
Emergency Medical Services
& Long-Term Care
Exploring solutions together
September 12, 2024 | 1 – 3 PM

Learning Outcomes

- Review EMS usage in assisted living and skilled nursing facilities
- Outline struggles of LTC providers and EMS staff
- Review realities of emergency department, emergency room resources
- Explore best practices for before, during, and after a resident-focused 911 call
- Discuss expectations to best serve residents, staff, EMS, hospital
- List possible solutions to decrease nonemergent 911 calls

The Cast & Crew

Before We Start

- Not intended as punitive
- Relationship development: we are partners in the continuum of care
- View all sides, perspectives
- Troubleshoot, brainstorm fixes
- Re-evaluate internal processes, policies, long-standing practice with an eye to best serve the resident

Why We're All Here Today

- Facilities
  - 556 assisted living facilities
  - 198 nursing homes
- Increase in nonemergent/non-transport calls
- Calls of concern
    - Lift assists
    - Minor injury falls
- Other calls to consider
    - UTI symptoms
    - Urinary catheter issues
    - Behavioral challenges

BEFORE THE EMERGENCY HAPPENS

Community Outreach

- Relationships building
- Provide an overview of your community:
  - # of residents
  - Differentiate types
  - Level(s) of care you provide
- Staffing levels, types on all shifts
- Disclosure of services (for AL)
- Situations typically warranting immediate call to EMS
- Actions staff take prior to calling 911

Community Outreach

- Know your DSHS case manager, RCS field manager
- Know other resources in your area
  - SNF
  - AFH
  - ALF
  - Home health, hospice
  - Home care
  - Urgent care options
  - Behavioral Health

Philosophy of Care, Capabilities, & Limitations

ALF: review your disclosure form

- Know your staffing, limitations, scope of care
- Be prepared to educate and advocate

SNF: What can you do with your own resources, within scope of practice?

- What has changed?
- Why is the facility unable to meet the need now?

Policies & Procedures

GUIDELINES

LAY TERMS, NO ABBREVIATIONS

TRAIN, RE-TRAIN STAFF ON USE, LOCATION, RESOURCE

CONSIDER DRILLS, PRACTICE

Educate/Train Staff, Residents, Families

- STAFF: Upon hire, routinely thereafter, follow-up/debrief
  - Common reasons to call 911
  - Policies and procedures
  - Address/phone number, specific location of emergency
- RESIDENTS
- FAMILIES

DSHS ALTSA "Dear Provider" letters: Use of Emergency Medical Services #2022-022, -033

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, Washington 98504-5600

May 27, 2022

ALTSA: AFH #2022-022
ALTSA: ALF #2022-019
ALTSA: ESF #2022-018
ALTSA: NH #2022-033
ALTSA: ICF/IID #2022-011
USE OF EMERGENCY MEDICAL SERVICES BY LICENSED AND CERTIFIED LONG-TERM CARE PROVIDERS

Dear Administrator, Provider, or Superintendent:

This letter rescinds ALTSA: NH #2015-013 – Use of Emergency Medical Services.

The purpose of this letter is to remind you of relevant state laws and rules pertaining to your responsibilities related to residents, their medical issues, and the use of the local fire department and emergency medical services (EMS) or 9-1-1. Please remember that you are required to have sufficient and trained staff at all times to respond to resident needs, including medical emergencies.

Nursing Homes (NH): Applicable sections in Chapter 388-97 WAC - include 1000, 1080, 1260, and 1660; and F-Tags: F656 (42 CFR 483.21); F689 (42 CFR 483.25); F725, and F726 (42 CR 483.35).

Assisted Living Facilities (ALF): Applicable sections in Chapter 388-78A WAC – include 2050, 2090, 2140, 2450, and 2600.

Intermediate Care Facilities for Individuals with Intellectual Disabilities: Applicable sections in W-Tag W186; and 42 CFR 483.430 (d)(1).

Enhanced Services Facilities (ESF): Applicable sections in Chapter 388-107 – include 0240, 0410, 0760, 1580, 1590, and 1600.

Adult Family Homes (AFH): Applicable sections in Chapter 388-76 WAC – include 10020, 10135, 10195, 10355, 10390, 10400, and 10405.

You should only call 9-1-1 when the resident:
- Has an acute, serious, life-threatening medical condition or complaint;
- Is medically unstable; or
- Has an immediate health risk.

Do not call 9-1-1 when the resident's condition is:
- Medically stable; or
- Non-acute or not serious.

This letter does not mean that you should never call 9-1-1. When your evaluation or assessment of the resident shows the resident may have a medical emergency, you should call 9-1-1. Please refer to the guidance on page 2 when calling 9-1-1.

GUIDANCE* FOR
EMERGENCY MEDICAL RESPONSE AND TRANSPORT REQUESTS

When Calling 9-1-1:	When EMS Arrives:
Be ready to relay the following information: • Your name and name of facility or home • Address where help is needed • Call-back number • Resident information: ✓ Age ✓ Gender ✓ Special medical complaint or problem: "Chest pain", "Shortness of breath", etc. ✓ Medical history relevant to or potentially impacted by the current medical event ✓ Any medical treatment provided and status change. Remember to call 9-1-1 again if conditions worsen.	Please be prepared to provide as much information as you can including: • Resident age and gender • Details of medical complaint or problem • Level of consciousness • Vital signs • Medical history • Medications • Care provided: oxygen, ECG (Electrocardiogram), IV (Intro-venous), medications, etc. • Plan and transport destination • Medical orders and directives

*This guidance includes information from King County Emergency Medical Services.

Thank you for your continued commitment to resident health and safety. If you have any questions, please contact your local RCS Field Manager. For additional guidance regarding medical emergency response in your facility, you may contact your local fire department or EMS provider.

Sincerely,
Mike Anbesse
Mike Anbesse, Director
Residential Care Services

DSHS: "Transforming Lives"

INTERACT Tools

- Early recognition of condition changes
- Conversations with residents, families regarding:
  - Advance care planning, CPR, comfort measure options
  - Hospitalization pros, cons
- Communication tools
  - Caregivers
  - RNs, LPNs
- Change in condition care paths
- https://pathway-interact.com/

Consulting with Resident's Health Care Provider

Consult with the resident's physician, and

Make reasonable efforts to notify the resident representative when:

- An accident involving the resident which requires or has the potential for requiring physician intervention;
- There is a significant change
- There is a decision to transfer or discharge the resident from the facility.

RCW 70.129.030

When NOT to Call 9-1-1

Non-Emergency: Should be directed to PCP, Community clinic/Urgent Care, or mAnnaged in-house	
Resident needs a ride to hospital or clinic	Non-injury fall; fall with minor injuries
Medication refill	Nausea (often occurs with dehydration, poor diet, or low/high blood sugars, if applicable)
Blood pressure check	Controlled bleeding
Headache	Urinary catheter problem, blood in catheter
Anxiety	Minor pain with ability to move
Cold or flu symptoms (stuffy nose, fever, cough, body aches, etc.)	UTI
Diarrhea	Constipation

911 should ONLY be used in emergency situations.
A medical emergency is something that will result in loss of life or limb if not treated immediately.

Preparing for Minor Emergencies

- Strong policies and procedures
- Staff training, coaching, mentoring
  - Problem-solving
  - Best practices re: care
- Anticipate care needs based on assessment, resident history
- Plans in place for falls, catheters
- Prepare for changes in condition, responses
- Ongoing collaboration with PCP, medical director
- First aid

Other Considerations Warranting Attention

- What does it mean to “consult” with the physician?
- Consider customary use of ER
  - Residents, families
  - Staff
- Discuss the realities of ER visits
  - Delays in care, isolation, potential additional decline/injury
- Alternatives to ER
  - Mobile X-ray, onsite urgent care, visiting MD/NP
- Take a “monitoring” approach

When to Call 9-1-1

Emergency: Dial 911
Trouble Breathing. Unable to speak in full sentences
Person is unresponsive
First time or longer than normal seizure
Skin or lips are blue, purple or gray
After head injury: decreased level of alertness, confusion, headache, vomiting
Large burn or cut that will not stop bleeding
Unstoppable vomiting or vomiting blood
Severe dehydration (sunken eyes, no tears or urination, extreme tiredness)
Chest, back or neck pain with lightheadedness, fatigue, nausea, cold sweat, shortness of breath, or numbness
911 should ONLY be used in emergency situations. **A medical emergency is something that will result in loss of life or limb if not treated immediately.**

Some Responses EMS Hears

- “I have to call 911. The state requires it.”
- “Our care staff cannot evaluate a resident.”
- “Our policy requires us to call 911 for all falls when the resident hits his head.”
- “We call 911 for all resident changes in condition.”
- “It’s a liability if a resident hits their head and we don’t call.”
- “We are a no-lift facility.”
- “If the resident wants us to call 911, we call.”

Catheters

- Issue: Indwelling; dislodged and need replaced. Facility staff consider this an emergency
- Issues with calling EMS:
  - Not an emergency call
  - EMS not able to replace
- Issues with facility:
  - Must have staff and/or contractors able to provide level of care needs
  - Policy, procedure
  - Staff training
  - Supplies available

Lift Assist

- Issue: Fall with no (or minor) injuries identified and facility calls EMS to evaluate the resident
- Issues with calling EMS:
  - Not an emergency call
  - EMS not a lift service
- Issues with facility:
  - Must have staff and/or contractors able to provide level of care needs
  - Policy, procedure
  - Staff training
  - Equipment available

UTIs

- Issue: facility staff view as an urgent change of condition
- Issues with calling EMS:
  - Not an emergency call
  - ED focus in major health crises
- Issues with facility:
  - Must have staff and/or contractors able to provide level of care needs
  - Policy, procedure, protocols
  - Staffing

Behavioral Challenges

- Issue: facility staff views this as an urgent and unmanageable change of condition
- Issues with calling EMS:
  - Not an emergency call
  - ED focus in major health crises
- Issues with facility:
  - Must have staff and/or contractors able to provide level of care needs
  - Policy, procedure, protocols
  - Staff training
  - For AL with SDC, ECS – must have behavioral resource available

Pronouncing Death, POLST

- DNAR, comfort only, no hospitalization
- Issues for EMS:
  - Pronouncing death in assisted living (not on hospice, no nurse on site)
- Age in place
- Issues for management:
  - Policies/procedures, protocols
  - Staff training, communication
  - Know what to do, when
  - System evaluation
  - Lessons learned
- Resources available

https://nursing.wa.gov/sites/default/files/2022-07/NCAO23.pdf

Discussion: What is Going On?

HOSPITALS

- Staffing challenges
- Diversion
- Inability to admit for certain conditions
- Long waits

LONG TERM CARE

- Staff changes
  - Turnover
  - Training, competency
  - Staffing challenges
  - Staff new to Washington state
- Agency staff
- Resident changes, needs
  - Fearful, anxious
  - Increase in complexity

WHEN THE EMERGENCY HAPPENS

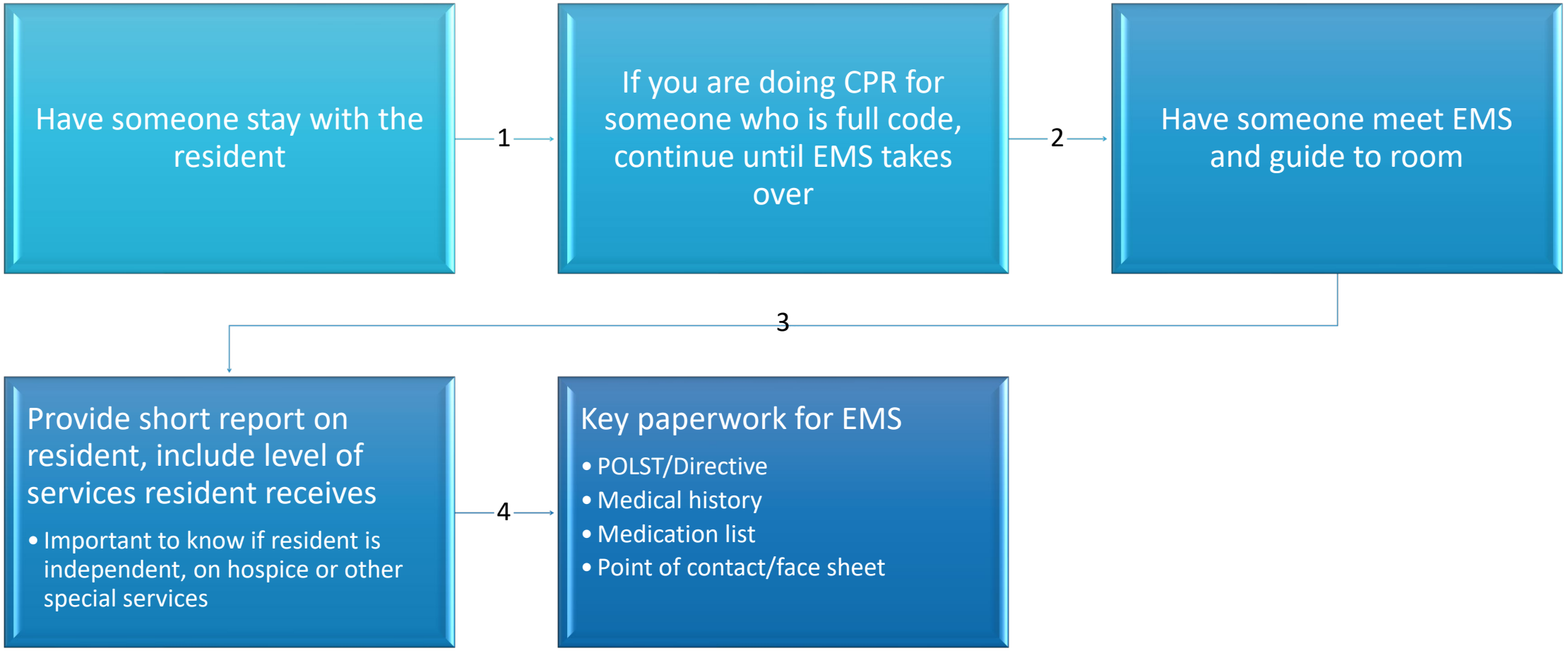
Calling 911

- Know when to make the call
- Be prepared
  - Facility address, specific room number, hallway, etc
  - Resident name, DOB
  - Specific issue at hand
  - Vital signs
  - POLST information (or no POLST available)
- Print any necessary documents for EMS
  - POLST, face sheet, insurance information, transfer form, current medication list
- Person who knows the resident, situation stays with resident during EMS onsite

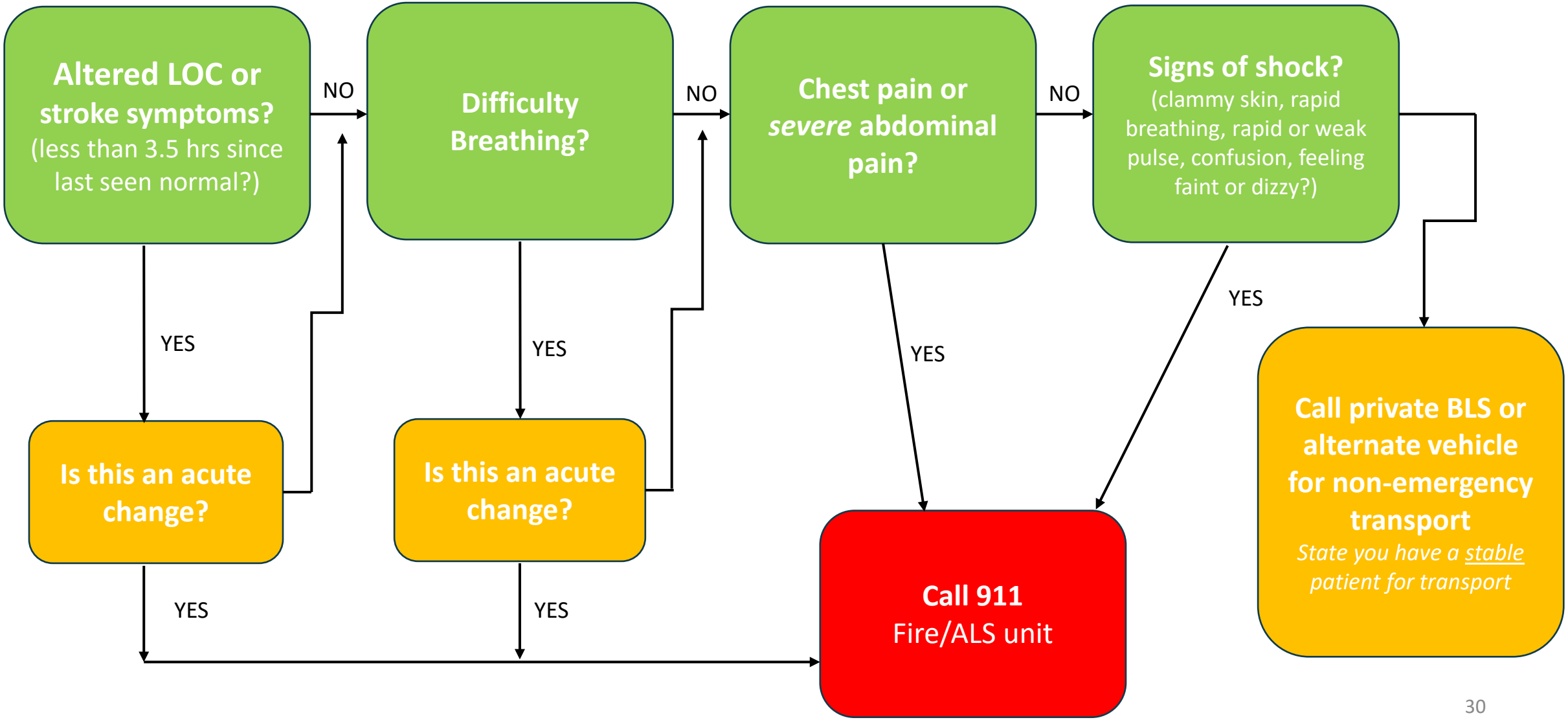
What happens when you call 911?

- 911, What are you reporting? Police, Fire, or Medical?
- Provide facility address, including building and/or room #
- Call receiver asks standard questions
  - Is the patient awake?
    - If no, is the patient breathing normally?
    - Is there a change in their cognitive status?
  - General age
  - Chief complaint
  - Any pertinent Data: ABNORMAL vitals, pain, description of acute problem
- As soon as the call receiver has address and medical need, EMS responders are being advised. 911 dispatches the appropriate resources
- STAFF SHOULD BE PREPARING FOR EMS ARRIVAL

Preparing for EMS Arrival



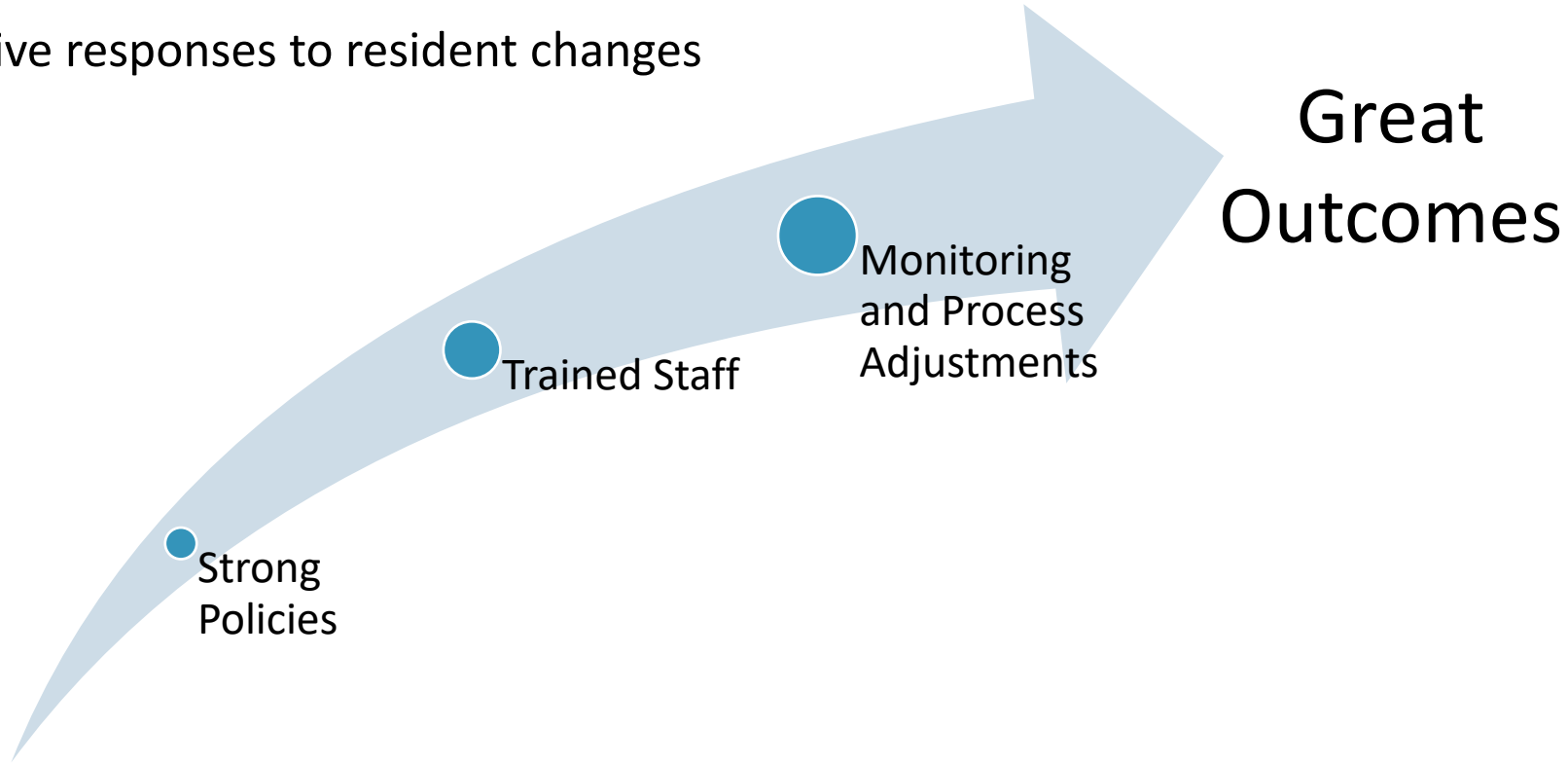
Making the Right Call



Facts of the Matter

Residents fare better in their own beds

Proactive vs. reactive responses to resident changes



Long Term Care: First Line Resources

- Front line staff
- The resident
- Care plan/service agreement
- Policies and procedures
- Leadership in the building
- Resident's PCP, specialist
- SNF Medical Director

Resource for Non-Emergent Resident Evaluation and Treatment

- Telehealth/virtual visits with PCP
- Urgent care
- Visiting PCP
- Explore options available, prepare

Resources For Non-Emergent & Interfacility Transport to the ER or other locations

- Cabulance
- Private Ambulance: available 24/7
  - Northwest Ambulance
  - Tri-Med
  - Trans-West Ambulance
  - Advanced Life Systems

Requirements

RCS

- RCS Supports
  - Behavioral Health Team
  - Technical Assistance
  - Field Managers
  - QIPs
- Proactive approaches to resident care
- Policy & Procedures
- Staff training
- Only accepting those whose needs the facility can meet and have staff availability and expertise
- Talk with residents and representatives about advance care planning

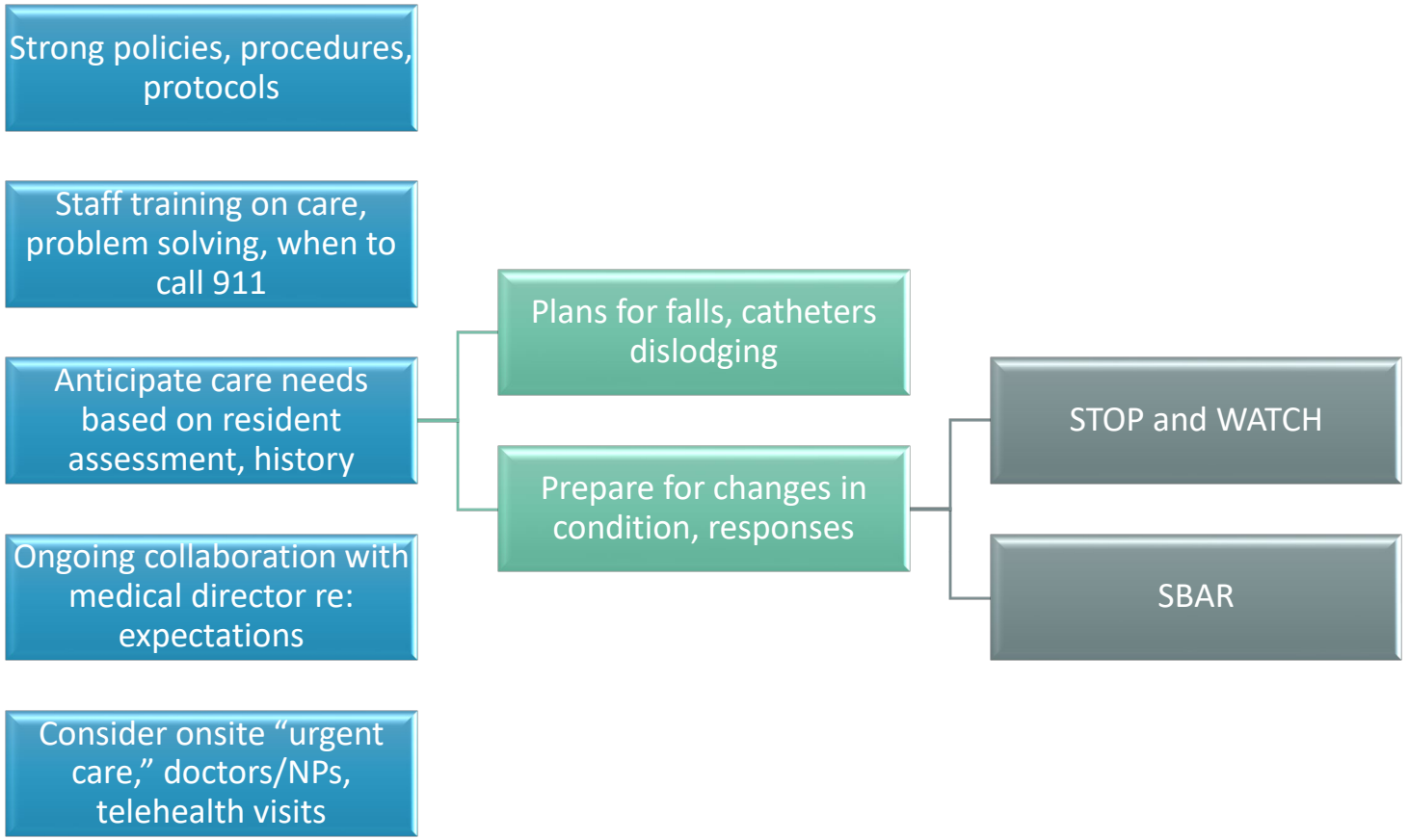
ALF: Requirements

- Disclosure of services
  - Limitations, services offered
- Resident characteristics
- Staff training
- Intermittent nursing
- Policies and procedures
- Nonresident individuals

SNF: Requirements

- 24-hour nursing coverage
- Sufficient staff
- Sufficient staff and equipment
- Policies and procedures
- Medical director guidance
- Transfer/discharge

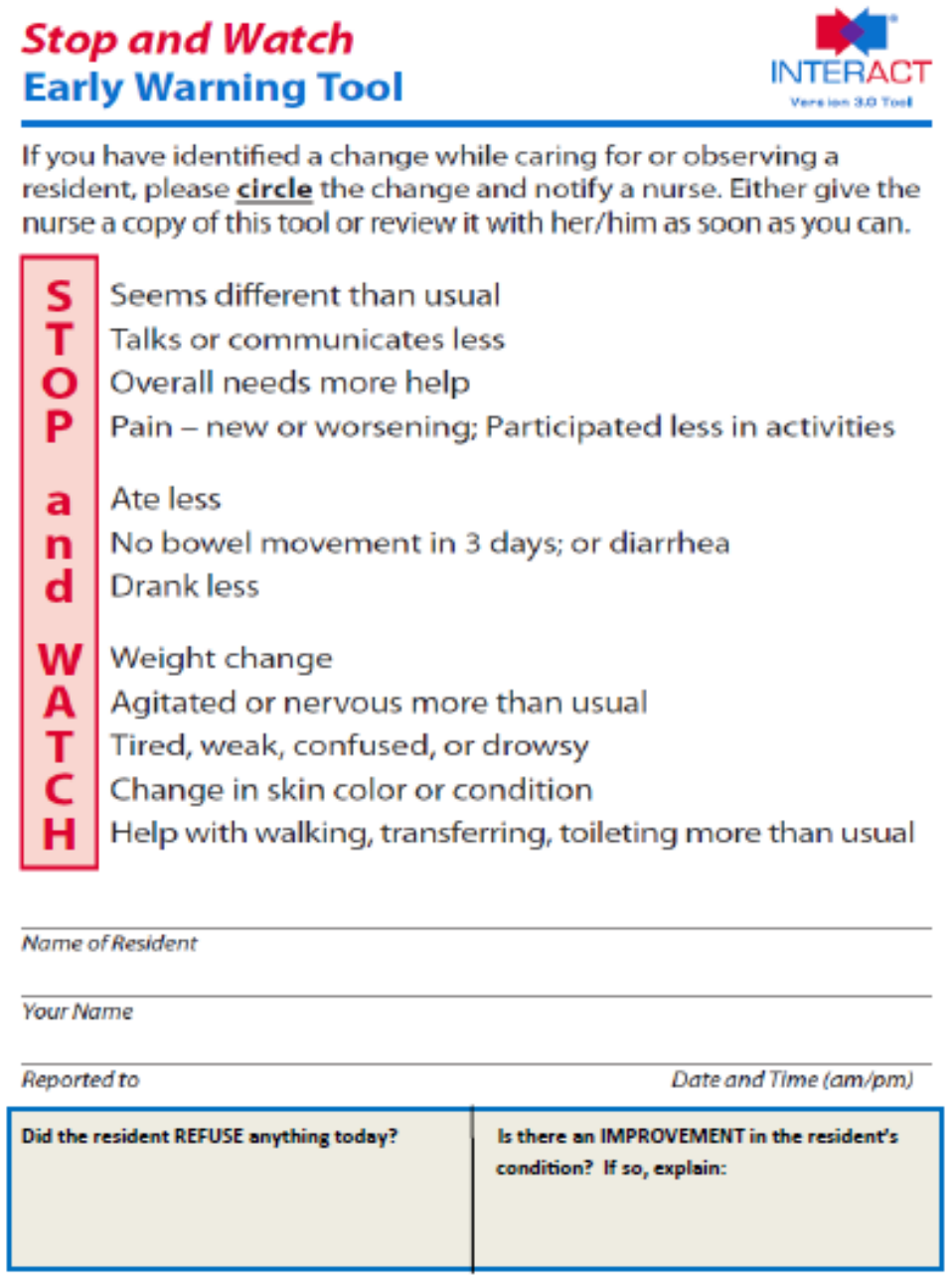
Non-emergent 911 Calls: Possible Prevention Measures



Resources

Resource: Interact Tools

https://pathway-interact.com/



Stop and Watch
Early Warning Tool

INTERACT
Version 3.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S
Seems different than usual

T
Talks or communicates less

O
Overall needs more help

P
Pain – new or worsening; Participated less in activities

a
Ate less

n
No bowel movement in 3 days; or diarrhea

d
Drank less

W
Weight change

A
Agitated or nervous more than usual

T
Tired, weak, confused, or drowsy

C
Change in skin color or condition

H
Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to *Date and Time (am/pm)*

Did the resident REFUSE anything today?	Is there an IMPROVEMENT in the resident's condition? If so, explain:

SBAR Communication Form

and Progress Note for Caregivers in Assisted Living

INTERACT Assisted Living* V1.0 Tool

This form is for caregivers who are not licensed nurses (RN/LPN/LVN). There is another INTERACT tool for licensed nurses.

Before Calling the Nurse/Supervisor:

☐ **Evaluate the Resident:** Complete relevant aspects of the SBAR form below
☐ **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, and finger stick glucose for diabetics
☐ **Have Relevant Information Available when Reporting**
(i.e. resident record, vital signs, advance directives such as DNR /POLST and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs I am calling about is/are _____

This started on ____/____/____ Since this started has it gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom ***worse*** are _____

Things that make the condition or symptom ***better*** are _____

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Other relevant information _____

BACKGROUND

Resident Description
This resident is in the facility for: ☐ Long-Term Care ☐ Respite ☐ Other: _____

Medication Alerts
☐ Changes in the last week *(describe)* _____

☐ Resident is on blood thinners Warfarin/Coumadin: Result of last INR Date ____/____/____

Resident is on: ☐ Hypoglycemic medication(s) / Insulin ☐ Digoxin

Allergies _____

Pharmacy name _____ Phone (_____) _____

Vital Signs

BP _____ Pulse _____ RR _____ Temp _____

Pain: ☐ No ☐ Yes (describe location, intensity) _____

Pulse Oximetry (*if indicated*) _____% on ☐ Room Air ☐ O_2 (_____)

Resident Evaluation

1. Mental Status Changes ***(compared to baseline; check all that you observe)***
☐ Decreased consciousness *(sleepy, lethargic)*
☐ Increased confusion *(disoriented)*
☐ New or worsening behavioral symptoms
☐ Unresponsiveness
☐ Other symptoms or signs of delirium *(e.g. inability to pay attention, disorganized thinking)*

Describe symptoms or signs _____

Resident/Patient Name _____

(continued)

SBAR Communication Form

and Progress Note for Caregivers in Assisted Living (cont'd)

INTERACT Assisted Living V1.0 Tool

2. Functional Status Changes ***(compared to baseline; check all that you observe)***
☐ Decreased mobility ☐ Falls *(one or more)* ☐ Weakness *(general)* ☐ Other *(describe)*
☐ Swallowing difficulty ☐ Needs more assistance with ADLs ☐ No changes observed

Describe symptoms or signs _____
☐ Not applicable to the change in condition being reported

3. Respiratory
☐ Cough (☐ Non-productive ☐ Productive of phlegm or sputum) ☐ Shortness of breath ☐ Other *(describe)*
☐ Labored or rapid breathing ☐ No changes observed

Describe symptoms or signs _____
☐ Not applicable to the change in condition being reported

4. Cardiac
☐ Chest discomfort or pain ☐ Irregular pulse ☐ Rapid pulse ☐ Other *(describe)* ☐ No changes observed

Describe symptoms or signs _____
☐ Not applicable to the change in condition being reported

5. GI/Abdomen
☐ Abdominal pain or tenderness ☐ Constipation ☐ Diarrhea ☐ Other *(describe)*
☐ Blood in stool Date of last BM ____/____/____ ☐ Nausea ☐ No changes observed
☐ Decreased appetite ☐ Vomiting

Describe symptoms or signs _____
☐ Not applicable to the change in condition being reported

6. GU/Urine Changes ***(compared to baseline; check all that you observe)***
☐ Blood in urine ☐ Painful urination ☐ Other *(describe)*
☐ New or worsening incontinence ☐ Urinating more frequently ☐ No changes observed

Describe symptoms or signs _____
☐ Not applicable to the change in condition being reported

Advance Care Planning Information ***(the resident has orders for the following advance directives)***
☐ Full Code ☐ DNR ☐ DNI *(Do Not Intubate)* ☐ DNH *(Do Not Hospitalize)* ☐ No Enteral Feeding ☐ Other Order or Living Will *(specify)*

_____

Other resident or family preferences for care _____

APPEARANCE

Sumarize your observations and evaluation: _____

_____

READY TO CALL

Name of Family/Primary Care Clinician Notified: _____ **Date** ____/____/____ **Time (am/pm)** _____

Caregiver Signature _____ **Date** ____/____/____ **Time (am/pm)** _____

Observation Reported Nurse/Supervisor _____ **Date** ____/____/____ **Time (am/pm)** _____

Resident/Patient Name _____

This form is also intended for other residential health care facilities including those listed by the National Center for Assisted Living *(www.ahcancal.org)*. Check state regulations and professional licensure laws relevant to using this tool.

SBAR Communication Form

and Progress Note for RNs/LPN/LVNs

INTERACT® Assisted Living* V1.0 Tool

Before Calling the Physician / NP / PA / other Healthcare Professional:

☐ **Evaluate the Resident:** Complete relevant aspects of the SBAR form below
☐ **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, and finger stick glucose for diabetes
☐ **Review Record:** Recent progress notes, labs, orders
☐ **Review an INTERACT Care Path** or **Acute Change in Condition File Card**, if indicated *(nurses only)*
☐ **Have Relevant Information Available when Reporting**
(i.e. resident record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs I am calling about is/are _____

This started on _____ /_____ /_____ Since this started it has gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom ***worse*** are _____

Things that make the condition or symptom ***better*** are _____

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Treatment for last episode *(if applicable)* _____

Other relevant information _____

BACKGROUND

Resident Description

This resident is in the facility for: ☐ Long-Term Care ☐ Respite ☐ Other: _____

Primary diagnoses _____

Other pertinent history *(e.g. medical diagnosis of CHF, DM, COPD)* _____

Medication Alerts

☐ Changes in the last week *(describe)*

☐ Resident is on *(Warfarin/Coumadin)* Result of last INR: _____ Date _____/_____/_____

☐ Resident is on other anticoagulant *(direct thrombin inhibitor or platelet inhibitor)*

Resident is on: ☐ Hypoglycemic medication(s) / Insulin ☐ Digoxin

Allergies _____

Pharmacy name _____ Phone (_____) _____

Vital Signs

BP _____ Pulse _____ (or Apical HR _____) RR _____ Temp _____ Weight _____ lbs *(date _____/_____/_____)*

For CHF, edema, or weight loss: last weight before the current one was _____ on _____/_____/_____

Pulse Oximetry *(if indicated)* _____% on ☐ Room Air ☐ O_2 (_____)

Blood Sugar *(Diabetics)* _____

Resident/Patient Name _____

(continued)

SBAR Communication Form

and Progress Note for RNs/LPN/LVNs (cont'd)

INTERACT® Assisted Living* V1.0 Tool

Resident Evaluation

Note: Except for Mental and Functional Status evaluations, if the item is not relevant to the change in condition, check the box for "not clinically applicable to the change in condition being reported".

1. Mental Status Evaluation *(compared to baseline; check all that you observe)*

☐ Decreased level of consciousness *(sleepy, lethargic)*
☐ Increased confusion *(disorientation)*
☐ Memory loss *(new or worsening)*
☐ New or worsened delusions or hallucinations
☐ Other symptoms or signs of delirium *(e.g. inability to pay attention, disorganized thinking)*
☐ Unresponsiveness
☐ Other *(describe)*
☐ No changes observed

Describe symptoms or signs _____

2. Functional Status Evaluation *(compared to baseline; check all that you observe)*

☐ Decreased mobility
☐ Falls *(one or more)*
☐ Needs more assistance with ADLs
☐ Swallowing difficulty
☐ Weakness *(general)*
☐ Other *(describe)*
☐ No changes observed

Describe symptoms or signs _____

3. Behavioral Evaluation

☐ Danger to self or others
☐ Depression *(crying, hopelessness, not eating)*
☐ Personality change
☐ Physical aggression
☐ Social withdrawal *(isolation, apathy)*
☐ Suicide potential
☐ Verbal aggression
☐ Other behavioral changes *(describe)*
☐ No changes observed

Describe symptoms or signs _____
☐ Not clinically applicable to the change in condition being reported

4. Respiratory Evaluation

☐ Abnormal lung sounds *(rales, rhonchi, wheezing)*
☐ Asthma *(with wheezing)*
☐ Cough (☐ Non-productive ☐ Productive)
☐ Inability to eat or sleep due to SOB
☐ Labored or rapid breathing
☐ Shortness of breath
☐ Symptoms of common cold
☐ Other respiratory changes *(describe)*
☐ No changes observed

Describe symptoms or signs _____
☐ Not clinically applicable to the change in condition being reported

5. Cardiovascular Evaluation

☐ Chest pain/tightness
☐ Edema
☐ Inability to stand without severe dizziness or lightheadedness
☐ Irregular pulse *(new)*
☐ Resting pulse >100 or <50
☐ Other *(describe)*
☐ No changes observed

Describe symptoms or signs _____
☐ Not clinically applicable to the change in condition being reported

6. Abdominal / GI Evaluation

☐ Abdominal pain
☐ Abdominal tenderness
☐ Constipation *(date of last BM _____/_____/_____)*
☐ Decreased/absent bowel sounds
☐ Decreased appetite/fluid intake
☐ Diarrhea
☐ Distended abdomen
☐ GI Bleeding *(blood in stool or vomitus)*
☐ Hyperactive bowel sounds
☐ Jaundice
☐ Nausea and/or vomiting
☐ Other *(describe)*
☐ No changes observed

Describe symptoms or signs _____
☐ Not clinically applicable to the change in condition being reported

Resident/Patient Name _____

(continued)

SBAR Communication Form

and Progress Note for RNs/LPN/LVNs (cont'd)

INTERACT Assisted Living* V1.0 Tool

7. GU/Urine Evaluation ***(compared to baseline; check all that you observe)***

- ☐ Blood in urine
- ☐ Decreased urine output
- ☐ Lower abdominal pain or tenderness
- ☐ New or worsening incontinence
- ☐ Painful urination
- ☐ Urinating more frequently or urgency with or without other urinary symptoms
- ☐ Other *(describe)*
- ☐ No changes observed

Describe symptoms or signs _____

☐ Not clinically applicable to the change in condition being reported

8. Skin Evaluation

- ☐ Abrasion
- ☐ Blister
- ☐ Burn
- ☐ Contusion
- ☐ Discoloration
- ☐ Itching
- ☐ Laceration
- ☐ Pressure sore
- ☐ Puncture wound
- ☐ Rash
- ☐ Skin tear
- ☐ Splinter/sliver
- ☐ Wound
- ☐ Other *(describe)*
- ☐ No changes observed

Describe symptoms or signs _____

☐ Not clinically applicable to the change in condition being reported

9. Pain Evaluation

Does the resident have pain?

☐ No ☐ Yes *(describe below)*

Is the pain?

☐ New ☐ Worsening of chronic pain

Location of pain: _____

Intensity of Pain *(rate on scale of 1-10, with 10 being the worst)*: _____

Does the resident show non-verbal signs of pain?

☐ No ☐ Yes *(describe)* _____

(restless, pacing, grimacing, new change in behavior)

Other information about the pain _____

☐ Not clinically applicable to the change in condition being reported

10. Neurological Evaluation

- ☐ Abnormal Speech
- ☐ Decreased level of consciousness
- ☐ Dizziness or unsteadiness
- ☐ Seizure
- ☐ Weakness or hemiparesis
- ☐ Other neurological symptoms
- ☐ No changes observed

Describe symptoms or signs _____

☐ Not clinically applicable to the change in condition being reported

Advance Care Planning Information ***(the resident has orders for the following advance directives)***

☐ Full Code ☐ DNR ☐ DNI *(Do Not Intubate)* ☐ DNH *(Do Not Hospitalize)* ☐ No Enteral Feeding ☐ Other Order or Living Will *(specify)*

_____

Other resident or family preferences for care _____

_____

Resident/Patient Name _____

(continued)

SBAR Communication Form

and Progress Note for RNs/LPN/LVNs (cont'd)

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APPEARANCE

Summarize your observations and evaluation: _____

_____

_____

REVIEW AND NOTIFY

Primary Care Clinician Notified: _____ **Date** ___/___/___ **Time (am/pm)** _____

Recommendations of Primary Clinicians *(if any)* _____

_____

_____

Check *all* that apply

Testing

- ☐ Blood tests
- ☐ EKG
- ☐ Urinalysis and/or culture
- ☐ Venous doppler
- ☐ X-ray
- ☐ Other *(describe)* _____

Interventions

- ☐ New or change in medication(s)
- ☐ IV or subcutaneous fluids
- ☐ Increase oral fluids
- ☐ Oxygen *(if available)*
- ☐ Other *(describe)* _____

☐ Transfer to the hospital (non-emergency) *(send a copy of this form)* ☐ Call for 911 ☐ Emergency medical transport

Nursing Notes ***(for additional information on the Change in Condition)***

_____

_____

_____

_____

_____

_____

Name of Family/Health Care Agent Notified: _____ **Date** ___/___/___ **Time (am/pm)** _____

Staff Name (RN/LPN/LVN) and Signature _____

Resident/Patient Name _____

CARE PATH
Dehydration (potential for)

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Change Noted in Resident at Risk for Dehydration
- Decreased oral intake over 48 hrs
- Multiple episodes of vomiting or diarrhea over 24-48 hrs
- Dependent on others for fluids *(dementia, tube feeding)*
- Diuretic use
- Swallowing difficulties

Take Vital Signs
- Temperature
- BP, pulse, apical HR *(if pulse irregular)*
- Check for orthostatic hypotension *(if possible based on clinical condition)*
- Respirations
- Oxygen saturation
- Finger stick glucose *(diabetics)*

Vital Sign Criteria *(any met?)*
- Temp > 100.5°F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Orthostatic *(drop of >20 systolic from sitting to standing)*
- Oxygen saturation < 90%
- Finger stick glucose < 70 or > 300

NO

YES

Further Nursing Evaluation
- Mental Status
- Functional Status
- Cardiovascular
- Respiratory
- Gastrointestinal/ abdomen
- Genitourinary
- Skin

Evaluate Symptoms and Signs for Immediate Notification*
- Acute mental status change
- Not eating or drinking at all
- Acute decline in ADL abilities
- New cough, abnormal lung sounds
- Nausea, vomiting, diarrhea
- Abdominal distension or tenderness
- Inability to stand without severe dizziness or light headedness
- New or worsened incontinence, pain with urination, blood in urine
- Very low urinary output
- New skin condition *(e.g., rash, redness suggesting cellulitis, signs of infection around existing wound or pressure ulcer/ injury)*
- Signs and symptoms suggest possible sepsis**

YES → **Notify MD / NP / PA**

NO

Consider Contacting MD/NP/PA for orders *(for further evaluation and management)*
- Portable chest X-ray
- Urinalysis and C&S in indicated
- Blood work *(Complete Blood Count, Basic Metabolic Panel)*

Tests Ordered

Evaluate Results
- WBC > 14,000 or neutrophils > 90%
- Infiltrate or pneumonia on chest X-ray
- Urine results suggest infection and symptoms or signs present

YES

NO

Manage in Facility
- Monitor vital signs *(including orthostatic)*, fluid intake/urine output every 4-8 hrs for 24-72 hrs
- Oral, IV or subcutaneous fluids if needed for hydration if available at your AL
- Check results of urinalysis and culture *(if ordered)*
- Consider antibiotic treatment for 7-10 days if culture positive *(check allergies)*
- Discontinue antibiotic if culture negative
- If on diuretic consider holding
- Offer frequent fluids
- If on tube feeding, give more water with flushes
- Speech therapy consult to evaluate for dysphagia *(if indicated)*
- Update advance care plan and directives if appropriate

Monitor Response
- Vital signs criteria met
- Worsening condition and/or immediate notification criteria met

YES

Refer also to other INTERACT Care Paths as indicated by symptoms and signs

****If sepsis is been considered, refer to INTERACT Guidance on Possible Sepsis and INTERACT Guidance on Infections***

Education on CPR for Residents and Families

INTERACT ASSISTED LIVING Version 2.0 Tool

The Problem

Many health problems are so serious that they cause your heart to stop beating. This is called cardiac arrest. When this happens, you also stop breathing.

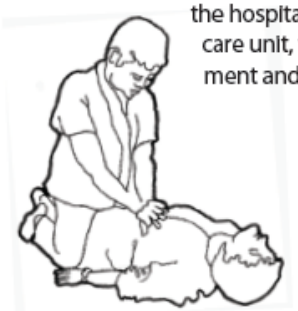
The heart pumps blood to all organs in your body to give them oxygen. When your heart stops beating, your body and brain do not get enough oxygen for you to live.

Treatment

There is only one treatment when your heart stops beating. That treatment is cardiopulmonary resuscitation or CPR. CPR is done to try to restart the heartbeat and breathing. It is the only treatment that could save your life when your heart stops beating.

CPR involves rapidly pushing on your chest, and placement of a tube through the mouth into the lungs to directly help you breathe. Sometimes electric shocks are given using a device called a defibrillator. Once started, CPR is continued until your heart restarts or it is clear beyond a doubt that your heart cannot be restarted.

CPR can be started in the assisted living, but as soon as possible, you will be transferred to the hospital, often an intensive care unit, for additional treatment and monitoring.



Your Choice

CPR is a choice – it is not a treatment that everyone must have. Some people believe that when their time comes or their heart or breathing stops, nothing more should be done to keep them alive. Other people want everything done to keep them alive. Neither of these choices is right or wrong. It is your choice.

You should understand, however, that if you choose not to have CPR, your choice will not affect any other aspect of your care. **All of your other treatments and care will continue.**

The only thing that will change is that if you are found without a pulse or heartbeat *(In cardiac arrest)* CPR will not be done.

Education on CPR for Residents and Families *(cont'd)*

INTERACT ASSISTED LIVING Version 2.0 Tool

Making the Decision: CPR or DNR

Many people make a decision in advance about whether or not they want CPR. You can choose between having CPR and asking for a 'Do Not Resuscitate (DNR)' order. If you choose the DNR order, CPR will not be done if your heart stops beating. You are unlikely to be able to make this decision for yourself at the time your heart stops beating. Making the decision in advance will help make sure that your wishes are carried out.

The decision whether or not to have CPR can be a difficult one. You may want to discuss it with your family, doctor, nurse, social worker, or a religious leader.

Understanding the benefits and risks of CPR is important when you make your decision. The chart below explains the benefits and risks of CPR.

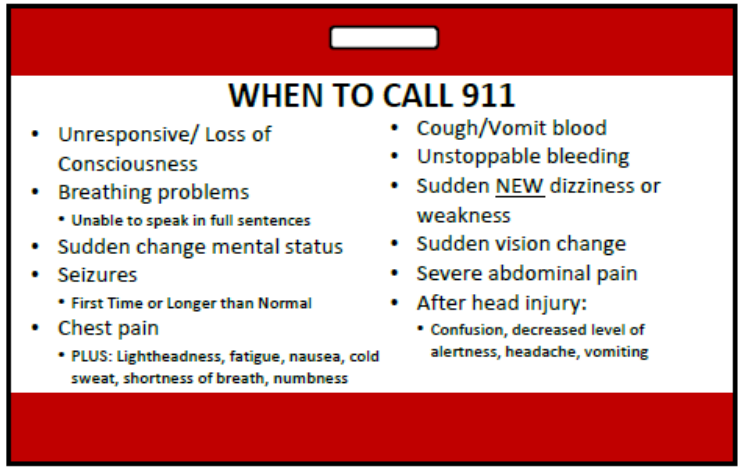
Benefits of CPR	Risks of CPR
If your heart stops beating, CPR is the only treatment that could save your life. However, you should also know that the rate of surviving CPR is low. • On average less than 1 in 10 people who receive CPR outside of a hospital survive. • The chances of surviving CPR are even lower in people of advanced age, and in people with serious medical problems such as advanced forms of cancer and diseases of the heart, kidneys, and liver.	Although in some cases CPR can save your life, CPR itself can cause bodily harm. For example: • Many people, especially older people with thin bones, suffer broken ribs as a result of CPR. • There is a small chance that if you survive CPR, you can have severe brain damage or be in a coma for some time or even th[No Title]your life

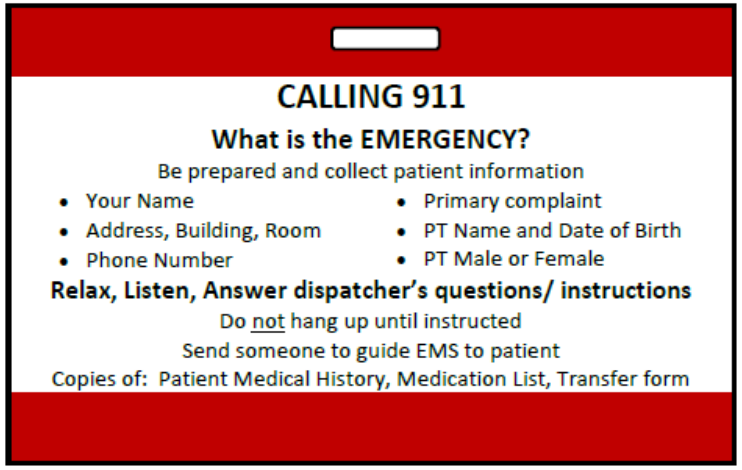
Help in Making Your Decision

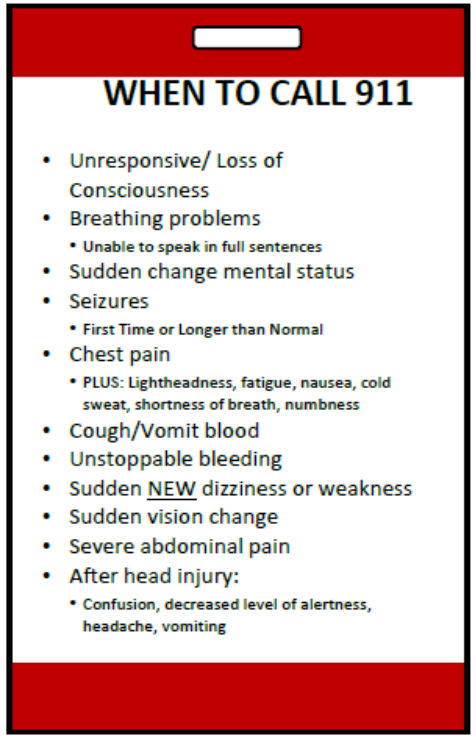
There are many resources available to you in making this decision. Organizations such as the American Association for Retired Persons, the Coalition for Compassionate Care, the Conversation Project, Closure, and Caring Connections of the National Hospice and Palliative Care Organization, as well as many others have information available in print and on their websites that may be helpful to you.

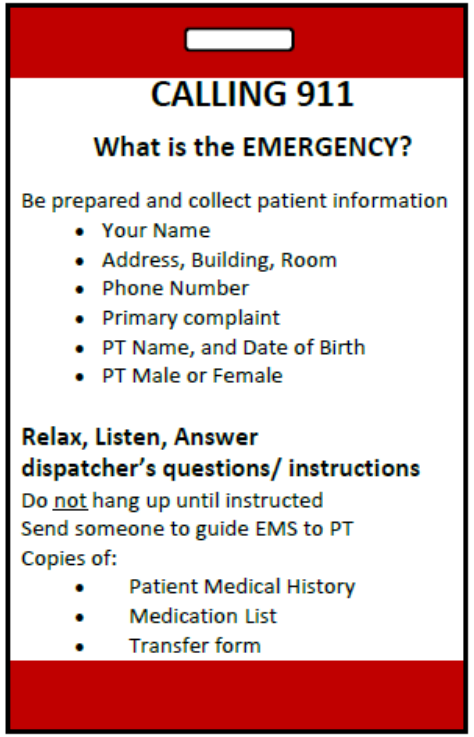
In addition, most states have standard forms for documenting your decisions in advance ('Advance Directives'), and many are recommending completing an order form in advance, such as Physicians Orders for Life Sustaining Treatment ('POLST') or other similar forms.

Resource: Badge Cards









RCS Offers Free Support to ALF and SNF Staff Through:

- ✓ General Behavioral Health Training
- ✓ Resident Specific Consultation
- ✓ Connection Café's with Behavioral Health Consultants

Free Staff Training on Topics Such As:

- Documentation basics (2 CEUs)
- Person- Centered Care
- Trauma-Informed Care (1.5 CEUs)
- Crisis Response & De-Escalation Training
- Coping with Verbal & Physical Abuse (2 CEUs)
- Professional Boundaries (1 CEU)
- …And more! See the Training Calendar here!

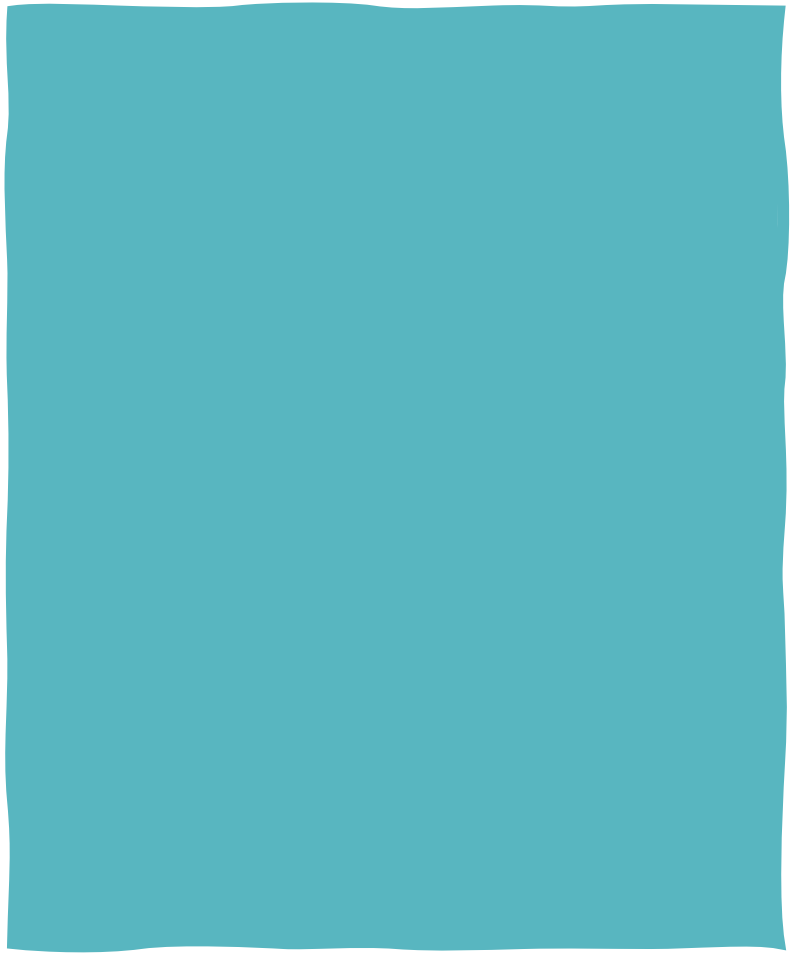
Learn more about the team & how to contact a support person here.

Behavioral Health Support Team

Send General Inquires to:
RCSBHST@dshs.wa.gov

Send Training Requests to:
ALTSABHSTTRAINING@dshs.wa.gov

How Can We Help You?



Questions
Comments
Suggestions
Ideas

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