STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-359	A. BUILDING: _____ B. WING _____	C 03/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWART HOME	35 EILEEN WAY LEICESTER, NC 28748

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on March 22, 2021. The complaint was unsubstantiated (Intake #NC00174806). A deficiency was cited. This facility is licensed for the following service category: - 10A NCAC 27G .5600F: Supervised Living for Alternative Family Living	V 000	V 291 - 27G.5603 Supervised Living - Operations This rule was not evdenced by: Based on the interview, observation and record review, the facility staff failed to maintain coordination between the faciltiy and qualified professionals responsible for treatment for one of one client surveyed. To ensure this rule is met the following has occurred: (1) The "When to Seek Medical Assistance and Safe Lifting and Transferring" training has been revised to include a section on "Communication of Incicents" (please refer to page 4 of the attached power point). This training will be shared with the QP's by the Regional Program Manager or the Clinical Director during a staff meeting. The QP's be responsible for ensuring this information is sharedwith the AFL Providers. In addition;	05/03/2021
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan.	V 291	(2) the "Incident Reporting" training will also be shared with the QP's by the Regional and the Manager or the Clinical Director during a staff meeting. Once again, the QP's will be responsible for ensuring this information is shared with the AFL Providers.(please refer to the attached "Incident Reporting' This will be monitored by the QP's monthly during their visits to the AFL and the Regional Program Msnager will do periodic reviews of the records to ensure regulations are being met. In addition to the above mentioned trainings, the medical preparedness plan has been updated to include training for this policy to reflect all staff (not only AFL Providers). This policy In order to prevent this type of problem from occurring again, the QP will ensure the team is aware of any mobility issues the individual may have and that the home and their living space pose no boundaries in that area. This will be discussed with the Regional Program Manager prior to the person being assigned to that home. DHSR - Mental Health APR 14 2021 Lic. & Cert. Section	04/15/2021 04/15/2021

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V 291	Continued From page 1 Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on interview, observation and record review, the facility staff failed to maintain coordination between the facility and qualified professionals responsible for treatment, for one (client #1) of one client surveyed. The findings are: Review on 3-2-21 of client #1 ' s facility record revealed: - she was admitted 9-20-05 - was 49 years old - diagnosed with: - Moderate to Severe Intellectual Disability Disorder - Anxiety Disorder Secondary to Obsessive Compulsive Disorder - Speech Impediment - Scoliosis - Osteoporosis - Urinary Incontinence Reviews on 3-2-21 and 3-11-21, of incident reports revealed: - client #1 was in her downstairs basement apartment getting ready for the day (2-18-21) - at approximately 9:39 am client #1 was walking up the steps to the main level, and fell - client #1 ' s husband, who also resides in the basement apartment came upstairs and told the Alternative Family Living Provider (AFLP) that she had fallen - when asked why she fell, client #1 stated	V 291		

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V 291	Continued From page 2 she felt she was running late and was hurrying up the stairs - client #1 may have been attempting to dress herself as she went up the steps, as she was not fully dressed when the AFLP got to her - AFLP noticed a bruise/scrape on her chin, and applied ointment - AFLP contacted the Qualified Professional (QP) and informed her of the fall, and that client #1 said she was okay and further medical attention was not needed - QP instructed AFLP to monitor client #1 more closely, and if she expresses that she is hurting; or swelling or limping is noticed, that he " ...is to take her to the doctor immediately" A second incident report for an event on February 24, 2021 revealed: - client #1 had been out of the facility with her Day Support (DS) services staff person for their daily 4 hour community time - they returned to the facility around 1:00 pm - client #1 was downstairs and DS and AFLP were on the main level of the facility - at approximately 1:20 pm they heard client #1 yell and went downstairs to find her on the floor in her bedroom - client #1 stated, "I hurt" and she was unable to get up independently - 911 was called, and she was transported to the local hospital - initial CAT (computerized axial tomography) scan revealed a small fracture on her clavicle - client #1 was admitted to the hospital from the Emergency Department Addendum February 26, 2021: - the Local Management Entity (LME) upgraded the incident to a level III Addendum March 2, 2021: - additional information added to the incident report	V 291		

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V 291	Continued From page 3 - hospital reported client #1 ' s injuries were more consistent with abuse, than fall - Sheriff ' s Department investigating possible sexual or physical abuse - hospital tests ruled out sexual abuse - Health Care Personnel Registry notified about allegations of possible abuse Observation at approximately 9:15 am on 3-2-21 at the facility revealed: - multi-level facility with a basement below the main floor - basement had been renovated, and contained a finished area - finished area had two rooms and a bathroom - entire floor in the basement is ceramic tile - one long straight flight of stairs between basement and main level - steps between basement and main level are bare wood Interview and observation at approximately 12:30 pm on 3-1-21 with client #1 revealed: - client #1 was in a hospital room - has an expressive language impairment - she patiently allowed surveyor to re-ask questions two and three times - acknowledged that she lived at the Stewart Home AFL - a small red abrasion was observed on client ' s chin, slightly to the right of center, about the size of a nickel - the Stewart Home was, "a good place to live" - acknowledged she fell downstairs at the facility - clarified she fell on the basement steps, could not remember when - reported she remembered the day she fell,	V 291		

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V 291	Continued From page 4 when the ambulance brought her to the hospital - stated "[AFL Provider] and her Day Worker (DS) were at her home upstairs" - she was alone in her room when she fell Interview on 2-26-21 with the Department of Social Services Adult Protective Services (APS) staff investigating the incident revealed: - client #1 was having surgery on her back this date, to fuse two vertebrae - in client ' s first fall on 2-18-21 she was walking up stairs - did not know how far up the staircase client was, before she fell - struck her chin and cheek - later reported she was sore - on second fall on 2-24-21 both the DS and AFLP were in the facility and heard client #1 yell for help - there have been no issues with this facility in the past - no significant changes with this facility in past 3 months - both client #1 and her husband have lived in this facility since 2009 Interview on 3-2-21 with client #1 ' s Legal Guardian Representative (LG) revealed: - she had been client #1 ' s LG for 17 years - had a, "very good relationship with her" - "[client #1] is happy to be at the Stewart Home" - the facility had lots of activities client #1 liked - she participated in client #1 ' s treatment team meetings - there was a fall in June of 2020, where she broke her right leg just above the ankle - "after [client #1] fell last June (2020) ...her falls were few and far between" There was no	V 291		

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V 291	Continued From page 5 increase in the frequency of falls, so no need to create a specific goal related to falling - "the surgeon who did her surgery back in June (2020), said her bones, ' were as brittle as a 90 year old ' s ' ." - client #1 has braces she is supposed to wear on her ankles because of her Osteoporosis, but frequently does not wear them - "we should have (already) addressed her living in the basement and having to go up and down those stairs." Interview on 3-2-21 and 3-16-21 with the AFLP revealed: - client #1 fell in June of 2020 - the doctor said she had brittle bones - she fell down the steps on 2-18-21 - client #1 ' s husband came upstairs and told me she was in pain and that she had broken something - I went down and found her in her recliner - she had fallen down the steps, but didn't know how many steps or how far she had fallen - she said she fell on the steps, "but couldn ' t tell me how, whether she was coming up or how high she had gotten" - she had a red mark below her left eye and a scrape on her chin - she was sore and moving slow, but wanted to go with her DS person into the community, and did - several things were considered in his decision to not seek medical help for client #1 ' s fall on 2-18-21: - she was able to move her arms and legs - he asked her to stand up and she stood right up - she came up the stairs and ate her breakfast like normal	V 291		

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V 291	Continued From page 6 - he knew she would be sore - he called her guardian, who gave him permission to give her aspirin - he didn ' t have any indication that anything was seriously wrong - he called the QP, "she didn ' t tell me to take her to the doctor either. She said to keep her posted and let her know how she ' s doing, keep an eye on her. All (the following) weekend we were doing good, going outside" - she fell again on 2-24-21 - the DS was talking with him when they both heard her yell - she went to the hospital because of that fall, due to her not being able to get up independently - "I ' ve been wracking my brains for what I could ' ve done to keep her from falling." Interviews with the QP on 3-2-21 and 3-12-21 revealed: - she talked to the AFLP every month on her visits to the facility as well as in between visits by telephone - prior to the fall on 2-18-21, she had thought about client #1 having, "a lot of stairs in the home" and wondered if a different AFL would suit her better - she had contacted the LG and client #1 ' s Care Coordinator prior to the fall on 2-18-21, to schedule a meeting for 3-3-21, to discuss relocating her - AFLP called her after the fall on 2-18-21. He said he checked on her and put ointment on her chin. There was no mention of any other marks or bruises - client #1, "went on and did her regular activities with her day staff" - "looking back on it, [client #1] should have been taken to a medical facility because she had Osteoporosis and Scoliosis, to be checked out"	V 291		

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V 291	Continued From page 7 - "even if she didn ' t have Scoliosis and Osteoporosis, I still think she should ' ve seen a medical person just because she ' s IDD (Intellectual Developmental Disability) and speech impediment and might not be able to answer questions you would ask, to assess someone else ' s cognitive or mental state after a possible fall involving her head" Review on 3-2-21 of the licensee ' s policies and procedures revealed: - in the "Participant Section" under "When to Seek Medical Assistance," was written, "It is your responsibility to know when to seek medical assistance" - "1. Experiencing deviations from normal breathing, skin color, movement and consciousness" - "2. Orientation, affect/mood, speech and attitude is to be assessed individually ..." - in the "Emergency Plans" section was written a list of procedures which included, "If the individual ' s condition indicates, Emergency Medical Services will be summoned for further evaluation and more intensive treatment" Interview on 3-12-21 with the Physician ' s Assistant who treated client #1 at the local hospital revealed: - she treated client #1 for the fall on 2-24-21 - client #1 had a previous thoracic vertebrae fusing (date not provided) - client #1 also had broken ribs on 2-24-21 - reported most of the bruises likely came from the fall 6 days earlier - the previous fall could have contributed to the injuries in the fall on 2-24-21 - When asked if the AFLP should have ensured client #1 was seen by a medical professional for the fall on 2-18-21 she answered,	V 291		

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V 291	Continued From page 8 "Yes, I agree, he should have." Interviews on 3-12-21 and 3-16-21 with the Regional Services Manager (RSM) revealed: - there was no policy or procedural directive that said, "If this happens, do this ..." - in hind sight, the AFLP should have called 911 after the first fall - if it had been just a short fall, such as off a chair, with no bruising and no marks, then administer first aid - but since it involved stairs, "a hard surface and there was a visible injury like the thing on her chin, then yes" medical professionals should have assessed her - looking back, the QP, "should have told him (AFLP) to make sure she sees a doctor, if only the urgent care. I ' d rather over-react than under-react." - new procedures have been put in place to insure providers make better decisions regarding handling injuries and whether or not to seek care: - re-train all our QPs regarding responses to injuries - re-train all our AFL providers for responses to injuries - insure everyone is trained the exact same way - created a checklist that helps AFLPs to know if they should: - move someone or not - call 911 or not - administer first aid or not - we reviewed our policies to consider updates and revisions - "I talked to [QP] and she agreed too, ...we should have had him (AFLP) at least take her somewhere" - "I concur 100%, if that was my own family member, I would want them to be checked out.	V 291		

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V 291	Continued From page 9 Our primary focus is for our consumers to live a meaningful and safe life." Review on 3-18-21 of a Plan of Protection written by the RSM and submitted on 3-17-21 revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? "February 26, 2021 the client/person served involved in the incident was removed from the home along with the other members residing in the Stewart Home to ensure their protection and safety." Describe your plans to make sure the above happens. "The client/individual involved in the incident will not return to the home, as the residential facility cannot meet her physical or medical needs. It has been determined that because of her physical and medical issues the home will be unsafe for her due to the construction design of the home. It involves lots of stairs to enter the home and additional stairs to access the bedroom the individual once occupied. The home will only be appropriate to accommodate individuals who do not have mobility issues and are able to ambulate safely up and down a flight of stairs." On February 18, 2021 a 49 year old client with diagnoses of Moderate to Severe Intellectual Developmental Disability, Anxiety Disorder secondary to Obsessive Compulsive Disorder, Speech Impediment, Osteoporosis and Scoliosis fell on a flight of stairs in her Alternative Family Living facility. She was known to have a history	V 291		

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V 291	Continued From page 10 of brittle bones, from a fall and broken leg 8 months earlier when her Orthopedic Surgeon reported she had the bones of a 90 year old woman. Regarding the fall on 2-18-21, there was no way to know if she had fallen from the top of the stairs, or somewhere below the top. It was known she struck her head, due to an abrasion on her chin and red mark on her cheek. Because of her Intellectual Development Disability and Speech Impediment, there was no way to accurately assess the client ' s orientation after the fall, which is required per policy; nor was she thoroughly physically assessed, despite being known to have brittle bones. When the client sustained another fall 6 days later, the attending Physician ' s Assistant reported the earlier fall could have contributed to her extensive injuries in the subsequent fall. Not having the client seen by a medical professional after the first fall, was detrimental to her health, safety and welfare. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance, beyond the 45th day.	V 291		

INCIDENT REPORTING

UNIVERSAL

MH/DD/SAS

"Caring People, Caring for People"

Universal MH/DD/SAS
Revised 09/25/18

WHO MUST REPORT?

- Providers of community based mental health services, developmental disabilities and /or substance abuse services are required to report incidents.

- Failure to do so may result in DHHS taking action against the provider's authorization to provide services and may result in Plans of Corrections which could affect funding.

WHAT IS AN INCIDENT? CONT.

- Any happening which is ***not consistent*** with the routine operation of a facility or

- Any service or the routine care of an individual and that is likely to lead to adverse effects upon the person.

WHAT IS AN INCIDENT? CONT.

- Medication errors
- Use of restraint
- Injury
- Communicable disease
- Infection control
- Aggression or violence
- Unauthorized use or possession of weapons

WHAT IS AN INCIDENT? CONT.

- Wandering or elopement
- Vehicular accidents
- Bio-hazardous accidents
- Unauthorized use or possession of licit or illicit substances
- Abuse and neglect
- Suicide or attempted suicide
- Other sentinel events

INCIDENT CATEGORY TYPES

- Death
- Restrictive Intervention
- Consumer Injury
- Allegations
- Medication Errors
- Consumer Behavior
- Suspension/Expulsion
- Fire
- Other Incident Type

LEVELS

- **Level I Incidents**
  - Are events in isolated numbers that do not significantly threaten health and safety of individual
  - Are NOT to be submitted in Incident Response Improvement System (IRIS)
  - Are to be documented on the agency's internal form (QMO2) and should not be submitted in IRIS

LEVELS

- **Level II Incidents**
  - Result in a threat to a consumer's health and safety
  - Is a threat to the health and safety of others due to consumer behavior
  - Requires documentation of the incident to be reported in IRIS and to other authorities as required by law
  - A consumer death due to natural causes or terminal illness.
  - MUST be documented in IRIS

LEVELS

- **Level III Incidents** – includes any incident that results in permanent physical or psychological impairment to the consumer, or another person's safety or significant danger to the community. Such as:
  - Death
  - Substantial risk of death
  - Sexual assault
  - Critical consumer behaviors (rape, homicide Amber/Silver alerts, etc.)
  - MUST be documented in IRIS
  - All allegations of abuse, neglect and/or exploitation by a staff member

DEATHS

- Report all deaths as soon as you learn of the death, even if the death occurred while the individual was not under your care.

- We must obtain cause of death from medical examiner.

DEATHS CONT.

- Original cause of death may be "unknown cause" (Level III)
  - (even if the family reports the individual had cancer) . . .
- Once medical examiner's certificate is obtained confirming the cause, report must be updated and changed to Level II "terminal illness."

RETRICTIVE INTERVENTION

- Level II:
  - Emergency or unplanned use
  - Planned use that exceeds authorized limits
  - Administered by an unauthorized person
  - Resulted in discomfort or complaint
  - Requires treatment
- Level III
  - Results in permanent physical or psychological impairment
  - Incident is perceived to be significant danger to cconcern of the community

INJURY

- Any injury that requires First Aid only is a Level I.
  - First Aid given by a licensed health professional should be considered a Level I incident and not reported outside of agency provider
  - A visit to an Emergency Room (in and of itself) is not considered an incident.

INJURY

- Any injury that requires "treatment" by a health care professional beyond First Aid is a Level II.
  - ER (think arm is broken, X-ray and it is not) = no report
  - What constitutes treatment?
    - Arm in cast, stitches, cleaning a wound, shots and prescriptions

- Any injury that results in permanent physical or psychological impairment is a Level III.

INJURY

Description

- Ache/Pain
- Broken Bone
- Burn
- Cut/Laceration
- Indication of Pain
- Sprain/Strain/Twist

Due to/Cause

- Assault
- Behavioral Outburst
- Fall
- Motor Vehicle Accident
- Seizure
- Self-Injurious Behavior

MEDICATION ERROR

- A pharmacist, physician or nurse practitioner should determine the:
  - level of threat to the person's health and treatment

MEDICATION ERRORS CONT.

- Missed dose
- Wrong dosage
- Wrong time
- Wrong administrative technique
- Wrong medication
  - *When listing medications, be sure to include dosages*

Abuse, Neglect, Exploitation

- Report ALL suspected or alleged cases to DSS

ALLEGATIONS

- *Physical and Sexual Abuse:*
  - Scratching, hitting, punching, biting, strangling or kicking
  - Throwing something at consumer such as a phone, book, shoe or plate
  - Grabbing, pushing or pulling consumer
  - Pulling hair
  - Using or threatening with a gun, knife or other weapon
  - Forcing consumer to have sex or perform a sexual act.

Sexual Abuse is ALWAYS a Level III!

ALLEGATIONS

- *VERBAL:*
  - Harassment
  - Belittling
  - Insulting
  - Teasing/Mocking
  - Scaring/Threatening
  - Berating
  - Cursing/Swearing

ALLEGATIONS

- *NEGLECT:*
  - Failure to supervise/protect (abandonment)
  - Failure to assist with daily care
  - Failure to provide basic necessities
    (food, water, medication, clothing, etc.)
  - Unsanitary living conditions
  - Self-neglect

ALLEGATIONS

- *EXPLOITATION:*
  - Using a person/belonging for another's gain
  - Cashing checks without permission
  - Forging signatures
  - Stealing money or belongings
  - Unauthorized cash withdrawals
  - Changes in wills without permission

ALLEGATIONS

- *LEVEL II:* ANY Allegation can be against ANYONE!

  Caretaker Friend

  Relative Stranger

  Anyone!

- *LEVEL III:*
  - Allegation of an act that has resulted in permanent physical or psychological impairment.
  - Incident is perceived to be a significant danger to or concern of the community (behavior that poses an eminent danger to the community)

BEHAVIOR

- Report any sexual, aggressive or destructive behavior to law enforcement
- Level I: throwing a chair, SIBs, etc.
- Level II: hit someone, destroy property, ingestion of illegal drugs
- Level III: results in death, permanent physical or psychological impairment caused by the person.

ABSENCE

- Level I: 0-3 hours and law enforcement not called
- Level II: absence greater than 3 hours or any absence that requires law enforcement contact
- Level III: Amber Alerts, Silver Alerts
    - *A Guardian is a person or corporation*

SUICIDAL BEHAVIOR

- Level I: any suicidal threat that indicates new or different behavior
- Level II: any suicidal behavior that does not result in death or impairment
- Level III: suicidal behavior that does result in impairment

GUIDELINES

- Don't be vague
- Do use extra paper if needed
- Report the detailed facts without opinions
- Give enough information to explain what happened who was there, when it happened
- Reports must be legible

    - *Remember, others will read the report!*

    - *Reports are NOT filed in person served's service records. File in notebook per office.*

GUIDELINES CONT.

- Include DSMIV diagnosis code along with the name of the diagnosis
- Separate mental diagnosis from medical diagnosis
- Do **NOT** leave blank spaces.
  - If something does not apply ~ check NA!

GUIDELINES CONT.

- Medical illness is not reportable unless:
  - it results in injury or death, or
- Is believed to be caused by:
  - abuse/neglect or
  - medication error
- Host vs Home:
  - Host = the County where services are provided
  - Home = County of legal residence(where Medicaid originates)

*Although the agency has 72 hours from the time we learn about the incident to report incident to DHHS …**the submission process takes time…***

Author of report MUST:

- *Have their Supervisor sign the report*
- Submit a completed report to the Incident Report folder

AND

- Send an email to Executive Administrator communicating that the report has been submitted to the Incident Report folder

URGENT

- **Reports for <u>ALL</u> Levels** must be completed and scanned on the same day on which the incident is learned

- Exception: IF the incident occurs on Saturday or Sunday
  - *These reports should be submitted first thing Monday am.*
  - *If any questions whatsoever, call the Executive Administrator BEFORE submitting the report to the Universal Incident Report folder!*

WHEN TO REPORT

ALL Levels:

- In REAL TIME
  - Universal Employees and Contractors are to report to their Supervisor when they are made aware of the incident!
  - IF it is a HCPR reportable incident, report must be submitted to IRIS by Universal within 24 hours.
  - All other reports are to be submitted to IRIS within 72 hours

72 hours is the deadline to submit to IRIS, not when the report is submitted to Executive Administrator!

WHEN TO REPORT

Level III: Verbal report IMMEDIATELY!

1. Written report to IRIS, DMH and DHSR within 72 hours

2. Death from suicide, accident, homicide or other violence: verbally report IMMEDIATELY and report to IRIS, DMH and DHSR within 72 hours

3. Death from unknown cause: Report to IRIS, DMH and DHSR within 72 hours

4. Death within 7 days of restraint: Report to IRIS, DMH and DHSR - IMMEDIATELY

REPORT ADMENDMENTS

IF at anytime additional information is obtained:

- **Scan the information to Incident Report folder**
- **Email Executive Administrator**
  - **an update will be submitted to DHHS**

Determining When to Seek Medical Assistance or call 9-1-1

- Ask yourself these questions:
  a. Does the individual's condition seem life-threatening?
  b. Could moving the person on your own cause further injury?
  c. Does the person need the medical skills or equipment of a paramedic or an emergency medical technician?
  d. Would the distance or traffic conditions cause significant delay in getting the person to the emergency room?
  e. Could the person's condition worsen and become life-threatening on the way to the emergency room?

Determining When to Seek Medical Assistance or call 9-1-1

❑ When to Seek Medical Assistance or call 9-1-1

a. If you see smoke or fire

b. If life is threatened or in danger

c. After one falls, faints, or collapses and there is suspicion of a concussion

d. When one has persistent chest pains, difficulty breathing or has high fever

e. One's face is drooping, they seem altered, incoherent, or confused

f. When there is a traffic collision with an injury

When Medical Attention is Needed and Before Helping, Follow Your CPR/FA Training:

(Refer to your First Aid and CPR Field Guide)

1. Size up the scene:
   a. Are there dangerous hazards present?
   b. How many people are involved?
   c. What is your first impression of the person?
   d. What happened?
   e. Are bystanders available to help?
2. Ask if you may help.
3. Determine if 9-1-1 needs to be called
4. Protect against diseases by avoiding contact with blood and other body fluids.
   a. Wear gloves!

Communication of Incidents

1. Communication of all incidents must take place ASAP between:
   a. Direct care individuals and their case responsible Qualified Professionals

   b. AFL Providers and their case responsible Qualified Professional and Guardian(s)

   c. All Qualified Professionals and their Program Manager and Regional Director

Determining When to Seek Medical Assistance or call 9-1-1

- *When **NOT** to call 9-1-1*

a. If you need transportation to the doctor's office

b. If you need a prescription refilled or have lost medication

c. Treatment for a minor cut or bruise

d. Cold or flu symptoms

e. For medical advice

f. When there is a power outage

UNIVERSAL

MH/DD/SAS

"Caring People, Caring for People"

Safe Lifting and Transferring

Safe Lifting and Transferring Outline

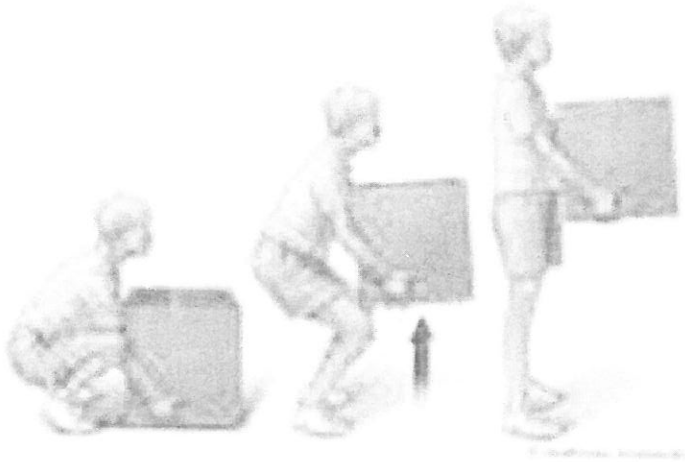
- ☐ Preventing Back Injuries Overview
- ☐ Safe Lifting and Transferring
- ☐ Body Mechanics Overview
- ☐ A-C-T Safely
- ☐ Types of Lifts/Transfers
- ☐ Lift-Assist Devices
- ☐ Other Considerations
- ☐ Practical Application

Preventing Back Injuries Overview

- Home Health: High Risk of Back Injury
  - Awkward postures, lifting, moving, turning patients
- What makes people risky?
  - Bulky, no handles, unpredictable…not a box!!
- Despite these risks, hazards can be minimized:
  - Good posture
  - Safe body mechanics
  - Protective lifting devices
  - A-C-T safely during the lift/transfer
  - Stay physically fit

Body Mechanics Overview

- Even though special circumstances are present in individual handling tasks, you must still remember to use proper body mechanics
- These include:
  - Neutral position, maintaining S-Curve in spine
  - Keep load close to the body (10x the weight)
  - Bend at the knees; tighten abdominals
  - Avoid twisting; pivot
  - Avoid overreaching in any direction
  - Good diet, exercise and sleep are essential



A-C-T: **ASSESS** the situation for hazards before you begin

- ☐ Identify hazards like crowded areas and situations where special lifting assists are needed.
- ☐ Observe the person's size, health condition, hearing or visual limitations and their ability to help
- ☐ Talk the person through all lifts and transfers

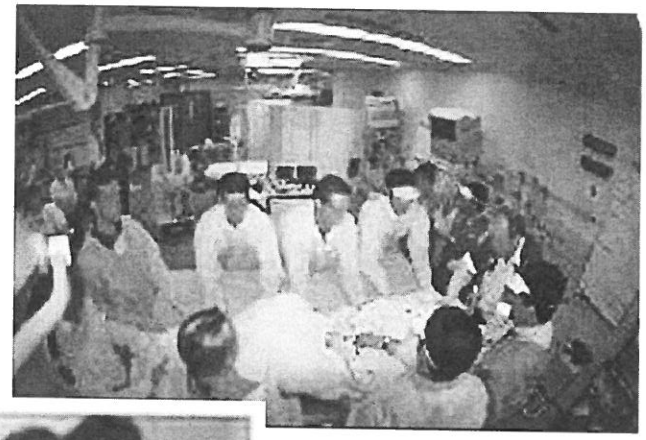
A-**C**-T: **CREATE** a safe workplace

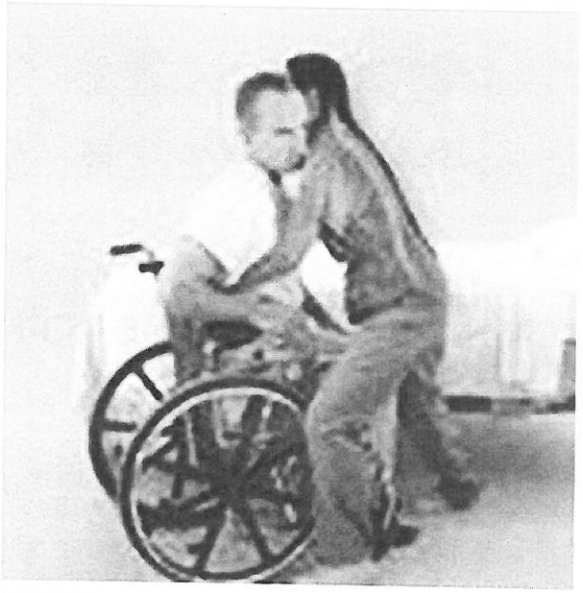
- ☐ Organize your space so that everything you will need is accessible
- ☐ Create a big-enough space for safely lifting and transferring the patient.

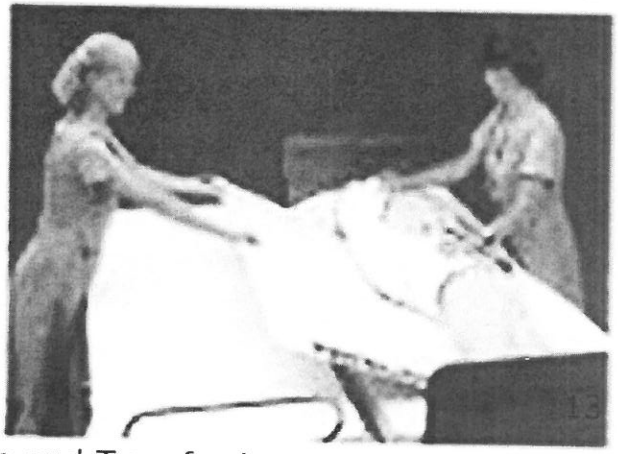
A-C-T: **TRANSFERRING** the person

- What types of lifts/transfers are there?:
  - Lateral transfers: sideways; e.g. bed to stretcher
  - Sit-to-Stand; Stand-to-Sit:
    - Bed to chair; chair to chair; chair to toilet; car to chair
  - Repositioning:
    - In bed or in chair
  - Floor:
    - Move individuals who have fallen on the floor to their bed

Types of Lifts/Transfers



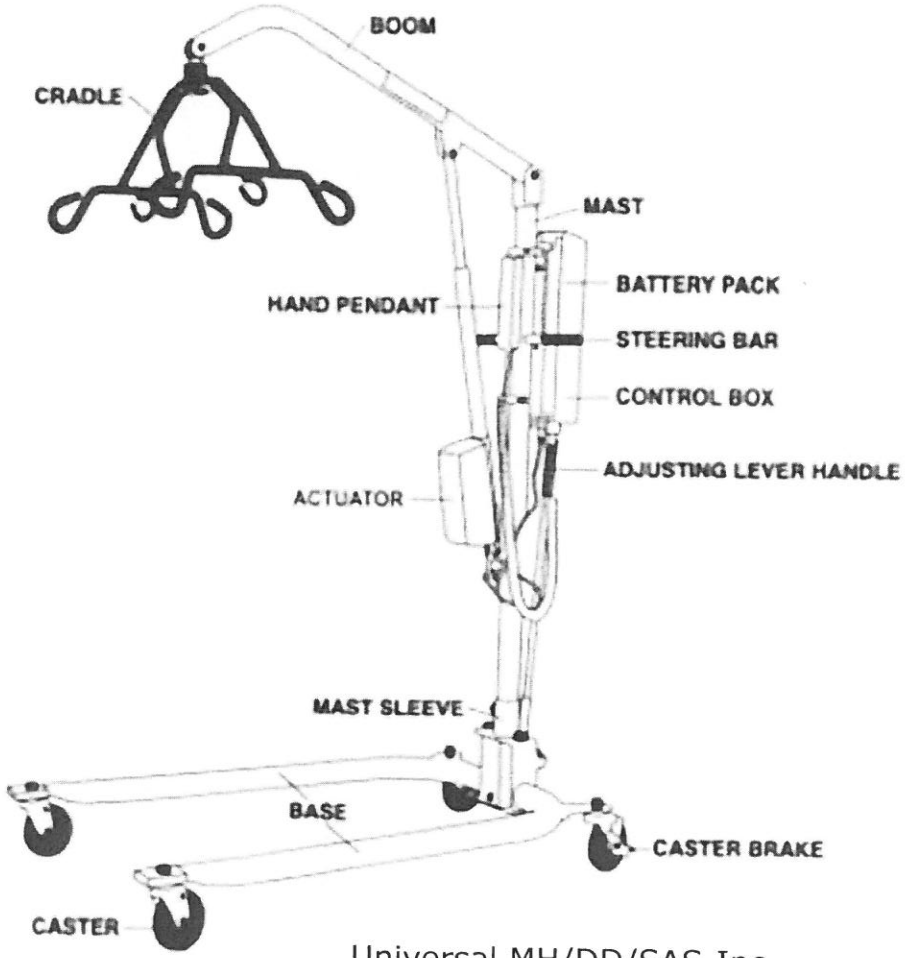




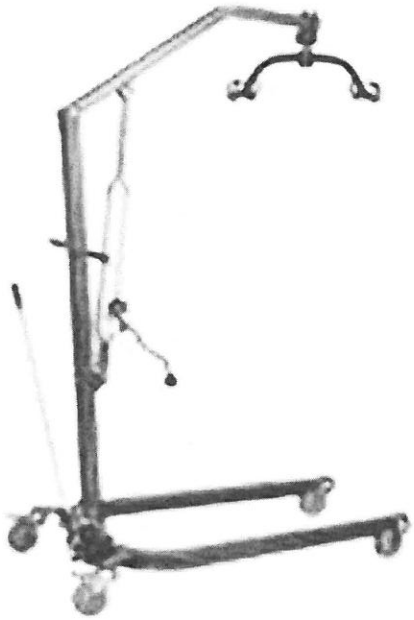
Lift-Assist Devices

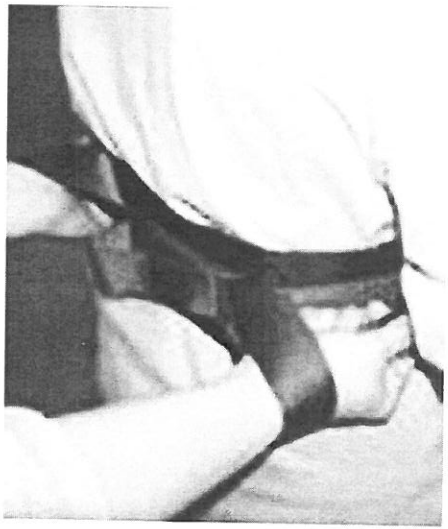
- For each type of lift/transfer
- Work-site specific
- Hands-on training
- Personal Care Plan; Individual Assessment
- Mechanical; battery-powered; gait belts

Hoyer


BOOM
CRADLE
MAST
BATTERY PACK
HAND PENDANT
STEERING BAR
CONTROL BOX
ADJUSTING LEVER HANDLE
ACTUATOR
MAST SLEEVE
BASE
CASTER BRAKE
CASTER

Hoyer, Gait Belt





A-C-**T**: **TRANSFERRING** the person

- ☐ Assess the person
- ☐ Assess the area
- ☐ Decide on equipment (e.g. Hoyer, etc.)
- ☐ Know how to use equipment

Person Considerations

- Person's ability to:
  - Provide assistance/bear weight
  - Cooperate & follow instructions
- Upper extremity strength of patient
- Person's height and weight
- CONSTANT COMMUNICATION IS KEY TO RISK MANAGEMENT!!!

Person Considerations

- Your clinical judgment is valuable for assessing special conditions that may complicate a lift:
  - Abdominal wounds
  - Contractures
  - Presence of tubes
  - Pregnancy
  - Physician or PT recommendations
    - e.g., maintaining knee or hip flexion during transfer

Practical Application:

- Transferring:
  - Always remember proper body mechanics
  - Tell the person what you plan to do
  - If possible, elevate the head of the bed with pillows (repositioning; reclining to sitting)
  - Secure gait belt to patient
  - Follow instructions for Hoyer lift
  - Lower wheelchair arms prior to lift (if applicable)
  - Remove wheelchair footrests prior to lift
  - Lock wheels on the bed and wheelchair prior to lift
- Sit-to-Stand and Stand-to-Sit

Practical Application: Individual Falls

- Person Falls:
  - Once the momentum has started, it's almost impossible to stop a patient from falling
- *Guiding the Fall*:
  - Help falling persons to the floor with as little impact as possible. If you're near a wall, gently push the person against it to slow the fall. If you can, move close enough to "hug" the patient. Focus on protecting the person's head as you move down to the floor. Then call for help.

Practical Application: Falls

- Moving a fallen person:
  - Don't panic!!
  - People who've fallen may feel dizzy or faint. Reassure them as you determine whether they've been injured. If so, tend to the injury before doing anything else. If the person isn't injured, you can prepare for the move back to a bed or stretcher. Get help. Four or more people may be needed.
    - Roll onto a blanket:
      - Roll the person onto his or her side.
      - Put a blanket under the person and roll the person onto it.
      - Position two or more people on each side of the patient.
    - Lift from Floor
      - Kneel on one knee and grasp the blanket.
      - On a count of three, lift the patient and stand up.
      - Move the person onto a bed or stretcher.