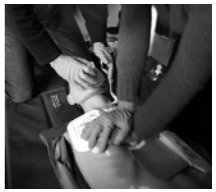
The Section for Long-Term Care Regulation Presents:

What would you do? Issues that may lead to an Immediate Jeopardy/Class I Citation

Cardiopulmonary resuscitation

Do you know what to do in an emergency?



SCENARIO

- It is 2:00 a.m. in the hall of a Skilled Nursing Facility (SNF).
- A C.N.A. doing rounds notices a resident lying on his side, facing the doorway. He does not look right.

You are the C.N.A.
What would you do?

SCENARIO continues…

- The C.N.A. gets the attention of the RN on duty, & asks her to come into the room.
- They both check the resident for a pulse.
- Neither feel a pulse, both think the resident feels warm.

You are the C.N.A.
What would you do?

SCENARIO continues…

- Now the C.N.A. and the Nurse ***leave the room*** together, go to the nurses' station to get a stethoscope and come back to the bedside.
- **There is definitely not a heartbeat or pulse.**

You are the C.N.A.
What would you do?

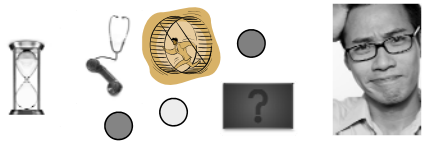
What should have happened?

- **A. Someone should call 911, then call the physician.**
- **B. Notify the DON and the Administrator, then look for the Emergency Supply Cart.**
- **C. Start CPR immediately, yell at all other staff to get out of the way!**
- **D. Quickly verify code status, & if no DNR order, start CPR immediately. Tell other staff to call 911 and get the CPR Cart.**

Answer

- **D. Quickly verify code status, & if no DNR order, start CPR! Tell other staff to call 911 and get the CPR Cart.**

What factors contributed to this situation for our scenario staff?



- After they found no pulse, the staff searched for the resident's chart to determine if the resident was "full code". However, they could not figure out which part of the chart contained the most current order, and did not know what the colored dots on the nameplate meant.

The resident did pass away…

The Staff on duty did **not** know:

- If the Nursing Home had a cart of emergency equipment for use in resuscitative efforts.

- About the door-based dot system used at the home to indicate whether each resident was to be a "full code" or was "DNR" (**DO NOT RESUSCITATE**).

Contributing Factors

The C.N.A.

- Was a new employee with 3-4 days of orientation.
- Had not received training regarding when a resident needs CPR.
- The employee's CPR Certification was expired.
- The employee was working the night shift for the first time ever, alone, on a hall with 30 beds.

The C.N.A.

The C.N.A. did not know (based on her interview):

- How to obtain oxygen (she had no access to the oxygen room).
- Where the CPR masks were kept.
- Where the suction machine was located.

Contributing Factors

The Night Shift RN

- Could not recall if the resident was on an Air Mattress.
- Did not (ever) notify the physician.
- Stopped chest compressions after 10 minutes, assuming there was no point in continuing.
- Had never been in this situation before.
- Was not familiar with the dot system.

BACKGROUND INFORMATION

The DON

- Had not provided an in-service to any staff about CPR.

(The DON believed this was the Administrator's responsibility.)

The Medical Director

- Stated that only chest compressions were required, due to new guidance from the American Heart Association.

Issues that lead to an Immediate Jeopardy/Class I Citation

1. An emergency cart with supplies is not accessible or properly maintained with the appropriate supplies.
2. Staff members fail to initiate CPR on a resident with a full code order, or staff members are unable to determine code status.
3. On-duty staff lacks CPR training or someone performs CPR incorrectly.

IMMEDIATE JEOPARDY OCCURS WHEN STAFF ARE UNSURE WHAT TO DO

Let's review each point:

1. Emergency Cart with supplies is not accessible or properly maintained with the appropriate supplies.

❖Someone, somehow, needs to be responsible for ensuring the cart is stocked and monitored, or that supplies are otherwise always available. (Someone else should be routinely double-checking this person.)

❖The nursing home should have supplies available to staff in *accessible* areas. No one should have to search the building for equipment in an emergency, and the location should *not* change. If the supplies are locked, ensure all staff know where the key is kept, and that the key is marked.

2. Staff members fail to initiate CPR on a resident without a DNR order, or staff members are unable to determine whether a resident has a DNR order.

❖If you have to leave the resident's room to find the medical record for code status, this causes a significant delay in starting CPR!

❖Do not assume that a resident on hospice has a DNR order.

❖ Nursing homes are required to review health care directives annually.

❖ When new residents are admitted, the nursing home staff must ensure they know his or her wishes regarding code status.

❖ Have a system in place for ensuring the code status documentation is up to date and accurate – and that any "colored dot" systems or "colored nameplate" systems are clearly understood and easily recognized by all staff.

❖The home should ensure that its employees understand the definition of the terms *DNR*, *Full Code*, *health care directive*, etc.

❖An immediate jeopardy situation could also occur for failure to perform basic first aid (such as the Heimlich Maneuver if a resident is choking) DNR does ***not*** mean that staff should not perform basic life-saving techniques.

3. On-duty staff lacks CPR training or someone performs CPR *incorrectly.*

❖ CPR performed <u>perfectly</u> in an elderly person may cause pain, damage to the chest wall, ribs, and internal organs.

❖If a poor technique is used, the potential for injury is increased and this could lead to prolonged agony for the resident and family.

❖**Make sure at least one staff person who can correctly perform CPR is on duty for every shift.**
(*A Nursing Home must have at least one staff person on every shift who can perform CPR and can meet the residents' needs during a medical emergency.)*

❖**Non-licensed personnel can perform CPR.**

❖***IMMEDIATE JEOPARDY OCCURS WHEN STAFF ARE UNSURE WHAT TO DO.***

❖Ensure new staff in the home know the residents before being left alone with them.

❖How often does your nursing home not only have in-services on CPR, but actually "role play" code status emergencies?

❖When a resident is found without a pulse and respiration, staff need a way to determine *immediately* if they should start CPR.

❖Do not leave the room to call 911 or call the doctor - instruct another staff member to call 911! Do not delay!

Internal Policy and Procedures

❖If a nursing home has residents who are full code, the home should *never* have a policy in place that would indicate: ***"Staff will not perform CPR, only dial 911"***. Nursing homes provide 24-hour care and services, and CPR is a basic life saving technique!

❖The home must ensure employees are available who know how to correctly perform CPR. (Staff may have had training, but forgotten, or who have never actually performed CPR on a person.) It is important to keep staff up-to-date on training and to conduct emergency drills.

❖Does the home's policy ensure that CPR is started immediately? Do *not* require in policy to ***"first call the physician or supervisor"*** - this delays action.

NURSING STAFF REMINDERS

❖ Nurses should never make the assumption that CPR will not help (this is a medical decision that falls outside of this scope of practice). A physician could give direction to stop CPR.

❖ EMS workers may appropriately stop CPR, because the medical director is communicating the decision by telephone, based on current assessments.

NURSES SHOULD EXERCISE CAUTION:

Nurses have been placed on the Employee Disqualification List, and also disciplined by the Board of Nursing for failing to administer CPR.

Deficiencies related to CPR preparedness normally fall under **F309 (**Quality of Care).

State Regulation References:

19 CSR 30-88.010 (10)
19 CSR 30-88.010 (11)
19 CSR 30-85.042 (13)
19 CSR 30-85.042 (22)
19 CSR 30-85.042 (37)
19 CSR 30-85.042 (67)

Resource Available:

Long Term Care Bulletin Fall 2010
CPR: Is Your Staff Qualified to Perform It?
By the University of Missouri's QIPMO Nurses
http://health.mo.gov/seniors/nursinghomes/providerinfo.php

QUESTIONS?

PART TWO:
Elopement

Would you recognize the warning signs?

Scenario

- A C.N.A. notices a new resident has just been admitted to the nursing home, in the Special Care Unit. The resident does not appear to be physically strong enough to "escape", since she is using a walker and does not have a signaling device bracelet on her wrist. The C.N.A. also overheard this resident talking (four hours earlier) about missing her house and garden.
- The C.N.A. asks a fellow co-worker about the new resident, and that employee doesn't know anything about the resident either, including what her name is. They cannot locate a written assessment or care plan for this resident and wonder why she is not wearing a bracelet.

You are the CNA.
What would you do?

- **The C.N.A. was right to notice the lack of a bracelet; the resident did receive one at the time of admission, but it had been placed on the non-dominant hand and the resident removed it with scissors.**
- **The nursing home should have ensured that direct care staff were familiar with the resident, as well as the assessment and care plan for each resident.**

Injury or death as a result of wandering or elopement is often preventable. Help protect your residents by adopting the following procedures:

- ❖ Assess risk.
- ❖ Identify and respond to risk factors (not disaster situations).
- ❖ Assess related needs.
- ❖ Provide care to meet needs while promoting health and safety.
- ❖ Evaluate the plan and revise when needed.

Nursing-home resident wanders away, found dead in parking lot

1 Comment Email Print

Published: Tue, April 10, 2012 @ 12:00 a.m.

Staff report

NILES

An 84-year-old resident of Grace Woods Senior Living, 7501 Youngstown-Warren Road, was found dead of hypothermia in the parking lot of the nursing home at 6:54 a.m. Monday after she wandered away from her room.

Eva Gorosics was in her room at 4 a.m. when an employee made her rounds. She was gone during the 6 a.m. check, Niles police said.

An employee looked for the woman in the other residents' rooms first, then notified another employee. Police were notified that Gorosics was missing about 6:30 a.m.

Employees found Gorosics in the parking lot covered in blankets, and ambulance personnel determined that she had died.

Capt. Ken Criswell of the Niles Police Department said an alarm system at the facility that would have notified employees that a door had been opened wasn't working properly.

The person who answered the telephone at Grace Woods on Monday afternoon said neither the owner nor anyone else was available to speak to a reporter.

Vindy.com

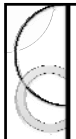
These incidents make headlines.

Always remember:

Door Alarms, Signaling Device Bracelets, Restraints and Locked Units do not replace staff supervision.

A confused resident who elopes or wanders may:

- ❖Enter areas that are unsafe, such as stairwells, poorly lit areas, construction areas or busy streets.
- ❖Get lost, not be able to find the way back and suffer from dehydration or exposure to heat or cold.
- ❖Enter a body of water and drown, or wander into traffic and be struck by a vehicle.
- ❖Encounter violent persons who may rob, assault or otherwise harm him or her.
- ❖Suffer a medical crisis because of a lack of medications or medical supervision.



- ❖ Unsafe wandering or elopement is a random or repetitive locomotion. This may be goal-directed (such as the person appears to be searching for something such as an exit) or non-goal-directed/aimless.
- ❖ Unsafe wandering may occur when the resident enters an area that is physically hazardous or that contains potential safety hazards.
- ❖ Non-goal-oriented wandering requires a response in a manner that addresses both safety issues and an evaluation to identify the root cause.
- ❖ An elopement occurs when a resident leaves the premises without staff being aware.

Assessment is the key!

Each person should be assessed upon admission and throughout his or her stay for the risk of wandering or eloping. What are some factors that may contribute to risk?

- ❖ Dementia and Alzheimer's disease.
- ❖ Medication changes.
- ❖ History of wandering or forgetting whereabouts.
- ❖ Restlessness – may the result of medication, medical problems, diabetes or infection.
- ❖ Infections can also increase a resident's confusion.

Assessment is the key!

Some examples of assessment questions:

1. Physical/ambulatory status: residents with wheel chairs are capable of leaving the facility.
2. Is the resident oriented to his or her place?
3. Is the resident able to make decisions about activities of daily living? Can he/she decide on clothing to wear or when to go to meals?
4. Are statements about going home frequent? A newly admitted resident may state that he/she wishes he/she could be at home. Make note of behaviors – especially after a family visit.
5. Anger may be a symptom of depression, which may alter the resident's concern for his/her own safety.
6. Conversations with family members may be helpful.

Pay careful attention to care plans for residents at risk of an elopement.

The plans should include precautionary measures to reduce both wandering and elopement.

Care plan instructions to prevent wandering should address, at minimum:

- **environmental modifications**
- **technology and safety**
- **physical and psychosocial interventions**
- **caregiver education**

❖Environmental Modifications:

- Prevent injury
- Create a sense of well-being
- Facilitate safe movement

❖Technology and Safety:

- Door Alarms
- Departure alert systems

❖Physical and Psychosocial Interventions:

•Provide meaningful activities
•Provide sufficient staff support and supervision

❖Caregiver Education:

•Communication techniques
•How to locate a missing resident
•Staff competencies should be measureable

An accident could occur as a result of failure to:

❖ Identify environmental hazards and individual risk assessments, including the need for supervision.

❖ Evaluate/analyze hazards and risks.

❖ Implement interventions (including adequate supervision) consistent with a resident's needs, goals, care plan and current standards of practice in order to reduce the risk of an accident.

❖Monitor the effectiveness of the interventions and modify as necessary

F323 (Accidents & Supervision) Common Deficiencies:

❖ Lack of individualized care plan intervention for wandering or elopement attempts, or the care plan has not been implemented or revised as needed.

❖ Door alarms and/or signaling devices are not properly maintained.

❖ The home did not try to determine the root cause of non-goal-directed or goal-directed wandering.

❖ Lack of staff supervision.

❖ No written assessment for new residents.

State Regulation References

19 CSR 30-85.032 (22)
19 CSR 30-85.032 (24)
19 CSR 30-85.032 (42)
19 CSR 30-85.042 (66)
19 CSR 30-85.042 (67)
19 CSR 30-87.020 (5)

24-Hour Protective Oversight

- This regulatory requirement (on the state side) is the same for every licensed level of care.

- SNF: 85.042(66)
- ALFs: 86.047(35)
- RCF IIs: 86.043(34)
- RCFs: 86.042(39)

24-Hour Protective Oversight

- Because the needs of the residents in different level of care may be different, the interventions required to provide protective oversight differ from one licensure level to another.

This Means RCFs Provide Protective Oversight, Too

- **Know your residents' habits** (i.e., he always leaves between 3 p.m. and 5 p.m., but he's always back for dinner at 5 p.m.).
- **Staff should *recognize* and *respond* to behavior that is abnormal and/or dangerous.**
- **Responses often include meeting with guardian, case workers, etc.** (and may ultimately involve notifying police or discharge).

Voluntary Leave

- **The minimum requirements are articulated in the 24-Hour protective oversight regulations:**
- "…For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave."

Resource Available:

Long Term Care Bulletin Spring 2010
Spring Fever: Your Residents Probably Have it Too!
By Kathryn Wolfe, SLCR
http://health.mo.gov/seniors/nursinghomes/providerinfo.php

QUESTIONS?

QUESTIONS LATER? CONTACT US:

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Searching for a previous article posted in the LTC Information Update?
Want to see what nursing homes are doing to promote culture change?
Visit the LTC Information Update Blog:
http://health.mo.gov/blogs/ltcblog/

Required Education Goes On-line

MANHA works with DHSS to bring solutions to training and education in the state of Missouri.

Courses Available Now

- Clinical Supervisor
- CNA Instructor/Examiner
- RCF/ALF State Study Course

- Contact MANHA at www.mlnha.org or at telephone: 573-634-5345 ask for Gayla or Ramona.

Courses Available in next 90 Days

- CNA Certification 08-01-12
- Orientation of all staff including NA 08-01-12
- Mentor I Training for seasoned CNA 08-01-12
- RCF/ALF National Study Course 08-01-12
- ICF/SNF State Study Course 08/01/12
- ICF/SNF National Study Course 08/01/12
- ALF Assessor 08/01/12

Courses Available Late Fall

- CMT Instructor/ Examiner
- CMT Certification
- L1MA Instructor/Examiner
- L1MA Certification
- Insulin Instructor/Examiner
- Insulin Certification
- DON Intensive Training Course
- Administrator Intensive Training Course
- End of Life Care Instructor Certification- RN/SS/Chaplain
- End of Life Care Certification for all staff

Description

- The classroom portion is on-line which can be started at anytime (student can start as needed without interrupting an on-going class)
- The on-the-job clinical components will be provided by regional network of facilities that can do the entire 100 hours of training. (Still recruiting for network facilities in Region 3 and Region 7.
- Regional Network will work with MANHA and Cheryl Parsons RN, Instructor to develop standards for consistency and core skill development for today's staff and standards for expectations for student, instructors and clinical supervisors.
- Facilities that are regional network facilities will receive a 25% discount on students from their own facilities.
- Regional Examiner pool will be developed to provide a pool of examiners for the area.
- Orientation and mentoring programs developed in conjunction with the training to improve new hire retention.

Questions/Comments

- Contact MANHA at www.mlnha.org or at telephone: 573-634-5345

Enhanced Leadership Development Academy

- MU's Academy for nurse leaders and Administrators in long-term care.
- Meets in Columbia, MO and at satellite locations.
- Data demonstrates that graduates:
  - Stay with their employers longer
  - Have increased confidence in their ability to lead in a transformational manner
  - Benefit from a new peer group of like-minded clinicians and Administrators
  - Are more likely to involve their staff members in operational decision-making, which reinforces teamwork and quality improvement initiatives

One Good Reason to Invest in the ELDA:

- **The quality of your education affects your job satisfaction.**

ELDA Program Details

- Cost is $650 (with scholarship)
- Sessions led by respected national consultants, health care executives, MU faculty and also some regulators.
- Runs from September to May, and the groups meet for 10 sessions.
- Curriculum squares with CMS / Don Berwick's "Partnership for Patients" initiative and the long-term care culture change movement.

To Enroll, or For More Info:

http://nursingoutreach.missouri.edu/