

# General Risk Management Program Guidelines & Implementation Strategies



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# Risk Management

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2002 Developed by the FHCA Quality Credentialing Program for Florida Health Care Association members. Special acknowledgement is extended to Linda Altendorf, Tra Beicher, Robin Bleier, Max Hauth, Cindy Pearse, and Howard Tuch for their contributions.

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## TABLE OF CONTENTS

As part of its administrative functions, nursing homes should establish an internal risk management and quality assurance program. Such a program may include the following components:

GENERAL PROGRAM GUIDELINES.....	3
CUSTOMER SATISFACTION.....	4
COMMUNICATION.....	5
Resident and Family	
Staff	
Physicians	
Expectations	
Plan of Care	
GRIEVANCES.....	11
ADMISSION.....	13
Pre-Admission	
Admission	
Post-Admission	
DOCUMENTATION.....	15
Basics	
Specifics	
Medical Care Needs	
STAFF DEVELOPMENT AND STAFF EDUCATION.....	17
Hiring	
Training	
Maintaining Competent Staff	
Using Agency/Contract Personnel	
MEDICAL STAFF.....	21
Medical Staff Appointments	
Physician's Services	
SECURITY AND SAFETY ISSUES.....	23
Security Preparedness	
Physical Plant and Safety Committee	
Elopement	
EQUIPMENT SAFETY.....	26
Medical Equipment	
General Equipment	
REPORTING REQUIREMENTS TO THE AGENCY FOR HEALTH CARE ADMINISTRATION.....	28
APPENDIX A	AGING PROCESS DISCUSSION
APPENDIX B	ADVERSE INCIDENT REPORTING FORMS
APPENDIX C	AHCA RISK MANAGEMENT PROTOCOLS FOR QUALITY MONITORS

## GENERAL RISK MANAGEMENT PROGRAM GUIDELINES & IMPLEMENTATION STRATEGIES

As part of its Quality Assurance administrative functions, nursing homes must establish an internal risk management program as the responsibility of the nursing home administrator. Such a program should include, but not be limited to:

- Designation of a qualified individual to implement and oversee the risk management process. The facility may have a contracted risk manager with a risk manager designee in the facility. The Risk Management and Quality Assurance Committee must meet at least monthly and include the facility risk manager, administrator, DON, medical director and at least three other facility staff. Participation may be by phone and attendance must be documented.
- Assessment of resident care practices; review of facility quality indicators; and deficiencies cited by the Agency for Health Care Administration with the development of Plans of Correction.
- Investigation and analysis of frequency and causes of general categories and specific types of adverse incidents to residents, and communicating this data.
- Analysis of grievances that relate to resident care and the quality of services.
- Abuse, neglect and exploitation prevention protocol.
- Development of appropriate measures to minimize the risk of adverse incidents to residents.
- Evaluation of the response of risk prevention/loss control techniques and their effect on the identified risks.
- Establish a procedure for preservation of evidence when an injury or accident occurs.
- Development of plans of action to correct and respond quickly to identified quality deficiencies.
- Encourage the implementation of innovative approaches to reduce the frequency and severity of adverse incidents to residents and violations of resident rights.
- Clearly delineate the reporting responsibilities of all staff.
- Establish an Attorney Contact procedure that instructs employees on the handling of information requests from an attorney for either current or former residents.
- At least annually, non-physician personnel of the nursing home providing resident care must receive one hour risk management training.
- Develop a procedure for obtaining informed consent.

## Customer Satisfaction

Develop a facility-wide Customer Satisfaction Program to include:

Guidelines	Examples
Determine resident and family expectations	<ul style="list-style-type: none"> <li>▪ Meet with families prior to or at admission and identify their expectations – ask them what they expect of the nursing center.</li> <li>▪ Discuss aging process and specific disease processes of patient.</li> <li>▪ Guide toward establishing realistic expectations considering the patient’s age, condition, and disease processes through education.</li> <li>▪ Assist the family in acknowledging and understanding the potential path of decline likely for patient’s age, condition, and diseases.</li> <li>▪ Explain to the family and patient what the center can and cannot do; for example, the facility cannot provide one on one care, your loved one may fall and break a hip, she or he may develop a pressure ulcer. Explain what the facility can do; for example, we will care plan problems and take action to prevent; we will check his or her skin, turn her, keep her dry and clean, but you may walk in and find her wet and dirty as we cannot be with her every minute, etc.</li> </ul>
Train employees on handling complaints effectively	<ul style="list-style-type: none"> <li>▪ Provide scenarios with common complaints and appropriate responses.</li> <li>▪ Employees will role-play the above scenarios.</li> </ul>
Solicit feedback from customers (residents and the community)	<ul style="list-style-type: none"> <li>▪ Interact with patients and their families. The best feedback will come from your most challenging customers. If you have a challenging family member, greet them most, of not all times they visit; ask them how thing are going; how was their mother today; do they have any more suggestions on ways you can improve the care you provide; when they complain, don’t make excuses – apologize and assure them you will look into the complaint and get back to them; and the follow up. Tell them what you can and can’t do; ask for their ideas and help.</li> </ul>
Establish a public relations philosophy.	<ul style="list-style-type: none"> <li>▪ Develop a relationship with the press before you need them to be on your side.</li> <li>▪ Meet crisis situations head-on; don’t say, “No comment.”</li> </ul>
Explore de-escalation techniques.	<ul style="list-style-type: none"> <li>▪ Again, in-service your staff on these techniques; do scenarios with role- playing. Have someone from the mental health center come in and teach. Make it a fun experience; order pizza for the group.</li> </ul>

Customer Satisfaction *continued*

Residents and their families must be treated with courtesy, dignity and respect.

Guidelines	Examples
Support a resident's self-esteem in all communications.	<ul style="list-style-type: none"> <li>▪ Educate staff on politeness, courteous behavior; ask them how would you like to be treated if you were a patient in this center.</li> <li>▪ Have the more cognitively aware patient explain to staff, during orientation, what it is like to be a patient in the center.</li> <li>▪ Have staff talk to patients during care-giving times vs. talking over and above them.</li> <li>▪ Remind staff, they are there to serve the patients; not talk about what they did last night!</li> </ul>
Foster a positive relationship with residents and families by approaching care and services compassionately.	
Encourage family members to assist in feeding, grooming and caring for the resident as clinically appropriate.	

**Communication**

Guidelines	Examples
Encourage residents and families to express themselves and actively listen to concerns.	<ul style="list-style-type: none"> <li>▪ Ask patients and families how things are going.</li> <li>▪ Do they have any suggestions that would make their life at the center better?</li> </ul>
Acknowledge and validate feelings of loss and concern.	
Be aware of verbal and nonverbal messages.	<ul style="list-style-type: none"> <li>▪ Educate staff on verbal and non-verbal communication.</li> </ul>
Keep families advised of changes in the resident's condition, incidents/accidents or other significant developments.	<ul style="list-style-type: none"> <li>▪ Keep families informed; e-mail them; call them; send them a little positive note with the bill. (Too often, the only times we ever communicate with family members is to call them to tell them about a fall, injury, or decline, or send the bill.)</li> <li>▪ Have the CNA, nurse, or social worker update a family member (if appropriate) about how their mother did today in the dining room, etc. "She really seemed to enjoy lunch today."</li> </ul>
Inform families of small successes as well as small setbacks.	
Candidly discuss treatment options, or the lack thereof, and encourage feedback.	Encourage attending physicians to communicate with patients and families.

Communication *continued*

<p>Invite family members to family council meetings, care planning conferences and other meetings involving the residents' care.</p>	<ul style="list-style-type: none"><li>▪ Invite families to care plan meetings, but ask them when it is convenient for them to attend. If they work during the day, they can't very well attend at 1300. Schedule them on Saturdays or in the evening or include them by conference call.</li><li>▪ Invite support groups to have their meetings in your center and let families know, in advance, so they can attend if interested.</li></ul>
<p>Utilize special activities, programs, and awards to connect the residents with each other, their families and the community.</p>	<ul style="list-style-type: none"><li>• Have monthly "theme" meals and invite family members to participate. For example, if you have an oriental family, have an oriental dinner; ask the family to help; ask them to dress in their native costume; assist dietary with planning the menu; supply recipes; do a little "travel-log", etc.</li></ul>

Encourage the resident and family to work with the facility to identify areas of improvement.

## Resident and Family Communication

Guidelines	Examples
Consider orientation and regular updates for employees on compassion, empathy, providing support and helping resident and families deal with the diagnoses, condition, and loss of independence and loss of control.	<ul style="list-style-type: none"> <li>• Acknowledge at the time of admission and on an ongoing basis the difficulty in placing a family member in a nursing home and some of the naturally occurring feelings relating to placement such as guilt, fear, financial concerns and inadequacy.</li> <li>• Engage families in and educate to productive activities such as reading mail to the resident, brushing hair, out of room tours, sitting outside, bringing in photographs or taking to activities.</li> <li>• Request families to contact the resident's church to notify of their stay in the facility for inclusion on the bulletin and/or visits by clergy.</li> <li>• Take resident/families to office to discuss complaints.</li> <li>• Listen to complaints/concerns without becoming defensive. Allow full expression of feelings whether you feel they are valid or not.</li> <li>• Observe the non verbal messages being sent by residents/families, these messages are powerful and should be explored not avoided.</li> </ul>
Consider implementing support groups in the facility for residents and families and provide a list of those available in the community.	
Provide education for resident families on the aging process.	
Promote family involvement in resident's care.	
Establish a forum for family meetings, resident council and other facility-sponsored meetings and ensure follow-up of concerns with QA trending.	
Consider utilizing resident and family feedback surveys.	
Develop a process to resolve resident and/or family complaints.	

## Staff Communication

Guidelines	Examples
Educate staff on effective communication techniques.	<ul style="list-style-type: none"> <li>▪ Education does not have to be a long, drawn-out formal process; education can be done in 10-minute little mini-sessions; during report at the beginning or end of the day; during lunch or breaks, be CREATIVE.</li> </ul>
Develop strategies to keep employees informed of changes.	<ul style="list-style-type: none"> <li>▪ Keep employees informed by having morning meetings – only 5-10 minutes long. Post notices in employee bathrooms and in meal areas.</li> </ul>
Establish a protocol for shift-to-shift report.	<ul style="list-style-type: none"> <li>▪ Protocol for shift-to-shift report – have nurses and aides tell each other about their patients; what they did or didn't do; how they are, etc.</li> </ul>
Establish a chain of command to facilitate concerns.	<ul style="list-style-type: none"> <li>• Tell employees that if they try to resolve an issue and can't, where to go next.</li> <li>• If a nurse attempts to notify a physician and he doesn't return the call, how long should she wait before calling the DON/Medical Director?</li> <li>• If the nurse can't get the DON, who should she call next?</li> </ul>
Consider establishing an Open Door management policy.	

## Physician Communication

Guidelines	Examples
<p>Develop procedures for physician communication in the event of:</p> <ul style="list-style-type: none"> <li>✓ Admission and change of condition</li> <li>✓ Abnormal lab values</li> <li>✓ Abnormal diagnostic test results</li> <li>✓ Resident or family complaints/concerns</li> <li>✓ Incapacity, DNRs and terminal conditions</li> </ul>	<ul style="list-style-type: none"> <li>• Have the medical director develop a cheat sheet with critical lab values and when to call the physician e.g. GI bleeding – vomiting of coffee grounds or tarry stools.</li> <li>• A list of signs and symptoms, and when to call the physician.</li> <li>• Have physicians do in-service education for staff. Provide food to encourage a better turn out.</li> <li>• Arrange for the medical director to attend family council meetings a couple times a year at a minimum. <ul style="list-style-type: none"> <li>▪ Have a periodic program on incapacity, advance directives and DNRs for families and patients.</li> </ul> </li> </ul>

### Expectations

- Resident and family expectations should be identified prior to admission. With the resident and family, discuss the effects of the aging process and set realistic expectations based on the resident's age, condition and disease.
- Assist families with understanding and acknowledging the path of decline likely for the resident's condition or disease.
- Provide orientation for each resident and family during the transition period.
- Involve the resident and family in setting health care goals and participating in the care planning process.
- Discuss realistic outcomes for the resident.
- Address the resident and family's expectation for medical care and interaction with the physician/ARNP/PA.

## Plan of Care Communication

The plan of care serves as a centralized resource of the resident's needs, and serves as a communication tool for all staff.

Guidelines	Examples
Caregivers should review the plan of care daily to ensure it reflects the current condition of the resident and that all caregivers are following it.	<ul style="list-style-type: none"> <li>• The care plan should be used – not just in a notebook under the desk for surveyors. Make it a “living document.”</li> <li>• Have nursing give report from the list of problems, chart from the care plan on care plan problems, etc.</li> <li>• If you use computerized care plans, make sure the goals and interventions are realistic and patient specific; you may handwrite on the care plan.</li> <li>• Schedule meetings (occasionally) at the family's convenience. Telephone conference them in to a meeting; e-mail, etc.</li> <li>• When you review and revise the care plan after an event, write on the care plan, initial and date it.</li> </ul>
The plan of care should reflect the realistic expectations for the resident.	
The resident and family members should be kept informed of the resident's condition and any changes in care or treatment provided. The resident/family should sign the care plan in a face-to-face meeting, or by conference call, or via email or mail with returned signature.	
Physicians and management staff should be readily available to resolve conflicts of care and meet with families.	
The DON (or their designee if they are not in the building) must sign the care plan as well as the resident, their designee or legal representative in accordance with the facility's policies and procedure.	
<p><b>Reassess the care plan interventions after an incident occurs; reassess the resident (MDS/RAPS), and revise care plan if appropriate. Document this process!</b></p>	

## Grievances

Guidelines	Examples
<p>Employees should be trained on the facility’s grievance and abuse process during orientation. A facility’s grievance process must include an explanation of how to pursue redress of a grievance including a procedure for providing assistance to residents who cannot prepare a written grievance without help.</p>	<p>In many hospitals the risk manager is responsible for handling complaints for litigation management purposes. Whenever a patient or family member complaints, staff calls the risk manager – who responds, even if to tell the complaining party, “I will call you tomorrow at 1500.” The risk manager is given \$\$ authority up to a certain amount. Above that amount requires consultation with business office. Complaints are resolved as quickly as possible on the spot, as appropriate. There is not the scenario where the patient tells the nurse, the nurse tells the social worker who interviews the patient and then reports to the administrator who asks more questions, or goes back to the patient and asks them to repeat the story over again. It is a much more streamlined process, aimed at customer satisfaction. And, it takes the front line worker out of the process and enables that caregiver to maintain only a caregiver relationship with the patient and family; not get involved in conflict resolution.</p>
<p>The grievance process must include the names, job titles and telephone numbers of the employees responsible for implementing the grievance process and include the address and toll-free numbers of the ombudsman and the Agency for Health Care Administration. Grievances from residents or families should be systematically documented, and a timeframe should be given to the complaining party as to when he/she will hear back regarding the grievance. Whenever possible, the reason for the grievance should be resolved immediately.</p>	<ul style="list-style-type: none"> <li>• Each staff member should be required to complete a grievance form when presented with a grievance. Education should include where grievance forms are located, whom the completed form should go to and the importance of grievances as a tool to improve customer satisfaction rather than a method to get staff into trouble.</li> <li>• Ask each staff member how a grievance is filed during rounds.</li> <li>• Expand thinking of grievance to both verbal expressions and non-verbal expressions.</li> </ul>
<p>Employees may be empowered to handle specific grievances or concerns at the time they are voiced.</p>	

Grievances *continued*

Guidelines	Examples
<p>Policies for the process through which a resident may contact the toll-free telephone hotline of the ombudsman or the Agency for Health Care Administration to report unresolved grievances.</p>	<ul style="list-style-type: none"> <li>• Consider events of family/resident frustration such as screaming at staff or chronic complaining as an opportunity to convert non-specific or non-verbal "grievances" into written grievances to be addressed. Be proactive not just reactive.</li> </ul>
<p>Develop a follow-up process to verify the grievance has been resolved to the complaining party's satisfaction.</p>	<ul style="list-style-type: none"> <li>• Keep a tickler file of all grievances, and 2 months after the grievance is reported, call or send a letter asking if and when and how the complaint was resolved; and, was it to their satisfaction. Have any new issues arisen?</li> </ul>
<p>Aggregate data on grievances may be used to identify common issues and areas of concern.</p>	<ul style="list-style-type: none"> <li>• Track and trend – count and categorize grievances to see if there is a common thread – staff, time, day, type of complaint, etc.</li> </ul>
<p>Maintain records of all grievances and report annually to the Agency the total number of grievances handled, categories of grievances and the final disposition of the grievances.</p>	<ul style="list-style-type: none"> <li>• Involve the social worker with the grievance process and the linkage to risk management</li> <li>• Provide feedback on the facility-wide grievance process to residents through the Resident Council and Family Council meetings</li> <li>• Recognize that food and lost personal items are the major facility complaints made by patients.</li> </ul>

## Admission

### Pre-Admission

Guidelines	Examples
<p>Provide realistic depiction of life in a nursing home, i.e., that one-on-one care is not the norm</p> <p>Policies and procedures should be in place for incapacity to make health care decisions, terminal conditions and diagnoses, do not resuscitate orders and living wills.</p>	<ul style="list-style-type: none"> <li>• Avoid implications that the physicians are agents of the facility especially when assisting the resident in obtaining physician coverage.</li> <li>• Insure there is an appropriately appointed agency (power of attorney, surrogate) to authorize treatment for the resident.</li> <li>• Require production of documents appointing alternate decision makers such as power of attorney, living wills and health care surrogate.</li> <li>• Ask hospital discharge planners about the family or alternate decision makers' expectations and behavior.</li> <li>• Inquire into the behavior of residents prior to admission.</li> <li>• Determine if life prolonging procedures are being withheld or withdrawn at the hospital or are expected to be withheld or withdrawn at the time of admission to the facility.</li> </ul>
<p>Consider providing an Admission Kit to the resident and family, which includes</p> <ul style="list-style-type: none"> <li>▪ Information regarding the facility</li> <li>▪ Information regarding meal service, activities and special events</li> <li>▪ Information regarding physician services</li> <li>▪ Important facility telephone numbers</li> <li>▪ Explanation of the transition process that the resident and family are likely to face</li> <li>▪ Advance Directive information</li> <li>▪ Grievance procedures for families and residents</li> <li>▪ Information on Geriatrics (Appendix A)</li> </ul>	<ul style="list-style-type: none"> <li>• Provide a copy of the grievance policy and procedure and a form for use at admission to residents and families.</li> <li>• Ask resident/families to contact the attending physician to discuss the resident's care and to express any concerns (new physician often the case at admission and family only has relationship with hospital physician).</li> <li>• Ask resident and families about their expectations of care.</li> <li>• Establish an open door policy for the DON and Administrator for residents and families.</li> </ul>

## Admission

- The admission should be communicated to the appropriate disciplines.
- If the resident is coming from a hospital or other facility, try to obtain a nurse-to-nurse report at admission.
- Determine prior to admission which physician will be the attending physician. Establish if the resident will need assistance with finding an attending physician.
- Verify admission orders and goals with the attending physician.
- A thorough admission assessment should be completed on the resident, including:
  - ✓ Skin Condition
  - ✓ Head-to-Toe System Review
  - ✓ Nutrition
  - ✓ Behavior
  - ✓ Cognitive Functioning
  - ✓ High-Risk Areas
  - ✓ Falls Risk
  - ✓ Wandering Potential

## Post-Admission

- The resident and family should participate in an admission orientation process that may include a tour of the facility.
- The staff should continue working with the resident and family, to gain a consensus on the goals, expectations and plan of care for the resident.
- Closely monitor residents at risk of falls to target care interventions appropriately around the clock.
- Assign permanent staff to new admissions.
- Randomly survey the admission process for family/resident satisfaction and suggestions; report results to Quality Assurance.

# Documentation

## Basics

Guidelines	Examples
Document legibly and include the full date/time and signature and title.	<ul style="list-style-type: none"> <li>• Educate your staff on how juries perceive different documentation failures and what it costs in \$ (awards and settlements).</li> </ul>
Document in chronological order, at the time an intervention or assessment was completed.	<ul style="list-style-type: none"> <li>• Ask staff why they don't document. Get their input on developing, purchasing, whatever, a system that would improve documentation. Don't be penny wise and pound poor.</li> </ul>
Use only facility-approved abbreviations.	<ul style="list-style-type: none"> <li>• Provide examples of terrible documentation and educate on how it could have/should have been documented. Quiz staff on purposes of documentation.</li> </ul>
Each page in the medical record should include resident identification and on both sides of a two sided form	<ul style="list-style-type: none"> <li>• Get nursing to run a quality improvement team that looks at quality of documentation – content v. quantity. Have nursing, not medical records staff, educate on documentation skills.</li> </ul>
Do not use the medical record to report or complain about another professional's care.	<ul style="list-style-type: none"> <li>• Make sure your monthly summaries don't parrot prior months. Assure that they are serving a purpose aside from extra paper and work.</li> </ul>
Make entries based on objective data.	<ul style="list-style-type: none"> <li>• Eliminate duplicate documentation – take a chart and yellow highlight everything that is documented somewhere else. No need to chart ABT on the MAR and in nursing notes.</li> </ul>
Avoid using ink colors, other than black or blue ink.	<ul style="list-style-type: none"> <li>• Assure staff is documenting patient's response to treatments, meds, interventions, etc. Not just that it was given.</li> </ul>
Make corrections and late entries only according to facility policy.	

## Documentation *continued*

### Specifics

- Documentation policies should complement federal and state requirements and guidelines.
- Review the medical record to ensure it accurately reflects the care and treatments provided, and that it meets the facility's medical record guidelines.
- Develop a procedure of reviewing charts for completeness, including ADL charting by Certified Nursing Assistants and advance directives.

### Care Needs

- The medical record should contain complete admission information, including initial assessments, according to facility policy.
- Changes in resident's condition, assessments, interventions and outcomes should be documented.
- Flow charts and checklists should be placed in the medical record, according to facility policy.
- Communicate and document interdisciplinary approaches to care needs.
- Include a monthly summary in the nurses' "progress notes" referencing the care plan by number and problem statement and including an assessment of the resident's progress toward stated goals and continued appropriateness of current interventions. Report functional decline or improvement to MDS Coordinator.
- Review assessment, care plan interventions, and quality indicators for appropriateness of care and need for reassessment and revisions.
- Document resident's refusal care and/or treatment, along with appropriate notifications.

## Staff Development and Staff Education

### Hiring

Guidelines	Examples
Ensure a complete application, licensure or certification and background checks on each prospective employee as required by applicable law.	Choose carefully. Have someone read and check applications to assure consistency in dates and information.
Ensure references are checked prior to hiring.	<ul style="list-style-type: none"> <li>• Call and check references prior to start date.</li> <li>• Do criminal background and abuse checks.</li> <li>• Verify current licensure or certification through the Dept. of Health – not just copying a license.</li> </ul>
Develop Recruitment and Retention programs.	<ul style="list-style-type: none"> <li>• Have a job fair or open house.</li> <li>• Provide an educational program on a long term care issue, and provide CEU credits and invite the local hospital nursing staffs to attend – provide refreshments.</li> <li>• Enlist family members to find staff.</li> <li>• Update your advertising and be creative, “Are you lonely? Single, nursing home seeks S, D, M or other, M or F. Do you desire love and attention? Want to help others? Looking for a permanent relationship? Come and meet us. We have a lot to offer! Happy Valley Nursing Home – 1 – 800 – WELUVEU.”</li> <li>• Pay as much as you can.</li> <li>• Provide flex scheduling – go that extra mile.</li> <li>• Offer career ladders.</li> <li>• Use hospitality aids, golden girls, etc.</li> <li>• Have applicant spend time on the unit before starting orientation – is this what they really want to do?</li> <li>• Administrators and DONs have a brief interview with the applicant/new hire.</li> </ul>

Staff Development and Staff Education *continued*

Training

Guidelines	Examples
Develop a mechanism to identify educational needs of staff.	<ul style="list-style-type: none"> <li>• During orientation complete a skills checklist on new employees. Have the charge nurse observe and check off skills as completed. This identifies areas where further education, experience, etc. is needed. Provide the new employee with the education.</li> </ul>
New employees, promptly following employment, should be instructed in the operation and responsibility of the incident reporting system, and receive risk management and risk prevention, abuse prevention and reporting, and grievance process training.	<ul style="list-style-type: none"> <li>• Have skills training labs yearly – it gives employees an opportunity to freshen up on skills not done frequently and allows you to assess competency.</li> </ul>
<p>Orient newly-employed individuals to the facility's:</p> <ul style="list-style-type: none"> <li>Philosophy, mission and goals</li> <li>Practice standards and guidelines</li> <li>Policies and procedures</li> <li>Job responsibilities and functions</li> <li>Resident population, age, culture and diversity</li> <li>Infection control and Standard Precautions</li> <li>Safety program</li> <li>Fire prevention program</li> <li>Implementation of the Resident Self-Determination Act</li> <li>Policy on confidentiality, abuse, restraint and residents' rights</li> <li>Documentation policies</li> <li>Grievance policies</li> <li>Abuse, Neglect, and Exploitation policies</li> <li>Risk Management process</li> </ul>	<ul style="list-style-type: none"> <li>• Start providing a “real orientation” program; not just sitting in a room and watching videos. Let the new employee tag along with someone, increasing their patient load as orientation progresses.</li> <li>• Introduce new staff members to department heads, other staff, patients and families; make them feel valued.</li> <li>• Orient to the important things; how to answer the phone; turn off a call light, etc.</li> <li>• Standardize orientation – everyone is getting the same information.</li> <li>• Orient to risk management and quality management.</li> <li>• Have a patient attend orientation to tell what it is like to be a patient in the center.</li> <li>• Have Alzheimer's group attend and explain what the disease is and what it is like to have it.</li> <li>• Educate on resident rights, survey, ombudsman, as well as abuse and neglect, grievances, and risk management, etc. Give new employees an idea of why we do the things we do.</li> <li>• Have a section or orientation on teamwork, time management, prioritizing tasks, and communication.</li> </ul>

Staff Development and Staff Education *continued*

Training

Guidelines	Examples
	<ul style="list-style-type: none"> <li>• Teach customer satisfaction/relations.</li> <li>• Put new employees with someone PLEASANT for a couple of days.</li> <li>• Start an assignment with only 3 patients; add a patient a day.</li> <li>• Have regularly scheduled meetings with the new hire and her mentor.</li> <li>• Have joint evaluations at day 10, 1 month, 3 months, and 6 months. Uncover problems and answer questions early.</li> <li>• Have weekly staff meetings; praise a staff member every day.</li> <li>• Provide staff with meals, etc. Show them they are valuable and you care. Learn something about every staff member. Make work a “fun place to be.”</li> <li>• When an employee resigns, find out what you can do to keep them (if they are valuable). Why are they leaving? Do they feel unsupported?</li> <li>• Develop a culture aimed at patient safety; a non-punitive reporting system aimed at improving systems v. identifying who made a mistake.</li> <li>• Show respect for employees.</li> <li>• Have current texts on the units for procedure books. Keep policies and protocols simple so staff can understand and follow.</li> <li>• Have agency nurses aware of policies and protocols before coming to work. Arrange in contract with agency. Assure they have been through same background checks.</li> </ul>
<p>Provide SAFETY education.</p>	<ul style="list-style-type: none"> <li>• Conduct disaster and missing patient drills. Can you evacuate all the patients, medical records, etc. in a timely and orderly manner?</li> <li>• What are you going to do in the event of chemical or germ warfare? Do you have a plan?</li> <li>• Do you have transfer agreements with hospitals, other center, etc. in the event you have to evacuate patients? Are they up-to-date?</li> </ul>

## Staff Development and Staff Education *continued*

### Training

- Consider implementing a continuing education program, which may include on an annual basis:
  - ✓ Competency Skills
  - ✓ Federal and state regulations
  - ✓ Special Needs required by resident population
  - ✓ Medication administration
  - ✓ Resident safety
  - ✓ Employee safety
  - ✓ Residents' Rights
  - ✓ Confidentiality
  - ✓ Grievances and Abuse, Neglect, and Exploitation
  - ✓ Incident Reporting
  - ✓ Risk Management/Quality Assurance
  - ✓ Documentation
  - ✓ Infection control and blood borne pathogens
  - ✓ Alzheimer's disease and related dementias
  - ✓ End of Life/Pain Management
  - ✓ Emergency preparedness and procedures
  - ✓ Fire prevention and life safety
  - ✓ Disasters and evacuations
  - ✓ Equipment use
  - ✓ Hazard communication, including Material Safety Data Sheets and OSHA

### Maintaining Competent Staff

- Obtain current licenses and certificates on each employee.
- Establish Performance Standards for each level of personnel
- Delineate job functions by documented licenses, certificates, skills tests, education and experience.
- Have available the comprehensive policies and procedures for treatments and processes used in the facility.
- Consider providing in-service education on services provided by other team members, such as dietary and nutrition support, physical therapy and transferring of residents, dental care, foot care, etc.

## Using Agency/Contract Personnel

- Review prospective agency contracts to ensure agency can meet the facility's needs, that the contract meets the facility's legal requirements, and that contract staff meet all relevant state and federal requirements which pertain to nursing home staff.
- Educate regular staff on their roles and responsibilities with regards to agency personnel.
- Require Agency to provide social security numbers for all contract staff.

## Medical Staff

### Medical Staff Appointments

Guidelines	Examples
<p>Establish a protocol for obtaining the following credentialing information:</p> <ul style="list-style-type: none"> <li>✓ Application that includes name, address and telephone numbers for reaching the medical professional after hours</li> <li>✓ Current medical or professional license and curriculum vitae</li> <li>✓ DEA number</li> <li>✓ Certificate of Insurance for malpractice coverage</li> <li>✓ References, both personal and professional</li> <li>✓ Hospitals for which the individual is on staff</li> </ul>	<p>Contact National Practitioner Data Bank for Adverse Actions Against Physicians and Other Health Care Practitioners (NPDB).</p>
<p>Appoint a qualified, credentialed Medical Director</p>	
<p>Verify licenses</p>	

## Medical Staff *continued*

### Physician's Services

- 24 hour Physician Services should be available, and the timing of the physician visits is based on the admission date of the resident. Visits will be made within the first 30 days and then at 30-day intervals up until 90 days after the admission date with a 10 day grace period. Physicians are also obligated to visit a resident when medically necessary. Most facilities also require the initial visit be within 72 hours of admission, and some provider groups require weekly visits for the initial three weeks while the resident is receiving skilled services.
- Note: Medicare will reimburse for all required visits in addition to those medically necessary, with appropriate documentation. Medicaid will reimburse one visit, per physician or provider group, per resident per month, in addition to those medically necessary, not to exceed one visit per day, with appropriate documentation. Subsequent ventilator management visits (Medicaid) may be reimbursed up to four times per month.
- The application of SNF or NF regulations for delegation of physician tasks is determined by the facility's type of certification. In a skilled nursing facility, after the initial physician visit, a qualified nurse practitioner or physician's assistant may make every other required visit.
- Develop a chain of command for nursing staff to use when there are conflicts between nursing and the physician or allied health professional.
- Assist the resident in selecting an attending physician if requested.

## Security and Safety Issues

### Security Preparedness

Guidelines	Examples
Identify trends in employee injuries and implementing appropriate workplace safety techniques.	<ul style="list-style-type: none"> <li>• Conduct disaster and missing patient drills. Can you evacuate all the patients, medical records, etc. in a timely and orderly manner?</li> </ul>
<p>Consider having a written Security Plan that defines who is responsible for security, how security is to be maintained, the responsibilities of employees, the reporting structure, including facility management, corporate office if applicable, and state/local authorities.</p> <ul style="list-style-type: none"> <li>✓ In-service all employees on the Security Plan and related requirements to maintain a safe and secure building, free from violence or disturbance.</li> <li>✓ Maintain a directory of emergency contact numbers in an updated emergency plan.</li> <li>✓ Make sure all employees know the “Emergency” egress responsibilities.</li> <li>✓ Have instructions on what to do if the facility is inundated with media, publicity and/or civil disturbance.</li> <li>✓ Utilize 911 as a community resource</li> <li>✓ Consider having a cell phone available to call 911, in the event of an emergency</li> </ul>	<ul style="list-style-type: none"> <li>• What are you going to do in the event of chemical or germ warfare? Do you have a plan?</li> <li>• Do you have transfer agreements with hospitals, other center, etc. in the event you have to evacuate patients? Are they up-to-date?</li> </ul>

### Physical Plant and Safety Committee

- Develop self-inspections to evaluate the effectiveness of loss control on identified hazards, such as smoking, compressed gas storage, fire detection alarm systems, etc.
- Lighting, inside and outside the facility, should be bright and reliable
- Schedule door locking and window closing, reflecting hours that the facility is open to business and visitors.
- Monitor any locked or secured wings, on a regular basis.

## Security and Safety Issues

### Physical Plant and Safety Committee *continued*

- Check outside and other supporting structures to make sure they lock and are secure when not in use. This may include any hazardous materials, closets, building and storage areas.
- The facility should have in place a thorough hazard analysis inspection that takes place at least monthly. This should consist of:
  - ✓ A survey of the entire property to determine if doors, walkways and accesses remain unobstructed and equipment is secure
  - ✓ A system for reporting needed maintenance repairs and completing repair work timely
  - ✓ Reports to the Safety Committee and other related committees in the facility
- The facility should have a site-specific OSHA program, which may include the following:
  - ✓ OSHA 200 documentation, and other policies for maintenance of any medical-related documentation
  - ✓ Determination of hazards by department and safe practices for all
  - ✓ Tuberculosis program, including Exposure Control Plan for TB
  - ✓ Blood borne Pathogen Exposure Control Plan
  - ✓ MSDS program, for hazardous chemical handling and materials storage
  - ✓ Personal Protective Equipment program, with equipment assessments for all PPE
  - ✓ Eye wash stations requirements
  - ✓ Lockout/Tagout program
  - ✓ Electrical safety issues
  - ✓ Emergency Disaster Plan, including responsibilities of employees
  - ✓ Life Safety responsibilities
  - ✓ Storage and use of oxygen
  - ✓ Reporting of medical device incidents, under the Safe Medical Device Act of 1990
  - ✓ Slip and Fall Prevention guidelines
  - ✓ Ergonomics in the workplace, including Back Injury and other accident prevention
  - ✓ Violence in the Workplace Prevention guidelines, including procedures to deter combative residents
  - ✓ Any other special exposures, such as Asbestos Standard, Driver's Safety Standard, painting and repairs safety
  - ✓ Radon testing

Physical Plant and Safety Committee *continued*

- The OSHA and related safety programs should be posted and/or kept in a conspicuous location, along with Safety Goals and Guidelines.
- Staff should be familiar with Life Safety Codes, as they parallel K-Tag requirements and OSHA Standards. This includes condition and maintenance of life safety equipment and building equipment, such as generators, stairs, doorways, etc.
- Consider having a Safety Committee, which documents its activities, whose function is to maintain a safe and healthy environment. Meetings should be held to discuss resident and employee safety related issues, which may include:
  - ✓ Incidents and Accidents
  - ✓ Safety training, and educational needs
  - ✓ Incentives, including Wellness programs
  - ✓ Changes in the Safety program
  - ✓ Safety suggestions
  - ✓ Corrections and preventative actions taken since the last meeting
- Security Measures and Practices:
  - ✓ Keep a record of visitors and vendors to the home, by having them sign in upon entry into the facility.
  - ✓ During their shift, all employees should wear badges identifying them as staff members.
  - ✓ Do background checks on all employees.
  - ✓ Consider implementing a documented Key Control program, where all keys and locks are monitored and numbered.
  - ✓ Air quality and/or HVAC failure reporting requirements.

## Elopement, as it relates to Security and Safety

- Develop a Missing Resident/Elopement procedure.
- Physical Plant:
  - ✓ Consider an electronic alarm system on exit doors and doors leading to stairwells. If installed, fully train staff on the proper use and limitations of the systems.
  - ✓ Analyze the possibility of placing residents identified as wanderers closer to centralized nursing stations or away from exits.
  - ✓ Consider making small changes in the physical plant to assist in redirecting wandering residents, through arrows, signs such as “Stop” or “Do Not Enter”, or good illumination of ground.
- Safety Measures and Practices:
  - ✓ Establish protocols for all facility staff to assist with periodic checks on identified wanderers.
  - ✓ Provide in-services on managing wandering residents, including recognizing wandering behaviors, diverting activities, and searching for missing residents.
  - ✓ Sponsor activities and exercise programs to minimize nocturnal wandering.

## Equipment Safety

### Medical Equipment

- Select medical equipment and supplies that are appropriate for the level of care provided at the facility.
- Develop a procedure for cleaning, disinfecting, and maintaining medical equipment in working order between resident use.
- Place medical equipment on a preventative maintenance schedule.
- Establish a procedure for preservation of evidence when an injury or accident occurs using medical equipment or supplies.

Equipment Safety *continued*

General Equipment

Guidelines	Examples
Purchase equipment that has been approved by the user, engineering department and purchasing department	<ul style="list-style-type: none"><li>• Have all equipment brought in to the building checked by plant operations, employees and patients. Once it has been checked put a special dot or identifying mark on the piece of equipment. Check them yearly.</li><li>• Do not alter or jerry rig equipment. If you deviate from the manufacturers instructions, design, etc. warranties are usually voided.</li><li>• If you don't have the appropriate equipment to care for a patient DO NOT admit that patient.</li><li>• Train staff, and document, on new equipment before they use it.</li><li>• Have a preventive maintenance program – list all equipment, call lights, etc. and check every 6 months to assure they are in working order. Do the same for a routine cleaning program.</li></ul>
Check leased equipment for proper functioning and compliance with manufacturers' service guidelines prior to utilization	
Train staff, who are to use the equipment, on the safe use of the equipment, hazard recognition and preventative maintenance.	

## Reporting Requirements to the Agency

First, determine if the Adverse Incident meets the criteria in Section I or II below.

I. Adverse Incident means “an event over which facility personnel could exercise control and which is associated in whole or in part with the facility’s intervention, rather than the condition for which such intervention occurred and results in one of the following”:

Death; brain or spinal damage; permanent disfigurement; fracture or dislocation of bones or joints; a limitation of neurological, physical, or sensory function; any condition that required medical attention to which the resident has not given his or her informed consent, including failure to honor advance directives; or any condition that required the transfer of the resident, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the resident’s condition prior to the adverse incident.

II. Adverse incidents that are to be reported without consideration of the event being within or outside the facility’s control.

- Abuse, neglect or exploitation as defined in s. 415.102
- Abuse, neglect and harm as defined in s. 39.01
- Resident elopement; or
- An event that is reported to law enforcement.

Reporting timeframes are as follows:

Report adverse incidents to the risk manager or their designee within 3 business days after their occurrence, initiate an investigation, and notify the agency within 1 business day after the risk manager or their designee has been notified.

The risk manager or their designee must report every allegation of sexual misconduct to the facility administrator and notify the resident, representative, or guardian of the alleged sexual misconduct.

Complete the investigation and submit an adverse incident report to the agency for each adverse incident within 15 calendar days after its occurrence.

**Note:** The Agency for Health Care Administration has 1 day and 15 day adverse incident reporting forms (Appendix B) for facilities to use in reporting.

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*Risk Management Program Guidelines and Implementation Strategies* has been provided to participants of Florida Health Care Association’s Quality Credentialing Program. The intent of the guide is to support participating member nursing homes in their risk management/quality assurance programs in accordance with SB 1202.

Appendix A

Aging Process Discussion

By Howard Tuch, MD

## ***Aging Process Discussion*** by Howard Tuch, MD, FHCA Consultant Physician

*Someone once said, "old age is the most unexpected of things that can happen to a man." Baby boomers, the latest and largest generation of this country, are also the generation of modern medical and bio technology. Modern technology allows people to live longer than ever in human history. It has found cures for many diseases that were fatal only a couple of generations ago. Cosmetic surgeries can help people disguise their physical changes. Hormone injections "reverse" the aging process. In today's society, aging is something people would fight against, rather than accept as a normal course of their lives. Many people don't want to know what is going to happen to them as they age, because people are afraid to know.*

Two basic concepts in geriatrics are as follows:

1. Older populations become more heterogeneous as they age.
2. Aging is associated with a loss of physiologic reserve.

The first concept suggests that we become more unique as we age. The functional capacity, cognitive abilities, social needs, clinical needs and metabolic parameters of a group of 90 year olds will be far more diverse than that of a group of typical 30 year olds. Within the older group will be those with extensive illness and disability alongside those functioning independently. Clinical presentations of common illnesses also likely to be more varied. For example, someone with pneumonia may not have a fever or changes in blood counts. A person with a heart attack may not have any chest pain. Timely recognition of important clinical events becomes more challenging.

The second concept suggests that the real change associated with age is not our ability to function when all is well. Rather it is when we are challenged by some stress, infection or metabolic change. We lack the cushion or reserve capacity to respond and maintain our function. We fall below some critical threshold from which recovery is less likely or more prolonged. The trauma of a fall and fracture may be fatal despite surgical repair. Recovery from the pneumonia may be delayed or incomplete despite adequate antibiotics. Inactivity and loss of appetite associated with a cold may lead to permanent weakness and inability to walk.

The frail elderly population has enormous clinical complexity and diversity. Relatively small physiological challenges may be devastating. This places additional responsibility on those who care for frail elders. We must be even more vigilant than those caring for other populations. It also means however, that our ability to prevent or control many adverse events and poor clinical outcomes is more limited. With the best of monitoring, prevention and treatment adverse events will occur. Moreover the consequences of those events may seem way out of proportion to the events themselves. We may not believe, as is often the case when an event undergoes intense regulatory or legal scrutiny, that a fracture could occur without significant or repeated trauma, even abuse. President Reagan's recent hip fracture suggests otherwise. We may not believe that one could become so dehydrated that he collapses without any prior warning or deprivation of fluid yet Senator Thurman's recent collapses from dehydration suggest otherwise.

Ultimately, we know very little about the clinical, social or financial consequences of caring for a large population of people living for long periods of time with extensive illness and disability.

Proof of the benefits of many of our clinical interventions and preventative strategies is lacking. This is a phenomenon of the modern age. As we learn more of what occurs as we age, how age and disease intersect and what is preventable with clinical interventions, we will be in a position to determine how to meet the needs of this population.

### ***Sensory Losses - Weight Loss, Dehydration***

A large proportion of the population older than 65 years has age-related sensory losses that impair overall health, self-sufficiency, and quality of life. Decrements in the chemical senses of taste and smell are an unfortunate but common aspect of aging. (Klein 1994, Schiffman 1997). Causes of taste losses result not only from normal aging, but also from medications and surgical interventions that older adults are more likely to undergo.

Older adults also have reduced capacity to identify odors. A study shows more than three fourth of elderly persons older than 80 years of age have major difficulty perceiving and identifying odors. The chemosensory losses older adults experience significantly affect their nutritional and immune status. Loss of taste and smell reduces motivation to eat. Under-nutrition resulting from taste and smell losses is a major cause of progressive involuntary weight loss (wasting) and ultimately increased disease susceptibility (Schiffman1983, Schiffman 1996).

Older adults also have decreased capacity to respond to thirst due to physiological changes as a part of normal aging process. They do not feel as thirsty as younger adults, even when they are dehydrated (Kobriger 2001). On September 31, 2000, Senator Strom Thurmond collapsed during lunch due to dehydration. Senator Thurmond is the oldest and longest-serving U.S. Senator who at age 97 recently described his health as “generally all right.” He routinely checked into hospitals for minor physical complaints, such as fatigue, over recent years and under the careful observation of his physicians. According to his physicians, none of the visits required overstay or caused him to miss any work. Still, it was not the first time Senator Thurmond had collapsed and been hospitalized in recent years. In fact, he has been hospitalized several times due to dehydration along with other minor physical conditions. Senator Thurmond’s experience demonstrates how difficult it often can be to detect and therefore prevent dehydration.

### ***Decreased Mobility - Falls***

Falls are a serious health concern for older adults. The risk factors responsible for a fall can be age-related physiologic changes, diseases and medications, or environmental hazards. Many patients who fell attribute a fall “just tripping,” but the physician must determine if the fall occurred because of any of above reasons (Fuller 2000). Medications older adults are more likely to take, such as for the treatment of depression or high blood pressure can affect their balance and often cause falls. Throw rugs or electrical cords across pathways around the house, while normally not endangering younger adults, can become a serious cause of accidents for older adults. However, often times, even walking at a hurried pace can make an older person to fall and be injured (Pavol, Owings, Foley & Grabiner 1999).

Falls can be reduced by taking certain precautions, such as trying to walk slowly, using walking aides like canes or handrails, wearing shoes with nonskid soles, removing rugs, or installing night lights. However, those precautions may not always be effective for older adults with cognitive impairment. On January 12, 2001, former president Ronald Reagan, 89, broke his hip and underwent the surgery. Since he was diagnosed with Alzheimer’s disease and withdrew

from public view in 1994, he has received his care at his home from “an irreplaceable support system of doctors, nurses, staff and Secret Service agents, ” as Nancy Reagan says. When asked about the cause of his broken hip, Nancy Reagan reported on air that “the doctors tell me that his hip appears to have broken when he put weight on the leg in a somewhat twisted position and this is what caused him to *fall*.” In this case, not even the best possible support system of health care professionals, staff, and family members prevented a person to fall. Reagan’s fall incident illustrates the difficulty in consistently preventing falls among older adults.

As people grow older, they start to become aware of various changes in their body and mind. Everyone seems to be aware and prepared for some common changes - eyesight diminishes, hearing becomes impaired, skin becomes sagged, and memory decreases. However, some elements of aging, such as changes in taste, and thirst and physical imbalance are less visible but nonetheless can pose enormous risk for adverse events.

## References

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Appendix B

Agency for Health Care Administration

Adverse Incident Reporting Forms

# Confidential Nursing Home Initial Adverse Incident Report – 1 Day



Refer to section 400.147, Florida Statutes. An adverse incident must be reported to the facility risk manager within 3 business days of the occurrence. The facility must send this report to the agency within 1 business day after the risk manager is notified.

**Send report to:**  
**Agency for Health Care Administration**  
Long-Term Care Unit  
2727 Mahan Drive, LS 33  
Tallahassee, FL 32308  
Phone: (850) 488-5861; Fax (850) 410-1512

### Resident Information

Name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_  
(if applicable)

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

### Nursing Home Information

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_

Phone: \_(\_\_\_\_)\_\_\_\_\_ FAX: \_(\_\_\_\_)\_\_\_\_\_

Person reporting: \_\_\_\_\_

Title: \_\_\_\_\_

### Nursing Home Risk Manager

Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Phone: \_(\_\_\_\_)\_\_\_\_\_ FAX: \_(\_\_\_\_)\_\_\_\_\_

**Date of Incident:** \_\_\_\_\_

### Outcome of Incident (please check):

- Death\*
- Brain or spinal damage
- Permanent disfigurement
- Fracture or dislocation of bones or joints
- A limitation of neurological, physical, or sensory function
- Any condition that required medical attention to which the resident has not given his or her informed consent, including failure to honor advanced directives
- Any condition that required the transfer of the resident, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the resident's condition prior to the adverse incident
- Abuse, neglect or exploitation as defined in 415.102 (Vulnerable Adult)
- Abuse, neglect and harm as defined in 39.01 (Child)
- Resident elopement
- Event reported to law enforcement

\*Note: If the incident involved a death, was the Medical Examiner notified?  Yes  No  
Was an autopsy performed?  Yes  No Name and contact number of the Medical Examiner \_\_\_\_\_

Do the events causing or resulting in the adverse incident represent a potential risk to other patients?  Yes  No

If yes, please explain: \_\_\_\_\_

Describe circumstances of the incident and what actions have been taken to implement the investigation:  
(Use additional sheets as necessary for a complete response)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Person Preparing Report

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

# Confidential Nursing Home Complete Adverse Incident Report - 15 Day



Refer to section 400.147, Florida Statutes. The facility must send this report to the agency within 15 calendar days after the occurrence of the adverse incident.

## SEND REPORT TO:

### Agency for Health Care Administration

Long-Term Care Unit  
2727 Mahan Drive, MS 33  
Tallahassee, FL 32308  
Phone: (850) 488-5861; Fax (850) 410-1512

## I. NURSING HOME INFORMATION

A. Facility Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_  
Phone: \_(\_\_\_\_\_)\_\_\_\_\_ FAX: \_(\_\_\_\_\_)\_\_\_\_\_  
Person reporting: \_\_\_\_\_  
Title: \_\_\_\_\_

## II. RESIDENT INFORMATION

Name: \_\_\_\_\_  
Medicaid ID #: \_\_\_\_\_  
(if applicable)  
Age: \_\_\_\_\_ Sex: \_\_\_\_\_

## B. Nursing Home Risk Manager

Name: \_\_\_\_\_  
Credentials: \_\_\_\_\_  
Phone: \_(\_\_\_\_\_)\_\_\_\_\_ FAX: \_(\_\_\_\_\_)\_\_\_\_\_  
Title: \_\_\_\_\_

## III. INCIDENT INFORMATION

A. Date of Incident: \_\_\_\_\_

B. Was an Initial Adverse Incident Report (1 Day report) submitted for this incident?  Yes  No

C. Date Submitted \_\_\_\_\_ (Attach Copy)

## D. Check one:

- After a complete investigation, the risk manager determined that **the incident was not an adverse incident**. No further entries are required; you may complete and sign the first page of this form, then send this form to AHCA.

\_\_\_\_\_  
Signature of Person Preparing Report

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

After a complete investigation, the risk manager determined that **the incident did qualify as an adverse incident**. Complete all requested information contained in this form, number of additional pages attached to form \_\_\_\_, and return completed form to AHCA.

**E. Outcome of the Adverse Incident (please check):**

- Death\*
- Brain or spinal damage
- Permanent disfigurement
- Fracture or dislocation of bones or joints
- A limitation of neurological, physical, or sensory function
- Any condition that required medical attention to which the resident has not given his or her informed consent, including failure to honor advanced directives
- Any condition that required the transfer of the resident, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the resident's condition prior to the adverse incident
- Abuse, neglect or exploitation as defined in 415.102 (Vulnerable Adult)
- Abuse, neglect and harm as defined in 39.01 (Child)
- Resident elopement
- Event reported to law enforcement

\*Note: If the incident involved a death, was the Medical Examiner notified?  Yes  No

Was an autopsy performed?  Yes  No

Name and contact number of the Medical Examiner \_\_\_\_\_

**F. Describe circumstances of the incident (narrative):**

(Use additional sheets as necessary for a complete response)

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**G. List name and license numbers of personnel and the capacity in which they were directly involved with this incident, i.e., registered nurse, certified nursing assistance, etc.** (List social security numbers and capacity of unlicensed personnel):

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**H. List name and license numbers of witnesses** (List social security numbers and capacity of unlicensed personnel):

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**IV. ANALYSIS AND CORRECTIVE ACTION**

**A. Analysis (apparent cause) of this incident** (use additional sheets as necessary for complete response):

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**B. Describe corrective or proactive action(s) taken** (Use additional sheets as necessary for complete response):

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\_\_\_\_\_  
Signature of Person Preparing Report

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

Appendix C

Agency for Health Care Administration

Risk Management Protocol for

Quality Monitors

**AHCA – Division of Managed Care & Health Quality Assurance  
Quality of Care Monitoring Program**

<b>Risk Management Monitoring Visit Protocol</b>	
Task 1: Offsite Preparation	Page 2
Task 2: Entrance Conference	Page 2
Task 3: Facility Tour	Page 2
Task 4: Information Gathering	Page 3
Task 5: Information Analysis	Page 3
Task 5a: Special Circumstances: Conditions observed which threaten the health or safety of a resident(s).	Page 4
Task 6: Exit Conference	Page 6
Risk Management Visit Summary Form	Attachment

AHCA – Division of Managed Care & Health Quality Assurance  
Quality of Care Monitoring Program

**Risk Management Monitoring Visit Protocol**

<b>Risk Management Monitoring Visit Protocol</b>	
<b>Task 1: Offsite Preparation</b>	<b>Guidelines</b>
<ol style="list-style-type: none"> <li>1. Establish facility’s visit priority for Risk Management focus. Each nursing home will receive a minimum of one Risk Management Monitoring Visit annually.</li> <li>2. Review the following:               <ul style="list-style-type: none"> <li>❑ Most recent monitoring visit summary report.</li> <li>❑ Facility specific adverse incident reports.</li> <li>❑ Complaints.</li> <li>❑ Abuse reports.</li> </ul> </li> <li>3. Contact Facility Administrator or designee to schedule <b>announced</b> visit with Risk Manager. Coordinate with Field Office scheduler.</li> </ol>	<ul style="list-style-type: none"> <li>• Cluster facility visits in a fiscally responsible manner.</li> <li>• Prepare resource materials, as appropriate.</li> <li>• Contact facility administrator via telephone, electronic mail, FAX, or letter. Written confirmation is optional.</li> </ul>
<b>Task 2: Entrance Conference</b>	<b>Guidelines</b>
<ol style="list-style-type: none"> <li>1. Introduce yourself to Administrator or person designated to act on behalf of the Administrator and the Risk Manager.</li> <li>2. Review with facility staff the visit focus and any specific concern(s) identified during off-site.</li> <li>3. Ask to be accompanied on a tour by a staff person familiar with the residents. Proceed if facility staff are not available.</li> </ol>	<ul style="list-style-type: none"> <li>• Encourage Administrator and/or Risk Manager to discuss any related issues/concerns the facility staff have identified.</li> <li>• Determine facility staff awareness of related regulations and rules.</li> </ul>
<b>Task 3: Facility Tour</b>	<b>Guidelines</b>
<ol style="list-style-type: none"> <li>1. Tour facility assessing overall <i>Quality of Life</i>.</li> <li>2. Locate residents identified through review of Adverse Incident Reports.</li> <li>3. Identify residents, family and staff for possible interview or perform interviews as appropriate</li> </ol>	<ul style="list-style-type: none"> <li>• Be as unobtrusive as possible.</li> <li>• Consider interviewing Resident Council President regarding any related issues.</li> </ul>

**AHCA – Division of Managed Care & Health Quality Assurance  
Quality of Care Monitoring Program**

	<b>Task 4: Information Gathering</b>	<b>Guidelines</b>
	<ol style="list-style-type: none"> <li>1. Interview Risk Manager regarding all aspects of the Risk Management and Quality Assurance Programs.</li> <li>2. Interview residents identified during tour assess identified areas of concern.</li> <li>3. Evaluate staff knowledge of Risk Management through interview of various staff members.</li> <li>4. Explore the effectiveness of the facility’s Quality Assessment and Assurance Committee.</li> <li>5. Interview as many facility staff members as necessary to clarify system and/or process concerns.</li> <li>6. Identify findings which impact residents’ overall Quality of Life and right to a safe environment, etc.</li> </ol>	<ul style="list-style-type: none"> <li>• Follow-up on concerns identified through observation, interview, and record review.</li> <li>• Model investigative skills.</li> <li>• Document interview and tour information on appropriate forms.</li> <li>• Protect confidentiality of residents, as appropriate.</li> <li>• Clarify and interpret rules and regulations for staff as necessary.</li> </ul>
	<b>Task 5: Information Analysis</b>	<b>Guidelines</b>
	<ol style="list-style-type: none"> <li>1. Evaluate positive and negative findings.</li> <li>2. Note any new issues identified related to visit focus or other areas.</li> <li>3. Identify issues which warrant an Action Plan on the part of facility staff.</li> <li>4. Document issues and recommendations on the <i>Risk Management Monitoring Visit Summary Form</i>.</li> </ol>	<ul style="list-style-type: none"> <li>• Discuss concerns/problems with appropriate staff to secure additional information as necessary.</li> </ul>

**AHCA – Division of Managed Care & Health Quality Assurance  
Quality of Care Monitoring Program**

	<b>Task 5a: <u>Special Circumstances</u>: Conditions observed which threaten the health or safety of a resident(s).</b>	<b>Guidelines</b>
	<p>1. If the Monitor determines conditions exist which threaten the health or safety of a resident(s), then:</p> <p>(a) Notify the facility Administrator, designee, and/or the Director of Nursing of your obligation to immediately report the situation.</p> <p>(b) Immediately confer with Quality of Care Monitoring Program management staff.</p> <p>(c) Report the situation to the proper authorities, Adult Protective Services, or the Department of Health, and the Agency’s complaint intake component-Consumer Assistance Unit (CAU), as appropriate.</p> <p>(d) In the event of potential “immediate jeopardy,” remain in the facility until the threat is resolved or appropriate regulatory staff or other Agency representative(s) are on-site.</p> <p>2. Track results of the referral for the facility file. Prepare brief report noting the date of the referral, date of the complaint investigation, outcome or findings of investigation. Forward a copy of report to the Quality of Care Monitoring Program Manager.</p>	<ul style="list-style-type: none"> <li>• Refer to Appendix Q, as necessary.</li> <li>• Notify and encourage facility staff intervention as appropriate.</li> <li>• Advise the Administrator or designee should facility staff not respond timely.</li> </ul>

**AHCA – Division of Managed Care & Health Quality Assurance  
Quality of Care Monitoring Program**

	<b>Task 6: Visit Documentation</b>	<b>Guidelines</b>
	<ol style="list-style-type: none"> <li>1. Complete the <i>Risk Management Monitoring Visit Summary Form</i>.</li> <li>2. Conclude report with your recommendations and a description of facility staff's Action Plan, including the name or title of individual(s) responsible for each of the plan's components.</li> <li>3. Maintain a copy of the <i>Risk Management Monitoring Visit Summary Form</i> and forward a copy to the QOC Monitoring Program Manager.</li> </ol>	<ul style="list-style-type: none"> <li>• Protect the confidentiality of monitoring visit findings.</li> </ul>
	<b>Task 7: Exit Conference</b>	<b>Guidelines</b>
	<ol style="list-style-type: none"> <li>1. Findings, both positive and negative, are to be provided verbally to the Risk Manager, facility Administrator, his/her designee, and/or the Director of Nursing.</li> <li>2. Note any new issues identified.</li> <li>3. Review comments and recommendations and provide facility representatives copies of the completed <i>Risk Management Monitoring Visit Summary Form</i>.</li> <li>4. Provide appropriate Field Office Manager a copy of the completed <i>Risk Management Monitoring Visit Summary Form</i>.</li> <li>5. Provide resources as appropriate.</li> </ol>	<ul style="list-style-type: none"> <li>• Respond to requests for information and ensure follow through.</li> <li>• Refer staff to the pertinent rules and regulations.</li> <li>• Request permission to share facility's <i>best practices</i> with other facility staff, if appropriate.</li> </ul>

AHCA-Division of Managed Care & Health Quality Assurance  
Quality of Care Monitoring Program

Risk Management Monitoring Visit Summary Form	
<b>Facility Name:</b>	<b>Date of Visit:</b>
<b>Risk Manager:</b>	<b>QOC Monitor:</b>
Internal Risk Management and quality assurance program— Ch. 400.147 F.S.	
	Comments/Recommendations
<input type="checkbox"/> <b>Appointed Risk Manager [400.147(1)(a) &amp;(b)]</b> Letter of appointment or job description and documentation of Risk Management/Quality Assurance committee members reviewed.  Risk Manager interviewed regarding all aspects of facility's Risk Management and Quality Assurance Programs.	
<input type="checkbox"/> <b>Policies and Procedures [400.147(1)]</b> <b>Reviewed with Risk Manager policies and procedures regarding inclusion of the following:</b> -Assessment of resident care practices. - Quality Indicator Reports review on regular basis. -Incident report reviewed.	
<input type="checkbox"/> <b>Adverse Incidents/Grievances</b> Sample of adverse incidents reviewed including abuse/neglect/elopement or police reported incident during the previous six months. Risk Manager's signature confirmed. Resolution and documentation in resident chart validated. Documentation in monthly Risk Management/Quality Assurance committee meetings confirmed.	

**AHCA-Division of Managed Care & Health Quality Assurance  
Quality of Care Monitoring Program**

<input type="checkbox"/> <b>Staff Training [400.147(1)(e)(1) &amp; (2)]</b> Sample of non-physician personnel files reviewed regarding appropriate training relative to grievance/adverse incident reporting.	
<input type="checkbox"/> <b>Facility Staff Response and Resolution</b> Random staff members and residents interviewed regarding responsiveness, consistency, and resolution.	
<b>QOC Monitor's Comments/Recommendations:</b>	<b>Facility Action Plan:</b>
<b>Important Notice: The Quality of Care Monitors' oral and/or written findings shall not be construed as evidence of facility compliance or non-compliance.</b>	
<b>Monitor Signature/Date</b>	

*Provide copy of this summary to facility Risk Manager and/or Administrator upon exit. No written response required.*