RESIDENT RIGHTS AND RESPONSIBLITIES
AT ARKANSAS HEALTH CENTER NURSING FACILITY

As a resident of Arkansas Health Center (AHC), you have the right to a dignified existence and to communicate with individuals and representatives of choice. Arkansas Health Center will protect and promote your rights as designated below.

Exercise of Rights -

- You have the right and freedom to exercise your rights as a resident of AHC and as a citizen or resident of the United States without fear of discrimination, restraint, interference, coercion or reprisal.
- If you are unable to act in your own behalf, your rights are exercised by the person appointed under state law to act in your behalf.

Notice of Rights and Services

- You will be informed of your rights and of all rules and regulations governing resident conduct and responsibilities both orally and in writing.
- You have the right to inspect and purchase photocopies of your records.
- You have the right to be fully informed of your total health status.
- You have the right to refuse treatment, to participate in experimental research and to formulate an advance directive in accordance with AHC policy.
- You will be informed of Medicare and Medicaid benefits. This information will be posted.
- You will be informed of AHC services and charges.
- AHC will inform you of procedures for protecting personal funds. If you deem necessary, you may file a complaint with the state survey and certification agency (Office of Long Term Care).
- You will be informed of your physician, his or her specialty, and ways of contacting him or her.
- AHC must consult with you and notify your physician and interested family member of any significant change in your condition or treatment, or of any decision to transfer or discharge.
- AHC will notify you and interested family members of a room or roommate change.
- AHC will periodically update the address and telephone number of your legal representative or interested family member.

Protection of Funds-

- You may manage your own financial affairs. You are not required to deposit personal funds with AHC.
- AHC must manage your deposited funds with your best interests in mind. Your money will not be commingled with AHC funds.
- AHC will provide you with an individualized financial report quarterly and upon your request.
- Any remaining estate will be conveyed to your named successor.
- All funds held by AHC will be protected by a security bond.

Free Choice-

- Full-time physician and pharmaceutical needs are provided within your daily charges at AHC. However, you may choose at your own expense, your own personal physician and pharmacist.
- You will be informed and may participate in your care and treatment and any resulting changes.

Privacy-

- You have the right of privacy over your personal and clinical records.
- Your privacy will include: personal care, medical treatments, telephone use, visits, letters and meetings of family and resident groups.
- You may approve or refuse the release of your records except in the event of a transfer or legal situation.

Grievances-

- You may voice grievances concerning your care without fear of discrimination or reprisal.
- You may expect prompt efforts for the resolution of grievances.

Examination of Survey Results-

- You may examine survey results and the plan of correction. These, or a notice of their location, will be posted in a readily accessible place.
- You may contact client advocate agencies and receive information from them.

Work-

- You may perform or refuse to perform services for AHC.
- All services performed must be well documented in the care plan to include nature of the work and compensation.

Mail-

- You may promptly send and receive your mail unopened and have access to writing supplies.

Access and Visitation Rights-

- You have the right to receive visitors at any reasonable time in AHC.
- You have the right and AHC will provide access to visit with any relevant agency of the state or any entity providing health, social, legal or other services.

Telephone-

- You have the right to use the telephone in private.

Personal Property-

- You can retain and use personal possessions as space permits.

Married Couples-

- A married couple may share a room.

Self-Administration of Drugs-

- You may self-administer drugs unless determined unsafe by the interdisciplinary team.

Admission, Transfer and Discharge Rights

Transfer and Discharge

- You may not be transferred or discharged unless your needs cannot be met, safety is endangered, services are no longer required, or payment has not been made.
- Notice of and reason(s) for transfer or discharge must be provided to you in an understandable manner.
- Notice of transfer or discharge must be given 30 days prior, except in cases of health and safety needs.
- The transfer or discharge notice must include the name, address and telephone number of the appropriate, responsible protective agency.
- AHC will provide sufficient preparation to ensure a safe transfer or discharge.

Notice of Bed-Hold Policy and Readmission-

- You and a family member must receive written notice of state and AHC bed-hold policies before and at the time of a transfer.
- AHC will follow a written policy for readmittance if the bed-hold period is exceeded.

Equal Access to Quality Care-

- AHC uses identical policies regarding transfer, discharge and services for all residents.
- AHC may determine charges for a non-Medicaid resident as long as written notice was provided at the time of admission.

Admission Policy-

- AHC will not require a third party guarantee of payment or accept any gifts as a condition of admission or continued stay.
- AHC will not require you to waive your right to Medicare or Medicaid benefits.
- AHC may obtain legal financial access for payment without incurring your personal liability.
- AHC may charge a Medicaid-eligible resident for items and services requested.
- AHC may only accept contributions if they are not a condition of admittance or continued stay.

Residents Responsibilities

- Resident will participate to the level of his/her capability in the development and implementation of their treatment plan.
- All residents must consider the rights of other residents at all times. It shall be the responsibility of administration to insure that all rights are protected and these responsibilities are adhered to by the residents.
- All ambulatory residents physically able to do so are expected to participate in the fire and evacuation drills when scheduled as a safety measure.
- Residents, their families, or visitors will not be permitted in any area of the nursing home which might be potentially dangerous, such as kitchen, laundry, medical records, boiler rooms, maintenance areas, and employee areas.

- When residents visit off the unit with their family and/or significant others, it is understood that this facility will not assume responsibility for any illness or injury incurred by the resident during such absences.
- Residents shall remain fully responsible for money and other valuables kept on the person of the resident on in his/her room. The facility will not assume any responsibility for money or personal items lost, stolen or misplaced.
- Special written permission must be obtained for the Fire and Safety Coordinator for the use of any appliance which heats or cools. Defective appliances will not be allowed to remain in the facility.
- Food shall not be brought in to or stored in the resident's room unless in a covered container.
- Smoking will be allowed only in areas as designated and at no time in the resident rooms.
- Resident will be considerate of other residents by cooperating in the use of heating and air conditioning equipment.
- Any resident who destroys another resident's property may be held responsible for making restitution.
- The resident, family members, or significant others will be responsible for making burial arrangements.

Resident Behavior and AHC Practices

Restraints-

- AHC may not use physical restraints or psychoactive drugs for discipline or convenience or when they are not required to treat medical symptoms.

Abuse-

- You have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion.

Staff Treatment-

- AHC must implement procedures that protect you from abuse, neglect or mistreatment, and misappropriate of your property.
- In the event of an alleged violation involving your treatment, AHC will report it to the appropriate officals.
- All alleged violations must be thoroughly investigated and the results reported.

Quality of Life-

- AHC will care for you in a manner that enhances your quality of life.

Dignity-

- AHC will treat you with dignity and respect in full recognition of your individuality.

Self Determination-

- You may choose your own activities, schedules and health care and any other aspect affecting your life at AHC.
- You may interact with visitors of your choice.

Participation in Resident and Family Groups-

- You may organize or participate in groups of choice.
- Families have the right to visit with other families.
- AHC will provide a private space for group meetings.
- AHC will provide a staff person to assist and follow up with the group's requests.
- AHC must listen to and act upon requests or concerns of the group.

Participation in Other activities-

- You have the right to participate in activities of choice that do not interfere with the rights of other residents.

Accommodation of Needs-

- You have the right as a resident to receive services with reasonable accommodations to individual needs and preferences.
- You will be notified of room or roommate changes.
- You have the right to make choices about aspects of your life at AHC that are important to you.

Activities-

- AHC will provide a program of activities designed to meet your needs and interests.

Social Services-

- AHC will provide social services to attain or maintain your highest level of well-being.

Environment-

- AHC will provide a safe, clean, comfortable, homelike environment, allowing you the opportunity to use your personal belongings to the extent possible.
- AHC will provide housekeeping and maintenance services.
- AHC will assure you have clean bath and bed linens and that they are in good repair.
- AHC will provide you with a private closet space as space permits.
- AHC will provide you with adequate and comfortable lighting and sound levels.
- AHC will provide you with comfortable and safe temperature levels.

24 HOUR NURSING REPORT

NOTE: The 24-hour nursing report should be used as a tool to communicate between shifts and key personnel. The report assists in ensuring continuity of care for residents and ensures staff awareness of changes in condition

1. The 24-hour nursing report should always include the following information:
   a. New orders
   b. Medication changes
   c. Change in condition
   d. Appointments
   e. I/A's
   f. PRN medications administered
   g. New admit/transfers/discharges/deaths/out on pass
   h. Behaviors
   i. Family requests
   j. Residents on antibiotics
   k. Residents with skin condition (new pressure area, skin tear, etc)
   l. Residents on Oxygen
2. This is NOT an all-inclusive list. Any information deemed pertinent in providing continuity in care must be reported to the oncoming nurse and accessible to the unit RN supervisor and thus should be included on the 24 hour nursing report
3. The 24 hour nursing report will be kept for 72 hours and then destroyed
4. The 24 hour nursing report should not be utilized to criticize or complain about fellow workers
5. As part of the Routine Start Up procedure, the unit RN supervisor will review the 24 hour nursing report for the past 24 hours or since the last time the or she reviewed the reports.
6. Create a priority list/target list of residents based on the information recorded on the 24 hour nursing report. Review the hot-rack charting list to ensure the resident has been placed on the list. Review the resident's medical record to ensure documentation is present. Has all parties been notified of changes? Look to make sure all areas were addressed in a timely manner.

Process for completion of:
Individual Resident 1910 QA Tracking Log / At a glance 1910 tracking log
and
QA Observation Log

1) When there has been a resident to resident altercation, the incident will be logged on the individual resident tracking sheet in the 1910 Tracking log notebook

2) The at a glance 1910 log will be completed with a short description of the incident for a quick reference to determine patterns with altercations among residents

3) The Observation log is updated with each order for 1:1, Q15", Q30" or LOS orders

4) With ANY specific observation orders that are received, it is the RN/LPN supervisor's responsibility to ensure the observation board in nursing services is updated each shift

ARKANSAS HEALTH CENTER
ACCIDENT/INCIDENT REPORT/ 1910 CHECKLIST

Complete this checklist along with the Accident/Incident Report /1910 Report; **if notification is not applicable please mark N/A** in that section. When form is complete submit to the RN on duty. RN will maintain check list with the 1910/I/A log book.

SECTION A (Completed by the nurse)

Resident Name:_____UNIT:_____

Incident Date:_____ Time:_____am/pm

_____I/A complete

_____1910 Complete

_____Employee removed from duty/Resident removed from area (IF APPLICABLE)

_____BR Form complete

_____Witness statements obtained

_____Physician notified and orders written and carried out

_____Short & long term safety plan implemented

_____Observation sheets initiated

_____Nurses note documentation complete

_____Mental Anguish Assessment

_____Staff assigned to aggressor until calm if R→R altercation

_____Body Audit Complete

_____Risk Management notified and documentation (including orders for any type of observation) fax to (860-0532)

_____Family/Responsible party notified

_____RN notified

_____24 hour Shift Report updated

_____Place on Hot Rack

_____Resident Information Sheet updated

_____Nursing Home Administrator/Administrator on duty notified

_____DON/ADON on call notified

Signature of Nurse completing form:_____

Section B TO BE COMPLETED BY RN. Reviewed for completeness, accuracy, and supporting documentation.

RN to complete with Follow up:

_____Update 1910 tracking form

_____Update resident observation tracking form

RN: _____ Date: _____

AT A GLANCE 1910 RESIDENT to RESIDENT ALTERCATION LOG

DATE	TIME	VICTIM	PERPETRATOR	SHORT DESCRIPTION	Nurses signature completing
examp. 5/9/11	1220	Jane Doe		was struck in face by John Doe	Nancy Nurse
" "	" "		John Doe	Hit Jane Doe in the face	" "

AT A GLANCE RESIDENT OBSERVATION STATUS LOG

DATE	RESIDENT NAME	DATE/TIME ORDER RECEIVED	TYPE OF OBSERVATION STATUS ORDERED	ORDER DC DATE	Nurses signature completing

INDIVIDUAL RESIDENT OBSERVATION ORDER TRACKING QA LOG

RESIDENT NAME:________________________________ UNIT:_______________

TYPE OF OBSERVATION STATUS ORDERED	DATE/TIME ORDER RECEIVED	REASON FOR OBSERVATION	DATE/TIME ORDER DISCONTINUED	Nurses signature completing

INDIVIDUAL RESIDENT 1910 QA TRACKING LOG

RESIDENT NAME	UNIT

DATE	TIME	Description of event	victim	Perp	Comments/orders received	Care plan update	Short term plan intervention	time initiated	Long term plan intervention	time initiated	Nurses initial

INCIDENT REPORT FORM * EXAMPLE *

***FOR USE BY DHHS CONTRACTED/LICENSED PROVIDERS ONLY; DHHS STAFF TO USE IRIS**

Information to be typed whenever possible; Otherwise, clearly PRINT

Please check appropriate boxes and complete all applicable blanks
Use designated space on back of form for additional information as necessary

Type of Report ☑ Initial Written Date/Time 5/9/11 1300
☐ Follow-up Date
☐ Follow-up Date

TO Ed Hood (Name of Division Director/Designee) DBHS (Division)

FROM Nancy Nurse (Name of Person Submitting Report) AHC (Provider/Program Name) Nurse's Station # (Telephone)

Type of Service/Program LTCF
(i.e., Mental Health, DD program, Day Treatment, Residential, etc.)

1) OTHER NOTIFICATIONS ..... Enter method, date & time communicated when appropriate

☐ Adult Protective Services Hotline (1-800-482-8049).....
☐ Child Abuse Hotline (1-800-482-5964).....
☐ DHHS Client Advocate.....
☐ DHHS Communications Director.....
☐ DHHS Office of Chief Counsel.....
☒ Next of Kin Relationship Husband ..... phone 5/9/11 1230
☐ Responsible Party Relationship(if different than above).....
☒ Law enforcement (Specify) PSO S. Durall ..... phone 5/9/11 1228
☐ Department of Health.....
☐ Other (Specify) All via phone on 5/9/11: 1235 DON T. Campbell; 1237 Adm. G. Gipson; 1240 R. Mgmt - M. Smith; 1242 Dr Sudderth; 1245 Social Worker; RN name 1227

2) VICTIM/COMPLAINANT/SUBJECT OF REPORT [Check applicable box(es) Add address and phone if non-DHHS person]

☒ Division Client ☐ Foster Child ☐ Client of Contract Agency ☐ Staff/Employee ☐ Other (Specify)

(victim) Jane Doe	3-4-56	Cauc.	female
NAME	DOB or AGE	RACE	GENDER

3) 5/9/11 (Date of Incident) 1220 (Time of Incident) Pine Court (Place of Incident)

4) TYPE OF INCIDENT (With information available at time of report, check/complete all that seem applicable)

* ☐ Death ..... Suspected Cause of Death *Complete if reporting death
* ☐ Suicidal Behaviors
If checked note date and results of clinical evaluation follow-up Complete if reporting Suicidal behaviors ☐ Pending
☐ Rape
Maltreatment/Abuse/Exploitation
☐ Neglect ☐ Verbal ☒ Physical ☐ Sexual ☐ Other
☐ Injury
☐ Client ☐ Staff ☐ Public Extent & Intervention
☐ Missing Client (AWOL) (Report return of missing client as follow-up report)
☐ Disturbance
☐ Property Destruction ..... Extent
☐ Theft – (to include Misappropriation of funds / property)
☐ Arrest
☐ Other
(Provided list not exhaustive; reference DHHS Policy 1090)

5) DESIGNATION OF INCIDENT [Check applicable box(es)]

☒ Client-to-Client ☐ Client-to-Staff ☐ Self-Inflicted ☐ Staff-to-Client ☐ Client-to-Public ☐ Public-to-Client ☐ N/A
☐ Other (Specify)

* EXAMPLE *

DHHS-1910 - Continued - Page 2 (Incident Report) RE: Jane DOE * EXAMPLE *
Name of Subject

6) ROLES (RELATIONSHIP TO SUBJECT) & NAMES OF OTHERS INVOLVED (Client, Staff, Witness, Participant, Perpetrator, etc.)
[Use separate line for each; Note all roles that apply per person, i.e. staff/participant, client/witness - identifiable abbreviations acceptable; Include addresses & phones of non-DHHS persons; Use designated space at bottom of page to provide additional information as needed]

Role(s)	Name	Address & Phone if non-DHHS person
RN	Nancy Nurse	AHC - 6701 Hwy 67, Benton AR
(Agency) Caregiver	Annie Aide	1234 Benny Hanna Dr; Hallelujah AR
* Be sure to identify if Agency *		
Resident/Aggressor	Resident X name	AHC

CLEAR, CONCISE NARRATIVE DESCRIPTION (Include known essentials of who, what, when, where, why and how regarding incident)

On 5/9/11 at approx 1220 pm Resident X was noted hitting Jane Doe in the face while outside during smoke break. Jane Doe was struck in the eye (R) causing a large red area around the eye socket.

(STP) Staff immediately intervened & separated R's. Proper notifications made. Orders recieved to apply ice pack to (R) eye for 15-30" as tolerated

(LTP) See Bottom for examples

8) SHOULD/COULD THIS INCIDENT HAVE BEEN PREVENTED/ANTICIPATED? ☐YES ☐NO

If yes, please explain: no need to complete unless it was anticipated or should have been prevented

9) FINDINGS/OUTCOME/CASE DISPOSITION (When appropriate, include Corrective Action or Preventive Plan for future)
☐Pending Investigation ☐Investigated with following plan/action

* DO NOT have to check or complete this area *

* EXAMPLE *

USE THE FOLLOWING SPACES TO PROVIDE ADDITIONAL INFORMATION AS NEEDED
[Please enter the number(s) of section(s) being referenced for clarity]

(LTP) Examples of possible options - NOT all-inclusive by any means.

1) R will be monitored closely & kept separated during smoking break for the next 48 hours.

2) Aggressor placed 1:1 until calm & verbalizes no hostility regarding this incident (OR) Aggressor placed 1:1 until seen by MD.

3) Residents will smoke at separate times for 48 hrs & then re-evaluate

DO NOT ATTACH ADDITIONAL DOCUMENTS: PROVIDER WILL BE CONTACTED FOR ADDITIONAL INFORMATION IF NEEDED
[EXCEPTION: CHILD DEATH FORM, CFS-329, TO BE SUBMITTED BY DCFS WITH DHHS-1910 WHEN APPLICABLE]

(STP) Short Term Safety Plan; (LTP) Long Term Safety Plan

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.

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

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 _____

ELOPEMENT FROM FACILITY REMAINING ON THE GROUNDS

ONCE RESIDENT IS LOCATED AND RETURNED TO UNIT—OBTAIN FULL BODY AUDIT

NOTIFY PUBLIC SAFETY OFFICE

NOTIFY MD

NOTIFY RN

NOTIFY DON/ADON

NOTIFY FAMILY

NOTIFY ADMINISTRATIOR ON CALL

COMPLETE I/A

PLACE ON HOTRACK

UPDATE ELOPMENT RISK ASSESSMENT

UPDATE 24 HOUR NURSING REPORT

OBTAIN WITNESS STATEMENTS FROM ALL STAFF ON DUTY (WHEN LAST TIME RESIDENT WAS SEEN)

COMPLETE DOCUMENTATION IN THE NURSES NOTES OF EVENT WITH TIMES

PLACE ON 1:1 SUPERVISION AND COMPLETE THE 15-MINUTE CHECK SHEET UNITL DISCONTINUED BY PHYSICIAN

**COMPLETE A 1910 IF INJURY OCCURS AND/OR THE RESIDENT REQUIRES OUTSIDE TREATMENT/HOSPITALIZATION

FAX ALL PAPERWORK TO RISK MANAGEMENT (860-0532)

April 2011

ELOPEMENT FROM THE FACILITY

NOTIFY PUBLIC SAFETY OFFICE & SWITCHBOARD IMMEDIATELY

NOTIFY DIRECTOR
(OBTAIN INFO TO INITIATE SEARCH PARTY)

NOTIFY ADMINISTRATOR ON CALL

NOTIFY DON/ADON

NOTIFY MD

NOTIFY RN

NOTIFY FAMILY

ONCE RESIDENT IS LOCATED AND RETURNED TO THE UNIT
(OBTAIN FULL BODY AUDIT, DOCUMENT NS NOTES & BODY AUDIT FORM)

COMPLETE I/A

COMPLETE 1910

PLACE ON HOTRACK

UPDATE ELOPMENT RISK ASSESSMENT

UPDATE 24 HOUR NURSING REPORT

OBTAIN WITNESS STATEMENTS FROM ALL STAFF ON DUTY
(WHEN LAST TIME RESIDENT WAS SEEN)

COMPLETE DOCUMENTATION IN THE NURSES NOTES OF EVENT
WITH TIMES

PLACE ON 1:1 SUPERVISION AND COMPLETE THE 15-MINUTE CHECK SHEET
UNITL DISCONTINUED BY PHYSICIAN

FAX ALL PAPERWORK TO RISK MANAGEMENT (860-0532)

April 2011

SECURITY SYSTEM DOCUMENTATION

1. Every resident with a security alarm bracelet should be checked each shift to ensure placement of the alarm. This information should be recorded on the Restraint/Special device record each shift.

2. The security alarm bracelet will be tested weekly and as needed. This information will be recorded on the Restraint/Special device record

3. Resident's with a security alarm bracelet will be monitored closely during fire drills or any time the alarm system is malfunctioning

4. Resident's with a security alarm will be supervised at all times when off the unit.

5. Review the Restraint/Special device record for documentation of alarm placement and checks

6. Conduct random observation rounds to identify placement of the alarm bracelet.

ELOPEMENT RISK SCALE (For Assessing Elopement Risks)

20 or above - High Risk | **15 to 20 - Medium Risk** | **2 to 15 - Low Risk**

RISK FACTOR	SCORE/DESCRIPTION				1	2	3	4
Mental Processes	**1. Totally diminished=** Unresponsive or extremely declined thought processes. Resident has no elopement risk. DO NOT PROCEED. REVIEW YEARLY FOR CHANGES.	**2. Very Diminished=** Oriented to own name but confused as to time and locations. Knows family only at times. Needs assistance to find room.	**3. Slightly Diminished=** Oriented to person, location. and time at least ½ of day. Able to find room on own.	**4. Alert/Oriented or little cognitive impairment=** Oriented to person, place, and time at least ¾ of day. Knows family all of the time.				
IF RESIDENT HAS SUSTAINED A PERSONAL TRAGEDY OR RECEIVED UPSETTING INFORMATION IN PAST 30 DAYS CODE 1 ADDITIONAL POINT.								
IF RESIDENT VERBALLY EXPRESSES A DESIRE TO GO HOME CODE 1 ADDITIONAL POINT.								
IF RESIDENT HAS ONE OR MORE OF THESE PERTINENT DIAGNOSES CHECK MARK AND CODE 1 ADDITIONAL POINT FOR EACH ONE NOTED: DEMENTIA___ OBS___ ALZHEIMER'S DZ.___ DELUSIONS___ HALLUCINATIONS___ ANXIETY DISORDER___ DEPRESSION___ SCHIZOPHRENIA___ BI-POLAR DISORDER___ MENTAL RETARDATION___ PERSONALITY DISORDERS___ OTHER MENTAL DISORDERS THAT COULD LEAD TO ELOPEMENT ___.								
HAS THERE BEEN A MEDICATION CHANGE OR IS THIS A NEW BEHAVIOR, IF YES CODE 1 ADDITIONAL POINT.								
Physical Activity/Mobility	**1. Very Impaired=** Able to be up in chair for limited periods of time. Non-ambulatory but propels chair short distances on own.	**2. Impaired=** Able to be up in chair part of day and propels chair on own. Walks but is unable to walk without assistance from staff.	**3. Slightly Impaired=** Able to walk with only observation or slightly assistance from staff. If in chair, propels on own at all times.	**4. NO IMPAIRMENT=** Able to walk on own with no assistance or oversight from staff.				
IF RESIDENT PACES OR WANDERS WITHOUT PURPOSE CODE 1 ADDITIONAL POINT.								
IF RESIDENT PACES OR WANDERS WITH A DETERMINED PURPOSE CODE 2 ADDITIONAL POINTS.								
IF RESIDENT IS EXPERIENCING ANY TYPE OF PAIN CODE 1 ADDITIONAL POINT.								
History of Elopement or Wandering	**1.** Has **No** past history of wandering or elopements, either by family knowledge or other documentation.	2. Has history of wandering at home or another facility but no actual elopements.	3. Has history of wandering and prior elopements from home or another facility.	4. Has history of elopement that required an organized search effort or that resulted in an injury.				
			Code both if applicable					
IF ELOPEMENT'S NOTED LIST EVENTS ON BACK AND ADD 2 POINTS TO SCORE FOR EACH EPISODE.								
IF THIS IS A NEW ELOPEMENT PLEASE EXPLAIN EVENT ON BACK AND ADD 5 POINTS TO SCORE								
1. IS THE RESIDENT A NEW ADMIT AND NOT ACCEPTING THE NEW ENVIRONMENT CODE 1 ADDITIONAL POINT.								
2. DOES THE RESIDENT RECEIVE ANY MEDICATION THAT INCREASES RESTLESSNESS OR AGITATION---CODE 1 ADDITIONAL POINT.								
3. DOES RESIDENT HAVE ANY VISUAL OR HEARING PROBLEMS CODE 1 ADDITIONAL POINT.								
				TOTAL SCORE				

ASSESS:	DATE	EVALUATOR SIGNATURE/TITLE	ASSESS:	DATE	EVALUATOR SIGNATURE/TITLE
1	/ /		3	/ /	
2	/ /		4	/ /	

NAME-Last First Middle	Attending Physician	Record No.	Room/Bed

Resid... 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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Revised 1-24-2008. Snj

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	Accounting for Residents	NS 105

1. PURPOSE: The purpose of this policy is to establish procedures to insure the safety and accountability of all residents.

2. SCOPE: Nursing Services, Recreational Activities, Social Work, Habilitation/Rehabilitation Therapy and the Maintenance Department.

3. POLICY: It is the policy of Arkansas Health Center to maintain accountability for all residents.

4. PROCEDURE:

    1. Nursing personnel will conduct rounds during shift reporting to account for all residents on the assigned unit. The on-coming nurse will be informed of any resident on leave of absence or off the unit.

    2. A Therapeutic Leave of Absence Form will be kept at the nurse's station. Residents leaving the unit for activities, appointments, therapy, or therapeutic leave will be signed out on the Therapeutic Leave of Absence Form and will be signed back in upon return to the unit. The person taking the resident off the unit will sign the resident out and the person returning the resident to the unit will sign the resident in. This includes but is not limited to the following:
        a. Pathfinders
        b. Therapy
        c. Activities
        d. Arts and Crafts
        e. Dentist
        f. X-ray
        g. Clinic Appointments
        h. Out on pass with family (dinner, shopping, home, etc.)

    3. Residents requiring a security alarm bracelet to alert staff of attempts to leave the unit without supervision:
        a. The nurse will obtain an order from the physician for the security alarm bracelet.
        b. The family or representative will be notified of the need for the bracelet.
        c. Prior to placing the security alarm on the resident, the nurse will test the alarm by activating the alarm on exit doors of the unit to insure proper functioning.
        d. Security alarm bracelet placement checks will be conducted every shift and recorded on the Special Device Flow-sheet.
        e. Nursing will check each resident's alarm bracelet weekly to insure the alarm activates exit doors on the assigned unit. Alarm checks will be recorded on the special device flow sheet. In the event the alarm does not activate, a new bracelet will be tested and then placed on the resident.
        f. In the event the door alarm is activated, staff will immediately respond to determine what activated the alarm. All residents with a security alarm bracelet will be accounted for before the alarm is re-set.
        g. Nursing, agency, social work, recreational activities, and habilitation/rehabilitation therapy personnel are authorized to turn off or re-set door alarms. All other disciplines **MAY NOT** turn off or re-set an alarm.

h. Any malfunction with the door alarm will be reported to the Maintenance Department. In the event the door alarm does not activate (due to activation of fire alarm or malfunctioning) an employee will be assigned to monitor each exit door to prevent residents from exiting the unit unsupervised.

i. A maintenance representative will go unit to unit every Friday to check door alarms to ensure proper functioning. It will be announced prior to alarm testing. This person will be allowed to reset the alarm upon testing.

AHC Director _____ Date _____

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Administration	Accounting for Residents	AP 500

1. PURPOSE: The purpose of this policy is to establish procedures to insure the safety and accountability of all residents

2. SCOPE: Nursing, Activities, Social, Rehabilitation Therapy, Administrative Assistants, Maintenance, Public Safety Officers, Administrative Staff, Physicians, Psychology and Supervisory Staff of All Departments.

3. POLICY: It is the policy of Arkansas Health Center to maintain accountability for all residents.

4. PROCEDURE:

1. Nursing personnel will conduct rounds and document on the Resident Check list every 2 hours from 7 a.m. to 7 p.m. and every hour from 7 p.m. to 7 a.m. to account for all residents on the assigned unit. The on-coming nurse will be informed of any resident on leave of absence or off the unit.
2. A Therapeutic Leave of Absence Form will be kept at the nurse's station. Residents leaving the unit for activities, appointments, therapy, or therapeutic leave will be signed out on the Therapeutic Leave of Absence Form and will be signed back in upon return to the unit. The person taking the resident off the unit will sign the resident out and the person returning the resident to the unit will sign the resident in. This includes but is not limited to the following:
    a. Pathfinders
    b. Therapy
    c. Activities
    d. Arts and Crafts
    e. Dentist
    f. X-ray
    g. Clinic Appointments
    h. Out on pass with family (dinner, shopping, home, etc)
3. Residents requiring a security alarm bracelet to alert staff of attempts to leave the unit without supervision:
    a. The nurse will obtain an order from the physician for the security alarm bracelet
    b. The family or representative will be notified of the need for the bracelet
    c. Prior to placing the security alarm on the resident, the nurse will test the alarm by activating the alarm on exit doors of the unit to insure proper functioning.
    d. Each resident who has a security alarm will have that number logged in the nursing service office in the security alarm bracelet book
    e. Security alarm bracelet placement checks will be conducted every shift and recorded on the Special Device Flow-sheet.
    f. Nursing will check each resident's alarm bracelet weekly to insure the alarm activates exit doors on the assigned unit. Alarm checks will be recorded on the special device flow sheet. In the event the alarm does not activate, a new bracelet will be tested and then placed on the resident.

g. In the event the door alarm is activated, staff will immediately respond to determine what activated the alarm. Authorized staff will de-activate the alarm and notify the RN or LPN on duty. If the cause for the alarm is not readily determined and corrected, assigned staff will immediately account for all unit residents with security alarm bracelets.

h. Nursing, Agency, Social Services, Rec. Activity, Hab/Rehabilitation Therapy, Public Safety Officers, Administrative Assistants, Maintenance personnel, Psychology, Physicians, Administrative Staff and Supervisory Staff of all Departments are authorized to turn off or re-set door alarms. All other disciplines **MAY NOT** turn off or re-set an alarm.

i. Any malfunction with the door alarm will be reported to the maintenance department. In the event the door alarm does not activate (due to activation of a fire alarm or malfunctioning) an employee will be assigned to monitor each exit door to prevent residents from exiting the unit unsupervised.

j. A maintenance representative will go unit to unit every Friday and check door alarms to ensure proper functioning. It will be announced prior to the alarm testing. This person will be allowed to reset the alarm upon testing.

AHC Facility Director _____ Date _____

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

ARKANSAS HEALTH CENTER

RESIDENT BEHAVIOR REPORT

_____ _____ _____ _____AM/PM _____AM/PM

ent'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

cally 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)

tive 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

BEHAVIOR REPORT
NARRATIVE COMMENTS

RESIDENT NAME:_____ **UNIT:**_____

DATE:_____

Additional Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature/Date

_____

Reviewed/Date

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	Change of Condition Reporting	NS 908

PURPOSE: The purpose of this policy is to establish guidelines for recognizing, assessing, reporting and documenting changes in a resident's condition

SCOPE: Nursing

POLICY: It is the policy of Arkansas Health Center that all licensed nurses are trained in recognizing and assessing changes in conditions. It is also the policy of Arkansas Health Center that the physician and the resident's responsible party be notified of changes in the resident's condition in a timely manner.

PROCEDURE:

1. **Definition of a Change in Condition <u>includes but is not limited</u> to the following:**
   - Any problem requiring special observation or nursing interventions
   - Incidents and Accidents (Refer to Incident and Accident Reporting policy)
   - Changes in cognitive or mental status: lethargy, increased confusion, signs and symptoms of delirium, etc.
   - Changes in psychosocial status: decrease in activities; resisting care; combativeness; aggression; agitation; depression; threats of suicide; refuses medications and/or treatments; and any other unusual and/or changes in behavior
   - Changes in physical/medical status: change in vital signs; seizure activity; changes in skin condition (pressure sores, rashes, edema, turgor, excessive bruising, color, etc); signs and symptoms of respiratory distress; infections; dehydration; bleeding (pallor, weakness, coffee ground emesis, change in pulse, etc); fecal impaction (i.e., restlessness, lethargy, abdominal pain and distention, loss of appetite, nausea, vomiting, change in bowel sounds or blood pressure); pain; nausea, vomiting, or diarrhea; critical labs, blood sugars, or radiology reports; adverse reactions to medications; etc.

2. **Assessing changes in condition <u>includes but is not limited</u> to the following:**
   - Any direct care nursing employee who recognizes or sees a resident in distress will immediately notify a licensed nurse
   - The licensed nurse will conduct a thorough assessment of the resident's condition utilizing the following guidelines:
   - Start the assessment with the ABCs of good care: Assess airway (is it open? is resident choking?); Assess Breathing (Is the resident breathing? How fast? Is breathing labored? Are accessory muscles being used? Are there pauses or periods of apnea?); Assess Circulation (Is there a pulse? How fast or slow? Is pulse regular? Are there skips? etc).
   - In the first few seconds it takes to assess the ABCs, a general feel of whether or not the resident is in significant distress can be established: If the resident is in distress, **<u>Call 911 IMMEDIATELY.</u>** If the resident is NOT in immediate/significant distress, continue with a head to toe assessment.

- A good assessment starts at the head and moves down the body. The amount of time spent on assessing each body system or region may vary. A thorough assessment provides the necessary information the physician will need in order to make a good medical decision and provide appropriate treatment options. The following information serves as guidelines for conducting a head to toe assessment and is not considered all-inclusive:
    - Is the resident conscious? How is the mental status different from usual? Does resident arouse or respond to stimulation? What type- verbal? sternal rub? etc.
    - Are the pupils dilated or pinpoint? Is there a change?
    - Is there cyanosis around the lips?
    - Chest: Listen to lung sounds. Are there any changes? Wheezes? Congestion?
    - Extremities: Cyanosis? Fever? Local or systemic? Deformities? Old or new? Edema? Range of motion? Is there symmetry in motion? Is this a change? Is there any swelling or pain? Pulses?
    - Abdomen: Distended? Soft or Hard? Bowel Sounds? Pain or tenderness?
    - Interpretation of vital signs: Are vital signs within resident's normal limits? Are changes indicative of fever, stroke, distress, pain, hypertension, infection, or impaction?
    - Interpretation of pulse oximetry: Is it within normal limits for the resident? Is the reading fluctuating after the initiation of oxygen? Is the resident cyanotic?

3. **Notifying physician and resident representative of changes in condition:**
    - After the head to toe assessment is completed, the nurse will utilize nursing judgment to determine the overall sense of acuity.
    - If this is an emergency, call 911 immediately and notify the physician, RN Supervisor and family.
    - If this is not an emergency, determine the acuity of the change.
    - Does the resident exhibit a significant change in condition? According to Federal Regulation F157, "a significant change in the resident's physical, mental, or psychosocial status (i.e., deterioration in health, mental, or psychosocial status in ***either*** *life-threatening conditions or clinical complications)*" and/or a "need to *alter treatment significantly*" as well as accidents resulting in injury that has the potential for requiring physician intervention and a decision to transfer or discharge the resident from the facility **require immediate notification** to the physician and resident representative. Life-threatening conditions is defined as "such things as a heart attack or stroke". Clinical complications are defined as such things as "development of a stage II pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression. A mean to alter treatment significantly is defined as "a need to stop a form of treatment because adverse consequences (e.g. an adverse reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure or therapy that has not been used on that resident before)".
    - Based on the acuity of the change in condition, the nurse will notify the physician in a timely manner. Changes in condition meeting the above definitions will require immediate physician notification.

- If the change in condition requires immediate physician notification and the on-call physician can not be reached or does not respond in a timely manner, the licensed nurse will contact and consult with the medical director.
- The licensed nurse will provide the physician with all necessary information about the resident and the change in the resident's condition.
- The licensed nurse will treat the resident as ordered by the physician and evaluate the effectiveness of the interventions.
- The licensed nurse will continue to monitor and notify the physician of any further changes in condition or lack of response to the ordered interventions as deemed necessary.
- Place the resident on the 24 hour nursing report to communicate change in condition to the oncoming shift

4. **Documenting changes in condition should include but is not limited to the following:**
   - Accurately and completely record all change of condition events in the nurse's notes in a time-line method.
   - Describe the change in condition and a description of the assessment findings.
   - Record any first aid provided
   - Record the name of person/s contacted, date and time.
   - Record any new orders received or interventions initiated
   - Document the evaluation of the effectiveness of treatment/interventions ordered
   - Documentation should reflect ongoing assessment and monitoring until the change of condition is resolved or the resident is stable. Frequency of documentation will be determined by the acuity of the change in condition and the stability of the resident.
   - Document any other information deemed appropriate as related to the change of condition
   - Place the resident on the Hot Rack Charting System for ongoing assessment and documentation

5. **Staff Education**
   - All newly employed licensed nurses will be trained on the change of condition policies and procedures during orientation.
   - The facility will conduct in-service training on change of condition policy on an annual basis.

6. **Quality Assurance**
   - The RN Supervisor/designee will review the 24 hour nursing report, hot rack charting system and incident and accident reports to identify residents with a change in condition
   - The RN Supervisor/designee will review the nurses' notes for residents identified with a change in condition to evaluate adequacy of documentation of the resident's change in condition, assessments, interventions, and notifications.

HOT RAC_ CHARTING

DATE OF INCIDENT/ CHANGE	NAME OF RESIDENT	7A	7P	DESCRIPTION OF EVENT	ON CALL MD NOTIFIED DATE/TIME	UNIT MD FOLLOW UP DATE/TIME	FAMILY NOTIFED DATE/TIME	DATE COMPLETED	RN FOLLOW UP

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	Disposal of Controlled Medication Patches (such as Fentanyl, Butrans, etc)	NS 418-A

1. **PURPOSE:** The purpose of this policy is to establish procedures for the disposal of controlled medication patches in accordance with state and federal regulations.

2. **SCOPE:** All Licensed Nurses

3. **POLICY:** It is the policy of Arkansas Health Center that medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in accordance with federal and state laws and regulations.

4. **PROCEDURE & DOCUMENTATION:**
   1. The administrator and consultant pharmacist are responsible for the facility's compliance with federal and Arkansas State laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications.
   2. For scheduled controlled medication patch change, the old patch is removed from the resident's skin and folded in half, (sticky side to sticky side). Then the patch must be cut and flushed in the hopper or toilet receptacle. This must be witnessed by 2 licensed nurses and documented appropriately according to facility procedures.
   3. When a controlled medication patch is removed from the package for administration but refused by the resident, or dropped, it is destroyed in the presence of two (2) licensed nurses by folding the patch in half (sticky side to sticky side), then cutting and flushing the patch in the hopper or toilet receptacle. The disposal is documented on the controlled substance record on the line representing that dose. The RN must be notified and sign off on the waste with the nurses.
   4. All controlled medications remaining in the facility after a resident has been discharged, or the order discontinued, will remain in the locked box of the medication cart and counted each shift until the medications are removed by the DON/Designee and returned to the Arkansas State Health Department: Pharmacy Services Division following state regulations.
   5. All controlled substances being returned to the Arkansas State Health Department will be recorded on the appropriate form. A copy of the form will be retained by the facility for five (5) years.
   6. The facility will follow the State and Federal regulations regarding disposition of controlled substances.

Director of Nursing	Leena Campbell RN	**Date** 11/4/13
Director	Jay Hill	**Date** 11/06/13
Medical Director	M. Allen	**Date** 11/7/13

PROCEDURE REGARDING RESIDENT INFORMATION SHEET AND GAIT BELT USE

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 MDSC 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 Supervisors 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/Gait belt sign in/out log each shift- verifying they have their gait belt present on their person and they have received a RIS

* The MDSC will take the RIS to the Care plan each week to review with the Care plan team to determine if any additional changes need to be made.

* ALL DIRECT care staff are to have a gait belt on their person at all times during working hours to be able to assist residents when needed with ambulation/positioning, etc.

***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 RIS DURING THE DAY, IT MUST BE FAXED TO NURSING SERVICES

April 2011

RESIDENT INFORMATION SHEET & GAIT BELT SIGN IN/OUT

Date:	Belt #	Time Out	Time in
7a-7p Signatures			

Date:	Belt #	Time Out	Time in
7a-7p Signatures			

Date:	Belt #	Time Out	Time in
7a-7p Signatures			

Date:	Belt #	Time Out	Time in
7a-7p Signatures			

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...)
ROOM 2A Jane Doe (Nana) Blue Dot Allergies: Eggs, Codeine, Sulfa	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 INFO[illegible]IATION 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...)
Falling Star Program									
SECURITY BRACELET:									
RED DOT- DO NOT RESUSCITATE BLUE DOT- FULL CODE GREEN DOT-SATELLITE									

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...)
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								

1. PURPOSE. It is the purpose of this policy to ensure the safety of the residents and staff of Arkansas Health Center (AHC) by obtaining and utilizing/wearing gait belts.

2. SCOPE. All nursing assistants and direct care staff providing services related to lifting, transfers and gait training, etc. to the residents of AHC.

3. POLICY. It is the policy of AHC to ensure that all required direct care staff has possession of and uses a gait belt when working with residents.

4. PROCEDURE.

   A. Each employee will be issued a gait belt. Employees are to report to Staff Development acquire the gait belt from the Nurse Educator.

   B. All new employees providing direct care will be issued a gait belt by the nurse trainer prior to their first day on the floor. The nurse trainer is responsible for communicating with Staff Development to ensure she has a list of new employees requiring a gait belt as well their anticipated date to start working on the units. Gait belts will be utilized in accordance with Nursing Policy – NS 905.

   C. Any nursing assistant not in possession of a gait belt will be allowed to borrow a belt from Nursing Education (Monday – Friday) and Nursing Service's Office on nights, weekends and holidays. A log of the employee and the number of the gait belt will be kept in the nursing education office. Each employee borrowing a gait belt will sign out the belt with time they checked it out and then sign in the time they returned their belt.

   D. The employee will be responsible for paying a $1.00 charge for each time they check out the belt. The payment must be made prior to receiving the gait belt.

   E. Failure to return the belt at the end of the shift will result in a replacement fee of $5.00.

   F. If a belt is lost or destroyed, then the employee will be charged $5.00 for a replacement belt. The $5.00 will be received prior to receiving the belt. Replacement fees exclude manufacturer's defects.

   G. All monies collected from the rental or replacement of gait belts is collected by Nursing Services Staff and stored in a lock box. The Nurse Educator picks up the monies from Nursing Services every other Friday at which time, the monies are turned into the Business Office and deposited into the General Funds account.

_____ _____

AHC Director Date

ARKANSAS HEALTH CENTER

DEATH PACKET

CONTENTS

1. Death of a Resident – Nursing Policy #116
2. Obtaining an Autopsy- Nursing Policy #117
3. Autopsy Consent and or Denial of Consent (Original and 1 copy)
4. 1910 Report Form
5. AHC personal belongings of Resident up to date Record #1005-A (Original and 1 copy)
6. White Identification Tags (2)
7. Body Release Consent (original and 1 copy)
8. Coroner Record of Death (send original to ADON, copy for chart)

If a resident expires that is on Hospice and the Hospice Nurse pronounces the death, they will initiate a Death Certificate. A copy must be kept with the residents chart and the original must be sent with the body to the funeral home

ONCE A DEATH PACKET HAS BEEN USED, PLEASE RETURN PACKET TO YOUR ADMINISTRATIVE ASSISTANT TO REFILL

Policy Type	Subject of Policy	Policy No.
Nursing	Death of a Resident	NS 116

1. PURPOSE: It is the purpose of this policy to ensure proper notification of individuals and agencies; to ensure proper identification and appearance of body; to ensure proper documentation of the death of a resident; and to dispose of personal belongings in the appropriate manner.

2. SCOPE: All Nursing Staff.

3. POLICY: the Registered Nurse on duty is responsible for assuring that all processes are completed upon the death of a resident.

4. NOTIFICATION:
   A. Contact the RN on duty.
   B. The RN on duty is to contact the physician on duty to obtain an order to release the body.
   C. Notify family member/guardian/significant other, etc.
   D. Notify the coroner. Complete the form titled Saline County Coroner Report of Death (this form is in the Death Packet). The original will be maintained in the medical record. Relate to the coroner if:
      - Death occurs as the result of violence or there are external signs of violence that raises questions as to the cause of death. This includes suicide.
      - Unexpected death
      - It is suspected that a crime has been committed
      - If the resident is found dead after an unauthorized absence from the facility
   E. Write physician's order (body may be released to the funeral home).
   F. Notify other appropriate individuals.
      1. Director of Nursing
      2. Administrator
      3. Switchboard Operator
      4. Public Safety
      5. Funeral home listed on resident's chart
      6. When calling the funeral home, specify if the resident has a communicable disease and the time of death.
   G. Send the Incident Report Form #1910 to the Risk Management Department. Number 5 of this form must be completed in detail (give a chronological history of current and past medical problems related to the death).

5. PREPARATION OF THE BODY:
   A. Remove all tubes (i.e., IV line, indwelling catheters, G-tube, or J-tube, etc.).
   B. Apply dressings if applicable.
   C. Put on a clean gown.
   D. Change bed linens if needed.
   E. Identify the body by placing completed name tags, one on the wrist and one on the opposite ankle.
   F. Place a red tag on the ankle if the resident had a communicable disease.

6. RELEASE OF THE BODY TO THE FUNERAL HOME: The representative from the funeral home will sign the appropriate slip found in the death packet. The original will go with the funeral home representative. A copy will remain in the medical record.

7. DOCUMENTATION:

A. In case of death, documentation must appear on both Form #1181 and the nurse's discharge notes, stating the disposition of medication and personal belongings. This documentation must include those medications that were returned to the pharmacy.

B. Document the following in Nurse's Notes:
   1. An RN assessment that included any problems leading up to the death of the resident and condition of the resident prior to death (i.e., color, vital signs, absence of chest movement, etc.)
   2. Time of death as determined by physician.
   3. That family or responsible persons was notified.
   4. That appropriate individuals were notified (list by name).
   5. Disposition of medications.
   6. Disposition of personal belongings, clothes radios, TVs, etc.

C. The death certificate will be completed by the unit Administrative Assistant and signed by the attending physician. However, if the OD pronounces the resident's death, he is to sign the death certificate.

8. DISPOSITION OF PERSONAL BELONGINGS:
   A. All jewelry, money, and valuables will be removed from the body by the nurse.
   B. The nurse will inventory all personal clothing, appliances, and equipment and complete Form #1181, in duplicate.
   C. If there is a responsible relative or guardian on the unit at the time of death, the nurse will add the jewelry and money on Form #1181 and ask the relative to sign for all the items.
   D. If there is no relative on the unit to receive the jewelry and money those items are to be listed in the Nurses' Notes and taken to Resident's Fund Personnel.
   E. Personnel from Resident Fund will mail these items to a responsible person designated by the Director.
   F. When there is no responsible relative or guardian present at the time of death, the nurse will take the personal clothing and equipment, with the completed Form #1181, to the unit clothing room.
   G. The clothing room worker will write the following statement on Form #1181: "The above items were mailed to (name, address, and date)".
   H. Clothing room worker will sign on the line "signature of person accepting responsibility" and will write their title after the signature.
   I. The clothing room worker will enclose the duplicate copy of Form #1181 with the resident's personal belongings and mail them to the responsible relative by registered mail.
   J. The clothing room worker will return the original copy of Form #1181 to the unit nurse for filing in the medical record.
   K. When the receipt for the registered mail is received, it will be forwarded to the Medical Records Department where it will be attached to Form #1181 in the medical record.

L. When a resident dies and our medical records do not contain the name of a responsible relative or guardian, the nurse will notify the Director and he will make a decision regarding the disposition of the personal belongings. When the clothing room worker has a large appliance or piece of equipment belonging to a resident who has died or is being discharged, the Director will be notified prior to mailing the item. If the responsible relative or guardian of the deceased resident wants to donate the personal belongings or equipment, the nurse or social worker is to write that statement on Form #1181. The statement is to include the date the information was received and the name and address of the relative or guardian donating the item. The nurse or social worker receiving the information is to sign their name and title on the line "signature of person accepting responsibility".

Director of Nursing		**Date**
Director		**Date**

SALINE COUNTY CORONER---WILL BEARDEN

Mailing Address: 200 N. Main , Room 116 Benton, AR 72015	501-317-2544—Cell Phone 501-315-2339—Home number 501-303-5611—fax number

Record of Death

Call Date: ___/___/___ Time:_____ Who Reported:_____

Name of Deceased	
Physical Address	
Incident Occurred At	

Age		Race		Sex		Date of Birth	

SSN		Phone	

Deceased's Primary Doctor		Address	

Time of Death		Witnessed by	
Found Where		By Whom	
Identified By		Relation	

Exam		Time Pronounced		Date	

Pronounced by		Title	

Death Certificate to be signed by	

Title		Date	

Cause of Death	

NAME ALL CURRENT MEDICATIONS

Revised April 2011

ARKANSAS HEALTH CENTER

CONSENT TO AUTOPSY

1. I hereby authorize the physicians on the staff of Arkansas Health Center and or such person or persons as they may designate, to perform an autopsy on the body name above, being the body of my _____.
(Relationship to deceased)

I authorize them also to have present at the autopsy such person or persons as they may deem proper.

2. I know of no surviving spouse of the deceased and of no closer kin than I available to assume the custody of this body and to provide for the disposal of it.
NOTE: The above paragraph (#2) should be marked out if form is signed by surviving spouse.
3. The autopsy here authorized may be either a complete autopsy or a partial autopsy with the retention of such tissues as may be necessary for study subsequent to the autopsy as, in the judgment of the physician by whom it is performed, may be necessary to accomplish its purpose.
4. After completion of the autopsy this body is to be released to:

_____ MORTURARY

_____ ADDRESS

_____ SIGNATURE OF RELATIVE GRANTING PERMISSION

_____ SIGNATURE OF DOCTOR WITNESSING SIGNING

_____ ADDRESS

_____ TITLE

_____ DATE

_____ DATE

COMPLETE THE FOLLOWING IF PERMISSION RECEIVED BY TELEPHONE:

_____ SIGNATURE OF DOCTOR OBTAINING PERMISSION

_____ SIGNATURE OF PERSON MONITORING CALL

_____ NAME OF RELATIVE WHO GAVE PERMISSION

_____ TITLE

_____ ADDRESS OF RELATIVE

_____ DATE

_____ RELATION TO DECEASED

AUTOPSY REPORT

Autopsy Performed By: _____ M.D.

On _____ AUTOPSY NO. _____
MONTH DAY YEAR

COMPLETE IN DUPLICATE

CONSENT TO AUTOPSY
FORM NO. 1165 (REV 8/95)

SALINE COUNTY CORONERS OFFICE
108 WEST NARROWAY STREET
BENTON, ARKANSAS 72015

OFFICE 778-2544
HOME 315-2339
FAX 778-5827

WILL BEARDEN- CORONER

I/WE _____ FAMILY OF _____

DO NOT GIVE AUTHORIZATION FOR AN AUTOPSY TO BE PERFORMED ON

THE ABOVE NAME DECEASED.

SIGNATURE:_____

RELATION:_____

DATE:_____

BODY RELEASE CONSENT

I, _____, representative of _____

Funeral Home, accept the body of _____

From the Arkansas Health Center Nursing Home.

Cc: Funeral home

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Nursing	Obtaining an Autopsy	NS 117

1. PURPOSE: It is the purpose of this policy to insure proper preparation of a body when an Autopsy is to be performed.

2. SCOPE: All Nursing Staff.

3. POLICY: An autopsy will be performed only when requested by the family, coroner, or Office of Chief Council.

4. PROCEDURE:
   A. The staff of this facility will not bring up the subject of any autopsy with the family unless the physician has specifically requested this to be done.
   B. If a family requests an autopsy to be done, they must understand it would be done at their expense and they would have to make arrangements to have the autopsy performed.
   C. If a resident dies under unusual or suspicious circumstances, then the coroner will direct the investigation as to the cause of death.
   D. If an autopsy is requested by the family, coroner or Chief Council, the following may give legal permission.
      1. Surviving spouse
      2. Children (all must consent)
      3. Parents
      4. Siblings (all must consent)
      5. Guardian
         - The closest relative will sign the authorization and this signature must be witnessed.
   E. Permission for autopsy may be obtained by telephone if the call is monitored. When permission is obtained by telephone, the lower portion of "Consent to Autopsy", Form #1165, must be signed by the physician obtaining the permission and the person monitoring the call. The physician will make arrangements for the autopsy to be performed. Telegraphic authorization is permissible and if done, the original telegram should be obtained and attached to this form.
   F. The duplicate copy of Form #1165 will be filed immediately in the resident's medical record. The original copy will be attached to the front of the medical chart and accompany the body to UAMS. The UAMS will keep the original form for their records. It is not necessary for the section of the form titled "Autopsy Report" to be completed in duplicate copy.
   G. Preparation of the body for autopsy;
      1. Do not remove any tubes that have been inserted into the body.
      2. Do not wash the body.
   H. Cover the body, draw the curtain, and close the door to the room (if in a private room).
   I. Document in the Nurses' Notes that an autopsy has been requested, all external tubings have been clamped and left in place, and that consent was obtained, from whom and by whom.

_____ AHC Director

_____ Date

Revision Date: March, 2010
Effective Date: March, 1999

Death and Dying

I. What does the term Death and Dying mean? All living beings experience death at some point in their life. To die is to complete the circle of life. When we are born, we are all born terminal and thus start the circle of life and inch our way toward death. Each person has a different life span depending on the way they choose to live their life, and some people are genetically different which shortens their life span, even though they make different choices and live a healthier life style. At any rate, we cannot escape death, but we can help to prepare ourselves when death occurs around us.

II. It is important to know that in the nursing field, we deal with death and dying on a daily bases. We gravitate toward the nursing field because we are natural caregivers and have some degree of compassion on those who require our help in order to sustain their life. It is absolutely natural to experience grief when we lose a resident or a family member. The grief process will carry us through various stages and in the end, will eventually lead to acceptance, however, what are we to do until we are acceptant of death? 1. Once we know that our loved on (be it family or resident) is critically ill, we can talk to them, and find out how they are feeling so that we will know how to care for them should they become unresponsive or unable to communicate with us. 2. We can take extra precautions not to cause them any further harm, such as to go slower when providing care so that we don't bruise them. We can take extra time to ensure that they eat their meals, and that they get all of the nutrition that they possibly can. 3. Involve the family, make the contact to encourage them to come visit. This will enrich their lives and help them go through the grieving process as well. 4. Know your limitations. Sometimes we as care givers, get to close to our residents and we become bitter at the nurses or the Physicians because we don't feel that they are doing enough to help the resident even though in reality they are doing exactly whet the resident has wished for. 5. If you feel that you are too close to a resident and they become critically ill, ask to be moved to another unit for a while until the resident has expired. It is ok to give yourself permission to grieve. Death is very sad, and we are hard wired to become sad at a death, but knowing that you helped fulfill the last wish of the resident, and that you took the extra effort to provide care for the resident, then you have every right to hold your head up and fell good about the role you have played in their life.

III. Allow your resident to die with dignity. Always provide privacy while providing care. Always talk to your resident when you are in the room or providing care and explain to them what you are about to do, even if they are in an unconscious state. Don't allow your residents skin to break down! Turn them at least every two hours, make sure their skin is clean (especially after pericare is given), lotion their skin often and report any change to the nurse no matter how slight it may be. Don't allow your resident to lie in bed all day in a hospital gown. Put their clothes on them and fix their hair as they normally would if they could. Make sure they are not left alone for extended periods of time (remember death may be scary for them also). Provide privacy for the resident and their families. Respect their time together, and try to meet any

request that they may have, such as a chair to sit in or offering them a cup of coffee. Ideally, these residents should be provided with a private room and if that is not possible, then placed in a room with a quiet roommate and without a lot of traffic.

IV. Allow your resident to die with respect. If your resident is "comfort care" then this is the decision that they have made and agreed upon by two-Physicians. It is not your decision to make nor is it your decision to go against their wishes. It is however appropriate to provide the best care you possibly can to your resident for the remaining time they have left. Never discuss their living will with the family or your co-workers. It is the responsibility of the Social Worker along with the Physician and unit RN to activate the resident's living will. Someone with a DNR (Do Not Resuscitate) does not mean Do Not Treat. You will always include them in all unit activities; you will always assess any change of condition and notify the physician as per AHC policy. You will always provide ADL care and maintain a normal routine just as before.

In Conclusion. There is a time to laugh and a time to cry. There is a time to live and a time to die. When death comes knocking at our door, we need to be prepared to answer it. It is the worst part of our job but a real part of our job and how we deal with it defines who we are as care providers. As professionals we are to provide care to the best of our ability and give our residents the dignity and respect that they deserve during the last stage of their life. If you are affected by a death to the point that you can't function in a professional manner, then you need to talk with your supervisor and work through them. Just as we set a standard of providing a quality of life for our residents, we also set a standard of the quality of death for our residents.

Arkansas Health Center Nursing Home
Personal Belongings of Resident
Up-Date Record

NAME PLATE

Article / Item	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE
	Number	Number	Number	Number	Number	Number	Number	Number
Bathrobe								
Belts								
Blouse								
Brassieres								
Coat								
Dusters								
Dresses								
Gloves-Mitts								
Handkerchief								
Hat								
Housecoat								
Jacket								
Pajamas								
Panties/Underwear								
Pants/Slacks								
Pant Suit								
Panty Hose								
Scarf								
Shirt								
Shoes								
Shorts								
Skirts								
Slippers								
Socks								
Sweat Suit								
Sweaters								
Undershirt/T-Shirt								

****Please document description of items on reverse side*****

Be sure to have family sign off on back of page when patient is discharged as receiving personal items.

FORM #1005-A

I certify by my signature below that I accept responsibility for the personal belongings.

Signature of Resident

Signature of Responsible Person

Date

Date

FORM #1005-A

DISCHARGE FROM THE FACILITY CHECK LIST

1. Obtain and write discharge orders
   Example: 1. Discharge to Greenbrier Nursing Home with all medications
   2. Discharge to son, John Black, with all medications
2. Inventory all personal belongings and place on the inventory record #1005-A
3. Pack belongings appropriately for transport
4. List all medications in nurses notes and have family or facility (whom ever is transporting) co-sign in the nurses they are picking up the resident and medications
5. If Narcotics are ordered to be sent with discharging resident, a licensed nurse MUST accompany the resident if AHC is transporting to new location
6. Obtain a full body audit
7. Copy MAR's, TAR's, Physician Orders to send
8. Notify appropriate administration of resident discharge

EMERGENCY DRUG BOX PROCEDURES

Purpose: To insure availability of medication in an emergency situation.

Procedure:

1. An emergency medication box will be provided and must be placed in the medication room of each unit.
2. The contents of the box will be determined by the Pharmaceutical Services committee which consists of a Medical Director, Director of Nurses and the Consultant Pharmacist. A listing of the contents will be on file with the appropriate signatures in the Pharmacy Policy and Procedure Manual and in the medication room housing the emergency medication box.
3. Evaluation of the contents will be done on an annual basis and as needed
4. A listing of the contents of the emergency medication box will be posted on the outside of the box.
5. When a medication is needed from the box:
    a. The RED tag should be cut and removed
    b. The medication needed should be removed and administered
    c. Remove the ER Box usage-charge slip
    d. Fill out all information (even if borrowing from another unit)
    e. Fax a copy of the charge slip to the pharmacy to request a new box and put a copy in the top of the ER Box
    f. Secure box with yellow tag
6. IF controlled substances are on the emergency medication list, the pharmacy will supply the controlled drugs in a small, plastic box. The facility will maintain an inventory and use log for the emergency box controlled substances in the same manner that eh facility currently stores, inventories and uses controlled substances. The nurse must notify the pharmacy about the use of these controlled substances so that the pharmacy can replace them when used. The pharmacy will not automatically exchange the controlled substances weekly.
7. The pharmacy must bill for any items used from the emergency drug box or the controlled substances box. Failure to complete the charge slip for any item will result in a memo sent to the Director of Nurses inquiring about the use. The facility will be billed for any items not accounted for.
8. See Attached ER box usage slip

ER-BOX USAGE - CHARGE SLIP

Facility _____ Date _____

Patient Name _____

Medication _____ Strength _____ Number of Doses Removed _____

Nurse Signature _____

Please complete, retain one copy in facility and send other copy to Allcare.

Arkansas Health Center
Box "I"

THE FOLLOWING IS A LIST OF MEDICATIONS TO BE KEPT IN THE EMERGENCY MEDICATION BOX. THIS EMERGENCY BOX IS TO BE MAINTAINED ON A FLOATING INVENTORY. THE MAXIMUM QUANTITY IS LISTED.

CLASSIFICATION	QTY	SIZE	MEDICATION	STRENGTH	LOCATION
Antibiotic (Oral)	5	Capsule	Cephalexin (Keflex)	500mg	Bottom
	5	Tablet	Ciprofloxacin (Cipro)	500mg	Bottom
	5	Tablet	Levaquin	500mg	Bottom
	5	Tablet	Sulfa/Trimeth DS (Bactrim/Septra)	800/160mg	Bottom
	5	Tablet	Azithromycin (Zithromax)	250mg	Bottom
Antibiotic (Injectable)	1	2ml	Gentamicin	40mg/ml	Bottom
	1	Vial	Ceftriaxone (Rocephin)	1 gram	Bottom
	1	Vial	Cefepime (Maxipime)	1 gram	Bottom
	2	10ml	Lidocaine	1%	Bottom
IV Flushes	3	5ml	Heparin syringe	100u/ml	Bottom
	3	10ml	Sodium Chloride syringe	0.9%	Bottom
Antihistamine (Injectable)	4	1ml	Diphenhydramine	50mg/ml	Bottom
	4	1ml	Promethazine	25mg/ml	Bottom
Antinauseants	4	2ml	Ondansetron (Zofran)	2mg/ml	Bottom
	4	Tablet	Promethazine	25mg	Bottom
	4	Suppository	Promethazine	25mg	Refrigerator
Antipsychotic (Injectable)	4	1ml	Haloperidol	5mg/ml	Bottom
	4	2ml	Chlorpromazine	50mg/2ml	Bottom
	2	10ml	Sterile Water for Injection		Bottom
Steroid (Injectable)	2	1ml	Methylprednisolone (Depo-Medrol)	80mg/ml	Bottom
Cardiac Life Support	2	1ml	Atropine	0.4mg/ml	Bottom
	2	2ml	Digoxin	0.25mg/ml	Bottom
	2	1ml	Epinephrine	1:1000	Bottom
	6	2ml	Furosemide	10mg/ml	Bottom
pertensive Crisis Meds	8	Tablet	Clonidine	0.1mg	Bottom
	1	Bottle of 25	Nitroglycerin	0.4mg	Bottom
Coagulant	1	1ml	Vitamin K	10mg/ml	Bottom
Anticoagulant	3	Tablet	Warfarin (Coumadin)	2mg	Bottom
Hypoglycemics	2	50ml	Dextrose 50%	25gm/50ml	Top
	1	Box	Glucagon	1mg	Top
	2	Tube	Glutose 15	37.5gm	Bottom
Large Volume Parenteral	2	1000ml	Sodium Chloride	0.45%	Top
	2	1000ml	Sodium Chloride	0.9%	Top
	2	1000ml	Dextrose/Sodium Chloride	5%/0.45%	Bottom
Poison Control	2	60ml	Sodium Polystyrene (Kayexelate)	15gm/60ml	Top
	2	1ml	Naloxone	0.4mg/ml	Bottom
Respiratory Distress	5	3ml	Albuterol updraft	0.083%	Top

Narcotic Box "E"

CONTROLLED SUBSTANCES (LOCKED IN A LOCK BOX AND COUNTED EVERY SHIFT)

algesics	6	Tablet	Hydrocodone/APAP	5/325	Narcotic Box
	6	Tablet	Hydrocodone/APAP	10/325	Narcotic Box
	6	Tablet	Tramadol	50mg	Narcotic Box
Analgesic (Schedule 2)	1	1ml	Morphine	10mg/ml	Narcotic Box
Anxiolytic	4	Tablet	Lorazepam	0.5mg	Narcotic Box
Seizure Control	2	1cc	Lorazepam	2mg/cc	Refrigerator
Antidiarrheal	10	Tablet	Diphenoxylate/Atropine	2.5/0.025	Narcotic Box

I APPROVE OF THE ABOVE LIST OF CONTENTS:

Medical Director: _____ Date: 3/22/11

Pharmacy: _____ Date: _____

Allcare

THE PROVEN PROVIDER OFFERING REAL SOLUTIONS

March 14, 2011

Enclosed you will find a new emergency box list for your medical director to sign.

Due to all propoxyphene products being pulled from the market and a new FDA request regarding acetaminophen strengths, the narcotic boxes have been altered. I have included the press release from the FDA if your medical director has any questions about the acetaminophen changes.

Please have it signed as soon as possible and faxed to the pharmacy at 877-420-9410 by March 24, 2011.

Thank you!

Kelly Dickey

Kelly,

We are in the process of changing our analgesic injection from Meperidine to morphine. I will be in touch with further details

Faxback Confirmation

[illegible]firmation of the fax received [illegible]

[illegible]

[illegible] the attached pages [illegible]

[illegible] Pharmacy

Date & Time: 2011-03-23 03:12:3[illegible]

Sender: 5018600802
Pages: 2
Quality: Normal
Call Duration: 0:01:15
Caller ID1: 5018600802
Caller ID2: AR HEALTH CENTE
File: fax001336241.tif

Allcare
THE PROVEN PROVIDER OFFERING REAL SOLUTIONS

March 14, 2011

Enclosed you will find a new emergency box list for your medical director to sign.

Due to all propoxyphene products being pulled from the market and a new FDA request regarding acetaminophen strengths, the narcotic boxes have been altered. I have included the press release from the FDA if your medical director has any questions about the acetaminophen changes.

Please have it signed as soon as possible and faxed to the pharmacy at 877-420-9410 by March 24, 2011.

Thank you!

Kelly Dickey

Kelly,
We are in the process [illegible] our analgesic injection [illegible] to morphine I will be in [illegible] further details
[signature]

Arkansas Health Center
Box "I"

THE FOLLOWING IS A LIST OF MEDICATIONS TO BE KEPT IN THE EMERGENCY MEDICATION BOX. THE EMERGENCY BOX IS TO BE MAINTAINED ON A FLOATING INVENTORY. THE MAXIMUM QUANTITY IS LISTED.

CLASSIFICATION	QTY	SIZE	MEDICATION	STRENGTH	LOCATION
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	5	Tablet	Ciprofloxacin (Cipro)	500mg	Bottom
	5	Tablet	Levaquin	500mg	Bottom
	5	Tablet	Sulfa/Trimeth DS (Bactrim/Septra)	800/160mg	Bottom
	5	Tablet	Azithromycin (Zithromax)	250mg	Bottom
Antibiotic (Injectable)	1	2ml	Gentamicin	40mg/ml	Bottom
	1	Vial	Ceftriaxone (Rocephin)	1 gram	Bottom
	1	Vial	[illegible]	1 gram	Bottom
	2	[illegible]	Lidocaine	1%	Bottom
IV Flushes	5	5ml	Heparin syringe	100u/ml	Bottom
	5	10ml	Sodium Chloride syringe	0.9%	Bottom
Antihistamine (Injectable)	4	1ml	Diphenhydramine	50mg/ml	Bottom
	4	1ml	Promethazine	25mg/ml	Bottom
Antiemetics	4	2ml	Ondansetron (Zofran)	2mg/ml	Bottom
	4	Tablet	Promethazine	25mg	Bottom
	4	Suppository	Promethazine	25mg	Refrigerator
Antipsychotic (Injectable)	4	1ml	Haloperidol	5mg/ml	Bottom
	4	2ml	Chlorpromazine	[illegible]/2ml	Bottom
	2	10ml	Sterile Water for Injection		Bottom
Steroid (Injectable)	2	1ml	Methylprednisolone (Depo-Medrol)	80mg/ml	Bottom
Cardiac Life Support	2	1ml	Atropine	0.4mg/ml	Bottom
	2	2ml	Digoxin	0.25mg/ml	Bottom
	2	1ml	Epinephrine	1:1000	Bottom
	2	2ml	Furosemide	10mg/ml	Bottom
Hypertensive Crisis Meds	8	Tablet	Clonidine	0.1mg	Bottom
		Bottle of 25	Nitroglycerin	0.4mg	Bottom
Coagulant	1	1ml	Vitamin K	10mg/ml	Bottom
Anticoagulant	3	Tablet	Warfarin (Coumadin)	1mg	Bottom
[illegible]	2	[illegible]	Dextrose 50%	25gm/50ml	Top
	1	Box	Glucagon	1mg	Top
	2	Tube	Glutose 15	15gm	Bottom
[illegible] Replacement	2	1000ml	Sodium Chloride	0.45%	Top
	4	1000ml	Sodium Chloride	0.9%	Top
	2	1000ml	Dextrose/Sodium Chloride	5%/0.45%	Bottom
Poison Control	[illegible]	60ml	Sodium Polystyrene (Kayexalate)	15gm/60ml	Top
	2	1ml	Naloxone	0.4mg/ml	Bottom
Respiratory Distress	5	3ml	Albuterol [illegible]	0.083%	Top

Narcotic Box "E"

CONTROLLED SUBSTANCES (LOCKED IN A LOCK BOX AND COUNTED EVERY SHIFT)

Analgesic	5	Tablet	Hydrocodone/APAP	5/325	Narcotic Box
	6	Tablet	Hydrocodone/APAP	[illegible]	Narcotic Box
	6	Tablet	Tramadol	50mg	Narcotic Box
Analgesic Schedule II		1ml	Morphine	10mg/ml	Narcotic Box
Anxiolytic	4	Tablet	Lorazepam	0.5mg	Narcotic Box
Seizure Control	2	1cc	Lorazepam	2mg/ml	Refrigerator
Antidiarrheal	[illegible]	Tablet	Diphenoxylate atropine	2.5/0.025	Narcotic Box

I APPROVE OF THE ABOVE LISTED CONTENTS:

Director *[signature]* Date *3/23/11*

[illegible] Date

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For Immediate Release: January 13, 2011

Media Inquiries: Shelly Burgess, 301-796-4651; shelly.burgess@fda.hhs.gov

Consumer Inquiries: 888-INFO-FDA

FDA limits acetaminophen in prescription combination products; requires liver toxicity warnings

Agency strategy caps maximum at 325 milligrams to reduce risk of liver toxicity

The U.S. Food and Drug Administration is asking manufacturers of prescription combination products that contain acetaminophen to limit the amount of acetaminophen to no more than 325 milligrams (mg) in each tablet or capsule.

The FDA also is requiring manufacturers to update labels of all prescription combination acetaminophen products to warn of the potential risk for severe liver injury.

Acetaminophen, also called APAP, is a drug that relieves pain and fever and can be found in both prescription and over-the-counter (OTC) products. It is combined in many prescription products with other ingredients, usually opioids such as codeine (Tylenol with Codeine), oxycodone (Percocet), and hydrocodone (Vicodin). OTC acetaminophen products are not affected by today's action.

"FDA is taking this action to make prescription combination pain medications containing acetaminophen safer for patients to use," said Sandra Kweder, M.D., deputy director of the Office of New Drugs in FDA's Center for Drug Evaluation and Research (CDER). "Overdose from prescription combination products containing acetaminophen account for nearly half of all cases of acetaminophen-related liver failure in the United States; many of which result in liver transplant or death."

The elimination of higher-dose prescription combination acetaminophen products will be phased in over three years and should not create a shortage of pain medication. Patients and health care professionals are being notified of the new limitation on acetaminophen content, and of the labeling change, in a drug safety communication issued by CDER. The FDA believes that prescription combination products containing no more than 325 mg of acetaminophen per tablet are effective for treating pain.

"There is no immediate danger to patients who take these combination pain medications and they should continue to take them as directed by their health care provider," said Kweder. "The risk of liver injury primarily occurs when patients take multiple products containing acetaminophen at one time and exceed the current maximum dose of 4,000 milligrams within a 24-hour period."

Acetaminophen is also widely used as an over-the-counter pain and fever medication, and is combined with other OTC ingredients, such as cough and cold ingredients. The actions FDA is taking for prescription acetaminophen products do not affect OTC acetaminophen products.

Because of continued reports of liver injury, FDA proposes that boxed warnings, the agency's strongest warning for prescription drugs, be added to all acetaminophen prescription products. Most of the cases of severe liver injury occurred in patients who took more than the prescribed dose of an acetaminophen-containing product in a 24-hour period, took more than one acetaminophen-containing product at the same time, or drank alcohol while taking acetaminophen products.

An FDA advisory committee discussed the issue at a meeting in June, 2009, and recommended strengthening the warning about severe liver injury on the drug labels of prescription products containing acetaminophen.

For more information and a list of affected products, please visit: www.fda.gov/acetaminophen

CONTROLLED SUBSTANCE LOG

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded as an all-inclusive list

1. All controlled substances should be recorded on the front hard cover or "Page Index". This creates a tracking system so that in the event a page is missing from the controlled substance book, we will be able to identify the medication and the resident the medication was prescribed for. It is the responsibility of the nurse who entered the controlled substance into the log to transcribe this information to the Page Index. This should be reviewed as part of the start-up routine and any areas of concern addressed immediately.
2. Nurses are required to sign the controlled substance log to verify the count is correct. Each shift, the on-coming nurse, and the off-going nurse count eh controlled substances and sign the log to signify the count is correct. There can be no blanks. Review the signature page as part of the star-up routine and address any areas of concern immediately.
3. On a random basis conduct a controlled substance count with the nurse. Does the nurse know how to count correctly? Does the nurse verbalize the name of the resident, name and strength of the drug and the quantity? Does the nurse check the back of the blister pack to ensure medications have not been taped? Does the nurse review the page AND verify the count by looking at the blister pack?
4. All controlled substances are to be stored behind double locks. Is the narcotic box locked? Is the medication cart kept locked when out of sight of the nurse?
5. The controlled substance log is to be carried with the nurse on the medication cart at all times during medication pass. The controlled substance count MUST be accurate at all times!!! Is the nurse signing the medication out from the controlled substance log immediately upon removing the medication from the blister pack? Randomly audit this by checking the controlled substance book while the nurse is on the medication pass. Address any concern immediately.
6. Randomly review pages of the controlled substance book as part of the start-up routine. Is the correct prescription number written on the page? If the order says give (1) every four hours---are the nurses signing out only one pill and at least four hours apart? If the order says "give (1) BID" ---has the medication been administered and signed out twice each day or where there any omitted doses? Address any areas of concern
7. The controlled substance count cannot be corrected without authorization from the Director of Nursing/Designee. In the even the count is off, the DON/Designee MUST be notified.

Policy Type	Subject of Policy	Policy No.
Nursing	Controlled Substance Accountability	NS 429

1. **PURPOSE:** The Purpose of this policy is to establish procedures for maintaining accountability of controlled substances in accordance with state and federal regulations.

2. **SCOPE:** All Licensed Nurses

3. **POLICY:** It is the policy of Arkansas Health Center that medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are accounted for in accordance with federal and state laws and regulations.

4. **PROCEDURE:**
   1. A record shall be maintained in a bound ledger book with consecutively numbered pages of all controlled medications procured and administered. This record shall contain the following information for each controlled substance:
      - Resident's name
      - Name, strength and quantity of drug received
      - Date received
      - Prescribing physician
      - Name of pharmacy
      - Date and time of each dosage given
      - Quantity of drug remaining
      - Signature of person administering the medication
   2. All controlled substances will be recorded on the front hard cover of "Page Index" of the controlled substance book. This creates a tracking system so that in the event a page is missing from the book, the facility will be able to identify the medication and the resident the medication was prescribed. It is the responsibility of the nurse who entered the medication into the controlled substance book to transcribe this information to the "Page Index".
   3. The medication nurse will be responsible for and accountable for the controlled medications during the shift.
   4. The controlled substance book will be carried on the medication cart during medication administration pass. Nurses are required to sign the controlled substance book immediately upon removing a medication from the controlled substance box. The controlled substance count should be accurate at all times.
   5. In the event, a resident refuses the medication or the medication is dropped on the floor, etc. The medication will be wasted in the presence of two (2) licensed nurses who will document the wasting of the medication in the appropriate locations.
   6. Controlled substances are to be checked and counted during shift change or anytime the medication nurse turns the key to the controlled substances over to another licensed nurse. The off-going nurse and the on-coming nurse will count every controlled substance medication as outlined:

a. Nurse #1, beginning with the first controlled substance listed in the controlled substance book, will read out-loud the following information:
   - Name of Resident
   - Name of Medication
   - Strength of Medication
   - Quantity remaining

b. Nurse #2 will read the controlled substance page along with nurse #1.

c. Nurse #1 will read out loud from the medication bingo/blister card.
   - Name of Resident
   - Name of Medication
   - Strength of Medication
   - Quantity remaining in medication bingo/blister card

d. Nurse #2 will read the label of the medication bingo/blister card along with nurse #1.

e. If the quantity is correct, both nurses will check the back of every blister/bubble card to insure medications have not been taped or tampered with.

f. Proceed with this process until all controlled substances have been accounted for.

7. Both nurses will sign the controlled substance log verifying the count is correct. Once the on-coming nurse accepts the keys to the controlled substances and signs that the count is correct, that nurse assumes responsibility and accountability for the medications.

8. The following steps will be utilized for use of tape on controlled medications.
   a. This facility utilizes the bingo/blister card for handling all oral controlled medications.
   b. As there is no way to know if the removal of the medication was an act of tampering or if the removal of medication was inadvertent, each taped dose of controlled medication will be treated as if it were a case of tampering.
   c. Each nurse that signs the controlled substance book verifying count is responsible to be sure that no taped controlled medication is accepted. All taped controlled medications will be the responsibility of the nurse who accepted the count.
   d. All taped controlled medications will be reported to the Director of Nursing/Designee, Pharmacy Consultant, and the Arkansas State Department of Health-Pharmacy Division.

9. If there is a discrepancy in the count, the following steps are to be taken:
   a. The off-going nurse may not leave until a urine drug screen has been obtained and approval from the RN/DON/ADON has been received to allow them to leave.
   b. The on-coming nurse does not accept the keys until the issue is resolved.
   c. If the problem cannot be resolved, the RN on duty is to be notified of the discrepancy. The RN on Duty will investigate the situation and notify the Director of Nursing/Designee.
   d. A Medication incident report and a 1910 will be completed for the missing controlled substance.

10. The controlled substance count cannot be corrected without authorization from the Director of Nursing/Designee.
11. In the event of a suspected loss, theft, or diversion of a controlled substance, notification and investigation will be initiated by the Director of Nursing/Designee and the following steps will be taken:
    a. Obtain UDS from nurses who had access to the missing controlled substance upon discovery
    b. The control loss report will be completed by the ADON and faxed to the Arkansas Department of Health, Pharmacy Division.
    c. Ensure completion of medication variance/1910 paperwork and appropriate notifications including Pharmacy consultant.

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

Revised July 2004
Revision March 2010

DURAGESIC PATCH PROCEDURE

1. 2 NURSES MUST BE PRESENT WHEN APPLYING A DURAGESIC PATCH.
2. THE PATCH MUST INCLUDE THE DATE, TIME AND INITIALS ON IT AND IT MUST BE SECURED INTO PLACE WITH TAPE
3. PATCH PLACEMENT MUST BE CHECKED BY 2 NURSES (oncoming and off going nurses) EVERY SHIFT AND INITIALED OFF ON THE MAR BY 2 NURSES.
4. A NOTE MUST BE WRITTEN IN THE NURSES NOTES REFLECTING PLACEMENT OF THE PATCH EVERY SHIFT.
5. WHEN A PATCH IS TO BE CHANGED, 2 NURSES MUST BE PRESENT TO WITNESS REMOVAL OF THE OLD ONE AND APPLICATION OF THE NEW ONE.
6. 2 NURSES MUST WASTE THE OLD PATCH AND BOTH NURSES MUST SIGN THE NARCOTIC BOOK.

Arkansas Health Center

Emergency Preparedness &
Fire Safety Plan
Presented by Nursing Education

Fire Emergency

- *Report of a "Fire" Emergency:*
- If lives are in danger, remove those endangered to a place of safety first, then report the fire. Any person discovering or suspecting a fire shall immediately trip the nearest ***Fire Alarm Box- place the key in the keyway and turn ½ turn, open box.*** The alarm will be activated and sound. When the alarm system activates, immediately dial **860-0503** for the switchboard operator notification.

Fire Evacuation Plan

- When the alarm sounded, the unit or area in which the fire is located shall be partially or totally evacuated immediately as condition warrant. The decision to evacuate will be the responsibility of the nurse in charge. All other units will be in an alert status, and prepare to evacuated if the need arises. In the event of an alarm during the night or inclement weather, the resident will be covered with sheets and blankets to prevent exposure. DO NOT WASTE TIME DRESSING THE RESIDENT.

Fire Evacuation Plan cont.

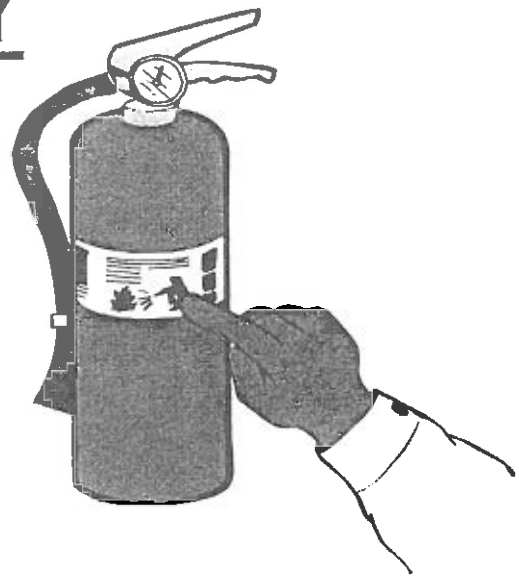
- Fire evacuation plan is done by unit specific: The proper procedure for resident removal in the event of evacuation is-
- 1st. The residents in the immediate danger.
- 2nd. Ambulatory residents
- 3rd. Resident's in wheelchairs.
- 4rd. Resident who are bedfast.
- Close all doors and windows when leaving the area. Place a pillow in front of the closed door so another person will not waste time going back in the room or area.

Fire Plan/ Code Red

- **Fire Plan/ Code Red**
- **RACE**
- **R- Rescue**
- **A- Alert/Alarm**
- **C- Confine**
- **E- Extinguish/Evacuate**
- **Sound the alarm: Removing the residents in immediate danger.**
- Call operator @ **860-0503** informing them:
  - Where fires is located on the unit, etc.
  - If you are evacuating.
- Take at least one fire extinguisher to the fire.
- Remove residents closest to the fire.
- (Do not take residents past the fire)
- As you clear the room, close door and place a pillow in front of the door. (informing staff that the room has been cleared)
- Remove fire book and informational binders for the unit.
- After all residents are in main hallway, take them as far from fire as possible. (Direct Care Staff is never to leave a group of resident's unattended)

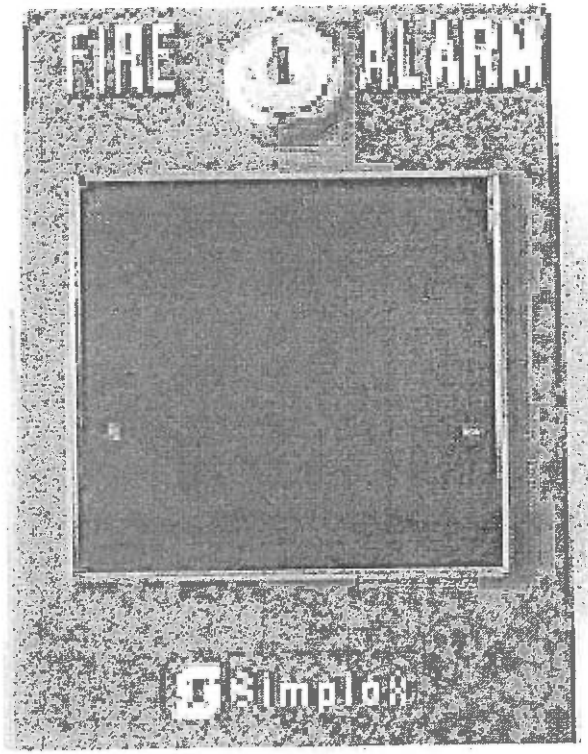
Fire Extinguisher Safety

- <u>FIRE EXTINGUISHER SAFETY</u>
- Pull
- Aim
- Squeeze
- Sweep



(Direct Discharge At Base Of Flame)

ENUNCIATOR PANEL/KEY STATION



Fire Evacuation Plan cont.

- As a general rule and depending on where the fire is located, residents behind the fire doors will be evacuated out the rear exits. RN supervisors or Unit Supervisors on duty will be responsible for getting the Fire Books before leaving the unit. All residents, visitors and employees must be accounted for. No-One is to re-enter the area until the fire officer or public safety officer in charge has given the “all clear”

Dietary Service Disaster Plan

- Purpose: To provide adequate meals to in-house patients according to individual needs as near as possible, and to those emergency victims housed at this facility.
- If the emergency effect the electrical power, covered disposal containers and flat wear will be used.
- If increased staff is needed, off duty employees will be contacted.

Bomb Threats

- Purpose: To establish an effective procedure to follow in critical situations involving bomb threats of bomb discoveries. **(See Bomb Threat Checklist)**
- Receiving the bomb threat: The employee should attempt to obtain information asked for on the "bomb threat checklist" by keeping the caller on the line as long as possible and noting any other information obtainable. The employee should immediately notify the Public Safety Officer Supervisor on duty at the time of the call. Public Safety will conduct an interview with the receiver of the call and immediately safety precautions practicable at the time will be taken.

Bomb Threat Responses

- After a call is made to the Office of Emergency Services or Saline County Sheriff's Department, pre-designated search team will be established and respond when the decision to search is made by the Director or Designee.
- Plan of action to be taken in the event of a bomb threat:
- Notifying Public Safety immediately by calling the Switch board operator @ 860-0500.

Chemical Emergency

- AHC is almost totally dependent no the Saline County Office of Emergency Service (OES). We must depend on OES to alert us of any hazard that would affect AHC property, residents and employees will be moved away from the danger that warrants. Employees will follow evacuation routes that have been designated.

Thunder Storm Warning

- Thunderstorm warning can produce straight winds that can exceed 100mph, large hail, deadly lightning and flooding. When AHC switch board is notified of a thunderstorm warning, they will notify all nursing units, maintenance, security, administration, and recreation department.
- Nursing will keep all residents inside the building. Move residents into the hall on their units, cover with blankets, close doors, and take safety precautions deemed necessary to protect the residents. ***"Window areas should be avoided" All doors should be closed and exterior walls should be avoided.***
- ***AHC switchboard shall monitor television/radio for weather bulletins.***

Tornado Warning

- The facility will receive notification of impending severe weather though the various public channels by television, weather radio, scanners, and telephone. The switchboard Operator will monitor broadcasts and in the event severe weather is imminent, proper notification will be made. When a "Warning" is issued the Switchboard operator will immediately notify Public Safety, Nursing Service, Administration, all nursing units, cottages, Birch Program, and the Department of Correction.
- In case of power outages, no telephone services, the operator will use walkie-talkies for on-ground communication and a cellular phone at switchboard for emergency services. After notification of a tornado warning/ tornado, each unit charge nurse and staff should remove all residents from residents rooms, dinning rooms, etc., away from windows and out into the hallway with resident room door closed. Each resident should be provided with a blanket.

Evacuation After A Tornado

- In case that AHC building and grounds have major damage the AHC Director will contact the Department of Correction for inmate help to clear debris for evacuation purposes. The injured will be transported to the nearest hospital.
- Employees shall not allow anybody to smoke in or around the building or parking lot because of the potential for gasoline leaks and explosions Wires should be avoided.

Emergency Water Supply

- In the event that the water supply is shut down or interrupted. The water department will continue to supply all nursing units and other necessary services with water from the elevated water tank and the clear well water tank.
- The facility would retain 49 gallon in reserve as containers are emptied they will be replaced. When a situation occurs that Warrant implementation of the **Emergency Water Provision Plan.** The switchboard will provide notifications for contact persons.
- *Resident care remain priority****

Loss of Natural Gas Emergency

- If fuel supply is interrupted for a long period of time, AHC must fall back on butane backup for Building #80. Residents from building #70 will be transported to building #80 as soon as possible.
- **Electrical Power Loss:**
- AHC depends on a generator for back-up electrical power Maintenance will monitor fuel levels of all generators until the emergency is over.

EARTHQUAKE AWARENESS

PROTECT YOURSELF DURING EARTHQUAKE SHAKING-DROP, COVER, AND HOLD ON:

What should you do during and after earthquakes?

The area near the exterior walls of a building is the most dangerous place to be.

Windows, facades and architectural details are often the first parts of the building to collapse. To stay away from this danger zone, stay inside if you are inside and outside if you are outside.

If you are:

Indoors: DROP, COVER, AND HOLD ON. Drop to the floor, take cover under a sturdy desk or table, and hold on to it firmly. Be prepared to move with it until the shaking stops. If you are not near a desk or table, drop to the floor against the interior wall and protect your head and neck with your arms. Avoid exterior walls, windows, hanging objects, mirrors, tall furniture, large appliances, and kitchen cabinets with heavy objects or glass. Do not go outside!

In Bed: If you are in bed, hold on and stay there, protecting your head with a pillow. You are less likely to be injured staying where you are. Broken glass on the floor has caused injury to those who have rolled to the floor or tried to get to doorways.

In a High-Rise: Drop, cover, and hold on. Avoid windows and other hazards. Do not use elevators. Do not be surprised if sprinkler systems or fire alarms activate.

Outdoors: Move to a clear area if you can safely do so; avoid power lines, trees, signs, buildings, vehicles, and other hazards.

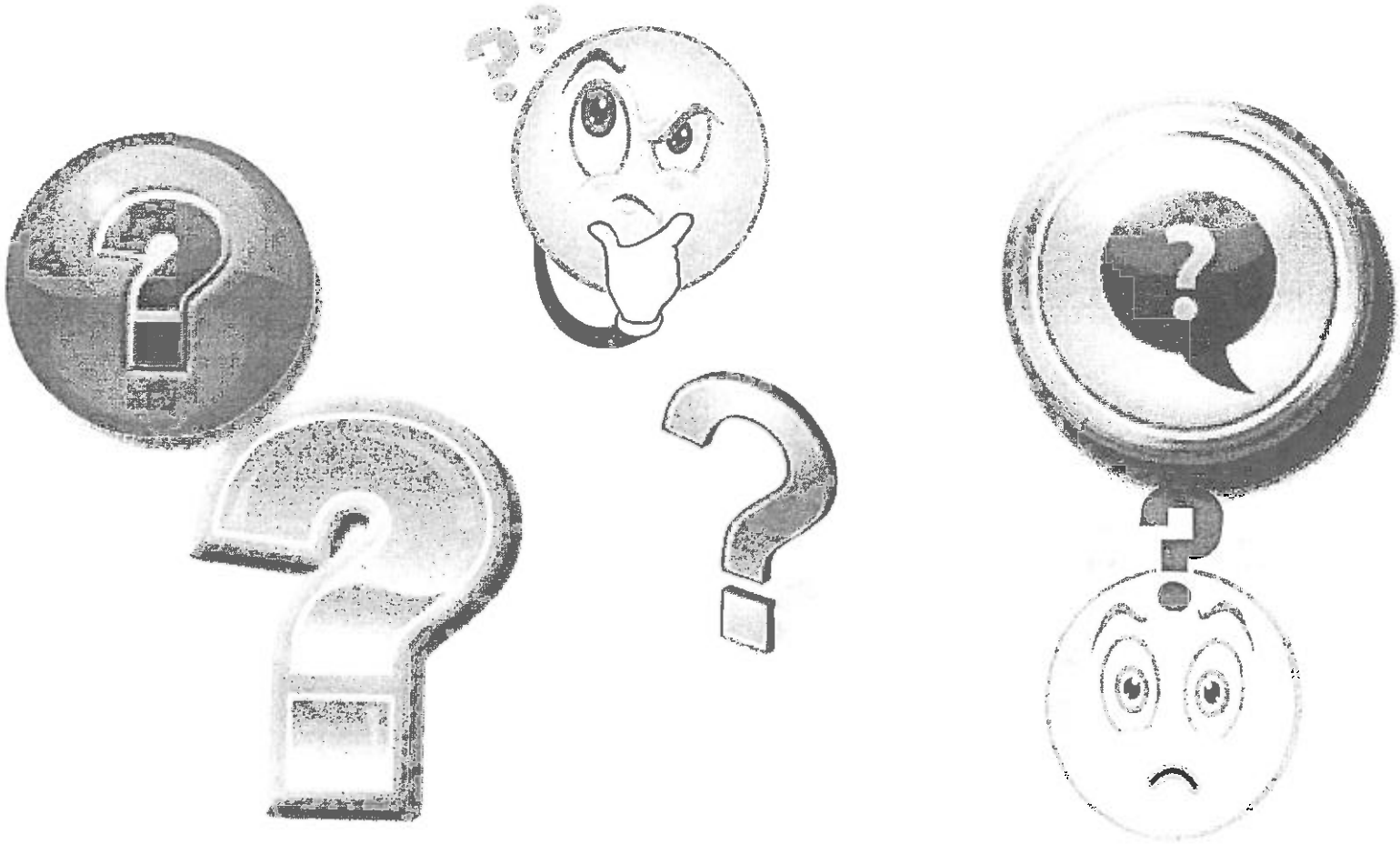
Driving: Pull over to the side of the road, stop, and set the parking brake. Avoid overpasses, bridges, power lines, signs and other hazards. Stay inside the vehicle until the shaking is over. If a power line falls on the car, stay inside until a trained person removes the wire.

In a stadium or theater: Stay at your seat and protect your head and neck with your arms. Don't try to leave until the shaking is over. Then walk out slowly watching for anything that could fall in the aftershocks.

Near the shore: Drop, cover and hold on until the shaking stops. Estimate how long the shaking lasts. If severe shaking lasts 20 seconds or more, immediately evacuate to high ground as a tsunami might have been generated by the earthquake. Move inland 2 miles or to land that is at least 100 feet above sea level immediately. Don't wait for officials to issue a warning. Walk quickly, rather than drive, to avoid traffic, debris and other hazards.

Below a dam: Dams can fail during a major earthquake. Catastrophic failure is unlikely, but if you live downstream from a dam, you should know flood-zone information and have prepared an evacuation plan.

Questions and Answers



FALLS CHECKLIST

COMPLETE I/A FORM

COMPLETE POST FALL INVESTIGATION FORM

NOTIFY THE RN

NOTIFY THE MD

NOTIFY THE FAMILY

FAX I/A TO REHAB DIRECTOR (860-0794)

FAX TO RISK MANAGEMENT (860-0532)

DOCUMENTATION IN THE CHART
(Body audit on all falls, neuro checks if applicable, document until injury is completely healed/resolved)

UPDATE THE FALL RISK ASSESSMENT (MDSC Complete)
(MDS COORDINATORS UPDATE CARE PLAN)

UPDATE FALL LOG BOOK

PAIN ASSESSMENT

WITNESS STATEMENTS

HOT RACK FOR 72 HOURS OR MORE IF NEEDED

UPDATE 24 HOUR NURSING REPORT

IF RESIDENT REQUIRES OUTSIDE MEDICAL INTERVENTION COMPLETE 1910
PAPERWORK AND MAKE PROPER NOTIFICATIONS

April 2011

WHEN A FALL OCCURS

NURSE WILL:
Immediately assess/document /emergently send out if needed
*body audit
*Assess ROM
*assess pain
*obtain Vital Signs
*finger-stick blood sugar
*assess cognitive status
*provide first aide
*investigate cause
*notify MD
*notify family/respon. Party
*complete I/A
*complete post fall form
*initiate neuro checks if struck head
*place on 24 hour report
*place on hot-rack

When a fall occurs.....Unit RN/Designee will :
*Review I/A (start-up)
*review post fall/eval reasons
*initiate/update fall tracking form
*update fall risk assessment
*review/update care plan

When a fall occurs.....Interdisciplinary Team will:
*review fall tracking form
*review for falling star program
*identify patterns/trends related to falls
*make recommendations for additional assessments/referrals
*review care plan

INDIVIDUAL RESIDENT FALL TRACKING LOG

RESIDENT NAME

DATE	TIME	LOCATION	INJURY	DESCRIPTION OF EVENT	CONTRIBUTING FACTORS	INTERVENTIONS

revised April 2011

NEUROCHECKS

Q 15 minutes X 1 hour

Q30 minutes X 2 hours

Q1 hour X 2 hours

Q 2 hours X 2 hours

Q 4 hours for remaining 72 hour period

NEUROLOGICAL ASSESSMENT FLOWSHEET

INSTRUCTIONS: Complete form and describe any neurological problems on the reverse.

DATE																
TIME																
Vital Signs	Blood Pressure															
	Temperature															
	Pulse															
	Respirations															
	Normal															
	Shallow/Irregular															
Pupil Response	R. Pupil Size/React															
	L. Pupil Size/React															

Chart pupil size in comparison to circles printed here. Chart reaction as + (reacts) or - (does not react).

Pupil size (mm).

Check the appropriate black circle and record number in pupil size.

Eye Response	Opens Spontaneously															
	Opens to Speech															
	Opens to Pain															
	Does Not Open															
Level of Consciousness	Alert															
	Drowsy															
	Stuporous															
	Comatose															
Speech	Speech Oriented															
	Confused Conversation															
	Inappropriate Words															
	Incomprehensible Speech															
	No Speech															
Motor Response	Lt. Upper Extremity															
	Lt. Lower Extremity															
	Rt. Upper Extremity															
	Rt. Lower Extremity															

Chart motor function based on the best of the worst.

1. Appropriately obeys commands and/or moves all extremities
2. Localizes signs of weakness, i.e., drifting of extremity
3. Withdraws to external stimuli
4. Flexes extremity abnormally
5. Extends extremity abnormally
6. Flaccid - no response of extremity

Nurse Initial (Identify on reverse)																

Resident Name - Last First Middle Attending Physician

AHC Form # 1160-B

☐ Comments on Reverse

NEUROLOGICAL ASSESSMENT FLOWSHEET

COMMENTS

INITIALS	SIGNATURE	INITIALS	SIGNATURE

Resident Name - Last	First	Middle	Attending Physician

AHC Form # 1160-B

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy #
Nursing Service	Fall Prevention Program	NS- To be Assigned

PURPOSE:

It is the purpose of this policy to:

A. Identify residents who are at risk for falls
B. Identify events leading up to a fall
C. Identify patterns of falls
D. Implement interventions to prevent or minimize risk for falls

SCOPE:

Nursing

POLICY:

It is the policy of Arkansas Health Center to complete a Fall Risk Assessment for every resident during the admission process, along with each MDS Assessment and after each fall occurrence. The purpose of the fall risk assessment is to identify residents who are at risk for falls in order that appropriate interventions are initiated

PROCEDURES:

1. The Unit RN Supervisor / Designee will complete a Fall Risk Assessment
   A. During the admission process
   B. Along with each MDS Assessment
   C. After each fall

All residents will be considered to be at risk for falls for a minimum of 14 days following admission regardless of the presence of any other risk factors. A short-term care plan will be developed to address the orientation process. Residents scoring at high risk for falls due to intrinsic factors, such as medications, diagnosis, physical function, cognitive status and so forth, will have a care plan entry for "Risk for Falls" with interventions specific to the assessment findings.

2. A fall occurs when the resident unexpectedly or in an unplanned manner sustains bodily contact with the floor or a lower surface.
   A. A fall without an injury is still a fall
   B. A fall without a witness is a fall
   C. The distance of a fall is not a factor in determining a fall
   D. A fall may occur during transfers assisted by nursing personnel who are unable to maintain control of the transfer, therefore lower the resident to the floor.

Date Revised 01/19/2004 Date Effective: 01/26/2004

3. In the event a resident falls the nurse will:
   A. Immediately assess the resident and document all findings in the medical record. The assessment may include (but not limited to) the following:
      a. A body audit to identify any injuries i.e., skin tears, abrasions, lacerations
      b. Assess range of motion of all extremities (hip and shoulder fractures are very common) for s/s of pain, swelling, changes in functional range of motion, etc.
      c. Assess for verbal / non-verbal signs or symptoms of pain
      d. Obtain a complete set of vital signs including temperature
      e. Obtain a fingerstick blood sugar for hypo/hyperglycemic residents
      f. Assess cognitive status i.e., confusion, disorientation, change in mental or cognitive status, etc.
   B. Provide any necessary first aid
   C. Investigate to determine cause and/or contributing factors related to the fall.
      a. Speak with the resident to obtain information
      b. Speak with staff or anyone who witnessed the fall
   D. Notify the physician
      a. Obtain orders for treatment (i.e., skin tears, transfers, etc)
      b. Document notification and any new orders in medical record
   E. Notify family / responsible party and document notification in the nurses' notes
   F. Complete an Incident and Accident report (refer to policy)
   G. Complete the Post Fall Investigation form and forward to the Unit RN
   H. Place resident on the 24 hour nursing report
   I. Place resident on the Hot Rack Charting list

4. In the event of a fall, the Unit RN Supervisor/Designee will:
   A. Review the incident and accident reports as part of the start up routine and identify any reports associated with a fall
   B. Review the Post Fall Investigation Form to identify any factors which may have contributed to the fall in order that appropriate interventions may be identified
   C. Initiate the "Individual Resident Fall Tracking" form
   D. Update the "Fall Risk Assessment"
   E. Review the resident's care plan and revise as indicated

5. Procedures for additional falls:
   A. The Unit RN Supervisor/Designee will update the "Individual Resident Fall Tracking" form after each fall
   B. The Unit RN Supervisor/Designee will update the "Fall Risk Assessment" form after each fall

   C. The Unit RN Supervisor/Designee will refer the resident to the appropriate discipline for a screen.

D. The Unit RN Supervisor/Designee will review the resident's care plan after each fall
E. The Interdisciplinary Team will meet weekly during care plan conferences to:
    a. Review the "Individual Resident Fall Tracking" form
    b. Identify residents who may qualify for placement in the "Falling Star" Program
    c. Identify any Patterns / Trends relating to falls
    d. Make recommendations for additional assessments, referrals, program placements and interventions
    e. Review the care plan and make recommendations for revisions

6. Falling Star Program Placement:
    A. Any resident who has had two or more falls in a thirty-day time frame or a pattern of falls such as one per month for three months in a row will be placed in the "Falling Star Program"
    B. A "Falling Star" symbol will be placed in designated locations
    C. Staff will be educated regarding the meaning of the falling star symbol (i.e., resident is not only at risk for falls but has a history of falls)
    D. As part of the Falling Star Program, direct care staff will be educated on the need to:
        a. Monitor the resident frequently to determine needs
        b. Place the call light within reach and respond to request for assistance promptly
        c. Maintain easy access to personal items such as telephone, water, remote control, etc.
        d. Maintain a safe environment by being alert to safety hazards
        e. Monitor for appropriate footwear
        f. Assess resident to ensure utilization of appropriate visual/hearing aides and assist as needed
        g. Monitor for utilization of special devices (i.e., walker, cane, wheel-chair, alarms, etc)
        h. Assist with toileting needs
        i. Monitor for excessive wandering / fatigue and encourage rest periods
        j. Respond promptly to alarms when applicable
        k. Use optimal bed height and locked wheels
        l. Report changes or concerns to nurse
        m. Utilize restraints as ordered

    E. After program placement, the Interdisciplinary Team will review the resident's "Individual Resident Fall Tracking" form on a routine basis.
    F. The care plan will be reviewed each time a fall occurs and interventions will be resolved or added as deemed necessary/appropriate.

7. Removal from the Falling Star Program:
   A. Any resident who has been placed in the Falling Star Program and has not had a fall in the past ninety days may be discharged from the program by recommendation from the Interdisciplinary Team
      a. Review the care plan and resolve applicable interventions
      b. Remove the "Falling Star" symbol
      c. Notify staff of resident's discharge from the program

8. The Interdisciplinary Team will forward any concerns regarding falls to the Fall/Restraint Quality Assurance Committee for review and recommendations

Approval:

_____ _____
Director of Nursing **Date**

_____ _____
Medical Director **Date**

_____ _____
Administrator **Date**

INDIVIDUAL RESIDENT FALL TRACKING LOG

RESIDENT NAME

DATE	TIME	LOCATION	INJURY	DESCRIPTION OF EVENT	CONTRIBUTING FACTORS	INTERVENTIONS

revised April 2011

POST FALL INVESTIGATION REPORT

RESIDENT: _____ Date of Fall: _____ Time of Fall: _____

Describe Incident:
- ☐ Found on Floor
- ☐ Fall from or slid out of chair
- ☐ Fall from or slid out of bed
- ☐ Lost balance
- ☐ Unassisted Ambulation
- ☐ Tripped
- ☐ _____

Location:
- ☐ Resident Room
- ☐ Bathroom
- ☐ Hallway
- ☐ Dining Room
- ☐ Dayroom/Activity
- ☐ By Nurses Station
- ☐ _____

Activity prior to fall:
- ☐ Unknown
- ☐ Walking
- ☐ Reaching Up
- ☐ Bending/leaning
- ☐ In a crowd
- ☐ Transferring
- ☐ _____
- ☐ Standing Still
- ☐ Reaching Down
- ☐ Walking
- ☐ Wandering
- ☐ Sleeping/lying down
- ☐ Responding to B/B
- ☐ _____

Extent of Injury:
- ☐ No injury
- ☐ Minor Injury (first aid only)
- ☐ Major Injury (medical attention)

Type of Injury:
- ☐ None
- ☐ Bruising
- ☐ Redness
- ☐ Swelling
- ☐ Swelling
- ☐ Skin Tear
- ☐ Abrasion
- ☐ Laceration
- ☐ Head Injury
- ☐ Fracture
- ☐ _____
- _____

Pain:
- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Severe

Medications:
Time meds last administered: _____
(Check each classification of drug administered)
- ☐ Psychotrophics
- ☐ Antianxiety
- ☐ Analgesics
- ☐ Antihypertensives
- ☐ Antiparkinson
- ☐ Antihistamine
- ☐ Antidepressants
- ☐ Diuretics
- ☐ Sedatives/hypnotics
- ☐ hypoglycemics
- ☐ Anticonvulsant/seizure
- ☐ _____

Vital Signs:
Blood Pressure:
Lying _____
Sitting _____
Standing _____
(wait 1 minute between each reading)

Pulse _____
Respirations _____
Temperature: _____
O2 Sat: _____
FSBS: _____

Bed Position:
- ☐ High
- ☐ Low

Restraints in use at time of fall:
- ☐ Yes
- ☐ No

Type _____

Side Rails
- ☐ Up
- ☐ Down

Assist Device
- ☐ None
- ☐ Walker
- ☐ Cane
- ☐ Prosthetic
- ☐ Not in use at time of fall

Equipment
- ☐ Geri-chair
- ☐ Wheelchair
- ☐ Other

Appliances:
- ☐ Catheter
- ☐ IV, Oxygen
- ☐ Cast/Sling/Brace
- ☐ Tube Feeding

Cognitive/Mental Status(check all that apply)
- ☐ Oriented x 3
- ☐ Disorientation
- ☐ Delusions
- ☐ Short-term memory deficit
- ☐ Poor Safety Awareness
- ☐ Impaired decision making

Behaviors/Moods:
- ☐ Resistant to care
- ☐ Pacing/Wandering
- ☐ Combativeness
- ☐ Anxiety/Agitation
- ☐ Depression
- ☐ _____

Vision:
- ☐ Adequate
- ☐ Impaired
- ☐ Blind
- ☐ Glasses

Hearing:
- ☐ Adequate
- ☐ Impaired
- ☐ Deaf
- ☐ Hearing Device

Communication:
- ☐ Non-communicative
- ☐ Makes needs known

Footwear:
- ☐ Barefoot
- ☐ Stocking/socks
- ☐ Non-skid shoes/slippers
- ☐ Loose/ill fitting shoes

Clothing:
- ☐ Hem line to long
- ☐ No Concerns

Environment:
- ☐ Obstructed Walkway
- ☐ Wet/Uneven Floor
- ☐ Dim light/Glare
- ☐ Other _____

Was the fall witnessed? ☐ Yes ☐ No (Document what witness report on back of page)

What additional information could be a contributing factor to the fall: _____

_____

_____

_____

_____

_____

Name of person completing form: _____

Revised April 2011

Arkansas Health Center Fall Risk Assessment

PARAMETER	SCORE	RESIDENT STATUS/CONDITION	DATE	DATE	DATE	DATE
Cognitive Skills	*	Comatose: For Comatose Resident's Place an Asterisk in the Box and Skip to the Total Score Section with a Score of Zero.				
	0	Oriented x 3.				
	2	Disoriented x 2 or More at ALL Times.				
	4	Intermittent Confusion.				
Decision Making Skills and Safety Awareness	0	Able to Make Decisions and Aware of Safety Issues.				
(Code All That Apply)	1	Slight to Mild Impairment Regarding Decision Making Skills and Safety Awareness.				
	2	Moderate Impairment Regarding Decision Making Skills and Safety Awareness.				
	3	Has Major Impairment Regarding Decision Making Skills and Safety Awareness.				
	4	Deficits in Decision Making Skills and Safety Awareness has Resulted in a Fall in Past 6 Months.				
History of Falls	0	No Falls in Past (3) Three Months.				
	1	Code EACH Fall in Past Three Months (1) One Point.				
(Code All That Apply)	2	Resident is Currently on the Falling Star Program.				
Vision	0	Adequate Without Glasses.				
	1	Adequate WITH Glasses.				
	2	Poor With or Without Glasses.				
	3	Legally Blind or NO Useful Vision or Unable to Determine				
Hearing	0	Adequate Without Any Hearing Device.				
	1	Adequate WITH Hearing Device.				
	2	Poor With or Without Hearing Device.				
	3	NO Useful Hearing or Unable to Determine.				
Continence	0	Continent at ALL Times.				
	1	Has Foley or Supra-Pubic Catheter.				
(Code All That Apply)	2	Incontinent with Some Control/Requires Assistance.				
	3	Incontinent with NO Control/Wears Briefs.				
	4	Incontinence Has Resulted in a Fall in Past 6 Months.				
Ambulation	0	Gait/Balance Normal or Does Not Ambulate.				
	1	Balance Problems When Standing/Walking.				
(Code All That Apply)	2	Decline in Muscular Coordination or Jerky Movements.				
	3	Gait Changes When Making Turns/Going Through Doors.				
	4	Gait/Balance Has Resulted in a Fall in Past 6 Months.				
Assistive Devices Such as Cane or Walker	0	None.				
	2	Utilizes Assistive Device Without Difficulty.				
	3	Difficulty Using Device or Forgets to Use.				
Medications:	0	None of These Meds Taken Within Last 7 Days.				
Antihistamines, Narcotics, Antiseizures, Sedatives or Hypnotics, Diuretics,	2	1-2 of These Meds Taken Within Last 7 Days.				
Psychotropics, Cathartics, Antihypertensives,	4	3 or More of These Meds Taken in Last 7 Days.				
Hypoglycemics, Benzodiazepines.	1	Score 1 Additional Point if Resident had a Change in Med or Dosage in Past 7 Days.				
Predisposing Diseases	0	None Present.				
Hypotension, Vertigo, CVA, Parkinson, TIA, Seizures, PVD, Diabetes, TBI, Dementia,	2	1 or 2 Present.				
Osteoporosis, Fractures, Arthritis, Syncope, Amputation, Huntingtons, Arrhythmia, Alzheimers.	4	3 or More Present.				
Behaviors	0	None Present.				
Resists care, Paces, Wanders	2	Exhibits 1 or More Behaviors at Least Weekly.				
Combativeness Other_____	4	Exhibits 1 or More Behaviors on a Daily Basis.				
High Risk= 12 or More.		TOTAL SCORE				
Resident's Name:						

Reason for Assessment: ☐ New Admit ☐ Fall ☐ MDS Assessment

Score: ☐

Change in score since last fall risk assessment:
☐ Initial Assessment ☐ None ☐ Increased ☐ Decreased

Comments: ______________________________

Signature / Title: ______________________________ Date: ______________

Reason for Assessment: ☐ New Admit ☐ Fall ☐ MDS Assessment

Score: ☐

Change in score since last fall risk assessment:
☐ Initial Assessment ☐ None ☐ Increased ☐ Decreased

Comments: ______________________________

Signature / Title: ______________________________ Date: ______________

Reason for Assessment: ☐ New Admit ☐ Fall ☐ MDS Assessment

Score: ☐

Change in score since last fall risk assessment:
☐ Initial Assessment ☐ None ☐ Increased ☐ Decreased

Comments: ______________________________

Signature / Title: ______________________________ Date: ______________

Reason for Assessment: ☐ New Admit ☐ Fall ☐ MDS Assessment

Score: ☐

Change in score since last fall risk assessment:
☐ Initial Assessment ☐ None ☐ Increased ☐ Decreased

Comments: ______________________________

Signature / Title: ______________________________ Date: ______________

Complaint/Grievance Checklist

	Information/Comments	Signature of Staff Addressing
Circle One: Resident/Family/Visitor/Employee & place person's name who voices a concern, comment, complaint or grievance		
Date & Time Reported		
Name of staff member receiving the report regarding the concern, comment or complaint.		
Name of RN Supervisor on duty at time of report notified immediately		
Administrative RN on call notified by RN Supervisor on duty		
Grievance/Complaint Form to be received or completed by the RN Supervisor on duty.		
OLTC Witness Statements obtained by the RN Supervisor on duty.		
RN Supervisor on duty *OLTC Witness Statement* written regarding what is reported to him/her in follow up.		
Completed *Grievance/Complaint* form and follow up including *Witness Statements*, nurses notes & this checklist to be placed in an envelope and under the ADON door.		

ADDITIONAL COMMENTS:

Grievance/Complaint Form

Date of this report: _____ Unit: _____
Name of Resident: _____ Room: _____
Name of person filing concern _____ Phone # _____
Relationship: ( ) Resident ( ) Representative ( ) Family or Friend
Date incident occurred: _____ Time: _____
Was the resident injured? ( ) YES ( ) NO
Describe the nature of the concern/grievance (be specific). (Use backside of paper if additional space is needed.)

_____
_____
_____
_____
_____

If other person involved, provide name and identify if they are an employee, other resident, or visitor:

_____
_____
_____

If there were witnesses, provide name and identify if they are an employee, other resident, or visitor:

_____
_____
_____

Signature of person filling concern _____ Date _____

FOR OFFICE USE ONLY

Recommendation/corrective action taken _____

_____
_____
_____
_____
_____

( ) Nursing Care ( ) Dietary ( ) Housekeeping ( ) Laundry ( ) Maintenance ( ) Other
Date action taken: _____ Name of responsible person: _____
Was grievance/concern resolved to the satisfaction of all concerned?
( ) YES ( ) NO (if no, give reason)

_____
_____
_____
_____

Date Follow up completed _____ Time _____ Initial _____
Comments _____

_____
_____
_____
_____
_____
_____

ARKANSAS HEALTH CENTER

Policy Type	Subject of Policy	Policy No.
Administrative	Resident Grievance/Complaint Process	AP 409

PURPOSE. It is the purpose of this policy is to assure that all residents have the right to voice grievances without discrimination or reprisal.

SCOPE. All AHC direct care staff.

POLICY. Staff may be notified of a grievance by a formal written complaint or by a resident or family/representative verbalizing a complaint to a staff member.

PROCEDURE.

1. Upon admission, the resident or family/representative will be notified of his rights to make grievances/complaints without discrimination or reprisal.
2. All complaints (verbal or written) will be documented on the Resident Complaint Form (see Appendix A) located at each Unit Nursing Station.
3. After completion of the complaint form, the RN or Social Worker will follow-up on resident complaint by writing the findings on the Resident Complaint Form.
4. The RN or Social Worker will forward a copy of the complaint form and follow-up response to the ADON or designee.
5. The resident and/or family or representative will be notified by the RN or Social Service Worker of the results of the investigation and/or the resolutions of their complaint/ grievance.
6. A log of all complaints will be maintained by the ADON or designee to document actions taken and follow up with resident, family or responsible party.
7. Complaints will be reviewed in the weekly Quality Assurance Meeting.

_____

AHC Director Date

ALL HOSPITAL TRANSFERS MUST BE VIA AMBULANCE EXCLUDING CLINIC APPOINTMENTS

TRANSFER FOR ACUTE PSYCHIATRIC EVALUATION MAY BE DONE BY PSO/SW/NSG

AN RT/NURSE MUST ACCOMPANY ALL VENT/TRACH RESIDENTS TO HOSPITAL/APPOINTMENTS

NSG STAFF MUST REMAIN WITH RESIDENT AND MAINTAIN CHART UNTIL ADMITTED TO/EVALUATED BY FACILITY

Patient Transfer Form

Original in Chart
Copy sent to Next Provider of Care

Infectious Pathogens (MRSA, VRE, C-diff, etc.):
❑ Current Infection
❑ Hx of MDRO

* Transfer From: _____ * Transfer To: _____ * Date: _____

* Name: _____ (Last / First / MI) * Date of Birth * Age Sex

Address: _____ (Street / City / State / Zip)

* Next of kin: _____ * Notified: ❑ Yes ❑ No

Medicare #: _____ Medicaid #: _____ Medipak #: _____

* SSN: _____ VA #: _____ Other #: _____

* Reason for transfer: _____

* Reason for Inpatient Admission: _____

* Principal Diagnosis at Discharge: _____

* Other health problems: _____

* Code status: _____ Allergies: _____

PATIENT STATUS

Condition:
❑ Stable ❑ Satisfactory
❑ Guarded ❑ Seriously ill

Mental Status: ❑ Fall Risk
❑ Alert ❑ Mild confusion ❑ Elopement risk
❑ Oriented ❑ Marked confusion ❑ Semi-comatose
❑ Depressed ❑ Hostile/combative ❑ Comatose

* **Last vital signs:** Time: _____ B/P: _____ HR: _____ RR: _____ Temp: _____

* Height: _____ * Date of last weight: _____ * Weight: _____ Daily Weight: ❑ Yes ❑ No

Intake: (This shift) _____ Last 24 hours: _____

Output: (This shift) _____ Last 24 hours: _____

Skin: ❑ Warm ❑ Cold ❑ Dry ❑ Moist ❑ No skin abnormalities noted
❑ Normal ❑ Pale ❑ Dusky ❑ Cyanotic ❑ Jaundiced ❑ Flushed

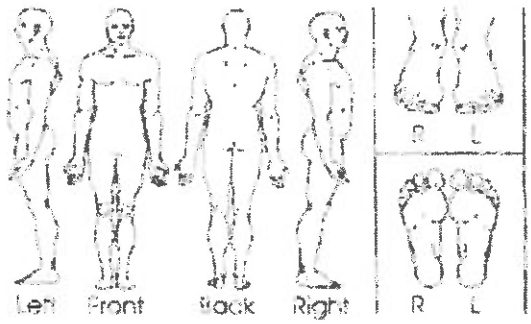
Note: If any skin abnormalities are present, mark the diagram for location and size. Beside diagram, describe size, stage, color, drainage, etc.

* Advance Directive Status.
❑ **Living Will** ❑ **POA** ❑ **DNR**
❑ **Comfort Measures** ❑ **Other**
❑ **None-Reason:** _____

Pneumococcal Vaccine Given:
❑ Yes Date given: _____
❑ No
Contraindication: _____

Influenza Vaccine Given:
❑ Yes Date given: _____
❑ No
Contraindication: _____

Diagram Code
B = Burn
C = Contusion
D = Decubitus
E = Erythema
*F = Fracture
H = Hematoma
I = Infection
L = Laceration
P = Petechiae
R = Rash
S = Scar
T = Poor turgor
V = Varicose Veins
W = Wound/incision



* Patient has received smoking cessation information, and notified that more information regarding smoking cessation or support groups is available by calling the American Cancer Society @ 877-937-7848.

* **Indicates mandatory field**

Patient Transfer Form
Page 1 of 2

2/21/11

Discharge Planning

Room Bed:
Age Desc:
DOB:

Admission:
MR:
Att. Phy:

AHC Form #1080

Red 47

Original in Chart
Copy sent to Next Provider of Care

* Indicates mandatory field

Peripheral Vascular Assessment (to be done if there is a fracture with a cast or splint)

Capillary Refill	Edema	Color	Sensation	Motion
❑ Rapid ❑ Sluggish	❑ Present ❑ Absent	❑ Pink ❑ Pale ❑ Cyanotic	❑ Present with stimulation ❑ Present without stimulation ❑ Absent ❑ Decreased	❑ Present ❑ Absent ❑ Decreased ❑ Moves all extremities ❑ Grips/Leg movement equal

PATIENT CARE NEEDS

* **Activity:** ❑ Bed rest ❑ BRP ❑ Amb ad lib ❑ Up in chair/W/C ❑ ROM exercises ❑ Turn every 2 hours
Level of Care: ❑ Total Care ❑ Assist ❑ Self-care ❑ Needs feeding ❑ Other: _____

Bath: _____ Shave: _____ Oral Care: _____

* **Diet:** ❑ Reg ❑ Cardiac ❑ Other _____ Dietician Consult r/t ❑ CHF diet ❑ Renal diet ❑ Coumadin diet

Skin Care
Decubitus Care
Dressing Changes

❑ Accucheck: _____ Date/Time: _____ ❑ Guaiac - Date: _____

Cardiopulmonary: ❑ Cardiac monitor: Rate/rhythm: _____ ❑ Oxygen: _____
❑ Updrafts: _____ ❑ Suction: _____ ❑ IS
❑ Chest percussion: _____ ❑ *Ventilator: Setting: _____ ❑ USN

Tubes: ❑ Foley, Size: _____ date placed: _____ ❑ N/G: date placed: _____ ❑ Dobhoff: date placed: _____
IV's: ❑ IV Access: ❑ Peripheral _____ ❑ Subclavian _____ ❑ Port _____
Gauge: _____ Date placed: _____
❑ IV Meds: _____ Date started: _____
❑ IV Meds: _____ Date started: _____

* **Major Procedures/Test Performed During Inpatient Stay & Results:** ❑ None

* **Studies Pending at Discharge:** ❑ None

CHF patients should be observed for increased SOB, edema, weight gain of 3 lbs/day or 5 lbs/week. If any S/S noted notify MD.
Patients on coumadin therapy should receive their Coumadin @ the same time daily, should have follow up INR for dosing adjustments, and ensure that PCP is aware patient is receiving Coumadin before administering any new meds or possible reactions or interactions.
Contact Medical Records @ 776-6071 for instructions to obtain pending results.
Call the patient's physician or Saline Memorial's ER at 501-776-6600 for any emergencies related to their inpatient stay.

TRANSFER INFORMATION

* Follow-up MD: _____ MD order sent? ❑ Yes ❑ No Ambulance transfer? ❑ Yes ❑ No
Will this M.D. care for patient after admission to new facility? ❑ Yes ❑ No
* Copies sent with: Transfer Form: MARS, Lab, X-Ray, H & P, ECG, M.D. progress notes, Medication Reconciliation Form, and Discharge Summary dictated
* Report called to: _____ *By: _____
* Discharge Nurse Signature: _____ * Date & Time: _____
* Discharge Unit Phone Number: _____

Saline Memorial Hospital
9/8/10

Patient Transfer Form
Page 2 of 2

Discharge Planning

Room/Bed:
Age/Sex:
DOB:
Admission:
MD:
Att Phy

AHC Form #1080

MEDTRAN AMBULANCE SERVICE
501-776-6002

PHYSICIAN'S CERTIFICATION STATEMENT (PCS)

Patients Name: _____ Date of transport: _____
Social Security: _____ Transport From: _____
Date of Birth: _____ Transport To: _____
Medicare ID#: _____ Private Insurance: _____
Medicaid ID#: _____ Policy/Group: _____

In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation and observation by medical trained personnel is required.

Check all appropriate spaces for the above named patient:

___ Unable to get up from bed without assistance, ambulate, or sit in a chair, including a wheelchair, due to other conditions indicated in narrative.

___ Exhibiting signs of a decreased level of consciousness

___ Frail/debilitated and at time of transport bed-confined, see narrative below

___ Requires Oxygen. Liters per minute:_____

___ Requires airway monitoring or suctioning

___ IV Maintenance

___ Comatose and requires trained personnel to monitor condition

___ Seizure prone requires trained personnel to monitor condition

___Medicated and needs trained personnel to monitor condition

___Suffers from paralysis or contractures and is bed confined. Location:_____

___Danger to self and others, requires restraint:____ Verbal, ____Chemical, ___Physical

___ Has decubitus ulcer and requires wound precautions. Location:_____

___ Requires isolation precautions (VRE, MRSA, etc)

Narrative:_____

_____

_____

I certify that the above information is true and correct based on my evaluation of this patient to the best of my knowledge and professional training, I understand this information will be used by the Health Care Financing Administration (HCFA) to support the determination of medical necessity for ambulance services.

_____ _____ Date_____

Printed Name of physician, physician's assistant, RN Signature of Physician, Physician Asst, RN

Definition of Bed confined: "Medicare covers ambulance services only if they are furnished to a beneficiary whose medical conditions such that other means of transportation would be contraindicated. For non-emergency ambulance transport the following criteria must be met to ensure that ambulance transportation is medically necessary: (1) the beneficiary is unable to get up from bed with out assistance. (2) the beneficiary is unable to ambulate, and (3) the beneficiary is unable to sit in a chair or wheelchair." (Medicare Provider Manual)

Complete if appropriate
Hospital Discharge to Out of Town Residence: Treatment received: _____
Hospital to hospital Transfer: Elevated Care needed (explain):_____

ARKANSAS HEALTH CENTER

MEMO:

To; Residents Scheduled for Therapeutic or Hospital Visits

RE: RESERVE BED POLICY

When you are going to be absent form the facility for a therapeutic or hospital visit, the Reserve Bed Policy begins the day of your departure. The duration of the reserve bed days will conclude when you return to the facility.

THERAPEUTIC LEAVE

Therapeutic leave is defined as a visit out of the facility that the staff thinks will be beneficial to you such as visit home. A therapeutic leave is limited to 14 days and nights; you must return to the facility on the 15ht day. Your income will be accepted as a reserve bed during the absence.

If you have not returned by the 15th day, you will be discharged from the facility. Depending on the availability of a bed, you much meet the following conditions to be remitted:

1. Require the services provided by the Arkansas Health Center; and
2. Be eligible for Medicaid nursing facility services.

The 14 day limit does not apply to non-Medicaid residents. As long as they pay their customary daily rate, the bed will be held for them.

HOSPITAL TRANSFERS

Hospital transfers are defined as a visit to the hospital that has been ordered by your physician. There are no limits to the number of days you can be absent. Your income will be accepted as a reserve bed payment during the absence. If you are a Medicaid recipient, Medicaid will continue its normal payment to the nursing facility for the first 5 days of your hospitalization. Other than your income, Arkansas Health Center will not charge extra to hold your bed while you are in the hospital. Non-Medicaid residents will pay their customary charge for reserving their bed.

You will be transferred back to the facility when the hospital staff notifies Arkansas Health Center that you are ready to return.

ACKNOWLEDGEMENT

The AHC Reserve Bed is provided to _____
And his/her representative_____on this date_____ by staff member_____

RESIDENT BODY AUDIT

Addressograph Name Plate

This form should be utilized at the time of admission/discharge/readmission of a resident as well as anytime an I and A form is filled out. Please check appropriate box below.

☐ Admission ☐ Discharge ☐ Readmission ☐ Other _____

DATE: _____ TIME: _____ Weight: _____ Height: _____

Vital Signs: B/P_____ P. _____ R. _____ T. _____

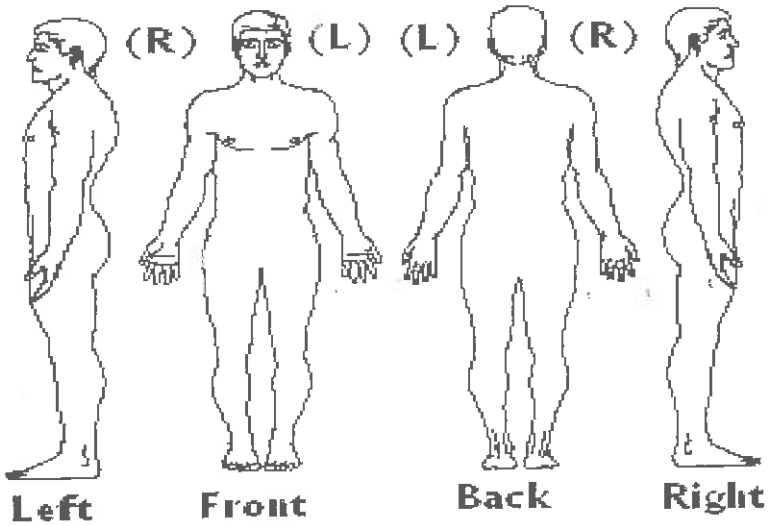
(Circle one) Dentures/Teeth Yes _____ No _____ Glasses Yes _____ No _____

SKIN: ☐ Warm ☐ Cold ☐ Dry ☐ Moist ☐ No Skin Abnormalities Noted

☐ Normal ☐ Pale ☐ Dusky ☐ Cyanotic ☐ Jaundiced ☐ Flushed

Note: If any skin abnormalities are present, mark the diagram for location and size. Beside diagram, describe sizes, stage, odor, drainage, etc.

Diagram Code:
B = Burn
C = Contusion
D = Decubitus
E = Erythema
F = Fracture
H = Hematoma
I = Infection
L = Laceration
P = Petechiae
R = Rash
S = Scar
T = Poor Turgor
W = Wound/Incision



*F – if fracture with cast or splint - ◆ Do the following Peripheral Vascular Assessment

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____ (Continue on Back as Necessary)

Done by: _____ **Date:** _____

Form 1161-A3

HOT RACK CHARTING SYSTEM

PURPOSE:

To ensure residents' experiencing changes in condition will receive consistent assessments and documentation at a minimum of every shift until the condition is resolved and or the resident is stable.

PROCEDURE:

1. Any resident experiencing a change in condition will be listed on the "Hot Rack Charting Form" located in a red or labeled three-ring binder at the nurse's station.
2. The "Hot Rack Charting Form" will be reviewed by the licensed nurses on each shift and follow up assessment and documentation will be completed in the resident's medical record.
3. The Unit RN Supervisor will review the Hot Rack Charting form as part of the start up routine and conduct random audits to ensure appropriate assessment, notification and documentation has been completed.
4. The residents name will remain on the "Hot Rack Charting" list until the residents condition is stable
5. Shred completed forms after 3 days.

HOT RACK CHARTING

DATE OF INCIDENT/ CHANGE	NAME OF RESIDENT	7A	7P	DESCRIPTION OF EVENT	ON CALL MD NOTIFIED DATE/TIME	UNIT MD FOLLOW UP DATE/TIME	FAMILY NOTIFED DATE/TIME	DATE COMPLETED	RN FOLLOW UP

Hydration Assessment Protocol

Purpose: Facility Guidelines to determine if a resident may be at increased risk for dehydration or displaying signs and symptoms of dehydration.

Scope: Licensed Staff

This form is to be completed:

- On admission/ readmission to AHC
- When a resident has refused food and fluid for 24hrs.
- When a significant decline in food and fluid intake is noted
- As needed. (See attached form 1046-E9)

Procedure:

PART 1- If any question is answered **"YES",** then the resident is at increased risk for developing dehydration.

PART 2- If any items are checked **"YES",** the resident may be dehydrated.

Notification:

- Fax a copy to Dietary (860- 0781)
- Provide a copy to unit MDS Coordinator.
- If any items are checked in Part 2 in addition to above actions notify MD, follow orders, and notify the family.
- **Original Hydration Assessment (file under the Sub tab of HYDRATION)**
- Fax copy to Nursing Education (860-0795)

Name: _____

Unit: _____

(Stamp with resident Addressograph plate here.)

Hydration Assessment (file behind the Nursing Summary Tab under a Sub tab of HYDRATION)

This form is to be completed on admission/ readmission to AHC, when a resident have refused food and fluids for 24 hours, when a significant decline in food and fluid intake is noted, or as needed.

Fax a copy to dietary and provide a copy to the MDS coordinator.

If any items are checked in Part 2 in addition to above actions notify MD, follow orders, and notify the family.

PART 1

To determine if a resident may be at increased risk for dehydration, decide if any of the statements below are true. Check all statements that apply, if any items are checked **"yes"** resident is @ risk

STATEMENT	YES	NO
Needs assistance to feed self, or drink from cup or glass.		
Has trouble swallowing liquids.		
Has current or recurrent vomiting, diarrhea, fever, constipation, or excessive urine output.		
Has been diagnosed with dehydration within the past 30 days, or has been diagnosed with dehydration more than once in the past 180 days.		
Is easily confused or frequently tired and is difficult to arouse.		
Drinks less than 6 cups of liquids per day.		
Has current infection, frequent UTI's, or **uncontrolled** diabetes.		
Has refused food and fluids for 24hrs or frequently refuses meals.		
Exhibits agitation, disorientated behavior, or resists food or fluid intake.		
Medications include frequent use of laxatives, enemas, or diuretics.		
Is Resident a gastric tube-feeder?		

PART 2

To determine if a resident has signs and symptoms of dehydration, decide if any of the symptoms are present. Check all that apply, if any items checked **"yes"** the resident may be dehydrated.

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Dry mouth			Poor skin turgor		
Cracked lips			Labs indicative of dehydration		
Sunken eyes			Increased confusion or decreased LOC		
Dizziness			Nausea or loss of appetite		
Thirst			Concentrated urine		
Constipation			Decreased blood pressure		
Fever			Increased pulse rate		
Dry Skin					

Hydration Notification Checklist:

- ☐ 1. Faxed a copy to Dietary @ (860-0781)
- ☐ 2. Provide a copy to unit MDS Coordinator for update (s) to Plan of Care
- ☐ 3. Notify M.D. New Orders: _____
- ☐ 4. Notify family
- ☐ 5. Assessment documented in nurse's notes
- ☐ 6. Notify Lab, skin team/PT if needed

Justification for Assessment &/or Comments:

Signature upon completion: _____ **Date:** _____

Form # 1046-E9 **(Send copy of this form to Nursing Education) updated 3/09**

"HYDRATION BOOKS & Food/Fluid Flow Sheets" Protocol

Purpose: Facility Guidelines to determine if a resident may be at increased risk for dehydration or displaying signs and symptoms of dehydration.

Scope: Direct Care Staff

Hydration Pass Books are located on each unit. The Book contains the Food and Fluid Flow Sheets (Form # 1160-A3) for each resident.

1. Direct Care Staff will complete the documentation for the hydration pass at 1000, 1400, and 2000, for each resident on the Food and Fluid Flow sheet in the Hydration Books.

A. Initial the box coinciding with the date.
B. Record the amount of fluid intake at each hydration pass in **ccs.** (See guidelines below)

Meal Consumption:

Meal consumption records are also located on the Food/Fluid flow sheets in the Hydration books. Nursing staff is responsible for the recording of meal percentages and for the recording of the Supplement % that are ordered and given with meals.

A. Initial the box for Special Equipment or Instructions (such as dycem, offset spoons, thickened liquids, leave upright for 30 minutes after meals, etc.)
B. **Only initial the box that states "Notify Nurse if resident refuses food and fluids for 24hrs identifying, it was reported to the nurse.** Initial and sign the form at the bottom. You only need to do this once a month on each form.
C. ***If a meal is refused and Resident has NO supplement ORDERED offer supplement of choice and count it as (1) item of the over-all meal percentage—Document on meal intake record.***

Guidelines for Recording CC's

Regular squat cup to line no ice= 240cc
Regular squat cup with ice=180cc
Coffee cup full = 240cc
Prepackaged juice or juice glass=120cc Blue mugs full=360cc, ½ full=180cc
Styrofoam cups large full to line =360cc, ¾ full=270cc and half full=180cc
Styrofoam squat cup full to line=240cc, ¾ full=180cc and ½ full=120cc
Small Styrofoam cup full = 120cc
Can Supplements (Ensure, Glucerna etc) = 240cc
Supplements = when offered as a meal replacement count as 1 item of the overall meal percentage (only if not on an ordered supplement already.)

I/A CHECKLIST

COMPLETE I/A FORM

NOTIFY THE RN ON DUTY

NOTIFY THE MD
(if middle of night and **non-emergency** can wait till next am)

NOTIFY THE FAMILY
(if middle of night and non-emergency can wait till next am)

DOCUMENT IN THE CHART
(THE EVENT, body audit if needed) AND ALL NOTIFICATIONS WITH TIMES)

FAX ALL PAPERWORK TO RISK MANAGEMENT (860-0532)

FAX TO SKIN OFFICE IF IT IS A SKIN RELATED ISSUE (860-0832)

UPDATE THE I/A LOG BOOK

PAIN ASSESSMENT (IF APPROPRIATE FOR I/A)

HOT RACK FOR 72 HOURS OR MORE IF NEEDED

DOCUMENT UNTIL THE INJURY IS COMPLETELY HEALED

NOTIFY MDSC OF EVENT FOR CP UPDATE

OBTAIN WITNESS STATEMENTS

MAKE A COPY FOR THE UNIT RN & MDSC

ALL SHIFTS MUST CHART THE HOT RACK CHARTS AND ALL I/A EVENTS

April 2011

INCIDENT AND ACCIDENT REPORT LOG
&
FALL LOG

NOTE: The following information regarding the audit process should assist you in developing audit criteria but should not be regarded as an All-inclusive list

1. Review the policy on incident and accident reporting
2. Review all incident and accident reports as part of the start-up routine
3. Enter the appropriate information on the unit I & A log and place the copy of the report with your notations in the I & A notebook. If you complete this as part of the start-up routine, you will not have to spend a great deal of time trying to get your report together.
4. For almost every I/A report made, the residents care plan will need to be updated.
5. Review the I/A report with a critical investigative eye. What happened? Why? What could be done to prevent this from happening again? Is all pertinent information pertaining to the incident documented on the I/A report? If not, address concerns with responsible person.
    a. Did the resident have a fall? If yes, record the appropriate information on the fall log. Refer the resident to Rehab for follow up. Update fall risk assessment after each fall (RN/MDSC) Update the residents care plan after each fall (RN/MDSC). Conduct an in-depth assessment to determine the cause for the falls (i.e. check blood sugar, orthostatic hypotension, change in condition, side effects of medication, infections, dehydration, incontinence, etc)
    b. If the I/A report is in regards to skin breakdown, has an order for a treatment been obtained? Has the care plan been updated to address the concern? **YOU DO NOT have to do I/A on a decub. ONLY if it is a newly found skin issue.
6. Was the resident placed on the Hot Rack Charting list for follow-up documentation?
7. Review the resident's medical record. Are the facts clearly recorded in the notation? Was notification completed per policy and documented? Review the time lines to ensure prompt documentation and notifications.

ARKANSAS HEALTH CENTER
ACCIDENT/INCIDENT REPORT/ 1910 CHECKLIST

Complete this checklist along with the Accident/Incident Report /1910 Report; **if notification is not applicable please mark N/A** in that section. When form is complete submit to the RN on duty. RN will maintain check list with the 1910/I/A log book.

SECTION A (Completed by the nurse)
Resident Name:_____UNIT:_____

Incident Date:_____ Time:_____am/pm

_____I/A complete

_____1910 Complete

_____Employee removed from duty/Resident removed from area (IF APPLICABLE)

_____BR Form complete

_____Witness statements obtained

_____Physician notified and orders written and carried out

_____Short & long term safety plan implemented

_____Observation sheets initiated

_____Nurses note documentation complete

_____Mental Anguish Assessment

___Staff assigned to aggressor until calm if R→R altercation

_____Body Audit Complete

_____Risk Management notified and documentation (including orders for any type of observation) fax to (860-0532)

_____Family/Responsible party notified

_____RN notified

_____24 hour Shift Report updated

_____Place on Hot Rack

_____Resident Information Sheet updated

_____Nursing Home Administrator/Administrator on duty notified

_____DON/ADON on call notified

Signature of Nurse completing form:_____

Section B TO BE COMPLETED BY RN. Reviewed for completeness, accuracy, and supporting documentation.
RN to complete with Follow up:

_____Update 1910 tracking form

_____Update resident observation tracking form

RN: _____ Date: _____

Revised April 2011

Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities

OLTC Witness Statement Form/AHC

Circle AHC Unit: ASPEN CEDAR ELM MAPLE OAK PINE REDWOOD WILLOW

Name of Resident(s):_____

Date:_____Time: _____ AM/PM (Circle one)

Witness Full Name:_____

Job Title: _____ Shift Assigned: _____Agency S? (Y or N)_____

Home Address:_____ City/Zip:_____

Home Phone #:_____ Work Phone #:_____

Relation to Resident (If Any)_____

State in your own words what you witnessed (be very descriptive) and sign below.

(Continue on Back as Necessary - If back used, re-**include resident's name, your signature, & date written)**

The information provided above is true to the best of my knowledge:

Signature of Witness:_____ Date statement written:_____

ARKANSAS HEALTH CENTER
ACCIDENT/INCIDENT REPORT

Unit: _____ Date: _____ Time of Incident: _____

RESIDENT NAME: _____ ROOM # _____

of Birth: _____ Age: _____ Sex: _____ Race: _____

ry Diagnoses: _____

Cognitive Status: _____

NARRATIVE OF ACCIDENT/INCIDENT: _____

IMMEDIATE INTERVENTIONS: _____

WITNESS(ES):

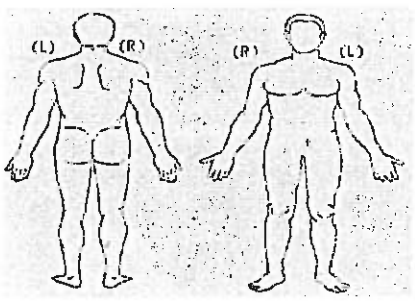
NAME _____ TELEPHONE: _____

NAME _____ TELEPHONE: _____

RESIDENT ASSESSMENT: VITAL SIGNS: B/P____ P_____ R_____ T_____

Primary Injury: (Mark location on diagram)

- ☐ No injury
- ☐ Contusion/Hematoma
- ☐ Laceration/Skin Tear
- ☐ Fractures
- ☐ Head involved
- ☐ Burn
- ☐ Swelling
- ☐ Redness
- ☐ Other _____



Narrative of Assessment: _____

TREATMENT

- ☐ First Aid in Facility
- ☐ Referred to ER/Clinic
- ☐ Hospitalized
- ☐ X-rayed
- ☐ None

DESCRIBE TREATMENT PROVIDED _____

Name of person completing report: _____ Date: _____

REVIEWED BY:

Director of Nursing: _____ Date: _____

al Director: _____ Date: _____

Administrator: _____ Date: _____

LOCATION: (Check all that apply)

- ☐ Resident Room
- ☐ Resident Bathroom
- ☐ Hall
- ☐ Dining Room
- ☐ Living Room
- ☐ Outside Facility
- ☐ Other _____

Nature of Accident/Incident

- ☐ Observed on floor
- ☐ Fall ☐ Bed ☐ Chair
  - ☐ Assisted
  - ☐ Unassisted
  - ☐ Ambulatory
- ☐ Injury during transfer care
- ☐ Self injury
- ☐ Choked
- ☐ Elopement
- ☐ Property: Broken/Missing
- ☐ Resistant to care/Combative
- ☐ Alleged Abuse
- ☐ Adverse medication reaction
- ☐ Altercation with other Resident
- ☐ Other: _____

RESTRAINT

Order as per Medical Record _____

Was restraint ON or OFF during time of incident/accident?

Side-rails: UP DOWN

Order as per Medical Record _____

NOTIFICATIONS:

PHYSICIAN:

Name _____

Date: _____ Time: _____

Time Responded: _____

Any New Orders? YES NO

RELATIVE/RESPONSIBLE PARTY

Name _____

Date: _____ Time: _____

SUPERVISOR:

Name _____

Date: _____ Time: _____

**For allegations of abuse, injuries requiring outside medication intervention, etc. Notify the DON and Administrator.

Name _____

Date: _____ Time: _____

Name _____

Date: _____ Time: _____

INCIDENT REPORT FORM

***FOR USE BY DHHS CONTRACTED/LICENSED PROVIDERS ONLY; DHHS STAFF TO USE IRIS**

Information to be typed whenever possible; Otherwise, clearly PRINT

Please check appropriate boxes and complete all applicable blanks
Use designated space on back of form for additional information as necessary

Type of Report ☐Initial Written Date/Time_____
☐Follow-up Date_____
☐Follow-up Date_____

TO _____ _____
Name of Division Director/Designee — Division

FROM _____ _____ _____
Name of Person Submitting Report — Provider/Program Name — Telephone

Type of Service/Program _____
(i.e., Mental Health, DD program, Day Treatment, Residential, etc.)

1) **OTHER NOTIFICATIONS** ..... **Enter method , date & time communicated when appropriate**

☐Adult Protective Services Hotline (1-800-482-8049). . . . . _____
☐Child Abuse Hotline (1-800-482-5964) . . . . . _____
☐DHHS Client Advocate. . . . . .
_____
☐DHHS Communications Director. . . . . .
_____
☐DHHS Office of Chief Counsel . . . . . _____
☐Next of Kin Relationship_____ _____
☐Responsible Party Relationship(if different than above)_____ _____
☐Law enforcement (Specify)_____ _____
☐Department of Health. . . . . _____
Other (Specify)_____ . . . . . _____

2) **VICTIM/COMPLAINANT/SUBJECT OF REPORT** [Check applicable box(es) Add address and phone if non-DHHS person]

☐Division Client ☐Foster Child ☐Client of Contract Agency ☐Staff/Employee ☐Other (Specify)_____

_____ _____ _____ _____
NAME — DOB or AGE — RACE — GENDER

3) _____ _____ _____
Date of Incident — **Time of Incident** — **Place of Incident**

4) **TYPE OF INCIDENT** (With information available at time of report, check/complete all that seem applicable)

☐Death . . . . . Suspected Cause of **Death**_____
☐Suicidal Behaviors
If checked, note date and results of clinical evaluation follow-up_____ ☐Pending
☐Rape
☐Maltreatment/Abuse/Exploitation
☐Neglect ☐Verbal ☐Physical ☐Sexual ☐Other_____
☐Injury
☐Client ☐Staff ☐Public Extent & Intervention_____
☐Missing Client (AWOL) (Report return of missing client as follow-up report)
☐Disturbance
☐Property Destruction . . . . . Extent_____
☐Theft – (to include Misappropriation of funds / property)
☐Arrest
☐Other _____
(Provided list not exhaustive; reference DHHS Policy 1090)

5) **DESIGNATION OF INCIDENT** [Check applicable box(es)]

☐Client-to-Client ☐Client-to-Staff ☐Self-Inflicted ☐Staff-to-Client ☐Client-to-Public ☐Public-to-Client ☐N/A
☐Other (Specify)_____

RE: _____
Name of Subject

6) ROLES (RELATIONSHIP TO SUBJECT) & NAMES OF OTHERS INVOLVED (Client, Staff, Witness, Participant, Perpetrator, etc.)
[Use separate line for each; Note all roles that apply per person, i.e. staff/participant, client/witness - identifiable abbreviations acceptable; Include addresses & phones of non-DHHS persons; Use designated space at bottom of page to provide additional information as needed]

Role(s)	Name	Address & Phone **if non-DHHS person**

CLEAR, CONCISE NARRATIVE DESCRIPTION (Include known essentials of who, what, when, where, why and how regarding incident)

8) SHOULD/COULD THIS INCIDENT HAVE BEEN PREVENTED/ANTICIPATED? ☐YES ☐NO

If yes, please explain_____

FINDINGS/OUTCOME/CASE DISPOSITION (When appropriate, include Corrective Action or Preventive Plan for future)
☐Pending Investigation ☐Investigated with following plan/action

USE THE FOLLOWING SPACES TO PROVIDE ADDITIONAL INFORMATION AS NEEDED
[Please enter the number(s) of section(s) being referenced for clarity]

DO NOT ATTACH ADDITIONAL DOCUMENTS: PROVIDER WILL BE CONTACTED FOR ADDITIONAL INFORMATION IF NEEDED
[EXCEPTION: CHILD DEATH FORM, CFS-329, TO BE SUBMITTED BY DCFS WITH DHHS-1910 WHEN APPLICABLE]

INCIDENT REPORT FORM *EXAMPLE*

***FOR USE BY DHHS CONTRACTED/LICENSED PROVIDERS ONLY; DHHS STAFF TO USE IRIS**

Information to be typed whenever possible; Otherwise, clearly PRINT

Please check appropriate boxes and complete all applicable blanks
Use designated space on back of form for additional information as necessary

Type of Report ☑ Initial Written Date/Time 5/9/11 1300
☐ Follow-up Date
☐ Follow-up Date

TO Ed Hood (Name of Division Director/Designee) DBHS (Division)

FROM Nancy Nurse (Name of Person Submitting Report) AHC (Provider/Program Name) Nurse's Station # (Telephone)

Type of Service/Program LTCF (i.e., Mental Health, DD program, Day Treatment, Residential, etc.)

1) OTHER NOTIFICATIONS ..... Enter method, date & time communicated when appropriate

☐ Adult Protective Services Hotline (1-800-482-8049) .....
☐ Child Abuse Hotline (1-800-482-5964) .....
☐ DHHS Client Advocate .....
☐ DHHS Communications Director .....
☐ DHHS Office of Chief Counsel .....
☒ Next of Kin Relationship Husband — phone, 5/9/11 1230
☐ Responsible Party Relationship (if different than above) .....
☒ Law enforcement (Specify) PSO S Durall — phone 5/9/11 1228
☐ Department of Health .....
☐ Other (Specify) Alivia phone on 5/9/11: 1235 DON T. Campbell; 1237 Adm. G.G. person; 1240 R. Mgmt - M. Smith; 1242 Dr Sudderth; 1245 Social Worker; RN name 1227

2) VICTIM/COMPLAINANT/SUBJECT OF REPORT [Check applicable box(es)] Add address and phone if non-DHHS person]

☒ Division Client ☐ Foster Child ☐ Client of Contract Agency ☐ Staff/Employee ☐ Other (Specify) .....

(victim) Jane Doe (NAME) | 3-4-56 (DOB or AGE) | Cauc. (RACE) | female (GENDER)

3) 5/9/11 (Date of Incident) | 1220 (Time of Incident) | Pine Court (Place of Incident)

4) TYPE OF INCIDENT (With information available at time of report, check/complete all that seem applicable)

* ☐ Death ..... Suspected Cause of Death *Complete if reporting death
* ☐ Suicidal Behaviors
If checked, note date and results of clinical evaluation follow-up Complete if reporting Suicidal behaviors ☐ Pending
☐ Rape
☒ Maltreatment/Abuse/Exploitation
☐ Neglect ☐ Verbal ☒ Physical ☐ Sexual ☐ Other .....
☐ Injury
☐ Client ☐ Staff ☐ Public Extent & Intervention .....
☐ Missing Client (AWOL) (Report return of missing client as follow-up report)
☐ Disturbance
☐ Property Destruction ..... Extent .....
☐ Theft – (to include Misappropriation of funds / property)
☐ Arrest
☐ Other .....
(Provided list not exhaustive; reference DHHS Policy 1090)

5) DESIGNATION OF INCIDENT [Check applicable box(es)]

☒ Client-to-Client ☐ Client-to-Staff ☐ Self-Inflicted ☐ Staff-to-Client ☐ Client-to-Public ☐ Public-to-Client ☐ N/A
☐ Other (Specify) .....

* EXAMPLE *

DHHS-1910 - Continued - Page 2 (Incident Report) RE: Jane Doe * EXAMPLE * Name of Subject

6) ROLES (RELATIONSHIP TO SUBJECT) & NAMES OF OTHERS INVOLVED (Client, Staff, Witness, Participant, Perpetrator, etc.)
[Use separate line for each; Note all roles that apply per person, i.e. staff/participant, client/witness - identifiable abbreviations acceptable; Include addresses & phones of non-DHHS persons; Use designated space at bottom of page to provide additional information as needed]

Role(s)	Name	Address & Phone if non-DHHS person
RN	Nancy Nurse	AHC - 6701 Hwy 67, Benton AR
(Agency) Caregiver	Annie Aide	1234 Benny Hanna Dr; Hallelujah AR
* Be sure to identify if Agency *		
Resident/Aggressor	Resident X name	AHC

CLEAR, CONCISE NARRATIVE DESCRIPTION (Include known essentials of who, what, when, where, why and how regarding incident)

On 5/9/11 at approx 1220pm Resident X was noted hitting Jane Doe in the face while outside during smoke break. Jane Doe was struck in the eye(R) causing a large red area around the eye socket.

(STP) Staff immediately intervened & separated R's. Proper notifications made. Orders relieved to apply ice pack to (R) eye for 15-30" as tolerated

(LTP) See Bottom for examples

8) SHOULD/COULD THIS INCIDENT HAVE BEEN PREVENTED/ANTICIPATED? ☐YES ☐NO

If yes, please explain < no need to complete unless it was anticipated or should have been prevented >

9) FINDINGS/OUTCOME/CASE DISPOSITION (When appropriate, include Corrective Action or Preventive Plan for future)
☐Pending Investigation ☐Investigated with following plan/action

* DO NOT have to check or complete this area *

* EXAMPLE *

USE THE FOLLOWING SPACES TO PROVIDE ADDITIONAL INFORMATION AS NEEDED
[Please enter the number(s) of section(s) being referenced for clarity]

(LTP) Examples of possible options - NOT all-inclusive by any means.

1) R will be monitored closely & kept separated during smoking break for the next 48 hours.

2) Aggressor placed 1:1 until calm & verbalizes no hostility regarding this incident (OR) Aggressor placed 1:1 until seen by MD.

3) Residents will smoke at separate times for 48 hrs & then re-evaluate

DO NOT ATTACH ADDITIONAL DOCUMENTS: PROVIDER WILL BE CONTACTED FOR ADDITIONAL INFORMATION IF NEEDED
[EXCEPTION: CHILD DEATH FORM, CFS-329, TO BE SUBMITTED BY DCFS WITH DHHS-1910 WHEN APPLICABLE]

(STP) Short Term Safety Plan; (LTP) Long Term Safety Plan

ARKANSAS HEALTH CENTER
ACCIDENT/INCIDENT REPORT

EXAMPLE

Unit: Pine Court Date: 5/9/11 Time of Incident: 1220

RESIDENT NAME: Jane Doe ROOM # 2

Birth: 3-4-56 Age: 55 Sex: female Race: Cauc

Primary Diagnoses: Schizophrenia; COPD; NIDDM

Cognitive Status: Alert but confused

NARRATIVE OF ACCIDENT/INCIDENT: While Outside Smoking this resident was Struck in the face by another female R. Large red area noted to (R) eye Socket.

IMMEDIATE INTERVENTIONS: R were immediately Separated; R facial area assessed for injury

WITNESS(ES):

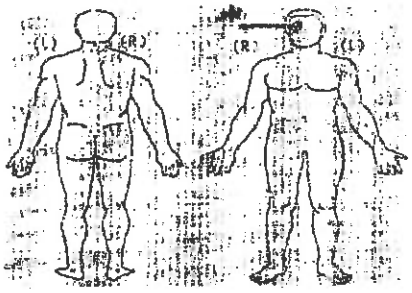
NAME Nancy Nurse TELEPHONE: XXX-XXXX

NAME Annie Aide (Ag) TELEPHONE 000-0000

RESIDENT ASSESSMENT: VITAL SIGNS: B/P 137/68 P 82 R 20 T 98.9

Primary Injury: (Mark location on diagram)

- [ ] No injury
- [ ] Contusion/Hematoma
- [ ] Laceration/Skin Tear
- [ ] Fractures
- [ ] Head Involved
- [ ] Burn
- [X] Swelling
- [X] Redness
- [ ] Other _____



Narrative of Assessment: (R) eye noted to have large red area around eye Socket. Slight edema noted.

TREATMENT

- [X] First Aid in Facility
- [ ] Referred to ER/Clinic
- [ ] Hospitalized
- [ ] X-rayed
- [ ] None

DESCRIBE TREATMENT PROVIDED: Ice pack as tolerated for 15-30 minutes; monitor for pain

Name of person completing report: Nancy Nurse Date: 5/9/11

REVIEWED BY:

Director of Nursing: _____ Date: _____

[illegible] Director: _____ Date: _____

[illegible]strator: _____ Date: _____

LOCATION: (Check all that apply)

- [ ] Resident Room
- [ ] Resident Bathroom
- [ ] Hall
- [ ] Dining Room
- [ ] Living Room
- [X] Outside Facility
- [X] Other: Smoking patio Pine

Nature of Accident/Incident

- [ ] Observed on floor
- [ ] Fall — [ ] Bed [ ] Chair; [ ] Assisted; [ ] Unassisted; [ ] Ambulatory
- [ ] Injury during transfer care
- [ ] Self injury
- [ ] Choked
- [ ] Elopement
- [ ] Property: Broken/Missing
- [ ] Resistant to care/Combative
- [ ] Alleged Abuse
- [ ] Adverse medication reaction
- [X] Altercation with other Resident
- [ ] Other: _____

RESTRAINT

Order as per Medical Record NA

Was restraint ON or OFF during time of incident/accident?

Side-rails: UP DOWN

Order as per Medical Record _____

NOTIFICATIONS:

PHYSICIAN:

Name Dr Sudderth

Date: 5/9/11 Time: 1242

Time Responded: 1250

Any New Orders? (YES) NO

RELATIVE/RESPONSIBLE PARTY

Name John Doe

Date: 5/9/11 Time: 1230

SUPERVISOR

Name RN Supv name

Date: 5/9/11 Time: 1227

**For allegations of abuse, injuries requiring outside medication intervention, etc Notify the DON and Administrator

Name NA

Date: _____ Time: _____

Name _____

Date: _____ Time: _____

EXAMPLE

ARKANSAS HEALTH CENTER INCIDENT/ACCIDENT LOG

DATE	UNIT	TIME	RESIDENT NAME	DESCRIPTION OF EVENT	P:PERP V:VICTIM	INJURY	OBSERVATION STATUS	COMMENTS

revised April 2011

1. PURPOSE. This policy establishes requirements and procedures for prompt reporting and handling of serious incidents/situations that may affect the health, safety, and/or property of Arkansas Health Center residents, employees, volunteers or visitors. The policy is in addition to the present requirements for completing Assault or Injury, Unauthorized Absence, and/or Employee's Report of Injury forms when applicable.

2. SCOPE. This policy is applicable to all Arkansas Health Center personnel. Administrators, department heads and/or program directors are responsible for ensuring that all applicable incidents are reported as outlined in this policy. These policies and procedures will be included in orientation training for all new employees and will be addressed at least annually in in-service training for all facility staff.

3. POLICY. All reportable incidents occurring at Arkansas Health Center will be immediately reported to the Facility Director, Nursing Home Administrator and the Director of Nursing by the senior person in charge of the area where the incident occurred. The Nursing Home Administrator or his designee will notify other appropriate officials and/or agencies. The Office of Long Term Care must be notified of all incidents as listed in Section 5.

4. APPLICABLE INCIDENTS TO BE REPORTED:

   A. Absence/Elopement shall mean circumstances when the resident cannot be located or has left the facility without authorization or there is sufficient question as to the whereabouts of the resident. Any resident whose participation in a program (as defined herein) can be terminated by the resident and does not require restriction, shall not be considered absent. If there is reason to believe such resident, upon discharge, may be an endangered adult (see Section 306.4.6 of the LTC Regulations) the facility remains obligated to make reports required by law (see Section 306.4 of the LTC Regulations).

   B. Maltreatment: (May include any or all of the following, Physical, Mental or Sexual Abuse, Neglect, Exploitation, Involuntary Seclusion, or Injury of Unknown Origin)
      a. Abuse
         1. Physical and Sexual - Any intentional and unnecessary physical act which inflicts pain on or causes injury to an endangered adult, including sexual abuse. Examples of physical abuse include, but are not limited to hitting, slapping, pinching, biting, kicking and controlling behavior through corporal punishment. Examples of sexual abuse include sexual harassment, sexual coercion, and sexual assault.
         2. Mental - Any intentional or demeaning act which subjects an endangered adult to ridicule or psychological injury in a manner likely to provoke fear or alarm, including humiliation, threats of punishment, or deprivation.
         3. Verbal - Use of oral, written or gestured language that willfully includes disparaging and derogatory terms to the residents. This includes anything said within hearing distance of those served, regardless of age, ability to comprehend, or disability. Some examples include, but are not limited to, cursing a resident, threatening harm, saying things to frighten or intimidate a resident.

c. Neglect:
1. Negligently failing to provide necessary treatment, rehabilitation, care, food, clothing, shelter, supervision, or medical services to an endangered adult.
2. Negligently failing to report health problems or changes in health problems or changes in health condition of an endangered adult tot he appropriate medical personnel
3. Negligently failing to carry out a prescribed treatment.

C. Misappropriate of Resident Property: Deliberate misplacement or wrongful use of a resident's belongings to include money, personal possessions, medications, etc.

D. Death - The death of any person from violence or neglect, whether apparently homicidal, suicidal, accidental or industrial, including but not limited to death due to suspected or actual abuse, neglect, thermal, chemical, electrical or radiation injury, and death due to criminal abortion, whether apparently self-induced or not, or suddenly when in apparent good health.

E. Death by Natural Cause - means death from natural causes including those deaths of residents under a physician's care whose end has been anticipated and/or deaths that do not meet the criteria outlined in "Death" above.

F. Disruption of Service Delivery - Disruption of service delivery which results in involuntary closure of AHC.

G. Endangered adult:
1. An adult eighteen (18) years of age or older who is found to be in a situation or condition which poses an imminent risk of death or serious bodily harm to that person and who demonstrates the lack of capacity to comprehend the nature and consequences of remaining in that situation or condition; or
2. A resident eighteen (18) years of age or older of a long term care facility, which is required to be licensed under Arkansas Code Annotated 20-10-224, who is found to be in a situation or condition which poses an imminent risk of death or serious bodily harm to such person and who demonstrates the lack of capacity to comprehend the nature and consequences of remaining in that situation or condition.

H. Epidemic Or Serious Communicable Disease – as defined by the State Department of Health.

I. Natural Disaster – tornadoes, floods, earthquakes, fires, etc., which place employees or residents in potential danger.

J. Prevention of Service Delivery: any condition or event that prevents the delivery of services for more than two hours (interruption in telephone service or the inability to fully occupy the facility due to fire, flood or other disaster. No report is necessary if the office is closed by Governor's Proclamation.

K. Property Damage - which results in the loss of state property exceeding $100.00, destruction of any significant property of others, major equipment failure, including loss of heat/air conditioning, loss

of fire alarm systems, or the disappearance of major property/supplies no matter the cause.

L. Serious Injury– An injury involving AHC residents, visitors, or employees which occur on AHC property or involve an AHC employee acting in their official capacity which may cause death or which is likely to result in substantial permanent injury.

M. Significant Injury – An injury involving AHC residents, visitors, or employee which occur on AHC property or involve an AHC employee acting in their official capacity which requires the medical attention of an Emergency Medical Technician (EMT), a paramedic or an off site physician.

N. Suspected Criminal Activity - where there exists reasonable cause to suspect a crime has been committed in the administration of a program by or upon a person while participating in a program. For further general principles to determine whether conduct is criminal, see DHS Policy 1090 Attachment A.

O. Arrest or Conviction of: an AHC resident or employee while acting in their official capacity.

P. Suspected illegal use of Drugs or Intoxicants - Where there exists reasonable cause to suspect the presence of illegal drugs or intoxicants on the premises.

Q. Suspected Use Of Or Persons Under The Influence Of Illegal Drugs Or Intoxicants – Where there exists reasonable cause to suspect use of/or persons under the influence of illegal drugs or intoxicants while on AHC property.

6. NEXT-BUSINESS-DAY REPORTING OF INCIDENTS:

5. The following events shall be reported to the Office of Long Term Care via email of the completed Incident & Accident Intake Form (Form DHS-1910) no later than 11:00 a.m. on the next business day following discovery by the facility. A listing of all persons to be contacted with phone numbers will be kept updated and available at the AHC Communications Office, with the DON and in the Shift RN Office. The AHC Communications Office will be responsible for keeping the list with phone numbers up to date and changes forwarded to the specified locations in Nursing Service.

a. Any alleged, suspected or witnessed occurrences of maltreatment.
b. Any accident or unusual occurrence that results in the death of an AHC resident. NOTE: This does not include death by natural causes.
c. Any fire or explosion within Arkansas Health Center.
d. Any disaster at Arkansas Health Center (i.e. tornado, flood, nuclear disaster, toxic waste spill, etc.
e. Violent acts within Arkansas Health Center such as shooting, rape, robbery, or assault. NOTE: This does not include conflicts between residents with no physical consequence.
f. Major power outages or losses of heat/air conditioning lasting for more than two hours and resulting in temperature deviation from the normal range required in state and federal regulations.

g. Any suspected occurrences of abuse and/or neglect to residents (including injuries of unknown sources and regardless of treatment outside the facility, whether or not occurring on facility premises).

h. Any suspected occurrence of misappropriation of resident property. Misappropriation shall be defined as circumstances where AHC or its employee(s) knowingly place a resident's property, or knowingly permits a resident's property to be placed, in the possession or control of someone other than the resident, except as provided in AHC Policies and Procedures.

i. Absence/elopement of a resident from the facility. If the resident cannot be located within two hours, he/she shall be considered absent.

In addition to the requirement of an email report by the next business day on Form DHS-1910, the facility shall complete a Form DMS-762 in accordance with Sections 7 & 8.

7. INCIDENTS OR OCCURRENCES THAT REQUIRE INTERNAL REPORTING ONLY – 1910 REPORT OR FORM DMS.

The following incidents or occurrences shall require the nursing facility to prepare an internal report **only** and **does not require** a facsimile report, or form DMS-762 to be made to the Office of Long Term Care. The internal report shall include all content specified in Section 8, as applicable. Nursing facilities must maintain these incident record files in a manner that allows verification of compliance with this provision.

a. Incidents where a resident attempts to cause physical injury to another resident without resultant injury. The facility shall maintain written reports on these types of incidents to document "patterns" of behavior for subsequent actions.

b. All cases of reportable disease, as required by the Arkansas Department of Health.

c. Loss of heating, air conditioning or fire alarm system of greater than two (2) hours duration.

8. INTERNAL-ONLY REPORTING PROCEDURE:

Written reports of all incidents and accidents included in section 7 shall be completed within five (5) days after discovery. The written incident and accident reports shall be comprised of all information specified in forms DHS-1910 and 762 as applicable.

All written reports will be reviewed, initialed and dated by the facility administrator or designee within five (5) days after discovery. All reports involving accident or injury to residents will also be reviewed, initialed and dated by the Director of Nursing Services or other facility R.N.

Reports of incidents specified in Section 7 will be maintained in the facility **only** and are not required to be submitted to the Office of Long Term Care.

All written incident and accident reports shall be maintained on file in the facility for a period of three (3) years.

9. OTHER REPORTING REQUIREMENTS:

A. The facility's administrator/designee is also required to make any other reports of incidents, accidents, suspected abuse or neglect, actual or suspected criminal conduct, etc. as required by state and federal laws and regulations.

a. Contacts with these services will be documented. Some examples are as follows:

1. The State Health Department should be contacted for any epidemics.
2. The Arkansas State Police, DHS Advocate, Saline County Sheriff, and Prosecuting Attorney are to be notified of any resident abuse and death from violence or criminal activity.
3. The Saline County Coroner and Sate Medical Examiner are to be notified of any deaths caused by violence. The Coroner and State Medical Examiner will be asked if they have any instructions regarding autopsies and/or notification to the local judicial prosecutor.

B. Appropriate AHC department heads should be contacted in the following situations.

1. The Administrator on Call and Director of Nursing/Designee are to be notified of all deaths, including deaths due to natural causes.
2. Appropriate department heads are to be contacted for disasters, property damage or major property/supplies disappearance for any cause affecting at AHC (Also see AHC Emergency Preparedness Plan).

C. Written reports of all incidents and accidents shall be completed within 72 hours after occurrence. The written incident and accident reports shall be comprised of all information specified above in Section 7.A. and in Section 8. OLTC forms entitled Facility Investigation Report for Resident Abuse, Neglect or Misappropriation of Property in Long Term Care Facilities Sections I through V and OLTC Witness Statement Form meet the requirements for reporting abuse, neglect or misappropriation of funds. DHS Form 1910 Incident Report must also be completed for submission to DHS. For incidents involving a resident injury MHS form 1125 Assault or Injury Report must be completed.

D. The administrator/designee will review and track all incident and accident reports. The AHC Quality Assurance Committee will review and track these incidents during its quarterly meetings and Risk Management Meetings. The purpose of these reviews is to identify health and safety hazards.

E. INCIDENT AND ACCIDENT REPORTS.

A. Content of reports

1. Full name, age, race and sex of any involved residents.
2. Full name, age race and sex of any involved AHC personnel.
3. Full name, age, race and sex of any accused party.
4. Time and location of incident
5. Time and date of the report. The identity of the person for which the report is given.
6. Name, address and telephone number of the facility administrator, or, in his/her absence, designee in charge of handling the situation.
7. Description/summary of the incident.
8. Status of the situation at the time the report is made.

E. RESIDENT FOLLOW-UP.

A. The complete vital signs, including temperature, of any involved residents shall be included in the initial examination of the resident following the incident/accident. The condition of any residents involved in the incident shall be addressed on the nurses' notes each shift for a minimum of 48 hours.

10. MALTREATMENT INVESTIGATION REPORT:

The facility must ensure that all alleged or suspected incidents involving maltreatment are thoroughly investigated. The facility's investigation must be in conformance with the process and documentation requirements specified on the form designated by the Office of Long Term Care, Form DMS-762, and must prevent further potential incidents while the investigation is in progress.

The results of all investigations must be reported to the facility's administrator, or designated representative, and to other officials in accordance with state law, including the Office of Long Term Care. Reports to the Office of Long Term Care shall be made via facsimile transmission by 11:00 a.m. the next business day following discovery by the facility, on form DHS-1910. The follow-up investigation report, made on form DMS-762, shall be submitted to the Office of Long Term Care within 5 working days of the date of the submission of the DHS-1910 to the Office of Long Term Care. If the alleged violation is verified, appropriate corrective action must be taken.

The DMS-762 may be amended and re-submitted at any time circumstances require.

11. REPORTING SUSPECTED MALTREATMENT:

A. The requirement that the facility's administrator or his or her designated agent immediately reports all cases of suspected abuse or neglect of residents of a long-term care facility as specified below:

a. Suspected abuse or neglect of an adult (18 years old or older) shall be reported to the local law enforcement agency in which the facility is located, as required by Arkansas Code Annotated 5-28-203(b).

b. Suspected abuse or neglect of a child (under 18 years of age) shall be reported to the local law enforcement agency and to the central intake unit of the Department of Human Services, as required by Act 1208 of 1991. Central intake may be notified by telephone at 1-800-482-5964.

B. The requirement that the facility's administrator or his or her designated agent report suspected abuse or neglect to the Office of Long Term Care as specified in this regulation.

C. The requirement that facility personnel, including but not limited to, licensed nurses, nursing assistants, physicians, social workers, mental health professionals and other employees in the facility who have reasonable cause to suspect that a resident has been subjected to conditions or circumstances which have or could have resulted in abuse or

neglect are required to immediately notify the facility administrator or his or her designated agent.

D. The requirement that, upon hiring, each facility employee be given a copy of the Maltreatment reporting and prevention policies and procedures (AP 405) and sign a statement that the policies and procedures have been received and read. The statement shall be filed in the employee's personnel file.

E. The requirement that all facility personnel receive annual, in-service training in identifying, reporting and preventing suspected Maltreatment, and that the facility develops and maintains policies and procedures for the prevention of Maltreatment, and accidents.

AHC Director _____ Date _____

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 varying hazards posed by the communicable diseases, degrees of isolation have been designated. All isolation procedures fall into the following categories.

   A. Standard (Universal) Isolation
   B. Droplet Isolation
   C. Airborne isolation
   D. Contact Isolation

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. Biohazard sign will be posted on the chart.
   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 contact 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).
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 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 change 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 physicians.

R. 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.

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

T. 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.

U. 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.

V. 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 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.

W. Refer to the Nursing Service procedure manual.

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

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. Shoe protectors will be worn when entering the room. Gown and gloves will be added for resident contact. 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 gown, gloves and shoe protectors 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 residents (cohort).

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. 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.
i. 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.
j. 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 with 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 negative cultures are obtained from the nares, urine and skin/ wounds concurrently. If the resident is febrile or symptomatic, you must obtain a 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**

CMS LAB REQUIREMENTS

THYROID SUPPLEMENTS	THYROID FUNCTION ASSESSMENT Q YEAR
ANIT-COAGULANT THERAPY	MONTHLY LAB
INSULIN OR ORAL HYPOGLYCEMICS	FINGER STICK DAILY OR FBS Q 60 DAYS
VITAMIN B-12 IRON PREPS OR FOLIC ACID	RED BLOOD CELL ASSESSMENT (H/H) WITHIN IN 30 DAYS AND Q YEAR
MANDELAMINE, HIPREX BACTRIM, NITROFURANTION, FURANTIN OR UREX	UA WITH IN 30 DAYS & Q YEAR
MANDELAMINE OR HIPEX	URINE PH WITHIN 30 DAYS (pH must be less than 6)
NIRTOFURANTION	BUN OR SERUM CREATINE W/IN 30 DAYS & Q YR
AMINOGLYCOSIDES (GENTAMYCIN, NEBCIN, AMIKIN, KANTREX)	SERUM CREATINE UPON INITIATION OF THERAPY
LANOXIN (DIGOXIN)	DIG LEVEL Q YEAR (Lanoxin 0.25mg or more Q days or elevated creatine recommend baseline dig level with in 30 days)
DIURETICS DIURETICS & CARDIOTONICS	K+ LEVEL WITHIN 30 DAYS & Q YEAR K+ LEVEL WITHIN 30 DAYS & Q 6 MONTHS
THEOPHYLLINE	THEOPHYLLINE LEVEL Q YEAR
QUINIDINE	QUINIDINE LEVEL Q YEAR
LITHIUM	LITHIUM LEVEL Q 6 MONTHS
PHENOBARBITAL	PHENOBARBITAL LEVEL Q YEAR
DEPAKOTE/DEPAKENE	VALPROIC ACID LEVEL Q YEAR (if given for seizures)
DILANTIN	PHENYTOIN LEVEL Q YEAR (More often if seizures occur)
TEGRETOL	CARBAMAZEPINE LEVEL Q YEAR (more often if seizures occur)
ANEMIC RESIDENTS	H & H Q 3 MONTHS (Recommendation)
TUBE FEEDERS	LYTES Q 3 MONTHS (recommendation)
ANTIOBIOTIC THERAPY W/ COUMADIN	PT AFTER 4TH DAY OF ABT THEN Q MONTH
ZYPREXA, RISPERDAL, SEROQUEL ABILIFY, GEODON, CLOZARIL DEPAKOTE	BASELINE BLOOD SUGAR & Q 6 MONTHS
CLOZARIL	CHECK WITH MD REGARDING WBC/CBC

Policy Type	Subject of Policy	Policy No.
Nursing	Labs	NS

PURPOSE: It is the purpose of this policy to ensure that all lab tests are handled in a timely and orderly manner and labs are completed as ordered by the physician.

SCOPE: Licensed nurses, Lab Techs

POLICY: It is the policy of the Arkansas Health Center to ensure labs are obtained as ordered by the physician.

PROCEDURE:

1. Orders for labs

    a. Upon receiving an order for a lab, the nurse will process the order and notify the lab by completing and faxing a lab request form.

    b. The nurse will enter the appropriate information in the lab order notebook located at each nurse's station.

    c. Upon receipt of the lab request, the Lab Tech will obtain the specimen as ordered by the physician and record the date the specimen was obtained along with his or her initials beside the corresponding order in the lab notebook.

    d. The results will be delivered to the unit and the unit RN Supervisor/Designee will note the receipt of the lab report in the lab notebook by placing the date the report was received in the section titled "Results Available"

    e. For routine lab draws resulting in critical lab values or non-routine lab orders (i.e., STAT labs), the RN Supervisor/Designee will promptly notify the physician and record date and time of notification along with any new orders in the nurses' notes as well as on the lab report.

    f. For all other routine lab draws, the Unit RN Supervisor/Designee will place the lab report in the physician folder for review and signature during the physician's next rounds.

    g. After the physician has reviewed the lab results and initialed /signed the lab report, the Administrative Assistant/Designee will file the form in the resident's medical record behind the "Lab Tab"

2. Conducting lab audits:

   A. All routine laboratory orders will be entered in the computer as follows:

      a. Name of test to be completed

      b. Frequency (Avoid placing specific months in the order) example: "CBC Q 6 months" AND NOT CBC Q 6 months (Jan & June)

      c. All laboratory tests should be coded under "Labs" when entered in the computer (exclude orders that may be completed on the unit such as Finger Stick Blood Sugars)

   B. The Unit RN Supervisor will print a lab list from the computer each month.

   C. The Unit RN Supervisor/Designee will conduct a lab audit for each resident on the unit by reviewing the results of each lab test ordered and recording the date of the most recent results available in the medical record on the computer printed lab list beside the corresponding order.

   D. Once the audit is completed, the Unit RN Supervisor/Designee will review the computer printed lab list and highlight all labs due for the month including the resident's name, and the type of test to be conducted.

   E. The Unit RN Supervisor/Designee will COMPILE a list of ALL labs to be completed for the month and fax this list to the lab department.

   F. The list of lab draws will be filed in a three ring binder labeled "LABS" by the first day of each month

   G. The lab will review their orders to ensure orders match with the Unit lab audit

   H. Any discrepancies noted by lab or unit audit will be discussed with Unit RN Supervisor/Designee and lab tech to verify correct orders.

Director of Nursing		**Date**
Director		**Date**

ARKANSAS HEALTH CENTER
REQUEST FOR LAB

UNIT:

DATE OF ORDER	RESIDENTS NAME	ROOM #	TYPE OF TEST ORDERED	FREQUENCY	REASON FOR LAB	DUE DATE

FAXED TO LAB BY: _____

DATE: _____

*******Enter above information on the Lab Order Form in the lab notebook*******

Revised April 2011

DATE ORDERED	RESIDENT NAME	ROOM #	TYPE OF TEST TO BE COMPLETED	DUE DATE	DATE SPECIMEN DRAWN	SITE DRAWN	LAB TECH INITIALS	MARK/INITIAL WHEN RESULTS AVAILABLE

1. **PURPOSE.** It is the purpose of this policy to assure protection of the residents of Arkansas Health Center (AHC) from any form of maltreatment, to include resident abuse, neglect, exploitation, and misappropriation of property; and to establish guidelines for reporting and investigating possible maltreatment.

2. **SCOPE**. All AHC staff, residents, employees, nursing agency staff, volunteers, and visitors to the facility.

3. **POLICY.** It is the policy of AHC to ensure that a system will be utilized to prevent, detect, and report, resident maltreatment, abuse, neglect, exploitation, and misappropriation of property. AHC will not employ, contract with, or accept, any volunteer services from any individual whose name appears on state maltreatment registries, or who has a documented history of maltreatment, abuse, or neglect.

4. **DEFINITIONS:** The following definitions are applicable guidelines regarding residents and are not necessarily all-inclusive.

   A. **Maltreatment:** For purposes of this policy, reference to maltreatment may include any or all of the following definitions or any associated actions.

   B. **Verbal Abuse:** Use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents. This includes anything said within hearing distance of those served, regardless of age, ability to comprehend, or disability. Some examples are: cursing a resident; threatening harm; saying things to frighten or intimidate a resident such as telling him/her that he/she will never be able to see his/her family again.

   C. **Sexual Abuse:** Sexual harassment, sexual coercion, or sexual assault.

   D. **Physical Abuse:** Hitting, slapping, pinching, biting, and kicking. It also includes controlling behavior through corporal punishment.

   E. **Mental Abuse:** Humiliation, harassment, threats of punishment, or deprivation.

   F. **Neglect:** Failure to provide any goods and services necessary for resident care that could result in mental anguish or distress.

   G. **Misappropriation of Resident Property:** Deliberate misplacement or wrongful use of a resident's belongings to include money, personal possessions, medications, etc.

   H. **Exploitation:** Any unjust or improper use of a resident, his/her assets, or property, for profit or advantage of another.

   I. **Involuntary Seclusion:** Separation of a resident from other residents or from his/her room or confinement to his/her room or other location (with or without roommates) against the will of the resident or the resident's legal representative. Involuntary seclusion does not include temporary therapeutic seclusion used as an intervention.

J. **Injury of Unknown Origin:** Discovery of a physical injury to a resident for which the cause is unknown.

K. **Expedited Investigation:** An expedited investigation may be granted only by the administrator on call (AOC) and does not alter any documentation requirements. An expedited investigation differs from a regular investigation **only** in that, following immediate, temporary separation/sequestering of the accused employee from all residents, the AOC may direct an immediate review/investigation of related facts by on-site investigators. If the resident's plan of care identifies a history of false allegations such as are present in the current allegation, **and** preliminary evidence reviewed by on-site investigators reveals no evidence to lend credence to the allegation, the AOC may permit the accused staff to return to duty. The remainder of the investigation will conform to all regulatory requirements (1910's, witness statements, and a 762).

PROCEDURES. Applies to all employees of AHC and full-time volunteers.

A. SCREENING:

1. Application For Employment or Full-Time Volunteer:

   a. Each applicant or full-time volunteer will complete and submit a State of Arkansas Employment Application or an application to serve as a full-time volunteer.

   b. Each applicant or full-time employee will complete a Request for Criminal Record Check.

   c. Each applicant or full-time employee must submit to a urine drug screen.

2. Registries, Licenses, and References:

   a. The Public Safety Office will contact the appropriate agency concerning the application for employment or volunteer.

   b. If an applicant indicates that he/she has been employed under another State Registry, that registry will also be notified.

   c. The hiring Supervisor will contact the appropriate state-licensing agency to verify the applicant's license prior to employment. In the event that the applicant has been licensed in another state, that licensing agency will also be contacted for license verification.

   d. Reference checks will be obtained prior to employment. Negative references should be considered when determining appropriateness for employment.

   e. The Public Safety Office will conduct background, central registry and FBI checks of applicants. Background checks will include:

      (1) Adult and Child Central Registries

(2) Criminal Background Checks

B. TRAINING:

1. New AHC employees will attend New Employee Orientation and receive training regarding the facility's Maltreatment Prevention Policy (AP405) prior to resident contact. Training of the full-time volunteer may also be provided by the Staff Development Department or supervisor of the Department to which the person is assigned. The individual receiving the maltreatment policy and training will sign acknowledgement of receipt of the information and training. Staff Development will ensure the training is provided for any employee missing New Employee Orientation prior to his/her resident contact.

2. Supervisors of volunteers and all independent agency employees working at AHC shall, upon initial arrival of the worker/volunteer and prior to resident contact, provide the person a copy of the AHC Maltreatment Prevention Policy (AP405). The supervisor will obtain that person's signature that he/she has read and understands his/her responsibility regarding maltreatment prevention and reporting at AHC.

3. Ongoing staff refresher training regarding maltreatment prevention will be provided by the Staff Development Department at least annually, and more frequently as necessary. Training topics for both new employees and refresher training will include, but is not limited to, the following:

   a. Definitions of maltreatment

   b. Appropriate interventions to deal with agitated, disruptive, destructive, dangerous behaviors, including threats of lethal behaviors from residents.

   c. Policy, procedure, and mandated requirements for reporting maltreatment, and provision of reassurance that such can be done without fear of reprisal.

   d. Recognition/identification of signs of "burn-out", stress, and/or frustration that could lead to maltreatment and the appropriate actions to take in such situations.

C. IDENTIFICATION

1. Incident and Accident (I&A) Reports will be reviewed to determine: Injuries of undetermined origin; the probable source of such injury; patterns and trends; appropriate interventions to deter recurrence; and to assess the likelihood [or possibility] of maltreatment.

   a. If review reveals that evaluation by another discipline is indicated, referral for such will be made to the appropriate department for follow up. For example: A resident with an injury determined to be related to a fall may be referred to Physical Therapy for evaluation. Any subsequent recommendations resulting from such referrals will be directed to unit staff for consideration, implementation, and any orders or care planning deemed appropriate. Documentation of referrals resulting from I&A

reviews will be maintained in facility files for reference as needed.

b. If review results in a determination that maltreatment is suspected, the injury will be reported and investigated according to AHC policy.

c. These reviews and determinations will routinely occur as a collaborative effort between the Risk Management, Public Safety, and Nursing Services Departments. Involvement of other disciplines, departments, and administration will be incorporated as necessary.

2. All reports of maltreatment for which no perpetrator is identified, as well as injuries of undetermined origin, will also be monitored for trends/patterns.

D. PREVENTION

1. AHC will identify, analyze and intervene in situations, which could foster maltreatment. This will include an on-going analysis of the following:

a. An analysis of resident needs and abilities is determined upon admission and continues throughout residence of AHC. The most appropriate placement is determined based on the training and knowledge of the staff assigned to each unit, the resident's specific needs, and the overall unit milieu. Additional training may be conducted as dictated by changing resident needs.

b. The deployment of staff on each shift in sufficient numbers to meet the specific needs of the residents and Office of Long Term Care (OLTC) standards.

c. Supervision of staff to identify inappropriate behaviors, such as using derogatory language, rough handling, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their bed.

d. The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors; residents who have intrusive behaviors, such as entering other residents' rooms, inappropriate sexual displays; residents with self-injurious behaviors; residents with communication disorders; those that require heavy nursing care; and/or are totally dependent upon staff.

e. The features of the physical environment that could foster the occurrence of maltreatment, such as secluded areas of the facility.

E. REPORTING

1. Facility staff, agency staff, and AHC full-time volunteers are mandated to report all injuries of unknown origin, and allegations of maltreatment, whether witnessed, suspected, or alleged/reported by another, for investigation.

2. Facility staff, agency staff, and volunteers are also required to report all injuries of

unknown origin for review and follow up as needed.

3. Families and other visitors are requested and strongly encouraged to report any suspicions, reports, observations, or knowledge of maltreatment, injuries of unknown origin, or any other suspicions or concerns they may have to AHC administration. Those wishing to voice anonymous concerns or complaints regarding this or other Arkansas long-term care facilities may do so by calling the OLTC Nursing Home Complaint Hotline toll free at: 1-800-582-4887.

4. The Risk Management Department will report maltreatment allegations, and injuries in which maltreatment is suspected as a cause, to OLTC via the DHHS Incident Reporting Information System (IRIS).

5. Any employee that is witness to, has knowledge of, or suspects maltreatment, or any employee to whom a report of maltreatment has been made, regardless of the source of the information, will immediately notify his/her supervisor. The reporting staff will also complete and submit DMS OLTC 762 Witness Statement reflecting any information they have regarding the events surrounding the maltreatment allegation.

6. In the event of multiple witnesses to maltreatment, responsibility for reporting lies equally with each witness. Each witness should verify with the direct supervisor that the maltreatment has been reported, and each witness is required to complete and submit a DMS OLTC 762 Witness Statement reflecting any information they have regarding the events surrounding the maltreatment allegation.

7. Upon being informed of an allegation of maltreatment, the direct supervisor will immediately notify the Administrator and Director of Nurses (DON) on call.

8. If the employee's direct supervisor is the alleged perpetrator of maltreatment, the employee is to report the allegation to the next supervisory level. If the employee feels the supervisor did not appropriately report the allegation the employee must report the incident to the next supervisory level. Per statute, the AHC Director ranks highest in the chain of command for AHC maltreatment reports.

9. Upon receiving a report of resident maltreatment, the direct supervisor will notify the nursing supervisor who will contact the Administrator and DON on call. The nursing supervisor will also notify the physician on duty, resident representative, and the Public Safety Office.

10. Any reported suspicion or allegation of abuse of an AHC resident that occurred outside the authority of AHC, such as at home or during hospitalizations will be reported to OLTC and the appropriate investigative entity, such as the DHHS Divisions of Health or Aging and Adult Services - Adult Protective Services Section, or law enforcement, for follow up.

F. PROTECTION:

1. Employees, volunteers, residents, and resident representatives should voice any knowledge of, or concerns related to possible maltreatment without fear of retribution.

Retribution or reprisal for reporting is strictly prohibited. Any violations that are determined to occur will be handled via strict disciplinary actions in accordance with policy.

2. When notified of possible maltreatment, the administrator on call will direct immediate action to protect the resident and/or residents. Protective actions may include, but are not limited to: Separation of the resident and/or residents from any potential or perceived threat; temporary or permanent reassignment; removal of an employee or resident allegedly involved in the maltreatment; and/or resident relocation or transfer.

   a. Whenever the alleged perpetrator is an employee, the employee is to have no contact with the resident allegedly involved. The administrator on call will determined if the nature of the allegation warrants the employee's removal from all resident contact during the period of investigation.

   b. The accused employee, at the administrator's discretion, may be placed on investigation-status leave during the period of investigation. If the allegation is unfounded, the employee will be allowed to return to work.

3. Upon notification of related events, the nursing supervisor will assess, and follow up with the physician on duty if needed, to seek direction regarding immediate precautionary measures and a longer-range safety plan to minimize the potential for harm to others. Interventions may include: Separation; re-direction; one-to-one observation; visual observation; time-check observation (Ref. AP 406, Resident Observation Policy).

4. Nursing staff will assess the resident for injuries and/or distress resulting from alleged maltreatment. If signs of injury or distress are noted, his/her needs will be treated. The physician on duty will be consulted immediately upon the determination of treatment needs not covered in resident's current treatment regimen. In case of an emergency, 911 will be called immediately.

5. In the event an immediate transfer or discharge is determined necessary to protect resident welfare due to the facility not being able to meet resident needs, or if the safety and/or health of individuals in the facility are endangered, the following steps will be taken:

   a. The social worker or nurse supervisor will document in the resident's medical record how the facility concluded that the transfer/discharge is necessary. The social worker or nurse supervisor will also assist the resident and/or resident representative to ensure an appropriate transfer/discharge from the facility.

   b. The physician will provide documentation in the medical record to support the facility's conclusion regarding the transfer/discharge need.

   c. The resident and/or resident representative will be notified of the need for transfer/discharge, and this notification will be documented in the medical record. Information regarding the resident and the problems resulting in the relocation will be provided to the receiving entity for interventions and treatment as needed.

G. INVESTIGATION:

Protocol:

1. All reports of resident maltreatment occurring under the jurisdiction of AHC will be investigated by AHC in a timely manner. Investigations involving residents will be overseen by the AHC Risk Management Department.

2. Upon receipt of a report of maltreatment, the supervisor will immediately notify the RN supervisor for the resident's unit of residence. The RN supervisor will take needed action for immediate assessment and assurance of the resident's safety, then notify and consult the administrator on call to determine and initiate other, appropriate resident protections (Reference Section F of this policy.)

3. The RN supervisor will initiate preliminary investigative actions by directing the writing of witness statements (Form 762) by any individual(s) believed to have knowledge of the incident. This may include visitors, other reliable residents, staff, etc.) In the event that the alleged maltreatment occurred on a date other than the date the allegation is made, the RN supervisor will assist in arranging for all pertinent individuals to provide witness statements.

4. The RN supervisor will follow up, delegating duties as needed, to assure: Summation of events on DHHS Form 1910; required notifications and documentation thereof; as well as collection of completed witness statements.

5. Interviews will be conducted as deemed appropriate, and polygraphing will be utilized when necessary.

6. The Department of Public Safety (DPS) will be notified within the hour whenever a maltreatment allegation has been made. DPS will assemble initial reports and witness statements and write a DPS report to include documentation of notice to local law enforcement.

7. Within one hour of receiving a maltreatment report during regular office hours, DPS will notify the Risk Management Department. DPS will notify the Risk Management Department by 9 a.m. of the next business day of maltreatment reports received outside regular business hours. (The Administrator on call may choose to involve the Risk Management Department outside regular office hours.)

8. DPS and the Risk Management Department will converge so that collected information, documents, etc., are dispensed to Risk Management as soon as feasibly possible after obtainment.

9. The Risk Management Department is responsible for assuring that maltreatment investigations are completed thoroughly and timely, and for reporting findings to the AHC Director, OLTC, and local law enforcement. All reports will be made in

accordance with the timeframes set forth by the Department of Health and Human Services, the Office of Long Term Care, and state and federal guidelines.

10. Whenever it is necessary to extend AHC staff leave past 5 days pending investigative outcome, Risk Management will provide a status report to the Director and involved executive staff every subsequent 5th day that the staff remains on leave status.

11. Maltreatment investigation reports and findings will be maintained for a period of 5 years by Risk Management to support AHC actions and findings; to aid in identifying patterns/trends.

Staff Responsibilities Regarding Investigations:

1. It is the duty of all AHC and contracted staff to provide full and total disclosure of information or knowledge they may have in regard to maltreatment investigations.

2. To help maintain the integrity of the investigation, staff involved in an investigation is directed to refrain from discussing the incident among themselves during the period of investigation.

3. AHC management staff will release the identify of a reporter on a need-to-know basis only.

H. DISPOSITION OF INVESTIGATION (Reporting/Response):

1. Investigative outcomes regarding resident maltreatment reports will be forwarded from the Risk Management Director to the AHC Director and OLTC.

2. Resident representatives will be notified of investigative outcomes by Risk Management Department. When determined more appropriate, the Director may designate the unit Social Service Worker of physician to make this contact. OLTC also notifies the responsible party of results of their reviews and determinations of AHC investigative outcomes.

3. In the event an allegation of maltreatment is found to have been perpetrated by an employee, the AHC Director and supervisor will confer regarding appropriate disciplinary actions in accordance with appropriate DHHS policy and law.

4. Any employee that is found to have had knowledge of maltreatment, which he/she failed to report, is subject to disciplinary action levels up to and including that imposed upon the offender.

5. AHC investigative findings are reviewed by OLTC, and disciplinary actions are subject to adjustments per their review and recommendations.

6. Maltreatment allegations and/or findings are also subject to review, actions, and investigation, including, but not limited to, the Arkansas Attorney General's Office, local prosecutorial authorities, etc.

7. Appropriate regulatory entities will be informed by the administrator or DON of maltreatment findings involving a licensed/certified/registered individual.

8. The name of any employee regarding whom a maltreatment finding has been made and upheld by OLTC will be placed on applicable Arkansas Maltreatment Registries by the appropriate regulatory agency.

9. Employees who have received any disciplinary actions associated with any maltreatment findings maintain their rights regarding any hearings, appeals, etc., which may include: Departmental administrative hearings/appeals; applicable grievance options; as well as legal remedies.

_____ _____

AHC Director Date

MEDICATION ORDERING AND RECEIVING BOOK

NOTE: The facility is held responsible and accountable for every single medication ordered, received, administered, wasted, destroyed, sent home, or sent to DHS Pharmacy Division for destruction. It is imperative that:

1. **All medications ordered and received are recorded in the medication ordering and receiving book**
2. **All medications administered are recorded on the Medication Administration Record**
3. **All medications wasted are recorded on the MAR / Controlled Substance book**
4. **All medications destroyed are recorded in the medication destruction log**
5. **All medications sent home (discharged with the resident) are recorded in the resident's medical record**
6. **All controlled substances sent to DHS Pharmacy Division for destruction are recorded on the Drug Surrendered form.**

1. The Medication Ordering and Receiving book will be reviewed during the start up routine as part of the telephone order audit.
2. All telephone orders are reviewed for new medications, changes in medication, discontinuation of a medication, transfer of a resident, etc.
3. The pharmacy must be notified of all medication orders as well as transfers, discharges, hospitalizations, etc. The procedure for completing this notification is to fax a copy of the order to the pharmacy, obtain a fax confirmation and attach to the order and file the order in the medication ordering and receiving book. Upon receipt of the medication, the nurse is required to note the date and time receiving the medication as well as the quantity received on the appropriate order form.
4. The Unit RN Supervisor will review the medication ordering and receiving book to ensure the medication was ordered and received.
5. Any order not recorded as received will be addressed immediately. First, check to see if the medication was actually received and placed in the medication cart but not recorded on the appropriate form as being received. If medication is present, make a note on the form indicating medication was received and address with the responsible nurse. If the medication was not received, notify the pharmacy immediately by phone.
6. Compare the medication received (including the label) to the physician's order to ensure the label and medication matches the order. Address and correct any discrepancies immediately.

EMERGENCY PHARMACY SERVICE

Policy

Emergency pharmaceutical service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply, which each provider pharmacy must supply, or by special order from the provider pharmacy.

Procedures

1. After hours and emergency telephone numbers for each provider pharmacy are posted at nursing stations (see Appendix).

2. When an emergency or "stat" order is received, the charge nurse:
   - Determines that the order is a true emergency, i.e., cannot be delayed until the scheduled pharmacy delivery.
   - Ascertains whether the ordered medication is contained in the emergency kit by referring to the list of contents posted at the nursing station or on the box.
   - If the medication is not available, calls the pharmacy, using the after-hours emergency number(s) if necessary.

3. Each provider pharmacy supplies emergency or "stat" medications according to the provider pharmacy agreement.

4. Medications are not borrowed from other residents. The required medication is obtained either from the emergency box or from the resident's provider pharmacy.

5. The resident's provider pharmacy is called if an emergency arises requiring immediate pharmacist consultation, using the after-hours emergency number(s), if necessary. In the event that the provider pharmacy is unable to supply essential information regarding the appropriateness of a new drug order, the consultant pharmacist is contacted.

Allcare Pharmacy Hours and Numbers (Jonesboro Location)

Regular Hours

Monday thru Friday 9:00 am to 5:00 pm
Saturday 9:00 am to 12:00 pm
Sunday closed

Phone (870) 403-9400 or 877-420-9400
Fax (870) 403-9410 or 877-420-9410

After Hours

A pharmacist may be reached after hours by dialing the pharmacy's regular number and choosing the option of paging the pharmacist on call. A pharmacist will call you back. If a non-emergency message needs to be communicated after hours a message should be left rather than paging the pharmacist.
The following pager numbers should only be used if the previous procedure is not functional.

Beeper Numbers

1. ~~(501) 488-0077~~
2. ~~(501) 668-5376~~

CONTROLLED MEDICATIONS - ORDERING AND RECEIPT

Policy

Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and record keeping requirements in the facility, in accordance with federal and state laws and regulations.

Procedures

1. The director of nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications.

2. Schedule II controlled medications prescribed for a specific resident are delivered to the facility only if a written prescription has been received by the pharmacy prior to dispensing. In an emergency situation, the provider pharmacy can accept a telephone order. A follow-up written (original) prescription is sent or faxed to the provider pharmacy by the facility or the prescriber within 72 hours.

3. New and refill orders for controlled medications other than those in Schedule II are ordered as detailed in the procedure for ordering and receiving medications.

4. Medications listed in Schedules II, III, IV, and V are dispensed by the pharmacy in readily accountable quantities and containers designed for easy counting of contents. When ordered for injection, controlled substance medications are provided in ampules or vials of the smallest available dosage unit.

5. A controlled medication accountability record is prepared when receiving or checking in a controlled substance medication for a resident. This record is maintained in a bound ledger with consecutively numbered pages. The following information is completed:
   - Name of resident
   - Prescription number
   - Drug name, strength (if designated), and dosage form of medication
   - Date received
   - Quantity received
   - Name of person receiving the medication supply

6. Medications listed in Schedules II, III, IV, and V are stored under double lock in a locked cabinet or safe designated for that purpose, separate from all other medications. This locked cabinet or safe can be stored in the medication cart. The access key to controlled medications is not the same key giving access to other medications. The medication nurse on duty maintains possession of a key to controlled medications. The Director of Nursing or their designee keeps back-up keys to all medication storage areas, including those for controlled medications.

7. Schedule II controlled substance medications are reordered when a seven-day supply remains to allow for transmittal of required original written prescription to the pharmacist.

8. From time to time the pharmacist and facility may designate a particular drug, which is not mandated as a controlled substance by State or Federal Laws and subject to abuse or diversion, to be handled under these procedures for controlled medications.

9. Controlled substances that are stocked as part of the emergency/stat box will be kept with other controlled substances and should be counted at each shift change.

Allcare

PHARMACY HOURS

Monday – Friday	9:00 a.m. – 6:00 p.m.
Saturday	9:00 a.m. – 2:00 p.m.
Sundays	Closed (On Call)
Holidays	Closed (On Call)

PHONE

877.420.9400

or

870.403.9400

MED ORDER FAX

877.420.9410

or

870.403.9410

FOR AFTER HOURS EMERGENCIES ONLY CALL

~~501.680.0017~~

Allcare

ORDERING MEDICATIONS

All medication orders are transmitted via the fascimile machine using the medication daily order form. This form serves as the order and receiving document and must be kept at the nurse's station in chronological order. These documents must be signed and dated by the nurses ordering the medication and also by the receiving nurse.

The pharmacy will call for an oral prescription on all controlled medication - except schedule II medications. In this case a written prescription must be supplied by the physician.

The form must be completed with the facility name, nurse's station and date before transmitting.

If an order is needed before or after pharmacy hours, the pharmacist should be called using the pager number and the order should still be faxed to the pharmacy.

MEDICATION REFILL ORDERS

When ordering a refill medication, the prescription number, resident's name, medication name, dosage, nurse's initials should be used. The "peel off" refill label is the preferred system.

NEW MEDICATION ORDERS

New medication orders may be transmitted on the same order form using the new prescription order section. The resident's name, medication name and strength, dosage frequency, physician, date and nurse's initials must be completed. If any special directions are needed it must be included on this form, such as, stat or emergency orders.

OTHER CHANGES OR ORDERS

All changes should be faxed to the pharmacy. There are sections provided for label changes, room changes, discharges and discontinued meds.

Allcare

MEDICATION DAILY ORDER FORM

Nurse's Signature _____

Orders received without a nurse's signature can not be filled by the Pharmacy.

Facility: _____ Station: _____ Date: _____

NEW PATIENTS AND READMISSION INFORMATION

Patient Name	Room#	D.O.B.	Allergies	Medicare/Medicaid/Insurance #

NEW PRESCRIPTION AND REFILL ORDERS

Patient Name	Prescription To Include (New Order: Dose, Route, Frequency, Strength Reorder: Prescription # / Place Refill Label Below)	Qty.	Doctor	Ordered By	Received By	Date
	PLACE LABEL HERE					
	PLACE LABEL HERE					
	PLACE LABEL HERE					
	PLACE LABEL HERE					
	PLACE LABEL HERE					
	PLACE LABEL HERE					

DOSAGE CHANGES AND/OR DISCONTINUED MEDICATIONS

PATIENT NAME	MEDICATION	OLD DOSAGE	NEW DOSAGE	DISCONTINUED	DATE

RESIDENT STATUS CHANGE

NAME	ROOM	WING	DISCHARGED	DECEASED	HOSPITAL STATUS

Notify Allcare of dose changes, discontinued medications, room changes, and/or discharges. Fax all orders to (877) 420-9410 or (870) 403-9410

NEW PATIENT! NEW ORDER!
REFILL ORDER! STAT ORDER!
NOW WHAT DO I DO?

NEW PATIENT?

- Fax Facility Face Sheet
- Fax Physician's Orders

NEW ORDERS?

- Use Medication Daily Order Form
- Complete New Prescription Orders Section
- Include resident name, medication, strength, dose direction, physician, date and nurse's initials

REFILL ORDERS?

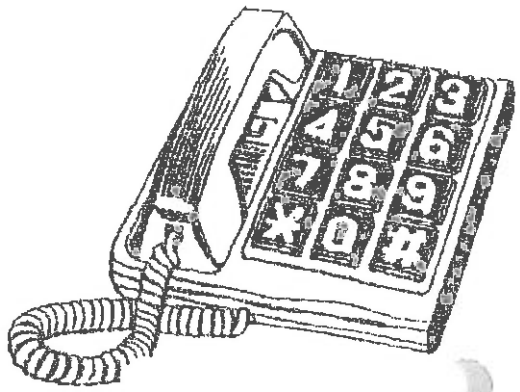
- Order refills 5-7 days in advance
- Refills will not be considered as emergencies
- Complete Refill Order Section on Medication Daily Order Form, include Rx #.
- Fax "peel off" refill label

STAT ORDERS?

- Always check your ER box first
- Identify "STAT" on order form with special directions
- Follow up with telephone call

CHANGE ORDERS?

- Fax dose changes, discontinued meds, room changes and discharges



FROM: ALLCARE
517 MAIN STREET
ARKADELPHIA, AR 71923

FOR: Home code:RW

Room	Patient Name	Pat.No	Rx#	Doctor Name	Drug Name	Qty	B/
210	HARRIS, FRED		101385	ABBOTT	APAP 325MG	31	
			101383	ABBOTT	ASPIRIN EC 81MG	31	
			101379	ABBOTT	METOPROLOL 100MG	31	
			101378	MD NEEDED	SKITTLES	21	

Totals for wing: NW Patients: 1 RX's: 4

Filled by: _____ Date/Time: _____

Delivered by: _____ Date/Time: _____

Received by: _____ Date/Time: _____

ALLCARE
ESTIMATED REORDER LIST

Period: 7-17-04 through 8-17-04

Report for: CLARK COUNTY NURSING FACILITY

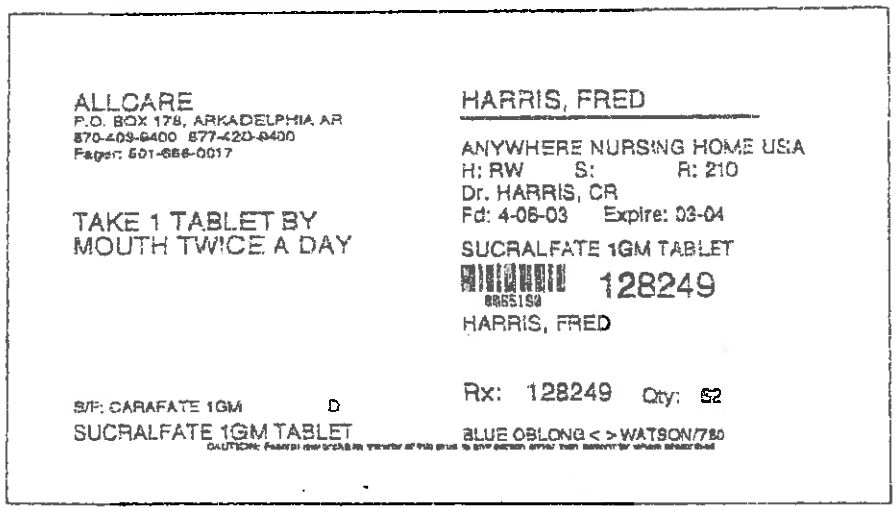
The following is estimated to be exhausted on: 8-18-04
Please reorder prior to: 8-18-04

Patient Name / Doctor	Check to Order	Rx	ID Filled	Room Drug Name	Day
BURKS, MAXINE					
HARRIS	[ ]	131237	7-24-04	TRIAMCINOLONE 0.1% CR ALP 80	25
	[ ]	131238	8-15-04	MONOPRIL 10MG	3
COHEN, HELEN					
SKAGGS	[ ]	131239	7-24-04	TRIAMCINOLONE 0.1% CR ALP 80	25
	[ ]	131240	8-15-04	MONOPRIL 10MG	3

This list is intended for informational purposes. It is an estimate of medications that may need to be reordered only, and is not intended to be an all inclusive reorder list. All medication supplies on hand should be reviewed.

ExactMed ✓ Dispensing System

Clear, Accurate, Informative Labeling



ALLCARE
P.O. BOX 178, ARKADELPHIA AR
870-403-9400 877-420-9400
Pager: 501-666-0017

TAKE 1 TABLET BY
MOUTH TWICE A DAY

S/P: CARAFATE 1GM D
SUCRALFATE 1GM TABLET

HARRIS, FRED

ANYWHERE NURSING HOME USA
H: RW S: R: 210
Dr. HARRIS, CR
Fd: 4-06-03 Expire: 03-04
SUCRALFATE 1GM TABLET
128249
HARRIS, FRED

Rx: 128249 Qty: 52
BLUE OBLONG < > WATSON/750

- Management prefers because system impacts on reducing risk and liability.
- Nursing prefers because label assists with identification of medication.
- Check Allcare out for other reliable pharmacy solutions.

Call 1-877-420-9400

ER-BOX USAGE - CHARGE SLIP

Facility _____ Date _____

Patient Name _____

Medication _____ Strength _____ Number of Doses Removed _____

Nurse Signature _____

Please complete, retain one copy in facility and send other copy to Allcare.

PART 1: TO BE COMPLETED BY PHYSICIAN

PHYSICIAN MEDICAID ID NUMBER:	PATIENT INFORMATION
Physician Name:	RECIPIENT MEDICAID ID NUMBER:
Address:	Patient Name:
City: State: Zip:	Address:
Phone ( )	City: State: Zip:
FAX ( )	Patient's date of birth: / /

Requested Drug: Celebrex Strength/Frequency _____

Compliance with all of the specific criteria listed below is a condition for payment for this drug by Arkansas Medicaid. Please limit the request to one drug per request form.

* Approved PA valid for 6 months

** Covered only IF prescription is non-refillable and limited to therapy of 5 days or less

Initial or check specific criteria boxes below:

☐ Patient is 18 years of age or older

AND

☐ Patient will *not* be on concurrent non-Cox-2 inhibitor NSAID therapy (including, but not limited to, combination pain medications that contain an NSAID)

AND

Diagnosis:

☐ Osteoarthritis*, *or* ☐ Rheumatoid Arthritis*, *or* ☐ Familial Adenomatous Polyposis (FAP)*, *or*

☐ Primary dysmenorrhea**, *or* ☐ Acute pain**

AND

☐ Patient currently on warfarin (Monitor for changes in INR if a COX-II is added), *or*

☐ Documented failure due to gastric ulcer or duodenal ulcer after a trial of one or more non-Cox-2 inhibitor NSAIDs (must specify NSAID tried) _____, *or*

☐ Documented history of GI hemorrhage or perforation, *or*

☐ Documented history of gastric ulcer or duodenal ulcer resistant to H. pylori treatment, *or*

☐ Documented active gastric ulcer or active duodenal ulcer, *or*

☐ Gastric outlet obstruction documented by endoscopy or x-ray

Physician Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

PART 2: PA INFORMATION FOR YOUR RECORDS - TO BE RETAINED IN PATIENT'S CHART

NDC Number: _____

PA Number: _____

Approved Dates: Start _____ End _____

Medicaid records should be maintained for a minimum of five (5) years.

MEDICATION VARIANCES

EVALUATE THE RESIDENT (PROVIDING APPROPRIATE CARE)

NOTIFY THE RN ON DUTY

COMPLETE THE MEDICATION VARIANCE FORM

NOTIFY THE MD

NOTIFY THE FAMILY

NOTIFY THE DON/ADON

DOCUMENT IN THE NURSES NOTES

COMPLETE I/A

COMPLETE 1910 **IF** THERE IS A NEGATIVE RESPONSE AND/OR THE RESIDENT HAS TO BE SENT OUT TO THE HOSPITAL AND MAKE ALL PROPER NOTIFICATIONS

IF THE NARCOTIC COUNT IS OFF REFLECTING A MISSING PILL/S
OR
IF THERE IS A MEDICATION MISSING, YOU MUST COMPLETE A 1910 AND COMPLETE THAT PROCESS

ONLY AN RN CAN CORRECT A NARCOTIC BOOK COUNT. THE SPECIFIED ADON WILL COMPLETE THE CONTROL LOSS REPORT AND NOTIFY DEPARTMENT OF PHARMACY BOARD

PLACE RESIDENT ON HOTRACK

UPDATE 24 HOUR REPORT

Revised April 2011

MEDICATION INCIDENT REPORT

Resident Name:_____ Unit:_____

Classification of Medication Incident

- ☐ Medication Error
- ☐ Transcription Error
- ☐ Medication Variance / Occurrence

Date of Medication Incident: _____Time of Medication Incident _____

Date of Discovery: _____ Time of Discovery: _____

Name of person responsible for incident: _____

Name of person finding/reporting incident: _____

Description of medication incident:

_____

_____

_____

_____

_____

_____

Describe resident's condition:

_____

_____

_____

Physician Notified:_____Date:_____Time:_____

Physician comments/orders:

_____

_____

Responsible Party Notified:_____Date:_____Time:_____

	Signature	Date
RN Supervisor		
Director of Nursing		
Medical Director		

MEDICATION INCIDENT REPORT

Resident Name:_____ **Unit:**_____

Classification of Medication Incident: Medication Error
Transcription Error
Medication Variance/Occurrence

Date of Medication Incident:_____ **Time of Medication Incident:**_____

Date of Discovery: _____ **Time of Discovery:** _____

Name of person responsible for incident:_____

Name of person finding/reporting incident:_____

Description of medication incident:

Describe resident's condition:

Physician Notified:_____ **Date**___/___/___ **Time**_____
Physician Comments/Orders:

Responsible Party Notified:_____ **Date**___/___/___ **Time**_____

DON/ADON Notified:_____ **Date**___/___/___ **Time**_____

	Signature	Date
RN Supervisor		
Director of Nursing/Designee		
Medical Director		

Director of Nursing		**Date**
Director		**Date**

DIVISION OF PHARMACY SERVICES AND DRUG CONTROL
ARKANSAS DEPARTMENT OF HEALTH & HUMAN SERVICES
Division of Health
P.O. Box 8183
Little Rock, AR 72203-8183

Telephone Number: (501) 661-2325 Fax Number: (501) 661-2769

REPORT OF LOSS OF CONTROLLED SUBSTANCES FORM FOR NON DEA REGISTRANTS

NAME AND ADDRESS OF FACILITY: _____ Telephone number: _____ COUNTY: _____

_____

_____

NAME OF CONSULTANT PHARMACIST: _____ Telephone number: _____

*TYPE OF LOSS: (describe) Date loss occurred: _____

WAS LOSS REPORTED TO THE OFFICE OF LONG TERM CARE? ☐ YES ☐ NO

Loss was also reported to: _____

*SECURITY MEASURES WHICH HAVE BEEN TAKEN TO PREVENT FUTURE LOSSES:

*LIST OF CONTROLLED SUBSTANCES LOST	QUANTITY

NAME OF PERSON FILING THIS REPORT: (PLEASE PRINT) _____

DATE OF REPORT: _____ Signature: _____

REPORT OF THEFT, LOSS OR DIVERSION SHOULD BE MADE IMMEDIATELY UPON DISCOVERY, BY TELEPHONE AT (501) 661-2325, AND THEN SUBMITTED BY FAX AT (501) 661-2769, OR BY U.S. MAIL.

*IF MORE ROOM IS NEEDED PLEASE ATTACH ANOTHER SHEET.

1. **PURPOSE:**
   The purpose of this policy is to establish procedures for the reporting of medication incidents and to differentiate between medication errors, transcription errors, and medication variances.

2. **SCOPE:**
   All Licensed Nurses

3. **POLICY:** It is the policy of Arkansas Health Center to safely and correctly administer medications as ordered by the physician and that all medication errors, transcription errors and medication variances or occurrences are reported and documented.

4. **PROCEDURE:**
   1. Upon discovery of an incident involving a medication, the licensed nurse will immediately notify the RN Supervisor on duty.
   2. The RN Supervisor will investigate to determine the proper classification of the medication incident.
   3. There are three classifications of medication incidents: Medication errors, transcription errors and medication variances/occurrences.
      A. A medication error occurs when: (This is **NOT**) an all-inclusive list).
         a. The wrong medication is administered.
         b. The wrong dose of a medication is administered.
         c. The wrong dosage form is administered (i.e., order is for a time released med but an immediate release medication is administered).
         d. Medication is administered by the wrong route.
         e. Medication is administered at the wrong time or on the wrong day.
         f. The resident does not receive a medication that has been ordered.
         g. The resident receives medication without an order that has been discontinued, has an automatic stop date or is expired.
         h. A medication administered by the nurse that was filled incorrectly by the pharmacy but the medication had necessary identification (manufactures label on container) for the nurse to determine the discrepancy prior to administration.
         i. Failure to follow OBRA guidelines (i.e., technique—not using a syringe to measure liquid medications, failure to wait the appropriate amount of time between eye drops or inhalers, etc.)
         j. Failure to follow manufactures recommendations (i.e., shaking suspensions, administering with recommended amount of fluids, etc).
         k. Failure to check the medication three (3) times prior to administering:
            1. Check the medication label against the MAR when removing the container (bottle, vial, blister pack, etc) from the cart.

2. Check the medication label against the MAR when removing the medication from the package.
3. Check the medication label against the MAR when returning the container to the cart.

B. A transcription error may or may not result in a medication error. When a transcription error results in a medication error, the person making the transcription error could be held responsible for making the medication error. A transcription error occurs when: (This is **NOT** an all-inclusive list).
   a. An order for a medication is not transferred or transcribed correctly to the medication administration record.
   b. The medication was charted as given but was not actually administered.
   c. Charting on the MAR is omitted i.e., resident received the medication as ordered but the medication administration record was not initialed.

C. A medication variance/occurrence is defined as an unusual, undesirable, or potentially harmful event, which does not meet the definition of a transcription error and does not result in a medication error to the resident. Examples include but are not limited to:
   a. Errors on controlled substance count.
   b. Failure to document and send the correct medications with the resident going on therapeutic leave.
   c. Failure to verify that there is a valid order prior to ordering or reordering medication from the pharmacy.
   d. Failure to check medications received from the pharmacy to be sure there is a current order and that the medication received is accurate and packaged correctly.
   e. Pharmacy related packaging, labeling, or dispensing errors.

4. In the event a medication error occurs, the RN Supervisor will:

A. Review the medication side effects sheet and/or PDR for potential adverse side effects to be monitored.

B. Assess the resident and document the assessment in the nurses' notes.

C. Notify the physician.

D. Notify the responsible family/legal guardian.

E. Notify the Director of Nursing/Designee.

F. Document all notifications in the nurses' notes.

G. If at any time the resident's condition changes, the attending physician will be notified again immediately.

H. If the resident experiences or exhibits any complications from the medication error, the resident will be immediately transferred to the hospital for evaluation and/or treatment.

I. Include the resident on the 24 hour nursing report and place the resident on the Hot Rack Charting.

5. A Medication Incident Report will be initiated for every medication error, transcription error and Medication variance/occurrence by the RN Supervisor/Designee.

6. The Medication Incident Report will be forwarded to the Director of Nursing/Designee and Medical Director for review and signature.

7. The Director of Nursing/Designee will make a decision, on a case-by-case basis, as to whether a corrective action plan or disciplinary action is indicated for the individual(s) who made or contributed to a medication incident. The decision will be based on (but not limited to) the following:

- **A.** Classification of the medication incident.
- **B.** The severity of the event.
- **C.** Previous medication incidents.
- **D.** Circumstances of the event.
- **E.** Employee's overall work performance.

8. Disciplinary/Corrective action plans for the nurse responsible for the medication incident may include (but not limited to) the following:

- **A.** The nurse may be required to provide a written plan of correction to include the reason the medication incident occurred and steps to prevent repeated incidents of the same type in the future.
- **B.** The nurse may be required to review the policy and procedure corresponding to the type of medication incident i.e., documentation, transcribing of physician orders, ordering and receiving medication, controlled substance counting, medication administration, etc. The nurse may be required to take a written test regarding the information reviewed as well as sign a policy and procedure acknowledgement form.
- **C.** The nurse may be required to complete a written competency test regarding medication administration.
- **D.** The nurse may receive a change in assignment/s.
- **E.** The nurse may be required to demonstrate proficiency in medication administration skills by having supervised medication administration pass.
- **F.** The nurse may be required to attend in-service training for medication administration, documentation, legal/ethical issues in nursing and so forth.
- **G.** The nurse's employee performance evaluation may be reviewed with appropriate follow-up.
- **H.** The nurse may receive disciplinary action as outlined in DHS Conduct Standards Policy 1085.
- **I.** Excessive medication errors or poor nursing practices may be reported to the Arkansas State Board of Nurses Examiners.

9. Each Medication Incident will be recorded on the monthly Medication Incident Log for tracking and trending.

10. The log will be forwarded to the Pharmacy and Therapeutics Quality Assurance committee for review and recommendations.

Director of Nursing		**DATE**
Medical Director		**DATE**

INCIDENT AND ACCIDENT REPORTING AND NOTIFICATION GUIDELINES

Incident and Accident	EATHS	I&A Regarding FALLS	I&A Regarding Injuries of Unknown Origin	esident to Resident Incidents ITH OR WITHOUT Injury	Alleged or Actual Verbal, Physical, Sexual e or Misappropr of property
Notify: physician, family, and RN on duty.	**Notify** physician, family, RN on duty, DON/Designee, Administrator, Public Safety, Coroner	**Notify:** physician, family, RN on duty. **If** resident sustains an injury requiring outside medical interventions-- **Notify** the DON/Designee, Administrator on call	**Notify** the physician, family and RN on duty.	**Notify** MD, family, RN on duty, DON/ADON, Admin, Public Safety (Public Safety MUST notify local law enforcement- and record notification on log) **Complete** I & A; 1910, BR, MAA **Complete** full body audit and doc.	**Notify** MD, family, RN on duty, Risk Management, DON/Designee, Administrator, Public Safety (Public Safety MUST notify local law enforcement- and record notification on log) **Complete** incident an accident report. **Complete** 1910. **Complete** full body audit and doc.
Complete an incident and accident report	**Complete** Death Packet	**Complete** an incident and accident report.**Fax** to rehab services for review.**Complete** post fall investigation	**Complete 1910;** incident & accident report. **Complete** full body audit, doc on body audit sheets and in ns notes.	**Obtain** OLTC 762 witness statements from employees, vistors, family members, residents roommate.	**Fax ALL** paperwork to RM. **Place** original report in designated box at the nurses station. **Make** a copy for the unit RN and MDSC.
Place original report in designated box at the nurses station. **Make** a copy for the unit RN and MDSC. **Update** I/A log book	**Complete** 1910	**Place** original report in the designated box at the nurses station. **Make** a copy for the unit RN and MDSC. **Update** fall log. **MDSC** to update fall risk assessment	**Place** original report in the designated box at the nurses station. **Make** a copy for the unit RN and MDSC and place in designated location	**Place** original report in the designated box at the nurses station. **Make** a copy for the unit RN and MDSC. **Update** 1910 & observation log books	**Obtain** 762 Witness Statements from all employees, visitors, family members, residents roommate, cognitive residents on the unit. **Social workers** will assist with this **If** the resident is able to communicate, staff must interview & document the resident's account of incident **If** the accused is an unidentified perpetrator then the nursing & social staff will be instructed to closely observe employees, residents and any visitors on the unit until the investigation is completed
Fax to skin office if it is a SKIN RELATED ISSUE **FAX** to Risk Mgmt	**Indicate** on the 24 hour Nursing Report that resident expired	**If** resident requires outside medical intervention .....**complete** 1910 and make proper notifications	**If** resident requires outside medical intervention ...**complete** 1910 **Notify MD, RN on duty, Family,** Public Safety, DON/ADON, Admin on call	**Separate** Residents, assess for Injuries. **Document** in Nurses Notes that you have separated the residents to a safe environment (Their room, The day room, try to involve them in an activity, ect...)	**Search** resident's room as well as ALL ROOMS on the units to ensure the accused was not present and still on the unit
Place on 24 hour nursing report **Place** on Hot Rack Charting	**Update** the Resident information sheet that the resident expired	**Complete** body audit & assessment for injury & document in body audit book & ns notes **Place** on 24 hour nursing report	**Obtain** OLTC statements from all employees **Complete** body audit **Place** on 24 hour nursing report	**Assign** staff to resident who is being the aggressor until calm, this will ensure this resident does not have repetitive behavior. **If** the resident does not calm down within 20 to 30 minutes you will need to call the MD back and get an order for 1:1 or line of sight observation	**Complete** mental anguish assessment of resident immediately and Q 2hrs for 24 hrs. **Monitor** and document residents where abouts/frequent observation
	(Night shift) Update unit census of time resident expired	**Place** on Hot Rack Charting List	**Place** on Hot Rack Charting List	**Complete** Behavior Report form and place in social worker's designated location	**If** the accused is an employee they will be removed from duty. **A** witness statement will be obtained from the accused employee and they will be interviewed by Risk Management Team
		Interdisciplinary team to review and update care plan.	**Investigate** potential sources or cause of injuries. **Review** and update care plan as indicated	**Assess Both res** Mental Anguish Q 2 hrs x 24 hrs **Place** on 24 hr nursing report **Place** on Hot Rack. **Review**/update care plan	**Place** on Hot Rack Charting List **Place** on 24 hour nursing report. **Risk** Management to conduct investigation and complete a written report

EXAMPLE OF MENTAL ANGUISH ASSESSMENT: RESIDENT DISPLAYS NO S/S OF DISTRESS OR MENTAL ANGUISH FROM EVENT ON 4-1-05 RESIDENT IS TEARFUL AND WITHDRAWN. ENCOURAGED TO VERBALIZE FEELINGS AND SUPPORT WITH REASSURANCE PROVIDED.

Revised April 2011