SECTION 11

CARDIOPULMONARY RESUSCITATION (CPR)

CARDIO-PULMONARY RESUSCITATION

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Administration	Cardio-Pulmonary Resuscitation	AP 215

1. PURPOSE. It is the purpose of this policy to ensure the safety of the residents and staff of Arkansas Health Center (AHC) during cardio-pulmonary emergencies and provide guidelines for proper implementation of Cardio-Pulmonary Resuscitation (CPR).

2. SCOPE. All staff of Arkansas Health Center.

3. POLICY. It is the policy of AHC to ensure that all staff are trained in Cardio-Pulmonary Resuscitation (CPR), and that they maintain current certification, so that in cardio-pulmonary emergency techniques are utilized by certified individuals to persons in physical distress.

4. DEFINITION.

   A. Cardio-pulmonary Resuscitation (CPR) – Action taken to ventilate and establish circulation on an individual with an absence of respirations and pulse.

   B. Automated External Defibrillator (AED) – A portable electronic device that diagnosis and treats potentially life threatening cardiac arrhythmias in a patient by application of electrical therapy which stops the arrhythmia, allowing the heart to re-establish an effective rhythm.

   B. Do Not Resuscitate (DNR) – Identifies that staff is to stop medical treatment and is not to initiate cardio-pulmonary resuscitation in the event of cardiac arrest.

   C. Advanced Directive – A signed document that gives directions to care givers regarding the desire of the resident concerning the withholding or withdrawal of treatment that is not necessary for comfort, alleviates pain, and only prolongs the process of dying or extends the period of unconscious existence.

   D. "Red Dot/Blue Dot" – A red dot on a resident's chart indicates he/she is not to be resuscitated if they are without pulse or blood pressure. A blue dot is a full- code status on a resident's chart and means the person will be resuscitated if they are found without blood pressure or pulse or if they arrest during their evaluation or transfer process.

   E. American Heart Association is the accreditation entity that sets the standards for persons at AHC providing CPR as well as trains persons to certified CPR instructors.

5. TRAINING.

   A. A certified instructor using the American Heart Association standards will teach CPR training.

   B. Upon completion of a course, the Staff Development Department will submit a training roster to a designated official training center for official record keeping. CPR cards will be provided from the official training center to Staff Development for trainees. Staff Development will retain a copy of the roster within the Department; will provide the trainee with their CPR card and a copy of the card will be submitted to the employee's formal personnel file.

C. The AHC Staff Development Department will provide certification update training to all employees on an annual basis and re-certification training every two years.

D. All new employees of AHC will receive CPR training as part of their New Employee Orientation.

6. PROCEDURE.

A. CPR using the AED will be performed according to the guidelines established in Appendix A.

B. CPR will be initiated on residents without pulse or respiration except for those designated as Do Not Resuscitate (DNR).

C. In the event a resident appears to be in serious physical distress, AHC will arrange immediate transfer of the resident to the emergency room by calling 911. Staff appointed to call 911 will also contact the Physician and family or responsible party.

D. When the resident presents with serious physical distress which is the direct result of an act of negligence or intentional misconduct on the part of another person, AHC will arrange for immediate transfer to the emergency room regardless of the individuals' advance directives.

E. Once begun, CPR must be continued until advanced life-support systems are available and operable. CPR may be discontinued only when the victim responds, or the Physician orders CPR to be discontinued.

7. DOCUMENTATION.

A. Nursing shall document in the Nurses' Notes the date, time, condition of the resident, and any other pertinent information such as vital signs or absence of vital signs. The documentation should further reveal if the resident was transferred to the emergency room, and the notification (date/time) of the Physician and family.

B. The care plan shall be updated as needed.

_____ _____

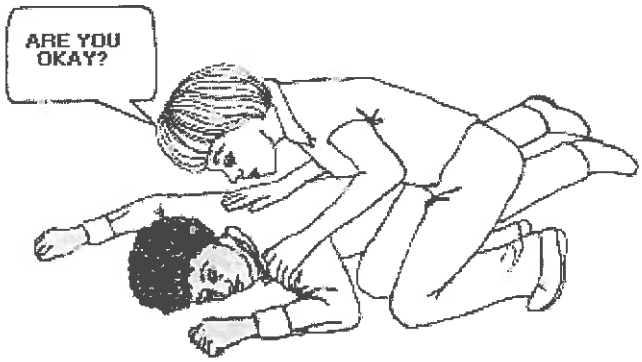
AHC Director Date

ARKANSAS HEALTH CENTER

A. PROCEDURE.

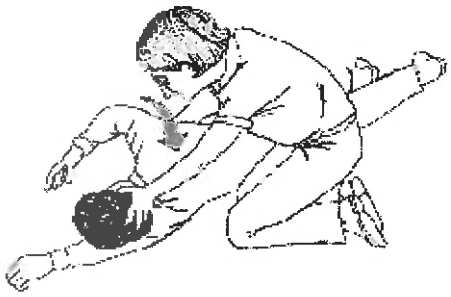
I. The CPR procedures should be learned and practiced on a training mannequin under the guidance of a qualified instructor. The step by step procedure for cardiopulmonary resuscitation is as follows:

A. Establish unresponsiveness. Gently shake the victim's shoulder and shout, "Are you OK?" The individual's response or lack of response will indicate to the rescuer if the victim is just sleeping or unconscious (Figure 3-1).



B. Call for help. ***CALL 911 or the operator at 860-0500 and have them call 911*** Help will be needed either to assist in performing CPR or to call for medical help.

C. Position the victim. If the victim is found in a crumpled up position and/or face down, the rescuer must roll the victim over; this is done while calling for help; ***you may instruct a co-worker to call 911 immediately.*** (Figure 3-2)



- When rolling the victim over, take care that improper handling does not further complicate broken bones. Roll the victim as a unit so that the head, shoulders, and torso move simultaneously with no twisting.
- Kneel beside the victim, a few inches to the side.
- The arm nearest the rescuer should be raised above the victim's head.
- The rescuer's hand closest to the victim's head should be placed on the victim's head and neck to prevent them from twisting.
- The rescuer should use the other hand to grasp under the victim's arm furthest from rescuer. This will be the point at which the rescuer exerts the pull in rolling the body over.
- Pull carefully under the arm, and the hips and torso will follow the shoulders with minimal twisting.
- Be sure to watch the neck and keep it in line with the rest of the body.
- The victim should now be flat on his/her back.

D. CPR Procedures for Single Rescuer:

A-Airway. Open the airway. The most common cause of airway obstruction in an unconscious victim is the tongue.

Use the head-tilt/chin-lift maneuver to open airway. (This maneuver is not recommended for a victim with possible neck or spinal injuries).

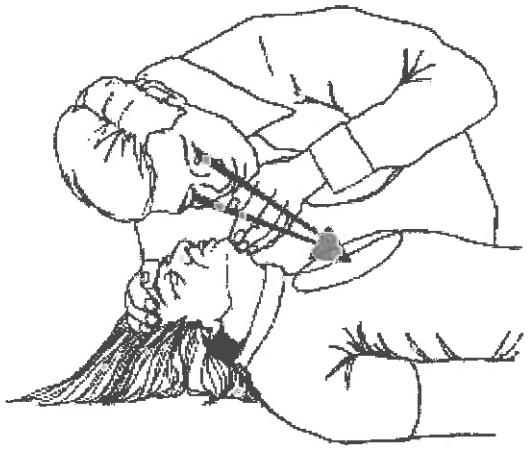
When opening the airway, check the neck for stomas and make sure this airway is not obstructed.

If a person is choking or appears to have an obstructed airway, perform the procedures outlined in section II. titled A and B under Emergency Procedures for Choking.

B-Breathing. Establish breathlessness. After opening the airway establish breathlessness.

- Turn your head toward the victim's feet with your cheek close over the victim's mouth or stoma(5 to 10 seconds).

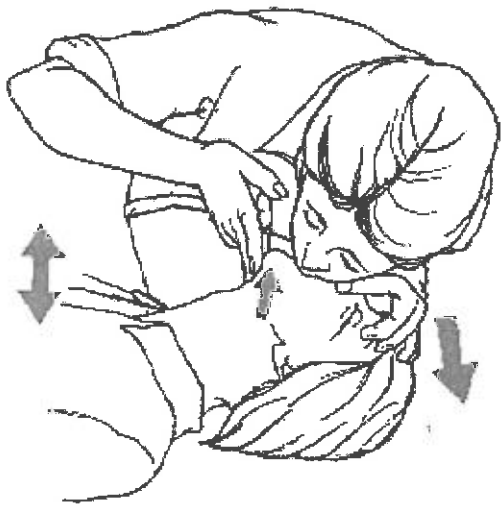
- **Look** for a rise and fall in the victim's chest
- **Listen** for air exchange at the mouth and nose or stoma.
- **Feel** for the flow of air (Figure 3-3).



Sometimes opening and maintaining an open airway is all that is necessary to restore breathing.

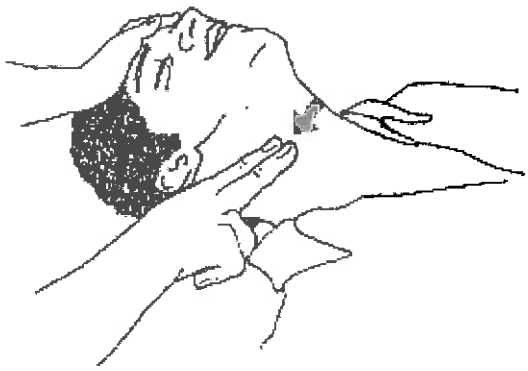
Provide artificial ventilation.

- If the victim is not breathing give two full breaths by mouth-to-mouth, mouth-to-nose, or mouth-to-stoma ventilation (Figure 3-4). Allow for lung deflation between each of the two ventilations.



C-Circulation. Check for pulse. Check the victim's pulse to determine whether external cardiac compressions are necessary.

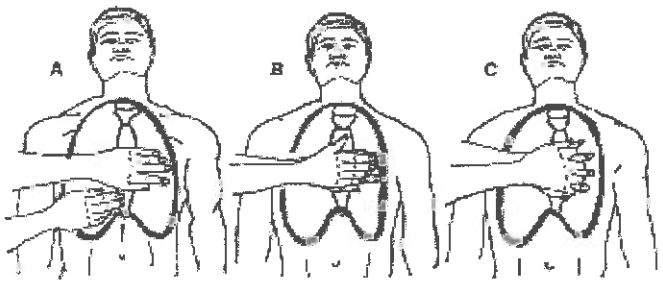
- Maintain an open airway position by holding the forehead of the victim.
- Place your fingertips on the victim's windpipe and then slide them towards you until you reach the groove of the neck. Press gently on this area (carotid artery) (Figure 3-5).
- Check the victim's carotid pulse for at least five to ten seconds but no more than ten seconds.



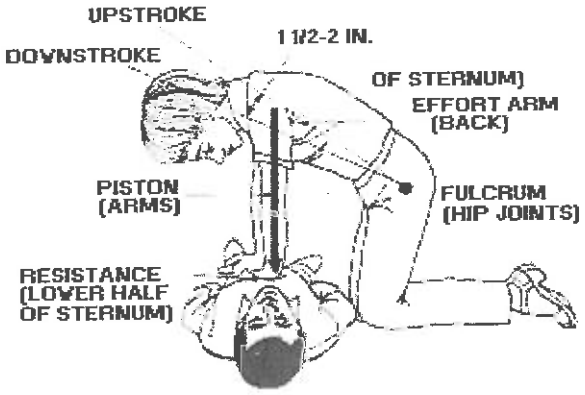
- If a pulse is present, continue administering artificial ventilation once every 5 seconds or 12 times a minute. If not, make arrangements to send for trained medical assistance and begin CPR.

Perform cardiac compressions.

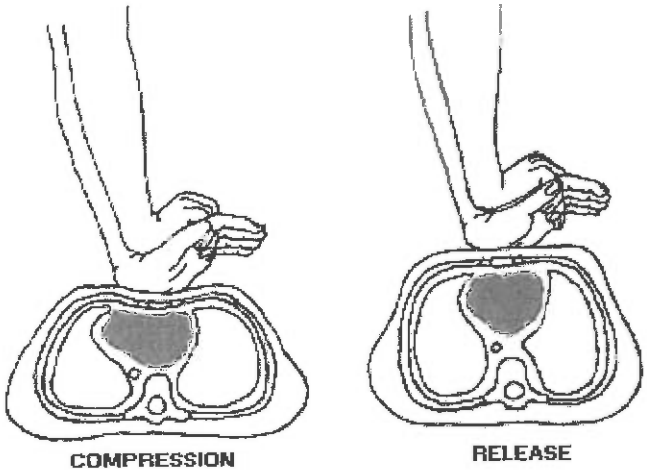
- Place the victim in a horizontal position on a hard, flat surface.
- Locate the victim's nipples and place your hands on top of the sternum directly in line with the nipples.
- Keep the fingers off the chest, by either extending or interlocking them (B and C of Figure 3-7).



- Keep the elbows in a straight and locked position.
- Position your shoulders directly over the hands so that pressure is exerted straight downward (Figure 3-8).



- Exert enough downward pressure to depress the sternum of an adult 1 1/2 to 2 inches.
- Each compression should squeeze the heart between the sternum and spine to pump blood through the body.
- Totally release pressure in order to allow the heart to refill completely with blood.
- Keep the heel of your hand in contact with the victim's chest at all times (Figure 3-9).
- Make compressions down and up in a smooth manner.
- Compressions should be "Hard and Fast"



- Perform 30 cardiac compressions at a rate of 100 per minute, counting "one and, two and, three and...thirty".
- Use the head-tilt/chin-lift maneuver and give two full breaths (artificial ventilation).
- Repeat cycle five times (30 compressions and 2 ventilations).
- After the fifth cycle, recheck the carotid pulse in the neck for a heartbeat (5 to 10 seconds).
- If breathing and heartbeat are absent, resume CPR (30 compressions and 2 ventilations).
- Stop and check for heartbeat every few minutes thereafter.
- Never interrupt CPR for more than 10 seconds.\

E. Two Rescuers

1. All of the above was for the single rescuer; below we will show you Two Rescuer CPR.

2. Two Rescuer CPR is done pretty much the same way "except" When performing with two; one is at the head giving breaths and the other one on one side of the chest doing compressions.

3. Now all compressions and breaths are done the same as taught above. There is no difference; the person at the chest will give 30 compressions then the other person will give two breath this is also done in a rotation of five cycles total of 200 compressions or 100 per minute. (This is approximately 2 minutes of CPR)

4. Next step once a cycle is done you need to check for a pulse, this is done the same way as taught above, and change places to avoid exhaustion. The exchange should take less than 10 seconds.

REMEMBER: IF you have two-people then one person should do CPR while the other person calls 911.

If no pulse continue CPR.

II. Emergency Procedures for Choking

A. Adults: Conscious Victim

1. Choking is indicated by the Universal Distress Signal (hands clutching the throat).

2. If the victim can speak, cough or breathe, do not interfere.

If the victim cannot speak, cough or breathe, give abdominal thrusts (the Heimlich maneuver).

Reach around the victim's waist. Position one clenched fist above navel and below rib cage. Grasp fist with other hand. Pull the clenched fist sharply and directly backward and upward under the rib cage 6 to 10 times quickly.

In case of extreme obesity or late pregnancy, give chest thrusts. Stand behind victim. Place thumb of left fist against middle of breastbone, not below it. Grab fist with right hand. Squeeze chest 4

3. Continue uninterrupted until the obstruction is relieved or advanced life support is available. In either case, a physician should examine the victim as soon as possible.

B. If Victim Becomes Unconscious

1. Help the victim to the floor and position victim on back with their arms by their side.

2. Shout for "Help". Call 9-1-1 or the local emergency number.

3. Look into the victim's mouth to see if you can see a foreign object. If you see the object, perform a finger sweep to try to remove the foreign body.

4. Perform rescue breathing. If unsuccessful, begin chest compressions as performed in CPR.

5. Continue uninterrupted until obstruction is removed or advanced life support is available. When successful, have the victim examined by a physician as soon as possible.

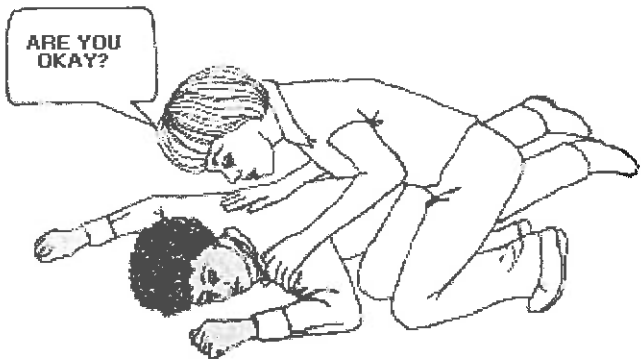
6. After obstruction is removed, begin the ABC's of CPR, if necessary.

DOCUMENTATION, REPORTING AND FOLLOW-UP POST CHOKING EPISODES OF AHC RESIDENTS

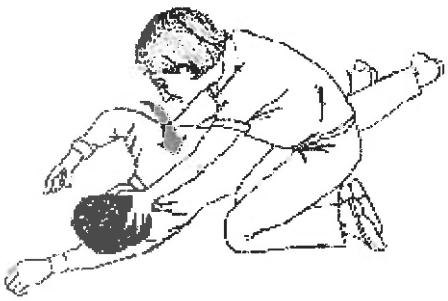
- THIS IS AN EMERGENCY SITUATION
- IMMEDIATELY FOLLOW CURRENT PRACTICE FOR OBSTRUCTED AIRWAY
- NOTIFY CHARGE NURSE & RN SUPERVISOR (SEND SOMEONE, DO NOT LEAVE THE RESIDENT)
- RN ASSESSMENT IN NURSES NOTES: AIRWAY, BREATH SOUNDS, O2 SAT, DESCRIPTION OF WHAT OCCURRED OR WAS REPORTED TO YOU, DETAILED DESCRIPTION OF INTERVENTIONS AND BY WHOM, VITAL SIGNS & OTHER PERTINENT INFORMATION
- NOTIFICATIONS: PHYSICIAN, FAMILY, & OTHERS AS REQUIRED BY REPORTING PROTOCOL
- I & A REPORT TO BE COMPLETED FOR ALL CHOKING EPISODES & FOLLOW I & A CHECKLIST.
- 1910 REPORT IS COMPLETED IF THE RESIDENT IS SENT TO THE EMERGENCY ROOM
- RESIDENT PLACED ON HOT RACK CHARTING & OBSERVATIONS TO BE CHARTED EACH SHIFT FOR 72 HOURS: O2 SAT, VITAL SIGNS
- PLACE RESIDENT ON PHYSICIAN LIST TO BE SEEN NEXT VISIT
- PHYSICIAN ORDERS AS INDICATED.
- NOTIFY SPEECH THERAPIST FOR CONSULT AT 860-0774. FAX ORDER TO REHAB DIRECTOR @ 860-0794.
- DIETARY STAFF TO BE NOTIFIED OF ANY CHANGE IN ORDERS

The CPR procedures should be learned and practiced on a training mannequin under the guidance of a certified AHA BLS CPR Instructor. The step by step procedure for cardiopulmonary resuscitation is as follows:

- **Establish unresponsiveness.** Gently shake the victim's shoulder and shout, "Are you OK?" The individual's response or lack of response will indicate to the rescuer if the victim is just sleeping or unconscious (Figure 3-1).



- **Call for help.** ***CALL 911 or the operator at 860-0500 and have them call 911*** Help will be needed either to assist in performing CPR or to call for medical help.
- **Position the victim.** If the victim is found in a crumpled up position and/or face down, the rescuer must roll the victim over; this is done while calling for help; ***You may instruct a co-worker to call 911 immediately.*** (Figure 3-2)



- When rolling the victim over, take care that improper handling does not further complicate broken bones. Roll the victim as a unit so that the head, shoulders, and torso move simultaneously with no twisting.
- Kneel beside the victim, a few inches to the side.
- The arm nearest the rescuer should be raised above the victim's head.

- The rescuer's hand closest to the victim's head should be placed on the victim's head and neck to prevent them from twisting.
- The rescuer should use the other hand to grasp under the victim's arm furthest from rescuer. This will be the point at which the rescuer exerts the pull in rolling the body over.
- Pull carefully under the arm, and the hips and torso will follow the shoulders with minimal twisting.
- Be sure to watch the neck and keep it in line with the rest of the body.
- The victim should now be flat on his/her back.

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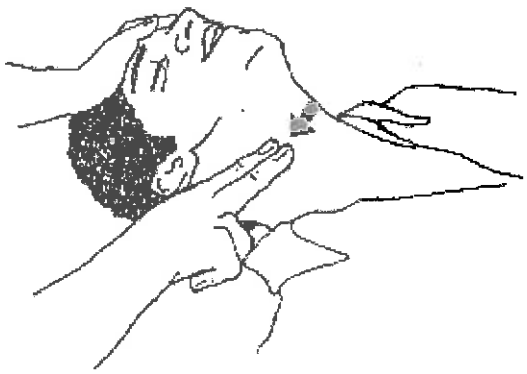

- If a pulse is present, continue administering artificial ventilation once every 5 seconds or 12 times a minute. If not, make arrangements to send for trained medical assistance and begin CPR.

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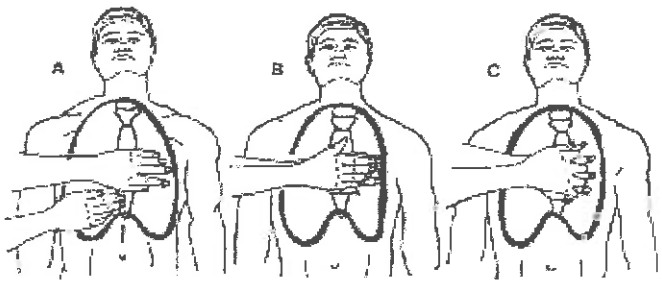

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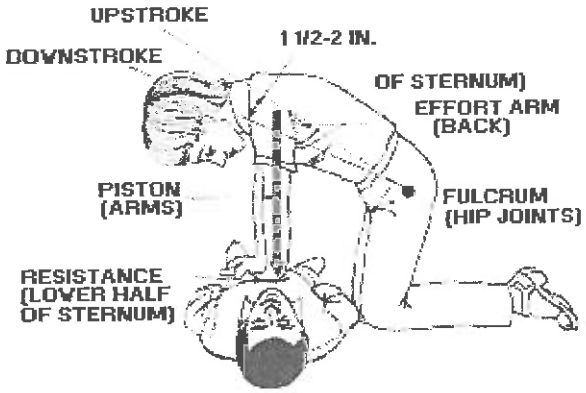

- Exert enough downward pressure to depress the sternum of an adult 1 1/2 to 2 inches.
- Each compression should squeeze the heart between the sternum and spine to pump blood through the body.
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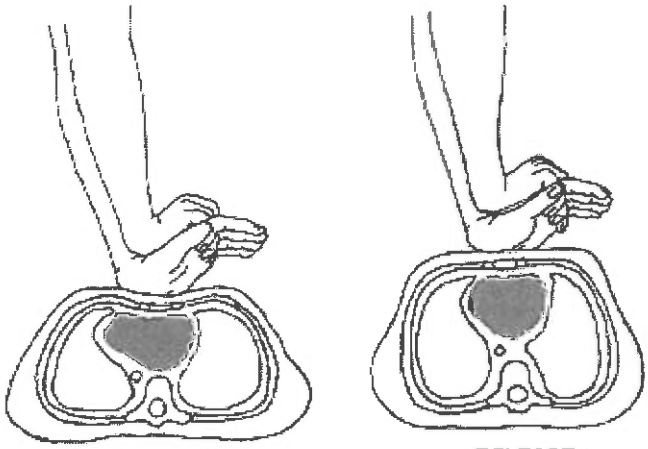
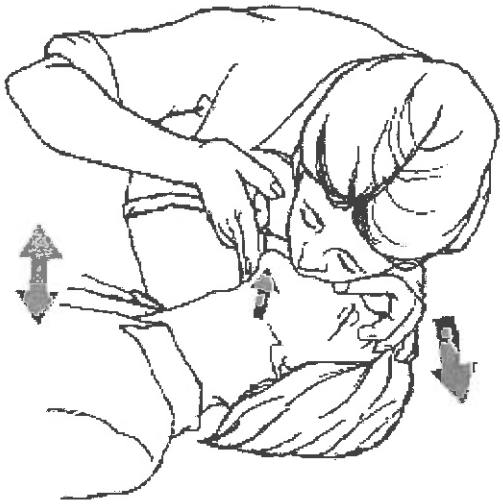


- Perform 30 cardiac compressions at a rate of 100 per minute, counting "one and, two and, three and,.....thirty".
- Use the head-tilt/chin-lift maneuver and give two full breaths (artificial ventilation).
- Repeat cycle five times (30 compressions and 2 ventilations).
- After the fifth cycle, recheck the carotid pulse in the neck for a heartbeat (5 to 10 seconds).
- If breathing and heartbeat are absent, resume CPR (30 compressions and 2 ventilations).
- Stop and check for heartbeat every few minutes thereafter.
- Never interrupt CPR for more than 10 seconds.

- **A-Airway. Open the airway.**
- Use the head-tilt/chin-lift maneuver to open airway. (This maneuver is not recommended for a victim with possible neck or spinal injuries use the jaw-thrust maneuver.)

B-Breathing. Establish breathlessness. After opening the airway establish breathlessness.

- Provide artificial ventilation.
  - If the victim is not breathing give two full breaths by mouth-to-mouth, mouth-to-nose, or mouth-to-stoma ventilation (Figure 3-4).



- Allow for lung deflation between each of the two ventilation's.

Two Rescuers

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Now all compressions and breaths are done the same as taught above.
There is no difference; the person at the chest will give 30 compressions then the other person will give two breath this is also done in a rotation of five cycles total of 200 compressions or 100 per minute. (This is approximately 2 minutes of CPR)
Next step once a cycle is done you need to check for a pulse, this is done the same way as taught above, and change places to avoid exhaustion. The exchange should take less than 10 seconds.

REMEMBER: IF you have two-people then one person should do CPR while the other person calls 911.

If no pulse continue CPR.

BEHAVIOR REPORT
NARRATIVE COMMENTS

RESIDENT NAME:_____ **UNIT:**_____

DATE:_____

Additional Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
Signature/Date

_____
Reviewed/Date

CODE STATUS

RED DOT--- **Do Not Resuscitate (DNR)**

If you find a resident who is a DNR without vital signs, then you DO NOT initiate CPR.

HOWEVER, if you find a resident who is a DNR with vital signs but they are "making a turn for the worse" or "crashing", you need to ACT IMMEDITAELY and call 911 to get them out of the facility. If while waiting on the paramedics to arrive, the resident loses vital signs, you WILL NOT initiate/perform CPR.

If the resident has an established comfort care activated DNR (and the addendum has been signed by 2 physicians) then the resident/family may choose to not seek any further treatment or treatment outside the facility.

Revised April 2011

CODE STATUS

BLUE DOT--- **Full Code**. If you find a resident who is a blue dot without vital signs, then you need to immediately initiate CPR and call 911. Continue CPR until the paramedics arrive unless a physician stops the code.

EVERYTHING must be done for a full code blue dot status.

Medical Director:_____

Director of Nursing:_____

Director:_____

Date:_____

Revised April 2011

⚠ Warning!

- Use the AED Plus unit only as described in this manual. Improper use of the device can cause death or injury.
- DO NOT use or place the AED Plus unit in service until you have read the AED Plus Operator's and Administrator's Guides.
- DO NOT use or place the AED Plus unit in service if the unit's status indicator window (located on the left side of the handle) displays a red "X".
- DO NOT use or place the AED Plus unit in service if the unit emits a beeping tone. Connect the
- electrode cable to the AED Plus unit after installing batteries.
- Keep the electrode cable connected to the AED Plus unit at all times. This device should
- only be used by properly trained individuals.
- Only use electrodes labeled "Infant/Child" on children less than 8 years old or weighing less than 55 lbs (25 kg). Use CPR -D padz if patient is older than 8 years or weighs more than 55 lbs (25 kg).
- Always stand clear of patient when delivering treatment. Defibrillation energy delivered to the patient may be conducted through the patient's body and cause a lethal shock to those touching the patient.
- DO NOT touch the electrode surfaces, the patient, or any conductive material touching the patient during ECG analysis or defibrillation.
- Move patient away from electrically conductive surfaces prior to use of equipment. DO NOT use the
- unit near or within puddles of water.
- Keep the patient as motionless as possible during ECG analysis.
- DO NOT use the unit near flammable agents, such as gasoline, oxygen-rich atmospheres, or flammable anesthetics.
- Avoid radio frequency interference from high-power sources that might cause the defibrillator to interpret cardiac rhythms incorrectly by turning off cell phones and 2-way radios.
- Disconnect non-defibrillation protected electronic devices or equipment from patient before defibrillation.
- Dry victim's chest, if wet, before attaching electrodes.
- Apply freshly opened and undamaged electrodes, within the electrode expiration date, to clean and dry skin to minimize burning.
- DO NOT place electrodes directly over the patient's implanted pacemaker. Pacemaker stimuli may degrade the accuracy of ECG rhythm analyses or the pacemaker may be damaged by defibrillator discharges.
- Check labeling inside the ZOLL AED Plus cover before using the cover as a Passive Airway Support

System (PASS) device to ensure it is intended for this use.

- DO NOT use the Passive Airway Support System (PASS) if there is a suspected head or neck injury. Place the patient on a firm surface before performing CPR.
- DO NOT recharge, disassemble, or dispose of batteries in fire. Batteries may explode if mistreated.
- DO NOT use or stack the AED PLUS unit with other equipment. If the unit is used or stacked with other equipment, verify proper operation prior to use.

⚠ Caution!

- DO NOT disassemble the unit. A shock hazard exists. Refer all servicing to qualified personnel.
- Use only commercially available type 123A lithium manganese dioxide batteries. Discard batteries properly after removal from unit. Use only batteries from recommended manufacturers. See the AED Plus Administrator's Guide (P/N 9650-0301-01) for a list of recommended battery manufacturers.
- If the device is stored outside the recommended environmental conditions, the electrode pads and/or batteries may be damaged or their useful life reduced.
- The CPR-D Padz Electrode can be connected to other ZOLL defibrillators with Multifunction Cables. Defibrillation can be administered when connected to other ZOLL defibrillators.The CPR function does not operate with any device other than the AED Plus defibrillator.

Important!

This symbol indicates that an AED Plus unit is equipped for treating adult and pediatric patients. An AED Plus unit without this symbol is not equipped to treat pediatric patients and will NOT work with pedi•padz II ™ pediatric electrodes. To upgrade an AED Plus unit for use with ZOLL pedi•padz II pediatric electrodes, contact ZOLL Medical Corporation or an authorized ZOLL distributor for information on the ZOLL AED Plus Pediatric Upgrade Kit.

Set-up and Check-out Procedure:

1. Insert 10 new batteries into AED Plus unit.
2. Connect electrode cable to AED Plus unit and pack sealed electrodes inside unit cover. Close cover.
3. Turn unit on and wait for "Unit OK" audio message. Verify that unit issues appropriate "Adult Pads" or "Pediatric Pads" audio message.
4. Turn unit off.
5. Wait 2 minutes. Verify that green check symbol (✓) appears in status indicator window (located on left side of handle) and that unit does not emit a beeping tone.
6. Place AED Plus unit in service.
7. Check AED Plus unit periodically to ensure that green check symbol (✓) appears in status indicator window.

Battery Replacement

Replace batteries before expiration date or if unit prompts. Use only type 123A lithium manganese dioxide batteries from recommended manufacturers.

Remove all batteries from battery compartment and discard before installing any new batteries.

- Insert 10 new batteries into battery well. Do not use old batteries. Press button in battery well only after installation of new batteries.

Cleaning

- Clean and disinfect unit with soft, damp cloth using 90% isopropyl alcohol or soap and water, or chlorine bleach (30 ml/liter water). Do not immerse any part of the unit in water.
- Do not use ketones (MEK, acetone, etc.).

Avoid using abrasives (e.g., paper towels) on the LCD display, if so equipped.

Do not sterilize the unit.

TROUBLE SHOOTING

Problem	Recommended Action
Self-test failed.	Manually test by pressing and holding the ON/OFF button for more than 5 seconds. If unit fails test again, remove from service.
"Change batteries" prompt.	Replace all batteries at the same time.
Red "X" in Status Indicator window OR beeping noise when unit is OFF.	Perform manual test. Check to see if cable is attached properly to unit. Replace batteries. If unit still does not operate correctly, remove from service.
Red "X" in Status Indicator window when unit is ON.	Power cycle the unit. If Red "X" is still present in Status Indicator

SECTION 12

RESIDENT OBSERVATION

Policy Type	Subject of Policy	Policy No.
Administrative	Resident Observation	AP 406

PURPOSE. The purpose of this policy is to provide guidelines for monitoring residents for medical or behavioral reasons.

SCOPE. This policy is applicable to all Arkansas Health Center (AHC) personnel.

POLICY. All AHC residents requiring medical or behavioral observation will be accounted for as determined by the physician's order. There are three levels of documented monitoring. These levels range in degree of staff to resident observation. The use of one to one observation, line of sight or visual contact and time check observation of residents will be provided for medical or behavioral reasons when ordered by a physician. Note: In cases of emergency when a physician is unable to be obtained within the first 15 minutes of the event, a nurse may institute this procedure. However, a physician's order must be obtained via telephone before the end of that nurses' shift or the resident will not remain on an ordered observation. Once the physician's verbal order has been obtained, it must be signed by the physician within 48 hours.

A. Time Check Observation is the observation of a resident at least every 15 minutes for the purpose of monitoring the resident's behavioral and/or medical condition. Time check observation will require the assignment of a staff member to observe and briefly evaluate the resident at least every 15 minutes.

B. Line of Sight Supervision or Visual Contact is the continuous observation of up to three residents by one staff member for the purpose of monitoring the behavioral and/or medical conditions. There is no defined distance between the observer and residents, but the observer must be able to see the actions of all residents assigned at all times.

C. One-to-One Observation is the constant observation of a resident by staff for the purpose of continuous visual monitoring and observation of the resident's behavioral and/or medical condition. One-to-one observation will require the assignment of staff to be within close proximity (approximately within arms length) of the resident at all times unless otherwise specified by physician's order. One to One Observation may be modified by a physician' order according to the individual resident in cases where arms length is determined to cause agitation, aggression, or anxiety. When performing one to one observation, staff should NEVER leave the resident alone nor cease observation of the resident regardless of the amount of space deemed appropriate between the assigned staff member and the resident. One to one observation is ordered for the purposes of ensuring safety of the resident and others. The assigned staff member should be aware of the resident's behavioral and/or medical status at all times so they can intervene in a quick and effective manner when necessary.

PROCEDURE.

A. The use of time check observation, line of sight/visual contact observation, or one-to-one observation will be based upon the clinical assessment of the resident by the physician and will require a physician's order.

B. The physician's order will include the specific level of observation, the duration of the observation and reason for the observation.

C. The physician must reassess the resident within 72 hours of the initial order for the specified type of observation. The physician will write a one to one modification order if one to one continues to be required and arms length proximity is determined to be too close for medical or behavioral reasons.

D. The physician will document in the Physician Notes the rationale for use of the specific observation technique.

E. The order will stand as written and will be reviewed at least every seven days after the initial 72 hour reassessment period.

F. The assigned staff (Nursing, Social Work, Psychology) will monitor the resident for suicidal ideation or attempt, escape intent or attempt, or any other behavioral or medical problems, and report any occurrences of the above to the nurse immediately. The assigned staff will document the resident's behavior every 15 minutes on the AHC 1160-C.

G. Nursing personnel will document the status of the resident at least one time per shift in the Nurse's Notes.

H. The nurse will document on the Behavior Report Form what interventions were utilized and the resulting outcomes.

I. A resident on one-to-one observation is restricted to the building except for medical emergencies or appointments unless otherwise specified in the physician's orders (e.g. smoking privileges).

J. One to one resident observation orders written by a physician are to be verified by the on duty RN or LPN supervisor before the staffing coordinator assigns extra staff to any building on any shift.
   (1) The unit nurse on duty will contact the designated RN or LPN Supervisor to advise of the number of CNA's present on the unit and to request additional assistance as needed to comply with the physician's order.

(2) The RN or LPN supervisor will direct the staffing coordinator to assign staff as available.
(3) The "pulled" or agency staff member will be instructed by the unit nurse what behaviors or medical issues are to be addressed, observed and reported to the nurse.

K. If the time check observation, line of sight/visual contact or one-to-one observation does not appear to provide the level of protection required, the assigned staff will notify the nurse who will notify the physician.

L. If a resident requires indefinite or long term one-to-one observation for medical purposes such as prevention of falls, they should be assessed by appropriate medical professionals for alternate sources of safety (e.g. obtain a physician's order for an evaluation by the appropriate rehabilitation professional, etc.). The procedure should be utilized to attempt the least restrictive protective devices. The physician should write an order for a modified one to one if this type of observation continues to be required, but there is no reason for the assigned staff to be within arms length.

M. If a resident requires indefinite or long term one-to-one observation for behavioral purposes such as aggressive behaviors, suicidal ideation or attempt, self-injurious behaviors, etc., then the resident should be referred for appropriate behavioral interventions (Social Services or Psychology Consult Services). This procedure should be utilized to attempt the least restrictive services.

N. All residents requiring time check observations, line of sight/visual contact observation or one-to-one observation should be reviewed on a weekly basis at the Care Team Meeting with the goal of attempting to find alternative methods of treating the resident and providing a safe environment for the resident and the other residents of the unit.

_____ _____

AHC Director Date

Arkansas Health Center Resident Observation Form

Date: _____

Resident Name: _____

Start Time: _____

Physician: _____

RN: _____

Observation Ordered:

□ 1:1 □ Visual □ q 15 min □ q 30 min

Addressograph

Reason for Observation:

□ Self Destructive □ Suicidal behavior □ Agitation □ Elopement risk

□ Violent/Aggressive towards others □ Falls □ Other _____

Safety Measures:

□ Shoes/Dangerous objects removed □ Other _____

Location Code:	**Behavior Code:**			
A Resident Rm	1 Standing Still	14 Interact/Visitors	26 Verbal	38 Restraint added
B Bathroom	2 Walking	15 Engaged Activity	27 Wheelchair	39 Other
C Hallway	3 Pacing	16 Yelling/Screaming	28 Amb-Walker	
D Nurse Station	4 Sitting	17 Disrobing	29 Relaxation	
E Kitchen	5 Laying	18 Combative	30 Fluids offered	
F Activity Room	6 Sleeping	19 Quiet	31 Food offered	
H Family Room	7 Awake	20 Crying	32 Toilet offered	
I Off Unit	8 Watching TV	21 Reading	33 Toilet/BM	
J Other	9 Isolating	22 Withdrawn	34 Toilet/Void	
	10 Socializing	23 Talking	35 Brief changed	
	12 Interact/Staff	24 Diversion	36 Bathing	
	13 Interact/Therapy	25 Redirection	37 Restraint released	

Time:	Initials:	Code:	Time:	Initials:	Code:
0700			1300		
0715			1315		
0730			1330		
0745			1345		
0800			1400		
0815			1415		
0830			1430		
0845			1445		
0900			1500		
0915			1515		
0930			1530		
0945			1545		
1000			1600		
1015			1615		
1030			1630		
1045			1645		
1100			1700		
1115			1715		
1130			1730		
1145			1745		
1200			1800		
1215			1815		
1230			1830		
1245			1845		

Signature:	Initials:	Signature:	Initials:

SECTION 13

RESIDENT INFORMATION SHEET

PROCEDURE REGARDING RESIDENT INFORMATION SHEET

The Resident Information Sheet (RIS) is a tool that was developed for the C.N.A.'s and Nurses to carry on their person for IMPORTANT and specific information regarding each resident according to their individual needs.

- The RIS is updated on a weekly and PRN basis according to changes.
- The RN/LPN Supervisors and MDS Coordinator are responsible for reviewing the RIS for accuracy.
- It is the responsibility of the direct care staff to notify the supervisors if information on the RIS is not correct or if it has changed.
- It is the responsibility of the direct care staff to be aware of the information stated on the RIS.
- If significant changes occur during the day, the RIS should be updated immediately.
- If the AA is not available to make the changes on the computerized copy for print out, it is the Supervisor's responsibility to ensure the Master copy in the information book is updated and the staff are made aware.
- It is the staff's responsibility to sign the RIS Sign In/Out Log each shift verifying they have received a RIS.
- The MDS Coordinator will take the RIS to the Care Plan meeting each week to review with the Care Plan Team to determine if any additional changes need to be made.

** **AN UPDATED COPY OF THE RESIDENT INFORMATION SHEET IS TO BE FAXED TO NURSING SERVICES EVERY FRIDAY (FAX# 860-0779) IF SIGNIFICANT CHANGES OCCUR ON THE RESIDENT INFORMATION SHEET DURING THE DAY. IT *MUST* BE FAXED TO NURSING SERVICES.**

RESIDENT INFORMATION SHEET SIGNATURE PAGE

Date:	
7a-7p Signatures	7p-7a Signatures

Date:	
7a-7p Signatures	7p-7a Signatures

Date:	
7a-7p Signatures	7p-7a Signatures

Date:	
7a-7p Signatures	7p-7a Signatures

RESIDENT INFORMATION SHEET

IM# IESIDENT NAME oreferred name) :ode Status- ıllergies:	TRANSFER ASSIST 0=INDEPENDENT 1= 1PERSON 2=2 PERSON G-GAIT BELT ML=Marissa Lift SL=Standing Lift	BOWEL FUNCTION C=CONTINENT I=INCONTINENT O=OSTOMY / BLADDER FUNCTION C=CONTINENT I=INCONTINENT SP/FC-SUPRA PUBIC/FOLEY CATH	RESTRAINT/ENABLER USED IN BED SR=SIDE RAILS LB-LOWBED FM-FLOOR MATS / RESTRAINT/ENABLER USED OUT OF BED SB=SEATBELT T-TRAY	RISKS E=ELOPEMENT RISK F=FALL RISK S=SMOKING PRIV. D=DIABETIC SZ-SEIZURES V=VENT T=TRACH/STOMA	NUTRITIONAL STATUS (DIET TYPE) N=NPO F=FEEDS SELF S=SPOON FED A=ASPIRATION PRECAUTIONS T=TUBE FEEDING AD-ASSIST DEVICE	SKIN/WOUND HR=HIGH RISK LR=LOW RISK S=SPLINTS H=HANDROLLS D=DRESSING POSITIONING DEVICES, SPECIAL MATTRESS, ETC.	ALARM DEVICES SB-SECURITY BRACELET; BA-BED ALARM; DA-DOOR ALARM; CA-CHAIR ALARM	ADLS: I=INDEPENDENT S=SET UP A=ASSISTANCE D=DEPENDENT	MISC COMMENTS AND INFORMATION Oxygen, ect…)
ROOM 2A ane Doe (Nana) ilue Dot llergies: Eggs, Codeine, ulfa	2P GB			High risk E; History of seizures	NCS solid, no salt packet on tray / F	Ted hose on Q am, off Q HS; heels off bed	SB; CA	S	Attends Pathfinders; wears bilat Hearing aid ; O2 prn

RESIDENT INFORMATION SHEET

:M# :ESIDENT NAME)referred name) :ode Status- .llergies:	TRANSFER ASSIST 0=INDEPENDENT 1= 1PERSON 2=2 PERSON G-GAIT BELT ML=Marissa Lift SL=Standing Lift	BOWEL FUNCTION C=CONTINENT I=INCONTINENT O=OSTOMY / BLADDER FUNCTION C=CONTINENT I=INCONTINENT SP/FC-SUPRA PUBIC/FOLEY CATH	RESTRAINT/ENABLER USED IN BED SR=SIDE RAILS LB- LOWBED FM-FLOOR MATS / RESTRAINT/ENABLER USED OUT OF BED SB=SEATBELT T-TRAY	RISKS E=ELOPEMENT RISK F=FALL RISK S=SMOKING PRIV. D=DIABETIC SZ-SEIZURES V=VENT T=TRACH/STOMA	NUTRITIONAL STATUS (DIET TYPE) N=NPO F=FEEDS SELF S=SPOON FED A=ASPIRATION PRECAUTIONS T=TUBE FEEDING AD-ASSIST DEVICE	SKIN/WOUND HR=HIGH RISK LR=LOW RISK S=SPLINTS H=HANDROLLS D=DRESSING POSITIONING DEVICES, SPECIAL MATTRESS, ETC.	ALARM DEVICES SB-SECURITY BRACELET; BA-BED ALARM; DA- DOOR ALARM; CA- CHAIR ALARM	ADLS: I=INDEPENDENT S=SET UP A=ASSISTANCE D=DEPENDENT	MISC COMMENTS AND INFORMATION Oxygen, ect…)
Falling Star Program									
SECURITY BRACELET:									

RESIDENT INFORMATION SHEET

RM# RESIDENT NAME preferred name) Code Status- Allergies:	TRANSFER ASSIST 0=INDEPENDENT 1= 1PERSON 2=2 PERSON G-GAIT BELT ML=Marissa Lift SL=Standing Lift	BOWEL FUNCTION C=CONTINENT I=INCONTINENT O=OSTOMY / BLADDER FUNCTION C=CONTINENT I=INCONTINENT SP/FC-SUPRA PUBIC/FOLEY CATH	RESTRAINT/ENABLER USED IN BED SR=SIDE RAILS LB-LOWBED FM-FLOOR MATS / RESTRAINT/ENABLER USED OUT OF BED SB=SEATBELT T-TRAY	RISKS E=ELOPEMENT RISK F=FALL RISK S=SMOKING PRIV. D=DIABETIC SZ-SEIZURES V=VENT T=TRACH/STOMA	NUTRITIONAL STATUS (DIET TYPE) N=NPO F=FEEDS SELF S=SPOON FED A=ASPIRATION PRECAUTIONS T=TUBE FEEDING AD-ASSIST DEVICE	SKIN/WOUND HR=HIGH RISK LR=LOW RISK S=SPLINTS H=HANDROLLS D=DRESSING POSITIONING DEVICES, SPECIAL MATTRESS, ETC.	ALARM DEVICES SB-SECURITY BRACELET; BA-BED ALARM; DA-DOOR ALARM; CA-CHAIR ALARM	ADLS: I=INDEPENDENT S=SET UP A=ASSISTANCE D=DEPENDENT	MISC COMMENTS AND INFORMATION Oxygen, ect...)
ED DOT- DO NOT RESUSCITATE BLUE DOT- FULL CODE GREEN DOT-SATELLITE									
FIRE PLAN-CODE RED P-PULL R-RESCUE A-AIM A-ALARM S-SPRAY C-CONFINE S-SWEEP E-EXTINGUISH	7 SIGNS OF ABUSE 1. SEXUAL 2. MENTAL 3. VERBAL 4. PHYSICAL 5. INVOLUNTARY SECLUSION 6. NEGLECT 7. MISAPPROPRIATION OF PROPERTY								

SECTION 14

USE OF RESTRAINT DEVICES

1. PURPOSE:

The purpose of this policy is to define restraint devices and provide guidelines for implementation of restraint procedures to ensure that restraints are used only for the safety and well being of residents after alternative/less restrictive procedures have been utilized and attempts have proven unsuccessful.

2. SCOPE:

A. The policy applies to Licensed Nurses, Nursing Assistants, Occupational Therapists, Physical Therapists, Psychologists, Social Workers Rehabilitation/Activity Staff and Habilitation/Rehabilitation Staff.
B. All newly hired personnel in the aforementioned departments will be required to undergo an orientation program on AHC's restraint policy and procedures
C. In-service training on the use and documentation of restraints will be on going for all personnel implementing restraints.
D. It shall be the responsibility of all personnel utilizing restraints to follow the restraint policy and procedures as well as report any violations to the Nursing Supervisor, Rehabilitation Supervisor or Designee.

3. POLICY:

A. Each resident has the right to be free from any physical or mechanical restraint imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.
B. Physical restraint is defined as any manual method or physical or mechanical device, material or equipment attached to or adjacent to a resident' body, which the individual cannot remove easily, that restrict freedom, range of movement, or normal access to one's body. When side rails are used for the purpose of keeping a resident from getting out of bed, side rails must be considered a physical restraint.
C. Approved restraints include, but are not limited to the following: limb restraints, mittens, enclosure beds, side rails, pelvic holders, lap belts, lap trays that restrict a resident to a chair.
D. The physician will determine if a restraint device is needed based upon the nurse or therapist's assessment and treatment team recommendation. Application of the restraint device will require a physician's order which includes the type of restraint, duration of use, and medical symptoms/diagnosis warranting a restraint device.
NOTE: PRN RESTRAINT ORDERS ARE NOT PERMITTED. INVOLUNTARY SECLUSION METHODS WILL NOT BE UTILIZED.
E. Alternative therapeutic interventions will be attempted prior to the use of restraint devices, unless assessment results indicate the need for immediate restraint interventions to maintain or attain the resident's highest level of functioning, Therapeutic interventions such as pillows, pads, removable lap trays, meaningful activities, environmental changes and aggressive rehabilitative or restorative programs are examples of less restrictive methods of meeting a resident's needs. Consultation with health professionals, i.e. treatment team members, Occupational Therapy, Physical Therapy, and /or Psychologist, will occur in the use of the least restrictive supportive devices prior to using physical restraints.
F. AHC will honor the resident's right to make an informed choice regarding the use of restraints. Risks, benefits and alternatives will be discussed with the resident and/or his/her representative prior to the use of the restraint device. A signature on the consent form will indicate agreement that the restraint should be utilized.

G. Treatment restraints may be utilized for the protection of the resident during treatment and diagnostic procedures including, but not limited to the following: intravenous therapy or catheterization procedures. Treatment restraints shall be applied for no longer than the time required to complete the treatment.

H. According to established Standards of Practice, Certified Nursing Assistants (CNAs) and/or nurses will perform checks of the resident every 30 minutes while in a restraint. Residents will be released, repositioned and exercised every two hours or as ordered by the physician.

I. The treatment team will review all residents with restraints upon admission, quarterly and with a change of condition. These will coincide with the resident MDS Assessments.

4. PROCEDURE:

A. Assessment and Documentation

1. When a nurse or therapist determines a restraint device is necessary to enable a resident to attain or maintain his/her highest level of functioning, the nurse/therapist will document the results of his/her assessment on the Pre-restraining Assessment (Initial Assessment) or Physical Restraint Elimination Forms (assessment used quarterly and annually following the initial placement of restraints). In addition to completing the aforementioned forms, the therapist or staff will document in their designated section of the medical chart a written assessment which will include:

   a. The resident's history of falls or risks for life threatening falls; and/or medical symptoms that led to the consideration of the use of restraints.
   b. The resident's history of problematic behavior e.g. self-injurious, combative, agitated, or aggressiveness toward others.
   c. What alternatives to restraints have been attempted.
   d. The resident's response to attempted restraint alternatives.
   e. Whether or not there has been a consultation by Occupational Therapy, Physical Therapy or Psychology.
   f. A recommendation for the least restrictive restraint device
   g. Instructions for when the restraint device is needed.
   h. The benefits associated with the use of the restraint.
   i. A statement reflecting that the Care Plan addresses risk factors associated with restraint use as well as approaches toward less restrictive devices and elimination or reduction of restraint.
   j. The nurse or therapist's note will include the type of restraint, reason for restraint, and the resident's response to its use. The nurse will document in the nurse's note the resident's response on each shift for at least the first 24 hours when a new restraint is implemented. During this time interval, observation of the resident should be documented in the nurse's notes and noted on the Hot Rack Form. At least monthly, the nurse's note will include the type of restraint in use, and any problems associated with its use.

B. Physician Approval & Review

1. The nurse will notify the physician of the results of the assessment.
2. The physician will determine if a restraint device is needed based upon the assessment. Application of the restraint device will require a physician's order that includes the type of restraint, the reasons for use of the restraint, and duration of use, medical symptoms and related diagnosis.
3. The physician's order will be reviewed and updated by the physician every 30 days.

C. Consent

a. The social worker will notify the resident and/or the resident's designated representative either by telephone or in person of the physician's decision to apply the restraint device. Risks, benefits, and alternatives will be discussed with them prior to the use of the restraint device. The Physical Restraint Informed Consent Form will be completed by the social worker or designee and given to the resident and/or the resident's designated representative. The staff member obtaining consent will also sign and date the consent form. The signed and dated consent form will be filed in the medical record under the legal section tab. If a change of condition occurs requiring a new restraint device or changes to the current orders, a new consent will be obtained.

b. The social worker, nurse, or therapist may obtain consent for use of restraint from the designated representative via telephone. The staff member who obtains verbal consent by telephone will document the conversation in the respective discipline's progress note section in the resident's medical record. The staff member who obtains verbal consent via telephone will complete, sign and date the Physical Restraint Informed Consent Form noting at the top of the form verbal consent was obtained via telephone. The completed original will be mailed by the unit social worker to the resident's designated representative for signatures and a copy will be kept in the medical record. The social worker will follow up with the resident's designated representative within 30 days of mailing the consent form. The social worker will document this follow-up in the social services section of the progress notes in the medical record. If after 30 days, the written consent has not been obtained from the resident's designated representative, the social worker will document in the progress notes section the inability to obtain written consent and the designated representative's documented verbal consent will stand as consent for continued use of the ordered restraint device.

D. Application of Restraints:

1. Restraints will be applied per manufacturer instructions. Copies of the manufacturer's application instructions will be maintained at each nursing station.
2. Restraints shall be used in a way to cause no physical injury to the resident and to ensure the least possible discomfort to the resident.
3. Restraints with locking devices will not be used.
4. Physical restraints will be applied in such a manner that they can be speedily removed in case of fire or other types of emergencies.

E. Observation of Restraints:

1. Nursing staff will document on the AHC Restraint Observation and Release Record resident checks every 30 minutes and when the resident is released, repositioned, and Range Of Motion (ROM) exercises are performed at least every two hours or as ordered by the physician.

F. Documentation:

1. A Restraint book will be maintained on each nursing unit. The restraint book will include the policy, forms, and manufacturer's instructions.
2. A copy of the current AHC Pre-Restraining Assessment and Restraint Elimination Assessments will be maintained in the Resident's Care Plan Book.
3. The Restraint and Special Device Form will be filled out and maintained in the Nursing ADL Book. The nurse will document the use of the restraint device in the Resident Care Plan and will document status of restraint usage in the monthly Nurse's Summary.

4. AHC Fall Risk Assessments, Individual Resident Fall Tracking logs, and Post Fall Investigation Forms will be maintained in the Resident Fall Book.

G. **Reassessment Criteria-Initial/Quarterly/Annual:**

1. The need for restraints will be re-evaluated by the care team at least quarterly with resident assessment updates, and efforts to eliminate their use will be tried and documented. During the care team meeting, the team will complete and sign the Physical Restraint Elimination Forms.
2. The Pre-Restraining Assessment or Physical Restraint Elimination Forms will be completed when a new restraint device is used and at least annually to coincide with the resident's RAI comprehensive assessments, i.e. initial, annual and significant change MDS assessment.
3. The MDS Coordinator noting the order will initiate a care plan for restraints or update the current care plan to include the new restraint order. The MDS Coordinator noting the order will also contact the unit Social Worker regarding the need to obtain verbal and/or written consent for the restraint device.

H. **Physical Restraints for Control of Behaviors:**

1. Physical restraints for behavior control shall only be utilized on the signed order of the physician, except in an emergency that threatens to bring immediate injury to the resident or others. In such an emergency, a physician's order may be received via telephone and the signature obtained following the initial telephone order. Full documentation of the episode in the medical record leading to the use of the physical restraint will include, but is not limited to the following:

a. The behavior leading to the restraint.
b. The interventions attempted prior to the use of the restraint.
c. The type of restraint utilized.
d. The length of time restraint was utilized.
e. The effectiveness of the restraint.
f. The name of individual(s) applying such measures

2. Physical restraints for behavior control shall only be used once a physician's order has been obtained. The order should be designed to lead a less restrictive way of managing, and ultimately the elimination of, the behavior for which the restraint was applied. There will be no orders for PRN physical behavioral restraints.

_____ _____

AHC Director Date

Arkansas Health Center Resident Observation Form

Date: _____

Resident Name: _____

Start Time: _____

Physician: _____

RN: _____

Observation Ordered:

□ 1:1 □ Visual □ q 15 min □ q 30 min

Addressograph

Reason for Observation:

□ Self Destructive □ Suicidal behavior □ Agitation □ Elopement risk

□ Violent/Aggressive towards others □ Falls □ Other _____

Safety Measures:

□ Shoes/Dangerous objects removed □ Other _____

Location Code:	**Behavior Code:**			
A Resident Rm	1 Standing Still	14 Interact/Visitors	26 Verbal	38 Restraint added
B Bathroom	2 Walking	15 Engaged Activity	27 Wheelchair	39 Other
C Hallway	3 Pacing	16 Yelling/Screaming	28 Amb-Walker	
D Nurse Station	4 Sitting	17 Disrobing	29 Relaxation	
E Kitchen	5 Laying	18 Combative	30 Fluids offered	
F Activity Room	6 Sleeping	19 Quiet	31 Food offered	
H Family Room	7 Awake	20 Crying	32 Toilet offered	
I Off Unit	8 Watching TV	21 Reading	33 Toilet/BM	
J Other	9 Isolating	22 Withdrawn	34 Toilet/Void	
	10 Socializing	23 Talking	35 Brief changed	
	12 Interact/Staff	24 Diversion	36 Bathing	
	13 Interact/Therapy	25 Redirection	37 Restraint released	

Time:	Initials:	Code:	Time:	Initials:	Code:
0700			1300		
0715			1315		
0730			1330		
0745			1345		
0800			1400		
0815			1415		
0830			1430		
0845			1445		
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1030			1630		
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1115			1715		
1130			1730		
1145			1745		
1200			1800		
1215			1815		
1230			1830		
1245			1845		

Signature:	Initials:	Signature:	Initials:

Resident Check List

Court _____

Date each day →	MONDAY							TUESDAY							WEDNESDAY							THURSDAY							FRIDAY							SATURDAY							SUNDAY						
NAME	7	9	11	13	15	17	19	7	9	11	13	15	17	19	7	9	11	13	15	17	19	7	9	11	13	15	17	19	7	9	11	13	15	17	19	7	9	11	13	15	17	19	7	9	11	13	15	17	19
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28																																																
Initials.....7A-7P																																															

RESTRAINTS

THE REGULATIONS REGARDING RESTRAINTS CLEARLY STATES THAT RESIDENTS HAVE THE RIGHT TO BE FREE FROM ANY PHYSICAL OR CHEMICAL RESTRAINTS THAT ARE IMPOSED FOR THE PURPOSE OF:

-DISCIPLINE
-CONVENIENCE
-AND NOT REQUIRED TO TREAT THE RESIDENT'S MEDICAL SYMPTOMS.

THEY CANNOT BE USED WITHOUT A PHYSICIAN'S ORDER THEREFORE IT IS VERY IMPORTANT THAT WE APPLY EXACTLY WHAT THE PHYSICIAN HAS ORDERED.

THERE IS STRONG EMPHASIS IN THE NURSING HOME INDUSTRY TODAY THAT RESTRAINTS BE USED AS A LAST RESORT. HOWEVER TO ENSURE SAFETY FOR CERTAIN RESIDENTS THEY ARE A NECESSITY WHEN ALL OTHER ALTERNATIVE METHODS HAVE FAILED.

WHEN THE RESIDENT HAS BEEN PROPERLY ASSESSED AND APPROPRIATE INDIVIDUALS HAVE BEEN INFORMED OF THE RISKS AND BENEFITS OF THEIR USE, THEN IT IS NURSING PERSONNELS JOB TO ENSURE THAT THEY ARE APPLIED AND UTILIZED CORRECTLY AND SAFELY.

BECAUSE THERE ARE SO MANY DIFFERENT TYPES OF RESTRAINTS, WHAT IS THE PROPER APPLICATION FOR ALL RESTRAINTS USED? ***ALWAYS FOLLOW YOUR FACILITY POLICY AND PROCEDURE/MANUFACTURER'S RECOMMENDATION*** FOR EACH SPECIFIC TYPE OF RESTRAINT.

THERE ARE KEY SAFETY TIPS FOR ALL RESTRAINT USAGE---(DISCUSS SAFETY TIPS)

-Policy/Procedure (see attached BSC P/P)
-Manufacturer's recommendation
-Use restraints within the carefully defined and documented parameters of the resident's individual care plan.
-After applying a restraint always monitor to make sure that the restraint stays in place as appropriately applied.
-Monitor at a minimum of every 30 minutes, release every 2 hours for 10-15 minutes of exercise, ambulation, toileting.
-Ensure that straps fit snugly,but does not interfere with breathing and circulation.
-Ensure that skin irritation does not occur
-Always use quick release ties in case of accidents or fire.
-Ensure that equipment is in good repair/correct size
-Always ensure that the call light is in reach and the resident is comfortable.

IMPORTANT KEY: IF YOU DO NOT FEEL COMFORTABLE APPLYING A RESTRAINT ALWAYS GO TO YOUR SUPERVISOR FOR ADDITIONAL ASSISTANCE AND/OR INSTRUCTIONS.

REVIEW: What is a manufacturers recommendation insert? (See attached example)

REVIEW: BSC Policies/Procedures for Restraints

DEMONSTRATIONS

Safety Information for the Use of Posey Restrictive Products

Safety Instructions for the Use of Posey Restrictive Products (See other side for application instructions specific to the product enclosed.)

⚠ WARNING: Monitor patients appropriately per your facility's policy.

Inappropriate and/or incorrect usage of any restrictive product may result in serious injury or death. The Posey Company recommends the following steps before any restrictive product is used:

#1 Identify the patient's symptoms.

#2 Determine and remove, if possible, the cause of the symptoms. This may include catering to individual needs and customary routines, increased rehabilitation and restorative nursing, modifying the environment, and increased supervision.

#3 If the cause cannot be determined and removed, attempt alternative treatments under proper medical supervision.

#4 A restraint should be used only when practicable alternatives have failed. The least restrictive device that will protect the patient and others should be selected and used for the shortest time while less restrictive alternatives are sought. It is critical that the appropriate restraint is selected.

#5 Follow the directions on the Application Sheet accompanying each product.

#1 Posey restrictive devices are labeled: Caution: Federal law (USA) restricts this device to sale by or on order of a physician. All staff should receive proper inservice training so products are applied in accordance with the manufacturer's instructions, state and federal regulations and the facility's policies and procedures. Posters, Videos and Inservice materials are available free from Posey Company.

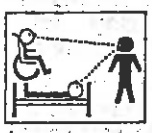
#2 Restrictive products should only be used within the carefully defined and documented parameters of the patient's Individualized Care Plan (ICP) which addresses (but is not limited to) restorative nursing, patient release, and pressure sore prevention. The ICP is created after an assessment by an interdisciplinary team which may represent (but is not limited to) PT, OT, Nursing, the Physician, and Social Services.

#3 NEVER use a Posey product as a seat belt in a moving vehicle. Posey products are not designed to withstand the force of a crash.

#4 DO NOT expose any Posey Product to open fire, flame, or contact with smoking materials. Components such as fabric, webbing, thread, etc. are susceptible to ignition and burning. The facility's smoking/no smoking policy should be vigorously enforced. Flame retardant fabric is available on request.

#5 Always use the proper size product. (Use Sizing Table for vests, jackets and belts) Products that are too small or large compromise patient comfort and safety and should not be used.

#6 After applying a restrictive product, always monitor to make sure the patient is not able to slide down, or fall off the chair seat or mattress. Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of device. If their body weight becomes suspended off the chair or the mattress, chest compression and suffocation could result. Restraints with pelvic pieces may be necessary to reduce sliding down or pulling the restraint over their head.



#7 Patients in restrictive products require appropriate monitoring per your facility's policy. Aggressive, agitated, restless patients and/or those in danger of aspirating their vomit require constant monitoring and a systematic review and evaluation of both physical and psychological status.

#8 All siderails MUST be in the up position when using restraints. If necessary, use a siderail cover, or gap protector, especially with split siderails, to prevent the patient's body from going under, around, through or between the siderails.

#9 Secure straps of restrictive products to the movable part of the bed frame at waist level, out of patient's reach. Make sure the device will not tighten or loosen when the bed is raised or lowered.

#10 Never crisscross the straps of a Posey Vest/Jacket in back of the patient unless there is a positioning slot in the rear of the product. Any restraint applied incorrectly and/or worn backwards may cause strangulation or injury.

#11 Straps must always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient. Make sure straps do not slide in any direction, changing position of device.

#12 Hips should be held securely against the back of the chair whenever any type of restrictive product is used. The straps should be at 45 degrees over the hips and secured under the seat out of the patient's reach. Use extreme caution with all cushions. If dislodged, patient injury could occur. (see #6).

#13 Always use quick-releasing ties (see drawings) or buckles to secure straps – they allow easy release in the event of accident or fire. Restraint release should be an integral part of the facility's fire/disaster evacuation drills. Straps can be cut with scissors in an emergency.

#14 Inspect before use for broken stitches or parts; torn, cut or frayed straps or fabric; or hook and loop fastener that does not hold securely. These products could fail, resulting in injury or death. Destroy and discard them. Straps must be long enough to secure out of the patient's reach. DO NOT alter products.

#15 Do not use Posey products on toilets, or on any type of furniture which does not allow application as directed in the product application sheet. Posey restrictive products should NOT be used at home without constant supervision of a licensed healthcare provider, physician's order and an Individualized Care Plan.

Just as patient behavior is not 100% predictable, no product is 100% fool-proof under all circumstances. A restraint is not a substitute for good nursing care. Patient safety requires regular reassessment and appropriate monitoring per your facility's policy. A product that worked successfully in the past may prove inappropriate as the patient's mental and physical health status changes. Never apply any product you feel is unsafe and consult with the proper medical authority if you feel a product is inappropriate for the patient.

How to Tie the Posey Quick Release Tie

1. Wrap the attachment strap once around the movable part of the bed frame leaving at least an 8" tail. Fold the loose end in half to create a loop and cross it over the other end.

2. Insert the folded strap where the straps cross over each other, as if tying a shoe. Pull on the loop to tighten.

3. Fold the loose end in half to create a second loop.

4. Insert the second loop into the first loop.

5. Pull on the loop to tighten.

Sizing Table for Posey Products

Binding Color	Size	Weight (lb./kg)	Chest (in./cm)
White	X-Small	60-90/27-41	28-34/71-86
Red	Small	80-120/36-54	32-39/81-99
Green	Medium	110-155/50-70	37-45/94-114
Yellow	Large	145-190/66-86	43-49/109-124
Blue	X-Large	180-230/82-104	47-52/119-132
Black	XX-Large	220-275/110-125	50-56/127-142

Posey belts are not color-coded, but are also sized according to this table.

Flame-retardant fabric is available on request.

Weight and size measurements give a general indication of the proper size. Individual physical characteristics should be taken into account before the medical authority determines the correct size. Refer to label on product for specific sizing indications.

J.T. Posey Company 5635 Peck Road · Arcadia, CA 91006-0020 USA · Tel. 800-447-6739 or 626-443-3143 · Fax 800-767-3933 or 626-443-5014 · www.posey.com

19200 012501

APPLICATION INSTRUCTION SHEET
POSEY® HOUDINI SUIT

Cat. No. 3420

DESCRIPTION OF PRODUCT: A very restrictive vest with a pelvic piece. For bed or chair application.

CAUTION: FEDERAL LAW (USA) RESTRICTS THIS DEVICE TO SALE OR USE BY OR ON ORDER OF A PHYSICIAN.

INDICATIONS:

- Patients who are assessed to be at risk of a fall which could result in injury.
- Patients who require a positioning product to assist medical treatment.
- Patients who have a tendency to slide down or try to remove the restraint by pulling it over their head.

CONTRAINDICATIONS:
Contraindications include, but are not limited to the following conditions:

- Aggressive, combative, restless, or suicidal patients should not be put into a restrictive product unless they will receive constant monitoring.
- Patients with ostomy, colostomy, G-Tubes, Hernias, severe Cardio Obstructive Pulmonary Disease (COPD), those with post-surgery incisions that might be compromised by the pressure from a restrictive product, or those with monitoring equipment, tubes or lines that might be compromised by rubbing against a restraint.
- Discontinue use immediately if the patient is able to slide forward or down underneath the device. The patient could slide far enough under the device to become suspended, resulting in chest compression and suffocation.

ADVERSE REACTIONS:
Severe emotional, psychological, and physical problems may occur if a patient's movement is severely limited. The patient may become restless or agitated if the device is uncomfortable or severely limits movement. Request assistance from a qualified medical authority for an alternative product or intervention.

Laundering Instructions:
This product was designed to be washed under CDC recommendations for linen soiled with blood or bodily fluids:

160°F 71°C — WASH HOT 25 MIN. | Cl — BLEACH AS DIRECTED ON CONTAINER | DRY ON LOW

Lower temperature washing and drying cycle for non-contaminated linen will prolong product life.

We welcome your suggestions for improving our products or service:

Posey Co.
5635 Peck Road
Arcadia, CA 91006 USA
Tel: 1-800-44-POSEY
Fax: 1-626-443-5014
www.posey.com

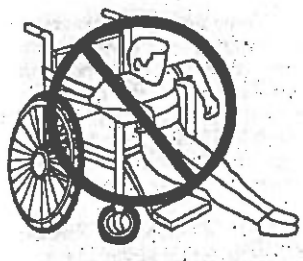
CE

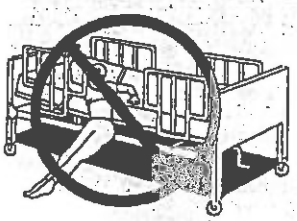
⚠ WARNING

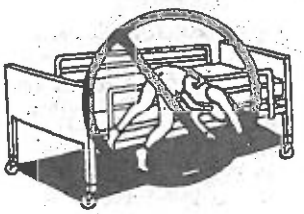
Straps must always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient. Make sure straps do not slide in any direction, changing position of device.

All siderails MUST be in the up position when using restraints. If necessary, use a siderail cover, especially with split siderails, to prevent the patient's body from going under, around, through or between the siderails.

After applying a restrictive product, always monitor to make sure the patient is not able to slide down, and fall off the chair seat or mattress. If their body weight becomes suspended off the chair or the mattress, chest compression and suffocation could result.



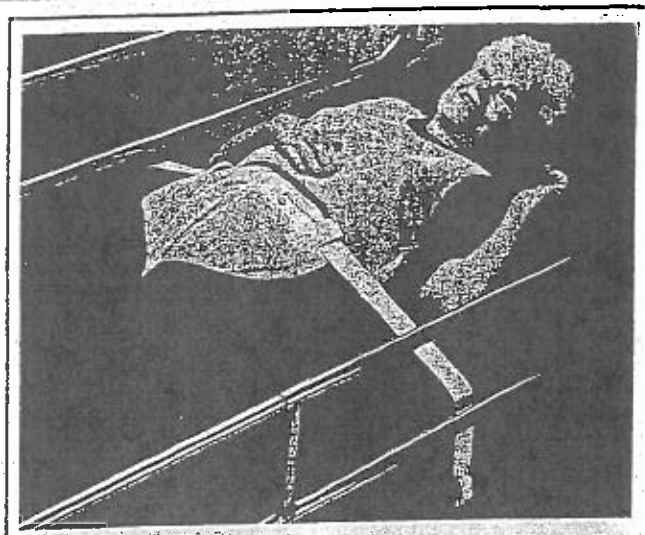


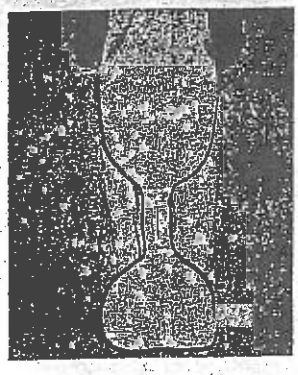


A patient in a supine position who cannot sit up requires extra vigilance. Should the patient vomit, he/she could aspirate his/her vomitus and suffocate. Monitor constantly and be prepared to intervene at the first sign of danger.

Monitor skin conditions in the groin area frequently. If the patient slides down or forward, pelvic straps could damage skin integrity.

ADDITIONAL SAFETY INSTRUCTIONS ON OTHER SIDE





APPLICATION INSTRUCTIONS:

1) Put the vest on over the top of the head, (like a T-shirt) with the pelvic piece behind the patient's buttocks.

2) Bring the pelvic piece up between the patient's legs toward the front.

3) Take both ends of the long strap through the vertical slot in the middle of the pelvic piece.

4) Put the horizontal loops on upper vest portion through the horizontal slots on the pelvic piece.

5) Separate the straps, taking one to the right through the loop which interlocks the top vest portion and the pelvic piece. Do the same in the opposite direction to the left with the other strap.

Straps should always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient. Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of device. (Ref: 11A)

BED APPLICATION:

Secure the straps at waist level to the movable part of the bed frame out of the patient's reach.

⚠ WARNING

Do not use the shoulder loops in bed to prevent the patient from sitting up. This could cause pressure over the chest and around the neck, resulting in suffocation.

CHAIR APPLICATION:

1) Position the patient's hips against the back of the chair.

2) Bring the straps over the hips at a 45 degree angle and secure them under the chair out of the patient's reach. "Snug up" tightness by pulling strap around back post before securing. Make sure straps cannot slide forward, allowing the patient to slide forward or down causing the body to fall off the chair seat.

3) If necessary, the shoulder loops may be used to prevent the patient from falling forward. Circle the strap through each shoulder loop twice so it will not slip if the patient leans to the side, and wrap around the push handles before connecting the strap with the buckle. Do not put the strap around or in front of the patient's neck.

Posey Houdini Security Suit; Small, Medium, Large, X-Large
Cat. No. 3420, Breezeline Mesh

I9235 092398

Safety Information for the Use of Posey Restrictive Products

Safety Instructions for the Use of Posey Restrictive Products (See other side for application instructions specific to the product enclosed.)

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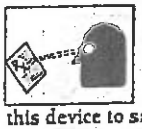
#2 Determine and remove, if possible, the cause of the symptoms. This may include catering to individual needs and customary routines, increased rehabilitation and restorative nursing, modifying the environment and increased supervision.

#3 If the cause cannot be determined and removed, attempt alternative treatments under proper medical supervision.

#4 A restraint should be used only when practicable alternatives have failed. The least restrictive device that will protect the patient and others should be selected and used for the shortest time while less restrictive alternatives are sought. It is critical that the appropriate restraint is selected.

#5 Follow the directions on the Application Sheet accompanying each product.



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#3 NEVER use a Posey product as a seat belt in a moving vehicle. Posey products are not designed to withstand the force of a crash.

#4 DO NOT expose any Posey Product to open fire, flame, or contact with smoking materials. Components such as fabric, webbing, thread, etc. are susceptible to ignition and burning. The facility's smoking/no smoking policy should be vigorously enforced. Flame retardant fabric is available on request.

#5 Always use the proper size product. (Use Sizing Table for vests, jackets and belts) Products that are too small or large compromise patient comfort and safety and should not be used.

#6 After applying a restrictive product, always monitor to make sure the patient is not able to slide down, or fall off the chair seat or mattress. Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of device. If their body weight becomes suspended off the chair or the mattress, chest compression and suffocation could result. Restraints with pelvic pieces may be necessary to reduce sliding down or pulling the restraint over their head.

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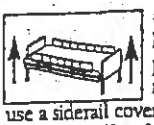

#8 All siderails MUST be in the up position when using restraints. If necessary, use a siderail cover, or gap protector, especially with split siderails, to prevent the patient's body from going under, around, through or between the siderails.

#9 Secure straps of restrictive products to the movable part of the bed frame at waist level, out of patient's reach. Make sure the device will not tighten or loosen when the bed is raised or lowered.

#10 Never crisscross the straps of a Posey Vest/Jacket in back of the patient unless there is a positioning slot in the rear of the product. Any restraint applied incorrectly and/or worn backwards may cause strangulation or injury.

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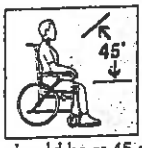


#12 Hips should be held securely against the back of the chair whenever any type of restrictive product is used. The straps should be at 45 degrees over the hips and secured under the seat out of the patient's reach. Use extreme caution with all cushions. If dislodged, patient injury could occur. (see #6).

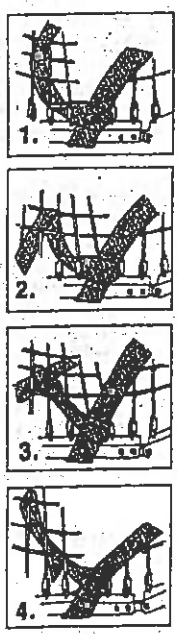
#13 Always use quick-releasing ties (see drawings) or buckles to secure straps – they allow easy release in the event of accident or fire. Restraint release should be an integral part of the facility's fire/disaster evacuation drills. Straps can be cut with scissors in an emergency.

#14 Inspect before use for broken stitches or parts; torn, cut or frayed straps or fabric; or hook and loop fastener that does not hold securely. These products could fail, resulting in injury or death. Destroy and discard. Straps must be long enough to secure out of the patient's reach. DO NOT alter products.

#15 Do not use Posey products on toilets, or on any type of furniture which does not allow application as directed in the product application sheet. Posey restrictive products should NOT be used at home without constant supervision of a licensed healthcare provider, physician's order and an Individualized Care Plan.

Just as patient behavior is not 100% predictable, no product is 100% fool-proof under all circumstances. A restraint is not a substitute for good nursing care. Patient safety requires regular reassessment and appropriate monitoring per your facility's policy. A product that worked successfully in the past may prove inappropriate as the patient's mental and physical health status changes. Never apply any product you feel is unsafe and consult with the proper medical authority if you feel a product is inappropriate for the patient.

How to Tie the Posey Quick Release Tie



Sizing Table for Posey Products

Binding Color	Size	Weight (lb./kg)	Chest (in./cm)
White	X-Small	60-90/27-41	28-34/71-86
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Green	Medium	110-155/50-70	37-45/94-114
Yellow	Large	145-190/66-86	43-49/109-124
Blue	X-Large	180-230/82-104	47-52/119-132
Black	XX-Large	220-275/110-125	50-56/127-142

Posey belts are not color-coded, but are also sized according to this table.

Flame-retardant fabric is available on request.

Weight and size measurements give a general indication of the proper size. Individual physical characteristics should be taken into account before the medical authority determines the correct size. Refer to label on product for specific sizing indications.

LT Posey Company 5635 Peck Road • Arcadia, CA 91006-0020 USA • Tel. 800-447-6739 or 626-443-3143 • Fax 800-767-3933 or 626-443-5014

APPLICATION INSTRUCTION SHEET
POSEY® ROLL BELTS

Applicable Products:
Cat. No. 1131, 1201, 1231, 1231Q

DESCRIPTION OF PRODUCT:
The Posey® Roll Belt is designed to allow the patient freedom to roll from side to side or sit up in bed. Bed or chair application.

CAUTION: FEDERAL LAW (USA) RESTRICTS THIS DEVICE TO SALE OR USE BY OR ON ORDER OF A PHYSICIAN.

INDICATIONS:

- Patients who are assessed to be at risk of a fall which could result in injury.
- Patients who require a positioning product to assist medical treatment.
- Patients who need freedom to roll from side to side or sit up in bed.

CONTRAINDICATIONS:
Contraindications include, but are not limited to the following conditions:

- Aggressive, combative, restless, or suicidal patients.
- Patients with ostomy, colostomy, G-Tubes, Hernias, severe Cardio Obstructive Pulmonary Disease (COPD), those with post-surgery incisions that might be compromised by the pressure from a restrictive product, or those with monitoring equipment, tubes or lines that might be compromised by rubbing against a restraint.
- Discontinue use immediately if the patient is able to slide forward or down underneath the device. They could slide far enough under the device to become suspended, resulting in chest compression and suffocation. Posey products with a pelvic piece are designed to help prevent sliding. Products without a pelvic piece between the legs will not hinder sliding as effectively. See your Posey catalog for other more suitable products to help prevent sliding.

ADVERSE REACTIONS:
Severe emotional, psychological, and physical problems may occur if a patient's movement is severely limited. The patient may become restless or agitated if the device is uncomfortable or severely limits movement. Request assistance from a qualified medical authority for an alternative product or intervention.

Laundering Instructions:
This product was designed to be washed under CDC recommendations for linen soiled with blood or bodily fluids:

160°F 71°C	Cl	
WASH HOT 25 MIN.	BLEACH AS DIRECTED ON CONTAINER	DRY ON LOW

Lower temperature washing and drying cycle for non-contaminated linen will prolong product life.

We welcome your suggestions for improving our products or service:

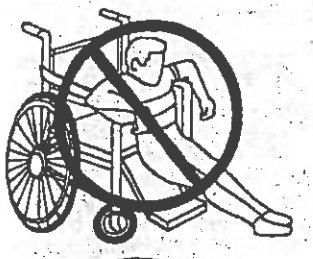
Posey Co.
5635 Peck Road
Arcadia, CA 91006 USA
Tel: 1-800-44-POSEY
Fax: 1-626-443-5014
www.posey.com

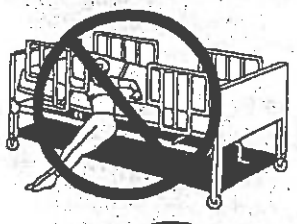
⚠WARNING

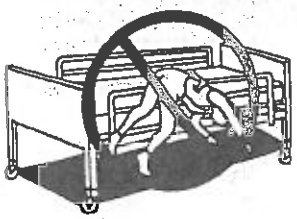
Straps must always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient. Make sure straps do not slide in any direction, changing position of device.

All siderails MUST be in the up position when using restraints. If necessary, use a siderail cover, especially with split siderails, to prevent the patient's body from going under, around, through or between the siderails.

After applying a restrictive product, always monitor appropriately per facility policy to make sure the patient is not able to slide down, or fall off the chair seat or mattress. Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of device. If their body weight becomes suspended off the chair or the mattress, chest compression and suffocation could result. Restraints with pelvic pieces may be necessary to reduce sliding down or pulling the restraint off over their head.



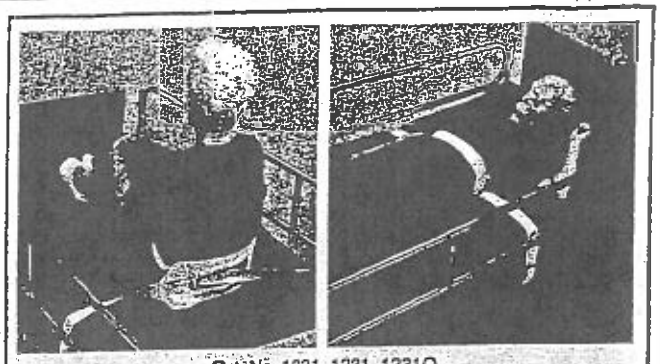




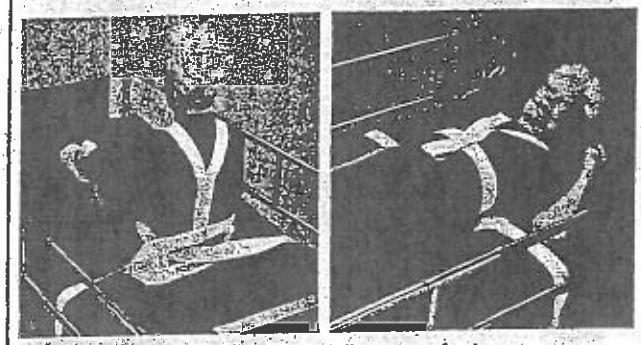
⚠WARNING

A patient in a supine position who cannot sit up requires extra vigilance. Should the patient vomit, he/she could aspirate his/her vomitus and suffocate. Monitor constantly and be prepared to intervene at the first sign of danger.

ADDITIONAL SAFETY INSTRUCTIONS ON OTHER SIDE



Cat. No. 1231, 1231, 1231Q



Cat. No. 1131 with "Y" harness (Bed application only)

APPLICATION INSTRUCTIONS

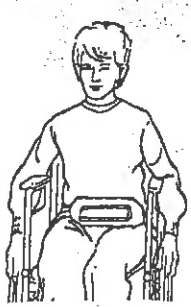
Bed Use (For Cat. No. 1131, 1201, 1231, 1231Q)

1. Lay the belt horizontally across the bed with the soft flannel side up toward the small of the patient's back, and the back pad in the center of the bed.
2. Secure the short strap to the movable part of the bed frame, with quick-release ties at waist level, out of the patient's reach.
3. Bring the long strap over and around the patient's waist and back behind the patient though the slot in the back pad.

   NOTE: The Posey® "V" Roll Belt has a shoulder harness. This goes over the patient's head, and the waist belt goes through the appropriate slot before going around through the slot in the back pad.
4. Secure the long strap to the movable part of the bed frame out of the patient's reach with quick-release knots or with quick-release buckles (Cat. no. 1231Q).

NOTE: In bed and wheelchairs, straps should always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient.

Wheelchair Use (Cat. Nos. 1201,1231 and 1231Q only)



1. Lay the pad across the patient's lap, flannel side down.
2. Bring the strap ends over the thighs between the seat and the wheelchair skirt guard.
3. Go around the back post and cross the straps behind the patient. Secure the straps on the wheelchair tilt levers. The belt should be over the patient's hips at 45 degree angles holding the hips against the back of the chair.

Posey® Roll Belt, one size fits all. (Without shoulder harness.)
Cat. No. 1201, Flame Retardant.
Cat. No. 1231, Cotton, connecting straps for quick-release knots.
Cat. No. 1231Q, Cotton, connecting straps w/quick-release buckles.
Posey® "V" Roll Belt, one size fits all. (With shoulder harness.)
Cat. No. 1131, Cotton. (Bed application only.)

19240 031301

APPLICATION INSTRUCTION SHEET
POSEY® "Y" BELT

Applicable Products:
Cat. No. 4120

DESCRIPTION OF PRODUCT: A two inch nylon belt. For chair application only.

CAUTION: FEDERAL LAW (USA) RESTRICTS THIS DEVICE TO SALE OR USE BY OR ON ORDER OF A PHYSICIAN.

INDICATIONS:

- Patients who are assessed to be at risk of a fall which could result in injury.
- Patients who require a positioning product to assist medical treatment.
- Upper torso postural supports are intended to support upper postural alignment, reducing tilting, leaning and falling out of chairs.

CONTRAINDICATIONS:

Contraindications include, but are not limited to the following conditions:

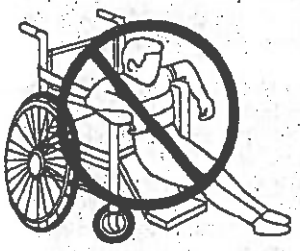
- Aggressive, combative, restless, or suicidal patients.
- Patients with ostomy, colostomy, G-Tubes, Hernias, severe Cardio Obstructive Pulmonary Disease (COPD), those with post-surgery incisions that might be compromised by the pressure from a restrictive product, or those with monitoring equipment, tubes or lines that might be compromised by rubbing against a restraint.
- Discontinue use immediately if the patient is able to slide forward or down underneath the device. They could slide far enough under the device to become suspended, resulting in chest compression and suffocation. Posey products with a pelvic piece are designed to help prevent sliding. Products without a pelvic piece between the legs will not hinder sliding as effectively. See your Posey catalog for other more suitable products to help prevent sliding.

ADVERSE REACTIONS:

Severe emotional, psychological, and physical problems may occur if a patient's movement is severely limited. The patient may become restless or agitated if the device is uncomfortable or severely limits movement. Request assistance from a qualified medical authority for an alternative product or intervention.

⚠WARNING

Straps should always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient. Loose straps may allow the patient's body to slide forward or down in a chair and become suspended in the restraint, resulting in chest compression and suffocation.



After applying a restrictive product, always monitor to make sure the patient is not able to slide down, or fall off the chair seat. Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of device. If their body weight becomes suspended off the chair, chest compression and suffocation could result. Restraints with pelvic pieces may be necessary to reduce sliding down or pulling the restraint off over their head.

Note: The straps cannot be properly and snugly tightened while kneeling behind the wheelchair. It's too difficult to push the slide buckles! Position yourself outside the rear wheels so you can pull the straps. It is much easier! See photo above.

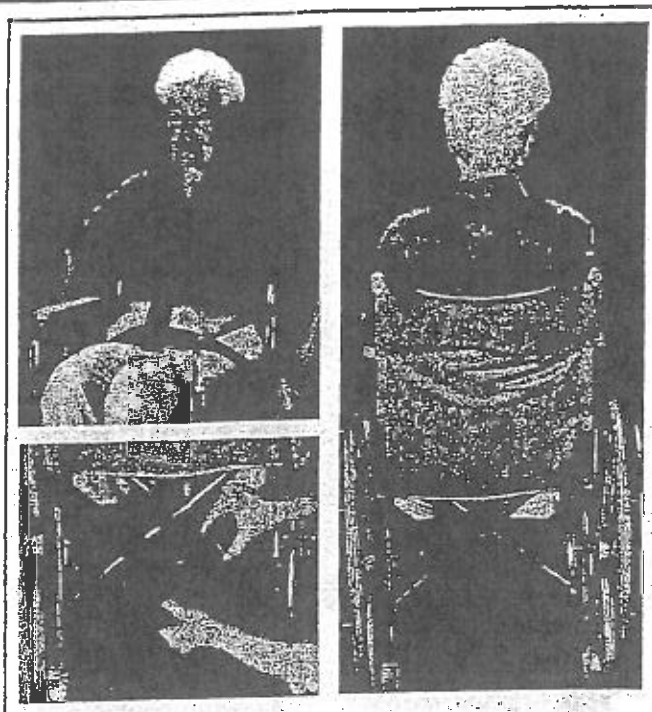
Laundering Instructions:

This product was designed to be washed under CDC recommendations for linen soiled with blood or bodily fluids:

160°F 71°C — WASH HOT 25 MIN. | Cl — BLEACH AS DIRECTED ON CONTAINER | DRY ON LOW

Lower temperature washing and drying cycle for non-contaminated linen will prolong product life.

ADDITIONAL SAFETY INSTRUCTIONS ON OTHER SIDE



APPLICATION INSTRUCTIONS:

This product is for use in wheelchairs only.

1) Position the patient's hips against the back of the chair. Lay the "Y" harness over the patient's shoulder with the long tail in front of the patient, and the top behind their back. Adjust so there is at least 8" (20cm) from the top of the "Y" to the base of the throat.
2) Secure the two loops to the push handles of the wheelchair. Tighten the slide buckle until the strap between the push handles is snug. (Note: An alternate method will make the strap very difficult to remove from the wheelchair push handles: Tighten the strap two inches smaller than the distance between the push handles and slide one loop onto one push handle. Stand on the outside of the chair, with your hip positioned against the push handle with the loop in place. Use both hands to pull the other push handle toward you, and slip the other loop over it. When you let go, the patient's weight will exert pressure on the strap to make sure it is not easily pushed off.) To prevent the strap from working loose, bring the end back through the slide buckle in the opposite direction and tighten.
3) Thread the long strap through the loop at the level of the patient's lap on the "Y" belt. Caution: make sure there are at least 8 inches (20 cm) between the junction of the "Y" belt and the base of the patient's throat. If there is not enough space between the throat and the junction, adjust the belt with the slide buckles. The long belt should be positioned over the patient's lower pelvis, NOT up around the waist. This will position the hips against the back seat rest.
4) Bring the strap over the lap and down at a 45 degree angle between the seat and the frame, and around the back post of the wheelchair.
5) Cross the straps behind the patient, and put the loops over the tilt bars.
6) Tighten the straps snugly using the slide buckles. Straps should always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient. Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of device.

Note: In order to tighten the belt easily follow these hints:

1) Kneel next to a back wheel, outside (not directly behind) the wheelchair. See photo above.
2) Reach inside between the two back wheels and grasp the strap that is sewn on to the slide buckle. Pull that strap firmly toward you. (see photo)
3) Use the other hand to slightly tilt the slide buckle up, and slide it up the strap until snug.
4) Repeat steps 1-3 on the other strap after moving to the same position on the other side of the wheelchair.

To Release:

1) Stand behind the chair, and push the slide buckles as close as possible to the tilt bar. This will create lots of excess slack on the lap belt.
2) Release the two loops off of the push handles.
3) Pull the "Y" belt over the patients head.
4) Pull the lap belt up over the patient's knees so they can step over it.

Cat. No. 4120, Posey "Y" Wheelchair Belt, universal adult size.

19234 060299

We welcome your suggestions for improving our products or service:

Posey Co.
5635 Peck Road
Arcadia, CA 91006 USA
Tel: 1-800-44-POSEY
Fax: 1-626-443-5014
www.posey.com

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APPLICATION INSTRUCTION SHEET
POSEY® ROLL JACKET

Applicable Products:
Cat. No. 3320

DESCRIPTION OF PRODUCT:
Versatile jacket that allows patient freedom to roll from side to side or sit up in bed. For bed or chair application.

CAUTION: FEDERAL LAW (USA) RESTRICTS THIS DEVICE TO SALE OR USE BY OR ON ORDER OF A PHYSICIAN.

INDICATIONS:
- Patients who are assessed to be at risk of a fall which could result in injury.
- Patients who require a positioning product to assist medical treatment.
- Patients who need freedom to roll from side to side or sit up in bed.

CONTRAINDICATIONS:
Contraindications include, but are not limited to the following conditions:
- Aggressive, combative, restless, or suicidal patients.
- Patients with ostomy, colostomy, G-Tubes, Hernias, severe Cardio Obstructive Pulmonary Disease (COPD), those with post-surgery incisions that might be compromised by the pressure from a restrictive product, or those with monitoring equipment, tubes or lines that might be compromised by rubbing against a restraint.
- Discontinue use immediately if the patient is able to slide forward or down underneath the device. They could slide far enough under the device to become suspended, resulting in chest compression and suffocation. Posey products with a pelvic piece are designed to help prevent sliding. Products without a pelvic piece between the legs will not hinder sliding as effectively. See your Posey catalog for other more suitable products to help prevent sliding.

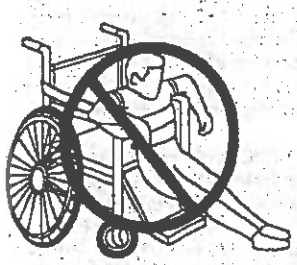
ADVERSE REACTIONS:
Severe emotional, psychological, and physical problems may occur if a patient's movement is severely limited. The patient may become restless or agitated if the device is uncomfortable or severely limits movement. Request assistance from a qualified medical authority for an alternative product or intervention.

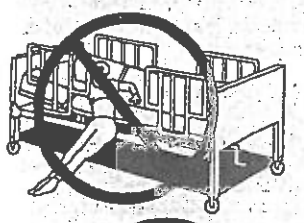
⚠WARNING

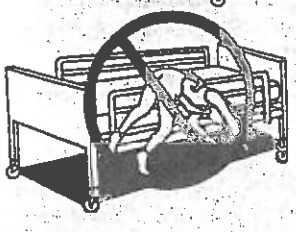
Straps must always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient. Make sure straps do not slide in any direction, changing position of device.

All siderails MUST be in the up position when using restraints. If necessary, use a siderail cover, especially with split siderails, to prevent the patient's body from going under, around, through or between the siderails.

After applying a restrictive product, always monitor appropriately per facility policy to make sure the patient is not able to slide down, or fall off the chair seat or mattress. Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of device. If their body weight becomes suspended off the chair or the mattress, chest compression and suffocation could result. Restraints with pelvic pieces may be necessary to reduce sliding down or pulling the restraint off over their head.







A patient in a supine position who cannot sit up requires extra vigilance. Should the patient vomit, he/she could aspirate his/her vomitus and suffocate. Monitor constantly and be prepared to intervene at the first sign of danger.

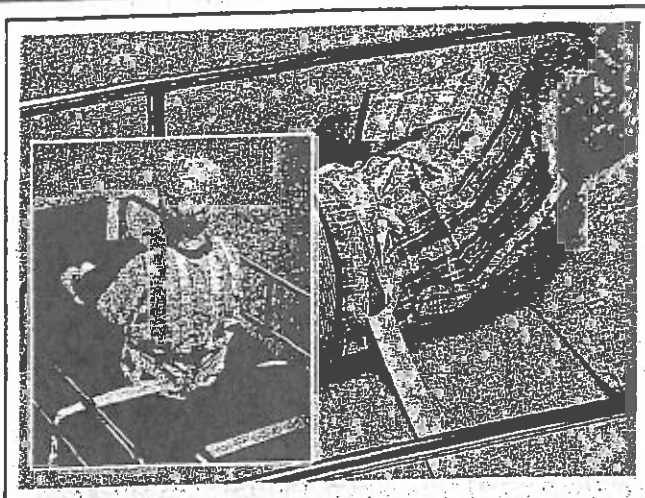
Laundering Instructions:
This product was designed to be washed under CDC recommendations for linen soiled with blood or bodily fluids:

160°F 71°C WASH HOT 25 MIN. | Cl BLEACH AS DIRECTED ON CONTAINER | DRY ON LOW

Zip up the product before laundering and turn inside out to protect zipper.

Lower temperature washing and drying cycle for non-contaminated linen will prolong product life.

ADDITIONAL SAFETY INSTRUCTIONS ON OTHER SIDE



APPLICATION INSTRUCTIONS: BED
1. Apply jacket on patient with zipper in the back.
2. Adjust side ties at waist level to insure snug fit. The side seams should be under the arms.
3. Bring long strap on each side around to the rear of the jacket.
4. Insert the long strap through square opening on the same side, threading it under the zipper and out of the jacket through the square opening on the opposite side. Be sure the strap lies UNDER the zipper, not over.
5. Repeat Step 4 with opposite strap.
6. Secure straps with quick-release ties to the moveable part of the bed frame at waist level, out of patient's reach.

NOTE:
When applying restraints to agitated patients, it is recommended to create an additional stress relief point on the connecting strap. Wrap the strap once around the movable part of the bed frame (point A) and secure to a second point on the same moveable part of the bed frame (point B) using a quick-release tie. The strap will absorb the stress of pulling and protect the knot.

APPLICATION INSTRUCTIONS: CHAIR
1. Apply jacket as described in Steps 1 and 2 above.
2. Position the patient in the chair with hips in the back of the chair.
3. Take the straps down the side of the chair, over the hips at a 45 degree angle and secure underneath the seat out of the patient's reach. In a chair, the straps do not cross behind the patient.

⚠WARNING

Straps should always be snug but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient.

Posey Roll Jacket
Cat. No. 3320, Sizes S,M,L,XL

I9262 112200

We welcome your suggestions for improving our products or service:

Posey Co.
5635 Peck Road
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Tel: 1-800-44-POSEY
Fax: 1-626-443-5014
www.posey.com

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APPLICATION INSTRUCTION SHEET
POSEY® SELF-RELEASING SOFT LAP BELT

Applicable Products:
Cat. No. 4126Q, 4126V

DESCRIPTION OF PRODUCT: A self-releasing padded belt.

INDICATIONS:

- Patients needing a reminder to call for assistance before they ambulate.

- Patients who require a positioning product to assist medical treatment.

If the patient/resident is not able to easily self-release this product, it would be considered a restrictive product and therefore must be prescribed by a physician.

CONTRAINDICATIONS:
Contraindications include, but are not limited to the following conditions:

- This is not intended to be a restrictive product, and may be easily self-released by the patient. Patients who cannot safely ambulate without assistance, or those at risk for a fall or re-injury should not use this product.

- Aggressive, combative, restless, or suicidal patients.

- Patients with Ostomy, Colostomy, G-Tubes, Hernias, severe Cardio Obstructive Pulmonary Disease (COPD), or those with post-surgery incisions that might be compromised by the pressure from a restrictive product.

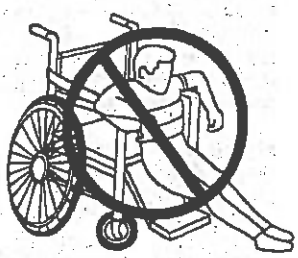
- Discontinue use immediately if the patient is able to slide forward or down underneath the device. They could slide far enough under the device to become suspended, resulting in chest compression and suffocation. Posey products with a pelvic piece are designed to help prevent sliding. Products without a pelvic piece between the legs will not hinder sliding as effectively. See your Posey catalog for other more suitable products to help prevent sliding.

SAFETY CONSIDERATIONS:
The Posey catalog offers "self-release" and "assisted-release" products and the doctor's order must specify exactly which product is required.

ADVERSE REACTIONS:
Severe emotional, psychological, and physical problems may occur if a patient's movement is severely limited. The patient may become restless or agitated if the device is uncomfortable or severely limits movement. Request assistance from a qualified medical authority for an alternative product or intervention.

⚠ WARNING

Straps should always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient. Loose straps may allow the patient's body to slide forward or down in a chair and become suspended in the restraint, resulting in chest compression and suffocation.



After the product has been applied, always monitor the patient to make sure he/she is not able to slide down, or fall off the chair seat. Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of device. If the patient's body weight becomes suspended off the chair, chest compression and suffocation could result. Restraints with pelvic pieces may be necessary to reduce sliding down or pulling the restraint off over their head.

Laundering Instructions:
This product was designed to be washed under CDC recommendations for linen soiled with blood or bodily fluids:

160°F 71°C	Cl	
WASH HOT 25 MIN.	BLEACH AS DIRECTED ON CONTAINER	DRY ON LOW

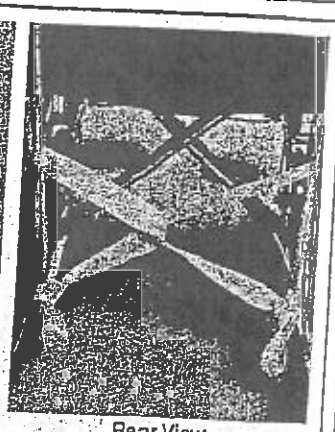
Fasten all buckles to minimize damage during wash and dry cycle.

Inspect buckles regularly and discard if cracked. Do not put buckles through extractors.

Lower temperature washing and drying cycle for non-contaminated linen will prolong product life.

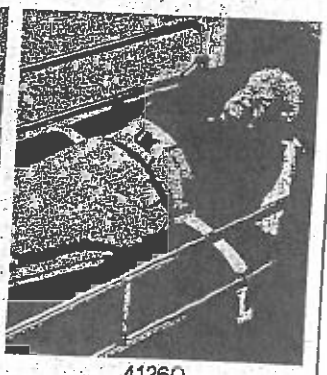
The "hook" of hook and loop closure material has a tendency to collect lint after repeated use and/or laundering, reducing the grip strength of the hook and loop. Test for secure hold before each use. Discard if it does not hold securely. Occasionally go over the "hook" with a stiff brush to remove lint. Fastening the "hook" to the "loop" during laundering will also help to prevent lint buildup.

4126V



Rear View

4126Q



4126Q

APPLICATION INSTRUCTION: CHAIR

1) Position the hips against the backrest of the chair. The soft foam pad goes toward the patient.
2) Bring the straps over the thighs at a 45 degree angle around the back post, and pass them between the seat and the side of the chair.
3) Cross the straps and twist behind the patient and attach them underneath the chair. Make sure the straps cannot slide forward if the patient begins to slide down. This might allow their buttocks to slide off the seat. See "Warning" to the left.

   Straps should always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient. Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of device.
4) The patient may release the belt by opening the quick-release buckle or "hook & loop" closure.

APPLICATION INSTRUCTIONS: BED

Put the belt around the patient's waist with the soft foam side facing in. Bring the straps around behind the patient to "criss-cross" in the back, and then continue the straps through the positioning loops on the ends of the blue foam pad. Secure the straps at waist level to the movable part of the bed frame, out of the patient's reach, using a quick-release tie or buckle. Always secure to a juncture of the frame which will not allow the straps to slide in any direction and change the position of the product.

Straps should always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient. Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of device.

Posey Self-Releasing Soft Belt, Universal Size:
Cat. No. 4126V with "hook & loop" closure in front.
Cat. No. 4126Q with Delrin Quick-Release buckle in front.

ADDITIONAL SAFETY INSTRUCTIONS ON OTHER SIDE

We welcome your suggestions for improving your products or service:

Posey Co.
5635 Peck Road
Arcadia, CA 91006 USA
Tel: 1-800-44-POSEY
Fax: 1-626-443-5014
www.posey.com

CE

RESIDENT-RELEASE NYLON BELTS
REALEZEE RELEASE NYLON BELTS

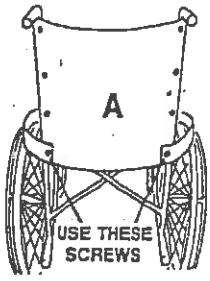
REORDER #	PRODUCT DESCRIPTION	CLOSURE	ADJUSTMENT RANGE
☐ 701010	RESIDENT-RELEASE BELT	SIDE-RELEASE BUCKLE	28" - 40"
☐ 701011	RESIDENT-RELEASE BELT	SIDE-RELEASE BUCKLE	40" - 54"
☐ 701015	REALEZEE RELEASE BELT	RESIDENT-FRIENDLY BUCKLE	UNIVERSAL
☐ 701030	RESIDENT-RELEASE BELT	VELCRO	28" - 40"
☐ 701031	RESIDENT-RELEASE BELT	VELCRO	40" - 54"
☐ 701035	REALEZEE RELEASE BELT	VELCRO W/RED LOOP	UNIVERSAL

PURPOSE

Resident-Release and Realezee Release Nylon Belts are designed to be released easily by most residents. These belts are not considered to be restraints when used by residents who have the ability to open them at will or upon request. However, they become physical restraints when used by residents who are unable to release them. The determination of the appropriateness of any of these belts for a specific resident is the responsibility of the professional and medical staff. These belts are intended for wheelchair use only.

INSTALLATION TO WHEELCHAIR

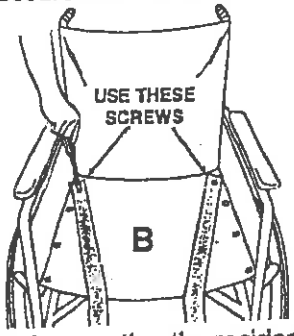
Each belt listed above may be attached to a wheelchair using either of the methods described below.



METHOD A.

1. Remove the bottom screws from the left and right sides of the wheelchair backrest. (See Illustration A.) Keep the grommets.

2. Place the grommets on the screws. Insert the screws through the holes in the metal tabs on the ends of the belt sections. Reinsert the screws into the screw holes and secure them to the backrest frame.



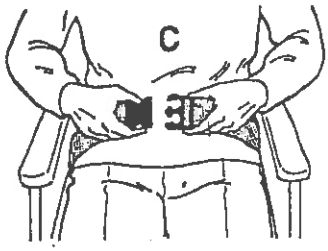
METHOD B.

1. Remove the rear screws from the left and right sides of the wheelchair seat. (See Illustration B.) Keep the grommets.

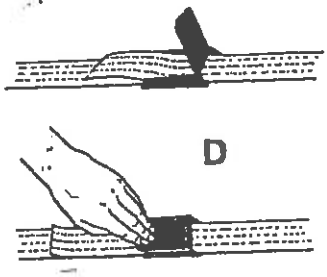
2. Place the grommets on the screws. Insert the screws through the holes in the metal tabs on the ends of the belt sections. Reinsert the screws into the screw holes and secure them to the seat frame.

APPLICATION

Before seating the resident, lock both wheelchair brakes and adjust the footrests to the out-of-the-way position. Seat the resident as far back on the wheelchair seat as possible. Position the footrests to the front of the wheelchair and place the resident's feet on them.



Side-Release Buckle (See Illustration C) Insert the male end of the buckle into the female end. A "click" indicates that the buckle is secure. To release, simultaneously press the tabs on the top and bottom of the buckle.



Resident-Friendly Buckle (See Illustration D) Lift faceplate of the buckle and insert the webbing through the space between the buckle cam and buckle base. Press faceplate all the way down to secure the buckle. To release, lift up the loose end of the webbing.

— OVER —

eZY WRAP®

RMI #0061
Version 2
KB

INSTRUCTIONS FOR THE FOLLOWING PRODUCTS:

MAXIMUM SECURITY SUIT

Fabrics	COMPLETE	TOP ONLY	BOTTOM ONLY
BLUE DENIM	2847-01-31000	2848-01-31000	2849-01-31000
LT. WT. MESH	2847-01-67000	2848-01-67000	2849-01-67000
MUSLIN	2847-01-75000	2848-01-75000	2849-01-75000
LT. WT. COTTON	2847-01-21000	2848-01-21000	2849-01-21000

ICU SECURITY SUIT

Fabrics	
LT. WT. COTTON	2825-21363
BLUE DENIM	2825-31363
LT. WT. MESH	2825-67363
MUSLIN	2825-75363

PONCHO RESTRAINT

Fabrics	
BLUE DENIM	2840-01-31000
LT. WT. MESH	2840-01-67000
MUSLIN	2840-01-75000
LT. WT. COTTON	2840-01-21000

SIZING:

SIZE	COLOR BINDING	WEIGHT
X-SMALL	WHITE	40 TO 80 LBS.
SMALL	PINK	80 TO 130 LBS.
MEDIUM	GREEN	120 TO 170 LBS.
LARGE	YELLOW	160 TO 210 LBS.
X-LARGE	BLUE	200 TO 250 LBS.
XX-LARGE	WHITE	230 TO 280 LBS.

BED APPLICATION OF eZY WRAP® MAXIMUM SECURITY SUIT:

1. Always be sure the Restraint is the correct size, please consult the sizing chart.
2. Determine the correct size and slip the vest over the patient's head like a T-shirt with lower neckline in front.
3. Position the diaper-like bottom between the patient's legs.
4. Thread the waist straps from the diaper bottom through the vertical slots of the vest, both front and back. To save time and/or for greater ease in application, the back or front of the pants may be attached to the vest before it is slipped over the head.
5. The bottom pants are now interlocked to the vest, both front and back with the velcro® and snap closures.
6. Take the straps directly to side of bed. Attach the straps to the bed spring frame once or twice then secure under the bed, out of patient's reach.

BED APPLICATION OF eZY WRAP® PONCHO RESTRAINT:

1. Always be sure the Restraint is the correct size, please consult the sizing chart.
2. Loosen the waist strap and put the Poncho over the patient's head with shoulder loops in the back and the lower neckline in the front.
3. Tighten the waist strap to comfort (4 fingers between patient's abdomen and strap).
4. To prevent a patient from sitting up, should this be desired, the waist strap may be attached to side of bed spring frame and then brought up and threaded through the shoulder straps and secured against the bed frame at shoulder level. Always have the bed side rails in the "UP" position.

BED APPLICATION OF eZY WRAP® ICU SECURITY SUIT

1. Always be sure the Restraint is the correct size, please consult the sizing chart.
2. Determine the correct size and insert the patient's arms through the arm holes of the jacket and zip up the back completely
3. Attach the bottom diaper to the jacket with the velcro® and snap closures both in the front and back.
4. Thread the waist straps from the bottom diaper through the vertical loops on the jacket both front and back. The waist straps from the jacket do not pass through the loops but ties directly to the side of bed.
5. Take the 3 straps directly to the side of the bed. Attach the side straps to the bed frame that moves with the patient, never attach them to the rails.

WHEELCHAIR APPLICATION OF eZY WRAP® PONCHO RESTRAINT:

1. Always be sure the Restraint is the correct size, please consult the sizing chart.
2. Loosen the waist strap and put the poncho over the patient's head with the shoulder loops in the back and the lower neckline in the front.
3. Tighten the waist strap to comfort (open palm between patient's abdomen and strap).
4. Pull the straps over the patient's hips to hold him back in the chair and secure the ends under the chair. If the patient has a tendency to slump forward, the shoulder loops may be put over the hand grips on the push handles to help keep the patient's posture correct.

We at Professional Products feel there are only two basic indications for placing a patient in restraints:

1. to prevent him from injuring himself, and
2. to prevent him from injuring others.

We recommend that anyone who places a patient [illegible] of restraint review the following points:

1. Explain to the patient and/or their family why the restraint is necessary.

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
F208 cont.	**§483.12(d)(4)** States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.	
	§483.13 Resident Behavior and Facility Practices	
F221	[Use Tag F221 for deficiencies concerning **physical** restraints.]	Use Guidance under Tag F222.
F222	[Use Tag F222 for deficiencies concerning **chemical** restraints.] **§483.13(a) Restraints** The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	**Intent §483.13(a)** The intent of this requirement is for each person to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. **Interpretive Guidelines §483.13(a)** **Definitions of Terms** **"Physical Restraints"** are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
F222 cont.		An enclosed framed wheeled walker, with or without a posterior seat, would not meet the definition of a restraint if the resident could easily open the front gate and exit the device. If the resident cannot open the front gate (due to cognitive or physical limitations that prevent him or her from exiting the device or because the device has been altered to prevent the resident from exiting the device), the enclosed framed wheeled walker would meet the definition of a restraint since the device would restrict the resident's freedom of movement (e.g. transferring to another chair, to the commode, or into the bed). The decision on whether framed wheeled walkers are a restraint must be made on an individual basis. **"Medical Symptom"** is defined as an indication or characteristic of a physical or psychological condition. The resident's medical symptoms should not be viewed in isolation, rather the symptoms should be viewed in the context of the resident's condition, circumstances and environment. Objective findings derived from clinical evaluation and the resident's subjective symptoms should be considered to determine the presence of the medical symptom. The resident's subjective symptoms may not be used as the sole basis for using a restraint. Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of restraints, and how the use of restraints would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being. Medical symptoms that warrant the use of restraints must be documented in the resident's medical record, ongoing assessments, and care plans. While there must be a physician's order reflecting the presence of a medical symptom, CMS will hold the facility ultimately accountable for the appropriateness of that determination. The physician's order alone is not sufficient to warrant the use of the restraint. It is further expected, for those residents whose care plans indicate the need for restraints, that the facility engage in a systematic and gradual process toward reducing restraints (e.g., gradually increasing the time for ambulation and muscle strengthening activities). This systematic process would also apply to recently admitted residents for whom restraints were used in the previous setting.

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
F222 cont.		**Consideration of Treatment Plan** In order for the resident to be fully informed, the facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use. Whenever restraint use is considered, the facility must explain to the resident how the use of restraints would treat the resident's medical symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical or psychological well-being. In addition, the facility must also explain the potential negative outcomes of restraint use which include, but are not limited to, declines in the resident's physical functioning (e.g., ability to ambulate) and muscle condition, contractures, increased incidence of infections and development of pressure sores/ulcers, delirium, agitation, and incontinence. Moreover, restraint use may constitute an accident hazard. Restraints have been found in some cases to increase the incidence of falls or head trauma due to falls and other accidents (e.g., strangulation, entrapment). Finally, residents who are restrained may face a loss of autonomy, dignity and self respect, and may show symptoms of withdrawal, depression, or reduced social contact. In effect, restraint use can reduce independence, functional capacity, and quality of life. Alternatives to restraint use should be considered and discussed with the resident. Alternatives to restraint use might include modifying the resident's environment and/or routine. In the case of a resident who is incapable of making a decision, the legal surrogate or representative may exercise this right based on the same information that would have been provided to the resident. (See §483.10(a)(3) and (4).) However, the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of the regulation solely based on a legal surrogate or representative's request or approval.

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
F222 cont.		**Assessment and Care Planning for Restraint Use** There are instances where, after assessment and care planning, a least restrictive restraint may be deemed appropriate for an individual resident to attain or maintain his or her highest practicable physical and psychosocial well-being. This does not alter the facility's responsibility to assess and care plan restraint use on an ongoing basis. Before using a device for mobility or transfer, assessment should include a review of the resident's: • Bed mobility (e.g., would the use of a device assist the resident to turn from side to side? Is the resident totally immobile and unable to change position without assistance?); and • Ability to transfer between positions, to and from bed or chair, to stand and toilet (e.g., does the raised side rail add risk to the resident's ability to transfer?). The facility must design its interventions not only to minimize or eliminate the medical symptom, but also to identify and address any underlying problems causing the medical symptom. • Interventions that the facility might incorporate in care planning include: ◦ Providing restorative care to enhance abilities to stand, transfer, and walk safely; ◦ Providing a device such as a trapeze to increase a resident's mobility in bed; ◦ Placing the bed lower to the floor and surrounding the bed with a soft mat; ◦ Equipping the resident with a device that monitors his/her attempts to arise; ◦ Providing frequent monitoring by staff with periodic assisted toileting for residents who attempt to arise to use the bathroom;

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
F222 cont.		◦ Furnishing visual and verbal reminders to use the call bell for residents who are able to comprehend this information and are able to use the call bell device; and/or ◦ Providing exercise and therapeutic interventions, based on individual assessment and care planning, that may assist the resident in achieving proper body position, balance and alignment, without the potential negative effects associated with restraint use. **Procedures §483.13(a)** Determine if the facility follows a systematic process of evaluation and care planning prior to using restraints. Since continued restraint use is associated with a potential for a decline in functioning if the risk is not addressed, determine if the interdisciplinary team addressed the risk of decline at the time restraint use was initiated and that the care plan reflected measures to minimize a decline. Also determine if the plan of care was consistently implemented. Determine whether the decline can be attributed to a disease progression or inappropriate use of restraints. For sampled residents observed as physically restrained during the survey or whose clinical records show the use of physical restraints within 30 days of the survey, determine whether the facility used the restraint for convenience or discipline, or a therapeutic intervention for specific periods to attain and maintain the resident's highest practicable physical, mental, or psychosocial well-being. **Probes: §483.13(a)** This systematic approach should answer these questions: 1. What are the medical symptoms that led to the consideration of the use of restraints?

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
F222 cont.		2. Are these symptoms caused by failure to: a. Meet individual needs in accordance with the resident assessments including, but not limited to, section III of the MDS, Customary Daily Routines (MDS Version 2.0, section AC), in the context of relevant information in sections I and II of the MDS (MDS Version 2.0, sections AA and AB)? b. Use rehabilitative/restorative care? c. Provide meaningful activities? d. Manipulate the resident's environment, including seating? 3. Can the cause(s) of the medical symptoms be eliminated or reduced? 4. If the cause(s) cannot be eliminated or reduced, then has the facility attempted to use alternatives in order to avoid a decline in physical functioning associated with restraint use? (See Physical Restraints Resident Assessment Protocol (RAP), paragraph I). 5. If alternatives have been tried and deemed unsuccessful, does the facility use the least restrictive restraint for the least amount of time? Does the facility monitor and adjust care to reduce the potential for negative outcomes while continually trying to find and use less restrictive alternatives? 6. Did the resident or legal surrogate make an informed choice about the use of restraints? Were risks, benefits, and alternatives explained? 7. Does the facility use the Physical Restraints RAP to evaluate the appropriateness of restraint use? 8. Has the facility re-evaluated the need for the restraint, made efforts to eliminate its use and maintained residents' strength and mobility?

ARKANSAS HEALTH CENTER

RESIDENT BEHAVIOR REPORT

_____ _____ _____ _____ AM/PM _____ AM/PM

Resident's Name | Unit | Date | Time Began | Time Ended

_____ _____ Vital Signs: BP_____; P_____; T_____; R_____

Location of Incident | Signature/Title of Person Completing Form

What Was Resident Doing Prior to Behavior?

___ Resident made a request that was denied
What was the request?_____
_____

___ Staff made a request of resident
What was the request?_____
_____

___ Change in daily schedule
___ Provoked by another resident
___ Waking up
___ Medical Procedure
___ Resident was alone
___ Resident was in group

___ Agitated
___ Meal
___ Bedtime
___ Bath
___ Unknown

Unwanted Behaviors Observed

Uncooperative with:
___ Medication
___ Meals
___ Scheduled programs
___ ADLs
Other _____
_____

Verbally Inappropriate to:
___ Staff
___ Family/Visitors
___ Other resident/s
Name: _____
_____

Type of Verbal Inappropriateness
___ Cursing
___ Yelling at others
___ Threats to
___ Staff
___ Other resident/s
___ Family/Visitors

Physically Inappropriate to:
___ Staff
___ Family/Visitors
___ Other resident/s
Name: _____
_____

Type of Physical Inappropriateness
___ Hitting ___ Shoving
___ Biting ___ Spitting
___ Scratching
___ Other
*(Specify)*_____

Sexually Inappropriate to:
___ Staff
___ Family Visitors
___ Other resident/s
Name: _____
_____

Type of Sexual Inappropriateness
___ Public masturbation
___ Inappropriate touching
___ Inappropriate sexual behavior

Other Inappropriate Behaviors
___ Stalking
___ Stealing
___ Public disrobing
___ Provoking others
___ Eating inappropriate objects
___ Wandering into other's rooms
___ Hears voices not there
___ Sees things not there
___ Crying
___ Sad expression
___ Leaves Unit
___ Attempts to leave unit unattended
___ Leaves *Pathfinders*
___ Urinating/defecating in inappropriate areas
___ Smearing feces
___ Throwing food
___ Elopement
___ Disruptive noises
___ Rummaging through other's belongings
___ Hoarding
___ Fearful
___ Anxious
___ Pacing
___ Other (use back to describe)

Negative Statements About Self
___ Expresses hopelessness
___ Expresses desire to hurt self
___ Expresses desire to die

FOR ADDITIONAL COMMENTS SEE BACK OF FORM

Staff Intervention

___ Reported to appropriate person
___ Separated residents
___ Redirected resident/s
Removed resident/s from area

Long Range Safety Plan:_____
_____

Response to Intervention

___ Behavior ceased
___ Behavior lessened
___ Behavior worsened
___ No change

Instructions for Completing BR Form

1. Any witness to an incident can complete this BR.
2. Check any appropriate item.
3. Be sure to complete all information at the top of form.
4. Make additional comments on back of BR form, if needed.
5. ***Submit to Nurse Supervisor for review and any needed immediate action.***

Routing of BR Form

1. Nurse Supervisor will review and initial the form and send original behavior report to Nursing Services for DON or ADON to review and initial
2. Risk Management will pick up the original form for Nsg. Service

___ *Nurse Supervisor Initials*
___ DON/ADON Initials

(Continued on back) Revised April 2011

PROCEDURE FOR BEHAVIOR REPORT SYSTEM

1. Any staff person may fill out the behavior report: Then it will be forwarded to the RN Supervisor/Designee.

2. The RN/LPN Supervisor will inform the MDS coordinator for updating needs of the care plan.

3. FAX ALL BEHAVIOR REPORTS TO RISK MANAGEMENT (860-0532)

In the Behavior Notebook the following information will be filed individually and kept in the RN office:

1. A **copy** of the BR report.
2. **Individual** behavior tracking log
3. **Copy** of any I/A that are related to the behavior

BEHAVIOR REPORT
NARRATIVE COMMENTS

RESIDENT NAME:_____ **UNIT:**_____

DATE:_____

Additional Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature/Date

_____

Reviewed/Date

SECTION 15

SUICIDE PRECAUTIONS

Subject: Suicide Precautions

Policy: To reduce the risk of suicidal behaviors, whether accidental or intentional. When a resident verbalizes thoughts of death or exhibits verbal intent of suicide or engages in self-injurious behaviors that are potentially life threatening, immediate precautions will be initiated to protect that resident.

Intervention Procedures: All staff members observing a resident voicing thoughts of death and/or making verbal, signed, or gestured threats of harm to themselves (with or without acting-out behaviors) must initiate intervention procedures.

These will include:

1. Staff will immediately notify the RN Supervisor on call, the LPTN/LPN Supervisor, and/or the Social Service Worker.

2. Upon notification, the LP will immediately notify the resident's physician and responsible party/guardian of the resident's change of condition and complete an I&A.

3. RN Supervisor (the Social Service Worker is the initiator when available) will evaluate the resident and complete an assessment tool to determine if the resident should be considered a Level I, II, or III. The Social Service Worker or RN Supervisor may choose to consult with other disciplines in determining the level of severity. If the resident meets the criteria for a Level I, II, or III, suicide precautions specific to the level will immediately be implemented. (See Page __ for Level I, II, III criteria)

4. Staff will be informed of the assessment results (Level I,II,III) and specific interventions that are to be implemented to ensure resident safety.

5. All staff will sign the Suicide Precaution Alert Form indicating they have been informed of the resident's status as well as individualized approaches to ensure resident safety.

6. The Social Service Worker or RN will summarize their findings in the medical record.

7. If the resident meets the criteria for Level I, II, the resident is referred to the Assessment team (Social Service Worker, RN Supervisor, Psychologist/Psychological Examiner and Psychiatrist) for a more in-depth evaluation. **If the resident meets the criteria for Level III, the LP/RN will immediately contact the physician for immediate transfer to a psychiatric facility or emergency room for evaluation.**

8. Based upon available clinical data, the team will complete the further assessment. The physician and Interdisciplinary team will be notified of their findings and recommendations. The resident's care plan will be updated to reflect new interventions.

9. The resident will be re-evaluated by the Social Service Worker/RN on a daily basis to determine if the level of suicidal intent has increased or decreased. A summarization of the evaluation will be documented in the resident's medical record.

Defining Levels and Precautions:

Level I:

Resident has verbalized thoughts of death or has made verbal, signed or gestured threats to harm self, but has no feasible plan or available means. No dangerous acting-out behaviors are present.

Precautions:

1. The resident will be observed and/or within line of sight for daily activities and log every 15 minutes.

Level II:

The resident has verbalized thoughts of death or made verbal, signed or gestured threats to harm self and has a feasible plan. Signs or symptoms of depression have been indicated. Dangerous acting-out behaviors may or may not be present.

Precautions:

1. Provide continuous visual observation and log every 15 minutes.
2. Remove as many implicated items as feasible. If removal is not possible, provide as much assistance as necessary to keep the resident in a safe environment.

Level III:

Dangerous acting-out behaviors are present (verbal, signed or gestured threats may or may not be present.)

Precautions:

1. The RN Supervisor will assign staff to assist in moving resident to a designated private room. The resident will remain in that room until transfer.
2. Provide continuous visual observations, stay within six feet of the person at ALL times and log every 15 minutes.
3. Begin immediate referral to psychiatric facility or to Emergency Room for evaluation.

Arkansas Health Center
Suicide Precaution Risk Assessment

Resident Name:_____ Date:_____ Time:_____

Reason for Referral:_____
_____

Diagnoses:_____
_____

Current Psychotrophic Medications/Last Medication Adjustment (Reduction or Increase):_____
_____

Does the resident have a suicide plan, if so, describe:_____
_____
_____

Describe resident's physical appearance and affect:_____
_____

Has the resident verbalized/engaged in the following:

1. Has the resident verbalized thoughts of death and/or made verbal, signed or gestured threats to harm self?
   __ Yes __ No
2. Does the resident have a feasible plan to harm themselves?
   __ Yes __ No
3. Are signs and symptoms of depression indicated (e.g. signs of hopelessness, giving away possessions, sleep disturbance, weight fluctuation, recent change in behavior)?
   __ Yes __ No
4. Are dangerous acting-out behaviors present?
   __ Yes __ No

Level I: Answered yes to question #1
Level II: Answered yes to question #1, #2, and #3
Level III: Answered yes to question #4 (could have answered yes to other questions also)

Describe any recent life event that may contribute to suicidal ideation or thoughts of death:_____
_____

List the mood and/or behavior symptoms that triggered on the most current MDS:_____
_____

Is the resident in a situation that is becoming significantly worse or painful?_____

Level of Precaution needed: (Check one)

___ Level I
___ Level II
___ Level III
___ None of the above

Signature of Staff Member completing form_____

Suicide Precaution List

Name	Precaution Level	Staff Aware

SECTION 16

LIFTING AND TRANSFERRING RESIDENTS

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	Lifting and Transferring Residents	NS 905

1. PURPOSE. It is the purpose of this policy to assure that residents are lifted and transferred safely in all instances.

2. SCOPE. All nursing personnel, Rehab and Activities.

3. POLICY.

   A. Nurses and/or Rehab assess and determine lifting and transfer requirements and the procedure used for each resident.

   B. All residents must be lifted or transferred according to the determined procedure.

   C. Procedure appears in the care plan.

   D. All members of the nursing staff, Rehab and Activities are responsible for using good body mechanics, knowing the proper procedures, and properly operating assistive devices.

   E. Approved techniques for lifting, transfer, and body mechanics are discussed and demonstrated during each orientation and periodically thereafter for nursing personnel, Rehab and Activities.

4. PROCEDURE.

   A. Using a drawsheet:
   - Fold sheet from foot to head
   - Place under the resident's shoulders and hips
   - Make sure two staff are present when turning a resident
   - When turning, pull resident away from the side being turned to
   - Use pillows to position resident on their side
   - Using a drawsheet limits the amount of pulling or tugging on the resident that can occur
   - It also avoids possible sheet burns that can occur from dragging

   B. Using a transfer belt:
   - Two people need to be present for a transfer requiring at least moderate assistance. (This means the staff member does at least 50% of the work during the transfer)
   - Assist the resident from the supine to sit position
   - Be careful with the resident's feet as they are being moved to the sitting position
   - Place the belt around the resident's waist snuggly, but not tight
   - You should be able to slide a hand between the belt and the resident
   - Place the W/C or other chair beside the bed at an approximate 45-60 angle
   - Make sure the W/C or gerichair is locked before transferring
   - Have the resident to scoot out to the edge of the bed or chair
   - Place shoes or nonslip socks on the resident's feet before transferring
   - Allow the resident to assist by pushing up with their arms
   - Avoid allowing the resident to hang on to the staff members neck
   - The staff member needs to bend at their hips and keep the resident close during the transfer

- Use of the belt avoids pulling on the resident's arms during the transfer which can lead to an injury

C. Use of a mechanical lift:
- Two staff need to be present when lifting
- Place the sling beneath the resident. This can be done by rolling the resident while lying and placing the sling under them. The top straps need to be even with the shoulders and the lower edge needs to come to the lower portion of the back.
- Place the lift over the resident and lower the lifting frame over the resident to attach the sling.
- Make sure the frame does not come down on the resident's arms.
- Have the resident's arms placed over their chest. If they feel they have to hold on, allow them to hold onto the frame, but keep their arms within the sling area.
- As the lift is raised, guide the resident's feet to make sure they are not caught on or hit any object.
- Some residents that do not have control of their head will need it to be supported.
- Guide the lift toward the chair. Make sure the brakes are locked on the chair.
- Adjustments can be made to the legs on the lift to accommodate the size of the chair being used. Set the brake on the lift before lowering the resident.
- Do not move the resident in the lift with the legs apart. This can cause the lift to be out of balance and tip over.
- As the resident is lowered into the chair, make sure the resident is placed as far back as possible and they are centered in the chair.
- A staff member can assist in guiding the resident into the chair as needed. This includes their feet and arms. Make sure they do not get caught on the chair or lift.
- Unattach the sling and position the resident in the chair as needed.
- When transferring back to the bed, follow the same protocol and precautions as above.

D. Mechanical Standing Lift:
- Two staff will be present to use a mechanical lift.
- Sit the resident up on the side of the bed safely if transferring from bed.
- Watch feet as the resident is sitting up to not catch them on the bed rails.
- Place the lift sling around the resident, keeping it as low towards the hips as possible.
- When fastening the belt on the sling, make sure it is snug, but not tight.
- Watch the residents' feet as the lift is brought towards them and assist with feet placement as needed.
- Fasten the sling onto the appropriate knob according to the size of the resident. (Only fasten a loop onto one knob)
- As lift is being raised, have resident hang onto the lift at the blackened areas below the knobs if possible.
- Make sure the brakes are locked on the lift before raising the resident.
- Lift resident to a standing or semi-standing position.
- Maneuver the lift to the surface the resident is being transferred to. Never transport the resident from one surface to another with the legs in the spread position. This will make it unstable. The legs can be moved apart when the lift is in front of the chair, bed, or toilet so the resident can be lowered or lifted.
- Lock the lift brakes before lowering the resident.

- The resident is to be lowered onto the surface with one staff acting as a spotter to make sure the resident is centered and their hips are as far back on the surface as possible.
- As the lift is pulled away from the resident, assist with the removal of their feet from the lift surface.

E. General precautions:
- If a resident can assist in their transfer, allow them to help.
- If a resident requires total assistance for transfers, a mechanical lift is safest for the staff member and resident.
- If a resident has contractures present in any limb, only move the joint to the point that you feel resistance. Do not apply additional force.
- Make sure the bed is locked before a transfer begins.
- Check the floor for any spills or obstacles that can be a safety hazard.

SECTION 17

INFECTION CONTROL

- Disease Reporting
- Criteria for Establishing the Presence of an Infection
- Communicable Disease Reporting Procedures
- Biomedical Waste Management Plan
- Rationale/Responsibilities for Isolation Procedures
- Routine Infection Control Guidelines for All Residents
- Body Substance isolation Precautions
- Methicillin-Resistant Staphylococcus Aureus
- Resident Colonized with MRSA
- Infection Control Guidelines for Residents with MRSA
- Hepatitis
- Isolation Precaution Technique
- Hand Washing
- Needle-Stick and/or Blood Exposure Injuries
- Disposal of Infectious Materials
- Disposal of Intravenous Equipment
- Sharps Disposal
- Multi Drug Resistant Acinetobacter Baumannii

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Disease Reporting	IC-303

1. PURPOSE. It is the purpose of this policy to maintain adherence to the state health department standards of reporting certain infectious diseases is required.

2. SCOPE. This applies to the Infection Control Coordinator.

3. POLICY.

   A. Notifiable diseases are to be reported to the State Health Department within 24 hours, or reports may be made to the local county health unit.

   B. All infectious diseases are reported to the infection control nurse by the nurse supervisor on duty at the time of discovery.

   C. The infection control nurse reports the infectious disease to the state and/or local health departments, stating relevant details.

   D. In the absence of the infection control nurse, the DON assumes the above duties.

4. REPORTING PROCEDURE.

   A. State agencies to notify in case of infectious disease outbreak or individual cases include
      1. Epidemiology Section of the State Health Department at 661-2597 or 1-800-482-8888
      2. Saline County Health Department at 776-5650

   B. The telephone report will consist of the following information
      1. the physician's name and location
      2. the suspected disease
      3. the number of cases and interval during which the cases were identified

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Criteria For Establishing The Presence Of An Infection	IC-401

1. PURPOSE. It is the purpose of this policy to define guidelines for an infection.

2. SCOPE. This applies to Nursing Service and the Infection Control Coordinator.

3. URINARY TRACT INFECTION.

   A. Asymptomatic Bacteriuria is applied to those persons having colony counts in urine of >100,000 organisms per ml without previous or current manifestations of infection. Such asymptomatic UTIs are classified as nosocomial if an earlier urine culture was negative at a time when the resident was not receiving antibiotics. If a resident is admitted to the facility with a urinary tract infection, subsequent culture of a new pathogen in numbers >100,000 per ml is classified as a nosocomial infection.

   B. Other Urinary Tract Infections: The onset of clinical signs or symptoms of UTI (fever, dysuria, costovertebral angle tenderness, etc.) in conjunction with a colony count >100,000 organisms per month or a carefully collected midstream urine specimen, developing after admission, is classified as a nosocomial UTI.

   C. If a resident with a prior negative urinalysis and/or culture develops clinical symptoms or UTI and neither urinalysis nor urine culture have been repeated, he/she is considered to have a nosocomial UTI.

4. RESPIRATORY TRACT INFECTIONS.

   A. Upper Respiratory Tract Infections: This category includes clinical manifest respiratory infections of the nose, throat, or ear (singly or in combination). The signs and symptoms vary widely and depend on the site or sites involved. Coryzal syndromes, streptococcal pharyngitis, otitis media and mastoiditis are included in this category.

   B. Lower Respiratory Tract Infections: Clinical signs and symptoms of a lower respiratory infection (cough, pleuritic chest pain, fever, and particularly purulence) are diagnosed as respiratory tract infection, whether or not sputum cultures or chest x-rays are obtained.

   C. The diagnosis of a lower respiratory tract infection is made in the presence of one or more of the following:
      1. Purulent sputum (with or without recognized pathogen on sputum culture) from a resident with a suggestive chest x-ray.
      2. Presence of a new pulmonary infiltrate on chest x-ray.
      3. Super-infection of a previously existing respiratory tract infection when a new pathogen is cultured from sputum and clinical or radiological evidence indicates that the neworganism is associated with deterioration in the resident's condition.

5. GASTROENTERITIS.

   A. Three stools a day for two days

   B. Watery or purulent stools.

C. Identification of pathogenic organisms such as Salmonella, shigella, staphlococcus aureus, Coagulase Positive and specific enteropathogenic E. Coli.

6. SKIN AND SUBCUTANEOUS INFECTIONS.

A. Burn Infections – Purulent drainage from the burn site and/or clinical evidence of bacteremia in a burn resident is diagnosed as a burn infection. Such infections are often caused by organisms carried by the resident on admission; nonetheless, such infections are regarded as nosocomial if the clinical onset occurs after admission.

B. Surgical Wound Infections – Any clean or clean contaminated would which drains purulent material, with or without a positive culture, is diagnosed as an infection. Wounds are categorized as clean, clean contaminated, contaminated. They are defined as follows:
   1. Clean Wound – a non-traumatic, uninfected operation wound in which neither the respiratory, alimentary or genito-urinary tracts nor the oropharyngeal cavities are entered. Clean wounds are elective, primarily closed and undrained wounds.
   2. Clean-contaminated Wound – Operation wounds in the respiratory, alimentary or genito-urinary tract or the oropharyngeal cavities are entered without unusual contamination or wounds that are mechanically drained (drain brought out through the wound).
   3. Contaminated Wound – Operation wounds, in which there is the presence of pus, traumatic wounds with entry into the colon, burn wounds, and those operations in where there has been a major break in technique.

C. Other Cutaneous Infections – Any purulent material in skin or subcutaneous tissue first developing after admission is classified as a nosocomial infection whether or not a culture is positive, negative or has not been taken. This category includes nonsurgical wounds as well as various forms of dermatitis and decubitus ulcers. Cellulitis caused by bacterial agents is usually not accompanied by purulent drainage; in such instances primary reliance must be placed on clinical judgment, which may be confirmed by cultures of tissue fluid aspirates.

D. Other Sites Of Infection – Any culture-documented bacteremia that develops in a resident after admission is classified as a nosocomial infection, unless the organism is judged to be a contaminant.

7. SEPTICEMIA.

A. Positive blood culture (prefer more than one).

B. Clinical evidence
   1. Fever
   2. If secondary, same organism isolated at primary anatomic site.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Communicable Disease Reporting Procedures	IC-304

1. PURPOSE. The "Rules and Regulations Pertaining to Communicable Disease Control" was adopted by the Arkansas State Board of Health in 1977, pursuant to the authority conferred by Act 96 of 1913 (Arkansas Statutes, 1947, Section 82-110). Under Section III, the responsibility for reporting certain communicable diseases is the duty of every physician, practitioner, nurse, superintendent or manager of a dispensary, hospital, clinic, nursing or extended care home, and laboratory personnel examining human specimens resulting in the diagnosis of notifiable .

2. SCOPE. This applies to the Infection Control Coordinator.

3. POLICY. Notifiable diseases should be reported to the State Health Department within 24 hours on the Toll Free Code-A-Phone Reporting System (1-800-482-8888). If desired, reports may be made to the county health unit. After-hours reporting should be by Code-A-Phone which is operational 24 hours a day. Individuals desiring to further discuss reportable disease may phone the Epidemiology Office, Division of Health Maintenance. Reporting data should include:

   A. Name and location (town) of reporting person.

   B. Disease or suspected disease and date of onset.

   C. Name, age, sex and address of patient (please spell patient's name).

   D. Physician's name.

   Often physicians designate nurses, laboratory technicians or record personnel to report for them. This is satisfactory as long as the attending physician's name is given. Our goal is to make disease reporting as easy and simple as possible and eliminate written reports whenever possible. It is our intent to aggregate, evaluate and disseminate communicable disease data to physicians throughout the state and to conduct epidemiological investigations when indicated. Your cooperation in reporting is sincerely appreciated.

   Diseases in ALL CAPITALS should be brought to the immediate attention of the State Epidemiologist as soon as they are suspected. These diseases are of extreme PUBLIC HEALTH SIGNIFICANCE and immediate assistance will be available. For the diseases listed below and marked by an * the reporting physician will be contacted for additional information.

4. COMMON REPORTABLE DISEASES.

GONORRHEA
HEPATITIS (report Type A, B, non-A, non-B, or unspecified and give results of all hepatitis serologies or "not done")
RASH ILLNESSES (including *MEASLES & *RUBELLA)
SALMONELLOSIS (including *TYPHOID)
SHIGELLOSIS
SYPHILIS
TUBERCULOSIS
*WHOOPING COUGH (PERTUSSIS)

5. LESS COMMON REPORTABLE DISEASES.

*AIDS – acquired immune deficiency syndrome
amebiasis
Anthrax
*aseptic meningitis
*blastomycosis
Botulism
*bruceliosis
camplobacter enteritis
chancroid
Cholera
Coccidioidomycosis
*congenital rubella syndrome
Diphtheria
*encephalitis, all types
Food poisoning, all types
Giardiasis
Gonococcal opthalmia
Granuloma inguinale
Guillain-Barre Syndrome
*histoplasmosis
influenze
Kawasaki Disease
*legionellosis
*leprosy
*leptospirosis
*lyme disease
lymphogranuloma venereum
*malaria
*meningitis, Hemophilus influenza type B
*meningococcal infections
mumps
pesticide poisoning
Plague
Poliomyelitis
*psittacosis (ornithosis)
Q fever
Rabies
*relapsing fever
*Reye's syndrome
rheumatic fever
*rocky mountain spotted fever
Smallpox
*tetanus
*toxic shock syndrome
toxoplasmosis
*trichinosis
*tularemia
Typhus fever
Yellow fever

Occupational diseases to include the pneumoconioses:

*asbestosis
*byssinosis
*coal workers pneumoconiosis
*silicosis
*mesothelioma

6. DISEASES FOR WHICH ONLY OUTBREAKS NEED TO BE REPORTED. The following diseases are also of public health importance and should be reported whenever there is an unusual incidence or outbreak (including seasonal outbreaks) of any of them. The telephone report need consist of: 1) the physician's name and location; 2) the suspected disease; 3) the number of cases and interval during which the cases were seen.

Acute upper respiratory disease
Chickenpox
Conjunctivitis
Dermatophytosis (ringworm)
Enteropathogenic E. coli diarrhea
Epidemic diarrhea of unknown etiology
Gastroenteritis
Herpangina
Hospital acquired infections
Infectious mononucleosis
Pediculosis
Pleurodynia
Pneumonia (bacterial, mycoplasma, viral)
Staphylococcal infections
Streptococcal infections

TOLL FREE CODE-A-PHONE REPORTING SYSTEM

1-800-482-888

DR. THOMAS MCCHESNEY

STATE EPIDEMIOLOGIST

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Biomedical Waste Management Plan	IC-305

1. PURPOSE. All regulated medical waste is handled, processed, stored and transported following state and federal regulations, including the Environmental Protection Agency (EPA) and Occupational Safety and Health Administration (OSHA) standards from the point of origin to the point of final disposal. Safe and sanitary practices are followed for all components of the waste management system, including transport and storage system.

2. SCOPE. This applies to Nursing Service employees, Housekeeping employees, and Lab personnel.

3. POLICY. Medical waste that is tracked (regulated medical waste) consists of:

   A. Cultures and stocks of infectious agents (including discarded live vaccines)

   B. Human pathological waste, including tissues and body fluids

   C. Human blood and blood products, including blood saturated bandages, IV equipment bags, bottles, tubing and disposable suction canisters

   D. Sharps (needles, syringes, scalpels)

   E. Isolation waste

   F. Catheters and drainage bags

4. PROCEDURE.

   A. Wastes are segregated into
      1. Sharps that are placed in sharp containers that are spill-proof and puncture resistant. When sharp containers are ¾ full, discard in infectious waste bldg outside of Lakeview.
      2. Fluids that are poured down a sink or toilet
      3. Other regulated medical waste that is placed in red bags, each red bag being at least 3 mil thick.

   B. After bagging is complete; waste is stored in a special receptacle in the soiled utility room until taken to infectious waste bldg at least once daily, more often if necessary.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Rationale/Responsibilities for Isolation Procedures	IC-500

1. PURPOSE. The spread of infection within a facility requires three elements: a source of infecting organisms, a susceptible host, and a means of transmission for the organism.

   Isolation procedures are designed to prevent the spread of microorganisms among residents, facility personnel, and visitors. Since agent and host factors are more difficult to control, interruption of the chain of infection is directed primarily at transmission. Isolation presents certain disadvantages to both the facility and resident. It may discourage staff from giving the best possible care to the isolated resident. Solitude deprives the resident of normal social relationships and may be psychologically injurious. Resident care should be directed at attempts to minimize these complications of isolation.

2. SCOPE. This applies to Nursing Service and the Infection Control Coordinator.

3. CATEGORIES OF ISOLATION. In an attempt to balance these disadvantages of isolation against the varying hazards posed by the communicable diseases, degrees of isolation have been designated. All isolation procedures fall into the following categories.

   A. Strict isolation

   B. Contact isolation

   C. Respiratory isolation

   D. AFB isolation

   E. Blood/body fluids

   F. Drainage/secretion precautions

   G. Enteric precautions

4. POLICY. Isolation precautions are carried out in accordance with the CDC Guidelines for Isolation Precautions in hospital manuals located on each unit. It is safer to "over-isolate" than under-isolate". For the resident who may have a disease requiring isolation but whose diagnosis has not yet been established, it is important to institute the appropriate precautions rather than wait for confirmation of the diagnosis. Furthermore, precautions may be required even though the resident does not fully meet the criteria of isolation outlined. Also, formal isolation practices might need to be modified according to the resident's individual needs. In order that these modifications do not increase the risk of infection to others, the infection control nurse should first be consulted.

5. PROCEDURE. This section contains information basic to the understanding of the use of isolation/precautions that are contained in this manual. Many of these recommendations are appropriate not only for residents known to be infected, but also for routine resident care. For example, the wearing of gowns is appropriate when soiling with feces is likely, whether or not the resident is known or suspected to have an infection.

   A. When a resident has a communicable disease, the infection control nurse is to be notified. He/she will advise the proper isolation precaution to be carried out.

   B. The isolation care for the specific disease will be posted on the isolation room door.

C. Hand washing is the single most important means of preventing the spread of infection. Personnel should always wash their hands after direct resident contact, even when gloves are used. Hands should be washed before performing any invasive procedure, touching wounds, or touching residents who are particularly susceptible to infections. When taking care of residents infected or colonized with virulent microorganisms, personnel should use an antiseptic agent for hand washing.

D. A private room is indicated when the infection is highly contagious and requires either strict or respiratory isolation. A private room is preferred, but optional, for any infected resident whose hygiene is poor (resident does not wash hands after touching feces, purulent drainage, etc., or is colonized with multiple resistant bacteria).

E. It should be remembered, however, that a private room is not necessary to prevent the spread of many infections.

F. In general, masks are recommended to prevent transmission of infectious agents through the air. A mask can protect the wearer from inhaling large particle droplets transmitted by close contact and usually travel short distances of about three feet and small particle droplets that remain in the air and travel long distances.

G. It should be remembered that once the mask becomes moist, it is no longer effective. Therefore, if masks are utilized, they should be changed frequently. Masks should be worn once, then discarded. A mask should never be worn dangling around the neck.

H. In general, gowns are recommended to prevent soiling of clothing when taking care of residents. Gowns are not used for most routine resident care because soiling is unlikely. An example of when to wear a gown would be when changing the bed of a resident with infectious diarrhea or copious amounts of purulent drainage not well contained with a dressing. When gowns are used, they should be worn only once and then discarded in appropriate receptacle.

I. There are three reasons for wearing gloves:

J. To prevent personnel from becoming infected with microorganisms that are infecting the resident.

K. To reduce the chance that personnel will transmit their own microbial flora to residents.

L. To reduce the possibility of personnel becoming colonized with microorganisms that can be transmitted to other residents.

M. Gloves are never a substitute for good hand washing. However, because most hand washing practices of personnel are inadequate, gloves are recommended for touching secretions, excretions, or blood or body fluids that are thought to be infectious.

N. Used articles may need to be double-bagged before they are removed from the room of any resident on isolation/precautions. Bags should be discarded in the infectious waste can.

O. Used needles should not be clipped or recapped. The used needle and syringe should be placed in a special puncture-resistant container. This container when full is placed in the isolation trash can.

P. No special precautions are indicated for sphygmomanometers and stethoscopes unless this equipment is contaminated with infective material. If contaminated, double-bag the item and send to Central Supply for reprocessing.

Q. Residents on strict or reverse isolation will not be allowed to have visitors unless specifically ordered by the physician. Residents on all other types of isolation may have visitors unless otherwise ordered by the physician.

R. Disposable dishes and utensils will be used only for residents in strict and enteric isolation. No special precautions are necessary for dishes used by residents in contact, respiratory, AFB, blood/body fluids, or drainage/secretions isolation/precautions.

S. All dressings, paper tissues, and other disposable items soiled by respiratory, oral, or wound secretions must be considered potentially infective. They should be bagged and deposited in the infectious waste can.

T. Personal clothing soiled with any infective material should be bagged and labeled before being sent home or to the laundry.

U. Residents infected with virulent or microorganisms requiring strict or respiratory isolation should leave their rooms only when absolutely necessary for scheduled procedures or tests. If transporting is necessary, the use of appropriate barriers (dressings, masks, etc.) is encouraged. The service to which the resident is going should be notified of the impending arrival and of the necessary precautions to be taken.

V. No special precautions are necessary for books, magazines, money, or letters unless they become soiled with infective material; then, they should be disinfected or destroyed.

W. The same routine daily cleaning procedures used in other areas should be used to clean rooms of residents on isolation/precautions. Cleaning equipment used in rooms of residents in isolation requiring a private room should be disinfected before being used in other resident rooms.

X. Environmental surfaces (walls, floors, tabletops, etc.) are rarely associated with transmission of infection to others (in contrast to contaminated resident-care equipment that is frequently associated with infection transmission if not appropriately decontaminated and reprocessed). Therefore, terminal cleaning should be primarily directed toward those items that have come into direct contact with the resident's infective material (secretions, excretions, blood, or body fluids). Terminal cleaning should consist of the following.
   1. Housekeeping personnel should wear gowns.
   2. All disposable items should be double-bagged and discarded into the infectious waste can on the unit. All infectious waste should be taken to the infectious waste bin outside of Building 80 at the end of each shift or more often if necessary.
   3. Any equipment that is not sent to Central Supply or discarded should be cleaned with a disinfectant solution (ZEP).
   4. All floors should be wet-vacuumed or mopped with a disinfectant solution (ZEP).
   5. Disinfectant fogging and/or "airing" a room is not an effective terminal disinfectant procedure and is not necessary.

Y. Refer to the Nursing Service procedure manual.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Routine Infection Control Guidelines for All Residents	IC-501

1. PURPOSE. It is the purpose of this policy to establish routine infection control guidelines for all residents.

2. SCOPE. This applies to Nursing Service and the Infection Control Coordinator.

3. POLICY.

   A. For residents with draining lesions at any site
      1. Draining lesions should be covered whenever possible.
      2. Contain dressings or linen visible soiled with drainage in separate bags.
      3. Wear gloves when touching drainage and wash hands well before and after gloving.
      4. Wear gowns only if soiling of clothing is likely. Gowns may be kept in the resident's room and reused until they become soiled; however, replace them with new gowns each shift. Do not wear gowns outside the resident's room.

   B. For residents with urinary catheters
      1. Change catheters when necessary, such as when they become crusted or clogged.
      2. Always use a closed drainage system. Keep drainage bags off the floor, but below the level of the resident's bladder.
      3. Use a separate graduate container for each resident and thoroughly clean it after each use. Avoid touching the catheter bag or draining spout to the side of the graduate container.
      4. Wash the resident's perineal area with soap and water and thoroughly dry it each day and when it becomes soiled. Avoid tension oar movement of the catheter.

   C. For residents with respiratory symptoms
      1. If possible, teach the resident to cough into a tissue and provide a bag for tissue disposal.
      2. If the resident has MRS and is coughing, staff should wear masks when in close contact with the resident (i.e., when suction or giving mouth or tracheostomy care).
      3. Use good hand washing after removing gloves when touching respiratory secretions.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Body Substance Isolation Precautions	IC-502

1. PURPOSE. It is the purpose of this policy to establish body substance isolation precautions.

2. SCOPE. This applies to Nursing Service and the Infection Control Coordinator.

3. POLICY.

   A. Wash hands often and well, paying particular attention to around and under fingernails and between fingers. Wash hands before and after gloving and before and after any and all direct resident care.

   B. Wear gloves when it is likely that hands will be in contact with moist body substances (blood, urine, feces, wound drainage, oral secretions, sputum, or vomitus).

   C. Protect clothing with a gown when it is likely that clothing will be soiled with body substances.

   D. Wear masks and/or eye protection when it is likely that eyes and/or mucous membranes will be splashed with body substances (e.g., when suctioning a resident with copious secretions).

   E. Discard uncapped needle/syringe units and sharps in puncture-resistant containers designed for this purpose.

   F. Discard trash in impervious plastic bags.

   G. Bag linen so that no leakage of moist body substances will occur.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Methicillin-Resistant Staphylococcus Aureus	IC-503

1. PURPOSE. It is the purpose of this policy to define MRSA and provide guidelines for treatment of resident with MRSA.

2. SCOPE. This applies to Nursing Service and the Infection Control Coordinator.

3. DEFINITION.

   A. Methicillin-resistant Staphylococcus aureus (MRSA) is a nosocomial pathogen that is being increasingly diagnosed especially in skilled nursing facilities, and is one of a number of such pathogens that has developed multiple antibiotic resistance patterns. The spectrum of illness can range from asymptomatic colonization to serious morbidity and death; therefore, control measures to prevent its spread are an important part of total patient care.

   B. Colonization is defined as the presence of the organism in or on a body site without symptoms or clinical manifestation of illness. Infection is defined as invasion and multiplication of MRSA in or on a body site associated with clinical signs and symptoms of infection.

4. SITES. Common sites of recovery of the organism are surgical wounds, respiratory secretions, sputum, IV catheter sites, indwelling catheters, burn sites, decubitus ulcers, and blood.

5. TRANSMISSION. The most likely method of transmission of this organism in the facility appears to be resident-residents via the hands of personnel. The presence of MRSA on the hands of facility personnel can occur after resident care procedures such as wound debridement, dressing changes, tracheal care, and catheter care. In addition, MRSA has been isolated from surfaces such as floors, sinks, and work areas. Daily cleaning of these areas with an EPA-approved hospital grade disinfectant is an important part of infection control.

6. RISK FACTORS. Several factors that increase a resident's susceptibility for acquiring MRSA include the following.

   A. Increased length of stay at a facility

   B. Multiple hospitalizations

   C. Age (over 65 years of age)

   D. Multiple invasive procedures

   E. Wounds

   F. Severe underlying disease

   G. Administration of multiple broad-spectrum antibiotics

7. CONTROL MEASURES.

A. All residents should be considered as a potential source for infection and managed accordingly. The spread of the MRSA organism throughout the facility can be controlled by the rapid implementation of several measures.

B. Universal blood and body fluid precautions (as defined by CDC) must be in effect for all residents at all times. universal precautions do not replace other category-specific isolation precautions such as contact isolation for residents with MRSA.

C. Our facility will be notified in advance of the resident's MRSA status so that appropriate precautions may be instituted.

D. MRSA residents will be placed in a modified contact isolation that consists of the following.
   1. Room placement – resident will be placed in a private room or a room with another MRSA resident. However, the resident could share a room with a non-MRSA resident who has no open wounds or other invasive devices (i.e., foley, gastrostomy feeding tube, tracheostomy, nasogastric tube, etc.).
   2. Hand washing must be rigorously practiced.
   3. Gloves should be worn when there is a possibility of direct contact with resident's secretions, body fluids, mucous membranes, or non-intact skin. Gowns should be worn when soiling of clothing is likely.
   4. Masks should be worn by staff members when caring for residents who have MRSA-positive sputum and have respiratory symptoms or while suctioning the oropharynx or tracheostomy site. The mask should continue to be worn during care until the resident no longer has respiratory symptoms or until suctioning is no longer necessary.
   5. Generally, residents may leave their room to go to group activities as long as good hygiene is observed and MRSA-positive wounds are covered. Residents who may not leave their room are:
      a. Those with acute respiratory symptoms who are MRSA-positive in their nares or sputum
      b. Those with MRSA-positive tracheostomy secretions
      c. Those with MRSA-positive draining lesions that cannot be contained with dressings

E. Modified contact isolation can be discontinued when three consecutive negative cultures, taken 48 hours after therapy for MRSA has ended and at least 24 hours apart, have been obtained from the original site of infection or colonization, other wounds and nares.

F. Suspected outbreaks (two or more cases related in time and place) must be reported to the local health department. Additional control measures may be required at the time.

G. Ongoing in-services will be given all employees on infection control procedures used in this facility.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Residents Colonized With MRSA	IC-504

1. PURPOSE. It is the purpose of this policy to establish guidelines for the treatment of residents colonized with MRSA.

2. SCOPE. This applies to Nursing Service, the Infection Control Coordinator, and Housekeeping.

3. POLICY.

   A. If the resident is discovered to be colonized with MRSA, evaluate the resident's roommate for risk factors which may predispose them to serious infection. To determine colonization in the absence of overt symptoms of MRSA infection, culture the resident's anterior nares.

   B. The physician will make the decision whether or not to treat the resident colonized with MRSA. However, treatment for colonization is seldom indicated because MRSA is difficult to permanently eradicate.

   C. Disposable dishes are an unnecessary expense. Never allow residents to eat food from another resident's tray.

4. LINEN. All soiled will be bagged at the location where it is used. It should not be sorted or rinsed in the resident care areas. Linen that is heavily soiled with moist body substances that may soak through a linen bag must be placed in a plastic bag to prevent leakage. Linen handlers must wear barrier protection which includes gloves, and take special precautions with soiled linen by bagging to prevent leakage. Soiled linen need not be washed separately.

5. TRASH.

   A. Routine waste from all residents' rooms is considered dirty, not infectious.

   B. Persons assigned to handle trash should wear gloves, wash hands, and report all accidents. It is important that all persons be discouraged from searching through trash (e.g., for aluminum cans). Contaminated dressings should be placed in a separate plastic bag and tied before placing in the trash receptacle.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Infection Control Guidelines For Residents With MRSA	IC-505

1. PURPOSE. It is the purpose of this policy to establish infection control procedures for residents with MRSA.

2. SCOPE. This applies to Nursing Service and the Infection Control Coordinator.

3. RESIDENTS WITH MRSA COLONIZATION OF THE RESPIRATORY TRACT.

   A. Place resident in a room with other MRSA colonized residents, if possible.

   B. Avoid placing them in rooms with high-risk residents (foley, gastrostomy, tracheostomy, etc.).

   C. Wear mask only if the resident is coughing or when performing suctioning procedures.

   D. Wear gowns only if clothes are likely to become soiled.

   E. Practice good handwashing and wear gloves when handling respiratory secretions.

4. RESIDENTS WITH MRSA COLONIZATION OF THE URINARY TRACT.

   A. Use routine precautions used for other residents with indwelling catheters.

   B. Use good handwashing and wear gloves when emptying the catheter.

   C. Masks are not needed.

   D. Wear gowns only if soiling of the clothes is likely.

5. RESIDENTS WITH MRSA COLONIZATION OF SKIN LESIONS AND DECUBITI.

   A. Use routine precautions used for other residents with skin lesions or decubiti.

   B. Cover the area with a dressing.

   C. Use good handwashing and wear gloves when touching the area.

   D. Masks are not necessary.

   E. Wear gowns only if soiling of the clothes is likely.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Hepatitis	IC 514

1. PURPOSE. Early diagnosis and control of hepatitis are required to prevent its spread to residents and staff.

2. SCOPE. This policy applies to Housekeeping, Nursing Services, and Infection Control Coordinator.

3. POLICY.

   A. Hepatitis A (oral or fecal transmission)
      1. All articles contaminated with feces or urine are handled with caution.
      2. Any resident suspected of having hepatitis A virus (HAV) is immediately placed in isolation following the Centers for Disease Control (CDC) guidelines for disease specific isolation procedures.
      3. Enteric precautions are practiced for one week after the onset of jaundice in residents who have HAV and poor personal hygiene.

   B. Hepatitis B (blood and body fluids transmission)
      1. All blood is handled with caution. Reportable
      2. All residents diagnosed with having hepatitis B virus (HBV) continue with universal precautions.
      3. All residents known to be an HBV carrier are placed on blood precautions, and residents with open wounds are placed on precautions for drainage.
      4. Pregnant personnel are excused from caring for any resident known to have hepatitis B.

4. PROCEDURE.

   A. Use proper isolation precaution procedure.

   B. Approved disinfectants are used to clean blood and other body fluids spills: A solution of 5.25% sodium hypochlorite (household bleach) diluted between 1:10 and 1:100 with water or chemical germicides approved for use as long-term care disinfectants that are tuberculocidal.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Isolation Precaution Technique	IC 600

1. PURPOSE. It is the purpose of this policy to ensure that isolation of a resident is performed to prevent the transmission of a communicable disease.

2. SCOPE. This policy applies to Nursing Services, Housekeeping, Infection Control Coordinator

3. POLICY.

   A. The RN on duty, the infection control nurse, or the physician initiates isolation precautions.

   B. The institution of isolation precautions must be reported to the infection control nurse and physician by the nurse placing the resident in isolation.

   C. Disease specific isolation recommendations from the Centers for Disease Control (CDC) are used as guidelines for isolation precautions.

   D. The infection control nurse, unit or shift RN supervise the staff in the maintenance of isolation technique.

   E. The unit and shift RN teaches resident and visitors the importance of isolation techniques of isolation with consultation from the infection control nurse.

   F. Infractions in isolation precautions are reported to the infection control nurse who reviews isolation precautions with the offender.

4. PROCEDURE.

   A. Process Standards
      1. Initiating isolation – refer to the infection control manual for specific guidelines for proper isolation for each diagnosis.
      2. Unit or shift RN
         a. Gathers needed supplies for proper disposal of contaminated linens and trash.
         b. Prepares resident for isolation precautions.
         c. Notifies housekeeping of the location and type of isolation precautions.
         d. Reviews procedures with the unit staff.
      3. Required equipment
         a. Outside room – room is stocked with disposable gowns, masks, gloves, large and small plastic bags, and biodegradable laundry bags.
         b. Inside room – isolation trash can lined with large red plastic bag and a bag for linen.
         c. Equipment required for regular nursing care – blood (BP) cuff, stethoscope, thermometer with holder
      4. Masks are used to prevent transmission of infectious agents through the air.
         a. Paper disposable masks are used.
         b. Masks are used once and discarded in the appropriate receptacle.
         c. All masks cover both nose and mouth.
      5. Gowns are indicated when taking care of residents on isolation precautions if clothes are likely to be soiled with infective secretions or excretions.
         a. Paper, water resistant, disposable gowns are used.
         b. Gowns are worn once and then discarded in the proper receptacle.
         c. If a gown becomes wet while caring for a resident, it is discarded immediately.

6. Gloves prevent transient hand colonization and spread of infection.
7. Hand washing is the single most important means of preventing the spread of infection. Employees wash hands:
   a. Before and after taking care of an infected resident or one who is colonized with microorganisms of special clinical or epidermiologic significance (MRS).
   b. Before and after touching excretions or secretions.
   c. Before and after touching wounds.
   d. Before and after touching residents who are particularly susceptible to infection.
8. Private rooms generally reduce the possibility of transmission of infectious agents. A private room may be indicated for residents with:
   a. Infections that are highly contagious or are caused by microorganisms likely to be virulent when transmitted
   b. Poor hygiene
   c. Infection or colonization with microorganisms of special clinical or epidermiologic significance
9. Taking vital signs
   a. Temperature
      1. If thermometer is likely to become contaminated with infectious material, obtain a disposable thermometer.
      2. Each time thermometer is used:
         a. Remove from holder.
         b. Rinse thoroughly with cold water after each use.
         c. Wipe with soapy solution and rinse with cold water after each use.
         d. Place in container.
      3. When isolation precautions are terminated, dispose of thermometer and container in appropriate receptacle.
   b. Blood pressure
      1. No special precautions are indicated unless this equipment is contaminated or likely to be contaminated with infectious material.
      2. If contamination of equipment is likely, sphygmomanometer and stethoscope are stored in room of resident for duration of isolation precautions.
      3. When isolation precautions are terminated, sphygmomanometer and stethoscope are bagged in a red bag and returned to Central Supply for disinfection.
10. Needles and syringes
   a. If contamination with infectious material is likely:
      1. Obtain a prominently labeled, puncture resistant container from Central Supply.
      2. Keep container in room for duration of isolation precautions.
   b. Use only disposable needles and syringes.
   c. Do not break or bend used needles.
   d. Do not recap needles.
   e. Place all used needles and syringes in the container.
   f. Remove from the room only after bagging.
11. Drinking water
   a. Use disposable water pitcher.
   b. Discard old pitchers in isolation trash.
   c. Do not remove pitchers from room.
   d. Change water at beginning of each shift at room sink.
   e. Bring ice into room in a small plastic bag. Discard bag in room.

12. Urine and feces
    a. When isolation precautions are required, the isolation room has a private bathroom.
    b. If a bedpan is used:
        1. Flush urine and feces down toilet.
        2. Do not remove bedpan, urinal, or bedside commode from room.
        3. Wash hands and change gloves after handling bedpan.
        4. For incontinent residents, use disposable diapers and discard in isolation trash can.
13. Respiratory secretions
    a. Provide tissues and paper or plastic bags at bedside for disposal of tissue.
    b. Seal bags before discarding into the appropriate receptacles.
    c. Wear gloves for contact with infectious respiratory secretions.
14. Trash likely to be contaminated with infectious materials is handled in the following manner.
    a. Obtain specially marked trashcan lined with red plastic bag.
    b. Remove trash contents at the end of each shift.
    c. Place isolation trash in special receptacle in dirty utility room and take to contaminated trash building at the end of each shift.
15. Linen likely to be contaminated with infectious materials is handled in the following manner.
    a. Use specially marked linen bag.
    b. Remove linen contents at the end of each shift.
    c. Place isolation linen in a special receptacle in the dirty utility room and take to the soiled laundry room for pickup.
    d. Handle soiled linen minimally and with a minimum of agitation to prevent gross contamination of air and of persons handling linen.
16. Laboratory specimens likely to be contaminated with infectious material are handled in the following manner.
    a. Put specimens in appropriately labeled container with lid closed securely; label container "contaminated".
    b. Put container in transparent bags.
    c. Label outside of bags "contaminated".
17. Dressings
    a. Wash hands thoroughly before and after dressing.
    b. Wear disposable gown if clothes are likely to be soiled with secretions.
    c. Use disposable mask if bacteria are likely to be airborne.
    d. Use disposable equipment.
    e. Use clean gloves to remove old dressings. Dispose of old dressings in a small red plastic bag.
    f. Remove gloves and dispose in red plastic bag.
    g. Wash hands.
    h. Put on fresh gloves and do dressing as prescribed.
18. Personal clothing of residents likely to be contaminated with infectious material is handled in the following manner.
    a. Bag clothing and send with linen to laundry.
    b. If contamination is likely, resident should wear a hospital gown until isolation precautions are discontinued.
19. Transporting residents

a. Appropriate barriers such as masks or impervious dressings are used to prevent transmission of organisms when isolated residents leave their room.
b. Notify personnel in the area to which the resident is taken if precautions are to be used.
c. If the wheelchair or stretcher is contaminated with infectious material, do not remove from the room until disinfected.

20. Money, outgoing mail, books, magazines do not require special precautions unless soiled with infectious material. If contaminated, disinfect or destroy.
21. Visitors
    a. Instruct visitors on hand washing technique, use of gowns, masks, gloves, and the importance of complying with isolation procedures.
    b. Do not allow visitors to bring coats, hats, purses, or other articles into isolation room if it is likely they will be contaminated with infectious material.
22. Special instruments tray
    a. If contaminated with the infectious material after using, divide items into the following.
    b. Disposable items are disposed of in isolation trashcan.
    c. Linen wrappers from Central Supply are placed in red bag and returned to Central Supply.
    d. Reusable items are bagged and placed in container marked "contaminated" and returned to Central Supply.
23. Cleaning
    a. The same daily routine cleaning procedures used in other resident rooms are used to clean rooms of residents in isolation precautions.
    b. Cleaning equipment used in rooms of residents whose infection requires a private room are disinfected before being reused.
    c. Dirty water is discarded.
    d. Wiping cloths are discarded.
    e. Bag mop heads in transparent bag, label outside of bag "contaminated" and send to laundry to be washed and thoroughly dried.
    f. Clean isolation room at the end of cleaning schedule.
24. Maintenance
    a. If an infection of a resident requires a private room, only emergency maintenance procedures are performed.
        1. Gown, gloves, and mask if required are worn by maintenance personnel.
        2. All tools and equipment are wiped with a disinfectant-detergent solution.
    b. In all other types of isolation precautions, routine maintenance is performed.
        1. Maintenance personnel use good hand washing techniques.
        2. Any tools or equipment that are contaminated or likely to be contaminated with infectious material are wiped down with a disinfectant-detergent solution.
25. Isolation technique
    a. When isolation precautions are initiated, the nurse performs the following.
    b. Consults with the infection control nurse or DON and review type of infection that exists.
    c. Reviews CDC guidelines to determine precautionary measures required.
    d. Informs resident and family.
    e. Posts the specific isolation precautions sign.
26. Gowning, masking, gloving

a. Remove watch and rings, as they are a source of contamination.
b. Wash hands.
c. Put on gown.
    1. Unfold paper gown, put arms through sleeves. Tie gown at neck.
    2. Overlap edges of back of gown and tie at waist.
d. Put on mask.
    1. Pick up mask by the strings.
    2. Tie upper strings over crown of head.
    3. Tie lower strings behind neck.
    4. Fit mask snugly over nose and lower face.
e. Put on gloves so glove cuffs are drawn over gown sleeves.

27. Removing gown, gloves, mask
    a. Remove gloves by turning them inside out. Discard them in isolation trash.
    b. Untie gown at neck and waist. Grasp gown at shoulders and pull gown down over arms and hands. Turn inside out and roll up, being careful not to touch your clothes. Discard in isolation trash.
    c. Wash hands.
    d. Remove mask by holding it by the strings and discarding into isolation trash.
    e. Leave room and wash hands outside room.
28. Providing therapy to residents on isolation precautions.
    a. The treating therapist must observe all of the isolation techniques and precautions that are in effect.
    b. The therapist must select equipment that can be disinfected, sterilized, or discarded after treatment.
29. When isolation is discontinued by physician's order or by authorization of the infection control nurse:
    a. Unit RN
        1. Notifies family
        2. Notifies housekeeping
        3. Notifies Central Supply
        4. Sees that all equipment is returned to Central Supply, if not disposable
    b. Housekeeping cleans room as required.

B. Documentation
1. Document in the Nurses' Notes the reason for implementing isolation precautions.
2. Update care plan.
3. Document in the Nurses' Notes when isolation precautions have been discontinued.
4. Update care plan after isolation has been discontinued.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Hand washing	IC 601

1. PURPOSE. To establish proper handwashing techniques.

2. SCOPE. This policy applies to all ARKANSAS HEALTH CENTER employees.

3. STANDARD POLICY. Proper hand washing technique is used for the prevention of transmission of infectious diseases. All personnel are required to wash their hands:

   A. Before and after resident contact

   B. Before and after performing any procedure

   C. After sneezing or blowing noses

   D. After using the toilet

   E. Before handling food

   F. Before and after eating

   G. Before entering and after leaving any isolation area

   H. When hands become obviously soiled.

4. PROCEDURE.

   A. Stand away from sink. Do not allow clothes to touch front of sink. Do not touch inside of sink during procedure.

   B. Turn on water faucet to a comfortable temperature.

   C. Moisten hands with water and apply soap from dispenser.

   D. Wash hands for approximately 15 seconds, being careful to cover every area (i.e., between fingers, beneath nails, etc.) using friction (one hand rubbing the other).

   E. Rinse hands thoroughly under running water.

   F. Pull paper towel from dispenser and dry hands.

   G. Turn faucet off with paper towel.

   H. Discard towel in waste container.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Needle-Stick and/or Blood Exposure Injuries	IC 700

1. PURPOSE. It is the purpose of this policy to ensure that all needle-stick injuries and significant blood exposures will be reported to the infection control nurse or shift RN at the time of injury or exposure.

2. SCOPE. This policy applies to all employees.

3. POLICY. The infection control nurse will establish and maintain health records on those employees who have had a significant exposure to blood.

4. PROCEDURE.

   A. An employee's report of injury will be completed and a copy sent to the infection control nurse and the DON.

   B. When a needle-stick occurs, a determination should be made as to whether the employee was injured with a clean or contaminated needle.

   C. Puncture wounds with needles that have not been used on residents only require cleansing and possibly tetanus prophylaxis (TD Toxoid).

   D. Puncture wounds with needles that have been used on residents and/or other significant blood exposures:
      1. Identify the resident as quickly as possible.
      2. Determine the Hepatitis B Surface Antigen (HBsAg) and HIV status of the injured employee.
      3. Determine the Hepatitis B Surface Antigen (HBsAg) and HIV status of the resident.
      4. If the employee is already HBsAg or anti-HBsAg positive, or if the involved resident is HBsAg negative, chemoprophylaxis with standard immune globulin or Hepatitis B Immune Globulin is not required.
      5. If, however, the resident involved is HBsAg positive and the employee is both HBsAg and anti-HBsAg negative, Hepatitis B Immune Globulin (HBIG) should be administered (0.06 ml/kg body weight) within seven days and again one month after exposure. If HBIG is not available, conventional Immune Globulin (ISG) should be administered in the same dose and schedule. HBIG is recommended only for parenteral, mucous membrane or conjunctival exposures to the blood or secretions of residents with proven Hepatitis B infection (HBsAg positive).
      6. If screening results for HBsAg and anti-HBsAg cannot be obtained within seven days, administer conventional Immune Globulin (ISG) if the needle has been used in a high risk resident: lab evidence of Hepatitis; a history of post-viral Hepatitis of unknown type; renal disease requiring hemodialysis; hematologic disease; surgical procedures requiring multiple blood transfusions; or drug abuse.
      7. If the needle has been used in a low risk resident or if the source cannot be identified, prophylaxis is optional. If used, administer ISG (0.06 ml/kg body weight) within 24 hours. No further action is necessary.

   E. The above procedures must be coordinated with the infection control nurse and the family physician.

   F. As a reminder-do not cap needles, and wear appropriate protective barriers when caring for all residents.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Disposal of Infectious Materials	IC 714

1. PURPOSE. It is the purpose of this policy to protect yourself and others from contaminated articles.

2. SCOPE. This policy applies to Nursing Services, Lab., Housekeeping and Laundry.

3. EQUIPMENT.

   A. For double-bagging
      1. For trash – 2 linen trash bags
      2. For linen – 1 biodegradable laundry bag

   B. For non-disposable items – special boxes for disposal of cut needles and syringes

4. PROCEDURE.

   A. Double-bagging technique
      1. Double-bagging technique requires two persons. One "contaminated person" inside the room and one "clean person" outside the room.
      2. Person inside the room places the items in the appropriate bag and ties the top or seals the bag.
      3. Person outside the room must stand at the door with the clean bag. Hold the bag so hands are covered by a large cuff at the top of the bag.
      4. From inside the room, gently place the full bag into the clean bag. Be careful not to touch the clean bag or other persons outside the room.
      5. The person outside the room must carefully close the bag and tie top securely.
      6. After removing attire in patient's room, "contaminated person" washes hands thoroughly, labels bags with the date, shift, and nursing unit and takes them to the appropriate places, either the special trash dumpster or the dirty linen room.
      7. Hands must be washed before proceeding to the next assignment.

   B. Non-disposable items
      1. Non-disposable items are washed thoroughly with hot soapy water and rinsed thoroughly.
      2. Hands must be washed thoroughly.
      3. Clean items are taken to Central supply for autoclaving.

   C. For syringes and needles
      1. Syringes and needles are placed in the hazard box unsheathed.
      2. When the hazard box is full, it is double-bagged and taken to the special dumpster for infectious materials.

   D. Laundry
      1. Soiled linens will be handled with minimum of agitation to prevent microbial contamination of the air and of persons handling the linen. All soiled linen will be bagged at the location it was used – take the bag to the linen, not the linen to the bag. All linen, except where noted, is to be sent to the downstairs laundry room. Linen soiled with blood or body fluids is to be double-bagged, first into a biodegradable melt away bag, then into an isolation bag.

E. Infective Waste

1. The Arkansas State Health Department guidelines regarding waste management will be followed. Trash generated by residents in the routine course of events will be disposed of by placing it in the trash receptacle. Trash generated by residents in isolation can on the unit and taken to the outside bin as necessary (at least at the end of each shift).
2. Excretory waste (urine, feces, vomitus) of the known HIV or Hepatitis B resident can be flushed down the toilet. Other items contaminated with blood or body fluids than cannot be flushed down the toilet, such as dressings and disposable devices, will be double bagged in appropriate bags, and placed in the isolation trash bin.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Disposal of Intravenous Equipment	IC 715

1. PURPOSE. It is the purpose of this policy to ensure all intravenous (IV) equipment, considered regulated medical waste, is handled, processed, stored, and transported according to state and federal regulations.

2. SCOPE. This policy applies to Nursing Services and Housekeeping.

3. POLICY.

   A. Residents with IV therapy have a waste receptacle placed in their room for the duration of IV therapy.

   B. IV equipment to be discarded is placed in the waste receptacle.

   C. Needles and syringes are placed in sharps containers for disposal.

4. PROCEDURE.

   A. When a resident is to start IV therapy, the nurse places a waste receptacle lined with a 3-ml red bag in the room.

   B. Housekeeping picks up the waste at least daily at around 1400 and replaces the red bag.

   C. When IV therapy is completed, housekeeping cleans the receptacle with a germicidal solution and returns it to the room.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Sharps Disposal	IC 716

1. PURPOSE. It is the purpose of this policy to ensure that all sharps including used needles, syringes, scalpel blades, and intravenous needles are disposed of in the appropriate receptacle.

2. SCOPE. This policy applies to Nursing Services and Lab.

3. POLICY.

   A. Used needles and syringes are not to be resheathed.

   B. Used needles are not to be cut or broken.

   C. Sharps receptacle is locked in the medication room.

4. PROCEDURE.

   A. All sharps are dropped unsheathed and unbroken directly through the opening in top of receptacle.

   B. New receptacles are delivered by Central Supply personnel upon request.

   C. When sharp receptacles are ¾ full, licensed staff close receptacle and dispose of container in the infectious waste bin.

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Infection Control	Multi Drug Resistant Acinetobacter Baumannii	IC 604

1. **PURPOSE**: To prevent the spread of multi-drug-resistant Acinetobacter in the Nursing Home and community.

2. **SCOPE**: All Nursing Personnel

3. **Definitions**: A resident with a positive culture growing MDR-Acinetobacter-AB is considered as any isolate that is sensitive to no more than one class of antibiotics.

4. **POLICY/PROCEDURE**:

    1. Prevention / Control of Nosocomial Spread of Acinetobacter:
        a. Isolate residents with MDR-AB in a private room or cohort them in the same room with another MDR-AB resident, using strict contact isolation precautions when entering the room.
        b. Gown and gloves will be worn when entering the room. Masks will be worn when contact with respiratory fluids or secretions can be anticipated, such as with respiratory treatments, productive cough, etc. Masks will be worn at all times if the resident has positive sputum culture for MDR-AB.
        c. Change gloves after contact with material that may contain high concentrations of MDR-AB.
        d. Carefully remove gloves and gown before leaving the residents room and wash your hands immediately. As with other organisms, hand hygiene is essential to prevent the spread of infection.

        a. Dedicate items to a single resident infected with MDR-AB. Use disposable equipment when possible (i.e., thermometer, stethoscope, blood pressure cuff, pillows, etc.) These items must be discarded upon discharge of the resident. Any other equipment should be dedicated to this resident's room (if possible), and thoroughly cleaned and disinfected before using again. Take only the supplies needed for the care of the resident into the room.
        b. Any excess supplies, i.e., IV's tube feeding, syringes, etc., that are not used but taken into the room, must be discarded upon discharge of the resident.
        c. Meals will be served on disposable dishes per MD orders.
        d. Equipment, i.e., wheelchairs, stretchers, etc., should be cleaned with the facilities approved disinfectant – allowing it to dry. Gloves will then be changed and the equipment cleaned again with the same approved disinfectant.
        e. If possible, every effort should be made to have 1:1 nursing care for the resident with MDR-AB. If this is not possible, the following will occur:
            1) The nursing staff caring for the MDR-AB resident will not be assigned to residents with breaks in the skin, open wounds/incisions, tracheotomies, immune-compromised residents, and/or have invasive lines (i.e. Foley, drains, dialysis catheter, etc.), and/or external devices (i.e. external fixators, halos, etc.).

2) If more than one MDR-AB resident is in the facility, one primary caregiver will be assigned the care of the MDR-AB resident (cohort).
3) If a primary caregiver should be assigned the care of other residents that are not MDR-AB residents, the primary caregiver must practice reverse isolation with the other residents. The primary caregiver should wear a clean gown and glove when entering the other resident's room.

f. Contain all linens in laundry bags in the resident's room before transporting to soiled utility area.
g. Caregivers' taking care of a resident with MDR-AB should not assist in the care of non MDR-AB residents unless absolutely necessary.
h. Staff not assigned to the resident but is assisting the primary caregiver is not required to practice reverse isolation on all of their other residents. They are required to practice STRICT isolation precautions. The reason is the assisting staff will have minimal resident exposure.
i. Essential personnel only should enter the room including physicians and necessary support personnel. These persons will follow strict isolation ,precautions and practice good hand hygiene.
j. Visitors should be limited and must report to the nurses' station before entering the room. The nursing staff will be responsible for educating the visitor about the use of gowns, gloves, and the importance of good hand hygiene. They should be instructed to wear a mask when indicated, and must wear them at all times if the MDR-AB is in the sputum.
k. The phone must be disposed of when the resident is discharged.

TESTING/TRANSPORT OF MDR-AB RESIDENTS:

a. All testing and procedures should be done at the bedside when possible.
b. When transporting out of their rooms, the resident should wear the appropriate barriers (i.e. masks, impervious dressings to reduce contamination of the environment. Any resident with draining wounds should have on clean clothing or gown prior to transport.
c. Stretchers and wheelchairs must be protected with linens or disposable under pads.
d. Healthcare workers are not required to wear PPE when transporting the resident with the exception of emergency situations, i.e., bagging a resident when transporting to the ambulance. In these situations, 2 persons will be required to transport the resident, allowing one to provide direct care and the other to remain clean to assist with opening doors, etc.

REPORTING MDR-ACINETOBACTER:

a. Immediate results of the Microbiology Lab and communication with the Director of Nurses, Staff Physician, Medical Director and the resident's primary physician will facilitate the containment of MDR-AB.
b. Nursing Administration will immediately notify the nursing staff and initiate the required isolation precautions.

AMBULATION OF RESIDENTS:

Residents may ambulate in the hallway and outside if there is a physician order. The resident and staff will wear gowns and gloves (mask if MDR-AB is in the sputum) while ambulating, and use dedicated equipment (walkers, wheelchairs, canes). The equipment will be kept in the resident's room. Draining wounds must be covered and contained by a dressing. If therapy is ambulating the resident, they should if at all possible see the resident with MDR-AB at the end of the day.

DISCONTINUING ISOLATION PRECAUTIONS:

Isolation can be discontinued when three (3) consecutive negative cultures at least 24 hours apart are obtained from stool, urine and skin. If the resident is febrile or symptomatic, you must obtain three (3) consecutive negative blood cultures.

DISCHARGING/TRANSFERS:

Communication is of great importance when a resident with MDR-AB is discharged and/or transferred, this includes the hospital emergency room, other nursing homes, and other facilities, etc.

DOCUMENTATION:

A. All IV medications, Heparin and/or saline flushes must be documented on current monthly IV medication administration record.
B. Dressing changes will be recorded on the IV MAR and in the nurses' notes with a description of site for swelling, redness, bleeding and drainage.
C. Monitor and document condition of site every shift. Report any changes to the physician immediately.
D. Observe and document any chest pain, SOB, diminished breath sounds, or altered mental status. Report to RN and physician immediately.

Director of Nursing		**Date**
Medical Director		**Date**
Administrator		**Date**

SECTION 18

DAILY STAFFING LOGS

DAILY STAFFING LOG

Facility: ______________________ Date: ______________________ Census: ________

☐ Day Shift ☐ Evening Shift ☐ Night Shift

Name (Print or Cursive)	Title	Location	In	Out	Hrs
	RN				
	LPN				
	CNA				
				Total Hrs:	

Comments: ____

____

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________________________________ ________________________

Administrator/DON/Designee Date

SECTION 19

CAMPUS MAPS
&
UNIT FLOOR
PLANS

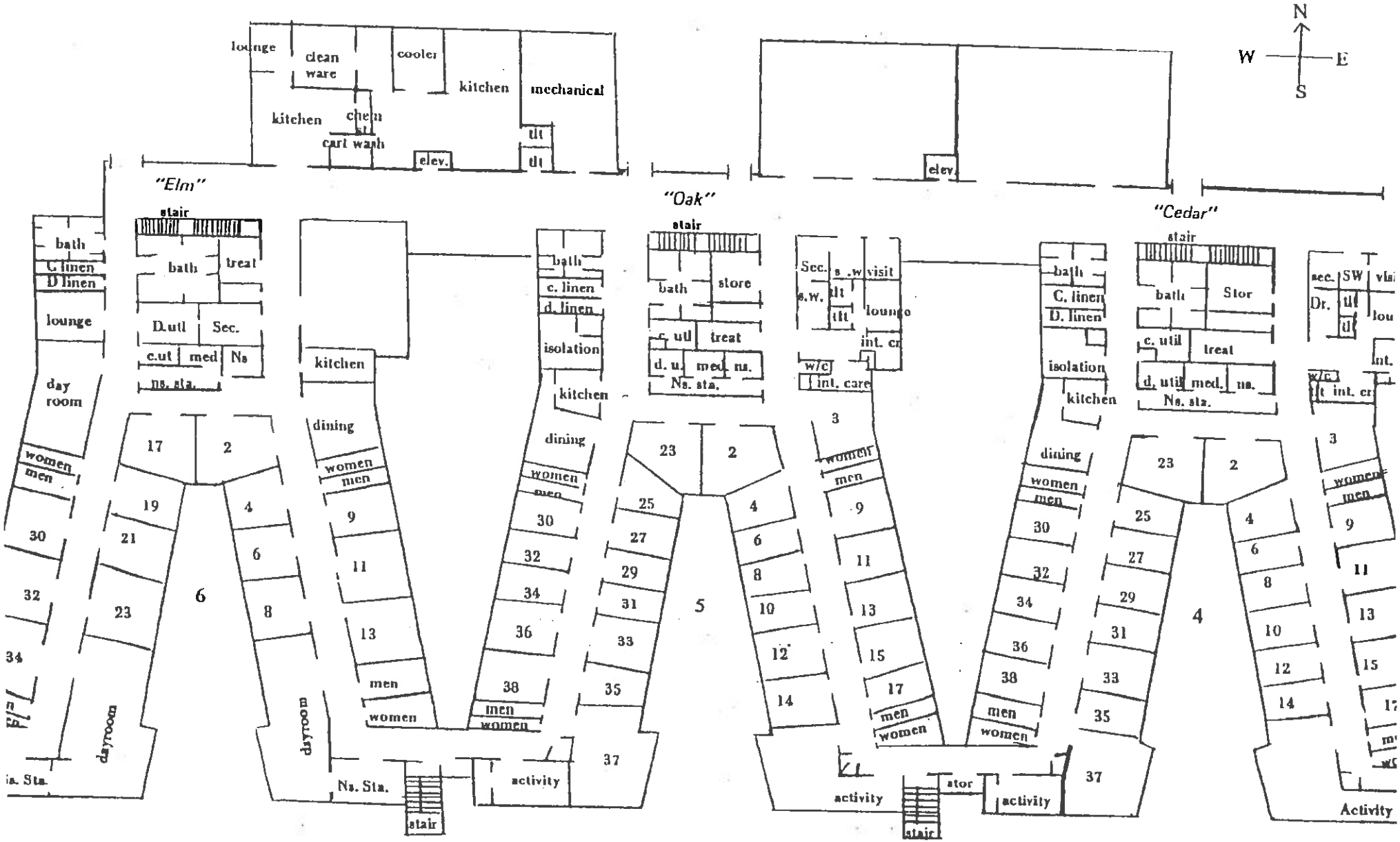
Lakeview (80 Building) Floor Plan

BENTON SERVICES CENTER

/ATE CARE NURSING HOME FACILITY

LEVEL ONE (Lower)

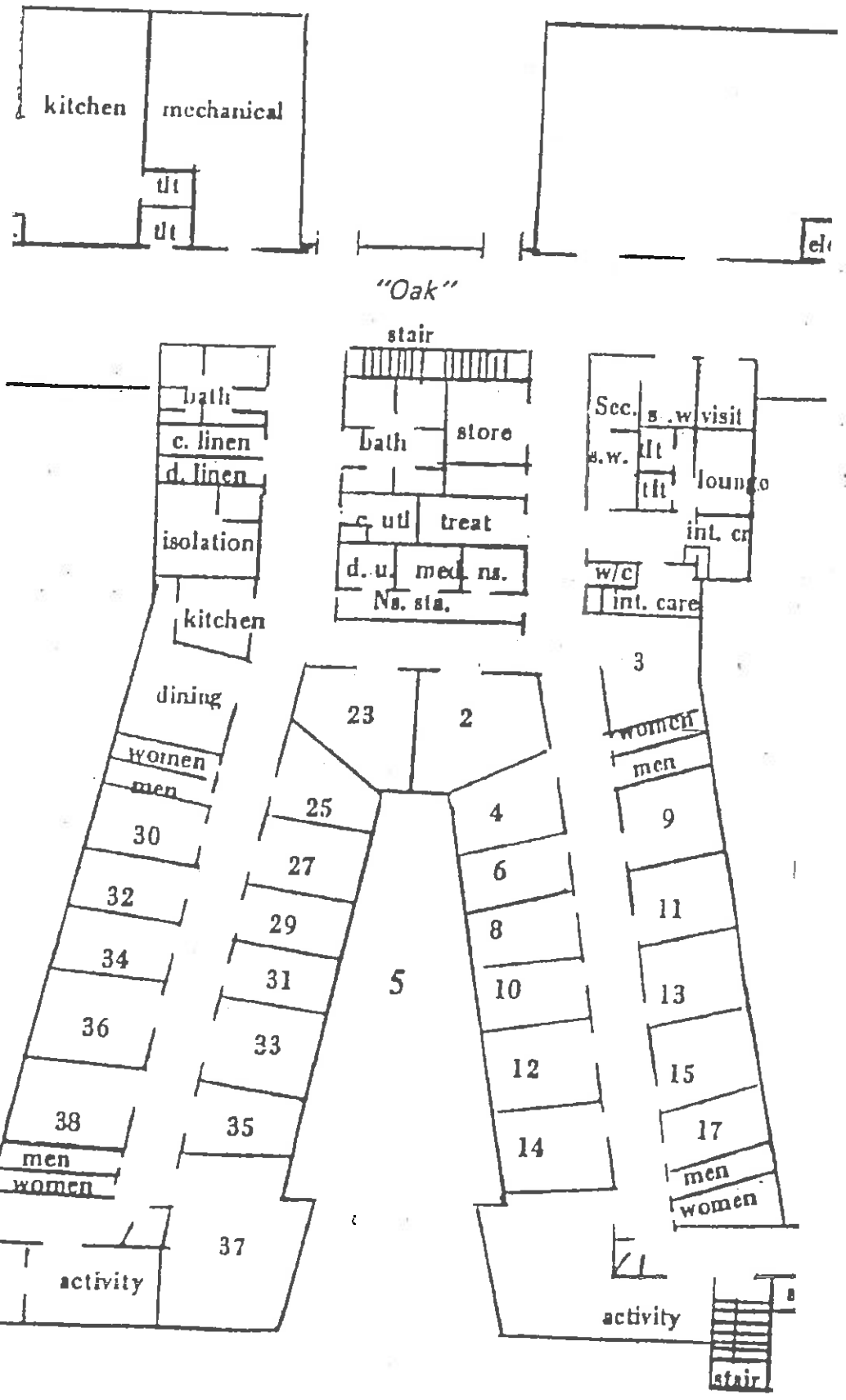
BENTON SERVICES CENTER INT[illegible]E CARE NURSING HOME FACILITY



LEVEL TWO (Upper)

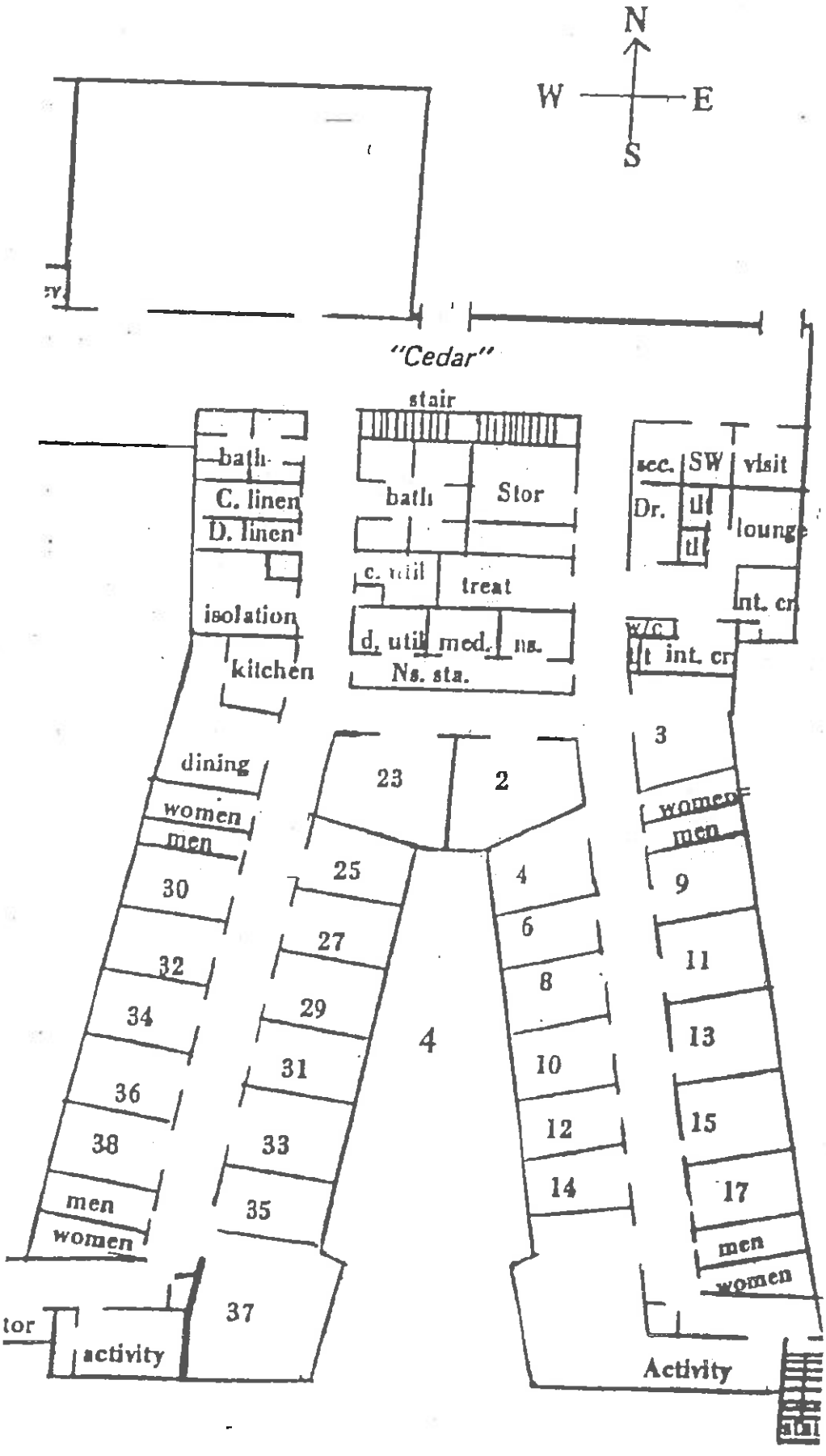
OAK COURT FLOOR PLAN

SERVICES CENTER INTERMEDIATE CARE NURSING HO



Cedar Floor Plan

ME FACILITY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WILLOW COURT
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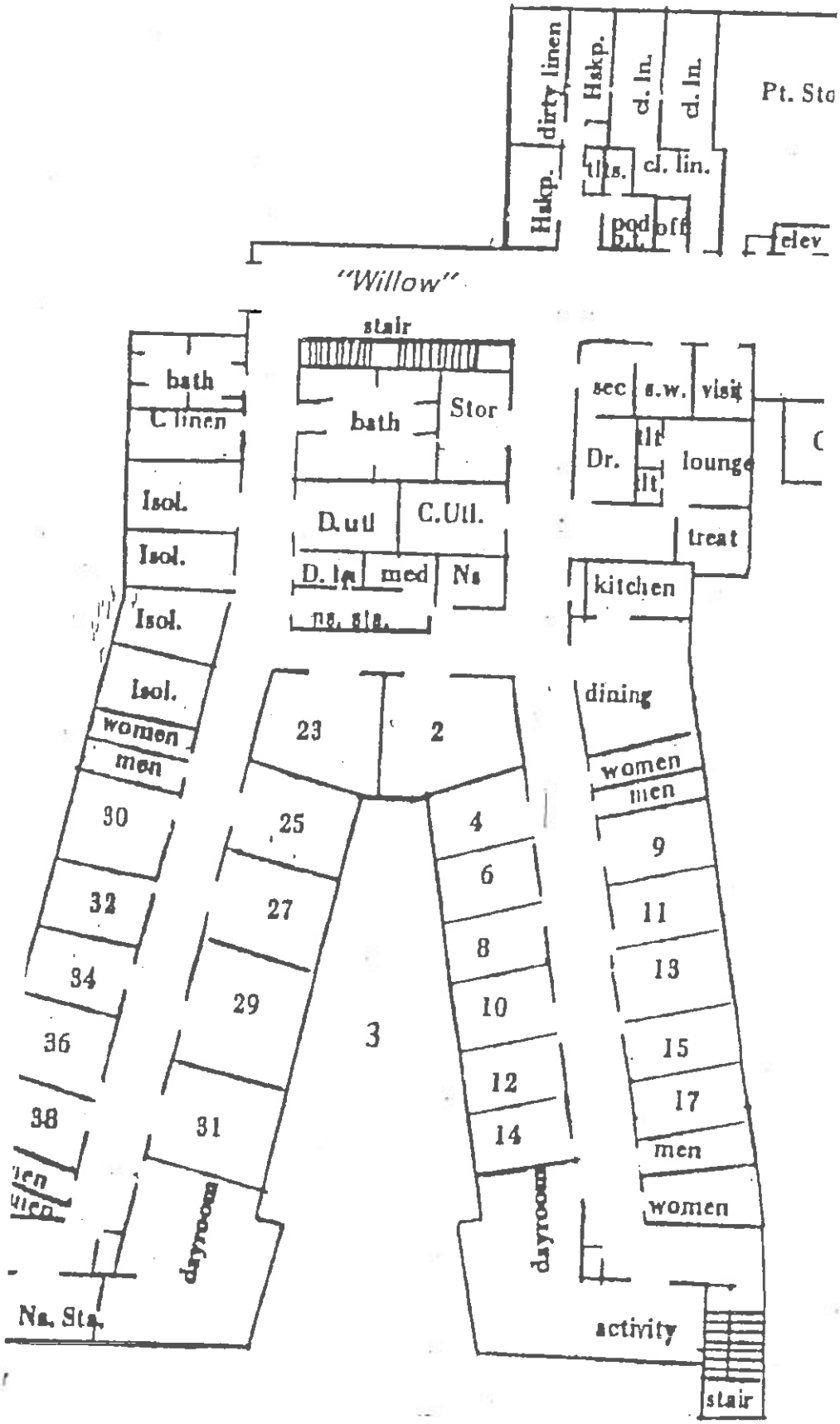
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MAPLE COURT
FLOOR PLAN

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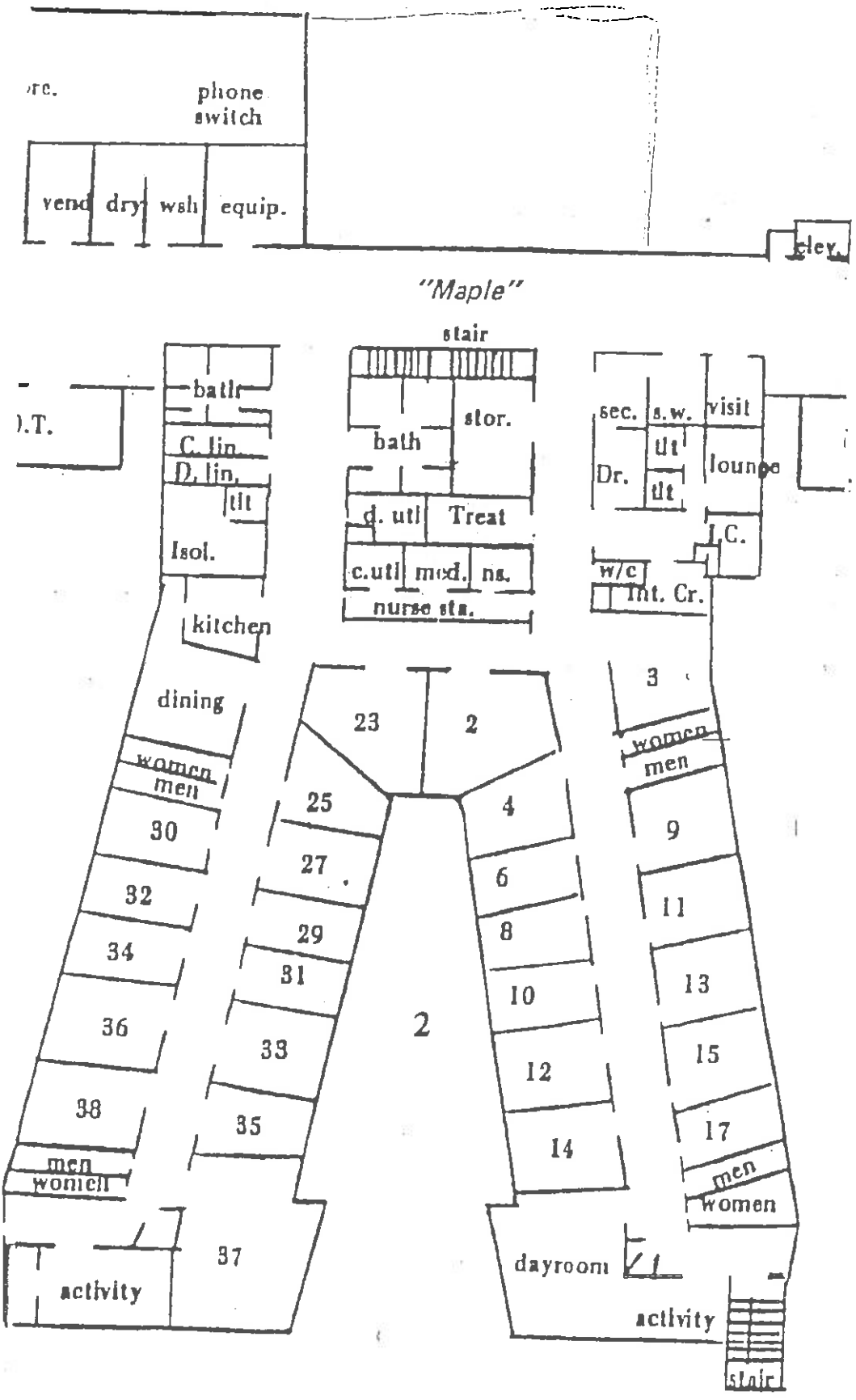
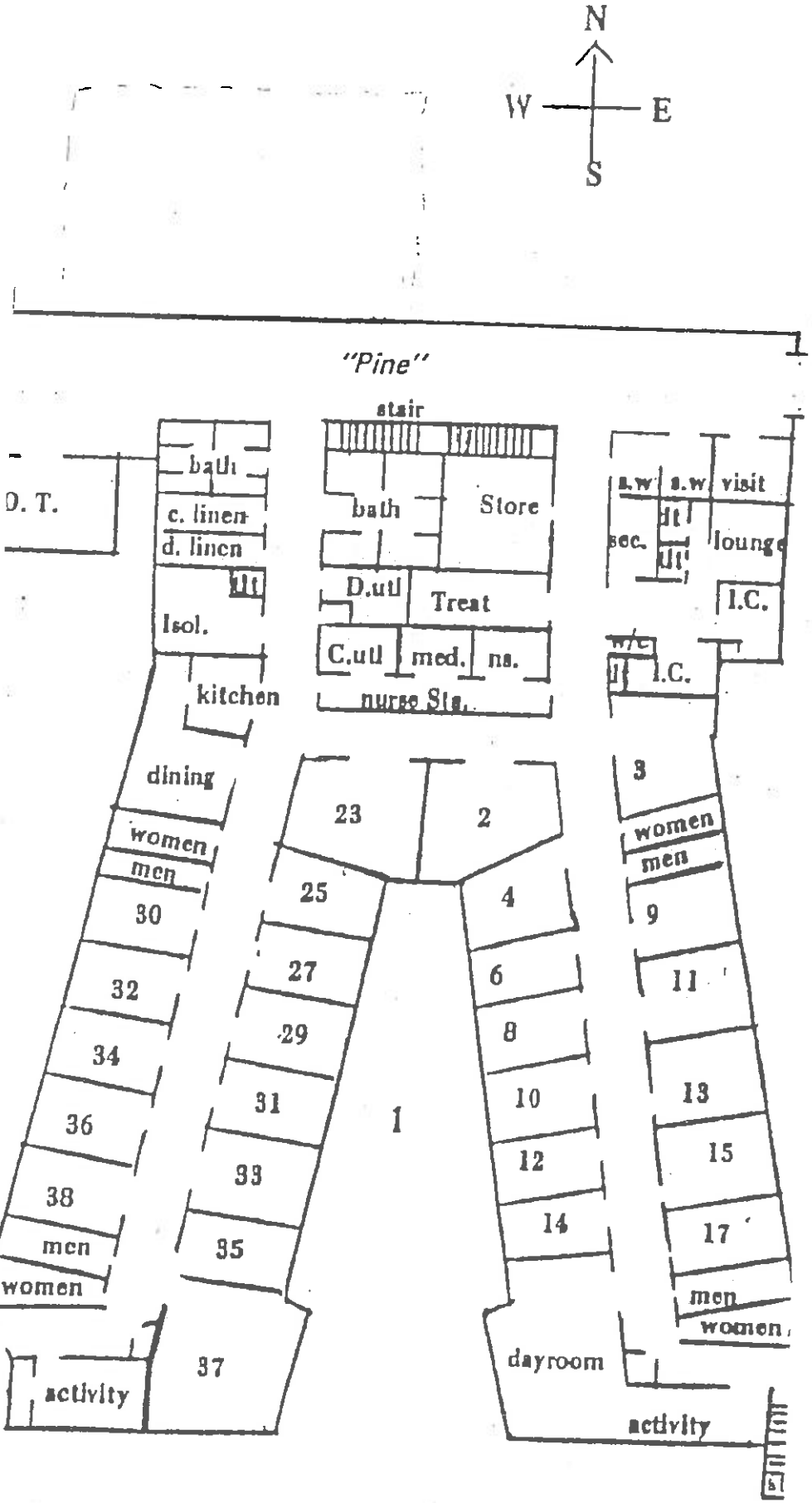


PINE COURT FLOOR PLAN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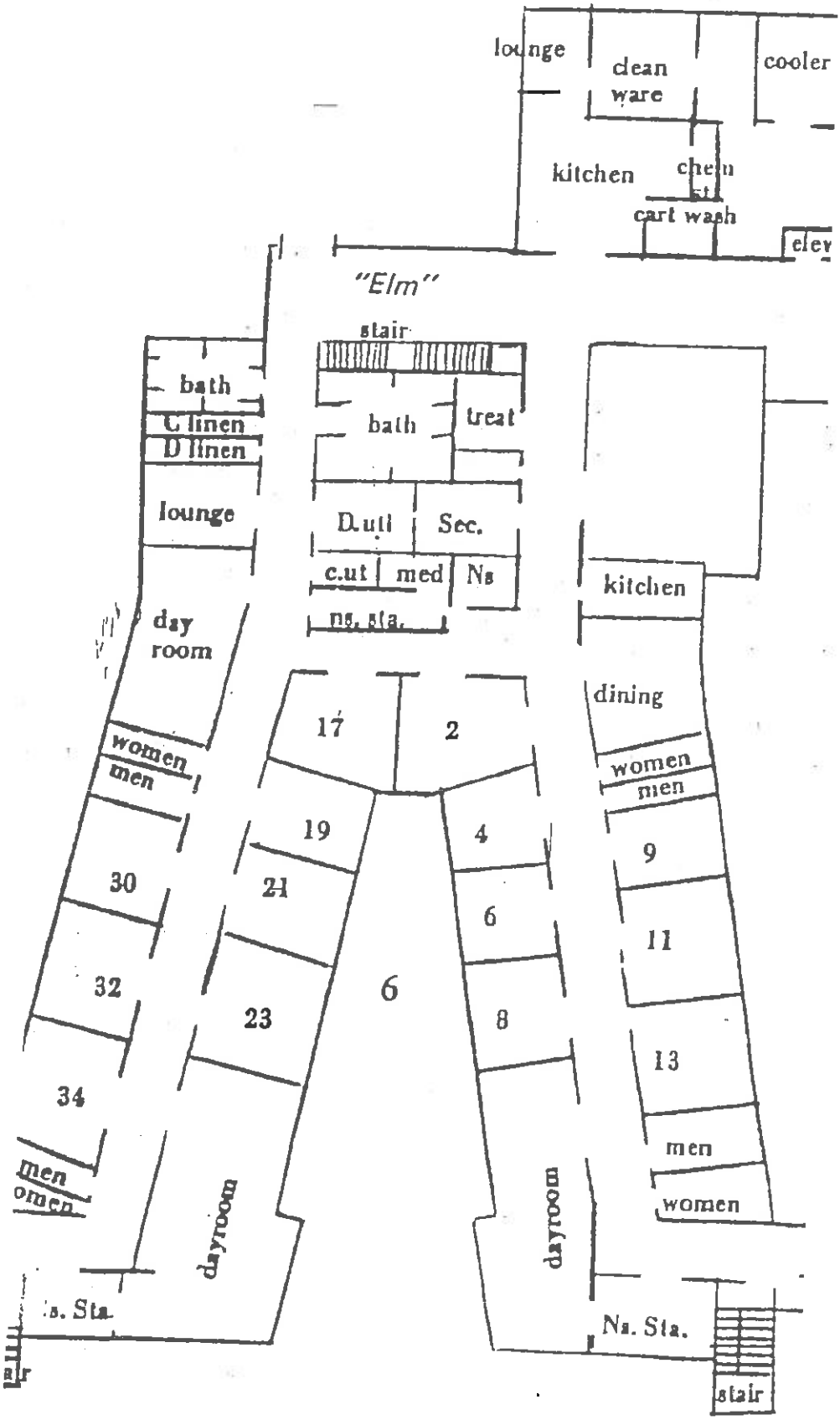
ELM COURT FLOOR PLAN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ASPEN COURT
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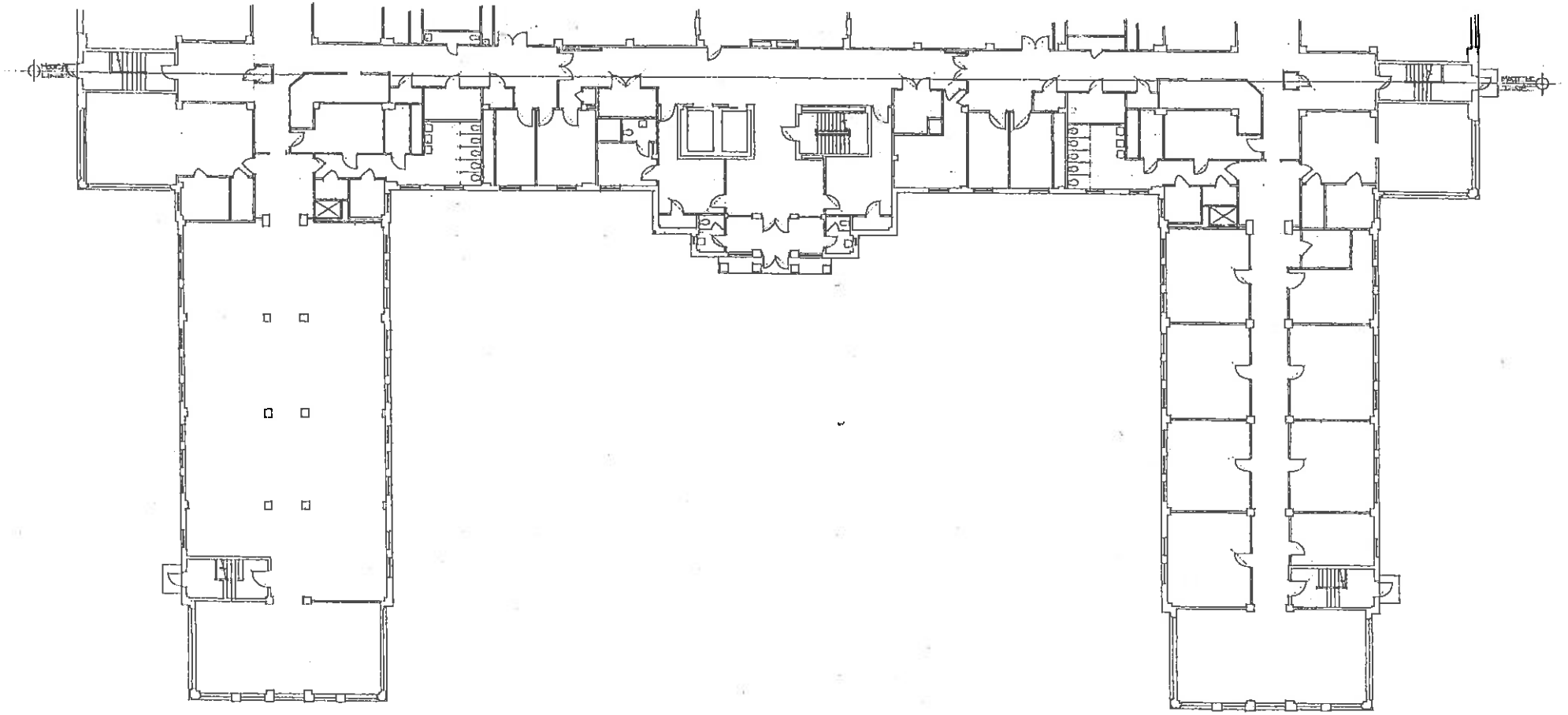
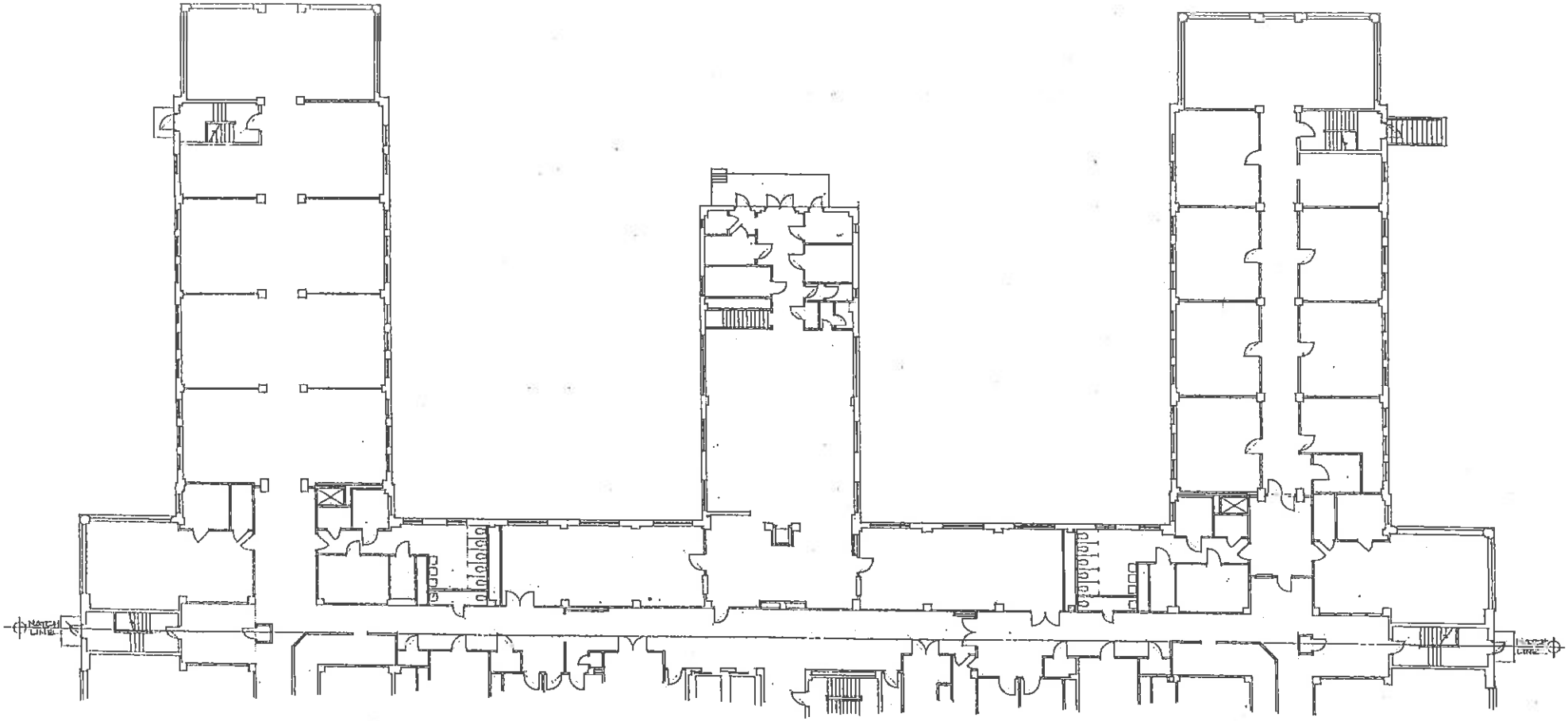


FIRST FLOOR PLAN-BLDG. 70-NORTH 1/8"=1'-0"

Asper

BENTON SERVICES CENTER-BLDG. 70 SHT. 3

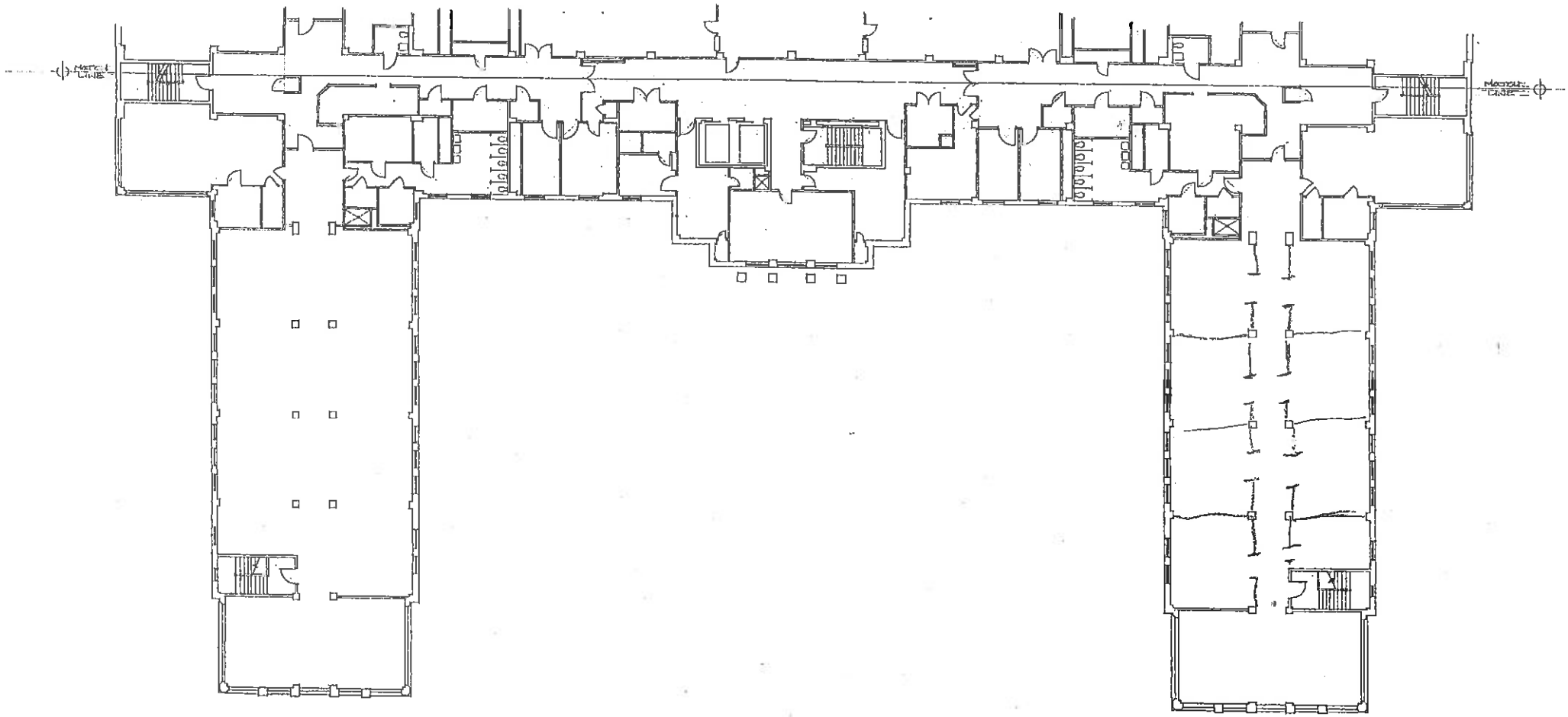


FIRST FLOOR PLAN - BLDG. 70 - SOUTH — 1/8" = 1'-0"

Aspen

BENTON SERVICES CENTER - BLDG. 70 - SHT. 1

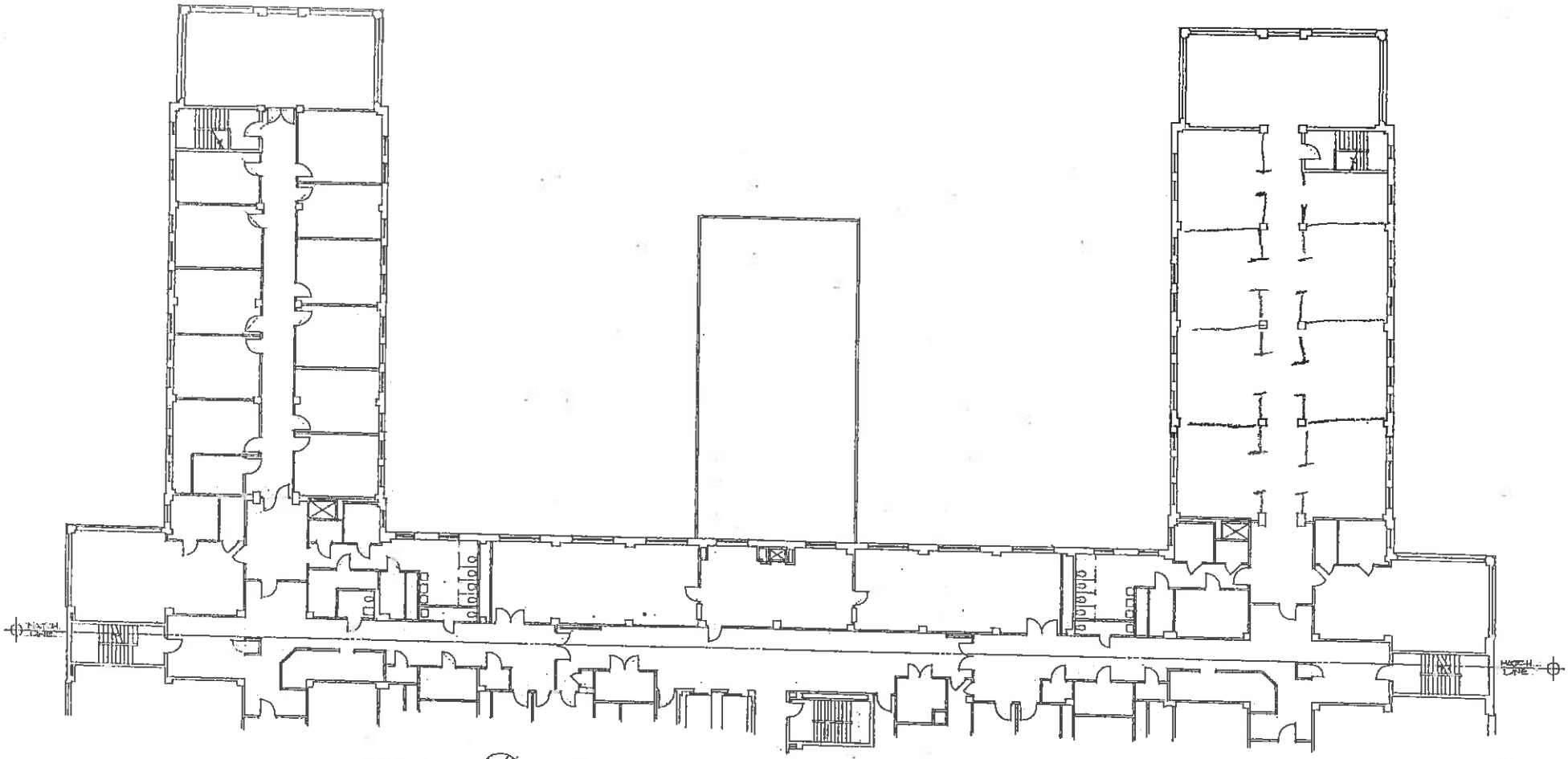
REDWOOD COURT
FLOOR PLAN



SECOND FLOOR PLAN-BLDG 70-NORTH 16'-1"=0"

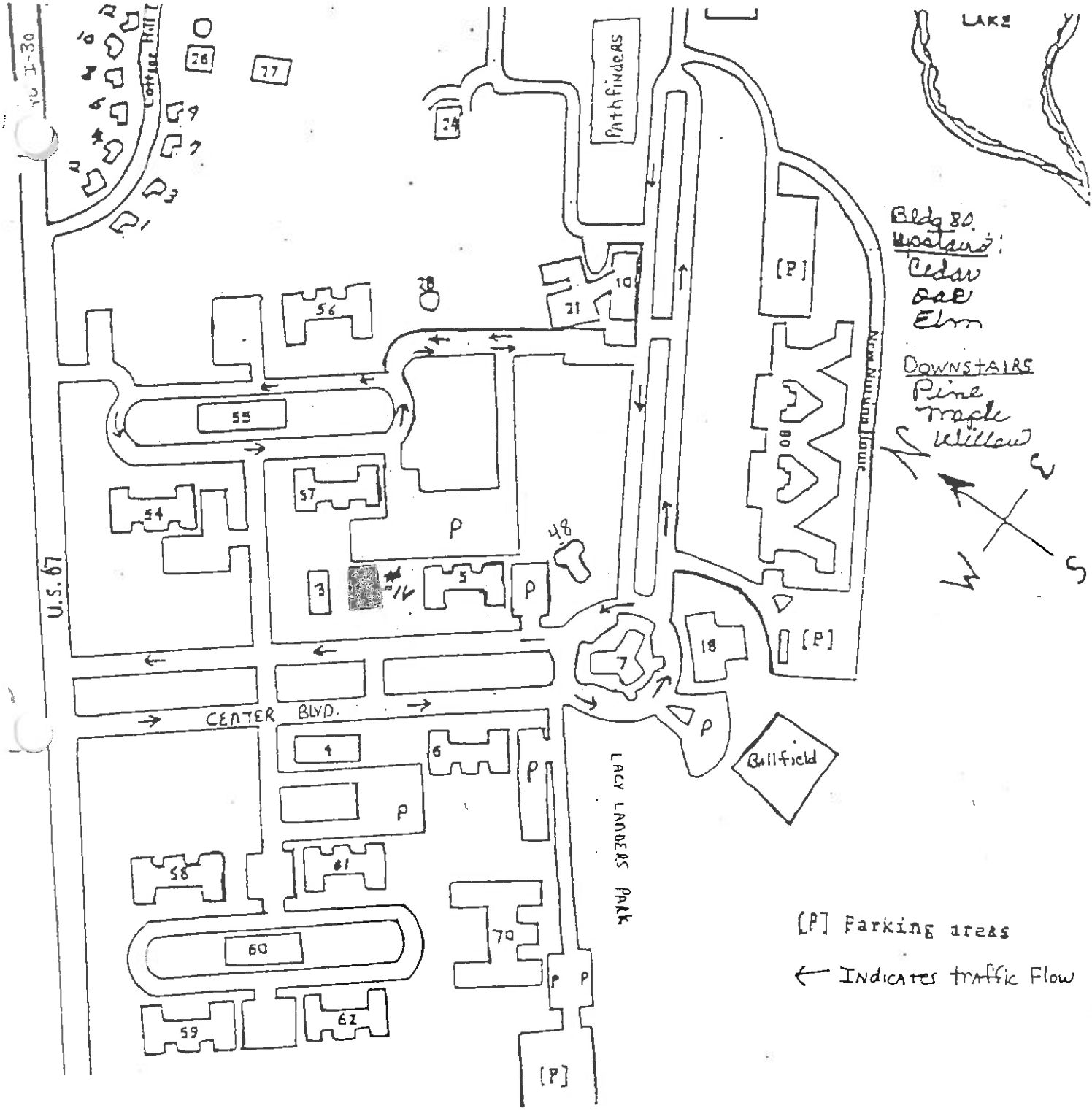
Redwood

BENTON SERVICES CENTER-BLDG 70-SHT 5



SECOND FLOOR PLAN - BLDG. 10 - SOUTH 1/8" = 1'-0"

BENTON SERVICES CENTER - BLDG. 10 - SHT. 2



1-4, 6, 12. Birch Residential Program 8. Vacant	18. Maintenance, Credit Union, Fire Chief	57. Storage
7 & 9. Community Re-Entry (CRE)	21. Supply Central Kitchen, Cold Storage	58. Dept. of Corrections
10. DOC Warden's Residence	24. Power Plant	59. Dept. of Corrections
3. Auditorium	25. Old Laundry (Vacant)	60. Storage
4. Birch Day Treatment Program	26. Water Plant	61. Vacant
5. Vacant	27. Water Storage	62. Dept. of Corrections
6. State Police Training Center	28. Water Tower	
7. Administration, Medical Records, Personnel, Purchasing, Patient Funds, Patient Eligibility/Statistics, Business Office, Computer Services, Staff Development, Computer Services	46. Public Safety, Fire Department	70. Aspen, Pharmacy, Psychology, Hickory, Redbud, Redbud-OT, Hope House (Birch Program)
10. Staff Dining, Bakery, Blue Room, Employee Gym	48. Chapel	80. Lakeview- Cedar, Oak, Elm, Pine, Maple, Willow, Infection Control, Lab, X-Ray, Social Services, OT, PT, ST
16. PBX (Switchboard), Post Office, Food Service Office, Dental Office	54. Vacant	
	56. Storage	

SECTION 20

OLTC SURVEY

QUESTIONS

AND

ANSWERS

OLTC SURVEY QUESTIONS AND ANSWERS
FOR STAFF

EMPLOYEES/DIRECT CARE STAFF

1. Name the 7 forms of abuse: (VIPS eats MNM)
   a. **(V) Verbal**
   b. **(I) Involuntary seclusion**
   c. **(P) Physical**
   d. **(S) Sexual**
   e. **(M) Maltreatment**
   f. **(N) Neglect**
   g. **(M) Misappropriation of property**

2. Who do you report abuse to? **Immediately to the supervisor.**

3. If the charge nurse is the abuser, who would you report it to? **Their supervisor and keep going up the chain of command if necessary**

4. If you notice a resident becoming aggressive or displaying a catastrophic reaction, what would you do? **Maintain resident/staff safety, provide a safe environment, report it to the nurse immediately/ try to de-escalate their behavior /follow the residents' plan of care. Utilize MANDT technique as needed.**

5. If a resident does not consume 50% of a meal or refuses a vegetable, what would you do? **Report to the nurse and offer a substitute or supplement of equal value to meal refusal content.**

6. In case of a fire, what would you do? **Procedure for R.A.C.E and P.A.S.S.**

   R-Rescue the residents closest to the fire
   A-Alert/Alarm-call for help/send someone to call switchboard
   C-Confine-keep the fire from spreading; shut fire doors
   E-extinguish-if you can do so safely, put the fire out

   P- Pull the pin
   A- Aim the extinguisher nozzle at the base of the fire
   S- Squeeze the handle
   S- Spray the contents of the extinguisher back and forth at the base of the fire in a sweeping motion.

7. If a resident stated somebody hit me last week and you did not witness the incident would you report it? **YES, immediately to supervisor**

OLTC SURVEY QUESTIONS AND ANSWERS

FOR FRONT LINE SUPERVISORS

1. How do you monitor the provision of care/services? **By observing the rounds staff are making and checking residents for cleanliness**

2. How do you monitor staff/resident interaction? **By observing residents with staff in different situations and areas**

3. How do you know that staff is meeting the resident's needs? **By interviewing the residents, checking for good hygiene and monitoring ADL's being provided**

4. How do you monitor for staff burnout, which could lead to abuse? What is your intervention? **Look for changes in behavior/performance/attitude/attendance. Offer them a few days off, change units or assignments/ allow them to vent.**

5. How do you determine which injuries of unknown origin should be investigated as alleged occurrences of abuse? **All injuries of unknown origin must be investigated.**