

CVS POLICY & PROCEDURE MANUAL

Policy Area: Service Delivery

Policy # & Name: 5.13 Health Care Protocols

Group: Staff

Purpose:

To provide information and guidelines with respect to Health Care Plans and protocols.

Policy Statement:

CVS staff are familiar with client health care plans and the various health care protocols prior to providing one on one service to the client.

All clients are treated professionally and respectfully at all times.

Practice Standards:

Staff must familiarize themselves with the client, their health care plan and protocols prior to providing service to the client.

Residential Care Plans are developed for all residential clients and Health Care Plans are developed as required. In the event of an adverse health condition employees will follow the general procedures or the specific health care protocols in the Health Care Plan.

CVS will document information concerning a client's typical seizure pattern for the purposes of instructing staff and volunteers in appropriate response, including emergency requirements, and ongoing seizure management. CVS will comply with requests from the client's family or caregiver, where possible, to record seizures using Seizure Record form (SDA 5.13.A) that occur while the client is attending the centre or day program. All staff will be required to know basic first aid for dealing with seizures and will receive training in seizure management as part of their orientation.

Note: *Clients who have a history of seizures will have a Health Care Plan that is written by the nurse consultant. Any PRN medication required immediately following seizure is considered a delegation of function task. Staff must be trained by the nurse consultant and recertified on an annual basis.*

Policy Audit: March Annually

Date Issued: March 2004

Date Revised: March 2005

Position

Responsible: Executive Director, Health & safety Committee

References:

- ☞ Health Care Procedures (attached)
 - ☞ SDA 5.13.A – Seizure Record Form
 - ☞ SDA 5.13.B – Vital Signs Monitoring Sheet
 - ☞ SDA 5.13.C – Comprehensive Bowel Record Form
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CVS POLICY & PROCEDURE MANUAL

Health Care Procedures

Definitions

Health Care Plan is a document outlining the individual's health care plan and protocol. This is usually generated by the Health Services – Community Living nurse assigned to the individual. The document is reviewed annually to ensure all information is up-to-date.

Delegation of Function of Task means that the staff member performing this task must be trained by a nurse consultant and recertified on an annual basis.

Blood Pressure

In the event that a blood pressure is to be taken for a resident, the HSCL Nurse Consultant is to be called to perform this function. In some cases CVS staff may be trained to perform this function. In such cases, staff may use the Vital Signs Monitoring Sheet (SDA 5.13.B) to record the results.

Blood Work

House Supervisors will ensure regular appointments are made for clients receiving medications to monitor medication levels. The client's physician will determine frequency of blood work and appointments.

Constipation / Diarrhea

Constipation / diarrhea must be monitored on an ongoing basis and may be recorded on the Comprehensive Bowel Record form (SDA 5.13.C). Any problems will be reported to the House Supervisor, Physician and/or Nurse Consultant. Staff will follow the specific bowel regimen outlined for each person. If the regime does not produce results contact the Physician and/or Nursing Consultant.

Enemas (Fleet And/Or Microlax)

Enemas are a delegation of function task. Staff who have not been certified cannot administer fleet / microlax enemas. For those certified, below is the general procedure.

1. Read specific individualized Health Care Plan on administration of enemas.
2. Wash hands, put on latex vinyl gloves and collect equipment.
 - ? latex / vinyl gloves
 - ? enema (fleet or Microlax)
 - ? toilet tissue
 - ? peri cloths
 - ? peri wash
 - ? water soluble lubricant
 - ? incontinent pad
3. Address the individual and explain procedure.
4. **Prepare the environment** - ensure privacy.
Prepare yourself - remove enema bottle from box and have within easy reach. (If fleet enema, warm in basin of warm water for 10 minutes).

CVS POLICY & PROCEDURE MANUAL

Prepare the individual - position him or her on left side with right knee and hip bent if possible. If the side lying position cannot be used, assist the individual to a supine (back lying) position with knees flexed.

5. Protect bed with incontinent pad.
6. Remove protective cap and squeeze upright until a small amount of fluid comes out. This removes all air.
7. Lubricate tip of enema with water soluble lubricant.
8. Lift the upper buttock to expose the anal area. Gently and slowly insert tip of enema 2-4 inches, pointing tip up towards umbilicus (belly button). Never push against resistance; withdraw slightly and advance slowly while rotating.
9. Have the individual take a deep breath and exhale while you insert the enema.
10. Insert contents by gently rolling up the bottom of the container or squeeze from the bottom until all fluid has been emptied into rectum.
11. Still applying pressure to the container, slowly withdraw it from rectum. This will prevent sucking action by the container.
12. Discard container in garbage receptacle.
13. Check bed for lowest position and assist client to commode chair or apply disposable brief.
14. Wait recommended time or until bowel movement is completed. When the individual is finished assist them with personal hygiene and peri care.
15. Position for comfort and safety.
16. Dispose of all soiled supplies.
17. Wash hands.
18. Tidy environment and report / record any significant findings. Chart BM result and clients tolerance to procedure as required.

Pressure Sores

To prevent development of pressure sores for individuals with limited mobility.

Procedure

1. Wash hands, put on latex / vinyl gloves and collect equipment.
 - ? latex / vinyl gloves
 - ? ointment / lotion
 - ? towel
2. Address the individual and explain procedure.
3. Observe bony prominences for redness or skin breakdown.
4. Apply lotion to hand. Rub hands together. Gently massage bony prominences in a circular motion.
5. Do not massage over inflamed or broken skin tissues.
6. Remove excess lotion with towel.
7. Reposition the individual frequently. This is the best method to prevent pressure sores from developing.

CVS POLICY & PROCEDURE MANUAL

8. Throw away all disposables.
9. Tidy environment and report / record any significant findings.

Routine Urinalysis

1. Wash hands, put on latex / vinyl gloves and collect equipment.
 - ? latex / vinyl gloves
 - ? sterile specimen bottle
 - ? bedpan, urinal, commode, toilet hat (this is an item that can be requested from doctor or lab-it can be used on a standard toilet to enable collection of urine.
 - ? clean graduate pitcher
 - ? tissue
 - ? paper bag
 - ? paper towels
2. Clean pitcher and bedpan / urinal / commode / toilet hat receptacle with hot water and antibacterial solution. Rinse and dry well.
3. Place graduate pitcher and specimen bottle in bathroom. Fill out specimen bottle label with correct and accurate information.
4. Address client and explain procedure.
5. Provide privacy.
6. Instruct the individual to urinate in appropriate receptacle. If he or she cannot void at will, then plan to do this procedure around their usual time for voiding.
7. When the individual is finished, take receptacle into bathroom. Put on gloves. Pour contents into graduated pitcher. Note amount if required.
8. Pour small amount into specimen bottle (half full is adequate). Cap bottle immediately.
9. Discard remainder of urine. Clean receptacle and pitcher with water and antibacterial solution.
10. Put specimen bottle in clean paper bag. Remove gloves.
11. Tidy environment and wash hands. Deliver specimen to lab ASAP.

Midstream Urine

1. Wash hands, put on latex / vinyl gloves and collect equipment.
 - ? latex / vinyl gloves
 - ? midstream collection kit: specimen bottle, label, towelette
 - ? bedpan, urinal or commode
 - ? tissue
 - ? paper bag
 - ? gloves
2. Address the individual and explain procedure.
3. Provide privacy.

CVS POLICY & PROCEDURE MANUAL

4. Assist the individual with bedpan, urinal or to the commode or toilet.
5. Open kit and remove specimen bottle (fill out label). Remove lid and take care not to touch container opening or inside of lid. Open package of towelettes. Put on gloves.
6. Clean meatus and perineum (pull back foreskin and wipe tip of penis). For females part labia and wipe gently around opening.
7. Instruct the individual to urinate. If the individual cannot void at will, then plan to do this procedure around their usual time for voiding.
8. Hold specimen bottle to catch a sample of urine. Do not touch any portion of the individual's genital area with container.
9. If the individual is able to stop voiding, have them do so, otherwise remove bottle from stream and cap it. Wipe outside of bottle with tissue.
10. Allow the individual to finish voiding.
11. Put specimen bottle in clean paper bag. Remove gloves and discard.
12. Tidy environment and wash hands.
13. Deliver specimen to lab ASAP.

Stool

1. Wash hands, put on latex / vinyl gloves and collect equipment.
 - ? latex / vinyl gloves
 - ? specimen bottle
 - ? tongue depressor
 - ? bedpan, commode or toilet hat (hat is available from doctor or lab and allows for collection of specimens on standard toilet)
 - ? paper bag
2. Label specimen bottle and place in bathroom.
3. Address the individual and explain procedure. Explain that a stool specimen is required. Request the individual to use bedpan or commode for next movement.
4. Assist the individual onto commode, bedpan or toilet (it may only be possible, for some clients, to collect a stool sample from their disposable brief. If this is the case, please inform doctor and lab that this is how the specimen was collected).
5. When the individual is finished use a tongue depressor to collect a small amount of stool and put in specimen bottle. Cap it immediately. Sometimes a smear sample is required in which case you will have received a smear card with designated areas to be smeared with a tongue depressor.
6. Dispose of remaining stool. Clean bedpan, commode or toilet hat with water and antibacterial solution.
7. Put specimen jar in paper bag.
8. Tidy environment and wash hands. Deliver bag to lab ASAP.

CVS POLICY & PROCEDURE MANUAL

Sputum

1. Wash hands, put on latex / vinyl gloves and collect equipment.
 - ? latex / vinyl gloves
 - ? specimen bottle
 - ? tissues
 - ? paper bag
2. Label specimen bottle.
3. Address the individual and explain procedure.
4. Ask the individual to rinse their mouth out with clear water.
5. Have the individual hold the container, if able. Only the outside of the container and lid may be touched.
6. Ask the individual to take three deep breaths and cough up sputum.
7. Have the individual expectorate the sputum directly into container.
8. Put lid on container immediately. Place container in the paper bag. Remove gloves.
9. Tidy environment and wash hands. Deliver specimen to lab ASAP.

Note: *All specimens required for diagnosis must be collected in a manner that ensures an untainted result for accurate diagnosis.*

Seizures

Definition

A seizure is when a surge of electrical energy passes between cells in a person's brain affecting either one small area of the brain or swamping the whole system. This may result in generalized tonic/clonic seizures, absence seizures or partial seizures.

Procedure

If present during a seizure:

- ? Protect the person from nearby hazards
- ? Loosen their tie or shirt collar
- ? Protect their head from injury
- ? Turn person on their side to keep airways clear– unless injury exists
- ? Reassure person as they return to consciousness
- ? Do not restrain the person
- ? Do not expect verbal instructions to be obeyed

An ambulance will be called when:

- ? The seizure has happened in water
- ? There's no medical history of seizures caused by epilepsy.
- ? The person is pregnant, injured or diabetic.
- ? The seizure continues for more than five minutes, or a time period longer than is typical of the seizure duration for that client.
- ? A second seizure starts shortly after the first one has ended.

CVS POLICY & PROCEDURE MANUAL

? Consciousness doesn't begin to return after the shaking has stopped.

Seizure Management Procedure:

Seizure Type	What it looks like
Generalized Tonic Clonic (also called Grand Mal)	Sudden cry, fall, rigidity, followed by muscle jerks, shallow breathing or temporarily suspended breathing, bluish skin, possible loss of bladder or bowel control. Usually lasts a couple of minutes. Normal breathing then starts again. There may be some confusion and/or fatigue followed by rerun to full consciousness.
Absence (also called Petit Mal)	A blank stare, beginning and ending abruptly, lasting only a few seconds, most common in children. May be accompanied by rapid blinking and/or some chewing movements of the mouth. The child or adult is unaware of what's going on during the seizure, but quickly returns to full awareness once it has stopped. May result in learning difficulties if not recognized and treated.
Simple Partial	<p>Jerking may begin in one area of body, arm, leg, or face. Can't be stopped, but patient stays awake and aware. Jerking may proceed from one area of the body to another, and sometimes spreads to become a convulsive seizure.</p> <p>Partial sensory seizures may not be obvious to an onlooker. Individual experiences a distorted environment. May see or hear things that are not there, may feel unexplained fear, sadness, anger or joy. May have nausea, experience odd smells, and have a generally "funny" feeling in the stomach.</p>
Complex Partial (also called psychomotor or temporal lobe)	Usually starts with a blank stare, followed by chewing, followed by random activity. Person appears unaware of surroundings, may seem dazed, and mumble. Unresponsive. Actions clumsy, not directed. May pick at clothing, pick up objects, try to take clothes off. May run, appear afraid. May struggle or flail at restraint. Once pattern is established, same set of actions usually occur with each seizure. Lasts a few minutes, but post-seizure confusion can last substantially longer. No memory of what happened during seizure period.
Atonic Seizures (also called drop attacks)	A child or adult suddenly collapses and falls. After 10 seconds to a minute he or she recovers, regains consciousness, and can stand and walk again.
Myoclonic Seizures	Sudden brief, massive muscle jerks that may involve the whole body or parts of the body. May cause person to spill what they were holding or fall off of a chair.
Infantile Spasms	These are clusters of quick, sudden movements that start between three months and two years. If a child is sitting up, the head will fall forward and the arms will flex forward. If lying down, the knees will be drawn up; with the arms and head flexed forward as if the baby is reaching for support.

"First Aid for Seizures" by Christine O'Dell. Exceptional Parent Magazine. March 2001.

CVS POLICY & PROCEDURE MANUAL



First Aid for Generalized Tonic Clonic (Grand Mal) Seizures

When providing seizure first aid for generalized tonic clonic (grand mal) seizures, these are the key things to remember:

- ✍ Keep calm and reassure other people who may be nearby.
- ✍ Don't hold the person down or try to stop his movements.
- ✍ Time the seizure with your watch.
- ✍ Clear the area around the person of anything hard or sharp.
- ✍ Loosen ties or anything around the neck that may make breathing difficult.
- ✍ Put something flat and soft, like a folded jacket, under the head.
- ✍ Turn him or her gently onto one side. This will help keep the airway clear. Do not try to force the mouth open with any hard implement or with fingers. It is not true that a person having a seizure can swallow his tongue. Efforts to hold the tongue down can injure teeth or jaw.
- ✍ Don't attempt artificial respiration except in the unlikely event that a person does not start breathing again after the seizure has stopped.
- ✍ Stay with the person until the seizure ends naturally.
- ✍ Be friendly and reassuring as consciousness returns.

Offer to call a taxi, friend or relative to help the person get home if he seems confused or unable to get home by himself.

First Aid for Non-Convulsive Seizures

You don't have to do anything if a person has brief periods of staring or shaking of the limbs. If someone has the kind of seizure that produces a dazed state and automatic behavior, the best thing to do is:

- ✍ Watch the person carefully and explain to others what is happening. Often people who don't recognize this kind of behavior as a seizure think that the dazed person is drunk or on drugs.
- ✍ Speak quietly and calmly in a friendly way.
- ✍ Guide the person gently away from any danger, such as a steep flight of steps, a busy highway, or a hot stove. Don't grab hold, however, unless some immediate danger threatens. People having this kind of seizure are on "automatic pilot" so far as their movements are concerned. Instinct may make them struggle or lash out at the person who is trying to hold them.









Stay with the person until full consciousness returns, and offer help in returning home.

Epilepsy Foundation 4351 Garden City Drive Landover, MD 20785-7223 - (800) 332-1000 Site
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First Aid Steps for Convulsions

(Convulsions, generalized tonic-clonic, grand mal)

	
Cushion Head	Loosen Necktie
	
Turn On Side	Nothing In Mouth
	
Look For ID	Don't Hold Down
	
As Seizure Ends	...Offer Help

Although most seizures end naturally without emergency treatment, a seizure in someone who does not have epilepsy could be a sign of serious illness. Call for medical assistance if:

- ✍ the seizure lasts more than 5 minutes
- ✍ there is no "epilepsy/seizure disorder" I.D. present
- ✍ there is slow recovery, a second seizure, or difficult breathing afterwards
- ✍ the woman is pregnant or other if there is other medical I.D.
- ✍ there is any signs of injury

Epil

CVS POLICY & PROCEDURE MANUAL

Suppositories

1. Wash hands, put on latex / vinyl gloves and collect equipment.
 - ? latex / vinyl gloves
 - ? suppository
 - ? water soluble lubricant
 - ? toilet tissue
 - ? peri care supplies
2. Address the individual and explain procedure.
3. Raise bed to comfortable working height.
4. Position the individual on left side, right knee flexed, facing away from you.
5. Remove suppository from wrapper. Put on glove. Lubricate suppository well.
6. Lift upper buttock to expose anus. Ask the individual to take a deep breath.
7. Insert suppository by grasping it between thumb and forefinger. Gently insert into anus, guiding it up into rectum with forefinger.
8. Withdraw finger, remove and discard glove.
9. Reposition the individual and encourage to retain suppository for as long as possible. If the individual is incontinent apply disposable brief and dress him or her appropriately for the day.
10. Wash hands.
11. Tidy environment and report / record any significant findings. Chart BM result as required.

Temperature

The normal body temperatures are as follows for:

axilla (underarm)	36.5 degrees Celsius
oral	37.0 degrees Celsius
rectal	37.5 degrees Celsius

Rectal thermometers can only be used rectally.

Electronic thermometers are preferred for safety reasons and are required when the individual is:

- ? less than five years of age
- ? unconscious or semiconscious
- ? unable to breathe through nose
- ? confused, restless or agitated
- ? experiencing facial paralysis
- ? coughing or sneezing frequently
- ? Experiences sores in mouth
- ? Prone to seizures

✍ Axilla temperature is recommended in these situations. DO NOT DO AN ORAL TEMPERATURE

Axilla

CVS POLICY & PROCEDURE MANUAL

Reading is taken under the arm and is the least accurate but the safest method.

1. Wash hands and collect equipment.
 - ? watch with second hand
 - ? clean thermometer
2. Address the individual and explain procedure.
3. Make sure thermometer is "on".
4. Raise arm and place tip of the thermometer in the fleshy portion of the axilla. Return arm to normal position.
5. Leave thermometer in place for 5 minutes or until it beeps (electronic).
6. Remove thermometer and remove sheath with a tissue.
7. Read thermometer.
8. Record the temperature, writing an "A" after the figure.
9. Report temperature if it varies more than one degree from normal.
10. Clean thermometer with water and antibacterial solution.

Oral

Oral temperature is very accurate but can be unsafe if a glass, mercury thermometer is used and, therefore, an electronic thermometer is required.

1. Wash hands and collect equipment.
 - ? watch with second hand
 - ? clean thermometer
 - ? tissue
2. Address the individual and explain procedure.
3. Check that the individual has not ingested hot or cold food in last 15 minutes.
4. Make sure thermometer is on.
5. Some thermometers have a disposable plastic sheath.. If so, place thermometer in sheath.
6. Place tip of thermometer under the clients tongue.
7. Ask the individual to hold thermometer with lips, not teeth.
8. Leave thermometer in place for three minutes or until it beeps (electronic).
9. Remove thermometer from the individual's mouth and remove sheath with a tissue.
10. Read the thermometer.
11. Record / chart temperature as required, writing an "O" after the figure.
12. Clean thermometer using water and anti-bacterial solution.
13. Report temperature if it varies more than one degree from normal.

Rectal

Rectal temperature is generally safe and accurate. Use an electronic thermometer with disposable plastic sheaths.

CVS POLICY & PROCEDURE MANUAL

1. Wash hands, put on latex / vinyl gloves and collect equipment
 - ? latex / vinyl gloves
 - ? watch with second hand
 - ? rectal thermometer (labeled 'rectal')
 - ? disposable sheaths
 - ? tissue
 - ? water soluble lubricant
2. Identify the individual and explain procedure.
3. Assist him or her to side lying position with upper leg flexed.
4. Make sure thermometer is on.
5. Place sheath on thermometer and then coat with water soluble lubricant.
6. Expose anus by raising upper buttock.
7. Gently insert tip of thermometer one inch into rectum.
8. Hold the thermometer in place for three minutes or until it beeps (electronic).
9. Remove thermometer and remove sheath with a tissue and discard with gloves.
10. Read and record temperature, writing an "R" after the figure.
11. Report temperature if it varies more than one degree from normal.
12. Clean thermometer with water and antibacterial solution.