Wisconsin Veterans Home at King

Code of Ethics for Nurses

Date of Origin: August 2009	No.: 103-00-21
Last Revision: January 2015	Page 1 of 1
Last Review: October 2015	Maintained By: Nursing

Applies To:

- All nursing staff.

Applicable Regulations/References:

- American Nurses Association, *Code of Ethics for Nurses with Interpretive Statements*, Silver Spring, MD: American Nurses Publishing, 2015.

The Code of Ethics consists of two components: the provisions and the accompanying interpretive statements. There are nine provisions. The first three describe the most fundamental values and commitments of the nurse, the next three address boundaries of duty and loyalty, and the final three address aspects of duties beyond individual patient encounters.

1. The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.

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

3. The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.

4. The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimum care.

5. The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.

6. The nurse, through individual and collective, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

7. The nurse, in all roles and settings, advances of the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.

8. The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

9. The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

Wisconsin Veterans Home at King

NOTIFICATION OF MEMBER STATUS CHANGE

Date of Origin: February 2010	No.: 107-00-01
Last Revision: March 2014	Page 1 of 3
Last Review: March 2014	Maintained By: Nursing

Applies To:

- Physicians, APNPs, RNs, Social Workers

Purpose/Overview:

- To assure that the members will receive timely medical and nursing care during a change in physical, mental or emotional status, an emergency and/or a sudden illness.
- To inform the physician and family of any situation that causes a change in status.
- To provide guidelines for nursing employees responsible for member care.

Related Documents:

- Spiritual Care Services, P/P 10-00-01
- Nursing Member Incident Reporting, P/P 124-00-43
- Physician's Orders/Progress Notes, form WDVA 3218

Definitions:

- MDS/Significant Change in Status Assessment – A comprehensive assessment when there is a decline or improvement in a member's status that:
  - Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions,
  - Impacts more than one area of the member's health status, and
  - Requires interdisciplinary review and/or revision of the care plan.
- Status Change – A change in health, mental, or psychosocial status in either life threatening conditions (i.e., heart attack, cancer, etc.) or clinical complications (i.e., development of a Stage II pressure sore; onset or recurrent periods of delirium; recurrent urinary tract infections; or onset of depression).
- Accident – Resulting in an injury; also has the potential for requiring physician intervention
- Need to alter treatment significantly – A need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.

Policy:

I. Any changes in the status of any member shall be reported to the nurse in charge who shall take appropriate action.

II. The RN or designee shall immediately inform the member; consult with the member's physician; and if known, notify the member's legal representative or an interested family member when there is:
   a. An accident involving the resident which results in injury and has the potential for requiring physician intervention:
   b. A significant change in the member's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
   c. A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);
   d. A change in the medication regimen, including adverse drug reactions and medication errors;
   e. A decision to transfer or discharge the resident from the facility.

III. The Social Worker, RN or designee shall promptly notify the member and, if known, the member's legal representative or interested family member when there is:
   a. A change in room or roommate assignment;
   b. A change in member rights under Federal or State law or regulations.

IV. Staff shall record and periodically update the address and phone number of the member's legal representative or interested family member.

V. Significant non-medical changes in member status including financial situation, plan to discharge member or plan to transfer member within the facility or to another facility shall be communicated to the responsible party by the Social Worker or designee.

VI. Changes in status shall require the initiation of a Temporary Care Plan (TCP) or changes/additions to the Total Plan of Care (TPOC).

VII. Members having a change of status shall be placed on the 24 Hr. Report for as long as necessary to resolve the situation.

VIII. Members on 24 Hr. Report shall have monitoring assessments and documentation.

IX. A significant change in status (condition) necessitates a full MDS be completed.

X. Notification of Chaplains shall occur per MCPC P/P #10-00-01.

XI. If a member has a sentinel event it must be reported to the physician even if treatment protocols are already in place. Appropriate documentation must be made for this notification. Sentinel events include:
   a. Dehydration
   b. Fecal Impaction
   c. Pressure sore, low risk

Procedure:

I. Detailed documentation of each attempt at notification of a member's status change to the physician and NOK/guardian (to include what the nurse told the physician/NOK, the physician's/NOKs response, and the exact time and date) is made in the clinical record.

II. Documentation of the nurse's assessment of findings, which she/he relays to the physician, via telephone, is recorded on the Physician's Orders/Progress Notes rather than the Member Progress Notes (MPN).

> *If a member has a sentinel event it must be reported to the physician even if treatment protocols are already in place. Appropriate documentation must be made for this notification.*

III. Notification of the NOK regarding medication changes are recorded in the progress notes column of the Physician's Orders/Progress Notes form WDVA 3218 adjacent to the written MD order.

IV. When from his/her assessment of the member, the nurse feels it is necessary for the physician to make a bedside visit, that judgment is to be made clearly known to the physician.
   a. If the nurse believes a bedside visit by the physician is necessary, and the physician is NOT responsive, the nurse informs the physician that she/he is taking the following action:
      1. **During regular business hours**, call the building Nursing Supervisor who in turn may consult with Administration and/or Medical Director.
      2. **When a medical emergency exists**, in which the nurse feels the member needs immediate medical attention, and the physician is not responsive, the nurse calls Gold

Cross Ambulance Service, Inc. for transfer to Riverside Medical Center emergency room.

Should a physician's absence be occasioned by emergency, power failure, car breakdown, or any other unforeseen eventuality, an alternate physician will be called in the following order:

a. ThedaCare Physicians has an internal arrangement to always provide an on-call physician. Therefore, the switchboard at RMC or Emergency Room at RMC may be aware of an alternate on-call physician.

b. The WVH Medical Director

c. Any other ThedaCare physician who can be contacted.

V. Arrange for transfer to another facility if indicated:
   a. Complete and send all necessary forms for transfer.
   b. Notify the member's family and/or responsible person or guardian that a significant change or sudden illness has occurred, and the reason for needing emergency care or transfer. Document each attempt at notification in the clinical record.
      1. This notification occurs prior to transfer unless the time delay required for notification would jeopardize the member's well-being.
   c. When unable to contact the member's family, and/or other responsible person or guardian, the Social Service staff is contacted for advice and assistance.
   d. If Social Services are unavailable, contact the Nursing Supervisor for further instructions.
   e. Complete Incident/Accident documentation per policy, "Nursing Member Incident Reporting," policy 124-00-43.
   f. Place member on 24 Hr. Report.

VI. If transfer to another facility is not indicated:
   a. Place member on 24 Hr. Report for follow up.
   b. Document assessment in Member Progress Notes, Physician's Notes or complete Incident/Accident documentation, if indicated per policy, Nursing Member Incident Reporting," policy 124-00-43.
   c. Notify physician. Document all attempts to notify in the clinical record. Include date, time, mode (i.e., paged, called office, etc.), and response (i.e., no answer, busy, etc.).
   d. Notify the member's family and/or responsible person, activated POAHC or guardian that a status change or sudden illness has occurred and the actions being taken. Document all attempts to notify in the clinical record. Include date, time, mode, and response (i.e., no answer, busy, etc.).
   e. Based on the status change, appropriate changes are made in the TPOC, DCP or a TCP is initiated and/or if it meets the MDS definition of a significant change of condition MDS/RAPs is completed. The care plan must be specific about what is to be done; who will do it; timetables for initiating repeat assessments and follow-up, etc.
   f. All further documentation in the progress note indicates the success or lack of success of the defined approaches; any further assessment necessary; and that this information is being communicated with other members of the health care team.

Wisconsin Veterans Home at King

NURSING 24 HOUR REPORT

Date of Origin: September 1988	No.: 108-03-01
Last Revision: February 19, 2018	Page 1 of 3
Last Review: February 19, 2018	Maintained By: Nursing

Applies To:

- All interdisciplinary team (IDT) members

Purpose:

- To have available to nursing staff and other IDT members a list of members, by unit, about whom information needs to be readily accessible for:
  - Appropriate nursing intervention (i.e., appointments, specific monitoring required changes in care plan, etc.).
  - RN follow-up and documentation.
  - Provider or NOK/Member representative notification.
  - To provide information to staff at change of shift.
  - A means to communicate member information to the Medical Director, nursing supervisory staff, and ancillary departments.
- To provide a communication tool for the nursing team, including standardizing what information is documented routinely on this report.

Related Documents:

- Nursing 24 Hour Report Form WDVA 3405
- 107-00-01 Notification of Member Status Changes
- 106-00-03 Member's Care Plan

Policy:

- Members shall be placed on the 24-Hour Report in the following situations:
  - New admission for three days
  - Hospital return for three days
  - New equipment–New equipment with the potential to cause pressure concerns for 9 shifts
  - Incident/Accident reported
  - New psychotropic medication orders, dose changes, or discontinued orders for 15 shifts
  - New diet texture modification or fluid consistency orders for 9 shifts
  - New problem related to infection for at least 3 shifts
  - A fall occurs – must be on report for 2 shifts after a fall
  - New or significant behavioral problems or abnormal behavior for the member
  - Any change in condition
  - Members having extended supervision staffing
  - Member transferred to another facility for treatment, diagnostic work ups or procedures, or admission
  - Member transferred back from another facility
  - Member death
- Information noted on back of Nursing 24-Hour Report:
  - Members needing frequent checks, (i.e., hourly, every 15-minute, etc.)
  - Members placed in isolation (date in – date out)
  - Work that needs completed by another shift or carried over to the next day (i.e., MDS, Assessments, etc.)

- Information required to be passed on to all shifts such as: changes in care plans, specific monitoring and documentation needing to be done, preps, temporary care plans (TCP), I & O, appointments, medication changes, etc.
- Awaiting member representative call backs
- Members on Bowel and Bladder assessments are to stay on report until completed and electronically documented as completed
- Members needing TPR or BP monitoring
- Members with infections that require surveillance documentation

- Members may be placed on the 24 Hour Report for information only. In that case, the Members marked with "info" after name may be exempt from further need for documentation and follow-up.
- Members may be placed on the 24 Hour Report according to staff's clinical judgment or as necessary to pass on important information.

Procedures:

1. Licensed nursing staff initiates a new Nursing 24 Hour Report, form WDVA 3405, at 2300 hours each night.
2. The midnight date is entered, as well as the Nursing Unit. Members still on report are carried over to the next day's report and any other pertinent information from the previous report. Forms are kept on a clipboard on each unit.
3. If a member is put on the 24 Hour Report, fill in the areas as prompted. Information should be listed, as follows:
   A. In Initial Column:
      1) Put initials and date in appropriate space to indicate if MD and NOK/Member Representative has been notified, needs to be notified, or if a message was left. All attempts and NOK/Member rep. notifications are documented in the electronic health record (EHR).
   B. In Member/Problem Column:
      1) Member's full name.
      2) A brief statement identifying reason member is on report (i.e., fever, UTI, behavior, etc.).
      3) Check appropriate boxes to indicate update or completion of total plan of care (TPOC), TCP, Kardex review, new fall intervention.
   C. In the columns labeled with the shift (NOC, AM, and PM) document the physical/psychosocial assessment and/or monitoring.
   D. If the entry is made by someone other than the shift RN, the RN signs their name after the entry to indicate they are aware of it.
   E. Check the appropriate box when documentation in the EHR has been completed.

   Documentation on the 24 Hour Report does not replace making an entry in the EHR. The nurse must electronically document all pertinent information.

   F. Signatures at bottom of page:
      1) The medication nurse and the RN must both sign the report each shift to indicate they are aware of the information on the report and are taking appropriate action.
4. The RN on each shift visits each member who is identified on the front of the 24 Hour Report. The RN documents their assessment on the 24 Hour Report and in the member's EHR. Member's names

and information are carried over to the next day's form if the situation continues to need assessment, monitoring, nursing intervention and some type of follow up.

A. If it is necessary to notify the provider, follow policy Notification of Member Status Changes, 107-00-01.
B. For a hospital return, documentation should include the reason for hospitalization and which day of return it is, (i.e., Hospital return ; day 1; Pneumonia).
C. For a member fall, the member is carried on report for at least 2 shifts following the fall.

5. Members are taken off the report when their condition/situation is stable and no longer requires acute monitoring and treatment. The final entry on the report indicates why the member is being discontinued and "Off" is written at the end of the entry. Just writing "Off" without proper documentation is not acceptable. Documentation must be made in the member's EHR indicating that the situation has been resolved, stabilized or further intervention is not needed at this time. This includes making appropriate changes and updates to the care plan, discontinuing a TCP, and making changes to the Kardex.
6. The 7 most recent day's reports are maintained on the clipboard. Reports more than 7 days old are given to the DON/ADON for filing; and are kept for a minimum of 7 years.

Wisconsin Veterans Home at King

Documentation in the Member's Clinical Record

Date of Origin: December 2001	No.: 108-03-10
Last Revision: December 20, 2016	Page 1 of 5
Last Review: December 20, 2016	Maintained By: Nursing

Applies To:

- Wisconsin Veterans Home at King (WVH-K) Nursing Staff

Purpose/Overview:

- To establish guidelines for maintaining a legal record of assessments, analysis of data, conclusions, plans, interventions, events, and evaluations made by staff and other professionals.
- To ensure continuity of care for members by the use of documentation.
- To establish guidelines for documenting care/interventions given to members and demonstrate the result of the care/interventions.
- To ensure confidentiality, security, and accuracy of documentation in handwritten and electronic documentation.

Related Documents:

- Chapter 4–Documentation and Informatics, Perry & Potter
- WVH 01-02-XX (00-29) HIPAA Policies
- DHS 132.45 (5) (c) 3. a. & b.; 4. a.-j.

Definitions:

- HIPAA: Health Insurance Portability and Accountability Act. Governs all areas of health information management.

Policy:

General Charting Guidelines:

- The medical record shall be a legal document and is subject to State and Federal Law.
- The paper record and the electronic record shall both be considered the member's medical/health record.
- The health record shall be handled in such a way as to protect its contents from people who are unauthorized to read it in accordance with HIPAA regulations.
- The medical record shall not be discarded or destroyed. Whenever parts of the health record need to be recopied, the original shall be kept. Any papers that may need to be destroyed (envelopes, returned copies of documents sent, etc.) that have member PHI on them shall be shredded.
- All documentation shall be made in the medical record as soon as possible.
- Initial Medicare charting for members on Medicare A shall be every shift for a minimum of 3 days and then AM, PM, and PRN.
- Weekly charting shall be done in Electronic Health Record (EHR) by the RN, as follows:
  - Members who require charting shall be determined by a set schedule for that day by all 3 shifts.
  - A summary note regarding any condition charting in the last 7 days, as well as designated topics, including:

ADLs	Skin	Oral/Nutrition	Sensory
Neurological	Respiratory	Cardiac	GI Upper
Mobility	Bowel/Bladder	Pain	Sleep

- Each entry shall have the time (Military time only) and date it was made.

Wisconsin Veterans Home at King

Documentation in the Member's Clinical Record

Date of Origin: December 2001	No.: 108-03-10
Last Revision: December 20, 2016	Page 2 of 5
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- Abbreviations shall be avoided and not used in the clinical record.
- All handwritten entries shall be permanent. Alteration of information in a record is not acceptable (i.e. "white-out").
- Use of vague terms such as "appears, seems, uncooperative", etc. shall be avoided. Each entry shall be accurate, factual, specific, and objective. Documentation shall reflect what the member is doing, such as "clenching teeth and refusing oral care".
- Proper spelling, grammar, and use of quotations marks shall be required.
- Use of terms shall only be utilized if you are sure of their meaning.
- Documentation shall be done in the EHR under the Assessment tabs, Progress Notes, and/or Care Plans.
  - Document member's condition upon admission, and upon each return to the facility from other facilities or furloughs in the Admission/Hospital Return Assessment.
- For all infections, licensed staff shall enter the following information in the EHR in the Nurse Charting/Systems folders for all new infections:
  - Signs/symptoms
  - Date of Onset and Resolution
  - If there was a culture obtained, results are entered by licensed nursing staff.
  - If there was a chest x-ray obtained
    - The Licensed Nursing Staff enters the x-ray results in the assessment.
  - If an antibiotic was started, changed, or discontinued
  - If the infection was facility acquired or community acquired
- Document the member's symptoms; the member's own words shall be used when possible, identifying with quotation marks.
- A record or report shall contain descriptive, objective information about what is seen, heard, smelled, be concise with measurements, and include any action you take in response and the member's response to your actions. Eliminating personal bias from written descriptions of the member or others (i.e., staggering gait, slurred speech, strong odor of ETOH, etc. vs. drunk.).
- The source of information such as discharge summary, resume note, etc. shall be documented.
- Team members shall not document for someone else.
- If documentation is made from information provided by another person, the person who provided the information shall be identified by name in the documentation (unless information is provided by a member, then the member shall be identified utilizing their WVH-K number).
- Any reference to another member made in a member's chart shall be made utilizing their WVH-K number instead of their name.
- Staff shall not reference any document in the medical record that is not part of the chart and will eventually be destroyed (i.e. 24 hour report, report book, etc.).
- The fact that a facility incident report was completed shall not be included in documentation of the incident or accident.
- Only care that has been given shall be documented. Charting care ahead of time shall not be done. Documentation of medications or treatments shall not be done until after they are administered.
- The person that logs into the member's EHR shall assume responsibility for the entries made.
  - Each entry on a paper document shall be signed by the person assuming responsibility for the accuracy of the entry.

- Note exact times of all critical treatments, abnormal observations (including changes of condition), physician/provider contacts, family/legal representative contacts and notices to supervisors. The following shall be document in the EHR:
  - Contact with any of these individuals by name and content of conversation.
  - Each attempt to contact and what method was used, including time.
  - Exactly what information was given to individuals including Physicians/provider and the result of that contact.
  - If a message was left with someone to return a call along with whom the message was left.
- When you tell a physician/provider about a member's condition and he/she orders no change in treatment, simply record, "physician/provider notified of member's condition (describe the condition), no orders received."
- Document any comments that a member/family makes about a potential lawsuit and bring it to the immediate attention of the supervisor on duty.
- If a member is non-compliant with recommended treatment, in addition to documentation of refusals, any alternative therapy and education that is offered shall also be documented. Indicate member's continuing refusal of care in their care plan and address that their risks and benefits are reviewed with them quarterly.
- The system identifies backdated entries as late when setting the date within the Progress Note or Assessment.
- Any referrals to other health professionals and any discussion held regarding the member shall be documented.
- Electronic communication such as email and fax between health care providers and family or health care providers and facility shall be documented in the medical record.

Hand Written Entries:

- Handwriting shall be neat and legible, on lines only, with no writing in the bottom or side margins.
- Black ink shall be used for all entries, unless otherwise specified.
- Lines shall not be skipped or left blank. Draw a line through any blank areas.
- The member's name shall appear on every page of the medical record. If both sides of the paper are used, the name shall appear on both pages.
- Mistaken entries in the paper document shall be corrected by drawing a single red line through the entry, it shall still be readable beneath the line, and place the date, "Mistaken entry", and your initials above or next to the incorrect entry. Indicate the reason for the error. No method shall be used to cover up the entry. Words shall not be squeezed in.
- If documentation is made on a separate sheet of paper (from a discipline other than nursing), it shall be stapled, adhered to or filed in the appropriate chart records. These sheets shall contain the member's name and room number.
- Authorship of each entry shall be indicated by signature that includes the writer's first and middle initials, full last name, and title.
- Ditto marks shall not be used in charting. No lines or arrows shall be used.
- When it is necessary to complete a note on the next page, "con't" shall be written at the end of the present narrative and signed. On the next page, again enter the date and time and focus and continue the documentation.

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Documentation in the Member's Clinical Record

Date of Origin: December 2001	No.: 108-03-10
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American Nurses Association standards of nursing practice require that documentation be based on the nursing process and that it should be ongoing and accessible to all members of the health care team. Nursing documentation should be:

- *Objective – not critical of subjective*
- *Clear, concise and comprehensive*
- *Accurate, truthful, and honest – does not appear self-serving, especially if an incident or injury occurs*
- *Relevant and appropriate*
- *Reflective of observations, not of unfounded conclusions*
- *Reflective of resident education*
- *Reflective of resident response to care and actions taken to rectify unsatisfactory response*
- *Timely and completed only during or after giving care*
- *Chronological*
- *Internally consistent*
- *A complete record of nursing care provided, including assessments, identification of health issues, a plan of care, implementation and evaluation*
- *Legible and non-erasable*
- *Unaltered*
- *Permanent Retrievable*
- *Confidential*
- *Resident-focused*
- *Outcome-based*
- *Completed using forms, methods, system provided or methods and systems consistent with these standards, facility policies, and state laws. From the Long-Term Care Legal Desk reference by Barbara Acello, RN MSN*

Electronic Clinical Records:

- Electronic health records shall be maintained for each member.
- Staff shall have access to information contained within the system, using unique assigned access codes.
- Information contained in the EHR shall be printed and placed in the individual's clinical record as indicated in specific policies.
- Pertinent information contained in the EHR shall be printed when members are sent to outside facilities for care or at the request of regulators during the survey process.
- Correctly identify late entries by selecting the late entry system worked prior to documentation. The date and time shall be included in the documentation. If an error was made in documentation it shall be corrected when it is identified. Review your entry for accuracy and completeness prior to signing the entry.
- If an electronic entry is made for the wrong member, the strike out button shall be used to correct the entry. The reason entry shall be "Wrong Chart". Choose the Select button next to the entry that is to be struck out, and select the strike out button again.
- If an entry is made that needs correcting, correction shall be done by using edit function for assessment(s) in progress if the entry is not locked. For completed assessment(s) use the strike out function and select the appropriate reason such as "incomplete documentation" or 'incorrect documentation" and for completed progress note(s) use either the strike out or follow up function.

Electronic Signatures

- Prior to being issued a password for the EHR every computer user shall complete the E-training for IS 400 Technology Use and complete the post-test indicating they have read and understand it is their responsibility to follow the policy as written. A hard copy of IS 400 is also in the training manual and each user shall also sign a "Receipt Acknowledgement" indicating they were provided the policies listed on the New Employee Orientation list.
  - This paperwork is initiated by Administration secretary for new nursing employees and the employee's supervisor in other areas.
- Each user will use their network username and be issued a password for accessing the EHR. They are identified by their unique initials when documenting in Point Of Care (POC) and eMAR/Etar. Their unique initials shall be considered the equivalent of a written signature. Under no circumstances shall computer entry be done under another person's code or should passwords be shared. Disciplinary action shall result if violations occur.

Wisconsin Veterans Home at King

Meal Service to Members

Date of Origin: August 1985	No.: 114-00-01
Last Revision: March 19, 2018	Page 1 of 3
Last Review: March 19, 2018	Maintained By: Nursing

Applies To:

- All Nursing Staff, Dietary Staff, Activities Staff, and Social Services Staff

Policy:

- All members shall be served meals in the main dining room of the building in which they live unless:
  - The member has made a request for other dining accommodations.
  - The member's medical condition warrants a dining situation where more assistance is provided than in the main dining area.
- Those members who are competent to make their own decisions, and who wish to be served the meals provided by the Wisconsin Veterans Home at King (WVH-K) in other than the areas usually served by nursing and dietary, shall have the risks and benefits of their request discussed with them by the Interdisciplinary team. If the member still chooses to eat in an "other than usual area", this shall be documented according per 12-00-09, "Member's Informed Choice of Health Care or Treatment", indicating that he/she is making an informed decision to eat his/her WVH-K provided meals in an area that does not have nursing or dietary staff in attendance.
- Member's requests for changes in dining arrangement on short notice (less than 24 hours) shall be handled through the unit/building charge nurse on a case by case basis.
- Member seating in the main dining room shall be determined by a combined effort of the Food Service Assistant/Dining Room Worker, available nursing staff whom are assigned to the dining room and occasionally the Dietitian or Social Worker.
- Each building's staff, including Social Services, Nursing, and Dietary, shall inform the members of the customary practices concerning the dining room. Customary practices may vary from building to building.

  Customary practices for the dining room include:
  - *When members may come into the dining area*
  - *How trays are passed*
  - *How trays are removed*
  - *When the members leave the dining area*
  - *Dress code etiquette*

- The dietary staff shall be present in the dining room during meal service except when transporting carts, or obtaining missed meal items.
- Adaptive equipment shall be set up before meal service by the Food Service Worker. Adaptive equipment that is required by members eating on the unit shall be sent in a bucket with the meal cart.

  A statement of "Adaptive Equipment" prints on the meal tickets to remind nursing staff to obtain equipment. All soiled adaptive equipment shall be placed back in the bucket for return to the Food Service Assistant for cleaning.

- Staff shall offer hand hygiene opportunities and assistance to members prior to meal service.
- Nursing staff shall pass trays to the members eating in the dining room. The Food Service Assistants shall assist with the tray pass after they have completed transportation of the food carts.
- Nursing staff and Dietary staff shall assist the members with tray setup as required.

- Dietary staff shall assist with pouring of the second cup of coffee, obtaining meal alternatives for members, recording feedback regarding meals and preferences as necessary.
- Nursing staff shall collect the tickets of the members who are absent without notice.
  - Nursing staff shall be responsible for contacting the units of those members who are absent without notice. The purpose of this contact is to determine if the member's whereabouts have been accounted for.
  - Nursing staff shall communicate to the dining room worker whether or not the member will be coming to meal time.
  - Nursing staff shall then document in electronic health record (EHR) the reason the member is absent from the meal. This indicates that nursing staff have located and verified the whereabouts of the member in question.
- Nursing staff shall be present in the dining room during a meal service and shall remain until all the members are done eating, not to include members who utilize the dining room area for socialization.
- Nursing and Dietary staff shall work together with collection of dirty trays and recording of meal percentage intakes.
- Dietary and/or nursing staff shall report any problems observed in the dining room to the RN and/or the food service supervisor on duty, immediately following the meal at which it occurred and document per policy Nursing Incident/Accident Reporting 124-00-43 or 01-00-16a Adverse Event Reporting on WDVA 3282.
- The Dietary staff shall clean the dining room area after the meal.
- Members shall be present for WVH-K meals served unless the member is on furlough or other arrangements have been made. See Member Meal Attendance/Check Out 06-00-07.
- If members who normally eat in the building's main dining room need closer attention during meal times related to a change of condition, either temporarily or long term, the risks and benefits of changing dining environments shall be explained to the member by the health care team if the member is able to understand. If the member is unable to understand, the family or member representative shall be contacted for this discussion.
- WVH-K staff shall not remove any items from a member's tray for their personal consumption, even if it is offered to them by the member.
- Members shall not remove any food items from another member's tray.
- Members shall not remove food, serving dishes, cups or mugs or utensils from the dining areas.

Dining Emergencies:

- All nursing, activity, and dietary staff shall be trained in the Heimlich maneuver with yearly updates provided within their own department's training schedule.
- Any emergency situation shall be called to the RN's attention immediately, by pager or public address announcement.
- Staff on the scene shall respond within their education and training. If more response is needed than that which they can provide, the RN shall be contacted to make an evaluation and call the ambulance if necessary.

Procedure:

1. Trays are brought to the designated areas by Dietary or Nursing staff.
2. Trays are passed in the building dining room by nursing and dietary staff in attendance.

3. After all the trays are passed the member is given any assistance needed, such as opening containers, cutting food, providing adaptive equipment 06-00-10, etc.

   During an electrical outage or other special circumstance, all trays may need to be brought to and served on the unit. Dietary assists with this.

4. If any member who is not present for a meal, and is not officially checked out for that meal, the Nursing staff must contact the nursing unit to check for member's whereabouts.

   Nursing staff must check on a member whenever they do not appear for their meal.

5. As the members finish eating in the building dining room, nursing staff observes the quantity consumed and cover and return the tray to the dietary cart.
6. Percent food and fluid are recorded in EHR by nursing staff after each meal.

   Fluids include any fluid served on meal trays, as well as ice water and extra coffee served at the meal.
   Usual servings at WVHK (mls):

Milk Carton 240	*Plain Jello 120*
Coffee/Tea 180	*Ice Cream/Sherbet 120*
Soup Bowl 210	*Styrofoam Cup 180*
Juice 120	*Dixie Cup (meds) 90*

7. Changes in member food preferences or other member comments about the meal may be written on the ticket that comes with the tray by the member or staff. This ticket is then returned to dietary services.
8. New admissions will dine on the unit for a minimum of three meals to be observed for any self-feeding or swallowing issues.
9. Members in need of assistance and members with specific dietary monitoring requirements usually eat on the unit.

Wisconsin Veterans Home at King

Hypoglycemia Protocol

Date of Origin: March 1994	No.: 116-00-20
Last Revision: July 5, 2016	Page 1 of 3
Last Review: July 5, 2016	Maintained By: Nursing

Applies To:

- Nursing, Dietary, Activities, Pharmacy, Diabetes Professionals, Physicians/Providers, Security, Social Services, Rehab Services, Mental Health Services, Respiratory Services.

Related Documents:

- 116-00-23 Hyperglycemia Management in the Diabetic Member

Definition:

- Hypoglycemia is best defined as a syndrome characterized by low plasma glucose (<70 mg/dl) and an associated group of symptoms that are relieved by the ingestion of food or carbohydrate.

Summary Information:

- Hypoglycemia is one of the most common short-term complications of diabetes treatment. The incidence of hypoglycemia rises substantially with age.
- Causes: inadequate CHO intake, increased activity, excess insulin or sulfonylureas, ethanol or drugs that lower blood glucose levels.
- Signs/symptoms: nausea, hunger, fatigue, drowsiness, irritability, vertigo, blurred vision, sweating, tachycardia, palpitations, shakiness, tingling in the extremities, numbness around the lips, slurred speech, dizziness, lethargy, confusion, poor concentration and poor coordination, hallucinations, generalized weakness, aggression, falling, seizures or coma. **In the frail elderly, neurological symptoms such as confusion or lethargy and falls may be more common than other signs.**
- Supplies:
  - Blood glucose meter 117-00-28
  - Food containing 15 grams of carbohydrate, including ½ cup fruit juice, ½ cup regular soda, or 1 cup of low fat/fat free milk
  - 1 tube of glucose gel
  - Glucagon 1mg

Policy:

- Early recognition and treatment of hypoglycemia shall be provided.
- The likelihood of recurrent or more severe hypoglycemia shall be reduced.
- To raise glucose without resulting in hyperglycemia.
- Security shall have a Blood Glucose Meter available in their emergency "jump" kit.
- If member is being held NPO for any reason 116-00-21 Management of NPO Status for Diabetics and hypoglycemia occurs, must follow the protocol for treating hypoglycemia and disregard NPO status unless specific orders are provided to manage that member.
- Re-evaluate member's individual care goals and goals of treatment. HBA1c goal may need to be revised to avoid risk of hypoglycemia.

Procedure:

Managing Hypoglycemia

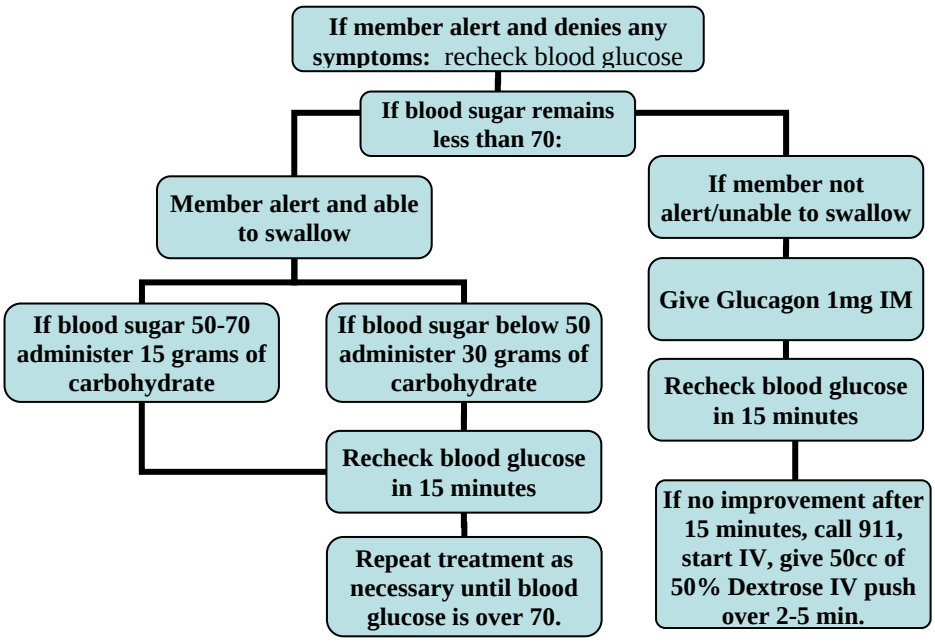
1. If concern for hypoglycemia occurs outside of the nursing unit, security should be called and will respond using the guidelines listed below.

Wisconsin Veterans Home at King

Hypoglycemia Protocol

Date of Origin: March 1994	No.: 116-00-20
Last Revision: July 5, 2016	Page 2 of 3
Last Review: July 5, 2016	Maintained By: Nursing

2. Nursing will utilize the following guidelines to manage hypoglycemia:
   A. Check blood glucose:
      1) **If less than 70 follow treatment tree below**:



      2) Monitor until signs and symptoms have disappeared and blood glucose is above 100.
      3) Document episode and blood glucose levels in EMR.
      4) Never force oral intake on a lethargic person.
      5) Place member on their side and monitor until completely alert.
         a. Glucagon may cause nausea.
      6) After glucagon, and when member is able to swallow safely, give 30 grams of carbohydrate such as 8 oz. fruit juice or 8 oz. regular soda.
      7) Once the member is alert and can tolerate oral intake, give a snack of protein and carbohydrates, unless a meal will be eaten within 30 minutes (e.g. 8 oz. milk, 1 cup yogurt, 1 cup Boost, 1 oz. cheese or 1 TBSP peanut butter and 4 crackers).
      8) Members unresponsive to IM interventions: call 911 and attempt to administer 50cc of 50% Dextrose intravenously. **Notify physician.**
3. Notify the physician of episode through monthly resume report.

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Hypoglycemia Protocol

Date of Origin: March 1994	No.: 116-00-20
Last Revision: July 5, 2016	Page 3 of 3
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A. **Notify physician immediately if member has had 2 or more low blood sugars requiring treatment in a 24 hour period or other concerning issues.**

Hypoglycemia Prevention Measures

1. Test blood sugars regularly and evaluate results frequently to find any patterns and possible causes.
2. Review the treatment plan when two to three episodes occur in a week.
3. Provide a consistent time for meals and the amount of carbohydrates.
4. Provide a bedtime snack for those with nighttime problems.
5. Provide some carbohydrates when the resident isn't able to eat as usual.
6. Educate the member and family about symptoms of low blood sugar and how to recognize/treat/report them.

Wisconsin Veterans Home at King

Management of NPO Status for Diabetics

Date of Origin: October 2013	No.: 116-00-21
Last Revision: July 5, 2016	Page 1 of 2
Last Review: July 5, 2016	Maintained By: Nursing

Applies To:

- Providers, Nursing staff

Policy:

- All diabetic members shall follow these guidelines during NPO status **unless other orders are provided by the provider.**

Procedure:

Members on Diabetes Medications (no insulin)

1. NPO for Procedures or Labs:
   A. Hold all diabetes medications during NPO status.
   B. If NPO > 8 hours, begin testing blood sugar every 4 hours. 117-00-28 Portable Blood Glucose Monitoring
   C. Begin correctional Novolog insulin every 4 hours based on scale below.
   D. If symptomatic hypoglycemia should occur while patient is to be NPO for procedure/lab, treatment must be completed based on hypoglycemia protocol and MD notified of NPO status failure.
2. NPO due to illness/nausea and vomiting or other situation:
   A. Hold all non-insulin diabetes medications until patient is eating normally. (Notify MD at scheduled visit of dates of protocol use).
   B. Test blood sugars every 4 hours.
   C. Use correctional insulin scheduled every 4 hours during fast based on scale below.
   D. Notify MD within 8 hours if: Blood sugar <80 (follow 115-00-34 hypoglycemia protocol) or >250 after 2 correction doses instituted.
   E. Resume normal diabetes medications and orders once meals have been re-established.
3. Correctional Insulin Scale for NPO status – Non-insulin using Members:
   A. Use only Novolog insulin
   B. Test blood sugars every 4 hours and as needed
   C. No insulin for blood sugars < 180.
   D. For blood sugar 181-230 give 1 unit
   E. For blood sugar 231-280 give 2 units
   F. For blood sugar 281-330 give 3 units
   G. For blood sugar 331-380 give 4 units
   H. For blood sugar 381-430 give 5 units
   I. For blood sugar > 430, call MD for orders

Members on Insulin Therapy

1. NPO for Procedures or Labs:
   A. Hold all diabetes non-insulin medications during NPO status.
   B. Give usual basal insulin dose.
   C. Hold all mealtime insulin during fast.
   D. Use correctional insulin scheduled every 4 hours during fast.
   E. Return to normal insulin and medication orders once meals have been started.

Wisconsin Veterans Home at King

Management of NPO Status for Diabetics

Date of Origin: October 2013	No.: 116-00-21
Last Revision: July 5, 2016	Page 2 of 2
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2. NPO due to illness/nausea, vomiting or other situation:
   A. Hold all diabetes non-insulin medications until patient is eating normally (notify MD at scheduled visit of dates of protocol use).
   B. Give basal insulin dose as usual.
   C. Give mealtime insulin based on proportion patient is eating or amount of carb consumed.
      1) 25% meal consumed, give 25% of prescribed mealtime dose.
      2) 50% consumed, give 50% of mealtime dose
      3) 75% consumed, give 75% of mealtime dose
   D. Use correctional insulin scheduled every 4 hours during fast.
   E. Notify MD within 8 hours if:
      1) Blood sugar <80 (follow hypoglycemia protocol P/P 115-00-34) or >250 after 2 correction doses implemented.
   F. Resume normal insulin, medication orders once meals have been re-established.

Wisconsin Veterans Home at King

Hyperglycemia Management in the Diabetic Member

Date of Origin: September 2013	No.: 116-00-23
Last Revision: July 5, 2016	Page 1 of 2
Last Review: July 5, 2016	Maintained By: Nursing

Applies To:

- Nursing, Dietary, Physicians/Providers, Diabetes Specialist

Summary Information:

- Hyperglycemia is defined as Blood Sugars (BS) above the recommended limit for an individual based upon their individualized treatment goal.
- Severe hyperglycemia is often described as a blood sugar **over 400 mg/dl.**
- Causes: Physical stress, illness, vomiting or diarrhea, infection, surgery, fever, emotional stress, too much food or overeating, other medications and poorly controlled diabetes or new onset diabetes.
- Examples of medications that may cause or increase risk of hyperglycemia are: Steroids (prednisone), thiazides, antipsychotics (Zyprexa), estrogen, thyroid hormones, phenytoin (Dilantin), calcium channel blockers (Norvasc) opiates (morphine), nicotinic acid (Niaspan), protease inhibitors (AIDS medicines), herbs such as Echinacea.
- Signs/symptoms: usually come on slowly over hours or days. Watch residents with cognitive impairment closely. A change in mental status or behavior may be related to high blood sugar.

  Symptoms may include:

  - Blurred vision
  - Lethargy (sluggish, drowsy)
  - Flushed dry skin
  - Signs of dehydration
  - Change in behavior or ability to think
  - Frequent urination
  - Vomiting
  - Incontinence
  - Weakness
  - Increased thirst
  - Weight loss
  - Falls
- A person with cognitive impairment is less able to remember, organize their thoughts or make decisions.

Policy:

- There shall be a standard for management of hyperglycemia in the diabetic member.
- Signs and symptoms of hyperglycemia and/or prevent complications shall be recognized.
- Blood sugar retesting 117-00-28 shall follow routine guidelines (before meals and 2 hours after meals or corrections) unless specific orders are received.

Procedure:

Managing Hyperglycemia

1. Check blood sugars. **Test blood sugars regularly to find any patterns and possible causes and update the clinician.**
   A. Test blood sugar before meals, at bedtime and as needed. Continue to check blood sugar before meals and at bedtime for at least 48 hours.

B. If blood sugars remain over 400 for more than 2 tests in a row, notify Primary Care Physician (PCP) or on-call MD.
C. Check vital signs (temperature, pulse and respiration, blood pressure).
D. Check food intake and output.

2. Encourage the member to drink sugar-free fluids or water whenever possible-approximately 6-8 ounces per hour.
3. If the Member is unable to eat and drink, watch more closely for risk of high blood sugars by testing more frequently. Report to PCP or on-call MD for any order changes for management of blood sugars or if medications should be changed.
4. If Member has orders for correction insulin, administer according to plan based on blood sugar result. If blood sugar is above outlined correction dosing: notify PCP or on-call MD for orders.
5. Avoid the risk of **stacking insulin** (which can lead to risk of hypoglycemia P/P 115-00-34) by avoiding administering additional **correction insulin** before at least 2 hours have passed since last correction dose, unless specific orders are given by the provider.
6. If resident has a change in condition, becomes sick or is suddenly unable to eat or drink, test their blood sugar and update the clinician.

Hyperglycemia Prevention Measures:

1. Nursing to test blood sugars as ordered 117-00-28 and prn as necessary. Notify RN of BS's out of normal range.
2. The RN should evaluate BS results weekly to find any patterns of concern and notify Provider.
3. RN/Diabetes Nurse Specialist to review the treatment plan when two to three episodes occur in a week. Discuss at care conference and with PCP as appropriate.
4. Dietary to provide a consistent time for meals and recommend/provide consistent amount of carbohydrates per meal. Provide on-going nutrition counseling to member as appropriate.
5. Nursing to educate the member and family about symptoms of high blood sugar and how to avoid/recognize/treat/report them.

Wisconsin Veterans Home at King

Vital Signs-Temperature, Pulse, Respirations and Blood Pressure

Date of Origin: June 1985	No.: 117-00-01
Last Revision: November 2015	Page 1 of 5
Last Review: November 2015	Maintained By: Nursing

Applies To:

- Physicians, APNPs, RNs, LPNs, CNAs

Related Documents:

- Clinical Nursing Skills & Techniques; Perry & Potter
- Assisting in Long-term Care; Hegner & Gerlach

Definitions:

- Vital Signs: Measurements of temperature, pulse, respiration, (TPR) and blood pressure (B/P).
- Orthostatic Vital Signs: Blood pressure and pulse taken in at least 2 positions. This is done to monitor for a drop in blood pressure that occurs when a member changes from a horizontal to a vertical position (orthostatic hypotension).
- Pulse Oximeter: A device used to determine oxygen levels in the bloodstream and monitor pulse.
- Normal ranges for vital signs:
    - Temperature: 96.6-98.8
    - Pulse: 60 – 100
    - Respirations: 16-24
    - Blood Pressure: 90-140/60-90
    - Orthostatic Vitals: Decrease in systolic blood pressure less than 20 mm Hg or more or diastolic blood pressure less than 10 mm Hg or more

Policy:

- **TPR** shall be obtained as follows:
    - New Admissions: Once per shift for 3 days.
    - Members returning from the hospital: BID for 3 days.
    - Members receiving antibiotics: BID for 3 days.
    - Members receiving IV therapy: BID for 3 days.
    - Members with a change of condition.
    - Members with elevated temperatures: Every 4 hours until below 99°F, then BID for 24 hours.
    - As directed by physician order.
    - At the discretion of a licensed nurse.
- Tympanic thermometers shall not be used on member currently having ear drops instilled or on members with ear infections.
- Temporal Artery Thermometry (TAT) scans shall not be used over scar tissue, open sores, or abrasions.
- Abnormal temperature, pulse, or respirations, as well as a newly irregular pulse shall be reported to the licensed nursing staff immediately.
- Rectal temperature shall be taken only by a RN.
- **Blood Pressure** shall be obtained as follows:
    - New Admissions: Daily for 3 days.
    - Upon return from the hospital. Daily for 3 days.

- Monthly, during the first 7 days of the month on bath day.
- After a member falls.
- Members with a change of condition
- As directed by physician order.
- At the discretion of a licensed nurse.

- The blood pressure required with dose increase or new medication orders shall be the licensed staff responsibility.
- Blood pressure orders shall be included on the profile sheets only when there is a specific MD written order for them.
- B/Ps shall be carried on the MAR if a medication requires monitoring that the B/P is taken in order to determine whether or not the medication will be given. The B/P shall be obtained by a licensed nurse.
  - Wrist blood pressure cuffs may only be used for this task by licensed nurse.
- CNA shall check a monthly blood pressure and pulse on the member on the member's bath day and document in the EMR.
  - Refer to Personalized Member Care (PMC) for member's blood pressure information.
- Abnormal blood pressures shall be reported to the licensed nurse immediately, unless specific parameters are specified in a physician order or nursing order. This includes:
  - Systolic less than 90 or greater than 140
  - Diastolic less than 60 or greater then 90
  - If Member has blood pressure reading out of normal range report to Nurse.
- Blood pressure readings with systolic below 90 or above 220 and/or a diastolic above 110 shall be reported to the physician immediately unless the physician has specified individual parameters in the physician order for that member.

Orthostatic Vitals:

- All orthostatic blood pressures shall have a pulse taken at the same time.
- Orthostatic BP shall be taken in at least 2 positions lying for at least 5 minutes, sitting and/or standing. Each reading is taken 1 to 3 minutes after the member changes position and is safely stable.
  - Always take the lowest position first.
- Orthostatic blood pressure shall be obtained as follows:
  - Upon admission
  - To assess for medication efficacy according to 11-07-25 Key Monitoring Requirements for Drug Requirements and 11-07-25B Drug Monitoring Requirements.
  - When the member's history and clinical symptoms indicate the need as part of a thorough assessment i.e. has a history of fainting, falling, postural dizziness, suspected depletion of blood volume or has a spinal cord injury.
  - Quarterly according to the MDS schedule (data needed for the fall assessment), unless contraindicated by the member's condition i.e. comatose or terminal.
  - As directed by physician order.
  - At the discretion of a licensed nurse.

Procedure:

1. Obtain the appropriate thermometer:

A. tympanic thermometer and disposable sheaths, (position sensitive toward the tympanic membrane in the ear)
B. temporal scanner, (infrared technology to detect the heat naturally emitting from the skin surface) scan along forehead and down behind ear.
C. electronic oral thermometer and disposable sheaths, (member needs to be 15 mins free from consuming hot or cold oral liquids and/or smoking.)
D. TempaDot® single-use thermometer.

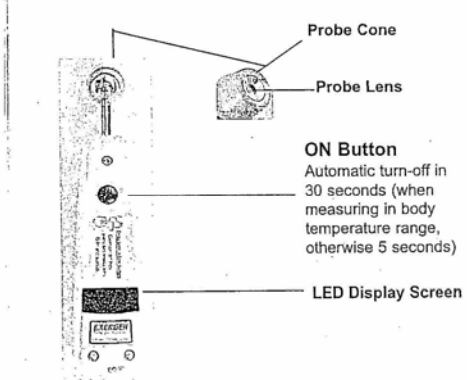
2. A member in isolation will have their temperature taken using the TempaDot® single-use thermometer, unless directed by a licensed nurse or physician.
3. When thermometer is taken into a member's room, the thermometer should not be placed directly on any surface unless a barrier (such as paper towel) is placed under it.
4. If a tympanic thermometer is used on a member with a hearing aid, the aid must be removed approximately 30 minutes prior to obtaining the tympanic temperature reading.
5. If a temporal scanner is used, make sure nothing is covering the area that needs scanning (forehead or behind the ear lobe).
   A. If the member is diaphoretic, has head trauma or has a bandage on their forehead, use the alternate area of behind the ear lobe. See last page of p/p for more information.
6. Explain procedure(s) to member.
7. Perform procedure according to "Assisting in Long-term Care" by Hegner & Gerlach.

If a rectal temperature is taken, use the electronic thermometer and change the probe. Insert the probe only 5/8 inch. This should be done by a RN.

8. Pulse may be counted for one full minute or for 30 seconds and multiplied by 2.
   A. Pulse may be obtained by using the Welch Allyn Spot Vital Signs machine.
   B. The pulse oximeter may be used for obtaining pulses. Portable Pulse Oximetry 118-00-49
   C. The temporal scanner has a 30 second timer device.
9. If the pulse is irregular it must be counted for one full minute.
10. Respirations may be counted for a full minute or for 30 seconds and multiplied by 2.
11. If the respirations are irregular, less than 12, or greater then 20, respirations must be counted for one full minute.
12. See step by step procedure for taking blood pressures in Assisting in Long-Term Care (section 6) by Hegner & Gerlach.
13. Licensed staff should compare B/Ps to the past readings and the member's clinical status.
    A. Any changes greater that 10mm shall be reported to the RN.
14. Obtain the right size B/P cuff for an accurate reading:
    A. Upper arm is the preferred location for taking B/P.
    B. Alternate B/P site must be care planned and obtained by trained Licensed Staff.
    C. The width of the cuff should be 40% of the circumference of the limb on which the cuff is to be used.
    D. The bladder enclosed with in the cuff should encircle at least 80% of the upper arm.
    E. Check with the Nurse before taking a BP if you are unsure of the proper extremity to use or which BP cuff to use.
    F. See common mistakes in B/P assessment Chapter 5 in Clinical Nursing Skills & Techniques; Perry & Potter

15. If necessary to recheck the blood pressure, wait 15-30 seconds before re-inflating the cuff.
16. Staff should not take the blood pressure on an extremity if any of the following are present unless it is unavoidable:
    A. An Intravenous infusion
    B. Impaired circulation
    C. Paralysis
    D. Hemodialysis shunt (Dialysis fistula)
    E. Edema
    F. Fracture or other trauma
    G. Surgical procedure
    H. Bulky dressings
    I. Burns
    J. Mastectomy history
    K. Pulse oximeter on a finger on that side
17. When obtaining orthostatic vital signs, if there is a decrease in systolic blood pressure of 20 mm Hg or more or a decrease in diastolic blood pressure of 10 mm Hg or more, it must be reported to the RN immediately.
18. When obtaining orthostatic blood pressures from the lying to standing positions, a member must be able to stand independently.
    A. For lying and sitting, it is preferred that the member sit on the edge of the bed.
    B. If they cannot sit independently, lying to sitting is taken in bed then adjusting the bed to a sitting position.
19. Document vital signs in EMR in the folder in which it applies. For example respiratory infection, digestive concerns, etc.
20. Clean thermometer as follows:
    A. Probe tip: If the lens on the probe tip becomes soiled, gently clean with lint free swab. Periodically wipe temperature probe clean with alcohol-dampened cloth, warm water or properly diluted disinfectant. Do not immerse probe. Use only isopropyl alcohol, not ethyl alcohol.
    B. All other parts: Clean with mild detergent and water. Never immerse in any type of fluid. (Do NOT use ethyl alcohol, detergents, or any fluid)
21. When “low battery” registers on the display, change battery. The thermometer automatically recalibrates.
22. To clean blood pressure cuff:
    A. Wipe with damp cloth or wash in warm water with soap. Before washing the blood pressure cuff, remove the tube fittings, close off tubes with plugs and place the hook and loop fasteners in the closed position. After washing, allow the blood pressure cuff to air dry before re-assembling.
    B. Wipe cable and pressure hose with a damp cloth moistened in a mild detergent solution. Do not immerse.
23. To clean the stethoscope:
    A. Clean the ear pieces with an alcohol pad.
    B. Clean the bell and diaphragm with a different alcohol pad.
    C. Wipe tubing with a damp soapy cloth followed by a damp clean cloth.

Product Map



Basics of Using the Temporal*Scanner*

Measure only the exposed side. Brush hair aside if covering the TA area.

Brush hair away if covering ear.

1. With probe flush on the center of forehead, depress red button, *keep depressed…*
2. Slowly slide probe midline across forehead to the hair line, *not down side of face.*
3. Lift probe from forehead and touch on the neck just behind the ear lobe.
4. Release the button, read, and record temperature.

Alternate sites when TA or BE are unavailable:

- Femoral artery: slowly slide the probe across groin.
- Lateral thoracic artery: slowly scan side-to-side in the area ~midway between the axilla and the nipple.
- Axilla: insert probe in apex of axilla for 2-3 seconds.

Questions? Please call us at 800-422-3006

7

Frequently Asked Questions

What is the Temporal*Scanner*?
The Temporal*Scanner* is an infrared thermometer designed for accurate, completely non-invasive temperature assessment by scanning the temporal artery (TA). *It is breakthrough technology.*

How does it work?
Temperature is measured by gently stroking the Temporal*Scanner* across the forehead, and includes a momentary touch of the probe to the neck area behind the ear lobe, to account for any cooling of the forehead as a result of diaphoresis. The patented arterial heat balance technology (AHB™) automatically measures the temperature of the skin surface over the artery and the ambient temperature. It samples these readings some 1000 times a second, ultimately recording the highest temperature measured (peak) during the course of the measurement. The Temporal*Scanner* emits nothing - it only senses the natural thermal radiation emitted from the skin.

How accurate is it?
It has been clinically proven in premier university hospitals to be more accurate than ear thermometry, and better tolerated than rectal thermometry. It is a superior method for patient and clinician alike.

What if the TA area has been traumatized by burns or lacerations, or is completely covered with dressings?
With head trauma, surgical or accidental, the temperature can be obtained from the alternative site behind the ear lobe. As with diaphoresis, the perfusion will be high in the presence of head trauma.

Why measure behind the ear lobe?
Sweat causes evaporative cooling of the skin on the forehead, and introduces the possibility of a false low temperature. Fortunately for the method, during diaphoresis the area on the head behind the ear lobe will always exhibit the high blood flow necessary for the arterial measurement.

Why not use only the area behind the ear lobe?
Since the arterial branch is deeper behind the ear lobe than at the temple, under normal conditions it is less accurate because of its variability. But under diaphoretic conditions, the blood flow behind the ear lobe is as high as at the TA, making it as accurate as the TA, *but only during diaphoresis or with head trauma as previously mentioned.*

What are the benefits of using temporal artery thermometry?
Besides the inherent accuracy of the method, TAT presents no risk of injury for patient or clinician, eliminates the need for disrobing or unbundling, and is suitable for all ages.

What is arterial temperature?
Arterial temperature is the same temperature as the blood flowing from the heart via the pulmonary artery. It is the best determinant of body temperature, and unaffected by the artifactual errors and time delays present with oral and rectal methods.

How does the Temporal*Scanner* compare to our old method?
Arterial temperature is close to rectal temperature, approximately 0.8°F (0.4°C) higher than oral temps. Expect larger differences at times, however, as the dynamics of thermoregulation favor the temporal artery method.

High readings?
Temperatures measured with Temporal*Scanner* may be higher than your current method, especially if you are used to oral or axillary temps. Oral and axillary temperatures can be misleadingly lowered due to patient activity such as mouth breathing, drinking, tachypnea, coughing, talking, etc, and periods of vasoconstriction during the fever process. Any or all of these conditions may even mask fevers that the Temporal*Scanner* will detect.

Low readings?
A patient's temperature measured with the Temporal*Scanner* is normally never appreciably lower than oral temperature. Lower temperatures are usually from scanning too fast, not keeping the button depressed, a dirty lens, or a sweaty forehead.

What else should I know?
False high readings:

- Measure only skin that is exposed to the environment. Any covering, hair, hat, bandages, etc, would prevent the heat from dissipating, causing the reading to be falsely high.

Frequently Asked Questions

Using the Temporal*Scanner*

Wisconsin Veterans Home at King

Wandering Members

Date of Origin: April 1988	No.: 124-00-04
Last Revision: July 2015	Page 1 of 2
Last Review: July 2015	Maintained By: Nursing and Administration

Applies To:

- All Wisconsin Veterans Home at King (WVH-K) staff.

Definitions:

- Wandering Member: A Member who is capable of being mobile and who is not accountable for his/her own safety/well-being when not in a supervised area.
- Elopement: A Member with diminished capacity or having been deemed at risk of eloping departs the WVH-K grounds or a safe area without authorization and/or any necessary supervision to do so. A member not deemed an elopement risk and with full mental capacity can only elope if they intend to elope.
- Unauthorized Departure: A Member without cognitive impairment and not deemed at risk of eloping departs WVH-K grounds or a safe area without notification and either misses a care opportunity or is absent for more than four hours. There is no intent to elope.

Policy:

- Staff shall report to the RN and DON/ADON, and nursing supervisor any member who appears confused and acting in a manner disregarding his/her own safety and well-being.
- Wandering behavior shall be evaluated/monitored/managed by implementing appropriate measures to keep the member safe.

Procedure:

Initial Identification of a Member as a Wanderer:

1. An Elopement Risk Assessment is completed in the EMR on all new admissions within 24 hours, then quarterly, annually, and with a change in condition.
2. Immediately following interdisciplinary team (IDT) consensus that a member is considered a wanderer OR, if a member scores as a risk for wandering/elopement per the Elopement Risk Assessment, the "Wanderers" information in Resident Information is completed by the RN.
   A. Open Resident Information, Select member, Select "Wanderers" from drop-down menu "Select Topic:" on upper right.
   B. The "Wanderer Information" must be completed within 8 hours of identifying a member as a wanderer. When completing this information be specific on habits, etc., and use lay person terminology so all staff can understand.
3. Implement appropriate safety interventions:
   A. Implement safety devices that may be appropriate, i.e. door alarm, floor mat, etc.
   B. Evaluate member using the Wandering Checklist.
   C. Implement 30 minute checks WDVA 4471, 1 hour checks WDVA 4472, or 1:1 monitoring as described in 105-00-24. WDVA 4621 is the 1:1 Monitoring Care Instructions form.
   D. Issue a Care Trak bracelet per 124-00-07_Care Trak Wandering Member Transmitter.
   E. Initiate the Member Freedom System 124-00-05.

F. Transfer to a secured unit per policy 124-00-08 Transfer of Members to the Legends on the Lake Community on Ainsworth Hall 1 or 2.
G. Initiate Incident Report, if indicated. See policy 124-00-43_Nursing Member Incident Reporting.

4. The charge nurse notifies the IDT, APNPs, and puts the member on the 24-hour report.
5. A care plan is developed and implemented to clearly evaluate the wandering activity or member's potential for elopement using specific approaches identifying:
   A. How often the member is to be checked and where information is documented.
      1) Documentation of periodic checks and 1:1 monitoring is done according to policy 105-00-24, 1:1 Monitoring.
   B. The person responsible for checks on the member.
   C. Other means of controlling the member's wandering, such as walks outside accompanied by staff, activity attendance, etc.
6. The IDT attempts to determine if there is a pattern and cause for the wandering/elopement attempts. Reviews Behavior Monitoring Record 105-00-25 if applicable. Once this has been identified, they are incorporated into the Care Plan.
7. The RN documents per 24-hour report regarding wandering/elopement attempts, action plans and effectiveness, changes in Plan of Care, etc. See policy 108-03-01 24 Hour Report.

Review/re-evaluation of a Wanderer:

8. Once the wandering is controlled or the elopement risk is minimized, review is done on a quarterly basis at care conferences, with a change of condition, and PRN.

Discontinuation of a Member as a Wanderer:

9. A member may be determined to be a non-wanderer or no longer an elopement risk following a change of condition or upon consensus of the IDT.
   A. Information/data from the unit staff should be obtained to reach this determination.
10. The RN makes necessary changes to the Care Plan, Resident Information, the 24-Hour report, and communicates this to appropriate staff.

Wisconsin Veterans Home at King

Nursing Member Incident Reporting

Date of Origin: December 1988	No.: 124-00-43
Last Revision: June 2015	Page 1 of 1
Last Review: June 2015	Maintained By: Nursing

Applies To:

- All Wisconsin Veterans Home-King (WVH-K) staff.

Related Documents:

- Member Grievances 01-01-38.
- Guidelines for Smoking in a WDVA Facility 01-00-41.
- Behavior Monitoring Record; 105-00-25

Definitions:

Incident – An occurrence which is out of the ordinary for a member or the routine operation of the WVH-K and is not abuse, neglect, missing property, or injury of unknown source 01-01-20. This may result in a specific injury, put someone or something at risk for injury or damage or be a disruption of routine operation at WVH-K (i.e., breaking or disregard of smoking or alcohol rules, falls, inappropriate behavior, elopement attempts, etc.).

Policy:

- Member incidents shall be documented in the appropriate folder in their EMR.
- Fall related incidents and other types of incidents shall all follow the same documentation procedure.

Procedure:

1. The person receiving reports from non-nursing personnel, security, and/or who witnesses or discovers an incident reports it immediately to licensed nursing staff on duty.
2. The licensed staff evaluates the member at the scene or when returned to the unit as circumstances allow. If the incident occurs outside of the nursing building, Security Staff may be the first on the scene to evaluate the member.
   A. Notifies the Physician of:
      1) Incidents with significant injury immediately.
      2) Incidents with minor or without injury within 24 hours, whenever possible notifies primary physician.
   B. Notify the Member's #1 Next of Kin (competent member agrees with notification) or Legal Representative of:
      1) Incidents with significant injury immediately.
      2) Incidents with minor or without injury within 24 hours.
   C. Places member on 24-Hour Report Board 108-03-01 for at least the initial and 2 consecutive shifts.
3. After assessment of the member is completed, the RN enters the information into the EMR, completes any further assessments (fall 105-00-16, elopement 105-00-23, etc.,), enters any nursing/physician orders and writes a note in the appropriate care plan evaluation. Follow up documentation is entered into EMR.
4. If an event involves Alcohol, the clicking on "Alcohol " button word in EMR documentation sends message to the AODA (Alcohol Other Drug Abuse) case manager and social workers regarding the event.
5. The member's building nursing supervisors receive and keep any documentation not maintained in the clinical record or EMR related to incidents.