MACOMB COUNTY COMMUNITY MENTAL HEALTH

NURSING MANUAL

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Macomb County

Community Mental Health Nursing Department

Mission: *Macomb County Community Mental Health nurses as consumer advocates, will promote dignity, wellness, maintenance and restoration of health to guide our consumers achieve optimal recovery.*

Vision: *Macomb County Community Mental Health nurses follow the Mental Health Promotion Model. The purpose of this model is to ensure that individuals with mental illness, developmental disabilities, and substance use disorder; have power, choice and control over their lives and mental health and that their communities have the strength and capacity to support individual empowerment and recovery. This vision is achieved through cost-effective collaborative care, evidence-based practices and integration of physical and behavioral health services*

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1.0 Definition of Nursing

Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.

Nursing's Social Policy Statement, Second Edition (2010)

2.0 Standards of Nursing Practice and Professional Performance

Nursing is guided by standards of practice and standards of professional performance. Standards are authoritative statements by which the nursing profession describes the responsibilities for which its practitioners are accountable. These standards reflect the values and priorities of the profession and are based on research and knowledge from nursing and various other sciences and disciplines. In addition, standards provide direction for professional nursing practice and a frame work for the evaluation and improvement of practice.

There are sixteen generic standards divided into six Standards of Practice and ten Standards of Performance.

3.0 Standards of Practice

The six Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. The nursing process encompasses all significant actions taken by registered nurses, and forms the foundation of the nurse's decision-making.

3.1 Assessment

The registered nurse collects comprehensive data pertinent to the patient's health or the situation.

3.2 Diagnosis

The registered nurse analyzes the assessment data to determine the diagnoses or issues.

3.3 Outcomes Identification

The registered nurse identifies expected outcomes for a plan individualized to the patient or the situation.

3.4 Planning

The registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

3.5 Implementation

The registered nurse implements the identified plan.

3.5a Coordination of care

The registered nurse coordinates care delivery.

3.5b Health Teaching and Health Promotion

The registered nurse employs strategies to promote health and a safe environment.

3.5c Consultation

The advanced practice registered nurse and the nursing role specialist provide consultation to influence the identified plan, enhance the abilities or others, and effect change.

3.5d Prescriptive Authority and Treatment

The advanced practice registered nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations.

3.6 Evaluation

The registered nurse evaluates progress toward attainment of outcomes.

Source: American Nurses Association (2010). Nursing: Scope and Standards of Practice. Washington, D.C.: Nursesbooks.org

4.0 Standards of Professional Performance

The ten Standards of Professional Performance describe a competent level of behavior in the professional role – including activities related to the quality of practice, education, professional practice evaluation, collegiality, collaboration, ethics, research, resourced utilization, leadership, and environmental health. Registered nurses are accountable for their professional actions to themselves, their patients, their peers, and ultimately, to society.

4.1 Quality of Practice

The registered nurse systematically enhances the quality and effectiveness of nursing practice.

4.2 Practice Evaluation

The registered nurse attains knowledge and competency that reflects current nursing practice.

4.3 Education

The registered nurse evaluates one's own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations.

4.4 Collegiality

The registered nurse interacts with and contributes to the professional development of peers and colleagues.

4.5 Collaboration

The registered nurse collaborates with patient, family, and others in the conduct of nursing practice.

4.6 Ethics

The registered nurse integrates ethical provisions in all areas of practice.

4.7 Research

The registered nurse integrates research finding into practice.

4.8 Resource Utilization

The registered nurse considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing services.

4.9 Leadership

The registered nurse provides leadership in the professional practice setting and the profession.

4.10 Environmental Health

The registered nurse practices in an environmentally safe and healthy manner.

Source: American Nurses Association (2010). Nursing: Scope and Standards of Practice. Washington, D.C.: Nursesbooks.org

5.0 Nursing Care Performance Measures

In February 2003, the National Quality Forum (NQF), a nonprofit quality measurement organization focused on national standards for health care quality and measurement reporting, started the "Nursing Care Performance Measures" project, which had three goals:

- Identify a framework for how to measure nursing care performance, with particular attention to the performance of nurses as teams and their contributions to the overall healthcare team;
- Endorse a set of voluntary consensus standards for evaluating the quality of nursing care (including designating consensus standards that are appropriate for public reporting); and
- Identify and prioritize unresolved issues regarding nursing care performance measurement and research needs.

5.1 Patient-Centered Outcome Measures

1. Death among Hospital patients with treatable serious complications (failure to rescue): The percentage of major surgical inpatients who experience a hospital-acquired complication and die.

2. Pressure ulcer prevalence: Percentage of inpatients who have a hospital acquired pressure ulcer.

3. Falls prevalence: Number of inpatient falls per inpatient days.

4. Falls with injury: Number of inpatient falls with injuries per inpatient days.

5. Restraint prevalence: Percentage of inpatients who have a vest or limb restraint.

6. Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients: Rate of urinary tract infections associated with use of urinary catheters for ICU patients.

7. Central line catheter –associated blood stream infection rate for ICU and high-risk nursery patients: Rate of blood stream infections associated with use of central line catheters for ICU and high-risk nursery patients.

8. Ventilator-associated pneumonia for ICU and high-risk nursery patients: Rate of pneumonia associated with use of ventilators for ICU and high-risk nursery patients.

5.2 Nursing-Centered Intervention Measures

9. Smoking cessation counseling for acute myocardial infarction.

10. Smoking cessation counseling for heart failure.

11. Smoking cessation counseling for pneumonia.

Each measure has the percentage of patients with a history of smoking within the past year who received smoking cessation advice or counseling during hospitalization.

5.3 System-Centered Measures

12. Skill mix: Percentage of registered nurse, licensed vocational/practical nurse, unlicensed assistive personnel, and contracted nurse care hours to total nursing care hours.

13. Nursing care hours per patient day: Number of registered nurses per patient day and number of nursing staff hours (registered nurse, licensed vocational/practical nurse, and unlicensed assistive personnel) per patient day.

14. Practice Environment Scale/Nursing Work Index: Composite score and scores for five subscales.: (1) nurse participation in hospital affairs; (2) nursing foundations for quality of care; (3) nurse manager

ability, leadership and support of nurses; (4) staffing and resource adequacy; and (5) collegiality of nurse-physician relations.

15. Voluntary turnover: Number of voluntary uncontrolled separations during the month by category (RNs, APNs, LVN/LPNs, NAs).

Sources: Kirchheimer, Barbara. (2008, July/August) Wrestling With a New Reality. Nursing Spectrum Midwest Edition, 30-31. Nursing Care Quality at NQF. National Quality Forum. Retrieved July 22, 2008, from http://2116.122138.39/nursing/. Sincox, Ann Kettering. (2008, September/October). The Nursing 15, Michigan Nurse, Vol. 81, No.5.

6.0 Description of Scope of Nursing Practice

The scope of practice statement describes the "who," where," "when," "why," and "how" of nursing practice. The profession of nursing has one scope of practice that encompasses the full range of nursing practice. The depth and breadth in which individual registered nurses engage in the total scope of nursing practice is dependent upon their education, experience, role, and the population served. (ANA, 2010a).

Tenets characterizing nursing practice

Five tenets characterize contemporary nursing practice:

6.1 Nursing practice is individualized.

6.2 Nurses coordinate care by establishing partnerships.

6.3 Caring is central to the practice of the registered nurse.

6.4 Registered nurses use the nursing process to plan and provide individualized care to their healthcare consumers.

6.5 A strong link exists between the professional work environment and the registered nurse's ability to provide quality health care and achieve optimal outcomes. (ANA, 2010a).

Source: Nursing Scope and Standards of Practice, 2010

7.0 Code of Ethics for Nurses

According to the American Nurses Association, the Code of Ethics for Nurses serves the following purposes:

- It is a succinct statement of the ethical obligations and duties of every individual who enters the nursing profession.
- It is the profession's nonnegotiable ethical standard

- It is an expression of nursing's own understanding of its commitment to society.

Source: American Nurses Association (2001). Code of Ethics for Nurses with Interpretive Statements. Washington, D.C.: Nursesbooks.org

7.1 The nurses, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by consideration of social or economic status, personal attributes, or the nature of health problems.

7.2 The nurse's primary commitment is to the patient, whether an individual, family, group or community.

7.3 The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.

7.4 The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.

7.5 The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.

7.6 The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.

7.7 The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.

7.8 The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.

7.9 The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

8.0 The Social Context of Nursing

Nursing is more than a profession. It is an essential part of society that people rely upon for their health and well-being. It is by nature dynamic rather than static and reflects the changing nature of societal needs. Because of nursing's influence and partnership with society, it is necessary for nursing to have a social contract between the profession and the society it serves. The social contract sets forth the professional rights and responsibilities of the nurse while acknowledging the need for public accountability.

> Society grants the professions authority over functions vital to itself and permits them considerable autonomy in the conduct of their affairs. In return, the professions are expected to act responsibly, always mindful of the public trust. Self-regulation to assure quality in performance is at the heart of this relationship. It is the authentic hallmark of a mature profession. (Henderson, V. 1961.Basic principles of nursing care, p.42. London: International Council of Nurses.)

8.1 Values and Assumptions of Nursing Social Contract

- Humans manifest an essential unity of mind, body, and spirit.
- Human experience is contextually and culturally defined.
- Health and illness are human experiences. The presence of illness does not preclude health nor does optimal health preclude illness.
- The relationship between nurse and patient involves participation of both in the process of care.
- The interaction between nurse and patient occurs within the context of the values and beliefs of the patient and the nurse.
- Public policy and the healthcare delivery system influence the health and well-being of society and professional nursing.

These values and assumptions apply whether the recipient of professional nursing care is an individual, family, group, community, or population.

Nursing's Social Policy Statement, Second Edition (2010)

9.0 Licensure and Nursing Practice

9.1 Nursing: A Separate and Independent License

Registered nurses are individually licensed and regulated by the State of Michigan. The license is an independent license. Nursing is recognized as a separate and independent occupation by the Michigan Public Health Code 1978 PA 368, as amended.

9.1a Why are nurses licensed in Michigan?

Nurses are licensed in Michigan to ensure that the public receives a high level of care consistent with the law and the standards set by the State of Michigan through the Michigan Board of Nursing and the Michigan Department of Community Health. The Public Health Code established criteria for determining when licensure will be recommended.

9.1b Where do licensing guidelines come from?

The legal regulation of nursing practice is based on the definition of nursing in the Nursing Section (Part 172) of the Michigan Public Health Code. Legal boundaries are derived from this definition of nursing and are used as the basis for interpreting the safe practice of nursing. Rules and regulations evolve from the nursing section and are the guidelines used by the Michigan Board of Nursing to issue licenses and promote the health, safety and welfare of the public.

The Michigan Public Health Code also provides for health profession specialty fields. Specialist must possess advanced education and training beyond that required for initial licensure. In

nursing these include nurse midwives, nurse anesthetists, and nurse practitioners who are certified by the Board of Nursing. The Board of Nursing uses the term certified for these specialists as a way of acknowledging the certification processes of specific national nursing organizations.

For further information about advanced practice nursing is on pages 60-67.

9.1c In what ways are RN and LPN licenses similar?

The Michigan Public Health Code provides a broad definition of nursing practice within which all licensed nurses' function. Because of variations in education, experience and competencies, not all nurses will perform all of the functions specified nor with the same degree of skill.

The degree to which nurses participate within the defined global boundaries of practice will change over time depending on knowledge, skill and career choice. Nurses practice differently ten years after graduation than as new graduates.

9.1d How do RN and LPN Licenses differ:

Registered nurses are identified as licensed health professionals who are independently accountable for their own actions in nursing. The RN has an obligation to practice and delegate within the individual's current range of educations, knowledge, skill and experience at all times. In Michigan, practical nursing is defined as a subfield of nursing; LPNs function under the supervision of an RN (or licensed physician or dentist).

9.1e 333.16105 Health profession subfield

Section 16105(4)

Health profession subfield means an area of practice which is within the scope of the activities, functions, and duties of a licensed health profession, and requires less comprehensive knowledge and skill than is required to practice the full scope of the health profession.

9.1f What are the legal responsibilities of the nurse and the employer?

The employer is the facilitator of care. The nurse is the provider and coordinator of direct care services. Both are legally accountable under law for what they do, and neither can assume the responsibility of the other party. The registered nurse bears the ultimate responsibility for the performance of nursing acts, functions or tasks. A non-nurse cannot assume this responsibility. When registered nurses have appeared in court, they have been held accountable for nursing functions. **Providing safe care to the public is dependent on both the nurse and the employer fulfilling their appropriate roles.**

9.2 Definition of Nursing Practice in Michigan

Part 172 Nursing:

Sec. 333.17201 Definitions; principles of construction.

(1) As used in this part:

(a) "Practice of nursing" means the systematic application of substantial specialized knowledge and skill, derived from the biological, physical, and behavioral sciences, to the care, treatment, counsel, and health teaching of individuals who are experiencing changes in the normal health process or who require assistance in the maintenance of health and the prevention or management of illness, injury, or disability.

(b) ""Practice of nursing as a licensed practical nurse" or "LPN" means the practice of nursing based on less comprehensive knowledge and skill than that required of a registered professional nurse and performed under the supervision of a registered professional nurse, physician or dentist.

(c) "Registered professional nurse" or "RN" means an individual licensed under this article [Article 15 of the Public Health Code] to engage in the practice of nursing which scope of practice includes the teaching, direction, and supervision of less skilled personnel in the performance of delegated nursing activities.

All licensed nurses (RNs and LPNs) practice within these legally defined parameters. The degree to which individual nurses function within the definition of practice is influenced by the type of license (some functions are specific for RNs), by initial and current levels of education, by experience, and by the needs of the recipients served. **The legal regulation of nursing practice applies to all license nurses regardless of a practice setting or employment status.**

9.3 Licensure - What are the different kinds of licenses?

9.3a Sec.333.16106 (2)

License means an authorization issued under this article [Article 15] to practice where practice would otherwise be unlawful. It includes an authorization to use a designated title which use would otherwise be prohibited under this article and may be used to refer to a health profession sub-field license, limited license, or a temporary license.

9.3b Sec. 333.16181 Temporary license; nonrenewable; exception; eligibility; duration; automatically voiding; expiration; supervision; issuance.

(1) Except as otherwise provided in subsection (2), a board may grant a nonrenewable, temporary license to an applicant who has completed all requirements for licensure except for examination or other required evaluation procedure. A board shall not grant a temporary license to an individual who has previously failed the examination or other required evaluation procedure or whole license has been suspended or revoked. A temporary license issued pursuant to this section is valid for 18 months, but a board shall automatically void the temporary license if the applicant fails the examination or other required evaluation procedure.

(2) The Michigan Board of Nursing may grant a nonrenewable, temporary license to an applicant for a license under this article to engage in the practice of nursing as a

registered professional nurse if the applicant is licensed as a registered professional nurse by an equivalent licensing board or authority in another state or, until January 1, 2012, is licensed as a registered professional nurse by an equivalent licensing nurse by an equivalent licensing board or authority in Canada. A temporary license issued under this subsection expires on the earliest of the following:

(a) One year after the date of issuance.

(b) The date the applicant is notified that he or she failed the Commission on Graduates of Foreign Nursing Schools qualifying examination, as approved by the department.

(c) The date of applicant is notified that he or she failed the national council licensure examination, as approved by the department.

(d) The date the applicant is issued a license under this article to engage in the practice of nursing as a registered professional nurse.

(e) The date the applicant is notified that he or she has failed to meet the requirements of this article and rules promulgated under this article for licensure.

(f) The date the applicant is notified that he or she has failed to complete the application process for full licensure.

(3) The holder of a temporary license issued under subsection (1) shall practice only under the supervision of a licensee who holds a license, other than a health profession subfield license, in the same health profession. The holder of a temporary license issued under subsection (1) shall not be supervised by a licensee who holds a limited license or temporary license.

(4) The department shall issue a temporary license within 48 hours upon receiving proof that the applicant's license issued by another state or a province in Canada is currently active and in good standing.

9.3c Sec. 333.1606 (5)

Limited license means a license to which restrictions or conditions, or both, as to scope of practice, place of practice, supervision of practice, duration of licensed status, or type or condition of patient or client served are imposed by a board.

9.3d Sec.333.16201

Renewal of license or registration; mailing notice; failure to receive notice; failure to renew; relicensing or re-registration; temporary license or registration; authority to impose sanctions not terminated by expiration or surrender of license or registration.

9.3e Sec.16201

(1) A license or registration shall be renewed by the licensee or registrant on or before the expiration date as prescribed by rule. The department shall mail a notice to the licensee or registrant at the last known address on file with a board advising of the time, procedure, and fee for renewal. Failure of the licensee or registrant to receive notice under this subsection does not relieve the licensee or registrant of the responsibility for renewing his or her license or registration.

(2) A license or registration not renewed by the expiration date may be renewed within 60 days of the expiration date upon application, payment of renewal, and late renewal fees, and fulfillment of any continued competency or continuing education requirements set forth in this article or rules promulgated under this article. The licensee or registrant may continue to practice and use the title during the 60-day time period.

(3) If a license or registration is not renewed within 60 days of the expiration date pursuant to subsection (2), the license or registration shall be considered null and void. The licensee shall not practice or use the title and a registrant shall not use the title. Except as otherwise provided by rule, a person may be relicensed or re-registered within three years of the expiration date upon application, payment of the application processing, renewal, and late renewal fees, and fulfillment of any continued competency or continuing education requirements in effect at the time of the expiration date, or which would have been required had the individual renewed his or her license or registration pursuant to subsection (1). A temporary license or registration may be issued under Section 16181 pending the results of action taken under this subsection.

(4) Except as otherwise provided in this article or by rule, a person may be relicensed or re-registered more than 3 years after the expiration date upon application as a new applicant, meeting all licensure or registration requirements in effect at the time of application, taking or retaking and passing any examinations required for initial licensure or registration, and payment of fees required of new applicants.

(5) The expiration or surrender of a license or registration does not terminate the board's authority to impose sanctions on the licensee or registrant whose license or registration has expired or been surrendered.

9.4 Administrative Rules Michigan Board of Nursing

Part 2. Licensure

9.4a R 338.10201 Definitions. Rule 201.

(1) As used in this part:

(a) Act means Act No. 368 of the Public Acts of 1978, as amended, being §333.1101 et seq. of the Michigan Compiled Laws.

(b) Board means the Michigan Board of Nursing.

(c) Completed a practice nurse education program acceptable to the board means one of the following:

I. That the applicant is a graduate of a practical nurse education program which is located in Michigan and which is approved by the board.

II. That the applicant is a graduate of a practical nurse education program which is located in another United States jurisdiction if, as required by 333.16186, that program is substantially equivalent to the program requirement of Article 15 of the act and the rules promulgated by the board.

III. That the applicant is a graduate of a nurse education program which is substantially equivalent to a practical nurse education program approved by the board and the applicant has completed the core curriculum for practical nurse applicants. The board shall consider a nurse education program which is not less than 30 weeks in duration and which includes courses in both theory and clinical practice in no less than three of the four areas of nursing included in the core curriculum for practical nurse applicants as substantially equivalent to a practical nurse education program that is approved by the board.

(d) Completed a registered nurse education program acceptable to the board means one of the following:

I. That the applicant is a graduate of a registered nurse education program which is located in Michigan and which is approved by the board.

II. That the applicant is a graduate of a registered nurse education program which is located in another United States jurisdiction if, as required by333.16186, that program is substantially equivalent to the program requirements of article 15 of the act and the rules promulgated by the board.

III. That the applicant is a graduate of a nurse education program which is located outside of the United States and that the applicant is in compliance with the requirements for a certificate from the Commission on Graduates of Foreign Nursing Schools pursuant to the requirements set forth in the document entitled path to CGFNS Certification: Applicant Handbook, Edition 29, August 2001. A copy of the guidebook can be obtained for inspection or

at cost, from the Michigan Department of Community Health, 611 West Ottawa, Box 30670, Lansing, MI 48909, or at http://cgfns.org.

IV. That the applicant is a graduate of a Canadian registered nurse program that is approved by a province in Canada and is taught in English. The applicant shall hold a license to practice nursing in Canada that is active and has not been sanctioned.

(e) Core curriculum for practical nurse applicants means courses in both didactic instruction and planned clinical learning in each of the following four areas of nursing:

I. Medical nursing, which consists of the study of nursing care for the adult patient, both male and female, who is in the acute or chronic phases of a medical illness.

II. Obstetrical nursing, which consists of the study of nursing care for women in the antepartum, labor/delivery, and postpartum phases of pregnancy, and includes the care of the newborn infant and may be referred to as maternal-child nursing. Gynecological nursing alone does not fulfill this obstetric nursing education requirement.

III. Pediatric nursing, which consists of the study of nursing care for children whose ages range from birth through adolescence and who are receiving nursing care for both medical and surgical reasons. This education does not include newborn nursing education.

IV. Surgical nursing, which consists of the study of nursing care for the adult patient, both male and female, who is receiving nursing care for a surgical procedure.

(f) Core curriculum for registered nurse applicants means courses in both didactic instruction and planned clinical learning in each of the following five areas of nursing:

I. Medical nursing, which consists of the study of nursing care for the adult patient, both male and female, who is in the acute or chronic phases of a medical illness.

II. Obstetrical nursing, which consists of the study of nursing care for women in the antepartum, labor/delivery, and postpartum phases of pregnancy, and includes the care of the newborn infant and may be

referred to as maternal-child nursing. Gynecological nursing alone does not fulfill this obstetric nursing education requirement.

III. Pediatric nursing, which consists of the study of nursing care for children whose ages range from birth through adolescence and who are receiving nursing care for both medical and surgical reasons. This education does not include newborn nursing education.

IV. Psychiatric nursing, which consists of the nursing care of patients who are receiving nursing care for an acute or chronic psychiatric disorder. It may also be referred to as mental health nursing. Education that covers only areas of mental retardation, organic brain syndromes, or neurological diseases does not fulfill the psychiatric nursing education requirement.

V. Surgical nursing, which consists of the study of nursing care for the adult patient, both male and female, who is receiving nursing care for a surgical procedure.

(g) Department means the Michigan Department of Community Health.

(2) Terms defined in the act have the same meaning when used in these rules.

9.4b. R 333.10201. Examination; adoption; passing scores. Rule 202

The board approves and adopts the examinations developed by the National Council of State Boards of Nursing, Inc, hereafter identified as the NCLEX-RN for the registered nurse and the NCLEX-PN for the practical nurse.

9.4c. R 338.10203 Licensure by examination; requirements. Rule 203.

(1) An applicant for licensure by examination shall submit a completed application on a form provided by the department, together with the requisite fee. In addition to meeting the other requirement of the act and the administrative rules promulgated pursuant thereto, an applicant shall satisfy the requirements of this rule.

(2) An applicant for a registered nurse license shall establish that she/he meets the eligibility requirements to sit for the NCLEX-RN set for in R338.10204 and shall pass the NCLEX-RN.

(3) Notwithstanding the provisions of section 16307(3) of the act, the fees paid by an applicant who has not completed all requirements for licensure by examination within three years after receipt of the application by the department shall be forfeited to the department and the application shall be void.

9.4d. R 338.10204 Examination; eligibility; reexaminations. Rule 204.

(1) To assure eligibility for the examination, an applicant shall submit a completed application on forms provided by the department, together with the requisite fee.

(2) To be eligible to site for the NCLEX-RN, an applicant shall establish that he or she or completed a registered nurse education program that is acceptable to the board.

(3) To be eligible to sit for the NCLEX-RN, an applicant shall establish that he or she has completed a practical nurse education program that is acceptable to the board.

(4) To be eligible to sit for the NCLEX-RN, an applicant whose nursing education was taught in a language other than English shall demonstrate a working knowledge of the English language in addition to meeting the other requirements of this rule. To demonstrate a working knowledge of English, an applicant shall document that he or she has obtained a scaled score of not less than 550 on the paper-based test or a scaled score of not less than 213 on the computer –based test of English as a foreign language that is administered by the educational testing service and obtained a score of not less than 50 on the test of spoken English that is administered by the educational testing service.

(5) An applicant shall complete the NCLEX-RN within 12 months of his or her first attempt at the test in this state or another state. The first attempt at the test shall occur within 2 years of graduation from a registered nurse education program. An applicant who not achieved a passing score on the examination with the 12-month period shall not be eligible to sit again for the NCLEX-RN until the applicant has completed a registered nurse education program that is acceptable to the board. Thereafter, an applicant may sit for the examination an additional cycle of 3 times after repeating the required registered nurse education program. An applicant may sit for the NCLEX-RN a maximum of 6 times total.

(6) If an applicant is a graduate of a Canadian registered nurse program that is approved by a province in Canada and is taught in English and the applicant holds a current license in Canada, the first attempt at taking the NCLEX-RN will not have to occur within 2 years of graduation.

(7) An applicant shall complete the NCLEX-PN within 12 months of his or her first attempt at the test in this state or another state. The first attempt at the test shall occur within 2 years of graduation for a practical nurse education program. An applicant who has not achieved a passing score on the examination within the 12-month period shall not be eligible to sit again for the NCLEX-PN until the applicant has completed a practical nurse education program that is acceptable to the board. Thereafter, an applicant may sit for the examination an additional cycle of 3 times after repeating the required practical nurse education program. An applicant may sit for the NCLEX-PN a maximum of 6 times total.

9.4e R 338.10206 Licensure by endorsement; requirements. Rule 206.

(1) An applicant for licensure by endorsement shall submit a completed application on a form provided by the department, together with the requisite fee. In addition to meeting the other requirements of the act and the administrative rules promulgated

(2) An applicant for a registered nurse license shall meet both of the following requirements:

(a) The applicant shall establish that she/he has completed a registered nurse education program that is acceptable to the board as defined in R 338. 10201 or that she/he meets all of the following requirements.

(i) Was first licensed in another state before the effective date of this amendatory rule.

(ii) Is a graduate of a nurse education program that is located outside the United States.

(III) Is a graduate of a nurse education program which is not less than sixty weeks in duration and which includes courses in both theory and clinical practice in not less than three of the five areas of nursing included in the core curriculum for registered nurse applicants.

(iv) Has completed the core curriculum for registered nurse applicants.

(b) An applicant shall establish one of the following:

(i) That she/he was first licensed as a registered nurse in another state pursuant to an examination that was taken before July 13, 1982.

(ii) That she/he was first licensed as a registered nurse in another state pursuant to an examination that was taken on or after July 13, 1982, but before February 14, 1989, and achieved a score of not less than 1600 on the NCLEX-RN.

(iii) That she/he was first licensed as a registered nurse in another state pursuant to an examination that was taken on or after February 14, 1989, and achieved a score of PASS on the NCLEX-RN.

(3) An applicant for a practical nurse license shall meet both of the following requirement:

(a) The applicant shall establish that she/he has completed a practical nurse education program that is acceptable to the board.

(b) An applicant shall establish one of the following:

(i) That she/he was first licensed as a practical nurse in another state pursuant to an examination that was taken before October 19, 1982.

(ii) That she/he was first licensed as a practical nurse in another state pursuant to an examination that was taken on or after October 19, 1982, but before October 18, 1988, and achieved a score of not less than 350 on the NCLEX-PN.

(iii) That she/he was first licensed as a practical nurse in another state pursuant to an examination that we taken on or after October 18, 1988, and achieved a score of PASS on the NCLEX-PN.

10.0 License Renewal / Continuing Education Rules

All nurses must be aware of license renewal and continuing education requirements.

10.a. What kind of continuing education is needed for license renewal?

The Michigan Public Health Code provides regulatory boards with the authority to promulgate rules that establish standards for license renewal [see R333.16148(1)]. With this authority, the Michigan Board of Nursing has promulgated administrative rules for RN and LPN license renewal (see pages 28 – 27), Rules 338.10601-10603).

RNs and LPNs must earn 25 continuing education contact hours (50 or 60 minutes each) during the two years preceding an application for license renewal. At least one of the 25 contact hours must be in pain and pain symptom management.

Nurses will keep their own records such as continuing education certificates, academic transcripts and other documents that verify participation in activities deemed acceptable for license renewal by the Michigan Board of Nursing. Only those nurses selected for audit will be required to send in evidence of compliance with the rules.

The rules offer many methods to obtain the necessary credit. The Michigan Board of Nursing adopted standards from the follow organizations as acceptable methods of approvel:

- American Nurses Credentialing Center (ANCC)

These standards are implemented by the Michigan Nurses Association as an American Nurses Credentialing Center accredited provider of nursing continuing education. Continuing education provided by MNA satisfies this standard.

- National Association for Practical Nurse Education and Service
- National League for Nursing
- American College of Nurse Midwives
- American Osteopathic Association

- Accreditation Council for Continuing Media Education
- Basic and advanced life support standards of the American Heart Association

10.1 Earn Unlimited Continuing Education Credits

1. Attend continuing education programs in compliance with standards set by one of the seven organizations identified above

2. Earn Michigan Board of Nursing specialty certification or recertification as a nurse midwife, nurse anesthetist or nurse practitioner

3. Attend continuing education programs which have been granted approval by another state board of nursing

4. Attend continuing education programs related to nursing practice offered by a Michigan Board of Nursing approved school/college of nursing

5. Read a journal and complete a test which has been developed for continuing nursing education

6. Attend academic courses related to nursing practice offered by a Michigan Board of Nursing approved school/college of nursing: a) five continuing education contact hours for each semester credit, b) three continuing education contact hours for each quarter credit

7. Ten continuing education contact hours may be granted for publication in a nursing or health care journal or textbook of an article or chapter related to the practice of nursing

10.2 Earn Limited Continuing Education Credits

1. Up to six continuing education contact hours may be earned by presenting a program that is not a part of licensee's regular job description in compliance with standards of the methods of approval (three continuing education contact hours for each 50 or 60 minute presentation).

2. Up to four continuing education contact hours may be granted for each documented hour of reading articles or viewing or listening to media devoted to nursing practice.

3. Ten continuing education contact hours may be granted in the year in which a licensee successfully completes a national nursing specialty examination.

4. Up to four continuing education contact hours may be earned for documented participation in a health care organization committee dealing with patient care issues.

5. Ten continuing education contact hours may be earned for participation in a workshop dealing with patient care issues offered by a health care organization or professional organization that falls outside the methods of approval.

Licensed nurses must retain documentation of meeting these requirements for a period of four years from the date of applying for license renewal

Failure to comply with these requirements shall be considered a violation of the law which could result in investigation of the license.

10.3 Administrative Rules Michigan Board of Nursing: Continuing Education

10.3a R 338.10601 License Renewals; relicensure; requirements; applicability.

Rule 1.

(1) This part applies to applications for renewal of a nursing license and applications for relicensure pursuant to R 333.6201 (3) that are filed two years or more after the effective date of these rules.

(2) An applicant for license renewal who has been licensed for the two-year period immediately preceding the expiration date of the license or an applicant for relicensure shall accumulate not less than 25 continuing education contact hours that are approved by the board pursuant to these rules during the two years preceding an application for renewal or relicensure.

(3) An applicant for license renewal shall complete at least 1 continuing education contact hour in pain and pain symptom management in each renewal period. Continuing education contact hours in pain and pain symptom management may include, but are not limited to, curses in behavior management, psychology of pain, pharmacology, behavior modification, stress management, clinical applications, and drug interactions. This subrule will take effect with the April 1, 2005 renewal cycle.

(4) Submission of an application for renewal or relicensure shall constitute the applicant's certification of compliance with the requirements of this rule. A nurse shall retain documentation of meeting the requirements of this rule for a period of four years from the date of applying for license renewal or relicensure. Failure to comply with this rule shall be deemed to be a violation of section 162219(g) of the Act.

10.3b R 338.10602 Acceptable continuing education; limitations.

Rule 2.

The board shall consider any of the following as acceptable continuing education:

(a) One continuing education contact hour, without limitation, may be earned for each 50 or 60-minute attendance at a continuing education program that is in compliance with the standards set forth in R338.10603 (1), (2), (3), (4), (5), and (6).

(b) Three continuing education contact hours may be earned for each 50 or 60-minute presentation of a continuing education program that is not a part of the licensee's regular job description that is in compliance with the standards set forth in R338.10601 (1), (2), (3), (4), and (5). Credit may be earned for the same program only once in each renewal period. A maximum of six continuing education contact hours may be earned pursuant to this subdivision.

(c) Five continuing education contact hours may be earned for each semester credit earned for academic courses related to nursing practice offered in an education program approved by the board pursuant to R 338.10201 (1)(c)(i) and (ii) and (d)(i) and (ii).

(d) Three continuing education contact hours may be earned for each quarter credit earned for academic courses related to nursing practice offered in an educational program approved by the board pursuant to R 338.10201 (1)(c)(i) and (ii) and (d)(i) and (ii).

(e) 25 continuing education contact hours may be earned by specialty certification or recertification as one of the following:

(i) Nurse midwife
(ii) Nurse anesthetist
(iii) Nurse practitioner

(f) One continuing education contact hour may be granted for each 50 to 60 minutes of program attendance, without limitation, at a continuing education program which has been granted approval by another state board of nursing.

(g) One continuing education contact hour may be granted for each 50 to 60 minute attendance, without limitation, at a continuing education program related to nursing practice offered by an educational program approved by the board pursuant to R 3338.10201 (1)(c)(i) and (ii) and (d)(i) and (ii).

(h) Ten continuing education contract hours may be granted for publication, in a nursing health care journal or textbook, of an article or chapter related to the practice of nursing or allied health.

(i) One continuing education contact hour may be granted for each documented hour of reading articles or viewing or listening to material devoted to nursing practice. A maximum of four hours may be credited pursuant to this subdivision.

(j) Ten continuing education contact hours may be granted in the year in which an applicant is advised she/he successfully completed a national nursing specialty examination.

(k) One continuing education contact hour may be granted for each 50 to 60 minutes of participation documented in a health care organization committee dealing with patient care related issues. A maximum of four credit hours may be earned.

(l) A maximum of ten continuing education contact hours may be earned for participation in a workshop dealing with patient care issues, with one continuing education contact hour granted for each 50 to 60 minute segment offered by a health care organization or a professional organization that falls outside the methods of approval references specified in R 338.10603.

(m) One continuing education contact hour may be granted for each 50 to 60 minutes of reading a journal and completing a test which has been developed for continuing nursing practice education.

10.5 R 338.10603 Continuing nursing education programs; methods of approval.

Rule 3.

(1) The board approves and adopts by reference the standards of the American Nurses Credentialing Center's Commission on Accreditation that are set forth in the publications entitled "Manual for Accreditation as a Provider of Continuing Education in Nursing 1991" and "Manual for Accreditation as an Approver of Continuing Education in Nursing 1991." Copies of the publications are available for inspection at the office of the Michigan Department of Community Health, 611 West Ottawa Street, P.O. Box 30018, Lansing, MI 48933, or may be purchased from the American Nurses Credentialing Center, 8515 Georgia Ave, Suite 400, Silver Spring, MD 30910-3492, at a cost as of the time of adoption of these rules of $20.00 per manual.

(2) The board approves and adopts by reference the standards and criteria of the national association for practical nurse education and service that are set forth in the publication entitled "NAPNES Criteria for Approval of Continuing Education 1986." A copy of the publication may be obtained from the Michigan Department of Community Health, 611 West Ottawa, P.O. Box 30018, Lansing, MI, 48909, at no cost, or the National Association for Practical Nurse Education and Service, 1940 Duke Street, Suite 200, Alexandria, VA 22314, at a cost as of the time of adoption of these rules of $3.00.

(3) The board approves and adopts by reference the standards, criteria, and guidelines adopted by the National League for Nursing in January 1983 and the American College of Nurse-Midwives in March 1988 and set forth in the publication entitled "The

Continuing Education Unit Criteria and Guidelines, Fifth Edition, International Association for Continuing Education and Training." A copy of the standards, criteria, and guidelines may be obtained at no cost from the Michigan Department of Community Health, 611 West Ottawa, P.O. Box 30018, Lansing, MI 48909, the National League for Nursing, 61 Broadway, 3rd Floor, New York, NY 10006, or the American College of Nurse-Midwives, 8403 Colesville Road, Suite 1550, Silver Sprints, MD 20910.

(4) The board approves and adopts by reference the standards, requirements, and guidelines adopted in January 1989 by the Committee on Continuing Medical Education, American Osteopathic Association that are set forth in the publication entitled "Continuing Medical Education Guide 1989." A copy of the publication may be obtained at no cost from either the Michigan Department of Community Health, 611 West Ottawa, P.O. Box 30018, Lansing, MI 48909, or the Division of Continuing Medical Education, American Osteopathic Association, 142 East Ontario Street, Chicago, IL 60611.

(5) The board approves and adopts by reference the standards of the Accreditation Council for Continuing Medical Education on October 29, 1982, in accrediting organizations in institutions offering continuing medical education programs.

The standards may be obtained at no cost from either the Michigan Department of Community Health, 611 West Ottawa, P.O. Box 30018, Lansing, MI 48909, or the Accreditation Council for Continuing Medical Education, 515 North State Street, Suite 1801, Chicago, IL 60654.

(6) The board approves and adopts by reference the standards for certification in basic and advanced life support set forth by the American Heart Association in the standards and guidelines for cardiopulmonary resuscitation, emergency cardiac care, and neonatal resuscitation and published in the "Journal of the American Medical Association" (JAMA), volume 268(16), October 28, 1992. A copy of the standards and guidelines for cardiopulmonary resuscitation, emergency cardiac care, and neonatal resuscitation may be obtained from either the Michigan Department of Community Health, 611 West Ottawa, P.O. Box 30018, Lansing, MI 48909, at no cost, or the American Heart Association, 7272 Greenville, Avenue, Dallas, TX 75231, at a cost as of the time of adoption of these rules of $1.04.

(7) The board may deny approval of programs offered by institutions and organizations if it appears to the board that the programs offered by those institutions or organizations fail to demonstrate compliance with the legislative intent to further educate licensees on subjects related to the practice of nursing.

10.4 Continuing Education Resources

MNA offers conferences, workshops, conventions and self-study activities that award participants contract hours congruent with the standards of the American nurses Credentialing Center. ANCC's standards are accepted by the Michigan Board of Nursing toward license renewal.

Visit MNA's website, www.minurses.org for more information.

11.0 Understanding Delegation and Supervision

Understanding delegation and delegating appropriately are critically important for nurses. The delegatory process can enhance the nurse's ability to provide complete, competent care efficiently and within nursing standards. The rules of delegation must be strictly followed to ensure that the quality of care provided is not compromised.

Delegation to unlicensed individuals involves both compliance with law and making professional judgments. This is an example of a practice issue where the line of demarcation between legal authority and professional responsibility becomes blurred. The medical supervision is necessary to perform medical task or provision in any care setting.

Four sections of the Michigan Public Health Code, plus rules promulgated by the Michigan Board of Nursing, provide the legal framework for delegation and supervision. The following sections are applicable to each licensee whose practice is regulated by the Public Health Code.

11.1 What is delegation?

R 333.16104 Delegation

(1) Delegation means an authorization granted by a licensee to a licensed or unlicensed individual to perform selected acts, tasks, or functions which fall within the scope of practice of the delegator and which are not within the scope of practice of the delegate and which, in the absence of the authorization, would constitute illegal practice of a licensed profession.

11.2 How is supervision defined?

R 333.16109 Supervision

(2) Supervision, except as otherwise provided in this article, means the overseeing of or participation in the work of another individual by a health professional licensed under this article in circumstances where at least all of the following conditions exist:

(a) The continuous availability of direct communication in person or by radio, telephone, or telecommunication between the supervised individual and a licensed professional.

(b) The availability of a licensed health professional on a regularly scheduled basis to review the practice of the supervised individual, to provide consultation to the supervised individual, to review records, and to further educate the supervised individual's functions.

(c) The provision by the licensed supervising health professional of predetermined procedures and drug protocol.

Section 333.16215 of the Public Health Code is not determinative in deciding whether nurses are "supervisors" as defined by the National Labor Relations Act (NLRA).

11.3 What must be done when delegating?

The Michigan Board of Nursing has promulgated the general rules concerning delegation by the authority conferred under 1978 P.A. 368.17201, MCL 333.17201 et seq:

R 338.10104 Delegation

Rule 104.

(1) Only a registered nurse may delegate nursing acts, functions or tasks. A registered nurse who delegates nursing acts, functions, or tasks shall do all of the following:

(a) Determine whether the act, function or task delegated is within the registered nurse's scope of practice.

(b) Determine the qualifications of the delegate before such delegation.

(c) Determine whether the delegate has the necessary knowledge and skills for the acts, functions or tasks to be carried out safely and competently.

(d) Supervise and evaluate the performance of the delegate.

(e) Provide or recommend remediation of the performance when indicated.

(2) The registered nurse shall bear ultimate responsibility for the performance of nursing acts, functions or tasks performed by the delegate within the scope of the delegation.

11.4 Determining when to Delegate

Nurses must draw upon their experience and use professional judgment when deciding if and when to delegate. Consideration of the education, training and experience of the delegate, as well as considering those factors in the person to whom you are delegating is essential. All factors are crucial.

11.5 Application of Legal Framework Delegation/Supervision

R 333.16215 Delegation of acts, tasks, or functions to a licensed or unlicensed individual; supervision.

(1) A licensee who holds a license other than a health profession subfield license may delegate to a licensed or unlicensed individual who is otherwise qualified by education, training or experience the performance of selected acts, tasks, or functions where the acts, tasks, or functions fall within the scope of practice of the licensee's profession and will be performed under the licensee's supervision. An act, task, or function shall not be delegated under this section which, under standards of acceptable and prevailing practice, requires the level of education, skill, and judgment required of a licensee under this article.

To assist in determining if a specific act, task or function should be delegated, examine the intent of each phrase in 333.16109 and 333.16215 (1) and consider its meaning for nurses.

"…A licensee who holds a license other than a health profession subfield may delegate to a licensed or unlicensed individual…"

- Licensees (e.g. RNs, MDs and Dos) may delegate to RNs and others
- RNs may delegate to RNs
- RNs may delegate to LPNs
- RNs may delegate to unlicensed individuals
- LPNs are a subfield and may not delegate

"A licensee may delegate to an individual who is otherwise qualified by education, training or experience…"

- **Appropriate delegation:** The decision of an RN to delegate duties must involve professional judgment. The RN uses assessment skills and judgment to evaluate the qualifications of the person to whom she/he delegates. The registered nurse must also evaluate the patient's needs, the complexity of the task and the environment in which the task must be performed. If the task can be performed safely and competently by the delegate, given the unique condition of that patient, then the task may be delegated. RNs may delegate to other RNs, to LPNs, or to unlicensed assistive personnel. While the scope of practice of other licensed nurses if fairly clear, the appropriate role of unlicensed individuals may be less distinctly defined. Some agencies provide written resources documenting the education, training and experience of unlicensed caregivers, but others do not.

- **Education:** What is the formal educational background of the delegate? Did the educational program prepare the individual to perform the task? Did the formal academic educational program provide the background in anatomy, physiology, biological, physical and behavioral sciences necessary to enable the individual to receive further instruction to perform the task?

- **Training:** Is there evidence the individual has had inservice, staff development or continuing education to qualify the individual to carry out the task to be delegated (for example, ACLS certification)? Did the training session have an appropriate educational design (i.e., behavioral objectives, definitive content outline, qualified instructors, appropriate teaching methods,

adequate time frames)? Was there a competency measurement to determine if the individual learned what was taught during the training program? How does one know whether or not individuals with whom she/he works have or have not successfully completed a training program? Are written agency procedures, policies and protocols used training programs? Is there a formal procedure whereby the employer indicates when staff have completed necessary training to accept certain delegated tasks?

- **Experience:** When individuals are employed by an agency, how is their experience assessed? Is this information forwarded in written form? How recent is the individual's experience? Is the individual's past experience congruent with what is now expected? Has the individual's work experience included employment where the individual was required to accept more responsibility or less responsibility than is now expected? Is the individual's experience consistent with her/his education and training?

"A licensee may delegate the performance of selected acts, tasks, or functions where the act, task, or function falls within the scope of practice of the licensee's profession…"

- **Task to be delegated:** A licensee cannot delegate responsibilities that are not within the licensee's scope of practice. For public safety reasons, certain professional responsibilities or tasks may never be delegated to non-RNs. A licensee may not delegate her/his entire scope of practice, but selects certain acts, tasks, or functions to delegate. The RN does not delegate the task of patient assessment to non-RNs; rather, the task delegated is collection of specific data, such as vital signs or appearance of skin. The RN does not delegate planning and evaluating nursing care to non-RNs.

"Delegated tasks will be performed under the licensee's supervision."

- **Responsibility for delegate:** If a task is delegated, the delegator must supervise or provide for supervision by an equally qualified person. A clear line of authority or "chain of command" must exist. The RN bears the ultimate responsibility for the performance of nursing acts, functions, or tasks performed by the delegate within the scope of the delegation.

"An act, task, or function shall not be delegated under this section which, under standards of acceptable and prevailing practice, requires the level of education, skill and judgment required of a licensee under this article."

- **Prevailing standard of care:** Standards are derived from many sources: legal, regulation, professional regulation, educational program curricula, professional literature, research, and other areas. These standards determine qualifications for persons to perform delegated functions. While an individual may claim she/he is capable of performing a certain task, the acceptable and prevailing standard of care determines the appropriateness of delegating that task.

11.6 Deciding to Delegate

When shouldn't delegation occur?

The American Association of Critical Care Nurses recommends that registered nurses assess the following five factors before deciding to delegate:

1. Potential for harm

2. Complexity of a nursing activity

3. Required problem solving and innovation

4. Predictability of outcome

5. Extent of patient interaction

11.7 Decision Grid for Delegation to a Non-Nurse

Instructions:

This grid can be used to evaluate activities being considered for delegation to a non-nurse. For the task at hand, consider both the task and the specific patient involved. Score each factor for this patient (0 = none, 1 = low, 2 = moderate, 3 = high). The higher the score, the less likely it is that the nurse would delegate the task.

As seen from the examples, the scores for the same activity – suctioning – are different for two different patients. The range of scores considered acceptable for delegation needs to be determined within each practice setting.

Five Factors Affecting Decision to Delegate						
Task and Specific Patient Combination	Potential for Harm	Complexity Of Task	Problem Solving and Innovation Necessary	Unpredictability of Outcome	Level of Interaction Required with Patient	Total
Suctioning patient has closed head injury and increased intracranial pressure	3	2	3	3	2	13

Suctioning patient is comatose with stable vital signs	1	2	1	1	2	7

From "Delegation: A Tool for Success in the Changing Workplace," American Association of Critical Care Nurses, 1995. Reprinted with permission.

11.8 Acceptable Use of the Authority to Delegate

The decision to delegate should be consistent with the nursing process (appropriate assessment, planning, implementation, and evaluation). Therefore, it is impossible to develop a list of nursing tasks that can be routinely delegated for all patients in all situations. Rather, the nursing process and decisions to delegate must be based on careful analysis of the patient's needs and circumstances. Before delegating any task, the delegating nurse is responsible for an individualized assessment of the patient and situational circumstances, and for ascertaining the competence of the delegate. After deciding to delegate a task, supervision, monitoring, evaluation, and follow-up by the nurse are crucial. Furthermore, the delegate is accountable for accepting the delegation and for her/his own actions in carrying out the task.

11.9 Delegation Decision-Making Process

In delegating, the nurse must ensure appropriate assessment, planning, implementation, and evaluation. The delegation decision-making process, which is continuous, is described by the following model:

I. Delegation criteria:

A. Nursing Practice Act (Michigan's Public Health Code)

1. Permits delegation

2. Authorizes task(s) to be delegated or authorizes the nurse to decide delegation

B. Delegator qualifications

1. Within scope of authority to delegate

2. Appropriate education, skills and experience

3. Documented/demonstrated evidence of current competency

C. Delegatee qualifications

1. Appropriate education, training, skills and experience

2. Documented/demonstrated evidence of current competency

Provided that this foundation is in place, the registered nurse may enter the continuous process of delegation decision-making.

II. Assess the situation

A. Identify the needs of the patient, consulting the plan of care

B. Consider the circumstances/setting

C. Assure the availability of adequate resources, including supervision

If patient needs, circumstances, and available resources (including supervisor and delegate) indicate patient safety will be maintained with delegated care, proceed to III.

III. Plan for the specific task(s) to be delegated

A. Specify the nature of each task and the knowledge and skill required to perform it

B. Require documentation or demonstration of current competence by the delegate for each task

C. Determine the implications for the patient, other patients, and significant others

If the nature of the task, competence of the delegate, and patient implications indicate patient safety will be maintained with delegated care, proceed to IV.

IV. Assure appropriate accountability

A. As delegator, accept accountability for performance for the task(s)

B. Verify that delegate accepts the delegation and the accountability for carrying out the task correctly

If the delegator and delagatee accept the accountability for their respective roles in the delegated patient care, proceed to V.

V. Supervise performance of the task

A. Provide directions and clear expectations of how the task(s) is to be performed

B. Monitor performance of the task(s) to assure compliance to established standards of practice, policies and procedures

C. Intervene if necessary

D. Ensure appropriate documentation of the task(s)

VI. Evaluate the entire delegation process

A. Evaluate the patient

B. Evaluate the performance of the task(s)

C. Obtain and provide feedback

VII. Reassess and adjust the overall plan of care as needed

Reprinted from "Delegation: Concepts and Decision-Making Process" prepared by the National Council of State Boards of Nursing, 1995, with permission.

11.10 When is it right to delegate?

The Five Rights of Delegation provide an additional resource to facilitate decisions about delegation.

The Five Rights of Delegation

1 Right Task

One that is delegatable for a specific patient.

2 Right Circumstances

Appropriate patient setting, available resources, and other relevant factors considered.

3 Right Person

Right person is delegating the right task to the right person to be performed on the right person.

4 Right Direction/Communication

Clear, concise description of the task, including Its objective, limits and expectations.

5 Right Supervision

Appropriate monitoring, evaluation, intervention,
As needed, and feedback.

Note. From "Delegation: Concepts and Decision Making Process," National Council of State Boards of Nursing, 1995. Reprinted with permission.

11.11 Creating an Environment for Appropriate Delegation

Unless the environment in which nursing is practiced supports appropriate delegation, it is not likely to be successful. Support must begin at the highest level of administration. Systems must be created to make appropriate delegation a realistic expectation. Registered nurses will not feel comfortable delegating unless they know what knowledge, skills and competencies potential delegates possess. RNs need to know how unsatisfactory delegate performance will be handled, and their role in the process.

11.12 What should not be delegated?

Nursing activities that include the core of the nursing process (assessment, diagnosis, planning, and evaluation) and require specialized knowledge, judgment, and/or skill should not be delegated. Examples of activities which should NOT be delegated:

- The initial nursing assessment and any subsequent assessment that requires professional nursing knowledge, judgment, and skill.
- The determination of the nursing diagnoses, establishment of the nursing care goals, development of the nursing plan of care, and e valuation of the client's progress in relation to the plan of care.
- Any nursing intervention which requires professional nursing knowledge, judgment, and skill. Nursing judgment is the intellectual process that an RN exercises in forming an opinion and reaching a conclusion by analyzing the data.

(ANA, "Registered Professional Nurse," 1992, 1994, p. 12).

12.0 The Registered Nurse and the Responsibility for Unlicensed Assistive Personnel

The utilization of unlicensed assistive personnel (UAP) provides an excellent opportunity to expand the capacity for services that can be provided in various health care settings. In order to utilize UAPs in a manner that protects the quality of care provided, some key factors must be in place. RNs must have a comprehensive understanding of appropriate utilization, must delegate appropriately, and supervise effectively.

The American Nurses Association (ANA) has developed a broad definition of unlicensed assistive personnel to serve as a basic frame of reference for current and future policy. The definition is:

"*Unlicensed assistive personnel (UAPs) are individuals who are trained to function in an assistive role to the registered professional nurse in the provision of patient/client care activities as delegated by and under the supervision of the registered professional nurse."*

12.1 What are UAPs?

"Unlicensed assistive personnel (UAPs) are individuals whose authorization to perform activities is not defined by individual state nursing practice acts. Only professional and practical nurses have legal scopes of practice and therefore legal authority to perform nursing acts."

The term UAP includes such job titles in the hospital setting as nurse aides or patient-care aides, orderlies, assistants, attendants or technicians. In long-term care settings, the title of competency-evaluated nurse's aide (CENA) remains the primary job title because it is defined in federal statute. In home care, the certified home health aide (CHHA) is the title used for UAPs.

ANA, "Principles for Delegation," Principles for Practice Package, 2010), Nursing's Professional Accountability

12.2 Who has accountability for UAPs?

IT IS THE NURSING PEROFESSION that determines the scope of nursing practice.

IT IS THE NURSING PROFESSION that defines and supervises the education, training, and utilization of any unlicensed assistant roles involved in providing direct patient care.

IT IS THE RN who is responsible and accountable for nursing practice.

IT IS THE RN who supervises and determines the appropriate utilization of any unlicensed assistant involved in direct patient care.

IT IS THE PURPOSE of unlicensed assistive personnel to assist the RN in providing patient care.

(ANA, 1991, 1996, p. 4).

"The current changes in the health care environment have and will continue to alter the scope of nursing practice and its relationship to the activities delegated to unlicensed assistive personnel (UAP). Nurses and the public must ensure that UAPs are not performing functions which are within the legal practice of nursing, unless these are appropriately delegated. To do otherwise would violate the state nursing practice act and be a threat to public safety. Today, it is the nurse who must have a clear definition of what constitutes the scope of nursing practice with the reconfiguration of practice settings, delivery sites and staff composition."

(ANA, 1992, 1996, p. 89).

In delegating, it is the RN who uses professional judgment to determine the appropriate activities to delegate. The determination is based on the concept of protection of the public and includes consideration of the needs of the patients, the education and training of the nursing and assistive staff,

the extent of supervision required, and the staff workload. Any nursing intervention that requires independent, specialized nursing knowledge, skill or judgment can not be delegated.

(ANA, 1992, 1996, p. 82).

Registered nurses need to be clear about the standards for which they are accountable. For the clinical setting, the ANA Standards of Clinical Nursing Practice defines RN accountability. Work settings vary in philosophy, mission, goals, culture, resources, client characteristics, and the availability of registered nurses to provide supervision to UAPs. In each work sett, therefore, RNs must first determine what nursing functions must be done by an RN.

Next, the RN determines what tasks may be delegated to unlicensed assistive personnel if the client condition warrants delegation.

12.3 UAP Competency Training

For those tasks that may be appropriate to delegate to the UAP, registered nurses should:

- Develop and teach a competency-based educational program for the UAP,
- Validate the competencies of the UAPA,
- Develop a plan for UAP continuing education and competency revalidation, and
- Develop a mechanism to communicate the competency status of each UAP to any RN who may be working with the UAP.

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: HEALTH PROMOTION AND PREVENTATIVE CARE

PURPOSE STATEMENT: To develop a high level of wellness and influence the consumer health behavior and the environment in which the consumer lives.

POLICY: NM 13.001

DEFINITION:

Health education is included in the American Nurses Association Standards of Care as is defined as an essential component of nursing care. It is directed toward promotion, maintenance, and restoration of health and toward adaptation to the residual effects of illness.

Health promotion areas: access to quality health care, arthritis, osteoporosis, chronic back conditions, cancer, chronic kidney disease, diabetes, disability and secondary conditions, environmental health, family planning, food safety, health communication, heart disease and stroke, human immunodeficiency virus, immunization and infectious disease, injury and prevention, medical product safety, maternal health, nutrition and weight control, oral health, physical activity and fitness, respiratory disorders, sexually transmitted infections, substance abuse, tobacco use, vision and hearing.

PROCEDURE:

I. Assessing learning readiness

1. Assist the consumer in physical readiness to learn by trying to alleviate physical distress that may distract the patient's attention and prevent effective learning.

2. Assess the consumer's emotional readiness to learn. Evaluate any barriers that any inhibit learning such as: threat of illness, social and cultural values, and the recognition of the need to learn.

3. Assess and promote the consumer's experiential readiness to learn. Determine what experiences the consumer has had previously with health and illness, and success or failures that consumer had with learning, and evaluate the consumer knowledge of health topics.

II. *Teaching Strategies*

Consumer health education can be presented at any time in any setting, if the environment is conducive to learning.

1. Utilize a variety of techniques to meet the need to the consumer.

2. Document the consumer teaching in the chart that should include the following:what topics presented the consumer response, the care giver response, and the nurse anticipatory plan in future topics.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ADMINISTERING MEDICATIONS

PURPOSE STATEMENT: To safely administer medications to the consumer.

POLICY: NM 13.002

PREPARATION: Prepare medications using appropriate equipment and techniques for the drug administration modality**.**

- Develop and use an environment that maximizes safe and efficient administration of medication.
- Follow the six rights of medication administration.
- Verify the prescription or medication order before administering the drug.
- Assess the consumer's allergies prior to administration.
- Ensure that medications are either discontinued or reordered on their renewal date.
- Note expiration date on all medications. Dispose of unused or expired medications, according to agency guidelines.
- Research the medications side effected, drug actions, interactions, and adverse effects.
- Assess the consumer's ability to swallow.
- Evaluate the consumer's knowledge of the medication and explore learning needs.
- Be informed of the reason why the consumer is receiving the medication, drug classification, contraindications, usual dosage, side effects, and nursing considerations for the administering and evaluating the medications.
- Check the medication administration record for the medication name, dosage, frequency, route of administration, expiration date, and compare the physicians order.
- Assess whether the consumer is nauseated or vomiting, or has diminished bowel sounds.
- Restrict medications that are not properly labeled.
- Monitor vital signs and laboratory values before medication administration.
- Do not set up medications in advance. Do not attempt to administer medications to more than one person at a time.
- Do not leave the medication unattended at the table or with the person for them to take later.

PROCEDURE:

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Review medication administration record for medications due.

4. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet.

5. Compare the label of the medication container or unit-dose package against the order on the medication administration record before taking them from storage.

6. Perform a second check that the medication labels due match the medication administration record while taking them from storage; making sure that all 6 rights are present.

7. Dispense medication into medication cup. Turn bubble packs over, sign and date back.

8. Third verification that medications dispensed matches the medication administration record.

9. Put away consumer's medication supply back in storage and locked storage area.

10. Verify correct consumer by 2 identifiers (but may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card).

11. Verify that the correct consumer matches MAR.

12. Provide education about medication administered.

13. Administer medication to the consumer. Remain with the consumer while he or she has swallowed the medications.

14. Dispose of the cup in the proper wastebasket and wash your hands thoroughly.

15. Monitor patient for adverse effects, toxicity, and interactions of the administered medications.

16. Observe, report and record the person's response to the medication.

17. Perform hand hygiene.

18. Document administration of medications.

REFERNECES:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: NASAL MEDICATION INSTILLATION

PURPOSE STATEMENT: To safely administer medications to the consumer.

POLICY: NM 13.003

PREPARATION: Prepare medications using appropriate equipment and techniques for the drug administration modality.

- Develop and use an environment that maximizes safe and efficient administration of medication.
- Follow the six rights of medication administration.
- Verify the prescription or medication order before administering the drug.
- Assess the consumer's allergies prior to administration.
- Ensure that medications are either discontinued or reordered on their renewal date.
- Note expiration date on all medications. Dispose of unused or expired medications, according to agency guidelines.
- Research the medications side effected, drug actions, interactions, and adverse effects.
- Assess the consumer's ability to swallow.
- Evaluate the consumer's knowledge of the medication and explore learning needs.
- Be informed of the reason why the consumer is receiving the medication, drug classification, contraindications, usual dosage, side effects, and nursing considerations for the administering and evaluating the medications.
- Check the medication administration record for the medication name, dosage, frequency, route of administration, expiration date, and compare the physicians order.
- Restrict medications that are not properly labeled.
- Monitor vital signs and laboratory values before medication administration.
- Do not set up medications in advance. Do not attempt to administer medications to more than one person at a time.
- Do not leave the medication unattended at the table or with the person for them to take later.

I. INSTILLATION OF NOSE SPRAY

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Review medication administration record for medications due.

4. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet.

5. When ready to administer medications unlock storage cabinet.

6. Compare the label of the medication container or unit-dose package against the order on the medication administration record before taking them from storage.

7. Perform a second check that the medication labels due match the medication administration record after taking medication from storage; making sure that all 6 rights are present.

8. Review any special instructions.

9. Third verification that medications dispensed matches the medication administration record.

10. Put supply of unused medications to the side, back in storage and locked storage area.

12. Verify correct consumer 2 identifiers; but may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card.

13. Verify that correct consumer matches MAR.

14. Explain to the consumer what you are about to do and how he or she can assist you;
Provide education about medication administered.

15. Don gloves.

16. Shake bottle gently and remove the cover. Medication may need to be primed before using. To prime, press downward and release on the shoulders of the spray several times into the air until a fine spray appears.

17. Ask the consumer to blow nose and then sit down with the head tilted slightly forward.

18. Close one nostril; insert nasal applicator into the opposite nostril holding the bottle upright.

19. Have the consumer take a deep breath through the nose while you simultaneously press downward on the applicators. Ask the consumer to inhale through the mouth.
After administering the spray, lean head backwards for 1-2 seconds. (Do not sniff; sniffing will cause the medication to go down the back of the throat)

20. Repeat steps if another spray is ordered. (Avoid blowing nose for 15 minutes after using the spray.)

21. With a clean tissue wipe the tip of the applicator.

22. Provide a tissue for nasal drainage. Remove gloves and dispose.

23. Put away consumer’s medication supply back in storage and locked storage area.

24. Monitor patient for adverse effects, toxicity, and interactions of the administered medications.

25. Observe, report and record the person's response to the medication.

26. Document administration of medications.

II. Instillation of Nose Drops

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Review medication administration record for medications due.

4. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet.

5. Compare the label of the medication container or unit-dose package against the order on the medication administration record before taking them from storage.

6. Perform a second check that the medication labels due match the medication administration record after taking from storage; making sure that all 6 rights are present.

10. Third verification that medications dispensed matches the medication administration record.

12. Review any special instructions.

7. Put supply of unused medications back in locked storage.

8. Verify correct consumer by name, and birth date. (2 identifiers)

9. Verify that correct consumer matches MAR.

13. Explain to the consumer what you are about to do and how he or she can assist you.

14. Don gloves.

15. Ask recipient to blow nose gently and then sit down with the head tipped back.

16. Draw med up into the dropper. Close one nostril; ask the consumer to breathe through the mouth. Instill the prescribed number of drops into each nostril. Do not touch the side of the nose with the dropper to prevent contamination.

17. Have the consumer head tilted back for 3-5 minutes after instillation of the drops. Do
Not sniff or medication will go down the back of the throat.

18. Provide a tissue for nasal drainage. Remove gloves and dispose.

19. Put away consumer's medication supply back in storage and locked storage area.

20. Monitor patient for adverse effects, toxicity, and interactions of the administered medications.

21. Observe, report and record the person's response to the medication.

22. Document administration of medications.

REFERNECES:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ADMINISTERING OTIC INSTALLATION

PURPOSE STATEMENTS: To install ear drops.

POLICY: NM 13.004

PREPARTION:

- Develop and use an environment that maximizes safe and efficient administration of medications.
- Ensure that medications are either discontinued or reorders on their renewal date.
- Be informed of the reason why the consumer is receiving the medication, drug classification, contraindications, usual dosage, side effects, and nursing considerations for administering and evaluating the medications.
- Restrict medications that are not properly labeled.
- Check the medication record for medication name, dosage, frequency, route of administration, expiration date, and compare to the physician order.
- Check the expiration date. Dispose of unused or expired medications according to agency guidelines.
- Check the consumer for any known allergies.
- Follow the six rights of medication administration.
- Evaluate the consumer's knowledge of the medication and explore learning needs.

PROCEDURE:

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Review medication administration record for medications due.

3. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet.

4. Compare the label of the medication container or unit-dose package against the order on the medication administration record before taking them from storage.

5. Perform a second check that the medication labels due match the medication administration record after taking from storage; making sure that all 6 rights are present.

9. Third verification that medications dispensed matches the medication administration record.

6. Put supply of unused medications in locked storage.

7. Verify correct consumer 2 identifiers; consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card

8. Verify that correct consumer matches MAR.

11. Explain to the consumer step by step the procedure you are about to perform; provide education about the medication.

11. Position client on side or sitting in a chair with affected ear facing up.

12. Straighten ear canal by pulling auricle upward and outward. (For an adult)

13. Draw up prescribed medication in the dropper and slowly place number of drops into ear canal from an inch away. Do not touch the dropper to any surface.

14. Ask consumer to remain in side-lying position for at least 2 minutes.

15. If drops are ordered for the other ear, wait 5-10 minutes before turning to the opposite side and repeat procedure.

16. Discard gloves and perform hand hygiene.

14. Put away consumer's medication supply back in storage and locked storage area.

16. Monitor patient for adverse effects, toxicity, and interactions of the administered medications.

17. Observe, report and record the person's response to the medication.

18. Document administration of medications.

REFERENCE:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ADMINISTERING OPTHALMIC INSTALLATION

PURPOSE STATEMENT: To introduce medications into the conjunctival sac of the eye.

POLICY: NM 13.005

DEFINITION: Eye medication may be used to lubricate the eye, to treat a medical condition, or used to treat an infection.

PREPARATION:

- Check the medication administration record for the medication name, dosage, frequency, route of administration, expiration date, and compare to the physician order.
- Read the label once you remove the medication from the locked storage container.
- Verify that the medication is marked “ophthalmic use only” for the eye.
- Review any special instructions.
- Follow the six rights of medication administration.
- Check the expiration date. Dispose of unused or expired medications according to agency guidelines. Eye solution should not be used if more than one month old after opening. All solution bottles should be dated when initially opened.
- Verify which eye(s) get the medication. **OD**=right eyes, **OS**=left eye, **OU**=both eyes.
- Assess consumer’s eyes for discharge or crusting of the eye, make sure eyelids and lashes are clean before administering the eye medication. Using a glove, moisten gauze/cotton ball with warm water. Place gauze, cotton ball on closed eye for a minute and gently wipe once from inner to outer eye. Discard after one wipe. Repeat steps until eye lashes and lids are clean.
- Check the consumer for any known allergies.
- Research the medications side effected, drug actions, interactions, and adverse effects
- Be informed of the reason why the consumer is receiving the medication, drug classification, contraindications, usual dosage, side effects, and nursing considerations for the administering and evaluating the medications.
- Restrict medications that are not properly labeled.
- Do not set up medications in advance. Do not attempt to administer medications to more than one person at a time.
- Do not leave the medication unattended at the table or with the person for them to take later.

I. INSTALLING EYE DROPS:

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Review medication administration record for medications due.

4. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet.

5. Compare the label of the medication container or unit-dose package against the order on the medication administration record before taking them from storage.

6. Perform a second check that the medication labels due match the medication administration record after taking from storage; making sure that all 6 rights are present.

7. Perform third check that the medication labels due match the medication administration record.

8. Put supply of unused medications back in locked storage.

9. Verify correct consumer 2 identifiers; but may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card

10. Verify that correct consumer matches MAR.

11. Provide education about medication administered.

13. Explain to the consumer what you are about to do and how they can assist you.

14. Don gloves

15. Stand behind the consumer to identify the correct eye.

16. Ask consumer to lie down or sit back in chair and ask them to tilt their head back and look upward.

17. Pull down the lower lid with you ring finger of you least dominant hand to form a pocket.

18. Rest dominant hand gently on client's forehead, and hold filled medication eyedropper approximately 1 to 2 cm (½ to ¾ inch) above conjunctional sac. (pocket)

19. Ask the consumer to look at the ceiling. Install the prescribed number of drops in the pocket. (Conjunctional sac). If consumer blinks or closes eye, causing drops to land on outer lid margins, repeat procedure.

20. Ask recipient to gently shut, not squeeze eye and then blink. Use a clean tissue to remove excess fluid.

21. If administering two different kinds of drops, wait at least 5 minutes between drops.

22. Return medication to storage, discard gloves and perform hand hygiene.

23. Document eye drop administration immediately after instillation.

24. Observe, report and record the person's response to the medication.

II. INSTALLING EYE OINTMENT

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Review medication administration record for medications due.

4. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet.

5. Compare the label of the medication container or unit-dose package against the order on the medication administration record before taking them from storage.

7. Perform a second check that the medication labels due match the medication administration record after taking from storage; making sure that all 6 rights are present.

8. Third verification that medications dispensed matches the medication administration record.

9. Put supply of unused medications back in locked storage.

10. Verify correct consumer by name, and birth date. (2 identifiers)

11. Verify that correct consumer matches MAR.

12. Provide education about medication administered.

13. Explain to the consumer what you are about to do and how they can assist you.

14. Don gloves

15. Stand behind the consumer to identify the correct eye.

16. Ask consumer to lie down or sit back in chair and ask them to tilt their head back and look upward.

17. Holding the ointment applicator above lower lid margin, apply thin ribbon of ointment evenly along inner edge of lower eyelid 1/3 to ½ way back from the tear duck, going away from the nose.

18. Have the consumer close his eye, and rub lid lightly in circular motion with a tissue, if rubbing is not contraindicated.

19. Discard gloves and perform hand hygiene.

20. Return medication to storage, discard gloves and perform hand hygiene.

21. Document eye drop administration immediately after instillation.

22. Observe, report and record the person's response to the medication.

REFERENCES:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ADMINISTERING MEDICATION BY INHALATION

PURPOSE STATEMENT: To maintain or restore the consumer airway passages.

POLICY: NM 13.006

PREPARATION:

- Develop and use an environment that maximizes safe and efficient administration of medication.
- Follow the six rights of medication administration.
- Verify the prescription or medication order before administering the drug.
- Assess the consumer's allergies prior to administration.
- Ensure that medications are either discontinued or reordered on their renewal date.
- Note expiration date on all medications. Dispose of unused or expired medications, according to agency guidelines.
- Research the medications side effects, drug actions, interactions, and adverse effects.
- Evaluate the consumer's knowledge of the medication and explore learning needs.
- Be informed of the reason why the consumer is receiving the medication, drug classification, contraindications, usual dosage, side effects, and nursing considerations for the administering and evaluating the medications.
- Check the medication administration record for the medication name, dosage, frequency, route of administration, expiration date, and compare the physicians order.
- Restrict medications that are not properly labeled.
- Monitor vital signs and laboratory values before medication administration.
- Auscultate breath sounds.
- Monitor the heart rate prior and after administration for consumer using bronchodilator medication.
- Record the pulse and respiration in the chart. If vital signs are not within normal limits contact the physician.

I. Use of Meter Dose Inhaler

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet.

4. Compare the label of the medication container or unit-dose package against the order on the medication administration record.

5. Prepare the medication.

6. Verify that the medication matches the medication administration record.

7. Third verification that medications dispensed matches the medication administration record.

8. Provide education about medication administered.

9. Put supply of unused medications back in locked storage cabinet.

10. Verify correct consumer by 2 identifiers; consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card.

11. Verify that correct consumer matches MAR.

12. Shake the inhaler well.

13. Remove the cap from the mouthpiece. The metal canister has to be fully inserted into the actuator.

14. Instruct the consumer to breathe out fully through the mouth, expelling as much air from the lungs as possible.

15. While the consumer is taking a deep, slow breath from the mouth piece,

fully depress the top of the metal canister with your index finger.

16. Instruct recipient to hold his/her breath for 10 seconds and then exhale slowly.

17. Wait one minute to repeat if more than one puff is ordered.

18. Document administration of the medication immediately after it has been administered.

I. Administer Nebulizer Treatment

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet.

4. Compare the label of the medication container or unit-dose package against the order on the medication administration record.

5. Prepare the medication, by calculating the medication dosage.

6. Verify that the medication container or unit dose package matches the MAR.

7. Third verification that medications dispensed matches the medication administration record.

8. Provide education about medication administered.

9. Put supply of unused medications back in locked cabinet.

10. Verify correct consumer by 2 identifiers; may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card.

11. Verify that correct consumer matches MAR.

12. Unscrew cap on the nebulizer and add the prescribed amount of (medication and saline) to the nebulizer. Connect the tubing to the compressor and set flow rate.

13. Place the cap on the chamber and turn clockwise until secured tightly on.

14. Assemble mouthpiece and insert into the top of the nebulizer cap. If using an aerosol mask, insert the bottom part of the mask directly into the top of the nebulizer cap.

15. Attach tubing to air-inlet connector at bottom of the nebulizer chamber. Turn switch on to start the compressor. Check to see if there is adequate misting.

16. Place mouthpiece in the mouth and instruct person to breathe in and out of mouth normally. If using an aerosol mask, place mask over nose and mouth. The treatment may last 10-20 minutes until no mist can be seen.

13. Instruct the consumer to breathe slowly and deeply until all the medication is gone.

17. At this time, turn the machine off, tap the reservoir and continue the treatment but note that a small amount of medication may remain.

18. Ask the consumer to cough following several deep breaths.

19. Document administration of medication and description of secretions.

20. To clean, disassemble mouthpiece from cap, open chamber and remove baffle. Wash all

Items except tubing, in hot water/mild fragrance-free dish detergent and allow to air dry. The tubing does not have to be washed because only filtered air passes through it.

21. Keep the equipment in the consumer's room.

22. Tubing should be changed and labeled weekly or per agency policy.

23. Record vital signs and the consumer response to the treatment.

24. Report any pertinent information to the physician.

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: PATCHES (TRANSDERMAL MEDICATION)

PURPOSE STATEMENT: To safely administer medications to the consumer

POLICY: MN 13.007

PREPARATION: Prepare medications using appropriate equipment and techniques for the drug administration modality.

- Develop and use an environment that maximizes safe and efficient administration of medication.
- Follow the six rights of medication administration.
- Verify the prescription or medication order before administering the drug.
- Assess the consumer's allergies prior to administration.
- Ensure that medications are either discontinued or reordered on their renewal date.
- Note expiration date on all medications. Dispose of unused or expired medications, according to agency guidelines.
- Research the medications side effected, drug actions, interactions, and adverse effects.
- Evaluate the consumer's knowledge of the medication and explore learning needs.
- Be informed of the reason why the consumer is receiving the medication, drug classification, contraindications, usual dosage, side effects, and nursing considerations for the administering and evaluating the medications.
- Check the medication administration record for the medication name, dosage, frequency, route of administration, expiration date, and compare the physicians order.
- Restrict medications that are not properly labeled.
- Monitor vital signs and laboratory values before medication administration.
- Do not set up medications in advance. Do not attempt to administer medications to more than one person at a time.
- Do not leave the medications unattended at the table or with the person for them to take later.

PROCEDURE:

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Review medication administration record for medications due. Identify if consumer has received a patch prior to this administration.

4. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet.

5. Compare the label of the medication container or unit-dose package against the order on the medication administration record before taking them from storage container.

6. Perform a second check that the medication labels due match the medication administration record after taking from storage container; making sure that all 6 rights are present.

7. Third verification that medications dispensed matches the medication administration record.

8. Put supply of unused medications back in locked storage.

9. Verify correct consumer by name, and birth date. (2 identifiers)

10. Verify that correct consumer matches MAR.

11. Read and identify any special instructions; provide education to the consumer.

12. Assess consumer's skin for any patches applied prior. Remove the old patch and dispose of it per agency policy.

13. Open patch and use the packaging as a clean surface to work on. On the non-sticky side of patch, write the date, time and your initials.

14. Apply patch by removing the adhesive cover and placing the patch on a non-hairy spot of the skin and applying pressure to all the edges. Hold hand over the patch for 60 seconds to seal the patch. Don't place the patch in the exact same spot as it may be irritating to the skin. Follow the physician's or pharmacist recommendation for area of placement.

15. Monitor patient for adverse effects, toxicity, and interactions of the administered medications.

16. Monitor patient for the therapeutic effect of the medication.

17. Observe, report and record the person's response to the medication.

18. Document administration of medications; include in documentation where the location of where the patch was applied.

REFERNECES:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ADMINISTERING RECTAL SUPPOSITORY

PURPOSE STATEMENT: To safely administer medications to the consumer.

POLICY: MN 13.008

PREPARATION: Prepare medications using appropriate equipment and techniques for the drug administration modality.

- Develop and use an environment that maximizes safe and efficient administration of medication.
- Follow the six rights of medication administration.
- Verify the prescription or medication order before administering the drug.
- Assess the consumer's allergies prior to administration.
- Ensure that medications are either discontinued or reordered on their renewal date.
- Note expiration date on all medications. Dispose of unused or expired medications, according to agency guidelines.
- Research the medications side effected, drug actions, interactions, and adverse effects.
- Assess the consumer's ability to swallow.
- Evaluate the consumer's knowledge of the medication and explore learning needs.
- Be informed of the reason why the consumer is receiving the medication, drug classification, contraindications, usual dosage, side effects, and nursing considerations for the administering and evaluating the medications.
- Check the medication administration record for the medication name, dosage, frequency, route of administration, expiration date, and compare the physicians order.
- Assess whether the consumer is nauseated or vomiting, or has diminished bowel sounds.
- Restrict medications that are not properly labeled.
- Monitor vital signs and laboratory values before medication administration.
- Do not set up medications in advance. Do not attempt to administer medications to more than one person at a time.
- Do not leave the medication unattended at the table or with the person for them to take later.

PROCEDURE:

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Review medication administration record for medications due.

3. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet.

4. Compare the label of the medication container or unit-dose package against the order on the medication administration record before taking them from storage.

5. Perform a second check that the medication labels due match the medication administration record after you take from storage; making sure that all 6 rights are present.

9. Third verification that medications dispensed matches the medication administration record.

10. Place one suppository in the cup. If it is unwrapped, put it into the jar lid first and then, from the lid to the cup. If it is wrapped in foil, remove the foil before placing it in the cup.

6. Put supply of unused medications into locked storage.

7. Verify correct consumer by 2 identifiers (but may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card).

8. Verify that correct consumer matches MAR.

12. Don gloves.

13. Use a water soluble lubricant to lubricate the bullet end of the suppository. Place an extra amount of lubricant on the inside of the cup to lubricate your gloved finger before insertion.

14. Explain the procedure to the consumer and provide any education needed.

15. Place the consumer on his/her left side with the left leg straight and the right leg bent toward the stomach. Cover exposed area with a towel or sheet.

16. Lift the upper buttocks to expose the rectal area.

17. Insert the suppository with lubricated finger one inch past the sphincter muscle located at the opening of the rectum. Lay the suppository against the rectal wall so it will melt and remove your finger immediately. Never force if you meet resistance when inserting. If resistance is observed notify physician.

17. Remain with the person for 15 minutes, until the suppository has melted.

18. Dispose of the gloves and perform hand hygiene.

19. Monitor patient for adverse effects, toxicity, and interactions of the administered medications.

17. Observe, report and record the person’s response to the medication.

18. Document administration of medications.

REFERNECES:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ADMINISTER MEDICATION VIA PERCUTANEOUS ENDOSCOPIC GASTROSTOMY TUBE.

PURPOSE STATEMENT: To administer medications using consumers (PEG) feeding tube.

POLICY: NM 13.009

EQUIPMENT: 60 ML Leur lock syringe, Catheter tip syringe, cylinder, water, pill crusher, medication cup.

PREPARATION:

- Develop and use an environment that maximizes safe and efficient administration of medication.
- Follow the six rights of medication administration.
- Assess the consumer's allergies prior to administration.
- Ensure that medications are either discontinued or reordered on their renewal date.
- Note expiration date on all medications.
- Research the medications side effected, drug actions, interactions, and adverse effects.
- Evaluate the consumer's knowledge of the medication and explore learning needs.
- Be informed of the reason why the consumer is receiving the medication. Classification, contraindications, usual dosage, side effects, and nursing considerations for the administering and evaluating the medications.
- Check the medication administration record for the medication name, dosage, frequency, route of administration, expiration date, and compare the physicians order.
- Assess whether the consumer is nauseated or vomiting, or has diminished bowel sounds.
- Restrict medications that are not properly labeled.
- Dispose of unused or expired medications, according to agency guidelines.
- Monitor vital signs and laboratory values before medication administration.
- Do not set up medications in advance. Do not attempt to administer medications to more than one person at a time.
- Do not leave the medication unattended at the table or with the person for them to take later.

PRECEDURE:

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Review medication administration record for medications due.

4. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet.

5. Compare the label of the medication container or unit-dose package against the order on the medication administration record before taking them from storage.

6. Perform a second check that the medication labels due match the medication administration record after taking from storage; making sure that all 6 rights are present.

7. Dispense medication into medication cup. Turn bubble packs over, sign and date back.

8. Third verification that medications dispensed matches the medication administration record.

9. Put supply of unused medications into locked cabinet.

10. Crush pills per agencies pill crusher. **Always ask your pharmacist regarding whether a medication can be crushed and/or given through the PEG tube.**

11. Place crushed medication in medication cup and add water to liquidity medication powder.
Be sure that all medication is dissolved in the water.

12. Verify correct consumer 2 identifiers; but may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card.

13. Verify that correct consumer matches MAR.

14. Unclamp and unplug peg feeding tube and flush the (PEG) feeding tube with 30cc of water prior medication administration to ensure patency.

15. Draw up the dissolved medication from the medication cup with the 60 ml Leur lock syringe.

16. Check the consumers peg feeding tube to ensure that it is clamped before unplugging feeding tube port.

17. Plug Leur lock syringe in peg feeding tube port or adapter.

18. Unclamp consumers peg feeding tube adaptor or port. If there is a dual port adapter, you may use either the medication port with a small Leur lock syringe or the feeding port with the catheter tip syringe.

19. Slowly administer medication via PEG feeding tube.

20. After medication administration flush peg feeding tube with 30 ml of water to prevent clogging of peg tube.

21. Clamp and plug PEG feeding tube.

22. Discard gloves and perform hand hygiene.

23. Monitor patient for adverse effects, toxicity, and interactions of the administered medications.

24. Monitor patients for the therapeutic effect of the medication.

25. Observe, report and record the person’s response to the medication.

27. Document administration of medications.

REFERENCES:

LEGAL AUTHORITY:

Effective date:
Prepared by:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: HEPARIN INJECTION

PURPOSE STATEMENT: To administer subcutaneous heparin

POLICY: NM 13.010

EQUIPMENT: Medication administration record, vial or ampoule of the medication, syringe, ½''-5/8'' (25 to 26) gauge needle, antiseptic swab, dry gauze, disposable gloves.

PREPARATION:

- Organize equipment. Develop and use an environment that maximizes safe and efficient administration of medications.
- Assemble equipment per agency policy
- Follow the six rights of medication administration.
- Assess the specific drug action, side effects and adverse reactions.
- Assess the consumer's knowledge and learning needs regarding the medication.
- Assess skin for lesions, swelling, inflammation, tissue damage, erythema, and ecchymosis from previous injections.
- Verify what previous site was used for the medication.
- Note the expiration date on all medications. Dispose of unused or expired medications, according to agency guidelines.
- Check the medication administration record for the name of the medication, dosage frequency, route of administration, expiration date, and compare it to the physicians order.
- Restrict medications that are not properly labeled.
- Monitor vital signs and laboratory values before medication administration.
- Check the MAR for any allergies to medications.
- Follow the three medications checks to the MAR: check the label when removing from the cart, cabinet, or storage compartment. Check medication prior to withdrawing the medication. Check the medication after withdrawing the medication from the vial.
- Identify consumer using 2 identifiers; but may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card
- Wash hands and observe agency standard precautions regarding infection control.

PROCEDURE:

1. Ensure consumer privacy.

5. Explain the procedure to the consumer and explain to them how they can assist you, provide any education.

6. Tell the patient to lie down, and assess the abdominal area.

7. Select a site on the abdomen 2 inches away from the umbilicus or scars and above the level of the iliac crest.

8. Avoid injecting heparin near bruised area.

9. Gently cleanse the site with an alcohol pad. Do not rub the site.

10. Place your thumb and forefinger 3 inches apart around the injection site, and then pinch your finger together to create a thick fold in the skin.

11. Use a 25 to 26 gauge needle, and insert it at a 90 degree angle. If a consumer is very lean or has muscle wasting, use a needle that is longer and insert a 45 degree angle. The arms or thighs may be used as alternate sites.

12. Do not aspirate when giving heparin by subcutaneous injection.

13. Alternate the sites of subsequent injections.

14. Document site, medication, time, response to medication.

15. Initial the MAR.

16. Report any pertinent findings to the physician.

REFERENCE:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: SUBCUTANEOUS INJECTION

PURPOSE STATEMENT: To administer a subcutaneous injection

POLICY: MN 13.011

EQUIPMENT: Medication administration record, vial or ampoule of the medication, syringe, 1/2" -5/8" (25-30 gauge) needle, antiseptic swab, dry gauze, disposable gloves, and paper towel.

PREPARATION:

- Organize equipment. Develop and use an environment that maximizes safe and efficient administration of medications.
- Assemble equipment per agency policy
- Follow the six rights of medication administration.
- Assess the specific drug action, side effects and adverse reactions.
- Assess the consumer's knowledge and learning needs regarding the medication.
- Assess skin for lesions, swelling, inflammation, tissue damage, erythema, and ecchymosis from previous injections.
- Verify what previous site was used for the medication.
- Note the expiration date on all medications. Dispose of unused or expired medications, according to agency guidelines.
- Check the medication administration record for the name of the medication, dosage frequency, route of administration, expiration date, and compare it to the physicians order.
- Restrict medications that are not properly labeled.
- Monitor vital signs and laboratory values before medication administration.
- Check the MAR for any allergies to medications.
- Follow the three medications checks to the MAR: check the label when removing from the cart, cabinet, or storage compartment. Check medication prior to withdrawing the medication. Check the medication after withdrawing the medication from the vial.
- Identify consumer using 2 identifiers; but may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card.

PROCEDURE:

1. Prepare medication in sterile syringe 1-3 ml capacity syringe with ½" – 5/8", 24-27 gauge needles.

2. Choose site which is free of bruising and lumps. Rotate sites using upper arms, thighs, abdomen and buttocks.

3. Cleanse site with alcohol wipe for one (1) minute.

4. Pinching up skin, insert needle in one swift motion at a 45°- 90°angle bevel of the needle should be facing up.

5. Aspirate for blood return by pulling back on plunger. If no blood return, inject medication slowly. If blood is aspirated, choose different site and prepare another syringe of the medication. Don't aspirate for blood return when giving insulin or heparin.
.
6. Remove needle quickly and massage with alcohol wipe, unless massage is contraindicated.

7. Note: No massage after Heparin and Insulin.

8. Dispose of needle properly.

9. Remove gloves. Wash hands.

10. Document the medication administration.(dose, route, location and response to medication). Initial the MAR.

11. Assess the effectiveness of the medication.

12. Report ant pertinent findings to the physician

REFERENCES:

LEGAL AUTHORITY:

Effective date:
Prepared by:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: **INTRAMUSCULAR INJECTIONS**

PURPOSE STATEMENTS: To administer intramuscular medications.

POLICY: NM 13.012

EQUIPMENT: Medication administration record, vial or ampoule of medication, syringe,

1-1 ½ '' (22-25 gauge) needle, antiseptic swab, dry gauze, disposable gloves.

PREPARATION:

- Organize equipment. Develop and use an environment that maximizes safe and efficient administration of medications.
- Perform hand hygiene and observe agency standard precaution regarding infection control.
- Assemble equipment per agency policy.
- Follow the six rights of medication administration.
- Assess the specific drug action, side effects and adverse reactions.
- Assess the consumer's knowledge and learning needs regarding the medication.
- Assess skin for lesions, swelling, inflammation, tissue damage, erythema, and ecchymosis from previous injections.
- Verify what previous site was used for the medication.
- Note the expiration date on all medications. Dispose of unused or expired medications, according to agency guidelines.
- Check the medication administration record for the name of the medication, dosage frequency, route of administration, expiration date, and compare it to the physicians order.
- Restrict medications that are not properly labeled.
- Monitor vital signs and laboratory values before medication administration.
- Check the MAR for any allergies to medications.
- Follow the three medications checks to the MAR: check the label when removing from the cart, cabinet, or storage compartment. Check medication prior to withdrawing the medication. Check the medication after withdrawing the medication from the vial.
- Identify consumer using to 2 identifiers; but may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card.

PROCEDURE:

1. Prepare medication in appropriate syringe.

2. Change needles if medication may clog needle.Change needle if medication was obtained from a vial with a thick rubber stopper (will dull needle).

3. Apply gloves.

4. Examine site, palpate for exact location in view of quantity of medication. Do not rely on visual examination – feel for bony prominences.
    - 1cc in deltoid
    - 3cc in gluteal and vastus lateralis
    - 3cc in ventral gluteal

5. Cleanse site with alcohol for one (1) minute.

6. Stretch skin over glutei sites, pinch up at deltoid and lateral thighs inserting needle at 90° angle making puncture in, on firm movement.

12. Aspirate for blood return by pulling back on plunger.
    a. If no blood return, inject medication slowly.
    b. If blood aspirate, withdraw needle and prepare another syringe of the medication.

13. Apply slight pressure on skin next to needle with alcohol wipe, pull needle straight out.

14. Apply digital pressure to puncture site with alcohol swab, massage if indicated.

15. Dispose needle properly.

16. Z-tract injections.
    a. Follow basic IM injection procedure making sure to change needle after medication drawn up into syringe. One-half of a cc of air must be drawn into syringe to permit complete injection of medication.
    b. Palpitate gluteal sites (only gluteal sites are used).
    c. Displace surface tissues by pulling skin tightly to one side and hold during entire injection procedure.
    d. Cleanse site with alcohol for one minute.
    e. Puncture skin at 90°angle in one quick movement, aspirate – then inject slowly – wait 10 seconds, keeping skin taut.
    f. Withdraw needle, released skin and do not massage area.
    g. Dispose of needle properly.

17. Document site, medication, time, response to medication.

18. Initial the MAR.

19. Report any pertinent findings to the physician.

REFERENCES:

LEGAL AUTHORITY:

Effective date:
Prepared by:

Authorized by:
Prepared by:

RELATED POLICY

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: BMI

PURPOSE STATEMENT: To calculate BMI

POLICY: NM 13.013

DEFINITION: Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems.

Measurement Units	Formula and Calculation
Pounds and inches	Formula: weight (lb) / [height (in)]^2 x 703 Calculate BMI by dividing weight in pounds (lbs) by height in inches (in) squared and multiplying by a conversion factor of 703.

The standard weight status categories associated with BMI ranges for adults are shown in the following table.

BMI	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal
25.0 – 29.9	Overweight
30.0 and Above	Obese

REFERENCE: Centers for Disease Control and Prevention.(2011). Healthy Weight-it's not a diet, it's a lifestyle, Retrieved from. http://www.cdc.gov/healthyweight/assessing/bmi/adult_BMI/index.html

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: **TOPICAL MEDICATIONS TO THE SKIN**

PURPOSE STATEMENT: To apply topical medications to the skin.

POLICY: NM 13.014

PREPARATION:

- Develop and use an environment that maximizes safe and efficient administration of medication.
- Follow the six rights of medication administration.
- Verify the prescription or medication order before administering the drug.
- Assess the consumer's allergies prior to administration.
- Ensure that medications are either discontinued or reordered on their renewal date.
- Note expiration date on all medications. Dispose of unused or expired medications, according to agency guidelines.
- Research the medications side effected, drug actions, interactions, and adverse effects.
- Evaluate the consumer's knowledge of the medication and explore learning needs.
- Be informed of the reason why the consumer is receiving the medication, drug classification, contraindications, usual dosage, side effects, and nursing considerations for the administering and evaluating the medications.
- Check the medication administration record for the medication name, dosage, frequency, route of administration, expiration date, and compare the physicians order.
- Assess whether the consumer is nauseated or vomiting, or has diminished bowel sounds.
- Restrict medications that are not properly labeled.
- Monitor vital signs and laboratory values before medication administration.
- Assess consumer for any known allergies.

PROCEDURE:

I. Administration of topical ointment

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Review medication administration record for medications due.

4. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet. (4*4 gauze is needed).

5. Compare the label of the medication container or unit-dose package against the order on the medication administration record before taking them from storage.

6. Perform a second check that the medication labels due match the medication administration record after taking from storage; making sure that all 6 rights are present.

9. Third verification that medications dispensed matches the medication administration record. (Lock the storage area.)

7. Verify correct consumer by 2 identifiers; may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card.

8. Verify that correct consumer matches MAR.

10. Explain to the consumer step by step the procedure you are about to perform.

11. Provide education about medication administered.

12. Ensure privacy for the consumer.

13. Position the consumer either laying down or sitting. Expose affected area while keeping unaffected areas covered; check for location, size, number and condition of areas.

14. Wash affected area, removing all debris, encrustations, and previous medication.

15. Pat skin dry, or allow to air dry.

16. If skin is excessively dry and flaking, apply topical agent while skin is still damp.

17. Remove gloves and reapply new clean gloves.

18. Obtain clean gauze pads (4*4). Place them on a tissue on your tray.

19. Remove the cap from the tube. Place a small amount of ointment on the center of each gauze pad. Replace the cap on the tube.

20. Apply the ointment, using a different gauze pad for each area. If the area is long, make one swipe going from top to bottom (clean to dirty). If the area is round, start in the middle and work outward.

21. Dispose of the gauze pads in the proper waste basket.

22. Discard gloves and perform hand hygiene.

23. Give the consumer what assistance is needed with clothes and positioning. Cover the area if ordered.

24. Put medication back in the storage and lock the storage area.

25. Observe, report and record the person’s response to the medication.

26. Document administration of medications.

II. Administration of topical lotion medication

1. Wash hands and observe agency standard precautions regarding infection control.

2. Prepare an area with adequate room for all supplies needed.

3. Review medication administration record for medications due.

4. Retrieve all supplies needed before unlocking the medication box, drawer, refrigerator, shelf, or cabinet. (Cotton balls, medication cup is needed.)

5. Compare the label of the medication container or unit-dose package against the order on the medication administration record before taking them from storage.

6. Perform a second check that the medication labels due match the medication administration record; making sure that all 6 rights are present.

10. Third verification that medications dispensed matches the medication administration record.

11. Verify correct consumer by name, and birth date. (2 identifiers)

12. Verify that correct consumer matches MAR.

14. Explain to the consumer step by step the procedure you are about to perform.

15. Provide education about medication administered.

16. Ensure privacy for the consumer.

17. Position the consumer either laying down or sitting. Expose affected area while keeping unaffected areas covered; check for location, size, number and condition of areas.

18. Wash affected area, removing all debris, encrustations, and previous medication.

19. Pat skin dry, or allow to air dry.

20. If skin is excessively dry and flaking, apply topical agent while skin is still damp.

21. Remove gloves and reapply new clean gloves.

22. Pour the estimated amount of lotion needed into the cup, continuing to protect the pharmacy label with tour palms.

23. Apply the lotion, using a different cotton ball for each area. If the area is long, make one swipe going from top to bottom (clean to dirty). If the area is round, start in the middle and work outward.

24. Stay with the person until the medication dries. Give assistance with clothes and positioning.

25. Depose of the gloves and cotton balls in the proper waste basket and wash your hands.

26. Observe report and record the person's response to the medication.

27. Put the medication container back in the storage and lock the storage area.

28. Document administration of medications

REFERENCES:

LEGAL AUTHORITY:

Effective date:
Date review/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ASSESSING THE PERIPHERAL PULSE DOPPLER

PURPOSE STATEMENT: To evaluate the consumer's peripheral pulse using a doppler.

POLICY: NM 13.015

PROCEDURE:

1. Plug the stethoscope headset into one of the two output jacks located next to the volume control.

2. Apply transmission gel either to the probe at the narrow end of the plastic case housing the transducer or to the client's skin.

3. Press the "on" button.

4. Hold the probe against the skin over the pulse site. Use a light pressure and keep the probe in contact with the skin.

5. Adjust the volume if necessary.

6. Distinguish artery sounds from view sounds. If arterial sounds cannot be easily heard, then reposition the probe.

7. After assessing the pulse, remove all the gel from the probe to prevent damage to its surface. Clean the transducer with aqueous solutions.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ASSESSING THE PHERIPHERAL VASCULAR SYSTEM

PURPOSE STATEMENT: To assess the consumer's peripheral vascular system.

POLICY: NM 13.016

PREPARATION: Determine the history of the following: past heart problems, arterial disease, hypertension, smoking habits, use of alcohol, lifestyle patterns, exercise patterns, and cultural preferences.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary, and how he/she can cooperate.

2. Wash hands and observe appropriate infection control measures.

3. Provide for consumer privacy.

4. Determine the history of the following: past heart problems, arterial disease, hypertension, smoking habits, use of alcohol, lifestyle patterns, exercise patterns, and cultural preferences.

5. Palpate the peripheral pulses (except the carotid pulse) on both sides of the body individually, simultaneously, and systemically to determine the symmetry of pulse volume. If you have difficulty palpating some the peripheral pulses, use a Doppler ultrasound probe.

6. Inspect the peripheral veins in the arms and legs for the presence and or appearance of superficial veins when limbs are dependent and when limbs are elevated.

7. Assess peripheral leg veins for signs of phlebitis.

8. Inspect the skin of the hands and feet for color, temperature, edema, and skin changes,

9. Assess the adequacy of arterial flow if arterial insufficiency is suspected.

10. Document findings in the consumer chart.

11. Report any pertinent findings to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

TITLE: ASSESSING CONSUMERS PULSE

PURPOSE STATEMENT: To identify and assess a consumers pulse.

POLICY: MN 13.017

DEFINITION:

Average rate: Adults-60-100 beats per minute, strong and regular

- ***Bradycardia***. A "slow heart rate" is below 50 beats per minute. If the consumers pulse rate is below 50 beats per minute, the consumer is said to have bradycardia. In young healthy adults bradycardia can be normal. But in other populations it can also be a sign of certain diseases and heart problems or result from taking certain medication.
- ***Tachycardia***. If the consumer has a "fast" pulse rate that is over 100 beats per minute, the consumer is said to have tachycardia. Temporary tachycardia can be caused by exercise, pain, strong emotion, excessive heat, fever, bleeding, or shock.
- **Strength**. The strength (force) of the pulse is determined by the amount of blood forced into the artery by the heartbeat. A normal pulse has a normal strength.

    a. **Bounding**. A bounding pulse is a strong and forceful heart rate. Some causes of a bounding pulse can be anemia, anxiety, heart failure, fever, thyroid disease, alcohol consumption.

    b. **Weak**. A weak pulse is when there is a difficulty finding a consumer's pulse. This type of pulse is called weak, feeble, or thready. An **absent** pulse means you cannot locate and feels a pulse at all. An absent pulse signals a medical emergency.

    c. **Strong.** A strong pulse is stronger than normal pulse, but is less than bounding. Shock and hemorrhage (serious bleeding) can cause a strong pulse.

- **Rhythm**. Rhythm refers to the evenness of the beats. In a regular pulse, the time between beats is the same (constant) and the beats are of the same strength.

    a. **Irregular**. A pulse is irregular when the rhythm does not have an even pattern. The time between beats may change, or the strength of the beats may change or the pulse may vary in both time between beats and strength.

    b. **Intermittent**. A pulse is intermittent when the strength does not vary greatly, but a beat is skipped either at regular or irregular intervals. If the missing beats in an intermittent pulse were present, then the pulse rhythm would be normal

Assemble equipment and supplies: watch with a second hand, stethoscope and antiseptic wipes, gloves

PROCEDURE:

1. Explain to the client what you are going to do, why it is necessary, and how he or she can cooperate.

2. Identify consumer using 2 identifiers. (May not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card).

3. Wash hands and observe other appropriate infection control procedures.

4. Provide for consumer privacy.

5. Position the consumer appropriately.

6. Assess the consumers pulse for 60 seconds.

- ✓ **Apical pulse:** The apical pulse can be felt over the apex of the heart. This site is located on the consumers, left of the breastbone and two to three inches above the bottom of the breastbone. The apical pulse is easily heard when a stethoscope is used.
- ✓ ***Radial pulse:*** The radial pulse is taken at a point where the radial artery crosses the bones of the wrist. If the patient's hand is turned so that the palm is up, the radial pulse is taken on the thumb side of top side of the wrist.
- ✓ ***Brachial***. The brachial pulse is taken in the depression located about one-half inch above the crease on the inside (not the bony side) of the elbow.
- ✓ ***Radial.*** The radial pulse (the pulse taken using the radial artery) is taken at a point where the radial artery crosses the bones of the wrist. If the patient's hand is turned so that the palm is up, the radial pulse is taken on the thumb side of top side of the wrist.
- ✓ ***Carotid***. The carotid pulse is taken on either side of the trachea (windpipe). The best location is the grooves located to the right and to the left of the larynx (Adam's apple).
- ✓ ***Brachial***. The brachial pulse is taken in the depression located about one-half inch above the crease on the inside (not the bony side) of the elbow. This site is used when taking the patient's blood pressure.
- ✓ ***Dorsalis Pedis***. The dorsalis pedis pulse is taken on the top portion of the foot just below the ankle. The pulse is taken in the middle of this area (not to the inside or outside).
- ✓ ***Popliteal.*** The popliteal pulse is taken in the middle of the area located on the inside of the knee (the area opposite the kneecap).

6. Document, rhythm, strength, and pulse deficit in the consumer record.

7. Report to the physician any pertinent findings.

LEGAL AUTHORITY:

REFERENCE:

- pennstatehershey.adam.com (December 6, 2013).

- Goldman L. Approach to the patient with possible cardiovascular disease. In: Goldman L, Schafer AI, eds. **Cecil Medicine**. 24thed. Philadelphia, PA: Saunders Elsevier; 2011: chap 50.

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY

POLICY TITLE: ASSESSING THE APICAL PULSE

PURPOSE STATEMENT: To evaluate the cardiovascular status of the consumer to restore to health.

POLICY: NM 13.018

EQUIPMENT: watch with a secondhand, stethoscope, antiseptic wipes.

PROCEDURE:

1. Assemble the equipment and supplies.
2. Explain to the consumer what you are going to do, why it is necessary and how he or she can cooperate.
3. Wash hands and observe other appropriate infection control procedures.
4. Provide consumer privacy.
5. Position the consumer appropriately in a comfortable supine position or a sitting position.
6. Expose the area of the chest over the apex of the heart.
7. Locate the apical pulse.
8. Palpate the angle of Louis, located just below the suprasternal notch and felt as a prominence.
9. Slide your index finger just to the left of the consumer's sternum, and palpate the second intercostal space.
10. Place your middle or ring finger in the third intercostal space, and continue palpating downward until you locate the fifth intercostal space.
11. Move your index finger laterally along the fifth intercostal space towards the MCL. Normally, the apical impulse is palpable at or just the medial to the MCL.
12. Auscultate and count heartbeats.
13. Use antiseptic wipes to clean the earpieces and diaphragm of the stethoscope.

14. Warm the diaphragm of the stethoscope by holding it in the palm of the hand for a moment.

15. Insert the earpieces of the stethoscope into your ears in the direction of the ear canals, or slightly forward to facilitate hearing.

16. Tap your finger lightly n the diaphragm to be sure it is the active side of the head.

17. Place the diaphragm of the stethoscope over the apical impulse and listen for the normal S1 and S2 heart sounds.

18. If the rhythm is regular, count the heartbeats for 30 seconds and multiply by 2. If the rhythm irregular, count the beats for 60 seconds.

19. Assess the rhythm and the strength of the heartbeat.

20. Assess the rhythm of the heartbeats by noting the pattern of intervals between the beats.

21. Document and record findings, report to physician is necessary.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ASSESSING RESPIRATIONS

PURPOSE: To assess the status of the consumer's airway function.

POLICY: MN 13.019

ASSESSMENT:

- Skin and mucous membrane color, position assumed for breathing, signs of cerebral anoxia, chest movement, activity tolerance, chest pain, dyspnea, medications affecting respiratory rate.
- Asses history of tobacco or marijuana use, include type of tobacco and duration of use. Determine the length of time since smoking has stopped, if client has quit.
- Assess if consumer experiences any of the following: persistent cough (productive or nonproductive), sputum production, chest pain, and shortness of breath, orthopnea, dyspnea during exertion, activity intolerance, or recurrent attacks of pneumonia or bronchitis.
- Check for history of allergies to pollen, dust, or other airborne irritants, as well as to any food, drug, or chemical substance
- Asses if the consumer is exposed to second hand smoke.
- Review history for known HIV infection.
- Ask consumer if he/she has history of cough, hemoptysis, weight loss, fatigue, night sweats, and or high fever.
- Review family history for cancer, TB, allergies, or chronic obstructive pulmonary disease (COPD).

DEFINITION: Adventitious sounds

Crackles: are frequently heard in lower lung fields: right and left lung bases. Crackles are fine, short, "popping" sounds. Most obvious heard during inspiration. But can exist during inspiration and expirations (breathing in and out). Crackles can vary in pitch from high to low. They may change with coughing.

Rhonchi: are described as a "snoring" sound heard primary over trachea and bronchi. Rhonchi can be heard over most lung fields. Rhonchi are produced from fluid or mucus obstructing the larger airways. They are low-pitched, continuous sound more pronounced during expiration. Rhonchi may be cleared by coughing.

Wheezes: are continuous musical tones heard over all lung fields. Wheezes are caused by severely narrowed and inflamed bronchus. They are high-pitched sound heard during inspiration or expiration, do not clear with coughing.

Pleural friction rub: more often heard over anterior and lateral lung field. Pleural friction is caused from inflamed pleura and visceral pleura rubbing together. Pleural friction has grating or squeaking quality heard best during inspiration. It does not clear with coughing.

Stridor: Occurs when there is a blockage in the windpipe. Stridor is a high pitched brassy sound heard on inspiration. Stridor can be caused from toxic inhalation, cancer, foreign body obstruction or laryngeal edema from croup or epiglottitis. It can often be heard without the aid of a stethoscope.

Average rate: Adult -12-16 breaths per minute, strong and regular

PROCEDURE:

1. Assemble equipment and supplies: watch with a secondhand.

2. Wash hands and observe other appropriate infection control procedures.

3. Explain to the client what you are going to do, why it is necessary, and how he or she can cooperate.

4. Identify consumer using 2 identifiers.(may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card).

5. Provide privacy for the consumer.

6. Observe or palpate and count the respiratory rate.

7. If you anticipate the consumer's awareness of respiratory assessment, place a hand against the consumer's chest to the chest movements with breathing, or place the consumers arm across the chest and observe the chest movements while supposedly taking the radial pulse.

8. Count the respiratory rate for 60 seconds. An inhalation and exhalation count as one respiration.

9. Observe the depth, rhythm and character of the respiration.

    - Observe the respirations for depth by watching the movement of the consumer.
    - Observe the respirations for regular or irregular rhythm.
    - Observe the character of the respirations-the sound they produce and the effort they require.

10. Document the respiratory rate, depth, rhythm and character on the appropriate record.

11. Report the findings to the physician as necessary.

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:

Prepared by:

RELATED POLICY:

POLICY TITLE: OBTAINING AND ASSESSING BLOOD PRESSURE

PURPOSE STATEMENT: To correctly take consumers blood pressure using a stethoscope.

POLICY: NM 13.020

DEFINITION:

SYSTOLIC (mmHg)		DIASTOLIC (mmHg)	
Below 90	or	Below 60	Hypotension
Below 120	or	Below 80	Average for adult
120-139	or	80-89	PREHYPERTENSION
140-159	or	90-99	STAGE 1 HYPERTENSION
160 or more	or	100 or more	STAGE 2 HYPERTENSION

ASSESSMENT:

A. Assess signs and symptoms of hypertension and hypotension:

   a. Signs and symptoms hypotension: tachycardia, weak, thread pulse, weakness, dizziness, or confusion, pale, dusky, or cyanotic skin, or cool, mottled skin over extremities.
   b. Signs and symptoms hypertension: headache, flushing of face, or nosebleed; older adults may note fatigue.

B. Assess factors that can affect blood pressure: Stress, exercise, smoking, dehydration, fever, and medications

PROCEDURE:

1. Communicate to the consumer what intervention you are going to perform, rationale for performing the procedure, and how the consumer can cooperate.

2. Wash hands and follow all appropriate infection control procedures.

3. Provide privacy for the consumer.

4. Correctly identify the consumer using 2 identifiers. (may not be limited to consume knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card).

5. Explain to the consumer the procedure you are about to perform.

7. Wash hands and Don on gloves.

8. Position the client appropriately.

9. The consumer should be sitting with both feet flat on the floor to facilitate circulation.

10. The elbow should be slightly flexes with the palm of the hand facing up and forearm supported at heart level.

11. The forearm should be supported using a side table with the arm slightly bent at the elbow. The consumer's palm of hand should be facing up.

12. Wrap the deflated cuff around the upper arm with the cuff's lower edge one inch above the antecubital space

13. Locate the brachial artery by palpating it with your finger.

14. Clean the bell of the stethoscope with alcohol pad.

15. Position the stethoscope bell over the consumer's brachial artery in the antecubital space just below the cuff's edge.

16. Pump up the cuff until the sphygmomanometer reads 30 mm Hg above the point where the brachial pulse disappeared.

17. Release the valve on the cuff carefully so that the pressure decreases at the rate of 2 - 3 mm Hg per second.

18. Listen with the stethoscope and watch the sphygmomanometer. The first thumping sound (Korotkoff) is the consumer's systolic pressure. When the thumping sound disappears, that is the diastolic pressure.

19. Deflate the cuff rapidly and completely.

20. Remove the cuff.

21. Document findings and call physician with any abnormal blood pressure readings.

REFERENCES: National Heart, Lung, and Blood Institute. High Blood Pressure. (April 2011). Retrieved from http://www.nhlbi.nih.gov/health/dci/Diseases/Hbp/HBP_WhatIs.html.

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: CONTINUOUS POSITIVE AIRWAY PRESSURE MASK

PURPOSE STATEMENT: To maintain or restore consumer oxygenation status.

POLICY: NM 13.021

PREPARATION: Preparation: Prior to application of the mask assess the gag reflex, LOC, respiratory rate, pallor, pulse rate, lung sounds, blood pressure and nares.

PERSON AFFECTED/RESPONSIBLE: Nursing.

EQUIPMENT: PROCEDURE: 02 Blender, Flow meter, CPAP mask, valve for prescribed peep, nebulizer with distilled water, large bore tubing (if needed)

DEFINITION:

The continuous airway pressure mask allows the spontaneously breathing patient to receive continuous positive airway pressure (CPAP) with or without an artificial airway.

CPAP system advantages:

- Is it that improves arterial oxygenation by increasing functional residual capacity.
- Allows the consumer to avoid intubation.
- Allows the consumer to talk and cough without interrupting positive pressure.

CPAP system disadvantages:

- It requires a tight fit, which could cause discomfort.
- Interferes with eating and talking.
- There is an increase risk of aspiration if the consumer vomits.
- Other associated risk include the following: increase pneumothorax, diminished cardiac output, gastric distention, bullous lung disease, decrease cardiac output, and is contraindicated with consumer's with chronic obstructive pulmonary disease.

Nursing Alert: The CPAP is ordered when the consumer has not responded to attempts to increase hi/her PaO2 status. The consumer will need frequent assessments to determine any changes in respiratory status, cardiovascular status and LOC.

The consumer's home should have "NO SMOKING" signs posted at every entrance.

PROCEDURE: Application of CPAP

1. Explain to the consumer what you are going to do, and why it is necessary for the procedure. Have the consumer assist if he or she can participate.

2. Verify the physician's orders.

3. Check the consumer identification using to identifiers. (may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card).

4. Position the consumer for the procedure.

5. Show the consumer the mask and explain that one strap will be placed behind the consumer's head and the strap will be over his head to ensure a snug fit.

6. Set desired concentration of 02 blender and adjust flow rate so it is sufficient to meet the consumer's demand.

7. Place the mask on the consumer's face, adjust the head strap, and inflate the mask cushion to ensure a tight seal.

8. Organize care to remove the mask as infrequently as possible. If the mask is removed for coughing or suctioning 02 concentrations will drop.

9. Assess LOC frequently, hemodynamic status, and arterial blood gases.
   Report any increase in PaCO2 status.

10. Document the date and time of treatment, the device used, record the flow rate, the vital signs, skin color and breath sounds.

11. Document the consumer response before and after treatment.

12. Note any family teaching presented.

13. Report any pertinent findings to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY

TITLE: VITAL SIGNS TEMPERATURE

PURPOSE STATEMENT: Purpose to restore the consumer thermal dynamic status.

POLICY: NM 13.022

ASSESSMENT: Clinical signs of fever, hypothermia, factors that may affect temperature, appropriate site for measurement. Delay oral measurement if consumer has recently ingested hot/cold fluids or foods, smoked, or received oxygen by mask or nasal canal.

Adult Oral Normal Range: 9.8-100.4*F (36-38*C)

- Oral: Adult normal 98.6*F(37.0*C)
- Rectal: Adult normal 99.5*F(37.5*C)
- Axillary: Adult normal 97.7*F(36.5*C)

EQUIPMENT: thermometer, sheath cover, disposable gloves, paper towels, tissues or wipes for axillary temperature.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary and how or she can cooperate.
2. Wash hands and observe other appropriate infection control procedures.
3. Clean thermometer.-wipe with alcohol swab and rinse under cool water.
4. Identify consumer using 2 identifiers.(may not be limited to consumer knowledge of social umber, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card).
5. Provide for the consumer privacy.
6. Place the client in the appropriate position.
7. Put on gloves.
8. Apply the protective sheath to oral, axillary, electronic or ear probe.
9. Place the thermometer (oral, axillary, tympanic, skin dot method, ear probe).
10. Wait the appropriate amount time to accurately measure reading per manufactures guidelines.
11. Remove the thermometer and discard the cover, wipe thermometer with alcohol wipe and rinse under cool water.

12. Remove gloves and wash hands.

13. Document the reading, report findings to physician if necessary.

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: PAIN INTENSITY SCALE

PURPOSE STATEMENT: Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient.

POLICY: NM 13.023

DEFINITION:

I. Pain assessment tool for consumers who are verbal

Pain Intensity Scale

No Pain			Distressing Pain					Intense Pain	
1	2	3	4	5	6	7	8	9	10

1-3= mild pain, 4-6= moderate pain, 7-10= severe pain

PROCEDURE:

1. Ask consumer to rate his or her pain from 0-10.
   a. "Can you rate your pain 0 to 10?"
   b. "Zero tells me that you are not experiencing any pain."
   c. "The number ten tells me that you are having the worst pain you can image."

2. After you have identified the consumer's pain level determine if consumer needs immediate medical evaluation or intervention.

3. Reassess pain 1 hour after pain intervention and document pain score.

4. If the consumer does not need immediate medical evaluation, see procedure on pain management.

5. Document pain score and notify physician of any findings.

REFERENCE: Pain Assessment with the"0—10 Numeric" Pain Intensity Scale. (n.d.) Retrieved fromhttp://www.geriu.org/uploads/painDVD/AdditionalMaterials/ZeroToTenPainScale.pdf

LEGAL AUTHORITY:

Effective date:

Date reviewed:

Authorized by:
Prepared by:

Related policy

MACOMB COUNTY COMMUNTIY MENTAL HEALTH

POLICY TITLE: PAIN MANAGEMENT

PURPOSE STATEMENT: Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient.

POLICY: NM 13.024

DEFINITION:

Acute pain begins suddenly. It serves as a warning of disease or a threat to the body. Acute pain might be caused by many events or circumstances.

Chronic pain persists despite the fact that the injury has healed. Pain signals remain active in the nervous system for weeks, months, or years.

II. Pain assessment tool

Pain Intensity Scale

No Pain				Distressing Pain					Intense Pain
1	2	3	4	5	6	7	8	9	10

ASSESSMENT:

- Assess the consumer's pain to include location, characteristics, onset/duration, frequency, quality, intensity or severity of pain, and precipitating factors.
- Assess nonverbal cues of discomfort.
- Assess the consumer's knowledge and beliefs about pain; identify any cultural influences on the pain response.
- Assess the impact of the pain experience on quality of life (e.g., sleep, appetite, activity, cognition, mood, relationships, performance of job, and role responsibilities.

- Assess factors that relieve/worsen pain.
- Ask the consumer about past experiences with pain and effective pain control measures.
- Assess pain by using a “0-10 numeric” pain intensity scale. (See figure A).
- Utilize a developmentally appropriate assessment method that allows for monitoring of change in pain and that will assist in identifying actual and potential precipitating factors.
- Consider the patients willingness to participate, ability to participate, support of significant others Identify if consumer has acute and chronic pain.

INTERVENTION:

1. Identify if consumer needs immediate medical evaluation. (for acute pain or unrelieved chronic pain).

3. Control environment factors that may influence the patient’s response to discomfort (e.g., room temperature, lighting, noise.)

3. Reduce or eliminate factors that participate or increase the pain experience (e.g., fear, fatigue, and lack of knowledge).

4. Select and implement a variety of measures (e.g. pharmacological, non pharmacological, interpersonal) to facilitate pain relief, as appropriate.

5. Reassess pain one hour after intervention and document pain score.

6. Teach principles of pain management.

7. Encourage consumer to monitor own pain and intervene appropriately.

8. Teach the use of non pharmacological techniques; relaxation, guided imagery, music therapy, distraction, hot/cold application,) before, after, and if possible, during painful activities; before pain occurs or increases; and along with other pain relief measures

9. Teach about pharmacological methods of pain relief.

10. Encourage patient to use adequate pain medication.

11. Collaborate with the patient, significant other, and health professional to select and implement non pharmacological relief measures, as appropriate.

11. Use pain control measures before pain is severe.

13. Monitor patient’s satisfaction with pain management at specific intervals.

REFERENCE: Pain Assessment with the“0—10 Numeric” Pain Intensity Scale. (n.d.) Retrieved fromhttp://www.geriu.org/uploads/painDVD/AdditionalMaterials/ZeroToTenPainScale.pdf
LEGAL AUTHORTY:

Effective date:
Date reviewed:

Authorized by:
Prepared by:

RELATED POLICY:

TITLE: FALL PREVENTION

PURPOSE STATEMENT: To identify consumers at fall risk and institute special precautions with consumers at risk for injury from falling.

POLICY: NM 13.025

DEFINITION OF FALL: To drop or descend under the force of gravity, as to a lower place through loss or lack of support. The presence or absence of a resultant injury is not a factor in the definition of a fall.

PREVENTION PROCEDURES:

1. Identify cognitive or physical deficits of a consumer that may increase potential of falling in a particular environment.
2. Identify behaviors and factors that affect risk of falls.
3. Review history of falls with consumer and guardian.
4. Identify and modify characteristics of environment that may increase risk of falls.
5. Monitor gait, balance, and fatigue level during and after ambulation.
6. Lock wheels of wheelchair during transfer of consumer.
7. Use proper technique to transfer consumer to and from wheelchair, bed, and toilet.
8. Assist with toileting at frequent, scheduled intervals.
9. Provide adequate lighting for increased visibility.
10. Provide nonslip, no trip floor surfaces.
11. Provide a nonslip surface in bathtub or shower.

CITE PROCEDURE:

1. Assessing fall risk.
2. Providers of care work at screening consumers who are at risk of falls.
3. Providers establish care plans for fall prevention for consumers at risk.
4. In the event of a fall, providers will develop a plan of action and write an incident report.

REFERENCE: *Nursing Interventions Classification (NIC)* (6th edition). (2013). St. Louis, Missouri: ELSEVIER MOSBY.

REFERENCES:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: BLOOD GLUCOSE CALIBRATION/QUALITY CONTROL TESTING

PURPOSE STATEMENT: To test the accuracy of blood glucose monitoring devices used in the facility
POLICY: NM 13.026

EQUIPMENT:

PROCEDURE:

I. **Calibration** blood glucose monitoring device, high and low glucose control solution (specific to brand and model of device, calibration test strip (specific to brand and model of device).

1. Calibration must be performed for every new box of test strips, and when test results are questionable.
2. Use only the calibrator that is packaged with the box of test strips to be used
3. To perform calibration**:**
    a. Place the calibration strip in the test port and await results.
    b. Lot # displayed should match lot # on calibrator strip and on foil test strip package. If it does not match, repeat procedure using calibrator strip for the box of strips in use.
    c. Remove calibrator and store in carrying case. Do not discard the calibrator until all of the test strips in box have been used.
    d. Results falling out of the calibration range indicate a problem. Until problem can be resolved, do not use the monitor to check consumer's' blood glucose levels. Refer to operators manual**.**

II. **Control Testing**

1. Run two control levels (High and Low) on a daily basis. At minimum, quality control testing is performed:
    a. When a vial of strips has been left open.
    b. Before using the blood glucose meter for the first time.
    c. Each time a new vial of strips is opened.
    d. If the meter has been dropped.
    e. Whenever the results contradicts the consumers condition.
2. Controls outside of the manufacturer's acceptable range indicate a problem. Until the problem can be resolved, do not use the monitor to check consumers' blood glucose levels. Refer to the operator's manual.
3. If calibration and/or control level problems cannot be resolved, the clinical laboratory must be relied upon for an accurate reading of glucose level until the device can be repaired.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: BLOOD GLUCOSE MONITORING

PURPOSE STATEMENT: To detect or monitor consumer's blood glucose levels.

POLICY: NM 13.027

DEFINITION: Blood glucose meter should be calibrated before use and a control sample run to ensure accurate test result. Use Blood Glucose Monitoring Quality Control Log.

Blood glucose meters are to be cleaned between each use if used on more than 1 resident.

EQUIPMENT: Portable blood glucose meter, diagnostic strips, gloves, gauze pads, alcohol sponges, disposable lancets (individual, single use), small adhesive bandage.

PROCEDURE:

1. Obtain / verify MD order for the procedure.
2. Blood glucose meters should be assigned to individual consumers if possible to prevent transmission of blood borne pathogens.
3. If a meter that has been used for one resident must be reused for another consumer, the device must be cleaned and disinfected with a bleach preparation of: 1 part bleach to 10 parts water or an approved designated cleaner. (**DO NOT use alcohol or ammonia solution)** let the bleach solution dry. **Note: Do not try to clean strip port, do not pour liquid into pour or buttons, do not place monitor on water or any bath.)**
4. Identify consumer, provide privacy, and explain procedure.
5. Select puncture site. (usually fingertip)
6. Wash hands and put on gloves.
7. Dilate capillaries, if necessary, by applying warm moist compresses to area for 10 minutes.
8. Wipe puncture site with alcohol sponge and dry thoroughly with gauze pad.
9. Draw sample from side or top of fingertips with a disposable lancet.
    a. Position lancet perpendicular to lines of fingertip.
    b. Pierce skin sharply and quickly.
10. Wipe away the first drop of blood and avoid squeezing puncture site.
11. Follow manufacturer's instructions to obtain test results.
12. Apply small adhesive bandage to puncture site, if necessary.
13. Discard Lancet in sharps container.

14. Remove gloves and wash hands.
15. If the glucose level is out of established ranges ordered by the physician:
    a. Repeat the test.
    b. Contact the physician.
    c. Provide treatment as ordered by the physician.

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

Related Policy:

POLICY TITLE: HYPERGLYCEMIA

PURPOSE STATEMENTS: How to identify and respond to a consumer with hyperglycemia.

POLICY: NM 13.028

DEFINITION: A normal fasting blood glucose target range for an individual without diabetes is 70-100 mg/dL (3.9-5.6 mmol/L). The American Diabetes Association recommends a fasting plasma glucose level of 70–130 mg/dL (3.9-7.2 mmol/L) and after meals less than 180 mg/dL (10 mmol/L).

Hyperglycemia is the medical term for high blood glucose (blood sugar). High blood glucose happens when the body has too little insulin or when the body can't use insulin properly.

PROCEDURE:

1. Learn and monitor consumers for signs and symptoms of hyperglycemia:

- High blood glucose
- High levels of sugar in the urine
- Frequent urination
- Increased thirst
- Weakness
- Lethargy
- Blurring of vision
- Headache

If a consumer shows signs of hyperglycemia contact their PCP/nurse immediately!

Hyperglycemia can be dangerous if left untreated. Untreated hyperglycemia can lead to a condition called ketoacidosis, which can then result in a diabetic coma. Insulin is a hormone produced by our pancreas that regulates carbohydrate and fat metabolism. Without insulin, our bodies do not use glucose for fuel resulting in a breakdown of fats.

When your body breaks down fats, waste products called ketones are produced. Your body cannot tolerate large amounts of ketones and will try to get rid of them through the urine. Unfortunately, our body may not be able to release all the ketones causing them build up in your blood. This can result in ketoacidosis. Diabetic ketoacidosis signs and symptoms often develop quickly, sometimes within 24 hours. Learning the signs and symptoms is important in preventing this life-threatening condition.

2. Ketoacidosis is life-threatening and needs immediate treatment. Symptoms include:

- Shortness of breath
- Breath that smells fruity
- Nausea and vomiting
- Very dry mouth

LEGAL AUTHORITY:

REFERENCE: American Diabetes's Association. (1995-2014). Hyperglycemia (High blood glucose).Retrieved from http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/hyperglycemia.html

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

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POLICY TITLE: HYPOGLYCEMIA

PURPOSE STATEMENTS: How to identify and treat hypoglycemia.

POLICY: NM 13.029

PERSONS AFFECTED/RESPONSIBLE:

DEFINITION: A normal fasting blood glucose target range for an individual without diabetes is 70-100 mg/dL (3.9-5.6 mmol/L). The American Diabetes Association recommends a fasting plasma glucose level of 70–130 mg/dL (3.9-7.2 mmol/L) and after meals less than 180 mg/dL (10 mmol/L).

Hypoglycemia refers to abnormally low blood glucose (blood sugar) levels, usually less than 70 mg/dl.

Hypoglycemia may also be referred to as an insulin reaction, or insulin shock.

Low blood sugar can be life threatening, so it is important to identify the signs and symptoms that can occur.

Signs and symptoms of hypoglycemia:

shakiness, tremor, sweating, nervousness, anxiety, irritability, impatience, tachycardia, palpations, chills, clamminess, light-headedness, pallor, hunger, nausea, headache, tiredness, drowsiness, weakness, warmth, dizziness, faintness, blurred vision, nightmares, crying out in sleep, paresthesis, difficulty concentrating, difficulty speaking, in coordination, behavior, confusion, coma, seizure.

TREATMENT:

1. If consumer is not able to follow instructions or is unconscious call 911.

2. If consumer is alert and able to follow instructions:

A. Have the consumer consume 15-20 grams of glucose or simple carbohydrates.
B. Recheck blood glucose after 15 minutes.
C. If hypoglycemia continues, repeat.
D. Once blood glucose returns to normal, eat a small snack if your next planned meal or snack is more than an hour or two away.

15 grams of simple carbohydrates commonly used:

- glucose tablets (follow package instructions)
- gel tube (follow package instructions)
- 2 tablespoons of raisins
- 4 ounces (1/2 cup) of juice or regular soda (not diet)
- 1 tablespoon sugar, honey, or corn syrup
- 8 ounces of nonfat or 1% milk
- hard candies, jellybeans, or gumdrops

3. If blood sugar returns to normal range and symptom subside after rechecking in 15 minutes call the consumer PCP to inform them about the consumer's fluctuation in blood sugar. PCP may have orders to monitor the consumer, change the consumer's diet, or change their insulin régime.

4. If blood sugar does not rise above 70 mg/dl or symptoms do not subside after first diet treatment call 911.

LEGAL AUTHORITY:

REFERENCE: American Diabetes Association.(1995-2014). Hypoglycemia (Low blood glucose). Retrieved from http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/hypoglycemia-low-blood. html

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

TITLE: PHLEBOTOMY: VENOUS BLOOD SAMPLE

PURPOSE STATEMENTS: Removal of a sample of venous blood from an uncannulated vein.

POLICY: NM 13.030

EQUIPMENT: needle(20- to 21- gauge for adults;23-to25- gauge for child), sterile syringe, alcohol swab(70% alcohol) or antiseptic swab, clean gloves, tourniquet, vacutainer (if available) and safety access device, sterile 2*2 gauze pad, proper sharp/biohazard receptacle, specimen tube, adhesive bandage or adhesive tape, completed identification labels(with appropriate client identifiers),completed laboratory requisition(including appropriate client identification, date, time, name of test, and source of culture), small plastic bag for delivery of specimen to laboratory

PREPARATION:

- Determine client understands of the purpose of test and ability to cooperate with procedure.
- Determine if special conditions need to be meet for specimen collection.
- Assess clients for possible risk of venipuncture, which include anticoagulant therapy, low platelet count, or bleeding disorder.
- Identify latex allergies, tape sensitivity, or betadine allergy.
- Review physician's order for sample to be drawn.
- Verify correct patient identification. (2 identifiers)
- Minimize anxiety for the patient by explaining the procedure and rationale, as appropriate.
- Provide a private environment.
- Have a syringe with needle attached.

PROCEDURE:

1. Assist client with lying supine or sitting in semi-fowlers position or in a chair with arm support and elbow extended. Place small pillow or towel under upper arm.
2. Apply tourniquet so that it can be removed by pulling end with single motion.
    a. Position tourniquet 5 to 10 cm (3 to 4 inches) above venipuncture site selected.
    b. Cross the tourniquet over the clients arm, holding the tourniquet between your fingers close to the arm.
    c. Tuck a loop between the clients arm ant the tourniquet so that the free end can be easily grasped.
3. Ask the consumer to gently open and close fist several times, leaving fist clenched.
4. Inspect extremity for venipuncture site, looking for straight, and prominent vein without swelling or hematoma.
5. Palpate the selected vein with finger. Note if vein is firm and rebounds when palpated or if vein feels rigid and cordlike and rolls when palpated.
6. Cleanse venipuncture site with antiseptic swab, moving in circular motion from the site outward for about 5 cm (2 inches) allow to dry.
    - If drawing blood alcohol level or blood cultures, use only antiseptic swab, not alcohol.
7. Remove needle cover and inform client of the puncture.

8. Place thumb or forefinger of no dominant hand 2.5 cm (1 inch) below site, and gently pull skin taut. Stretch skin steadily until vein is stabilized.
9. Hold syringe and needle at a 15-to30 degree angle from the consumers arm with the bevel up.
10. Slowly insert needle in to vein.
11. Hold syringe securely, and pull back gently on plunger.
12. Observe for blood return and withdraw until desired amount of blood is collected.
13. Release tourniquet before removing needle.
14. Apply 2*2 gauze pad or alcohol swab over puncture site without pressure. Withdrawal needle and apply pressure after removal of needle.
15. Activate needle safety cover and immediately discard needle in proper receptacle.

Vancutainer system method:

1. Attach double-ended needle to vacationer tube.
2. Have blood specimen tube resting inside vacationer, but do not puncture rubber stopper.
3. Cleanse venipuncture site with alcohol swab using circular motion out from site for approximately 5 cm allow to dry.
4. Remove needle cover, and inform client that the puncture will be felt for a few seconds.
5. Place thumb and forefinger of no dominant hand 2.5 cm (1 inch) below site and pull skin taut. Stretch skin down until vein is stabilized.
6. Hold vacationer needle at 15-30-degree angle from the arm with bevel of needle up.
7. Slowly insert needle in to vein.
8. Grasp vacationer securely, and advance specimen tube into needle of holder.
9. Note flow of blood into tube, which should be fairly rapid.
10. After specimen tube is filled, grasp vacationer firmly and remove tube. Insert additional specimen tubes as needed.
11. Release tourniquet and apply gauze.
12. Discard vacationer and needle per agency policy.
13. Remove gloves and perform hand hygiene.

REFERENCE:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: CLEAN-VOIDED URINE SPECIMEN

PURPOSE STATEMENT: To collect clean-voided urine specimen.

POLICY: NM 13.031

EQUIPMENT: clean gloves, commercial kit for clean-voided urine containing: antiseptic towelettes, sterile specimen container

PROCEDURE:

1. Explain to consumer reason specimen is needed, how the consumer can assist, and how to obtain a specimen that is free of tissue and stool.
2. Give consumer antiseptic towelettes.
3. Wash hands and don gloves.
4. Open specimen container, maintaining sterility of inside surface up. Do not touch inside of cap or container.
5. Allowing consumer to independently clean perineum and collect specimen

A. Female:

a. Spread labia minora (vagina) with finger of nondominant hand. Using a new antiseptic swab each time, cleanse the area from front to back over the urinary meatus and along each side.

b. Use the dominant hand, using three separate antiseptic swabs, cleanse from front to back three times. (begin with center, then do left and right sides)

c. Consumer initiates urine stream into the toilet; after stream is achieved, pass specimen container into stream and collect 30-60 ml of urine.

B. Male:

a. hold penis with one hand: using circular motion and antiseptic towelette, clean meatus three times(tip of penis), moving from center to outside. Use a separate antiseptic swab each time.

b. after client has initiated urine stream urine stream into the toilet; pass specimen container into stream and collect 30-60 ml of urine.

6. Remove specimen container before flow of urine stops and before releasing penis or labia. Consumer can finish voiding into toilet.

7. Replace cap securely on specimen container, touching only the outside

8. Cleanse urine from outside the container.

9. Label specimen container.

10. Dispose of gloves and perform hand hygiene.

C. Collect urine from urine drainage bag.

1. Wash hands with soap and water.

2. Put on disposable gloves.

3. Kink drainage tubing a minimum of 3 inches below the blue sampling port until urine is visible under the access site.

4. Swab surface with alcohol swabs or Hibiclens.

6. Using aseptic technique, position the syringe in the center of the sampling port. The syringe should be held perpendicular to the surface of the sampling port. Press the syringe firmly and twist gently to access the sample port.

6. Slowly aspirate desired sample amount in syringe and remove syringe from sample port.

7. Unkink tubing and transfer urine specimen into sterile specimen container.

8. Discard syringe.

9. Replace cap securely on specimen container, touching only the outside

10. Cleanse urine from outside the container.

11. Label specimen container.

12. Dispose of gloves and perform hand hygiene.

REFERENCES:

LEGAL AUTHORITY

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: URINARY INCONTINENCE

PURPOSE: To provide direction to nursing staff regarding the management of patients with urinary incontinence.

POLICY: NM 13.032

DEFINITION:

Stress incontinence is the leakage of urine during physical activity. Physical activity such exercise, coughing, sneezing, laughing, lifting heavy objects, can cause undesirable leakage of urine from pressure placed on the bladder**.**

Urge incontinence: is the inability to hold urine. The consumer feels a sudden and strong urge, or need to urinate and often does not make it to the toilet in time.

Overflow incontinence: is the leakage of small amounts of urine from a bladder that is always full. This can occur in men with enlarged prostates, in diabetics with neurogenic bladders, or in patients suffering strokes or spinal cord injuries.

Functional incontinence occurs: in people who have normal urine control but who have difficulty reaching a toilet in time due a physical disability that does not allow them to get to the bathroom in time.

Nursing Assessment:

First, attempt to determine which type of urinary incontinence your patient suffers from. Discuss the patient's condition with his/her physician. Look for the following underlying problems:

- Fecal Impaction is a common cause of urinary incontinence
- Urinary tract infection
- Multiple sclerosis, diabetes, Parkinson's, paralysis
- Prostate enlargement
- Bladder irritants: caffeine, wine, Nutra Sweet, chocolate, OTC meds with caffeine (i.e., Anacin, Excedrin, Midol, Dristan, Sinarest)
- Urinary retention

Urinary incontence:

Behavioral Therapy gives the patient control and has no side effects**.**

a. Bladder Retraining- This method is used for urge incontinence by teaching the patient to delay the urge to void through distraction techniques.
b. Urinary Habit Training-Establish interval for toileting every 2 hours. Use power of suggestion by running water or flushing toilet. Determine ability to recognize urge to void. Keep record.
c. Prompted Voiding-Make routine contact with patient. Take the patient to the bathroom when they express the urge to void. Provide positive feedback about maintaining continence.

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Procedure for Urinary habit training:

1. Keep a record of the consumer's incontinence for 3 days. Establish when incontinence is likely to occur.
2. Establish a voiding time interval with the consumer to minimize incontinence.

3. Offer to take the consumer to the toilet at least every 2 hours.
4. Assist consumer to the toilet and instruct to try to void
5. Use running water in the sink or flush the toilet to stimulate the urge to void.
6. Reduce toileting interval by one half hour if there are more than two incontinence episodes in 24 hours.
7. Maintain toileting interval if there are two or less incontinence episodes in 24 hour.
8. Increase the toileting interval by one half hour if patient has no incontinence episodes in 48 hours, until optimal 4 hour interval is achieved.
9. Communicate daily record of voiding pattern and incontinence in the health care chronological/progress note.
10. Give positive feedback to the consumer.

.

REFERENCE: *Nursing Interventions Classification (NIC)* (6th edition). (2013).St. Louis, Missouri: ELSEVIER MOSBY.

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

Related policy:

MACOMB COUNTY COMMUNTIY MENTAL HEALTH

POLICY TITLE: FOLEY CATHETER

PURPOSE STATEMENT: How to care for a Foley catheter.

POLICY: NM 13.033

PREPARATION AND PROCEDURE:

1. Explain to the consumer what your planned intervention is.
2. Provide privacy for the consumer.
3. Have any equipment needed available at bedside.
4. Always wash your hands and wear gloves before you touch the catheter or insertion site.
5. Secure catheter tube so the consumer does not pull or move the catheter. Use medical tape or a strap to secure the catheter to the consumer's body.
6. Keep the catheter and the area around it clean with soap and water to help prevent infection.
7. Allow gravity to drain urine down the catheter tube. Do not loop or kink the tubing so that it stops the flow of urine.
8. Keep the drainage bag below the level of your waist.
9. Do not let the drainage bag touch or lie on the floor.
10. Be sure to empty the drainage bag when it becomes ½ to 2/3 full.
11. Notify doctor:
    - If catheter comes out.
    - There is less urine than 30 ml hour in the bag.
    - Urine is leaking from around the catheter, tubing, or drainage bag.
12. Do not disconnect parts of the closed system unless it is necessary such as when changing the bag.
13. Monitor consumer for fever, sediment in tubing, change in mental stasis, foul smell in urine, change in the color of urine, pain in the consumer's hip, back, pelvis, or lower abdomen.
14. When empting drainage bag, use a clean container to empty urine into, carefully open the spigot at the bottom of the bag to empty. Do not allow spigot to touch the container or toilet. Close the spigot securely to prevent leaking.

15. Always close the drainage spigot after emptying urine out of the drainage bag.

16. Discard gloves and wash hands.

REFERENCE:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

Related policy:

MACOMB COUNTY MENTAL HEALTH DEPARTMENT

POLICY TITLE: CARE OF THE PATIENT WITH AN OSTOMY

PURPOSE STATEMENT: To provide and maintain a device to collect waste products from an ostomy and protect the skin from erosion.

POLICY: NM 13.034

PROCEDURE:

1. Measure stoma using ostomy measuring guide. Cut ostomy pouch opening 1/8" larger than the stoma. Initially the stoma will shrink over time.

2. Remove the old pouch by gently and slowly pushing the skin away from the adhesive backing using warm water and washcloth. Do not ripe it off because this could damage the skin. Remove exudates with tissue or gauze. Save the pouch clamp.

3. Wash pouch clamp with soap and water if soiled.

4. Cleanse the peristomal skin with water and/or a mild soap if needed. Soap may be used as a patient preference but may leave a residue on the skin.

5. Apply protective skin barrier prep to skin and fan dry (optional).

6. Stoma powder may be used to protect irritated skin and provide a dry pouching surface. Only a light dusting of an ostomy skin barrier should be used.

7. If gaps exist, fill with stoma paste and/or apply in a ring around the stoma onto the back of the wafer opening after removing the paper backing.
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8. Transverse loop ostomies require a 2 piece, 4-inch cut-to-fit pouching system. Colostomies and Ileostomies require either a 2 piece 2 3/4inch cut to fit pouching system or a 1 piece cut to fit drainable pouching system which delivers flexibility for uneven pouching surfaces. Urostomies require a urostomy pouch that has a drain adaptor at the distal end.

9. Empty flatus out by opening the bottom of the pouch. The pouch should be emptied when 1/3 to 2/3 full.

10. Tape may be applied around the pouch in a picture frame fashion, but is not necessary (patient preference).

11. Give patient/caregiver ostomy teaching educational materials. Assess patient's level of acceptance. Encourage the patient to verbalize feelings about the ostomy. Elderly patients with visual difficulties may benefit with magnifying devices.

13. Leaking pouches cannot be "patched up" but rather a new system must be applied.

14. The pouching system ideally should be changed twice weekly. (usually every 3 to 5 days)

REFERENCES:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: TRACHEOSTOMY TUBE SUCTIONING

PURPOSE STATEMENT: To provide tracheotomy suctioning to facilitate airway patency, avoidance of infection and clients comfort.

POLICY: NM 13.035

EQUIPMENT: Sterile suction catheter 12 to 16 Fr (approximate, adult: size of the catheter should be no more than half of the internal diameter of the artificial airway, bedside table, two sterile gloves or one sterile and one clean glove, sterile basin, sterile normal saline, clean towel or sterile drape, portable or wall suction machine, connecting tubing (6 feet), face shield

PROCEDURE:

1. Apply mask or face shield as appropriate.

2. Turn on suction machine; adult: suction pressure -80 to -120 mmHg (Breath of Life Home Medical Equipment and Respiratory Service, 2009).

3. Apply sterile gloves.

4. Attach non- sterile suction tubing to sterile catheter, keeping hand holding catheter sterile.

5. Check that equipment is functioning properly by suctioning small amounts of saline from basin.

6. Hyper -oxygenate consumer before suctioning by taking 3-4 deep breaths.

7. Without applying suction and using dominant thumb and forefinger, gently but quickly insert catheter into tracheotomy opening until resistance is met or client coughs: then pull back 1 cm (1/2 inch).(**see A**)

8. Apply intermittent suction by placing and releasing non- dominant thumb over vent of catheter. Slowly withdrawal catheter while rotating it back and forth between dominant thumb and forefinger. If catheter “grabs” mucosa, remove thumb to release suction. The maximum time catheter may remain in airway is 15 seconds (AARC, 2004). Encourage consumer to cough. (**See B**)

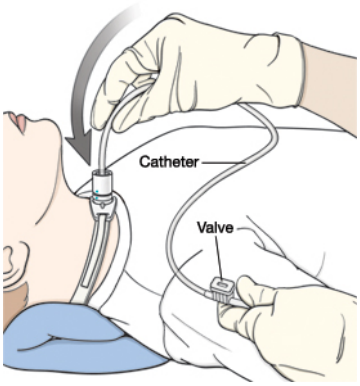
9. Replace oxygen if applicable and encourage consumer to deep breathe.

10. Rinse catheter and connecting tube with sterile water or normal saline until clear. Use continuous suction.

11*. Assess the consumer for secretion clearance and complications. Allow time (up to 2 minutes) between suction passes to reestablish baseline oxygen.*

12. Disconnect catheter from tubing. Discard gloves and catheter into appropriate receptacle.

13. Perform hand hygiene



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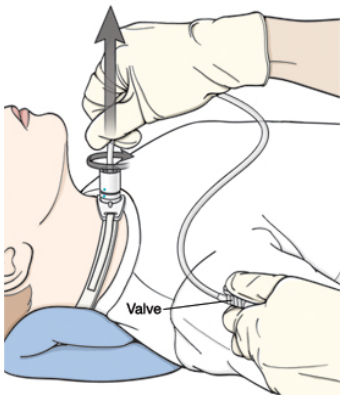


B.

REFERENCES:

- WhenYourChildNeedsTracheotomy:Suctioning.(2013). Retrieved from http://www.uofmmedicalcenter.org/healthlibrary/Article/88999

- Tracheotomy Care and Suctioning Manual. (2009).Retrieved from http://www.bolhme.com/education/TracheostomyCare&Suctioning.pdf

LEGAL AUTHORITY:

Effective date:
Prepared by:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY MENTAL HEALTH DEPARTMENT

POLICY TITLE: TRACHEOSTOMY DRESSING

PURPOSE STATEMENT: To apply 4 by 4 dressing under tracheostomy tube.

POLICY: NM 13.036

DEFINITION: Some consumers use tracheostomy dressings that are “pre-cut” tracheostomy gauze dressings. DO NOT cut the gauze. The fraying can make lint or fuzz that could enter the tracheostomy. Use a folded 4*4 gauze.

Stoma site will require dressing change under the following circumstances:

- Secretions accumulating around site
- Dressing soiled
- Dressing wet
- Signs of infection
- Discomfort expressed at stoma site by patient
- To inspect site a minimum of every 24 hours
- Dressing change has not occurred in last 24 hours

PROCEDURE:

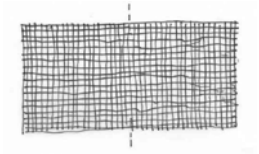
To make a folded 4 x 4 gauze dressing to be placed around the tracheostomy tube.

1. Open sterile 4 x 4 gauze to it fullest length.

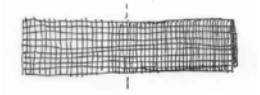
2. Fold the gauze in half lengthwise to form a long, thin rectangle.

3. Fold center of gauze. Fold each gauze side to center to create a V-shaped gauze

4. Put gauze under the neck flange.



1.



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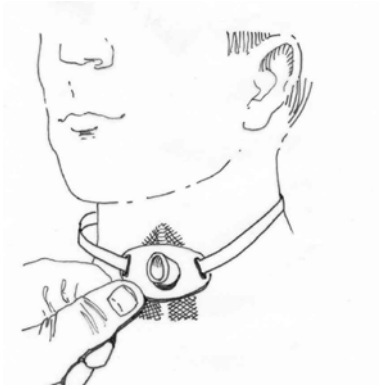


REFERENCES:

- University of Pittsburgh medical Center. (2007).Trachestomy care. Retrieved from http://www.upmc.com/patientvisitors/education/documents /tracheostomycare.pdf

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY MENTAL HEALTH DEPARTMENT

POLICY TITLE: **TRACHEOSTOMY SKIN CARE**

PURPOSE STATEMENT: To provide tracheostomy skin care

POLICY: NM 13.037

PERSONS AFFECTED/RESPONSIBLE: Nurse, Direct care provider

EQUIPMENT: gloves (clean, disposable, and powder less) clean, hydrogen peroxide,4 x 4 gauze dressing without cotton filler, cotton tip applicators, normal saline or sterile water, container to mix hydrogen peroxide and saline (or sterile water), clean tracheostomy ties.

DEFINITION: This procedure aims to keep the stoma site clean and dry, reducing the risk of skin irritation and infection. Stoma site should be assessed every time patient attended to or as a minimum frequency of 8 hours.

PROCEDURE:

1. Wash your hands and observe agency standard precautions regarding infection control.

2. Gather the supplies.

3. Clean around stoma site with gauze soaked with 0.9% sodium chloride, being careful not to disturb the tracheostomy tube.

4. Crusts may be removed by loosening with peroxide (dilute equal parts of peroxide and 0.9% sodium chloride or sterile water) on a cotton-tip applicator. Hold cotton tip applicator securely to keep it from going into the stoma.

5. Dry the stoma site thoroughly with clean gauze.

6. If mucus is a problem, use 4 x 4 gauze without cotton filler around the tracheostomy tube. (refer to tracheostomy dressing procedure).

7. Adjust the tracheostomy ties or apply new ones. (refer to tracheostomy ties procedure.)

8. Check your skin daily for redness or irritation. Report to the physician if there is irritation, redness, bleeding, and evidence of infection (signs include purulent discharge, patient experiencing, pain, odor, abscess formation, cellulitis and discoloration).

- **REFERENCES:** Tracheotomy Care and Suctioning Manual. (2009).Retrieved from http://www.bolhme.com/education/TracheostomyCare&Suctioning.pdf

LEGAL AUTHORITY:

Effective date:
Prepared by:

Authorized by:

Prepared by:

RELATED POLICY:

POLICY TITLE: **TRACHEOSTOMY TIES**

PURPOSE STATEMENT: To change tracheostomy ties

POLICY: **NM 13.038**

EQUIPMENT: twill tape (approx 30 inches long), scissors, gloves, and an assistant.

PROCEDURE:

A. Twill tape

1. Wash hands and don glove

2. Tell consumer what you are about to perform

3. Hyper oxygenate and then suction if needed.

4. Remove soiled dressing.

5. With glean glove on and while your assistant is holding the tracheostomy tube in place, cut and remove current twill tape. Note: if you must perform this procedure alone, you MUST fasten the new ties completely before cutting off old tube ties.

6. Change ties every 24 hours or as often as needed.

7. Insert one new tie end through the face plate and pull until ½ of the tape is through the eyelet. Slide the doubled tie around the consumer neck, pull snug and tie in a double square knot on the consumer neck. Allow one finger space between the twill tape and the consumer's neck.

B. Velcro ties

1. Follow manufacturer's directions for measuring and applying the tie.

2. Use fingers to hold both sides of the neck plate of the tracheostomy tube in place. Release 1 side of the Velcro fastener.

3. Insert and secure the clean Velcro strip into the same neck plate hole.

4. With fingers still holding both sides of the neck plate, remove the old Velcro tie from the other side.

5. Insert and secure the clean Velcro strip into the neck plate, and remove the old Velcro tie from the other side.

6. Adjust the clean ties to fit your neck. You should be able to fit 1 to 2 fingers between the tie and the neck.een the tie and the neck.

- **REFERENCE:** University of Pittsburgh medical Center. (2007).Trachestomy care. Retrieved from http://www.upmc.com/patientvisitors/education/documents /tracheostomycare.pdf

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: **WOUND DRESSING**

PURPOSE STATEMENT: To perform basic dressing change

POLICY: **NM 13.039**

EQUIPMENT: Clean gloves, necessary dressings: fine-mesh, dressings, and or ABD pads, antiseptic ointment as prescribed, cleaning solution as prescribed, sterile normal saline, tape or ties as needed, including non allergenic tape if necessary, measuring guide(optional), adhesive remover(optional), protective gown, goggles, and mask as needed, waterproof bag

PROCEDURE:

1. Provide privacy for consumer.

2. Explain procedure to consumer.

3. Premedicate consumer with ordered pain medication 30 minutes before dressing change if indicated.

4. Position consumer comfortably, and drape to expose only wound site.

5. Place waterproof bag next to work area and within reach.

6. Put on clean gloves.

7. Remove tape by pulling parallel to skin, toward dressing. If hairy areas, remove in the direction of hair growth.

8. Remove dressing one layer at a time, observing appearance and drainage on dressing.

9. Inspect wound for appearance, color, size, depth, drainage, edema, drains, odor, and approximation (wound edges are together). Fold dressings with drainage contained inside, and remove gloves inside out. Hold soiled dressing in hand and remove glove to wrap inside out around dressing. Repeat with second glove and discard in disposable bag.

10. Dispose of gloves and soiled dressings according to agency policy.

11. Put on clean gloves.

12. Clean the wound with prescribed solution and gauze pad. *Clean from least-contaminated to most-contaminated areas. Use new pad for each stroke.*

13. Apply ointment as ordered.

14. Apply dry sterile dressing:

15. Apply loose, woven gauze as contact layer.

16. Apply additional layers of gauze as needed.

17. Apply thicker woven pad. (e.g. ABD pad)

18. Secure dressing with tape, ties, or binder.

19. Remove gloves and dispose of waste according to the Agency Waste Disposal Policy.

20. Perform hand hygiene

21. Document in the clinical record:

a. Appearance, odor, and size of wound.
b. Amount and characteristics of drainage.
c. The client's tolerance of the procedure.
d. Dressing procedure and time of dressing change.

LEGAL AUTHORITY:

Effective date:
Date review/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: SUTURE REMOVAL

PURPOSE STATEMENT: To remove sutures from a healing wound.

POLICY: MN 13.040

PERSONS AFFECTED/RESPONSIBLE: Nursing

EQUIPMENT: Suture removal kit or set, Povidone-Iodine swabs, if allergic can use Chloraprep, normal saline per physicians order, 4x4's, adhesive tape remover swabs, 1 or 2 inch paper tape, exam gloves, sterile gloves is less than 48 hours old, red biohazard bag, and dressing supplies if ordered by the physician, and sterile gloves.

*If needed contact the physician to obtain physician orders for pain medication.

PROCEDURES:

1. Obtain physicians order.

2. Check for consumer allergies.

3. Identify the consumer may not be limited to consumer knowledge of social security number, consumer knowledge of date of birth, a State identification card, a driver's license, an insurance/Medicaid card.

4. Obtain suture removal kit

5. Wash hands per agency guidelines and adhere to infection control protocol.

6. Don on exam gloves.

7. If dressing is present remove. Rewash hands and reapply new gloves. If the wound is less than 48 hours old use sterile gloves.

8. Assess incision. Note healing and approximation of wound edges. Assess signs for infection.

9. If any signs of wound dehiscence, do not remove any more sutures. Apply dressing and notify the physician.

10. Remove staples according to physician order.

A. Place lower tip of staple extractor under first staple.

B. Close handle. The upper tip of the staple extractor depresses the center of the staple. This causes both ends of the staple to bend upward and exit their insertion sites at the same time. **Do not lift the stapler while squeezing the handle.**

C. Securely hold staple extractor and move the staple away from the incision site.

D. Holding the staple extractor over the disposable bag, release handles. The staple should drop into the bag.

E. Repeat until all staples are removed.

11. Assess incision site.

12. Clean skin of tape marks.

13. Apply lightweight, sterile dressing or steri-strips or leave to air, depending on physician's directions.

14. Discard disposable suture set in the sharps container.

15 .Discard any other contaminated supplies and place in the biohazard red bag.

16. Perform hand hygiene.

17. Record the date, time, and appearance of wound, any complications, any bleeding, number of staple removed and the consumer response.

18. Record the new dressing placement of steri- strips or left open to dry.

19. Report any pertinent findings to the physician.

REFERENCES:

LEGAL AUTHORITY

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ENTERAL NUTRITION GUIDELINES

PURPOSE STATEMENT: A feeding tube is used to deliver a liquid feeding formula directly to the stomach, duodenum or jejunum.

POLICY: NM 13.041

DEFINITION: Enteral feedings are typically indicated for the consumer who cannot eat normally because of dysphagia, oral, or esophageal obstruction or injury. They are also given to the consumer who is unconscious, intubated, or who cannot ingest food orally.

PROCEDURE:

1. The dietitian and licensed nurse observe the consumers and review assessment. The consumer is evaluated for the appropriateness of the feedings.
2. The dietitian conducts a comprehensive nutritional assessment using input from the physician, nursing, and caregiver(s) The nutrition assessment includes, but is not limited to:
    - Medical/surgical history impacting nutritional status
    - Nutrition history
    - Weight history, emphasis on recent weight change
    - Food/formula and fluid intake
    - Clinical signs and symptoms of malnutrition
    - Laboratory values that indicate nutritional status
    - Protein, calorie, and fluid requirements
    - Oral assessment
    - Cognitive function
    - Food/medication interactions
    - Appropriateness and adequacy of enteral feedings
    - Presence of advanced directives
3. The dietitian and physician evaluate the need for the long-term enteral access, e.g., gastrostomy, PEG, jejunostomy, for consumer with a nasal tube for greater than 4 weeks
4. Decisions about the appropriateness of enteral feeding for a consumer are developed with the consumer or his/her family/responsible party as part of the care planning process.

5. The Social Service staff evaluates the psychosocial issues resulting from or impacting the use of enteral feeding.

6. The nurse, dietitian and social worker collaborate with the physician to develop a comprehensive plan of care for the resident.

7. The nurse will obtain a physician's order for the placement of an enteral tube. Feeding orders include the following information:

    - The product to be used
    - The rate and /or timing of administration
    - Total volume to be given per 24-hour period
    - Total calories to be provided per 24-hour period
    - Route of delivery (nasogastic, gastrostomy etc.)
    - Method of administration(i.e. pump, gravity, bolus)
    - Volume of water to be given as water flush and before/after medications

8. The nurse checks placement of all feeding tubes prior to intermittent feedings and periodically during continuous feeding.

9. The nurse administers the enteral feeding regimen according to formula, system, type and method of delivery by the physician.

10. The head of the bed/chair must be elevated 30-45 degrees before starting a feeding/med pass and for at least 45 minutes to one hour afterwards (decrease risk of aspiration).

11. The nursing staff provides for the routine cleaning of enteral feeding equipment. Pumps in need of preventative maintenance are returned to the supplier. Backup pumps will be available.

12. The nurse irrigates the feeding tube with the prescribed amount of water every 4-8 hours to maintain or restore patency of the feeding tube and to provide free water to maintain adequate hydration for the consumer.

13. The nurse irrigates the feeding tube with 30-50 cc of water before and after administration of medications, before initiating a feeding or when there is an interruption of feeding.

14. The irrigation syringe is changed every 24 hours. The syringe should be changed with the feeding bag/container.

15. Nursing and dietary routinely monitor the following factors for evaluation of therapeutic efficacy, adverse effects, and clinical changes:

    - Weight
    - Hydration

- Intake and output
- Laboratory values
- Nutrition requirements
- Oral intake

16. The consumer is evaluated for tolerance to the enteral feeding regimen each shift. Intolerance man be manifested by:
    - Diarrhea, constipation
    - Nausea/vomiting
    - Abdominal distention/cramping
    - Dehydration/fluid overload
    - Aspiration
    - Increased gastric residual
    - Hyper/hypoglycemia
17. The nurse observes the consumer with long-term placement for potential complications.
    - Nasal erosion
    - Sinusitis
    - Esophagitis
    - Gastric ulceration
    - Skin irritation (from tape)
    - Pulmonary infection
18. The skin around the feeding tube is kept clean and free from irritation and/or infection. The site is evaluated for signs of redness, tenderness, drainage or erosion.
19. The nurse evaluates the consumer for signs/symptoms of dehydration.
    - Dry skin/poor skin turgor
    - Weight change
    - Dry oral mucous membranes
    - Decline in mental status, lethargy, somnolence
    - Rapid pulse, low blood pressure

- Decreased urine output, concentrated urine

20. The nurse checks for presence of skin breakdown and/or pressure ulcers.
21. The nurse contacts the physician to discuss and receive orders when complications from or intolerance to enteral feedings and/or inadequate progress toward goals is identified.
22. Storage of Formulas:
    - Store unopened formula at room temperature unless otherwise recommended by the manufacturer
    - Cover partially used formula, label with consumer's name, date opened, and refrigerate (discard the unused portion after 24 hours)
    - Do not hang formula in the open system longer than 8 hours
    - Do not hang formula that has been diluted with water for more than 4 hours.
    - Hang closed system products up to 36 hours or according to manufacturer's guidelines
23. The use of food coloring dye is contraindicated (studies have shown that food coloring dye may become contaminated and may cause nosocomial infection).

DOCUMENTATION:

24. All assessments pertaining to enteral therapy are documented in the:
    - MDS and resident care plan
    - Nutritional assessment
    - Social Services assessment
    - Nursing Date review
    - Rehab assessment (if applicable)
    - Progress notes
25. All procedures pertaining to enteral therapy are documented on the medication and/or treatment records.
26. Physician's orders are documented in the medical record and include the following:
    - Size and type of tube
    - Insertion of tube and frequency of change (if applicable)
    - Name of formula, total calories and flow rate
    - Method of administration (gravity , bolus, pump)

- Amount and frequency of water to flush the tube
- Frequency of residual checks and what amount to report to the physician
- Number of hours to run the continuous drip
- Stoma site care, if a gastrostomy or jejunostomy

27. The care plan includes specific details on:
    - Who should provide care and how often
    - What supplies/equipment needed
    - How the care is undertaken
    - Immediate and long term goals of the enteral feedings'
    - Anticipated duration of the enteral feeding
28. The progress notes include information pertinent to the consumer's clinical progress, enteral feeding regimen (tolerance, complications, and psychological issues), fluid intake/output and/or laboratory data.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ENTERAL FEEDING: RESIDUAL CHECK

PURPOSE STATEMENT: Residual checks are performed to monitor gastric emptying and to prevent complications

POLICY: NM 13.042

EQUIPMENT: Gloves and 60 cc syringe

DEFINITION:

- Residual checks are recommended before each feeding
- For best results, wait at least one hour after feeding or medicating before checking
- Less than 100 cc denotes adequate gastric emptying
- Large amounts of aspirant indicate a delay in gastric emptying
- Always return aspirant contents to the stomach (due to fluid and electrolytes contained in the aspirant).

PROCEDURE:

1. Explain procedure to the consumer and provide for privacy.
2. Wash hands and put on gloves
3. If pump is being used, place the pump on hold and close roller clamp. Disconnect feeding set from tube or, if using a Y-connector, open "Y" port.
4. Attach 60 cc syringes to feeding tube and gently aspirate stomach contents. If less than 50 cc, return contents to stomach and resume feeding.
5. If more than 50 cc is aspirated (unless another amount in specified by the physician), return contents to stomach and notify the physician for further feeding instructions.
6. Record date, time, and initials on the MAR.
7. In progress notes, record any physician notification and instructions.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ENTERAL FEEDING: VERIFYING TUBE PLACEMENT

PURPOSE STATEMENT: Placements of enteral feeding tubes are verified before medication administration, flushes, and feedings to reduce the risk aspiration.

POLICY: NM 13.043

EQUIPMENT: 60 cc syringe (catheter tip), Stethoscope and gloves.

DEFINITION: Signs and symptoms of inadvertent placement of a tube:

- Coughing
- Choking
- Cyanosis

Signs and symptoms that increase risk of tube dislocation:

- Coughing
- Retching
- Nasotracheal suctioning

PROCEDURE:

1) Explain procedure to the consumer and provide privacy
2) Wash hands and put on gloves
3) Verify placement of the tube before feeding, med pass, flushes or at least every 8 hours by one of the following:
   I. Aspiration of stomach contents
   II. Air Auscultation:
      - Auscultate with stethoscope over the left upper quadrant of the abdomen and using a 60 cc syringe, quickly inject 10-20cc of air (without resistance) into the feeding tube.
      - Air (whooshing or gurgling sound can be heard entering the stomach.
      - This method is not consistently reliable, since a tube inadvertently placed in the lung; pharynx or esophagus can transmit a similar sound.
   III. Bowel Sounds: If bowel sounds are absent, notify the physician before initiating a feeding or medication administration.

4. If the nasogastric tube is displacing, remove old tube, insert a new one, x-ray to verify placement.
5. If the gastrostomy or jejunostomy tube is displaced, contact the physician.
6. Record type of tube, length of tube exposed and consumer's tolerance of the procedure in the medical record.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ENTERAL FEEDING: TUBE FLUSHING

PURPOSE STATEMENT: Tube flushing maintains patency of the feeding tube, provides tube, and maintains adequate hydration.

POLICY: NM 13.044

EQUIPMENT: Water, 50-60 cc syringe

DEFINITION: About tube flushing

i. Tubes should be irrigated before and after med pass, before initiating a feeding or when there is an interruption of feeding.

ii. It is recommended that the small bore feeding tubes be flushed every 4-8 hours to prevent clogging

iii. Use resident-specific syringe. Store the syringe properly after the procedure

iv. Change irrigation syringes every 24 hours

v. Use warm water for flushing tubes (cold water may cause cramping.

PROCEDURE:

1. Verify physician's order for amount of water to use.
2. Explain procedure to the consumer and provide for privacy.
3. Wash hands.
4. If using a pump, place pump on hold and close roller clamp. Disconnected feeding set from tube, or if using a Y-connector, open the "Y" port.
5. Attach the consumer's syringe to the feeding tube and check for placemat.
6. After correct placement is verified, infuse the ordered amount of water slowly by gravity. Never force liquids.
7. Remove syringe and reconnect tubing or cap off part of the "Y" connection.
8. Resume feeding.
9. Record time, date and initials of fluid flushed on the MAR.
10. Record fluid intake on I&O sheet if ordered.
11. Record placement check and consumer's tolerance to the procedure in the medical record.

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ENTERAL FEEDING; READY TO HANG

PURPOSE STATEMENT: Ready to hang formula provides a balanced nutritional formula in a form that minimizes risk of contamination or spillage

POLICY: NM 13.045

EQUIPMENT: Ready to hang formula and administration tubing, Stethoscope, IV pole, pump, 60 cc Cather tip syringe, Warm water.

PROCEDURE:

1. Verify physician's order.
2. Explain procedure to the consumer and provide for privacy.
3. Obtain ready to hang container and proper administration set.
4. Check tamper resistant tape at top of the container (the seal must be intact).
5. Fill information on the label (name, room, date/time, and rate). Mark the feeding set with the start time.
6. Turn the container upside down and shake vigorously.
7. Holding the neck with one hand, use other hand to twist top portion in the direction of the arrows. Tamper resistant tape will break, protective overcap will come off. Take care not to touch the spike port, piercing pin or any part that comes in contact with the formula.
8. To spike, completely pierce spike port on feeding cap wit feeding set. Do not touch end of piercing pin or port during this process.
9. Close clamp on set before inverting container.
10. Follow directions for use provided with feeding set.
11. Verify tube placement per procedure.
12. When container empties, close the roller clamp.
13. For continuous feeding:
    i) Flush the feeding with ordered amount of warm water
    ii) Hang a new container of formula and open roller clamp
14. For intermittent feeding:
    i) Disconnect clamp administration set from the feeding tube
    ii) Flush feeding tube with ordered amount of warm water
    iii) Replug or reclamp feeding tube.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ENTERAL FEEDING: BOLUS METHOD

PURPOSE STATEMENT: Bolus enteral feeding is provided, by physician's order, to the consumer who does not require continuous gastric feeding.

POLICY: NM 13.046

EQUIPMENT: Aseptic-syringe, gloves, Water, Prescribed feeding at room temperature.

PROCEDURE:

1. Verify physician's order.
2. Explain procedure to the consumer, provide for privacy.
3. Assist consumer to semi-fowlers position or turn on side, unless contradicted.
4. Put on gloves, remove plunger from syringe and remove cap from consumer's tube.
5. Check tube placement (refer to procedure on specific tube guidance).
6. Place tip of syringe into feeding tube. Hold syringe and feeding tube straight up.
7. Flush with 30-50 cc of warm prior to feeding.
8. Using syringe as a funnel, slowly pour formula into it. Continue to refill syringe until prescribed amount has been delivered.
9. Infuse 250-400 cc over 20 minutes. Observe for signs of intolerance or aspiration.
10. Flush with 30-50 cc of warm water after the feeding.
11. Clamp the tube before it empties and remove the syringe (this prevents air from entering into the stomach).
12. Replace the cap into the tip of the feeding tube to prevent contamination.
13. The consumer should remain in upright position for approximately 45 minutes to one hour to prevent aspiration.
14. Clean equipment and store properly.
15. Record date, time and initials on the MAR.
16. Record fluid intake on I &O record for ordered.
17. Record placement check and consumer's tolerance to the procedure in the progress notes.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ENTERAL FEEDING PUMP METHOD

PURPOSE STATEMENT: A pump is used to administer feeding at a constant, controlled infusion rate per physician's order. Intermittent delivery schedules are recommended.

POLICY: NM 13.047

EQUIPMENT: Pump and administration set, stethoscope and syringe, Formula, feeding bag, IV pole.

PROCEDURE:

1. Verify physicians orders
2. Explain procedure to consumer and provide for privacy.
3. Check expiration dates on formula and administration sets.
4. Close roller clamps and pour prescribe amount of formula into the bag
5. Open the roller clamp to clear air out of tubing and fill drip chamber halfway up.
6. Close the roller clamp and "thread" tubing though the pump per pump instructions.
7. Check enteral feeding tube placement and flush with 30-50cc warm water.
8. Connect administration tubing and turn on/set proper rate on pump per manufacturer's instructions.

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ENTERAL FEEDING: GRAVITY METHOD

PURPOSE STATEMENT: The gravity method is used to deliver formula continuously or intermittently over a specified period of time.

POLICY: NM 13.048

EQUIPMENT: Enteral formula, enteral feeding bag , IV pole, 50-60 cc syringe, warm water, stethoscope

NUTRITON INFORMATION: Calculating Formula Delivery Rate

Most administration sets deliver approximately 10 drops/cc per minute of use the manufacturer's recommended drop rate noted on the package of the enteral tubing set.

Delivery Rate= Total volume of feeding x number of drops/cc per min ÷ feeding time.

Example: To administer 300cc of formula over 4 hours (240 minutes), the Delivery Rate would be 300 cc x 10 ÷240 = 12.5 drops per minute.

PROCEDURE:

1. Verify physician's order.
2. Explain the procedure to the resident and provide for privacy.
3. Check the enteral formula and administration set expiration date
4. Close the roller clamp on the feeding set.
5. Add the prescribed amount of formula to the feeding bag. Open the roller Clamp and expel the air from the administration set ("priming"). Close the roller clamp.
6. Check the enteral tube for placement and flush with 30-50 cc warm water.
7. Connect the administration feeding set to the enteral feeding tube.
8. Regulate drip rate with clamp. Flow rate should not exceed 200cc/hour.

DOCUMENTATION:

9. Record date, time, and initials on the MAR.
10. Record fluid intake on I &O sheet if ordered.
11. Record placement check and consumer's tolerance to procedure in the medical record.

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ENTERAL FEEDING: TUBE PATENCY

PURPOSE STATEMENT: Restoring patencies dissolve coagulated material that is occluding the enteral the so that feeding may continue.

POLICY: NM 13.049

EQUIPMENT: 60 cc warm water (primary method), warm water (primary method), cola product (only of the primary method is unsuccessful)

DEFINITION: Restoring patency dissolve coagulated material that is occluding the enteral the so that feeding may continue.

PROCEDURE:

1. Wash hands.
2. Explain procedure to the consumer and provide for privacy.
3. Verify placement of the tube per procedure.
4. Draw up 30-50 cc warm water and slowly inject into tub, alternating positive and negative pressure (DO NOT FORCE).
5. If successful, gently pinch and roll tube between fingers in a “milking” fashion.
6. Repeat step 4 until success and/or do procedure with cola product.
7. Flush with water if patency is restored before resuming feeding. If unsuccessful, notify the physician for further instructions.
8. Document and record in the consumer chart.

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: SEIZURE MANAGEMENT

PURPOSE STATEMENT: Care of a consumer during a seizure and the potential state.

POLICY: NM 13.050

PERSONS AFFECTED/RESPONSIBLE: Nursing, Direct care worker

DEFINITION: Seizures result because of sudden abnormal electrical activity in the brain. Most seizures last for 30 seconds to 2 minutes and do not cause permanent harm. There are over 20 different types of seizures. Seizures can be categorized based on whether they involve the whole brain or part of the brain.

Generalized seizures:

- **Grandmal or generalized tonic-clonic** seizures exist on both sides of the brain and affect both sides of the body. The consumer will lose consciousness and will usually fall to the ground. The loss of consciousness is followed by violent muscle contractions. This type of seizure consists of 2 phases the tonic phase where the muscles contract. In this phase the consumer will collapse to the ground. Following this phase is the clonic phase. This is characterized by rhythmic and violent jerking. It last about 30-60 seconds.
- **Absence "Petit mal seizure"** consists of a brief loss of consciences**.** The signs of absence seizures include a vacant stare, absence of motion without collapse, lip smacking, eyelid flutters, chewing motions, and hand movements. This type of seizure last for just a few seconds and can occur several times a day. The consumer may not be aware of the seizure activity.
- **Myoclonic seizure** during wakefulness and are associated with sporadic muscle jerking. This jerking movement can become forceful and result in loss of balance and throwing objects.
- **Clonic seizure** is classified by rhythmic and violet jerking of both sides of the body at the same time.
- **Tonic seizures** are characterized rigid stiffening of a consumer's body**.**
- **Atonic seizures** produce an abrupt loss of muscle tone resulting in a fall.

Categories of **Partial seizures**:

- **Simple partial seizure** consists of electrical activity originates from a specific area of the brain. The consumer's consciousness and awareness is retained. This type of seizure consists of muscle jerking, muscle rigidity, unusual sensations and disturbances affecting the consumer's vision, hearing sense of smell or touch. It may also consist of memory or emotional interference.
- **Complex partial** seizure consists of electrical activity originates from a specific area of the brain. There is a impairment in awareness with signs such as; lip smacking,, chewing, repetitive involuntary but coordinated movements. Usually last 1-2 minutes and may consist of an aura.

Status Epilepticus seizures are prolonged, or occur in a series, there is an increased risk of status epilepticus, a true life threatening emergency.

When to contact emergency personal:

- If the consumer is pregnant.
- If the consumer injured themselves during the seizure.
- (for instance, by falling or hitting something while They are seizing).
- If it's the consumers first time they've had a seizure.
- If the consumer seizure continues for more than 5 minutes (a condition known as *status epilepticus*)

Common Anti-Seizure Drugs

☐Carbamazepine (Tegretol, Carbatrol)
☐Clonazepam (Klonopin)
☐Ethosuximide (Zarontin)
☐Felbamate (Felbatol)
☐Gabapentin (Neurontin)
☐Lacosemide) Vimpat)
☐Lamotrigine (Lamictal)
☐Levetiracetam (Keppra)
☐Oxcarbazepine (Trileptal)
☐Phenobarbital
☐Phenytoin (Dilantin, Phenytek)
☐Pregabalin (Lyrica)
☐Primidone (Mysoline)
☐Rufinamide (Banzel)
☐Tiagabine (Gabitril)
☐Topiramate (Topamax)
☐Valproate
☐Vigabatrin (Sabril)
☐Zonisimide (Zonegran

PROCEDURE:

1. Ensure consumer safety.

3. Monitor direction of head and eyes during seizure.

6. Maintain airway.

- Use equipment to suction the oral airway if the client vomits or has excessive oral secretions.

5. Assist consumer to the floor and lateral position, if possible.

6. Apply oxygen, as appropriate.

7. Remain with patient during seizure.

8. Monitor neurogological status.

9. Record length of seizure.

10. Reorient after seizure.

11. Monitor vital signs and skin color.

12. Administer medication, as appropriate.

13. Administer anticonvulsants, as appropriate.

14. Monitor antiepileptic drug levels, as appropriate.

15. Monitor postictal period (time after active seizure, the time the consumers consciousness is altered) duration and characteristics.

16. Record seizure characteristics: body parts involved monitor activity, and seizure progression, skin color.

17. Document information about seizures.

REFERENCE:

- Epilepsy Foundation.(2014). Retrieved from www.epilepsyfoundation.org
- Epilepsy Seizure Types and Symptoms.(2012).Retrieved from http://www.webmd.com/epilepsy/guide/types-of-seizures-their-symptoms

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ASPIRATION PRECAUTIONS-ADULT

PURPOSE STATEMENT: Precautions to follow when a consumer has an alteration in their swallowing ability.

POLICY: MN 13.051

PERSONS AFFECTED/RESPONSIBLE: Nursing, Direct care workers:

DEFINITIONS: For adult patients, a swallow screen should be completed at any time the patient is at risk for aspiration or suspected alteration in his/her ability to swallow safely.

PROCEDURE: ORAL FEEDINGS

1. Obtain suction equipment for bedside.

2. Assess the patient's tolerance of the prescribed diet and notify the physician and nurse if diet is not well tolerated. Obtain order for consultation to the Speech and Language Pathology Department if there is questionable safety for oral feeding or possible swallowing disorder contributing to poor oral intake.

3. Keep HOB elevated as tolerated, and if not contraindicated.

4. Remain upright at 90 degrees while eating and for 30 to 45 minutes after meals

5. Take liquids with a cup or spoon only (no straws).

6. Supervise feedings at all times.

7. Ensure swallowing before taking another bite or sip.

8. Feed when alert and fully awake.

9. Feed slowly.

10. Limit food portions to less than 1 teaspoon at a time.

11. Honey or nectar thickened liquid if ordered.

12. Check oral cavity for pocketing.

13. If ordered, crush medication if permitted and administer in applesauce.

14. After feeding, keep HOB up 45-90 degrees for at least 30 minutes.

15. Provide mouth care after each meal.

REFERENCES:

LEGAL AUTHORITY:

Effective date:

Prepared by:

Authorized by:
Prepared by:

RELATED POLICY:

TITLE: ORAL SUCTIONING

PURPOSE STATEMENT: To remove oral secretions when the patient is unable to do it on their own.

POLICY: NM 13.052

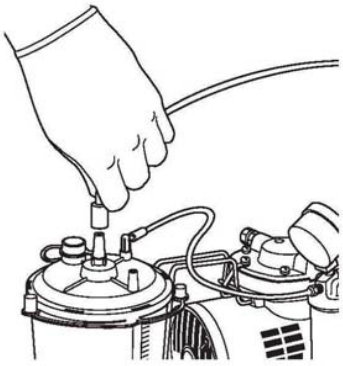
EQUIPMENT: Suction Machine, Connecting Tubing, Collection Bottle, Yankaur catheter container of water.

PROCEDURE:

1. Place the suction machine on a sturdy surface that will support its weight. Plug the cord into a properly grounded (three prong) electrical outlet.
2. Wash your hands and don glove.
3. Explain to the consumer what you are going to do.
4. Connect the tubing to the outlet port on the lid of the collection bottle. (**See A**)
5. Attach the Yankaur catheter to the other end of the connecting tubing. (**See B**)
6. Turn on the suction machine and check for negative pressure. Kink the connecting tubing with the machine running and note the reading on the gauge. The correct setting should be 20-30 mm of Hg (Mercury) for adults. Adjust negative pressure by turning the regulator knob on the suction machine. (See C and D)
7. Insert the Yankaur catheter into the mouth advancing slowly to the back. If patient starts to cough or gag wait until the patient recovers before continuing. NEVER SUCTION FOR LONGER THAN 15 SECONDS.
8. If repeated suctioning is needed, allow the patient to rest 30-60 seconds before continuing with the suctioning.
9. After suctioning the patient, suction water through the catheter until the catheter and tubing are clear. **NEVER ALLOW THE SUCTION CONTAINER BOTTLE TO RISE ABOVE THE FILL LIMIT LINE. (EMPTY THE BOTTLE WHEN THE FLUID REACHES THE FILL LIMIT LINE.)**
10. Turn machine off and wash your hands.

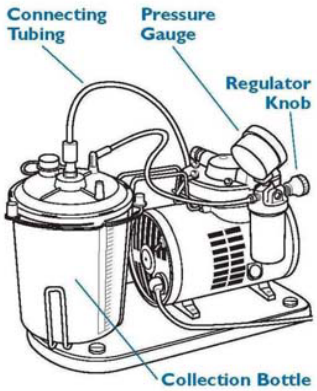
11. Place catheter in a clean, dry area for reuse with suction turned off or within consumers reach or with suction on if consumer is capable of suctioning self.

A.



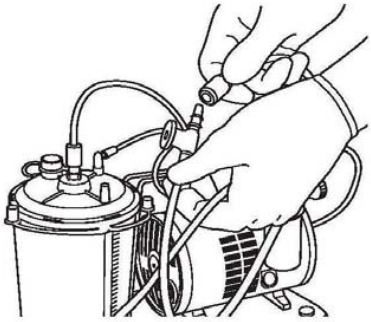
Attach the connecting tubing

B.



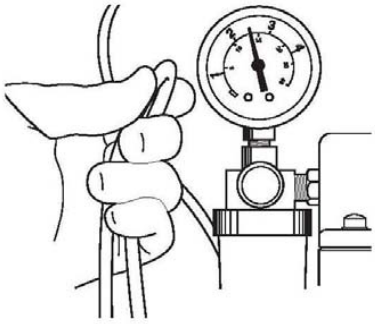
A typical suction machine

C.



Attach the suction tubing to the suction catheter

D.



Check for proper negative pressure

REFERENCE: Harkreader, H. & MH Hogan*, Fundamentals of Nursing (2nd ed.) Saunders, 2004.*

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: CAST CARE

PURPOSE STATEMENT: To care for a consumer with a cast

POLICY: NM 13.053

PERSONS AFFECTED/ RESPONISIBLE: Nursing

PRECEDURE:

I. **Assessment**

a. Document type of cast (fiberglass, plaster).
b. Note any tightness at proximal and distal edges (should be able to put finger comfortably under edges).
c. Note soft or cracked areas.
d. Maintain proper positioning of upper extremity sling or immobilizer.
e. Assess neurovascular status of affected extremity every 4 hours for 24 hours, then every 8 hours.
f. Elevate the extremity above heart level.
g. Apply ice if ordered.
h. Note any bleeding on cast and document and call physician with any significant change.
i. Assess if the consumer is having any pain and treat as ordered and prescribed.

II. **Monitor for Compartment Syndrome**

a. Assess for signs of compartment syndrome: pain upon passive stretch of muscle, progressive pain out of proportion to what is anticipated, weakness of involved muscles, hypoesthesia, or palpable tightening of the muscle compartment.
b. Notify physician.
c. DO NOT ELEVATE the effected extremity above heart level if compartment syndrome is suspected.
d. Call physician or take consumer to E.R. Document signs/symptoms.

III .**Patient Teaching**

a. Instruct patient on signs/symptoms to report: severe pain, burning, numbness, tingling, skin discoloration, and swelling, foul odor, warm spots, soft areas, cracks, and fever.
b. Instruct patient to keep cast dry.
c. Instruct patient on activity level, weight bearing status, and use of ambulation device if indicated.
d. Instruct patient to keep extremity elevated when possible.
e. Instruct patient not to insert any foreign objects in cast. Contact the physician if itching becomes unbearable

REFERENCES:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ASSESSING ABDOMEN

PURPOSE STATEMENT: To restore or maintain the consumer's gastrointestinal status.

POLICY: NM 13.054

EQUIPMENT: examining light, tape measure, water soluble pencil, and stethoscope.

PREPARATION:

- Explain to the consumer what you are going to do, why it is necessary, and how he can cooperate.
- Wash hands and observe appropriate infection control procedures.
- Provide privacy for the consumer.
- Assess consumer's gastrointestinal history, abdominal pain: location, onset, description of pain, and associated symptoms.
- Ask about the consumer about his/her bowel habits, incidence of diarrhea, and changes in appetite, food allergies, detailed signs or symptoms of previous problems.
- Assist the consumer to a supine position, with the arms placed comfortable at the sides.
- Place small pillows beneath the knees and the head to reduce tension in the abdominal muscles. Expose on the consumer's abdomen from the chest line to the public area to avoid chilling and shivering, which can tense abdominal muscles.

PROCEDURE:

1. Inspect the abdomen for skin integrity.
2. Inspect the abdomen for contour and symmetry.
3. Observe the abdominal contour while standing at the client's side when the client is supine.
4. Ask the client to take a deep breath and to hold it.
5. Assess the symmetry of contour while standing at the foot of the bed.
6. If distention is present, measure the abdominal girth by placing a tape around the abdomen at the level of the umbilicus.
7. Observe abdominal movements associated with respirations, peristalsis, or aortic pulsations.
8. Observe vascular pattern.
9. Auscultate the abdomen for bowel sounds, vascular movements, and peritoneal friction rubs.

10. Percuss several areas in each of the four quadrants to determine presence of tympani and dullness.

11. Use a systematic pattern: Begin in the lower left quadrant, then proceed to the lower right quadrant, the upper right quadrant and the upper left quadrant.

12. Percuss the liver to determine its size.

13. Perform light palpation first to detect areas of tenderness and or muscle guarding.

14. Explore all for quadrants.

15. Perform deep palpations over all four quadrants

16. Palpate the liver to detect enlargement and tenderness.

17. Palpate at the area above the pubic symphysis if the client‘s history indicates possible urinary retention.

18. Document findings and report to the physician any pertinent findings.

LEGAL AUTHORITY:

Effective date:
Prepared by:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ASSESSING HEAD AND NECK

PURPOSE STATEMENT: To give a thorough assessment of a consumer head and neck

POLICY: NM 13.055

PROCEDURE:

1. **Inspect the head:**
    a. Note head position and facial features.
    b. Note the client's facial features for symmetry.
2. **Assess the eyes:**
    a. Inspect position of eyes, color, condition of conjunctivae, and movement.
    b. Assess clients near vision and far vision.
    c. Inspect pupils for size, shape and equality.
    d. Test papillary reflexes. To test reaction to light, dim room light. As client looks straight ahead, move penlight from side of the consumers faces and directs light on pupil. Observe papillary response of both eyes, noting briskness and equality of reflex.
3. **Assess hearing:** Note consumer's response to questions and presence or use of a hearing aide.
4. **Assess the sinuses**: If there is nasal discharge, assess color, odor, and associated symptoms.
5. **Assess mouth**:
    a. Use a tongue blade to depress the tongue and inspect the oral mucosa, tongue, teeth, and the gums for hydration, discoloration, and obvious lesions.
    b. Determine if consumer wears dentures or retainers and if they are comfortable. Use may remove dentures and palpate gums.
6. **Inspect and palpate the neck**. Ask consumer if there is a history of neck pain or difficulty with movement of neck
    a. **Neck muscles**: inspect neck of bilateral symmetry of muscle. Ask consumer to flex and hyperextend neck and turn side to side.
    b. **Lymph nodes**:
        1. With clients chin raised and head tilted slightly, inspect area where lymph nodes are distributed and compare both sides.
        2. Have consumer relax with neck flexed slightly forward. To palpate, face or stand to the side of client and use pads of middle three fingers of hand. Palpate gently in a rotary motion for superficial lymph nodes.
        3. Note if lymph nodes are large, fixed, inflamed, or tender.

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ASSESSING BREAST AND AXILLAE

PURPOSE STATEMENT: To maintain the consumer's health status.

POLICY: NM 13.056

EQUIPMENT: centimeter ruler

PROCEDURE:

1. Assemble equipment.
2. Explain to the consumers what you are going to do, why it is necessary, and how he or she can assist.
3. Wash hands and observe other appropriate infection control procedures.
4. Provide privacy for the consumer.
5. Inquire regarding consumer history: Breast self exams, breast masses, any pain in the breast area, medications such as hormone therapy, obesity, age of menstrual cycle, and use of oral contraceptives.
6. Assess the breast size, symmetry, and contour or shape while the consumer is in a sitting position.
7. Inspect the skin of the breast for discolorations or dimpling, swelling, or edema.
8. Have the consumer raise arms above the head, to assess any retraction.
9. Push the hand together, with elbows flexed to assess retraction.
10. Press the hands down on the hips to assess any assess retraction.
11. Inspect the areola area for size for shape, symmetry, color, surface, and any masses.
12. Inspect the nipples for size, shape, position, color, lesions.
13. Palpate the axillary, subclavicular and supraclavicular lymph nodes.
14. The consumer is seated with the arms abducted and supported on the nurse's forearm.

15. Use the flat surfaced of all findings to palpate the four areas of the axillae: The edge of all greater pectoral muscle along the anterior axillary line. The thoracic wall in the midaxillary area, the upper part of the humerus, and the anterior edge of the latissimus dorsi muscle along the posterior axillary line.

16. Palpate the breast the masses, tenderness, and any discharge from the nipples.

17. Palpate the areola and the nipples for masses.

18. Compress each nipple to determine the presence of any discharge. If discharge is present, milk the breast along its radius to identify the discharge -producing lobe.

19. Assess any discharge for amount, color, consistency, and color.

20. Teach the consumer the technique of breast self examination.

21. Document the findings and report any pertinent information to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ASSESSING THE EYE STRUCTURES AND VISUAL ACUITY

PURPOSE STATEMENT: To maintain or restore visual acuity.

POLICY: NM 13.057

EQUIPMENT: Cotton tip applicator, examination gloves, millimeter ruler, penlight, Snellen's or E chart, Opaque card.

PREPARATION: Determine the consumer history of the following: family history of diabetes, hypertension, blood dyscrasias, eye disease, injury, eye surgery, last ophthalmologist, current use of eye medications, use of contact lenses or eyeglasses, hygienic practices for corrective lenses, and any current eye problems.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary, and how he/she can cooperate.
2. Wash hands and observe the agency infection control policy and procedures.
3. Provide for the consumer privacy.
4. Inspect the eyebrows for hair distribution and alignment and for skin quality and movement.
5. Inspect the eyelashes for evenness of distribution and direction of curl.
6. Inspect the eyelids for surface characteristics, position in relation to the cornea, ability to blink, and frequency of blinking. Inspect the lower eyelids while the consumer's eyes are closed.
7. Inspect the bulbar conjunctiva for color, texture, and the presence of lesions.
8. Inspect the palpebral conjunctiva by everting the lids.
9. Evert the upper lids if a problem is suspected.
10. Inspect and palpate the lacrimal gland.

11. Inspect the cornea for clarity and texture. Ask the consumer to look straight ahead. Hold a penlight at an oblique angle to the eye, and move the light slowly across the corneal surface.

12. Perform the corneal sensitivity (reflex) test to determine the function of the fifth trigeminal cranial nerve.

13. Ask the consumer to keep both eyes open and look straight ahead. Approach from behind and beside the consumer, and lightly touch the cornea with a corner of the gauze.

14. Inspect the anterior chamber for transparency and depth. Use same oblique lighting used when testing the cornea.

15. Inspect the pupils for color, shape, and symmetry of size.

16. Assess each pupil's direct and consensual reaction to light.

17. Assess each pupil's reaction to accommodation.

18. Assess peripheral visual fields.

19. Assess six ocular movements to determine eye alignment and coordination.

20. Assess near vision.

21. Assess distance vision.

22. Perform functional vision test if the consumer is unable to see the top line (20/20) of Snellen's chart.

23. Document findings in the consumer record.

24. Report any pertinent findings to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ASSESSING THE FEMALE GENTITAL AND INGUINAL AREA

PURPOSE STATEMENT: To maintain or improve the consumer's present health status.

POLICY: NM0.58

EQUIPMENT: Examination gloves drape, assistant, supplemental lighting if needed.

PREPARATION: Determine the consumer's history of the following:

Menstrual age, last menstrual period, cycle regularity, pain while urinating , pain during intercourse, vaginal discharge, pregnancies, live births, labor or delivery complications, blood in the urine, incontinence, history of sexually transmitted infections.

PROCEDURE:

1. Explain to the consumer what you are going to do, and why it is necessary, and how he or she can assist with the procedure.

2. Wash hands and observe other appropriate infection control procedures.

3. Provide for consumer privacy.

4. Position the consumer supine with feet elevated on the stirrups of an exam table or bed. Alternately, assist the consumer into the dorsal recumbent position with knees flexed and thighs externally rotated.

5. Inspect the distribution, amount, and characteristic of pubic hair.

6. Inspect the skin of the pubic area for parasites, inflammation, swelling, and lesions. To assess pubic skin adequately, separate the labia majora and labia minora.

7. Inspect the clitoris, urethral orifice, and vaginal orifice when separating the labia minora.

8. Palpate the inguinal lymph nodes.

9. Document findings and report any pertinent information to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: PHYSICAL ASSESSMENT OF HAIR

PURPOSE STATEMENT: To do a physical assessment of a consumer's hair.

POLICY: NM 13.059

PREPARATION: Determine the consumer history of the following: use of hair dyes, rinses, curling or straightening preparations, chemotherapy, and presence of disease.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary, any how he/she can cooperate.
2. Wash hands and observe appropriate infection control policy and procedures.
3. Provide for privacy for the consumer.
4. Inspect the evenness of the hair growth over the scalp.
5. Inspect hair thickness or thinness.
6. Inspect hair texture and oiliness.
7. Note the presence of infections or infestations by parting the hair in several areas and checking behind the ears and along the hairline at the neck.
8. Inspect amount of body hair.
9. Document findings in the consumer record.
10. Report any pertinent findings to the physician.

REFERENCES:

LEGAL AUTHORITY:

Effective date:
Date review/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ASSESSING THE HEART AND CENTRAL VESSELS

PURPOSE STATEMENT: To maintain or restore cardiac function.

POLICY: NM 13.060

EQUIPMENT: Stethoscope and Centimeter

PREPARATION: Determine the consumer history of the following: family history of heart disease, hypertension, stroke, obesity, arterial disease, heart murmur, heart attack, heart failure, high cholesterol, congenital heart disease, rheumatic fever, varicosities, symptoms of heart disease, diseases that affect the heart, and lifestyle habits.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary, and how he/she can cooperate.

2. Wash hands and observe the agency infection control measures.

3. Provide consumer privacy.

4. Simultaneously inspect and palpate the precordium for the presence of abnormal pulsations, lifts, or heaves.

5. Inspect and palpate the aortic and pulmonic areas, observing them at an angle and to the side, to note the presence or absence of pulsations.

6. Inspect and palpate the tricuspid area for pulsations and heaves or lifts.

7. Inspect and palpate the apical area for pulsation, noting its specific location (it may be displaced laterally or lower) and diameter. If displaced laterally, record the distance between the apex and the MCL in centimeters.

8. Inspect and palpate the epigastric area at the base of the sternum for abdominal aortic pulsations.

9. Auscultate the heart in all four anatomic sites: aortic, pulmonic, triscupid, and apical.

10. Palpate the carotid artery. ***Use extreme caution.

11. Auscultate the carotid artery.

12. Inspect the jugular veins for distention.

13. The consumer is placed in a semi-Fowler's position, with the head supported on a small pillow.

14. If jugular vein distention is present assess the jugular venous pressure (JVP).

15. Locate the highest visible point of the distention of the internal jugular vein.

16. Measure the vertical height of this point in centimeters from the sternal angle.

17. Repeat the steps above on the other side.

18. Document findings in consumer chart.

19. Report any pertinent data to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ASSESSING THE MALE GENITALS AND INGUINAL AREA

PURPOSE STATEMENT: To maintain or restore the consumer health status.

POLICY: NM 13.061

PREPARTION: Determine the consumer's history of the following: voiding patterns, bladder control, incontinence, urgency, frequency, abdominal pain, any symptoms of sexually transmitted infection, any swelling that could indicate hernia, family history of cancer of prostrate or kidney.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary and how he or she can assist with the procedure.

2. Wash hands and observe other appropriate infection control.

3. Provide for client privacy.

4. Inspect the public region for hair distribution, amount, and characteristics of hair

5. Inspect the penile shaft and glans penis for lesions, nodules, swellings, and inflammation.

6. Inspect the urethral meatus for swelling, inflammation, and discharge.

7. Compress or ask the consumer to compress the glans slightly to open to urethral meatus to inspect it for discharge.

8. If the consumer has reported a discharge instruct the consumer to strip the penis from the base to the uretha.

9. Palpate the penis for tenderness thickening and nodules.

10. Use your thumb and first two fingers.

11. Inspect the scrotum for appearance, general size, and symmetry.

12. To facilitate inspection of the scrotum during the physical examination, as the consumer to hold the penis out of the way.

13. Inspect all skin surfaces by spreading the rugated surface skin and lifting the scrotum as needed to observe posterior surfaces.

14. Palpate the scrotum to assess status of underlying testes, epididymis and spermatic cord. Palpate both testes simultaneously for comparative purposes.

15. Inspect both inguinal areas for bulges while the client is standing, if possible.

A. Inspect while the consumer remains at rest.

B. Inspect while the consumer holds his breath and strain or bear down, as though having a bowel movement.

A. Palpate hernias.

16. Document findings and report any pertinent information to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ASSESSING THE MOUTH AND OROPHARYNX

PURPOSE STATEMENT: To maintain or restore the oral cavity.

POLICY: NM 13.062

PREPARATION: Determine consumer history of the following: daily routine of dental care, last visit to dentist, any lesions, ulcers, bleeding gums, discomfort, swelling, and all medications taken

EQUIPMENT: Examination gloves, tongue depressor, 2x2 gauze pads, flashlight or penlight.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary, and how he/she can cooperate.
2. Wash hands and observe agency infection control measures.
3. Provide for consumer privacy.
4. Position the consumer comfortably.
5. Inspect the outer lips for symmetry of contour, color, and texture.
6. Ask the consumer to purse the lips as if to whistle.
7. Inspect and palpate the inner lips and buccal mucosa for color, moisture, texture, and the presence of lesions.
8. Inspect the teeth and gums while examining the inner lips and buccal mucosa.
9. If the consumer has dentures as the consumer to remove both upper and lower dentures to inspect the gums.
10. Inspect their partial condition, noting particular broken or worn areas.
11. Inspect the surface of the tongue for position, color, and texture.
12. Ask the consumer to protrude the tongue.

13. Inspect the tongue movement.

14. Ask the consumer to roll the tongue upward and move it from side to side.

15. Inspect the base of the tongue, the mouth floor, and the frenulum.

16. Ask the consumer to place the tip of his tongue against the roof of the mouth.

17. Palpate the tongue and floor of the mouth for any nodules, lumps, or excoriated areas.

18. Use a piece of gauze to grasp the tip of the tongue and with the index finger of your hand, palpate the back of the tongue, its borders, and its base.

19. Inspect salivary duct openings for any swelling or redness.

20. Inspect the hard and soft palate for color, shape, texture, and the presence of bony prominences.

21. Ask the consumer to open his mouth wide and tilt his head backward. Then, depress tongue with a tongue blade as necessary, and use a penlight for appropriate visualization.

22. Inspect the uvula for position and mobility while examining the palates.

23. To observe the uvula, ask the consumer to say “ah” so that the soft plate rises.

24. Inspect the oropharynx for color and texture.

25. Inspect one side at a time to avoid eliciting the gag reflex. To expose one side of the oropharynx, press a tongue blade against the tongue on the same side about halfway back while the consumer tilts his head back and open the mouth wide. Use a penlight or illumination, if needed.

26. Inspect the tonsils for color, discharge, and size.

27. Elicit the gag reflex by pressing the posterior tongue with a tongue depressor.

28. Document findings in the consumer chart.

29. Report any pertinent findings to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ASSESSING THE MUSCULOSKELETAL SYSTEM

PURPOSE STATEMENT: To maintain or restore the consumer musculoskeletal care.

POLICY: NM 13.063

EQUIPMENT: Goniometer

PREPARATION: Determine the consumer's history of the following:

history of pain, location, onset, aggravating factors and alleviating factors

Any limitations to movement or inability to perform activities of daily living

history of previous injuries, loss of function without pain.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary, and how he or she can assist.
2. Wash hands and observe other appropriate infection control procedures.
3. Provide for privacy.
4. Inspect the muscles for size.
5. Compare each muscle on one side of the body to the same muscle on the other side.
6. Inspect the muscles and tendons for contractures.
7. Inspect the muscles for fasciculation and tremors.
8. Inspect any tremors of the hands and arms by having the client hold the arms out in from of the body.
9. Palpate muscles at rest to determine muscle tonicity.
10. Palpate muscles while the client is active and passive for flaccidity, spasticity, and smoothness of the movement.
11. Test muscle strength. Compare the right side with left side.

12. Inspect the skeleton for normal structure and deformities.

13. Palpate the bones to locate any areas of edema or tenderness.
    Inspect joint for swelling.

14. Palpate each joint for tenderness, smoothness of movement, swelling, crepitation, and the presence of nodules.

15. Assess joint range of motion.

16. Ask the client to move selected body parts, if available, use a goniometer to measure the angle of the joint in degrees.

17. Document findings and report any pertinent information to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: ASSESSING THE NECK

PURPOSE STATEMENT: To perform an assessment of a consumer's neck.

POLICY: NM 13.064

PROCEDURE:

1. Explain to the consumer what you going to do, why it is necessary, and how he/she can cooperate.

2. Wash hands and observe agency infection control measures.

3. Provide for consumer privacy.

4. Determine the consumer history of the following: any problems with neck lumps, neck pain, stiffness, thyroid problems, any surgery or treatments including radiation.

5. Inspect the neck muscles (sternocleidomastoid and trapezius) for abnormal swellings or masses.

6. Ask the consumer to hold his/her erect.

7. Observe head movement>

8. Ask the consumer to move his/her chin to the chest (determines function of the sternocleidomastoid muscle).

9. Move her head back so that the chin points upward (determine function of the trapezius).

10. Move her head so that the ear is moved toward the shoulder on each side (determines function of the sternocleidomastoid muscle).

11. Assess muscle strength.

12. Ask the consumer to turn his/her head to one side against the resistance of your hand. Repeat with other side.

13. Shrug her shoulders against the resistance of your hands.

14. Palpate the entire neck for enlarged lymph nodes.

15. Palpate the trachea for lateral deviation.

16. Place your fingertip or thumb on the trachea in the suprasternal notch, and then move your finger laterally to the left and the right in spaces bordered by the clavicle, the anterior aspect of the sternocleidomastoid muscle, and the trachea.

17. Inspect the thyroid gland.

18. Stand in front of the consumer.

19. Observe the lower half of the neck overlying the thyroid gland for symmetry and visible masses.

20. As the consumer to hyperextend his/her head and swallow. If necessary, offer a glass of water to make it easier for the client to swallow.

21. Palpate the thyroid gland for smoothness.

22. Note any areas of enlargement, masses, or nodules.

23. If enlargement of the gland is suspected: auscultate over the thyroid area for a bruit.

24. Use a bell-shaped diaphragm of the stethoscope.

25. Document the findings the consumer chart.

26. Report any pertinent findings to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ASSESSING THE RECTUM AND ANUS

PURPOSE STATEMENT: To assess the consumer's rectum and anus.

POLICY: NM 13.065

PREPARATION: Determine the consumer's history of the following:

history of bowel movement patterns, history of blood in the stools, tarry black stools, diarrhea, constipation, abdominal pain, excessive gas, hemorrhoids, or rectal pain.

Family history of cancer, last occult stool collection, and signs or symptoms of prostrate.

EQUIPMENT: gloves and water-soluble lubricant

PROCEDURE:

1. Assemble examination gloves and water-soluble lubricant

2. Explain to the consumer what you are going to do, and why it is necessary, and how he or she can cooperate.

3. Wash hands and observe other appropriate infection control procedures.

4. Provide the consumer privacy.

5. Position the client in a left lateral Sim's position with the upper leg acutely flexed.

   A. For females: a dorsal recumbent position with hips externally rotated and knees flexed or a lithotomy.

   B. For males: A standing position while the consumer bends over the examining table or bed may also be used.

6. Inspect the anus and surrounding tissue for color, integrity, and skin lesions.

7. Ask the consumer to bear down as though defecating.

8. Describe the location of all abnormal findings in terms of a clock, with the 12 o'clock position toward the pubic symphysis.

9. Palpate the rectum for anal sphincter tonicity, nodules, masses, and tenderness.

10. On withdrawing the finger from the rectum and anus, observe it for feces.

11. Document findings and report any pertinent information to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ASSESSING THE SKULL AND FACE

PURPOSE STATEMENT: To evaluate the cardiovascular status of the consumer to restore to health.

POLICY: NM 13.066

PREPARATION: Determine the consumer history in regard to the following: any past injuries to face or skull, syncope, seizures, lumps or bumps, itching or scaling, any recurring symptoms and treatment

PERSON AFFECTED/RESPONSIBLE: Nursing.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary, and how he/she can cooperate.
2. Wash hands and observe the agency standard for infection control measures.
3. Provide for consumer privacy.
4. Inspect the skull for size, shape, and symmetry.
5. Palpate the skull for nodules or masses and depressions.
6. Inspect the facial features.
7. Inspect the eyes for edema and hollowness.
8. Note symmetry of facial movements.
9. Ask the consumer to elevate the eyebrows, frown, or lower the eyebrows, close the eyes tightly, puff the cheeks, and smile and show the teeth.
10. Document findings in the consumer chart.
11. Report any pertinent findings to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ASSESSING THE THORAX AND LUNGS

PURPOSE STATEMENT: To maintain or restore oxygen intake

POLICY: NM 13.067

PREPARATION: Determine the consumer history of the following: family history of illness, allergies, tuberculosis, smoking, any medications prescribed, current problems such as swellings, coughs, wheezing, or pain, history of tuberculosis, and occupational hazards.

EQUIPMENT: Stethoscope, skin marker or pencil, and centimeter ruler

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary, and how he or she can cooperate.

2. Wash hands and observe the agency infection control policy and procedures.

3. Provide for consumer privacy.

4. Inspect the shape and symmetry of the thorax from posterior and lateral views.

5. Inspect the spinal alignment for deformities.

6. Have the client stand. From a lateral position, observe the three normal curvatures: cervical, thoracic, and lumbar.

7. To assess for lateral deviation of spine (scoliosis), observe the standing consumer from the rear.

8. Have the consumer bend forward at the waist and observe from behind.

9. Palpate the posterior thorax. For consumers who no respiratory complaints, rapidly assess the temperature and integrity of all chest skin.

10. For clients who do have respiratory complaints, palpate all chest areas for bulges, tenderness, or abnormal movements. Avoid deep palpation for painful areas, especially if a fractured rib is suspected.

11. Palpate the posterior chest respiratory excursion.

12. Place the palms of both your hands over the lower thorax, with your thumbs adjacent to the spine and your fingers stretched laterally. Ask the consumer to take a deep breath while you observe the movement of your hands and any lag in movement.

13. Palpate the chest for vocal (tactile) fremitus.

14. Place the palmar surfaces of your fingertips or the unlar aspect of your hand or closed fist on the posterior chest, starting near the apex of the lungs.

15. Ask the consumer to repeat such words as “blue moon” or “one, two, three.

16. Repeat the two steps, moving your hand sequentially to the base of the lungs.

17. Compare the fremitus on both lungs and between the apex and the base of each lung, either 1) using one hand and moving it for one side of the consumer to the corresponding area on the other side or 2) using two hands that are placed simultaneously on the corresponding areas of each side of the chest.

18. Percuss the thorax.

19. Percuss for diaphragmatic excursion.

20. Auscultate the chest using the flat disc diaphragm of the stethoscope.

21. Use the systematic zigzag procedure used in percussion.

22. Ask the consumer to take slow, deep breaths through the mouth. Listen at each point to the breath sounds during a complete inspiration and expiration.

23. Compare findings at each point with the corresponding point on the opposite side of the chest.

24. Inspect breathing patterns.

25. Inspect the costal angle and the angle at which the ribs enter the spine.

26. Palpate the anterior chest.

27. Palpate the anterior chest.

28. Palpate the anterior chest for respiratory excursion.

29. Place the palms of both your hands on the lower thorax, with your fingers laterally along the costal margins.

30. Ask the consumer to take a deep breath while you observe the movement of your hands.

31. Palpate tactile fremitus in the same manner as for the posterior chest.

32. If the breasts are large and cannot be retracted adequately for palpation, this part of the examination is usually omitted.

33. Percuss the anterior chest systematically.

34. Begin above the clavicles in the supraclavicular space, and proceed downward to the diaphragm.

35. Compare one side of the lung to the other.

36. Displace female breasts for proper examination.

37. Auscultate the trachea.

38. Auscultate the anterior chest.

39. Use the sequence in the percussion segment above, beginning over the bronchi between the sternum and the clavicles.

40. Document findings in the consumer's chart.

41. Report any pertinent findings to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:

Prepared by:

RELATED POLICY:

POLICY TITLE: ASSESSING THE NOSE AND SINUSES

PURPOSE STATEMENT: To maintain or restore the nasal passages.

POLICY: NM 13.068

PERSON AFFECTED/RESPONSIBLE: Nursing.

EQUIPMENT: Nasal speculum, flashlight or penlight.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary, and how she can cooperate.
2. Wash hands and adhere to the agency infection control policy.
3. Provide consumer privacy.
4. Determine the history of the following: allergies, difficulty breathing, sinus infections, injuries to the nose, nosebleeds, any medications taken, and any changes in sense of smell.
5. Position the consumer comfortably.
6. Inspect the external nose for any deviations in shape, size, or color and glaring, or discharge from the nares.
7. Lightly palpate the external nose to determine any areas of tenderness, masses, and displacements of bone and cartilage.
8. Determine patency of both nasal cavities.
9. Ask the consumer to close the mouth, exert pressure on one naris, and breathe through the opposite naris.
10. Repeat the procedure to assess patency of the opposite naris.
11. Inspect the nasal cavities using a flashlight or nasal speculum.
12. Observe for the presence of redness, swelling, growths, and discharge.

13. Inspect the nasal septum between the nasal chambers.

14. Palpate the maxillary and frontal sinuses for tenderness.

15. Document findings in the consumer record.

16. Report any pertinent findings to the physician.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: PHYSICAL ASSESSMENT SKIN

PURPOSE STATEMENT: To perform a skin assessment.

POLICY: NM 13.069

PREPARATION: Determine the consumer history of the following: pain or itching, lesions, abrasions, bruises, pigmented spots, and previous skin problems.

EQUIPMENT: Millimeter ruler, examination gloves, and magnifying glass, body surface diagram.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary, and how he/she can cooperate.
2. Wash hands and observe the standard infection control policy of the agency.
3. Provide the consumer with privacy.
4. Determine the consumer history of the following: pain or itching, lesions, abrasions, bruises, pigmented spots, and previous skin problems.
5. Ask the consumer is there a tendency to bruise easily.
6. Assess for any clinical signs of skin abnormals.
7. Inspect skin color.
8. Inspect uniformity of the skin color.
9. Assess edema, if present.
10. Inspect, palpate, and describe skin lesions. Apply gloves is lesions are open or draining.
11. Palpate skin temperature. Compare the feet and the hands, by using the backs of your fingers.
12. Note skin turgor.
13. Document findings in the client record.

14. Draw location of the skin lesions on the body surface diagrams.

15. Report any pertinent findings to the physician.

REFERENCES:

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: ESTABLISHING AND MAINTAINING A STERILE FIELD

PURPOSE STATEMENT: To prevent infection and further spread of microorganisms.

POLICY: NM 13.070

EQUIPMENT: Package containing a sterile drape, and sterile equipment as needed.

PREPARATION:

- The nurse will determine what sterile technique is required for the procedure.
- Assemble the equipment and supplies: Package containing a sterile drape, and sterile equipment as needed.
- Confirm sterility of package(s).
- Insure that the package is clean and dry.
- Check the sterilization expiration dates on the package, and look for any indications that is has been previously opened.
- Follow agency practice for the disposal of possibly contaminated packages.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary, and how he or she can cooperate.

2. Wash hands and observe other appropriate standard infection control measures.

3. Provide privacy for the consumer.

4. Open the package.

    A. Place package in the center of the work area so that the top flap of the wrapper opens away from you.

    B. Reaching around the package (not over it) pinch the first flap on the outside of the wrapper between the thumb and index finger. Pull the flap open, laying it flat on the far surface.

    C. Repeat for the side flaps, opening the top one first. Use the right hand for the right flap, and the left hand for the left flap.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

MACOMB COUNTY COMMUNITY MENTAL HEALTH

POLICY TITLE: DONNING AND REMOVING PERSONAL PROTECTIVE EQUIPMENT

PURPOSE STATEMENT: To decrease the contamination of pathogens to staff, consumer, and community.

POLICY: NM 13.071

EQUIPMENT: Gown, Mask, Eyewear, and Clean Gloves

PREPARATION:

- Evaluate which activities will be required while the nurse in the consumer's room or office setting to determine which personal equipment is required.
- Evaluate if special handling Is indicated for removal of any specimens or other materials from the room.
- Check the supplies that are present within the consumer's room, and which supplies must be brought to you by another nurse.
- Arrange for the care of other consumer's if necessary.
- Supplies Needed: Gown, Mask, Eyewear, and Clean Gloves,
- Remove and secure all loose items, such as name tags, watches, or any hanging jewelry.

PROCEDURE:

1. Explain to the consumer what you are going to do, why it is necessary, and how he or she can cooperate.
2. Pick up a clean gown and allow it to unfold in front of you without allowing it to touch any area soiled with bold surfaces.
3. Slide the arms and the hands through the sleeves.
4. Fasten the ties at the neck to keep the gown in place.
5. Overlap the gown at the back as much as possible, and fasten the waist ties or belt.

6. Don the face mask.

7. Locate the top edge of the mask. The mask usually has a narrow metal strip along the edge.

8. Hold the mask by the top two strings or loops.

9. Place the upper edge of the mask over the bridge of the nose, and tie the upper ties at the back of the head or secure the loops around the ears. If glasses are worn, fit the upper edge of the mask under the glasses.

10. Secure the lower edge of the mask under the chin, and tie the lower ties at the nape of the neck.

11. If the mask has a metal strip, adjust this firmly over the bridge of the nose. Wear the mask only once, and do not wear mask longer than the manufacturer recommends or after it becomes wet. Do not leave a used face mask hanging around the neck.

12. Don the protective eyewear if it is not part of the face mask.

13. Don clean disposable gloves.

14. If you are wearing a gown, pull the gloves up to cover the cuffs of the gown. If you are not wearing a gown, pull the gloves up to cover the wrists.

15. To remove soiled protective equipment, remover the gloves first, since they are the most soiled.

16. If wearing a gown that is tied at the waist in front, undo the ties before removing gloves.

17. Remove the first gloves by grasping it on its palmar surface just below the cuff, taking care to touch only glove to glove.

18. Pull the first glove completely off by inverting or rolling the glove inside out.

19. Continue to hold the inverted removed gloved by the fingers of the remaining gloved hand. Place the first two fingers by turning it inside out. This pulls the first glove inside the second glove.

20. Using the bare hand, continue to remove the gloves, which are now inside out, and dispose of them in the refuse container.

21. Wash your hands per agency policy.

22. Remove the mask.

23. If using a mask with strings, first untie the lower strings of the mask.

24. Untie the top strings and while, holding he ties securely, remove the mask from the face; or, if side loops are present, lift the side loops up and away from the ears and face.

25. Discard disposable mask in the waste container.

26. Wash the hands again if they become contaminated by accidentally touching the soiled part of the mask.

27. Remove the gown before leaving the room.

If a gown is grossly soiled:

28. Avoid touching soiled parts on the outside to of the gown, if possible.

29. Grasp the gown along the inside of the neck and pull down over the shoulders.

30. Roll up the gown with the soiled part inside, and discard it in the appropriate container.

31. Remove protective eyewear and dispose of properly, or place in the appropriate receptacle for cleaning.

32. Report to the nursing supervisor any pertinent information.

33. Communicate to other nursing staff the supplies needed for future use.

LEGAL AUTHORITY:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

POLICY TITLE: DONNING A STERILE GOWN AND GLOVES (CLOSED METHOD)

PURPOSE STATEMENT: To implement proper technique for the reduction of the spread of pathogens.

POLICY: NM 13.072

PERSON AFFECTED/RESPONSIBLE: Nursing Services (Home Visitation and Clinic Based Services).

EQUIPMENT: sterile pack containing a sterile gown and sterile gloves

PREPRATION:

- Assess the client for latex allergies. If the clinician has an allergy to latex, have non-latex gloves readily available.
- Assemble equipment and supplies needed.
- Explain to the consumer what you are going to do, why it is necessary, and how he or she can cooperate.
- Wash hand and observe the agency standard infection control procedures.
- Provide for consumer privacy.

PROCEDURE:

I. Donning s Sterile Gown

1. Open the package of sterile gloves.
2. Remove the outer wrap from the gloves and leave the gloves in their inner sterile wrap on the sterile field.
3. Unwrap the sterile gown back.
4. Wash and dry hand carefully.
5. Put on the sterile gown by grasping the sterile gown at the crease of the neck, holding it away from you, and permit it to unfold freely without touching the outside of the gown.

6. If donning sterile gloves by using the closed method, work the hands down the sleeves only to the proximal edge of the cuffs; or; if donning sterile gloves by using the open method, work the hands down the sleeves and through the cuffs.

7. Have a coworker grasp the neck ties without touching the outside of the gown and pull the gown upward to the cover the neckline of your uniform in front and back. Have the coworker tie the neck ties.

8. Have a coworker take the two ties at each side of the gown and tie them at the back of the gown, making sure that your uniform is completely covered.

NOTE: When worn, sterile gowns should be considered sterile in front from the waist to the shoulder.

The sleeves should be considered from 2 inches above the elbow to the cuff, since the arms of a scrubbed person must move across a sterile field.

II. Removal and disposal of used gown and gloves.

1. Remove them by turning inside out.

2. If appropriate, document that sterile technique was used in the performance of the procedure.

III. Donning Sterile Gloves (Closed Method)

1. Open the sterile wrapper containing the sterile gloves.

2. Open the sterile glove wrapper while the hands are still covered by the sleeves.

3. Put the glove on the non-dominant hand.

4. With dominant hand, pick up the opposite glove with the thumb and index finger, handling it through the sleeve.

5. Lay the glove on the opposite gown cuff, thumb-side down, with the glove opening pointed toward the fingers. Position the dominant hand palm upward inside the sleeve.

6. Use the non-dominant hand to grasp the cuff of the glove through the gown cuff, and firmly anchor it.

7. With the dominant hand working through its sleeve, grasp the upper side of gloves's cuff, and stretch it

over the cuff of the gown.

8. Pull the sleeve up to draw the cuff over the wrist as you extend the nondominant hand in to the glove's fingers.

9. Put the glove on the dominant hand.

10. Place the fingers of the gloved hand under the cuff of the remaining glove.

11. Place the glove over the cuff of the second sleeve.

12. Extend the fingers into the glove as you pull the glove up over the cuff.

13. Document that the sterile technique was used in the performance of the procedure.

LEGAL AUTHORITY:

REFERENCE:

Effective date:
Date reviewed/revised:

Authorized by:
Prepared by:

RELATED POLICY:

References:

1.0, 2.0, and 3.0 are adapted from the *Michigan Nurses Association's Professional & Legal Regulation of Nursing Practice in Michigan*, 3rd edition. See URL http://minurses.org/