Stand-Alone Care Communities: Checklist of Essential Risk Management Features

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Stand-Alone Memory Care Communities: Checklist of Essential Risk Management Features

The following checklist is designed to aid stand-alone memory care communities in evaluating the effectiveness of their existing practices and protocols.

Risk Control Measures		
Community Mission & Quality Framework	**Present Yes/No**	**Action Plan**
1. The memory care community (MCC) has articulated its philosophy regarding treatment of memory-impaired residents in a written plan, including these primary goals: • Comprehensive needs-assessment on all residents • Application of evidence-based interventions in behavioral management care planning • Reduction of the use of physical and chemical restraints for managing adverse behaviors • Optimization of quality of life and independence through activities and environmental design • Management of risks related to physical endangerment and bodily harms		
2. Nationally recognized dementia care guidelines or programs are the basis of memory care.		
3. The MCC has voluntarily complied with the Joint Commission's memory care requirements for nursing care center accreditation.		
4. A licensed medical director is employed by the organization and is not a contractor or consultant.		
5. An on-site licensed nursing professional coordinates dementia care within the MCC.		
6. A quality assurance committee (QAC) reports to the MCC's leadership and governing board on a quarterly basis.		
7. The QAC, consisting of the Director of Nursing, Medical Director and a minimum of three staff members, meets at least quarterly to address quality-related issues.		
8. The QAC monitors compliance with policies and procedures, and corrects any identified deficiencies.		
9. Marketing and admission materials both on-line and in print clearly convey the resource capabilities of the MCC, including the likely possibility of resident transfer to a skilled care facility.		

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Resident and Family Relations	Present Yes/No	Action Plan
1. A top-down commitment to treating residents in a patient, positive, and caring way is evidenced in all resident/family interactions.		
2. Residents and family members are apprised of therapy goals, medication adjustments and side effects, and the overall treatment plan on an ongoing and regular basis.		
3. A family council is established in order to further two-way communication between the MCC and family members regarding resident care and quality-of-care concerns.		
4. Shared risk agreements, liability waivers, and arbitration agreements are used to mitigate risky resident behaviors.		
5. The fee structure is clearly articulated and billing statements contain separate fees for housing and care.		
6. The discharge policy is provided in writing to residents and their families upon admission, containing clear criteria for discharge.		
7. A written protocol details the process for transitioning memory care residents to outside skilled care providers.		

Staffing, Training, and Retention	Present Yes/No	Action Plan
1. Memory care certification, through such organizations as National Council of Certified Dementia Practitioners and the Alzheimer's Association, is a pre-requisite to employment for professional staff and direct care providers.		
2. Background criminal history checks and drug testing are conducted on all employment candidates.		
3. Staffing requirements comply with minimum staffing levels for long-term care organizations as set forth in the federal Nursing Home Reform Act, 42 CFR 483.30.		
4. A licensed RN or LPN is present at all times in the MCC.		
5. Staffing protocols provide for increased staffing levels in response to resident census and acuity, e.g., a ratio of 1 caregiver to 5 residents in memory care.		

Staffing, Training, and Retention	Present Yes/No	Action Plan
6. Direct care and ancillary workers, e.g., dietary, recreational therapy, laundry and housekeeping employees, receive ongoing training to an appropriate level regarding behavioral manifestations of dementia and appropriate interventions, including: • Detecting behavioral disturbances in residents • Communicating with behavior-challenged residents • Responding to aggressive outbursts and signs of violence • Reporting and documenting behaviors		
7. Skill training sessions include a combination of mediums, such as videos, on-line case presentations, and live clinical practicums, in order to help staff conduct baseline assessments, clarify target behaviors, and identify appropriate behavioral interventions.		
8. All training and skills development sessions are documented, including staff participation and results of proficiency testing.		
9. A career pathway is designated to facilitate upward mobility for entry-level, non-certified caregivers.		

Resident Selection	Present Yes/No	Action Plan
1. The MCC has a skilled, knowledgeable, full-time admissions coordinator.		
2. Information packets and online marketing messages sent to local agencies, senior centers, adult day programs, and geriatric practitioners clearly delineate the services and program offerings, while expressly stating what services are not offered.		
3. A written resident selection plan reflects the practical and psychological complexities of resident placement by requiring a pre-placement cognitive and behavorial assessment, including a designated observation period for the purpose of compiling a resident's behavior profile.		
4. A licensed physician documents the diagnosis of Alzheimer's disease or other dementia-related condition, and attests in writing that the resident's medical needs do not override the cognitive/behavorial deficits.		
5. A psychiatric examination is conducted on prospective residents that are taking a psychotropic drug or who display acute/chronic depression.		

Resident Selection	Present Yes/No	Action Plan
6. Resident selection parameters include the use of rating scales to measure ongoing resident agitation, aggression, and depression.		
7. A determination is made and documented that physically abusive/combative behaviors are manageable through therapeutic and/or pharmacological approaches.		
8. A written appraisal of the resident's physical and mental capabilities as well as agreed-upon services is ackowledged in writing by the resident and/or family members.		
9. Admission agreements and oral representations made during the selection process do not contain misleading promises or statements that can be misinterpreted, such as "the highest quality in memory care," "your loved-one will be secure," or "independent living at its best."		
10. A written policy exists that governs wait-list procedures and other vacancy-related issues, such as specific time limits for removing a deceased resident's belongings.		

Care Planning and Documentation	Present Yes/No	Action Plan
1. Resident care policies and procedures outline a systematic process for resident care.		
2. An interdisciplinary team completes a comprehensive evaluation of resident physical and cognitive needs, in order to enable residents to attain their highest practicable level of functioning.		
3. A documented consultation with family members occurs during the assessment process to gain insight into the resident's usual routines and activities, in order to understand what prompts behavioral disturbances and craft effective care plan interventions.		
4. Assessment findings are documented in the clinical care record and promptly communicated to nursing staff.		
5. Direct care staff can demonstrate where resident assessment findings and care plans are located in the clinical care record, and they are trained on how and when to access the record for documentation purposes.		
6. A comprehensive written care plan is structured around resident needs and reflects specific care strategies, measurable goals, and timetables for monitoring outcomes.		

Care Planning and Documentation	Present Yes/No	Action Plan
7. Care plans are resident-centered and flexible in regard to routines and activities, identifying triggers for dementia-related behavioral manifestations such as these: • Anger and physical aggression • Anxiety • Self-injurious behavior • Wandering and elopement • Sexual inhibition • Delirium • Psychosis		
8. Every effort is made to manage behavioral disturbances using non-pharmacologic interventions, such as: • Exercise • Hobbies • Light therapy • Memory games • Music therapy • Pet therapy		
9. Direct care staff is able to describe daily approaches to individual resident care and can articulate how to obtain additional support if interventions are not effective.		
10. Resident laboratory and diagnostic findings are regularly reviewed and incorporated into the care plan, especially the effects of psychopharmacological medications.		
11. Direct care staff and non-nursing personnel have a designated format for documenting specific resident behaviors and triggers on a daily basis, in order to enable disciplines across all shifts to monitor outcomes and revise care plans accordingly.		
12. Care plans are regularly reviewed in collaboration with a medical practitioner, in order to adjust treatment approaches based on their effectiveness and the occurrence of adverse consequences.		

Pharmacologic Safeguards	Present Yes/No	Action Plan
1. Written guidelines exist for the pharmacologic treatment of agitation, dementia, and psychosis.		
2. A documented consultation with a geriatric psychiatrist and a pharmacist occurs before drug therapy ensues for behavioral management purposes.		
3. Medical and clinical criteria for the use of psychopharmacologic drugs are documented in the clinical care record.		
4. An interdisciplinary team receives a weekly progress report on residents with behavior management plans, in order to address their effectiveness and adjust the plan accordingly.		
5. The interdisciplinary team completes a monthly review of clinical indications for drug use for all residents receiving two or more psychopharmacologic drugs.		
6. The interdisciplinary team reports to the QAC to ensure coordinated activities and action plans.		

Nutrition and Hydration	Present Yes/No	Action Plan
1. An assessment is conducted upon admission to ascertain whether a resident's underlying medical conditions and/or adverse drug effects impede adequate nutrition.		
2. Admission assessment parameters include a check of pre-disposing factors that can negatively impact nutrition and hydration, such as clinical depression, swallowing difficulties, tremors, and oral sores/missing teeth/loose dentures.		
3. Family members are involved in the care planning process for nutrition and hydration.		
4. Dining patterns and food choices factor in personal habits and cultural preferences, as well as when and how long it takes a resident to eat.		
5. Staff educational programs address the risks of malnutrition in the memory impaired resident as well as indicators for feeding assistance.		
6. Feeding assistance needs are assessed regularly and noted in a resident's clinical record and care plan.		
7. An adequate number of feeding assistants are available to assist residents with eating and drinking.		

Nutrition and Hydration	Present Yes/No	Action Plan
8. Care plans include methods to stimulate the appetite, including exercise and sensory stimulation.		
9. Routine checks for dental hygiene, weight loss, and malnutrition and dehydration occur at set time intervals, with results documented in the clinical record.		

Environmental Design and Safeguards	Present Yes/No	Action Plan
1. The environmental design reflects input by experts in dementia care, i.e., an open floor plan that permits residents to independently and safely navigate their environment.		
2. Contrasting color schemes help to visually distinguish changes in surfaces, furniture, and interior décor.		
3. Natural and artificial lighting is dispersed throughout living spaces to maximize resident orientation.		
4. Circulation paths intentionally avoid dead-end spaces, and locked doors are camouflaged to avoid triggering anxiety in residents.		
5. Simple way-finding cues exist throughout the environment, such as color-coded spaces to reinforce the purpose of the space.		
6. The MCC has ample and secure outdoor space that is dedicated to resident exercise, hobbies, and special events.		
7. Safeguards exist in living spaces, bathrooms, and kitchens to minimize the likelihood of falls and burns, e.g., non-skid flooring, grab bars, durable furniture, mixed hot water valves, and heat sensors.		
8. A comprehensive falls prevention program includes the following features: • Resident assessment for pre-disposing factors • Prevention and protection devices, such as clip-on alarms and pressure sensitive floor mats • Shift report formats that help to communicate fall risk factors • Methods to designate high-risk residents in the clinical record and care plan, on the resident's body, and in the environment • Fall-management education for all employees • Tracking and monitoring of falls activity with regular reporting to the QAC of interventions taken		

Wandering and Elopement	Present Yes/No	Action Plan
1. All residents are assessed for the risk of wandering and elopement prior to admission, whenever their condition changes, and on a quarterly basis at a minimum.		
2. All initial assessments, reassessments, and observations are documented in the clinical care record.		
3. All residents are photographed upon admission and the photos are kept in the resident care record.		
4. Written policies and procedures are in place regarding the prevention of wandering and elopement.		
5. Environmental alarms at points of ingress/egress are utilized to alert staff to potential elopements, and are routinely checked for proper working order.		
6. Safety measures taken to prevent wandering and elopement are noted on the resident care plan, e.g., ankle bracelets and laser sensors.		
7. Windows are present throughout the MCC to help orient residents to place, season, and time of day.		

Emergency Response	Present Yes/No	Action Plan
1. An emergency response protocol exists for resident elopements and behavioral emergencies, ensuring the following provisions are in place: • A code system to alert staff and deploy an internal response team • Steps to activate a local emergency response system • First-aid care for injured residents • Assigned responsibilities for safeguarding other residents from imminent harm and endangerment • Notification of family		
2. A written plan outlines a property search in the event of resident elopement, including external roads, bus stops, bodies of water, and high balconies.		
3. Periodic drills to assess the overall effectiveness of the emergency response protocols are held, and records are maintained of staff participation.		

Adverse Event Reporting and Error Disclosure	Present Yes/No	Action Plan
1. An incident report program requires prompt reporting of adverse events on a designated form to a risk manager or other person responsible for tracking adverse occurrences.		
2. A sequence-of-events analysis of high-risk exposure incidents is conducted and documented.		
3. The known facts of the occurrence are promptly reported to the resident and family, along with an explanation of any clinical implications.		
4. A formal report following an in-depth investigation is shared with the QAC, including actions taken and steps to avoid recurrence.		
5. In the event the investigation reveals the standard of care was not met, a spokesperson for the MCC – in collaboration with legal counsel and an insurance company representative – meets with the resident and family, in order to offer redress and provide closure.		

Disclaimer

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