

DANE COUNTY DEPARTMENT OF HUMAN SERVICES LONG TERM SUPPORT

2010 AFH SPECIALIZED SERVICES QUESTIONNAIRE

This questionnaire should be completed by each AFH contracting with Dane County to serve residents funded by the Community Options Program and MA Waiver. Homes may submit policy and procedure statements to answer some or all of the questions. Additional relevant information is welcome.

Please return completed forms to: South Madison Coalition of the Elderly, Attn: Sharon Larson, 128 E. Olin Avenue, Madison 53713. To receive and complete this questionnaire electronically, send an email to larson@smcelder.com. Thank you!

General Information:

AFH Name:

AFH Address:

Owner/Administrator:

Owner/Administrator's e-mail address:

AFH Phone Number:

AFH Fax Number:

:

Target Population(s) Served:

Number of beds:

Do you accept residents who are: Male Female Both

Is the AFH: Licensed or Certified

Name/title of person completing form _____

Date completed _____

Specialized Health Services:

Are you able to work with the following issues:	Yes	No
Hoyer Lifts	<input type="checkbox"/>	<input type="checkbox"/>
Insulin	<input type="checkbox"/>	<input type="checkbox"/>
Sliding Scale Insulin	<input type="checkbox"/>	<input type="checkbox"/>
Tube Feeding	<input type="checkbox"/>	<input type="checkbox"/>
Catheters	<input type="checkbox"/>	<input type="checkbox"/>
Bladder incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness Diagnosis/Behaviors	<input type="checkbox"/>	<input type="checkbox"/>
End of life care with Hospice support	<input type="checkbox"/>	<input type="checkbox"/>

Staff:

Do you have:	Yes	No
Awake staff at night?	<input type="checkbox"/>	<input type="checkbox"/>
Access to a Registered Nurse?	<input type="checkbox"/>	<input type="checkbox"/>
Licensed Practical Nurse?	<input type="checkbox"/>	<input type="checkbox"/>

Miscellaneous:

	Yes	No
Do you admit residents who smoke? If yes, is there a smoking room within the facility?	<input type="checkbox"/>	<input type="checkbox"/>
Do you transport and accompany residents to medical appointments?	<input type="checkbox"/>	<input type="checkbox"/>

Admission Policy and Procedures:

1. Please enclose a copy of any written materials about your home which you provide to prospective residents and family members. ***Please include a copy of your Program Statement.***
2. What factors do you consider when determining whether or not a resident is appropriate for your home upon initial assessment?
3. Do you have specific criteria by which you will know immediately that a prospective resident would not be appropriate for your home (specific health issues, behaviors, etc)?

4. How do you gather information about a potential resident's personal preferences, daily routine, likes/dislikes, interests, etc upon admission? ***Please include a copy of social history forms, personal preference forms, etc. used in the admission process.***

Health/Medical Policy and Procedures:

1. Please provide a copy of any written policies or procedures that you have related to the following:
- Identifying and responding to health status changes/changes in condition (Please include any tracking tools utilized to monitor health issues such as blood pressures, weights, blood sugar reading, behaviors, etc)
 - Identifying and responding to health emergencies
 - Process for responding when a resident falls
 - Incident Reports

If there are not written policies related to each of these areas, please provide a written description below:

2. Is the pharmacy your facility utilizes available on-call to provide/deliver medications on weekends and/or evenings?
- Yes No

If not, what back up plan is in place to ensure residents receive medications on weekends and/or evenings?

3. Do you utilize a formal falls risk assessment?
- Yes No

- | If yes, when is the tool utilized? | Yes | No |
|------------------------------------|--------------------------|--------------------------|
| • Upon Admission | <input type="checkbox"/> | <input type="checkbox"/> |
| • At the annual ISP Review | <input type="checkbox"/> | <input type="checkbox"/> |
| • After a fall | <input type="checkbox"/> | <input type="checkbox"/> |

Please include a copy of any fall risk assessment tool you are using.

Specialized Training:

1. Do you and/or your staff receive specialized training in providing care to persons with Alzheimer's disease and/or other related dementias?

Yes No

If yes, who provides the training and how often is the training offered?

2. Do you and/or your staff receive specialized training in providing care to persons with mental illnesses such as depression, anxiety, bi-polar disorder, etc?

Yes No

If yes, who provides the training and how often is the training provided?

3. Do you and/or your staff receive specialized training in working with persons who may exhibit challenging behaviors related to mental illness and/or dementia?

Yes No

If yes, who provides the training and how often is it provided?

4. The Assisted Living Quality Program offers free training opportunities for assisted living staff several times each year. Are there any specific areas of training that you would like to see offered?

THANK YOU FOR COMPLETING THIS FORM!