

Part 624 Handbook History

- Part 624 was originally promulgated In February, 1996.
- Interpretative Guidelines (The Part 624 manual) were developed at that time.

Part 624 Handbook History

- Memoranda interpreting the regulations and updating the Handbook were periodically issued.
- The next major revision of the Handbook was issued in June, 2005. The revision encompassed all interpretations since the original issuance.

Part 624 Handbook History

- Numerous regulatory and statutory changes have occurred since 2005 and periodic memoranda were issued as changes occurred.
- The enactment of Jonathan's Law necessitated major changes to the interpretations in the Handbook and caused a need for a major revision.

Changes to the Part 624 Handbook Who made the changes?

- The Statewide Standing Committee on Incident Review (SCIR) is comprised of representatives from OMRDD Central Office/DDSOs and Voluntary Providers.
- The members are appointed by the Commissioner.
- SCIR is charged with the responsibility to provide policy guidance and technical assistance in all matters concerning Incident Management.

***Changes to the Part 624 Handbook
Who made the changes?***

- SCIR meets on a monthly basis as well as interactions via e-mail and telephone.
- All proposals for changes to regulation or the Handbook are discussed by the committee and voted upon.
- Changes are reviewed by OMRDD Senior Management and by OMRDD Counsel.
- Regulatory changes are subjected to the regulatory review process.

What are the Major Changes?

- Guidance in incorporating the provisions of Jonathan's Law.
- Guidance in deciding when an injury requires an incident report to be submitted.
- Extensive revisions in guidance relative to allegations of abuse and neglect.
- Guidance on investigations of deaths.

Major Changes

- Guidance on agency responsibility in allegations of familial abuse for adults and the role of Protective Services for Adults (PSA).

***Changes to the Part 624 Handbook
Injuries***

- Not all injuries require a 147.
- Injuries REQUIRING medical/dental treatment (Beyond First Aid) are Reportable Incidents
- Injuries REQUIRING admission to a hospital, are Serious Reportable Incidents (Must be reported to DDSO).
- The use of OTC drugs for an injury, does NOT make it a reportable incident.

Changes to the Part 624 Handbook Injuries

- Administration of a Tetanus booster does NOT make it a reportable incident.
- Diagnostic procedures ordered by a practitioner does NOT make it a reportable incident UNLESS treatment beyond first aid is required.
- Reportable and Serious Reportable injuries require telephone notice to the Parent, Guardian, Spouse, Adult Child or Correspondent or the CAB (For Willowbrook Class members)

Changes to the Part 624 Handbook Injuries

- Injuries of unknown origin should NOT be automatically reported as Allegations of Abuse.
- An annual trend analysis of injuries of unknown origin is required.
- NOTE: Part 633.10(a)(4) requires that Parent/Guardian or Correspondent/Advocate be notified of admission to hospital or ED treatment.

Changes to the Part 624 Handbook Medication Error

- Humans Make Mistakes!
- A mistake is not necessarily a medication error (In relation to Part 624.).
- Part 624 defines Medication Errors as conditions where a person evidences MARKED ADVERSE EFFECTS or their health and welfare is in JEOPARDY.
- Part 624 is NOT intended to capture all errors on the part of staff. Errors not causing jeopardy or marked adverse effects should be dealt with administratively.

Changes to the Part 624 Handbook ABUSE

- There is new guidance on Psychological Abuse.
- Abuse is not to be used as a “catch-all” category, or for Personnel issues.
- The mere presence of individuals, when staff may be arguing or using inappropriate language, does NOT constitute Psychological Abuse.
- For an allegation of Psychological Abuse, there should be evidence that the individual(s) were adversely affected by the staff action

Changes to Part 624 Handbook Restraint

- Manual Supports (Physical holding) at the direction of a Practitioner to facilitate a medical procedure do not constitute restraint.
- Mechanical Supports (Devices) used at the direction of a Practitioner to facilitate a medical procedure/treatment do not constitute restraint.
- Supports to be used should be incorporated into the individual's program plan.
- Devices used to ensure safety (Seat belts, helmets for seizures, etc) do not constitute restraint.

Changes to the Part 624 Handbook Restraint

- The use of Pre-Sedation to facilitate a medical/dental procedure does not constitute restraint.
- There must be documentation that behavioral approaches have been attempted or considered.

Changes to the 624 Handbook Neglect

- There is a large amount of additional guidance on Neglect;
- Neglect is the result of:
 - A gross error in judgment; or
 - A pattern of failure to provide appropriate services, treatment or care; or
 - An egregious failure to provide a person with a needed service or a safe environment.

Changes to the 624 Handbook Neglect

- Neglect is generally regarded as a "Condition of Deprivation" and is generally not a one-time occurrence.
- However, a one time occurrence which is "Egregious" may require an allegation of neglect.
- Administrators need to make decisions as to whether a staff failure should be handled as a personnel issue or an allegation of neglect.

Changes to the Part 624 Handbook Neglect

- To make a neglect allegation, administrators should consider whether the physical or emotional well being of the individual was endangered.
- A neglect allegation should NOT be used to bolster a possible personnel action.
- Many issues characterized as neglect should, more appropriately be dealt with administratively.

Additional Changes

- Although we have highlighted the major revisions, there are many additional changes throughout the Handbook and you should familiarize yourself with them.

Finding the 624 Handbook

- The revised Handbook and a cover memo are available on the OMRDD website (www.omr.state.ny.us).
 - Look under “News & publications” and then under “Manuals” or
 - access the document directly using this link: http://www.omr.state.ny.us/hp_part624_index.jsp
- For additional guidance, call your DDSO Incident Coordinator or DQM.

Technical Assistance

- SCIR answers questions from the field. The E-Mail address is: SCIR@OMR.STATE.NY.US
- You may also contact your DDSO Incident Coordinator or the DQM Regional Office for assistance

Questions?



Updates

Nursing Orders



What is a Nursing Order?

- A nursing order is direction written by an RN for others to follow
 - In OMRDD most typically DCS and LPNs
- Through critical thinking, the RN makes sound conclusions for the prevention, reduction or elimination of potential or actual health issues

Nursing orders

- RN thoroughly
 - assesses the situation,
 - selects appropriate interventions to ensure the quality of care provided to the individual
 - Determines interventions to be used
 - Writes orders to communicate the intervention to be used
 - Periodically evaluates the situation, and revises orders as appropriate.

Nursing Orders

- For each possible intervention, the RN must assess:
 - benefits,
 - risks and
 - consequences the intervention
- The RN selects the intervention that is most likely to be effective with the minimum of risk

Elements of a Nursing Order

- To ensure a good nursing order, the following elements must be included:
 - order date,
 - action verb,
 - detailed description,
 - time frame and
 - signature
- EG: April 16, 2010: If lips are dry and/or cracked, apply Blistex cream 1% to lips after shower, after each meal and before going outside. *Kathleen Keating, RN, MSN*



Application of Heat and Cold



Application of Heat and Cold

- Application of either heat or cold should be recommended by a health care provider.
- Need very specific parameters
 - s/s that indicate use of heat/cold
 - Length of application
 - Frequency of application
- Do not apply over creams/ointments unless specifically ordered to do so.

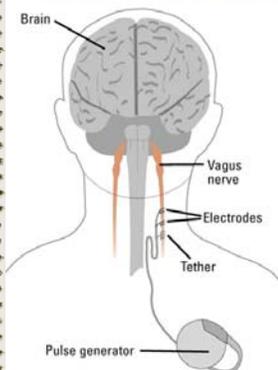
Application of Heat and Cold

- Do not put people to bed at night with heat/cold in place.
- Cold compresses must be kept away from the skin by a barrier such as a pillow cover, linen towel etc.
 - Do not use terry towels as they absorb the cold

Vagal Nerve Stimulators



VAGAL NERVE STIMULATOR



A pulse generator is implanted on the left side of the chest, and a lead connects it to a tether and two electrodes that coil around the vagus nerve. The VNS generates an electrical pulse that stimulates the vagus nerve. The pulse prevents the abnormal electrical activity that causes a seizure and patients are able to activate the VNS when they feel a seizure coming on.

VNS Stimulation

- Programmed by neurologist to fire at a strength and timing determined by each person's needs
- Also activated by an external magnet to interrupt or prevent seizures



Who can “wave the magnet”?

- Discussed with the State Board for Nursing
- Opinion:
 - VNS critical to the welfare of some people with seizures
 - Unlicensed staff in both certified and non-certified sites can be educated to activate the VNS via an external magnet.

VNS stimulation

- OMRDD expectations:
 - Staff must be trained by an RN on
 - Individual's seizure pattern
 - point at which VNS will be activated
 - How to activate
 - RN will write a plan of nursing service to include details listed above plus:
 - Other instructions given by the prescriber
 - When to call 911

Questions?



*QUESTIONS / TECHNICAL
ASSISTANCE*

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