This update will address a number of questions that we have received in the past few months pertaining to when an RCFE must call 9-1-1.

**Question:** Can an RCFE allow a family member to take a resident to the hospital in lieu of calling 9-1-1?

**Answer:** It depends on the specifics. Title 22, Section 87465(g) states as follows: “The licensee shall immediately telephone 9-1-1 if an injury or other circumstance has resulted in an imminent threat to a resident’s health, including, but not limited to, an apparent life-threatening medical crisis except as specified in Section 87469(c)(2) or (c)(3) [which pertain to honoring DNRS as discussed below].” Not every instance in which a resident needs to go to the hospital involves an imminent threat to the resident’s health such as a life threatening emergency. Obviously, if a resident, for example, is bleeding profusely, sustains a serious head injury or appears to be having a heart attack, 9-1-1 must be called [subject to the exceptions discussed below]. On the other hand, if a resident has a condition or injury which is less serious, it may be appropriate to use other means to get the resident needed medical attention, including the use of a non-emergency ambulance service or having a staff member or relative take the resident to the hospital (or his/her physician or an urgent care center).

It is difficult to give precise direction here, as each situation is unique. We had one client receive a deficiency citation for not calling 9-1-1 where a resident fell and sustained a hip injury. Instead of calling 9-1-1, the RCFE ordered a mobile x-ray which revealed a fracture. The resident was then taken to the hospital and admitted as an inpatient. On appeal, we demonstrated that the use of the mobile x-ray (which was ordered by the resident’s physician who was called immediately) was a better response than calling 9-1-1. The resident in question had severe dementia and subjecting him to a hospital emergency room was not conducive to his well being. We also argued that the time it took to have the mobile unit come out and x-ray him was likely significantly less than the time he would have spent awaiting x-rays in the emergency room. We also noted that the injury in question was not life threatening and that it was not necessary to have paramedics immediately on the scene. Our appeal was granted.

**Question:** If a resident has a DNR, do we still have to call 9-1-1?

**Answer:** It depends on the specifics. Regulation Section 87469(c) states that if an RCFE resident has a DNR, the RCFE must call 9-1-1 and present the DNR to the paramedics unless (a) the RCFE has an established written policy pertaining to honoring DNRS and the DNR is handed to a licensed physician, RN or LVN who is in the resident’s presence at the time of the emergency and assumes responsibility for the resident; or (b) the resident is on hospice as discussed below. Most RCFEs do not have nurses on duty around the clock. This makes it difficult to implement a policy of honoring DNRS as the policy would have to vary depending on whether there was a nurse on duty and readily available to attend to a resident experiencing an emergency (and willing to assume responsibility for that resident). Therefore, most RCFEs (even including those that have round the clock nurses on duty) adhere to the policy of calling 9-1-1 in the event of a life threatening emergency, even if the resident has a DNR and there is a nurse in the building at the time of the emergency. Nevertheless, an RCFE that has nurses on staff could implement a policy of not calling 9-1-1 as long as the specific requirements of Section 87469 were followed.

**Question:** If a resident is on hospice, we don’t have to call 9-1-1, right?

**Answer:** While this is generally true (and you may discern a pattern emerging here), it depends on the specifics. Health and Safety Code Section 1569.73(c) states that an RCFE that has a hospice waiver “need not call emergency response services at the time of a life-threatening emergency if the hospice agency is notified instead” and specified conditions are met. Among the conditions are that the RCFE has documented that “facility staff have received training from the hospice agency on the expected course of the resident’s illness and the symptoms of impending death.” DSS has interpreted the foregoing to mean that if there is an emergency that is not related to the normal course of death given the resident’s illness, an RCFE must call 9-1-1 even if the resident is on hospice. Thus, for example, if a resident who was dying of cancer fell and was bleeding profusely from her head, it is the position of DSS that 9-1-1 must be called. DSS has cited providers for calling the hospice agency rather than 9-1-1 under such circumstances.

**Question:** Can we use an alternative emergency response system in a life threatening emergency or do we have to call 9-1-1?

**Answer:** As noted above, Regulation Section 87465(g) specifically requires that an RCFE call 9-1-1. On its face, the regulation does not permit a provider to utilize an alternative...
emergency transportation service where there is an imminent threat to a resident’s health. Thus, unless there is a waiver in place, 9-1-1 would have to be utilized in these circumstances. We know of at least one situation in which DSS did grant a waiver to an alternative ambulance company. A Sacramento area ambulance company developed a special training program for its paramedics which focused on responding to emergencies involving the frail elderly, including how to deal with those with dementia. The company was able to demonstrate that its response times within the approved geographic area were comparable to those of 9-1-1 and otherwise satisfied DSS that the needs of RCFE residents would be adequately protected. DSS then granted waivers to a number of RCFEs that submitted formal requests to utilize this alternative emergency responder. Absent such a waiver, however, RCFEs must call 9-1-1 where there is an imminent threat to a resident’s health.

**State Budget Update**

Still no state budget as of press time, despite the June 15 Constitutional deadline. What will we see when we do get a budget? That’s up for debate, but what we unfortunately won’t see is more inspections by CCLD. Earlier in the process, the Legislature rejected CCLD’s proposal to adopt an inspection protocol that would enable LPAs to inspect every facility on an annual basis. The proposed “compliance assessment protocol” would look at key indicators of compliance and include on-site inspection each year. Complaint investigations would continue. Apparently, anything less than a comprehensive inspection was seen as a lesser degree of protection, even if it only happens once every five years. To CALA, any type of annual on-site inspection provides more oversight than the status quo that has CCLD making only 52% of the required random sample inspections and a projected increase in the backlog of five year safety net inspections.

CCLD is continuing to develop and test the proposed protocol and work with their counterparts in other states who currently use similar systems. In the meantime, unfortunately, CCLD will also continue to fail to meet the current statutory inspection schedule.

CALA supported the CCLD proposal and is committed to ensuring a strong and regular CCLD presence in licensed communities. CALA has launched its own **Comprehensive Compliance Audit** as a way members can demonstrate compliance in absence of regular CCLD inspections. You can learn more about this new program at the CALA website, under Tools and Information on the homepage.

**POLST, con’t from page 1**

A recent study has found that patients with a completed POLST form available to health care providers are 59% less likely to receive unwanted treatments, according to the Coalition for Compassionate Care. Data like this suggests that a completed POLST form does help in communicating a patient’s wishes.

**THE CHALLENGE FOR ASSISTED LIVING**

CALA fully supports the use of POLST, and did participate in the development of the form in addition to supporting the passage of AB 3000, the POLST legislation. One of the challenges of using POLST in Assisted Living is helping residents understand how their choices may affect their ability to stay in Assisted Living. Some of the care options available on a POLST form exceed the care that may be provided in Assisted Living. Nothing in POLST expands an Assisted Living community’s scope of services. If the resident’s needs cannot be met at the community in accordance with the regulatory and statutory requirements, the resident will need to be relocated. It is important that residents understand what care options may make transferring out of their community necessary.

**MORE INFORMATION**

The Coalition for Compassionate Care of California is an excellent resource for further information about POLST. Visit their website at **www.finalchoices.org** for more information, and to answer any further questions about POLST. You can access informational pamphlets designed for providers and information pamphlets designed for patients. Copies of the form itself can also be accessed there. In addition, CALA, along with the Coalition for Compassionate Care, has developed a Q&A sheet specifically for Assisted Living providers which can be accessed at CALA’s website at **www.CAassistedliving.org** on the Operational Resources page.

**LPAs Receive Hospice Training**

CALA and the California Hospice and Palliative Care Association (CHAPCA) developed a hospice presentation for the LPA gerontology training provided through California State University, Sacramento. The training focuses on the role of hospice and how it works in the Assisted Living setting. It was delivered for the first time this past June and will be part of the training going forward.

Thank you to Eric Hostetter, PremieraCare, for his role in developing the curriculum and joining two hospice provider colleagues in delivering the training.