Beyond Natural Disasters Managing Critical Events in Congregate Settings

Panelists: Mary Chiles and Linda Glasson
Moderator: Jennifer Inker

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Jennifer Inker: Good afternoon. Happy spring, and welcome to today's live events! We're so pleased you could join us today. My name is Jenny Inker. I'm a gerontologist, and the joint program director of the Assisted Living Administration's Specialty Area at Virginia Commonwealth University Department of Gerontology, and I'm also your host for today's webinar.

Today, Linda Glasson and Mary Chiles will present Beyond Natural Disasters: Managing Critical Events in Congregate Settings. This series was created by the Virginia Geriatric Mental Health Partnership. This is the first of three webinars in our sixth series hosted by VGMHP. I hope you will be able to join us for all three.

We would like to thank the Virginia Center on Aging for the Geriatric Training and Education Initiative Grant that funds this webinar series. The Geriatric Mental Health Planning Partnership in collaboration with the VCU Department of Gerontology, and the Riverside Center for Excellence in Aging and Lifelong Health is organizing this series of webinars, dedicated to mental health and aging training.

Today we have two presenters. Mary Chiles is president and owner of the Chiles Healthcare Consulting, LLC. She's a registered nurse, and a long-term care consultant for nursing facilities and adult care residences. Mary works collaboratively with facility staff to implement systems that will enhance compliance with regulatory requirements and improve the facility's overall efficiency, effectiveness, resident care, and value.

Linda Glasson is a certified healthcare protection administrator, lifetime, and a registered private investigator with Virginia's Department of Criminal Justice Services. Linda has experience in training, program development, crisis management, safety, emergency management, and investigations. For complete biographies for our two presenters today I'll refer you to our webinar website and page. Before we begin, I'd like to cover a couple of brief housekeeping items.

Once again, these webinars are funded in part by a Virginia Center on Aging GTE Grant. It is part of our grant agreement to collect demographic data. We therefore kindly ask that you help us out in continuing this free training by taking five minutes to complete the demographic survey which we shall send tomorrow by email. Certificates of attendance will be made available one week after this event. To receive your certificate you will need to complete the exit survey which should pop up following your exit from today's webinar, and which will also be sent by email tomorrow.

Today's webinar will begin with Linda and Mary's presentations. These will be followed by a question and answer period. To submit your questions, please use the questions tab on the control panel on your screen. Please feel free to submit your questions throughout the presentation. Following the presentation I will share your questions with Linda and Mary, and we will address as many as possible in the time remaining. Without further ado I will now ask Linda to begin her presentation. Take it away, Linda.

Linda Glasson: Thank you. As you can see, routine security issues can go beyond normal in a split second. Are you prepared? We have lost our screen here, so I'll ask Jennifer if you can control the screen from there.

Jennifer Inker: Let me see if Nico can help us. Okay, I see your presentation's there.

Linda Glasson: We're back.

Jennifer Inker: There you go. Perfect.

Linda Glasson: As we were saying, routine security issues can go beyond normal in a split second. You may have an intruder walk into your facility. It could be someone's just lost, you redirect them, or it could be that you have an intruder walk in. They have a weapon, and they begin to use a weapon in your facility. I'm going to digress a minute, and we're going to go to the next slide.

Are you conducting or have you-

Nico: Ms. Glasson, if I may interrupt for a second, would you be so kind to hold the handset to your ear please?

Linda Glasson: Yeah.

Nico: Thank you so very much.

Linda Glasson: Have you conducted or had conducted a Security Hazard Vulnerability Assessment? Many of you all already do assessments for weather emergencies. You may do other assessments related to equipment or potential in your community that can impact upon your facility. Some facilities takes what's called an All-Hazard Vulnerability Assessment approach. We're suggesting that you can add security to that, and look at your access control.

What is going on in the community that might impact you? Do you have a potential for a wandering resident to leave and develop into a crisis situation? Do you have an increase in the crime rates in your community that could impact upon you? Have there been use of weapons in the community that could intrude into your facility as well? Those are just several of the key items.

As you can see, the violence continuum ranges from bullying to murder, and unfortunately in this day and time some folks do not know how to deal with verbal interventions or strategies, and they may not be happy with services, and they don't stop at words, the next thing fists might be flying, or they could pull out a weapon, and then begin to demand satisfaction.

One of the other issues that happens with violence is that you can have a domestic situation within your facility. For example, you might have a staff member that has an issue with their significant other. We had an unfortunate example of that in 2009 down in Carthage, North Carolina. There were eight people killed inside a Carthage nursing home in 2009. The individual involved was sentenced in 2011 to 141 to 179 years. Unfortunately that won't bring the individuals back that were harmed.

The individual went in looking for his estranged wife, and anyone that he saw was shot. There were, as I said, eight fatalities. There were three significant injuries during that event. The individual has filed a lawsuit saying that he did those actions because he was on inappropriate medications. As you can see on the slide, not all shooters are active shooters, but dead is dead.

If you pull the trigger, and you get shot, it doesn't make any difference if it's a multiple shooting or if it's one individual. Unfortunately staff have not been immune to these circumstances. In residence sometimes you have mercy killings. You might have a murder or suicide. You may have an individual run in off the street looking to hide from law enforcement.

That goes back to part of are you prepared. Do you have an access control? Is that access control more than a receptionist sitting at the front door watching who's coming and going? If you don't have an access control system do you have a switch at that front desk where the staff or the volunteer there can lock the door if they see trouble coming?

That's just one small idea for you, but prevention is better than reaction. You all know that through your professional practice. A few things for your consideration. We just gave a brief example about access control. CPTED is short for crime prevention through environmental design. Most of your local police departments are familiar with that. It ranges from do you have appropriate lighting? Is your landscaping inappropriate for your facility? By that I mean do you have tall shrubs around your parking lot that your employees have to walk past to get to your facility? Do you have shrubs up against the window of your facility that people can use to hide in, or adjacent to your egresses, your doorways as they come and go?

The local police department may be able to assist you if you do not have a security professional on-site. If you're part of a large corporate system you may have a corporate program all in place that you can take advantage of as well. How do you identify individuals in your facility? Do they just have a name tag, or is it a photo and a name tag? Your residents may be identified by a band, and you may have some of your residents who have a tendency to wander, you may have their photo on file.

What are your processes and procedures that you have in place? I mentioned a few minutes ago that you may have a receptionist or a volunteer at your front door. If it's a staffer and they're required to do other things they cannot do two contradictory processes. They cannot be working on the computer and looking at the door at the same time. If you're fortunate enough to have camera system in your facility, and the monitor's where the reception is, please, you have to have your monitor in the same direction that the receptionist is looking.

I've been into several facilities, and the computer's in front of the receptionist, but the monitor is behind the receptionist, and that's counterproductive. Training is not only what program, but it's how you're teaching it. Are you teaching it according to the standards of the program? Is the training program applicable to your needs in that facility? Is the individual teaching it, are they familiar with your environment? Are they familiar how the training applies to the outcomes in your facility? Do you evaluate that training program every so often to make sure it's meeting the performance standards that you have established for it?

One of the things I see happening unfortunately is facilities invest in the time and resources to have an on-site instructor, and maybe the course is eight hours, but when the instructor comes back to teach in their facility they're only given one hour for the course. Those are considerations that you need to take a look at as well.

You see on your screen a six step approach to dealing with violence. I think that here what you need to do is to plug in your own needs. For example, under recognition you might be training

your staff to recognize the potential for aggressive violent behavior, or in individuals with cognitive issues. You can be talking about some of the behaviors or actions associated with that.

One of the important things here is be it behavior, situations, etc., is train your staff not to ignore what they see or hear. Signs and symptoms can be as obvious as someone already acting out through subtle non-verbal communication. That is seen through body language usually. Verbal threats are as important as physical acting out, and that should put staff on notice. Your staff should know who to alert, and when. This is not a time to keep a secret.

Hopefully you have taught your staff to know who the resources are and how to alert them. Under preparedness you can go back and look at your assessments, determine what can happen, review the incidents that have occurred, have appropriate protocols and procedures in place or that you develop. That also includes equipment, not only people. Your staff should know the locations and how to access them, and address any other considerations or issues that you consider important for your staff at this point.

Design applies to both new construction and renovation. It's not only aesthetics and functions, but even in the design part in the architect stage you need to be considering your potential for security issues, emergency management, fire safety, etc. The needs of the individuals receiving this service and those providing that service also need to be considered and balanced.

In some geographical areas it may not be safe for weather to use normal glass in the resident rooms. You may have regulatory requirements that specifies the type of glass that should be used in certain circumstances. If you have windows that have locks on them for safety reasons, just remember if you need to evacuate that facility and you need to get a resident or staff out through the window will you be able to accomplish that?

Education, determine what your education and training needs are. You can develop your own training program. You can use a commercial program. You can look for an individual to come in, or you can train your own staff, but make sure that they have the knowledge and expertise to do so. One of the unfortunate things that I'm seeing recently is every time something new comes out in a regulation, and I'll use the Conditions of Participation, the CMS's Final Rule on Emergency Preparedness. I can't tell you how many experts I've seen come on in lying that they have the perfect program for you. Exercise appropriate due diligence when you're looking to obtain programs and services for your facilities.

Enforcement. Individuals, employees, patients, and visitors alike should be held accountable for their behavior. This can be accomplished through the administrative, treatment, civil, or criminal process. When you're writing policies for your facilities and you're looking at zero tolerance from violence and for inappropriate behavior, you might want to consult with your legal authority in risk management, if you have a risk manager assigned to your staff.

Zero tolerance can be a double edged sword. Unfortunately in some jurisdictions it also means that if somebody is making an inappropriate joke in the break room they can be held accountable under that zero tolerance policy. So, use caution as you're writing your policies. Do not put anything into a policy or procedure that you either can't back up or you're not willing to back up.

You see a five step approach to violent incidents and aggressive behavior: evaluate, plan, implement, document, and review. This is not too unlike the plan-do-check-assess that many

healthcare professionals, especially nurses are familiar with. What you want to know, and you can plug your own into here as well, but some examples under evaluate, what's happening, who's involved, is there an immediate danger or not? Who or what may be affected?

One thing here is if you have an audience to a situation, if at all possible either remove the audience or move the situation away from the audience. You want them concentrating on you and not everybody else in the situation, unless they're trying to harm you, then that's another circumstance. Then the environment can help or hurt you.

Then, under plan, deicide what you're going to do and how. Hopefully all the resources are available and everybody's been trained. Communicate with each other, and whatever you do you should address the situation. Implementation just simple means carrying out the plan that you have, and if things don't go according to plan don't panic. Have another backup in place, and then use the backup. You should be able to adjust to the situation.

Unfortunately with an active shooter that is the ultimate that you do not want to have happening. Those situations are very fluid, and where they start and where they end are not the same thing. Your documentation, you all are already very familiar with documentation, but it should include, you know, what happened, who's involved, what the response were, and if you collect documentation that should also be part of that, and any other documentation required by regulatory local law or federal mandate.

Review is very important. It gives your staff and you a time to sort of recuperate from the situation. It gives you a chance to get your body, your adrenaline back to normal. It's also a chance to make sure everybody is okay, and it can either be formal or informal, but this is your opportunity to begin to return to normalcy. Do you need extra support? Do you need peer support? Do you need critical incident briefing?

Address any concerns about the handling of the situation, and show appreciation for a job well done. You may have other considerations that you want to plug in here as well, but I think one of the best approaches is a multi-disciplinary approach to management of instances regarding behavior.

Do the people involved communicate on a regular basis? Are training opportunities provide? Are there adequate security considerations if you do not have a staff? Which also leads to the question, did you appoint someone in your facility to be the security? And, is that person the housekeeper? Is that person the maintenance guy? Did you appoint them because they had an interest or a background? They should not be appointed because they're the male individual in the facility, and if they are appointed or they have that function they need to be trained in it.

Weapons, anything can be used as a weapon. A magazine, somebody can swat you in the face with it, and that can be pretty painful. Again, in this time these are just considerations. Reporting requirements, I'm not going to go into that in detail, but have you done what you're supposed to if local law enforcement needs to be involved, if the local elder abuse folks need to be involved? Does the fire department need to be involved? Do you have a regulatory issue that needs to be reported?

Again, and you all have your own list that I'm sure you can add to that as well. As you can see, fire, police, and local EMS can serve as a resource as you develop and upgrade your applicable

facility plans, but remember one thing: you know your environment. They have a lot of information, and between you all working together you can make that work for the benefit of your association.

Fire and EMS is a prime example. Fire department needs to know how to get in and out of your building, how that's going to figure into any evacuation plans that either you or they may need to implement. Weather is a big source of concern for evacuation. You may not always be able to evacuate in place or stay in place, you may have to leave your facility. So, I always suggest to facilities to have a drill where they come in and you actually have hands-on experience. Because, if you've got a fire in your facility none of us wan that or anything else, but it only takes 30 seconds for a fire to create enough smoke that you can't see anything.

You can test this out for yourself by getting a piece of wax paper and hold it in front of your face, and then try to find your way out, but if you're going to do that make sure you have a partner that doesn't have the wax paper in front of their face. As we briefly alluded to, who at your facilities qualify to perform security functions and emergency management? If they have that assigned that to them have they been trained to do that? Do you have an ongoing relationship with fire, police, EMS? Are there other agencies that you need to have a relationship with?

For example, if you have an emergency management council, do you all have a relationship with them? A number of healthcare facilities, and I also understand facilities in the congregate settings are working together in some areas forming local councils. That's not a bad idea. If you're talking to each other, that is a time where we're not competitors, but that's a time where we all have one common goal in place, the safety of those that we care for and the safety of those that work for us.

I wanted to share some resources with you. Active shooter planning and responsibilities. In the last month the Healthcare and Public Health Sector Coordinating Council, under the Department of Homeland Security updated their active shooter material. This is free. It's open source. You can go to Google and Google this and find the current plan.

There is a model policy in the back of that. Please don't do what some organizations have done, is take the model policy and just plug your name into it. If you're tempted to do that, look at that policy. See whether or not it applies to your facility and your environment, and look at that and see whether or not you can use any of the information. There's a lot of good information in that that are applicable to any environment.

We've all heard the Run, Hide, Fight, and that gives you some options, but it's kind of hard to try to hide when you've got glass windows on the outside. If you can get out though that's a way of maybe helping folks flee or escape. In some ares of the country we actually have staff that doesn't know what a gunshot sounds like. They might think it's a pop. They may think it's part of the normal business day, but it's not. You stand up and you're the first target, so again you can find free training programs on the Department of Homeland Security, and on the resource slide when we get to that there's a couple other resources.

Going back to emergency planning for a minute. If your staff has not had any training in emergency planning or your management staff hasn't there are several free sites under FEMA that you can go to and take that training on your own time. Again, coordinate with the locals. They may have training that they would let you come into for free.

Many of you all may have already heard that OSHA has just proposed a rule on violence. They have that rule on their website that you can read, and April the 6th is the final date for deadlines. So if you have a comment or if you would like to put some input into that go to the website and see what that proposal is going to be. We understand that there is potential research coming up for NIOSH to look at the long-term care environment.

In fact, some of that, there's a study that has already been put out, and it is violence in the long-term care setting, and that was done by a number of professionals. That is available on Google, and it was published I think in 2015, 2016. June 7th of 2016. The tile on that paper is Workplace Violence and Safety Issues in Long-Term Medical Care Facilities: The Nurses' Perspective.

One of the other concerns that I have, ladies and gentleman, as you see the resource screen, when you look at this material most of the bibliography is from clinical sources. Very rarely do you see a security source in the bibliography of that professional paper. There's really nothing wrong with that, but there are, as you can see on the resource page, you have a couple of security resources there that could be very helpful to you.

The Journal of Healthcare Protection is basically related to hospital security. It comes out twice a year and it's a subscription. It's not listed in PubMed or any of the normal places that the clinicians look. You can go to the National Library of Medicine Health Planning and Administrative Database and find the articles from that journal there. The block bullets, if you're in an area where you do have to worry about bullets coming into your facility from the outside this is just one of the many commercial products. I'm not endorsing it. I'm just saying that this is a starting place if you should ever have to look at something like that.

There are a number of training programs that you all are already familiar with in your own practices, but you have a number of programs, probably 14, 15 minimum nationally that would be acceptable in any type of environment with residents, staff, patients, etc. When you're looking at it, if you're looking at any future training programs, again it's not only what's being used in your area, but is it applicable to your needs? Do you have the resources to implement that program appropriately?

With behavior and violence you can't do a 10 second program and expect to have results. You also have other issues. You may have family issues, and in healthcare it's the nurses that are the highest injured population. Long-term care facilities your CNAs are on the frontline. You may have resident on resident. You could have resident against staff. You have these and many other challenges in your environment. You know that better than I do.

I want to go back to one other security issue that happens, is missing items. How many times have you had a resident say they're missing something? One facility that I went into to help them out with a missing television, we found the source of the problem. The facility had done everything correct with this new hire. They'd done the criminal records check. They had done everything appropriate, and even went beyond that.

By the time the circumstance was finally investigated the CNA involved had four different social security numbers, five different identities, and he had been convicted under his original name, so when they ran the social security number that they gave him, and yes they did check the government photo ID and driver's license, he had actually made a fake driver's license that looked real, had a real driver's license number on it, and when they checked that there was no

problem with that. No infractions or anything else, but the social security number of the individual that he had, when they did a criminal records check, sexual offenders check, and a few other things, came back perfect.

When we found out who his identity really was we knew that he had several convictions already, but he didn't use his real identity when he applied to for the job, so simple went from complex. When he was reported to the appropriate agencies and the police department they were given all of the information and they find out that he had also registered as a CNA in another state and used one of the other folks as the security numbers. Those are just a couple of the examples.

The information is on the screen for you. My phone number is available as you will find, Mary's as well. I do thank you for your courtesy and your opportunity to share a few hints/tips with you today. I'm going to turn the program over to Mary at this time.

Jennifer Inker: All right, and while Mary is getting ready to present, Linda, let me thank you for a fascinating, and quite a sobering presentation too. I know our audience is going to have many questions that we can go through in the question and answer session at the very end of the webinar today, so let me encourage our audience, go ahead and type any questions you have into the chat box, and then we'll have a chance to put those to our presenters.

We have coming up next Mary Chiles. Mary will be speaking to us on the important subject of wandering and elopement. I know that's another safety risk that probably keeps many folks up at night, or the potential for that keeps many folks up at night. Mary, take it away.

Mary Chiles: Thank you all so much for inviting me to share some thoughts with you this afternoon. As indicated, my topic is to talk about wandering, unsafe wandering specifically, and residents' risk for elopement. This is certainly something that many of us struggle with on a day-to-day basis, regardless of whether we are working in the nursing home, or whether we're working in some form of an assisted living or retirement home.

One of the important things that we want to accomplish today are two different objectives. We want to certainly look at methods that will help us to identify resident characteristics and behaviors that may place them at risk. Then we want to spend some time talking about different strategies that could be utilized by the retirement community, nursing home, or assisted living facility, in an effort to allow that resident to continue to be mobile throughout the facility, but to do so in a safe manner.

I believe that one of the things that we need to start with is to get a real good understanding about the definitions. As you can see on this particular slide, there are two definitions. The first has to do with unsafe wandering. Wandering in itself is simply the act of aimlessly moving about one's environment. It becomes unsafe when that includes a resident who may wander into an environment that may create risk, or create a potential for the resident to receive some type of injury.

Elopement is a little bit different. Elopement means that the resident actually leaves an area that is safe for them. That they actually leave the premises, or an area that they are able to be in without adequate supervision, without authorization. As we begin to look at these two we're going to start our discussion about wandering first. Let's talk a little bit about some of the more frequent risk factors that apply to both of these conditions.

We often hear from family members, you know, mom and dad's been wandering around the house, mom and dad has had a little bit of history of getting lost, they went to the grocery store, they couldn't remember exactly where they parked their car, or they just tend to pace a lot. We're going to have some indication, oftentimes it's simply by a clinical diagnosis. A resident has dementia, has some form of condition that results in cognitive impairment. What we really need to do is to look at those things that occur throughout our day that may increase their risk. Because we're going to talk about actually doing risk assessments in the next slide.

The first one is looking for change in resident's conditions. You'll see that there are quite a few bullet points on this page. Some of them can be grouped together, certainly when we look at looking at changes in their medical condition. Have they had an acute illness? Do they have a new infection? Is there something systemically going on with them? Are there blood sugars unstable, for example. These may increase as we create changes that would result in a change in that resident's particular risk factor.

Looking at changes in mood, or looking at changes in their mental status. Are they showing more anxiety? Are they pacing more? Are they beginning to have some hallucinations, or increased confusion, or some paranoia thoughts? Is there a difference in their memory, in their ability to recall? Looking at changes in their functioning status. Now I want to pause for this one just a moment, because oftentimes when we think about how our risk factors can change we think about their being a decline. That we had been at one base level and we now are at a decline.

In reality, in terms of risk for unsafe wandering, or in terms of risk for elopement, we often see a significant change in the resident's functional ability that demonstrates improvement. For example, a resident had had a fall, sustained a hip fracture, was in the hospital, and was then sent to the skilled nursing facility for rehab. At the time of admission to the rehab facility the resident had some elements of confusion. The resident had a lot of pain, and the resident was pretty dependent in mobility. Needed assistance getting in and out of the bed. Really even needed assistance in moving around using the wheelchair.

Well, as would happen, and what we would hope would happen is that we have what's a positive impact upon that resident. Now we still have a little bit of confusion, but it's beginning to clear. The pain has subsided, and it's very well managed with the medication. The resident is improving in their mobility. They are now independent with wheelchair mobility throughout the facility, and now they have a different level, and a different type of risk than what they had when they were first admitted.

We need to look at both the decline and the improvement as it relates to a functional change in residents. There is some other considerations for changes that are equally important, because they have a direct impact on how the resident responds to both the staff that are being caregivers, and to the environment in which that resident is residing.

When we look at change in the daily routine of the residents it can have an impact. When we look at change in who is providing care, or the way that we are approaching the resident, all of this can be perceived differently by the residents, and are going to have different levels of reaction and response, which could either increase or decrease their actual risk for unsafe wandering and/or eloping.

Let's take just a minute and look at the first of three steps that I want to talk about. The first step is identification of the risk factors. It starts prior to admission, whether we're talking about admission to an assisted living facility or we're talking about admission to a skilled nursing facility. The more that we can know about the resident's history, and on the slide you will see that I use the word good and honest information.

We know that admission to many of our facilities is very challenging, often emotionally charged by residents and by their family members who are having to make these decisions, oftentimes not in the best time of their life, but, getting that real information about what that resident's history is. Has this resident wandered away? Have they been exit seeking? Do they get lost? What is their level of memory?

Plus looking at other components that we talked about. What is their normal functional ability, what is their normal mental status, what is their normal cognitive status, will begin to give us that initial baseline. Because moving into a community environment, including moving within that environment to another level of care or even to another wing.

Let me say that in a little bit different way. While we talk about preadmission as coming into your facility, if you are working in a retirement community that has various levels of care it's important that we talk about those residents at the level they were at prior coming into the newest level. If I was in independent living, and I fell, and I now have to go to the skilled nursing facility for rehab, we want to know, what was this resident really like while in independent living?

Same for going for AL or to the skilled nursing facility. History is the best. Getting the most solid information, and drilling down in a positive partnership way with whoever is making that decision or has the best knowledge about that resident, so that the information that we get is good, honest information. I have found too many times that family members fail to say, well you know dad was lost twice, and that's one of the reasons that we had to make the decision to admit him to the assisted living facility.

Well, if we don't know that upfront then we cannot be the best prepared that we can for dad. It's a matter of reality. The second bullet on this page talks about doing risk assessments. Now, in assisted living facilities and nursing homes there is no federal or state regulation that I am aware of, and I do understand that we have some states on the phone that I do not know your state regulations, so I am not aware of any however that actually require these facilities to do a risk assessment for elopement.

However, I will tell you that it has become a standard of practice, and it should be a standard of practice for both assisted livings and nursing homes. Prevention of one of these events is our ultimate goal, and by knowing that resident then we're going to be able to have the best systems in place to prevent the incident from occurring, because we should be prepared.

Once we complete that risk assessment we have to respond to it. Ii want you to hear me say that in a different manner. Having a risk assessment is only going to be useful to you if you use the information that is obtained during that assessment. Simply filling the form out may meet some policy requirement that you have, but unless we really look at that assessment form and then put some responsive interventions in place based upon the knowledge of that, then we have not done our due diligence and you will not have a proactive and positive outcome.

There are four pieces to this. The first is to make sure that each identified risk on your assessment has some form of responsive, and that's a key word, but responsive and reactive plan in place to address the particular risk factor. If my risk factor has to do that I am an independent ambulator, it may be different than the fact that I am confused, but I have to have somebody assist me to use the wheelchair. It doesn't meant that I don't have the risk, but how we respond and react would be different.

The plan needs to have a goal that we're going to minimize unsafe wandering or elopement and injury, and it needs to be individualized to the resident. One of the things that we're seeing across the board is the emergence of electronic medical record systems in many long-term care environments. Whether we are writing a care plan, or whether we're writing an individual service plan, or whatever the plan of care is called in your state, the focus on that plan needs to be individualized for that particular resident.

Now, electronic medical record systems are wonderful systems to help us improve our documentation. Many of these systems come equipped with a library to help us develop that plan of care. That's fine. Utilize the library, but only select the interventions that are reflective of that particular resident's needs, risks, or preferences. We have to make sure that if I took a risk assessment and put I on a piece of paper with a line down the middle, and the left side of the paper identifies the risk, and the right side of the paper was the plan of care, I should be able to draw a dotted line from every risk to an intervention on that plan of care to show that it's responsive.

If we're just selecting interventions out of a library that we got somewhere we've not done our job. There's another way to critique this, and I would like to challenge you to do this yourself. Identify two or three residents in your facility that you have already identified as being at risk for unsafe wandering or elopement. Pull their plans of care our, cover up their names, and read each plan of care. If you're reading the same plan of care then we have not individualized it to address that resident's specific needs, risk, or preferences.

Now, once we've got a good plan of car that is individualized and responsive to that resident's risk, our next responsibility is communicating that plan of care to your staff. We're going to talk a little bit about that in future slides, but I said the word staff. I want you to hear me also say it's equally important that we communicate that plan of care to all interested parties. We may need to communicate it to some of our consultants. For example if you have a resident who is receiving hospice, the hospice staff. The folks coming in to care for that resident needs to know the plan and the risks that are associated with this resident for unsafe wandering.

It's also important that we not only include the resident in this plan of care, but that we also include the resident's representative, responsible party, or other interested people that could assist the resident. Now, we've got the plan of care built. We've communicated it to everybody this is what we're going to do, and this last bullet really talks about now monitoring this plan of care. Is it being effective, or is this resident still demonstrating a change in, excuse me, is this resident still demonstrating risk in their behavior that could put them in line for unsafe wandering, elopement, or injury?

Have those risk factors changed? We talked about the example that I gave you earlier about coming into rehab, and changing functionally, and how that would require a different plan of care. We want to make sure that we're looking at the resident as a whole, and not getting

comfortable with ourselves to simply say the resident has not had any of the incidents, therefore we need to continue the same plan of care.

The second step is the expansion of the education that we need to do to our staff, residents, the residents' families, and other people regarding the actual plan. We have to look at the carryover in the implementation of this particular plan. It is a team effort. You've heard me talk about that the staff, which would include departments for nursing, activities, social work, etc. You can see everybody listed. It's important that we examine the ways in which we communicate this.

Again, this is not just a piece of paper. This is the way that everybody is going to care and approach this resident in order to keep them safe. I want you to think about if I were a new CNA coming in to take care of this resident today, how would I know that the resident is at risk? How would I know what I'm supposed to do? And, how would I know what may be effective?

Looking at those points of knowledge is critical. There are multiple ways in which we can communicate this. Again, many of you with the electronic records have systems built in so that when the CNAs come on board they have to read a profile, or they have to sign off on some type of treatment record that they have carried out particular tasks. Others have us use communication books.

We want to think about how we're going to keep that information current, and how are we going to make it easiest for staff to know what is important to them. We also need to look at involving other people. The physicians, pharmacists, external organizations such as hospice or dialysis, and certainly include any type of information that we could share with to the mental health consultants that may be seeing this particular resident.

We've written a plan of care, and now we have to determine what is the expected outcome? What is the objective of this plan of care? What is the goal that we hope that this resident will be able to obtain? On this particular slide I've given you three different examples. You certainly want to make it pertinent to that resident, but we want to make it appropriate for the situation.

The resident will continue choice of movement throughout the facility, so if we're going to say something generic like that, then let's take the opportunity of personalizing it. What is their choice of movement? Are they able to be independent? Ambulators, do they need to walk with a walker? Are they using a powered wheelchair, etc.? Do they require assistance with mobility?

The third bullet talks about the resident will not elope from the facility, or wander into unsafe areas that may place him or her at risk for injury or for harm. Again, if we don't have the resident who is able to ambulate throughout the facility, then we may have a totally different goal in mind.

On this particular page I've given you a couple of suggestions for developing a plan of care. I'm not going to read every one of these, but I want you to look at the very first one. It really boils down to you have to know your resident. This is not, again, just a piece of paper, a compliance. This is an opportunity to identify why that resident is at risk, and what can we do as a team to assist the resident in being able to freely move throughout their environment in a safe manner.

Knowing the resident is the key. We need to know their daily routine. We need to know what is important to them. We need to know their likes and dislikes. Because by getting to know this, as

a person, then we're going to be able to have better strategizing about what we can do in an effort to redirect or to keep this resident safe when these behaviors begin to occur.

Another bullet on this page that I want to spend just a few minutes on is the bullet that talks about monitoring. You need to track and trend. It's just as important. If you don't hear me say anything else today I want you to hear me say it is just as important to identify when the activity occurs as to when it does not occur, because often times we say, well he wanders all of the time.

Well, does he wander when he's eating? Does he wander when he's getting dressed? Does he wander when he is sleeping? We can then look at those patterns of when the behavior is not occurring in an effort to identify normal routines, perhaps, for that resident, but also identify opportunities in which we could replicate those particular times of risk for that resident.

Frequently used interventions. The key word on this page is consistency. Just like one shoe does not fit each and every one of us, there is no plan of care that is going to work for every single resident. When you find something that works, when you find something in which the resident responds positively, the key is then for it to be consistent. You want to look at establishing a daily routine, and I know this is hard, but establishing as much of a daily routine that can be consistent for that resident.

Looking at when something occurs, the timing that it occurs, where it occurs, and who is involved, so that we can minimize the amount of differences that occur. We want to look at caregiver assignment. Consistent assignment is well worth your investment. I didn't get off the boat yesterday, so I know that we can't do it every single day, but as much as we can do consistent assignment you're going to find that that caregiver knows that resident's routine, and it's going to come about more naturally to them. They will begin to develop their own.

Looking at a schedule so that the resident receives meals at approximately the same time. While we don't prescribe the time that somebody goes to bed, there's a routine. You and I each have a basic routine. It doesn't mean that we don't vary on it on occasion, but there's a basic routine that we want to adhere to. Looking at giving medications on a scheduled time, and we certainly want some personalization about that, and we can still couple personalization of meal times along with the resident's schedule.

Looking at whether or not it is needed to have a scheduled rest time, for example. Trying to create the same routine that is repetitive day and day, and making sure that we have fairly consistent approaches in the way that we interact with the residents, and the way that we care for the resident. So that it is appropriate for that resident then to know that this is going to be the routine.

On this next slide we're going to talk about a couple of strategies that you may want to consider that could promote safe wandering, because remembering is not bad. It's only bad when it becomes unsafe for that resident. Unsafe for that resident can be defined in many different levels. For example, the resident who constantly wanders and is unable to be redirected is at higher risk for falling, higher risk for weight loss than other resident who simply wander occasionally, but their risk may be that they wander into unsafe areas, and that they don't know how to respond to.

Again, looking at the personalization, getting to know that resident, making sure that we have appropriate lighting, that we try to do whatever we can do to declutter their environment. If we happen to have one of those residents who is a hoarder, how can we best keep that under control to promote a safe environment and still recognize and respect their need and desire for clutter?

You also want to look at being sure that we have use of appropriate seating devices. For example, often there is this feeling that I need to be moving, and are we going to have chairs that would be appropriate that may help meet that need, and at the same time provide a break in pacing and wandering? For example, rocking chairs versus gliders. There may be some residents who are very appropriate and could really benefit from having just an old fashioned rocking chair.

However, if that resident is also at risk for falling, or rocks that chair too hard, then we've got an increased opportunity for injury. In that case we might want to look at a glider chair which provides much more stability than what a rocker would do, but also meets that internal need to be in move.

Identification of key areas within the facility. When we think about this identification of key areas, I want us to think about it in a couple of different ways. I want us to think about it in ways that we could identify the most common areas that the resident may need to be. For example, simply putting their picture outside of their door, or putting some symbol that the resident is still able to recognize. At the same time, identifying where the bathrooms are. Sometimes it takes a visual, a picture, as opposed to the words saying that this is the bathroom, in order for that resident to recognize.

However, we also want to identify those areas that are unsafe, and make sure that those areas are secured, or have any type of chemicals or biological materials that could create a hazard or a risk for that resident, including things such as equipment. When I use the word equipment I'm talking very broadly. I'm not just talking about maintenance type of equipment, or your electrical closet, but simply access to things such as sharp scissors, and so forth that could create an opportunity of risk.

One of the opportunities that we often see in many facilities is designated areas for work or play. These would be small areas in which there could be little pocket activity with residents who stop and utilize. Sometimes there is a little work station setup with a typewriter, particularly if you have staff who used to do clerical work. We often see boards setup with things such as locks and so forth for some of our male residents, looking at small areas in which there may be some musical instruments that they could play with, or puzzles, or something that is readily accessible.

Minimize the TV. It's not that it's always bad, but it should not become our crutch for saying that there is something for this resident to do. There are quite a few other bullets on this page, but I want to move on to the next page that talks about strategies for redirection when we have those residents that are actively wandering.

The first thing that we want to do is think about the opportunity of simply walking side-by-side with that resident. As we begin to have some conversation or interactions with that resident while we're walking we are then often times able to gently redirect and realign the resident's thoughts. Think about having some opportunity in which we can replicate activities that is part of

their daily life. Whether it has to do with their work, their current interests, etc, and making these readily accessible.

Look at the use of music. One of the nicest things that I saw was a facility that created individualized iPods for residents as the residents' behaviors were increasing. So that, if you happen to be a resident who liked country music, and your neighbor did not like it, then the iPod was created specific for you in collaboration with your family and other interested people.

They identified favorite entertainers, exact songs that this particular resident liked, so that rather than just going and turning the radio on or turning the TV to the music channel, that there was something special for this resident. By using an iPod then the music was kept quiet from other residents. We were not disturbing them, and so it was something that was very personal and worked extremely well.

When you're doing this I want you to also think not only about the type of music, but about the tempo. We all know that our bodies automatically respond, so if we have somebody who is constantly pacing, and we need to slow them down, then whatever genre of music they like should be at a little bit slower tempo, if that's what we're trying to do. If we want the to speed up and walk, then let's give them something with a snappy tune because that's what they're going to respond to.

Looking at it with a purpose when we select the music. Not just going and turning something on automatically. The use of animals is wonderful. We all very often see that we have visiting pets, etc. That's fun, and that's a start, but look at and explore the opportunity for having pets in the environment with the residents, because oftentimes pets can become a great distraction.

Whether it is having an aviary in your facility in which the residents can be directed to, fish tanks are absolutely wonderful. Sometimes they just mesmerize the residents, and they may have been pacing, but by the time they get around to the fish tank that's where they're going to slow down and watch that action. Certainly things like cats and dogs on an individual basis, and within your own facility policy and protocol could be helpful.

Every now and then wandering is going to interfere with the care and the safety of our residents. As this begins to occur it's important that we utilize some techniques that allow us to hopefully redirect, and to give us the opportunity for less disturbance and better safety awareness and across with our staff. We want to break our task into very short simple tasks.

For example, go into the resident's room in the morning and we say, John it's time to get up. Now let's get dressed. Well, we've already given John a couple of options to consider. We might be better saying, John let's get up and sit on the side of the bed. Once John gets up and he sits on the side of the bed, then instead of saying let's get dressed, we might need to break that discussion and request down to, John, take your pajama top off, or John, put your shirt on. John, let's put your socks on.

Each one of those segmented things John may be able to follow more readily and become less frustrated. We often know that frustration is one of the key things to behaviors, and once we get frustrated, then we have to figure out a way in which to relieve that. Oftentimes that is when we get into pacing that may lead to unsafe wandering.

We've talked about the placement of chairs. Many facilities utilize stop signs, the little Velcro attach signs, particularly if we have residents wandering into other residents' rooms. We can look at keeping the doors open or shut. Sometimes it's appropriate one for one resident, and one way for somebody else, so you certainly want to look at the activities within your own community. Certainly having a variety of snacks, and hydration, and most of all making sure that our residents are appropriately dressed both in clothing and in footwear.

The next slide talks about some strategies for exit seeking behavior. Much of what we've already talked about builds up to this. As we look at some other strategies we want to again have built a true assessment based upon our knowledge of this resident. Looking and tracking those trends and behaviors. When does this occur? When does it not occur. If we can figure out when it occurs, then let's begin to think about what was the trigger? Because can we prevent or minimize that trigger from recurring again?

Many facilities use alert devices. These can be both audible or silent devices. They can be often worn by the residents. Sometime they are applied to doors, or to stairways, to elevators, etc. Look within your own environment. Oftentimes the audible alarms tend to create a level of disturbance. For years, when we hear an alarm we have been taught it means to get out of the way. Pick it up, move, do something. If we hear the police alarm it means get out of the way, pull over. If we hear the alarm on our stove it means you better go check your cake, because it's done. It means you have to get up and move.

Until we move into the retirement community that uses some alarm, now all of the sudden I'm expected to hear an alarm and know that it means stop. It's counterintuitive to how we have lived our lives. Look at the purpose of the alarm, and whether or not it's serving value to your particular resident.

We want to look at maintaining a current photo, visual description. Some facilities have a requirement that these need to be updated on a regular basis. We would certainly support that. Looking at the use of a secured memory unit may be appropriate for a particular individual. Most importantly we really have to educate both residents and the family members, not only of appropriate disease processes, but educate them in the risk, educate them in your plan of care, and keep them involved.

As we move into spring, and I'm certainly excited that today's the first day of spring, in many cases it actually increases the residents' risk for unsafe wandering and elopement. All of the sudden now the weather looks enticing. We're seeing flowers out our window. We're seeing a lot more sunshine, so we want to go out and explore. Let's recognize that wandering is a natural behavior. Let's recognize that wandering and being mobile is positive to our overall healthcare. It is certainly one of the things that we want to continue for the resident, but do so in a safe manner, because to confine someone we would actually be creating bigger risks, and some of these are identified on this summary page.

I know that I am right at my time. I would like to thank you all for your attention, and I'm going to turn this back over.

Jennifer Inker: Thank you so very much, Mary. That was a fascinating presentation, and I want to thank Linda also. We have had some questions come in and I know that we are at time, but perhaps I could at least ask one of these. We have an audience member who works in the secure memory care

home, and shares that their windows are mechanically prevented from opening more than six inches, clearly a safety feature. The question is what suggestions might you have for evacuation egress?

Linda Glasson: All right, this is Linda speaking. Of course you're going to look at the obvious ambulatory rights. In a number of states, and I'm not which state the question is coming from, there is now a requirement that some of the windows, that the fire department be able to access in another manner to get that window opened farther. Or, to have the fire department come in and take a look at the window to see whether or not that window could be modified to expand farther with some type of a mechanical combination.

The problem is if you've got to use a key to open a window then the key might not be in the place that you need it when you need to get the resident out. The fire department quite frankly has no compunction about breaking the window if they need to get somebody out. If your maintenance folks, working in conjunction with the local fire officials cannot figure out an alternative that's consistent with the applicable codes they have tools that will take that window out for you.

That's not a definitive answer, but unless that window is very unusual they will break it out or pull it out with one of their fire tools.

Jennifer Inker: Thank you Linda, well that is reassuring I'm sure for people to hear, because that does sound like something of a dilemma there. All right, I want to be respectful of time. Maybe there's time for one quick question for Mary here. Mary, you stressed the tremendous importance of taking a person-centered approach with regards to resident risk factors. Could you perhaps give us maybe a 60 second answer helping us understand a little better what makes an action and a risk management care plan both responsive and reactive? What's the difference between being responsive and being reactive?

Mary Chiles: That's a great question. Being responsive is a plan of care that is put in place prior to an incident, and is based upon the identified risk factors. Being reactive means that our plan of care may have to be changed based upon a change in the resident's condition, or perhaps the resident has experienced an incident, meaning that the plan of care needed further expansion. Something has occurred that has now made us act.

Jennifer Inker: That's great. That's so helpful. Thank you very much Mary. To be respectful of everybody's time, because I think we're just a little past time now, I'm going to go ahead and wrap this up. I'd like to once again thank Linda and Mary for fascinating and informative presentations, and for joining us today. I'd also like to thank you, our audience, for participating in today's webinar. This webinar has been recorded, and so if you've missed any portion of our presentation today, or you would like to share it with a colleague, please do visit the webinar page on our website.

As a reminder, information alongside the survey links will be emailed to all registrants by tomorrow. I'd like to also remind you that next month's webinar is titled Best Practices for Medication Management of Dementia-Related Behaviors. This will be hosted on Wednesday, April 21st, 2017, at 1:30 p.m. Eastern time, so mark your calendars.

This webinar will give an overview of current best practices for medication management of dementia-related behaviors. Presenters will provide an update on current research on safety and efficacy, and will present case studies featuring the use of medications for challenging behaviors

in persons with dementia. Until our next live webinar, thank you once again for joining us today, and enjoy the rest of your day and the beginning of spring.