Policy:

Staff MUST be able to work independently and make decisions based on the Individual Support Plan for the supported individual, with the individual's health and safety in mind. In a situation where staff is unsure of best course of action, the Call Protocol should be used. Especially when it concerns the client's health and safety. Sound judgement should be used regarding what constitutes an event that requires immediate contact/action versus situations that can wait. If staff have any questions, discuss with your immediate supervisor or if there is question, contact using the Call Protocol.

Comments:

In a true emergency (as defined by the first aide/CPR or Level 1 Med Aide class) **ALWAYS** call 911 first. Otherwise, all direct support staff will follow the Call protocol for ALL questions of health and safety.

Depending on the nature of the request/question, this is the order of calling. If there is no answer, direct support staff should wait 15 minutes for a return call, then try again. If there is no answer and no response after another 15 minutes, then call the next person on the list. If the client is in need of immediate answers or relief, then this protocol can be expedited.

CALL PROTOCOL

1. House Manager/Live-In Staff/Host
2. Degreed Professional Manager assigned to the individual
3. COO
4. CEO
4. Owner

If/When the issue is of a medical nature, Community RN should be contacted by House Manager/Live-In Staff/Host, and/or Degreed Professional Manager, see the following for when to contact the Community RN. For direct support staff, if the house manager/administration fails to answer in the time defined above, or the condition of the client served worsens, follow the guidelines below.

WHEN TO CONTACT COMMUNITY RN (This List is Not Inclusive):

*If a true emergency as defined by as defined by the first aide/CPR or Level 1 Med Aide class, dial 911, then notify Community RN and House Manager/DPM following the above protocol. IN MOST CASES, IT WILL BE THE HOUSE MANAGER/DPM THAT WILL CONTACT THE COMMUNITY RN.

***A Physician Order supersedes any guideline set forth in this document.**
**If a Physician Order is in place, it will be followed by all staff for the individual it pertains to. If there is not an order in place that addresses a particular situation, then these guidelines are to be followed.

Illnesses

After following the call protocol list: When calling the RN– be prepared to provide blood pressure, temperature, pulse, O2 sat, and respiration. If the client is a diabetic, then blood sugars should be provided as well. You should call the RN when:

- Elevated temperature, any ancillary temperature reading of 100.0 Fahrenheit or above
- O_2 saturation below 92%

- Nausea/Vomiting; unusual or accompanied by other symptoms of illness.
- Diarrhea (More than one episode)
- Difficulty breathing – call 911 if an emergency then page Health Services with priority 1
- Fainting/Dizziness – more than 1 episode in a 12-hour period
- Urination problems
- Distended abdomen
- Blood in stool
- Blood pressure reading Systolic (Higher Number) greater than 140 or less than 90
- Blood pressure reading Diastolic (Lower Number) greater than 100 or less than 60 (if diastolic is at or higher than 120, it is a medical emergency, call 911 or transport to the ER)
- Pulse less than 60 or greater than 100
- Respirations less than 12 or greater than 22

Prescribed PRN medications used for purposes other than behavior (coughing, runny noses, slightly elevated temperature) may be given to an individual according to the parameters set by the physician without calling the DPM or RN prior to administering the medication. Nurses will review all PRN dosing frequency at each monthly nurse's visit and PRNs must be documented appropriately on MAR. All PRN medications require a follow up note in the MAR after 1 hour.

Medication Errors

Following the Call protocol: Including but not limited to:
- Failure to administer
- Wrong dose
- Wrong time
- Wrong individual
- Wrong medication
- Wrong route

Seizures

Always follow the seizure protocol individualized per client.

- If a client does not have a seizure history and experiences a seizure, call 911 and then call Community RN.
- If a client has a history of seizures with multiple seizures per month, and the client's seizure is similar in type and duration as his/her previous seizures, staff will follow the client specific protocol, including PRN if physician orders on file, and then contact the house manager. Also document the seizure in the appropriate manner. The House manager will contact the Community RN via voicemail/text/email.
- If a client only experiences seizures every few months /years, follow the client specific seizure protocol if the client has one. If not, the follow the standard seizure protocol which is located in the home and emergency books. Staff will call the house manager. House manager will call the Community RN immediately. Document in the appropriate manner.

Injuries (Staff or Individuals)

Call RN. Including but not limited to:

- Lacerations
- Scratches/Abrasions
- Falls
- Bites, including person, animal, spider or bug
- Stings, including bees and wasps
- Limping
- Bleeding
- Burns

Emergencies

Call 911 first then notify Community RN. Including but not limited to:

- Cardiac event
- Breathing difficulties
- Accident with serious injuries
- Unresponsiveness
- Severe bleeding
- Choking
- Orthopedic injuries

Behavior

Contact RN AFTER behavior protocol has been followed. Including but not limited to:

- Changes in normal behavior
- Threat to harm self or others
- Injuries to the individual
- Injuries to staff or other individuals
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*Note: The Individualized Support Plan (ISP) shall include methods to address the situation surrounding the need for PRN psychotropic medications. If PRN medications are indicated, Administration/Community RN should be notified and can give permission for the use of the PRN medication.

Contacting RN

- All staff have Community RN and Administration phone numbers to call.
- If anyone in the process is not responding, seek medical attention by taking the individual to the ER or by calling 911.

Information Sharing with the RN if You Need to Call:

1. Provide the most detailed information possible regarding the individual to the nurse so that an appropriate evaluation, O2 sat, and recommendation can occur. Be prepared to provide the blood pressure, blood sugar if diabetic, pulse, respiration, and temperature of the individual when calling.
2. Always document in your daily notes the recommendation from the nurse. Make sure the information is passed along to additional staff members working in the home or during shift change.

3. If the nurse recommends that the individual receives treatment by the Primary Care Physician, Urgent Care, or ER, the nurse must be made aware of when the visits will be occurring to assure that they are within an acceptable time frame.
4. If a staff person is uncomfortable with the recommendations of the nurse, they may ask for the nurse to come to the home.
5. Any direct support person may contact the community RN at any time to discuss concerns regarding the well-being of an individual supported.
6. If at any time a manager feels like an individual supported needs an assessment by their Primary Care Physician, Urgent Care or Emergency Room Physician, arrangements may be made for this to occur and the RN notified of the decision.