olic Charities Disabilities Services	
Standard and Procedure	
Residential	
Obtaining a Clinical Evaluation Following Changes to an Individual's Functional Ability	
06/14/2013	
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Standard:

Changes in an individual's typical functional ability as recognized by staff must be immediately evaluated. All necessary actions up to and including alterations to the individual's plan of care will be taken following a defined protocol.

Procedure:

- 1. In the event of a medical emergency staff should:
 - Call 911 and follow all directions given by the dispatcher.
 - Stay with the individual until EMS arrives.
 - When EMS arrives, they are in control of the situation and staff should only assist as requested.
 - As soon as possible, staff must contact the house RN and supervisory staff. If it is before 8:00 am, after 4:00 pm, on a weekend, or on a holiday, staff must call the On-Call Nursing Service and the Administrator On-Call.
 - Any medical emergency must be documented in a T-Log and GER.
- If staff notices a change in an individual's typical functional ability, the staff member will notify supervisory staff and the residential RN. This staff member will also document the perceived change and how supervisory staff and the residential RN were notified in a T-log.
- 3. The residential RN will review the T-log and follow-up with an initial evaluation as to whether or not the staff person's observation is accurate and whether or not further review is necessary. The results of the evaluation and any recommendations for further review will be documented in a T-log. Supervisory staff may also participate in the evaluation with the residential RN or complete their own observation and document their observation in a T-log.

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- 4. If the residential RN determines no further action is necessary, the supervisory staff or residential RN will inform the staff member either in person or through electronic communication.
- 5. If the residential RN determines that a clinical evaluation is warranted, the residential RN or Clinical Specialist will contact the Individual's Primary Care Physician for a referral to the appropriate clinical discipline and schedule the appointment. The referral being made and the scheduled appointment will be documented in T-logs.
- 6. Once the residential RN receives the results of the evaluation, the results of the evaluation and any recommendations for changes to the individual's plan of care will be documented in a T-log and the treatment team will be notified. The treatment team will either meet or discuss via e-mail the changes that have been proposed for the Individual's plan of care and update the plan as necessary.
- 7. When the changes are made to the plan of care the appropriate person (Director of Residential, Regional Program Manager, Program Manager, Shift/Site Supervisor, or RN) will note the change in a T-log to inform program staff, and ensure that staff receive the necessary training in the new plan of care.
- 8. If the treatment disagrees with the recommendation the Individual's treatment team will discuss further options such as seeking a second opinion.

Non-Emergency Medical Injury/Illness Requiring Immediate Attention

- 1. If between 8:00 am and 4:00 pm Monday Friday, call the residential RN, on a weekend, or holiday, call the On-Call Nursing Service, and describe the medical situation and any relevant history.
- 2. When calling the On-Call Nursing Service, have the MAR available for any questions about medications, dosages and times given.
- Follow the instructions given by the RN. If the RN recommends the individual be evaluated at the emergency room, staff should immediately call 911 and notify Administration On-Call, IRA On-Call, and/or the family needs to be notified, it should be determined who will make those calls.
- 4. The medical injury/illness should then be documented in a T-log and GER if deemed necessary by the RN.