**The Salvation Army – William Booth Special Care Home**

**Administrative Risk Management Policies and Procedures**

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# Incident Reporting

**POLICY:**

RQHR Special Care Home Policies (2016); Section 17.1 Incident Review Investigation and Reporting.

To ensure all incidents that had the potential to or did affect the health and safety of a Resident / Staff / Visitor and / or others in the special care home are reviewed and result in a change to prevent reoccurrence of the same or similar incident.

**EQUIPMENT (forms):**

* RQHR Confidential Occurrence Report form 210745 (02/16)
* RQHR Employee Report of Incident / Hazard form

**PROCEDURE:**

There are 2 incident report forms:

1. RQHR Confidential Occurrence Report form
* To be completed when there is evidence of injury or potential hazard (injury) to a RESIDENT / VISITOR / VOLUNTEER (e.g.: AWOL, fall, assault, etc)
	+ Medication occurrence
	+ Falls Details
	+ To be completed for potential hazards / “near misses”.
1. RQHR Employee Report of Incident / Hazard form
* To be completed when there is evidence of injury or potential hazard (injury) to a EMPLOYEE

**RESIDENT (visitor / volunteer) – RQHR CONFIDENTIAL OCCURANCE REPORT**

The **Reporting employee** is responsible to:

1. The reporting employee is the person who witnessed, discovered or was involved in the occurrence. The reporting employee should sign and date the occurrence report. The reporting employee is responsible to:
2. report the occurrence immediately to the RN / RPN / LPN
3. in a timely manner, complete the section:
4. Name of resident
5. Description date and time of occurrence
6. Briefly state facts of occurrence (physical findings).
7. Signature of reporting employee and date
8. Document the occurrence in the progress notes. No opinions or assumptions should be documented, only the observed facts.

The **RN / RPN / LPN** is responsible to:

1. Document on the Confidential Occurrence Report form:
2. Complete all required information (addressograph) and Admitting Diagnosis
3. Assess and document in Injury Report (section C). Include V/S, Neuro, etc.
4. Indicate is there is an Apparent Injury: Yes No
5. Indicate if Treatment Required: Yes No
6. D – Type of Occurrence
7. E – Medication Details
8. F – Falls Details
9. Care team to complete Post-Falls Huddle care plan review
10. Document follow-up to occurrence in the progress notes. No opinions or assumptions should be documented, only the observed facts.
11. NOK must be notified of occurrence. Documentation must include that NOK was notified. During the night, if there is no evidence of injury, notification of NOK can be completed in the morning.
12. Forward completed Confidential Occurrence Report form to the Care Coordinator / DOC within 24 hours (**EXCEPTION** - Code 3 / 4 occurrence, must notify immediately)
13. Confidential Occurrence Report form is not part of the health record, forward to Care Coordinator / DOC.

The **Care Coordinator** / DOC are responsible for:

* Within 48 hours (**EXCEPTION** - Code 3 / 4 occurrence):
	+ Review documentation of occurrence in progress notes
	+ Review documentation that indicates resident’s condition is being monitored in relation to occurrence
	+ Confirm there is documentation that NOK notified
	+ B – complete occurrence classification and notification
		- **Code 1 -** No clinical significance / no known injury.
		- **Code 2 -** Minor self limiting injury requiring basic first aid or short term monitoring. X-ray and lab tests (if performed) remain normal or unchanged.
		- **Code 3 -** Actual adverse outcome with successful intervention or significant potential for adverse outcome.
		- **Code 4 -** Incident that results in irreversible complications or death
	+ Indicate whether problem is resolved or whether further action is required.
	+ Indicate action taken to prevent reoccurrence.
* The DOC is responsible to report CODE 3 or 4 occurrences to:
	+ RQHR Patient Safety (patientsafetyintake@rqhealth.ca)
	+ RQHR RR&CC
	+ Salvation Army Incident Report
		- Aviva Insurance Company Claims Department
		- BFL CANADA Risk and Insurance Services Inc.
		- THQ Insurance Director
		- Divisional Commander

**NOTE**: monthly, the blue copy of all Code 1 and 2 confidential occurrence reports are forwarded to RQHR Patient Safety (2016).

**EMPLOYEE – RQHR EMPLOYEE REPORT of INCIDENT / HAZARD form**

**Page 1** – to be completed by Employee

1. To be completed when there is an occurrence of an employee incident and / potential hazard / “near misses”.
* No opinions or assumptions should be documented, only the facts.
* Form is not part of the health record, forward white copy to Manager ASAP (yellow copy to be retained by employee)

**Page 2** – INCIDENT INVESTIGATION – to be completed by the Manager / designate within 24 hours

1. Gather information: Review the Employee Report of Incident / Hazard with the Employee to ensure it is completed and accurately describes the incident and the events before, during and after the incident; who was involved including witnesses; where the incident happened; when the incident occurred and who it was reported to.
2. Have the Employee demonstrate the work task and visit the scene to inspect the work area and equipment / PPE used as needed.
3. Use the questions (refer to INCIDENT INVESTIGATION TOOL) to help identify causal factors. Use the “5 why” method to determine the root cause(s) of the incident.
4. Manager to forward completed page 2 to DOC / designate within 48 hours.
* Copy will be forwarded to the Co Chairs of OH&S for review of the incident. Confidentiality will be maintained / the name of the employee will not be disclosed.

**Source:**

RQHR Special Care Home policies (17.1) Incident review investigation and reporting

Salvation Army Liability Incident / Claim Report

**Approval/Implementation/Evaluation Process**

Initial Implementation Date: September 1999

Review Date: September 2016

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Daily 24 Hour Report

**POLICY:**

Health Care Staff are responsible to complete a Daily 24 Hour Report form. The purpose of the Daily 24 Hour Report is to ensure communication to the Health Care Manager(s) of the daily (24 hour) events / condition of the residents.

Completed Daily 24 Hour Report form is forwarded to the Health Care Manager:

**PROCEDURE:**

1. Daily 24 Hour Report sheets are kept at each Nursing Unit.
2. The Night RN / RPN / LPN begins the report by entering the Unit and the Date.
3. Items to be reported:
4. Admissions/Transfers/Discharges
5. All admissions / transfers / discharges that have occurred during the 24 hour period.
6. All internal or external movement.
7. Residents in hospital
8. Incidents (attached)
* Enter all resident incidents that have occurred during the 24 hour period.
* Attach confidential occurrence report form
* Infection Control Surveillance
* All resident who exhibits signs / symptoms of infection should be entered in this section. This includes residents who are currently on an antibiotic for an infection (even when symptoms subside).
	+ ARO (MRSA / CDiff / ESBL / VRE)
	+ UTI
	+ Viral Infections
	+ Other (symptoms / treatments)
* New Physician Orders
* Resident absences / appointments / LOA
* Issues for Health Care Manager / DOC (care, family, equipment, etc)

Initial Implementation Date: July 7/98

Review Date: April 14, 2003 / January 31, 2006 / May 14, 2007 / July 3, 2012 / December 1, 2013

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Private Duty Nursing / Health Care Worker

**POLICY:**

This policy is written to provide direction to WBSCH staff when the resident / family employ a private Health Care Worker (HCW).

A resident / family may acquire the services of a private-duty HCW. The HCW must adhere to the policy of the WBSCH pertaining to private-duty HCW and also any other existing policies which could impact the care of the resident.

Private-duty HCW would include care provided by an RN / RPN /LPN / Health Care Aide / sitter/companion.

**PROCEDURE:**

1. The resident/family is responsible for undertaking the hiring process when

 contracting with a private agency, and for arranging for direct reimbursement

 for services rendered.

1. The resident/family must give prior notice to the facility when they are arranging for private-duty HCW to provide care/services to the resident.
2. The private-duty HCW must be advised of, and agreeable to the policies and procedures of the facility. This is done by the Health Care Manager / DOC / designate.
3. The private - duty HCW must report to the Unit Nurse and receive direction regarding the care to be provided. The Unit Nurse is responsible for providing all relevant information to the private- duty HCW, and for clarifying which functions the private - duty HCW will perform, prior to him/her assuming responsibility for providing care to the resident. This will ensure the required standard of care is maintained.
4. If the private - duty HCW is a professional nurse (s)he must provide proof of current registration to the Health Care Manager / DOC / designate.
5. The private - duty HCW is responsible to undertake only the tasks (s)he is

competent and qualified to perform, and to request assistance, if needed, for other

aspects of care provision.

1. The private - duty HCW **will not** administer medications. Administration

of medications will be done only by the WBSCH RN/RPN/LPN.

1. The facility staff are expected to assist the private - duty HCW (i.e.: Assisting

with transferring, turning and positioning the resident).

1. The private - duty HCW must:
2. give an oral report to the Unit Nurse before leaving at the end of his/her shift.
3. if another private-duty HCW is working the succeeding shift, give an oral report
4. to that HCW.
5. The Unit Nurse remains responsible for the resident’s well-being and would be expected to take action should it be deemed necessary to ensure that safe care is maintained.

**Approval/Implementation/Evaluation Process**

Initial Implementation Date: July 7/98

Review Date: January 30/05 / November 27/07 / December 1/13

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Least Restraint

**POLICY:**

WBSCH is a least restraint facility and as such, physical and / or chemical restraints are discouraged.

Every attempt to maintain a resident’s dignity without compromising his/her safety is undertaken before the implementation of physical and / or chemical restraints:

**NOTE:**

* Alternate diversional measures should be exhausted prior to the use of a “least restraint”
	+ Only safety approved physical restraints are to be used.
	+ Chemical restraints will only be used after consultation between physician / Nurse in charge has occurred regarding the intention of the effects of the medication.
* When safety to a resident or others around them is at risk, a least restrictive device will be implemented.
* Implementation will occur once a complete assessment is carried out and all other alternatives have been exhausted.

**EQUIPMENT:**

Each resident will be assessed for the most effective device.

Approved physical restraints are:

1. Broda Chairs
2. Wheelchair trays (used for positioning)
3. Tabs Monitors / Personal Alarms
4. Wanderguard door monitors
5. Front closure safety belts (used to remind residents not to ambulate)
6. Side rails on beds

Chemical restraints are those medications prescribed for the treatment of anxiety / mental health diagnosis.

* Medications which could be considered a “Chemical Restraint” are reviewed quarterly by the Physician / Pharmacist. The Nurse and care staff will monitor effects daily. There will be documentation in the progress notes indicating the effect of the medication on the resident.

**PROCEDURE:**

**Admission:**

1. Upon admissionall residents are assessed for potential for falls / falls history ((#13.23)
2. Care staff will assess ability to ambulate safely, using TLR Guidelines.
3. If a history of falls is present a Tabs Monitor will be placed on the wheelchair

 And on the bed. Assessment continues over the week to assess the degree of

 risk present and what types of measures are required to maintain safety.

 (Not applicable to ambulatory residents)

 **Ongoing:**

1. Asfollow-up to an incident report involving a fall, healthcare staff will reassess safety measures in effect prior to incident and make recommendations as needed (document assessment on Post Falls Huddle form).
2. Healthcare staff may reassess TLR / ambulation at any time if there is a change of mobility status or if increased measures are require to maintain resident safety.
3. Resident / family are consulted regarding the least restrictive device required to maintain safety and this will be reviewed at the resident care conference or on a “as needed”.

**Approval/Implementation/Evaluation Process**

Initial Implementation Date: January 7/98

Review Date: April 4/03, January 31/06, Sept 12/07, December 1/13

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# TABS Monitoring System

**POLICY:**

WBSCH is a least restraint facility and as such, physical and / or chemical restraints are discouraged.

Every attempt to maintain a resident’s dignity without compromising his/her safety is undertaken before the implementation of physical and / or chemical restraints:

TABS monitors are used as a “least restraint” device. The TABS Monitor System is to be used for Residents who have a documented history of preventable falls, or if the Resident is assessed as at risk for falls (TLR).

**EQUIPMENT:**

1. TABS Monitor
2. Monitor Cord with clip (long cord when in bed / short cord when in chair)
3. Bracket to stabilize monitor (chair / bed / toilet).

**PROCEDURE:**

* The RN / RPN / LPN is to complete an admission Falls assessment (history of previous falls / risk for falls). Any resident who has a history of previous falls / risk for falls should be placed on this program. The admission Falls assessment involves reviewing the SWADD admission data and completing the admission interview with resident / family.
* Previous Falls history / risk for falls is to be documented on WBSCH admission data base
* Following a fall the Post Falls Huddle is completed (Falls policy 13.23). The care Team must reassess whether fall was an isolated incident / preventable fall / at risk for future falls.
* If assessed as at risk for falls, documentation must appear on the Individual Care Plan and in the Progress Notes, stating why this resident was assessed as needing the TABs device.
* Care staff monitor the TABS monitor is in place / working as a component of PIPERRS (safety devices).

**Approval/Implementation/Evaluation Process**

Initial Implementation Date: October 5, 1997

Review Date: April 7/03, January 31/06, December 1/13

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Missing Resident – Code Yellow

**POLICY:**

This policy is written to provide direction to WBSCH staff when a resident is missing (CODE YELLOW).

All WBSCH staff are responsible for ensuring the safety of residents who are at risk to wander.

All WBSCH staff are responsible to participate in the search for a missing resident (Code Yellow).

**PROCEDURE:**

**PROACTIVE PHASE**

1. Upon admission to WBSCH the resident’s previous history / risk to wander should be documented on the Care Plan.
2. Family will be notified regarding the policy/procedure of Least Restraint.
* When taking resident on an excursion outside of the facility, family will sign the LOA Log.
* Maintain care plan(s) / MAR(s) with a current photograph of each resident.
* Notify other staff members and volunteers that the resident has a tendency to wander.
* Provide reception / other nursing units with a current photograph of residents who may wander.
1. Attempt to keep wandering residents in sight at all times.
2. Involve in recreational programming.
3. Signage posted at WBSCH entrance(s), directing visitors **NOT** to assist residents to exit the building.
* Implement Wander Guard bracelet if resident is ambulatory / mobile and has been assessed as at risk to wander.

**SEARCH PHASE:**

* CODE YELLOW – Emergency Preparedness Binder
* Immediately inform the Unit nurse that resident is missing (assume CHARGE throughout the CODE YELLOW until charge responsibility is transferred to another more appropriate person (Health Care Manager / DOC).
* Conduct a thorough search of the Unit / building.
* Check that resident is not in a recreation program off the Unit.
* Identify when the client / resident was last seen
* Identify what clothing the client / resident was wearing
* Check LOA book
* Over head page to request client / resident to return to their room
* Check if personal clothing and items have been removed from room
* Notify Health Care Manager / DOC
* Identify when client / resident last seen
* Identify what clothing the client / resident was wearing
* Check security cameras
* Announce / page “CODE YELLOW, looking for (name resident). Please check area”; three times.
* Direct Unit staff to again check all areas within WBSCH (main floor – all resident rooms; garden room; recreation programming area; dining rooms; PT area; public washrooms; etc)
* Direct Unit staff to again check all areas within WBSCH (basement – stairwells; laundry; maintenance area; boiler room; staff room; etc)
* Direct Unit staff to again check all outdoor areas around WBSCH (garden area; Balfour patio; gazebo; Hospice patio; benches at front entrance; etc)
* Direct Unit staff to walk a one block radius outside / around WBSCH (North, East, South, West)
* Notify family member to ensure they have not taken resident away from the building on an LOA.
* Inform the Health Care Manager / Director of Care, if resident not located.
* Notify City Police of missing resident, providing details regarding attire and appearance. Provide current photograph.
* Once resident located, announce / page “CODE YELLOW ALL CLEAR” three times.
* Once the situation is resolved, complete a Confidential Occurrence Report form including time, action taken, personnel involved, outcome of search and actions taken to prevent reoccurrence
* Immediately forward completed confidential occurrence report form to Health Care Manager / DOC (code 3)
* DOC / Health Care Manager to review the incident with staff to determine future corrective actions, as necessary.

**Source:**

WBSCH Emergency Preparedness Manual – CODE YELLOW

Government of Saskatchewan, Regional Health Services Policy & Procedure Manual (2013) 20.2 Emergency Plans

**Approval/Implementation/Evaluation Process**

Date Approved: October 24, 1998

Review date: January 31/06 / December 1/13

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Resident Outings (Leave Of Absence)

**POLICY:**

To ensure a consistent procedure is followed when residents go on an outing.

**EQUIPMENT (form):**

* LOA LOG

**PROCEDURE:**

* When leaving WBSCH / RWGH, the resident / responsible person will document in the LOA log book, specifying the destination of the LOA, contact telephone number, and expected time of return. The Nurse will initial this entry.
* The Nurse will determine / assess the need for medication to be sent with the resident / responsible person.
* The resident / responsible person is responsible for getting the resident into and out of vehicle being used to transport the resident for an outing. Care staff are not required to transfer / assist residents into private vehicles, as it may not be compliant with TLR.
* When the resident returns the care giver will document in the LOA log book the time the resident returned to WBSCH / RWGH.
* Should the resident not return at the designated time, the Nurse will contact:
	+ The responsible person for the resident identified during the LOA;
	+ The next-of-kin; and
	+ WBSCH Administrative person on-call (the Administrative person on-call will direct the Nurse if the police should be notified)

**REGINA WASCANA GRACE HOSPICE (**in addition to the above**)**

* The resident / responsible person is given narcotic medications for the LOA, up to a maximum of 24 hours of narcotics, regardless of length of LOA. If length of LOA is longer than 24 hours, resident / responsible person may be given an Rx for the narcotics or return to RWGH for the additional narcotics that are required for the duration of their LOA (24 hours at a time).
* If LOA is for longer than 24 hours, the resident / responsible person must communicate by telephone with RWGH every 24 hours to update about resident’s condition.
* Instruction is to be given to resident / responsible person that if there are questions / concerns while on LOA, to telephone RWGH for information.
* Palliative Home Care will **not** be involved while resident is on LOA unless prior arrangements have been made and agreed upon.
* If the resident chooses not to return to RWGH while on LOA, the resident / next-of-kin will contact RWGH. The attending physician and WBSCH Administrative person on-call must be informed.
* The Nurse will follow policy 11.4 Discharge against medical advice. The Nurse will document in the progress notes the risks discussed and the possible consequences of this action.

Sources:

WBSCH Handbook

RQHR SCH policies (2016), 15.8 Resident Outings.

**Approval/Implementation/Evaluation Process**

Date Approved / Revised: October 24/98; January 31/06; May 14/18

Review date: May 2018

Recommended by: Heather Ness/Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Ethics Committee Referral

**POLICY:**

**The Ethics Committee is an ad hoc committee of the Management Committee Meeting.**

In care environments we find ourselves in situations that call for thoughtful consideration about the way we care or how we feel we should care for a resident. To address these situations we follow an ethical framework that assists in working through the process and arriving at a recommendation.

The Ethics Committee provides a forum for discussion and consultation as well as aneducational and advisory resource to the WBSCH staff regarding ethical issues.

(see Terms of Reference / attached)

The functions include:

1. Advise and make recommendations about:

* policies regarding bioethical considerations such as Health Care Directives
* research proposals involving bioethical consideration
* special procedures and practices that are referred to the Committee for consideration and advice
* ethical dilemmas on a case-by-case basis through the Committee
* Consultation process, when requested by a physician, other health professional, resident or family member/concerned party.

2. Discuss topical bioethical issues and advise the Administration and staff of ways in which these issues may affect resident care.

3. Recommend and arrange for educational activities and reference materials relating to ethical issues.

**EQUIPMENT (form):**

* Terms of Reference
* Ethics Consultation Form

**PROCEDURE:**

1. Staff, residents or families may submit an issue for consideration / direction to the Ethics Committee.

2. The Ethics Consultation Form will be used to document the issue and any surrounding circumstances relevant to the issue at hand.

3. The Ethics Consultation Form is submitted to the Executive Director for processing / meeting of the Ethic Committee.

4. The Ethics Committee meeting will be convened at the direction of the Executive Director (within 5 working days).

5. At the discretion of the Chair (ED) the appropriate persons shall be summoned to attend the meeting.

6. A decision shall be rendered to the appropriate person (person who submitted the documented issue) within 10 working days of the decision.

7. Salvation Army Ethics Center (Winnipeg) or RQHR Ethics Board may be access for advisement, if deemed appropriate.

Source:

RQHR SCP policies (2016) 15.4 Resident Right To Decide

**Approval/Implementation/Evaluation Process**

Initial Implementation October 2016

Review Date:

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Research

**POLICY:**

Any Research Proposal and/or any study involving human subjects who are residents of WBSCH must be screened and approved by the WBSCH Senior Management Team.

Only Research Proposals that have been approved by the RQHR Research Committee will be considered (prior approval from RQHR Ethics Committee).

**PURPOSE:**

To ensure that:

* No harm occurs to any human subject involved in a research project in which WBSCH is involved
* The research project does not create or have the potential to create liability for WBSCH
* WBSCH resources are not required to support the research unless authorized by the Ethics Committees of WBSCH and The Salvation Army Ethics Centre.

**PROCEDURE**

1. The Proposal is received and screened by the Senior Management Team.

2. The Research will be considered if prior approval has been given by the RQHR Ethics Committee.

3. Approval will be dependent upon:

 adequate funding resources

 cannot exhaust staffing resources

 does not interfere with Resident & Family centered care philosophy and service.

 **Approval/Implementation/Evaluation Process**

Initial Implementation October 2016

Review Date:

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Concern Or Complaint Procedure

**POLICY:**

This policy is written to ensure that residents / families have a process to follow when there are concerns related to care.

WBSCH staff work hard to deliver quality care and service to residents / family. However, things can sometimes happen to cause concern. Residents / family are encouraged to speak with someone if not happy with the treatment, care of service received.

**PROCEDURE:**

* Care staff will report all resident / family concern to the Unit nurse. The Unit nurse will speak with the resident / family and attempt to resolve the concern. The Health Care Manager / DOC should be informed of the concern and resolution.
* If unable to resolve with the Unit nurse, the resident / family will be directed to speak with the Health Care Manager. The Health Care Manager is responsible to assist the resident / family to resolve concerns as quickly as possible. The Health Care Manager will respond to the resident / family in as timely a manner as possible.
* As appropriate, the Health Care Manager will schedule a Care Conference. The care conference provides an opportunity to review / discuss the care plan, and to address any changes in care needs.
* As appropriate, the Health Care Manager will assist the resident / family to schedule an appointment with the attending physician.
* The Health Care Manager will ensure that the DOC / Executive Director is aware of the complaint / actions to resolve. The resident / family may request to meet with the DOC / Executive Director.
* Should the resident / family wish assistance from outside WBSCH, information will be provided on how to contact the RQHR Client Advocate (patient advocate); 306-766-3232.
* Should the resident / family wish assistance from outside the RQHR, information will be provided on how to contact the Ombudsman Saskatchewan; 306-787-6211; [www.ombudsman.sk.ca](http://www.ombudsman.sk.ca)

Sources:

WBSCH Handbook

Program Guidelines for SCH (2013), 17.3 Quality of Care Concerns

Ombudsman Saskatchewan Promoting and protecting fairness in Health Facilities

**Approval/Implementation/Evaluation Process**

Date Approved / Revised: July 31/14

Review date:

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Resident / Client Safety Incident Disclosure

**POLICY:**

Accreditation Standard Leadership 14.6 (2017) states “A documented and coordinated approach to disclosing patient safety incidents to clients / residents and families that promotes communication and supportive response, is implemented.”

The Salvation Army William Booth Special Care Home (WBSCH) is committed to providing quality care to clients / residents and families. We believe that clients/ residents and families are entitled to information about the outcomes of tests, treatment and care. In some cases, poor outcomes may result of an adverse event.

WBSCH will disclose adverse events that have caused harm during the course of providing care, and near miss events that present an on-going safety concern. Disclosure is to the client / resident, and will be extended to a family (substitute decision maker / next of kin) as appropriately allowable under privacy policies and legislation. Initial disclosure will take place as soon as possible within 48 hours of the adverse event.

**Purpose:**

* To achieve a culture of accountability with respect to disclosure to clients / residents.
* To be transparent and compassionate with clients / residents and families when adverse events or potentially serious near miss events have occurred.
* Achieve a culture of patient safety by focusing on system improvement, and not personal blame.
* To hold accountable all physicians and staff to consistently demonstrate competence, professionalism and compliance with WBSCH and RQHR’s policies.
* To acknowledge that clients / residents and family, are legally, ethically and morally entitled to be informed about the care they receive, including the occurrence of adverse events.

**Definitions of Terms:**

**Adverse Event:**An unexpected event in healthcare delivery that results in harm and is not attributable to a recognized complication[[1]](#footnote-1).

**Patient:**Refers to all clients, patients, and residents.

**Disclosure:**Informing the patient or substitute decision maker about adverse events.

**Harm:** An unexpected or normally avoidable outcome that negatively affects a patient’s health or quality of life. The type of harm that can be triggers for adverse events include:

* Harm that was not anticipated and therefore not communicated during the process of obtaining informed consent;
* Harm that may have been caused by human or system error

**Seriousness of Occurrence (Classification System):**

* **Code One**: No clinical significance / No known injury
* **Code Two**: Minor self limiting injury requiring basic first aid or short term monitoring. X-ray and lab tests (If performed remain normal or unchanged).
* **Code Three**: Actual adverse outcome with successful intervention or significant potential for adverse outcome. In addition to the Code 3 definition, the following list of occurrences shall always be considered as Code 3:
	+ Wandering requiring police protection
	+ Breach of confidentiality
	+ Loss of clinical records
	+ Certified client who is AWOL
	+ Intended self harm (suicide attempt) while under care in RQHR facility
* **Code Four**: Irreversible complications or death[[2]](#footnote-2)

**Most Responsible Physician**: The physician who initiates the admission of the patient to the hospital and who coordinates the care of the patient[[3]](#footnote-3).

**Near Miss**: An adverse event that did not reach the patient because of timely intervention or good fortune[[4]](#footnote-4).

**Risk**: The probability of injury, damage, loss or liability; the possible occurrence of an undesirable outcome.

**Substitute Decision Maker**: A proxy or nearest relative as per The Health Care Directives and Substitute Health Care Decision Makers Act, 1997 (RAW9).

**PROCEDURE:**

1. **Complete Confidential Occurrence Report and inform RQHR Patient Safety Department for all Code 3-4 Incidents**
	1. Direction will be given by the Patient Safety Department regarding how to manage incident
	2. Ensure guidance is given as to if there is obligation to disclose the event or if the incident will be managed by RQHR
2. **Determining Need for Disclosure**

Both Adverse Events and Near Misses may need to be disclosed to patients.

Adverse events that require disclosure are those where:

* harm was caused but not anticipated.
* harm was caused and the potential for harm was anticipated, but was not discussed with the patient prior to the event

Other events that require disclosure

* An adverse event that reaches the patient but does not cause harm;
* A near miss event where an ongoing safety concern exists.
1. **Procedure for Disclosure**
* **Needs of Patients**
	+ Immediately after the adverse event has occurred, ensure patient care needs are met.
* **Needs of Staff and physicians**
	+ Immediately after the adverse event has occurred, ensure staff and physician needs are met. Employees and physicians who experience emotional distress due to adverse events should contact counseling services available through E.F.A.P. if necessary.
	+ Staff and physicians who have questions or concerns about disclosure should contact the Executive Director or Director of Care.
1. **Preparing for initial disclosure**
* Depending on the nature and level of severity of harm caused by the adverse event, preparation for initial disclosure of the adverse event to the client / resident should consider the following (see Appendix A for checklist):

**WHO**

**Providers of Disclosure:**

* A team approach should be used.
* The lead for the disclosure should be the person who has the most knowledge of the event that led to the harm (Executive Director, Director of Care or Care Manager).
* May include the most responsible physician and must include the opportunity for participation by the most responsible physician or their designate.
* Depending on the severity of harm, the team may include a representative of the RQHR (i.e. Patient Safety, LTC Program).
* Some disclosures may require the presence of specialized areas such as a Patient Advocate (RQHR), social worker or spiritual care to support the client / resident.
* Inform all other health professionals directly involved in the adverse event prior to initial disclosure.

**Recipients of Disclosure:**

* Recipients of disclosure will include the patient and/or substitute decision maker.
* With permission of patient, include family for support.

**Who Must be Informed that Disclosure is Occurring:**

* The individuals directly involved in the event
* Most Responsible Physician

**WHAT**

* Gather the facts of the incident. Avoid placing blame on individuals.

**WHEN**

* The initial disclosure meeting/telephone conversation should take place as soon as possible within 48 hours of the adverse event. If the patient will be the recipient of the disclosure, he/she must be physically and mentally stable before the initial meeting/conversation to take place.

**WHERE**

* The initial disclosure should take place in person where possible. Arrangements must be made for a quiet, private location.

**HOW**

* The providers of disclosure must be in agreement with how the disclosure will unfold prior to the meeting.
1. **Initial Disclosure**
* Should take place as soon as possible within 48 hours.
* Express regret for what happened. Be open and sincere. Be sensitive to cultural and language needs.
* Use clear and straightforward terms and language that the patient can understand.

**What to Disclose:**

* Provide only the **facts**. A more thorough report may be given during subsequent disclosure meetings after an investigation has been completed.

**What Not to Disclose**

* Do not speculate. Do not assign blame or use personal names.
* Although expressions of regret are encouraged, do not apologize for the incident until after a review is complete.

Explain the care plan and steps that will be used to minimize health effects of the adverse event.

Provide a brief overview of the investigative process that will follow, and what the patient can expect to learn from the investigation.

If the situation warrants investigation, arrange a time for a follow-up, or exchange contact information for communications in the future.

Support the patient’s emotional needs by providing contact information for counseling services.

Patients have the right to decline disclosure. If the patient waives the right to disclosure it must be documented in the patient’s chart.

Clarify the patient’s understanding of the situation. Ensure there is enough time for the patient to ask questions and voice concerns.

1. **Documentation**
* A brief and factual entry must be made into the patient’s health record (e.g. Chart) reflecting the nature of the disclosure discussion with the patient / substitute decision maker. The entry must include the date, time, and facts provided and who was present during the discussion.
* Complete a Confidential Occurrence Report on the incident and notify the Patient Safety department if not already completed.
* If the initial disclosure meeting with the patient occurs after discharge, documentation of the meeting must be included as an entry into the patient’s health record.
1. **Subsequent Disclosure Discussions**

● Subsequent disclosure discussions take place after a review of the event has been completed. Factual findings of the review of the event and the steps undertaken to prevent future occurrences may be disclosed to bring closure to the patient. For code 3 & 4 occurrences, this is usually done by Patient Safety

● Details of the review, including information collected through privileged discussions (i.e. interviews with staff, discussion during quality improvement meetings, etc.), cannot be disclosed without approval by Patient Safety.

● A statement of apology from the Region or person(s) responsible may be appropriate at this time.

**Responsible Officers:**

* Executive Director
* DOC
* Care Manager
* All staff, health care providers and health care professionals working, training or volunteering within WBSCH

Sources:

* Program Guidelines for SCH (2014), 17.1 Incident review investigation and reporting
* Canadian Patient Safety Institute National Guidelines for the Disclosure of Adverse Events – DRAFT
* RQHR Occurrence Reporting Procedure – 1.4.2.04
* RQHR Rules and Regulations – Article 30
* RQHR Disclosure of Adverse Events Reference #603
* Disclosure Decision Tree – RQHR policy 6031-

**Approval/Implementation/Evaluation Process**

Date Approved / Revised: July 31/14

Review date: January 2017

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Appendix A – Checklist to Prepare for Disclosure** |
| Is the client / resident and family (substitute decision maker) is physically and mentally capable of receiving the disclosure? |  |
| Decide who will be present at the disclosure meetingProviders of Disclosure* ED / DOC / Care Manager
* Person with most knowledge about event
* Most responsible physician
* Patient Safety representative (RQHR)
* Client Advocate (RQHR)
* Spiritual Care
* Other supporter

Recipients of Disclosure* Client / Resident
* Substitute Decision Maker (SDM) when appropriate
* Family/support when requested by client /resident / SDM
 |  |
| Inform all other health professionals directly involved in the adverse event as well as appropriate managers |  |
| Gather facts or produce sequence of events |  |
| Ensure all providers of disclosure are in agreement of facts or sequence of events |  |
| Ensure facts do not place blame on any individual |  |
| Ensure facts are not speculative |  |
| Arrange for meeting to take place in person where possible |  |
| Arrange for a quiet and private space to hold meeting |  |
| Providers of disclosure should be in agreement of how the conversation will unfold prior to meeting and decide who will lead discussion |  |
| Develop strategy for expressing regret without apologizing when appropriate |  |
| Prepare care plan and steps that will be used to minimize health effects of the adverse event |  |
| Determine the investigative process that will be used and what the client / resident / SDM can expect to learn |  |
| Prepare contact information for spiritual care to offer  |  |
| Ensure there will be enough time to ask questions and voice concerns |  |

# Informed Release From Responsibility

**POLICY:**

When a resident / substitute decision maker refuses to consent to the use of protective measures / safety devices, against the advice of their or the WBSCH Care Team, the resident / substitute decision maker will be asked to sign the **Release from Responsibility** form.

The Physician, DOC/CCC and Executive Director must be advised of the resident’s / substitute decision makers request / refusal.

The **Release from Responsibility**, cannot supersede any other policies of the Home.

The **Release from Responsibility** form is completed after a care conference has been held.

**PROCEDURE:**

A care conference will be held with the resident / substitute decision maker to discuss the request / refusal.

Documentation on the **Release from Responsibility** form and progress notes should contain the risks discussed and the possible consequences of this action. Should the resident / substitute decision maker refuse to sign this form, the refusal should also be documented along with the aforementioned.

The **Release from Responsibility** form is completed after a care conference has been held.

The safety of other residents and staff must be considered when a request is made for release of responsibility.

The Home may refuse to assume the risk deemed upon the circumstances. If resident is not in compliance then the Home will initiate a conference with the RQHR for alternate placement.

**Approval/Implementation/Evaluation Process**

Date Approved / Revised: December 18/98; December 1/10

Review date: August 22/05; August 23/07

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Wander Guard Sensor Check

**POLICY:**

To provide direction for the practice of **least restraint** use in order to support a safe environment for residents and staff, while maintaining quality of life, preserving self-worth and dignity for each resident.

WBSCH adheres to the philosophy of **least restraint** and as such, physical and / or chemical restraints are discouraged. Every attempt to maintain a Resident’s dignity without compromising his / her safety is undertaken before the implementation of physical and / or chemical restraints.

The Wander-Guard alert system is compliant with the philosophy of **least restraint**. The Wander-Guard alert system is intended to promote the safety of Residents identified as “at-risk” to trying to leave the facility

**EQUIPMENT (form):**

* Pocket Tag Reader
* WanderGuard Daily Safety Check form
* Work Standard – WanderGuard Sensor Check

**PROCEDURE:**

* Work Standard (attached)

**NOTE:**

The Wander-Guard alert system, sounds an Exit alarm when the sensor is brought near an exit protected by a Door Controller (i.e.: main entrance, garden room, RWGH entrance).

Wander Guard bracelets and sensors are available from Reception. After hours, there is one Wander Guard bracelet and sensor stored in Balfour (locked) medication cupboard.

**Source:**

RQHR SCH policies 15.10 Restraints (2016)

WBSCH Nursing Policy 13.4 Least Restraint

**Approval/Implementation/Evaluation Process**

Date Approved: June 1, 2005: April 21, 2012

Review / Revised date: September 2016

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Review Of Resident Charts

**POLICY:**

To provide direction to staff when requests from Resident / POA / Executor, are made to review the health record / chart.

A procedure, ensuring privacy / confidentiality of all health records will be followed when a request is made to review resident documentation.

**EQUIPMENT (form):**

* Consent for Disclosure of Resident Information form

**PROCEDURE:**

Staff are to direct all inquiries / requests to the Executive Director / designate.

All reviews of the resident’s health record chart / documents must be done Monday – Friday during regular business hours.

Should a request be made outside normal business hours the staff are to advise the person making the request to contact the business office on the next business day.

For release of information by either viewing the resident’s health record or requesting a photo copy, the Resident / POA / Executor is required to complete the attached, “Consent for Disclosure of Resident Information” form. This form can only be witnessed by Administrative Personnel. Documents which provide proof of POA / Executor status must be provided, along with photo identification.

The only information that will be released is the health record generated at WBSCH. Any health information generated outside of WBSCH will not be released. Health information generated outside of WBSCH must be obtained from the original source (RQHR; consultant; etc).

**At no time should a staff member release the health record / chart or any components of the health record to any individual.**

**Approval/Implementation/Evaluation Process**

Date Approved / Revised: June 1, 2005: April 21, 2012

Review date: September 2016

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Bath Water Temperature Testing

**POLICY:**

WBSCH has implemented this policy of testing and documenting water temperature at point of care to ensure water temperature is kept at the optimum temperature for the safety of residents.

Prior to bathing a resident in a tub, the caregiver shall test the water temperature using 3 safety checks.

**EQUIPMENT:**

* Bath water temperature log sheet
* Float water thermometer
* Tub control panel – temperature

**PROCEDURE:**

* Start with empty bath tub
* Fill bath tub with bath water noting the setting of the temperature on the tub control panel
* When bath tub full with water, test bath water temperature by putting hand and floating thermometer in tub water
* Read floating water thermometer temperature; ensure it is within safe limit (no warmer than 39 degrees C / 102 degrees F)
* Document on the Water Temperature Log kept in each tub room; resident name / date / the 3 temperature checks / staff initials

**ALERT:**

Should there be a fluctuation in the water temperatures recorded (difference between the temperature recorded by the floating thermometer and the temperature indicated on the tub control panel, the staff member will document in the maintenance request book to have the tub thermometer resent. The tub will be placed out of order until maintenance has reset the tub thermometer.

If the hand test and the floating water thermometer are within safe limits the bath may continue.

Source:

Program Guidelines for SCHs (2014) 18.5 Water Temperature

September 2006 Issue Alert: Recommendation to prevent water burns of residents.

**Approval/Implementation/Evaluation Process**

Initial Implementation Date: June 2007

Review date: April 2016

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Transfer Of Medical Function – Immunization Of Staff

**POLICY:**

Nursing practices “by transfer of medical functions “ are those medical functions primarily performed by physicians or outside the usual scope of nursing practice, but which may be transferred to specific nurses in the interests of client care (SRNA, The Registered Nurse Scope of Practice: Special Nursing Procedures and Nursing Procedures by Transfer of Medical Functions 1993, p. 10).

Transfer of Medical Function requires the written agreement from a qualified physician acting as the Medical Advisor of William Booth Special Care Home.

The only Transfer of Medical Function approved is the Immunization of Staff.

**PROCEDURE:**

The Registered Nurse/ Registered Psychiatric Nurse must be certified by the Medical Advisory Physician to perform the Transfer of Medical Function / Immunization of Staff. Re-certification must recur every 12 months.

The Executive Director, the Director of Care, and the Clinical Care Coordinator shall administer immunization to staff according to product monograph(s) and RQHR Public Health Directives and only upon signed Transfer of Medical Function by the Medical Advisor who has agreed to provide medical consultation services to William Booth Special Care Home.

The Executive Director, Director of Care and Clinical Care Coordinator are responsible to maintain competency as per the “Guidelines for Immunization Administration and Immunization Programs” (SRNA, 2003) document.

Yearly, prior to administering immunization, the Executive Director, Director of Care, and Clinical Care Coordinator shall demonstrate competency by attending a Population and Public Health educational update and successfully completing an Influenza Review quiz.

**Approval/Implementation/Evaluation Process**

Date Approved / Revised: **October 26, 2009**

Review date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Pain Protocol

**POLICY:**

To meet the requirements of resident-centred care, every effort is made to recognize, assess and appropriately manage pain.

The following procedure is to be followed when a resident expresses that they are experiencing pain.

**Definitions:**

* Pain is defined as “an unpleasant, subjective sensory and emotional experience associated with actual or potential tissue damage. This definition recognizes the physical and psychological nature of the pain experience.
* PAINAD (Pain Assessment in Advanced Dementia) Scale
* Observational behavioural tool of 5 items: breathing, facial expression, body language, negative vocalizations and consolability
* Each time rated on a scale of 0-2 for a total score from 0 (no pain) to 10 (severe pain); score 1 or 2 indicates some pain

EQUIPMENT:

* SBAR form
* PointClick Care PAINAD
* Numeric pain score

**PROCEDURE:**

When the resident complains of pain and the scheduled pain medication is not effective:

* Use available PRN pain medication to maximum dosing (resident uses breakthrough pain medication for 3 days)
* Provide alternative pain relieving therapies (i.e.: positioning for comfort, relaxation music, warm blanket, warm drink, etc).

The staff member will begin a 3 day assessment of pain, every 4 hours, while resident awake. Pain will be assessed and documented for

* **Type of pain-** Stabbing, shooting, aching
* **PAINAD or 1-10 Pain Scale** depending on residents ability to explain about pain experience
* **Location of pain**-back pain, headache, leg pain
* **Duration of pain**-how long this pain has happened
	+ This may be a chronic pain that is worsening or
	+ An acute pain that has happened suddenly
	+ Medication name, dose route and effectiveness

**Non Physician Visit Day**

* Using SBAR tool, the nurse will phone the physician to discuss the increased need for pain medication relief based on WHO pain ladder.
* The nurse will fax the PAINAD and current MAR.

**Physician Visit Day**

* The nurse, will have the necessary paperwork ready for the physician; the PAINAD and current MAR.
* The nurse will be prepared to discuss the need to increase the pain relief medication with the physician and resident/family

Should pain continue not to be controlled, the physician may decide to refer to a Pain Relief Specialist.

Reference

RQHR Special Care Home policies (2016) (section 1.4 (x))

PointClickCare: PAINAD

**Approval/Implementation/Evaluation Process**

Date Approved / Revised: April 2016

Review date:

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Falls Reduction / Injury Prevention Program

**POLICY:**

The RQHR LTC Falls Reduction / Injury Prevention Program will be implemented at WBSCH to reduce falls / prevent injury.

A **fall** is defined as, “any unintentional change in position where the resident ends up on the on the ground, floor or onto the next lower surface (i.e.: onto a bed, chair)” (MDS 2.0 J4). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. … Falls are not a result of an overwhelming external force (i.e.: a resident pushes another resident).

Guiding Principles for Fall Reduction / Injury Prevention

* Falls are predictable and preventable
* Fall prevention strategies will improve the Resident Experience and Improve Resident Safety
* Actions must be evidence based, recognizing that activities and initiatives to minimize the risk for falls and fall-related injuries will be diverse and suited to the particular resident setting
* Fall prevention and injury reduction is everyone’s responsibility

The WBSCH Falls Reduction / Injury Prevention Program is to be implemented for all LTC residents within 72 hours of admission; when there is a significant change in the resident’s clinical condition / TLR; and in conjunction with the Admission and Annual Care Conference(s).

The Falls Reduction / Injury Prevention Program is composed of **5 risk factors** that the RQHR has identified as a “best practice” approach in the assessment for falls risk:

1. FALLS Matrix – Mobility (TLR) & Cognition (CPS) review. Mobility and cognition are known to be significant for fall risk. Mobility is determined by the resident’s assessed TLR (mobility) and cognition is determined by the resident’s assessed MDS Cognitive Performance Scale (CPS)
	* MDS Cognitive Performance Scale (CPS) is found on the PointClickCare “DASH”. CPS is used to determine the resident’s short term memory, ability to make decisions, ability to be understood, and organize daily self-care activities:
		+ CPS score 0 – intact
		+ CPS score 1 – borderline intact
		+ CPS score 2 – mild cognitive impairment
		+ CPS score 3 – moderate cognitive impairment
		+ CPS score 4 – moderate to severe cognitive impairment
		+ CPS score 5 – severe cognitive impairment
		+ CPS score 6 – very severe cognitive impairment
2. Medication Review – reviewed to identify any risk factors that would influence mobility and / or cognition, putting the resident at risk for a fall
3. Clinical Review – reviewed to identify any clinical indicators that would influence mobility and / or cognition, putting the resident at risk for a fall
4. Environmental Audit - reviewed to identify any hazards in the environment that increase the resident’s risk for falling
5. Toileting risk - reviewed to identify any risks factors rated to toileting that increase the resident’s risk for falling

**PROCEDURE:**

**ADMISSION**

The Falls Reduction / Injury Prevention Program document is to be completed within 72 hours of admission; when there is a significant change in the resident’s clinical condition / TLR; and in conjunction with the Annual Care Conference.

The Falls Reduction / Injury Prevention Program document is to be completed with input from the members of the Care Team. The completed document is to remain as part of the permanent health record.

Care plan actions / safety strategies identified in the Falls Reduction / Injury Prevention Program are to be documented in the Care Plan.

The Falls Reduction / Injury Prevention Program is to be reviewed at the resident’s Admission and Annual Care Conference(s).

**FOLLOWING A RESIDENT’S FALL**

Following a resident’s falls, the Nurse will complete a thorough head to toe nursing assessment to identify any injuries sustained, prior to moving the resident. The Nurse will be alert and monitor for signs and symptoms of potential fractures, head injury / subdural haematoma (PEARL), or other internal injuries.

The Nurse’s assessment is documented on the:

* RQHR confidential occurrence report (section C)
* PointClickCare progress notes (see WBSCH policy #13.1).
	+ Type – **Fall**s
* RQHR – Post Falls Assessment
* Vitals to be completed Q4H x 24 hours, then Q – SHIFT X 48 HOURS FOLLOWING FALL
	+ Known or Suspected Head Trauma – Vital signs, GCS and strengths required q15min for first hour, then q1hr x 4 hours, then q4hr x 24 hours, then q8hr x 24 hours
* Utilize the Falls Algorithm to assist in decision making post fall

The **Post Falls Huddle** document must be completed:

* Following a resident’s fall
* In conjunction with a confidential occurrence report form
* By the care team on duty (e.g. SCA, LPN, RN/RPN, Recreation, RCC)
* By end of shift
* The Post Falls Huddle document is attached to the confidential occurrence report form and forwarded to the Manager
* Within 48 hours, the Manager will ensure:
	+ monitoring for injury completed
	+ the falls prevention / injury reduction strategies have been implemented
	+ family / NOK was notified

**All residents that have sustained a fall shall have:**

* A Falls Alert identified on their **picture care plan**
* Evidence of falls prevention /injury reduction strategies documented in his/her care plan.
* Family / Next of Kin (NOK) notified

**NOTIFICATION OF FAMILY / NOK FOLLOWING A FALL / INJURY**

Family / NOK must be notified of all resident falls. If the resident has sustained an injury, the family / NOK must be notified immediately. If the resident is not injured, notification of family can be delayed to occur during normal waking hours. All incidents of Falls will be reviewed with the family / NOK at the Admission and Annual Care Conference(s).

Reference

RQHR LTC Falls Reduction / Injury Prevention Program

RAI-MDS 2.0 Canadian Version User’s Manual (February 2012), J4 Accidents.

RAI-MDS 3.0, Section J Defining Falls (google)

**Approval/Implementation/Evaluation Process**

Date Approved / Revised: March 10, 2011

Review date: August 20/12

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#  Smoke-Free Environment

**POLICY:**

The Salvation Army William Booth Special Care Home / Regina Wascana Grace Hospice is a smoke-free environment.

The negative health effects of smoking are widely known. We believe that a smoke-free environment promotes the health and safety of residents, clients, staff, family members, visitors and volunteers.

WBSCH / Hospice is guided by the City of Regina By-Law #9423 which prohibits smoking/vaping in public facilities. Residents, clients, staff, family members, visitors and volunteers are not permitted to smoke/vape within the building or on the grounds.

**PROCEDURE:**

Residents, clients, staff, family members, visitors and volunteers are not permitted to smoke/vape within The Salvation Army William Booth Special Care Home / Regina Wascana Grace Hospice or on the grounds.

Staff may smoke/vape off the property or in their own private vehicles, on their scheduled / designated break times.

All clients admitted to Convalescent / RWGH must be accompanied by family / friend when exiting building to smoke/vape off the property or private vehicle. The staff nurse on duty must be informed when the client is being accompanied out of the building.

All residents admitted to Long Term Care and Respite, must be non-smoker for a minimum of one year. WBSCH does not accept the admission of a resident into long term care or respite, who smoke/vape.

All day program clients must agree not to smoke/vape for the time they are attending WBSCH Day Program.

WBSCH staff / volunteers are not permitted to accompany / supervise client smoking/vaping.

For fire safety, no smoking or vaping materials can be kept in client rooms (i.e.: lighter, matches, cigarettes, etc.). Smoking or vaping materials must be stored at the nursing station.

Source: WBSCH Administrative Policy & Procedure Manual, Policy #1.10.06, SMOKE-FREE ENVIRONMENT

**Approval/Implementation/Evaluation Process**

Date Approved: November 3, 2011

Review date: July 11, 2012

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Identification Of Residents

**POLICY:**

**Prior to the provision of any health service(s), resident identification must be confirmed. Resident identification is intended to reliably identify the resident for whom a health service is intended.**

**All staff unfamiliar with a resident / client will follow the resident identification procedure to ensure care to the correct resident / client. Resident identification must be confirmed using two (2) resident identifiers.**

**PROCEDURE:**

Internal resident identifiers (identification of residents within WBSCH)

For care staff, unfamiliar with resident / client, identification must be confirmed using two (2) identifiers:

1. Resident Photograph – current and recognizable is placed with the resident’s:
	* MAR sheet(s) in the medication binder
	* PointClickCare care plan (photo)
	* PointClickCare flow sheet(s) (photo)
2. Verbally verifying by asking the resident to state his / her first and last name and date of birth
3. Asking another staff member familiar with the resident, who is able to confirm the resident’s first and last name

External resident identifiers (identification of residents outside WBSCH)

All residents leaving WBSCH to receive a health service must have a white ident-a-band applied to their wrist with three (3) identifying attributes:

* A standard white ident-a-band will be applied to the wrist of any resident who is transported from WBSCH to a site where he/she will receive medical assessment / care / intervention (e.g.: hospital, physician office, medical laboratory / Gamma Dynacare, dental office, mental health clinic, dialysis unit, ect.)
* The three (3) identifying attributes that must be included on the ident-a-band are:
	+ Resident Name
	+ HSN
	+ Date of Birth

Reference:

WBSCH / RWGH EMS Transfer Sheet

RQHR Policy Reference #612

**Approval/Implementation/Evaluation Process**

Date Approved / Revised: September 2015

Review date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Compassionate Care

**POLICY:**

The Mission of the Salvation Army William Booth Special Care Home is to provide in the Spirit of Christ, care and support for the well-being of residents, clients, their families and staff.

When there is a change in the resident’s health status and supportive / comfort care is implemented (death is expected within next 24 - 72 hours), intentional care and support is extended to the family.

**PROCEDURE:**

This procedure is intended for care staffs use only and is to guide staff in providing supportive care to families:

* Professional staff to ensure family has been notified of change in resident’s health status and the provision of supportive/comfort care
* Professional staff informs the family the Chaplain is available. After business hours, if the family requests the Chaplain, the Professional staff will contact the Chaplain
* Professional staff informs the Chaplain of change in resident’s medical status. Notification of Chaplain would occur in the morning, during business hours, unless already requested by family.
* Chaplain provides spiritual care and support to family: offers to contact Religious affiliation; provides comfort basket (Journey’s End & other reading material, CDs / player, tea, candy, etc.)
* When family present on Unit, the LTC staff demonstrate support / caring by taking time to speak with family, asking if there is anything they need, offering tea / coffee / juice
* Should family indicate they wished to remain thru the night, Professional staff to offer to provide an easy chair (if one not already in the room) or a cot. Expectation that family remain in resident’s room through night. Suggestion, limit to 2 family members present through the night. WBSCH is unable to provide overnight accommodation in lounge, sunroom, etc.
* When a family member has stayed over the night, care staff to offer to provide a breakfast tray (toast, coffee, juice). Notify kitchen that breakfast tray is required.
* Ensure family aware of the process for ordering lunch and supper. If more than two family members present, suggest that family take turns going out for meals.
* If imminent death occurring over a meal period, care staff to offer nourishment. Notify kitchen to provide sandwiches and cookies
* If no family present and death is imminent, the Chaplain should be contacted / requested to remain with the resident. In the absence of the Chaplain, contact the DOC.

MEMORY BOX

* To promote dignity and respect in the packing of the resident’s belongings, a pre-wrapped “memory box” will be made available to the family. The pre-made “memory box” is provided for the family to take the resident’s personal items with them. The pre-made “memory box” is stored in the Hunt supply room.

**Approval/Implementation/Evaluation Process**

Date Approved: December 1, 2013

Review date: September 2016

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Palliative Performance Scale

**POLICY:**

When the Resident is deemed “compassionate care / comfort care” the Palliative Performance Scale (PPS) will be the communication tool used for measuring progressive decline in a Resident’s health status, over the course of illness.

Daily, TLR ambulation will be reassessed as a component of the PPS.

**EQUIPMENT (form):**

Palliative Performance Scale form

**PROCEDURE:**

The PPS can be used by any Licensed health care provider (RN / RPN / LPN).

The PPS% and TLR is to be documented daily in the progress notes.

PPS scores are determined by reading horizontally at each level to find a “best fit” for the Resident which is then assigned as the PPS% score.

Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity / evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that Resident. In this way, “leftward” columns (columns to the left of any specific column) are “stronger” determinants and generally take precedent over others.

PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a “best fit” decision. The combination of clinical judgment and “leftward precedence” is used to determine whether 40% or 50% is the more accurate score for the Resident.

**DEFINITION OF TERMS FOR PPS**

**Ambulation**

* The items “**mainly sit/lie**”, “**mainly in bed**”, and “**totally bed bound**” are clearly similar. The subtle differences are related to items in the self-care column. For example, “**totally bed bound**” at PPS 30% is due to either profound weakness or paralysis such that the Resident not only can’t get out of bed but is also unable to do any self-care. The difference between “**sit/lie**” and “**bed**” is proportionate to the amount of time the Resident is able to sit up vs. the need to lie down.
* “**Reduced ambulation**” is located at the PPS 70% and PPS 60% level. The person is still able to walk and transfer on their own but at PPS 60% needs occasional assistance.

**Activity and extent of disease**

**Self-care**

* “**Occasional assistance**” means that most of the time Residents are able to transfer out of bed, walk, wash, toilet and eat by their own means, but that on occasion (perhaps once daily or a few times weekly) they require minor assistance.
* “**Considerable assistance**” means that regularly every day the Resident needs help, usually by one person, to do some of the activities noted above. For example, the person needs help to get to the bathroom but is then able to brush his or her teeth or wash at least hands and face. Food will often need to be cut into edible sizes, but the Resident is then able to eat of his or her own accord.
* “**Mainly assistance**” is a further extension of “considerable”. Using the above example, the Resident now needs help getting up but also needs assistance washing his face and shaving, but can usually eat with minimal or no help. This may fluctuate according to fatigue during the day.
* “**Total care**” means that the Resident is completely unable to eat without help, toilet or do any self-care. Depending on the clinical situation, the Resident may or may not be able to chew and swallow food once prepared and fed to him or her.

**Intake**

* Changes in intake are quite obvious with “**normal intake**” referring to the person’s usual eating habits while healthy. “**Reduced**” means any reduction from that and is highly variable according to the unique individual circumstances. “**Minimal**” refers to very small amounts, usually pureed or liquid, which are well below nutritional sustenance.

**Conscious level**

* “**Full consciousness**” implies full alertness and orientation with good cognitive abilities in various domains of thinking, memory, etc.
* “**Confusion**” is used to denote presence of either delirium or dementia and is a reduced level of consciousness. It may be mild, moderate or severe with multiple possible etiologies.
* “**Drowsiness**” implies either fatigue, drug side effects, delirium or closeness to death and is sometimes included in the term stupor.
* “**Coma**” in this context is the absence of response to verbal or physical stimuli; some reflexes may or may not remain. The depth of coma may fluctuate throughout a 24 hour period.

**Source:**

The Pallium Palliative Pocketbook; 1st Edition, page A6 – A9

Special Care Home guidelines

**Approval/Implementation/Evaluation Process**

Date Approved: November 23/15

Review date:

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Adaptive Clothing

**POLICY:**

Through the course of the resident’s care at WBSCH, functional abilities and care needs may change. It may become necessary to have the resident’s clothing modified / adapted to facilitate dressing and undressing.

Adaptive clothing will be used when there is difficulty dressing and undressing the resident or when the resident has progressed to requiring a mechanical lift to transfer.

Circumstances that may indicate the need for adapted clothing include but are not limited to:

* Difficulty dressing / undressing the resident that may result in care staff / resident injury
* Resident discomfort during dressing / undressing
* When TLR assessment indicates mechanical lift required
* Maintaining normalcy of wearing clothing, not open back night gown / PJs

**Adaptive clothing** (also called open back, seatless, split back, free back) is clothing that has been modified / adapted to support the dressing and undressing needs of residents who are not able to stand, who have limited mobility (painful / stiff joints), or who require a mechanical lift to transfer. The caregiver can assist the resident to dress and undress while they remain seated or lying in bed.

**PROCEDURE:**

1. Care staff identify when they are having difficulty dressing and undressing the resident or when the resident has progressed to needing a lift for transfers.
2. Every effort will be made to find appropriate alternatives prior to adapting a resident’s clothing (i.e.: larger sizes, fabric with greater elasticity / stretch, etc).
3. The RCC (or designate) will discuss with the resident / family the safety concern identified related to dressing and undressing and the request for a suitable alternative (i.e.: larger clothing, different kind of clothing, adapted clothing).
4. Provide the resident / family with options for adapted clothing (i.e. suggest options for purchase, make alternations to present clothing). Adaptive clothing can be purchased with the adaptations or can be modified by a seamstress (information will be provided on seamstress available through WBSCH). All costs associated are the responsibility of the resident / family.
5. Document (progress note) on the choice the resident / family have made.
6. Care staff givers are to ensure the resident’s dignity is maintained. Adaptive clothing (open back tops and pants) are to be positioned /tucked close to the body with no skin exposed.
7. Adaptive clothing must be changed every time it becomes wet or soiled.

Source:

Providence Place (2010).

**Approval/Implementation/Evaluation Process**

Initial Implementation Date: June 3, 2014

Revised Date:

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Pets (Family / Visiting Pets)

**POLICY:**

Family members are encouraged to visit with their pets. Pets shall be allowed to visit the facility subject to reasonable rules as to the type of pet(s) and the care required.

Family members visiting with pets should be aware of and comply with guidelines regarding health, grooming and temperament.

Suitable animals for visitation include household pets (i.e.: dogs and cats), but do not include animals at high risk for transmitting infectious diseases to humans (i.e.: birds, fish, gerbils, hamsters, mice, rats, reptiles).

WBSCH may request written evidence of immunization status and / or veterinarian’s health report for any animal visiting the facility.

Provision will be made for service animals.

**NOTE**

This policy does not address WBSCH in-house pets or Therapy Dog program. Refer to WBSCH Recreation Policy # 9.1.07 RECREATION – PETS.

**PROCEDURES**

1. Individuals must practice hand hygiene before and after pet (animal) contact.
2. Pets should not be placed directly onto the bed. Instead, place a disposable pad, impermeable barrier between the bed and the animal. Dispose of this barrier when the visit is finished.
3. Staff member(s) will assist family / visitor should the animal urinate, defecate or vomit. PPE is to be worn to clean up the animal waste. Place animal waste into a plastic bag, tie up bag, and place into the garbage (do not leave in resident’s room). Hand hygiene is to be performed after glove removal. Notify Housekeeping to ensure that the area is properly cleaned and disinfected.
4. During an Outbreak, there will be no pet visits until the Outbreak is declared over by Public Health, unless extenuating circumstances exist.

**GUIDELINES**

* Pets (animals) must be clean and well-groomed
* Pets (animals) must be free from disease
* Pets (animals) should be sociable, friendly, and relaxed.
* When in common areas, pets (animals) should be leashed or be transported in a carrier
* Consideration must be given to those residents who do not wish to be visited by pets (allergies, phobias, or dislikes)
* Pets (animals) are restricted from the kitchen, food preparation and dining areas

Source:

WBSCH Recreation Policy # 9.1.07 Recreation – Pets

Five Hills Health Region (2009); 4-10-13 Pets

(2013) Animals in Health Care Facilities. Management Guidelines

Saskatchewan Ministry of Health, Program Guidelines for SCH (2013); 14.3 Pets in the Special-Care Home

**Approval/Implementation/Evaluation Process**

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Revised Date:

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Access License For Request Of Private Services From Residents

**POLICY:**

This policy is written to provide direction to WBSCH staff when the resident / family employ a private health care service provider.

A resident / family may acquire the services of a private health care service provider. The private services provider must adhere to the policy of the WBSCH pertaining to private services of healthcare provider, and also any other existing policies which could impact the care of the resident.

Private health care providers would include services / care provided by a private business such as:

* Massage Therapy
* Reflexology
* Dental care
* Foot care
* Reiki

**PROCEDURE:**

* The resident/family is responsible for undertaking the hiring process when contracting with a private agency, and for arranging for direct reimbursement for services rendered.
1. The resident/family must give prior notice to the facility when they are arranging for private business / private services provider to provide care/services to the resident.
2. The private services provider must obtain an **Access License** prior to delivering the care requested.
3. The **Access License** is approved by Executive Director / DOC. The Access License requires / must have the following document attachments:
4. Business License (as required)
5. Insurance certificate / 2 Million dollars minimal coverage
6. WCB / or equivalent coverage (as required)
7. Criminal Record Check for Vulnerable Sector / within 6 months
8. Educational Certificate of specific field of services offered: e.g. copy of Certificate of Reflexology
9. Licensure if applicable: RN / RPN / LPN / Physiotherapist etc
10. Confidentiality agreement signed
11. Computer access agreement signed (as required)
12. Private services provider shall be advised of, and agreeable to the policies and procedures of the facility, which will impact their service. This is done by the DOC / designate.
13. Private services provider shall notify the unit Nurse prior to providing the service to the resident.

**Approval/Implementation/Evaluation Process**

Initial Implementation Date: July 7/2015

Review Date: January 27, 2017

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Suicide Prevention

**POLICY:**

Every year close to 3.700 people in Canada die by suicide. Many of these deaths could be prevented by early recognition of the signs of suicidal thinking and offering appropriate intervention.

As a requirement in the Accreditation guidelines (8.8), WBSCH will assess and monitor for risk of suicide.

The MDS (Section E – Mood and Behaviour Patterns) will be the assessment tool used to assess and monitor for the risk of suicide.

**DEFINITIONS:**

Depression Rating Scale (DRS) – is used as a clinical screen for depression.

|  |  |
| --- | --- |
| **Score** | **MDS Section E Item** |
| 0 - 3 | Made negative statements (E1a) |
| 0 - 3 | Persistent anger with self or others (E1d) |
| 0 - 3 | Expressions (including non-verbal) of what appear to be unrealistic fears (E1f) |
| 0 - 3 | Repetitive health complaints (E1h) |
| 0 - 3 | Repetitive anxious complaints / concerns (non-health related) (E1i) |
| 0 - 3 | Sad, pained, worried facial expression (E1l) |
| 0 - 3 | Crying tearfulness (E1m) |

The DRS is calculated by summing all seven input items after recording each input item to a three-point:

0 – not triggered

1-2 – triggered (behaviours exhibited up to 5 days / week)

3 – high risk (behaviours exhibited daily or almost daily)

**EQUIPMENT:**

* Depression Rating Scale score (DRS)
* Most recent completed MSA assessment (Section E)
* MDS CAPs triggered (mood)
* LTC Admission Data Base

**PROCEDURE:**

When available upon admission, the most recent completed MDS assessment (Section E), the DRS score and triggered CAPs (mood) will be used for the initial risk of suicide assessment.

When the MDS assessment is not available on admission, the LTC Admission Data Base will be used for the initial risk of suicide assessment (Section E).

The risk of suicide is assessed for each client at regular intervals (Quarterly) or as needs change:

* MDS quarterly CAPs (mood)
* Point-Click-Care / DASH / MDS scores / DRS
* MDS Quality Indicator reports

Identify and address any immediate threats to the client’s safety that is posed by the mood state:

* Has the client made a suicide plan?
* Has the client attempted suicide in the past?
* Has the client taken any risky actions such as stockpiling pills, saying good-bye to family, giving away possessions or writing a note?
* Has the client intentionally harmed or tried to harm self?

Notify physician of assessed suicide risk.

The immediate safety needs of clients identified as being at risk of suicide are addressed (i.e. frequent monitoring; reassurance).

Referral to RQHR Geriatric Assessment Team / Psychiatrist to identify and treat any underlying conditions that may have caused or contributed to the mood state.

Care plan (document) treatment and monitoring strategies in the client record.

Monitor for response to treatment or adverse effect of treatment.

Reference

RQHR Special Care Home policies (2016) (section 1.4 (h))

RAI – Clinical Assessment Protocols (CAPs), Mood CAP Guidelines

RAI – MDS 2.0 Canadian Version User’s Manual – Section E – Mood and Behavior

Accreditation Canada Long Term Care Services (8.8)

**Approval/Implementation/Evaluation Process**

Date Approved / January 2017

Review date:

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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