
# Residential Policy & Procedure Manual

The policies, procedures, and guidelines in this manual have been reviewed and approved by the program director and the Director of Quality Enhancement & Standards.

Last Updated: 07/24/18

# Table of Contents

## RESIDENTIAL PROGRAM MISSION STATEMENT

*The Mission of the Residential Program is to provide a safe, comfortable home for individuals with developmental disabilities and to offer services which value and celebrate the contributions, creativity, and initiative of each and every person.*

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PROGRAM DESCRIPTION

The Residential Program is designed to assist individuals with living in their community.

Admission into the Residential Program is determined by the individual's:

a. Diagnosis of developmental disability;
b. Eligibility for Medicaid;
c. Need for support and guidance in their home.

Staff are committed to each individual and their happiness and will assist each individual with exploring:

◊ Personal interests and goals,
◊ Interests in his/her local neighborhood and community,
◊ What independence means to her/him and help her/him achieve it!
◊ Hobbies and fun things to do during his/her spare time,

To accomplish this, staff will:

♦ Listen to, learn from and get to know each person,
♦ Talk with each person,

*and*

♦ Encourage and support each person with their dreams and visions.

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The primary service areas include Tompkins, Cortland and Tioga Counties. Individuals from other geographical areas are also considered. The program's success is measured primarily through satisfaction surveys, internal quality assessments and standards set by regulatory agencies.

## CODE OF CONDUCT

- All FRC employees are expected to abide by the Center's *Code of Conduct*, which may be found online at http://www.rackercenters.org/files_private/employeehandbook.pdf (Adobe Reader or Acrobat required).

## SUPERVISION

- Letters of hire provided to each new staff member identify each person's supervisor.

- Organizations charts and lines of supervision are reviewed during agency orientation.

- Throughout employment lines of supervision, including how and when to notify an administrator on call are reviewed.

- Reviews of one's employment as well as future planning are completed with each staff member periodically. This includes evaluation of those in supervisory roles. The process by which this is done is called the *Individualized Staff Development Process*, also known as the ISDP.
    - For more information, see the Staff Development section in the Employee Handbook.

**REFERENCE:** Part 633.6 regulations for further information

## TRAINING

Within the first 90 days of employment, all new employees in Residential Services will receive trainings on the following mandated topics:

1. 633 Regulations - Client Protection;
2. 624 Regulations - Reportable Incidents, Serious Reportable Incidents, and Abuse (Prevention, Identification, Reporting, and Processing);
3. Human Growth and Development;
4. Individual Specific Information;
5. Topics Relative to Safety & Welfare;
6. Medical Mandated trainings - Infection Control, Universal Precautions, Blood borne Pathogens, Chemical Exposure/Right to Know, Tuberculosis, and HIV Confidentiality;

Further, staff will receive:

1. In-house trainings
2. Medical Protocols
3. CPR/1st Aid prior to working alone
4. *Medication Administration Course* before administering any medication in any form.
5. Supervisory training is provided to all those hired or promoted as supervisors. This training is in the form of experiential, mentoring, external educational opportunities, in-house trainings, and supervisory meetings/in-services. All of these are offered on an on-going basis.

Other agency, program, and quality enhancement trainings will be determined by the Residential Director.

**PROCEDURE:**

**Quality Enhancement will:**

1. On a quarterly basis, draft and distribute a three month training calendar noting times and locations of trainings for people in the OMR funded programs;
2. Coordinate trainings per mandates and program need.

**The Hiring Supervisor will:**

1. Refer to the training calendar to schedule new employees to attend within her/his first three months;
2. Notify Quality Enhancement of anticipated attendance for respective trainings;
3. Ensure staff attend mandated and other trainings as assigned;
4. Print a copy of the 'in-house trainings' for all new staff.
5. Ensure "in-house trainings" are completed within ninety days with all new staff.

**The staff member will:**

1. Attend the scheduled trainings as directed by the supervisor.

**Quality Enhancement will:**

1. Provide feedback to the supervisor of each staff member's attendance;
2. Maintain records of the staff member's training attendance.

**REFERENCE:** Part 633.8 regulations for further information

## CERTIFICATION & RECERTIFICATION FOR MEDICATION ADMINISTRATION/TUBE FEEDING

**PROTOCOL**

It is the practice of the Agency to follow all OMRDD rules and regulations pertaining to achieving Medication Administration Certification and Tube Feeding Certification.

Designated staff in houses will be provided specific training in medication administration, tube feeding, and hydration.

- All full and part–time Residential Direct Care staff will receive training in Medication Administration as one requirement for their position. The training will be optional for Relief staff.
- Designated staff in houses where resident(s) have feeding tubes, will be trained in maintenance and administration of medication and feedings specific to those residents.
- No staff person is permitted to administer medications or feedings, without being certified through the OMRDD training curriculum(s).

Training will be provided minimally quarterly for *initial* certifications for new full and part-time staff. The OMRDD curriculum(s) will be followed for the training.

The protocol for obtaining ***full Medication Administration Certification*** is as follows:

1. Attend the full five day (35 hour + practical [pourings]) Medication Administration class;
2. Obtain a minimum course examination grade of 80% on both exams;
3. Pass the Clinical Practicum with 100% accuracy in a minimum of three (3) errorless performances (under the supervision of a Registered Nurse) that include pouring medications, knowing the reason each medication is given, knowing the side effects of each medication given, recording medications administered, and being able to state the protocol to follow if a medication error occurs.

The protocol for obtaining ***Full Tube Feeding – medication certification and feeding*** is as follows:

1. Be certified in medication administration;
2. Attend a four hour tube feeding/medication administration class;
3. Obtain a minimum course examination grade of 80%;
4. Pass the Clinical Practicum with 100% accuracy in three (3) errorless performances (under the supervision of a Registered Nurse), demonstrating safe feeding, hydration, and medication administration, knowing: the reason for medication/side effects of each medication given, recording requirements, and being able to state the protocol to follow if an error occurs.

Staff who successfully complete the above practicum(s) will receive a Certification Form (see attached) completed by the registered nurse who supervised the practicum(s) and will be certified for a period of six months.

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***Recertifications*** for staff will occur annually. The annual recertification will be a written test(s) and repeated practicum while being observed by a nurse.

The protocol for all Medication Administration recertification is as follows:

1. Perform a minimum of three (3) errorless administrations of medications per OMRDD and the agency's standards;
2. State the procedure for obtaining Stat, newly ordered, or after hour medications;
3. State the protocol to follow if a medication error occurs;
4. State the classification and side effects of each medication administered.

The protocol for all Tube Feeding recertifications is as follows:

1. Demonstrate competency in the following areas:
   a. Care of feeding tube;
   b. Checking for placement and residual;
   c. Safe administration of feedings, hydration, and/or medication administration.

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***Additional certifications and trainings*** :

1. *Specialized, resident specific, medication administration certification* may be offered to select currently Medication Administration Certified staff at the discretion of the residence licensed nursing staff after consultation with the Health Care Director;
2. **Medication Administration** and **Tube Feeding** *refresher* courses will be facilitated by the Health Care Director/designee and available to staff as needed. These courses will be specifically for staff who:
   a) Have experienced some difficulties with the procedures;
   b) Other certified staff who have not administered medications/tube feedings for a period of time (e.g., staff who have taken a leave, etc.)
   c) Staff that have exceeded 90 day period from class to certification.
3. Trainings to highlight *Individual Specific updates* will be held minimally quarterly to Direct Care staff working with the individuals.

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Certification(s) may be *revoked* for the following reasons:

1. Having three (3) errors within any six (6) month period;
2. Having thirty (30) documentation errors within any six (6) month period;
3. Any combination of documentation/medication errors = 3 errors;
4. Any action during medication administration/tube feeding, which a licensed member of the Agency nursing staff deems to be unsafe or dangerous. The Health Care Director will be notified as soon after this action as possible.

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Certification(s) will be reinstated by the Health Care Director *[for 1st time certification pull]* if:

1. A grade of 80% is obtained on the recertification test;
2. Participation in a 1:1 refresher with the house nurse;
3. Three (3) errorless practicums are demonstrated.

Certification(s) will be reinstated by the Health Care Director *[for 2nd time certification pull within two (2) year period]* if:

1. Participation in a full certification class;
2. 80% or better on the exam(s);
3. Three (3) errorless practicums are demonstrated.

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Certification(s) may be *revoked* under the following circumstances:

1. After having Certification(s) revoked three (3) times within a two (2) year period. This would include having taken the Course(s) and not receiving certification, retaking the full course, receiving certification and having it revoked two (2) times prior.

**AND**

2. At the discretion of the Health Care Director, in consultation with the Director of Residential Services, for the following reasons:
   a) Knowingly trying to cover up an error;
   b) One or more clearly negligent and dangerous medication errors which clearly violate regulations for medication administration/tube feeding;
   c) Other actions which can be clearly documented that may effect the safety and well-being of any resident.

   Permanent revocation may occur in certain circumstances and is at the discretion of the Health Care Director and Director of Residential Services.

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Situations where a staff member who has not taken the OMRDD course(s), and has not previously been certified, may do treatments and medications - include:

1. A Graduate Nurse and Graduate Practical Nurse from an approved nursing school or college may do treatments, medications, and nursing procedures ***after*** being trained by a licensed staff member.
2. A newly hired staff member may (while waiting to take the Medication Course) do foot treatments, apply lotions to the hands, feet and face and administer oral rinses as designated on ADL sheet ***after*** being trained by a currently certified staff.

**PROCESS**

**Quality Enhancement will:**

1. Coordinate Medication Administration/Tube Feeding Trainings with the Health Care Director/designee minimally on a quarterly basis;
2. Make notifications to the Residential Directors and Team Directors of when the trainings are to occur;

**The Residential Regional Director/Team Director/designee will:**

1. Reference listings of who is in need of the Course(s);
2. Schedule necessary staff into the Course(s);
3. Provide confirmation to Quality Enhancement regarding anticipated attendance.

**The Health Care Director/or designee will:**

1. Provide a Medication Administration/Tube Feeding Course to full and part-time staff as scheduled (and Relief staff, if space is available);
2. Provide opportunities quarterly for refresher courses for certified staff, as necessary;
3. Ensure semi-annual opportunities for recertification for staff in need.

## ADMISSIONS (updated 2015)

**All information is required to be current within 6-12 months unless otherwise indicated.**

The admissions process of someone entering into the Residential Program is broken down into five time frames outlined below.

**PROCEDURE:**

***A. Within one month prior to admission:***

**The Service Coordinator will:**

1. Obtain the following documentation if available or if requested and forward to the Residential Program.
   - Current CFA/ISP
   - Discipline specific evaluations
   - Social history
   - Current Agency physical exam report form
   - Current behavioral plans or interventions
   - **Must have** current psychological (within past three years).
2. Investigate day program and enroll individual.
   - Complete "Request to Change Re-payee" to Racker Centers, when agreed by current re-payee.
3. Complete or Obtain:
   - DDP4 (if admission is not in FRC residential)
   - DDP2 (if admission is not in FRC residential)
   - LCED
   - Preliminary Individualized Service Plan (or updates current ISP)
   - Notice of Decision for HCBS Services
   - Document of Choices

**The Residential Director/designee will:**

1. Ensure the following documents are given to the individual and their parent/guardian/advocate for their review, signatures and return:
   - Admissions Agreement
   - Liability for Services notice (if appropriate)
   - Client Rights form
   - Medical Release Agreement
   - A Plan for Protective Oversight will be developed
   - Notify Agency business office of admission
   - DDP2, DDP1
2. Schedule and conduct an admissions conference involving:
   - IRA clinical and administrative staff
   - pertinent day program staff
   - the individual as appropriate
   - the individual's family or advocate
   - Service Coordinator

OR

- informs IRA clinical and administrative staff of date of discharge meeting conducted by current residential provider.

***B. Within one week prior to admission:***

**The Residential Director/designee, RN, Psychologist, and the Individual's Service Coordinator will:**

1. Meet to review information regarding the individual with IRA direct care staff.

**The Residential RN will:**

1. Obtain or complete the individual's physician orders for admission and medications
2. Establish Medication and Treatment, administration record
3. Obtain or request individual's immunization record
4. Obtain or administer 2 step PPD
5. Assess concerns for refusal to eat, etc.
6. Ensure necessary adaptive eating utensils, positioning equipment, or other equipment to meet Occupational or Physical Therapy needs.
7. Make contact with physician or obtain new primary care physican

**The Residential Behavioral Specialist will:**

1. Establish data collection for individual's non-functional or maladaptive behaviors, as identified in the pre-admission process.
2. Advise staff on extraordinary needs to be met or strategies to address specific behaviors.

***C. Day of Admission:***

**The Residential RN will:**

1. Conduct admission physical assessment
2. Enter admission note in Medical log
3. Complete a Bed Risk Assessment
4. Train staff in individual specific medical procedures
5. Establish menses record, seizure record and bowel/bladder function records as applicable
6. Obtain private insurance claim forms from family and distribute copies to the Agency business office.
7. Ensure physician orders and MAR are accurate
8. Complete/update IPOP

**The Individual's Service Coordinator will**:

1. Enter admission note in Case Notes
2. Submit any other requested documentation from other agency, if available.
3. Coordinate Work/Day Program start date if appropriate.
4. Obtain Social Security, Medicaid and Medicare cards from individual's previous residential provider or family and send copies to the Agency business office.
5. Call Social Security Administration to register protective filing date for SSI benefits. Letter to be sent to SS Administration confirming admission to the Agency's Residential Program.
6. Contact DSS, Food stamps, Veteran's Benefits, etc., as appropriate.

**The Residential Director/designee will**:

1. Assist individual with settling in
2. Establish personal financial ledger
3. Enter admission note
4. Complete personal effects inventory
5. Review "house rules" with individual as appropriate

6. Complete Fire Drill involving new resident.

***D. Within the first 30 days of admission:***

**The Service Coordinator will:**

1. Notify the local DSO Team Leader of the individuals' admission
2. Schedule and conduct meeting to develop Individual Services Plan (ISP), if not already written.
3. Assemble elements of Service Coordination notebook.
4. Reevaluate DDP2

**The Residential Nurse will:**

1. Assess the individual's ability to self-administer medications
2. Facilitate assessment of individual's nutritional needs by consulting dietitian
3. Write nursing care assessments for individual as applicable
4. Create PONS/Client Specifics

**The Residential Behavior Specialist will:**

1. Assess the individuals abilities related to:
   - Signing financial ledger
   - Voting
   - Sexuality
   - Protection from abuse
   - Use of public transportation
2. Develop behavioral plans or protocols to address maladaptive behaviors.

**The Residential director/designee will:**

1. Review 'Rights' with individual as appropriate;
2. Set up bank account with individual as appropriate;
3. Schedule appointment with Department of Social Services- interview for Food Stamp and Medicaid benefits.

***E. Within the first 60 days of admission:***

**The Service Coordinator will ensure:**

1. The ISP (Individualized Service Plan) is written including the IPOPO (Individualized Plan of Protective Oversight) and Habilitation Plans.
2. Distribution of same to the parent/guardian/advocate and applicable programs.
3. Check on satisfaction of services with consumer and family.

**The Residential Director/designee will**:

1. Write the individual's Opportunity Development Plan/Residential Habilitation Plan based on the valued outcomes of the ISP.

## INDIVIDUALS' RIGHTS

To ensure all individuals are aware of and understand her/ his rights, a ***Rights and Responsibilities Booklet*** is available in English and Spanish.

**The Director/designee will:**

1. Ensure the individual, parent, guardian, or advocate (as appropriate) receive the Rights booklet, prior to or at admission into the Residential Program;
2. Review and clarify the Rights with the individual, as necessary;
3. Provide subsequent reviews of the Rights as updates/revisions to the Rights occur;
4. Ensure tracking occurs to verify that Rights booklets have been distributed, as required;
5. Advocate for and assist individuals with exercising their rights.

- To obtain a 'Rights' Booklet in either language, contact Quality Enhancement.
- An electronic version of the 'Rights' Booklet may be found at the following URLs:
  - http://www.rackercenters.org/files_private/rights%20&%20responsibilities%20booklet.pdf
  - http://www.rackercenters.org/files_private/rights(sap).pdf

  (Adobe Reader or Acrobat required)

**REFERENCE**: Part 633.4 regulations for further information

## INDIVIDUALIZED SERVICE PLAN

- An Individualized Service Plan (ISP) is developed with each individual by the individual's Service Coordinator.
- Each ISP serves as a guide for the types of supports/services needed and desired by the individual.
- Semi-annual reviews occur to determine the effectiveness of each service the individual receives.
- The Service Coordinator and individual attend the meetings as well as anyone else the individual desires present (and is available to attend).
- Pending the review process at the meetings, the ISP will be revised accordingly.
- ISP's may include, but are not limited to, service/support in areas such as: self-advocacy, self medication administration, knowledge/utilization of community resources, employment opportunities, money management, living arrangement, sexuality awareness and individual rights.
- The ISP will specify all services and service providers, indicate service component, frequency and duration, reflect individual's choice, capabilities and assessments, and provide the basis for waiver services payment.
- Upon completion of revisions to the ISP, the individual (or guardian) will sign the final ISP, signifying acceptance and approval of the new ISP.
- ISP's are meant to be a working document; hence, revisions may occur at any time. However, the individual must be involved and agree with the changes.

**REFERENCE:** ***"The Key"*** (Home and Community-Based Services Provider Guide) for further information.

DEFINITIONS:

**Individualized Plan of Protective Oversight (IPOPO):**
An Individualized Plan of Protective Oversight or IPOPO is a plan that is individualized for each person receiving services. The plan focuses on the type and level of support the individual requires to ensure her/ his safety throughout the course of each day. The plan also describes the intended goal/ reason for the level of support to be provided.

- **One-on-one –** staff assignment to an individual. Staff are to stay within close proximity to an individual for specified period of time.
  - Often one-on-one assignments are transferred from staff to staff after a period of time to depersonalize the oversight and prevent fatigue by staff and the individual.
  - It should be understood that assistance can and should be provided to the individual if the assigned person, for whatever reason, is not able to provide it.
- **Range of Scanning** – staff will ensure the specified individual is always within their visual range. This does not mean the staff member needs to be constantly looking at the person, but rather be able to see the person at any given time while available to observe surroundings and help others if necessary. Proximity to the person will be described in each IPOPO where this type of oversight is necessary. Ex.'s:
  - Within the same room
  - Within 10' or 15' or 30' etc.

  The responsibility of range of scanning may change from staff to staff. It is absolutely necessary to have clear communication between staff to ensure when responsibility changes.
- **Periodic observations –** staff are responsible for ensuring a visual check is completed of the individual during a specified time interval. Each observation should last *two to three minutes* minimally and observation should include the immediate surroundings for safety of the individual as well. Aside from a visual check, some other type of connection with the individual may be necessary, such as verbal communication, to ensure the individual is okay.
- **Verbal prompt –** verbally cuing an individual to initiate or cease a specified action. It may be that more than one verbal prompt is necessary.
- **Instantaneous verbal prompt** – one brief verbal prompt
- **Physical Assistance –** physically assisting/ supporting an individual with an action. The individual is also taking part in the action. This should always be coupled with verbal communication with the individual, regardless of the person's perceived abilities.
- **Total Support –** assisting or supporting an individual in the entirety. This should only occur when the individual is not capable of completing the action and is also unable to assist. Verbal communication should occur throughout the assistance as to what is occurring and why.

- **Independent** – the individual is capable of independently initiating, completing and ceasing an action without any verbal or physical assistance or monitoring.

PROCESS:
**It is understood that professional and reasonable judgment by all staff will prevail to ensure the safety and well being of all the individuals. This process serves as a reference and guide and is not inclusive of all situations and circumstances.**

**Individualized Plan of Protective Oversight**

Drafting >

- At the admission of an individual into the Residential program an IPOPO will be drafted to describe the levels of support the individual requires in various areas of daily living. Input to compile the plan will be gathered from the individuals, parents/ advocates, former staff/ agency, and anyone else who may know the individual.

Staff review and responsibilities of plans >

- IPOPO's are to be reviewed with all staff working with the individual each time it is revised in any way, and minimally, monthly – this includes 'signing off' by each staff member after each review.
- Supervisors are responsible for ensuring update/ monthly reviews and 'sign off's' occur regularly.
- It is expected that Relief staff will review all IPOPO's prior to working in a house with respective individuals.
- <u>All staff</u> working with the individual are responsible for ensuring the IPOPO is followed.

Plan review, revisions/ additions, deletions and updating >

- Everyone's IPOPO is to be reviewed for accuracy and appropriateness and updated as necessary - ***minimally*** every six months at Individualized Service Plan meeting as well as semi-annual meetings.
- Specific attachments may be added to a person's IPOPO that provide further information on the needs of the individual. Examples may include a specific Seizure Protocol or a Behavior Support plan.
- It is also noted that, on occasion, due to one's medical condition/ status the individual might need interim addendums to their IPOPO until they have returned to baseline.

## <u>Addendum</u> regarding **Transportation Safety:**

In line with the aforementioned process for Plans of Protective Oversight individualized details, as warranted, will be in each person's plan of protective oversight. To complement individual specific information the following will apply to all individuals:

a. Individuals will not be left unattended in a vehicle unless the IPOPO specifically states the individual has the capacity to safely be left and there is a time restriction;
b. All drivers must complete on-board inspections (reviewing visual inspection of front to back of inside of vehicle) to ensure no one remains in the vehicle;
c. Documentation must be maintained to ensure on-board inspections occur after each trip;
d. All staff providing transportation are to be familiar with each person's IPOPO details regarding transportation;
e. Everyone (residents <u>*and*</u> staff) must use seatbelts whenever a vehicle is in motion. This includes the use of wheelchair safety devices when warranted;
f. Contracted services who provide transportation must also have practices in place that meet these standards.

# REVIEWING OPPORTUNITY DEVELOPMENT PLANS

*(Residential Habilitation Plans)*

## A quick reference

In order to ensure that the plans continue to be relevant, and that the folks we support are learning and growing through the implementation of the plans, we need to be careful when updating, reviewing, and changing them.

This reference guide is meant to be a short "checklist," if you will, to help Team Directors, Opportunity Development Facilitators, and others who take part in the updating of Opportunity Development Plans, so that important steps are not missed.

## I. When do we review plans?

The short answer is "whenever we need to." Helpful, huh? There is a longer answer:

Opportunity Development Plans are "living plans." This means that they change with the changing needs or desires of the individual. We review a plan when:

a. It has been decided by the team (inc. TD, Staff, and OD Facilitators) that the plan just isn't working; this, of course, is after exploring all avenues of implementing the core values of the plan;
b. The person has decided they don't wish to continue their plan;
c. The person has achieved the goal (or made progress) and the plan needs to grow with them;
d. It has been in place for six months;
e. The person's valued outcomes change as a result of an ISP meeting;
f. There is a change in the person's ability to do one or more things outlined in his or her plan (that is, if they are injured, sick, or there is some other extenuating circumstance)

## II. Where do I get the information I need?

If the plan is being reviewed as a result of the person's ISP meeting, your notes from that meeting, as well as the discussion between the person we support and their Residential team, will provide some direction. But that is only the beginning.

Discussions with the person, the people who care about him or her, and the people who work most closely with the person are critical to ensure that the plan is reflecting the interests and gifts of the person as well as being helpful to their growing in all aspects of their lives.

## III. So what goes into the Review of an ODP?

**Things you will need:**

- Monthly Reports for the past three to six months and Short Term Objective notes
- Your notes from ISP or staff meetings
- A copy of the most current ISP (Call Service Coordinator to make sure yours is the most current). It is essential that the most current Valued Outcomes are included in the plan
- The current Opportunity Development Plan

**Components of an ODP**

- **"Date of ODP Review"** This date is generally the date of the ISP. If there is an "off-schedule" review an *off schedule review date* should be added below the Review date

- **Ensure that the Service Coordinator's name is accurate:** It is an unfortunate reality that people enter and leave the lives of those we support. Make sure that the information is correct!

- **Ensure the appropriate Medicaid # is on the plan.**

- **Compare the Valued Outcomes on the ODP with the ones on the most recent ISP.** This often entails calling the Service Coordinator to ensure that you have the current Outcomes. Remember, the Valued Outcomes must match *word for word* with the ones in the HCBS Waiver Section of the ISP.

- **Ensure that the Plan addresses each Valued Outcome.** This can be done through the Short Term Objectives and Ongoing Services

- **Update "Personal Goals and Desired Outcomes."** Review this with the person to see if there is anything that they would like to change; also make sure that everything in the section is accurate. Even if there are no substantial changes that need to be made to this section, it is a good idea to at least reword or "freshen" the language – this will get you in the habit of checking the section each time you review a plan.

- **Review Monthly Reports and Short Term Objective notes for the past 3 to 6 months:** but don't stop there – talk with those who care

about the person and the person themselves, to get a clear picture of where the person is with regard to their objectives. Your first goal is to determine if the main objective (the STO) needs to change or if a different STO needs to be put in place.

- **If a new Objective needs to be put in place,** do so. Remember, the Short Term Objective should be something that is IMPORTANT TO THE INDIVIDUAL. For example, we should not have an STO for Laundry, unless the person has stated specifically that that is what they want to do. Otherwise, something like "(Name) wants to contribute to the household by taking part in chores such as . . ." Again, this has to be something that the person has identified as important to them.

- **If no changes are made to an STO,** update the current skill level to accurately reflect what the person can and does do.

- **If changes ARE made to an STO,** determine the current skill level for that new Learning Area, or indicate that a baseline will be taken (over the next 1-3 months).

- **State the current skill level for the new STO.**

- **Ongoing Services** Here is where Valued outcomes would be addressed that are not addressed as part of an STO. Ongoing services may also include health, well-being and safety concerns. If an ongoing service is going to be addressed in an IPOP, the phrase, "refer to IPOP" should follow. If an ongoing service is going to be used on the HCBS Waiver summary as a "billable service", it should be in "bold". These are generally services that are provided on a daily basis (ie, assistance with bathing; communication etc)

- **Check the "Services provided" section of the Plan.** Make sure that the information there is current and accurate.

- **"Personal Finance" section of the Plan.** Identify who is representative payee for the individual.

**Valued Outcomes page** below is a description of what goes into this section.

**<u>Valued Outcomes</u>**

Here is where you will identify the valued outcome(s) that will be addressed in this objective

**Current Skill level**
Identify where the person is within the skill

**Short Term Objective #1**
**Skill Development/Skill Maintenance**

The objective should be clear/direct and identify the skill that the individual will be working on.

**Staff Activity**

- Generally two steps. Each staff activity should include the staff *action* and the consumer *action*.
  - Staff will_____ John will_____.
  - If John _____ then staff will____.

**Implementation Frequency:**
Staff will support _____with Skill #1 **__X__ times per week**.
**Documentation Frequency:**
Staff actions will be documented at least **__X__times per week**.

The implementation and documentations are generally different. If a goal is to be implemented 5 times, it may only need to be documented 2-3x per week to be able to effectively follow skill development. If the implementation is less than 3x per week, best practice would be to document each time it is implemented.

**Staff consideration** This is a section to put information that would be helpful for the staff to know when helping the individual engage in the objective. Ie…places that they like to go, things they like to do, tips to help them be successful etc.

- **Sign the plan.** The person who wrote the plan, and the person whose plan it is. If the person cannot sign the plan for themselves, omit the line.

- **File the new plan and ensure that staff are trained in it.** The plan should be filed in place of the old one. The old plan should be kept in the inactive file, to be retrieved if asked for by DQA or someone else, or if you may need it for some reason (don't throw it away).

**Staff training.** The ODF should present changes to the plan at a staff meeting, as well as placing the plan in the communication log, to be initialed by each staff member as they read it. Remember to have a sign-in sheet for your meeting!

## Revising/Reviewing ODPs, A "Quick" Checklist

An Opportunity Development Plan (ODP) is the blueprint for a person's habilitation services at the Centers and fills the place of Habilitation Plans. The Opportunity Development Facilitator (ODF) is the staff member with primary responsibility for completion, maintenance and oversight of the ODP based on the individual's Valued Outcomes.

ODP Contents:

- ✓ **Date of ODP Review:** Usually the date of the ISP meeting. If not, "off schedule review date" should be written beneath the review date.
- ✓ **Name of *Current* Service Coordinator *&* *Accurate* Medicaid ID#:** Double check these with *every* review.
- ✓ **Valued Outcomes from ISP:** These must match ***exactly*** (word for word, letter for letter) the Valued Outcomes as they appear on the ***current*** ISP.
- ✓ **Plan that addresses Valued Outcomes assigned from ISP:** This can be done using the STOs and Ongoing Services.
- ✓ **Updated Personal Goals & Desired Outcomes:** This should be reviewed with the person to see if there is anything they would like to change. Even when no changes occur, take the opportunity to "freshen" language.
- ✓ **Updated Short Term Objectives:** Add/alter STOs to reflect current goals and valued outcomes using sources of information above. STOs should only be for activities the person is interested in.
- ✓ **Updated Ongoing Services:** Add/alter services to reflect current IPOP. If detailed knowledge of IPOP content is required to provide service, refer to it in ODP but don't repeat entire IPOP section.
- ✓ **All goals and services in plan must relate to one or more of the following:**
  - Skill acquisition/retention
  - Exploration of new experiences
  - Staff supports necessary to maintain individual's health and/or safety
- ✓ **Updated/Current "Services Provided" Section**
- ✓ **Updated/Current "Personal Finance" Section**

Does it need revision and/or review? Yes, if **one or more** of the following is true:

- ✓ The plan has been in place for 6 months.
- ✓ The person's valued outcome(s) changed at an ISP meeting.
- ✓ The person has decided they don't want to continue with the current plan.
- ✓ The person achieved a goal or made enough progress so that the goal must be revised.
- ✓ The person has made no progress for some time and it must be revised to reflect current skill levels.
- ✓ The team (including TD, ODF and other staff) thinks it needs revision to work.
- ✓ The person's life circumstances (health or other event) is preventing progress towards a goal.

| Sources of Information for a Plan Revision: |
|---|

- ✓ Discussion and direct interaction with the person, taking into account:
  - Interests/priorities/personal goals
  - Skills/gifts/abilities
- ✓ Notes and discussion from the ISP meeting
  - Use most recent valid ISP available (call MSC if it hasn't been sent out yet). It is essential that the most ***current Valued Outcomes*** are reflected in new ODP.
- ✓ Discussions with staff and other individuals that most closely support the person, such as:
  - Family, friends, other people with relationships to the person
  - Agency and house staff, MSC, behavior specialist
- ✓ The last ODP, the previous six months of Short Term Objective notes and Monthly ODP Reports.

| Staff Action Sheet Contents |
|---|

- ✓ **Short Term Objectives:** Written and numbered exactly as on ODP.
- ✓ New objectives must be broken down into **learning areas**.
- ✓ Review **learning areas** for revised and/or continuing objectives.
  - Revise skill levels to reflect progress and alter learning area(s) accordingly.
- ✓ Ensure that the **"Staff will support…"** section of the staff action sheet is accurate, clear and easy for staff to understand in order to implement supports effectively.
- ✓ Ensure that the **"Documentation will include"** section is specifically related to one or more learning areas and instructs staff to document what the person will do, what staff will do to support them and what the person's response to the supports that staff will provide.
- ✓ Include a section which states what the **Monthly Summary** will include. This does not change and may be cut and pasted, *as long as the correct person is listed in the second bullet*.

| Finally… |
|---|

- ✓ **Send** the plan to the *Opportunity Development Team Leader*, who will forward it to the MSC after giving feedback.
- ✓ **Sign** the plan, *and* get signature from person the plan is for *or* write "Cannot sign due to..." and obtain advocate signature.
- ✓ **File** the new plan in place of the old one, if any. *Re-file old plans* appropriately so they remain accessible.
- ✓ **Train** staff on the plan at a *staff meeting* and ensure they initial they have read it and completed the meeting's sign-in sheet. Also place a copy of the plan in the communication log.

## Daily Note

Daily Notes are general notes regarding the person. Daily notes are beneficial in communicating how a person is doing in general. Even though daily notes are not required to be completed daily, it is recommended that staff complete them frequently. Examples of a daily note are as follows:

- Participation in outings
- Progress in daily living skills not addressed in attendance
- Progress in circle of courage
- Events that may have occurred pertaining to the individual
- Contact from family/friends, relationship building
- Progress in coping skills

The Team Director is responsible for ensuring that individual attendance, STO's, and daily notes are completed. Team Directors are encouraged to look at this documentation daily with the expectation that this will occur at least every three days. Team Directors must follow up if there is no documentation.

**Daily Billing**
**Residential Program Practice**

**Paper Billing**

**Attendance Form**

- Staff will initial attendance sheet for services provided as in previous practice
- If a resident is away for the purpose of a ***therapeutic leave***, the letter "**T"** will be placed in the row that says **Billing Standard** under the corresponding date column. A corresponding description of the leave will be entered on the back side of the form.
- If a resident is in the hospital, a ***retainer day*** will be used and the letter **"R"** will be placed in the **Billing Standard** row under the corresponding date column. A corresponding description of the leave will be entered on the back side of the form
- If program staff provide services on vacation, the letters ***OS*** (***Off Site Services***) will be placed in the **Billing Standard** row under the corresponding date column, however the staff will also initial for the service provided. A corresponding description, including specific location will be entered onto the back side of the form.

**Team Director Responsibilities**

**Daily-**

- Check to ensure that each individual has a billable service for the previous day.
- Enter any therapeutic leave or retainer days as a placement disruption in evolve as indicated on the attendance document
- Check to ensure that overnight staff have completed the nightly attendance record.

**Weekly**

- The billing cycle is weekly and takes place from Sunday at 12midnight to Saturday at 11:59pm.
- Placement disruptions must entered and verified for the previous week by each Wednesday at noon.

**Therapeutic Leave-**A day when the individual is away from the supervised residence and is not receiving services from Residential Program staff. The purpose for this leave is for time spent away for vacation (i.e Tulip Travel) or visiting with family or friends.

**Retainer Day-**A retainer is a day in which an individual is away from the IRA for the purposes of medical treatment (any time Medicaid is being billed by another agency/institution). Examples include inpatient hospital stays, inpatient rehabilitation.

**Off Site Services**-A service that will be provided by residential program staff while the person is staying away from the IRA (ie. Vacations) This designation is ONLY necessary when an individual is away from the IRA overnight.

**Overnight Staff**

- Attendance must be taken each night at 1130pm. Staff must document "P" for Present or "A" for away

# Residential Roster / Placement Disruption Processes

**Updated 9/11/14**

Table of Contents



## Daily Attendance Roster Form (all houses)

This form will be completed by the staff present at 11:30pm each night. Staff will write **"A"** (absent) or **"P"** (present) for each day. This is a hard copy form that is not currently on the Evolv system and all houses need to ensure completion each day.

- Write the location site on the form, i.e. Circle Drive IRA
- Complete month and year on the form, i.e. June 2014
- Write each residents name on an individual line, i.e. John Doe
- When a resident is absent an **"A**" will be placed on the line, i.e. resident went to their families for the weekend.
- When a resident is present a **"P"** will be placed on the line when they are at the IRA, i.e. Circle Drive.

## HCBS Waiver Checklists (houses not in Evolv)

**There is a row on the HCBS Waiver checklist that is to be used to indicate where the individual is on that day. Direct Support Staff will enter a letter on that row when a person is not present at the house.**

- Retainer days = **"R"**
  - "R" should be entered any day that the individual spends time *admitted* to a hospital or other placement facility that bills Medicaid. [NOTE: When doing placement disruptions in Evolv, there is a distinction between an admission day and a regular retainer day]

- Therapeutic days = **"T"** these days will be identified in the residents' Opportunity Development Plan (ODP). i.e. visit with family/friends or a Tulip Travel trip.
  - "T" should be entered if the individual is away from the home and not at another placement based facility and also not receiving services from residential staff – e.g. when folks visit family on weekend, take vacations with Tulip Travel, etc.
    - Only those individuals with a Therapeutic Leave Statement in their Opportunity Development Plan may utilize therapeutic leave days and the general frequency and purpose of the therapeutic leave must be reflected in the therapeutic leave statement in the ODP.

- Off-site services = **"OS"**
  - There are two scenarios in which "OS" should be entered:
    - Overnight stay –FRC staffing provided, i.e. Darien Lake trip for a weekend.
    - Temporary relocation, i.e. Where one house needs to relocate to another house or a hotel due to a weather emergency such as flooding.
  - All Attendance and Short Term Objective documentation that occurs while a person is receiving Off Site Services needs to note the location that the Off Site Service was provided.

## Evolv Placement Disruptions (all houses)

**Review** of all information **must** be completed by the **Team Director.**

**For houses in Evolv,** the Team Director will be entering placement disruptions based solely on the Daily Attendance Roster.

**For houses not in Evolv,** the Team Director will be entering placement disruptions based on both the Daily Attendance Roster and the HCBS Waiver Checklist.

How-To Instructions for entering these placement disruptions are available on the Evolv Help Portal: http://EvolvHelp.rackercenters.org (must login to see the Residential Help Documents)

**Placement disruptions** for a week (Sun – Sat) **must be completed** before the following Wednesday, when the bill for that week will be run. **Best practice is to have placement disruptions entered daily as they occur.**

## A Note on Open-Ended Placement Disruptions

It is possible to leave the end date blank until the individual has returned which creates an open-ended placement disruption. If there is an open-ended placement disruption in Evolv during a period that is going to be billed, the billing will be held automatically by Evolv. Do not worry about ending placement disruptions early to allow billing unless told otherwise. As a courtesy, if someone is going to be on a placement disruption for longer than 7 days, email Sheila Enstine in Finance to let her know.

## Placement Disruption Mistakes

If you make a mistake on a placement disruption entry and the bill has not run for that time period, you can edit and make changes as needed. Once the bill has been run, however, you must contact Sheila Enstine in Finance to let her know that you have made a change so that she can determine if billing for that day needs to be re-run.

## "Lost Days"

If there is a day that the person is in the home and no one entered any services, the system will automatically NOT BILL for that day so TD's and other key staff need to ensure that services are being entered every single day or we will end up losing billing. Staff should check the system often enough that they can find a no-service day with enough time to get staff to go back and add the entry within the contemporaneous time limit.

## Definitions of Placement Disruptions in Evolv

**Hospital- Day of Admission only** – used only on the day that a person is admitted to the hospital or another Medicaid billing facility. The start date and time should be as accurate as possible to the admission date and time. The end time should always be 00:00 on the day *following* the admission day. This will end the admission day at the end of the admission calendar day. For overnight hospital stays, you will enter the rest of the retainer days as regular hospital days (see next placement disruption)

**Hospital** – use this for non-admission hospital (and other Medicaid placement facility) days. This kind of placement disruption should always start at 00:01 on the day following a "Hospital-Day of Admission only" placement disruption. The end date and time should be as accurate to when the person is discharged as possible.

**Therapeutic Leave- Identified in ODP** – this is used when the individual is not in our care but is participating in activity that generally conforms to a therapeutic leave statement in the individual's Opportunity Development Plan. Start and end dates and times should be as accurate as possible for this kind of placement disruption.

**Overnight Trip – FRC Staffing Provided** - this type of placement disruption should be used when an individual spends the night somewhere other than their own IRA but is receiving services from residential staff, such as when an individual goes on a staff-supervised vacation. [NOTE: All services that are provided by staff during this type of placement disruption must have the off-site location noted in service documentation for it to be considered a qualifying service.]

**Temporary Relocation – Facility** – this type of placement disruption should be used when the individual is temporarily relocated for some reason such as an emergency where folks are staying at another IRA or in a hotel but are still receiving services from residential staff. [NOTE: All services that are provided by staff during this type of placement disruption must have the off-site location noted in service documentation for it to be considered a qualifying service.]

How-To Instructions for entering these placement disruptions are available on the Evolv Help Portal: http://EvolvHelp.rackercenters.org (must login to see the Residential Help Documents)

## Fast Track Service Entry (non Evolv Houses)

Team Directors will be responsible for entering Fast Track Attendance services in Evolv so that Finance can generate an accurate bill.

Fast Track Services are like stub services—they contain a date, time and type but do not have notes or other service details and they can be added en masse via the Fast Track module.

Team Directors will add an Attendance Documentation fast track service for each resident who has at least one documented attendance service on their HCBS Waiver Checklist for that day. On days where an individual does not have an Attendance Service documented on their HCBS Waiver Checklist *and* there is not a placement disruption entered, the Team Director should look for a documented Short Term Objective to be used as the day's qualified service.

Team Directors will add an Attendance fast track service for each resident to cover days where the resident does not have a documented Attendance service on their HCBS Waiver Checklist but does have a documented Short Term Objective service.

Other services may count as qualified services for billing, so if a resident does not have at least one documented attendance service or short term objective service on a day when they were in our care but there are other documented services that may count, Team Directors will contact their regional director to check that the service qualifies and enter an Attendance fast track for the individual for that day.

### Note on Services Provided on Placement Disruption Start/End Dates

When entering fast track services, a time and duration is designated that every service will be entered for on their respective dates. When you mark residents as "present" (i.e. as having received a service), the time is modifiable on individual specific dates. You must modify the times for individual specific services on days that placement disruptions occur so that the service does not appear to overlap the placement disruption.

**For example,** if staff helps someone brush his teeth at 6am and then at 2pm, the resident goes home for the weekend, you will have a placement disruption starting at 2pm. If when you do the fast track service entry for that week, you designate all services to have been provided at 3pm, then the fast track attendance service will appear to have been provided after the individual left. On that date, you must modify the time so that the service was provided before the therapeutic leave placement disruption began.

How-To instructions for entering Fast Track Services are available on the Evolv Help portal: http://evolvhelp.rackercenters.org (must login to see Residential Help Docs)

**Fast Track Services must be entered on the same schedule as the placement disruptions.**

## FOOD AND NUTRITION

**GUIDELINES**

- Residential Services consults with a licensed dietician to ensure each individual receives a nutritious, well-balanced diet according to his or her health needs

- Services provided by Residential Services in the area of food and nutrition services include:
  - Individual nutritional assessments
  - Menu planning
  - Food purchasing, receiving, storing , inventory
  - Food preparation, handling

- A medical order is required if individuals are to:
  - receive a diet other than solid foods,
  - fed in any setting other than a suitable dining area,
  - use particular adaptive equipment,
  - be fed in a positon other than an upright position.

- Family-Style dining is the manner in which all meals will be provided.
  - A balanced and nutritious diet, served at appropriate times and in as normal a manner as possible,
  - It is understood that at times, assistance with portion control and feeding is required for some individuals,
  - *At no time* will a nutritionally adequate diet be altered or totally denied for behavior management or disciplinary purposes

- Food will be served:
  - In appropirate quantities
  - At appropriate temperatures [hot=>140; cold<45]
  - In a form consistent with medical needs – e.g., mechanical; pureed; etc.
  - With appropriate utensils

# SEXUALITY (CONSENT)

**POLICY**

Residential Services recognizes the individual's innate right to sexual expression. The program also has a strong commitment to both protect the individual from harm, abuse, and exploitation as well as ensure their freedom of sexual expression.

**DEFINITIONS**

A. *Sexuality* – the integration of physical, emotional, intellectual, and social aspects of an individual's personality which express maleness or femaleness

B. *Sexual Expression* – the demonstration of an individual's sexuality

C. *Sexual Contact* – any touching of the sexual or other intimate parts for the purpose of sexual gratification

D. *Informed Consent* – the ability of the individual to make the decision whether to engage in sexual contact. Four areas are considered to assess ability to give consent:
   - Understanding of human sexual behaviors, understanding human sexual anatomy, STD's/HIV and pregnancy
   - Understanding private versus public behaviors
   - Voluntary versus involuntary
   - Legal consequences of improper actions

E. There are two levels of consent:
   - *Global Consent* – person has understanding and is capable of generalizing the four areas of assessment.
   - *Situational Consent* - person has understanding for a specific relationship only.

**PROCEDURE**

- ❖ The level of sexual expression for each individual will be determined by providing assessment, education, and training in the areas required for informed consent.
- ❖ Staff will be trained to assist and guide individuals in their level of sexual expression that best meet their physical, emotional, intellectual, and social needs as well as ensure their safety and well-being.

**ASSESSMENT:**

**The Behavior Specialist/designee will:**

1. Assess every consumer in the four areas of informed consent within 60 days of admission to program, in preparation for his/her initial ISP (Individualized Service Plan) meeting;
2. Reassess each individual regarding their ability to give informed consent, annually from date of last assessment.
3. A determination of *Global* or *Situational Consent* will be made.

***Education for Service Recipients:***

**The Behavior Specialist/designee will:**

1. Provide or facilitate contacts with available resources for each service recipient to receive education in sexual matters appropriate to their assessed level of functioning and/or desirability. This may be both formal and informal methodology.

***Training for Staff Members:***
**Quality Enhancement will:**

1. Organize and coordinate trainings for all new staff, in the area of sexuality and the developmentally disabled population. The training will be offered semi-annually and is open to veteran staff as well.

## INDIVIDUAL/PERSONAL FUNDS

**POLICY**

Residential Services is committed to protecting and preserving the financial interests and rights of the individuals in its programs. It is the intent of the Residential Program to have individuals use their money in as normalized a fashion as possible. The money available to the individual may come in the form of work payment, gifts or benefits.

PROCESS

"Show Me the Money" and individuals' Personal Expenditure Plans (PEP) describes the process of obtaining, planning, managing, securing, and auditing individuals' monies in the Residential Program.

**REFERENCE:** Part 633.15 regulations for further information.

# Guidelines; Monitoring; & Support Plans

Best Practices:
The Centers focuses on strength based approaches which include relationship building and opportunities for positive experiences. The intention of this focus is to assist people with intellectual or developmental disabilities (I/DD) to have successful, happy, and meaningful lives. At times added support is necessary for some people who have particular challenges and struggles that prevent them from experiencing relationships and opportunities. For optimal effectiveness the added support needs to be provided in a consistent manner. Those who provide that support need direction that is thoughtful, sensible, clear, concise and given in a manner that may be generalized to a host of situations, interactions, and experiences. To maintain a common language and approach, written plans are developed that take into account the person's interest, strengths, struggles, and needs. Plans are developed using assessments, reviewing histories, talking with others (staff, family, advocates) who know the person, and most importantly, meeting and speaking with the person who needs added support.

The Centers employs staff skilled in creating a variety of guidelines and plans for community support professionals (CSP's), direct support professionals (DSP's) and, at times, families to reference and follow as they are supporting people with I/DD. Guidelines and plans range from general environmental guidelines to support plans with restrictions/ limitations on personal rights. The type of guideline or plan created depends on the type and intensity of the needs of the person. The following are a list of different types of guidelines and plans:

*General environmental or person specific guidelines* >
These guidelines provide *general* information on **natural environments** and **a person's preferences/ interests** that may be used to provide optimal support to a person. Examples may include, but not be limited to: how a room/ home is set up; calm vs. chaotic environments; other 'atmosphere' descriptors; sensory considerations; general or personal routines; staying home or going out; food preferences; special interests; special skills s/he likes to pursue. The guidelines might also include new environments or experiences the person might enjoy and how to introduce these to the person. In the Residential Program environmental guidelines may be of benefit to everyone – so a house may have specific environmental guidelines.

*Monitoring plan* [for Residential only] >
This is a written plan that targets symptoms of a diagnosed co-occurring psychiatric disorder which are to be prevented, reduced, or eliminated. Interventions are included to address challenging behaviors that may occur and methods by which progress in symptom control and functional improvement will be measured, documented, and reviewed. [**Note**: the interventions in these plans are not restrictive, physical or anything that involves limitations on personal rights. If these approaches are considered necessary, refer to the Support Plan development.]

*Support Plan* >
This is a written plan that outlines specific interventions designed to support, develop or increase replacement or alternative behaviors and/ or modify or control a person's challenging behavior. It should be a component of the person's overall plan of services. Interventions may include:

1. Medications to prevent, modify, or control certain behaviors not associated with a diagnosed co-occurring psychiatric condition;
2. An intermediate or restrictive physical intervention technique(s);

a. [At times, intermediate or restrictive interventions may be necessary to implement in a spontaneous and/ or instantaneous manner but are not part of an individual's habilitation plan. When such interventions are used in these instances, documentation will be maintained in the form of a *Events to Consider* form and reviewed by the supervisor and QE to ensure appropriate and thorough follow up is completed.
b. If two or more occur in a month or four or more occur in six months the treatment team will meet to determine the need for a Support Plan.]

3. A mechanical device used to modify or control certain behaviors. [Anything used for safely transporting someone is not considered a mechanical restraining device(s)].
    a. *Several standards and requirements regarding the specifics of mechanical devices are provided in regulation and should be consulted prior to including in a plan*;
4. Restrictions of a person's rights – e.g., limiting phone calls, access to community, etc.

Certain qualifications and /or credentials are necessary for staff who write the various plans.

1. Program Directors may designate certain individuals to write environmental guidelines or guidelines for a person.
2. Monitoring plans and support plans may be written by a behavior intervention specialist (BIS), licensed psychologist or licensed clinical social worker (LCSW)
    a. See attached flow chart for drafting, reviewing, overseeing, consenting, and approving various types of Support Plans. Flowchart references base position which may draft a Monitoring or Support Plan.
    b. Specific degrees, certifications, licenses, experience and training for a BIS1 or 2 may be referenced in the OPWDD 633.16 regulations.

**All Monitoring and Support Plans must:**

1. Be written by the appropriate employee;
2. Be written in consultation with person receiving services, as appropriate.
3. Include conditions under which an "as needed" medication may be given, expected effects and when it may be re-administered.

**All Monitoring Plans must:**

1. Specify medication to be used and target symptoms;
2. Specify how progress reflected in symptom reduction and relevant functional improvement, or lack of progress, will be measured and documented;
3. Describe how a challenging behavior(s) – including those that reflect psychiatric symptomatology, should they occur – will be addressed through use of non-restrictive interventions as opposed to those possibly Support Plans.

**All Support Plans must:**

1. Be based on a functional behavioral assessment (FBA) of specific identified behaviors that need to addressed;
2. Include:
    a. A concrete, specific description of the identified behaviors;
    b. A hierarchy of evidence-based *positive* approaches, strategies and supports to address behavior requiring intervention
        i. If positive approaches are unsuccessful alternatives starting with least restrictive interventions may be considered;
    c. Active reinforcement and teaching of alternative skills and alternative/ adaptive behaviors for the person to feel satisfaction, independence, and success;

4. Direct a method of data collection that must include positive and well as negative behavioral results – for assessment of effectiveness of plan;
5. Include a schedule of review for effectiveness of the restrictive interventions/ limitation on a person's rights – minimally semi-annually – including review of frequency, duration, and intensity of positive and negative behavior data.

If restrictive interventions or limitations on a person's rights are included in a Support Plan the plan must include:

1. A description of the person's behavior that justifies the intervention or limitation;
2. A description of all positive, less intrusive, and other restrictive intervention or limitations on rights that have been used in the past and were unsuccessful.
    a. This collective history may be an attached addendum to the actual Support Plan;
3. A hierarchy of implementation from most positive to most restrictive intervention/ limits on rights;
4. A specific plan to minimize or fade each restrictive intervention or limitation of rights in an effort to ultimately eliminate the restrictive intervention /limitation;
5. Instruction on how restrictive intervention or limitation on rights is to be documented (including mandated reporting);
6. A schedule (minimally semi-annually) to review the intensity, duration, and frequency of the use of the restrictive intervention or limitation on rights – with documentation of the review to include whether or not the plan should be continued, modified, or discontinued.

**Prior to Implementation of a Monitoring or Support Plan there must be:**

1. Proper prescription by a physician for the use of medications and/ or mechanical restraining devices – there are required components for the prescriptions – see QE or 633.16;
2. Proper oversight sign off (by BIS, LCSW or licensed psychologist)
3. Human Rights approval for any plans with restrictive interventions/ limitations on rights -
    a. Reference the Human Rights Committee process for specifics
4. Informed consent for any medication and/ or plans with restrictive interventions/ limitations on personal rights -
    a. Reference 633.16(g) for specifics on obtaining this.
5. Staff must be trained in all areas of the plan
    a. This includes specific techniques to implement various restrictive interventions and limitations on personal rights.

**Process of Creating Guidelines, Monitoring or Support Plan >**

1. The program becomes aware of the possible need for Guidelines, a Monitoring Plan or a Support Plan from staff, a family member, or other;
2. Initial information is directed to the Director of the Program and the Behavior Specialist, who completes a review to determine next steps to address need(s):
    a. environmental changes or review with staff on specific needs of the individual >
        i. If environmental/ specific needs training is necessary and anticipated to be effective and sufficient this will be completed under the direction of a behavior specialist or supervisor and in consultation with the individual and/or a family member;
    b. monitoring plan >
        i. one may be drafted by the appropriate person;
    c. or, a Functional Behavioral Assessment (FBA) >
        i. An FBA is completed by the appropriate person (a clinician with training in FBA techniques);

ii. If the outcome the FBA determines a support plan is necessary, one may be drafted by the appropriate person.

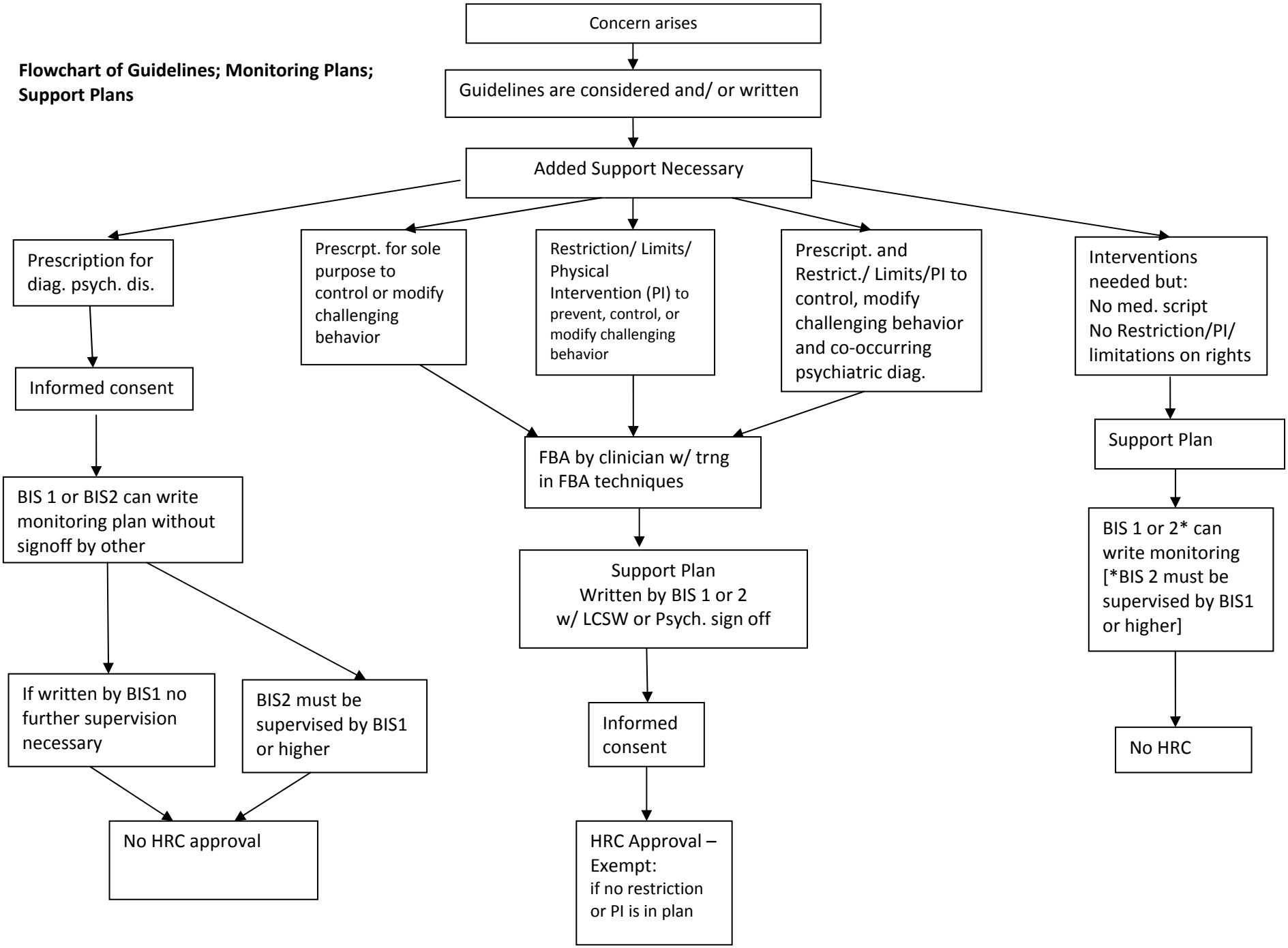
d. and/ or, a referral >

i. a referral is made to another professional or support.

3. When plans are warranted, they must be created involving the individual/ family member; staff; and appropriate others who are active in the person's life, as they know the individual best;
4. The program director/ designee will review the draft and direct for revisions if necessary;
5. Appropriate professional shall review and sign off on plan (see flow chart);
6. If the plan includes any restrictive interventions or limitations on rights, it will be forwarded to the chair of the Human Rights Committee (HRC) for committee approval.
    a. Revisions may be requested/ recommended for final approval.
7. Once the plan is final, informed consent must be obtained prior to implementation of the plan.
8. The plan will be reviewed periodically by the treatment team, BIS, LCSW and/ or licensed psychologist as prescribed in the plan and minimally every six months (the HRC may request more frequent reviews) until the plan is discontinued. This review may warrant changes according to the progress of the individual and effectiveness of the plan.

For more information regarding these practices and processes please contact a supervisor, the QE depart, or reference the 14 NYCRR 633.16 regulations.

**Flowchart of Guidelines; Monitoring Plans; Support Plans**




**10/11/13 QE/scb**

# Human Rights Committee

Franziska Racker Centers' Human Rights Committee provides review, feedback and approval or disapproval to behavior support plans that include some form of restriction on a person's rights, intermediate or restrictive physical intervention (PI), or use of a medication to prevent, control, modify, or eliminate challenging behaviors. The committee's standard is to assess if the proposed plan includes the least restrictive approach to assist a person with communicating her/ his thoughts, needs, frsutrations, and other emotions having a successful achievement in less restrictive approaches have been used and were unsuccessful in addressing the challenging behavior(s) prior to implementation of the limitations, PI's, or medication.

Please see the attached flowchart for direction on the type of plan that would be drafted and which plans would need HRC approval.

**Membership:**

- There must be 4 members on the committee;
- There must be at least 3 members present to proceed with its deliberations;
- Members must include:
    - A licensed psychologist or a behavior intervention specialist (BIS);
    - A clinician, licensed and registered in NYS as one of the following: social worker, physician, physician assistant, nurse practitioner, speech pathologist, occupational therapist, physical therapist or pharmacist;
    - A party with no ownership, employment relationship or other interest in the agency.
- A committee member must recuse himself/herself from reviewing a plan for a person for whom he/she is actively involved in the delivery of services.

**Meetings:**

- Occur quarterly, if needed;
- E-mail polls may occur between meetings
    - If committee provides approval to a plan, the plan and subsequent data will be presented in full at the next meeting.
- Minutes will be maintained by Quality Enhancement & Standards and available to committee members upon request.

**Committee's charge:**

1. Prior to the implementation of the proposed behavior support plans, the committee shall approve or refuse to approve, in writing, proposed plans which contain a limitation on a person's rights and/or utilize one or more restrictive/intrusive interventions which includes:
    a. Any intermediate or restrictive physical intervention;
    b. Use of any mechanical restraining device;
    c. Use of medication solely to prevent, modify, or control challenging behavior.
2. The committee will verify that all required components are included in a support plan:
    a. Description of behavior to be addressed that justifies the use of restrictive/ intrusive approaches or limitation on the person's rights;
    b. Description of positive, less intrusive or other restrictive/ intrusive approaches or limitations used that were unsuccessful;
    c. Hierarchy of approaches/ interventions from least restrictive to most restrictive;
    d. Plan to minimize and/ or fade the use of each intervention or limitation on rights;
    e. Description of how each use of intervention or limitation is documented (positive and negative);

f. Schedule for review of program and use of restriction and/ or limitation.

3. The committee's chairperson must verify:
    a. Approval does not exceed one year;
    b. Written informed consent is obtained prior to the implementation of the approved support plan.
        i. Verbal consent witnessed by two staff is acceptable for a 45 day period.
4. The committee shall review and make suggestions to the agency's management and/or governing body about its policies, practices, and programs as they relate to topics addressed by this section.

NOTE:

1. After HRC approval is given, plans are not in effect until:
    a. Informed consent is obtained;
    b. Appropriate staff are sufficiently trained in the use of the restriction, limitation or the use of the medication.
2. Until the new or recently modified plan is in place (effective, per above) the former plan (if there is one) will continue to be in place.
    a. This time period will end by the last month of the following month or 45 days – whichever is shorter.
    b. If informed consent or training does not occur within the time period, the plan must be presented to HRC – which should include updates on the person's status and need for the plan.
    c. It is the behavior specialist's responsibility to track the 45 day period and follow up with HRC as necessary.
3. The chair may, upon request of the behavior specialist, extend the length of approval for up to 30 days.

**Regulations:**
14 NYCRR 633.16

## INFORMED CONSENT OF MEDICAL TREATMENT

**POLICY**

Franziska Racker Centers understands an individual may need or choose to have an invasive medical procedure. The Centers is committed to ensuring that proper consent is obtained or provided prior to the procedure.

**SITUATIONS REQUIRING CONSENT**

- There are various types of invasive medical procedures and they are categorized below according to priority.
- [When consent for a *non-invasive* procedure is requested by the provider for an individual who is not capable of giving consent, the parent/legal guardian or Executive Director/designee of agency (when parent/legal guardian is not available) will be contacted for consent.]

***A.*** Emergency - ***a significant danger to life or limb of the patient if the procedure is delayed.***

*Imminent situation (immediate to within a couple of days)*

- ***The physician will provide services as necessary. [Exception is availability and knowledge of DNR.]***

**Urgent situation (necessary to be done in or @ a week's time)**

- If person is capable of giving consent, the person makes the decision.
- If person is not capable of giving consent the parent/guardian/Health Care Proxy will be contacted for consent.
- If person is not capable of giving consent and does not have someone to act on his/her behalf, the agency will seek determination for consent from Surrogate Decision Making Committee (SDMC).

B. ***Elective Invasive Diagnostic/Treatment Procedures -***

- If person is capable of giving consent, the person makes the decision.
- If person is *not* capable of giving consent the parent/guardian/Health Care Proxy will be contacted for consent.
- If person is *not* capable of giving consent *and does not have* someone to act on their behalf, the agency will seek determination for consent from Surrogate Decision Making Committee (SDMC).

C. ***Routine Diagnostic Treatment Procedures -***

- If person is capable of giving consent, the person makes the decision.
- If person is not capable of giving consent the parent/guardian/Health Care Proxy will be contacted for consent.
- If a person is not capable of giving consent and the parent/guardian and Health Care Proxy is not available or doesn't exist, the following individuals may give authorize consent:
  - Executive Director of Agency
  - Associate Executive Director
  - Director of Residential Services
  - Residential Health Care Director
  - Residential Nursing Supervisor

**OBTAINING CONSENT**

- If a person is 18 years of age or older and has capacity to understand appropriate disclosures regarding proposed professional medical treatment, such treatment shall be initiated only upon the individual's informed consent.

- If an individual is 18 years of age or older, but lacks capacity to understand appropriate disclosures regarding proposed professional medical treatment, informed consent must be obtained by parent/guardian, Health Care Proxy, or Surrogate Decision Making Committee (SDMC).

- If an individual is *less than* 18 years of age, informed consent must be obtained from a parent/guardian, or SDMC - or physician if no other person is available *and* an imminent situation is present.

**REFERENCE: Part 633.11 for further information**

## OBJECTION TO/APPEAL OF CARE/TREATMENT

**POLICY:**
When the individual is receiving services from Residential Services adult individuals, parents, guardians or advocates, may object to and appeal any plan of services plans for placement, other care of treatment, or any part thereof, with which they disagree. This does not apply to major medical treatment for which informed consent is required. Individuals, parents, guardians or advocates are informed of this right to object and appeal as part of their notification of Individual Rights including the right to select a representative such as the Mental Hygiene Legal Service.

Please Note: An adult individual may refuse the initiation of a formal objection or subsequent appeal on his or her behalf.

**PROCEDURE:**
Objections may be initiated regarding:

- Any plan of services (including ISP)
- Plans for placement
- A proposal from the agency to discharge the individual
- A proposal to reduce, suspend, or discontinue services

**Informal:**
Adult individuals, parents, guardians or advocates who wish to object to or appeal any plan of services care treatment or plans for placement (including any reduction/suspension/or discontinuation of services), should discuss their concerns with the effected individual's Service Coordinator who will try to seek a resolution. If a satisfactory resolution cannot be found, the formal procedure may be implemented.

[Specific to *Medical Treatments* if/when an individual chooses not to have a particular medical treatment –
**The Residential Nurse will:**

1. Ensure the individual understands the pros and cons of the recommended treatment;
2. Ensure a parent/guardian is involved if the individual is not capable of understanding the pros and cons;
3. Document all conversations and outcomes of conversations;
4. Notify Health Care Director of final decision.

**The Health Care Director will:**

1. Ensure the Medical Director is aware of the situation;
2. Ensure Mental Health Legal Services is notifiied in the event the individual is non-consenting;
3. Document all conversations in the individual's medical file.]

**Formal:**
**The concerned party (Adult individual, parent, guardian, advocate, MHLS) will:**

1. Inform the individual's appropriate program/residential administrator formally by letter that their concern has not been resolved through the informal process and requests a meeting for further discussion.

**The Director of the Program will:**

1. Within five (5) working days of receipt, schedule a meeting with at least ten (10) days advance notice to discuss and try to resolve the expressed concerns.

**The Executive Director will:**

1. Send a written decision to the involved parties within ten (10) working days of that conference.

**The concerned party may:**

1. If not satisfied with the decision of the Executive Director, submit a formal appeal in writing to the appropriate B/DDSO director within ten working days. Within five working days of receipt of a request for an appeal a hearing shall be scheduled before the B/DDSO director with no less than ten days notice. A written decision to the involved parties shall be sent by the B/DDSO director within fourteen working days of the conference.
2. If not satisfied with the decision, appeal it within ten working days to the commissioner of OMRDD who will issue a final written decision to all parties within ten working days of receipt of the appeal. The commissioner may, at his or her discretion, call a conference of all parties to review the objection. In this event, the decision shall be sent to all parties within ten working days of that conference.
3. The commissioner's decision is the final administrative remedy available and may be appealed in accordance with the provisions of Article 78 of the Civil Practice Laws and Rules.

**NOTE:**

The individual shall not be denied the opportunity to participate in any of the aforementioned meetings. During the period the concerns are being reviewed or appealed, the individual shall participate in programming that is mutually agreeable to all, with every effort being made to maintain the individual at his or her current level excluding necessary relocation to protect health, safety or welfare. Treatment may be given (other than professional medical requiring informed consent) despite objections where it is felt necessary to avoid services harmful to the individual or others in accordance with agency policy.

**REFERENCE:** Part 633.12 regulations for further information

## EMPLOYMENT OF INDIVIDUALS

**POLICY**

Residential Services is committed to providing opportunities for growth and development in the area of work and work related experiences to developmentally disabled individuals. Those individuals who participate should be appropriately reimbursed for their work.

**PROCESS**

- When work performed is for the Agency's benefit, Agency funds will be used to pay the individual.
- In cases where the individual is employed at a financially independent workshop, the workshop is the employer and therefore the payer of wages.

# Residential Filing Process and Record Retention Guidelines

## I. 3 Binder system

- **"Current" = current information (1-12 months)**
- **"A" = inactive/overflow (7-24 months)**
- **"B" = one full prior year (24-36 months)**

**Within 3 Binders there will be minimally 2 years and up to three years of information**

## II. Break down

- **Current Binder-** Most current information as identified on the divider page for each section. When a document in this binder is being replaced, move that item to the same section of binder **A**. For example: You have had to update an Ipop, the current Ipop will be pulled from this section and placed into the program plans section of binder **A** and the current Ipop is filed in **Current binder** . The same rules apply for ODP's, support plans etc. It is very important that items are pulled and replaced simultaneously to avoid misplaced documents. (Optional- note on the top right corner of the pulled document "pulled or updated _/_/_"). Service notes and monthly reports older than 6 months may be moved to binder **A** in order to keep your current binders thin and organized.
    - The ISP in the **Current** binder must remain in place for the entire "ISP" year. Therefore if a resident has an ISP dated 5/7/07 and you receive a six-month addendum in 11/07, the entire plan (which includes the 6 month review) will remain active until 5/08 when a new ISP has been sent. The old ISP will then be filed in Binder **A**.
    - Upon receipt of an ISP, the Team Director must complete an **ISP review checklist.** Once complete, the form will be filed in the Audit review binder. If follow up is needed, the TD/RRD will be responsible for completing follow up within one week.

- **Binder A-** This is essentially an overflow of the **Current** binder and will have up to 2 years worth of information. Typically, inactive ISP's, ODP's, Support plans etc would be housed here. In addition, this is where an over-flow of service notes and monthly reports older than 6 months can be housed. The prior year's MAR's will be housed in this binder.
- **Binder B-** One full year. As information in this binder passes the "two-year" mark, it should be moved to Binder **B.** At the end of a year, this binder should house one full year of information to be purged.
- **There should not be an "Inactive" section in any binder.**

### III. Purging

- In the first quarter of a new year, each file should be purged using the process noted above. If filing has been done continuously through the year, it should be easy to pull out one full year of information from Binder **B**. For example, by the end of January 2009, you should be able to pull out one full year for 2006 out of Binder **B**. When purging, be careful to check dates as some documents, such as ISP's, are good for one full year. An annual ISP dated 5/18/06 would be valid until 5/31/07 so it should *not* be purged with the 2006 information. Corresponding ODP's should remain with that ISP.

# Residential Record Retention

**Client specific records to be maintained for 7 years**

All files will be housed in alphabetical order
Grouped by year with in box (years 1-2 (most current) maintained at IRA , years 3-7 in cage= 5 yrs in cage) Sectioned as follows:

- Medicaid billing info grouped
    - ISP (without attachments); ODP's
- Supportive billing docs
    - STO notes; Implementation checklists; Monthly Reports; daily notes (old)
- *For those who attend FRC day program, a billing section and supporting docs section will be added here.*
- MAR
- Non-billing related – Perm file records
    - Assessments; Ipops/attachments; Financial; notables/FBI's; Correspondence etc.
- *Additional section may be added for Notable occurrences/FBI if needed.*
- Financial (in-house/bank records)
- Medical Information (under evaluation)

Each resident will have approximately 2 boxes. The front label will identify:

Name
Box ___ of ___ ( 1 of 2 ; 2 of 2 etc)

**Box 1** is always the oldest year- (*Year 7)* for newer residents; the initial box will be labeled Box 1 of ___. Left blank until a second box is created/needed. In this case, the oldest year will vary. In this case, the oldest year may be "year 4" and will need to be changed the following year.

**House files**

Maintain separate "house files" set up with same system as above (years 3-7)- Filed alphabetical with house name being "Last" name - "Eddy", IRA etc

- Master Signature log
- Bi-monthly fire safety
- Monthly fire drills
- Medical information as identified by RN (in review)

**We no longer need to retain all non-billable records! After careful review and discussion, we have identified records that can be destroyed after 1 or 2 years. (Refer to Shred vs. Recycle rules for disposal/destruction requirements)**

**General client records/ house specific**

| Destroy after 1 full year | Destroy after 2 full years |
|---|---|
| Bed Checks – daily and individual | Health care checks (individual specific) |
| Support plan documentation | Hot water/Radon checks |
| Visual checks | Sprinkler inspections |
| Site inspections | Monthly bed inspections |
| Weekly documentation reviews | Bi-monthly bed safety trainings |
| Overnight cleaning check list | Receipt books |
| Communication log/general staff memos | Blue Narc Sheets |
| Staff meeting minutes | Pharmacy Reviews |
| Time sheets/schedules/printed versions | Medication Errors |
| Various Program audits | |
| Vehicle inspections | |
| Petty cash ledgers with check stub; purchase requests | |
| Pharmacy delivery slips; med ordering sheets | |
| Shift/key sign off | |
| Transfer logs; medication comm logs etc. | |

*Other records not listed?*

**Filing system annual maintenance**

Within the first quarter of the new year, all files ready for shredding ( Year 7) will be pulled. At that time, the tab order will need to be changed- moving each section up one year.

**Record sign out (under construction)**

Whenever records or portions of a record are removed or reviewed, the individual reviewing the files will be required to sign. (Record tracking system)

# DISCHARGE

**GUIDELINES**

To ensure the continuation of each individual's safety and well being, during their discharge from the Residential program the following guidelines will be used.

Counseling regarding the advantages and disadvantages of a discharge will be provided to the individual, parent or guardian who requests the discharge. Planning for discharge must include ensuring the provision of necessary and appropriate services in the individual's new environment, including protective supervision and other follow-up services. When the individual is permanently released, the facility is responsible for preparing and placing in the individual's record a summary of: **findings, progress and plans.**

The residence will provide discharge summaries to appropriate referral sources and the parent or guardian when applicable.

**PROCESS**

**The Service Coordinator will ensure:**

1. Provision of appropriate services in the individual's new environment per the individual's needs/interests;
2. Protective supervision and other follow-up services in the individual's new environment;
3. Written evidence of the reason for the transfer and written consent of the individual and his/her guardian is completed.
4. Contact MHLS.
5. Contact Medicaid, Social Security, DSS.

**The Residential Director/designee and Service Coordinator will:**

1. Provide counseling to the individual, parent or guardian who requests the release, concerning the advantages and disadvantages of the release.

**The Residential Director/designee will:**

1. Ensure a record summary of findings, progress, and plan is placed in the individual's record as a tool for relay of accurate information;
2. Provide referral source(s) and parent or guardian when applicable with copies of the record summary.

**REFERENCE:** part 633.12 regulations for further information

## MEDICAL PROTOCOLS

**PROCESS**

- All residential settings have medical protocol notebooks for reference to address the various medical needs individuals may have or encounter.
- Training on protocols and guidelines is provided to all Residential Staff. Such training includes the expectation to use the protocols and guidelines as necessary.
- Only trained staff may complete 'intrusive procedures'
- Established Protocols/guidelines include:
  - When to Call the Nurse on Call (NOC)
  - Falls
  - Potential for Physical Trauma (staff and supervisor versions)
  - Identifying signs & symptoms of shunt malfunction
  - Airway Guidelines
  - Burn Care Guidelines
  - Choking
  - Epi-Pen Guidelines
  - Pica
  - Seizure Management/Classifications
  - Vital Signs
  - Automatic Blood Pressure Guidelines
  - Bowel Management
  - Diarrhea
  - Urinary Tract Infections
  - Flu Shot Guidelines
  - Heating Pad Guidelines
  - Illness/Infection Control Guidelines
  - Refusal to Eat Guidelines
  - Spinal Rod Guidelines
  - Sunscreen
  - Vomiting Guidelines
  - Water Bed Safety
  - Accepting Medication Keys
  - Obtaining Stat or New Prescriptions
  - Receiving Medications
  - PRN Medication
  - Medication Refusal
  - Off-Site Medication Guidelines
  - How to Use Nebulizer
  - Diabetic Care
  - Blood Glucose Monitoring
  - Accu-Check Code Maintenance
  - Administering Gravity Feeding
  - Administering Medication via G-tube
  - Protocols related to Tube Feeding and Medication Administration via Tube
  - Hospital Admission/Discharge Process
  - Post-Hospital Assessment form

# *Protocol for Potential Physical Trauma*

**For Direct Support Professionals (DSP's)**

**Potential Physical Trauma** means any injury or possible injury to a person which may include - but is *not* limited to - broken bones, bruised muscles, torn ligaments, significant external or internal bleeding, head injury, shock, etc., and others *not necessarily noticeable* by visual assessment.

Causes that may lead to such injuries include:

- All vehicle accidents, regardless of any medical condition they may have;
- Falls of significant distance or with significant impact;
- Falls of individuals with contraindicated medical conditions (rods or other hardware, shunts, osteoporosis, people recently recovering from surgery, etc.) Examples may include people with:
  - joint replacements
  - scoliosis (people may typically have rods in their backs for support)
  - hydrocephalus (individuals have AV shunts)
- Blows to the head (by objects or assaults) with significant impact, which may result in concussion. Occasionally individuals may bump their head that may not necessarily constitute physical trauma. The NOC will assist you in determining whether or not there is potential physical trauma;
- Significant swelling which may or may not be accompanied by pain.

We must consider each individuals medical state and reference each person's Plan of Protective Oversight (IPOPO) for vulnerabilities and medical concerns and any individual specific protocol for direction.

**Protocol for Responses to Injuries and Potential Injuries:**

1. After event (e.g., fall, blow to head, etc.) occurs, DO NOT move the individual or have them move;
2. Take control of the situation to prevent possible or further injury;
3. **Take vitals** – compare to the person's *baseline* vitals and ask her/ him how they feel;
4. Support the individual with any necessary comforts (e.g., blanket, pillow, reassurance, TLC, etc.)
5. Call the AOC. The AOC may then instruct you to call 911 or the NOC for direction;
6. If unable to contact the AOC, call the next administrator in line (AOC, DOC, etc.) until successful;
7. If administrator is still not reachable, call the NOC for support and direction;
8. Information will be requested from you – BE PREPARED with specific info. such as:
   - what happened;
   - was it observed or discovered;
   - vitals and how the person says s/he feels;
   - have there been recent medication changes;
   - medication regimen;
   - is there any noted swelling, bleeding, etc.;
   - is the person able to move body parts;
   - integrity of body parts;
   - specific medical information about the individual (shunts, rods, osteoporosis, etc.) found on the hospital sheet and IPOPO
9. Further instruction, depending on information provided to the NOC, will be given and must be followed immediately. This may include, but is not limited to:
   a. calling 911;
   b. staying with the individual until help arrives;
   c. or, assisting the person with resuming normal activities.
10. Complete an FBI for each person who has an injury or potential injury.
    a. Submit FBI to nurse or supervisor before end of shift.

# *Protocol for <u>Potential</u> Physical Trauma*
## For <u>AOC's, NOC's, and Supervisors</u>

**Potential Physical Trauma** means any injury or potential injury to a person which may include - but is *not* limited to - broken bones, bruised muscles, torn ligaments, significant external or internal bleeding, head injury, shock, etc., and others *not necessarily noticeable* by visual assessment.

Causes that may lead to such injuries or potential injuries include:

- <u>All</u> vehicle accidents, regardless of any medical condition they may have;
- Falls of significant distance or with significant impact;
- Falls of individuals with contraindicated medical conditions (rods or other hardware, shunts, osteoporosis, people recently recovering from surgery, etc.) Examples may include people with:
  - joint replacements
  - scoliosis (people may typically have rods in their backs for support)
  - hydrocephalus (individuals have AV shunts)
- Blows to the head (by objects or assaults) with significant impact, which may result in concussion. Occasionally individuals may slightly bump their head and may not necessarily constitute potential physical trauma. The NOC will assist you in determining whether or not there is potential physical trauma;
- Significant swelling which may or may not be accompanied by pain.

We must consider each individuals medical state and reference each person's Plan of Protective Oversight (IPOPO) for vulnerabilities and medical concerns and any individual specific protocol for direction.

**Protocol for Responses to Injuries and Potential Injuries**:

1. Direct Support Professional will follow the Protocol for Potential Physical Trauma – for DSP's
2. When called by the DSP you will be provided with the following information:
   a. What happened
   b. Was it observed or discovered
   c. **<u>Vitals</u>** and how the person feels
   d. Any recent medication changes
   e. Is there any noted swelling, bleeding, etc.
   f. Is the person able to move body parts
   g. Integrity of body parts
   h. Specific medical information about the individual (shunts, rods, osteoporosis…) found on the Hospital Emergency Information sheet
3. Call 911 if the situation is regarding:
   a. A breathing scenario
   b. A significant bleeding scenario
   c. A shock scenarios
   d. The person's level of consciousness has changed
4. NOC will either physically go to the site where the individual is or make the decisions to have the person go to the hospital (this may involve either the DSP transporting or to call an ambulance)
5. A nurse or medical personnel must evaluate all potential physical trauma as soon as being contacted. This may include:
   a. Establishing an interim plan – i.e., vital signs q2hr, completing neuro checks, etc.
   b. Nurse going to site to directly assess and determine:
      i. Need for interim plan
      ii. Or, send to ER
6. When event occurs and involves more than one person the AOC and nurse will ensure ETC is completed for 'event' and FBI is completed for each person's potential injuries.
7. **AOC will** ensure all necessary notifications are completed – families, administration, etc.
8. The **nurse will** support staff with proper follow up upon return from the hospital as recommended by MD.

# *Protocol for Administration of Emergency (STAT) Medications*

**Administration of emergency (STAT) medications is a vital part of ensuring prompt and continual care for individuals requiring such medication.**

**The Residential Program is responsible for ensuring properly trained and/ or certified staff are available to administer medications within the prescribed timeframes for each person's emergency (STAT) medication.**

**DEFINITIONS:**

**Emergency (STAT) medications** include, ***but is not limited to***, those that require immediate or prompt administration to address a person's presenting health concern such as a seizure, allergic reaction, chest pain, etc…

Examples include, ***but are not limited to***: Diastat; Epi-Pen; Nitroglycerin; Albuterol

**Properly trained/ certified staff** is determined by the medication and training/ certification requirements. Some medications may be administered by a staff member with proper training and some medications require staff to hold a specific certification to administer the medication. ***All training and certifications to administer any emergency (STAT) medication must be provided by a Residential Registered Nurse.***

**PROTOCOL:**

The following protocol must be followed for individuals requiring any type of emergency (STAT) medication:

- The medication must be listed properly on the medication administration record
- ***ALSO*** - There must be specific information **in writing** for each emergency (STAT) medication that:
    - Explains the medication's use and how to support the individual who may need it.
    - Is located where *all staff* have immediate access (for reference and reviewing).
        - Minimally, this must be on the Individualized Plan of Protective Oversight (IPOPO) which may include an attachment to the IPOPO.
        - The information (in ***all*** locations where it is maintained) must be promptly updated as the person's prescribed medication changes.
        - Any changes must be approved by the Residential Health Care Director/ designee.
    - Describes:
        - What the medication is and what it is for
        - Specific circumstances for which the medication must be administered
        - The specific period of time in which the medication must be administered.
        - Qualifications of the staff who is to administer the medication
- ***All staff*** (including Relief or other substituting staff) who support an individual who has a prescription for an emergency (STAT) medication, must be informed of:
    - The potential need, reason, and specifically described circumstances for administration of the STAT medication;

- Prescribed time frame for administration of the medication;
- What her/ his responsibility is, to ensure the medication is administered. This may include:
  - Administering the medication per doctor's order, ***if*** properly trained and/ or certified;
  - Immediately alerting someone who is properly trained and/ or certified;
  - Contacting emergency personnel, as directed by supervisor; administrator on call; nurse on call; etc.
- Any changes must be approved by the Residential Health Care Director/ designee.

- **A properly trained and/ or certified staff member must be present at all times so that administration of the prescribed emergency (STAT) medication may be done without delay.**
- If a person who requires the emergency (STAT) medication goes out for any reason (shopping, taking a walk, dining out, movies, doctor's appt., etc.), a properly trained and/ or certified staff member accompanies the individual.
  - NOTE: the medication MUST be taken along as well.

**Any exceptions or deviations *from any* of the instructions above, must be prior-approved by the Residential Health Care Director.**

Franziska Racker Centers
Residential
Protocol for ***Follow-Up*** to:

## ***Injuries of Unknown Origin***

An "**Injury of Unknown Origin**" is an injury in which the cause is not immediately identifiable. When the origin is 'unknown', due diligence ***must*** be exercised to identify '**possible**' causes to the injury(ies) - regardless of the significance of the injury. Assessment of possible causes and appropriate follow up to minimize recurrence ***must*** occur promptly with each possibility.

Injuries may include: bruises, scratches, cuts/ lacerations, scrapes, brush burns, fractures, head injuries, etc.

It is understood that some injuries may be very minor – such as a small, superficial scratch or light colored bruise smaller than a quarter, etc.. A notation in the nursing notes (with possible causes) is warranted and suffices, so tracking of what initially appears to be a minor injury, is documented.

*All other injuries should be promptly reported to a supervisor or nurse*.

If an event occurs and there is a potential for injury, but one is *not observable*, refer to the ***Protocol for Potential Physical Trauma*** for instructions.

## When the **origin (cause) of the injury is *unknown***, use the following guide:

Staff will immediately:
1. Follow basic first aid procedures, as necessary;
2. Contact emergency personnel if injury appears life threatening or otherwise needs immediate medical attention due to: excessive bleeding/ unresponsiveness/ unconsciousness.
3. Contact AOC and/ or NOC for further instruction.
4. Complete an Fall, Bruise, Injury [FBI] form and submit to nurse or supervisor *before end of shift*.

***When contacted*** >
Supervisor/ AOC/ Nurse will promptly:
1. Seek clarifying information to ensure complete picture;
2. Provide subsequent guidance and support, as necessary. E.g., direction on care; going to site to directly assist; arrange for additional staffing, etc.
3. Review and complete remainder of FBI (bottom of front page and back of page)
4. Contact Residential Regional Director (RRD) if further reporting is deemed necessary.

***Within 24 hours*** of reported injury of unknown origin >
Team Director & Residential Regional Director (RRD) will:
1. Ensure picture is taken of injury – and labeled properly – time/ date of picture; description; who took picture;
2. Review FBI and provide additional information if available;
3. Ensure FBI is provided to Residential Health Care Director;
4. Follow up with assessing circumstances on how injury may have occurred:
   a. Ask resident how injury occurred and document response (including if they cannot tell you). Include:
      i. Assess if her/ his is a reliable reporter – document;
      ii. Assess if her/his description of cause and the injury itself are consistent – regardless, document.
5. Gather information regarding:

a. When first noticed;
b. Who first noticed injury;
c. Last time person was assisted with daily care where injury ***could*** **have been noticed, but was** ***NOT.***

6. Review possible causes and rule out as possible. Examples include but are not limited to:
   a. past events/ activities
   b. environmental factors – at home, in vehicle, at day program/ work
   c. falls
   d. physical interventions
   e. previous notation in nursing notes
   f. diagnosis (that may cause bruising)
   g. medications (that may cause bruising or lethargy)
   h. altercations or other types arguments with housemates or people are day program
   i. self-injurious behavior or habits
7. For *each remaining cause* that cannot be ruled out develop plan(s) for immediate implementation on how to avoid potential injuries.
   a. Document plan(s)/ Update IPOPO as warranted.
8. Ensure all staff are familiar with plan(s) and follow accordingly.
9. Seek feedback from staff; monitor implementation and effectiveness.

## LAST STEP:

**DOCUMENT <u>EVERYTHING</u> – E.G., WHAT YOU REVIEWED AND RULED OUT; DOCUMENTS OR PORCEDURES YOU REVISED; CONCLUSION'S; DIRECTIONS PROVIDED TO STAFF; WHO/ WHAT/ WHEN /WHERE; ETC.**
***<u>EVERYTHING!</u>***

## THE REVIEW MUST BE THOROUGH

# MEDICATION ERRORS

**POLICY**

Medication errors have serious implications for the health and safety of individuals. Residential Services has specific standards for reporting and follow-up to medication errors.

**PROCEDURE**

- ❖ Staff assuming the responsibility of medications have the obligation to do so in a conscientious and safe manner.
- ❖ If a medication error occurs, staff have the responsibility to document and report this error immediately.

**The Staff Member will:**

1. Upon discovering the medication error, notify:
   a. The nurse on site;
   b. If the nurse is not on site, notify the supervisor-on-duty;
   c. If a supervisor is not on duty, notify the A-O-C.
2. Document the error on the medication error sheet.

**The Team Director/A-O-C will:**

2. Make necessary follow-up contacts for direction as the information sheet indicates or if no pre-instructed information is available. Contacts are in the following order, until someone is successfully contacted:
   a. Nurse on site at time of error;
   b. Nurse who is responsible for medical follow-up at that location – during daytime on Monday through Friday;
   c. AOC (Administrator on Call);
   d. NOC (Nurse on Call);
   e. Another Residential Nurse
   f. The individual's physician;
   g. The Agency Medical Director;
   h. The Emergency Room.
2. Ensure necessary follow-up is completed, as instructed.

## ADMINISTRATOR ON CALL

**PROCESS**

- There is a designated Administrator-On-Call (AOC) for use by the Residential Program. Designated Residential Supervisors rotate the AOC duties. [A separate on call system for medical issues is also available for the Residential Program. Residential Nurses rotate for the Nurse on Call (NOC) system – see Medical Protocols.]

- The standard AOC rotation is for a one-week period.

Staff may call the AOC in the following circumstances:

1.) **MEDICAL EMERGENCY** - i.e., accidents (vehicle and/or other requiring intervention), serious medication errors, acute illness, need to transport to ER and/or questionable need for medical/nursing intervention.

2.) **BEHAVIORAL EMERGENCY** - i.e., uncontrollable behavior, need to transport to ER, need for crisis counseling, SCIP–R restrictive intervention lasting more than 10 minutes, questionable need for intervention.

3.) **OTHER EMERGENCY** - i.e., natural disasters, building/utilities (water, heat, electrical, etc.)

4.) **STAFF PROBLEM** - i.e., unable to obtain adequate staff coverage, approval for additional staff due to an emergency situation, employee misconduct (allegation of abuse, not following direction, coming to work but unable to work, etc.).

- The AOC may need to contact the nurse-on-call (NOC) or Residential Regional Director for further support.

- Schedules for the AOC are posted in each residence for staff to refer to.

- If AOC cannot be reached, it is anticipated staff will use the chain of command until contact is successful.

- See Emergency Response Plans for further information/direction for emergencies.

# AMBULANCE TRANSPORT TO ER

**PURPOSE**

Residential Services understands that at times individuals will require transport to a Hospital Emergency Room for examination or treatment. Examples of necessary situations may include: need for immediate emergency personnel on location due to seriousness of medical emergency, inability to transport the individual in one of the program vehicles, etc.

**PROCEDURE**

**The Staff will:**

1. Assess the situation. Provide first aid or life support as necessary;
2. Alert other staff on duty of the emergency situation;
3. Dial "911" for an ambulance.

**If there is only one staff member >**

1. Remain with the other individuals;
2. Contact AOC for support.

**If there is sufficient staffing >**

1. One staff person will accompany the individual to the hospital either in the ambulance or following in another vehicle;
2. The staff person remaining with the other individuals will contact the AOC/CLS nurse for further support/direction.

**The AOC will:**

1. Ensure a staff member goes to the hospital to meet the individual, if someone did not accompany him/her from the residence directly;
2. Provide further support/assistance (e.g., staffing, etc.), as warranted.

## INDIVIDUAL AT EMERGENCY ROOM

**PURPOSE**

Residential Services understands the responsibility of advocating and providing necessary information for individuals in medical emergency situations. This includes during a visit to the hospital emergency room.

**PROCEDURE**

**The Provider/Staff Member will:**

1. Know why the individual is being taken to the emergency room.
2. Advocate for the individual to the best of his/her ability, keeping mind the agency's guiding principles.
3. Encourage the individual to answer any questions the hospital personnel may have. With positive role-modeling as an example, it is expected that the individual will learn to advocate for his/herself.

**The Residential Staff Member will:**

4. Ensure the following items are taken along to the emergency room:
    a. Individual's medical file
    b. Personal information sheet (in Medical File)
    c. Xeroxed copies of the medication/treatment sheets (in Medication Book)
    d. Medicaid card and hospital card (in Medical File)
    e. Physician's order sheet (one kept in Medication Administration Book)
    f. Consult sheet (one kept in Medical File)
5. When the treatment is completed, request a copy of the discharge papers and have the physician complete the consult sheet. Ensure that the diagnosis, medications given, treatment done, lab or x-ray results and all follow-up recommendations are written on the discharge paper or consult sheet. Have the physician write any treatments or medications they want the individual to be on after discharge, on the physician order sheet. Request that copies of the lab work and x-ray reports be sent to the residence.
6. When he/she have returned to the residence:
    a. Write on the Physician Visit/Consultation Record why the individual went to the emergency room and what treatment was given.
    b. Leave the consult sheet and/or discharge summary in nurse's mailbox for review the next day.
    c. Re-file the Physician's Order Form in medication Administration File.
    d. Put away the medical file, Medicaid and hospital cards.
    e. Ensure that all prescriptions written at the emergency room are filed and recorded on the medication/treatment form.
    f. Document in individual's daily notes what occurred.
    g. Write in the communication book any pertinent information staff need to know.

If the individual is to be admitted to the hospital refer to **hospital admission protocol**.

**Racker**
**Residential Services**
***Incident Management – <u>Under the Auspices</u> of the Agency***

**POLICY**

Racker is committed to the responsibility of assuring the safety and well-being of the individuals at all times. This commitment includes proper, timely and thorough reporting, reviewing, correcting, and monitoring of certain events or situations in order to enhance the quality of care and to ensure that individuals are free from all forms of abuse. In addition to the agency's Protective Oversight Policy and Guidelines, OPWDD funded programs abide by supplemental regulatory requirements.

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**NOTE**

The following definitions and procedures are applicable to events and incidents that occur **under the auspices of the agency**. *** For events and situations that occur, <u>but are not under the auspices of the agency</u>, see the appropriate policy and procedure for *Events & Situations (that occur) <u>Not</u> Under the Auspices of the Agency*.

**DEFINITIONS**

<u>UNDER THE AUSPICES</u>

When agency personnel (staff, interns, contractors, consultants, and/or volunteers) are, or should have been, physically present and providing services at the time of the incident.

<u>*NOT* UNDER THE AUSPICES</u>

When an event or situation exclusively involves the family, friends, employers, or co-workers of an individual receiving services, whether or not in the presence of agency personnel or at a certified site.

<u>CUSTODIAN</u>

A *custodian* is a person who is an employee, consultant, or volunteer of an agency who has regular and substantial contact with individuals receiving services. Although not used in this P&P, the regulation uses this term. We alternatively use the word "staff".

<u>EVENTS TO CONSIDER (ETC'S)</u>

'Events to Consider' are situations that include:

a. *Destruction* of Property
b. Vehicle accident – *one* ETC regarding the accident itself
c. Aggressive behavior requiring physical intervention
*d.* Suicidal Ideation (accompanied by lethality assessment) – *when assessment reveals significant potential*
e. Sensitive community situations – may include those that involve emergency personnel or occurrences in the community that may compromise someone's dignity or well-being
f. Initial information of any Reportable Incident (allegations of abuse or significant incident) or Notable Occurrence (serious or minor). For events that warrant completion of an FBI form (except vehicle accidents), an ETC is not necessary.

<u>FALL, BRUISE, INJURY (FBI)</u>

a. For ***<u>all</u>*** falls (no exceptions) – including intentional 'dropping'
b. One for each individual in a vehicle accident – even if no injury immediately observed
c. Choking that requires an intervention
d. Bruises and other injuries that
    1. are suspicious in nature, or
    2. require ***more than*** *basic first aid*
e. AOC's/ NOC's to complete, *as necessary,* per Protocol for Potential Physical Trauma

NOTABLE OCCURRENCES (Minor and Serious)

***Injury***
**Minor N.O.** Any suspected or confirmed harm, hurt, or damage to an individual receiving services, caused by an act of that individual or another, whether or not by accident, and whether or not the cause can be identified, that results in an individual requiring medical or dental *treatment* by a physician, dentist, physician's assistant, or nurse practitioner, ***and*** such treatment is *more than first aid*. [Note: Illness in itself should not be reported as an injury or any other type of incident or occurrence.]

***Theft and Financial Exploitation***
**Minor N.O.** Any suspected theft of a service recipient's personal property (including personal funds or belongings) or financial exploitation that involves a value of more than $15.00 and less than or equal to $100.00, that does not involve a credit, debit, or public benefit card, and is an isolated event.

***Death***
**Serious N.O.** The death of any person receiving services, regardless of the cause of death. This includes all deaths of individuals who live in residential facilities and other deaths that occur *under the auspices* of the agency.

***Sensitive Situations***
**Serious N.O.** Situations involving a person receiving services that do not meet the definitions of other incidents that may be of delicate nature to the agency, and are reported to ensure awareness of the circumstances. Sensitive situations include, but are not limited to, possible criminal acts committed by an individual receiving services.

REPORTABLE INCIDENTS
(Allegations of Abuse & Significant Incidents)

**Allegations of Abuse**

A. ***Physical abuse*** is the conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental, or emotional condition of the individual receiving services, or causing the likelihood of such injury or impairment. Such conduct may include, but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any party.

B. ***Sexual Abuse*** is any conduct by a custodian that subjects a person receiving services to any offense defined in penal law, or any conduct or communication by such custodian that allows, permits, uses, or encourages a person receiving services to engage in any act described in penal law.

C. ***Psychological Abuse*** includes any verbal or nonverbal conduct that may cause significant emotional distress to an individual receiving services.

(i) Examples include, but are not limited to, taunts, derogatory comments or ridicule, intimidation, threats, or the display of a weapon or other object that could reasonably be perceived by an individual receiving services as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury.

(ii) In order for a case of psychological abuse to be substantiated after it has been reported, the conduct must be shown to intentionally or recklessly cause, or be likely to cause, a substantial diminution of the emotional, social or behavioral development or condition of the individual receiving services. Evidence of such an *effect must be supported by a clinical assessment* performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor.

D. ***Deliberate inappropriate use of restraints*** is the use of a restraint when the technique that is used, the amount of force that is used, or the situation in which the restraint is used is deliberately inconsistent with an individual's

plan of services (e.g. individualized service plan (ISP) or a habilitation plan), or behavior support plan, generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other party. For purposes of this paragraph, a restraint shall include the use of any manual, pharmacological, or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

E. ***Aversive Conditioning*** is the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services. Aversive conditioning may include, but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, and the withholding of meals and the provision of substitute foods in an unpalatable form. The use of aversive conditioning **is prohibited** by Racker and OPWDD.

F. ***Obstruction of reports of reportable incidents*** is the conduct by a custodian that impedes the discovery, reporting, or investigation of the treatment of a person by falsifying records related to the safety, treatment, or supervision of an individual receiving services; actively persuading a custodian or other mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register (VPCR) or OPWDD with the intent to suppress the reporting of the investigation of such incident; intentionally making a false statement, or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with OPWDD regulations, policies or procedures; or, for a custodian, failing to report a reportable incident upon discovery.

G. ***Unlawful use or administration of a controlled substance*** is any administration by a custodian to a person of a controlled substance as defined by public health law, without a prescription, or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by public health law, at the workplace or while on duty.

H. ***Neglect*** is any action, inaction, or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a service recipient. Neglect shall include, but is not limited to:

(i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described if committed by a custodian;
(ii) failure to provide adequate food, clothing, shelter, or medical, dental, optometric or surgical care, , and provided that the agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric, or surgical treatment have been sought and obtained from the appropriate parties; or
(iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with education law and/or the individual's individualized education program.

***Significant Incidents***

Significant incidents are incidents, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of a person receiving services, and shall include but shall not be limited to:

A. ***Conduct between persons receiving services that would constitute abuse*** as described if committed by a custodian;
B. ***Conduct on the part of a custodian, that is inconsistent with the individual's plan of services***, generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, and which impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services, including but not limited to:
   (i) ***seclusion*** which is the placement of an individual receiving services in a room or area from which he or she cannot, or perceives that he or she cannot, leave at will. Any seclusion **is prohibited** at Racker;

(ii) ***unauthorized use of time-out***, which is the use of a procedure in which a person receiving services is removed from regular programming and isolated in a room or area for the convenience of a custodian, or as a substitute for programming. Any time out, per this definition, **is prohibited** at Racker;

(iii) ***the administration of a prescribed or over-the-counter medication, which is inconsistent with a prescription or order*** issued for a person by a licensed, qualified health care practitioner, and which has an adverse effect on an individual receiving services. "Adverse effect" is the unanticipated and undesirable side effect from the administration of a particular medication which unfavorably affects the wellbeing of a person receiving services; and

(iv) ***inappropriate use of restraints*** is the use of a restraint when the technique that is used, the amount of force that is used, or the situation in which the restraint is used is inconsistent with an individual's plan of services (including a behavior support plan), generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies. "Restraint" includes the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body; and

(v) ***mistreatment*** is other conduct on the part of a custodian, inconsistent with the individual's plan of services, generally accepted treatment practices, and/ or applicable federal or state laws, regulations, or policies, and that impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services.

C. ***Missing person at risk for injury*** is the unexpected absence of a person that based on the person's history and current condition exposes him or her to risk of injury;

D. ***Unauthorized absence*** is the unexpected or unauthorized absence of a person after formal search procedures have been initiated by the agency. Reasoned judgments, taking into consideration the person's habits, deficits, capabilities, health problems, etc., shall determine when formal search procedures need to be implemented. It is required that formal search procedures must be initiated immediately upon discovery of an absence involving a person whose absence constitutes a recognized potential danger to the wellbeing of the person or others.

E. ***Choking, with known risk*** is the partial or complete blockage of the upper airway by an inhaled or swallowed foreign body, including food, that leads to a partial or complete inability to breathe, involving an individual with a known risk for choking and a written directive addressing that risk;

F. ***Choking, with no known risk*** is partial or complete blockage of the upper airway by an inhaled or swallowed foreign body, including food that leads to a partial or complete inability to breathe. Involves an individual with no known risk for choking.

G. ***Self-abusive behavior, with injury***, is a self-inflicted injury to an individual receiving services that requires medical care beyond first aid.

H. ***Injury, with hospital admission*** is any injury that results in the admission of a person to a hospital for treatment or observation because of injury.

I. ***Theft and financial exploitation*** is any suspected:
   a. theft of a service recipient's personal property (including personal funds or belongings) or financial exploitation, involving a value of *more than* $100.00;
   b. theft involving a service recipient's credit, debit, or public benefit card (regardless of the amount involved); or,
   c. a pattern of theft or financial exploitation involving the property of one or more individuals receiving services.

J. ***Other significant incident*** is an incident that occurs under the auspices of an agency, but that does not involve conduct on the part of a custodian, and does not meet the definition of any other incident - but that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in harm to the health, safety, or welfare of a person receiving services.

QUALIFIED PERSON (QP)

Per Mental Hygiene Law §33.16 – the individual or a capable adult/parent/spouse/adult child/or guardian of the individual.

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**PROCEDURE FOR REPORTING A NOTABLE OCCURRENCE OR REPORTABLE INCIDENT:**

***It is understood that professional and reasonable judgment will be used to address all situations involving injuries and incidents. This procedure serves as a reference and guide and is not inclusive of all situations and circumstances.***

**Also note: The Director of Quality Enhancement & Standards may and should be consulted for clarification on any part of this procedure.**

**The Staff Member observing or discovering the incident will:**

1. Respond to the individual involved. Take **immediate** action/ intervene to stop continuation of the incident/ abuse, if needed;
2. Contact 911 if emergency personnel are needed;
3. Provide First Aid treatment or secure treatment from others, if needed.
   a. Reference protocols, as necessary for:
      i. Injuries of Unknown Origin **[Appendix A]**
      ii. Potential Physical Trauma **[Appendix B-1]**
4. If individual has a person specific Protocol for False Reporting, contact supervisor/ AOC ***immediately!!***
   a. Inform supervisor/ AOC of protocol
   b. **Then skip to #6.**
5. If it is believed that a Reportable Incident (as defined above) has occurred within the certified Residential program **and** under the auspices of the agency, call the Vulnerable Person's Central Registry at:
   1-855-373-2122.
   a. staff *may* request assistance from a supervisor/ administrator with making call, ***but should not delay*** in reporting to the registry.
   b. When placing the call staff must provide names of all others who have knowledge of the incident.
   c. Only one staff member needs to place call to JC. All others with knowledge MUST ensure call to JC was completed and documented – otherwise s/he must place a call to the JC as well.
6. Inform Supervisor or Administrator on Call (A-O-C) of event, if not done already;
7. Follow instructions as provided by supervisor or A-O-C;
8. Initiate, complete, and submit an 'Events to Consider' (ETC) form to supervisor or FBI to nurse.
   a. Include names of all staff who have knowledge of the incident.
   b. Do NOT jointly write description of event on ETC – rather, write separate ETC's.
   c. The 'staff health assessment' section should be completed by a staff member other than the one who completed the 'description of event' section, whenever possible.
   d. If the individual threatens suicide, complete the Suicide Risk Assessment form **[Appendix F-1] – regardless if it is believed the person is serious or not!** This assessment should NOT be done in lieu of the ETC.

**The Supervisor/ A-O-C will:**

1. Ensure the safety and well-being of the individual is being addressed;
2. Provide support to staff member with suggestions, directives, etc.;
3. Ensure ETC or FBI (and suicide risk assessment, if necessary) is completed;
4. *If it is solely* a **ETC and no further filing is necessary** >
   Ensure the supervisor of the house becomes aware of the situation minimally by the next working day

***or***

   *If it is solely* an **FBI** >
   Instruct staff to contact the Nurse on Call (NOC) for direction

5. *If situation is possible false report* and person has specific protocol
   a. Reference specific person's protocol for instructions
   **b.** Contact RRD **immediately!**

c. Reference False Reporting Protocol [Appendix C]for further instructions

6. *If the situation is a **possible** Reportable Incident (allegation of abuse/ neglect or significant incident) or Notable Occurrence **or if unsure** >*
   Immediately notify Residential Regional Director (RRD) or Director on Call (D-O-C)
7. Assist with other filing of reports, staffing coverage, as well as any instructions provided by RRD or D-O-C. If entering IRMA, be sure to complete all necessary fields.
   a. If staff member calling reports a tenuous situation, minimal staffing, or other circumstance that requires staff to focus full attention on individuals, DO NOT instruct staff to carry out tasks that would take them away from that responsibility - such as: finding coverage, etc.
8. If event or situation occurred ***not under the auspices*** of the agency, refer to policy and procedure *Events & Situations (that occur) Not Under the Auspices of the Agency*

**The Residential Regional Director (RRD)/ Director-on-Call will:**

1. Seek information on how individual is currently doing.
   a. Ensure her/his safety and well-being is being addressed sufficiently;
   b. Make arrangements for physical exam and further medical treatment, if necessary;
   c. If any injury is involved or alleged – **ensure photos are taken IMMEDIATELY of affected area on body.**
      i. **Ensure all photos:**
         1. Can demonstrate scale and characteristics (e.g., use ruler to show size)
         2. **Are properly labeled with time, date, who took picture and what picture is intended to reflect.**
         3. Do not include the person's face unless injury is on the face.
         4. Are only taken with agency phone or camera.
2. Seek any further ***objective*** information necessary to gain clear understanding of what occurred: who, what, when, where and what happened afterwards.
   a. Ensure ***accurate*** information is gathered, as much as possible – e.g., ask for direct quotes (to avoid misinterpretations by someone paraphrasing statements)
3. Provide direction as warranted to ensure:
   a. event is stabilized;
   b. all individuals are okay;
   c. all individuals are receiving/ will receive short term and long term continuity of supports (e.g., from shift to shift; week to weekend; etc.);
4. If the situation involves an "**injury of unknown origin**", also refer to *Protocol for Addressing Injuries of Unknown Origin* [**Appendix A**]
5. If the situation involves '**potential' physical trauma**, also refer to *Protocol for Potential Physical Trauma* [**Appendix B-2**].
6. If situation may be 'false report' **and** person has person specific Protocol for False Reporting:
      a. Reference person's specific protocol
      a. Reference False Reporting Protocol **[Appendix C]**for further instructions.
7. Determine if incident is a Reportable Incident or a Notable Occurrence
   a. If unable to make determination or to double check on determination, will contact Director of Residential Services and Director of Quality Enhancement/ designee for assistance;
   b. Support any party with reporting to JC [for Reportable Incidents], if s/he (party) feels it is warranted
      i. provide resources to assist party to determine if reporting to JC is warranted – i.e., incident definitions, etc.
      ii. *NEVER tell anyone not to report* something to the JC.
8. If the situation is deemed a(n):
   a. Reportable Incident or death, ensure:
      i. Pertinent materials (files/ records, etc.) and immediate vicinity of the incident are secured (if necessary), unless the area must be used;
         1. If area must be used, promptly take/ obtain photos of where event occurred.
      ii. Telephone notification is made to the Justice Center (JC will enter initial info into IRMA);
      iii. Telephone notification is made to OPWDD (speak with live person or as directed when placing call);

iv. Follow-up information is thoroughly and correctly entered by Racker staff into IRMA within 24 hours/ end of next business day – whichever is later.

b. Allegation of physical or sexual abuse **consult with Human Resources (HR)** to determine any necessary changes in status of staff member. Change in status may include: increase of supervision, removal, reassignment, relocation, or placement on paid administrative leave of a staff member. Decision making includes:
   i. assessing current level of supervision and/ or contact with individuals;
   ii. and ensuring a higher level of supervision or decreased opportunity for contact to prevent recurrence of incident.

   Progression of supervision from lower to high – supervisor & HR may skip some levels, if warranted:
   - ❖ Counseling > instruction to 'not work directly with involved individual(s)' > reassignment to work with other individuals > direct supervision by senior staff > direct supervision by supervisor > relocation with supervision > removal/ non-contact duties > paid administrative leave.

   iii. **NOTE**: If a staff person is suspected of abuse, neglect or mistreatment that poses a 'serious and immediate threat' to an individual's health and safety, the staff person may not work in direct contact with any individuals until the review is complete, taking into account outcome of the review;

c. Allegation of **'psychological abuse'** – either by staff member or housemate, notify clinician (LCSW, LMSW, LMHC) to have psychological assessment completed.

9. Receive and review information provided on ETC or FBI form and provide further direction as necessary
   a. Systemic follow up to any incidents, regardless of degree of seriousness, should begin as soon as information becomes available
      i. It is not necessary to wait to outcome of review to make changes that will ensure the safety and well-being of an individual.
10. Obtain appropriate Quality Enhancement (QE) Reviewer for a comprehensive review of situation if the Justice Center or OPWDD has assigned the agency to investigate;
11. Require all witnesses to remain on duty or available until they are interviewed by the QE Reviewer or JC or OPWDD investigator (emphasize confidentiality of all information pertaining to incident and investigation);
12. Ensure all mandated notifications are made and documented – [see **Appendix D** for specifics and timeframes].
    a. Contact police for all instances of physical, sexual, in some cases psychological abuse and whenever a crime is thought to be committed to a person receiving services;
    b. When contacting 'qualified person' (QP), use 24 hour contact form [**Appendix E-1**] to ensure all information is provided. *Also* complete the OPWDD 163 form [**Appendix E-2**.] This contact must be made by telephone or in person and ***must include*** to parent, spouse, adult child or guardian ***unless:***
       i. the individual, who is a capable adult, objects (must be in writing);
       ii. the Q.P. objects to being notified (in writing – maintained by RRD);
    c. The complete notification to the Q.P. may be conveyed in more than one conversation with the Q.P. but initial contact with ***description of the situation*** must be made or attempted within 24 hours.
    d. If there is no Q.P. (aside from self) and the individual has an Advocate, notification must be made to the Advocate.
    e. If there is no Q.P. and person is capable adult, notification is made to her/ him;
13. Scan and send all documentation to QEIncidents@rackercenters.org ;
14. If not done already, notify the house's respective RRD;
15. Per request from Qualified Person, hold 'sit down' conversation
    a. Draft minutes of meeting held in response to request and list those present and QP's input and response to information provided in meeting.
    b. Forward minutes of meeting and those present to the QEIncidents@rackercenters.org .
16. Ensure subsequent initial information is entered into IRMA (by end of next working day).

**The Physician or Nurse, as necessary, will:**

1. Provide instructions to staff for follow-up, if situation is solely an FBI;
2. Reference and utilize protocols: *Addressing Injuries of Unknown Origin* [**Appendix A**] and *Potential Physical Trauma* [**Appendix B-2**], as necessary;

3. Provide needed examination and treatment, as necessary, if situation is a Reportable incident (allegation of abuse or significant incident).

**The Clinician (if contacted for allegation of psychological abuse) will:**

1. Follow *Guidance for completing psychological assessment post incident* [**Appendix F**] for completing psychological assessment.

**The Director of Residential <u>and</u> Director of Quality Enhancement/ designee will:**

1. Ensure the safety and well-being of the individual is being addressed
   a. If not already completed, this may include the Dir. of Res. and HR determining appropriateness of increase of supervision, removal, reassignment, relocation, or placement on paid administrative leave of a staff member, as stated above.
2. Consult with one another to ensure a cohesive and comprehensive approach is implemented;
3. If not already completed and the JC and OPWDD have opted not to complete the investigation, assign a QE Reviewer for all Reportable Incidents and Serious N.O.'s
   a. The Reviewer must be someone objective to the program and cannot be a supervisor or party in the chain of command of directly involved staff;
4. Ensure completion of all mandated notifications as described under RRD/ DOC responsibilities;
5. Provide other direction to RRD, as necessary;
6. Ensure all information is provided to JC or OPWDD as requested, if they opt to complete investigation;
7. Ensure a *program review* continues even if the JC or OPWDD are investigating, as a process to assess internal practices.

**The Quality Enhancement Reviewer will (if warranted/ directed):**

1. If potentially false report and person involved has person specific Protocol for False Reporting, reference
   a. Person specific protocol for false reporting
   b. False Reporting Protocol **[Appendix C]** for further instructions
   c. Be sure to complete review and report **<u>within 24hours</u>**!
2. Go to the site of incident (or appropriate location) and conduct a comprehensive QE Review;
3. Within 3 weeks, submit final written QE Review report (with applicable statements) to the Chairperson of the Agency Review Panel;
4. If situation involves a resident who has a Support Plan which addresses reporting of false allegation, ensure review and report are completed within 24 hours, if it is deemed by the review that the allegation is false.
   a. If there, during the 24 hour review there is reasonable cause to suspect abuse occurred or if the review and report cannot be completed within 24 hours, notify the supervisor/ AOC immediately.
   b. See further instructions for in the Protocol for False Reporting.

**The Qualified Person or Advocate:**

2. May request a copy of the incident report;
3. Must put the request ***in writing*** to the Director of Quality Enhancement, if the agency is conducting the review – otherwise direct the request to either the JC or OPWDD, whichever is conducting the investigation.

**The RRD will:**

1. Forward any request for copies of the incident report to the Director of Quality Enhancement;
2. Provide ten day follow-up letter to the Q.P. who received the 24 hour contact [see **Appendix F]**. Ten day letters are to be sent to Q.P.'s for all Reportable Incidents and Notable Occurrences
3. Send copy of ten day letter to <u>QEIncidents@rackercenters.org</u>;
4. If the situation is deemed a *Minor Notable Occurrence,* review and prepare and present a written report of the situation to the Special Review Committee.
5. Promptly report to the VPCR additional information discovered during the review process, if the information may warrant the incident to be upgraded.
6. Ensure the Protocol for False Reporting is followed, if applicable.
   a. See Protocol for False Reporting for further instructions.

**The Qualified Person:**

1. May request a copy of records pertaining to allegations and investigations (quality enhancement review) of abuse;
2. Must put the request ***in writing*** to the Director of Quality Enhancement, if the agency is conducting the review – otherwise send request to either the JC or OPWDD, whichever is conducting the investigation;
3. Note: an **Advocate** is not eligible to receive records pertaining to allegations of abuse and QE reviews.

**The Director of Quality Enhancement/ designee will:**

1. Maintain all original reports, records, QE Reviews, and minutes
2. Submit to the JC's WSIR (Web Submission of Investigation Reports) system the complete QE Review packet upon completion of the review of any allegation of abuse that the agency conducts;
3. Date/ time stamp all requests for information;
4. Verify that the person requesting any information – incident forms, or investigation packets - is a "Qualified Person" or other authorized person;
5. *If requestor is a Q.P. and there is no objection by the individual, as a capable adult and the Q.P. and the agency completed the review -*
   a. Promptly provide redacted copy of the incident report, if requested
      - with attached letter stating that all information is preliminary and has not been substantiated
   b. Provide redacted copies of records pertaining to allegations and investigations (quality enhancement review) of abuse, if requested – promptly after final review by the Special Review Committee.
      - with attached letter stating that by law, the information may not be further disseminated
   c. Maintain documentation of all requests and copies of all materials that are provided to Q.P.
   d. If the agency did not complete the review direct the QP to the JC or OPWDD, whichever is appropriate.

   *If requestor is not a Q.P. or other authorized person,*
   Contact person and inform her/him that s/he is not eligible to receive reports and records;

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**REVIEW PROCESS**

**The RRD's; Director of Residential Services; Director of QE/ designees will:**

1. Be familiar with their individual responsibilities for reporting, notifications, follow-up and closures.
2. *Ensure adherence to the required timeframes* for completing their individual responsibilities for reporting, notifications, documenting, follow-up and closures [**Appendix G**].

**The Quality Enhancement Reviewer will:**

1. Receive specific training regarding the completion of 'investigations', known at Racker as *Quality Enhancement Reviews.* Specific training is defined by OPWDD and the JC;
2. Attend annual updates for completing QE Reviews, provided by the Director of Quality Enhancement;
3. Complete QE Reviews as assigned and have a second reviewer proofread the report for clarity and thoroughness, then submit final report to QEIncidents@rackercenters.org. The report must follow the directed format and include all necessary components –
   a. A finding of substantiated or unsubstantiated must be included for all allegations.
   b. A finding of *substantiated* must be supported by a "preponderance of evidence."
4. Present the report to Review Panel members when a Panel is convened.
5. Promptly complete any further follow-up, fact gathering, etc. as requested by the Review Panel and submit the information to QEIncidents@rackercenters.org.

**The Director of Quality Enhancement (designee) will:**

1. Upon receipt of final report from QE Reviewer, schedule a Review Panel and forward report to members;
2. Convene and chair Review Panel;
3. All documents used/ obtained in the QE Review process will be available for viewing by the Panel;

4. Draft minutes and forward to: Executive Director, Residential Director, others present for Review Panel, and Executive Secretary for distribution to Centers' Board President.
    a. Minutes will include a brief summary of the situation (including date and type), what caused the report to be generated, Panel findings (including whether allegation is substantiated or unsubstantiated) and recommendations;
5. Notify necessary Residential staff to obtain any outstanding documents and follow up to recommendations, as necessary to complete incident file.
6. Ensure all necessary documentation is uploaded into IRMA/ WSIR, as appropriate.

**The Director of Residential Services will ensure:**
1. All outstanding documentation to complete incident file is forwarded to QEIncidents@rackercenters.org
2. All recommendations are addressed and follow-up to recommendations is sent to QEIncidents@rackercenters.org within two weeks of receipt of minutes.

**The Director of QE/ designee will:**
1. Convene the monthly (but not less frequently than 1/4ly) Special Review Committee (SRC);
2. All documents used/ obtained in the QE Review process will be available for viewing;
3. Record and securely maintain minutes. Minutes will include:
    a. follow-up from prior month's minutes/ recommendations for closure to incidents;
    b. reference to the Reportable Incident reports, Notables Occurrences (serious and minor) and Review Panel minutes; any discussion/ questions and answers during the committee meeting; actions taken on the part of the agency/program as a result of Review Panel recommendations and any further recommendations made by the SRC – including when to close incident.
    c. Some follow-up/ updates may occur via email with committee members.
4. Ensure minutes are entered into IRMA, and MHLS (for allegations of abuse) receives a copy as well;
5. Maintain and secure minutes with incident file.

**The respective RRD's will:**
1. Provide Q.P.'s with status to incidents once it has been deemed that no further review is necessary;
2. Follow-up on any outstanding Review Panel recommendations or further recommendations made by the SRC, OPWDD or the JC and forward follow-up to QEIncidents@rackercenters.org.

**The Director of QE/ designee will:**
1. Confirm *agency* closure to all incidents once SRC decides no further review is necessary;
2. Record when all recommendations have been adequately addressed;
3. Ensure all Review Panel members have necessary training and knowledge of their responsibilities;
4. Convene annual trainings and trend reviews with SRC;
5. Draft and submit annual report of incidents and trends to the Executive Director, Board President and OPWDD;
6. Update policy and procedure as program or regulatory changes occur;
7. Obtain Board approval for any policy change.

**********

The Agency has established a **Special Review Committee** (SRC) to review incidents. A sub-committee to the SRC is a Review panel made up of directors within the agency. The following are the committee's and panel's responsibilities and the subsequent procedure surrounding the review process:

REVIEW PANEL

**RESPONSIBILITIES**:
1. Convene as needed, after completion of a QE Review – no later than thirty days after filing of incident;
2. Examine QE Reports for all Reportable Incidents (allegations of abuse and significant incidents) and Serious N.O.'s. The examination includes reading the QE Report and speaking with the QE Reviewer to ascertain:

a. if Reportable Incidents and Serious Notable Occurrences were handled, reported, reviewed (via the QE Review process) and documented according to the provisions of this policy and procedure;
b. if necessary and appropriate corrective, preventive, and/or *action has been taken* to protect individuals from further harm and to safeguard against the recurrence of a similar situation;
c. if further review for additional corrective, preventive, and/or action is necessary;
d. if prior similar situations have occurred and review how they were handled, etc./ identify trends;
e. the quality of the review
f. if all mandated notifications were completed as required.

3. Request further information from the QE Reviewer, if needed/ desired;
4. Determine finding of all allegations of abuse (substantiated or unsubstantiated)
   a. There must be a preponderance of evidence to support a substantiated allegation;
5. Make recommendations to the Director of Residential Services based on information received. Examples of recommendations may include, but are not limited to:
   a. Administrative/ remedial action (scheduling, supervision level, procedural changes, etc.);
   b. clinical action (health assessments, medical attention, counseling to individual, etc.);
   c. staff training/ counseling;
   d. assessment of staff's employment status with Human Resources;
   e. referral or notification to other programs/ agencies for supports/ services;
   f. environmental modifications/ considerations;
   g. upgrading of incident.
6. Abide by confidentiality policy of agency with regards to information shared in the committee.

SPECIAL REVIEW COMMITTEE

**RESPONSIBLITIES:**

1. Convene monthly, as necessary, to review all Reportable Incidents and Notable Occurrences;
2. Maintain regular attendance by all members (at either SRC or in a Review Panel);
3. Review summary of QE Reports as presented at the meeting;
4. Ask questions for further information or clarification about incidents, as needed;
5. Ensure no individual directly involved, in chain of command for the involved individual or completing the QE Review, participates in deliberation (decision making) during the SRC review;
6. Review follow-up to all recommendations made by Review Panels;
7. Offer other recommendations such as those listed above and ensure they are addressed;
8. Monitor status of all on-going reviews;
9. Provide final completion of investigations to all Reportable Incidents and Notable Occurrences once no further review is required;
10. Track that all recommendations have been addressed adequately;
11. Review final outcomes for all incidents which include:
    a. Final closure to all SI's and NO's
    b. Final closure as determined by the JC for all allegations of abuse.
12. Review quarterly trend reports for all Notable Occurrences, FBI's, Medication Errors, Reportable Incidents and offer recommendations for follow-up. Ensure all recommendations are addressed
13. Complete annual trend review and offer recommendations for follow-up. Ensure all recommendations are addressed;
14. Attend annual update training with regards to responsibilities, policy and procedure, making recommendations, etc.
15. Abide by confidentiality policy of agency with regards to information shared during committee meetings.

Review Panel

Membership

Director of Quality Enhancement (as Chairperson)
Director of Department (*if* panel is reviewing incident from Residential an RRD may be designated)
Round Table Directors and Director of Donor & Government Relations
Medical Director or other Agency Health Professional *for* Reportable Incidents involving significant health concerns or death.
Assistant Director of Quality Enhancement
Assistant Director of Standards
QE/Standards Specialist

**Each panel meeting *must* include a <u>minimum</u> of three people from the following pool:**
**RT Directors**(*if* panel is reviewing incident from Residential an RRD may be designated)**;**
**Dir of D&GR**

Special Review Committee

Membership

Director of Q.E./ designee (as Chairperson)
All Review Panel members
Representative/ Presenter from each Residential Region (if reviewing incident from respective region)
Representatives from Community Support (if reviewing incident from respective program)
Residential Health Care Director / designee
Agency Medical Director (as a consultant)
Residential Behavior Specialist(s)
2-4 other representatives outside of Residential
Board Member
Parent representative(s)
Direct Care Staff representatives
Individual receiving services
Other professional staff for specific expertise, as necessary and requested
Director of Residential Services (present but not 'member' for Residential presentations)
Director of Community Support./ designee (present but not 'member' for Community S&S presentations)

## APPENDICES

**Appendix A –Protocol for Injuries of Unknown Origin**

**Appendix B-1 – Protocol for Potential for Physical Trauma (Direct Support version)**
**Appendix B-2 – Protocol for Potential for Physical Trauma (supervisor/ nurse version)**

**Appendix C – False Reporting Protocol**

**Appendix D - notification timeframes**

**Appendix E-1 – 24 hour contact form**
**Appendix E-2 – OPWDD 163 form**

**Appendix F – Psychological Assessment**
**Appendix F-1 – Suicide Risk Assessment form**

**Appendix G – ten day letter instructions**

**Appendix H – timeframes for reporting, documenting, follow-up, closure, etc.**

**This procedure is based on 14 NYCRR 624 regulations and subsequent applicable OPWDD memorandums.**

**POLICY**

Franziska Racker Centers is committed to the responsibility of assuring the safety and well-being of the individuals at all times. This commitment includes proper, timely and thorough reporting, reviewing, correcting, and monitoring of certain events or situations in order to enhance the quality of care and to ensure that individuals are free from all forms of abuse. In addition to the agency's Protective Oversight Policy and Guidelines, OPWDD funded programs abide by supplemental regulatory requirements.

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**NOTE**

The following definitions and procedures are applicable to events and situations that occur **under the auspices of the agency**. *** For incidents that occur under the auspices of the agency, see the appropriate policy and procedure for *Incident Management – Under the Auspices*.

**DEFINITIONS**

UNDER THE AUSPICES

An event or situation in which agency personnel (staff, interns, contractors, consultants, and/or volunteers) are, or should have been, physically present and providing services at that point in time.

*NOT* UNDER THE AUSPICES

Any event or situation that exclusively involves the family, friends, employers, or co-workers of an individual receiving services, whether or not in the presence of agency personnel or at a certified site.

EVENTS & SITUATIONS

1. *Physical abuse*. The non-accidental use of force that results in bodily injury, pain or impairment, including but not limited to, being slapped, burned, cut, bruised or improperly physically restrained.
2. *Sexual abuse*. Non-consensual sexual contact of any kind, including but not limited to, forcing sexual contact or forcing sex with a third party.
3. *Emotional abuse*. The willful infliction of mental or emotional anguish by threat, humiliation, intimidation, or other abusive conduct, including but not limited to, frightening or isolating an adult.
4. *Active neglect*. The willful failure by the caregiver to fulfill the care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, willful deprivation of food, water, heat, clean clothing and bedding, eyeglasses or dentures, or health related services.
5. *Passive neglect*. The non-willful failure of a caregiver to fulfill care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment or denial of food or health related services because of inadequate caregiver knowledge, infirmity, or disputing the value of prescribed services.
6. *Self neglect*. An adult's inability, due to physical and/or mental impairments, to perform tasks essential to caring for oneself, including but not limited to, providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety; or managing financial affairs.
7. *Financial exploitation*. The use of an adult's funds, property, or resources by another individual, including but not limited to, fraud, false pretenses, embezzlement, conspiracy, forgery, falsifying records, coerced property transfers, or denial of access to assets.
8. *Death.* The end of life, expected or unexpected, regardless of cause.

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**PROCEDURE FOR REPORTING AN EVENT OR SITUATION THAT OCCURS NOT UNDER THE AUSPICES OF THE AGENCY:**

***It is understood that professional and reasonable judgment will be used to address all situations. This procedure serves as a reference and guide and is not inclusive of all situations and circumstances.***

**Also note: The Director of Quality Enhancement & Standards may and should be consulted for clarification on any part of this procedure.**

**The Staff Member observing or discovering the event or situation will:**

1. Respond to the individual involved. Take **immediate** action/ intervene to stop continuation of the event/ situation, if needed;
2. Provide First Aid treatment or secure treatment from others, if needed;
3. If possible child abuse (individual is under the age of 18) has occurred, **call New York State Central Registry (Child Abuse Hotline) at 1-800-635-1522**
   a. staff may request assistance from an administrator with making call, ***but should not delay*** in reporting to hotline;
4. Inform supervisor or Administrator on Call (A-O-C), if not done already;
5. Follow instructions as provided by supervisor or A-O-C;
6. Initiate, complete, and submit an 'Events to Consider' (ETC) form to supervisor.

**The Supervisor/ A-O-C will:**

1. Ensure the safety and well-being of the individual is being addressed;
2. Provide support to staff member with suggestions, directives, etc.;
3. Ensure ETC form is completed;
4. Notify Residential Regional Director.

**The Residential Regional Director (RRD)/ Director-on-Call will:**

1. Ensure the safety and well-being of the individual is being addressed;
2. Determine if:
   a. Situation occurred under the auspices of the agency
      *i.* If so, follow policy and procedures for *Incident Management - Under the Auspices of the Agency*
   b. Situation occurred under the auspices of another agency/ program certified or operated by a State Oversight Agency (OPWDD, OMH, OASAS, DOH, OCFS, SED)
      i. If so, notify that agency/ program
      ii. Ensure an ETC form is completed
   c. Situation did ***not*** occur under the auspices of the agency or another agency that is certified or operated by a State Oversight Agency (OPWDD, OMH, OASAS, DOH, OCFS, SED) and the event or situation falls into one of the definitions as listed above:
      i. Ensure intervention occurs which may include, but is not limited to:
         1. Contacting CPS, PSA, CPS; family members; school; hospital
            a. It is required to contact PSA (Protective Services for Adults @ local DSS) if protective services are necessary for individual and the Centers is unable to provide those services.
         2. Making referral (s)
         3. Interviewing people
         4. Reviewing records and other relevant documentation
         5. Assessing and monitoring the individual;
         6. Educating the individual about his or her choices and options regarding the matter;
      ii. Receive and review information provided on ETC form;
      iii. Enter the situation into IRMA – be sure all necessary fields are completed.

3. Notify the Director of Residential and Director or Quality Enhancement

**The Director of Residential <u>and</u> Director of Quality Enhancement will:**

1. Ensure the safety and well-being of the individual is being addressed;
2. Consult with one another to ensure a cohesive and comprehensive approach is implemented;
3. Ensure completion of IRMA entry as well as subsequent information in following days;
4. Provide other direction to RRD, as necessary.

## INFECTION CONTROL

**POLICY**

Residential Services is committed to providing services in a manner that ensures best practices in Infection Control.

**PROCEDURE**

**The Nurse Educator/ designee will:**

- Provide training to all new staff members regarding infection control: i.e., infectious diseases, universal precautions, individual responsibilities, etc.
- Annual updates/ reviews are provided to all staff members.
- The training curriculum for infection control is updated annually and includes but is not limited to:
    - hand washing,
    - understanding bloodborne pathogens,
    - proper handling of body fluids
    - sterilization/ disinfecting equipment and living areas,
    - individualized personal hygiene supplies,
    - labeling / dating foods; and
    - general best practices for housekeeping (e.g., dishwashing, etc.)
- Specifically the training curriculum will discuss such illnesses and diseases as (but not be limited to):
    - Common colds and flu
    - Tuberculosis
    - HIV/ AIDS
    - Hepatitis
    - Lice/ Scabies
    - Whooping Cough
- At times, if there is possible exposure of an infectious disease to an individual or staff member the following will occur:
    1. appropriate incident report will be completed by staff member;
    2. prompt visit to a doctor or emergency room for evaluation (for staff: as s/he desires);
    3. any/ all testing is voluntary and the individual must sign that s/he is agreeing to testing;
    4. necessary follow-up will be determined by the health department and hospital/ doctor office's guidelines.
    5. Subsequent to a person's doctor/ hospital visit, information provided only to the HCD, regarding a service recipient, will only be on a 'needs to know basis'.
    6. Determination and specifics of information provided to staff members will be determined by the Health Care Director.
- Staff are trained in established protocols to address cleaning, disinfecting of medical equipment; spills involving any body fluids.
- Other protocols are established and available to all staff regarding all aspects of infection control.
- Necessary equipment is made available to all staff so that infection control protocols may be followed.

## TUBERCULOSIS TESTING

**POLICY**

Residential Services is committed to ensuring the health and wellness of the individuals in the Residential Program. In part we do this by providing yearly tuberculosis (TB) screening of individuals in the program and staff who provide supports and services to them.

**PROCEDURE**

As part of the new employee orientation Residential Staff meet individually with a Centers nurse to discuss tuberculosis and the requirement for screening.

***For Individuals Who Receive Services***

**Centers Nurses will:**

- Upon admission and annually:
  - provide explanation and information regarding/concerning tuberculosis testing
  - place the test (purified protein derivative – PPD) under the skin of the individual
  - document on medication administration record (MAR)
  - read result within 48 and 72 hours
  - document result of test on the MAR
- Provide results to other agencies the individual is affiliated with, who require TB testing.
- If the initial test result is positive for exposure to TB – using the Health Department standard for individuals living in congregate care settings - the following process will occur:

**The Health Care Director/designee will:**

- Re-read result to confirm positive result
- If confirmed as positive, call Primary Care Physician (PCP)

**The Primary Care Physician will:**

- Order a chest x-ray
  - Yearly screenings will no longer be done, as it is understood any future PPD test will read positive.
- Review results from chest x-ray for active TB
- If determined that person does *not* have *active TB* >
  - Order periodic chest x-rays (as Health Department prescribes for congregated living.)
- If determined that the person has *active TB* >
  - Prescribe medication or other treatment as warranted
  - Provide follow-up as warranted.

For Staff

**Centers Nurses will:**

- Provide information on tuberculosis with regards to the rationale for the screening, that screening is done annually and the responsibility of all staff to fulfill this requirement.
- Place the test (purified protein derivative – PPD) under the skin of the individual
- Provide written instructions on proper reading of result of test – To be done between 48 and 72 hours.

- ❖ Record result and information will be placed and maintained in medical records of Human Resources Department.
- ❖ Provide annual testing for as long as the staff member is associated with the agency.
- ❖ If the initial test result is positive for exposure to TB – using the Health Department standard for health care workers - the following process will occur:

**The Health Care Director/designee will:**

- ❖ Re-read result to confirm positive result
- ❖ If confirmed as positive:
    - o obtain script for individual from Medical Director for chest x-ray

  or
    - o refer staff member to her/his Primary Care Physician (PCP)
- ❖ Inform staff member s/he may not work until results of chest x-ray have been received, reviewed by the Medical Director/designee or PCP, and determined result is negative for active TB
- ❖ If staff member is non-active for TB, obtain periodic scripts for chest x-ray for staff member and ensure staff member follows through.
    - o Yearly screenings will no longer be done, as it is understood any future PPD test will read positive.
- ❖ If at any point the staff member tests positive for active TB, have staff member follow-up with PCP or Health Department and provide results and note that s/he poses no risk for exposing other individuals and is clear to work

**Staff Member will:**

- ❖ Fulfill all responsibilities and requirements as described above
- ❖ Not work until any follow-up testing necessary, after the initial testing, is completed and results are negative for exposure risk and provided to Centers Nurse.

## HUMAN IMMUNE-DEFICIENCY VIRUS (HIV)
## ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

**POLICY**

Residential Services is committed to ensuring confidentiality with regards to all medical and personal information of individuals receiving services at the Centers. This includes ensuring the confidentiality of information concerning an individual admitted for service or any party proposed for admission who has been the subject of an HIV related test; has HIV infection, HIV related illness or AIDS; and including information indicating a person's potential exposure to HIV.

**GUIDELINES**

- It is understood that HIV related information specific to an individual may be necessary to maintain to provide continual care and treatment to an individual specific to their HIV status.
- When such information is necessary to maintain, it will be secured in a locked file by the Health Care Director (HCD).
- ***No HIV related information will be included in an individual's medical chart.***
- Training will be provided to all staff members providing direct service that includes exposure to infectious diseases. This training will be on Infection Control and annual updates/reviews will be completed with these same staff members. Documentation of trainings and reviews will be maintained in a staff member's training file.
- At times, if there is possible exposure of an infectious disease to a service recipient or staff member the following will occur:
    1. appropriate incident report will be completed by staff member;
    2. prompt visit to a doctor or emergency room for evaluation (for staff: as s/he desires);
    3. any/all testing is voluntary and the individual must sign that s/he is agreeing to testing;
    4. necessary follow-up will be determined by the health department and hospital/doctor office's guidelines.
- Subsequent to a person's doctor/hospital visit, information provided ***only*** to the HCD, regarding a service recipient, will only be on a 'needs to know basis'.
- Determination and specifics of information provided to staff members will be determined by the HCD.

**REFERENCE**: Part 633.19 regulations for further information.

Racker
Residential Services

**~ Medical Order of Life Sustaining Treatment (MOLST) ~**

**POLICY**
Racker's Residential program is committed to ensuring the rights of all individuals. An individual's rights include the right to be involved in decisions about his/ her health care – including decisions regarding medical life sustaining treatment. When someone is not able to make decisions about one's health care, s/he has the right to have a Health Care Proxy or physician to act in her/ his best interest.

** Consent to a DNR/ DNI order does not constitute consent to withdraw or withhold medical treatment other than cardiopulmonary resuscitation (CPR) and intubation.*
*** DNR and DNI orders are separate orders, but may be on one form. Below when referring to DNR/ DNI it should be interpreted as either or both*

**DEFINITIONS**
*Life Sustaining Treatment* may include: DNR's, DNI's, treatment guidelines, instructions for mechanical ventilation, future hospitalizations, artificial fluid and nutrition, antibiotics, or other instructions about treatments such as dialysis, infusion, etc.

**GUIDELINES**
- To provide direction on treatment care that reflect individuals' wishes, Racker utilizes a MOLST (Medical Order of Life Sustaining Treatment).
- MOLST's are recognized both in the hospital and in community settings – it is a universal order.
- MOLST will provide direction on DNR's and DNI's, as well as any other medical orders for life sustaining direction. See attached form for further information.
- Instances when various areas on a MOLST may be considered/ established include, but are not limited to:
  - Terminal condition
  - Person is permanently unconscious
  - Resuscitation would be medically futile
  - Resuscitation would impose an extraordinary burden on the individual in light of the individual's medical condition and the expected outcome of resuscitation for the individual.
- **The initial conversation** about the possible need for a MOLST may come up in any setting at any time.
  - Conversations about a MOLST should ALWAYS include the person and/ or her/ his parent/ guardian.
- **Establishment of a MOLST** will be accomplished using the following guide:
  - If an individual is 18 years of age or older and has capacity to understand the right to accept or refuse medical treatment including life-sustaining treatment, the individual may make a decision about having a MOLST (including DNR/ DNI order).
  - If an individual is *over 18* years of age and lacks capacity to understand the right to accept or refuse medical treatment including life-sustaining treatment, a Health Care Proxy or SDMC (if no Health Care Proxy is established) may make a decision about the MOLST order.
  - If an individual is *less than 18* years of age, s/he may *not* make a decision about a MOLST order. In this situation, his/ her parent/ guardian or SDMC (if no parent/ guardian is available) may make a decision about a MOLST.
- **Prior to providing consent for a MOLST**, the attending physician must provide the person giving the consent, information about the person's diagnosis, prognosis, risks, and benefits of CPR and the consequences of a DNR.
- **NOTE:** Prior to initiating a MOLST form, individuals who reside in an OPWDD certified setting, must have a 'MOLST Legal Requirements *Checklist* for Individuals with Developmental Disabilities' completed by two physicians (See attached form).

- This must also be signed by a licensed psychologist with proper credentials, who has assessed the individual for capacity to understand health care decisions.
- Either the attending physician or the concurring physician or licensed psychologist must:
  a) be employed by a DDSO;
  b) have been employed for at least 2 years in a facility or program operated, licensed or authorized by OPWDD; or
  c) have been approved by the commissioner of OPWDD as either possessing specialized training or have 3 years experience in providing services to individuals with DD.
- On the checklist form there are instructions for the physician to notify the family, MHLS, and Racker (the Residential Health Care Director is the designated person to receive this) of the MOLST checklist.
  a) This needs to be distributed to these parties ASAP
  b) The parties each have 48 hours to review and make a determination if they will agree to or object to the elections.
  c) The parties each send a letter to the physician with their individual determination.
  d) If everyone agrees, the MOLST is then implemented.
  e) If anyone disagrees, there is further conversation until an agreement is made by all parties on the MOLST checklist (i.e., all the individual components of the MOLST checklist.)
  f) The checklist is then updated reflecting final agreement.

❖ After the checklist is completed and agreed upon, the MOLST order is written.
- The MOLST order MUST follow what is agreed upon in the final MOLST checklist form.

❖ Review of the MOLST will be completed by a physician minimally every three months until it is no longer considered desired or necessary.

❖ Termination or revocation of a MOLST may occur at any time and the decision for such, needs to come from:
  a) the individual (or Health Care Proxy, if established and necessary)
  b) a court order

*and* must be in writing with the involvement of a physician.

❖ The Residential Health Care Director will be informed of any MOLST in place (for Residential).

**PROCEDURE**

❖ Establishment and specifics of a MOLST must be communicated to all *Racker* staff who are providing services to the individual.

*Racker* staff will:

❖ Abide by the decision and instruction of MOLST's whenever they are in place.

❖ Residential management and nursing staff will provide staff with clarifications regarding the MOLST and other necessary supports (educationally, processing, etc.) while a MOLST is in place.

**The information is based on the following references:**

**14NYCRR 633.18**
**Surrogate Court Procedure Act Section 1750-B**
**Public Health Law Section 2981 - Appointment of health care agent; HCP**
**Mental Health Legal Services (MHLS)**
- **MHLS's flowchart for: "Who can Provide or Withhold Consent for Routine and Major Medical Treatment for this Adult Hospital patient"**
- **MHLS's flowchart for: "Who Can Consent to the Witholding/ Withdrawl of Life-Sustaining Treatment forAdutl Hosptial Patient"**

**OPWDD's "Health Care Choices: Who Can Decide?" publication (February 2012)**

# HEALTH CARE PROXY

**POLICY**

Residential Services is committed to ensuring the rights of all individuals. An individual's rights include the right to be involved in decisions about his/her health care – including establishing a Health Care Proxy for one's self. The individual is also entitled to have someone, such as a service coordinator, assist in coordinating the establishment of a Health Care Proxy.

**GUIDELINES**

- Information is available for all individuals who receive services in Residential, regarding Health Care Proxies. Information will include:
  - What is a Health Care Proxy (HCP);
  - How to establish a Health Care Proxy and the HCP form;
  - To what extent a Health Care Proxy may make decisions regarding one's health (including restrictions);
  - When a Health Care Proxy is expected to make decisions regarding one's health.

- A representative from the Agency, OMRDD, or the individual's physician may not:
  - Become a HCP for an individual receiving services;
  - Sign as witness on HCP (unless someone outside the agency is co-signing).
  - [There are stipulations regarding who the other witness must be – reference 633.20.]

- FRC must:
  - Assist the individual with establishing a HCP, as desired/requested/necessary;
  - Maintain a copy of the HCP;
  - Ensure the individual's HCP information is provided to Health Care agencies, as needed;
  - Support the process and establishment of a HCP.

**REFERENCE**: Part 633.20 regulations for further information.

## AUDITING

The following is Residential Services' internal documentation auditing procedure.

I. ISP Review
   a. Upon receipt of an ISP, the Team Director completes the ISP Review Checklist.
      i. If all elements of ISP are present, the Team Director files the ISP in the individual's chart.
      ii. If signatures are missing with no notation from the MSC the Team Director sends the MSC the Signature Request Letter and attaches a copy to the ISP and files ISP with attachment in the individual's chart.
      iii. If any other element is missing, the Team Director contacts the MSC to request the required information.

II. ODP Review
   a. When an ODP is completed the ODF completes the ODP Status Report indicating its completion as well as attesting to the completion of the required ODP elements.
   b. The ODP Status Report is forwarded to the Regional Director and the Program Director. The Regional Director is responsible to ensure that the document is completed and that the ODP was completed in the required timeframe.
   c. The ODF team conducts a quarterly Peer Review of the ODP's, Service Notes and Monthly Reports using the Peer Review Form. Every quarter an ODF is assigned 2 charts to review by the Peer Review Coordinator. The Peer Review Coordinator receives all Peer Review Forms.

III. Billing Review
   a. The Team Director reviews the IRA Res Hab Daily Checklist and indicates the appropriate unit of service to bill.
   b. The Finance Department is sent the IRA Res Hab Daily Checklist and the HCBS Waiver Summary to confirm that service provision documentation is present to support billing.
   c. Quarterly the Residential Audit Team conducts an audit of 1-2 charts in every IRA using the Billing Audit Form. Copies of the form are sent to the Team Director, Director of Standards, Residential Audit Team Coordinator and the Regional Director.
   d. Regional Director will submit Plan of Correction to the Residential Program Director, Director of Standards and the Residential Audit Team Coordinator within 1 week of the audit.

IV. Complete File Review
   a. Semi-Annually the Team Director or their designee complete the Quarterly Review Checklist for each Chart in the IRA to best ensure all required documents are up-to-date and filed correctly.

## PROGRAM EVALUATIONS

**PRACTICE:**
Residential Services will conduct satisfaction surveys with individuals receiving services, as appropriate, on a periodic basis. Surveys will vary in methods - written format, phone calls, face to face interviews. Surveys will also be conducted with respective family members/advocates of the individuals. These surveys will seek information on how the individuals and their families perceive the *quality* of the services provided.

Returned surveys will be compiled and summarized. Summaries of the information gathered will be presented to respective program administrators/supervisors, the Agency's Board, and people who responded to the surveys.

It will be the responsibility of the Director/Team Director from each program to carefully review and provide follow-up to *any and all* questions/concerns/feedback provided in the surveys. This follow-up may vary in degree or specificity, but should directly address any and all questions/concerns/feedback given in the surveys as well as provide for the overall enhancement of services.

## APPROVAL OF RESEARCH PROJECTS

**PROCESS**

Residential Services considers research projects which may have direct benefits for the individuals it serves.

In rare instances, research projects might have indirect and long-term benefits in the field of developmental disabilities and therefore may be given consideration.

Research projects entertained by Residential Services are divided into two categories:

- Category I research projects are those which propose direct involvement of individuals with developmental disabilities and/or access to clinical records.
- Category II research projects are those that include literature search and analyzing, program evaluation studies, participation of staff in questionnaire surveys, interviews, completion of paper and pencil tests and other instrumental tasks.

❖ The Director of Residential Services will be responsible for:

- Seeking approval from the Executive Director;
- Ensuring regulatory requirements are met (Mental Hygiene, OMR, HIPAA, etc.);
- The initial and continuing review and monitoring of research project;
- Ensure consent procedures are followed;
- Submitting results to Executive Director.

## PREVENTIVE MAINTENANCE

Routine checks are done in each house to ensure the proper accessibility, functioning, and reliability of various systems in the houses.

**PROCEDURE**

**Facility Services will ensure:**

1. Ensures quarterly checks for annual fire system checks are completed by local vendor.
2. Maintenance furnace checks
3. Change smoke detector batteries
4. Service fire extinguishers as needed
5. General review of houses' needs

**The Team Director will ensure**:

1. Routine preventive maintenance checks are completed as directed. These checks include:
    - Water temperature - not to exceed 110 degrees
    - Quarterly smoke detector tests
    - Sprinkler system checks
    - Parker tub checks
    - Emergency light checks
    - Dryer check vent
    - GFI checks (outlet checks)
    - Pull box resets
    - 18 inch clearance around sprinklers
    - Check that all exits are clear
    - Emergency Supply checks
    - Bed checks and bed rail checks
    - General site inspection of house
    - Vehicle inspections and registrations
    - General vehicle checks
    - Vehicle maintenance: oil changes, tire rotation
2. All checks are documented and logs of such are on file.

## REPAIRS (HEATING, PLUMBING OR ELECTRIC)

**PROCEDURE**

Upon discovery of non-functioning items or systems requiring maintenance services:

**The Staff will:**

1. Note a non-functioning or malfunctioning system or appliance;
2. Visually inspect system to see if malfunction cause can be determined;
3. Take corrective action if appropriate, i.e., plunge toilet, replace bulb, etc.;
4. If repair cannot be resolved and *prompt attention is necessary*, report malfunction to Team Director/AOC;
5. If immediate resolution is not necessary and *can wait* until next business day, leave message/note for Team Director.

**The Team Director/AOC will:**

1. Provide direction on how to resolve concern;
2. If correction cannot be made, call Facility Services at (607)272-5891 during weekdays, or cell phone number 227-1722 nights and weekends. If not at home leave message and phone RRD as well.
3. Ensure needs of individuals continue to be met.
4. If situation is not possible to be resolved in a reasonable time and the individuals need alternative shelter, seek guidance from RRD.

**The Residential Regional Director will:**

1. Refer to ***Emergency Response Plans*** for relocating.

## *Now which form do I fill out?????*

First > Whenever a Reportable Incident occurs, notification to the Justice Center & OPWDD should occur immediately. A staff member may consult with a supervisor prior to contacting the Justice Center or OPWDD for guidance. Note: The Justice Center will make an entry into IRMA to initiate the documentation process.

Second > If not done already, after contacting the Justice Center or OPWDD, the staff member ***must*** contact a supervisor whenever a Reportable Incident occurs.

Third > Whenever a Notable Occurrence (minor or serious) occurs, the staff member ***must*** notify a supervisor immediately.

Fourth > The staff member ***must*** then <u>thoroughly</u> complete and sign and date one of the two forms listed below (or both forms in cases of vehicle accidents) and submit it to a supervisor:

**Event to Consider (ETC) form:**

1. Destruction of Property
2. One per vehicle accident
3. Aggressive Behavior requiring physical intervention
4. Suicidal Ideation (accompanied by lethality assessment) – *when assessment reveals significant potential* (i.e., a plan and means to carry out plan)
5. Sensitive *community* situation –may include those that involve emergency personnel or occurrences in the community that may compromise someone's dignity or well-being
6. <u>And,</u> for initial information of <u>*any*</u> *Reportable Incident (Allegation of Abuse* or *Significant Incident)* or *Notable Occurrence (Serious or Minor), unless an FBI is more appropriate (see FBI list)*
7. Any event of a sensitive nature that occurs ***<u>not</u>*** under the auspices of the agency.
8. Otherwise requested to do so by supervisor or AOC or other administrator.

**Fall, Bruise, Injury (FBI) form:**

1. For ***<u>all</u>*** falls (no exceptions)
2. One for each individual in a vehicle accident
3. Choking that requires an intervention
4. Bruises and other injuries requiring ***more than*** *basic first aid*
5. AOC's/ NOC's to complete, *as necessary*, per Protocol for Potential Physical Trauma
6. Otherwise requested to do so by a nurse, NOC, supervisor, or AOC, or other administrator.

**Suicide Risk Assessment form:**
***<u>Every time</u>*** someone states s/he is going to commit suicide – *regardless of* whether or not you believe her/ him.

**Supervisors' Responsibilities**:

1. If a Reportable Incident was reported to the Justice Center, the Justice Center initiates the documentation into IRMA. Within 24 hours the supervisor will need log into IRMA and complete initial information that program has obtained including providing updates to what the JC had entered into IRMA.
2. Ensure notification has also been made to OPWDD.
3. Initial notification to OPWDD regarding *Serious* Notable Occurrences should be communicated via e-mail @ OPWDD.Incident.Notifications@opwdd.ny.gov.
4. Initial notification to OPWDD regarding *Minor* Notable Occurrences may be completed by entering information into IRMA within 48 hours.
5. Sensitive Situations occurring outside the auspices of the agency should be entered into IRMA under '625' tab.

***Commonly asked questions or confusing dilemmas:***

*A. What if the person has an injury that doesn't require more than basic first aid and they didn't get it from falling?*

**Answer:** Write the info. in the person's medical notes. These notes are *not just for nurses* to write in!

*B. What is considered more than basic first aid?*

**Answer:** Anything that is more than we can do at home – such as (but not limited to) stitches, a cast, prescribing an anti-biotic, hospitalization.

*C. What do I complete if Mary hits Jack and Jack gets hurt and needs stitches?*

**Answer:** Write an ETC on Mary and an FBI on Jack – Please be sure to use full names of both parties on the ETC form so that there is a clear picture to the reader of what occurred and who did what. Also, contact the RRD to assess if this rises to level of Significant Incident (conduct between individuals receiving services).

*D. Well, he just fell playing basketball. It's to be expected.*

**Answer:** An FBI form needs to be completed for every fall.

*E. What happens if the person has a Support Plan and I had to physically intervene with an intermediate or restrictive SCIP-r technique.*

**Answer:** An ETC needs to be completed ***every time*** there is an intermediate or '*restrictive*' physical intervention, whether there is a Support Plan in place or not. This is to ensure the safety and well-being of the person after the technique is used. Also, if technique is classified as a 'restrictive

intervention' information will need to be entered into IRMA under 'RIA' for– see QE or an RRD for specifics.

*F. Do I ever need to write both an ETC and FBI for the same thing?*

**Answer:** Not typically – see the following exceptions. You do not need to double document the same thing.

a. Consider question C above. Technically in example 'C' there are `two situations which occurred – an action by one person, that needs documenting;, and an injury sustained by another person that needs to be documented.
b. Vehicle accidents. An ETC should be completed for the accident itself and an FBI for each person in the vehicle (whether or not they have an injury)

*G. What do I do with the form(s) once I fill it/them out?*

**Answer:**

Submit all ETC's and FBI's to your immediate supervisor.

For all **ETC's** –

a. RRD should review to understand event; and ensure accuracy and thoroughness of the form's completion;
b. *if they lead to* a Reportable Incident or Notable Occurrence (Serious or Minor) scan and email a copy to QEIncidents@rackercenters.org
c. *if they are just ETC's*, originals stay in the house's ETC notebook or file, then go into the respective individual's personal file.
d. Put all ETC's in electronic shared folder under respective house:
   **Shared folders>Quality Enhancement>QE and OMRSRCsubcom>ETC's…**

For all **FBI** forms –

a. copies go to Cathe (Health Care Director)– always – after the nurse at the house has reviewed them.
b. *if they lead to a Reportable Incident or Notable Occurrence (Serious or Minor)* provide QEIncidents with electronic copy as well, after the nurse has entered their notes.

*H. What happens if someone has a series of situations/ incidents over the course of a shift? Do I need to complete a ETC for each situation?*

**Answer:**

- If the person involved is not able to really deescalate and relax and the situations all seem to be interconnected, only one ETC needs to be

completed, but should reflect the entire time frame the situation(s) have been occurring.

- If the situations do not seem interconnected in any way and are actually an hour or two or more apart, yes, write separate ETC's.

*I. What happens if I receive a call from another agency that someone has been hurt, allegedly abused, etc. <u>in that other program</u>?*

**Answer:** Notify your respective Director right away and complete an FBI or ETC (whichever is appropriate) as documentation of the situation called in. Have a nursing assessment completed if any injury is reported, alleged, observed, or possible. The Director will be in contact with the other agency for further information and follow-up.

Resources for further information regarding Residential Incident Management processes:

1. Policy & Procedure: *Incident Management for Under the Auspices of the Agency* – may be found on intranet
2. Policy & Procedure: *Events & Situations (that occur) <u>Not</u> Under the Auspices of the Agency* – may be found on intranet
3. *Regulation 624 Reporting Requirements/ Time Frames – Guide* – may be found on intranet
4. Contacting:
    *a.* Sue Budney @ 272-5891 ext. 249 or cell ph. @ 738-5797 or sueb@rackercenters.org
    *b.* Jessica Jones @ 272-5891 ext. 206 or jessicaj@rackercenters.org
    *c.* David Williams @ 272-5891 ext. 218 or davidw@rackercenters.org
    *d.* Frank White @ 272-5891 ext. 380 or frankw@rackercenters.org
    *e.* Cortney Baker @ 687-0678 ext. 424 or cortneyb@rackercenters.org

# Event to Consider (ETC)

| **Person:** | | **Date of Event:** | **Time of Event:** |
|---|---|---|---|
| # of Staff Present: | # of Others Present: | Name of Nurse Notified: Date: Time: | |
| **How was the safety and welfare of the individual immediately ensured?** | | | |
| Name of Supervisor Notified: | | | Date: |
| Location of ETC/ **include primary residence**: | | | |

| Description of Event: include **antecedents/behavior/consequence** and all involved: | | | |
|---|---|---|---|
| Print Name of Person Completing: | **SIGNATURE:** | Title: | Date: |

| Staff Health Assessment (of person receiving services): | | | |
|---|---|---|---|
| Print Name of Person Completing Section: | **SIGNATURE:** | Title: | Date: |

**Person's Name:**_____**Date/ time of event:**_____

**NURSING COMMENTS (RN)**

**NURSE'S SIGNATURE:** **Date:**

**SUPERVISOR COMMENTS/ FINDINGS/ FOLLOW-UP/ RECOMMENDATIONS**

Is there a protocol that pertains to this ETC? Y ◯ N ◯
If yes, was the protocol followed? Y ◯ N ◯
If no, explain:

Does this person have a Behavior Support Plan, Monitoring Plan, or Behavior Support Guidelines? Y ◯ N ◯
If yes, was the plan followed? Y ◯ N ◯
If no, explain:

When was _____, Behavior Specialist notified? Date: _____ time: _____

If the situation occurred in the community, was Community Relations notified? Y ◯ N ◯
If yes, who was notified and when:

Has the person's safety/ welfare been addressed in accordance to their IPOPO? Y ◯ N ◯
If no, explain:

Reportable Incident? Y ◯ N ◯ category _____

Notable Occurrence? Y ◯ N ◯ category _____

Service Coordinator Notified: by whom: Date:
**[Do NOT send ETC]**

**SUPERVISOR'S SIGNATURE:** **Date:**

*If occurrence rises to level of Reportable Incident or Notable Occurrence >*

Scanned & e-mailed to QEIncidents@rackercenters.org : Date/ Time _____

**FRANZISKA RACKER CENTERS**
**Residential**
**Fall/ Bruise(s) / Injury (FBI form)**

**Please Classify:** **Fall ☐** **Bruise ☐** **Injury ☐**

| Resident's Name: | Date: | Time: AM / PM |
|---|---|---|
| Activity/Location When Noticed: | | Site: |
| Name of Nurse-on-Call Notified: | Direction Given: | |
| Number of Staff Present: | Number of Residents Present: | |
| Origin Known: Yes ___ No___ | | |

| Description and Location of Fall/Bruise/Injury: | ***Please Note: This is in place of a N.O. if more than basic first aid is provided.* |
|---|---|

| First Aid Treatment: | | |
|---|---|---|
| Blood Pressure | Pulse | Respiration |

Print Staff Name: _____ Title: _____

Staff Signature: _____

**THIS SECTION IS TO BE COMPLETED BY SUPERVISOR ON DUTY**

Extrinsic ☐ Intrinsic ☐

Plant Considerations:

Findings:

Supervisor Signature: _____ Date: _____

**sb/QE forms 9/29/09**

| THIS SECTION TO BE COMPLETED BY NURSE-ON-DUTY |
|---|
| Nursing Comments: |
| |
| |
| |

PCP Notified: Yes ☐ No ☐

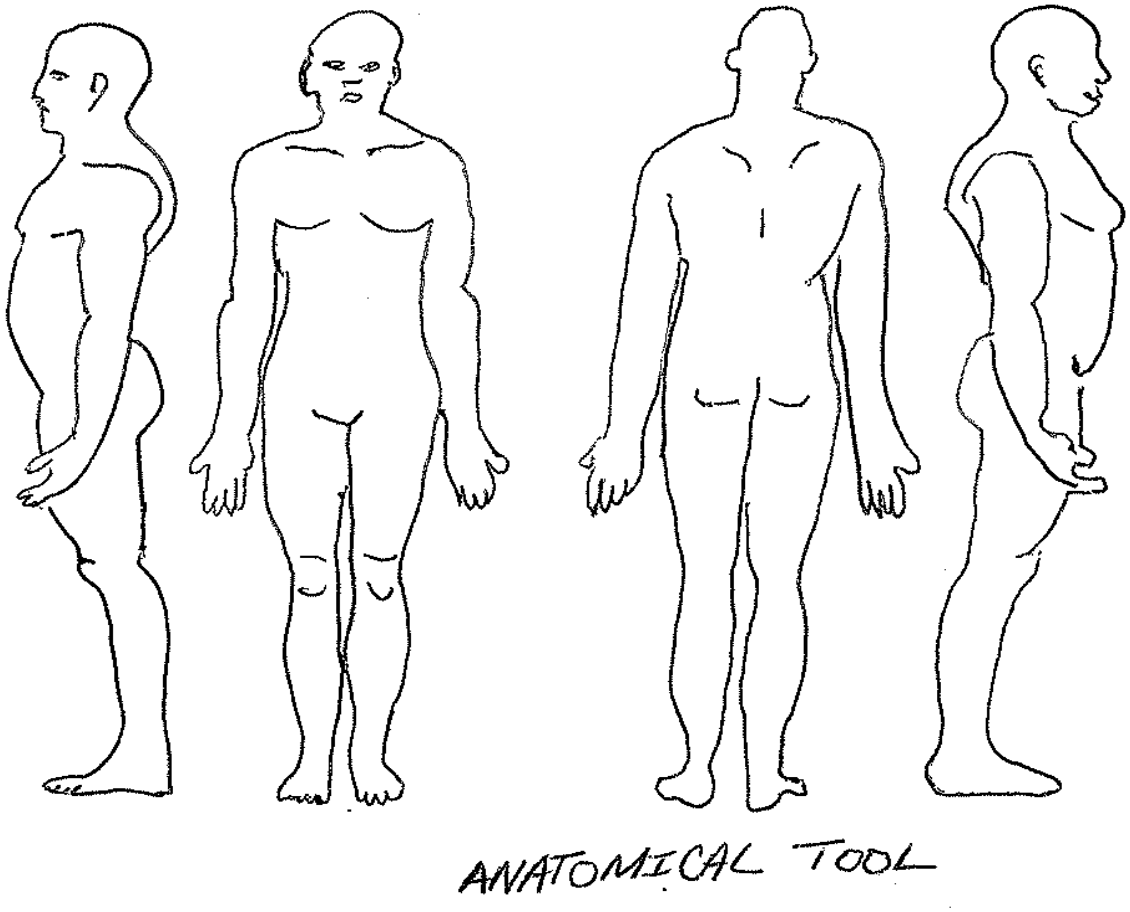
Nurse's Signature: _____ Date: _____

Team Director's Signature: _____ Date: _____

Final Outcome: _____

Nurse's Signature: _____

**ANATOMICAL TOOL**



## Residential – Notification Guide to Timeframes for Incident Management

| Timeframe / Incident/ form | Immediately/ via | Within 24 hours or by end of next business day/ via | Within 48 hours/ via | Within 3 working days/ via | Within 5 working days |
|---|---|---|---|---|---|
| **Events to Consider**<br><br>**ETC form** | ❑ Supervisor or AOC – call<br>❑ Nurse/ NOC – call and provide ETC | ❑ Team Director – original<br>❑ RRD – reviews original<br>❑ Nurse/ NOC –provide original ETC<br>❑ Serv. Coor. – call or e-mail – do ***NOT*** send ETC | ❑ RRD emails Dir. of QE copy only if sensitive/ questionable | XXXXXX | XXXXXXX |
| **Fall/ Bruise/ Injury**<br><br>**F.B.I. form** | ❑ Supervisor or AOC – call<br>❑ Nurse/ NOC – call and provide FBI | ❑ Team Director – original<br>❑ Health Care Director (HCD) – scan and email copy<br>❑ RRD – reviews original | XXXXXX | XXXXXX | XXXXXXX |
| **Minor Notable Occurrence (N.O.)**<br><br>**ETC or FBI and IRMA** | ❑ Supervisor or AOC – call<br>❑ Nurse/ NOC – call, if injury<br>❑ Team Director – call<br>❑ DOC/RRD - call | ❑ RRD – reviews original<br>❑ If injury: Nurse/ NOC – scan and email ETC or FBI<br>Call or e-mail (no form)<br>❑ Serv. Coor.<br>❑ Dir. of Res.<br>❑ QEIncidents@rackercenters.org<br>❑ Q.P. – call* | ❑ Exec. Dir – e-mail<br>❑ OPWDD via IRMA | ❑ QEIncidents@rackercenters.org – scan and email completed ETC or FBI; 24 hour contact | XXXXXXX |
| **Serious Notable Occurrence**<br><br>**ETC or FBI and IRMA** | ❑ Team Director or AOC – call & ETC<br>❑ Nurse/ NOC- call<br>❑ RRD/ DOC – call | ❑ Team Director – originals<br>❑ RRD – originals<br>Call or email (no form)<br>❑ Serv. Coor.<br>❑ Dir. of Res.<br>❑ QEIncidents@rackercenters.org<br>❑ Exec. Dir.<br>❑ Q.P. – call*<br>❑ OPWDD – e-mail & IRMA | XXXXXXX | ❑ QEIncidents@rackercenters.org – scan and email completed ETC or FBI; 24 hour contact | ❑ Update IRMA |
| **Reportable Incident (Allegations of Abuse & Significant Incidents)**<br><br>**ETC *or* FBI and IRMA**<br><br>**Justice Center will initiate IRMA report** | ❑ Team Director or AOC – call & ETC or, if injury, F.B.I<br>❑ Nurse/ NOC, if injury – call and F.B.I.<br>❑ RRD/ DOC – call<br>❑ Justice Center – call (they make initial entry into IRMA)<br>❑ OPWDD – call | ❑ Team Director – originals<br>❑ RRD – originals<br>Call or e-mail (no form)<br>❑ Serv. Coor. –<br>❑ Dir. of Res. – call or e-mail<br>❑ QEIncidents@rackercenters.org – call or e-mail<br>❑ Exec. Dir. – call or e-mail<br>❑ Q.P. – call<br>❑ OPWDD – update IRMA | XXXXXXXX | If ***abuse***,<br>❑ MHLS – Scan and email 147<br>❑ QEIncidents@rackercenters.org – scan and email completed ETC or FBI, 24 hour contact; OPWDD 163(allegations only!) | ❑ Update IRMA |

| | | | | | |
|---|---|---|---|---|---|
| | **If *"Crime"* has been committed *to* person receiving services**<br>**❑ call police** | **❑ *update* IRMA** | | | |
| **Deaths**<br><br>**ETC**<br>***and***<br>**IRMA (as SNO)**<br>**[beware – there is extra tab and submission in IRMA]**<br>***and***<br>**Justice Center** | **❑ Team Director or AOC – call**<br>**❑ Nurse/ NOC**<br>**❑ RRD/ DOC – call**<br>**❑ Dir. of Residential**<br>**❑ OPWDD – call**<br>**❑ Justice Center - call**<br>**❑ HCD – call**<br>**❑ call police (if unattended)**<br>**❑ Coroner (if death is suspicious, unnatural, suicide, homicide, accidental)** | **❑ Team Director – originals**<br>**❑ RRD – originals**<br>**Call or e-mail (no form):**<br>**❑ Serv. Coor.**<br>**❑ QEIncidents@rackercenters.org**<br>**❑ Exec. Dir.**<br>**Call:**<br>**❑Q.P.**<br>**❑ Medical Director**<br><br>**❑ IRMA as S.N.O.** | **XXXXXX** | **XXXXXX** | **❑ Update IRMA** |

**Residential - Regulation 625 Reporting Requirements/ Time Frames**

***Not under the auspices*** (events/ situations that occur when staff are not involved and did not occur under the auspices of a certified (i.e., site based) program)

| **Timeframe** / **Incident/ form** | **Immediately/ via** | **Within 24 hours/ via** | **Within 48 hours/ via** | **Within 3 working days/ via** | **Within 5 working days** |
|---|---|---|---|---|---|
| 625<br>Events and Situations<br><br>ETC *and*<br>IRMA | **If *"Child Abuse"***<br>**❑ NYS Central Registry** | **❑Team Director – originals**<br>**❑RRD – originals**<br>**❑Dir. of Res. – call or e-mail**<br>**❑ QEIncidents@rackercenters.org**<br>**❑ OPWDD - IRMA** | XXXXXXXXX | XXXXXXXXX | ❑ Update IRMA |

Centers' contacts: **Exec. Dir**. – w(ext.221)/ c(279-5350); **Dir. of Res**. – w(ext. 204)/ h(844-9901)/ c(280-6761); **QE** #'s 272-5891 ext. 249; 380; 424; 218 or c(738-5797)

**Justice Center:** (1-855-373-2122); for *deaths* call (1-855-373-2124)
**OPWDD (IMU): between 8:30-4:30 M-F >** Lilly Levkovets (518) 473-8079; if unavailable 1(518)473-7032; after hours (1-888-479-6763)
For Serious Notable Occurrences and highly sensitive 625's send e-mails only @ liliya.x.levkovets@opwdd.ny.gov
**MHLS:** Marge Whispel – mwhispel@nycourts.gov – Only for allegations of Abuse/Neglect
**NYS Central Registry:** 1-800-635-1522 (for allegations reported on people *younger than* age 18 *and not* under the auspices of the agency)

* Q.P. must be contacted within 24 hrs. for all Reportable Incidents (allegations of abuse and significant incidents) *and* all Notable Occurrences (serious and minor).

~ Racker ~

OPWDD & OMH funded programs

**24 hour Notification to Qualified Person**

Post event that warrants filing of an Allegation of Abuse/ Neglect or Significant Incident, involving _____ (individual's name) on _____(date of incident), notification was made to qualified person _____ (Q.P.'s name) on _____ (time & date to be **within 24 hours** of occurrence or discovery). The following items were discussed:

- ❑ description of event (other people's names - staff or individual – should NOT be provided.)
- ❑ status of individual (e.g., outcome of medical assessment)
- ❑ how immediate safety of individual is being ensured
- ❑ offer to have 'sit-down' conversation with Director/ designee
  - o Accepted _____ date of sit down _____
  - o Declined _____
- ❑ follow up information will be given (minimally) via letter, in 10 days: ___(note date)
- ❑ final outcomes will be provided upon conclusion of the review
- ❑ If it is considered a possibility, share that the person (receiving support/ services) may be interviewed during the course of the review ***and*** ask if there are any suggestions the interviewer may use to glean information during the interview.
- ❑ **Contact information of supervisor** (so they may contact someone at any point during the review process.)

_____ _____

signature of Director/ designee date/ time

Times & dates attempted calls –:

_____ _____

_____ _____

_____ _____

**Once completed, the original form should be sent to the Director of Quality Enhancement**

~ Racker ~
OPWDD/ OMH Funded
Programs **Ten-Day** Written
Follow-up

**A ten day letter must be sent to the Qualified Person who was provided the initial 24 hour notification. This letter must be sent ten days after the event occurred or was discovered.**

The format for the ten-day follow-up notice **must** be/ include:

- ❑ In letter format and on agency letterhead
- ❑ Reference to the specific incident (what happened)
- ❑ Reference to the date of the incident
- ❑ Reference that the letter is follow-up to the initial (24 hour) notification made
- ❑ Description of the immediate action(s) taken to ensure the individual's safety
- ❑ Description of the interim plan in place to ensure the continued safety/ well-being of the individual
- ❑ Description of any initial medical and dental treatment or counseling provided to the individual
- ❑ How the individual is currently doing
- ❑ There will be notification of the conclusion of the QE Review process
- ❑ Offer to be contacted if further information is desired – and how to be contacted.

Other items you may want to consider - not all items will fit to every situation:

- ❑ If a particular staff person was allegedly abusive, that staff person is NOT working with the individual. (And, that this is program procedure.) **You should NOT state the specific personnel action taken.**
- ❑ Changes in program that may be necessary for Qualified Person to know, that will effect the individual
- ❑ A brief explanation of the QE Review process. This depends on how familiar a Qualified Person is with the program's procedures.

***Refrain from*:**

- ➢ Phrasing that the letter is being sent because of a law/ regulation. If worded that way it can easily be interpreted that we wouldn't be telling them anything if we weren't told to do so. We need to take 'ownership' of why we are sending the letter.
- ➢ Specifying personnel action taken – i.e., 'staff has be placed on paid administrative leave', 'staff has been terminated.' It suffices to let them know of the actual effect from a personnel action, such as "the staff member is currently not working with your 'daughter, son,' whomever.
- ➢ Using other peoples' names – of individuals or other staff.

## A copy of the ten-day letter should promptly be sent to the Director of QE

Residential Program

# Time line of Reporting, Documenting, Follow up to Incident Management

**Immediately**

1. Notify Executive Dir. of Reportables and Serious N.O's – e-mail is acceptable
2. Notify OPWDD for Reportable Incidents and Serious N.O.'s
    a. Phone call for Reportables
    b. Phone call or e-mail for SNO's
3. Deaths of people in certified settings
    a. Immediate notification to JC
    b. [Deaths are filed as SNO's with OPWDD]

**<u>Within</u> 24 hours (*no later than*)**

1. Notify Q.P.'s (no later than 24 hours)
2. Notify police regarding crime *against* a person – pg 29
3. Service Coordinator notification of all Reportables and all N.O's after entry into IRMA – pg 32

**Within 24 hours or by end of next workday** (using State's holiday calendar – *not* Racker's)

1. Update info in IRMA for Reportables, Deaths, and S.N.O.'s within 24 hours or end of next working day – whichever is later – pg 17
    a. Include Info about implementation of immediate protections – pg 17

**Within 48 hours**

1. Notify Executive Dir. of Minor Notable Occurrences
2. Enter Minor N.O.'s into IRMA

**Within 3 working days – pg. 28**

1. Notification to MHLS within three ***working*** days for allegations of abuse/ neglect (**<u>NOT</u>** SI's)

**Within 5 working days**

2. Subsequent info (any updates) into IRMA within five working days – pg. 17
3. Deaths – Subsequent info (updates) into IRMA – pg. 17
    a. JC will receive this update via IRMA

**Within 10 working days – pg 32**

1. Send Ten day letters to Q.P.'s

**Within 30 days**

1. Investigations must be completed within thirty days
2. Investigation info into IRMA after report is completed. Pg 25
    a. Typically this is in the form of Review Panel or SRC minutes
3. QE enters Investigations info into IRMA after report is completed.

**Within 10 days after investigation report is complete**

1. Within ten days after completion of investigation of an allegation of abuse/neglect, the agency shall develop and implement plan of protection and remediation – pg 24
    a. Needs to include written endorsement by CEO or designee

2. Within 10 days after completion of an investigation, service coordinator needs written info re: investigation conclusions and recommendations *pertaining to person's care, protection, and treatment:* NOT personnel issues/ determinations; program actions. – pg. 34

**Within 5 days after development of plan of protection and remediation for allegations**

1. Enter plan into IRMA – pg 31

**Within 30 days after investigation report is complete**

1. Review Panel or SRC Review must occur – pg. 34
2. Reporting updates in IRMA every thirty days *incident* is open. Pg. 33
    a. For Significant Incidents & Serious Notable Occurrences
        i. An incident is closed once the SRC determines no further investigation is necessary.
        ii. Final closure may occur with Q.P. at this point
    b. For Allegations of Abuse/ Neglect
        i. If agency investigates, an incident is closed once the LOD is received from the JC
        ii. If the JC investigates, the incident is closed once the LOD is received.
        **iii. NOTE: *The JC* will provide final closure, regardless of who completed the investigation.**

**Within 3 weeks after SRC –pg. 34**

1. Three weeks after SRC *additional* findings, conclusions, and recommendations re: person's care, protection and treatment must be provided to service coordinator in written form
    a. If no additional findings, conclusions, recommendations re: person's care, etc. – then no additional follow up needs to be provided to service coordinator.

**IRMA Entries of SRC minutes within three weeks after meeting.** Include in minutes:

1. Identification code
2. Full names of all parties – not initials

**Within 50 days – pg 26**

1. Final reports to VPCR within 50 days for Allegations of Abuse/ Neglect;

**Within 60 days – pg 26**

1. Deaths - Results of autopsy within 60 days (of death to JC)
2. Final reports to IRMA within 60 days for Significant Incidents

**Within 90 Days**

1. Respond to JC recommendations in writing within 90 days to recommendations the JC has made.

Suicides, homicides, accidental deaths, suspicious deaths, unusual or unnatural causes – all to be reported to coroner

Copy of requested initial incident report to requestor within ten days of request
Copy of requested investigations report to requestor within 21 days of request

# Suicide Risk Assessment

INDIVIDUAL: _____ DATE: _____

When a resident makes a statement that they want to kill themselves, it must be taken seriously. Don't automatically dismiss the statement as an attempt to get attention. Speak with and assess the individual to determine if they are truly wishing to hurt or kill themselves or if they are feeling some strong emotions about something and do not know how to more accurately express them. Monitor your own reaction-remain calm and don't overreact. Do not be afraid to ask about their statement. For example, you can ask, "Are you feeling so bad that you're thinking of suicide/killing yourself?" If the answer is yes, follow through with further questions "Have you thought how you'd do it?" "Have you decided when you do it?" The following should be watched for when assessing potential risk:

| | YES | NO |
|---|---|---|
| PLAN- Does the individual have a plan to hurt or kill themselves? (Are they able to tell you how and when?) | ☐ | ☐ |
| LETHALITY- Is the plan lethal? Can they die? | ☐ | ☐ |
| AVAILABILITY- Do they have the means to carry out the plan? | ☐ | ☐ |
| EMOTIONAL STATE- Is the person sad, withdrawn, irritable, anxious apathetic, unusually tired? | ☐ | ☐ |
| PREVIOUS ATTEMPTS- Has the individual tried to kill themselves in the past? How recently? How many times? | ☐ | ☐ |
| LOSS- Have they suffered a recent loss through death, separation from family or significant other, loss of job, loss of interest in friends, hobbies, activities previously enjoyed, loss of self-esteem? | ☐ | ☐ |
| FUTURE- Does the person seem to have no hope for the future, believing things will never get better? (Or is the person able to talk and plan for future events, activities or trips?) | ☐ | ☐ |
| IMPULSIVITY- Does the person seem to be unusually reactive or impulsive? Is the person giving away prized possessions? | ☐ | ☐ |
| SUBJECTIVE ASSESSMENT- Are you uncertain that you will see this person tomorrow? Your gut reaction may fill in the gaps left by the object assessment and should not be ignored. | ☐ | ☐ |

If your assessment leaves you feeling the risk of suicide is high or that you are unsure about the individual's intentions, **immediately** call the nurse-on-call. Notify the psychologist by the next working day. The individual should remain within your field of vision until a decision is made about further action or until it is determined that the person is not at risk for harm.

If your assessment leads you to conclude that the individual does not intend to harm themselves, try to determine what is bothering them and work together to come up with possible solutions.

Staff Signature: _____ Date: _____

# "Show Me the Money"

**Personal Allowance**

- Personal allowance for an individual is a portion of an individual's income which is made available on a monthly basis to every person which is intended for the personal expenditure by an individual.
- Personal Allowance Amount is determined by the person's benefit eligibility. Exact amounts may be found on each person's current annual admission agreement.
    - Per 633.15(k)(3) – Personal allowance must be credited to the appropriate persons account within ***three working days*** of receipt.
    - *These funds are electronically deposited to the appropriate persons account by the third of every month.*
    - Bank accounts must be interest bearing.
    - If a person has a representative payee other than FRC, the rep-payee will receive the P.A. in the same time frame.
    - Team Directors are to check the appropriate persons account for verification of funds.
- Wherever possible, individuals will have the opportunity to learn to handle their own funds. **Personal Expenditure Plans (PEP's)** are created for each individual. 633.15(j).
- Funds may be disbursed to parents or family members to either help defray costs of taking the individual for visits to their homes.
- The amount of disbursement to a parent or family member to provide spending money while an individual is at their home should not cause undue hardship to the individual based on her/his monthly income and accumulated balance.

**Clothing Allowance**

- Clothing Allowance is $125 twice per year for a total of $250.
    - Per Section 41.36n of the Mental Hygiene Law (from 1/7/97 memo) – This may be used for:
        - Replacement of necessary clothing
        - Personal requirements and incidental needs
        - Recreational and cultural activities
    - The FRC business office will notify the Team Directors via e-mail when the Clothing Allowance Debit Cards arrive. The Debit Cards will be issued to the Franziska Racker Centers but paperwork accompanying the cards will identify the individual's name, which may be transferred to the card with a permanent marker.
    - The Team Directors will arrange with the individual when and how they wish to spend the funds depending on the needs of the individual.
    - The Team Director will use the Debit Card for the purchase of these items for the individual.

***Please Note: These semi-annual funds do not belong to the person, must not appear anywhere in the personal allowance ledger (Resident financial ledger), and must not be co-mingled with the person's own funds. The funds should not be given to a parent, family member, friend or any other not employed by FRC, despite the good intentions they may have.***

- A separate Clothing Allowance Ledger must be used to track how this money is spent with all receipts attached (photocopied receipts). The Clothing Allowance Ledgers are maintained at the house w/ each of the individuals' Resident Account Ledgers.
- The individual must spend the Clothing Allowance of $125 within six months of receipt of the notification from the Business Office when the funds first arrived.

  ***Please Note: If an individual does not spend the $125 prior to the next six-month period, the individual will <u>not</u> be eligible to receive the next $125 clothing allowance.***
- Prior to submitting for the Clothing Allowance for each individual, the Program Director will generate and email the Team Directors to verify that clients are eligible for the next payment. Team Directors will verify that the individual has spent the previous amount on appropriate items and will indicate whether or not the individual is eligible.
- A new Clothing Allowance Ledger will be created for every allowance ($125) the individual receives.
- The Residential Regional Directors will review the clothing ledgers semi-annually to ensure the money has been and is being used appropriately.
- Specifics on the eligibility requirements can be obtained from the Director of Quality Enhancement.

**Banking**

- Personal Allowance
  - Bank accounts must be interest bearing.
  - If the person needs an increase in their cash on hand then complete a withdrawal from the savings account.
- Paychecks
  - Paychecks can be deposited into the individuals' savings accounts or cashed by the individual.
  - If the paycheck is cashed the entire amount of the check should be logged into the individual account ledger and a receipt written for any cash given back to the individual. ***<u>(Individual will initial or sign receipt)</u>***
    - Paycheck stubs will be attached to the corresponding month's ledger.
  - If the paycheck is deposited into the person's savings account and an entry needs to be handwritten into the bankbook, the entry of the "paycheck" deposit is to be clearly written.
    - Paycheck stub is to be stapled to the corresponding bank receipt for the deposit.
  - **No split deposits! (I.e., % to savings and a % to cash.)**
  - For individuals who receive Social Security and/or Supplemental Security Income, the Social Security Office needs to receive reports on monthly income the person is earning, if it exceeds $65 a month. Here's how:
    - If a person is employed by a sheltered workshop such as Challenge or JMMC the sheltered workshop will forward the information to Social Security. This includes individuals who are associated with the workshops, but don't necessarily work directly at that location – e.g., someone is employed at Wegmans *but through Challenge.*
    - If someone has independent employment that is not associated with a sheltered workshop, reports of **earned income** (e.g., paychecks) must be submitted to Social Security monthly – responsibility of this task should be

determined between the TD and Service Coordinator. *The individual who is earning the paycheck should be involved in this process!*
        - The business office will notify the Team Director with the current amount owed to Franziska Racker Center due to the individual's earned income exceeding the set limit of the earned income determined by Social Security.
- Deposits/ Withdrawals
    - Deposits and withdrawals must be completed by:
        - *The individual* if they have their own account
        - *Authorized staff* if FRC is the representative payee along with the individual.
    - A receipt should be obtained for *all* deposits and withdrawals. These receipts need to be maintained separately for each individual.
    - It is understood that some banks do not issue deposit/ withdrawal receipts because entries are made directly into bankbooks/passbooks by the bank.
    - As monthly or quarterly bank statements are received, the deposit/ withdrawal receipts or bankbooks/passbooks should be checked against the statement for accuracy & verification. If a discrepancy is found the TD will immediately follow up to resolve the issue and notify their RRD. The withdrawal/deposit receipts are to be stapled to the back of the statement. *Please note: the day that the bank statements are received the TD must initial/date the statements.*
    - Bank statements are to be filed with the respective individual's financial information – and available for audits.
    - If there are any discrepancies discovered they should be resolved *immediately* with the bank!
- Person- Owned Bank Accounts
        - Per 633.15(h)(3) an account that is established at a local financial institution into which some or all of an individual's funds including personal allowance may be deposited, when an agency is managing such personal allowance.
        - Personal allowance may not be moved from an account except to one which reflects the beneficiary's sole ownership in accordance with the PEP.
        - This is to be separate from the agency's account for the person.
        - A person shall exercise independent control of a person –owned account consistent with his/her money management assessment.
        - The use of person-owned account shall not relieve the agency of its responsibility pursuant to the PEP.
        - Funds in a person-owned account are resources of the individual, and such as, the agency shall be responsible for monitoring the account balance to ensure the individual's total resources remain below the applicable resource limit so that the individual's benefits are not reduced.
        - Though highly desirable, person-owned accounts need not be interest bearing.
        - Further information may be obtained from the regulation or the Director of Quality Enhancement.

**Cash on Hand**

- Per 633.15(h)(4)(iii) a person's cash on hand at the residence is not to exceed the minimum personal needs allowance for Congregate Care Level 3 plus $20.00, currently $213 as of 1/1/2015.
    - Any monies not used that result in the cash on hand exceeding $213 are to be returned to the person's savings account as soon as possible. Under no circumstances should the excess be on hand for more than 7 days.
- An individual ledger is to be maintained for each person's cash on hand in the residence.

- Ledgers are to be maintained on the computer
  - The computer will automatically and accurately complete the math
  - A hard copy of the ledger is to be printed out on a *weekly* basis and maintained with the respective person's cash on hand.
  - Do NOT do calculations by hand – UGH!
- Receipts are to be obtained for all purchases made from a person's cash on hand
  - Before departing to make a purchase(s), a staff person must sign a receipt from a receipt book for the exact amount of money they are given.
  - After a purchase is made and staff returns to the residence, the staff person who assisted with the purchase must assist the individual complete the receipt from the receipt book and ensure the correct change is returned to the appropriate supervisor.
  - If a supervisor is not available to distribute funds or receive the change and receipts upon return, the house will have a secure procedure (see 'Security' section) for the money to be obtainable for appropriate staff. These monies (and any receipts) are to be resolved by the Team Director/ designee on the next working day.
  - If an individual maintains some pocket money for personal use (as determined by/with the treatment team), the individual may sign a receipt for it and this suffices for the total amount. The person does not have to obtain further receipts.
  - Per 633.15(i)(6) – individuals who are capable (as determined by/with the treatment team) should also sign either the receipt or ledger to demonstrate *consistently* that they are reviewing their accounts. If an individual refused to sign staff must document that on the receipt/ledger.
  - Receipts should be maintained with the individual's corresponding ledger.
- Write a receipt for **all** cash *deposits* into the individual's cash-on-hand account (same receipt used for cash withdrawals). This includes money withdrawn from the savings account to go into the house account, gift money, and paycheck money. The consumer should initial or sign the receipt if possible.
- A new ledger is begun each new month.
- Balance forward from the previous month will need to go on the top of the new ledger.

**Pre-paid Visa Cards and Gift Cards**

- Per 633.15(h)(4)(iii) a person's cash on hand at the residence is not to exceed $213. This includes if a person has a pre-paid visa card or gift card that carries a cash value. For example, if an individual has a $100 pre-paid Visa card then they would only be permitted to have $113 cash in the house safe equaling $213.
- If an individual has a pre-paid Visa card or has received a gift card that carries a cash value a separate ledger *(indicating the last four digits of the card)* must be used to track all purchases pertaining to that pre-paid Visa card. All receipts from the pre-paid Visa card need to be kept with the ledger for future auditing.
- The individual must spend the total amount on the pre-paid Visa Card before purchasing a new pre-paid Visa Card. Please follow the same process as indicated above. Each pre-paid Visa card has its very own ledger indicating the last four digits of the pre-paid Visa card.
- Pre-paid Visa Card ledgers are to be kept with the individual's monthly ledger for future audits.

- Pre-paid Visa Cards and Gift Cards carrying a cash value are to be secured in the house safe at all times.
- There is no need to maintain a separate electronic ledger for Gift Cards that carry no redeemable cash value or store credit, i.e. restaurant gift cards. However, such cards will be kept in envelopes that will illustrate the cards actual balance.

**ATM/Debit Cards**

- Per 633. 15(h)(4)(iii) a person's cash on hand at the residence is not to exceed $213. This includes if a person has an ATM/Debit Card.
- If an individual chooses to obtain an ATM/Debit Card the individual needs to apply for checking account at their local bank.
- Once they have their new checking account with ATM/Debit Card they may withdraw monies from their savings account to deposit into their checking account. (*It is important to remember that the bulk of the individuals monies (75%) need to remain in the person's savings account due to savings accounts being interest bearing.)* For example, if an individual has $2000 dollars in their savings account and would like to withdrawal monies to deposit into their checking account, the maximum amount they can transfer into their checking account would be $500.
- The only time it's considered appropriate to have more than 25% of an individual's total monies into a checking account is when an individual is making a pre- planned large purchase. *(The day of the pre-planned purchase the individual needs to go to the bank and withdrawal the monies from their savings account and deposit into the checking account).*
- If the individual decides not to make the purchase, the monies need to be returned to their savings account within 48 hours.
- If the individual decides to regularly withdraw monies for their savings and then deposit into their checking account for everyday use, this plan needs to be addressed in the individuals PEP.
- After a purchase is made with the ATM/Debit Card and the individual returns to the residence, the staff person who assisted with the purchase will assist the individual to hand in the store receipt.
- On a weekly basis the Team Director will print off a "print out" of the individuals purchases via online from the individual's bank. The Team Director will attach the receipts to the "print out "and verify that all the receipts are accounted for.
- On a monthly basis the Team Director will close out and print off the final "print out" of the individual's purchases via online from the individual's bank. The Team Director will attach all the receipts from that month to the "print out" and verify that all the receipts are accounted for. The "print out" with attached receipts are to be kept with the individuals monthly ledger for future audits.
- Online Banking – it is not permissible to transfer funds from a savings account to a checking account via online banking due to our program practice of needing two signatures for withdrawals of monies from the individuals account. All withdrawals and deposits need to completed onsite at the individual's bank.
- ATM/Debit card is to be kept in the house safe at all times.

**Security of Funds**

- Individuals' monies are to be maintained in the safe in each residence.
- Accessibility to the safe is to be limited to the Team Director/appropriate designee.

- Direct Support Professionals will have access to a lock box separate than the house safe. The lock box will contain Petty Cash for agency expenses. The lock box will also contain Resident's cash sufficient to cover expenses when there is no access to the safe due to absence of supervisor.
- The secure system should include:
    - a secure location for the funds such as a lockbox that is mounted to a stationary object
    - each resident's cash and Petty Cash will remain separate of each other and a sub-ledger will be maintained for each, no commingling! Sub-ledger need not be electronic and will minimally reflect date withdraw was made, purpose of withdraw, amount of withdraw, transaction total, change returned, current balance available to Direct Support Professional, and initials of person responsible for cash withdrawn.
    - resolution of monies every day by the Team Director for prompt accounting. This will include resolution of sub-ledgered funds.

**Group Purchases**

- When circumstances are such that an item is to be used routinely by a group of individuals over a period of time, the item may be obtained through a group purchase.
- The amount that any one individual contributes must be equal to his/her expected personal use of, or advantage from the group purchase and must be shared by the group accordingly.
- In situations where an individual is not expected to benefit equally from a group purchase, the amount contributed by the individual must be proportionate to his/her personal use of, or advantage from such purchase as described in the request proposal for approval of the group purchase.
- Prior written approval from the director of Residential Services, as subsequently described, is necessary in order to obtain an item through the group purchase procedure.
- Although group purchase items are typically expensive, cost is not the critical factor in determining the need for a group purchase. An item may be obtained through a group purchase if:
    1. It is to be routinely used for the benefit of two of more individuals who contribute to the cost based on each individual's expected use; and
    2. It is not expected to be used or consumed in less than 24 hours (e.g., most foods, parties, etc.).
- Group purchase is distinct from a situation in which quantity buying is done for the purpose of convenience or price reduction. In such a case, purchases are made collectively and are distributed equally to each of the contributing individuals.
- A group purchase shall be made only if all of the following conditions are met:
    1. The item purchased is expected to contribute to a more normal lifestyle for the individual involved;
    2. Each participating individual is expected to receive benefit from the purchase in proportion to the contribution made;
    3. It is not expected that any of the contributing individuals will be discharged, relocated, or otherwise not be in a position to benefit from the group purchase;
    4. After the group purchase is made, the personal account balances of each of the contributing individuals must be sufficient to meet the personal needs of such individuals for the next three months. In no case should the remaining personal account balance of the contributing individual be less than $100.00.
    5. The item is not required to be provided by the Residential Program or Agency, part of its operation or in order to comply with certification, licensure, accreditation, or legal mandate.

6. Group purchase is to be used to buy those items which personally benefit the contributing individual and are not the responsibility of or cannot be provided by any other parties (the agency, program, Medicaid, other insurance, etc.).
7. The written request proposal for a group purchase will include:
    a. A description of the item under consideration for the group purchase.
    b. Total cost involved.
    c. List of individuals contributing to the group purchase and the prorated cost for each.
    d. Unencumbered balance in each contributing individual's personal account.
    e. Claim number for those individuals receiving SSA or SSI benefits.
    ***f. A description of the method to be used to reimburse a contributing individual in the event s/he becomes unable to share or otherwise benefit from the acquired item.***
    g. Individual responsibility for the maintenance of the acquired item including the upkeep costs.
    h. A description of the methods for determining cost and for documenting benefit for any individual participating in the group purchase, who will not benefit equally and will therefore be contributing a proportionate rather than an equal amount toward the cost of the item.
    i. Documentation that all contributing individuals agree with the proposal.

- Examples of possible group purchase items >
    1. Decorative items for the group living area (e.g., wall clock, wall hanging, painting).
    2. Stereo, CD's, DVD's, TV, or other entertainment equipment for the group living areas.
    3. An aquarium for the group living area.
    4. Equipment used to prepare "fun" foods (e.g. popcorn machine, ice cream maker, wok, waffle maker).
- For individuals who are their own payees or who have other representative payees, a signed statement indicating consent for the group purchase must be obtained from the individual or the representative payee, respectively. A copy of this statement shall be reviewed by the Treatment Team and be included each Individual's Opportunity Development Plan.
- It is the Residential Regional Director's responsibility to ensure all stipulations of a group purchase are adhered to and to coordinate the purchase and appropriate documentation for rationale and actual purchase.

**Restitution**

In cases where property damage has occurred, as a result of an activity by an individual, it may be appropriate for the individual to make *restitution* for the damage. However, adequate safeguards are established to ensure that the individual benefits therapeutically from the restitution process.

- Any property damage caused by an individual should be reported to the Treatment Team for initial determination of the appropriateness of restitution.
- Restitution can then occur only after the following steps have been included:
    1. The Residential Team has addressed the individual's maladaptive behavior;
    2. The Residential Team has determined that financial restitution is appropriate *and has meaning for the individual;*
    3. The representative payee, if any, has provided written approval for the use of a portion of the individual's personal allowance for such purpose; and
    4. The Human Rights Committee, charged with protecting the rights of individuals, has reviewed the use of an individual's personal allowance for such purpose.
- Support Plans will be drafted to assist the individual with minimizing/ eliminating the destruction that necessitates restitution.

❖ After each situation that requires restitution, the Residential Team will regroup and assess if the restitution had appropriate effect for the individual and whether or not to proceed with the restitution plan for future situations.

**Audits (All audits must occur on site)**

- Weekly
  - Once a week the Team Director or designee, will verify that the cash on hand matches the ledgers, including ensuring all necessary receipts are present. The same person will sign-off on the hard copy that has been printed off for the week.
  - The following week a new hard copy will be printed off, and the person reviewing the cash on hand will sign the new copy. The former copy may be destroyed and the new copy will be maintained until the following week.
  - Any discrepancies are to be resolved with the person distributing the monies immediately. Also, the Team Director is to be made aware of any discrepancies.
- Monthly
  - The previous month's ledger will then be audited by another party, who <u>does not</u> distribute the monies or complete the weekly review. The monthly audit will include:

    *<u>Resident Account Ledger:</u>*

    1. Ledger balance matches the cash-on-hand
    2. All receipts are present and accurately entered into the ledger
    3. All transactions on bank statements/passbooks are accounted for and properly documented.
    4. Stubs from paychecks, bank statements, and transaction receipts are attached.
    5. Receipts are signed by the individual, when applicable
    6. Items purchased are OK to be purchased by individual (vs. petty cash)

    ** 635.9.1(a)(1) [with exception 633.15(c)(5)] or the Director of Quality Enhancement may be referenced to see what *are not* appropriate expenditures for individual.

    7. The Bankbook/Savings ledgers are current and up to date.
    8. Verification of P.A. Funds electronically deposited w/in the first 3 working days on the month. (Bank Statement)
    9. Excess of $213 was not in cash on hand for more than 7 days
    10. No borrowing from other accounts!
    11. Personal Expenditure Plan is present w/the necessary signatures.
    12. All expenditures are based on the individual's personal and recreational wants and desires and benefit the person and reflect his/her personal spending choices 633.15(c)(4) and (5).

    *<u>Clothing Allowance Ledger:</u>*

    1. All receipts are present and accurately entered into the ledger
    2. All clothing allowance of $125 was spent prior to the next 6-month period.
    3. All items purchased are appropriate within the necessary Clothing Allowance guidelines.
  - Any discrepancies will be resolved immediately with the person responsible for distribution of the monies and notification of it will be made with the Team Director.

- Notation of any corrections will be made to the ledger and initialed by those making corrections.
- Periodically, the auditor may audit property and clothing records as well as visually verify the existence of an individual's personal possessions obtained per ledger notations.
- Person completing monthly audit will sign the bottom of ledger to document that the audit was completed.
- The closed out/ audited ledger will then be maintained in a file of purged ledgers specific for each individual in chronological order for further audits, review, etc..

*Pre-paid Visa card Ledger:*

1. Ledger is compared with the attached receipts.
2. All receipts are present and accurately entered into the ledger.
3. Items purchased are OK to be purchased by individual (vs. petty cash).
4. Pre-paid Visa Card amount and house account did not exceed $213. (Pre-planned large purchases are an exception).
5. Pre-Paid Visa cards are maintained in the house safe?

*ATM/Debit Cards:*

1. Final "print out' is compared with the attached receipts.
2. All receipts are present when compared with the "print out".
3. Items purchased are OK to be purchased by individual (vs. petty cash).
6. No more than 25% of the individual's total monies were in the individual's checking account at one time. *(Pre-planned large purchases are an exception).*
4. After a pre-planned large purchase, any monies over 25% were returned to the individual's savings account with 48 hours.
5. Is it addressed in the individuals PEP if the individual regularly withdraws monies from their savings and then deposit into their checking account for everyday use?
6. ATM/Debit Cards are maintained in the house safe?

- Quarterly
  - The Full Scope Financial Audit Committee made up of both Residential and Business Office personnel will audit 25% of Consumer accounts scrutinizing the last calendar quarter.
  - The intention of this audit is for a thorough and complete check to ensure:
    - review of savings accounts' bankbooks/passbooks/ checking accounts/savings ledger and bankbooks with corresponding bank statements;
    - resident account ledger which reflect the cash on hand and attached receipts;
    - clothing allowance ledger which reflect amount spent within the necessary timeframe with attached receipts;
    - That previous weekly and monthly reviews and audits have occurred.
    - That the Personal Expenditure Plan is present w/the necessary signatures.
    - That the Money Management Assessment is present w/the necessary signatures.
  - A write-up of the audit will be completed by the auditor and submitted to the respective Team Director with copies sent to the respective Residential Regional Director – for thorough and immediate resolution of any discrepancies.
  - Per 633.15(i)(9) – for individuals who have someone other than FRC as the rep-payee, the Team Director will ensure that copies of three months of ledgers are sent to the respective rep-payee for their review. Signed copies or a signed note

saying that the review took place should be returned to the TD and be filed promptly in the respective person's financial section of their personal file.

- Results of Financial Full Scope Audits will be trended by someone appointed to do so by the Financial Full Scope Audit Committee and results will be shared with the Residential leadership Team.

Red Flags!!!
If at any time during the auditing process you:

1. Cannot locate bankbook/passbooks
2. Cannot locate Bank statements
3. Resident Account Ledgers are not found or completed timely
4. Bankbook/Passbooks / Individuals cash- on- hand does not match with the individuals ledgers or bank statements
5. Audits have been cancelled once by the TD and would like to reschedule again.

You will immediately STOP the audit and inform the TD of the discrepancies and contact the RRD immediately. The RRD will then contact the Residential Director and follow-up will be arranged.

**Establishing an Account for a New Resident (and interim plan)**

- At the admissions meeting FRC will make a formal offer to become the individual's representative payee.
- If offer is accepted:
  - Application to become the representative payee will be completed by the agency's business office.
  - Upon approval, the business office and Residential Regional Director will make arrangements to establish a bank account for the individual's funds.
  - The bank account must be interest bearing.
- Until arrangements are made for a new individual's finances to be transferred to this agency, the individual is to never "do without"! The agency will make purchases for the person. How?
  - Submit a requisition for the person's P.A. from the business office
  - For clothing or other items that the individual needs for daily living may be purchased using the residence's petty cash, credit card, and a purchase order or purchase request.
  - A separate financial ledger needs to be maintained of all of these purchases so that the individual may reimburse the agency for appropriate costs when their personal finances are finally resolved.
  - The Business Office and Service Coordination will contact the agency to secure finances until the rep-payee process is completed.
  - FYI – per 633.15(n)(1) – a person's finances should be forwarded to the new residential setting (with a designated rep-payee) within ten working days of the person's departure from the previous program. Unless a portion of those finances were derived from the Social Security Administration (SSA), in which case the finances must be returned to SSA within 10 days.

**What not to do!!!!!!!!!!!!! Ever!**

- Robbing Peter to Pay Paul

    - Do NOT borrow money from an individual for staff expenditures or for another individual.
- Do NOT *EVER* wait to log purchases of any kind. Keep on top of the logging for everything. This includes: personal accounts, petty cash, requisitions, and purchase requests, purchase orders……. EVERYTHING!
- Do NOT just have one person complete all receipts all the time. Direct Support Professionals <u>need</u> to learn the practice and actually do it themselves. This teaches them a new skill as they may pursue other positions, provides an opportunity to have a second person check the math, system usage, etc., and this lightens your workload.
- Do NOT make Split Deposits
- Do NOT keep large quantities of cash accessible to various people. Ensure all monies are secured and accounted for at all times.
- Do NOT leave an amount of individual's cash on hand accessible to all Direct Support Professionals to be tracked by sub-ledger that exceeds that resident's anticipated need for cash.

**Petty Cash**

- For small *agency* purchases and when VISA is not accepted.
- Petty cash used or staff meals should not exceed: breakfast - $8; lunch - $10; dinner - $13 (staff need to pay any amount over these limits.)
- Shift to shift count and sign off of petty cash left in lockbox, which will include two signatures to verify the amount.
- Don't forget to use tax-exempt form for agency purchases!
- Maintain a Petty Cash Statement of petty cash expenditures <u>on computer</u> in Excel. This may be obtained from the Finance Dept, if you do not have it on your computer already.
- A log is to be maintained as purchases are made (i.e., SAME DAY as purchases)
- Print out a hard copy weekly to be maintained directly with the money so you may quickly, easily check against the money
- Reimbursement requests are to be submitted minimally when petty cash gets down to $150 so that you still have money on hand as turnaround time to get the reimbursement takes about one week (As per Finance Dept. – If you submit petty cash by Wednesday 12 noon you can have the check available by Friday of the same week)
- For reimbursement, the Petty Cash Statement with corresponding receipts attached needs to be submitted ***<u>to the respective Residential Regional Director</u>*** for approval **<u>& signature</u>** *and then* to the Finance Dept.
- Ensure that the request form is completed in its entirety – otherwise, this <u>will</u> delay your reimbursement. **<u>It will be sent back to you for completion.</u>**
- The sum of the receipts (or amount of request) and the cash on hand remaining in Petty Cash should equal the designated maximum amount of the residence's respective Petty Cash (i.e., $300 for small houses; $400 for larger houses.)
- When a reimbursement is requested with the Petty Cash Statement, the total petty cash reimbursement amount needs to be logged on the Purchase Log.

**Other Avenues of Making Purchases & Their Applicable Forms**

- Visa Cards
    - This is an alternative to purchase orders
    - In the case when a purchase will exceed the limit on the Visa card, please contact the Business office and your Residential Regional Director for approval for a temporary raise on the Visa limit to accommodate the purchase.

    - Need to be secured with monies at all times when not in use
    - On-line web site for allocation of expenses due weekly by 7am Fridays
    - Receipts from Visa cards are due the following week (Wednesdays) to Business office
    - Never make a purchase for an individual on the agency Visa Card unless the agency is absorbing the cost of the purchase.
    - Always use Tax-exempt form
- Purchase Request <$>
    - Need to be submitted *within the same week* that a purchase is made (with the Purchase Log)
    - Forms need to be completed **thoroughly** – this includes writing in the cost center, expense category, etc. If not completed thoroughly, the form may be sent back to you.
    - The business office will not pay for items if they a have not received a requisition or an incomplete requisition. At times, this has lead to bills not being paid and a hold on using credit cards, purchase orders, etc.
    - If the vendor is on the list as one where you use a Purchase Request, ***do not*** use a P.O.
    - For designated stores where a Purchase Request is used, reference the Finance Policy & Procedure Manual
    - Remember tax-exempt forms!
    - Team Directors may approve up to $150
    - Residential Regional Director needs to approve $150-300 purchases
    - Residential Director needs to okay purchases $300 and over.
    - [The exception for these amounts is groceries! However, the TD should still be monitoring grocery expenses – ensuring expenses are within the budget and purchases are appropriate.]
    - Purchases need to be logged on the Purchasing Log promptly
- Purchase Orders <$>
    - A legal document that obligates the Centers to pay for goods and services as identified
    - May be obtained through the Business Office
    - Are numbered in sequence for tracking purposes (and should be used accordingly)
    - All P.O.'s between $150 and $300 need to be signed by the Residential Regional Director
    - All P.O.'s over $300 need to be reviewed and signed by the Residential Regional Director ***and*** the Residential Director.
    - Purchases must be logged on a Purchasing Log.
- Tax Exempt <$>
    - For agency purchases ONLY!
    - Ensure you use a current year's form
    - Not for individuals' purchases – i.e., purchases an individual makes or is made for them with their own personal money.
    - May be used for items that are purchased for an individual with *agency funds*

**References for Further Information**

- For further financial information on Management of Personal Funds, see 633.15
- For further financial information on Provision of Required Supports and Services see 635.9 (if you do not have a copy, but are interested in obtaining one, you may go on-line

to the OPWDD website and look under regulations or see Director of Quality Enhancement)

- OPWDD's "Personal Allowance Manual" available on OPWDD's website
- For Agency Policies and Procedures regarding monies see:
  - The Finance Department's Policies and Procedures
  - Residential Services Policies and Procedures on the Intranet
- Representative Payee (Rep-payee) Definition 633.15(r)(iii):
  - A party specifically designated in accordance with provisions of the Social Security Administration (SSA) to handle benefits payable to an individual who is deemed, by the SSA, to be incapable of handling his/her benefits by reason of mental or physical incapacity. Benefits covered include social security and supplemental security income (SSI) payments.
  - An individual may be his/her own payee or
  - The representative could be one of two parties:
    - A family member(s), guardian, or advocate for the individual
    - The agency (specifically, the Executive Director)

*10/08 bm*
*Updated 2/20/15 br*

# Personal Expenditure Plan Guidelines

A Personal Expenditure Plan is an estimated projection of an individuals personal spending over a 12-month period.

Please ensure these points are addressed:

- Implement by January 1,2008 or next ISP review, whichever is sooner.
- A written plan is required. (Please use designated PEP form.)
- Project the individuals spending over a 12-month period
- Day Program/Services spending over a 12-month period must be included
- The PEP is developed via a team process. See diagram on back.
- The use of a person's personal allowance must take into account all other personal and recreational spending choices for the person throughout the year

Key points to remember:

- Spending should benefit the person, not OMRDD or the provider
- The Individual must have access to their monies to purchase items of choice
- Items purchased with personal allowance are the property of the individual
- Personal allowance *may not* be withheld.

Categories for Personal Spending:

- Personal Shopping or Luxury Items
- Entertainment
- Associational Life
- Vacations, Home and Family Visits
- Other Spending Considerations
- Total Annual Spending

**Other spending considerations:

- Burial Planning
- Gifts and Donations (Must be in PEP and comply with benefit paying agency rules. The gift/donation must be reasonable and personally benefit the individual in some way. Additionally, individuals cannot give money away to friends and relatives.)
- Trusts

12/07 bm

# Personal Expenditure Plan: Team Process

**Individual**
**Parent/Advocate/Legal Guardian**
**Medicaid Service Coordinator**
**Team Director/residence designee**
**Day Services Staff**

ISP

Day Habilitation/Program

Protective Oversight (IPOPO)

Opportunity Development Plan (Res Hab)

- Plan must be written by FRC designee
- Spending monitored for consistency by Team Director/familiar staff

# Franziska Racker Centers
# Fire Safety Procedures
# Program Standards

## Fire Drills

- The Franziska Racker Centers' IRAs will conduct a minimum of 12 planned fire drills per year.
- Under the guidance of the Team Director or designee, drills will be conducted during various shifts and various times of a shift, as specified on the Fire Drill Record sheet, as a means to train and practice emergency evacuation under the various time frames and conditions. All residents and staff are expected to evacuate the building within the designated time period for each house.
- Administrative staff (above the position of Team Director) will observe at least one evacuation on an overnight and one on another shift as designated by the agency. These dates and shifts are designated on the "Fire Drill Record Sheet". These administrative observation evacuations will be conducted using the houses' minimum staffing.
- All overnight evacuation drills will be conducted using the houses' staffing minimum. The other drills can be conducted with 1 staff over the minimum.
- Overnight drills will be conducted at a time of night when all residents have been asleep at least ½ hour and during the first 3 hours of sleep, 4 times a year, 1 each quarter.
- All residents and staff will evacuate the house during ALL alarm activations and will evacuate by means of the safest and closest exit. Once the evacuation is complete, no one will re-enter until an All Clear is given.
- In the event that a resident does not evacuate during a fire drill or within the designated time for the house or if the drill was considered problematic, the supervisor/AOC must be contacted and a decision will be made as to what action will be taken.
- All houses are equipped with smoke and heat detectors, some with sprinklers, fire doors, etc. as designated in the House Plan of Protective Oversight. Dialing 911 on a phone is required whenever an alarm activates for any reason other than a scheduled drill. <u>This includes those houses that have automatic dialers to ensure emergency personnel received the alarm.</u>
- Each house has an Evacuation Plan-House Specific, that designates assignments for staff on duty that staff need to know and be prepared to follow in case an evacuation is needed, including drills.
- The Team Director will train Overseers to conduct drills as a means of ensuring that they have the knowledge and hands on experience for overseeing a fire drill from beginning to end.
- Documentation of residents and staff performance will be entered and maintained for a minimum of one year in the Safety Systems Log and then stored for 10 years. A copy will be posted after each drill in the Communication Log for all staff that were not in the drill to review. A copy of all Evacuation Report forms are to be faxed or emailed to the Regional Director of the house and faxed to the Safety Systems Manager, Marcia Vann, at 272-2823 (Campbell Ave fax #)
- The Team Director needs to inform the Regional Director that there is an Evacuation Report Form for their review and signature.
- All staff should have a house door key <u>on their person</u> at all times during their shift. There should be a Relief key available for substitute staff to use during their shift.

**<u>The Standard Practice for All Staff on Duty:</u> R-A-C-E**

**R=RESCUE -and Close the Door to the room of the fire origin.**
**A=ALARM-pull the nearest alarm box (if available) and shout "FIRE!"**
**C=CONFINE the fire by closing all doors while exiting.**
**E=EVACUATE the building by the closest exit and go to meeting area.**

## Procedure for conducting a Fire Drill

***Overseer*-** (Does Not Participate)

1. Overseer will activate the fire alarm by pulling the alarm on one of the pull boxes or activating a smoke detector to sound the alarm.
2. The Overseer of the drill will keep the time of activation, then time to ground level, then again time to the meeting area. (as required on the Evacuation Report Form for that house).
3. The Overseer indicates which exit or area, for the purpose of the drill, cannot be used. A sign or something similar is used to clearly indicate the "fire".
4. The alarm will continue to sound until all residents and staff have evacuated the house.
5. During the drill, the Overseer is checking to see that all required procedures are being done, done correctly and within the required time frame for the house. (See Evacuation Plan-House Specific and each individual's Fire Safety/Self-Preservation Assessment)
5. Upon the conclusion of a drill the Overseer will reset the alarm systems as necessary, evacuate themselves and then give the "All Clear", at which time everyone may return to the house.
6. If staff were not able to complete the drill within the designated time frame for the house on any shift, the Overseer must immediately contact the Team Director/AOC for further direction.
7. Following the drill, Overseer will document, with input from the Fire Coordinator, all information onto the Evacuation Report Form, ensuring it is complete. Participating staff are to print and sign the form themselves.
8. The Overseer will follow up with all folks and staff regarding their overall performance, skills, and any specifics regarding the fire evacuation.
9. All follow-up information needs to be documented on the Evacuation Report Form in the appropriate sections.
10. The Overseer ensures that the Evacuation Report Form gets to the Team Director for their review.

## Procedure for conducting a Fire Drill or actual Emergency Evacuation

***All Staff on Duty*** **-**including Fire Coordinator:

**Action to be taken:**

**1.** If you discover fire before an alarm goes off, or if an alarm goes off and you discover the location of the fire, yell "Fire", and activate a pull box, if necessary/available.
2. Do not open any doors that have signs of fire/smoke behind them, always feeling the handle with the back of your hand first before opening.
**3.** Never try to fight a fire yourself.
4. If, on your way to the fire location, you pass any folks that can ambulate and safely be outside without supervision, direct them out the closest exit.
5. If, on your way to the fire location, there is anyone in a room that cannot ambulate themselves and is not in immediate danger, tell them you will be right back and shut their door to protect them until you are able to return and assist them.
6. Start at the safest point closest to the fire and begin to assist and evacuate residents to exit the house calmly by way of the closest, safest exit, following each individual's Fire Safety/Self-Preservation Assessment.
7. If an individual is refusing and not in immediate danger, tell them you'll be right back, shut their door, move on and assist others and then return to assist that individual.
8. Any folks needing assistance walking or being pushed in a wheelchair to the meeting place and can be temporarily out of staff sight, can wait outside the exit until you have assisted others out and then return and assist anyone who was waiting.
9. While working away from the fire, all rooms, including bedrooms, bathrooms, basement, porches, etc. (any areas accessible to residents), are to be checked.
10. Once it is determined that no one is in a room, the door is to be closed to contain the fire and the room is to be marked as checked as outlined in the house's Evacuation Plan. (If a staff marks a room as checked, the Fire Coordinator will not need to re-check)

11. In the event that you are unable to safely enter an area and there is someone inside, communicate to the person to move toward the window area if it is safe to do so and call for assistance.
12. Continue to assist residents out the closest and safest exit until everyone has evacuated.
13. In the event that you and the individual are in immediate danger, initiate the evacuation in the safest and quickest means available to you.
14. As needed, staff will direct residents to the meeting area, which is designated in the House Plan of Protective Oversight and the Evacuation Plan-House Specific.
15. Staff will confirm the presence of all residents at the meeting area.
16. 911 is called and medical attention is sought as needed.
17. Staff must be with all folks at all times while outside unless otherwise stated in their Fire Safety/Self-Preservation Assessment.
18. During drills, residents will be provided the minimum assistance needed to exit the house safely in order to evaluate their evacuation skills. In the event that assistance is needed, staff will begin with the least amount of assistance as is necessary (gestures, verbal prompts, and physical assistance).
19. Staff give reassurance to all and praise for a successful drill, as appropriate.

**Fire Coordinator:** -person with the med keys (if no med person is working, most senior trained staff will be assigned Fire Coordinator and make other staff aware of it. There will be an assigned Fire Coordinator carrying the designator bracelet at all times during all shifts. If all staff will be leaving the house, the designator bracelet will be put in a designated place for the next expected staff.

## Action to be taken by Fire Coordinator:

### Participate in evacuations as listed above and...

1. Attempt to determine the location of the fire, (checking the fire panel if necessary/if you have one.) Yell "Fire", and activate a pull box, if needed/if you have one, if you discover fire before an alarm goes off. Do not attempt to reset or stop an alarm.
2. Ensure ALL rooms have been checked and marked as checked as instructed in the Evacuation Plan ensuring everyone has evacuated.
3. Get a cordless or cell phone and vehicle keys to take out with you, if possible.
4. Do a head count to ensure all have evacuated.
5. Notify emergency personnel immediately if anyone is missing and you are unable to locate them in a real emergency.
6. Once all folks and staff have evacuated the house, DO NOT re-enter.
7. Call 911 for actual emergency-including all unscheduled alarm activations.
8. Notify emergency personnel immediately if anyone is missing and you are unable to locate them in a real emergency.
9. Communicate with the fire department as needed:
    a. what happened
    b. if anyone failed to evacuate
    c. nature of the emergency
    d. location of fire
    e. overall status of house and folks
    f. medical attention needed
12. The Fire Coordinator must stay on sight until all aspects of the evacuation have been completed.
13. If/when an "All Clear" is given, conduct another head count once folks return to the house to ensure all folks have returned safely.

## Staff Development/Training

**The Team Director, with assistance from the Safety Systems Leader will**:

1. Ensure that all staff are trained in Fire Safety during their first week of employment and before they work alone or with another untrained staff. (Outline included in the House Training pkg.)
2. New staff (including Relief) must participate in a fire drill within a reasonable time frame (1 month) and before they are allowed to staff a shift alone or be on duty with another staff that has had no drills. This initial drill needs to be done on the shift the staff will regularly work. (If this is not possible, a mock drill can be done (for example, a new overnight staff could participate with another staff, simulating all folks are asleep in beds.) This simulated drill will be in addition to a regular drill on another shift.
3. Staff must participate in a fire drill at least once a year thereafter.
4. All staff need to view the 3-hour OPWDD Fire Safety Level One video and take the post test. It is suggested that new staff view 1 hour at each of their 3 shadowing days. There is a training sign off sheet for this purpose.
5. Ensure that the Plans of Protective Oversight are regularly reviewed (monthly) in respect to the fire safety for each consumer- the attachment to IPOP - Fire Safety/Self Preservation Assessment.
6. Staff will be trained on the fire alarm system as appropriate for the house assignment.
7. A Bi-Monthly Fire Safety Training will be conducted at Team Meetings during odd months with a sign-off sheet and outline filed in the house Safety System Log when complete.
8. The Evacuation Plan-House Specific and Fire Safety/Self-Preservation Assessments for each individual must be reviewed at each of these trainings and with all other staff that were not in attendance before the end of that month.
9. All drills, Bi-Monthly Training records and Smoke Detector and Sprinkler quarterly inspections need to be stored in house file for 10 years.

## Non-operational fire alarm system

**When the fire alarm system is not working the Fire Coordinator will:**

1. Contact the supervisor/AOC as to the problem and the actions taken.
2. A Regional Director needs to be contacted, who will see that OPWDD is notified.
3. The Maintenance Department may need to be informed that the system is inoperable (discuss with TD/AOC).
4. Richardson Brothers (or other) may need to be notified to inform them that the system is not working. (discuss first with TD/AOC/Maint)
5. Notify all consumers and on-duty staff of the situation. Individuals may need extra assistance to evacuate as there may be no alarm as they have practiced. If a fire occurs, they will need to yell "FIRE!"
6. 15-minute checks of the house are to be completed and documented by a designated staff person, including all rooms, basement and storage areas, etc. Instructions and house check forms are located in the Safety Systems Log. (These forms will need to be saved and filed.)

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The Safety Systems Leader is responsible for completing the Safety Systems Monthly Checks. An audit is conducted quarterly for each house by the Full-Scope Audit Team and sent to the overseeing Regional Director of each house and Audit Team Leader, Marsha Burnham, TD. Audit Team Leader compiles a report from the audits quarterly and sends to designated Regional Director and to Safety Systems Manager to be put onto schloss.

Any questions in reference to these Program Standards can be directed to your house Team Director, Regional Director or Safety Systems Manager Marcia Vann at Campbell Ave 272-2820.


# Residential Program Emergency Preparedness Disaster Plan

**Developed 1/07**

# Table of Contents

**Introduction**

The Franziska Racker Centers' Residential program maintains homes for individuals with special needs in Tompkins, Cortland and Tioga Counties. In keeping with the Mission, Vision and Guiding Principles of the Franziska Racker Centers, we have developed an Emergency Response Plan to help ensure the health, safety and well being of the residents and the staff that work within these homes. This plan was designed in accordance with the regulations and policies that governs crisis/emergency preparedness and reflects the best and most current thinking in this area.

The Emergency Response Plan was designed to provide residential staff with a comprehensive guide to follow in the event of an emergency or crisis situation. This plan is put into effect whenever an emergency, either man-made or natural, disrupts operations, threatens life or causes major damage and is not intended to replace normal operating procedures. An emergency is any unplanned event that has the potential to cause serious injury to the residents of the Franziska Racker Centers, to the staff that support them, or damage to the homes that they live in.

**Section I** of this plan defines the different categories of emergencies that will be referred to throughout the plan. The Centers recognizes four levels/categories of emergencies. While this plan may address some aspects of Category I and IV emergencies, it has been developed to deal primarily with Category II and III emergencies.

**Section II** of this plan addresses specific emergencies and the emergency procedure to follow. Each procedure will provide staff with specific directions to follow should an emergency arise.

**Section III** of the plan is the Reference section. In this section, you will find things such as Emergency contacts, Evacuation plans, Maps, Community resources, Guidelines for sheltering in place, and staffing plans.

**Section IV** of the plan identifies Emergency equipment available to you within your residence. Here you will find instructions for use of equipment, information on locations of breaker boxes, and gas/water shut offs etc. In this section you will also find requirements for routine maintenance/inspection of equipment such as generators.

**Section V** is the Post emergency plan section. In order to ensure the procedures in place were effective, it is important to follow-up after each emergency. The Emergency situation review sheet found in this section will provide detailed information on the emergency and will note any concerns that may have come up and/or identify weaknesses in the plans.

**Section VI** will contain the quarterly inspection sheets and the guidelines for completing the inspections. Inspections will be completed for the emergency food supply, water supply, client specifics sheet and emergency supply bin. Updates, supply rotation etc should occur during the quarterly inspections. In addition to the quarterly inspections, an Emergency planning committee member will complete an inspection annually.

**Section VII** identifies the Emergency/Disaster Preparedness training that should occur with all staff employed in the residential program. This training should occur within the first 3months of employment.

# Section I

# Categories of Emergencies

**Section I~ Categories of Emergencies**

**Category I :** A category I emergency refers to unforeseen situations that may endanger the health and safety of an individual.

Examples: Poisoning, kidnapping, abandoned child/individual; missing person

**Category II :** A category II emergency refers to unforeseen situations that may endanger the health and safety of a group of individuals, site/location.

Examples: Fires, hostages, explosions or threats there of ,power failure, suspicious male/people, gas leaks, communicable diseases, vehicle accidents.

**Category III:** A category III emergency addresses weather related/natural disasters that may endanger the safety and well-being of individual(s).

Examples: High winds, tornadoes, flooding, hurricane, earthquake, winter storms.

**Category IV:** A category IV emergency refers to unforeseen situations that involve man-made catastrophic events that may endanger the health and safety of an individual(s).

Examples: Bio-terrorism; chemical warfare; nuclear disaster; exposure (due to proximity of our locations – example being, near hospital, Cornell etc.)

# Section II

# Emergency Procedures

# Section IIa.
# External Disasters or Emergency Situations

**Procedures:**
For all external disasters including, Fire, flood, high-winds, heat etc which affect the community, the following will occur.

**Staff will:**
1. Ensure all residents and staff are accounted for.
2. Tune-in to a local radio or TV station for news reports, weather forecasts etc.
3. Contact the TD or AOC for directions and support as needed.
4. Locate Emergency supply bin and Emergency food and water.
5. Contact emergency personnel as needed.

## Emergency situations

**Power outages:**
1. Locate battery operated radio or crank radio from Emergency bin and tune into local radio station.
2. Locate flash lights, lanterns or other emergency light sources.
3. Turn off electrical items not in use. This will help to prevent blown fuses or breakers when the power returns and protects equipment from sudden electrical surges.
4. Do not open the refrigerator or freezer unless absolutely necessary.
5. If necessary and if equipped with generator, contact the AOC and follow instructions.

**Flooding/high waters:**
1. Tune into local radio station.
2. Locate emergency kits, food and water supplies.
3. Contact AOC if flooding interferes with program operation, i.e. staffing, water in house.
4. Contact emergency personnel as needed.
5. Go to upper most level of home if necessary.
6. If instructed to evacuate, follow procedure.

**High Winds/Tornado/Hurricanes:**
1. Tune into local radio station.
2. Contact AOC or TD if danger is immanent.
3. Locate emergency kits, food and water supplies.
4. Put away and secure outdoor furniture i.e. lawn chairs, grills tables etc.
5. Close windows and doors and keep everyone away from windows and doors
6. Identify safe zones in home and move to as needed. Safe zones are: lowest levels, interior rooms (bathrooms, closets) and doorways.

**Snow/ice/cold weather:** ***Residential Never Closes!***
1. Tune into local radio station.
2. Locate emergency kits, food and water supplies.
3. Contact AOC and NOC as needed.
4. Contact incoming staff to suggest they leave early if needed.
5. Identify emergency heat source if needed.
6. Ensure residents are dressed warmly.
7. If there is no heat in the house, identify with NOC what temperature warrants evacuation and follow procedures.

**Heat emergency:** ***10 degrees above the normal High temperature for the region.***

1. Heat wave is 3 days with temperatures above 90degrees.
2. Keep residents inside if possible.
3. Wear light colored clothing
4. Utilize cooling equipment available.
5. Ensure residents and staff are adequately hydrated. Have cold water available.
6. Watch for signs of Heat related illness and contact AOC/NOC as needed.

**Fire emergency:**

1. Follow house specific Emergency procedures.

# Section III

# References

# Section IIIa.
# Emergency Response systems

**Maintenance Response systems**
**Phone numbers and Notifications**

******For all life threatening emergencies dial 911******

Presently you have for your use, a Residential Telephone list that includes program numbers and on call systems for the administrator and nurse. In addition, on the reverse side of this list there are maintenance staff numbers. These numbers are use for non-emergency situations occurring during typical work week hours. During typical workweek hours when a ***maintenance emergency*** exists (which affects or threatens health and safety), please contact Rick Darfler at is office or on his cell phone. If you are unable to reach Rick, please contact Dan Fuller. If you are unable to reach either, contact Claire Van Deusen, Residential Program Secretary. She will assist you in making contact with staff that can assist you in an emergency situation.
If a house/program site has a ***maintenance emergency*** during evening or weekend hours and needs maintenance support immediately, please contact Rick Darfler *and* Dan Brown. If you are unable to reach either contact your respective Regional Director and Pat Montanez. The AOC needs to be notified so he/she can provide further support and the necessary 24-hour follow-up call.
For all other emergencies, contact the Administrator on Call (AOC) and follow directions provided.

| **Person to contact** | **Numbers to call** |
|---|---|
| AOC East…… | Pager 897-2899 |
| | Cell 279-0044 |
| AOC West……... | Pager 897-0274 |
| | Cell 279-5377 |
| NOC…… | Pager 897-0880 |
| | Cell 280-0005 |
| Regional Director of Site…… | Refer to phone list |
| | |
| Dan Fuller (maintenance emergencies)…….. | Home 662-0033 |
| | Cell 280-4179 |
| Rick Darfler (maintenance emergencies)……... | Home 533-7013 |
| | Cell 227-1722 |
| Dan Brown (maintenance emergencies)……. | Home 533-7724 |
| | Cell 279-5350 |
| Pat Montanez…….. | Home 844-9901 |
| | Cell 280-6761 |

# Section IIIb.

**What "sheltering in place" means and what to do**

During certain emergency situations, you may be advised to "Shelter in Place" rather than evacuate the building. In such a case it may be safer for people to stay indoors than to go outside. It is a way for people to keep residents and staff safe and protect them until help arrives or until the emergency is over.

As with any type of emergency, the most important thing is to remain calm. Staff should act quickly and follow the instructions in the Emergency disaster plan.

If electricity is still on, it is advisable to turn on the radio and tune into your local emergency station. Keep a telephone close at hand, but don't use it unless there is a serious emergency.

**What should you do while Sheltering in place?**

As noted above, you should follow instructions in the Residential Emergency Response Plan and follow instructions provided by the Administrator(s) on call. You will follow and refer to, different guidelines based on the type of emergency, i.e.: Heat related, High wind, Power outages etc.

Identify tasks that need to be done i.e.: phone calls and follow-up, regular checks of the house if the power is out, closing doors and windows and other important tasks. Once you have identified tasks, assign staff within the team. There is less room for error and miscommunication if the team splits up the responsibilities and focuses on their task.

Locate your emergency bin, food and water supply. Never use items in the emergency supplies until all resources within the home are already exhausted. For example, use the perishable food items in the refrigerator, extra batteries and flashlights that you have, tap water etc.

The most important thing is to continue with daily routines with what resources are available and remain calm. It is important to model appropriately for the individuals in the home who may not understand what is happening. Provide reassurance as needed. Use creative solutions to keep people occupied. Read books, do crafts or projects, indoor games or board games etc.

Continue communication with Administrators as noted in the emergency plan and follow any instructions. Keep tuned to the local emergency radio station for updates. Staff should use one note pad for documentation of all communication with individuals with outside organizations such as NYSEG.

# Section IIIc.

**Family contact and communication**
**During Emergency situations**

Each residence will be responsible for identifying family members/advocates that would need to be contacted in the event of an emergency. Some family members may only wish to be contacted if the emergency requires evacuation. Other family members may want to be contacted in order to assure their family member is safe/comfortable or may wish to take them home. It is important to have this information available in the event of an emergency so we can communicate with families.

| **Resident** | **Family/advocate to contact** | ***When to contact family*** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# Section IIId.

**Evacuation Procedure/Emergency Housing**

**Emergency Procedure**

Staff member on duty will:

1. Call the appropriate emergency number (911) State Police if 911 is busy 1-800-342-4357
2. Identify self
3. Identify the emergency situation
4. Identify the person(s) needing help
5. Identify what is being done to help
6. Identify your location and the location of the emergency
7. Provide them with the number you are calling from.

**Additional Emergency numbers:**

| | |
|---|---|
| Cayuga Medical Center | 274-4411 |
| Cortland Memorial Hospital | 756-3740 |
| Poison Control | 1-800-252-5655 |
| Owego/Tioga County | ? |

**Radio Stations**

| | |
|---|---|
| Tompkins/Cortland county | 870AM WHCU |
| | 97.3FM WYXL |
| | 91.7FM WICB |
| National Weather Service (radio) | 770-9531 ext 223 |

**Emergency Housing**

In the event that you are unable to stay at your location, you should follow instructions of the Administrator on Call or emergency personnel. Emergency housing is available at:

**Franziska Racker Centers**
**Racker Campus**
**3226 Wilkins Rd.**
**Ithaca, NY 14850**
**Phone (607) 272-5891**

**Or**

**Franziska Racker Centers**
**Cortland**
**882 NYS Rt. 13**
**Cortland, NY 13045**

**Or**

**Washington-Gladden**

**Owego, NY**

**Each program will identify a specific location to maintain keys to the above evacuation sites. The AOC will know the location of the keys so they can instruct staff or retrieve the keys as necessary.**

The decision to evacuate will be determined by the AOC, other administrative personnel or emergency personnel. In addition to the above emergency locations, there are 17 residences within Tompkins, Cortland and Tioga Counties and there are community evacuation sites which may include Fire Departments, schools etc. If the emergency is a site-specific emergency, the administrator may direct you to evacuate to another residence. The names and locations of the residences can be found in this section.

If there is a potential for and emergency situation, staff will gather a one to three-day supply of medications, clothes, attends etc. for the residents. The Team Director or AOC should be notified and an evacuation site will be determined based on the nature of the emergency. Staff will ensure there is adequate transportation available to evacuate all residents. AOC will offer support and direction if there is not adequate transportation available which may include the use of personal vehicles. An agency cell phone should be taken. Emergency numbers, including NOC and AOC pagers, will be programmed into the phone.

Staff should refer to the “Family Contacts” section to identify family members that may need to be contacted if evacuation is immanent. In addition, staff should take a copy of the Client Specific sheet.

While at the evacuation site, staff should maintain contact with the AOC at least hourly unless directed otherwise.

# Section IIIe

**Staffing Plan**

In the event of an emergency requiring additional staffing, the usual procedure for calling in additional staff will be followed. Contact the AOC for approval and support as needed.

**Procedure:**

1. Staff will identify and contact relief staff.
2. Staff will maintain documentation of calls.
3. Once the relief list has been exhausted, the Part-time staff will be called.
4. In the event coverage is still needed, full-time staff may be called in.
5. The AOC should be notified and will determine whether extra coverage need continue.

In emergency situations, staff should notify the TD or AOC if a staff is going to be working in excess of 16hrs.

# Section IV

# Emergency Equipment

# Section V

# Post Emergency Plan

**FRANZISKA RACKER CENTERS**
**EMERGENCY SITUATION REVIEW SHEET**

**Administrator's Name:**

**Date of Incident: _____ Time of Incident:_____specified days Type of Incident: _____**

**Program/ Location:**

**Could this situation have been avoided?**

**Were the staff trained to handle this emergency?**

**Where there appropriate supplies on hand?**

**Was there appropriate and adequate communication (including to outside agencies)?**

**What were the difficulties faced as a result of this incident?**

**What were the successes noted from this incident?**

**What community resources were used?**

**How was the situation resolved?**

**List any recommendations you have for:**

**1 Training:**

**2 Supplies (including replenishing):**

**3 Communication:**

**4 Implementation of response for the future:**

*After completing, please return to Director of Quality Enhancement*

# Section VI

# Quarterly Inspections Master Forms

**EMERGENCY FOOD SUPPLY KIT**
**QUARTERLY INSPECTION CHECK SHEET**
**SMALL HOUSE 4-6 RESIDENTS**

**CIRCLE ONE: 1ST QUARTER 2ND QUARTER 3RD QUARTER 4TH QUARTER**
**January-March April-June July – September October- Dec**

Inspection Completed by: _____ _____ _____ _____

**********Please complete a new form for each quarterly inspection***********

| Food Item in kit | # of boxes/ cans etc | Date purchased | Expires on | Date to be Pulled | Date item pulled and Replaced on |
|---|---|---|---|---|---|
| Oatmeal | 1 lg. containers | | | | |
| Nutrigrain Bars | 3 boxes/8 | | | | |
| Canned Fruit | 6 sm. cans | | | | |
| Juice | 4 cans | | | | |
| Ensure | 1 cases | | | | |
| Peanut butter | 1 lg. | | | | |
| Saltine crackers | 1 boxes | | | | |
| Canned chili | 3 sm. Cans | | | | |
| Baked beans | 3 sm. Cans | | | | |
| Pork and beans | 3 sm. Cans | | | | |
| Canned Stew | 3 sm. Cans | | | | |
| Spaghettio's | 3 sm. Cans | | | | |
| Pudding cups | 6/ 4pks | | | | |
| Canned veggies | 6 sm. Cans | | | | |
| Canned tuna | 3 lg. cans | | | | |
| Canned chicken | 3 lg. cans | | | | |
| Bottled Water | | | | | |
| Goldfish crackers | 4 pkgs. | | | | |
| Graham Crackers | 2 boxes | | | | |
| Applesauce | 3 cans | | | | |
| Pet food | 1 bag | | | | |
| Emergency supplies bin | ************ | ********** | ********* | ********** | ************ |
| Batteries | | | | | |
| Hand sanitizer | | | | | |

- **Items in bin are to be pulled 3 months prior to expiration date. Item is not to be pulled until a replacement is purchased.**
- **Food items need to be replaced with identical items (brands may vary)**
- **The rotation of items will be completed with in 2 weeks.**
- **2yr. Maximum shelf life on all canned goods and bottled water/ rotate into stock at 21 months.**
- **Emergency supplies bin complete? _____**
- **Client Specific sheet current/accurate? _____**

# Emergency preparedness checklist

Initial inspection

House: _____Location of bins/water:_____

*Check off when completed. Make copy for house and EPC committee.*

- Adequate gallons of water- marked with expiration date?
- Appropriate/adequate foods as per list- dated?
- Contents of Emergency bin
  - Crank Radio
  - Hassock toilet
  - Flashlight/batteries
  - Emerg. Blankets
  - Emerg. Medical kit
  - Sharpie
  - Gloves
  - Matches
  - Hand sanitizer
  - Duct tape
  - Whistle
  - Client specifics sheet- current?
  - Are bins clearly labeled?
  - Are bins/water easily accessible?

Initial quarterly inspection completed on ___/___/___

Inspection completed by:_____

*EPC committee member and staff assigned*

Comments:

_____

_____

_____

_____

**EMERGENCY FOOD SUPPLY KIT**
**QUARTERLY INSPECTION CHECK SHEET**
**LARGE HOUSE 10-12 RESIDENTS**

**CIRCLE ONE: 1ST QUARTER 2ND QUARTER 3RD QUARTER 4TH QUARTER**
**January-March April-June July – September October- Dec**

Inspection Completed by: _____ _____ _____ _____

********Please complete a new form for each quarterly inspection*********

| Food Item in kit | # of boxes/ cans etc | Date purchased | Expires on | Date to be Pulled | Date item pulled and Replaced on |
|---|---|---|---|---|---|
| Oatmeal | 2 lg containers | | | | |
| Nutrigrain Bars | 6 boxes/8 | | | | |
| Canned Fruit | 12 sm. cans | | | | |
| Juice | 8 cans | | | | |
| Ensure | 2 cases | | | | |
| Peanut butter | 2 lg | | | | |
| Saltine crackers | 2 boxes | | | | |
| Canned chili | 6 sm. Cans | | | | |
| Baked beans | 6 sm. Cans | | | | |
| Pork and beans | 6 sm. Cans | | | | |
| Canned Stew | 6 sm. Cans | | | | |
| Spaghettio's | 6 sm. Cans | | | | |
| Pudding cups | 12/ 4pks | | | | |
| Canned veggies | 12 sm. Cans | | | | |
| Canned tuna | 6 lg cans | | | | |
| Canned chicken | 6 lg cans | | | | |
| Bottled Water | | | | | |
| Goldfish crackers | 8 pkgs | | | | |
| Graham Crackers | 4 boxes | | | | |
| Applesauce | 12 cans | | | | |
| Pet food | 1 bag | | | | |
| Emergency bin supplies | ********** | ********** | ********** | ********** | ********** |
| Batteries | | | | | |
| Hand sanitizer | | | | | |

- **Items in bin are to be pulled 3 months prior to expiration date. Item is not to be pulled until a replacement is purchased.**
- **Food items need to be replaced with identical items (brands may vary)**
- **The rotation of items will be completed with in two-weeks of the "to be pulled" date.**
- **2yr. Maximum shelf life on all canned goods and bottled water/ rotate into stock at 21 months.**
- **Emergency supplies bin complete? _____**
- **Client Specific sheet current/accurate? _____**

# Section VII

# Training

FRANZISKA RACKER CENTERS
COMMUNITY LIVING SERVICES
(Family Resource_____/Residential_____/Service Coordination_____)

NAME: _____ TITLE: _____

PRIMARY SITE: _____ DATE: _____

**INITIAL/REVIEW TRAINING IN RESIDENTIAL PROGRAM EMERGENCY PREPAREDNESS**

A) Introduction _____

B) Categories of emergencies _____
- Define four categories

C) Emergency Procedures _____
- Types of emergencies

D) References
- Contacts
- Evacuation and Staffing plans
- Sheltering in Place

E) Emergency Equipment _____
- Identify equipment-House specific
- Usage/Instructions
- Maintenance of Equipment

F) Post Emergency plan _____
- Emergency Situation review sheet

G) Quarterly Inspections _____
- Location of Emergency bins/supplies
- Inspection sheet and guidelines for completion

*I have received training on "Residential Program Emergency Preparedness" and understand my responsibilities.*

_____
STAFF MEMBER'S SIGNATURE,
TITLE

_____
FACILITATOR'S SIGNATURE,
TITLE

UPDATED 12-21-06
ATG