144A.4795

Subd. 7, paragraph (b)

(1) Documentation requirements for all services provided.

- Sign-in sheet, time sheet, maintenance request, supply request, notes from nurse, resident observation record, blood sugar record, blood pressure record, medication error, incident report.

(2) Reports of changes in the client's condition to the supervisor designated by the home care provider.

- Report to RN when you notice any unusual change in physical and/or behavioral condition of clients.
- Check vital sign (body temperature, blood pressure, pulse, and breathing rate) and report them to RN.
- When blood glucose is 300 and over, report to RN (RN will contact and get direction from doctor if needed)
- When blood pressure is over 160/90, wait 10 minutes and measure it again. If it is still high, report to RN.
- Report to RN if there is any incident (such as fall) or medication error.
- Report to RN if you find new injury and/or bruise.
- Report to RN if a client has no bowel movement for 3 days or more.
- Report to RN if there are only few medical supplies such as blood glucose measurement strips, needles, insulin, pull ups, and diapers.
- Call 911 if the client is not breathing, has no pulse, has obvious external injury, suicidal behavior and any other situation which might cause harm to clients.
- If you can't decide if it is an emergency situation or not, call RN and ask about it.
- If you can't reach RN, call 911.

(3) Basic infection control, including blood-borne pathogens.

Every year, lives are lost because of the spread of infections in hospitals. Health care workers can take steps to prevent the spread of infectious diseases. These steps are part of infection control.

Proper hand washing is the most effective way to prevent the spread of infections in hospitals. If you are a patient, don't be afraid to remind friends, family and health care providers to wash their hands before getting close to you.

Other steps health care workers can take include

- Covering coughs and sneezes
- Staying up-to-date with immunizations
- Using gloves, masks and protective clothing
- Making tissues and hand cleaners available
- Following hospital guidelines when dealing with blood or contaminated items

Infectious diseases are caused by microscopic organisms that penetrate the body's natural barriers and multiply to create symptoms that can range from mild to deadly. Although progress has been made to eradicate or control many infectious diseases, humankind remains vulnerable to a wide array of new and resurgent organisms.

Obstacles in Infection Treatment

- New, potentially dangerous bacteria, viruses, fungi and parasites such as severe acute respiratory syndrome (SARS) emerge every year.
- Previously recognized pathogens can evolve to become resistant to available antibiotics and other treatments.
- Population crowding and easy travel also make us more vulnerable to the spread of infectious agents.
- Recent concerns about bioterrorism have focused new attention on eradicated or rare infectious diseases such as smallpox and anthrax.

Types of Infection

Some infections, such as measles, malaria, HIV and yellow fever, affect the entire body. Other infections affect only one organ or system of the body. The most frequent local infections, including the common cold, occur in the upper respiratory tract. A serious and usually local infection of the respiratory tract is tuberculosis, which is a problem worldwide.

Other common sites of infection include the digestive tract, the lungs, the reproductive and urinary tracts, the eyes or ears. Local infections can cause serious illnesses if they affect vital organs such as the heart, brain or liver. They also can spread through the blood stream to cause widespread symptoms.

The outcome of any infection depends on the virulence of infectious agents, the number of organisms in the infecting inoculum and the response of the immune system. A compromised immune system, which can result from diseases such as AIDS or treatment of diseases such as cancer, may allow organisms that are ordinarily harmless to proliferate and cause life-threatening illness.

Modes of Infection

Common ways in which infectious agents enter the body are through skin contact, inhalation of airborne microbes, ingestion of contaminated food or water, bites from vectors such as ticks or mosquitoes that carry and transmit organisms, sexual contact and transmission from mothers to their unborn children via the birth canal and placenta.

Prevention and Treatment

Immunization
Modern vaccines are among our most effective strategies to prevent disease. Many devastating diseases can now be prevented through appropriate immunization programs. In the United States, it is recommended that all children be vaccinated against diphtheria, pertussis (whooping cough), tetanus, polio, measles, rubella (German measles), mumps, Haemophilus influenza type B (a common cause of pneumonia and meningitis in infants), hepatitis B, varicella (chickenpox) and influenza.
Travelers to foreign countries may require vaccinations against yellow fever, cholera, typhoid fever or hepatitis A or B.

Public Health Measures
Measures that assure clean water supplies, adequate sewage treatment, and sanitary handling of food and milk also are important to control the spread of infectious disease.

Surveillance
The fight against infectious diseases requires worldwide surveillance by physicians, scientists and public health officials who gather information on communicable diseases, report new or resurgent outbreaks of disease, and develop standards and guidelines for treating and controlling disease.

Treatment
The development of antibiotics and other antimicrobials has played an important role in the fight against infectious diseases, but some microorganisms develop resistance to the drugs used against them. Modern physicians must prescribe antibiotics carefully, and research and development of new drugs is needed. The more widely antibiotics and antivirals are used, the more likely it is that antimicrobial-resistant strains of microorganisms will emerge.

What are bloodborne pathogens?

Bloodborne pathogens are infectious microorganisms in human blood that can cause disease in humans. These pathogens include, but are not limited to, hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV). Needlesticks and other sharps-related injuries may expose workers to bloodborne pathogens. Workers in many occupations, including first responders, housekeeping personnel in some industries, nurses and other healthcare personnel, all may be at risk for exposure to bloodborne pathogens.

What can be done to control exposure to bloodborne pathogens?

In order to reduce or eliminate the hazards of occupational exposure to bloodborne pathogens, an employer must implement an exposure control plan for the worksite with details on employee protection measures. The plan must also describe how an employer will use engineering and work practice controls, personal protective clothing and equipment, employee training, medical surveillance, hepatitis B vaccinations, and other provisions as required by OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030). Engineering controls are the primary means of eliminating or minimizing employee exposure and include the use of safer medical devices, such as needleless devices, shielded needle devices, and plastic capillary tubes.

(4) Maintenance of a clean and safe environment

- A clean, safe, and healthy environment is essential to achieve health care objectives. In hospitals, clinics, skilled nursing facilities, and home care providers, great care is taken to ensure that the surroundings are clean and safe.

CLEANING

Cleaning Appliances

- Dishwasher: Clean exterior and interior
- Freezer: Wipe inner surface with a damp cloth. Check for outdated food and dispose.
- Refrigerator: Clean inside and outside with soft wet cloth and mild soap or baking soda. Check for spoiled food and dispose.
- Garbage disposal: Run cold water during use and for one minute after. Oranges, lemons, and ice can be used to maintain freshness.
- Microwave oven: Wipe with wet cloth and soap. Rinse and wipe dry.
- Stove/oven: Wipe up spills and grease immediately. Clean oven with vinegar in water to remove grit.
- Washing machine: Wipe exterior and interior with soft wet cloth. Clean lint filter.
- Dryer: Clean lint filter. A heavy build up of lint can catch fire.

Dishwashing

- Rinse with hot water and allow to air dry.

Bathroom

- Wear gloves.
- Clean from cleanest areas to dirtiest (toilet is considered the dirtiest).
- Clean sink, countertops, and shower/tub with disinfectant.
- Use a brush to clean the toilet, and brush under the rim.

Floors
- Use a clean mop and change mop water frequently. Flush dirty water down toilet.
- Carpets: Vacuum frequently. Be sure the bag does not get overfilled. To remove stains, a carpet stain remover like Spot Shot works well.

Trash Removal
- Empty trash on a daily basis to decrease mold and bacterial growth.

- Rinse out and clean household trash containers with a bleach solution on a regular basis.

Bed Making

- Place clean linens near the bed.
- Strip the bed gently to avoid spreading pathogens into the air.
- Take soiled linens to bathroom or laundry.
- IF you have linens that are soiled with body fluids (feces, urine, vomit):
  - Put on gloves before handling soiled linens.
  - Put linens in a plastic bag (NOT THE FLOOR) and take them to the bathroom.
  - Rinse the large solids out in the toilet and place the soiled linens back in the plastic bag.
  - Launder immediately, using bleach if linens are white. If the sheets are colored, make sure they are dried completely in the dryer (the heat is as effective as bleach in killing the bacteria).

SAFETY

• Practice safety at all times.

• Think safety for both you and your employer.

• Take the time to do it right.

• Keep quick access to a phone to call 911

• Use gloves and personal protective equipment when handling chemical, blood or body fluids/substances.

• Follow the Task List and any other instructions carefully.

• Lift safely.

• Use utility ladders and step stools instead of chairs.

• Use gloves and good ventilation when working with household chemicals.

• Make sure smoke detectors are in place and are working.

• Use good lighting.

• Keep firearms and ammunition safe.

• Don't use broken equipment.

• Know your emergency evacuation escape routes and back-up plans.

• Ask for help if you have a hazard you can't resolve with your employer.

• Maintain a drug-free workplace.

(5) Appropriate and safe techniques in personal hygiene and grooming.

i) **Hair care and bathing**: Remove hairpin, don't pull the hair, use detangles.
ii) **Care of teeth, gums, and oral prosthetic devices**: Handle with care, assist when putting it on, use glove.
iii) **Care and use of hearing aids**: Keep it in a safe place. Protect from direct sunlight. Avoid direct contact with chemicals.
iv) **Dressing and assisting with toileting**: Select clothing that has front access. Select comfortable shoes with non-slip soles. Have all necessary clothing easily accessible.

TOILETING

- Set up the bathroom to make it as easy as possible for the person to get on to and off of the toilet, e.g. having a raised toilet seat and grab bars.

- Notice when the person gives a sign about needing to use the toilet, e.g. agitation, fidgeting, tugging on clothing, wandering, touching the genital area. Have a routine and take the person to the bathroom on a regular schedule, e.g. every two hours. You may have to respond quickly if someone indicates they need to use the bathroom.

- Some people have a regular schedule, especially for bowel movements. If this is so, remind the person to go to the bathroom at the usual time, e.g. right after breakfast.

- If the person needs help removing clothes, help him/her by moving slowly and encouraging him/her to help. Remind the person that they need to pull down their pants before sitting down. Clothes that are easy to remove will help, such as those with elastic waist bands.

- Don't rush the person; allow time for them to empty their bowel and bladder. It may take a little time to get started. Walk away and come back in a few minutes or stand just outside the door.

- Hand the person toilet paper to use as appropriate. You may need to help get the person started. Using wipes can sometimes be easier than toilet paper if you need to wipe for them.

- Assist as needed to pull pants back up. Sometimes the person will walk away without pulling pants up, which is a fall hazard. Provide as much privacy and modesty as possible.

- Put a sign, preferably with a picture, on the door to the bathroom. Keep the door to the bathroom open so the person can see the toilet.

- Use a commode or urinal by the bed at night so the person doesn't have to get up and walk to the bathroom, which increases the risk of falls and incontinence. Have a night light if the person does go to the bathroom at night. If a person has urgency when needing to urinate, a commode or urinal by the chair in the living room can also be helpful.

- Sometimes people reduce their fluid intake for fear of not making it to the bathroom. Dehydration can lead to other problems, including urinary tract infections. Make sure they stay hydrated by drinking throughout the day. However, limiting fluid at night might be helpful. Caffeine and alcohol can also increase urgency with urination.

- Using incontinence pads in the underwear might be a way to reassure someone that they don't have to rush or panic when they have the urge to urinate.

- Flower pots on the floor, wastebaskets, and other containers can be mistaken for a toilet. Remove them from the area the person stays in and from near the toilet. Keep the path to the bathroom clear of obstacles and clutter.

(6) Training on the prevention of falls for providers working with the elderly or individuals at risk of falls.
- Monitor clients when moving.
- Remove any objects from clients' path.
- Assess clients' frailness.
- Practice safe transfer skill.

(7) Standby assistance techniques and how to perform them.
- Standby assistance is used when the client is able to perform an activity independently, but needs assistance intermittently and as necessary. You should be ready to give the client assistance with balance and/or verbal cues.
- During stand-by assist, you do not touch clients or provide any assistance, but you may need to be close by for safety in case clients lose the balance or need help to maintain safety during the task being performed.

(8) Medication, exercise, and treatment reminders.

- Remind clients how to and when to take medication, perform exercise, and receive treatments.

(9) Basic nutrition, meal preparation, food safety, and assistance with eating.

Build a Healthy Eating Style

All food and beverage choices matter – focus on variety, amount, and nutrition.

- Focus on making healthy food and beverage choices from all five food groups including fruits, vegetables, grains, protein foods, and dairy to get the nutrients you need.
- Have clients eat the right amount of calories for them based on their age, sex, height, weight, and physical activity level.
- Building a healthier eating style can help clients avoid overweight and obesity and reduce their risk of diseases such as heart disease, diabetes, and cancer.

Choose an eating style low in saturated fat, sodium, and added sugars.

- Use Nutrition Facts labels and ingredient lists to find amounts of saturated fat, sodium, and added sugars in the foods and beverages you choose.
- Look for food and drink choices that are lower in saturated fat, sodium, and added sugar.
  - o Eating fewer calories from foods high in saturated fat and added sugars can help clients manage their calories and prevent overweight and obesity. Most of people eat too many foods that are high in saturated fat and added sugar.
  - o Eating foods with less sodium can reduce clients' risk of high blood pressure.

- Getting adequate nutrition can be a challenge as you get older. With age, the number of calories you need begins to decline. Every calorie you consume must be packed with nutrition in order to hit the mark.

- Even then, you may fall short. "As we get older, the body becomes less efficient at absorbing some key nutrients," says Katherine Tucker, RD, PhD, chair of the department of health sciences

at Northeastern University in Boston. In addition, the ability to taste food declines, blunting appetite. Some foods become difficult to chew or digest.

- Several key nutrients in particular may be in short supply as you get older. Here are the top vitamins and nutrients to look out for -- and how to get enough.

Vitamin B12

- B12 is important for creating red blood cells and DNA, and for maintaining healthy nerve function. "Getting enough B12 is a challenge for older people because they can't absorb it from food as well as younger people," says Tucker. "Even if your diet contains enough, you may be falling short."

- **How to hit the mark:** Eat more foods rich in B12. The richest sources include fish, meat, poultry, eggs, milk, and milk products. Talk to your doctor about whether you should take a B12 supplement.

Folate/Folic Acid

- You may have heard of folate. Too little of this essential B vitamin is known for contributing to anemia and increasing the risk of a pregnant woman having a baby with a neural tube defect. Older people whose diets don't include a lot of fruits and vegetables or fortified breakfast cereals may be falling short.

Calcium

- Calcium plays many roles in the body. But it is most important for building and maintaining strong bones. Unfortunately, surveys show that as we age, we consume less calcium in our diets. " Calcium is so essential that if you don't get enough, your body will leach it out of your bones," says Zelman. Coming up short on calcium has been shown to increase the risk of brittle bones and fractures.

FOOD SAFETY

Clean: Wash hands and surfaces often

Bacteria can be present throughout the kitchen, including on cutting boards, utensils, sponges and counter tops. Here's how to check your steps for food safety:
- Wash your hands with warm water and soap before and after handling food and after using the bathroom, changing diapers and handling pets.

- Wash your cutting boards, dishes, utensils and counter tops with hot water and soap after preparing each food item and before you go on to the next food. Periodically, kitchen sanitizers (including a solution of 1 tablespoon of unscented, liquid chlorine bleach to 1 gallon of water) can be used for added protection.

- Once cutting boards (including plastic, non-porous, acrylic and wooden boards) become excessively worn or develop hard-to-clean grooves, you should replace them.

- Consider using paper towels to clean up kitchen surfaces. If you use cloth towels, wash them often in the hot cycle of your washing machine.

- Also Important: Rinse raw produce in water. Don't use soap or other detergents. If necessary -- and appropriate -- use a small vegetable brush to remove surface dirt.

Separate: Don't cross-contaminate

Cross-contamination is the scientific word for how bacteria can be spread from one food product to another. This is especially true when handling raw meat, poultry and seafood, so keep these foods and their juices away from foods that aren't going to be cooked. Here's how to check your steps for food safety:

- Separate raw meat, poultry and seafood from other foods in your grocery-shopping cart and in your refrigerator.

- If possible, use a different cutting board for raw meat, poultry and seafood products.

- Always wash cutting boards, dishes and utensils with hot, soapy water after they come in contact with raw meat, poultry, seafood, eggs and unwashed fresh produce.

- Place cooked food on a clean plate. If you put cooked food on the unwashed plate that held raw food (like meat, poultry or seafood), bacteria from the raw food could contaminate your cooked food.

ASSISTANCE WITH EATING

The preferred seating position for mealtime is sitting in a dining room chair with armrests rather than sitting in a wheelchair. If an older adult can sit in a chair, the caregiver should assist with transferring if needed. If a person cannot sit in a dining room chair, a wheelchair is preferable to sitting in a geriatric chair or sitting in bed. Regardless of the type of chair, caregivers should pay attention to the posture of the person, looking at the alignment of the head, neck, trunk, and hips.

The following are factors to look for in proper positioning:

- The pelvis should be positioned in neutral, with a slight anterior tilt.

- The posture should be erect and symmetrical, with weight distributed equally on each hip.

- The head should be positioned in midline, with the chin slightly tucked.

- Both arms should have support available on a table or lap tray of appropriate height.

- The legs should be in a weight-bearing position, with hips and knees flexed at 80 to 90 degrees, ankles in neutral position under the knees, and the feet flat on the floor.
- A stool or wheelchair footrest should be used to provide a secure base of support if the person's feet do not touch the floor. Feet should never be left dangling; if the feet are unsupported, the body will slowly begin to slide down. In addition, the arms may be needed for support and therefore unavailable for eating.

Feeding in Bed

If feeding a person in bed is the only option, the head of the bed should be elevated to 45 degrees or more and a pillow may be placed behind the person's back to increase upright trunk posture and hip flexion. Some of the positioning devices that can aid a person in keeping an upright posture are:
- Padded solid back and solid seat inserts
- High-back wheelchairs to facilitate lumbar and thoracic support
- Wedges, lateral and forward trunk supports
- Headrests, pelvic belts, pillows, and towel rolls

Special Positioning Considerations

- If a person has a kyphotic posture (particularly in the thoracic region), caregivers should have the person lean back slightly so the chin is parallel to the floor.
- People with a hemiplegic arm should have the arm placed on the table, and the arm and hand should be incorporated as a stabilizer as much as possible during meals.
- Anyone with an amputated lower limb may need special postural adjustments to create a comfortable seating arrangement for mealtime.
- If edema is present, lower extremities may need to be elevated.

(10)   Preparation of modified diets as ordered by a licensed health professional.
- Prepare modified diets as ordered by RN.

Examples of modified diets

Clear Liquid

Liquids that are transparent at room temperature. This includes broth, gelatin, popsicles, and most beverages (juices without pulp and zero nectar). Dishes include Healthy & Healing broth.

Full Liquid

Anything that is liquid at room temperature. Clear liquid diet items plus milk, milk products, creamy style soups, and cooked cereals. Dishes include Daily Bisque Soup.

Regular

All foods allowed, no restrictions.

Soft

Restricts raw fruits, vegetables, and batter-fried foods.

Mechanical Soft

Restricts foods that are difficult to chew such as raw fruits, raw vegetables, and whole red meats. Chopped, well-cooked meats are allowed. Dishes include Turkey meatloaf, whitefish burger, veggie burgers.

Low Residue, Low Fiber

Restricts raw fruits, raw vegetables and whole grains. Limits dairy products.

Low Sodium

Restricts salt and limits foods with high salt content.

Cardiac

Limits foods high in cholesterol, saturated fat and salt.

Low Fat

Limits foods with high fat saturated and/or unsaturated fat content.

Renal

May limit total protein, dairy products, fluid intake, foods high in salt, potassium and phosphorus depending upon if the patient is pre-dialysis or dialysis.

Diabetic

Carbohydrate controlled at all meals.

(11)   Communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family.

Dignity and mental health care in practice

- Treat people with respect – as individuals and fellow human beings. Avoid labeling people because of their diagnosis or their association with any other group.
- Provide person-centered care and support – place the individual and their needs, preferences and aspirations at the centre of care. An ethos of person-centered care upholds the dignity both of people using services and of staff.
- Promote good practice in safeguarding – focus on prevention and make proportionate, person center responses to abuse.
- Adopt a recovery approach to mental health – in particular, help people sustain their personal identity and self-respect, which are both closely associated with the concept of dignity.
- Promote good communication – this demonstrates respect and maintains an individual's dignity. Good communication means enabling both professionals and service users to communicate. Professionals may be trained in the relevant attitudes and communication skills, but services users may need support with communication, particularly if they lack capacity.
- Tackle discrimination – through individual and local community initiatives, national programs, policy and legislative measures.
- Engage service users from black and minority ethnic groups – take active steps to engage people and ensure their views are recorded in their care plan.
- Adopt a human rights-based approach to mental health care – ensure that people's human rights are protected at a time when their capacity, autonomy, choice and control may be compromised under mental health legislation. Where someone has been deprived of their liberty under the Mental Health Act, offer them support to deal with any related trauma.
- Preserve autonomy, choice, control and independence – provide person-centered care and enable people to state their needs and preferences in advance of loss of capacity. Methods you can use include advance statements, crisis cards and life story resources for people with dementia.
- Improve the quality of care in inpatient settings – provide patient-centered care that is individualized, comprehensive and continuous; a range of therapeutic resources; a relaxed and secure atmosphere. See for example the Sainsbury Centre for Mental Health (2006).
- Promote a positive organizational ethos – from the top, encourage an ethos of respect and dignity (Carter, 2009). Include taking a person-centered approach to care and a zero tolerance of abuse.
- Provide training, clinical supervision and support – adopt measures to enable staff to examine their own attitudes and to feel supported in their role. This will encourage them to treat others with respect.
- Address environmental risks to dignity – provide single sex wards, privacy in personal care and use of bathroom facilities, clean facilities, adequate space and appropriate staffing levels.

(12)   Awareness of confidentiality and privacy.

Confidentiality refers to the duty to protect privileged information and to share entrusted information responsibly. It stems from the notion that a person's wishes, decisions, and personal information should be treated with respect. The duty of confidentiality can apply to individuals, organizations, and

institutions. In fields like medicine, the law, and counseling, there are explicit, professional obligations to keep personal information in confidence, because the trust is the foundation for meaningful professional relationships.

As a general rule, health care providers have a responsibility to avoid disclosing personal and medical information that has been entrusted to them without the patient's consent. In accordance with professional standards, when a patient's private information is shared, there is the expectation that health care providers will keep the information in confidence. This might include details pertaining to a patient's diagnosis, prognosis, history of illness, drug use, family history, and sexual activity.

Privacy refers to the right to be free from interference. Privacy is supposed to enable individuals to exert control over their own lives, which includes deciding who should have access to personal information, and when and how this information will be disclosed. Although there continues to be vigorous debate about whether the U.S. Constitution guarantees a right to privacy, the legal basis for the right to privacy typically stems from the Fourteenth Amendment. In Florida, the right of privacy is discussed within the state's constitution in Article I, Section 23.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that was created in part to protect information contained within the medical records of patients. One of the primary goals of HIPAA was to establish federal standards regulating how electronic data is transmitted and shared. In principle, storing medical records electronically can give physicians, insurance companies, and other parties easier access to these records, which raises concern that private information might be shared without the knowledge or consent of patients.

In most circumstances, under the revised HIPAA guidelines, health care providers are required to obtain a patient's consent before confidential information is shared with other parties. Depending on the situation, a physician's office may be required under HIPAA to provide written notice of privacy practices to the patient. This notice should include the rights that the person has as a patient and the measures that will be used to keep his/her personal and medical information private. HIPAA also regulates marketing practices in order to protect a patient's information from being sold and distributed to health plans, pharmacies, and drug companies without the patient's consent.

Although there remain disputes concerning what the concepts of privacy and confidentiality precisely entail, it is generally agreed that they are not absolute notions. The level of privacy that one can reasonably expect, for example, varies dramatically depending on the context. One's privacy can appreciably diminish when one discloses information in a public area. Medical information that a patient discusses with his/her physician while walking in a city park might be overheard by other individuals. Yet if this information is discussed while in a private office, it is more likely that privacy can be maintained.

Concerns of justice and of upholding the common good can sometimes supersede the duty to keep information confidential. In most circumstances, health care providers must obtain a patient's consent before sharing that patient's information with other parties. Yet there are rare circumstances, such as when a court order has been issued, wherein a physician may be legally obligated to disclose a patient's information without the patient's consent. Similarly, a physician might have a "duty to warn" the state if it is believed that a patient poses an obvious threat to other individuals. With regard to elderly patients, it is a fairly common problem that a physician treats an elderly individual who is unwilling to stop driving a car, but whose physical or mental capacity to do so may be compromised. This type of situation

illustrates the tension that may arise between the obligation to keep the patient's information in confidence and the obligation to prevent the patient from causing harm.

The importance of privacy and confidentiality to elderly patients should not be overlooked. Although health care teams, family, and friends might assume that these concepts are unimportant to an elderly patient, the patient might not agree. A competent patient should expect that information shared with a health care team will be kept confidential regardless of the patient's age. Further, if privacy is maintained, this might enable elderly patients to feel that they have an appreciable level of control over their own lives even when they are in the hospital. Health care teams should not, for example, automatically assume that an elderly patient wants family and friends in the hospital room when personal and medical information is being shared. The desire to maintain one's privacy does not necessarily decline with age.

(13)   Understanding appropriate boundaries between staff and clients and the client's family.

How to maintain professional boundaries in home and community care work

All formal working relationships need rapport and trust to function well. This is particularly relevant to the relationship between an individual and the person/s who are employed to provide them with home care – carers or support workers. It is certainly important that the carer makes sure client's feel at ease with approaching and relating to them – but it is equally important that the lines don't become blurred. This relationship between an individual and their carer, should never come at the expense of maintaining clear professional boundaries. Successful and ethical working relationships are based on a clear understanding of what the carers role is – and just as importantly – what their role isn't.   The work is personal – but carers have to maintain professional boundaries. These boundaries protect the worker from burn out – AND protect the client from having a staff member encroaching on their private affairs. So here are some guidelines for appropriate boundaries:

Staff should empower clients – not do everything for the clients

The support workers role is to assist clients to achieve their goals through guidance and encouragement – but not by doing all the work for them. When workers do things for a client that the client can do for themselves, they may be denying the individual the opportunity to learn and the satisfaction of completing a task. Everyone is capable of solutions and the support worker should not imply or try to enforce that their solution or way of doing this is the right / best way.

There is a line between work and home life for staff

Community Service workers can burn out very quickly – if they don't recognize where work ends and where personal life begins. Care staff should always respect working hours, and not work outside of these. This ensures the worker is taking care of themselves, and in turn being effective in their role. The client needs to

respect this line and refrain from wanting – or accepting any offers of – further contact with a staff member outside their rostered hours. This also includes the client or their family members having access to workers personal phone number.

Service Time is Not "Me" Time for Staff

The staff member's focus should always be – the client or individual they are providing a service to. In general it is not appropriate for staff to disclose information about their personal life / circumstances – and if they do it should only be to provide information that may help in addressing a client's needs. Staff should never use the time that they are providing a service as an opportunity to vent their feelings or discuss their problems. They should be listening…. not talking, so the focus remains on the person who is receiving the service. Service time is not a time to respond to text or email messages or to make those phone calls you've been meaning to make!

Don't Open Your Wallet or Ask a Staff member to open theirs

While this may seem obvious, it's very easy for this to happen, especially when someone is operating on good intentions – on both sides of the relationship. It is NEVER appropriate for a staff member to ask for money or suggest that they are having financial difficulties. This is a two way street – it is also never appropriate for a client to ask a staff member for money.
Don't offer to provide other Services to a Staff member or ask them to do this for you:
At times staff or a client may have other skills that they can provide on a commercial basis. It is inappropriate for either party to ask the other to perform or provide services for them – whether it be for free or for pay. This may represent a serious conflict of interest that could cost the staff member their job. It also limits opportunities for the client to pursue competitive employment and may be seen as favoritism.

Professional Behavior

Staff should never exhibit behavior that is unprofessional. Unprofessional behavior includes the subjects already mentioned here but may also include:
- Being late for shifts
- Asking you if they can leave a shift early or start later
- Not attending to the duties they are required to undertake
- Not treating the client with dignity and respect at all times
- Swearing, raising their voice
- Attending to personal errands whilst providing a service
- Spending unreasonable amounts of time on the phone whilst providing a service
- Inviting a client into their home during service time or outside of work hours
- Touch – from a worker should only ever be of a nature that is essential to the person's care
- Keeping information about a client from their employer
- Arriving for work under the influence of alcohol or drugs or consuming these whilst providing a service

- Sexual advances or misconduct
- Talking negatively about their employer or other staff that provide a service to the client
- Disclosing information about other clients or staff

The setting and maintaining of professional boundaries within a home and community care environment can seem almost unnatural or counter-intuitive – and that may be because it is!! BUT it is also absolutely critical, because it creates an environment of mutual respect and productivity AND it enables the support worker to 'support' the client more effectively in the long run. It also protects the client from a staff member being over involved in their personal life and potentially putting them at risk.

(14)   Procedures to utilize in handling various emergency situations.

Emergency Procedures

- Fire

1. In the event of a fire, staff shall follow these steps:

R = Rescue   C = Confine   A = Alert

1) Rescue resident - remove resident from hazard.

2) Stay calm, reassure resident.

3) Confine - close door if possible to confine fire in one area.

4) Evacuate resident and self immediately to closest exit.

5) Alert - Dial 911, state this is an emergency, if possible, give your name, address and telephone number where you are calling from, and describe the problem.

6) Follow directions of 911 dispatcher.

7) Plan and reevaluate escape plans and practice with residents monthly

2. Fire extinguishers are located at the disignated areas. These fire extinguishers are designated for use against small fires that have just started and are small enough to fight safely.

3. Do not attempt to fight a large fire by yourself.

4. Use fire extinguishers only when there is a clear escape path to allow you to get out safely if the fire gets worse.

5. To Use Fire Extinguisher:

1) Pull pin, hold unit upright,

2) Start back from the fire eight feet, aim at the base of the fire

3) Depress, push lever, sweep side to side.

6. Smoke alarms and carbon monoxide detectors are place in designated areas by the city fire department. Alarms are checked every month and to be recorded on the alarm check log.

- Severe Weather

1. Weather Terminology

Weather "Watch": indicates conditions are likely to affect your area and precautions should be taken.

Weather "Warning" : indicates conditions are imminent and action must be taken immediately.

2. Tornado Watch Procedures

1) Notify residents of Tornado Watch

2) Make sure all residents stay inside

3) All blinds shall be pulled and instruct residents to stay away from windows

4) Keep being informed using radios & TVs

3. Tornado Warning Procedures

1) The radio shall be turned to WCCO 830 AM to monitor the weather report.

2) All blinds shall be pulled immediately. Remove loose items from the window sill to prevent glass/items from flying and causing injury.

3) All doors in the bedrooms and bathrooms should be closed.

4) Move all residents to designated area (livingroom donstairs).

   * If time permits, bring blankets, pillows and comfort items for the residents.

   * Bring battery operated radio and flashlights to safe area

5) Once in designated area, notify the house coordinator of severe weather.

6) Stay in designated area until weather subsides.

4. Winter Storm & Extreme Cold Procedures

    1) Make a back-up staffing plan

    2) Check 72-hour Kit to make sure you have enough supply

    3) Stay inside if instructed to do so by the Local Emergency Response Team

    4) Prepare alternative heat source (portable heater etc)

    5) If using alternative hat appliances, use fire safeguards and properly ventilate

    6) Faucet should be kept running to prevent pipes from freezing

5. Extreme Heat Procedures

    1) Make sure that residents drink plenty of fluids to avoid dehydration

    2) Have residents avoid outdoor activities and limit Sun exposures

    3) Use a fan or air conditioner during temperatures above 80 degrees

    4) If air conditioner is not working, call local power company immediately for repair. Tell them you have senior residents and their medical conditions if necessary.

6. Power Outages

    1) Flash light should be available in 72-hour kit as well as in the office

    2) Never use candles

    3) Avoid opening the refrigerator and freezer

    4) Standard telephone handset that does not require electricity should be available with 72-hour kit.

    5) If heater or air conditioner stopped working due to power outage, take steps to keep residents warm/cool

- Emergency Interventions to Residents

1. Examples of significant adverse changes in the resident's condition which may necessitate emergency contact and notifying 911 include:

    1) has trouble breathing or has stopped breathing

    2) has no pulse

3) is bleeding severely

4) is having: chest-neck-jaw-arm pain

5) is in a state of deteriorating unconsciousness or is unconscious

6) if a fracture is suspected

7) if the person has been badly burned

8) if unable to move one or more limbs

9) is having a seizure

10) is suffering from: hypothermia-below normal body temperature or hyperthermia-well above normal body temperature

11) has been poisoned

12) is having a diabetic emergency

13) has suffered a stroke

14) If there is any doubt as to seriousness of the situation

2. Staffs are to be trained regularly of signs and symptroms that require emergency interventions and how to use 911.

3. All emergency interventions must be reported immediately to the director of nursing and recorded on an accident/incident report form (see Policy #4). Within 24 hours of an emergency intervention the director of nursing must notify the resident's case manager, family members and legal representatives, and adult foster care licensing of the emergency situation and the intervention methods used.

Administrators must notify AFC Licensing in the following situations:

- Fire
- Ambulance/911 calls
- VA reports made to the Common Entry Point
- Incidents the result in resident needing medical attention
- Unusual behavior that results in an incident

(15)   Awareness of commonly used health technology equipment and assistive devices.

BLOOD PRESSURE MONITORS:

PULSE OXIMETER

DOPPLER

OPHTHALMOSCOPE / OTOSCOPE SET

VACCINE FRIDGE

EXAMINATION LAMPS

EAR THERMOMETER

SURGERY COUCH

SCALES / HEIGHT MEASURES:

Instrument	Uses
Bandage	to cover and protect areas of the body, such as a recent injury
Bedpan	for patients who are unconscious or too weak to sit up or walk to the toilet to defecate
Canula	to create a permanent pathway to a vein (or artery) for the purpose of repeated injections or infusion of intravenous fluids
Cardioverter / Defibrillator	to correct arrhythmias of the heart or to start up a heart that is not beating
Catheter	to drain and collect urine directly from the bladder (primary use); also to act as a makeshift oxygen tube, etc.
Dialyser	to remove toxic materials from the blood that are generally removed by the kidneys; used in case of renal failure
Electrocardiograph machine	to record the electrical activity of the heart over a period of time
Enema equipment	to passively evacuate the rectum of faeces
Endoscope	to look inside the gastrointestinal tract, used mainly in surgery or by surgical consultants
Gas cylinder	as a supply of oxygen, nitrous oxide, carbon dioxide, etc.

Gauze sponge	to absorb blood and other fluids as well as clean wounds
Hypodermic needle / Syringe	for injections and aspiration of blood or fluid from the body
Infection control equipment	as in gloves, gowns, bonnets, shoe covers, face shields, goggles, and surgical masks for preventing nosocomial or healthcare-associated infection
Instrument sterilizer	to sterilize instruments in absence of an autoclave
Kidney dish	as a tray for instruments, gauze, tissue, etc.
Measuring tape	for length, height, and girth measurements
Medical halogen penlight	to see into the eye, natural orifices, etc. and to test for pupillary light reflex, etc.
Nasogastric tube	for nasogastric suction or the introduction of food or drugs into the body
Nebulizer	to produce aerosols of drugs to be administered by respiratory route
Ophthalmoscope	to look at the retina
Otoscope	to look into the external ear cavity
Oxygen mask and tubes	to deliver gases to the mouth/nostrils to assist in oxygen intake or to administer aerosolized or gaseous drugs

Pipette or dropper	to measure out doses of liquid, specially in children
Proctoscope	to look inside the anal canal and lower part of the rectum
Reflex hammer	to test motor reflexs of the body
Sphygmomanometer	to measure the patient's blood pressure
Stethoscope	to hear sounds from movements within the body like heart beats, intestinal movement, breath sounds, etc.
Suction device	to suck up blood or secretions
Thermometer	to record body temperature
Tongue depressor	for use in oral examination
Transfusion kit	to transfuse blood and blood products
Tuning fork	to test for deafness and to categorize it
Ventilator	to assist or carry out the mechanical act of inspiration and expiration so the non-respiring patient can do so; a common component of "life support"
Watch / Stopwatch	for recording rates like heart rate, respiratory rate, etc.; for certain hearing tests

[Weighing scale](#)	to [measure weight](#)

Images

Bandage

Bedpan

Blood infusion set

Cannula, intraveneous (separated)

Catheter, Foley

Defibrillator

Dialyser, hemodialysis

Enema bulb

Enema set

Endoscope

Face shield

Gas cylinder, oxygen

Gauze sponges

Instrument sterilizer

-

Kidney dish

-

Medical halogen penlight

-

Nasogastric tube, Levin

-

Nebulizer

-

Ophthalmoscope

Reflex hammer

Reflex hammer, queen square

Sphygmomanometer, electronic

Stethoscope

Syringe and needle

Thermometers, mercury

Tongue depressors

Tuning fork

Ventilator, high-frequency

Weighing scale

Subd. 7, paragraph (c)

(1) Observation, reporting, and documenting of client status.

Observations

- Observations are the facts and events that you notice as you go about your daily work. (See page three for more about making observations.)

Daily Measurements

- You may be ordered to record your client's:

    - Vital signs

    - Weight

    - Intake and Output

    - Blood sugar level

Safety Issues

- This includes measures you took to ensure a client's safety and any concerns you have about possible safety hazards in the client's environment.

Client Statements & Complaints

- Document—in their exact words—any pertinent statements your clients make about how they are feeling. This may include statements about pain, appetite or emotions.

- Be sure to report complaints. (Again, use the client's exact words.) Complaints help your workplace improve client care and/or find new ways to meet a client's needs.

Unusual Events

- Report anything out of the ordinary that happens while you are with a client. For example, be sure to document if a client refuses care or if the heat in the client's room doesn't work. (Notify your supervisor as soon as possible, too.)

THE RULES OF GOOD DOCUMENTATION

RULE #1: MAKE IT COMPLETE!

Complete documentation is thorough and follows your workplace policies. In general, your documentation will be complete if you include:

- The correct date and time.

- The client's correct name.

- The tasks you perform with each client and how the client responds to your care.

- Any changes you notice in a client's condition.

- Any care that was refused by the client.

- Any phone calls or oral reports you made about the client to a supervisor. (Include the supervisor's name.)

- Your signature and job title.

- Note: Check with your supervisor about how to complete the specific forms used in your workplace.

RULE # 2: KEEP IT CONSISTENT!

 Documentation is consistent when it remains true to:

- The client's care plan.

- Physician and nursing orders.

- The observations that your coworkers have made about the same client.

- Your workplace policies.

RULE #3: KEEP IT LEGIBLE

 Remember, the purpose of documentation is to communicate with other members of the health care team. (If you are the only person who can read your handwriting, your documentation won't communicate anything to anybody!)

- Use a black or blue ballpoint pen. (The ink from felt tip pens tends to "bleed".)

- Watch your handwriting . . . messy documentation could come back to haunt you in a lawsuit. ● Print with block letters. Cursive handwriting tends to be hard to read and should not be used in a medical chart.

REPORTING CLIENT CARE

You may be responsible for giving an oral report about a client to your coworkers. This report may be one-on-one with another person or in a group setting such as a team meeting or client care conference.

● Some health care organizations use tape recorders or voice mail systems for reporting client care.

● Oral reports should be given in a professional manner according to your workplace policy. For example, it's not appropriate to tell your supervisor about a client's problem while she's on the phone or is dashing off to eat lunch. She might forget what you told her—and client care could suffer.

(2) Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel.

Body systems

Our bodies consist of a number of biological systems that carry out specific functions necessary for everyday living.

The job of the circulatory system is to move blood, nutrients, oxygen, carbon dioxide, and hormones, around the body. It consists of the heart, blood, blood vessels,arteries and veins.

The digestive system consists of a series of connected organs that together, allow the body to break down and absorb food, and remove waste. It includes the mouth, esophagus, stomach, small intestine, large intestine, rectum, and anus. The liver and pancreas also play a role in the digestive system because they produce digestive juices.

The endocrine system consists of eight major glands that secrete hormones into the blood. These hormones, in turn, travel to different tissues and regulate various bodily functions, such as metabolism, growth and sexual function.

The immune system is the body's defense against bacteria, viruses and other pathogens that may be harmful. It includes lymph nodes, the spleen, bone marrow, lymphocytes (including B-cells and T-cells), the thymus and leukocytes, which are white blood cells.

The lymphatic system includes lymph nodes, lymph ducts and lymph vessels, and also plays a role in the body's defenses. Its main job is to make is to make and move lymph, a clear fluid that contains white blood cells, which help the body fight infection. The lymphatic system also removes excess lymph fluid from bodily tissues, and returns it to the blood.

The nervous system controls both voluntary action (like conscious movement) and involuntary actions (like breathing), and sends signals to different parts of the body. The central nervous system includes the brain and spinal cord. The peripheral nervous system consists of nerves that connect every other part of the body to the central nervous system.

The body's muscular system consists of about 650 muscles that aid in movement, blood flow and other bodily functions. There are three types of muscle: skeletal muscle which is connected to bone and helps with voluntary movement, smooth muscle which is found inside organs and helps to move substances through organs, and cardiac muscle which is found in the heart and helps pump blood.

The reproductive system allows humans to reproduce. The male reproductive system includes the penis and the testes, which produce sperm. The female reproductive system consists of the vagina, the uterus and the ovaries, which produce eggs. During conception, a sperm cell fuses with an egg cell, which creates a fertilized egg that implants and grows in the uterus.
[Related: Awkward Anatomy: 10 Odd Facts About the Female Body]

Our bodies are supported by the skeletal system, which consists of 206 bones that are connected by tendons, ligaments and cartilage. The skeleton not only helps us move, but it's also involved in the production of blood cells and the storage of calcium. The teeth are also part of the skeletal system, but they aren't considered bones.

The respiratory system allows us to take in vital oxygen and expel carbon dioxide in a process we call breathing. It consists mainly of the trachea, the diaphragm and the lungs.

The urinary system helps eliminate a waste product called urea from the body, which is produced when certain foods are broken down. The whole system includes two kidneys, two ureters, the bladder, two sphincter muscles and the urethra. Urine produced by the kidneys travels down the ureters to the bladder, and exits the body through the urethra.

The skin, or <u>integumentary system</u>, is the body's largest organ. It protects us from the outside world, and is our first defense against bacteria, viruses and other pathogens. Our skin also helps regulate body temperature and eliminate waste through perspiration. In addition to skin, the integumentary system includes hair and nails⬀.

Vital organs

Humans have five vital organs that are essential for survival. These are the brain, heart, kidneys, liver and lungs.

The <u>human brain</u> is the body's control center⬀, receiving and sending signals to other organs through the nervous system and through secreted hormones. It is responsible for our thoughts, feelings, memory storage and general perception of the world.

The <u>human heart</u> is a responsible for pumping blood throughout our body.

The job of the <u>kidneys</u> is to remove waste and extra fluid from the blood. The kidneys take urea out of the blood and combine it with water and other substances to make urine.

The <u>liver</u> has many functions, including detoxifying of harmful chemicals, breakdown of drugs, filtering of blood, secretion of bile and production of blood-clotting proteins.

The <u>lungs</u> are responsible for removing oxygen from the air we breathe and transferring it to our blood where it can be sent to our cells. The lungs also remove carbon dioxide, which we exhale.

What types of changes in a patient's condition should be reported?

It is not possible to list all of the changes to a patient's condition that should be reported, but the following list mentions just a few of the major changes that should be reported:

- Adverse drug reactions;
- Agitation;
- Bleeding;
- Blood glucose levels;
- Blood pressure;
- Body temperature or fever;

- Bruises;
- Changes in skin color;
- Chest pain;
- Cognitive changes;
- Confusion;
- Difficulty breathing;
- Disorientation;
- Falls;
- Facial Droop;
- Fatigue;
- Heart rate;
- Loss of consciousness;
- Loss of body movement or function;
- Muscle spasms;
- Neurological Changes;
- Oxygen saturation;
- Pain level;
- Pressure sores and ulcers;
- Skin breakdown;
- Slurred Speech, and
- Weakness.

(3) Reading and recording temperature, pulse, and respirations of the client.

READING AND RECORDING TEMPERATURE, PULSE AND RESPIRATIONS

INTRODUCTION

Reading and recording a patient's temperature, pulse, and respirations is one of the most important things you will do. Why is it so important? For two simple reasons:

- These measurements are one of the quickest, simplest, and most reliable indicators of a person's basic state of health.

- Abnormal changes in these measurements are one of the quickest, simplest, and most reliable indicators that someone is sick.

It is easy to see then why the body temperature, pulse, and respirations are called, collectively, the *vital signs.* These measurements are very sensitive tools that can tell us if a patient has an infection, if a patient is having an adverse reaction to a drug, if a patient needs oxygen – the temperature, pulse and respirations provide a "window" through which we can assess someone's medical condition.

READING AND RECORDING TEMPERATURE

What Is Body Temperature?

Body temperature is, basically, a measurement of how warm or cold we are. It represents a balance between two things: *the amount of heat we produce and the heat we lose.* We produce heat by the process of metabolism and by normal physical activity (and sometimes because of illness). We lose heat by one or more of the following mechanisms:

- Radiation: Heat naturally moves away from our bodies to the surrounding environment in much the same way that a radiator spreads heat into a room.
- Conduction: Heat moves from a hot object – our bodies – to a cold object when the two are in contact; the heat is *conducted* to the cold object. If you sit on a block of ice, you will lose body heat.
- Convection: You can lose body heat when the warm air surrounding you is replaced by cold air. This happens when you stand in the wind; the warm air is moved away and your body heat then is lost to the cold air.
- Evaporation: Water on the skin is evaporated by body heat and as this happens, body heat is lost.

Body temperature then can be decreased or increased by the environment. It can also be increased or decreased by the presence of a disease, an injury, an infection, the time of day or hormone levels, or by our level of physical activity. Body temperature is checked to a) detect a fever, b) as part of the normal health screening process, and c) determine the effectiveness of medications given to reduce a fever.

What Is Normal Body Temperature?

Human physiology has adapted so that we maintain body temperature within a relatively narrow range. If we are too hot or too cold our bodies cannot function properly, and if body temperature rises or falls above or below certain limits, there can be serious effects to our health.

Traditionally, normal body temperature has been defined as an oral temperature of 98.6°F (Note: The F stands for Fahrenheit. Fahrenheit is simply the name of one of the systems of measurement that can be used to record body temperature). However, "normal" body temperature differs from person to person as much as 1°. Also, everyone's body temperature goes up and down through the day: it is the lowest during the middle of the night during sleep and it is the highest during the day when we are active. Body temperature also fluctuates for women when they are ovulating or menstruating.

Learning Break: No can say with absolute certainty what a normal body temperature is. However, we will define it here as *an oral temperature of 98.2°F ± 1.2°.* Normal would then be anywhere from 97°F to 99.4°F. A normal rectal temperature is defined as 99.6° F ±1°F

Learning Break: It is important to remember what normal body temperature is, but it is also important to remember that what is "normal" varies from person to person.

You may be working in a clinical setting where the body temperature is measured and recorded using the *Celsius system*. In this system, *a normal body temperature is defined as an oral temperature of 36.8°C ± 0.7°* A normal rectal temperature would be 37.5°C ± 0.7°

How Is Body Temperature Measured?

When we measure body temperature, what we are trying to do is determine the patient's *core temperature.* This is the temperature of the body at its core, the temperature that the body and its vital organs are truly experiencing. Body temperature can be measured a) orally, b) rectally, c) by placing the thermometer in the axilla (armpit), d) by placing the thermometer in the ear canal (the *otic* method), or e) by placing a thermometer against the forehead. The proper method to use will depend on several things:

- The patient's age: Very young children and very elderly people may have difficulty keeping an oral thermometer in the mouth for the required time.
- The patient's medical condition: There are many instances in which a patient's medical condition would determine how you would measure his/her temperature. Example: Someone who is unconscious or disoriented would not be a candidate for an oral temperature measurement. Example: Someone who cannot breathe through the nose would not be a candidate for an oral temperature.
- Need for accuracy: Although all of the methods (e.g., oral, rectal, etc.) of measuring body temperature are accurate, some will more closely reflect the core temperature. *The rectal (preferably) and otic methods would be used if you wanted to determine the patient's core temperature.*
- The clinical setting: Where you work can determine which method of measuring body temperature is the most appropriate. Example: If you are working in a busy adult clinic and there is limited time, and limited options for maintaining privacy and protecting the patient's modesty, measuring body temperatures rectally would obviously be impractical. Example: If you are working in a busy pediatric clinic, privacy and modesty concerns might not be as important and using the rectal method would be okay.

Learning Break: Using one of the less "accurate" methods for measuring body

temperature would be appropriate for routine screening and assessment. *But if*

the oral temperature is elevated or the patient may be ill or is obviously sick,

then it is best to take the temperature rectally, if possible.

- Oral temperature: Wait at least 20 to 30 minutes after the patient has eaten or had something to drink or smoked a cigarette: if you don't, the temperature may be not be accurate. Place the thermometer in the patient's mouth under the tongue and instruct the patient to close his/her mouth tightly.
- Rectal temperature: Make sure that you can protect the patient's privacy and modesty. Apply a lubricating jelly to the tip of the thermometer and *gently* insert the tip 0.5 to 1 inch into the rectum. *Do not use force!*
- Otic temperature: Insert the tip of the thermometer gently into the ear canal. Do not use force.
- Axillary temperature: Place the tip of the thermometer in the center of the patient's armpit, then have the patient hold his/her arm tightly against the side of the body.
- Forehead temperature: Make sure the forehead is clean and dry. Place the thermometer or temperature strip on the middle of the forehead.

Electronic thermometers are used almost exclusively today; when the temperature has been recorded, most will beep to let you know.

Remember, a rectal or otic temperature measurement is preferred for accuracy if the patient is ill or the oral/axillary/forehead temperature is elevated. Rectal and otic temperatures are usually 0.5° to 1° F higher than an oral temperature. An axillary temperature is usually 0.5° to 1° F lower than an oral temperature.

Inaccurate body temperature measurement may be due to the patient recently eating, drinking or smoking, recent vigorous physical activity, not keeping the mouth closed around the thermometer, not leaving the thermometer in place for the proper length of time, or not putting the thermometer in the proper area.

Recording Body Temperature/High Temperatures And Low Temperatures

Make sure that you record the patient's body temperature as soon as possible after you have performed this procedure: it is all too easy to forget the reading during a busy day. When you record the temperature make sure you document what method you used.

Notify the R.N. or your supervisor immediately if the patient's body temperature is abnormally high or low or if there has been a significant change from the patient's baseline. *These are signs that there may be a serious illness present.* For example, a high body temperature usually indicates the presence of an infection, e.g., pneumonia or a urinary tract infection. A low body temperature may be cause by exposure to cold or a drug overdose.

Learning Break: An elevated body temperature is called a fever, and *a fever is defined as a temperature that is 100°F or higher (if the temperature is taken orally) or 101°F (if the temperature is taken rectally. In the Celsius scale, a fever would be an oral temperature higher than 37.7°C or a rectal temperature higher than 38.3°C.*

Learning Break: A low body temperature is defined as a rectal temperature that is less than the lower limit of normal: *Less than 97°F orally, less than 98.6°F rectally. In the Celsius scale, these would be 36.1°C orally and 37°C.*

BODY TEMPERATURE: SUMMARY

- Measuring the body temperature is a reliable and easy way to determine someone's basic state of health.

- Measuring the body temperature is a reliable and easy way to determine if someone is sick.
- Body temperature represents the balance between heat production and heat loss.
- Body heat can be lost by conduction, convection, evaporation, or radiation.
- Body temperature can be measured in various ways: the rectal or otic are the most accurate and are higher than the axillary, forehead, or oral methods.
- The normal oral temperature is 98.2°F ± 1.2° or 36.8°C ± 0.7°. The normal rectal temperature is 99.6°F ± 0.7° or 37.5°C ± 0.7°.
- Fever is defined as an oral temperature 100°F or higher or a rectal temperature 101°F or higher. In the Celsius scale, a fever would be an oral temperature 37.7° or higher or a rectal temperature 38.3° or higher.
- *If a patient has a fever, report this immediately to the R.N. or your supervisor.*

READING AND RECORDING THE PULSE.

What Is The Pulse?

The heart, the blood, and the blood vessels make up the circulatory system. The heart pushes the blood through the blood vessels to vitals organs and tissues; the blood carries the oxygen they need to function, removes waste products that are a byproduct of metabolism, and carries them to the lungs for elimination.

The heart acts like a pump, and each heartbeat has two phases, a resting phase (*diastole)* and a pumping phase (*systole*). During diastole, the chambers of the heart fill with oxygenated blood. During systole, the walls of these chambers contract and send out a "wave" of blood to the lungs, brain, kidneys, muscles, etc. Taken together, systole and diastole make up the heartbeat. *The pulse is a measurement of the number of times the heart beats in one minute.*

In certain areas of the body, the blood vessels are close to the surface of the skin and this wave that represents a heartbeat can be felt. The pulse can also be measured by listening to heart with a stethoscope. Measuring the pulse rate is like measuring the body temperature; it is a quick, reliable, and easy way to determine someone's basic state of health or to determine if he/she is sick. The heart rate speeds up or slows down in response to stress, injury, infection, activity level, changes in the environment, drugs, etc.

Example: If someone is bleeding – say they have a stomach ulcer that is bleeding – there is less blood available in the circulation. Less blood means that there is a diminished capacity of the circulatory system to deliver oxygen, and without oxygen the body cannot function. To compensate for this loss of blood and oxygen carrying capacity, the heart speeds up and the pulse rate increases.

Example: An asthma attack narrows the bronchial passages and decreases the amount of oxygen that can be transferred from the lungs to the blood. In response, the heart will speed up in order to deliver a greater amount of blood per minute to the body because   each volume of blood is not carrying the normal load of oxygen.

Example: Patients who take the cardiac medication digoxin will often have heart rates that are relatively slow.

What Is A Normal Pulse Rate?

As with the other vital signs there is a range of pulse are that is considered to be normal.

- Babies up to the age of 1: 100-160 beats per minute.
- Children of the ages 1 to 10: 60 to 120 beats per minute
- Children of the ages 11-17: 60 to 100 beats per minute.
- Adults: 60 to 100 beats per minute.
- Athletes: 40-60 beats per minute.

These values are considered to be normal for the given ages. But just as important as the rate, however, is the *rhythm*. *A normal heartbeat will be regular like the ticking of a clock. The amount of time between each beats will be the same and if it is not, this is considered abnormal.*

Learning Break: A pulse rate that is below the lower limit of normal is called *bradycardia.* A pulse rate that is above the upper limit of normal is called *tachycardia.*

How To Measure And Record The Pulse

Measuring and recording the pulse is simple. It can be done in many places in the body, but the two most common sites used to check the pulse are a) the chest, directly over the heart, using a stethoscope, and b) on the side of the wrist using the radial artery.

- Radial artery: The radial artery is located on the wrist (on the side *opposite* the back of the hand) just below the base of the thumb. You can find it taking two fingers and placing them in this area: you should easily feel a rhythmic pulse. Count the pulse for at least 30 seconds and then multiply times by two; the result will be the heart rate. Do *not* use your thumb to count the pulse. Many people have a strong pulse in their thumbs and this can interfere with accurately feeling someone's pulse.
- The chest: The heart is located on the left side of the chest, *approximately* midway between the waist and the shoulder. Place your stethoscope in that area and listen for the heartbeat. Count for 30 second and then multiply times two; the result will be the pulse rate.

Learning Break: When you are listening to someone's heart rate with a stethoscope, you will hear two sounds with each beat: these are commonly described as "lub-dub." These are the sounds of the heart valves opening and closing *with each single heart beat* and *together* they represent *one heart beat.*

Make a note of the heart rate *and* the rhythm (regular or irregular) and record it in the proper place in the patient's chart. If the heart rate is abnormally slow or fast or irregular, notify the R.N. or the supervisor immediately. *You should also notify the R.N. or your supervisor if the patient's heart rate is unusually slow or fast for that patient.*

PULSE RATE: SUMMARY

- The pulse is a measurement of the number of heartbeats in one minute.
- The pulse can be increased or slowed down by illness, injury, infection, drugs, the environment, or activity level.
- The normal pulse for an adult should be regular and between 60 and 100 beats per minute.
- A pulse rate that is abnormally slow is called bradycardia.
- A pulse rate that is abnormally fast is called tachycardia.
- The two most accurate places to measure the pulse are the radial artery and the chest.
- *Notify the R.N. or your supervisor if the patient's heart rate bradycardic, tachycardic or is unusually slow or fast for that patient.*

MEASURING AND RECORDING THE RESPIRATIONS

Respirations Explained

Respiration is the medical term for breathing. The respiratory system delivers oxygen to the blood when we inhale and helps eliminate by-products of metabolism (specifically, carbon dioxide) when we exhale. Depending on the need for oxygen or the need to eliminate carbon dioxide, the respiratory rate – the number of breaths in a minute – can increase or decrease. The respiratory rate can be influenced by the environment, stress, drugs, illness, activity level, or injury.

Example: A myocardial infarction (heart attack) is caused by blockage of the arteries in the heart. The heart is deprived of oxygen and to compensate, the respiratory rate increases.

Example: When someone exercises, the muscles have a greater need for oxygen because they are working harder. In response, the respiratory rate is increased.

How To Measure And Record Respirations

- Count the number of breaths the patient takes for 30 seconds and then multiply times two: that will be the respiratory rate.
- The normal respiratory rate for an adult is 12 to 20 a minute. For infants and children, the respiratory rate is higher: normal for newborns and infants would be 30 to 40 breaths a minute, for children normal would be 25 to 30 breaths a minute.
- A respiratory rate that is below the normal limits is called *bradypnea.*
- A respiratory rate that is above the normal limits is called *tachypnea.*
- The respiratory rate should be regular.
- Notify the R.N. or your supervisor if the patient's respiratory rate is below or above the normal limits or is unusually slow or fast for that patient.

RESPIRATIONS: SUMMARY

- The respiratory rate is a measurement of the number of breaths in one minute.
- The normal respiratory rate for an adult is 12 to 20 breaths a minute.
- The respiratory rate for newborns, infants, and children is higher than the respiratory rate of adults.
- The respiratory rate should be regular.
- A respiratory rate that is below the normal limits is called bradypnea.
- A respiratory rate that is above the normal limits is called tachypnea.

(4) **Recognizing physical, emotional, cognitive, and developmental needs of the client.**

An **Identification of Needs** process should be undertaken within the first few weeks of a new client arriving at a home care facility.

Clients should be assessed on various aspects of their lives; **sleeping patterns, diet, cognitive ability and mobility** among other things.

The assessment is a **team effort** involving RNs and other care providers.

Identification of Needs: Where to Start?

The identification of needs is usually collected in two documents; the **Social Profile** and the **Resident Assessment**. The more elaborate and detailed the information collected, the better.

Identifying Needs: The Social Profile

The **Social Profile** is a form that is usually given to the residents to fill in upon admission. If the resident is not able to fill it in, then a relative will do so. Each facility has its own Social Profile which may go by a different name at your facility.

The Social Profile Form should include background information and personal preferences:

- family dynamics (which relative is closer to the resident),
- education,
- country of origin,
- age,
- status of war service and relevant details,
- whether they lead a sedentary life (prefer solitary pursuits) or enjoyed socializing,

- whether they are currently enrolled in the electoral roll,

- whether they have any special possessions that could be brought to facility to make their adjustment a little easier,

- sleeping habits,

- any cultural date the resident enjoys celebrating

- etc

Identifying Needs: The Resident Assessment

The **Resident Assessment** endeavors to collect social, emotional and spiritual needs and also all sorts of information that could hinder or enhance recreation and leisure.

Start with the resident:

Pay the resident a visit to develop rapport and establish trust. Observe the resident; their demeanor:

- How often do they smile?

- Do they have any concern about staff or another resident?

- Are they nervous?

- Do they dislike crowds?

- Do they need encouragement to attend programmed activities?

Interview family and friends:

- Family can provide information about routines and past and present leisure.

- Friends may shed light on different facets of their personalities.

Don't be put off by anecdotal information; it may come in handy when you are reminiscing with the resident.

Other Health care providers and staff:

Registered Nurses and other staff may discover important information for the assessment. In fact, any member of staff including office workers and support staff who may have had the opportunity to chat with the resident can add to your collection of data.

Past and present skills and interests

Find out what hobbies they enjoyed, jobs they had and which aspect of the job they liked. We should not assume that just because a lady was a dress-maker she necessarily enjoys needlework. The reality may be that it was financial hardship which compelled her to take up this occupation and she may even resent it.

Religious (and cultural) background

Religion plays a central role in the lives of many older people.

- Does this person wish to attend Church services?
- Can you meet this need by providing transport?
- Find out if you need to engage ministers of religion and/or lay people to make individual visits to residents who are bed ridden or unwilling to attend religious programs.
- Do they wish to have access to broadcasts or telecasts of religious programs?
- Have they expressed what sort of religious rites they would like to receive when the time comes?

Their Abilities:

1. Physical: mobility, dexterity

2. Sensory: sight, heating, touch, smell, taste.

3. Psychological: attention span.

Family dynamics

- What role did they have in their family? Mother, father, older sister, bread-winner etc.

- Are there any estranged family members?

Personality

What sort of personality do they have? sensitive, loving, controlling. Sensory loss can affect the personality of certain people. They may become angry and/or aggressive.

Dementia

What sort of diagnosis do they have? For example Alzheimer's, stroke, or a neurological disorder? Even mild dementia plays often havoc with a person's social life and often propels personality change.

Community Affiliations

Did they belong to any clubs, choirs, folk dance groups in the past? Would they like to continue to do so?

Past memories (reminiscing)

Are there painful memories you should know about? Sad memories of wars, refugee camps etc. Do they mind talking about their memories in WWII?

(5)   Safe transfer techniques and ambulation.

Assisting with ambulation

Ambulation not only maintains muscle tone, muscle strength, and joint flexibility, but it also stimulates the respiratory, circulatory, and gastrointestinal systems to help each one function properly. When patients are immobile because of surgery, injury, or illness, all of these systems are affected, putting them at risk for developing complications, such as decreased muscle strength, deep vein thrombosis, and paralytic ileus. It is important to keep this in mind and start the patient ambulating and exercising early on in the recovery process.

Before assisting patients out of bed and helping them walk, it is important to determine the level of assistance each patient requires. This varies with each patient's health status and the length of time the patient has been inactive.

For patients who are ill or recovering from surgery, provide a simple "assist." It can involve just walking alongside the patient or using a gait belt for additional stability. For patients who need more than that, offer an assistive device such as a cane, a walker, or crutches.

Patients who have been immobile or on bed rest often experience vertigo and orthostatic hypotension the first few times they sit up in bed or try to stand. Therefore, it is often beneficial to break the ambulatory process into stages to ensure safety.

Begin the ambulation process by having patients sit up in bed for a few minutes. If they tolerate sitting up, have them dangle their legs at the side of the bed. If they tolerate dangling, help them to a standing position at the side of the bed. If they tolerate standing, the next step is ambulation.

If a patient becomes weak or dizzy during ambulation and begins to fall, it is important to protect both yourself and her from injury. Instead of trying to hold the patient up or catch her, help ease her gently to the floor.

You can do this safely by placing your arms underneath the patient's axillae and then placing one leg forward and allowing her to use it for support as you ease her to the floor. To help prevent injury to your lower back, bend at the knees as you help the patient to the floor.

Transferring

When patients are able to get out of bed, sit in a chair, or leave the room, their physical and psychological well-being improves. When patients are unable to do these things on their own, it becomes your responsibility to help them with these tasks.

Before beginning the process of transferring a patient, it is important to determine how capable the patient is physically of participating in the transfer and what assistive devices or additional staff you'll need. It is also important to explain the transfer process so that the patient understands what you are doing. That usually makes the transfer less stressful.

In addition, it is important to make sure that all equipment is functioning properly and is in good condition before beginning the transfer. When moving patients from a bed to a wheelchair or a gurney, put all brakes in the locked position to prevent falls and injuries.

A major concern when transferring patients is safety – yours and the patient's. To help prevent injuries, maintain correct posture, use appropriate body mechanics and lifting techniques, and use assistive devices whenever possible.

When you decide to use an assistive device, let the patient's condition and the level of assistance required help guide your selection. The most common choices are a transfer or gait belt, a transfer board, a transfer sheet, and a mechanical lift.

A transfer or gait belt is a wide piece of canvas that fits around the patient's waist and is held in place by a buckle. To allow for a better grip, some transfer belts have built-in handles on each side. You'll use this type of belt for transferring and ambulating to provide balance and stability for the patient. You can also use it to help the patient move from a sitting to a standing position.

A transfer board is made of a slick plastic that reduces friction as you transfer the patient. A large transfer board is commonly used to transfer patients from bed to gurney and back. Smaller transfer boards can be used to assist patients from a bed into a wheelchair and back.

Grab bars are metal bars mounted on walls for patients to hold onto for balance as they transfer. They are commonly found in bathrooms next to tubs, showers, and toilets.

A transfer sheet is a heavy half sheet or a top sheet that is folded in half and placed underneath the patient. You then use the sheet to help position the patient in bed. You can also use it with a transfer board.

Mechanical lifts are used to transfer patients who are very heavy or extremely incapacitated. They consist of a wheeled base, an overhead bar with a sling suspension system, and a sling that supports the patient's weight. Depending on the lift used, the lifting bar may be moved using a manual hydraulic pump or a remote-control electrical device.
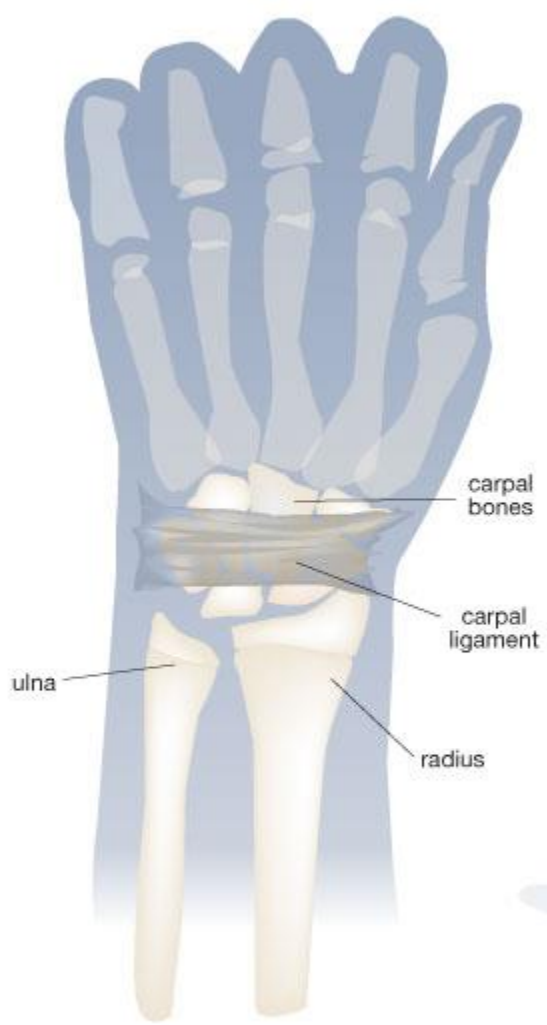

No matter which assistive device you use, it is important to remember that some patients have muscle weakness or paralysis of an extremity and that you must support that extremity during the transferring process to prevent injury. It is also important to keep in mind that patients who have been on bedrest or have been inactive for several days or weeks may experience weakness, dizziness, and orthostatic hypotension when transferred.
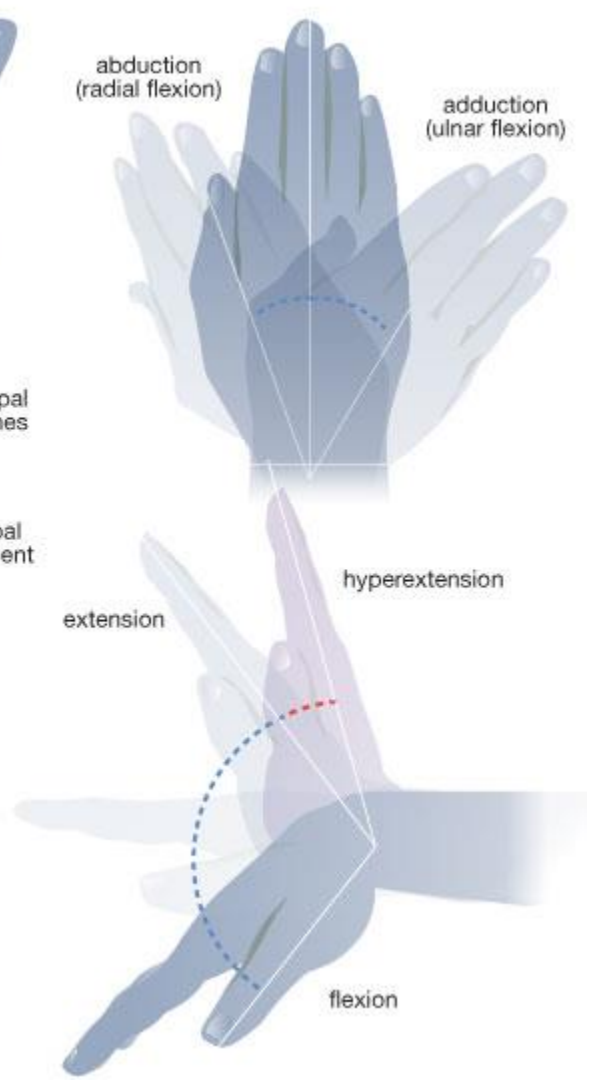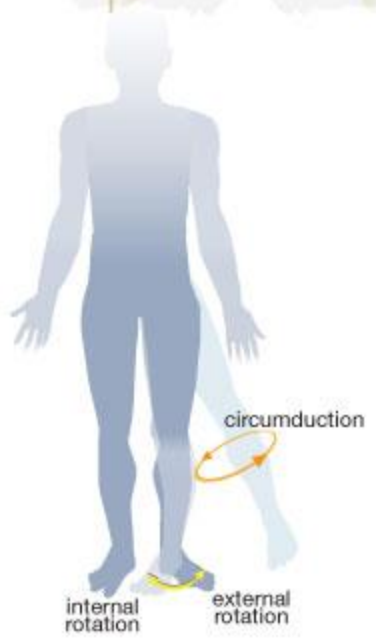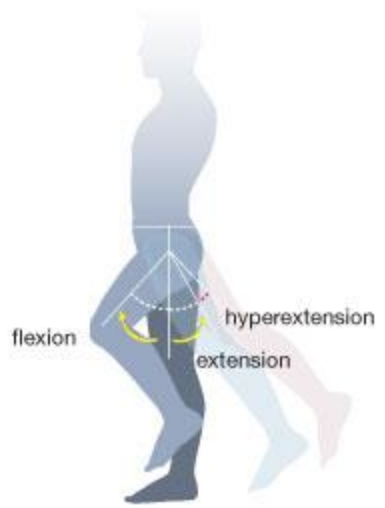
(6) Range of motioning and positioning.

Range-of-motion

wrist

carpal
bones

carpal
ligament

ulna

radius

abduction
(radial flexion)

adduction
(ulnar flexion)

hyperextension

extension

flexion

flexion

hyperextension

extension

hip

iliac
bone

acetabulum
socket

femur

pelvis

adduction

abduction

circumduction

internal
rotation

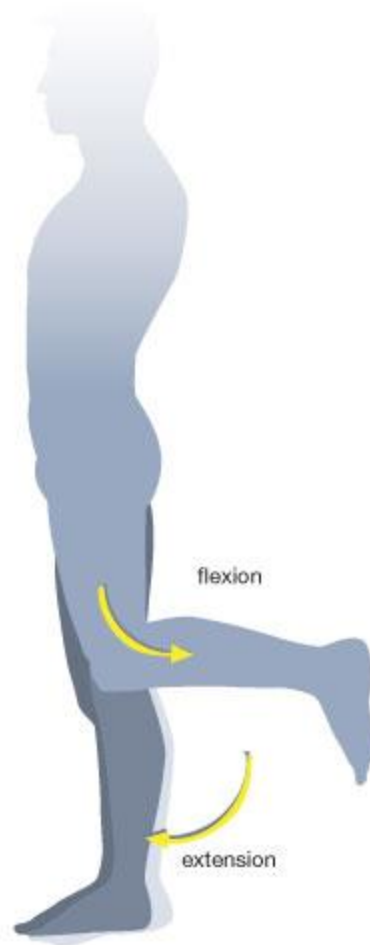external
rotation

knee

patella

femur

tibia

flexion

extension
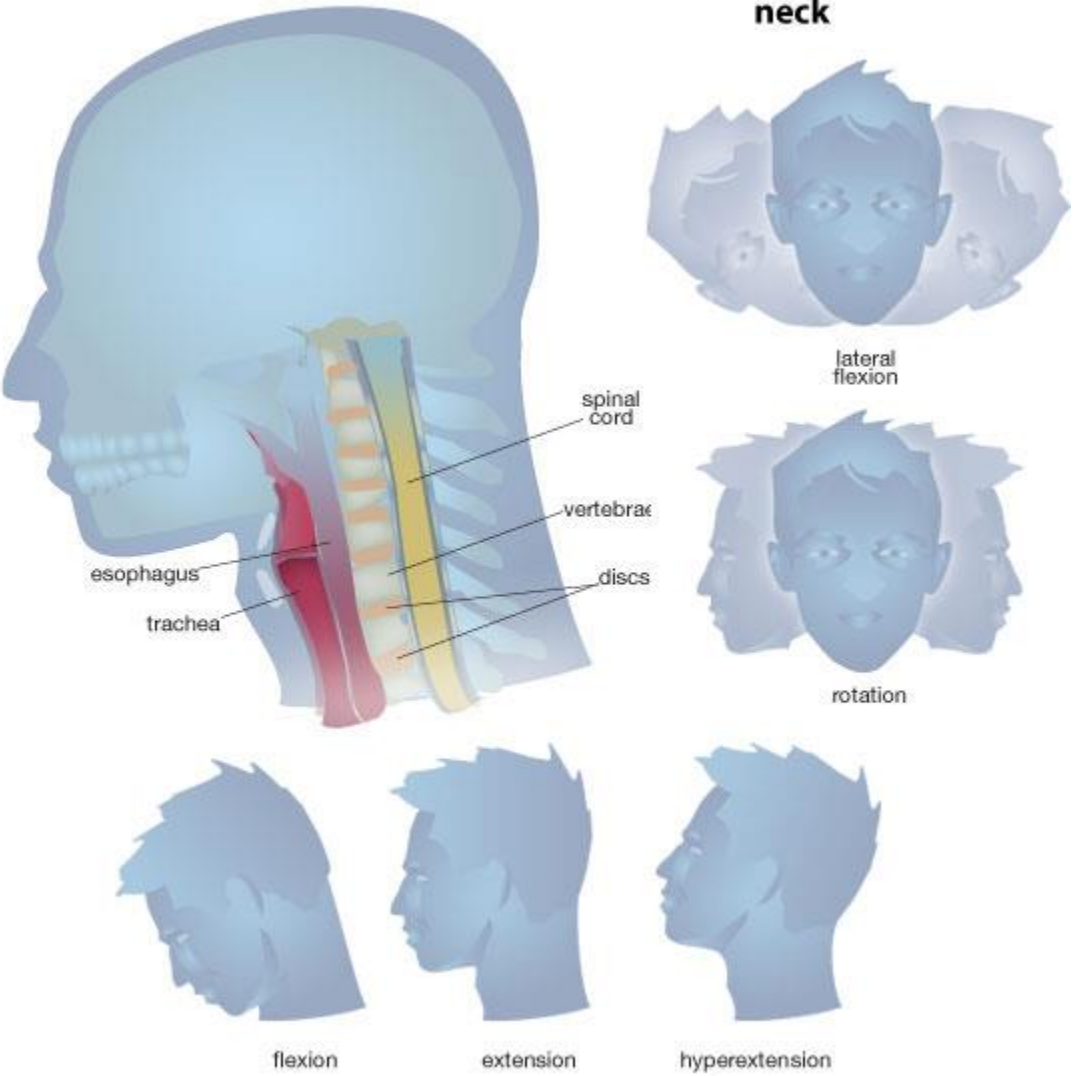
Positioning

Positioning patients correctly is important for maintaining body alignment and preventing complications such as pressure ulcers, contractures, and foot drop. Because these complications can develop over a short period of time, it is essential to position your patients properly and reposition them at least every 2 hours, or according to your facility's policy.

When positioning patients in bed, you can use any of several support devices designed to help ensure proper body alignment and to make the patient more comfortable. Some of these are pillows, foot boards, trochanter rolls, and handrolls.

Pillows help you support and maintain the patient in specific positions. For example, place several behind the patient's back to help maintain a lateral position or between the patient's knees and ankles for comfort and to keep them from rubbing together and possibly causing skin breakdown. Use pillows to elevate the patient's extremities or upper body as well.

A footboard is a flat panel composed of either wood or plastic. To help prevent footdrop, place it at the foot of the bed to keep the patient's feet dorsiflexed.

You'll use trochanter rolls for patients who have muscle weakness or paralysis on one side of the body. The roll keeps the patient's hips in a neutral position. You can make a trochanter roll by folding and rolling up a bath blanket.

You'll help prevent deformities and contractures by placing a hand roll in the patient's hand to position and maintain the wrist and fingers in a functional position. You can roll up a washcloth to make a hand roll.

One of the most common position changes you'll assist with is moving a patient up in bed. One person can do this, but it is more easily accomplished and safer with two people. To move the patient up in bed, place a draw sheet under the patient, extending from the shoulders to the thighs. Place a pillow between the patient's head and the top of the bed to keep the patient's head from hitting the bed's headboard. Roll the draw sheet close to the patient and then grasp the sheet at the shoulders and hips (with one person at each side of the bed). Using appropriate body mechanics, move the patient up in bed.

The supine position provides comfort in general and specifically for patients recovering from some types of surgery. To provide support and maintain body alignment in this position, place a pillow under the patient's head and shoulders and a towel roll or small pillow under the small of the back and under the thighs to keep the patient's knees slightly flexed. You can also elevate the patient's forearms on pillows placed at the patient's sides.

In the prone position, the patient lies on the abdomen with the head turned to one side. The hips are not flexed. Sometimes, one or both arms are flexed on each side of the patient's head. Because this position can cause hyperextension of the lower back, difficulty breathing due to pressure on the chest, and foot drop, it is not a position you'll use often. If a patient does lie prone, place a pillow under the patient's head and a small pillow or towel roll under the abdomen just below the diaphragm. Also, place a pillow under the lower legs to keep the toes from touching the bed.

In the lateral or side-lying position, the patient lies on one side of the body with the top leg in front of the bottom leg and the hip and knee flexed. This position helps relieve pressure on the sacrum and is especially useful for patients who are on bed rest and spend a lot of time supine or in Fowler's position. To maintain proper body alignment in this position, place a pillow under the patient's head and neck, another under the upper arm (with the lower arm flexed), and another between the legs to keep the hips properly aligned.

In Sims' position, the patient is halfway between the lateral and the prone positions. The upper arm is flexed at the shoulder and elbow, and the lower arm is positioned behind the patient. Both legs are in a flexed position in front of the patient, with the upper leg more flexed than the lower one. This position is most often used when patients are receiving an enema or for an examination of the perineal area.

To keep the body in proper alignment in this position, place a pillow underneath the patient's head and under the upper arm to prevent internal rotation. Place another pillow between the legs.

Patients who have breathing problems are often placed in the orthopneic, or tripod, position since it allows maximum expansion of the chest. For this position, the patient sits in bed or on the side of the bed with an overbed table in front to lean on and several pillows on the table to rest on.

Patients are often placed in Fowler's position to increase comfort, to improve ventilation, and to promote relaxation after thoracic surgery or for patients with cardiovascular problems. For this position, the head of the bed is elevated 45 degrees. The patient's hips may or may not be flexed. You'll place pillows behind the patient's head and lower back and underneath the forearms, thighs, and ankles for support. You might also use a footboard to keep the patient's feet in proper alignment and to help prevent footdrop.

For semi-Fowler's position, the head of the bed is elevated 30 degrees. This position is useful for patients who have cardiac, respiratory, or neurological problems and is often optimal for patients who have a nasogastric tube in place.

Placing a patient in Trendelenburg's position involves lowering the head of the bed and raising the foot of the bed. Patients who have hypotension can benefit from this position because it promotes venous return.

The reverse Trendelenburg's position is the opposite of Trendelenburg's position: The head of the bed is elevated with the foot of the bed down. This is often a position of comfort for patients with gastrointestinal problems, and it can help prevent or minimize esophageal reflux.

(7) Administering medication or treatments as required.

Medication Administration

1. The provider and/or all employees will be trained and instructed in proper medication administration, documentation and monitoring of side effects in order to meet the needs of the residents served.

2. Medication will be stored centrally in a locked cabinet including all schedule II controlled substances.

3. Staffs shall not give injections unless:

    1) the caregiver is a registered nurse or a licensed practical nurse with a current Minnesota license and is authorized to do so in writing by the resident's physician or

    2) the medications are regularly scheduled insulin and the it has been delegated by a registered nurse

4. A record of all medications administered (MAR) will be maintained for each resident. The medication administration documentation will be filed in the resident's medical record.

5. In the case of pro re nata medications, the administration of the medication is reported to a registered nurse within 24 hours after its administration.

6. Doctor's orders are required for all medications and treatments, including changes in dose, changes in procedure, and discontinuations. Doctor's orders will be kept in the resident file and can be found on prescriptions, as well as Doctor Visit/order forms.