TRAIN FOR SUCCESS INC.
WORKING WITH RESIDENTS IN THE NURSING HOME SETTING 18 Hr

PREPARED BY MICHELLE BROOMFIELD RN

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PURPOSE

The purpose of this course is to review some of the requirements / regulations and policies within the Nursing Home /long term care setting, to educate and reinforce the knowledge of nurses; ARNP, RN, LPN, Therapists, CNAs, other professionals who are working in the Long Term care environment, as well as individuals who would like to work within this setting. Review of Policies regarding acceptance of patients, admission and coordination of patient services. Review of the requirements for the plan of care and the MDS/ RAI the Comprehensive assessments. Review of the guideline for proper documentation and legal aspects. The course also reviews the clinical record review requirements, the CNA role with assisting with the activities of daily living, the requirements for the comprehensive emergency management plan, the Background screening requirements, the importance of the drug review, medication management, and Ombudsman involvement/ duties in long term care.

OBJECTIVE

After successful completion of this course the students will be able to:
1. Describe the Nursing Home regulations and services that are usually provided
2. Discuss Policy regarding Acceptance of patients
3. Discuss admission and coordination of patient services
4. Describe the requirements for the plan of care
5. Discuss duties of the nursing home administrator, nurses, and other practitioners
6. Describe the Comprehensive assessments, RAI / MDS
7. Discuss the guideline for proper documentation and legal aspects
8. Describe clinical record review requirements
9. Discuss the Ombudsman involvement
10. Describe the CNA role with assisting with the activities of daily living
11. Discuss resident's rights
12. Discuss the requirements for the comprehensive emergency management plan
13. Describe the Background screening requirements
14. Discuss the importance of the medication/drug review

THE NURSING HOME ENVIRONMENT

RESIDENTS' RIGHTS

Rights are often defined as legal, ethical or social principles of entitlement or freedom; which involves normative rules about what is allowed of people or what is owed to people or a legal or moral entitlement to obtain or have something or to act in a certain way.

Within the nursing home setting, residents' rights are the moral and legal rights of the residents of a nursing home. There are legislations that exist in various jurisdictions to help to protect such rights. In 1980 the Florida statute was enacted to protect such rights; Florida statute 400.022, commonly known as the Residents' Rights Act.

All individuals who work with residents must be aware of the rights of the resident, so that they can adhere to the legal /ethical principles, respect the residents' rights and also follow the standards of practice (See resource for your state guidelines).

FLORIDA STATUTES 400.022 RESIDENTS' RIGHTS — NURSING HOMES AND RELATED HEALTH CARE FACILITIES states that:

(1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:

(a) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decision, which will not be infringed upon, and the right to encouragement and assistance from the staff of the facility in the fullest possible exercise of these rights.

(b) The right to private and uncensored communication, including, but not limited to, receiving and sending unopened correspondence, access to a telephone, visiting with any person of the resident's choice during visiting hours, and overnight visitation outside the facility with family and friends in accordance with facility policies, physician orders, and Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act

regulations, without the resident's losing his or her bed. Facility visiting hours shall be flexible, taking into consideration special circumstances such as, but not limited to, out-of-town visitors and working relatives or friends. Unless otherwise indicated in the resident care plan, the licensee shall, with the consent of the resident and in accordance with policies approved by the agency, permit recognized volunteer groups, representatives of community-based legal, social, mental health, and leisure programs, and members of the clergy access to the facility during visiting hours for the purpose of visiting with and providing services to any resident.

(c) Any entity or individual that provides health, social, legal, or other services to a resident has the right to have reasonable access to the resident. The resident has the right to deny or withdraw consent to access at any time by any entity or individual. Notwithstanding the visiting policy of the facility, the following individuals must be permitted immediate access to the resident:

1. Any representative of the federal or state government, including, but not limited to, representatives of the Department of Children and Families, the Department of Health, the Agency for Health Care Administration, the Office of the Attorney General, and the Department of Elderly Affairs; any law enforcement officer; any representative of the State Long-Term Care Ombudsman Program; and the resident's individual physician.

2. Subject to the resident's right to deny or withdraw consent, immediate family or other relatives of the resident.

The facility must allow representatives of the State Long-Term Care Ombudsman Program to examine a resident's clinical records with the permission of the resident or the resident's legal representative and consistent with state law.
(d) The right to present grievances on behalf of himself or herself or others to the staff or administrator of the facility, to governmental officials, or to any other person; to recommend changes in policies and services to facility personnel; and to join with other residents or individuals within or outside the facility to work for improvements in resident care, free from restraint, interference, coercion, discrimination, or reprisal. This right includes access to ombudsmen and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. The right also

includes the right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to the behavior of other residents.

(e) The right to organize and participate in resident groups in the facility and the right to have the resident's family meet in the facility with the families of other residents.

(f) The right to participate in social, religious, and community activities that do not interfere with the rights of other residents.

(g) The right to examine, upon reasonable request, the results of the most recent inspection of the facility conducted by a federal or state agency and any plan of correction in effect with respect to the facility.

(h) The right to manage his or her own financial affairs or to delegate such responsibility to the licensee, but only to the extent of the funds held in trust by the licensee for the resident. A quarterly accounting of any transactions made on behalf of the resident shall be furnished to the resident or the person responsible for the resident. The facility may not require a resident to deposit personal funds with the facility. However, upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility as follows:

1. The facility must establish and maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

2. The accounting system established and maintained by the facility must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

3. A quarterly accounting of any transaction made on behalf of the resident shall be furnished to the resident or the person responsible for the resident.

4. Upon the death of a resident with personal funds deposited with the facility, the facility must convey within 30 days the resident's funds, including interest, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate, or, if a personal representative has not been appointed within 30 days,

to the resident's spouse or adult next of kin named in the beneficiary designation form provided for in s. 400.162(6).

5.The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Title XVIII or Title XIX of the Social Security Act.

(i) The right to be fully informed, in writing and orally, prior to or at the time of admission and during his or her stay, of services available in the facility and of related charges for such services, including any charges for services not covered under Title XVIII or Title XIX of the Social Security Act or not covered by the basic per diem rates and of bed reservation and refund policies of the facility.

(j) The right to be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent under Florida law, or the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being; and, except with respect to a resident adjudged incompetent, the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by the resident's physician; and to know the consequences of such actions.

(k) The right to refuse medication or treatment and to be informed of the consequences of such decisions, unless determined unable to provide informed consent under state law. When the resident refuses medication or treatment, the nursing home facility must notify the resident or the resident's legal representative of the consequences of such decision and must document the resident's decision in his or her medical record. The nursing home facility must continue to provide other services the resident agrees to in accordance with the resident's care plan.

(l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

(m) The right to have privacy in treatment and in caring for personal needs; to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated; and to security in storing and using personal possessions. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. Residents' personal and medical records shall be confidential and exempt from the provisions of s. 119.07(1).

(n) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis.

(o) The right to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint and, in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter. Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.

(p) The right to be transferred or discharged only for medical reasons or for the welfare of other residents, and the right to be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home, or in the case of conflicting rules and regulations which govern Title XVIII or Title XIX of the Social Security Act. For nonpayment of a bill for care received, the resident shall be given 30 days' advance notice.

A licensee certified to provide services under Title XIX of the Social Security Act may not transfer or discharge a resident solely because the source of payment for care changes. Admission to a nursing home facility operated by a licensee certified to provide services under Title XIX of the Social Security Act may not be conditioned upon

a waiver of such right, and any document or provision in a document which purports to waive or preclude such right is void and unenforceable.

Any licensee certified to provide services under Title XIX of the Social Security Act that obtains or attempts to obtain such a waiver from a resident or potential resident shall be construed to have violated the resident's rights as established herein and is subject to disciplinary action as provided in subsection (3). The resident and the family or representative of the resident shall be consulted in choosing another facility.

(q) The right to freedom of choice in selecting a personal physician; to obtain pharmaceutical supplies and services from a pharmacy of the resident's choice, at the resident's own expense or through Title XIX of the Social Security Act; and to obtain information about, and to participate in, community-based activities programs, unless medically contraindicated as documented by a physician in the resident's medical record. If a resident chooses to use a community pharmacy and the facility in which the resident resides uses a unit-dose system, the pharmacy selected by the resident shall be one that provides a compatible unit-dose system, provides service delivery, and stocks the drugs normally used by long-term care residents.

If a resident chooses to use a community pharmacy and the facility in which the resident resides does not use a unit-dose system, the pharmacy selected by the resident shall be one that provides service delivery and stocks the drugs normally used by long-term care residents.

(r) The right to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other residents or unless medically contraindicated as documented in the resident's medical record by a physician. If clothing is provided to the resident by the licensee, it shall be of reasonable fit.

(s) The right to have copies of the rules and regulations of the facility and an explanation of the responsibility of the resident to obey all reasonable rules and regulations of the facility and to respect the personal rights and private property of the other residents.

(t) The right to receive notice before the room of the resident in the facility is changed.

(u) The right to be informed of the bed reservation policy for a hospitalization. The nursing home shall inform a private-pay resident and his or her responsible party that his or her bed will be reserved for any single hospitalization for a period up to 30 days provided the nursing home receives reimbursement.

Any resident who is a recipient of assistance under Title XIX of the Social Security Act, or the resident's designee or legal representative, shall be informed by the licensee that his or her bed will be reserved for any single hospitalization for the length of time for which Title XIX reimbursement is available, up to 15 days; but that the bed will not be reserved if it is medically determined by the agency that the resident will not need it or will not be able to return to the nursing home, or if the agency determines that the nursing home's occupancy rate ensures the availability of a bed for the resident. Notice shall be provided within 24 hours of the hospitalization.

(v) For residents of Medicaid or Medicare certified facilities, the right to challenge a decision by the facility to discharge or transfer the resident, as required under 42 C.F.R. s. 483.12.

(2) The licensee for each nursing home shall orally inform the resident of the resident's rights and provide a copy of the statement required by subsection (1) to each resident or the resident's legal representative at or before the resident's admission to a facility. The licensee shall provide a copy of the resident's rights to each staff member of the facility.

Each such licensee shall prepare a written plan and provide appropriate staff training to implement the provisions of this section. The written statement of rights must include a statement that a resident may file a complaint with the agency or state or local ombudsman council. The statement must be in boldfaced type and include the telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the numbers of the local ombudsman council and the Elder Abuse Hotline operated by the Department of Children and Families.

(3) Any violation of the resident's rights set forth in this section constitutes grounds for action by the agency under s. 400.102, s. 400.121, or part II of chapter 408. In order to determine whether the licensee is adequately protecting residents' rights, the licensure

inspection of the facility must include private informal conversations with a sample of residents to discuss residents' experiences within the facility with respect to rights specified in this section and general compliance with standards and consultation with the State Long-Term Care Ombudsman Program.

(4) Any person who submits or reports a complaint concerning a suspected violation of the resident's rights or concerning services or conditions in a facility or who testifies in any administrative or judicial proceeding arising from such complaint shall have immunity from any criminal or civil liability therefor, unless that person has acted in bad faith, with malicious purpose, or if the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party (See your state for more information).

All professionals have to make sure that they are aware of these rights and provide care / services to the clients/ patients, ensuring that the rights of the clients/ patients are being honored and there are no violations.

DOCUMENTATION

Some of the purposes of documentation include:

- Fulfilling professional responsibility and establishing accountability
- Legal standards
- Compliance with standard of practice
- Communication among the health care team and providing education to staff
- To provide continuity of care
- Providing information for research

- For reimbursement.

A COMPLETE MEDICAL RECORD

A complete medical record must have an accurate and complete representation of the actual care/experience of the resident/patient in the facility. It needs to have enough information to demonstrate that the institution knows the status of the resident/patient, has care plans identified to meet the resident's/patient's conditions, and provides enough documentation of the effects of the care provided.

Documentation should provide a picture of the resident /patient and the results of treatment and the resident's/ patient's response to the treatment. Documentation should also show the changes in status or condition of the resident/patient and any changes in orders or treatments.

THE CERTIFIED NURSING ASSISTANT (CNA)

THE SCOPE OF PRACTICE FOR THE CERTIFIED NURSING ASSISTANT (CNA)

Check with your state to detail your role as a CNA/HHA. The Florida Statutes describe below, provides specific guidelines regarding the role of the nursing assistant within the long term and home health care settings.

Chapter 464 of the Florida Statues;

Practice of a certified nursing assistant means providing care and assisting persons with tasks relating to the activities of daily living. Such tasks are those associated with:

- personal care,

- maintaining mobility,
- nutrition and hydration,
- toileting and elimination,
- assistive devices,
- safety and cleanliness,
- data gathering,
- reporting abnormal signs and symptoms,
- postmortem care,
- patient socialization and reality orientation,
- end-of-life care,
- cardiopulmonary resuscitation and emergency care,
- residents' or patients' rights,
- documentation of nursing-assistant services, and other tasks that a certified nurse assistant may perform after training beyond that required for initial certification and upon validation of competence in that skill by a registered nurse.

FLORIDA STATUES 464

A certified nursing assistant shall complete 12 hours of in service training during each calendar year. The certified nursing assistant shall be responsible for maintaining documentation demonstrating compliance with these provisions. The Council on Certified Nursing Assistants, in accordance with s. 464.2085(2)(b), shall propose rules to implement this subsection.

CONFIDENTIALITY

Confidentiality is defined as a set of rules or a promise that limits access or place restrictions on certain types of information. Within the health care setting, confidentiality is a major issue in patient/resident care.

Certified nursing assistants as well as everyone who works with the patient has to maintain confidentiality of patient information. For example: you cannot talk about the patient with others who are not working with the patient and you cannot leave patient's chart at the bedside for unauthorized personnel to view. Legally, you can be fined or imprisoned; if you talk about the patient or share patient information. HIPAA laws must be followed and maintained.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Confidentiality of patients' information.
HIPAA violations involves both civil and criminal penalties which include fines and imprisonment. The fines can range from $100 for each violation of the law to a limit of $25,000 per year for multiple violations. For misusing or disclosing any of the patient's information, criminal sanctions carry fines of 50,000 to 250,000 and one to ten years imprisonment.

Always maintain confidentiality of patients' information. **The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security and Breach Notification Rules:**

The Office for Civil Rights enforces the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; the HIPAA Breach Notification Rule, which requires covered entities and business associates to provide notification following a breach of unsecured protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

The HIPAA Privacy Rule provides Federal protections for individually identifiable health information held by covered entities and their business associates and give the patient an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it allows the disclosure of health information needed for patient care and other important purposes.

Protected Health Information (PHI)

The HIPAA Privacy Rule protects most "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form; electronic, on paper, or oral. The Privacy Rule calls this information *protected health information* (PHI). Protected health information is information, including demographic information, which relates to:

- the person's present, past, or future physical, mental health or condition,

- the provision of health care to the individual, or
- the present, past, or future payment for the provision of health care to the individual, and that identifies the person or for which can be used to identify the individual.

Protected health information includes many common identifiers such as name, address, Social Security Number, date of birth when they can be associated with the health information.

A medical record, hospital bill or laboratory report, would be Protected health information because each document would contain a patient's name and the other identifying information associated with the health data content.

LEGAL DOCUMENTATION

Certified Nursing Assistant (CNA)

Legal documentation involves:

- Careful and accurate charting, never document a task if it was not done, this too is illegal (always notify the nurse for assistance as needed),
- Never document for another CNA, this is illegal,
- Always document the facts,
- Do not place personal feelings in the chart
- If you observe something abnormal with the patient, do not just write it down; make sure the charge nurse is notified so that the patient can be assessed,
- only document care when it is given,
- Avoid using abbreviations, Potential for errors (refer to the Do not use list)
- Make sure hand writing is clear and can be read by others of the health care team, everything that you document or chart can be used in court and the lawyers and everyone involved in the legal team must be able to read it.

NURSE

Nurses need to know the state law, the policies and the professional standards that relates to the specialty in which they are practicing. If there is any doubt or lack of knowledge consult with a supervisor or an expert to assist.

THE NURSE PRACTICE ACT

The 2015 Florida Statues 464 states:

464.002 Purpose: The sole legislative purpose in enacting this part is to ensure that every nurse practicing in this state meets minimum requirements for safe practice. It is the legislative intent that nurses who fall below minimum competency or who otherwise present a danger to the public shall be prohibited from practicing in this state.

Members of the Health care Team

As previously mentioned, it is very important to complete appropriate documentation within the patient's medical record because other members of the healthcare team will also be reviewing and reading the document. Therefore always provide information about the patient that is current, accurate, factual, complete, and it reflects a picture of the resident/patient while under the care of each health care worker (nurse, CNA, physician etc.)

GOAL OF DOCUMENTATION

The overall goal of the nursing documentation is to:

- Ensure that there is documented timeline for the care that the patient receives. Every entry that is completed by each nursing staff or members of the healthcare team has to be coordinated. This coordinated documentation will allow members of the health care team and other who need to review the chart, to see the patient's status at specific times and assist the health care team in determining if changes have occurred within the patient and at what time the changes were observed, reported and documented.

- Always remember that documentation is considered a legal document which reflects the care the patient received and should reflect that patient care was given in accordance with appropriate standards of care.

Personnel completing the documentation

As a health care worker, you are also documenting for your own purpose. When you have appropriately documented, this documentation will be available for you to access as needed, if you need to recall complete details of what did for the patients.

If there is a lawsuit or claim filed within a year or more, you might not remember all the details of care given to that patient or even the time that care or medications were administered therefore your complete and accurate documentation will be useful at that time. See your state for the statute of limitation (time frame); within some states, the statute of limitations allows lawsuits within 2 years or more of the date of the event resulting in a claim. The timeframe may be extended as much as 20 years if the patient involved is a minor.

Everyone within the health care team must document and the documentation should be at the time of patient care so that the information is accurate and complete. Never leave your shift without documenting; never say “I will come back in the morning and document.”

Lawyers, consultants, Judge and Jury

When there is a lawsuit, all of the documentation of the patient’s medical record will be reviewed by the lawyers, consultants, nurses and other experts involved. The team will

look for what was not done per standard of care, what could have been done better, what was not accurately done, what was not done that should have been completed etc. The documentation will be read by the jurors involved in the case.

Follow the nursing process

The nursing process should always be followed. The nursing process requires :

- Assessment,
- Nursing diagnosis,
- Planning,
- Implementation, and
- Evaluation.

Assessment

Assessment is the first step in delivering nursing care.
Nursing assessment is defined as the gathering and analyzing of information about a patient's physiological, economic, psychological, sociological, cultural and spiritual status.

Diagnosis

The nursing diagnosis is the nurse's clinical judgment about the patient's response to actual or potential health status/conditions.

Planning

Based on the assessment and diagnosis, the nurse establishes measurable and achievable short- and long-term goals and expected outcomes for the patient. The information is placed in the plan of care.

Implementation
Implementation involves carrying out the nursing care according to the plan of care.

Evaluation
Ongoing evaluation is completed to check the patient's status and the effectiveness of the nursing care. The care plan is then modified as needed.

State nurse practice acts may vary from state to state so follow the established guidelines for documentation. Some tips for accurate and complete documentation are listed below:

- Always write clearly (legibly), everyone within the health care team needs to be able to read what you have documented. This is vital to accurate and continuity of care for the patient. It is good to use block printing if your handwriting is illegible.

- Avoid charting in advance, this too is illegal and can lead to devastating errors.

- Always complete your documented entry using a chronological documentation format. This will provide separate entries for each narrated item because you want to provide a clear picture of the events and times surrounding the care that was provided for that patient.

- Document timely; charting should be done every 1-2 hours for routine care. Medication administration and other interventions or changes in condition should be documented immediately. If medications are not recorded in a timely manner, there is a possibility that the patient may receive that medication again.
- When standard time is used, always include AM or PM with notations. Some healthcare facilities use military time to reduce errors.
- Your Signature is very important. The healthcare worker must always sign for every notation in the patient's medical record.
- If you are to assess the patient's baseline mental status, document it because if there is a change or deviation noted from baseline this could indicate an injury or an acute illness.
- If you completed a task or an intervention, always document the intervention followed by an evaluation; did the intervention help the patient, was it effective? If intervention was not effective, what was done? Was the physician updated, all basis covered? Patient's needs met?
- Also document any complaints of the patient and/ or family and ensure follow up is done with the supervisor, with timely resolution and documentation.
- If you document a body system abnormality, always note the details because over a period of time the abnormality may become worse.
- Always accurately document how your assessment was done. For example, if you watch the chest of the patient rise and fall, you cannot document that the patient has normal breath sounds unless you have used the stethoscope to listen to the lungs.
- Do not use abbreviations unless they are approved, acceptable and included in your facility's policy and procedure. Therefore if you are unable to complete an entry on that page, do not shorten the word (do not make up your own word) move to the next page; follow your facility's policy and procedure for continuing an entry on the next page.
- Do not use slangs within the patient's medical record. As mentioned before the patient's medical record is a legal document. All documentation should be in Standard English with accurate grammar. Accurate spelling is also required because misspelled words may lead to different interpretations.

- Writing must be done using permanent ink pen (dark ink, blue or black) and writing needs to be neat and legible. Do not use pencil or pen that can be erased. Check your facility policy, some only allow black ink.
- Always assess the patient at the time of admission, transfer and discharge. You need to know the status of a patient when he/she enters your care and before he/she leaves.
- Avoid leaving spaces in charting. If blank spaces are left, this will allow others to make additions to the patient's medical record, to your notation. Make a straight line through any empty space.
- Make sure if you have to complete a late entry, always follow your facility's policy. Late entries must indicate the date and time they were actually entered into the patient's medical record, and you have to include the notation -*Late entry*; followed by the date and time of the event.
- When medications or treatments are delayed, the healthcare worker must document in the patient's medical records, noting the reason for the delay. For example, the patient may be completing a diagnostic examination and has not yet returned to the unit. If aware that the patient is scheduled for the examination, prioritize and make plans to complete the treatment before the patient leaves for the examination; if possible.
- When you have to continue notes from one page to another, make a notation that the entry is continued on the next page, this is to indicate that the note is not complete. Then document also on the next page to indicate that it is a continuation. Both of the pages have to contain your signature.(Follow your facility's Policy).
- When making corrections in the medical record, the error cannot be white-out, erased, scratched out to make illegible. The error can be corrected by drawing a line through the text and writing the word "error." sign your name and date the cross off. Follow your facility policy.

ALWAYS REMEMBER !!

- Writing has to be legible –clear for others to read and understand
- Use dark ink pen on the patient's medical records
- Whenever you make an error, use your pen and cross it off with **one thin line**. Write error, sign your name and date the cross off. Do not try to cover up the mistake with marker or scribble. Do not rewrite over the error; just one straight line through the error. White out cannot be used when you make a mistake.

Documentation Variations among health care institutions

Healthcare workers often work in various settings. Physicians, nurses, CNAs and other healthcare personnel often work in more than one facility at the same time. Therefore it is very important to understand the basic formats for effective documentation. Appropriate and accurate documentation requires the nurse to have an understanding of the nursing process and nursing diagnosis.

NANDA International (formerly the North American Nursing Diagnosis Association) is a professional organization of nurse's standardized nursing terminology that develops researches, disseminates, and refines the nomenclature, criteria,
and taxonomy of nursing diagnoses.

NANDA International sets the standards for nursing diagnoses with a taxonomy that includes domains, classes, diagnoses, based on health patterns; domains such as:

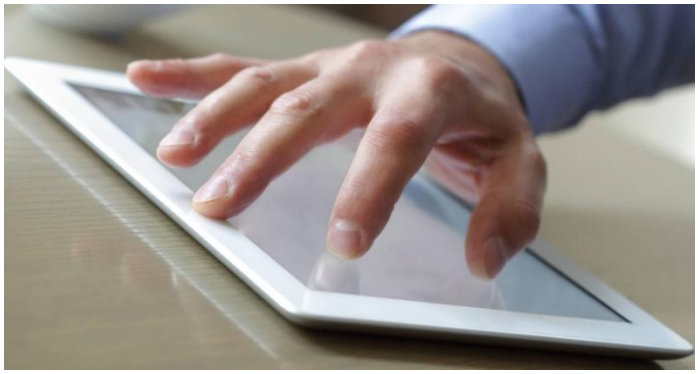
Activity/Rest
Comfort
Coping/Stress Tolerance
Elimination
Growth/Development
Health Promotion
Life Principles
Nutrition
Perception/Cognition
Role Relationships
Safety/Protection
Self-perception
Sexuality

Nursing Interventions Classification (NIC) and Nursing Outcomes Classification (NOC)

Nursing Interventions Classification; a standardized list of several of different interventions and activities needed to implement the interventions. The patient outcomes related to the nursing interventions classification are detailed in the Nursing Outcomes Classification (NOC), which contains several outcomes, each with measures to determine if outcomes are met.

NANDA International Nursing Diagnoses: Definitions and Classification 2015-2017 is available and approved by NANDA-I. The new 2015-2017 edition has been updated and revised throughout. There are 235 diagnoses presented and are supported by definition, defining characteristics, related factors, or risk factors. The new / revised diagnosis is based on latest global evidence, and approved by expert nurse

diagnosticians, educators and researchers. (See the new 2015-2017 edition for updates).



Computerized documentation systems

Computerized documentation systems often incorporate nursing diagnoses into the system, which produces lists of interventions and expected outcomes. More institutions are utilizing computerized systems for documentation. These computerized systems however vary from one facility to another; however security is a common factor for all systems.

Training has to be provided for the staff, which usually include securing patient information from unauthorized persons whether the computer is at the nurses' station or at the bedside, security of password information; no one is allowed to share their password with their co-worker etc. Computer systems usually track the use of the system, therefore it is documented who is logged on and time and date. There has to be training regarding how to correct errors when an entry error is made.

Computerized documentation systems have many advantages, including but not limited to:

- Eliminates handwritten orders,
- The records are legible; no need to worry about unclear handwriting,
- Enters signatures automatically,
- Security of patient information; need password to log in to access patient information,
- Orders can be automatically transmitted to pharmacy and medication is ordered quickly,
- Reduction in errors,
- Prevents tampering of the medical record,
- Difficult to delete information from the record.

Computerized documentation systems may include:

Electronic medical record (EMR)

Electronic medical record is the computerized patient medical record. With the use of the computerized documentation system, computer terminals may be located in the patient's room, therefore healthcare providers / workers, professionals have to be educated/ trained regarding the importance of logging off the computer system so that persons who are not authorized will not be able to access and view the patient's information. The computerized documentation system usually has computerized physician order entry, clinical decision support system; therefore the notes can be entered electronically.

Clinical decision support system (CDSS)

Clinical decision support system refers to the interactive software systems which has evidence based medical information. Clinical decision support system can be used for different purposes such as providing diagnosis and treatment options when the symptoms are imputed into the computer system. Clinical decision support system may also monitor the orders and the treatments to prevent repetitions or duplications.

Computerized physician or provider order entry (CPOE)

Computerized physician or provider order entry (CPOE) refers to the interactive software application that automates ordering for medications or treatments. Orders must be entered in a prompted format that eliminates many errors. These systems usually

include Clinical decision support system to provide alerts if there is an inaccurate dose or duplication order. Computerized physician or provider order entry eliminates handwritten orders and the information is automatically transmitted to the pharmacy, reducing errors and medication is ordered quickly.

Documentation Formats

Many institutions utilize the narrative format when documenting in the clinical record. Healthcare workers must utilize the system that is in place / follow the policy and procedures of the facility that they work in.

Some of the formats that are available include:

- Narrative format
- Focus
- Charting by exception (CBE)
- Problem Oriented medical record (POMR)
- Flow Sheet, Assessment, Concise, Timely (FACT)
- Problem/ intervention/ Evaluation (PIE)
- Core

Narrative format

Narrative format is used in the most of the institutions. Narrative charting involves recording data using progress notes, with the flow sheets supplementing the notes. Narrative charting does not follow a specific outline and follows the thought process of the healthcare worker who is documenting.

Focus

Organized into patient centered topics, the Focus system encourages integrating assessment data to evaluate the patient's condition on an ongoing basis. The Focus system is best used where the procedures are repetitive and is utilized primarily in acute

care settings. Progress notes are written utilizing the DAR (Data, Action, and Response) format.

Charting by exception (CBE)

Charting by exception requires the development and use of practice standards or protocols for each body system. The forms utilized in the documentation are developed following specific guidelines. Developing the standards and forms eliminates the need to document in narrative format standard nursing care. The healthcare worker check off the areas on the flow sheet through which the patient has met the established standard, then writes a narrative note when the patient's condition deviates from the established standard.

Problem Oriented medical record (POMR)

Problem oriented medical record (POMR) is utilized in many health care institutions. The POMR system follows a problem list format, identifying all areas (both positive and negative) that are impacting the patient. The notes and all the documentation refer back to the problem list, using the Subjective, Objective, Assessment, Plan (SOAP), the Intervention, Evaluation (SOAPIE) and/or SOAPIER (Revision) format.

Flow Sheet, Assessment, Concise, Timely (FACT)

Flow Sheet, Assessment, Concise, Timely (FACT) developed to help eliminate repetitive notes, irrelevant data, inconsistency and to reduce amount of time required to complete documentation. Flow sheets are designed to address the redundant activities in caring for a resident. The narrative documentation utilizes the Data, Action, Response (DAR) format of the Focus charting system.

Problem/ intervention/ Evaluation (PIE)

Problem/ intervention/ Evaluation (PIE) organize information according to the patient's problems to simplify the documentation system. Problem/ intervention/ Evaluation (PIE) utilize flow sheets which have been developed for daily documentation supplemented with structured narrative documentation. This system also integrates the care plan into the daily documentation.

Core

Core focuses on the nursing process. The Core framework utilizes the data base, flow sheets, care plan, progress notes, discharge summary to chart the patient's needs and progress. Progress notes follow the data, action, evaluation/response (DAE) for each of the problems.

Use of abbreviations

Abbreviation is a shortened form of a word or phrase. Abbreviations can lead to some serious or life threatening errors, therefore there are guidelines in place. The Joint Commission has set guidelines and rules; all healthcare settings has to standardize abbreviations, acronyms and symbols that they are using. They are also required to adhere to a Do Not Use list.

The Do Not Use List includes some of the following:

Do Not Use u, or for unit. Mistaken some times for zero. You must write "unit"
Do Not use iu for international unit. Mistaken for IV. Write "international unit"
Do Not Use Q.D., QD, q.d., qd (Daily). Mistaken for each other. Write "Daily".
Do Not Use Q.O.D. QOD, q.o.d., qod (every other day). Write "every other day"
See the complete Do Not Use List (The Joint Commission http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf**)**

TIMELY DOCUMENTATION

Time is a very crucial factor within the nursing process. Healthcare workers; Physicians, Nurses, CNA have to document the time of all interventions and notations.

DOCUMENTATION /PHYSICIAN ORDERS

Telephone order and Verbal order

Always follow the institution's Policy when noting orders on the physician order sheet. When the nurse receives a telephone order (the physician telephones and gives an order) then it has to be documented as a Telephone Order (T.O.)

The telephone order should indicate a telephone order with the time, date, physician's name and that the order has been repeated to the physician, also Verbal orders, must be documented as V.O. and must be written exactly as dictated and then verified.

Vital Information

Some information such as allergies/ sensitivities, Patient's identification; name and other identifying information should be on every page of every document in the patient's medical record.

Notation of Medications and treatments

When medications and treatments are administered, the healthcare worker has to document in the patient's medical record. Also If the wrong medication or treatment is administered, this also has to be documented. The nursing note has to indicate all treatments and medications given to the patient, even if it was the wrong medication or treatment. The individual who administers the wrong medication or treatment has to document the:

- Name of the medication
- the dose of medication,
- Name of physician notified
- time the physician was notified,
- Nursing interventions or physician orders to prevent or treat adverse effects,
- Patient's response to treatment.

Follow the facility policy and procedure regarding with medication and treatment errors. An incident report will also be completed.

LONG TERM CARE DOCUMENTATION

Complete and accurate documentation within the long term care setting is also very vital due to several factors such as:

- Regulations
- Surveys conducted by The Agency For Health Care Administration (AHCA)
- Litigations (laws suits)
- Documentation based on reimbursement/ payment systems
- Increased legal challenges
- Complex clinical needs
- Complex patient decision making

Federal Regulations and Clinical Record guidelines

Long-term care facilities such as Skilled Nursing Facilities (SNF), rehab. centers often review their documentation policies and procedures/ guidelines. They frequently have to incorporate accreditation requirements, payer requirements (for reimbursement purposes) and state regulations into the documentation systems.

Federal regulation requires that the facility has to maintain clinical records on each resident/patient in accordance with accepted professional standards and practices that are:

- Accurately documented,
- Complete,
- Readily accessible and
- Systematically organized.

NURSING DOCUMENTATION IN THE LONG TERM CARE SETTING

ADMISSION RECORD

Every clinical record needs to have an admission record or face sheet or that provides the demographic information, diagnosis, financial, insurance information, patient's/ resident's responsible party and contact(s) and other contact information for other professionals involved in the patient's/ resident's care outside of the facility for example, attending physician etc. The face sheet has to be revised and updated with changes as they occur. Long Term care and other facilities have designated individuals who are responsible for this task. Sometimes a nurse or nursing supervisor may be responsible for adding new information when changes occur after regular business hours; then the designated medical records personnel is updated and log the changes. The old face sheet is kept in another designated section of the chart. Nothing is thrown out from the medical record even after several changes or updates are made.

Admission Assessment:

An admission or readmission assessment usually incorporates data that would be considered a nursing assessment and the physical examination. Although there is no Federal regulation to perform the admission assessment, professional practice standards for the healthcare industry indicates that an admission assessment should be completed so that there will be baseline information and better awareness of the client/ resident needs so that appropriate and accurate care plan can be initiated. State regulations may provide specific details on information to collect such as vital signs, pain assessment, a review of systems, skin integrity etc.

Assessments within Long Term Care

There are several assessments that are used within the long term care environment. Some include:

- Resident Assessment Instrument (RAI)
- Nursing Assessment,
- Pain Assessment,
- Fall Risk Assessment,
- Pressure ulcer risk assessment
- Dietary assessments
- Elopement Assessment,
- Bowel and Bladder assessment
- Social Service Assessment,
- Smoking assessment etc.

Assessments can be documented in various ways. Documentation of an assessment may be simple as completing an assessment form or writing a narrative assessment.

The Resident Assessment Instrument (RAI)

The Resident Assessment Instrument (RAI) is the mandated assessment tool under the Federal Omnibus Budget Reconciliation Act of 1987 (OBRA) that is required in Long term care settings. Then RAI assessment also includes assessments required by the Prospective Payment System (PPS).
Some of the Omnibus Budget Reconciliation Act (OBRA) requirement includes:
Comprehensive Admission assessment
Quarterly Assessment
Significant Change
Annual assessment
Significant Correction to Prior Quarterly Assessment
Significant Correction to Prior Comprehensive Assessment

Prospective Payment Required
5 day Assessment
14 day Assessment
30 day Assessment
60 day Assessment

90 day Assessment
Other Medicare Required Assessment (OMRA)
Readmission/Return
Start of Therapy (SOT)
End of Therapy (EOT)
End of Therapy revised (EOT-r)
Start and End of Therapy
Change of Therapy (COT)
Other required records/assessments
Entry record
Discharge Assessment return anticipated
Discharge Assessment return not anticipated
Death in Facility

Types of Assessments and Requirements:

Some of the following assessments are required by Federal regulation and others are standard practice within the healthcare industry. The assessments may be completed on separate forms; the format may be manual or electronic or may be documented in narrative notes.

SEE LINK FOR MORE -RAI

Preadmission Assessment and Admission Assessment:

Completion of a preadmission assessment is not required by Federal regulation, but is commonly completed to obtain information and determine the needs of the resident/ client and ensure that the institution /facility has adequate resources to provide care for that resident.

Admission Assessment – mentioned above.

Fall Assessment Documentation

The facility/ institution has to identify each client/ resident who is at risk for accidents/incidents and/or falls and appropriately document, care plan and implement measures/ procedures to prevent accidents. Due to the time allowed to complete the Resident Assessment Instrument (RAI), it is recommended that the risk for falls assessment be completed on admission and readmission. Some of the risk factors may include:

- AGE,
- Medications that the resident is taking may have side effects such as dizziness, hypotension etc.
- sedation,
- Patient has a history of falls,
- Diagnosis that increase risk for falls,
- Infection,
- sensory impairments,
- sleep disorders,
- confusion,
- Patient has unsteady gait,
- Poor balance,
- Patient requires assistance with walking,
- Patient may require assistance for transfer,
- History of wandering,
- orthostatic hypotension,
- poor judgment,
- Pain,
- urinary frequency,
- urinary incontinence
- weakness

The healthcare worker / nurse has to document /include the risk factors in the care plan should include the risk factors and the interventions to be implemented to try to prevent falls or other accidents. Based on the Fall risk assessment findings interventions may include:

- Monitoring for side effects of medications,
- Ensure patient has assistive devices; such as cane, walker or wheelchair to assist with mobility,
- Assistance with ambulation,
- Ensure non-skid footwear,
- Referral to Physical Therapy for Eval /strength building exercises,
- Provide a clutter free environment,
- Ensure patient has eyeglasses in place prior to ambulation,
- Pain management,
- Adequate nutrition and fluids,
- Toileting schedule,
- Remove objects in walkway,
- Ensuring adequate lighting etc.

Within the long term care setting the fall risk should be reassessed with each Resident Assessment Instrument (the MDS), with change in the resident condition, and after every fall. The plan of care should also be reviewed after each fall and revised to include a different intervention to try to prevent another fall from occurring.

The Minimum Data Set (MDS) is part of the U.S. Federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. The MDS provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staffs identify and treat health problems.

The Minimum Data Set is a powerful tool for implementing standardized assessment and for facilitating care management in nursing homes. MDS 3.0 has been designed to improve the reliability, accuracy, and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols used in other settings.

Skin Assessment documentation

Documentation regarding the resident's skin integrity is very important. Based on the comprehensive assessment the facility must make sure that a resident who is admitted to the facility without a pressure ulcer or skin impairment, does not develop pressure ulcers or skin breakdown unless the resident's clinical condition indicates that they are unavoidable. If the residents develop pressure ulcer or skin impairment, they must receive the necessary treatment and services that will promote healing, prevent infection, prevent new ulcers and prevent increasing size/ stage of pressure ulcers from developing.

The nurse has to document progress with each treatment, whether there are signs or symptoms (s/s) of infections noted and follow up with the physician for change in treatment as needed. The resident's skin condition must be reviewed for each MDS including the discharge assessment. Although it is not a requirement, it is advisable that documentation regarding the resident's skin condition be provided when the resident departs and returns from a leave of absence, for example out with the family, or other events away from the facility. This will provide information regarding the presence or absence of bruises that may be determined to be facility acquired if it is not documented that the injury was sustained while the resident was out of the facility.

The documentation has to support:

- The promotion of the prevention of pressure ulcer development,
- The promotion of the healing of pressure ulcers and infections, and
- The prevention of the development of additional pressure ulcers.

Documents for the identification and documentation of resident's at risk or with existing pressure ulcers include:

- Skin Assessment; the nurse has completed a visual examination of the skin on admission,
- History & Physical (H&P) and Discharge Summary medical findings,

- Dietician Evaluation,
- Laboratory Work/ blood work,
- the use of a standardized skin at risk assessment for example the Braden scale,
- Intake and Output Totals (I &O),
- Resident Assessment Instrument

Skin at Risk Assessment

When there is early identification of the risk areas, this helps to facilitate prompt implementation of the plan of care; which documents the interventions needed to stabilize, decrease, or remove the risk factors.

Some of the Risk Factors include:

- Impaired mobility /decreased mobility,
- weight loss, medical diagnoses,
- decreased functional ability,
- co-morbid conditions, for example, diabetes mellitus, end stage renal disease or thyroid disease,
- medications such as steroids that may affect wound healing,
- history of healed ulcers,
- decline in appetite,
- impaired blood flow, such as arterial insufficiency,
- resident refusal of care and / or treatment,
- skin exposed to urinary and fecal incontinence,
- cognitive impairment,
- malnutrition, and hydration deficit,
- devices that may cause pressure

The care plan documentation should include the risk factors and the interventions to be implemented to try to reduce or eliminate risk factors related to skin at risk and/or pressure ulcers. Based on the assessment findings the interventions may include:

- Preventative Skin Care,
- Turning and repositioning,
- Pressure relieving devices on beds and chairs,
- Management of pain,
- Encouraging ambulation,
- Encouraging movement,
- Encouraging time out of bed,
- Placement of supportive surfaces to reduce pressure in bed and chair,
- Nutritional approaches that have been designed for adequate nutritional support,
- Adequate fluid intake etc.

Actual Skin Problems

Accurate and complete documentation must be completed on admission and should include the skin assessment. A complete review of the resident's skin, from head to toe must be completed to establish a baseline. There should also be ongoing documentation of the skin integrity so that change in skin integrity can be addressed and treated promptly. Long term care facility usually has an on-going system in place to assess the condition of the skin such as routine monitoring for skin conditions which could occur at the time of the resident's bath or shower. The Certified Nursing Assistants documents and if abnormal findings are observed the CNA reports the findings/ observations to the nurse, the charge nurse or nursing supervisor who would then check the resident's and follow up with physician and others of the health care team as needed.

The documentation of Assessment and Treatment of Pressure Ulcers include:

Identification of the skin's condition upon admission,
Measurements,
monitor on an on-going basis throughout the resident's stay,
potential for development of additional pressure ulcers,
Characteristics of ulcer,
Factors that influence the development of the pressure ulcer,

Potential for deterioration of existing pressure ulcers,
Stage of ulcer including if ulcer is not stageable,
Description of ulcer,
Color of skin surrounding ulcer
Signs /symptoms of infection,
Potential complications,
Presence of pain,
Change in the level of pain,
Progress toward healing,
Dressings and treatments,
Description of the skin surrounding dressing, when dressing is not due to be changed,
Monitor for the presence of complications.

Documentation must be completed according to the policy and procedures of the facility. Documentation is usually done with each dressing change and can be noted :

- In a narrative format in the progress notes,
- On a specific flow sheet or,
- On the reverse side of the Treatment Record.

Charting should include:

- Date and time of documentation,
- Stage of the pressure (document if it is unstageable)
- Document the location,
- Dimensions and presence of undermining / tunneling
- Drainage/ exudates,
- If drainage is present is it (serous, what color is it, presence of odor, purulent, and approximate amount of drainage)
- Document if resident reports pain,
- if pain is present ; document the nature of the pain, frequency, continuous or intermittent,

- Does resident report relief after treatment or increase pain,
- Document the wound bed; color, characteristic of tissues; necrosis or granulation,
- Describe the wound edges and the surrounding tissues; any redness, rolled edges, hardness or maceration,
- Document whether there are signs / symptoms of infection,
- Document response to treatment also is the resident compliant with treatment plan or non-compliant,
- Update physician if there is lack of healing, or increase deterioration and all abnormalities including resident non-compliance if applicable and document.

Whenever the documentation reflects that an intervention was either not applicable or not feasible, there has to be adequate documentation from the healthcare worker and the practitioner of clinically valid reasons why the interventions were not implemented.

Re-Evaluation and Documentation

If the pressure ulcer does not show some evidence of healing within two to four weeks, the pressure ulcer and the resident's overall clinical status needs to be reassessed. The healthcare team needs to re-evaluate the treatment plan and determine whether to continue the treatment or change the current interventions. If the healthcare team decides to keep the current treatment regimen, there has to be documentation regarding the reasons for continuing the present treatment when there has been no progress towards healing.

Skin ulcers or abnormalities are documented in the resident's Care Plan. The interventions and the implementation of these interventions are critical and should include preventative measures.

Interventions to treat pressure ulcers may include, but not limited to:

- Turning and repositioning

- Protective skin care
- Using pressure relieving devices on beds and chairs
- Effective pain management
- Ensuring nutritional supplements
- Adequate fluids
- Treatments as ordered by physician

Documentation regarding Bowel and Bladder

On admission to the facility, the Admission Nursing Assessment identifies the status of the resident such as:

- Continence status as described by resident,
- Continence status by observation,
- Risks or conditions that may affect continence,
- Environmental factors that may affect the ability to access the toilet, ambulatory devices or status,
- If catheter is present; documentation of medical justification for the catheter, type and size of catheter, color of urine, flow of urine, potential for removal of catheter,
- The use of medications that may affect continence, etc

Documentation /progress notes for bladder and bowel retraining programs are usually recorded weekly until the resident has reached the goal or the program is discontinued.

Documentation regarding Self-Administration of Medication

If the resident requests to self-administer medications, the interdisciplinary team needs to determine that it is safe for the resident to self-administer drugs before the resident is

allowed to do so. The assessment may include cognitive status, vision and manual dexterity. If it is determined that the resident is capable and is a suitable candidate for a self-medication program, the physician is notified and an order is obtained. Documentation within the plan of care needs to reflect the self-medication program and goals. Narrative notes or flow sheets will reflect the resident's progress in the program.

Documentation regarding Nutrition

The institution needs to make sure that the residents maintain acceptable nutritional status, for example ideal body weight and albumin/protein levels; unless the resident's clinical condition demonstrates that it is not possible. When a nutritional problem is identified the institution needs to make sure that the residents receive a therapeutic diet. Adequate documentation must be maintained. The resident also needs to be interviewed to determine food allergies and food preferences to ensure that the residents' needs are being met. The certified nursing assistant needs to accurately document the residents meal intake and update the nurse when there is a decrease noted in meal and fluid intake.

The Nutrition Assessment should include identification of the factors that put the resident at risk for malnutrition. The Nutritional Assessment may require a Registered Dietitian to assist. The healthcare team will need to review the factors that contributed to the decline, the potential for decline or the lack of improvement for residents who are at risk. The medically related conditions and the nutritional problems need to be documented in the resident's care plan.

Some interventions may include:

Therapeutic diet
Altered fluid consistency
Altered texture of diet
Periodic review by the dietitian
Review of laboratory results
Special dinning program that encourage meal / fluid intake (restorative dining)

The problem and goals of the care plan is reviewed quarterly and with a significant change using the progress note or the reassessment form.

Documentation regarding Mental and Psychosocial Functioning

Based on the comprehensive assessment the facility must make sure that a resident, who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem. Some assessments used to identify mental and psychosocial functioning include, but not limited to:

Resident Assessment Instrument
Social History and Evaluation
Mini Mental State Exam (MMSE)
Neuropsychiatric Inventory (NPI)
Neuropsychological Tests
Clock Draw Test
ADAS-Cog (Alzheimer Disease Assessment Scale-Cognitive)
Behavioral Pathology in Alzheimer's Disease Rating Scale (BEHAVE-AD)
Cornell Depression Assessment
CERAD (The Consortium to Establish a Registry for Alzheimer's Disease) Clinical and
Cornell Scale for Depression in Dementia (CSDD)
Geriatric Depression Scale (GDS)
The 7 Minute Screen

Documentation regarding Restorative/Rehab Nursing Assessment

The long term care facility has to provide care and services to maintain or attain the resident's highest level of independent function. Based on the assessment the facility has to make sure that a resident who enters the facility without limited range of motion

(ROM), functional activities of daily living does not experience a decline in their functional status unless the resident's clinical condition shows that it is unavoidable.

Assessments may include but not limited to:

The Resident Assessment Instrument
ADL assessments; bathing, grooming, hygiene, toileting, dressing
Screens and recommendations by physical therapist, occupational therapist and speech therapist,
Range of motion (ROM)
Bed mobility, ambulation and transfer
Self feeding ability
Bladder and/ or bowel status
Communication

Documentation within the care plan must include the functional deficit with measurable goals, and the restorative training program. The nurse who is in charge of the nursing restorative program needs to record progress notes that addresses the resident's progress toward goals. Many facilities ensure that documentation of the resident's progress is completed at least quarterly.

Documentation within the Care Plan

Documentation within the resident's care plan is critical to the resident's condition, needs and progress. The care plan has to provide direction to the healthcare team regarding providing care and treatment to the resident.

The facility has to develop a comprehensive care plan for every resident. The plan must include measurable objectives and time frames to meet the resident's nursing, medical, mental and psychosocial needs that have been identified in the comprehensive assessment.

The documentation within the care plan needs to describe the services that will be provided to maintain or attain the resident's highest possible physical, mental, psychosocial well-being; and any services that would otherwise be required but are not provided because the resident refused treatment etc.

The care plan must reflect steps for each outcome objectives if identification of those steps will enhance the resident's ability to meet his/her objectives. The healthcare team will use these objectives to monitor the resident's progress.

The care plan interventions need to be prioritized. This should be documented in the clinical record or on the plan of care. The care plan must be prepared by the interdisciplinary team which includes the physician, a nurse with the responsibility for the resident and other appropriate staff and disciplines as determined by the resident's needs, the participation of the resident, the resident's family or the resident's legal representative (if they would like to attend). There should be evidence/ documentation that the care plan is reviewed periodically by a team of qualified persons after each assessment and as the resident's status changes.

Documenting Skilled Nursing and Therapy services

The resident's medical record must have proof that the resident needed and have received skilled services such as nursing and / therapy services on a daily basis.
The residents who are receiving skilled services have to show evidence in the medical record documentation of the need for daily skilled services that is being given. The content of the documentation needs to be objective and measurable.

When the therapy services are justifying the Medicare coverage, the nursing documentation should be consistent with the therapy documentation and address how skills the resident learned in therapy are being applied on the nursing unit.

Documentation regarding Activities of Daily Living (ADL)

Activities of daily living means functions and tasks for self-care, including ambulation, bathing, dressing, eating, grooming, toileting and other similar tasks. As the Certified Nursing Assistant documents, the documentation in the medical record should provide support for the scoring on the MDS along with observation and interviews. The facility needs to utilize ADL charting to collect information from all three shifts during the 7 day observation period. If the staff member assessing the ADL status and completing the MDS does not agree with the supporting documentation based on observations and / or interviews, a clarification note needs to be written documenting the reasons for the ADL scoring on the MDS.

ADL (Activities of Daily Living) Flow sheets and NAR (Nursing Assistant Record) Flow sheets

If the ADL flow sheets are used, it is best if they are tailored to the resident's care plan. ADL flow sheets can be either documented by nursing after consulting with direct care staff or by the certified nursing assistant providing the care. When the nursing assistant completes the flow sheets, there should be a system to monitor completion every shift. Unless you are using an electronic care tracking program, flow sheets are the easiest way to document amount of care rendered to the resident. ADL scores are critically important to scoring the ADL section of the MDS correctly. Scoring on the ADL flow sheets should be consistent with the scoring on the MDS to increase consistency in data collection and assessment.

Rehabilitative Therapy Documentation

Rehabilitation Services are provided to improve the physical functioning of the resident, to allow them to return to the community. The Rehabilitation Services Assessment should be conducted within a reasonable timeframe after the physician's order is received. When the services have been started, a progress note needs to be

documented within specific time lines; (some states within 14 days and then at least every 30 days as long as the resident is receiving therapy services).

The physician needs to certify the assessment and plan of care documented by the therapists. Within some facilities, the therapists utilize a specific government generated form for this purpose. The form may include:

- assessment of the resident's functional condition / status,
- the plan of care going forward and
- location for the physician's to sign, certifying the need for and approval of therapy services.

When the residents have reached their goal, a therapy discharge summary needs to be completed. The documentation must include the number of days and minutes of therapy. The clinical record needs to reflect the dates and times, usually documented in a flow record (electronic and /or hard copy). The therapists may include a notation regarding what the resident's performance level was for that therapy session and a weekly summary is often documented.

Nurse Practitioner (NP)/Physician Assistant (PA) Documentation

Federal regulations allow a nurse practitioner and Physician Assistant working with a physician to make every other required physician visit after the initial visit. The nurse practitioner and Physician Assistant needs to write a progress note at the time of the visit. The federal regulations do not require countersignature by the attending physician; however, state law usually defines the nurse practitioner and Physician Assistant authority and should be reviewed to determine if the countersignatures are required. Federal regulations allow the physician and nurse practitioner to alternate the required visits, after the initial visit by the attending physician.

Physician Orders/ Admission Order

When a resident is admitted to the facility, the institution has to have physician orders for the resident's immediate care. These orders should include, at least, the resident's medications, diet and routine care to maintain or improve the resident's functional abilities until the healthcare worker/ staff can complete a comprehensive assessment and develop a comprehensive interdisciplinary plan of care. When the transfer orders are confirmed with the attending physician, the physician may add or delete some of the orders provided via the transfer document. These should be documented, as appropriate, following documentation standards.

Content of the Order

The physician's order should include the medication or treatment, the correlating reason or medical diagnosis. The medication order should include dosage, strength, the route of administration, frequency, and reason for administration should be documented in the order.

Telephone Orders

All orders that were received by telephone should be countersigned by the physician in the required timeframe as defined by state law. The documentation should indicate that the verbal order was read back and was verified with the physician. Follow your facility's policy regarding the appropriate timeframe for countersignature (some state may not indicate timeframe).

Standing Order

Standing orders have to be used with caution. Standing orders should not be used in place of notification to the physician of a change in status; the nurse has to update the

physician with changes in resident's status. Some states do not allow the use of standing orders.

Transcription of Orders and Noting Orders

Transcription of orders, for example telephone orders, is the responsibility of the professional nurses (RN, LPN/LVN per the scope of practice defined by State law/practice acts), can also be delegated to a trained individual if allowed by state law or practice acts. If the transcription of order was delegated, the nurse still has to sign off on the order and retain the responsibility for accurate transcription. When the telephone order or fax order is transcribed into the resident's medical record, it should be transcribed/ documented "verbatim" as given from the physician.

Contacting the physician and obtaining the order

Nurses, Therapists and other professionals designated to take orders has to first contact the physician to obtain the order. Each resident's medical care has to be supervised by a licensed physician. Licensed nurses are not authorized to independently write the physician orders without first contacting the physician and receive direction of the physician. It is not acceptable to write the telephone order, implement the order and then send the order for signature without contacting the physician. The nurse practitioner and physician assistant has the authority by law and scope of practice to write orders on behalf of a physician.

Documentation regarding discontinuing an order when a new order is obtained

Accurate and complete documentation has to be complete when the physician changes a physician order that is currently in use. The original physician order must be discontinued first then the new order has to be written that reflects the change.

Accepting orders from a Nurse Practitioner (NP)/Physician Assistant (PA)

Orders should only be accepted from a nurse practitioner or physician assistant if the state practice acts allows the nurse practitioner or physician assistant to give orders or prescribe and the attending physician has given authorization through a scope of care agreement. Both the scope of care agreement with the attending physician and a copy of the nurse practitioner or physician assistant's license should be kept on file by the facility.

Documentation in the Medication and Treatment Records

Medication administration record (MAR) and treatment administration record (TAR) are derived from the physician orders. Nurses are required to document the delivery of medications and treatments, by placing their initials in the blocks of the MAR and TAR form when the medication or treatment has been administered. Some facility requires the initials to be circled if the medication or treatment was not administered / completed and to document the reason in the medical record, with appropriate to physician as needed. There should be no spaces or gaps noted in the Medication administration record (MAR) and treatment administration record documentation.

The medical record may also contain a legend that matches staff initials with full signature and title. Any medications and / or treatments given on a as needed (PRN) basis must be initialed, and the information pertaining to the need for the PRN, documented either on the back of the Medication administration record and treatment administration record or elsewhere in the resident's medical record as required by the facility's policy. For electronic records; the Medication and Treatment Records may only have the initials on the Medication administration record and treatment administration record, either on print or view. Some electronic medication administration records (e-MARs) may be able to perform audit functions at the end of medication pass to make sure that all required documentation is in place.

Documentation regarding New Medication and Treatment Records on Readmission

Documentation of medications and treatments within the resident's medical record is crucial when the patient returns from another setting such as the hospital. To eliminate possible errors in transcription or administration of medications and treatments, new medication and treatment records should be initiated with a return from the hospital rather than continuing on the previous record. The new medication and treatment records would be based on the new orders received after hospitalization.

Documentation regarding Consents, Acknowledgements and Notices

Documentation must include an Informed Consent for the use of restraints
Check with your state regarding use of restraints. Within the long term care facility, when a restraint is being considered for a resident, the facility needs to obtain informed consent from the resident or from the resident's legal surrogate/representative. The facility has to explain the potential risks and benefits of using the restraint, the risks and benefits of not using a restraint, and alternatives to restraint all within the context of the resident's condition.

The informed consent should include:

- Explanation of how the restraint will treat the resident's medical symptoms,
- An explanation of how the restraint will assist the resident in maintaining and /or attaining his or her highest possible level of physical and/ or psychological well-being,
- An explanation of the negative outcomes of restraint use.

If the resident is not capable of making a decision, the legal representative or surrogate may exercise the right based on the information that would have been provided to the resident.

Documentation regarding Advance Directives

The facility has to inform all residents and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive. A written description of the facility's policies to implement advanced directives and applicable state laws must be provided to the resident or the representative.

A copy of the advanced directive should be kept in the resident's medical record. Some states utilize the Physician Orders for Life Sustaining Treatment (POLST) or Medical Orders for Life Sustaining Treatment (MOLST) as the approved method for documenting the resident's wishes for treatment. The Physician Orders for Life-Sustaining Treatment is an approach to improving end-of-life care in the United States, encouraging physicians to speak with patients and create specific medical orders to be honored by health care workers during a medical crisis. The form is to be accepted by all health care providers.

Discharge Information

First there has to be a discharge order, the resident's physician must document that a discharge or transfer is necessary. This documentation is usually obtained by a physician order prior to transfer or discharge.

Discharge Documentation

A discharge narrative note should be written at the time of the resident's discharge and should include:

- The date of discharge,
- The time of discharge,
- The condition of the resident at discharge,
- The resident's disposition,

- The instructions, education/ training provided,
- Information regarding where the resident was discharged to, and
- The individual taking responsibility for the resident.

Discharge Summary Documentation

For the planned discharge such as discharge to another facility or to home, federal regulations require that the facility complete the discharge summary that includes:

- A concise summary of the resident's stay
- a final summary of the resident's status based on the comprehensive assessment, and
- A post discharge plan of care.

The post discharge plan of care will serve as the discharge instructions for a resident who is going home or as the transfer form for a resident going to the hospital or to another health care facility.

Content for the post discharge plan of care includes:

- A description of the resident and family's preference for care,
- how the resident and family will access the services, and
- how care should be coordinated if continuing treatment involves multiple care givers.
- Specific resident needs after discharge, such as personal care, sterile dressings, and therapy, as well as a description of resident/care giver education needs to enable the resident/care giver to meet needs after discharge.

Some facilities, depending on the policy will give a copy of the discharge summary to the resident when discharged from the facility.

CORRECTION OF CLINICAL RECORDS

When corrections are needed in the clinical records; the correction needs to be made using an addendum/ which will note that a correction has been made. If in the event of staff turnover or staff schedules changes and the original clinician is no longer available, the Director of nursing or a designated clinician will be assigned to make the necessary corrections.

THE MINIMUM DATA SET (MDS)

RESOURCE from CMS.GOV:

The MDS is a powerful tool for implementing standardized assessment and for facilitating care management in nursing homes (NHs) and non-critical access hospital swing beds (SBs). Its content has implications for residents, families, providers, researchers, and policymakers, all of whom have expressed concerns about the reliability, validity, and relevance of MDS 2.0.

Some argue that because MDS 2.0 fails to include items that rely on direct resident interview, it fails to obtain critical information and effectively disenfranchises many residents from the assessment process. In addition, many users and government agencies have expressed concerns about MDS 2.0 data quality and validity. Other stakeholders contend that items used in other care settings should be included to improve communication across providers.

MDS 3.0 has been designed to improve the reliability, accuracy, and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols used in other settings. These improvements have profound implications for NH and SB care and public policy. Enhanced accuracy supports the primary legislative intent that MDS be a tool to improve clinical assessment and supports the credibility of programs that rely on MDS.

MDS 3.0 – See What's New

Future Needs for Long Term Care

- By 2026, the population of Americans ages 65 and older will double to 71.5 million.
- Between 2007 and 2015, the number of Americans ages 85 and older is expected to increase by 40 percent.
- Among people turning 65 today, 69 percent will need some form of long-term care, whether in the community or in a residential care facility.
- By 2020, 12 million older Americans will need long term health care.

COMMUNICATION WITH CLIENTS/ PATIENTS, FAMILIES

Interpersonal skills are very important in establishing and maintaining an effective and productive and rewarding relationship with the clients/patients.

EFFECTIVE INTERPERSONAL RELATIONS

Effective interpersonal relationships involve:

Maintaining open communication,

Being a good listener

Being honest

Being sincere

Being courteous,

Being patient

Being hopeful.

Developing trusting and supportive relationships with clients/ patients by being trustworthy and supportive.

Encouraging clients/ patients to express their feelings.

Respect each client/ patient as a unique individual with their own behavior patterns.

APPROPRIATE STEPS TO STARTING A CONVERSATION

If the client/patient is in a private room with door closed, knock on the door before entering.

Identify yourself by name and title and greet client/ patient by their name.

Greet the client/patient in a courteous manner

Approach the client/patient in a calm manner.

Explain what you are going to do.

Explain the procedure to the client/ patient

Encourage the client/ patient to participate as needed.

SPEAKING/ ATTENTIVE LISTENING

It is recommended that you get the client's /patient's attention before speaking.

Always use courtesy when you are communicating.

Use normal tone of voice and adjust your volume to the individual client's/ patient's needs.

Listen and respond appropriately to the clients/ patients

Keep conversations brief and concise

Avoid using slang while communicating.

Speak slowly (avoid the rush tone)

Avoid mumbling and speak clearly

Employ positive messages by using praise, encouragement, smiles and other methods that are acceptable to the client/ patient.

Your verbal and nonverbal message should match

Be attentive and listen to what the client/ patient is saying.

Give/ receive feedback and/or request feedback as appropriate to make sure the communication is understood.

AVOID BARRIERS TO CONVERSATION

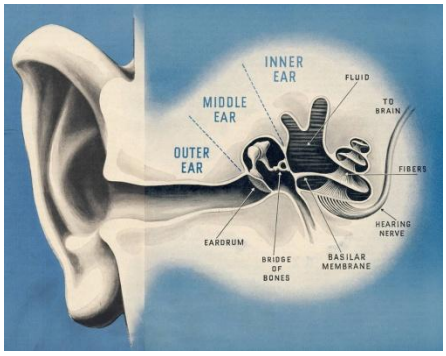
Avoid discussing or talking about your own personal problems and the problems of other patients or co-workers with the client/patient.

Avoid expressing your own opinions if it involves passing judgment

Avoid interrupting the clients/ patients when they are speaking

Avoid changing the subject.

COMMUNICATING WITH CLIENTS / PATIENTS WITH HEARING LOSS (HARD OF HEARING)



Avoid startling the client/ patient.

Stand comfortably close to the client/ patient in a good light and face him/her while you are speaking.

Speak at a normal or only slightly increased volume, so that you avoid shouting.

Write down key words if necessary or use other communication assistive devices such as communication boards if applicable.

Utilize short words and sentences.

Always clarify client's/ patient's understanding and rephrase message if applicable.

Eliminate as much as possible, any distracting background noise and /or activity.

Assist the client/ patient to use a hearing aid as applicable.

If the client/ patient hears better in one ear, then stand on the preferred side.

Speak slowly and distinctly/ clearly.

Avoid chewing gum or covering your face with your hands while speaking.

Avoid conveying negative messages by the tone of voice or even by your body language.

If the client/ patient use sign language, try to locate an individual who knows sign language to interpret.

COMMUNICATING WITH CLIENTS/ PATIENTS WITH LOSS OF VISION

Always identify self by name and title as you enter room to avoid startling the client/ patient.

Encourage and assist patient to keep glasses clean and to wear them (as applicable).

Ensure there is good light in the room and face client/ patient when you speak.

Speak in a normal tone of voice.

Give explanations of what you will be doing and what is expected of the client/ patient.

Clarify client/ patient's understanding as appropriate.

Remember not to rearrange the environment without the client's/ patient's knowledge.

If rearrangement is necessary, always replace items to their original location in the client's /patient's room.

Always inform the client/ patient when you are finished and when you are leaving.

COMMUNICATING WITH PATIENTS WHO HAVE PROBLEMS WITH SPEECH /SPEAKING

Try to keep conversation short as much as possible.

Ask direct questions if client/ patient can answer - Yes or No.

If you are unable to understand the words or uncertain, validate what you think the patient is saying.

Allow the client /patient adequate time to respond.

Employ attentive listening (listen carefully).

Emphasize positive aspects.

Take the time and complete every conversation, to avoid conveying any impatience.

Assist the client /patient to point, write or use assistive devices for communication for example word boards or picture board as appropriate.

Encourage the client /patient to nod as appropriate.

Monitor body language to make sure you are not giving negative messages.

NON-VERBAL COMMUNICATION

Non- verbal communication is also an important aspect of communication. Gestures, nodding of head, waving of hand all convey a message; therefore it is vital for the professionals to be aware that effective non-verbal communication is also needed while working with the clients/patients and other colleagues.

Non- verbal communication has several functions:

Non- verbal communication is sometimes a substitute for verbal message such as gestures or facial expressions.

Non- verbal communication is frequently used to accent verbal messages.

Non- verbal communication is sometimes used to repeat the verbal message for example pointing in a direction while giving directions.

Non- verbal communication often complements the verbal message.

Non- verbal communication often regulates interactions for example non-verbal cues may indicate when the other person should respond or not respond.

The Florida statutes 2016, chapter 400: NURSING HOMES AND RELATED HEALTH CARE FACILITIES

400.23 Rules; evaluation and deficiencies; licensure status states:
(1) It is the intent of the Legislature that rules published and enforced pursuant to this part and part II of chapter 408 shall include criteria by which a reasonable and consistent quality of resident care may be ensured and the results of such resident care can be demonstrated and by which safe and sanitary nursing homes can be provided. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a nursing home. In addition, efforts shall be made to minimize the paperwork associated with the reporting and documentation requirements of these rules. (2) Pursuant to the intention of the Legislature, the agency, in consultation with the Department of Health and the Department of Elderly Affairs, shall adopt and enforce rules to implement this part and part II of chapter 408, which shall include reasonable and fair criteria in relation to:

(a) The location of the facility and housing conditions that will ensure the health, safety, and comfort of residents, including an adequate call system. In making such rules, the agency shall be guided by criteria recommended by nationally recognized reputable professional groups and associations with knowledge of such subject matters. The agency shall update or revise such criteria as the need arises. The agency may require alterations to a building if it determines that an existing condition constitutes a distinct hazard to life, health, or safety. In performing any inspections of facilities authorized by this part or part II of chapter 408, the agency may enforce the special-occupancy provisions of the Florida Building Code and the Florida Fire Prevention Code which apply to nursing homes. Residents or their representatives shall be able to request a change in the placement of the bed in their room, provided that at admission they are presented with a room that meets requirements of the Florida Building Code. The location of a bed may be changed if the requested placement does not infringe on the resident's roommate or interfere with the resident's care or safety as determined by the care planning team in accordance with facility policies and procedures.

In addition, the bed placement may not be used as a restraint. Each facility shall maintain a log of resident rooms with beds that are not in strict compliance with the Florida Building Code in order for such log to be used by surveyors and nurse monitors during inspections and visits. A resident or resident representative who requests that a bed be moved shall sign a statement indicating that he or she understands the room will not be in compliance with the Florida Building Code, but they would prefer to exercise their right to self-determination. The statement must be retained as part of the resident's care plan. Any facility that offers this option must submit a letter signed by the nursing home administrator of record to the agency notifying it of this practice with a copy of the policies and procedures of the facility. The agency is directed to provide assistance to the Florida Building Commission in updating the construction standards of the code relative to nursing homes.

(b) The number and qualifications of all personnel, including management, medical, nursing, and other professional personnel, and nursing assistants, orderlies, and support personnel, having responsibility for any part of the care given residents.

(c) All sanitary conditions within the facility and its surroundings, including water supply, sewage disposal, food handling, and general hygiene which will ensure the health and comfort of residents.

(d) The equipment essential to the health and welfare of the residents.

(e) A uniform accounting system.

(f) The care, treatment, and maintenance of residents and measurement of the quality and adequacy thereof, based on rules developed under this chapter and the Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100-203) (December 22, 1987), Title IV (Medicare, Medicaid, and Other Health-Related Programs), Subtitle C (Nursing Home Reform), as amended…

(g) The preparation and annual update of a comprehensive emergency management plan. The agency shall adopt rules establishing minimum criteria for the plan after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; and responding to family inquiries. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions. (h) The availability, distribution, and posting of reports and records pursuant to s. 400.191 and the Gold Seal Program pursuant to s. 400.235. (3)(a)1. The agency shall adopt rules providing minimum staffing requirements for nursing home facilities. These requirements must include, for each facility:

a. A minimum weekly average of certified nursing assistant and licensed nursing staffing combined of 3.6 hours of direct care per resident per day. As used in this sub-subparagraph, a week is defined as Sunday through Saturday.

b. A minimum certified nursing assistant staffing of 2.5 hours of direct care per resident per day. A facility may not staff below one certified nursing assistant per 20 residents. c. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day. A facility may not staff below one licensed nurse per 40 residents.

2. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing ratio for certified nursing assistants if their job responsibilities include only nursing-assistant-related duties.

3. Each nursing home facility must document compliance with staffing standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public.

4. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants if the nursing home facility otherwise meets the minimum staffing requirements for licensed nurses and the licensed nurses are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted toward the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and not also be counted toward the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. The hours of a licensed nurse with dual job responsibilities may not be counted twice.

(b) Nonnursing staff providing eating assistance to residents shall not count toward compliance with minimum staffing standards.

(c) Licensed practical nurses licensed under chapter 464 who are providing nursing services in nursing home facilities under this part may supervise the activities of other licensed practical nurses, certified nursing assistants, and other unlicensed personnel providing services in such facilities in accordance with rules adopted by the Board of Nursing.

Health Care Advance Directives

THE PATIENT'S RIGHT TO DECIDE

This is a very important topic to discuss as individuals are being asked to participate in making decisions about end of life wishes and care. Every competent adult has the right to make decisions regarding his or her own health, which includes the right to choose or refuse medical treatment.

When an individual becomes unable to make decisions due to a physical or mental change, such as being in a coma or other conditions or disease such as Alzheimer's disease, they are considered incapacitated.

Only the patient's primary physician can determine if they are incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). Check your state for the specific legislature.

The law recognizes the rights of a competent adult to make an advance directive which will:

- Instruct his or her physician to provide, withdraw or withhold life-prolonging procedures

- Designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions and /or

- Indicate the desire to make an anatomical donation after death.

Also, the law states that the individuals do not have to be incapacitated to elect a health care surrogate to make their decisions.

By law hospitals, long term health care facilities; nursing homes, home health agencies, hospices, health maintenance organizations (HMOs) are required to provide their patients with written information concerning health care advance directives.

ADVANCE DIRECTIVES

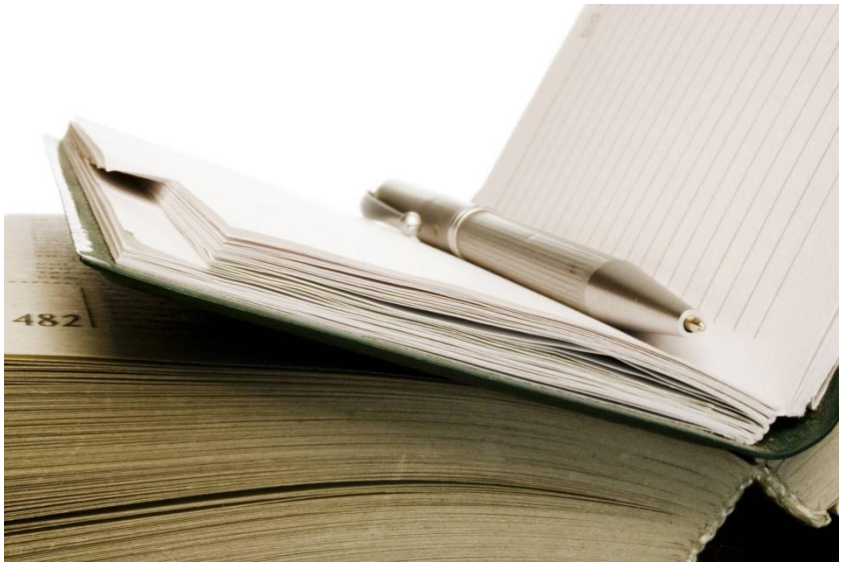
An Advance Directive is a written or oral statement about how individuals want medical decisions made in the event that they are not able to make them themselves and/or it can express the individuals' wish to make an anatomical donation after death. Communicating wishes about end of life wishes or care will ensure that patients with terminal illnesses face the end of their lives with dignity.

Some individuals make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, sometimes as apart of their estate planning.

Three types of advance directives are:

- A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

Some individuals may choose to complete one, two, or all three of these forms; to best serve their needs.

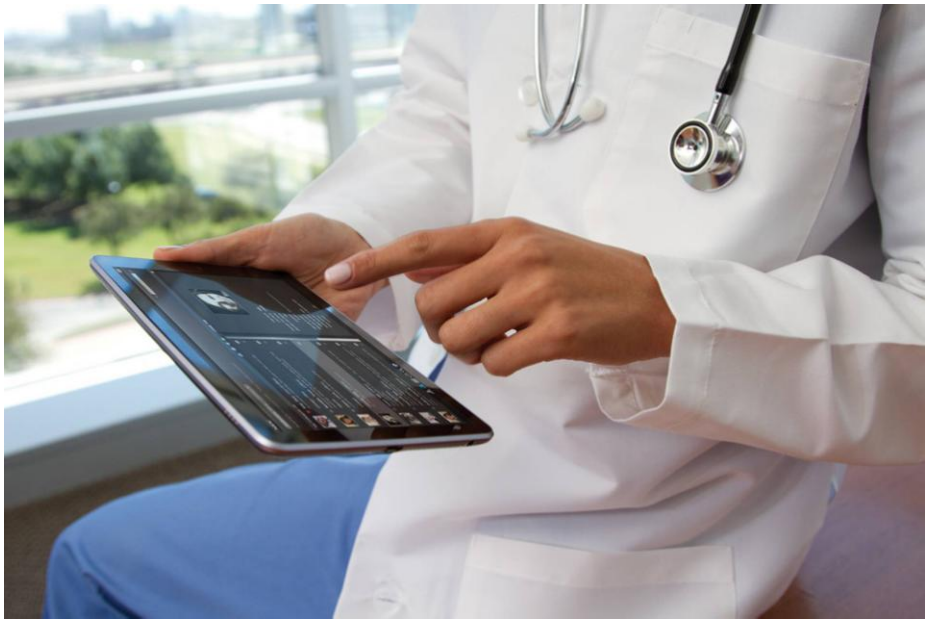


LIVING WILL

A Living will is a written or oral statement of the kind of medical care the resident/ patient or individual want or do not want if they become unable to make their own decisions. It is referred to as a "living will" because it becomes effective while the individuals are still living. Each individual may wish to speak to their attorney or health care provider to be certain they have completed the living will in a way that their wishes will be understood.

HEALTH CARE SURROGATE DESIGNATION

A Health Care Surrogate Designation is a document which has the name of another person as the representative to make medical decisions for the patient if he /she is unable to make the decisions themselves. The patient /individual may include instructions about any treatment that they want or do not want. The patient can also designate an alternate surrogate.



ANATOMICAL DONATION

An Anatomical Donation is a document that indicates the individuals' wish to donate all or part of their body; at death. This donation can be an organ and tissue donation to people in need, or donation of their body for training of health care workers.

The individuals can indicate their choice to be an organ donor by designating it on their driver's license or on their state identification card; this may be done at the driver's license office. The individuals may also sign a uniform donor form or expressing their wish in a living will.

The individual may wish to complete any one or a combination of the three types of advance directives depending on the individual's needs. Within the state of Florida, there is no legal requirement to complete an advance directive. However, if the individual does not make an advance directive, decisions about his/ her health care or an anatomical donation may be made for them by:

- A court-appointed guardian,
- A spouse (wife or husband),
- Their adult child,
- Their parent,
- Their adult sibling,
- An adult relative or
- A close friend.

Sometimes the person making decisions for the patient/ resident may or may not be aware of their wishes. When an advance directive is made and is reviewed or discussed with the significant person in their lives, it will better ensure that the patients' wishes will be carried out the way they desired it to be done.

The advance directive procedures are simple and do not require an attorney; however the individual may choose to consult one. An advance directive completed in another state, as described in that state's law, can be honored in Florida.

WITNESSES

An advance directive, a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a blood relative or a spouse. Many states including Florida law provides a sample of each of the following forms: a living will, a health care surrogate, and an anatomical donation.

CANCEL OR CHANGE AN ADVANCE DIRECTIVES?

An individual may change or cancel an advance directive at any time. Changes should be written, signed and dated. Changes may also be by oral statement, physical destruction of the advance directive or by writing a new advance directive.

If the individual has a driver's license or state identification card that indicates that he/ she is an organ donor, but he/ she no longer want this designation, the individual should contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to them.

When the individual choose to have an advance directive:

If the patient/ individual designate a health care surrogate and an alternate surrogate it is best to ask them if they agree to take this responsibility and also to review / discuss how matters should be handled,

It is also best to give them a copy of the document,

The patients/ individuals should make sure that their health care provider, attorney, and the significant people in their lives know that they have an advance directive and where it is located. Giving them a copy will also be helpful.

The patients/ individuals can set up a file where they can keep a copy of their advance directive as well as other important papers. Some individuals may keep original papers in a bank safety deposit box.

The patients/ individuals may keep a card or note in their wallet, purse / bag that states that they have an advance directive and where it is located; so that it will be found when needed.

WHEN CHANGES ARE MADE

When the patients/ individuals have made changes to their advance directive, they need to make sure that their health care provider, attorney and the significant persons in their lives have the updated copy.

MEDICATION /DRUG REVIEW

The comprehensive assessment has to include a review of all medications the patient is currently using (including over the counter and supplements) in order to identify any potential adverse effects and drug reactions, including:

- Ineffective drug therapy,
- significant side effects,
- significant drug interactions,
- Duplicate drug therapy, and
- noncompliance with drug therapy.

The drug regimen review must include documentation of ALL medications the patient is Taking (including over the counter and supplements).

Review medications on the current physician plan of care and in clinical record notes to determine the accuracy of the medication regimen.

STATE LONG-TERM CARE OMBUDSMAN PROGRAM: THE 2016 FLORIDA STATUTES STATES:

400.0063 - Establishment of the State Long-Term Care Ombudsman Program; designation of ombudsman and legal advocate:

(1) There is created the State Long-Term Care Ombudsman Program in the Department of Elderly Affairs.

(2)(a) The State Long-Term Care Ombudsman Program shall be headed by the State Long-Term Care Ombudsman, who shall serve on a full-time basis and shall personally, or through representatives of the program, carry out its purposes and functions in accordance with state and federal law.

(b) The state ombudsman shall be appointed by and shall serve at the pleasure of the Secretary of Elderly Affairs. The secretary shall appoint a person who has expertise and experience in the fields of long-term care and advocacy to serve as state ombudsman.

(3)(a) There is created in the office the position of legal advocate, who shall be selected by and serve at the pleasure of the state ombudsman and shall be a member in good standing of The Florida Bar.

(b) The duties of the legal advocate shall include, but not be limited to:

1. Assisting the state ombudsman in carrying out the duties of the office with respect to the abuse, neglect, exploitation, or violation of rights of residents of long-term care facilities.
2. Assisting the representatives of the State Long-Term Care Ombudsman Program in carrying out their responsibilities under this part.
3. Pursuing administrative, legal, and other appropriate remedies on behalf of residents.
4. Serving as legal counsel to the representatives of the State Long-Term Care Ombudsman Program in any suit or other legal action that is initiated in connection with the performance of the official duties of the representatives of the State Long-Term Care Ombudsman Program.

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WORKING WITH RESIDENTS IN
THE NURSING HOME SETTING 18 Hr

400.0074 Local ombudsman council onsite administrative assessments

(1) A representative of the State Long-Term Care Ombudsman Program shall conduct, at least annually, an onsite administrative assessment of each nursing home, assisted living facility, and adult family-care home. This administrative assessment must be comprehensive in nature, must be resident-centered, and must focus on factors affecting residents' rights, health, safety, and welfare. Each local council is encouraged to conduct a similar onsite administrative assessment of each additional long-term care facility within its jurisdiction.

(2) An onsite administrative assessment conducted by a local council shall be subject to the following conditions:

(a) To the extent possible and reasonable, the administrative assessment may not duplicate the efforts of surveys and inspections of long-term care facilities conducted by state agencies.

(b) An administrative assessment shall be conducted at a time and for a duration necessary to produce the information required to complete the assessment.

(c) Advance notice of an administrative assessment may not be provided to a long-term care facility, except that notice of followup assessments on specific problems may be provided.

(d) A representative of the State Long-Term Care Ombudsman Program present for the administrative assessment must identify himself or herself to the administrator of the facility or his or her designee.

(e) An administrative assessment may not unreasonably interfere with the programs and activities of residents.

(f) A representative of the State Long-Term Care Ombudsman Program may not enter a single-family residential unit within a long-term care facility during an administrative assessment without the permission of the resident or the representative of the resident.

(g) An administrative assessment must be conducted in a manner that does not impose an unreasonable burden on a long-term care facility.

(h) Upon completion of an administrative assessment, the local council shall conduct an exit consultation with the facility administrator or a designee representing the facility to discuss issues and concerns in areas affecting residents' rights, health, safety, and welfare and, if needed, make recommendations for improvement.

(3) Regardless of jurisdiction, the state ombudsman may authorize a state or local council member to assist another local council to perform the administrative assessments described in this section. (4) An onsite administrative assessment may not be accomplished by forcible entry. However, if a representative of the State Long-Term Care Ombudsman Program is not allowed to enter a long-term care facility, the administrator of the facility shall be considered to have interfered with a representative of the State Long-Term Care Ombudsman Program in the performance of official duties… 400.0083(1) and to have committed a violation of this part. The representative of the State Long-Term Care Ombudsman Program shall report the refusal by a facility to allow entry to the state ombudsman or his or her designee, who shall report the incident to the agency, and the agency shall record the report and take it into consideration when determining actions.

400.0075 Complaint notification and resolution procedures

(1)(a) Any complaint verified by a representative of the State Long-Term Care Ombudsman Program as a result of an investigation which is determined by the local council to require remedial action may be identified and brought to the attention of the long-term care facility administrator subject to the confidentiality provisions of s. 400.0077. Upon receipt of the information, the administrator, with the concurrence of the representative of the State Long-Term Care Ombudsman Program, shall establish target dates for taking appropriate remedial action. If, by the target date, the remedial action is not completed or forthcoming, the representative of the State Long-Term Care Ombudsman Program may extend the target date if there is reason to believe such action would facilitate the resolution of the complaint, or the representative of the State Long-Term Care Ombudsman Program may refer the complaint to the district manager, who may refer the complaint to the state council.(b) If the representative of the State Long-Term Care Ombudsman Program determines that the health, safety, welfare, or rights of a resident are in imminent danger, the representative of the State Long-Term Care Ombudsman Program must immediately notify the district manager and local council chair. The district manager or local council chair, after verifying that such imminent danger exists, must notify the appropriate state agencies, including law enforcement agencies, the state ombudsman, and the legal advocate to ensure the protection of the resident.

(c) If the state ombudsman or legal advocate has reason to believe that the long-term care facility or an employee of the facility has committed a criminal act, the state ombudsman or legal advocate shall provide the local law enforcement agency with the relevant information to initiate an investigation of the case.

(2) Upon referral from a district or local council, the state ombudsman or his or her designee shall assume the responsibility for the disposition of the complaint. If a long-term care facility fails to take action to resolve or remedy the complaint, the state ombudsman may:

(a) In accordance with s. 400.0077, publicize the complaint, the recommendations of the local or state council, and the response of the long-term care facility.

(b) Recommend to the department and the agency a series of facility reviews pursuant to s. 400.19, s. 429.34, or s. 429.67 to ensure correction and nonrecurrence of the conditions that gave rise to the complaint against the long-term care facility.

(c) Recommend to the department and the agency that the long-term care facility no longer receive payments under any state assistance program, including Medicaid.

(d) Recommend to the department and the agency that procedures be initiated for action against the long-term care facility's license in accordance with chapter 120.

(3) If the state ombudsman, after consultation with the legal advocate, has reason to believe that the long-term care facility or an employee of the facility has committed a criminal act, the state ombudsman shall provide the local law enforcement agency with the relevant information to initiate an investigation of the case.

400.0079 IMMUNITY

(1) Any person making a complaint pursuant to this part who does so in good faith shall be immune from any liability, civil or criminal, that otherwise might be incurred or imposed as a direct or indirect result of making the complaint.

(2) Representatives of the State Long-Term Care Ombudsman Program are immune from any liability, civil or criminal, that otherwise might be incurred or imposed during the good faith performance of official duties.

400.0081 ACCESS TO FACILITIES, RESIDENTS, AND RECORDS

(1) A long-term care facility shall provide representatives of the State Long-Term Care Ombudsman Program with access to:

(a) The long-term care facility and its residents.

(b) Where appropriate, medical and social records of a resident for review if:

1. The representative of the State Long-Term Care Ombudsman Program has the permission of the resident or the legal representative of the resident; or

2. The resident is unable to consent to the review and does not have a legal representative.

(c) Medical and social records of a resident as necessary to investigate a complaint, if:

1. A legal representative or guardian of the resident refuses to give permission;

2. The representative of the State Long-Term Care Ombudsman Program has reasonable cause to believe that the legal representative or guardian is not acting in the best interests of the resident; and

3. The representative of the State Long-Term Care Ombudsman Program obtains the approval of the state ombudsman.

(d) Administrative records, policies, and documents to which residents or the general public have access.

(e) Upon request, copies of all licensing and certification records maintained by the state with respect to a long-term care facility.

(2) The department, in consultation with the state ombudsman, may adopt rules to establish procedures to ensure access to facilities, residents, and records as described in this section.

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400.0083 INTERFERENCE; RETALIATION; PENALTIES

(1) A person, long-term care facility, or other entity may not willfully interfere with a representative of the State Long-Term Care Ombudsman Program in the performance of official duties.

(2) A person, long-term care facility, or other entity may not knowingly or willfully take action or retaliate against any resident, employee, or other person for filing a complaint with, providing information to, or otherwise cooperating with any representative of the State Long-Term Care Ombudsman Program.

(3) A person, long-term care facility, or other entity that violates this section:

(a) Is liable for damages and equitable relief as determined by law.

(b) Commits a misdemeanor of the second degree, punishable as provided in s. 775.083.

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400.0236 STATUTE OF LIMITATIONS

(1) Any action for damages brought under this part shall be commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered or should have been discovered with the exercise of due diligence; however, in no event shall the action be commenced later than 4 years from the date of the incident or occurrence out of which the cause of action accrued.

(2) In those actions covered by this subsection in which it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time that the injury is discovered with the exercise of due diligence, but in no event for more than 6 years from the date the incident giving rise to the injury occurred.

(3) This section shall apply to causes of action that have accrued prior to the effective date of this section; however, any such cause of action that would not have been barred under prior law may be brought within the time allowed by prior law or within 2 years after the effective date of this section, whichever is earlier, and will be barred thereafter.

In actions where it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time that the injury is discovered with the exercise of due diligence, but in no event more than 4 years from the effective date of this section. **History.**—s. 8, ch. 2001-45.

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400.0255 Resident transfer or discharge; requirements and procedures; hearings;

(1) As used in this section, the term:

(a) "Discharge" means to move a resident to a noninstitutional setting when the releasing facility ceases to be responsible for the resident's care.

(b) "Transfer" means to move a resident from the facility to another legally responsible institutional setting.

(2) Each facility licensed under this part must comply with subsection (9) and s. 400.022(1)(p) when deciding to discharge or transfer a resident.

(3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer.

Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant.

(4)(a) Each facility must notify the agency of any proposed discharge or transfer of a resident when such discharge or transfer is necessitated by changes in the physical plant of the facility that make the facility unsafe for the resident.

(b) Upon receipt of such a notice, the agency shall conduct an onsite inspection of the facility to verify the necessity of the discharge or transfer.

(5) A resident of any Medicaid or Medicare certified facility may challenge a decision by the facility to discharge or transfer the resident.

(6) A facility that has been reimbursed for reserving a bed and, for reasons other than those permitted under this section, refuses to readmit a resident within the prescribed timeframe shall refund the bed reservation payment.

(7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstances, the facility shall give notice as soon as practicable before the transfer or discharge:

(a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, and the circumstances are documented in the resident's medical records by the resident's physician; or

(b) The health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.

(8) The notice required by subsection (7) must be in writing and must contain all information required by state and federal law, rules, or regulations applicable to Medicaid or Medicare cases. The agency shall develop a standard document to be used by all facilities licensed under this part for purposes of notifying residents of a discharge or transfer.

Such document must include a means for a resident to request the local long-term care ombudsman council to review the notice and request information about or assistance with initiating a fair hearing with the department's Office of Appeals Hearings. In addition to any other pertinent information included, the form shall specify the reason allowed under federal or state law that the resident is being discharged or transferred, with an explanation to support this action.

Further, the form must state the effective date of the discharge or transfer and the location to which the resident is being discharged or transferred. The form must clearly describe the resident's appeal rights and the procedures for filing an appeal, including the right to request the local ombudsman council review the notice of discharge or transfer. A copy of the notice must be placed in the resident's clinical record, and a copy must be transmitted to the resident's legal guardian or representative and to the local ombudsman council within 5 business days after signature by the resident or resident designee.

(9) A resident may request that the State Long-Term Care Ombudsman Program or local ombudsman council review any notice of discharge or transfer given to the resident. When requested by a resident to review a notice of discharge or transfer, the local ombudsman council shall do so within 7 days after receipt of the request.

The nursing home administrator, or the administrator's designee, must forward the request for review contained in the notice to the State Long-Term Care Ombudsman Program or local ombudsman council within 24 hours after such request is submitted. Failure to forward the request within 24 hours after the request is submitted shall toll the running of the 30-day advance notice period until the request has been forwarded.

(10)(a) A resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge. The resident, or the resident's legal representative or designee, may request a hearing at any time within 90 days after the resident's receipt of the facility's notice of the proposed discharge or transfer.

(b) If a resident requests a hearing within 10 days after receiving the notice from the facility, the request shall stay the proposed transfer or discharge pending a hearing decision. The facility may not take action, and the resident may remain in the facility, until the outcome of the initial fair hearing, which must be completed within 90 days after receipt of a request for a fair hearing.

Further, the form must state the effective date of the discharge or transfer and the location to which the resident is being discharged or transferred. The form must clearly describe the resident's appeal rights and the procedures for filing an appeal, including the right to request the local ombudsman council review the notice of discharge or transfer. A copy of the notice must be placed in the resident's clinical record, and a copy must be transmitted to the resident's legal guardian or representative and to the local ombudsman council within 5 business days after signature by the resident or resident designee.

(9) A resident may request that the State Long-Term Care Ombudsman Program or local ombudsman council review any notice of discharge or transfer given to the resident. When requested by a resident to review a notice of discharge or transfer, the local ombudsman council shall do so within 7 days after receipt of the request.

The nursing home administrator, or the administrator's designee, must forward the request for review contained in the notice to the State Long-Term Care Ombudsman Program or local ombudsman council within 24 hours after such request is submitted. Failure to forward the request within 24 hours after the request is submitted shall toll the running of the 30-day advance notice period until the request has been forwarded.

(10)(a) A resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge. The resident, or the resident's legal representative or designee, may request a hearing at any time within 90 days after the resident's receipt of the facility's notice of the proposed discharge or transfer.

(b) If a resident requests a hearing within 10 days after receiving the notice from the facility, the request shall stay the proposed transfer or discharge pending a hearing decision. The facility may not take action, and the resident may remain in the facility, until the outcome of the initial fair hearing, which must be completed within 90 days after receipt of a request for a fair hearing.

(c) If the resident fails to request a hearing within 10 days after receipt of the facility notice of the proposed discharge or transfer, the facility may transfer or discharge the resident after 30 days from the date the resident received the notice.

(11) Notwithstanding paragraph (10)(b), an emergency discharge or transfer may be implemented as necessary pursuant to state or federal law during the time after the notice is given and before the time a hearing decision is rendered. Notice of an emergency discharge or transfer to the resident, the resident's legal guardian or representative, and the State Long-Term Care Ombudsman Program or the local ombudsman council if requested pursuant to subsection (9) must be by telephone or in person. This notice shall be given before the transfer, if possible, or as soon thereafter as practicable. The State Long-Term Care Ombudsman Program or a local ombudsman council conducting a review under this subsection shall do so within 24 hours after receipt of the request. The resident's file must be documented to show who was contacted, whether the contact was by telephone or in person, and the date and time of the contact. If the notice is not given in writing, written notice meeting the requirements of subsection (8) must be given the next working day.

(12) After receipt of any notice required under this section, the State Long-Term Care Ombudsman Program or local ombudsman council may request a private informal conversation with a resident to whom the notice is directed, and, if known, a family member or the resident's legal guardian or designee, to ensure that the facility is proceeding with the discharge or transfer in accordance with this section.
If requested, the State Long-Term Care Ombudsman Program or the local ombudsman council shall assist the resident with filing an appeal of the proposed discharge or transfer.(13) The following persons must be present at all hearings authorized under this section:

(a) The resident, or the resident's legal representative or designee.

(b) The facility administrator, or the facility's legal representative or designee.

A representative of the State Long-Term Care Ombudsman Program or the local long-term care ombudsman council may be present at all hearings authorized by this section.

(14) In any hearing under this section, the following information concerning the parties shall be confidential and exempt from s. 119.07(1):

(a) Names and addresses.

(b) Medical services provided.

(c) Social and economic conditions or circumstances.

(d) Evaluation of personal information.

(e) Medical data, including diagnosis and past history of disease or disability.

(f) Any information received verifying income eligibility and amount of medical assistance payments. Income information received from the Social Security Administration or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data.

The exemption that is created by this subsection does not prohibit access to such information by the State Long-Term Care Ombudsman Program or a local long-term care ombudsman council upon request, by a reviewing court if such information is required to be part of the record upon subsequent review, or as specified in s. 24(a), Art. I of the State Constitution.

(15)(a) The department's Office of Appeals Hearings shall conduct hearings under this section. The office shall notify the facility of a resident's request for a hearing.

(b) The department shall, by rule, establish procedures to be used for fair hearings requested by residents. These procedures shall be equivalent to the procedures used for fair hearings for other Medicaid cases, chapter 10-2, part VI, Florida Administrative Code. The burden of proof must be clear and convincing evidence. A hearing decision must be rendered within 90 days after receipt of the request for hearing.

(c) If the hearing decision is favorable to the resident who has been transferred or discharged, the resident must be readmitted to the facility's first available bed.

(d) The decision of the hearing officer shall be final. Any aggrieved party may appeal the decision to the district court of appeal in the appellate district where the facility is located. Review procedures shall be conducted in accordance with the Florida Rules of Appellate Procedure.

(16) The department may adopt rules necessary to administer this section.

(17) The provisions of this section apply to transfers or discharges that are initiated by the nursing home facility, and not by the resident or by the resident's physician or legal guardian or representative.

400.1183 RESIDENT GRIEVANCE PROCEDURES

(1) Every nursing home must have a grievance procedure available to its residents and their families. The grievance procedure must include:

(a) An explanation of how to pursue redress of a grievance.

(b) The names, job titles, and telephone numbers of the employees responsible for implementing the facility's grievance procedure. The list must include the address and the toll-free telephone numbers of the ombudsman and the agency.

(c) A simple description of the process through which a resident may, at any time, contact the toll-free telephone hotline of the ombudsman or the agency to report the unresolved grievance.

(d) A procedure for providing assistance to residents who cannot prepare a written grievance without help.

(2) Each nursing home facility shall maintain records of all grievances and a report, subject to agency inspection, of the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances.

(3) Each facility must respond to the grievance within a reasonable time after its submission.

(4) The agency may investigate any grievance at any time.

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400.1413 VOLUNTEERS IN NURSING HOMES

(1) It is the intent of the Legislature to encourage the involvement of volunteers in nursing homes in this state. The Legislature also acknowledges that the licensee is responsible for all the activities that take place in the nursing home and recognizes the licensee's need to be aware of and coordinate volunteer activities in the nursing home. Therefore, a nursing home may require that volunteers:

(a) Sign in and out with staff of the nursing home upon entering or leaving the facility.

(b) Wear an identification badge while in the building.

(c) Participate in a facility orientation and training program.

(2) This section does not affect the activities of state or local long-term care ombudsman councils authorized under part I.

400.142 EMERGENCY MEDICATION KITS; ORDERS NOT TO RESUSCITATE

(1) Other provisions of this chapter or of chapter 465, chapter 499, or chapter 893 to the contrary notwithstanding, each nursing home operating pursuant to a license issued by the agency may maintain an emergency medication kit for the purpose of storing medicinal drugs to be administered under emergency conditions to residents residing in such facility.

(2) The agency shall adopt such rules as it may deem appropriate to the effective implementation of this act, including, but not limited to, rules which:

(a) Define the term "emergency medication kit."

(b) Describe the medicinal drugs eligible to be placed in emergency medication kits.

(c) Establish requirements for the storing of medicinal drugs in emergency medication kits and the maintenance of records with respect thereto.

(d) Establish requirements for the administration of medicinal drugs to residents under emergency conditions from emergency medication kits.

(3) Facility staff may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. Facility staff and facilities are not subject to criminal prosecution or civil liability, or considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such order. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.

400.145 COPIES OF RECORDS OF CARE AND TREATMENT OF RESIDENT

(1) Upon receipt of a written request that complies with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and this section, a nursing home facility shall furnish to a competent resident, or to a representative of that resident who is authorized to make requests for the resident's records under HIPAA or subsection (2), copies of the resident's paper and electronic records that are in possession of the facility. Such records must include any medical records and records concerning the care and treatment of the resident performed by the facility, except for progress notes and consultation report sections of a psychiatric nature. The facility shall provide the requested records within 14 working days after receipt of a request relating to a current resident or within 30 working days after receipt of a request relating to a former resident.

(2) Requests for a deceased resident's medical records under this section may be made by:

(a) A person appointed by a court to act as the personal representative, executor, administrator, curator, or temporary administrator of the deceased resident's estate;

(b) If a judicial appointment has not been made as provided in paragraph (a), a person designated by the resident to act as his or her personal representative in a last will that is self-proved under s. 732.503; or

(c) If no judicial appointment has been made as provided in paragraph (a) or no person has been designated by the resident in a last will as provided in paragraph (b), only the following individuals:

1. A surviving spouse.
2. If there is no surviving spouse, a surviving child of the resident.
3. If there is no surviving spouse or child, a parent of the resident.

(3) All requests for a deceased resident's records made by a person authorized under:

(a) Paragraph (2)(a) must include a copy of the letter of administration and a copy of the court order appointing such person as the representative of the resident's estate.

(b) Paragraph (2)(b) must include a copy of the self-proved last will designating the person as the resident's representative.

(c) Paragraph (2)(c) must be accompanied by a letter from the person's attorney verifying the person's relationship to the resident and the absence of a court-appointed representative and self-proved last will. (4) A nursing home facility may charge a reasonable fee for the copying of resident records. Such fee may not exceed $1 per page for the first 25 pages and 25 cents per page for each additional page. The facility shall allow a person who is authorized to act on behalf of the resident to examine the original records, microfilms, or other suitable reproductions of the records in its possession upon any reasonable terms imposed by the facility to ensure that the records are not damaged, destroyed, or altered.

(5) If a nursing home facility determines that disclosure of the records to the resident would be detrimental to the physical or mental health of the resident, the facility may refuse to furnish the record directly to the resident; however, upon such refusal, the resident's records shall, upon written request by the resident, be furnished to any other medical provider designated by the resident.

(6) A nursing home facility that in good faith and in reliance upon this section releases copies of records shall be indemnified by the party who requested the records pursuant to subsection (2) for any damages resulting from such release, and may not be found to have violated any criminal or civil laws, and is not civilly liable to the resident, the resident's estate, or any other person for any damages resulting from such release.

(7) A nursing home facility is not required to provide copies of a resident's records requested pursuant to this section more than once per month, except that copies of physician reports in the resident's records must be provided as often as necessary to allow the effective monitoring of the resident's condition.

(8) A nursing home facility may not be cited by the agency through the survey process for any alleged or actual noncompliance with any of the requirements of this section.

(9) This section does not limit any right to obtain records by subpoena or other court process.

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400.162 Property and personal affairs of residents

(1) The admission of a resident to a facility and his or her presence in the facility shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of the aforementioned persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safety and orderly management of the facility.

(2) No licensee, owner, administrator, employee, or representative thereof shall act as guardian, trustee, or conservator for any resident of the facility or any of such resident's property unless the person is the resident's spouse or a blood relative within the third degree of consanguinity.

(3) A licensee shall provide for the safekeeping of personal effects, funds, and other property of the resident in the facility. Whenever necessary for the protection of valuables, or in order to avoid unreasonable responsibility therefor, the licensee may require that such valuables be excluded or removed from the facility and kept at some place not subject to the control of the licensee.

At the request of a resident, the facility shall mark the resident's personal property with the resident's name or another type of identification, without defacing the property. Any theft or loss of a resident's personal property shall be documented by the facility. The facility shall develop policies and procedures to minimize the risk of theft or loss of the personal property of residents.

A copy of the policy shall be provided to every employee and to each resident and the resident's representative if appropriate at admission and when revised. Facility policies must include provisions related to reporting theft or loss of a resident's property to law enforcement and any facility waiver of liability for loss or theft.

(4) A licensee shall keep complete and accurate records of all funds and other effects and property of its residents received by it for safekeeping.

(5)(a) Any funds or other property belonging to a resident which are received by a licensee shall be held in trust. Funds held in trust shall be kept separate from the funds and property of the facility; shall be deposited in a bank, savings association, trust company, or credit union located in this state and, if possible, located in the same district in which the facility is located; shall not be represented as part of the assets of the facility on a financial statement; and shall be used or otherwise expended only for the account of the resident.

(b)1. Any licensee which holds resident funds in trust, as provided in paragraph (a), during the period for which a license is requested or issued shall file a surety bond with the agency in an amount equal to twice the average monthly balance in the resident trust fund during the prior year or $5,000, whichever is greater. The bond shall be executed by the licensee as principal and by a surety company authorized and licensed to do business in the state as surety. The bond shall be conditioned upon the faithful compliance of the licensee with the provisions of this section and shall run to the agency for the benefit of any resident injured by the violation by the licensee of the provisions of this section.

2. A new bond or a proper continuation certificate shall be required on the annual renewal date of each licensee's bond. Such bond or certificate shall be filed with the agency as provided in subparagraph 1.

3. Any surety company which cancels or does not renew the bond of any licensee shall notify the agency, in writing, not less than 30 days in advance of such action, giving the reason for the cancellation or nonrenewal.

(c) As an alternative to posting a surety bond, the licensee may enter into a self-insurance agreement as specified in rules adopted by the agency. Funds contained in the pool shall run to any resident suffering financial loss as a result of the violation by the licensee of the provisions of this section. Such funds shall be awarded to any resident in an amount equal to the amount that the resident can establish, by affidavit or other adequate evidence, was deposited in trust with the licensee and which could not be paid to the resident within 30 days of the resident's request. The agency shall promulgate rules with regard to the establishment, organization, and operation of such self-insurance pools. Such rules shall include, but shall not be limited to, requirements for monetary reserves to be maintained by such self-insurers to assure their financial solvency.

(d) If, at any time during the period for which a license is issued, a licensee that has not purchased a surety bond or entered into a self-insurance agreement, as provided in paragraphs (b) and (c), is requested to provide safekeeping for the personal funds of a resident, the licensee shall notify the agency of the request and make application for a surety bond or for participation in a self-insurance agreement within 7 days after the request, exclusive of weekends and holidays. Copies of the application, along with written documentation of related correspondence with an insurance agency or group, shall be maintained by the licensee for review by the agency and the State Long-Term Care Ombudsman Program.

(e) Moneys or securities received as advance payment for care may at no time exceed the cost of care for a 6-month period.

(f) At least every 3 months, the licensee shall furnish the resident and the guardian, trustee, or conservator, if any, for the resident a complete and verified statement of all funds and other property to which this subsection applies, detailing the amounts and items received, together with their sources and disposition. In any event, the licensee shall furnish such a statement annually and upon the discharge or transfer of a resident. Any governmental agency or private charitable agency contributing funds or other property on account of a resident also shall be entitled to receive such statement annually and upon discharge or transfer and such other report as it may require pursuant to law.

(6) In the event of the death of a resident, a licensee shall return all refunds and funds held in trust to the resident's personal representative, if one has been appointed at the time the nursing home disburses such funds, and if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the nursing home to the resident.

In the event the resident has no spouse or adult next of kin or such person cannot be located, funds due to the resident shall be placed in an interest-bearing account in a bank, savings association, trust company, or credit union located in this state and, if possible, located within the same district in which the facility is located, which funds shall not be represented as part of the assets of the facility on a financial statement, and the licensee shall maintain such account until such time as the trust funds are disbursed pursuant to the provisions of the Florida Probate Code.

All other property of a deceased resident being held in trust by the licensee shall be returned to the resident's personal representative, if one has been appointed at the time the nursing home disburses such property, and if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the nursing home to the resident. In the event the resident has no spouse or adult next of kin or such person cannot be located, property being held in trust shall be safeguarded until such time as the property is disbursed pursuant to the provisions of the Florida Probate Code.

The trust funds and property of deceased residents shall be kept separate from the funds and the property of the licensee and from the funds and property of the residents of the facility. The nursing home needs to maintain only one account in which the trust funds amounting to less than $100 of deceased residents are placed. However, it shall be the obligation of the nursing home to maintain adequate records to permit compilation of interest due each individual resident's account. Separate accounts shall be maintained with respect to trust funds of deceased residents equal to or in excess of $100. In the event the trust funds of the deceased resident are not disbursed pursuant to the provisions of the Florida Probate Code within 2 years of the death of the resident, the trust funds shall be deposited in the Health Care Trust Fund and expended as provided for in s. 400.063, notwithstanding the provisions of any other law of this state. Any other property of a deceased resident held in trust by a licensee which is not disbursed in accordance with the provisions of the Florida Probate Code shall escheat to the state as provided by law.

(b)1. Any licensee which holds resident funds in trust, as provided in paragraph (a), during the period for which a license is requested or issued shall file a surety bond with the agency in an amount equal to twice the average monthly balance in the resident trust fund during the prior year or $5,000, whichever is greater. The bond shall be executed by the licensee as principal and by a surety company authorized and licensed to do business in the state as surety. The bond shall be conditioned upon the faithful compliance of the licensee with the provisions of this section and shall run to the agency for the benefit of any resident injured by the violation by the licensee of the provisions of this section.

2. A new bond or a proper continuation certificate shall be required on the annual renewal date of each licensee's bond. Such bond or certificate shall be filed with the agency as provided in subparagraph 1.

3. Any surety company which cancels or does not renew the bond of any licensee shall notify the agency, in writing, not less than 30 days in advance of such action, giving the reason for the cancellation or nonrenewal.

(c) As an alternative to posting a surety bond, the licensee may enter into a self-insurance agreement as specified in rules adopted by the agency. Funds contained in the pool shall run to any resident suffering financial loss as a result of the violation by the licensee of the provisions of this section. Such funds shall be awarded to any resident in an amount equal to the amount that the resident can establish, by affidavit or other adequate evidence, was deposited in trust with the licensee and which could not be paid to the resident within 30 days of the resident's request. The agency shall promulgate rules with regard to the establishment, organization, and operation of such self-insurance pools. Such rules shall include, but shall not be limited to, requirements for monetary reserves to be maintained by such self-insurers to assure their financial solvency.

(d) If, at any time during the period for which a license is issued, a licensee that has not purchased a surety bond or entered into a self-insurance agreement, as provided in paragraphs (b) and (c), is requested to provide safekeeping for the personal funds of a resident, the licensee shall notify the agency of the request and make application for a surety bond or for participation in a self-insurance agreement within 7 days after the request, exclusive of weekends and holidays.

Copies of the application, along with written documentation of related correspondence with an insurance agency or group, shall be maintained by the licensee for review by the agency and the State Long-Term Care Ombudsman Program.

(e) Moneys or securities received as advance payment for care may at no time exceed the cost of care for a 6-month period.

(f) At least every 3 months, the licensee shall furnish the resident and the guardian, trustee, or conservator, if any, for the resident a complete and verified statement of all funds and other property to which this subsection applies, detailing the amounts and items received, together with their sources and disposition. In any event, the licensee shall furnish such a statement annually and upon the discharge or transfer of a resident. Any governmental agency or private charitable agency contributing funds or other property on account of a resident also shall be entitled to receive such statement annually and upon discharge or transfer and such other report as it may require pursuant to law.

(6) In the event of the death of a resident, a licensee shall return all refunds and funds held in trust to the resident's personal representative, if one has been appointed at the time the nursing home disburses such funds, and if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the nursing home to the resident.

In the event the resident has no spouse or adult next of kin or such person cannot be located, funds due to the resident shall be placed in an interest-bearing account in a bank, savings association, trust company, or credit union located in this state and, if possible, located within the same district in which the facility is located, which funds shall not be represented as part of the assets of the facility on a financial statement, and the licensee shall maintain such account until such time as the trust funds are disbursed pursuant to the provisions of the Florida Probate Code.

All other property of a deceased resident being held in trust by the licensee shall be returned to the resident's personal representative, if one has been appointed at the time the nursing home disburses such property, and if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the nursing home to the resident. In the event the resident has no spouse or adult next of kin or such person cannot be located, property being held in trust shall be safeguarded until such time as the property is disbursed pursuant to the provisions of the Florida Probate Code.

The trust funds and property of deceased residents shall be kept separate from the funds and the property of the licensee and from the funds and property of the residents of the facility. The nursing home needs to maintain only one account in which the trust funds amounting to less than $100 of deceased residents are placed. However, it shall be the obligation of the nursing home to maintain adequate records to permit compilation of interest due each individual resident's account. Separate accounts shall be maintained with respect to trust funds of deceased residents equal to or in excess of $100. In the event the trust funds of the deceased resident are not disbursed pursuant to the provisions of the Florida Probate Code within 2 years of the death of the resident, the trust funds shall be deposited in the Health Care Trust Fund and expended as provided for in s. 400.063, notwithstanding the provisions of any other law of this state. Any other property of a deceased resident held in trust by a licensee which is not disbursed in accordance with the provisions of the Florida Probate Code shall escheat to the state as provided by law.

CERTIFIED NURSING ASSISTANTS

464.201 Definitions as used in this part, the term:

(1) "Approved training program" means:

(a) A course of training conducted by a public sector or private sector educational center licensed by the Department of Education to implement the basic curriculum for nursing assistants which is approved by the Department of Education. Beginning October 1, 2000, the board shall assume responsibility for approval of training programs under this paragraph.

(b) A training program operated under s. 400.141.

(2) "Board" means the Board of Nursing.

(3) "Certified nursing assistant" means a person who meets the qualifications specified in this part and who is certified by the board as a certified nursing assistant.

(4) "Department" means the Department of Health.

(5) "Practice of a certified nursing assistant" means providing care and assisting persons with tasks relating to the activities of daily living. Such tasks are those associated with personal care, maintaining mobility, nutrition and hydration, toileting and elimination, assistive devices, safety and cleanliness, data gathering, reporting abnormal signs and symptoms, postmortem care, patient socialization and reality orientation, end-of-life care, cardiopulmonary resuscitation and emergency care, residents' or patients' rights, documentation of nursing-assistant services, and other tasks that a certified nurse assistant may perform after training beyond that required for initial certification and upon validation of competence in that skill by a registered nurse. This subsection does not restrict the ability of any person who is otherwise trained and educated from performing such tasks.

(6) "Registry" means the listing of certified nursing assistants maintained by the board.

464.202 Duties and powers of the board

The board shall maintain, or contract with or approve another entity to maintain, a state registry of certified nursing assistants. The registry must consist of the name of each certified nursing assistant in this state; other identifying information defined by board rule; certification status; the effective date of certification; other information required by state or federal law; information regarding any crime or any abuse, neglect, or exploitation as provided under chapter 435; and any disciplinary action taken against the certified nursing assistant.

The registry shall be accessible to the public, the certificate holder, employers, and other state agencies. The board shall adopt by rule testing procedures for use in certifying nursing assistants and shall adopt rules regulating the practice of certified nursing assistants and specifying the scope of practice authorized and the level of supervision required for the practice of certified nursing assistants. The board may contract with or approve another entity or organization to provide the examination services, including the development and administration of examinations.

The board shall require that the contract provider offer certified nursing assistant applications via the Internet, and may require the contract provider to accept certified nursing assistant applications for processing via the Internet. The board shall require the contract provider to provide the preliminary results of the certified nursing examination on the date the test is administered. The provider shall pay all reasonable costs and expenses incurred by the board in evaluating the provider's application and performance during the delivery of services, including examination services and procedures for maintaining the certified nursing assistant registry.

464.203 Certified nursing assistants; certification requirement:

(1) The board shall issue a certificate to practice as a certified nursing assistant to any person who demonstrates a minimum competency to read and write and successfully passes the required background screening pursuant to s. 400.215. If the person has successfully passed the required background screening pursuant to s. 400.215 or s. 408.809 within 90 days before applying for a certificate to practice and the person's background screening results are not retained in the clearinghouse created under s.

435.12, the board shall waive the requirement that the applicant successfully pass an additional background screening pursuant to s. 400.215. The person must also meet one of the following requirements:

(a) Has successfully completed an approved training program and achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion approved by the board and administered at a site and by personnel approved by the department.

(b) Has achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion, approved by the board and administered at a site and by personnel approved by the department and:

1. Has a high school diploma, or its equivalent; or
2. Is at least 18 years of age.

(c) Is currently certified in another state; is listed on that state's certified nursing assistant registry; and has not been found to have committed abuse, neglect, or exploitation in that state.

(d) Has completed the curriculum developed under the Enterprise Florida Jobs and Education Partnership Grant and achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion, approved by the board and administered at a site and by personnel approved by the department.

(2) If an applicant fails to pass the nursing assistant competency examination in three attempts, the applicant is not eligible for reexamination unless the applicant completes an approved training program.

(3) An oral examination shall be administered as a substitute for the written portion of the examination upon request. The oral examination shall be administered at a site and by personnel approved by the department.

(4) The board shall adopt rules to provide for the initial certification of certified nursing assistants.

(5) Certification as a nursing assistant, in accordance with this part, may be renewed until such time as the nursing assistant allows a period of 24 consecutive months to pass during which period the nursing assistant fails to perform any nursing-

related services for monetary compensation. When a nursing assistant fails to perform any nursing-related services for monetary compensation for a period of 24 consecutive months, the nursing assistant must complete a new training and competency evaluation program or a new competency evaluation program.

(6) A certified nursing assistant shall maintain a current address with the board in accordance with s. 456.035.

(7) A certified nursing assistant shall complete 24 hours of inservice training during each biennium. The certified nursing assistant shall maintain documentation demonstrating compliance with this subsection.

(8) The department shall renew a certificate upon receipt of the renewal application and imposition of a fee of not less than $20 and not more than $50 biennially. The department shall adopt rules establishing a procedure for the biennial renewal of certificates. Any certificate that is not renewed by July 1, 2006, is void.

464.204 DENIAL, SUSPENSION, OR REVOCATION OF CERTIFICATION; DISCIPLINARY ACTIONS

(1) The following acts constitute grounds for which the board may impose disciplinary sanctions as specified in subsection (2):

(a) Obtaining or attempting to obtain certification or an exemption, or possessing or attempting to possess certification or a letter of exemption, by bribery, misrepresentation, deceit, or through an error of the board.

(b) Intentionally violating any provision of this chapter, chapter 456, or the rules adopted by the board.

(2) When the board finds any person guilty of any of the grounds set forth in subsection (1), it may enter an order imposing one or more of the following penalties:

(a) Denial, suspension, or revocation of certification.

(b) Imposition of an administrative fine not to exceed $150 for each count or separate offense.

(c) Imposition of probation or restriction of certification, including conditions such as corrective actions as retraining or compliance with an approved treatment program for impaired practitioners.

(3) The board may, upon the request of a certificate holder, exempt the certificate holder from disqualification of employment in accordance with chapter 435 and issue a letter of exemption. The board must notify an applicant seeking an exemption from disqualification from certification or employment of its decision to approve or deny the request within 30 days after the date the board receives all required documentation.

464.205 Availability of disciplinary records and proceedings

Pursuant to s. 456.073, any complaint or record maintained by the department pursuant to the discipline of a certified nursing assistant and any proceeding held by the board to discipline a certified nursing assistant shall remain open and available to the public.

464.206 EXEMPTION FROM LIABILITY

If an employer terminates or denies employment to a certified nursing assistant whose certification is inactive as shown on the certified nursing assistant registry or whose name appears on a criminal screening report of the Department of Law Enforcement, the employer is not civilly liable for such termination and a cause of action may not be brought against the employer for damages, regardless of whether the employee has filed for an exemption from the board under s. 464.204(3). There may not be any monetary liability on the part of, and a cause of action for damages may not arise against, any licensed facility, its governing board or members thereof, medical staff, disciplinary board, agents, investigators, witnesses, employees, or any other person for any action taken in good faith without intentional fraud in carrying out this section.

464.207 PENALTIES

It is a misdemeanor of the first degree, punishable as provided under s. 775.082 or s. 775.083, for any person, knowingly or intentionally, to fail to disclose, by false statement, misrepresentation, impersonation, or other fraudulent means, in any application for voluntary or paid employment or certification regulated under this part, a material fact used in making a determination as to such person's qualifications to be an employee or certificate holder.

464.208 Background screening information; rulemaking authority:

(1) The Agency for Health Care Administration shall allow the board to electronically access its background screening database and records.

(2) An employer, or an agent thereof, may not use criminal records or juvenile records relating to vulnerable adults for any purpose other than determining if the person meets the requirements of this part. Such records and information obtained by the board shall remain confidential and exempt from s. 119.07(1).

(3) If the requirements of the Omnibus Budget Reconciliation Act of 1987, as amended, for the certification of nursing assistants are in conflict with this part, the federal requirements shall prevail for those facilities certified to provide care under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act.

ADL

ASSISTANCE WITH ACTIVITIES OF DAILY LIVING (ADL)

Assistance with activities of daily living means a certified nursing assistant (CNA) provide to the patient individual assistance with activities of daily living, including the following:

AMBULATION

Providing physical support to enable the patient to move about within or outside of the patient's place of residence. Physical support includes holding the patient's hand, elbow, under the arm, or holding on to a support belt worn by the patient to assist in providing stability or direction while the patient ambulates.

BATHING

Helping the patient in and out of the bathtub or shower being available while the patient is bathing. Can also include washing and drying the patient.

DRESSING

Helping patients, who require assistance in dressing themselves, put on and remove clothing.

EATING

Helping with feeding patients who require assistance in feeding themselves.

PERSONAL HYGIENE

Helping the patient with shaving. Assisting with oral, hair, skin and nail care.

TOILETING

Reminding the patient about using the toilet, assisting him to the bathroom, helping to undress, positioning on the commode, and helping with related personal hygiene, including assistance with changing of an adult brief. Also includes assisting with positioning the patient on the bedpan, and helping with related personal hygiene.

ASSISTANCE WITH PHYSICAL TRANSFER

Providing verbal and physical cueing, physical assistance, or both while the patient moves from one position to another, for example between the following: a bed, chair, wheelchair, commode, bathtub or shower, or a standing position. Transfer can also include use of a mechanical lift.

TAKE EXAM

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