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"NEWS AND VIEWS YOU CAN REALLY USE"

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SENT EACH MONTH TO YOU AS A MEMBER OF THE HEALTHCARE HEROES

THE ADELMAN ADVANTAGE

by Rebecca Adelman

"The 4 Outs" – Active Shooter/Armed Intruder Preparedness

I am so grateful to co-author this month's article with Steve Wilder, president and Chief Operations Officer of security consulting firm Sorensen, Wilder & Associates. Over the past several years, there have been many reports on active shooter and armed intruders in senior living and just last July, two people died in what was believed to be a murder-suicide in a Delaware nursing home.

On this critically important topic of readiness, I invited Steve to share his vast experience and advice on proven strategies to combat the unique challenges that accompany an active shooter or armed intruder in a healthcare setting.

Preparing for the Unthinkable

One of the most difficult parts in preparing for the risk of an active shooter event is accepting the fact that it can happen in your facility. Everyone wants to believe that it can't happen in their facility, but in reality, there are many case studies that prove it can happen in any senior living facility. Every facility has the fiduciary obligation to recognize the risk and prepare the facility and the people to face the unthinkable.

The first step in preparedness is to know where your vulnerabilities exist. This is accomplished through a security vulnerability assessment (SVA). An SVA is a systematic review of the facilities security management program, and is intended to identify 3 critical factors:

- What are the ***THREATS*** that could result in an active shooter event (or any other security related incident)?
- What are the ***VULNERABILITIES*** (chinks in the armor) in the existing security management plan that could contribute to the likelihood of an event occurring?
- What are the ***RISKS*** (outcomes) that might be recognized if an event does occur?

Once the answers to these questions are known, you can begin to make improvements in your security management plan to minimize the vulnerabilities and lessen the likelihood of an event. It is critical to realize that there is no sure way to prevent it from happening. As long as people are walking in the doors, the risk is present, and the focus has to be on minimizing the risk and developing a plan to minimize the casualty count.

The next step is to develop an active shooter plan for the facility. It is critically important to realize that the plan must be specific to the facility. Packaged plans will seldom work. Your SVA allowed you to identify where your vulnerabilities exist, and your plan should be built with those vulnerabilities in mind; that cannot be achieved with an "off the shelf" plan.

Senior living, like all disciplines in healthcare, presents unique challenges. Unlike manufacturing or retailing where each individual is responsible for themselves, in a senior living facility we are responsible for ourselves and for others who cannot take care of themselves. Our challenges are unique, and our plan must reflect that. In an environment where each person only has to worry about themselves, the **RUN-HIDE-FIGHT** program by the United States Department of Homeland Security should be considered the program of choice. That said, in the senior living environment, we have to include considerations for those who cannot take care of themselves, especially those in rooms where doors cannot be locked. For these facilities, **THE 4 OUTS** has become the model program for the industry.

THE 4 OUTS program bears a striking resemblance to **RUN-HIDE-FIGHT**, with considerations built in to protect those who are not able to exit the building and are not able to secure themselves in a locked room. Each of the 4 Outs (Get Out; Hide Out; Keep Out; Take Out) remains focused on both the staff member and the resident.

Training becomes the next critical component in developing a program. Once your plan is developed, start with a tabletop exercise, which is designed to test the plan to make sure it does what you intended it to do. If deficits in the plan are identified, amend the plan and repeat the tabletop exercise. This will almost become cyclical until your plan is ready. Once the plan is set, begin training your employees. Training starts at the awareness level and progresses. It is also critical to stress that watching a video does not constitute training. Your training must be both cognitive based and competency based. *Always remember: educate the mind, train the hands.*

Drills and exercises become a critical part of your training program. In a crisis situation, your employees will perform as they have practiced. Along with didactic training, drills and exercises must be included. Start slow and allow your people to grow and develop as they become familiar with the plan. Once

Continued on page 2

The Adelman Advantage continued from page 1

your staff begins to show competency in their respective roles, you will be ready for a full-scale exercise which will also include local public safety agencies such as police, fire and EMS.

A final word on training. Your staff must be trained to your plan. Local law enforcement professionals will respond and will act in the case of an event. That said, when police train, they train for their response, not yours. They are not familiar with your plan and will not likely be able to train you on how to respond according to your plan. In an active shooter event, police response will be anywhere from 3 to 10 minutes depending on your location. Your plan is developed to focus on minimizing the casualty count before the police arrive. That must be the emphasis of your training as well. With all due respect to police, they are the experts in response. But until they arrive, you are on your own, and your staff must be trained on your plan.

The final component of building your plan is recovery. Regardless of the criticality of the event, there will be a tomorrow, and the facility must be able to continue to care for your residents and your staff. Recovery is seldom thought of when discussing emergency preparedness. Focus typically goes into response and mitigation, and seldom into recovery (think about your fire drills). Recovery is about returning to normal, whatever that may look like. Think about the resources you may need following an active shooter event. Typically, the list will look something like this:

- crisis counseling for staff, residents and families
- clean up and restoration
- additional security on site, armed or unarmed
- public relations and media assistance
- legal / defense counselors
- relocation of residents
- transportation of residents
- risk management assistance
- staffing and continuity of care

For these resources, and any others that might be identified, it is likely that you will be turning to outside agencies for assistance. It is critical that you have a pre-established relationship with each of the providers of these services, so that in the event that you call them in a crisis situation, they are there for you, have all of your information, and can immediately respond immediately.

OSHA Regulations and Policies

From and legal and regulatory framework, employers need to consider the General Duty Clause, Section 5(a)(1) of the Occupational Safety and Health Act (OSHA) of 1970. Employers are required to provide their employees with a place of employment that "is free from recognizable hazards that are causing or likely to cause death or serious harm to employees." Vulnerability Risk Assessments and Safety and Security Assessments can help determine your organization's level of preparedness and while alone they would not mitigate the risk of an OSHA violation, the knowledge gained from the assessment will provide a benchmark, facilitating the development and deployment of a comprehensive workplace violence prevention program to include the training programs described by Steve.

According to OSHA, healthcare accounts for nearly as many serious violent injuries as all other industries combined. In addition to the valuable resources Steve offers, OSHA has compiled a suite of resources to help you build and implement a comprehensive workplace violence program in your healthcare facility.

The strategies and tools complement OSHA's *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*, updated in 2015. The Guidelines describe the five components of an effective workplace violence prevention program, with extensive examples.

The products include: *Workplace Violence in Healthcare: Understanding the Challenge*, which presents some estimates of the extent of the problem from various sources; *Preventing Workplace Violence: A Road Map for Healthcare Facilities* expands on OSHA's guidelines by presenting case studies and successful strategies from a variety of healthcare facilities; and *Workplace Violence Prevention and Related Goals: The Big Picture* explains how you can achieve synergies between workplace violence prevention, broader safety and health objectives, and a "culture of safety." They can all be found at https://www.osha.gov/dsg/hospitals/workplace_violence.html.

Finally, review the details of your Workplace Violence Prevention and Response Policy.

In developing your policy, consider including these elements:

A stated management commitment to protecting employees against the hazards of workplace violence, including both physical acts and verbal threats;

A statement that the employer has a "zero tolerance" policy toward threats or acts of violence and will take appropriate disciplinary action against employees who engage in such conduct;

Identify means and methods for employees to notify the employer of perceived threats of violent acts in a confidential manner;

Establish a means to promptly investigate all such threats or violent acts;

Develop consistent, firm discipline for violations of the policy;

Provide training to managers and employees to identify signs and symptoms of employee behavior which may predict potential violence (erratic behavior; employee comments regarding homicide or suicide; provocative communications; disobedience of policies and procedures; presence of alcohol, drugs or weapons on the worksite; physical evidence of employee abuse of alcohol or drug use) which should be reported to the employer;

A non-retaliation policy for employees who report verbal and physical conduct to the employer which they reasonably believe represents a threat of potential workplace violence;

Establish a team of qualified individuals (e.g. human resources; risk managers; legal; medical; security) either within the

Continued on page 6

Getting on the Same Page by Paige Hector, LMSW

Adults Can Be Ornery Learners. Yes, YOU!

Ok, so the title likely caught your attention. Maybe it got your ire up?! Please know that I mean no disrespect. My intention is to bring attention to the important subject of adult learning and how it relates to training in post-acute and long-term care settings. There are unique qualities about adult learners, and anyone teaching or thinking of teaching in this space, would do well to heed them.

The method and practice of teaching adult learners is called andragogy. In order to be successful with adult learners, one must follow specific strategies and principles. Ever been to a training or a conference session that you couldn't wait to escape? It's likely that the presenter or instructor may have missed the mark when it came to crafting the learning experience with adult learning principles in mind. It makes me think of a quotation by Mark Twain: "If teaching were the same thing as telling, we would be so smart we couldn't stand it."

Teaching is definitely not the same thing as telling! Adults come to a training with history and experience, even if it's not with the topic being taught, but life experience. Whenever I can, I ask the participants in my sessions how many years' nursing home experience they bring with them. Recently, I gave a day-long seminar with 40-some people, and in the room, we had close to 1000 years' experience. Think about that for a moment, a thousand years of experience, all sitting in one room. Think of your own facility and the number of people that work there and be mindful of the amount of experience in the room. While they may be there to learn, it's likely they already have a lot of knowledge and it would be wise to respect that and build upon it.

Do an internet search on adult learning and you'll get an overwhelming number of websites, articles and resources. I'm going highlight a few resources that I use in my work and have found very effective.

WIIFM. This acronym stands for 'What's In It For Me' and is one of the most fundamental principles of adult learning. The instructor/presenter should establish WIIFM right away and capture participants' attention immediately. Sometimes, WIIFM can be hard to identify, especially if the training is mandatory and not something that staff consider particularly relevant or helpful to their job. Work hard on making a connection between the material and the participants, identify how it makes their job easier or better.

Other key adult learning principles include:

- Content must be meaningful and relevant – whenever possible, relate the material to peoples' lives and work. Don't just talk at them, learn with them. If you need to teach a new policy, regulation or procedure, find a way to connect it to their experience and make it meaningful, not just something they have to remember or do "because it's required."

- Adult learners are problem-centric, not content-centric – they come expecting to get their problems solved, not just get more information. Before they know the 'how', they need to know the 'why.'

- Emotional connection (***not*** fear) enhances learning and recall – garnering emotions like excitement, compassion and empathy enhance learning. Doing a mandatory inservice on HIPAA compliance? Have staff write down two things about their health or personal history and then ask them to imagine what it would be like to have that information shared with everyone in the room. By identifying with how vulnerable and exposed residents and patients are in the nursing home, an inservice on a "mundane" aspect of healthcare becomes more personal and elicits feelings of compassion for staff to be mindful of how, and when, health information is shared.

    - If the learning experience is laced with fear or has the flavor of "do this or else…", people go into fright, flight or fight mode. Those states of being certainly do not facilitate learning. If the instructor or administration use the carrot and stick approach to teaching (which is based in fear), people will do what they need to do to get by and keep their job.

- Have fun! This seems so obvious, but I can recall many presentations that I have endured with a presenter or instructor that, at least outwardly, didn't seem to be enjoying himself or herself. So, I conclude, again, that the principle of fun is not so intuitive. Whenever possible, get people laughing and be intentional about finding ways to bring fun into the session!

- See every participant as a resource, someone who can contribute to the overall learning experience.

- Get staff actively involved in creating the content whenever possible. Collaborating with staff engenders buy-in, which increases commitment to successful outcomes. (1) and (2)

Learning starts with curiosity. Get someone curious about the topic and you've likely got a willing learner. For example, check out the University of Virginia Medical Center Training Room, "Room of Errors" - https://uvamagazine.org/articles/room_errors. In an effort to reduce medical errors, the medical center created a simulation lab where staff from all disciplines are challenged to identify dozens of errors in under

Continued on page 4

Getting on the Same Page continued from page 3

10 minutes. This training tool incorporates multiple adult learning principles by making the experience engaging, fun, interactive and informative.

Whatever you do, avoid the 'spray and pray' approach to training. When mistakes, near misses, incidents or sentinel events happen in our facilities, often the knee-jerk reaction is to initiate immediate training. "We spray education on everyone and pray that it improves outcomes" (3). Sometimes training is NOT the answer and can actually do harm by way of wasted time, money and increased staff cynicism.

In addition to using adult learning principles, keep in mind that people have different learning styles: auditory (hearing and listening), visual (reading or seeing pictures) and tactile (touching and doing, hands on) (4). As you develop training programs, be cognizant of these styles and try to incorporate instruction that utilizes them in the training. For example, let's say you are designing a training on a new type of medical equipment. You might give participants a copy of the equipment instructions and the facility policy which recognizes the visual learner. Then, you describe the new policy and provide step-by-step instruction on how to use the equipment which is auditory instruction. Then, you give participants the opportunity to use the equipment which helps facilitate tactile learning.

Consider the wisdom of Confucius: "I hear and I forget. I see and I remember. I do and I truly understand." So, back to the title of this article and the assertion that adults are ornery learners. Maybe we are, sometimes, but it's not entirely without justification. Training is a crucial part of a successful nursing home. But it's time we revamp our "training as usual" approach and be intentional about integrating adult learning strategies into every inservice. Ultimately, it makes the experience for everyone much better and more effective.

1. 7 Top Facts About The Adult Learning Theory (2018 Update) by Christopher Pappas

https://elearningindustry.com/6-top-facts-about-adult-learning-theory-every-educator-should-know

2. Adult Learning Techniques by CoreNet Global

https://www.corenetglobal.org/files/summits_events/Callfor-Content/pdf/AdultLearningTips.pdf

3. Excerpted from: Competency Assessment Field Guide: A Real World Guide to Implementation and Application by Donna Wright, https://chcm.com/wp-content/uploads/2015/05/Competency-Field-Guide-Excerpt.pdf

4. What's Your Learning Style?

http://www.educationplanner.org/students/self-assessments/learning-styles.shtml

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Discover more about her at www.paigeahead.com

The Adelman Advantage continued from page 2

company or readily available third parties, to respond to a potential or actual incident; and

Consider establishing an Employee Assistance Plan (EAP) to provide assistance to employees who may be experiencing mental or emotional stress before an act of violence occurs.

Above all, be prepared and stay safe.

PLEASE SAVE THE DATES OF April 22-23, 2020 for the 8th annual National Long-Term Defense Summit! 2019 was amazing and look forward to education, networking and fun in New York City in 2020! You'll love The Parker Hotel and the penthouse Estrela conference room with 360 degree views of the city and Central Park! Please plan to join us!!!! For more information, please contact me at rebecca@adelmanfirm.com.

Rebecca Adelman is an entrepreneur, influencer, thought leader and founder of Adelman Law Firm, a Women's Business Enterprise National Council (WBENC) certified Women Business Enterprise (WBE) established in 2001. For nearly 30 years, Rebecca has concentrated her practice in insurance defense and business litigation. The firm's practice extends through the Tri-States of Arkansas, Mississippi and Tennessee. Rebecca's insurance defense practice includes representation of insurance companies and long-term care providers and their insurers, both regionally and nationally. She also provides consulting services and educational programming to healthcare professionals and business associates. She has active practices in the areas of general liability, professional liability, premises, and employment law. She is a listed mediator serving all areas of business and healthcare litigation. Contact Rebecca at rebecca@adelmanfirm.com and visit www.adelmanfirm.com and www.rebeccaadelman.com.

Steve Wilder has spent the past 30 years in healthcare safety, security, and risk management. He has provided consultation services to hundreds of clients, including hospitals, CCRC's, physician practices, clinics, mental health facilities, hospice and home care agencies and more. He has also worked with schools, manufacturing, government entities, and communities. An experienced trial expert, Steve regularly consults for law firms and insurance companies on matters of safety, security, and risk management. He has become a nationally recognized subject matter expert in active shooter preparedness and response and works with over 300 clients in 44 states. Steve proudly served on the Illinois School Security and Standards Task Force as the only professional security consultant on that task force, appointed by the Governor of the State of Illinois. Contact Steve at swilder@swa4safety.com.

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What's Next? CMS Updates Key Docs after PDPM Implementation!

By: Joel VanEaton, BSN, RN, RAC-CT MT VP of Compliance and Regulatory Affairs

October 1 marked the biggest change to Long Term Care reimbursement since the implementation of PPS in 1998. Getting ready and assimilating to this change has and continues to be a monumental task. And yet, before we have had a chance to get our feet wet with PDPM, CMS has not hesitated to bring even more to the table.

On October 4th, CMS updated three important manuals in the internet only Manual system;

- Pub 100-01 Medicare General Information, Eligibility, and entitlement, Chapter 4 Physician Certification and Recertification of Services,
- Pub 100-2 Medicare Benefits Policy Manual, Chapter 3 Duration of covered Inpatient services, and Chapter 8 Coverage of Extended Care (SNF) Services Under Hospital Insurance,
- 100-4 Medicare Claims Processing, Chapter 6 SNF Inpatient Part A Billing and SNF Consolidated Billing.

The revisions that have been made to these manuals are all related to the effect that the PDPM has had on various CMS policy related to SNFs. These revisions are slated to become effective November 5th 2019. As of the writing of this article, the online manuals themselves have not been updated. The change documents that contain the impending revisions are located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019-Transmittals.html by searching for Change Request 11454.

A 4th Manual was also revised by CMS and posted the same week. On October 23rd, CMS updated the 5-Star rating system and posted a revised manual to accommodate those changes. Here is a summary of the changes from that manual:

In October 2019, several changes will be made to the Nursing Home Compare website and the Five-Star Quality Rating System. These changes will affect the health inspection and quality measure domains. This section provides details on these changes.

Ratings changes for facilities that receive the abuse icon: To make it easier for consumers to identify facilities with instances of non-compliance related to abuse, starting in October 2019, CMS is adding an icon to highlight facilities that meet either of the following criteria:

1) Harm-level abuse citation in the most recent survey cycle: Facilities cited for abuse1 where residents were found to be harmed (Scope/Severity of G or higher) on the most recent standard survey or on a complaint survey within the past 12 months.

Point Ranges for the QM Ratings (as of October 2019)

QM Rating	Long-Stay QM Rating Thresholds	Short-Stay QM Rating Thresholds	Overall QM Rating Thresholds
★	155–469	144-473	299–943
★★	470–564	474–567	944–1,132
★★★	565–644	568–653	1,133–1,298
★★★★	645–734	654–739	1,299–1,474
★★★★★	735–1,150	740 – 1,150	1,475–2,300

Note: the short-stay QM rating thresholds are based on the adjusted scores (after applying the factor of 1,150/800 to the unadjusted scores)

Continued on page 6

PDPM continued from page 5

2) Repeat abuse citations: Facilities cited for abuse where residents were found to be potentially harmed (Scope/Severity of D or higher) on the most recent standard survey or on a complaint survey within the past 12 months and on the previous (i.e., second most recent) standard survey or on a complaint survey in the prior 12 months (i.e., from 12 to 24 months ago).

Nursing homes that receive the abuse icon will have their health inspection rating capped at a maximum of two stars. Due to the methodology used to calculate the overall rating, the best overall quality rating a facility that has received the abuse icon can have is four stars.

Removal of quality measures related to pain: CMS will be removing two quality measures (QMs) from the Nursing Home Compare website and the Five-Star Quality Rating System in October 2019. These measures are:

- *Percentage of short-stay residents who report moderate to severe pain.*
- *Percentage of long-stay residents who report moderate to severe pain.*

As a result of dropping these two measures, the cut-points for the long-stay, short-stay, and overall QM ratings will change starting in October. These changes will be made to maintain, as close as possible, the same distribution of short-stay and long-stay QM ratings as were posted on Nursing Home Compare in July 2019. The new cut-points are shown in the table below. Note that this table will replace Table 6 in the Technical Users' Guide (TUG) starting after these changes are implemented in October 2019.

Providers should download each of these revised documents and familiarize themselves with the changes. One thing is for sure, there is never a dull moment. Truly the only constant with CMS lately is change.

We would love to Chat. Visit us at www.broadriverrehab.com or call us at 800.596.7234. Do you have a tough PDPM related question?

Ask an expert at https://www.broadriverrehab.com/expert/

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FIND THE WORDS

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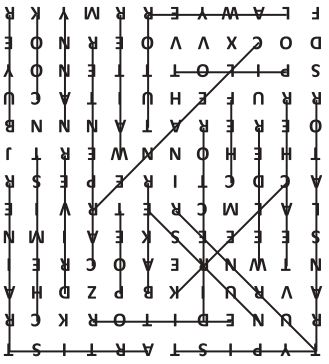

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