person on Duty:

Time Started: Time all Clear: Total Time:

Supervisor or RSC Notified: Time:

Administrator Notified: Time:

Police Notified: Time:

Family Notified: Time:

Resident found: If yes, time:

Number of Staff in Participation:

Staff Performance Results: Excellent Good Fair Poor

Staff did \_\_\_\_\_/ did not \_\_\_\_\_\_ respond in accordance with established procedures.

Comments:

Conductor(s):

Elopement

Attachment 2

Resident Elopement Search Drill

Staff Sign-In Log

Signature Print Name Department

Elopement

Attachment 3

Elopement Drill or Post-Elopement Checklist

Date: Time:

Resident Name: Room #

Resident Missing Time: a.m. p.m.

Resident Found Time: a.m. p.m.

Circle the following Yes or No

1. Did staff verify resident was not signed out? Y N

2. Did staff check unit? Y N

3. Did staff notify supervisor? Y N

4. Was the Administrator notified? Y N

5. Was a full search of the facility and grounds implemented? Y N

6. Were the police notified? Y N

7. Was search called off when resident was located? Y N

8. Was resident examined when located? Y N

9. Was resident physician notified when resident was discovered missing? Y N

 Found? Y N

10. Was family and/or responsible party notified when resident

was discovered missing? Y N

Found? Y N

11. Was Incident/event report completed? Y N

12. Was notation included in the Resident Record? Y N

13. Did the alarm system function (if an egress system was in place)? Y N

Name of person completing report

# Falls Prevention

I. **POLICY GUIDELINES**

The facility strives to promote resident safety through the fall management program focusing on assessment and education, medication management, environmental modifications, and exercise to maximize effectiveness of the program, yet allow for resident autonomy and choice

The facility assesses each resident for his or her risk for falls, designs a service plan, and implements procedures to minimize falls and/or injury.

II. **DEFINITIONS**

A fall is an unintended landing on a floor or lower position not caused by a sudden major health event such as a stroke.

A fall can be inferred if the fall is witnessed, if the resident is found on the floor, or if the resident states that a fall has occurred.

Note: The Quality Management/Risk Management Committee needs to define what constitutes a fall

Intrinsic or internal factors: relates to the person’s physiological condition due to aging, and/or chronic disease

Extrinsic or external factors: relates to the environment, includes visitor and family interactions and staff performance and conduct

Anticipated: Intrinsic or extrinsic risk factors that can be addressed before a person falls

Unanticipated: Intrinsic or extrinsic factors that are addressed after a fall occurs

Fall Mitigation Strategies: Activities to lessen, diminish, or minimize a potential fall from occurring. Used in place of the words “fall prevention” since a facility cannot prevent all resident falls from happening

III. **PROCEDURAL COMPONENTS**

A. Assessment

1. A fall risk assessment is completed on each resident on admission, periodically thereafter, upon change of condition, and immediately following a fall

2. A facility-approved scoring system is used and is based on various risk factors that may precipitate a greater likelihood of falling. The calculated risk score includes a defined parameter which, when reached, indicates an increased risk and prompts mitigation strategies, as described below

a. Examples of risk assessment tools: Tinetti Fall Risk Index, Downton Fall Risk Index, Nyberg Fall Risk Index, Charlson Comorbidity Score, Confusion Assessment Method, and Briggs Fall Risk Assessment

3. A resident identified as high risk for falls at any time during his or her stay remains on the Fall Mitigation Protocol for the duration of his or her stay unless their risk assessment score declines such that the risk no longer meets the high risk criteria

4. Any resident experiencing an accidental fall remains on the Fall Mitigation Protocol for the remainder of his or her stay

5. Risk factors are divided into intrinsic and extrinsic factors:

a. Intrinsic Factors include physiologic factors such as:

i. Failing eyesight and hearing

ii. Slower reflexes

iii. Sensory deficits (vision, somatosensory, or vestibular changes)

iv. Unstable gait, decreased balance, or mobility deficit (e.g., poor sitting balance)

v. Confusion and inability to communicate needs

vi. Cognitive impairment

vii. General weakness

viii. Joint pain

ix. Physical disability resulting from a medical condition (Parkinson’s, cardiovascular accident (CVA), diabetic neuropathy, seizures, orthostatic hypotension, cardiac arrhythmias, transient ischemic attacks (TIAs), Alzheimer’s disease, other dementia, spinal cord syndromes, etc.)

x. Depression

xi. Alcohol use

xii. Incontinence

xiii. Dehydration

xiv. Hypoglycemia

xv. Recent history of falls (i.e., within the past two months)

xvi. Initiation of new medications, especially benzodiazepines and antipsychotics

xvii. Medications that are associated with a higher risk for falling, including:

(a.) Psychotropics

(b.) Analgesics

(c.) Sedatives

(d.) Polypharmacy

(e.) Tricyclic antidepressants

(f.) Diuretics

(g.) Antihypertensives

(h.) Anticonvulsants

(i.) Topical eye medications

(j.) Narcotics and/or daytime medications that may cause drowsiness or dizziness

(k.) Drugs that cause delayed reaction time, sedation, decreased benzodiazepines, antihistamines, antihypertensive drugs, nitrates, levodopa, metoclopramide)

(l.) Some cardiac drugs

(m.) Changes in medication management

b. Environmental Factors (or extrinsic risks) may include:

i. Slippery or wet floors

ii. Loose carpets or rugs

iii. Poor lighting

iv. Non-use of handrails and grab bars

v. Objects that are out of reach

vi. Clutter

vii. Equipment failure (wheel chair brakes, assistive devices)

viii. Improper footwear

ix. Improper bed height

B. Fall Mitigation Strategies

1. General safety precautions and interventions should be used for all residents and include:

a. Orienting resident to room and surroundings at the time of admission

b. Maintaining bed in low position

c. Maintaining strong activity program

d. Exercise program

e. Providing call system that is within easy reach and secured

f. Use of alert wristband or necklace

g. Promoting resident use of non-slip footwear/proper shoes when ambulating

h. Encouraging residents to use canes and walkers as instructed

i. Minimizing medications with sedative side effects (and not using sedatives as a fall-mitigation strategy)

j. Maintaining adequate hydration

k. Encouraging the use of eye glasses to decrease visual impairment

l. Locking brakes on beds, gurneys, or wheelchairs that are mobile

m. Providing adequate light in all rooms and common areas

n. Using nightlights

o. Keeping the resident’s environment free of obstacles

p. Providing resident and/or family with fall mitigation education

q. For those with cardiovascular instability, encouraging the resident to rise slowly from a sitting position

r. Installation and proper maintenance of handrails

s. Installation of grab bars in bathrooms and use of elevated toilet seats when needed

t. Prohibiting use of throw rugs

2. High risk to fall mitigation strategies

a. Additional interventions that may be used on residents identified as fall risk include:

i. Implementing facility defined identifiers (such as Falling Star, Falling Leaf) to promote communication of high-risk residents to all staff

ii. Moving the resident to a room closer to a staff station

iii. Conducting resident rounds more frequently

iv. Considering physical therapy and balance training for residents who have gait instability, functional limitations, or a fall within the prior 30 days (with physician’s order)

v. Evaluate resident for placement to a higher level of care

b. Additional safety precautions and interventions for Alzheimer’s/dementia units may include:

i. Encouraging the resident to ask for help when rising

ii. Emphasizing to family members that they should call the staff instead of trying to help an unsteady resident themselves

iii. Verifying that frequently used resident items are within reach

iv. Placing a commode, urinal, and/or bedpan near the bedside

v. Offering toileting to the resident every two hours while awake and every four hours during the night (less than four hours of rest at night increases the risk of acute confusion due to sleep deprivation)

vi. Conducting resident rounds more frequently, minimally every hour and PRN (pro re nata or as needed)

vii. Utilizing chair and bed alarms for residents with impulsive, unsafe behaviors

viii. If alternatives such as wheelchair modifications, napping and toileting schedules, exercise programs, physical and occupational therapy, and use of sitters are unsuccessful and restraints are absolutely essential to provide safety, obtain a physician consultation for a restraint order in accordance with the Restraint Policy

ix. If resident restraints are in use but have been removed while the family is visiting, educate family regarding the importance of notifying staff when leaving

3. Mitigation strategies to be implemented are listed on the resident service plan. Periodic evaluations of the service plan and effectiveness of mitigation strategies are conducted in accordance with facility policy

4. Environmental rounds are conducted to minimize accidents by providing an environment free from hazards. Areas of review include:

a. Restraints (if applicable)

b. Equipment

c. Bathing facilities

d. Flooring and floor surface integrity

e. Environmental hazards (clutter, spills on floor, location of cords and wires, etc.)

f. Water temperature

g. Safe smoking practices

C. Intervention

1. If a resident falls, the following steps should be taken:

a. Assess the resident post-fall including:

i. Vital signs (pulse, temperature, respirations, and blood pressure)

ii. Inspection for bruises, swelling, and lacerations

iii. Level of consciousness

iv. Presence of pain

v. Presence of other injuries

b. Notify physician in accordance with facility guidelines

c. Implement physician orders

d. Notify the resident’s family

e. Monitor the resident’s condition for 72 hours and until any injury or complaints are resolved. Document findings with each assessment

f. Implement High Risk to Fall Mitigation Strategies

g. Update the resident’s service plan

h. For an injured resident, implement the facility’s policy on medical emergency management

i. Obtain assistance, if necessary, to help lift uninjured residents (e.g., “buddy system” or lift team)

2. In the event that a resident begins to fall in the presence of staff, the following steps should be taken:

a. Do not try to prevent the fall. Guide the resident easily and safely to the floor, bending your knees, not using your back

b. Stay close to the resident

c. Assess resident, as described above

d. For an injured resident, implement the facility’s policy on medical emergency management

e. Document the fall in accordance with the documentation section

D. Documentation

1. Document all falls, including objective and factual statements regarding:

a. Circumstances at time of fall

i. For an unwitnessed fall, the record should reflect the resident’s statement with quotes

ii. For an unwitnessed fall, notes should indicate the resident’s condition and location upon staff arrival

iii. For a witnessed fall, notes should indicate the resident’s activity prior to the fall and other precipitating factors

b. Results of assessment and condition of the resident

c. Care rendered

d. Notification of physician, family, and emergency room transport company if utilized

e. Physician orders

f. Mitigation strategies implemented to minimize reoccurrence

2. If the resident is injured, also notify the director or supervisor

a. Complete an Incident Report. Forward the report to the Administrator/Risk Management Coordinator. Do not record or maintain the Incident Report in the resident’s record

3. Document resident/family education about activities to minimize falls whenever it is conducted

E. Education

1. Staff training at orientation and during annual in-services is provided, reviewing both intrinsic and extrinsic factors that contribute to increased risk of falls

2. Fall mitigation strategies are reviewed with all staff, including the method and frequency of assessing effectiveness

3. Upon admission and/or when a resident is identified as high risk following admission, family and/or resident education should be conducted. Educational items should include:

a. Use of the facility’s call system

b. When to call staff for assistance

c. Safety measures, i.e., use of non-slip footwear, not using the bedside table for support

d. Use of equipment, i.e., handrails

e. Instructions regarding sitting or standing slowly to allow time for resident to gain equilibrium

F. Risk Management Review

1. The Quality Management/Risk Management Committee evaluates fall data to measure and analyze falls and reviews potential contributing factors and follow-up actions

2. Based on compiled incident report data, a periodic trend summary should be provided and discussed at Quality Management/Risk Management Committee meetings

3. Data should include:

a. Number of falls per month

b. Number of falls resulting in significant injury

c. Number of repeat falls

d. Fall index or rate, which is falls per resident days (number of falls x 1,000 divided by number of resident days)

e. Comparison of fall rate with established benchmark

# Hiring / Screening

I. **PURPOSE**

The facility strives to promote resident safety and to improve the quality of life for its residents.

The facility selects a competent and knowledgeable workforce, in part, through screening of its prospective employees.

The facility hires staff in accordance with the Equal Employment Opportunity program and offers equal opportunity to its applicants without regard to race, color, religion, national origin, disability, veteran status, sexual orientation, sex, or age (except where sex or age is a bona fide occupational qualification).

II. **PROCEDURAL COMPONENTS**

The facility’s job descriptions define the required experience, education, licensure, certifications, skills, and physical requirements for each position. Employees are hired based on their ability to perform in accordance with their designated job description

Employees are also hired based on information and measures that address basic characteristics, such as honesty, reliability, responsibility, freedom from criminal activity, and commitment

A. Application

1. Prospective employees are required to complete an application for employment. The application includes:

a. Vital information such as name, address, and phone number

b. Prior education, including locations and dates of graduation

c. Licensure, including license numbers and dates of issue

d. Certifications

e. Prior work experience (five years minimum)

f. Two personal references

g. Emergency contact information

2. Copies of licenses and certifications are made and retained in the prospective employee’s file

B. Interview

1. An interview is conducted by the Human Resources Director as well as the department head who supervises the position for which the applicant is applying. The Administrator interviews all candidates applying for management positions

2. Interview questions should be focused on obtaining information necessary to assess the skills and qualifications of the applicant. Interviewers must avoid questions that request information that is discriminatory or may have a discriminatory impact

3. The essential functions and other requirements for the position should be described to candidates at the start of the interview

4. Interview questions may include:

a. Applicants should be asked if they can perform the functions as described and as defined in the job description

b. Interviewer may ask questions related to the candidate’s training and experience and his or her ability to perform the essential functions and skills of the job

 c. Interviewer may request:

i. Information on the candidate’s prior job duties and their relevance to the position for which he or she has applied

ii. Reasons for leaving prior positions

iii. Additional information needed to clarify the information provided on the application or resume

iv. Documentation of any required licenses

v. Eligibility for employment in the United States (but not country of origin)

vi. The candidate should be given the opportunity to provide additional information or to ask questions about the position available

C. Employment Verification

1. Past employment verification is conducted for prospective employees. The contents of this verification include:

a. Employer’s name

b. Applicant’s title

c. Dates of employment

d. Candidate’s reasons for leaving

e. Salary history, as applicable

f. Whether the candidate is eligible for rehire

g. Statements about the candidate’s attendance record

h. Job performance specific to the position for which the candidate is applying, such as work habits, attendance, professionalism, work ethic, and adaptability

2. In all cases where verification is made—whether the applicant is subsequently hired or not—the results are recorded on the facility’s employment verification form

D. Professional License Verification and Certified Nursing Assistant State Registry Check

1. All professional licenses are verified. This includes:

a. The validity of the applicant’s professional licenses

b. Date of issue

c. Renewal and expiration dates

d. Current status

e. Any disciplinary action

2. All nurse aide registries are checked for the following:

a. Verification of certification

b. Date of certification, renewal and expiration

c. Any findings of abuse, neglect or misappropriation of funds

3. For staff who are relocating, licensure or registry/certification is verified in each state in which the person worked for at least the prior five years

E. Personal References

1. The facility contacts the prospective employee’s listed references

a. References are asked:

i. Length of time they have known applicant

ii. Relationship to applicant

iii. Whether they recommend applicant for hire

2. The person conducting the reference check documents the discussion on the facility’s standardized reference contact form

F. Criminal Background Check

1. The criminal background check is designed to identify felony and misdemeanor convictions based on applicable federal and state law. These searches are utilized to protect the facility from problems such as workplace violence, resident abuse, and employee theft

a. All employees are required to complete a statement that lists any prior criminal convictions, as well as authorization to conduct a criminal background assessment

b. Background checks are conducted using databases that have current information (that is, stored database searches are not conducted, since they may be outdated by as much as 90 days)

c. A signed statement authorizing the facility to conduct a criminal background check is obtained during the initial application process

d. Fingerprinting is required in cases where a criminal background assessment has never been conducted. Fingerprints are obtained by the facility’s contracted service

e. A job applicant is not automatically disqualified because of a police record. In making this determination, the Human Resources staff, in conjunction with the Administrator, may consider whether the person’s background is inconsistent with safe, honest, or effective performance of the duties required. This may take into consideration:

i. Type of charge

ii. Whether charge resulted in conviction

iii. Length of the record

iv. How long ago the charges occurred

v. The applicant’s age at the time

vi. His/her subsequent behavior

2. Criminal background checks are completed on licensed nursing staff even though license verification is conducted, since license verification indicating absence of disciplinary action may rely on self-reported criminal activity

G. State Sex Offender Registry

1. The national sex offender Web site (http://www.nsopr.gov) is to be checked as a preliminary screen prior to receipt of background check information. A state specific Web site may be used; however, for potential employees previously employed out of state the sex offender registry for that state should also be checked

H. Health Screening

1. After an offer of employment, employees are required to undergo a physical examination that screens for their ability to perform the job duties as defined in the job description. At this time, prospective employees are asked if they require any specific physical accommodations to complete their assigned duties

2. This process is designed to validate that the individual has no health limitation that could endanger the health of residents, other employees, his/her own health, or create a liability to the facility

3. The health evaluation includes:

a. Review of health history, including determining immunization status and obtaining history of any condition that might predispose the employee from acquiring or transmitting communicable diseases. This information also assists in decisions about immunizations or post exposure management

b. A physical examination to screen personnel for conditions that might increase the risk of acquiring or transmitting work-related diseases and/or injuries. This serves as a baseline for determining whether future diseases or injuries are work related

c. Screening for vaccine-preventable diseases, such as hepatitis B

d. Tuberculosis screening

e. Decisions regarding vaccines that are included in the immunization program, such as the likelihood of personnel exposure to vaccine-preventable diseases, the consequence of not vaccinating personnel and the nature of employment, including contact with residents and their environment

f. Whether there are any physical conditions that may limit the employee’s ability to perform the assigned tasks

g. A contact number in the event of an emergency

I. Drug and Alcohol Test Results

1. In accordance with the facility’s policy on a drug-free workplace, applicants are required to submit to substance abuse screening as a condition of employment. A final offer of employment is contingent upon successful completion of this screening. Processing of the hire may not take place until the substance abuse screening has been completed with satisfactory results

2. Applicants who fail or refuse the pre-employment substance abuse screening are not hired. They are not permitted to reapply for employment for any position for one year from the date of the substance abuse screening. An unsatisfactory test result (positive) rescinds any conditional offer of employment

3. The facility’s designated vendor conducts the substance abuse screening. Applicants must sign authorization for testing and release of results to the facility

J. Motor Vehicle History Report/Driving Records

1. If the applicant’s job description requires that he or she drives either a company car or his/her own vehicle during work time, the applicant's driving record is obtained to identify:

a. Suspended licenses

b. Failures to appear in court

c. Arrest warrants

d. Drug and alcohol related driving offenses, such as driving under the influence and possession of drugs

# Incident Reporting

I. **POLICY GUIDELINES**

All incidents or adverse events occurring in the facility or on facility property must be reported immediately.

All incidents/adverse events that occur in the facility are investigated to assure appropriate actions are taken to prevent reoccurrence and/or reduce risk of injury.

An incident report is to be completed when there is any unexpected event or near-miss involving a resident or a visitor or when a situation occurs that varies from established policy or procedure and may lead to an undesired effect.

Incident reports are confidential documents that are transmitted to legal counsel and the insurance carrier/third party administrator (TPA) through the Risk Management process.

II. **DEFINITIONS**

Incident: An unusual or unexpected event that is not consistent with the routine operation of the facility or routine care of the resident. Synonym: occurrence.

Incident report: The documentation for any unusual problem, incident, or other situation that is likely to lead to undesirable effects or that varies from established policies and procedures or practices. Synonym: occurrence report.

Adverse event: An untoward, undesirable, and usually unanticipated event, either resulting from omission or commission, which does not achieve its intended outcome. The term adverse event is also used to describe a negative or bad result stemming from a diagnostic test, medical treatment, or surgical intervention.

Adverse medication event: An unintended outcome as the result of one or more processes in medication management: prescribing, dispensing, and administration which may or may not have caused harm.

Near miss: Potential or no harm errors (sometimes referred to as close calls or good catches). Tracking near misses may point the way to the identification of specific potential system issues that if left unresolved may eventually result in an actual error with resident harm. Near misses are not state-reportable events.

III. **PROCEDURAL COMPONENTS**

A. Purpose of the Incident Report Form

1. The primary objective and intent of the incident report form is to:

a. Identify opportunities to improve resident safety

b. Identify, aggregate, and trend incidents to improve quality of care

c. Record adverse events, incidents, or circumstances involving residents or visitors that have potential liability for the organization

d. Promote timely and accurate flow of information to risk management, administration, legal counsel, insurance agent, and insurer/claims administrator

e. Promote compliance with the requirements of federal and state law

B. Use of the Incident Report Form

1. An incident report should be completed in the following circumstances:

a. An unexpected event or near-miss involving a resident or a visitor

b. An unusual event which results in personal injury or that is inconsistent with normal resident care

c. A significant violation of established policy and procedure

d. A disturbance that may (or does) disrupt facility functions or that may affect the standing of the facility in the community

e. A willfully unsafe act that threatens the safety of residents, staff, or visitors including acts of hostility or violence

f. A resident, visitor, or family member requests compensation or voices credible threat of litigation

g. A crime, substance abuse, or report of inappropriate sexual activity

h. When a medication error occurs

C. Completion of the Incident Report Form

1. An incident report is completed on the shift that the incident occurred. Incidents are to be immediately reported by the person or persons most directly involved or by those who observed, have direct knowledge of, or discovered the event or the near-miss situation. More than one individual may complete an incident report concerning the same occurrence

2. Writing on the incident report form must be legible, written in ink, and complete and contain observed facts, not opinions or judgments

3. Information noted on the form includes:

a. Date and time of the incident

b. Place where the incident occurred

c. Name of the resident, visitor, or staff member

i. For visitor-related events, include visitor contact information such as address and phone number and the name and location of the resident being visited

d. Nature of the event (e.g., bruise, fall, needle stick, etc.)

e. Circumstances surrounding the incident or adverse event, if known

f. Names of any witnesses

g. Date and time the physician and legal representative or next of kin were notified

h. Physical assessment findings, including vital signs

i. Actions taken to address any injury (note refusal of treatment)

j. Disposition of the injured person (i.e., transferred to hospital, put to bed, etc.)

k. Signature and title of person completing report

D. Submission of Incident Reports

1. The completed incident report form is to be submitted to the employee’s immediate supervisor prior to the end of the shift. The completed form is submitted to the Administrator no later than 24 hours after the incident

2. For a major event, including a catastrophic event or death, the event is reported verbally immediately to the Administrator in addition to completing the incident report form

3. The Administrator determines additional notifications, which may include regulatory agencies and the insurance agent, insurer, or claims administrator

E. Event and Resident Management

1. Any employee witnessing an incident involving a resident, employee, or visitor, regardless of how minor an incident may be, must report such occurrence to his or her immediate supervisor as soon as practical. Do not leave an injured person unattended unless it is absolutely necessary to summon assistance

2. Administrator or designee responsibilities include:

a. Assess the victim for injury

b. Inform the attending physician of the incident and document notification and any receipt of orders for treatment in the resident’s record

c. Notify the resident’s responsible party of the incident and status of the resident and document notification in the resident record

d. Conduct and document the incident, head-to-toe assessment of resident or result of evaluation of injuries, first aid and interventions, and ongoing monitoring of resident status in the resident record

e. If necessary, transfer the injured person to the hospital

F. Documentation in Resident Record

1. An event and its effect on the resident must be documented in the resident’s record. Documentation should be a record of the event as it impacts the resident

2. This should include:

a. Factual statement of the event

b. Resident assessment findings

c. Condition of the resident

d. Immediate actions taken, such as timely notification of the physician and first aid implemented

e. Documentation of the resident condition on each shift for 72 hours post incident

f. Discussion with the resident

g. Resident’s comments should be recorded using quotes whenever possible

h. Blame, speculation, personal commentary, opinions, or comments regarding causation or potential liability should not be recorded

G. Incident Investigation

1. An investigation is completed within 24 hours of each incident by designated supervisory staff, utilizing a facility-approved format

2. The goal of the investigation is to identify the underlying causes, referred to as root cause analysis. Understanding the cause of an event assists in making necessary system changes and/or promote actions needed to address human error

3. Incident investigation includes:

a. Evaluation of the environment

b. Review of pertinent record

c. Review of the event follow-up including review and modification of the resident service plan, staff in-servicing, reporting to regulatory agency if required, and counseling

d. Review of related policies and procedures for compliance

e. Interviewing of residents involved and witnesses with findings documented by the interviewer

i. Interview of witnesses is completed shortly after the event so the information may be clearly recalled

ii. The interviewing technique should include the basic questions of who, what, when, where, and how. The interviewer needs to write the information provided by the witness utilizing facility-approved forms/formats. The witness should then review what is written and sign the form. Written witness statements are NOT obtained unless directed by legal counsel

iii. The general facts of the event, information provided by other witnesses, as well as strategies for intervention being considered should not be discussed with the interviewee at the time of the interview

4. In the event that equipment failure is believed to be the cause of an injury, remove the equipment immediately from service and notify the vendor

a. Tag the equipment so that it is not placed into use until released by the Administrator or legal counsel

b. The vendor should not be allowed to evaluate and/or remove the equipment from the facility. If at all possible, obtain a third-party evaluation of the equipment for the cause of failure

c. Equipment failure causing injury may require completion of a report to a regulatory agency per state and/or federal requirements (Med Watch: www.fda.gov/medwatch/)

5. If there is concern of a claim or litigation relating to an event, the resident’s record should be secured in a locked area where access is limited

6. All investigative information such as investigative forms, witness interviews, related information reported to the state or other agency, and other pertinent information should be maintained in a separate, locked file. Investigative information should not be secured to the incident report

7. Once the cause of an event is identified, interventions are taken to prevent reoccurrence. These actions are outlined in a corrective action plan and monitored for compliance. Actions specific to the resident’s care are documented on the resident’s service plan

H. Confidentiality of Incident Reports

1. Information contained on the incident report is deemed to be legally-privileged communication and is confidential

2. The incident report is an internal document and is marked by administration as “Confidential, Prepared for Quality Assurance and Peer Review Purposes”

3. The incident report should not be photocopied, duplicated, or faxed

4. The incident report is not a part of the resident’s record (unless state regulations dictate otherwise)

5. No mention of an incident report is to be documented in the resident’s record

6. Incident reports will be secured in a locked cabinet until forwarded to legal counsel

I. Risk/Quality Management

1. All incident data shall be compiled into comparative reports for review by the facility’s Quality Assessment/Risk Management (QA/RM) Committee

2. The QA/RM Committee shall review incident tracking and trending on an ongoing basis to assure systems are in place to prevent or minimize reoccurrences and to verify that appropriate follow-up action has been taken. This includes discussion of facility communication with the family and satisfaction of the family’s expectations related to follow-up

3. The QA/RM Committee shall monitor compliance with corrective action plans developed in response to events

# Loss Prevention

I. **POLICY GUIDELINES**

In order to provide a safe environment, the facility undertakes efforts to secure resident belongings.

The facility has established processes to reduce incidents of theft and loss.

The facility complies with state and federal regulations to safeguard a resident’s belongings and to prevent theft and loss.

II. **PROCEDURAL COMPONENTS**

A. Provision of Theft and Loss Policies

1. The facility maintains a theft and loss policy that complies with the regulations of the state

2. This theft and loss policy is provided by the facility to residents and their responsible parties at the time of admission and is available upon request to all of the facility’s prospective residents and their responsible parties

3. The facility posts in a prominent public area a copy of the residents’ rights, including the facility’s theft and loss policy

B. Inventory of Belongings

1. A written personal property inventory for each resident is taken upon admission and updated and retained during the resident’s stay

a. A copy of the written inventory is provided to the resident or the person acting on the resident’s behalf

b. Subsequent items brought into or removed from the facility should be added to or deleted from the personal property inventory by the facility at the written request of the resident, the resident’s family, a responsible party, or a person acting on behalf of a resident

c. The facility has established a method of marking, to the extent feasible, personal property items for identification purposes upon admission and as added to the property inventory list, including engraving of dentures and tagging of other prosthetic devices

2. The resident and family/responsible party is informed that the facility is not liable for items that have not been requested to be included in the inventory or for items that have been deleted from the inventory

3. A copy of a current inventory is made available upon request to the resident, responsible party, or other authorized representative

4. The resident, resident’s family, or responsible party may list those items that are not subject to addition or deletion from the inventory, such as personal clothing or laundry, which are subject to frequent removal from the facility

C. Personal Funds

1. The facility maintains a secured area that is available for safekeeping of residents’ property upon the request of the resident or the responsible party. This may include a lock for the resident’s bedside drawer or cabinet upon request of, and at the expense of, the resident or authorized representative, or the resident’s family. The facility Administrator may have access to the locked areas upon request

2. All transactions concerning the resident’s personal funds are documented in the resident’s financial record in accordance with state regulations

3. An ombudsman is involved, per state regulations, for management of the resident’s personal funds

4. The ombudsman may submit written comments pertaining to transactions into the resident’s financial record

D. Event Investigation

1. Lost and missing property incidents are documented in the resident’s record

2. The Administrator or his/her designee investigates any theft or loss immediately. The investigation should include:

a. The reported loss/theft

b. Interview with staff who were present or who have knowledge of the event

c. Interview with the resident and/or responsible parties

d. Interview with any other knowledgeable parties

e. Itemized list of missing items

f. Reporting of the event in accordance with state regulations

E. Reporting of Theft Loss to Regulatory Agencies and Involvement of the Ombudsman

1. The facility reports all theft and loss events to the State Department of Health (or other designated regulatory agencies) in accordance with state regulations

2. The office of the state long term care ombudsman is notified as soon as the incident is reported or suspected

3. The facility maintains a log of all thefts and losses and makes the log available to regulating agencies such as the State Department of Health Services, the county health department, law enforcement agencies, and the office of the state long term care ombudsman

4. The documentation log should include:

a. A description of the article

b. The estimated value

c. The date and time the theft or loss was discovered

d. If determinable, the date and time the loss or theft occurred

e. Action taken by the facility

5. Reports are made to the local law enforcement agency within the required time frame and for the value as mandated by state regulations

6. Copies of reports for the preceding 12 months are made available to the State Department of Health Services and law enforcement agencies

F. Discharge

1. Upon discharge, an inventory and surrender of the resident’s personal effects and valuables is made to the resident or authorized representative in exchange for a signed receipt

2. The inventory and surrender of personal effects and valuables following the death of a resident is made to the authorized representative in exchange for a signed receipt.

3. Immediate notice to the public administrator of the county upon the death of a resident without known next of kin is made in accordance with state regulations

G. Evaluation of Effectiveness

1. Evaluation and documentation is made, at least semiannually (or as required by the regulations), of the facility’s efforts to control theft and loss, including review of theft and loss documentation and investigative procedures and results of the investigation by the Administrator and, when feasible, the Resident Council

H. Employee Orientation and Education

1. Employees are oriented to the facility’s Theft and Loss Prevention and Management policies and procedures at the time of hire and annually including:

a. The state/federal regulations regarding resident theft and loss prevention

b. Specific strategies that are in place to protect the residents’ belongings, property, and funds

c. The process to report a theft or the suspicion of theft or of a loss

d. The facility’s disciplinary process for responding to theft and loss

e. Employees sign proof of receipt regarding:

i. The facility’s theft and loss prevention programs

ii. Agreement to comply with program

iii. Acknowledgment of disciplinary actions and termination policy for violations

iv. Agreement to report any alleged or suspected incident

# Maintenance / Plant Services

I. **POLICY GUIDELINES**

Any machine part, function, or process that may cause injury is to be safeguarded. When the operation of a machine or accidental contact with it can injure the operator or others in the vicinity, the hazards are controlled or eliminated.

Equipment is isolated from all potentially hazardous energy and locked out or tagged out before employees perform any servicing or maintenance where the unexpected start-up or release of stored energy could cause injury.

In compliance with state and federal regulations, safety measures have been established to isolate energy (both stored and potential) prior to equipment repair, adjustment, or removal. This includes electrical, chemical, thermal, hydraulic, pneumatic, and gravitational energy.

II. **DEFINITIONS**

Lockout: Lockout consists of applying a lock on the energy isolation device in such a way that it cannot be utilized or energized.

Tagout: Some machinery cannot be locked out. When this occurs, a special tag must be applied to provide a warning about danger. In addition, when equipment is locked out, a tag will be applied that contains pertinent information as defined below.

Dangerous moving parts fall into three basic areas requiring safeguarding:

The point of operation: That point where work is performed on the material, such as cutting. Examples: mixers, slicers, garbage disposals, and bench grinders.

Power transmission: All components of the mechanical system that transmit energy to the part of the machine performing the work. These components include flywheels, pulleys, belts, connecting rods, couplings, cams, spindles, chains, cranks, and gears. Examples: dryer belts, compressor belts, generator couplings.

Other moving parts: All parts of the machine that move while the machine is working. These include reciprocating, rotating, and transverse moving parts, as well as feed mechanisms and auxiliary parts of the machine.

III. **PROCEDURAL COMPONENTS**

A. No work on energized circuits is permitted

B. Before shutdown, the person authorized to perform lockouts needs to know the type, magnitude, and hazards of the energy being controlled

C. All potentially affected employees are instructed by the person performing the lockout that a lockout/tagout system is going to be utilized and the reasons for the lockout/tagout

D. Stop the machinery/equipment by the usual method (i.e., turn off the switch, unplug the equipment, etc.)

1. Operate the switch, valve, or other energy isolation device so that the equipment is isolated from any energy source. Any stored or resident energy such as springs, elevated machine members, rotating flywheels, hydraulic systems, and air, gas, steam, or water pressure must be dissipated or restrained after the shutdown

E. Once the machinery/equipment is turned off, the main power switch and circuits are then turned off

F. A lockout device is placed on the switch(es)

1. Locks may be keyed or combination but are of the same size, shape, and color

2. The person installing the lockout device places his or her name on the lock

3. If more than one individual is required to lockout and tagout the equipment, each places his/her own assigned device on the energy isolation device

4. If shift or personnel changes occur, a system is established so that authorized employees may exchange their assigned locks/tags. Authorized personnel assuming control of lockout of equipment are fully briefed on the scope and stage of work by those being relieved

G. With no one near the equipment, the employee authorized to do the repair attempts to start the machine to determine if proper shut down has occurred. After ensuring that no one is exposed, verify the disconnection of the energy source by operating the push button or other normal operation controls to make certain the equipment will not operate. After the test, return the operating controls to “neutral,” “safe,” or “off” so that the equipment is ready to be locked out

H. Some machinery cannot be locked out. When this occurs, the following tagout procedures are implemented:

1. A special tag is used that meets the following standard

a. The print and format of each tag is the same throughout the facility

b. The tag is easy to read and understand, even if used in areas that are dirty, corrosive, or damp

c. Tags are durable enough so they cannot be removed accidentally

d. The tag includes the date and time that the work is being performed

e. The tag includes the type of activity being performed

f. The tag includes the name of the employee who applied it and how that person can be reached

2. Tags are attached in a manner that they:

a. Cannot be reused

b. Can be attached by hand

c. Are self-locking

d. Cannot be released with less that 50 pounds of strength

3. Note: Tags don’t lockout. They only provide a warning about danger

I. Perform necessary repairs/maintenance as necessary

J. Only the authorized employee who installed the lock may remove it unless otherwise authorized by the Maintenance Director

1. When the repair/maintenance is completed and the equipment is ready for normal operation, check the area around the machines and equipment to be sure no one is exposed. Verify all employees are a safe distance from the machinery/equipment

2. Remove all tools and supplies from the machinery/equipment

3. Reinstall any machinery/equipment guard plates removed during the repair maintenance procedures

K. Remove lockout devices and tags

L. Turn on energy to the machine or equipment

M. Notify employees that the machine/equipment is operational

N. In the event that a vendor or contractor is involved in the lockout of equipment, they are informed of all components of this program

O. Contractors and personnel are made aware of lockout and tagout devices at the facility

P. Employee training record should include the trainer’s name, the date that lockout/tagout training was conducted, and the employee’s signature. This record is retained in the employee’s Human Resources file

# Maintenance - Preventative Maintenance

I. **POLICY GUIDELINES**

In order to provide a safe environment for residents, employees, and visitors, a preventative maintenance program has been implemented to promote the maintenance of equipment in a state of good repair and condition.

Routine inspections promote safety throughout the facility and aid in keeping equipment in good working order and operating in accordance with manufacturer’s guidelines.

Regular inspection, testing, and replacement or repair of equipment and operational systems contribute to preservation of the facility’s assets.

II. **DEFINITIONS**

Preventative maintenance (PM) is the care and servicing by personnel for the purpose of maintaining equipment and facilities in a satisfactory operating condition by providing for systematic inspection, detection, and correction of incipient failures either before they occur or before they develop into major defects.

Maintenance includes tests, measurements, adjustments, and parts replacement that is performed specifically to prevent faults from occurring.

III. **PROCEDURAL COMPONENTS**

A. Scheduling

1. An annual inventory of all equipment is conducted

2. Based on the inventory, a calendar is developed that guides the PM staff in completing timely servicing and maintenance of all equipment. The calendar lists the PM due on a daily, weekly, monthly, and annual basis

3. Assessed equipment includes items owned by the facility, supplied by a vendor, leased, or rented

4. The PM is completed in accordance with the defined procedure. When manufacturer’s guidelines are available, PM is completed in accordance with the manufacturer’s guidelines

B. Record Keeping

1. A separate file or tabbed section of a notebook is designated for each piece of equipment requiring PM. Cover material should include the maintenance procedure for each piece of equipment, as well as any instructional manuals. The required parts and material list should also be noted

2. The file or tabbed section includes an equipment-specific log to document maintenance completion. The record should note whether routine PM was provided and whether any problems in servicing were identified. If problems are identified, the corrective action taken is recorded

3. In the event that maintenance cannot be completed, the reason should be noted along with the action plan for completion

4. Records are retained for five years, unless a different requirement has been set forth by state/federal regulations and statutes

C. Inspections

1. A schedule is developed to delineate all inspections that are to be completed on a regular basis. Inspections verify that all equipment and furnishings are in working order and free from safety hazards

2. Inspection checklists are developed for at least:

a. The building

b. Each resident room

c. Common areas

d. Company vehicles

e. Other specific areas, such as kitchen and laundry

f. Alarms

Alarms are calendared on the routine inspection checklists. Alarms are inspected to verify that they are in working order and are calendared for inspection in accordance with manufacturer’s specifications. Alarms include any personal protective devices, such as bed alarms, floor alarms, and alert bracelets. If staff is responsible for any component of alarm verification, such as alert bracelets, the scheduling and documentation should correspond to the same standards set for all preventive maintenance

3. Where alarm batteries are utilized, a routine schedule for verifying that batteries are operational is maintained, along with a regular schedule for changing batteries

4. Replacement and/or repair of all furnishings and equipment is completed as soon as possible

5. Building inspection should include at least:

a. Heating and air conditioning systems

b. Ventilation ducts, including clothes dryer ducts

c. Electronic doors

d. Cement cracks

e. Signs, including lighting

f. Generators

g. Sprinkler systems

h. Wiring and electrical outlets

i. Oxygen storage

j. Medical gas storage

k. Emergency lighting

l. Drains and gutters

m. Storage areas

n. Refrigerator and freezer

o. Utility and housekeeping storage areas, including all chemicals

p. Areas behind large equipment, such as refrigerators, stoves, washers, dryers, and fans

6. Vehicle inspections should include:

a. Coolant

b. Oil

c. Tire pressure

d. Lights

e. Directional

f. Brakes

g. Wipers and blades

h. Windshield cleaner

i. Other vehicle safety items

D. Work Orders and Service Requests

1. A system for work orders is established among all staff, residents, and PM employees that provides rapid communication regarding equipment problems

2. The system should include documentation of:

a. The problem

b. Date the problem was identified

c. Who was notified

d. Corrective action (servicing, repair, or replacement)

e. Completion date

# Medical Emergencies

I. POLICY GUIDELINE

In order to access emergency medical care when indicated, facility staff are trained to respond in a rapid and coordinated manner to medical conditions that warrant immediate attention.

II. PROCEDURE COMPONENTS

A. The facility has established an emergency call system

1. All residents are oriented to activation of this notification system at the time of admission

2. When activated, staff respond to the call system as immediately as possible

B. Resident rounds are performed according to the facility’s predefined schedule

C. When the emergency call system is activated or when a resident is found unresponsive or in any condition that indicates a potential emergent medical condition, staff immediately initiate the emergency medical response system

1. A resident who is found on the floor and is experiencing pain that indicates a possible injury or who is found unconscious should not be moved

2. If the condition is deemed to be non-emergent, the care instructions—including physician and resident/responsible party’s instructions—should be followed

3. If the resident appears to be in an acute condition:

a. Remain with the resident until emergency personnel arrive

b. Call 911

c. Provide the facility address, name of the resident, and entry method into building

d. Obtain assistance from other staff if available

e. Obtain resident’s emergency medical documents, including advance directive information and any other relevant instructions

f. Obtain resident’s record, including medical history and name of physician and family members/responsible persons

g. Assist emergency medical personnel as needed until resident is transferred

4. Acute condition may be evidenced by:

a. Alteration in responsiveness/change in level of consciousness

b. Acute alteration in resident’s behavior

c. Acute or significant bleeding

d. Acute or severe pain

e. Obvious injury of a significant magnitude

f. Abnormal vital signs that may indicate an acute medical condition

5. Document the events with timed entries, including:

a. Circumstances leading to concern and/or description of event

b. Initial condition upon staff arrival

c. Assessment

d. Emergency notification to physician and instructions given

e. Actions taken

f. Response to emergency treatment

g. Notification of family, including time and name of person contacted

h. Disposition

i. Condition at time of transfer

6. Notify supervisor or administrator of event

7. Refer to incident report policy for documentation of the event on the facility’s approved incident report form

8. As part of general orientation and annually, staff are trained in the facility’s emergency response procedure

# Medications

I. **POLICY GUIDELINES**

The facility strives to promote resident safety and to protect resident rights and dignity.

The facility implements strategies to promote workforce competency and maintains current policies on medication administration.

The facility has established a process for the reporting of medication errors that is used to identify trends or patterns to promote improved quality and safety of care provided.

II. **DEFINTIIONS**

Medication Error: “A medication error is any preventable event that may cause or lead to inappropriate medication use or patient (resident) harm while the medication is in the control of the healthcare professional, patient, or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use” (from The National Coordinating Council for Medication Error Reporting and Prevention [NCC MERP]).

A medication error is a dose of medication that deviates from the physician’s order. Except for errors of omission, the medication dose must actually reach the patient. A wrong dose that is detected and corrected prior to administration to the resident is not a medication error but should be documented and reported as a “near miss” on an incident reporting form.

A significant medication error means one that causes the resident discomfort or jeopardizes his or her health and safety (as defined by Centers for Medicare and Medicaid Services [CMS]).

The following list contains descriptions of the various types of medication errors that must be reported:

• Omission error: Failure to administer an ordered dose, excluding resident refusal

• Improper dose: Any dosage that is above or below the ordered dose

• Wrong route: Administration of a drug by a route other than ordered. Also included are doses via the correct route but at the wrong site

• Wrong or incorrect preparation of dose: The medication dose is prepared inaccurately

• Wrong dosage form: Administration of a drug by the correct route but in a different dosage form than specified

• Wrong time: Administration of a dose at least 60 minutes before or after its scheduled administration time

• Unauthorized drug: Administration to the resident of medication not authorized/ordered

• Wrong administration technique: Inappropriate procedure or improper technique in the administration of a drug

• Deteriorated drug: Administration of a drug that has expired or for which the physical or chemical dosage integrity has been compromised

• Compliance error: Inappropriate resident behavior regarding adherence to a prescribed medication regimen

III. **PROCEDURAL COMPONENTS**

A. Preventing Medication Errors

1. Facility medication policies and procedures are written, approved, and address the following:

a. Acquisition of medications (e.g., from caregivers or pharmacies)

b. Medication transcription process including documentation requirements, if applicable

i. Telephone order read-back

ii. “Do not use” list of abbreviations

iii. Medication orders written and rewritten on admission and readmission

c. Specification of which personnel are allowed access to medications and to administer medications to residents

d. Administration of medications and related documentation

e. Resident self-administration of medications

f. Labeling and packaging of medications

g. Storage of medications, including medications that may require refrigeration

h. Secure storage and accountability of controlled drugs

i. Limitations on the types of medications permissible for use or storage in the organization

j. Disposition of medications that are no longer needed or in use

k. Documentation and reporting of medication errors and adverse drug reactions

2. Training is provided to personnel with responsibilities related to medication management. Training corresponds to the written policies and procedures, and the staff member’s scope of duties. Initial and ongoing training on accepted standards of practice related to accurate medication administration is offered with the ultimate goal of medication error reduction

3. Medication administration audits are completed on staff administering medications during orientation and annually with documentation maintained in the personnel file

4. Resident medications are reviewed quarterly by a licensed pharmacist or registered nurse

5. The following checks are performed immediately prior to medication administration:

a. The right medication

b. The right dose

c. The right resident

d. The right route using the right dosage form

e. At the right time

f. With the right documentation

6. Any order that is incomplete, illegible, or of any other concern is clarified prior to administration using an established process for resolving questions

7. Staff is to administer only medications that are properly labeled. During the administration process, labels are read three times:

a. When reaching for or preparing the medication

b. Immediately prior to administering the medication

c. When discarding the container or replacing it into its storage location

8. Where controlled medications are stored and/or administered, safeguards are in place to prevent and detect theft and diversion of controlled drugs

9. When a medication error occurs, the Administrator or his/her designee evaluates possible causes in order to improve the facility’s system for medication management and to prevent future errors

10. All staff who administer medications are provided access to product information as close to the point of use as possible, including:

a. Indications for use of the medication

b. Precautions and contraindications

c. The expected outcome from the medication’s use

d. Potential adverse reactions and interactions with food or other medication

e. Actions to take when adverse reactions or interactions occur

f. Storage requirements

B. Responding to an Error

1. In the event of an error, the following steps should be taken:

a. Staff conducts an immediate assessment of the resident in relation to the nature of the error

b. All errors related to medications are reported to the supervisor or the Administrator.

c. If the error is potentially life threatening, the error is reported immediately to the Administrator and the error and resident assessment data is communicated to the attending physician immediately

i. If the error has no serious effect on the resident, the physician is notified as soon as possible (for example, if during the night shift, then notify physician in the morning)

d. The medication is documented on the Medication Administration Record (MAR). For example, if an incorrect medication was given, it should still be noted on the MAR

e. Follow-up notes should reflect any adverse effects, including monitoring of the resident and actions taken

f. The Administrator or designee investigates the error to determine the cause

C. Medication Error Reporting

1. The facility maintains a process for the reporting of medication errors. These medication error reports may be used to identify significant trends or patterns that can lead to improvements in processes and systems, and teach others how to prevent similar errors

2. A medication error/omission report is completed on the facility-designated form immediately after an error is discovered

3. The staff member committing the error is responsible for completing the Medication Error/Omission Report and forwarding it to the Administrator

4. The supervisor or Administrator reviews all medication error/omission reports

5. The designated quality assurance employee completes a monthly summary of medication errors/omissions and present it to the Quality Assurance Committee and pharmacist (if necessary) for review and follow-up

6. Data are collected and analyzed regarding the actual and potential errors for the purpose of continuous quality improvement

7. The medication error report should identify whether the error relates to order prescribing, pharmacy preparation and dispensing, administration, transcription or administration, and describe the following:

a. Medication error category such as

i. Wrong medication

ii. Wrong dose

iii. Wrong time

iv. Doses omitted (with number of doses)

v. Wrong dosage form

vi. Wrong route

vii. Expired drug

viii. Wrong label

b. Other interventions necessary due to error (i.e., lab work, rescheduled procedure or appointment, extra monitoring, etc.)

c. Notification of physician

i. Name of physician

ii. Time/date of notifying

iii. Whether orders or other instructions were received

D. Self-administered Medication Errors

1. Medication errors made by a resident who self-administers medications are documented in the resident’s record

2. Errors should prompt a medication self-administration reassessment

3. Medications errors made by the resident are not

# Medications – Self Administration

I. **POLICY GUIDELINE**

The facility strives to promote resident safety. Residents who wish to administer their own medications and are deemed medically competent to do so, are assessed periodically for their ability to comply with prescriptions, and instructed how to safeguard their medications for the safety of other residents.

II. **PROCEDURAL COMPONENTS**

A. Residents are permitted to administer their own medications after they have been assessed and can demonstrate the ability to safely do so. If, at the time of admission, a resident requests to self-administer his or her medications, this determination should be made within seven days

B. All medications require a physician’s order

C. Self-administration is permitted for inhalants, ointments, topicals, sublinguals, oral preparations, subcutaneous injections, and drops

D. Following a history and physical examination, a physician’s determination that the resident may self-administer his/her medications is required. A written physician’s approval for self-administration of medications must be received by the facility and filed in the resident’s record

E. The facility conducts a medication self-administration assessment on all residents who wish to self-administer. This includes:

1. An assessment of the resident’s cognitive, functional, and visual status, noting normal status or impairment

2. The resident’s ability to state the:

a. Name

b. Dose

c. Time of administration

d. Route

e. Frequency of the medication

3. The resident’s ability to recognize the colors of the medication

4. The resident’s ability to read the label of the medication

5. The resident’s ability to demonstrate that he/she can open, pour, prepare, and place medication in mouth or inject or apply medication as directed

6. The resident’s ability to state if the medication requires any special monitoring such as blood pressure, pulse, blood glucose, or other

7. The resident’s ability to state the purpose of the medication and why he or she is receiving it

8. The resident’s ability to state any special precautions: take with food, drug-drug interactions, drug-food interactions, etc.

9. The resident’s ability to state the safety concerns associated with self-administration, such as preventing access to medications by other residents and the reason for documenting that medications were taken

F. An interdisciplinary team reviews the physician’s evaluation and the resident’s self-administration assessment. This review is recorded in the resident’s record. A notation regarding the interdisciplinary team members who participated in the assessment and their decision is recorded in the resident’s record with one of the following notations:

1. Recommended for self-administration: no impairments or safety issues identified

2. Not recommended for self-administration: impairments result in high safety risk

G. A periodic reassessment for self-administration is made. This is accomplished at least quarterly or with any change in the resident’s condition

H. If concern is raised about a resident’s ability to administer his/her medications safely, staff administer the medications until such time as a physician and facility reassessment can be conducted and reviewed by the interdisciplinary team. Concerns include resident’s inability to comply with facility rules regarding medication storage and safety in administration of medications

I. The facility staff determines who is responsible for:

1. Storage of medications

2. Documentation of administration

3. Location of drug administration records

J. Provisions are made to safeguard the resident’s medications. This requires that either:

1. The resident comes to the medication station to obtain medications at the specified time, thus having the medication stock maintained in control of the clinical staff

2. The resident maintains the medication storage in his/her room or unit. If so, medications are kept under lock at all times. The staff maintains a duplicate key

K. The resident needs to sign consent for self-administration of medications. The consent includes:

1. An acknowledgment of the resident’s right to self-administer medications as prescribed by the physician, unless the interdisciplinary team determines that it would not be safe for him or her to carry out this responsibility

2. A notation that he or she wishes to self-administer the medications

3. An agreement to undergo an assessment for his or her ability to safely carry out this responsibility

L. Medication errors made by residents who self-administer medications are documented in the resident’s record. Errors prompt a medication self-administration reassessment. Medication errors made by the resident are not be include

# Motorized Mobility Aids

I. **POLICY GUIDELINES**

The facility promotes that residents with disabilities and physical limitations have access to devices that improve their independence. Motorized mobility aids may improve access to the facility and services.

In order to provide a safe environment for residents, employees, and visitors, the facility maintains a policy for use of motorized mobility aids whether wheelchairs, carts, or scooters.

Orientation for safe use of motorized mobility aids augments safety for the resident using these devices as well as other residents, visitors, and employees.

Routine inspection of motorized mobility aids promotes the maintenance of equipment that remains in good working order.

II. **DEFINITION**

A motorized mobility aid or device is a wheelchair, cart, or scooter that serves as an assistive device to allow an individual to be more independent and/or enables an individual to accomplish a task.

III. **PROCEDURAL COMPONENTS**

A. Resident Assessment and Orientation

1. Residents using motorized mobility aids need to demonstrate evidence of sufficient skills to follow all facility safety rules pertaining to motorized mobility aids in order to operate their device safely

2. Residents are oriented to the facility and the safe use of their motorized mobility aid upon admission. This includes orientation to the facility layout and environment to increase their familiarity with any hazards that may be encountered while using their motorized device. In addition, the resident is oriented to processes that promote the operation of a motorized mobility device with the utmost courtesy, care, and consideration for the safety and convenience of other residents, employees, and visitors

B. Safety Rules

1. Motorized mobility aids are permitted in any area of the facility unless they pose a direct threat to the safety of others or would result in physical damage to the property of others

2. Motorized devices are not to be operated at a speed that is faster than ambulatory residents walking in the immediate area. This is considered the “safe speed” for the facility

3. Ambulating residents are afforded the right-of-way at all times

4. Based upon the initial assessment of resident safety with use of a motorized mobility aid, staff assistance may be required for safe transfer of the resident to a wheelchair or other surfaces when indicated

5. Residents who are using motorized mobility aids should pause prior to entering a corridor or public walkway and stop at the corridor or sidewalk intersections where ambulating residents and others may not be readily observed

6. Motorized mobility aids are to be operated in such a manner that they do not impede or interfere with normal resident flow, including a roommate’s ability to freely access the common area of the room

7. When common area activities are in progress and crowded, the facility may request that those using motorized devices enter or exit prior to or after other residents to encourage safe resident traffic flow

8. Operators must reduce speed on common walkways and maintain a safe distance from pedestrians and other motorized carts

9. Motorized mobility aids are to be parked near common areas in a manner that they do not pose a safety hazard for flow of residents or emergency exits

10. Motorized aids may not block entrances to buildings, doorways, stairways, walkways, disability ramps, corridors, or sidewalks. They are not to be parked where they obstruct the entrance or exit of any building

11. When parked, the motorized device must be secured from movement, including maintaining the device in the off position and engaging an emergency brake if one exists. Devices that require a key for operation are not to be left with the key in the ignition when the resident is not present

12. Electric motorized mobility devices are charged in designated areas

C. Unexpected Events and Injuries and/or Safety Rules Violations

1. Any unexpected event, accident, or injury must be immediately reported to the staff

2. Following an unexpected accident or injury in which a resident’s motorized device is involved where failure to follow the safety rules has been identified, the resident is re-evaluated for safe operation of the cart. If the resident is determined to be safe with continued operation of the device, he/she is reoriented to the facility’s safety rules

D. Resident Responsibilities and Agreement

1. Residents must agree that motorized mobility devices are operated in accordance with the manufacturer’s recommendations. Devices may not be modified in any manner that affects their recommended mode of operation, speed, or safety

2. Residents are responsible to make sure the vehicle is in safe working order and that mechanical or equipment defects are reported as soon as possible

3. The facility obtains and maintains a statement signed by each resident who has a motorized mobility device, attesting their knowledge and understanding of the facility’s procedure regarding safe use of the device. This agreement language may include:

**I understand it is my responsibility to respect the rules and regulations of the facility when using my (motorized wheelchair, cart, or scooter). I agree to operate my (motorized wheelchair, cart, or scooter) safely and in consideration of other residents, employees, and visitors. If I fail to do so, I agree to reorientation and instruction, including reassessment of my ability to follow the safety rules of the facility.**

# Pets

I. **INTRODUCTION**

Studies have shown that animals appear to provide the elderly and infirmed with a source of comfort and enjoyment and reduce loneliness and depression. Pets have also been shown to contribute to the healing and well-being of their owners. Interaction with pets has demonstrated increased willingness of residents to accept treatments and nourishments.

II. **POLICY GUIDELINE**

Approved pets are permitted in the facility to serve as a source of comfort and enjoyment to the residents and possibly reduce their loneliness and depression. Guidelines for pet management have been established to promote the safety of the residents.

III. **PROCEDURAL COMPONENTS**

A. Acceptable pets are limited to “house pets” and may include dogs, cats, fish, rabbits, and certain types of birds

B. Dogs should be of reasonable size, although this may vary depending on the temperament of the dog

C. Dogs and cats must have an annual physical examination by a veterinarian, including a fecal check. Other types of pets are to have health screening per veterinarian recommendations

D. Pet vaccinations must be current, including rabies and any others as advised by the veterinarian. Records must be kept by the owner with a copy maintained by the facility

E. Pets are to be clean and well-groomed. This includes trimmed nails, clean teeth, free of internal and external parasites, and in overall good health

F. Pets are to be free of ticks and fleas

G. Pets must be free of fresh wounds. If injuries are present, the animal must be removed from the facility until recovered and healed

H. Dogs must wear a collar with their licenses

1. Spike, electronic, or pinch collars are not permitted

2. Acceptable collars are slip, buckle-types, quick release, and made of chain, nylon, or leather

I. Owners must be able to clean up after their pet

J. Dogs and cats are to be at least one year old or past the “puppy” or “kitten” stage

K. Female dogs may not visit while in season

L. Small birds, not prone to create excessive noise, are acceptable

M. The owner must assure that the animal is:

1. Safe

2. Obedient

3. Able to follow commands

4. Housebroken

5. Healthy (as attested by a veterinarian)

6. Prepared for and of the temperament to adapt to the environment (e.g., socialized, free from excessive noise or disruptive tendencies, non-violent)

7. Always under supervision of the owner or a knowledgeable adult

N. In all cases where there is inhabitation (living within the facility) of the pet, it is contingent for a period of 90 days. Should the pet demonstrate behaviors that are not compatible with living in the facility and with the other residents, the owner must be prepared to make alterative arrangements for the pet

1. If continual complaints are received from other residents regarding a pet in the facility, the owner must be prepared to make alternative arrangements for the pet

O. With a resident-owned pet in the facility, the resident must provide the name of someone who would be willing to care for the animal should the resident suffer an emergency medical condition

1. The resident must have a plan for the pet that includes:

a. Grooming

b. Exercising

c. Removal of waste

d. Maintaining the health of the pet, including regular veterinary visits

e. Ability to provide the costs of having the pet in the facility, including food, supplies, flea control, water and food bowls, bedding, and leash.

# Photographic and Procedure Management

I. **POLICY GUIDELINES**

The resident has the right to privacy, confidential care, and protection of health information.

Healthcare professionals have a duty to protect each resident’s healthcare information and privacy.

Violations of the resident’s rights undermine the public’s confidence in healthcare organizations.

In order to safeguard resident privacy, the facility does not permit photographing of any kind or use of audio recording devices, unless prior written permission is obtained from the resident and facility management.

II. **DEFINITIONS**

A photographic device is any device that captures an image and outputs the resulting image on a display surface. This includes all video and still capture devices.

An audio device is any device that records sound.

III. **PROCEDURAL COMPONENTS**

A. All photographic and audio devices are prohibited throughout the facility unless prior written permission is obtained from facility management. This permission may only be granted by:

1. Corporate leadership

2. The Administrator

3. The Director of Nursing

4. The Director of Activities

5. The Risk Manager

B. Photographic and audio devices may include, but are not limited to:

1. Cell phone cameras

2. Video cameras that create digital or film recordings

3. Still cameras, both digital and film

4. Instant or Polaroid™-type cameras

5. Tape recorders

C. If consent for photography is granted by the resident, photographs may only include those activities involving social situations, such as parties or holiday gatherings, and may only include the resident who has provided permission

D. The facility educates all residents and family members about this policy upon admission and thereafter as needed. This information is included in the admission consent that is signed by the resident or responsible party. Example language includes:

In order to protect resident privacy and in order to comply with privacy regulations, I agree that the use of photographic or audio devices will not be used within the facility without the prior written authorization of the resident(s) and approval by facility management

E. Visitors who do no comply with this policy are required to leave the facility

# Policy & Procedure Management

I. **POLICY GUIDELINES**

Administrative and resident care policies and procedures form the framework for the facility’s operational practices and reflect its compliance with current standards of care and practice.

A formal process is maintained for the completion of an annual review of policies and procedures with revisions as needed and archiving of outdated documents.

II. **DEFINITIONS**

A policy outlines the “rules” governing various processes.

A procedure reflects the process for implementation of a policy or a step-by-step guideline for carrying out a process. Procedures evolve over time as new tools emerge and new processes are designed, and risk-associated change is needed in response to changes in knowledge or environment. Procedures are an ordered set of tasks for performing some action.

III. **PROCEDURAL COMPONENTS**

A. Format

1. A standard template is utilized for all facility policies and procedures that includes:

a. Facility letterhead

b. Effective date of policy and procedure

c. Review and/or revision dates

d. Title of policy and procedure

e. Required sections (purpose or policy statement, procedure, equipment, designated staff, definitions, etc.)

f. Standardized formatting (font type and size, use of roman numerals, bullets, etc.)

2. Policies and procedures should clearly identify date ranges that include the date the policy or procedure was initiated (went into effect) to the date the policy or procedure was reviewed and/or revised to clearly identify what policies and procedures were in effect at any given time during the facility’s operation

B. Archive System

1. An archiving system has been established for maintaining outdated policies and procedures in accordance with any corporate directive (if applicable) and the state’s statute of limitations

2. Policies and procedures should clearly identify when it became outdated or ineffective

3. A designated location has been determined for storage of all archived policies and procedures. This includes storage of computerized policy and procedures files

4. A designated individual is charged with maintaining the archive process

C. Approval

1. A standard annual process is established for review and approval of all current policies and procedures that requires signatures of at least the following:

a. Administrator

b. Executive leadership at the corporate level (if a corporation)

c. Board of Directors (if Board exists)

d. Relevant department heads

2. All policies are to be approved by any designated committees prior to implementation

D. Location

1. Administrative and departmental policy and procedure manuals are located where they are easily accessible to staff

E. Education

1. Staff education and training is provided prior to the implementation of a revised and/or new policy and procedure with documented attendance

2. Staff is educated upon hire as to the importance of complying with the facility’s policies and the consequences of non-compliance

# Private Sitters

I. **POLICY GUIDELINES**

A resident, responsible party or legal representative may choose to employ a private sitter in accordance with the Bill of Rights for Residents of Long Term Care Facilities.

A private sitter may be obtained by a resident or the resident’s legal representative upon written agreement to comply with the facility’s policies and procedures relating to the use of private sitters and following administrative approval.

A criminal background check and sexual abuse registration check are conducted prior to a private sitter providing services to a resident in the facility

A private sitter does not take the place of facility staff and may only provide those services outlined in the sitter policy or as agreed by the resident or resident’s legal representative and facility administration as documented in the written sitter agreement.

II. **DEFINITIONS**

Private Sitter: Also referred to as personal or private attendant, companion or private duty. A private sitter provides companionship or basic services such as providing safety measures for residents who may wander, providing minimal assistance to help a resident to the dining room, bathroom, etc. and assistance with personal hygiene.

III. **PROCEDURAL COMPONENTS**

A. Before a Private Sitter is Acquired

1. The use of a private sitter for a resident is reliant upon the approval of the Administrator

2. Prior to the private sitter working at the facility, the following information should be provided to the facility:

a. A satisfactory background check determined through written verification provided by family or agency

b. Satisfactory results of a sexual offender registration check

c. Determination of tuberculosis status

d. Annual influenza vaccine and hepatitis B vaccination series

3. All sitters who are functioning under a specific license or certification are to remain current and in good standing with the licensing board

4. A sitter is employed by the resident or resident’s legal representative and is not an employee of the facility

a. The sitter is paid by the resident or resident’s legal representative

b. Any withholding taxes are the responsibility of the sitter

c. The facility assumes no financial liability for the financial arrangements or payments to the sitter including vaccinations, annual PPD (tuberculosis test), or criminal investigation bureau

5. The facility may provide a list of local agencies that provide private sitter services to the resident or resident’s legal representative

6. The resident or resident’s legal representative should be encouraged to obtain a private sitter from an agency that conducts pre-employment screening including criminal background checks, license or certification verification, and health screening

7. A resident or resident’s legal representative and the private sitter will sign an acknowledgement of understanding and agreement to abide to the Private Sitter Policy and Private Sitter Rules prior to the sitter working at the facility

8. The Administrator and Resident Services Coordinator of the facility reserve the right to determine the eligibility of a sitter to provide services at the facility

9. The Administrator, Resident Services Coordinator, or shift supervisor has the right to withdraw sitter privileges at the facility and ask the sitter to leave the facility if deemed necessary

B. Screening and Orientation

1. The resident or resident’s legal reprehensive needs to provide the facility the private sitter’s name, address, phone number, emergency contact information, the duties they wish the private sitter to perform, and the schedule (days and times) as to when services will be provided

2. Responsibilities of a sitter may be limited to:

a. Providing safety measures for a wandering resident

b. Basic companionship including taking walks with the resident

c. Minimal assistance with ambulation to the dining room, activities, bathroom, etc.

d. Assisting the resident at mealtime

e. Assistance with personal hygiene including brushing hair and teeth, assuring the resident is dressed appropriately, basic grooming and skin care, etc.

3. The facility provides the private sitter a general orientation to the facility including:

a. Resident rights, confidentiality

b. Facility management team and chain-of-command

c. Abuse and neglect prevention

d. Theft and loss policy

e. Safety policy and fire safety

f. Smoking policy

g. Reporting a resident incident or accident

h. Dress code and use of identification badge noting the title of private sitter

i. Infection control

j. Disaster preparedness and emergency response procedures

4. Prior to the private sitters first day of service, the facility obtains the following information and maintains a file for the sitter including:

a. The sitter’s contact information including an emergency contact

b. Documentation of completion of background check

c. If applicable, copy of current license or certification

d. Documentation of orientation to the facility

e. Signed acknowledgement of understanding and agreement to abide to the Private Sitter Policy and Procedure and to the Private Sitter Rules

f. Copy of the sitter’s sign-in/sign-out log

5. Private sitters are not included in the facility staffing requirements

C. Private Sitter Rules

1. Observe facility policy and procedure regarding personal conduct and behavior, health requirements, backgrounds checks (including sex offender registry checks) and the smoking policy

2. Allow the facility staff to provide care as outlined by the Resident Services/Care Plan and not interfere with the facility’s responsibilities and duties to the resident

3. Treat all residents, family members, visitors, and employees with courtesy and respect

4. Not portray his or herself as a facility employee

5. Adhere to the facility dress code and wear clothes which are neat, clean and professional

6. Wear an identification badge noting their title as a private sitter (or equivalent)

7. Report to the shift supervisor prior to beginning work and report off when they are leaving the facility

8. Required to log-in and log-out at the beginning and end of the shift they are working

9. Notify the resident or resident’s legal representative when there is a change in their scheduled times at the facility

10. Notify staff of any care needs of the resident or if any resident physical, emotional, or mental changes are observed

11. May not have visitors during working hours and may not bring children to work

12. Sleeping is prohibited unless the sitter is employed during the midnight shift and sleeping is approved by the resident or legal representative

13. Discussion of any confidential information about residents with any unauthorized individual in or outside the facility is prohibited. Any violation of this policy will result in sitting privileges being revoked

14. Responsible for any damage they may do or injury they may cause to property, residents, visitors, or employees while they are at the facility

15. Refrain from entering the facility if they are sick with an illness that is infectious

16. Must be free from tuberculosis in order to work at the facility

**Private Sitter Agreement**

Employment of a sitter is an arrangement between the resident or resident’s legal representative and the sitter.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Resident or Legal Representatives Name) desires to employ a private sitter for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Resident’s Name) in \_\_\_\_\_\_\_\_\_\_\_ (Room Number) to provide the following sitter services:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The following is understood by the resident, resident’s legal representative and the sitter:

1. Sitters are employed by the resident or legal representative and will be paid directly by the resident or legal representative

2. Any withholding taxes will be the responsibility of the sitter

3. The facility assumes no financial liability for the financial arrangements or payments to the sitter, including a pre-employment physical, annual PPD (tuberculosis test) or criminal investigation bureau

4. Prior to working at the facility, the private sitter must complete a satisfactory criminal background check and specific health screening as stated in the Private Sitter Policy and Procedure

5. The facility sets forth policies, procedures and rules regarding private sitters employed privately by the resident or resident’s legal representative. The resident, resident’s legal representative and sitter must abide by these policies, procedures and rules

6. At any time the facility determines that the health or safety of the resident is not being maintained due to involvement of a sitter, the facility is responsible to make alterations in the listed sitter functions/tasks as appropriate for the welfare of the resident. This will be communicated and discussed with the resident/family.

The days and hours for sitter services to be provided are:

Sunday \_\_\_\_\_ to \_\_\_\_\_ Monday\_\_\_\_\_\_ to \_\_\_\_\_ Tuesday\_\_\_\_\_\_ to \_\_\_\_\_

Wednesday \_\_\_\_\_ to \_\_\_\_\_ Thursday \_\_\_\_\_ to \_\_\_\_\_ Friday \_\_\_\_\_ to \_\_\_\_\_ Saturday \_\_\_\_\_ to \_\_\_\_\_

The Private Sitter hired is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Sitter’s Name)

License/Certification # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if applicable)

The Private Sitter’s contact information includes:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name/Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I herby acknowledge that I have received a copy of the facility Private Sitter Policy and Procedure and the Private Sitter Rules. By signature, I acknowledge that I have read and understand all the requirements and rules for a private sitter to work at this facility. I hereby agree to abide by these policies, procedures and rules of the facility.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Resident or Legal Representative Date

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 Signature of Sitter Date

By signature, the Facility Administrative Representative has approved the above named sitter to provide private sitter services to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Resident) at the facility.

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Signature of Facility Administrative Representative Date

# Skin / Wound Care

I. **POLICY GUIDELINES**

The facility promotes an environment as free of risks as possible for the development of skin breakdown.

The facility provides interventions to minimize the risk of skin breakdown and promote healing,

II. **DEFINITIONS**

Abrasion is a superficial injury to the skin caused by rubbing or scraping.

Dry Skin (Xerosis) is a skin condition due to loss of moisture, including but not limited to, dryness due to excessive bathing, aging, topical medications, or environment.

Intertrigo (Skin-to-Skin Excoriation) is an inflammation of the top layers of skin caused by moisture, bacteria, or fungi in the folds of the skin. The affected areas are usually pink to brown. If the skin is particularly moist, it may begin to break down. In severe cases, there may be a foul odor. Intertrigo tends to occur in warm, moist areas of the body where two skin surfaces rub or press against each other. It is common in obese individuals. It may also be seen in residents who wear medical devices that may trap moisture against the skin, such as splints and braces.

Perineal Excoriation is the erosion of skin caused by urine (uric acid) and feces (e-coli). Also referred to as “diaper rash,” “urine burn,” or “red bottom.” This condition can be quite difficult to avoid in residents with frequent loose stools associated with certain medical conditions.

Pressure Ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers (Centers for Medicare and Medicaid Services [CMS], F314, Definitions §483.25).

Rash is a term used to describe an area, or group of spots, on the skin that is/are red and inflamed. A rash is usually a sign of some underlying condition or disorder such as an allergic reaction or an infectious illness.

Skin Tear and Lacerations are cuts and tears to the skin that usually result from impact (or related incidents) to extremely fragile skin.

Vascular Ulcers/Damage may be seen particularly on the legs or feet, as a result of circulatory disorders or damage to the peripheral nerves. Although these types of lesions may be associated with benign trauma (i.e., bumping against a leg of a chair), each ulcer has distinct distinguishing features, pathologic processes, and treatment regimen.

III. **PROCEDURAL COMPONENTS**

A. Admission Skin Care Assessment

1. At the time of admission (same shift) or, if not possible, within 24 hours, a skin care assessment consisting of a full head-to-toe assessment is conducted to identify any alterations in skin integrity

 2. The admission skin care assessment should include at a minimum:

a. Interview of resident or family about history of falls, weight loss, poor appetite, easily or frequent bruising, other skin issues and medical conditions such as peripheral vascular disease (poor circulation), diabetes, etc.

b. Physical evaluation to include identification of:

i. Abrasions

ii. Bruises (hematoma)

iii. Edema (swelling)

iv. Erupting lesion, cysts

v. Lacerations

vi. Puncture wounds

vii. Rashes

viii. Redness or open areas

ix. Scratches

c. Identification of nutritional status and related issues

3. Documentation of findings in the resident record includes (use of a skin assessment tool with an anatomical drawing is recommended):

a. Location

b. Size (length, width, and depth, if applicable, in centimeters)

c. Color

d. If drainage, amount and characteristics including color, consistency, and odor

e. Description of surrounding tissue

f. Pain

4. Risk reduction measures are implemented as needed and may include:

a. Use of creams, lotions, and ointments to moisturize the skin

b. Encouraging resident to wear long sleeves and pants

c. Encouraging hydration

d. Adequate lighting to reduce risk of bumping into furniture

e. Padding of side rails, wheelchair arms, and/or leg supports

f. Use of gauze wraps, stockinettes, or other wraps to secure a dressing rather than tape

g. Dietary consult to address nutrition and hydration needs

5. Identified issues and interventions implemented are documented on the resident service plan

6. Notification of physician and family is based on findings

B. Ongoing Skin Integrity Management

1. Re-assessment

a. Ongoing skin inspections are conducted when personal care is being provided and checks documented

b. A formal skin assessment is completed semi-annually at a minimum and/or with change in resident condition.

2. Interventions

a. Skin tears receive first aide which includes:

i. Washing hands prior to providing first aide

ii. Gentle cleaning of the skin tear with normal saline

iii. Allowing area to air dry or gently pat dry

iv. Assessing the size of the skin tear—measurements can be approximated using a saline moistened cotton tipped applicator

v. Applying petroleum-based ointment, steri-strips, or a moist non-adherent dressing daily and/or as needed

(a) Use caution with film dressings as skin damage can occur during removal of dressing

(b) Consider putting an arrow to indicate the direction of the skin tear on the dressing—this will help minimize further skin injury during dressing removal—and remove in direction of the arrow

b. When a wound is identified, the facility wound care protocol is implemented, progress toward healing is monitored and documentation is noted in the resident record at a minimum weekly

C. Documentation

1. Documentation of a change in skin integrity should include:

a. Location

b. Description

c. Length and width of affected area

d. Degree of pain if present

e. Drainage, amount and appearance

2. The resident record reflects notifications, care provided, and if applicable interventions taken to prevent re-occurrence

3. When any lesion, bruise, skin tear, etc. is identified it is noted on a skin integrity log in order to track and trend issues relating to changes in skin integrity

D. Notifications

1. Identified changes in a resident’s skin integrity are reported to the supervisor

2. A written protocol is established for:

a. Physician notification of wounds and responses to treatment

b. Family notification of changes in the resident’s skin integrity, treatment plan, response to treatment, and changes in treatment due to wound deterioration

c. “In-house” notification of staff of the presence of a change in resident’s skin integrity

E. Education

1. Staff training includes:

a. The aging process, effect on skin, and the increased risk of skin breakdown

b. Education to certified nursing assistant staff members is provided on inspection, prevention, and management strategies upon orientation and annually

c. Identification and reporting of environmental issues that may contribute to alterations in resident skin integrity such as:

i. Rough edges on handrails and grab bars

ii. Low light areas

2. Education to residents and family members is provided during care planning meetings

F. Quality Improvement

1. Oversight of resident skin integrity issues and facility prevention and follow-up strategies is provided by the Quality Improvement (QI) Committee and includes:

a. Review of observations and documentation audits

b. Review of incidences and/or prevalence of skin integrity issues (skin integrity log)

2. Statistics, analysis of data, and performance improvement strategies are documented in the QI minutes

3. Confidentiality language is noted on all quality documents

# Smoking Management

I. **POLICY GUIDELINES**

A smoking policy and procedure has been implemented to promote resident safety and protect resident rights and dignity.

Residents who wish to smoke are assessed by the facility to determine the individual’s ability and willingness to comply with the facility’s rules and regulations governing smoking.

II. **DEFINITIONS**

Through the assessment process, smokers are designated as either independent or supervised smokers.

An independent smoker is defined as one whom:

* Uses all smoking material in a safe and responsible manner
* Can state smoking rules and appropriate smoking places
* Observes all smoking rules and adheres to policy

A supervised smoker is defined as one whom:

* Demonstrates unsafe behavior in the use of smoking and/or lighting materials
* Cannot state rules
* May not carry smoking materials or lighters; smoking materials are labeled with the resident’s name and locked in the medication room
* May smoke only with staff supervision

III. **PROCEDURAL COMPONENTS**

A. General Rules

1. Upon admission, residents are informed of the Smoking Policy by the admissions coordinator

2. Each resident who smokes is provided the degree of independence appropriate to his or her demonstrated ability to smoke safely and within the facility guidelines

3. All cigarettes purchases are coordinated through the Activities/Business Office. A resident who wishes to purchase cigarettes must first coordinate this purchase with the Activity Department. If visitors provide cigarettes, the resident must coordinate inventory of smoking materials with the Activities/Business Office

B. Restrictions of Privileges

1. Failure by the resident to comply with smoking rules results in removal of smoking privileges

2. Smokers are not permitted to:

a. Smoke in non-designated areas

b. Behave unsafely in any way with smoking materials

c. Acquire or take smoking materials from another resident

d. Smoke without staff supervision, if determined to require supervision through the smoking assessment

e. Collect discarded smoking materials

C. Designated Smoking Areas

1. Smokers are allowed to smoke in designated areas within the building and outside the building only

2. Supervised smokers can smoke in the designated areas only when being supervised by a staff member or family member

3. Residents should smoke inside when the outside temperature is less than 50 degrees Fahrenheit

4. Responsible parties, family members, and visitors are not permitted to smoke inside the facility with the resident

D. Smoking Safety Assessment

1. All residents who wish to smoke undergo a safety assessment

a. A smoking safety assessment should be completed within the first seven days of admission on residents who smoke/use tobacco products. The assessment may be completed sooner at the discretion of staff

b. A new smoking safety assessment should be completed each time the service plan is updated

c. If the assessment indicates problems with safety compliance, objective documentation should be recorded in the resident’s record along with actions taken. Incidental notes should be made whenever the person demonstrates non-compliance with smoking safety rules

d. The smoking safety assessment should include the following:

i. The resident’s cognitive function including evaluation of

(a) Short-term memory

(b) Long-term memory

(c) Adequate memory/recall ability

(d) Ability to make decisions regarding tasks of daily life

ii. Visual function adequacy

iii. Ability to communicate effectively with others

iv. Resident observation

(a) The resident can light and smoke a cigarette or other smoking device while demonstrating a safe technique for putting out the matches or lighter and disposing of ash

(b) The resident is able to physically hold the device while smoking

(c) The resident remains alert while smoking

v. Resident interview

(a) The resident is able to communicate that he or she understands smoking materials are for his or her own personal use

(b) The resident is able to communicate that he or she understands that smoking materials can be used only in the designated smoking area

(c) The resident can communicate the consequences of not abiding by the smoking rules

2. Based on the safety assessments, residents are categorized as either:

a. Safe to smoke without supervision

b. Require supervision while smoking for safety

3. A periodic reassessment of the resident’s smoking safety is recorded in the resident’s record. This should include an objective list of behaviors that have been evaluated to determine whether the resident continues to be safe with smoking materials

a. Description of the assessed behaviors may include the following:

i. Burns fingers, careless use of smoking materials

ii. Burns holes in clothing

iii. Drops ashes on self, floor, and furniture

iv. Smokes cigarette dangerously low to the butt and has nicotine stains on finger tips

v. Panhandles, begs, or steals smoking materials

vi. Does not place ashes in proper ashtray

vii. Extinguishes cigarettes on the floor

viii. Places lit cigarette in garbage can

ix. Constant requests to smoke

x. Smokes cigarette butts

xi. Smokes in non-designated areas

xii. Smokes at non-designated times

xiii. Refuses to cooperate with staff re-direction

xiv. Refuses to relinquish unauthorized smoking material

xv. Displays poor, inappropriate social skills

xvi. Shares smoking materials

E. Smoking Contract

1. A smoking contract is developed and serves as an agreement between the resident and the facility. The contract should include:

a. Effective date

b. Termination date, if applicable

c. The resident’s agreement to comply with the smoking policy

d. Other conditions, such as smoking under supervision

e. Agreement to refrain from smoking should the facility determine that the resident’s behavior presents a risk to the health, safety, and welfare of other individuals, or the resident fails to comply with the smoking policy

f. Awareness that smoking materials are removed if the resident continues to disregard smoking safety regulations

g. Awareness that continued non-compliance jeopardizes the resident’s ability to remain at this healthcare residence

# Social Media

I. POLICY STATEMENT

The facility recognizes that communication through and general use of social media and other online networks and Web-based communication is prevalent among most individuals. However, in the healthcare arena, there are increased risks associated with use of social media by employees of this facility because of the sensitive and confidential nature of the protected health information they handle and are exposed to in the workplace. This policy outlines the expectations for conduct with regard to use of social media and online communications. It applies to paid employees, volunteers, trainees, and agency staff. This policy is not meant to interfere with the rights of employees granted by the National Labor Relations Act (NLRA) to discuss or share information related to wages, hours, or other terms and conditions of employment.

II. **DEFINITIONS**

Social Media: Web-based platforms, tools, and interfaces where people communicate with each other and share information about their lives and opinions, with varying levels of self-selected and system-implemented privacy controls. Social media and the platforms available are ever-evolving. It is defined to include, but not be limited to:

• Social networks (e.g., Facebook, Twitter, LinkedIn, Instagram, Snapchat, Pinterest, etc.)

• Blogs

• Message boards, online forums, and chat rooms

• Video sites (e.g., YouTube, Vine, etc.)

• Instant messaging tools

Social Media Profile: A personal account within a social media platform where users post their personal information.

Protected Health Information (PHI): Any individually identifiable information about a person’s health status, health care, or payment for health care.

III. **POLICY**

A. User Privacy on Social Media

1. On many social media platforms, users have the ability to control the privacy settings on their profiles. However, one cannot assume that any information posted will remain private. Information posted by a user can be viewed, stored, copied, and/or disseminated by any person in their social network, and in many cases, by people outside of their network and by the social media platform itself. In addition, any online platform or profile is subject to hacking or security breaches. Therefore, a user should have no expectation of true privacy in any social media communication whether on Company or personal devices.

2. The company provides training on appropriate use of social media, but it is ultimately the employee’s responsibility to understand the risks involved with posting information on any social media platform that he or she uses.

B. Social Media Use at Work

1. Use of social media during work hours (excluding break times) is prohibited unless it is being used in the course of one’s official duties.

a. Employees using social media as a representative of the company must abide by the facility’s Code of Conduct, official communications policy, and this social media policy.

b. Only authorized employees may prepare, publish, or modify information about the facility on behalf of the facility.

2. Personal social media accounts are not to be accessed at any time on facility computers or other facility-owned devices connected to the Internet.

C. Social Media Monitoring by Facility

1. Employees are personally responsible for the content they publish online.

2. Employees should be aware that their posts can be reviewed by anyone including the facility management/leadership.

3. The facility reserves the right to monitor all online content about the facility, including content posted by employees. Employees are encouraged to understand the expectations and requirements for work-related social media posts and use good judgment and common sense when posting.

D. Social Media and PHI

1. Employees are expected to follow the requirements of the Health Insurance Portability and Accountability Act (HIPAA) as well as state laws and the company’s confidentiality policies with regard to PHI. This means that employees may not make social media posts or statements about residents that include any kind of information that would allow others to identify those residents.

2. PHI includes:

a. Names or nicknames

b. Information about a resident’s diagnosis, medical care, or medical condition

c. Photographs of or including a resident

d. Geographic identifiers (e.g., where a resident is from or where a resident used to live)

e. Resident room numbers

f. Dates directly related to an individual (e.g., birthday, date of admission)

g. Contact information (e.g., phone numbers, email addresses)

h. Social Security numbers

i. Medical record numbers

3. If employees for any reason take photographs inside the business facility or anywhere on its grounds with the intent to post them on social media, they must be vigilant about ensuring that no information about or image of any resident is included in the photograph(s).

4. Employees may not take, store, or share photographs of residents or resident PHI on their personal phones and electronic devices.

5. Any other online activity that infringes on resident rights or compromises a resident’s dignity is prohibited.

6. Employees are discouraged from sending or accepting friend or similar requests from current/former residents and from family members of current/former residents.

7. A resident’s image or other health information is considered PHI. Posting of events or other similar items on social media networks that contain a resident’s image must have a valid release in place from the resident or resident’s legal representative if the resident is incapacitated. The release should be obtained with every new posting.

E. General Conduct on Social Media

1. Employees are not prohibited from discussing the workplace on social media. This policy will be applied in accordance with the protected activities outlined in Section 7 of the NLRA.

2. Employees are expected to work cooperatively with coworkers, management, residents/ customers, and others who come into the facility. Therefore, discriminatory, harassing, libelous, defamatory, threatening, or retaliatory social media posts or online statements about current or past residents, resident families/representatives, visitors, other customers, employees, vendors, or other parties affiliated with the facility are prohibited.

a. Employees are expected to follow the company’s anti-discrimination and anti-harassment policies in any social media content.

b. Disparaging statements about race, religion, gender, sexual orientation, disability, national origin, or any other protected class under local, state, or federal law are prohibited.

3. Employees may wish to discuss or disclose their affiliation with the company in their social media profiles and posts or other online communications, such as personal blog posts. When posting a personal point of view, employees must:

a. Clearly disclose their affiliation with the company if they make a post endorsing it, e.g., “I work for Company and think this facility provides the best services in town” (in accordance with Federal Trade Commission requirements).

b. Make clear that they do not speak for the company or as a representative of the company through a statement such as, “Viewpoints expressed are my own and do not necessarily reflect the facility’s position or services.”

c. Follow all copyright and trademark laws if using the facility’s logo or other branding elements.

d. Abide by the policies outlined in the facility’s official communications policy if contacted by a member of the media.

4. Although employees may discuss the facility online, they may not disclose certain types of information about the company, including “business secrets,” intellectual property, financial data, or similar confidential information about or belonging to the company or its clients, partners, vendors, and suppliers. Should employees have any questions about what constitutes “business secrets,” they should contact management.

F. Reporting Violations/Anti-Retaliation

1. Employees are encouraged to voice concerns of violations of these policies or laws/regulations referenced in these policies and of suspected privacy or security breaches.

2. Employees should notify their supervisor or other management/leadership team member(s). Anonymous notifications are acceptable.

3. The company prohibits taking negative action against an employee for reporting potential deviations from this policy or cooperating in an investigation. If an employee retaliates against another employee for reporting a possible deviation from this policy or for cooperating in an investigation, he or she will be subject to disciplinary action, up to and including termination.

G. Investigation and Disciplinary Action

1. If the facility becomes aware of or receives a report of a social media post that violates this policy, an investigation will be conducted by facility leadership.

2. The facility will attempt to determine who made the post, where it appeared, and the extent to which it was disseminated.

a. Interviews with witnesses or others who may have information will be conducted as necessary.

3. The facility will request that the post be removed by the individual who posted it should the investigation warrant its removal.

4. The facility will make efforts to find and remove or request removal of instances where the original post was shared by others.

5. For HIPAA violations, the facility will contact the social media platform and request that the post be removed.

6. The company reports violations to government regulatory agencies per requirements.

7. Family members and/or residents will be notified of any social media posting which may be deemed violative of a resident’s rights.

H. Disciplinary Action

1. Disciplinary actions will be enforced for violations of this policy, up to and including termination.

2. Harm to the resident(s), company, or other party discussed in this policy; intent; previous violations; and severity of the violation will be considered in determining the appropriate disciplinary action.

# Special Care Units

I. **POLICY GUIDELINES**

Admission criteria have been established to promote proper placement of the Alzheimer’s/dementia resident in a secured environment where specialized programming is provided.

Specific admission and discharge criteria are used for the Alzheimer’s/dementia special care unit in order to maximize safety, optimal functioning, and well-being of persons with dementia.

Discharge criteria comply with regulatory guidelines and are specific to the purpose and goals of the special care unit.

Decisions regarding admission to and discharge from the special care unit are based on individualized assessment.

II. **PROCEDURAL COMPONENTS**

A. Admission Criteria

1. A resident is admitted to the special care unit when his or her identified needs can be met through the unit’s scope of service for eligible admissions which includes, but is not limited to:

a. A primary diagnosis of an irreversible dementia such as Alzheimer’s disease, Pick’s disease, Lewy body or vascular dementia, Parkinson’s dementia, etc., as diagnosed by a physician and with evidence of a dementia work-up

b. Evidence of cognitive impairment

c. The resident’s behavior and behavioral needs do not represent a danger to self or others.

d. A secured environment and specialized programming specific to meeting the special needs of persons with dementia is considered beneficial

e. Psychosocial needs outweigh his or her nursing needs

2. Reasons for a resident to be ineligible for admission to the special care unit include, but are not limited to:

a. A contagious or infectious disease for which, in the opinion of the Administrator and Resident Services Director, the special care unit is unable to provide the necessary care and services

b. The resident’s inability to fully recognize danger or to protect his or her personal safety and whose needs can be met in another level of care

c. An acute psychiatric or mental illness for which the special care unit is unable to provide appropriate care and services

d. Any other resident whose needs cannot be met through the special care unit’s scope of services

B. Pre-admission Assessment

1. Prior to admission, a designated team identifies the resident’s service needs and the special care unit’s ability to meet those needs. This is accomplished through a pre-admission assessment including:

a. Mental status assessment

b. Behavioral assessment

c. Falls assessment

d. Wandering and elopement assessment

e. Functional assessment

f. Psychosocial and well-being assessment

g. Activity assessment

2. Prior to admission, a pre-admission health screening is completed by a physician

C. Discharge Criteria

1. A resident is discharged or transferred from the special care unit based on the scope of services offered and when the unit can no longer meet his or her need. This may include:

a. The resident’s medical or nursing care needs outweigh his or her psychosocial needs

b. A change in the primary diagnosis

c. Change in acute medical status resulting in the need for hospitalization

d. Disruptive or aggressive behavior is of such frequency, intensity, or duration that a more restrictive setting is indicated

e. Behavior that represents a danger to self or others

f. The special care environment and programming do not meet the resident’s needs

g. Change in financial status resulting in inability to pay

h. Disease has advanced to a level where the resident no longer benefits from the unit’s services

D. Admission and Discharge Decision-Making Process

1. All decisions regarding admission or discharge are based on an individualized initial assessment, quarterly reassessments, or reassessment when there is any change in condition

2. Objective assessment tools targeted specifically to assess the level of cognitive impairment, behavior problems, wandering and elopement risk, fall risk, and psychosocial and activity functioning of persons with dementia should be used

a. Resources for these tools may be found at the Alzheimer’s Association web site at www.alz.org; the Alzheimer’s Disease, Education, and Referral Center (ADEAR) at www.alzheimers.org; and the National Guideline Clearinghouse at www.guideline.gov

3. Acute medical conditions, such as urinary tract infections, impactions, or medication interactions, which may trigger behavior problems, mood changes, or change mental and physical functioning, should be identified and treated before decisions are made to discharge a resident from the special care environment

4. Decisions regarding admission and discharge are made using a team approach to include the Administrator, Resident Services Director, any involved allied health professionals, the special care unit supervisor, and the family or legal representative of the resident

# Staff Training & Orientation

I. **POLICY GUIDELINES**

In order to provide a safe environment for residents, staff members develop and maintain the skills necessary to provide appropriate care and services.

The facility provides formal orientation and regular, ongoing in-services to promote adequate training of staff members and to meet the needs of the resident population.

A thorough and effective staff development program is fundamental to risk management practices.

Documentation of employee orientation, attendance at educational sessions, and competency checklists verify that the facility has taken steps to promote a prepared and competent workforce.

A comprehensive educational program encourages meeting each resident’s needs within the current standard of care and practice.

II. **PROCEDURAL COMPONENTS**

A. Orientation for New Employees

1. Orientation, consisting of classroom and on-the-job training, is provided to new employees prior to job placement

2. Topics to be offered in a classroom training setting (general orientation) for employees include:

a. Human Resource policies and procedures regarding benefits, attendance, and the employee handbook

b. Organizational structure, history of the facility, and mission and vision statements

c. Infection control/communicable disease exposure plan including handwashing and blood borne pathogens

d. Resident rights

e. Abuse identification and notification

f. Fire safety

g. Health Insurance Portability and Accountability Act of 1996 (HIPAA), if applicable or confidentiality of facility and resident information

h. Customer service

i. Managing complaints and grievances

j. Managing incidents and reporting adverse events

k. Elopement precautions

l. Employee safety

m. Psychosocial needs of the resident, including the special needs of residents with dementia or Alzheimer’s disease

n. Any additional topic areas required under state regulations

3. New hires receive a formal tour of the facility

4. An orientation checklist is developed and includes orientation and educational topics discussed with the employee. This is retained in the employee’s personnel file

5. A signed confidentiality statement is obtained from new hires

6. Each department develops competency checklists to be utilized for additional departmental training following completion of general orientation. Completed competency checklists are retained in employee personnel files

B. Ongoing Education

1. An annual in-service calendar is developed and implemented for mandatory programs including:

a. Fire safety

b. Infection control

c. Abuse prevention

d. Resident rights

e. HIPAA (if applicable) and confidentiality

f. Elopement prevention

g. Additional topics required under state and federal guidelines

h. Incident reporting and management

i. Dementia care and communication

2. Additional topics are added as they are identified through the facility’s performance improvement processes, which may include:

a. Fall prevention

b. Skin integrity assessment and management

c. Restraint use (if appropriate to facility)

d. Charting and documentation

e. Medication management

3. Educational topics may be specific to a department or provided to staff as appropriate

4. Staff education attendance is documented in the facility’s in-service records, as well as in the employee personnel files

5. The facility’s in-service records include:

a. Topic

b. Date of in-service

c. Audience

d. Presenter

e. Methods used (videotape, lecture, return demonstration, etc.)

f. Outline of materials

g. Length of in-service

h. List of attendees

6. The in-service information is further detailed for each employee attending to be added to the employee’s personnel file, including:

a. Topic

b. Date of in-service

c. Length of in-service

# Transportation

I. **POLICY**

To establish a process to ensure that all [Facility Name] employees assigned to transport residents are competent, have a suitable driving record, and are physically capable of the safe operation of the vehicle.

II. **PURPOSE**

To promote the safety of our residents/employees during transport in company vehicles and to minimize resident/employee injury and property damage associated with vehicle accidents.

III. **PROCESSES**

A. Care of Residents During Transport

1. The safety of our residents is of the utmost importance during the transport process. During periods of excessively hot or cold temperatures, care should be taken to ensure that the heating and air conditioning systems are working properly. Leaving residents in the van without appropriate ventilation is strictly prohibited.

2. Residents shall not be left in the van unattended at any time or for any purpose. When circumstances require the transport of more than one resident, Facility management will consider the medical condition of each resident prior to the trip and ensure that the medical needs of the residents can be met by the accompanying personnel. If multiple stops are scheduled for multiple residents, the number of attendants will be based on the number and medical condition of the residents being transported. The appropriate number of attendants will accompany the driver, will remain in the vehicle, and will assist with the remaining residents.

3. When unforeseen emergencies do occur, van drivers will dial “911” immediately for emergency assistance. A charged and workable cell phone will be present in the van during each trip.

4. In the event a minor medical emergency exists, a first aid kit will be present in each van for use by trained staff members. The van driver will not be responsible for administering first aid, but will be responsible for checking the contents of the kit and replacing used or expired materials.

B. Wheelchair Restraint Systems

1. All vans used to transport residents are required to be equipped with the [System Name] as manufactured by [Manufacturer].

2. All resident wheelchairs will be secured using the QRT “Restraint” system and all residents will be secured with the lap and shoulder restraints before movement of the van.

3. All bus drivers and assistants will be trained using the instruction material and video clip before transporting residents in the van. Training will include a demonstration of the use of the restraint system. Initial and annual training will be documented and placed in the employee’s personnel file.

C. Wheelchair Lifts

1. The [Wheelchair Lift Name] will be used to provide wheelchair access to vans and buses.

2. All bus drivers will be trained using the video clip before Lifting residents in the bus. Training will include a demonstration of the use of the Wheelchair Lift. Initial and annual training will be documented and placed in the employee’s personnel fil

# Vehicle & Driver Safety Management

I. **POLICY GUIDELINES**

The facility strives to promote resident safety. In doing so, the facility purchases and maintains vehicles with safety in mind and has implemented a comprehensive fleet safety program.

The facility promotes safe motor vehicle practices through the implementation of a driver screening and training process.

A comprehensive preventative maintenance program is utilized to extend the economical service life of the vehicle and equipment, improve vehicle and equipment availability, decrease breakdowns during operation, and ensure safe operating conditions.

Vehicular accidents involving employees driving company-owned vehicles or personal automobiles during scheduled work hours are reported immediately.

II. **PROCEDURAL COMPONENTS**

A. Vehicle Management

1. Criteria that are utilized in selecting vehicles for purchase include:

a. Intended and potential uses

b. Accessibility

c. Safety features present or to be added (equipment added should be intended for use in specific vehicle type)

d. Maintenance requirements

e. Common repair requirements for vehicle

f. Availability of resources to provide needed maintenance or repair services

2. Inspection and maintenance records are maintained for each vehicle owned. This includes:

a. Purchase information

b. Maintenance checks

c. Inspections and repairs

d. Other vehicle recordkeeping that may be mandated by federal or local statute

3. A regular vehicle maintenance schedule is established that conforms with manufacturer’s guidelines, including both the vehicle and equipment

4. Both scheduled and unscheduled inspections of the condition of the vehicle’s interior and exterior are conducted

5. Pre- and post-trip vehicle inspections are conducted

6. Regular inspections of storage containers, tie-down devices, and lifts are conducted

7. Critical or safety-related spare parts are stored in the vehicle, where they are readily accessible

8. Identified safety deficiencies are corrected on a scheduling priority basis

B. Driver Pre-Screening Process

1. Preliminary qualifications for individuals being considered for authorization to operate a motor vehicle include:

a. Presentation of a current, valid, unlimited/unrestricted driver’s license (except for corrective lenses)

b. Drivers of a vehicle transporting 16 or more passengers, including the driver, require a commercial driver’s license (CDL). Commercial vehicle license holders must possess a valid health certificate approved by the state and must pass a written examination. For details in licensing drivers with a CDL, contact the state motor vehicle licensing department

c. Be at least 18 years of age (or 21 if transporting residents)

d. Presentation of a current and completed Motor Vehicles Records Check Request

e. Completion of reference check

f. Completion of past employment records

g. Completion of drug screening

h. Evaluation of applicant’s skills

2. Individuals are not authorized to operate a motor vehicle on company business with driving records including any of the following:

a. A conviction for:

i. Driving under the influence of alcohol or drugs (DUI/DWI) within the past 36 months

ii. Failure to stop when involved in an accident

iii. Vehicular homicide

iv. A felony under the motor vehicle laws

v. Use of a vehicle for the commission of a felony

vi. A pattern of accidents or citations which suggests poor driving skills

3. The applicant is informed that motor vehicle record checks are conducted on individuals who, while in the course and scope of employment, are regularly required to operate a motor vehicle

4. Drivers will be required to sign and comply with an Individual Safety Responsibilities: Authorized Driver statement

C. Temporary Driver

1. During the initial 30-day period of completing the training program, the individual may serve as a temporary driver. Individuals who have satisfactorily completed the screening process and training program may be designated as authorized drivers

D. Skills Validation and Training Program

1. Orientation for newly hired drivers should include the facility’s general orientation as well as job-specific training including:

a. Pre-trip van inspection

b. Boarding a wheelchair-bound resident into a van

c. Wheelchair and resident securement in a van

d. Removing a wheelchair-bound resident from the van

e. Operation of a lift and use of manual backup system

f. In-servicing relating to any deficiencies identified in the application process

g. Safe driving practices and responsibilities such as:

i. Drivers obey all laws regarding speed lights, traffic signs, etc.

ii. Use of seat belts are required by all facility vehicle occupants

iii. Use of a cell phone is prohibited by the driver during transport

iv. Picking up unauthorized passengers is prohibited

v. Substance abuse prior or during operation of a facility vehicle will not be tolerated and is grounds for dismissal

vi. Facility vehicles are inspected daily prior to operation

vii. No facility vehicle is left unsecured. Doors are locked

h. The driver’s participation in general and job-specific orientation is documented and maintained in the employee’s file

i. A skills validation checklist is completed prior to the driver being authorized to transport residents. The completed checklist is maintained in the employee’s file

j. A corporation- or state-approved defensive driving course is required at least every two years for drivers who transport residents. This training must be accomplished not more than 30 days following assignment as a temporary driver unless a defensive driving course has been completed in the past two years

k. In-service training on passenger transport is required at least annually for drivers who are responsible for transporting residents

E. Driver Monitoring

1. A driver evaluation through the department of motor vehicles (DMV) is completed annually with the re-evaluation of skills using a skills validation checklist

2. A driving record query should be obtained on all authorized drivers at least annually. It is suggested that all motor vehicle records be ordered simultaneously for all drivers in April of each year to simplify administration

3. Authorized drivers must immediately report any motor vehicle violations, convictions, or accidents to their supervisors

4. A driver involved in a serious accident who is found to be “at fault” may have driving privileges revoked

5. A current file is maintained for each authorized driver, including:

a. Copy of current driver’s licenses

b. State DMV reports

c. Proof of insurance (personal vehicles)

d. Individual safety responsibilities: authorized driver

e. Defensive driver course certifications for completion of in-services on transporting passengers

f. Applicable skills

F. Use of Personal Vehicles

1. The use of personal vehicles for company business is not recommended since the facility’s auto policy does not provide coverage for fire, theft, collision, or any other damage claims for personal vehicles. Also, the facility’s automobile insurance policy only provides liability coverage after the driver’s personal automobile liability insurance policy limits are exhausted

2. If personal vehicles are used for company business, the facility maintains in the employee’s file the following:

a. Copy of a current driver’s license

b. Current proof of automobile insurance including liability limits

c. Signed automobile insurance coverage statement

3. Drivers using personal vehicles for company business need to be informed that in the event of an accident, their auto insurance policies apply

G. Vehicular Accident Reporting

1. A copy of the vehicle registration, insurance card, Vehicle Accident Reporting Policy and Procedure, vehicle insurance coverage card, and blank copies of a Vehicular Accident Report Form should be maintained in the glove compartment of all company vehicles

2. In case of a traffic accident:

a. Stop immediately to investigate. Do not leave the scene

b. Notify police

c. Help anyone who is injured, call an ambulance if necessary

d. Do not move vehicles until the police arrive, unless the vehicle is impeding traffic flow

e. Exchange information with parties involved including name, address, phone number, license plate number, and name of insurance company

f. Do not admit any type of fault or negligence as a result of the automobile accident or sign any statement of responsibility. Indicate only that the matter will be turned over to the appropriate company representatives for investigation

g. Attempt to secure names, addresses, and phone numbers of all witnesses. Witnesses include persons arriving on the scene, even if they did not actually witness the automobile accident

h. Report the incident to the facility Administrator

i. Complete a Vehicular Accident Report Form and submit to the facility Administrator

j. The Administrator notifies the Corporate Risk Manager, if any, and the insurance provider

H. Accident Investigation

1. A written protocol for the investigation of vehicular- or transportation-related accidents has been established

2. One individual is designated to coordinate the accident investigation (the initial investigation ordinarily is done by the immediate supervisor of the involved employee)

3. A master accident report file is maintained containing data specific to each accident including:

a. Date

b. Time

c. Place

d. Driver’s name

e. Description of the accident

f. Insurance company claim number

g. Estimated incident cost

4. A Driver Accident Record and Driver Accident Record Action Plan is maintained in each driver’s personnel file

a. The Driver Accident Record is completed when a driver is involved in any type of transportation-related accident

b. A Driver Accident Record Action Plan is developed to document supervisory follow-up addressing employee performance issues, actions taken to improve employee performance, and determination of continued driver eligibility

I. Repairs

1. If a company vehicle is damaged and the vehicle is drivable, two estimates for repairs are obtained and reviewed by the facility Administrator along with any photographs clearly documenting the damage to the vehicle

2. If the vehicle is not drivable, it is towed to the nearest service center, garage, or dealership for repairs

3. The Administrator or Corporate Risk Manager, if any, notifies the auto insurance carrier

4. Repairs are not initiated until approval is received from the Corporate Risk Manager, if any, or the Administrator

# Visitor Risk Reduction

1. Require all visitors to sign in when entering the facility

2. Include an explanation of the “Visitor Log” protocol to residents and families in the Family Council and in the admission process, obtaining a signed statement of understanding regarding this new process by the resident and/or the sponsor or responsible party

3. Visitors should also be issued a name badge at the reception desk

# Volunteers

I. **PURPOSE**

The facility strives to promote resident safety and to improve the quality of life for the residents as well as the community.

To this end, volunteers are utilized as an adjunct to the facility staff in the performance of non-care duties. Volunteers do not replace designated staff positions or perform direct resident care.

II. **PROCEDURAL COMPONENTS**

Volunteers are utilized for assisting the facility and its staff in carrying out activities in non-direct care functions. Volunteers perform their duties in the presence of facility staff and are not utilized for any direct resident care, such as assisting with bathing. Volunteers are not assigned tasks that present a risk of exposure to blood-body fluids

A. Volunteer Screening

1. All volunteers are screened prior to being offered a volunteer position. Screening includes:

a. An application that states:

i. Education

ii. Prior work experience

iii. Two personal references

iv. Hours of availability

v. Contact information

vi. A statement indicating that the volunteer has no prior criminal conviction

vii. A statement regarding the volunteer’s health status including:

(a) Whether there are any physical conditions that may limit the volunteer’s ability to perform the assigned tasks

(b) That the volunteer is free of communicable diseases

(c) Whether the volunteer requires any special accommodations to perform the assigned duties

(d) A contact number in the event of an emergency

2. A sex offender registry verification is conducted

a. For any volunteer who is out of the direct sight and sound of facility staff at any time

i. A signed statement authorizing the facility to conduct a criminal background check is obtained. A criminal background check is performed in accordance with the procedure used for staff background checks

ii. A sexual abuse registration check is conducted via the National Sex Offender Web site (www.nsopr.gov)

b. An interview is conducted by the Activities Director or whoever is responsible for oversight of the volunteer program. The interview summary is documented and includes:

i. The prospective volunteer’s goals

ii. Times of availability

iii. Understanding of volunteer role and limitations

iv. Willingness to undergo orientation to the facility

c. References are contacted with documentation of the conversation

B. Volunteer Duties

1. A job description or “duty list” is provided to all volunteers prior to their agreeing to volunteer at the facility. This outlines the activities in which the volunteers is involved, and includes:

a. Task list

b. Required oversight

c. Any special qualifications required

d. Need to complete orientation

e. Any specific physical requirements

2. Each volunteer is provided with a copy of the duty list that is signed with a copy retained in the volunteer’s file

3. Duty lists are reviewed by facility staff on an annual basis to verify that the volunteer duties have not changed

C. Confidentiality

1. Volunteers are oriented to the confidentiality policy of the facility

2. Volunteers are required to sign a confidentiality statement acknowledging that they:

a. Understand the confidentiality policy

b. Are committed to maintaining patient privacy

c. Understand that they will be terminated for breach of confidentiality

D. Volunteer Orientation

1. General facility orientation is completed prior to the volunteer commencing any duties. Orientation includes:

a. Duties

b. Reporting structure

c. Duties that are not to be performed by volunteers

d. Confidentiality policy

e. Sign-in procedure

f. Tracking of hours of volunteers, including students who are accruing hours for school commitment

g. Illness policy

h. Process for calling in to report absence

i. Basic infection control (handwashing)

j. Management of injuries that occur while onsite

k. Fire safety

l. Disaster safety

m. Corrective actions taken for volunteers who function outside their roles

n. Immediate dismissal process

2. Verification of orientation, including the date of completion, is signed by all volunteers and maintained in their files

3. If additional duties are assigned on a unit- or department-specific basis, additional orientation is provided by that department and documented on a checklist

E. Volunteer Oversight and Documentation

1. Volunteers report directly to the Activities Director, unless otherwise specified

2. An annual summary of the volunteer’s activity is maintained as well as any general comments about work performance. Hours are tracked for each volunteer. The volunteer is informed that ongoing services are dependent upon successful accomplishment of the defined tasks

3. A file for each volunteer is maintained and includes a signed job description or tasks list, completion of orientation, and a signed acknowledgment of confidentiality policy with annual updates

F. Volunteer Identification

1. Volunteers are expected to comply with the facility’s process for identification (such as name tags)

# Workplace Violence

I. **POLICY GUIDELINES**

The facility is committed to providing a secure environment to protect the safety and well-being of all employees and does not tolerate violence in the workplace. The facility takes appropriate actions to prevent violent incidents from occurring and has implemented a Workplace Violence Prevention Program (WVPP).

It is the responsibility of all employees to report any acts of violence to their immediate supervisor and/or Human Resource Director immediately.

All reports of workplace violence are investigated immediately. Any violent actions committed by employees or members of the public while on the property are subject to prompt disciplinary action, up to and including termination of employment and/or notification of legal authorities, and may be subject to criminal prosecution.

The facility does not discriminate against victims of workplace violence.

II. **DEFINITIONS**

**Workplace violence** is defined as “violent acts (including physical assaults and threats of assault) directed toward persons at work or on duty” (National Institute for Occupational Safety and Health).

**Violent acts** are actions or words that endanger or harm employees or result in others having a reasonable belief that they are in danger such as:

* Verbal or physical harassment
* Verbal or physical threats
* Assaults or other violence made directly or indirectly by words, gestures, or symbols
* Any other behavior that causes others to feel unsafe (e.g., bullying, sexual harassment)
* Use or possession of a weapon on the company’s premises

**Workplace violence incidents** can be categorized by the relationship of the assailant and the worker/workplace. They are as follows:

* Violence by strangers—persons who have no connection to the workplace
* Violence by customers, clients, residents, etc.
* Violence by co-workers—former or current employment relationship. Incidents that occur outside the workplace but that resulted or arose from the employment relationship are counted in this category
* Violence by personal relations—incidents committed by someone who has a personal relationship with the worker, such as a current or former spouse or partner, relative, or friend

**U.S. Department of Labor, Occupation, Safety and Health Administration (OSHA) 300 Log** is required to be maintained by the facility to log any work-related injury and illness within seven days of notification that a recordable injury or illness has occurred (see [www.osha.gov](http://www.osha.gov/)).

III. **PROCEDURAL COMPONENTS**

**Threat Assessment Team**

A Threat Assessment Team (TAT), comprised of managers and line staff, is established to assess the risk and vulnerability to workplace violence, as well as recommend and implement preventative actions

**Hazard Assessment**

The TAT conducts a hazard assessment annually that includes review of the OSHA 300 logs for the last three years, incident reports, insurance loss reports, police reports, accident investigations, training records, grievances, and worker’s compensation records to determine trends. Near-miss incidents should also be reviewed. Preventative actions and controls are recommended for noted patterns of workplace violence incidents.

Examples of such incidents could be:

* Resident physically strikes an employee
* Visitor verbally harasses or threatens an employee
* Employees from one department complain that another employee from another department is bullying them and having emotional outbursts at work

**Workplace Security Analysis**

The TAT inspects the workplace annually, or as needed, and evaluates work tasks of all employees to determine the presence of hazards and conditions which may place the employees at risk for violence

A Workplace Security Checklist is used to document inspections (see attached sample)

The TAT identifies issues and recommends measures, engineering controls, work area redesign, etc., to minimize the risk of workplace violence for all employees

Employees are surveyed at least annually to seek their input regarding security concerns and issues.

An Employee Security Survey form is used to conduct these surveys (see attached sample)

Examples of identified issues include, but are not limited to:

* Access to facility is not controlled
* Lighting in the parking lot is inadequate
* Night shift has lower staffing levels, making them more vulnerable
* Training of security needs improvement

 Examples of controls and preventative actions to minimize risk include, but are not limited to:

* Implementation of visitor identification badges
* Improved lighting in the employee parking lot
* Security escort for 3:00 p.m.–11:00 p.m. and 11:00 p.m.–7:00 a.m. shift workers departing and arriving to work
* Improved security training

**Employee Education**

Employees are trained upon hire and annually thereafter. Training includes, but is not limited to:

* Review and definition of workplace violence
* Severity of workplace incidents in healthcare settings
* Factors placing healthcare settings at higher risk
* Warning signs and behaviors of a violent employee/individual
* Ways to prevent/diffuse volatile situations or aggressive behavior
* Review of the Resident Restraint Policy
* Process for reporting and investigating incidents for workplace violence
* Prevention of workplace violence program

Employees receive de-escalation training and are taught techniques to promote their physical safety when responding to an individual, whether resident, family, visitor or co-worker, who is considered potentially violent or has committed a violent act

De-escalation training techniques may include, but are not limited to:

* Do not argue or provoke. Intrusiveness can provoke aggression
* Do not make individual sit. They may be unable to do so
* Do not walk behind the individual. Voices out of direct vision may be frightening
* Position self off to individual’s side, not toe-to-toe
* Even if person swears and shouts, don’t respond similarly
* Use open-ended sentences: “You feel people are treating you unkindly?”
* Avoid staring
* Avoid aggressive postures
* Stay attentive to the individual but avoid aggressive or offensive tactics
* Avoid rapid movements, which may provoke the person
* Delineate the rules and make behavioral expectations clear. Clear guidelines and timeframes are reasonable
* Don’t challenge the person

Physical safety techniques include, but are not limited to:

* Avoid dangling jewelry
* Keep keys hidden
* Limit objects that can serve as weapons
* If the individual’s physical movements escalate, implement self defense techniques:
* Stay more than an arm’s length away
* Maintain self-defense stance (lean in toward the person at an angle, feet shoulder-width apart, knees part, hands open with arms at side)
* Block or deflect fists or kicks, avoiding body contact
* Hair grabbing: pull their hands into your head so they cannot keep pulling, then bend head down as low as possible so they move down with you and loosen grip
* If choked, bend head to chest to maintain blood and airflow
* If bitten, push harder into perpetrator’s mouth to cause them to release, if they don’t release, pinch their nostrils and hold

**Incident Reporting, Investigation, and Follow-Up**

All incidents must be reported immediately to one’s supervisor or the Human Resources Director. The Administrator is then notified immediately. An incident form is completed and confidentiality is respected

The facility contacts the local police if necessary, determines if the work area where the disturbance occurred is safe, promotes the safety of others remaining in the area, and secures the area

An investigation occurs immediately for all incidents and near misses. The investigation process includes:

* Collection of the facts on who, what, when, where, and how the incident occurred
* Documentation of information
* Identification of contributing causes
* Recommended corrective action
* Implementation of appropriate follow-up
* Changes in controls, policies, etc., as needed

Follow-up includes meeting the employee’s medical and psychological needs following an incident of workplace violence through usage of an Employee Assistance Program (EAP).

**Recordkeeping**

Any injury that requires more than first aid, loss of consciousness, requires modified duty, or results in lost time from work must be logged on the OSHA 300 log and the Injury and Illness Log

An employee death resulting from an employment accident or illness caused by or related to a workplace hazard or the hospitalization of three or more employees resulting from an employment accident or illness caused by a workplace hazard must be orally reported to OSHA within eight hours

All minutes of the safety meetings, TAT meeting minutes, inspection reports, employee security surveys, and employee training records are maintained

**WORKPLACE SECURITY CHECKLIST**

Facility:

Inspector:

Date of Inspection:

**1. Security Control Plan:** ❑ Yes ❑ No

If yes, does it contain:

(A) Policy Statement ❑ Yes ❑ No

(B) Review of Employee Incident Exposure ❑ Yes ❑ No

(C) Methods of Control ❑ Yes ❑ No

 If yes, does it include:

1. Engineering ❑ Yes ❑ No
2. Work Practice ❑ Yes ❑ No
3. Training ❑ Yes ❑ No
4. Reporting Procedures ❑ Yes ❑ No
5. Recordkeeping ❑ Yes ❑ No
6. Counseling ❑ Yes ❑ No

(D) Evaluation of Incidents ❑ Yes ❑ No

(E) Floor Plan ❑ Yes ❑ No

(F) Protection of Assets ❑ Yes ❑ No

(G) Computer Security ❑ Yes ❑ No

(H) Plan Accessible to All Employees ❑ Yes ❑ No

(I) Plan Reviewed and Updated Annually ❑ Yes ❑ No

(J) Plan Reviewed and Updated When Tasks Are Added or Changed ❑ Yes ❑ No

**2. Policy Statement by Employer** ❑ Yes ❑ No

**3. Work Areas Evaluated by Employer** ❑ Yes ❑ No

 If yes, how often?

**4. Engineering Controls** ❑ Yes ❑ No

If yes, does it include:

(A) Mirrors to see around corners and in blind spots ❑ Yes ❑ No

(B) Landscaping to provide unobstructed view of the workplace ❑ Yes ❑ No

(C) “Fishbowl effect” to allow unobstructed view of the interior ❑ Yes ❑ No

(D) Limiting the posting of sale signs on windows ❑ Yes ❑ No

(E) Adequate lighting in and around the workplace ❑ Yes ❑ No

(F) Parking lot well lighted ❑ Yes ❑ No

(G) Door Control(s) ❑ Yes ❑ No

(H) Panic Button(s) ❑ Yes ❑ No

(I) Door Detector(s) ❑ Yes ❑ No

(J) Closed Circuit TV ❑ Yes ❑ No

(K) Stationary Metal Detector ❑ Yes ❑ No

(L) Sound Detection ❑ Yes ❑ No

(M) Intrusion Detection System ❑ Yes ❑ No

(N) Intrusion Panel ❑ Yes ❑ No

(O) Monitor(s) ❑ Yes ❑ No

(P) Video Tape Recorder ❑ Yes ❑ No

(Q) Switcher ❑ Yes ❑ No

**WORKPLACE SECURITY CHECKLIST** *(continued)*

(R) Hand Held Metal Detector ❑ Yes ❑ No

(S) Hand held video camera ❑ Yes ❑ No

(T) Personnel traps ("Sally Traps") ❑ Yes ❑ No

(U) Other ❑ Yes ❑ No

**5. Structural Modifications**

Plexiglas, glass guard, wire glass, partitions, etc. ❑ Yes ❑ No

 If yes, comment:

**6. Security Guards** ❑ Yes ❑ No

(A) If yes, are there an appropriate number for the site? ❑ Yes ❑ No

(B) Are they knowledgeable of the company WPVP Policy? ❑ Yes ❑ No

(C) Indicate if they are:

 \_\_\_\_\_\_Contract Guards (1)

 \_\_\_\_\_\_In-house Employees (2)

(D) At Entrance(s) ❑ Yes ❑ No

(E) Building Patrol ❑ Yes ❑ No

(F) Guards provided with communication? ❑ Yes ❑ No

 If yes, indicate what type:

(G) Guards receive training on Workplace Violence situations? ❑ Yes ❑ No

 Comments:

**7. Work Practice Controls** ❑ Yes ❑ No

If yes, indicate:

(A) Desks Clear of Objects which may become Missiles ❑ Yes ❑ No

(B) Unobstructed Office Exits ❑ Yes ❑ No

(C) Vacant (Bare) Cubicles Available ❑ Yes ❑ No

(D) Reception Area Available ❑ Yes ❑ No

(E) Visitor/Client Sign In/Out ❑ Yes ❑ No

(F) Visitor(s)/Client(s) Escorted ❑ Yes ❑ No

(G) Barriers To Separate Clients from Work Area ❑ Yes ❑ No

(H) One Entrance Used ❑ Yes ❑ No

(I) Separate Interview Area(s) ❑ Yes ❑ No

(J) I.D. Badges Used ❑ Yes ❑ No

(K) Emergency Numbers Posted By Phones ❑ Yes ❑ No

(L) Internal Phone System ❑ Yes ❑ No

 If yes, indicate:

1. Does it Use 120 VAC Building Lines ❑ Yes ❑ No
2. Does it Use Phone Lines ❑ Yes ❑ No

(M) Internal Procedures for Conflict (Problem) Situations ❑ Yes ❑ No

(N) Procedures for Employee Dismissal ❑ Yes ❑ No

(O) Limit Spouse & Family Visits to Designated Areas ❑ Yes ❑ No

(P) Key Control Procedures ❑ Yes ❑ No

(Q) Access Control to the Workplace ❑ Yes ❑ No

(R) Objects which may become Missiles Removed from Area ❑ Yes ❑ No

**WORKPLACE SECURITY CHECKLIST** *(continued)*

(S) Parking Prohibited in Fire Zones ❑ Yes ❑ No

 Other:

**7a. Off Premises Work Practice Controls**

(For staff who work away from a fixed workplace, such as: social services, real estate, utilities, policy/fire/sanitation, taxi/limo, construction, sales/delivery, messengers, and others.)

(A) Trained in Hazardous Situation Avoidance ❑ Yes ❑ No

(B) Briefed About Areas Where They Work ❑ Yes ❑ No

(C) Have Reviewed Past Incidents by Type and Area ❑ Yes ❑ No

(D) Know Directions and Routes for Day’s Schedule ❑ Yes ❑ No

(E) Previewed Client/Case Histories ❑ Yes ❑ No

(F) Left an Itinerary with Contact Information ❑ Yes ❑ No

(G) Have Periodic Check-In Procedures ❑ Yes ❑ No

(H) After Hours Contact Procedures ❑ Yes ❑ No

(I) Partnering Arrangements if Deemed Necessary ❑ Yes ❑ No

(J) Know How To Control/Defuse Potentially Violent Situations ❑ Yes ❑ No

(K) Supplied with Personal Alarm/Cellular Phone/Radio ❑ Yes ❑ No

(L) Limit Visible Clues of Carrying Money/Valuables ❑ Yes ❑ No

(M) Carry Forms To Record Incidents by Area ❑ Yes ❑ No

(N) Know Procedures if Involved in Incident ❑ Yes ❑ No

 (see also Training Section)

**8. Training Conducted** ❑ Yes ❑ No

If yes, is it:

(A) Prior to Initial Assignment ❑ Yes ❑ No

(B) At Least Annually Thereafter ❑ Yes ❑ No

(C) Does it Include:

1. Components of Security Control Plan ❑ Yes ❑ No
2. Engineering and Workplace Controls Instituted at Workplace ❑ Yes ❑ No
3. Techniques To Use in Potentially Volatile Situations ❑ Yes ❑ No
4. How To Anticipate/Read Behavior ❑ Yes ❑ No
5. Procedures To Follow After an Incident ❑ Yes ❑ No
6. Periodic Refresher for On-Site Procedures ❑ Yes ❑ No
7. Recognizing Abuse/Paraphernalia ❑ Yes ❑ No
8. Opportunity for Q and A with Instructor ❑ Yes ❑ No
9. On Hazards Unique To Job Tasks ❑ Yes ❑ No

**9. Written Training Records Kept** ❑ Yes ❑ No

**10. Incidents Reported** ❑ Yes ❑ No

If yes, are they:

(A) Reported in Written Form ❑ Yes ❑ No

(B) First Report of Injury Form (If Employee Loses Time) ❑ Yes ❑ No

**11. Incidents Evaluated** ❑ Yes ❑ No

(A) EAP Counseling Offered ❑ Yes ❑ No

**WORKPLACE SECURITY CHECKLIST** *(concluded)*

(B) Other Action (Reporting Requirements, Suggestions, Reporting To
Local Authorities, Etc.)

(C) Are Steps Taken To Prevent Recurrence? ❑ Yes ❑ No

**12. Floor Plans Posted Showing Exits, Entrances, Location of
Security Equipment, Etc.** ❑ Yes ❑ No

If yes, does it:

(A) Include an Emergency Action Plan, Evacuation Plan, and/or
a Disaster Contingency Plan? ❑ Yes ❑ No

13. Do Employees Feel Safe? ❑ Yes ❑ No

(A) Have Employees Been Surveyed To Find Out Their Concerns ❑ Yes ❑ No

(B) Has the Employer Utilized the Crime Prevention Services and/or
Lectures Provided by the Local or State Police? ❑ Yes ❑ No

 Comments:

General Comments/Recommendations:

Source: [www.osha.gov](http://www.osha.gov), *Elements of a Workplace Violence Prevention Program*

**EMPLOYEE SECURITY SURVEY**

This survey will help detect Security Problems in your building or at an alternate worksite.

Please fill out this form, get your co-workers to fill it out, and review it to see where the potential for major security problems lie.

NAME:

WORK LOCATION:

(IN BUILDING OR ALTERNATE WORKSITE)

1. Do either of these two conditions exist in your building or at your alternate work site?

 Work alone during working hours.

 No notification given to anyone when you finish work.

Are these conditions a problem? If so when, please describe. (For example, Mondays, evening, daylight savings time)

2. Do you have any of the following complaints (that may be associated with causing an unsafe worksite)?

(Check all that apply)

 Does your work place have a written policy to follow for addressing general problems?

 Does your work place have a written policy on how to handle a violent client

 When and how to request the assistance of a co-worker

 When and how to request the assistance of police

 What to do about a verbal threat

 What to do about a threat of violence

 What to do about harassment

 Working alone

 Alarm system(s)

 Security in and out of building

 Security in parking lot

 Have you been assaulted by a co-worker?

 To your knowledge have incidents of violence ever occurred between your co-workers?

3. Are violence related incidents worse during shift work, on the road, or in other situations?

Please specify:

4. Where in the building or worksite would a violence related incident most likely occur?

❑ lounge ❑ exits ❑ deliveries ❑ offices ❑ parking lot

❑ bathroom ❑ entrance ❑ other

Other (specify)

**EMPLOYEE SECURITY SURVEY** *(concluded)*

5. Have you ever noticed a situation that could lead to a violent incident?

6. Have you missed work because of a potential violent act(s) committed during your course of employment?

7. Do you receive workplace violence related training or assistance of any kind?

8. Has anything happened recently at your worksite that could have led to violence?

9. Can you comment about the situation?

10. Has the number of violent clients increased?

Source: [www.osha.gov](http://www.osha.gov/), *Elements of a Workplace Violence Prevention Program*