# AGENCY ORIENTATION

## CLINICAL RESOURCES: ASSISTIVE NURSING PERSONNEL

**INSIDE THIS ISSUE:**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI Skin Integrity</td>
<td>2</td>
</tr>
<tr>
<td>Pressure Ulcer Prevention</td>
<td></td>
</tr>
<tr>
<td>Fall Prevention</td>
<td>3-4</td>
</tr>
<tr>
<td>One to One Sitters</td>
<td></td>
</tr>
<tr>
<td>Care for a Patient in Restraints</td>
<td></td>
</tr>
<tr>
<td>Venous Thromboembolism Prevention</td>
<td>5</td>
</tr>
<tr>
<td>Oral Hygiene</td>
<td></td>
</tr>
<tr>
<td>Intake &amp; Output (I &amp; O)</td>
<td>6</td>
</tr>
<tr>
<td>Mealtime Preparation</td>
<td></td>
</tr>
<tr>
<td>Nursing Assistant Skills</td>
<td>7</td>
</tr>
<tr>
<td>Delegation and teaming</td>
<td></td>
</tr>
<tr>
<td>Safe Patient Handling</td>
<td>8-9</td>
</tr>
<tr>
<td>Hovermatt/Zoom Cart/Ceiling Lifts</td>
<td></td>
</tr>
<tr>
<td>Resource List</td>
<td>10</td>
</tr>
</tbody>
</table>

Revised 4.2014
Nursing Sensitive Indicators

**CATHETER ASSOCIATED URINARY TRACT INFECTIONS (CAUTI)**

You may be asked to remove a foley catheter. The procedure is available in Lippincott Procedures on the infoNET.

It is important to deflate the balloon fully before attempting to remove the catheter. If the balloon ruptures, report it to the RN immediately.

Monitor and record the amount of urine voided after removal. Report to RN any concerns. Date and time the removal in the appropriate documentation.

Use a securement device to prevent movement and other complications when using a catheter.

**ROLE OF THE NURSING ASSISTANT**

During routine cares, it is important to look for redness and watch any skin condition changes. It is important to notify the RN immediately if changes are found.

Nursing assistants follow through with the skin care interventions implemented to treat and prevent skin breakdown. Understand the patient plan of care for skin.

Repositioning per the patient’s plan of care. The minimum standard is every 2 hours.

**PRESSURE POINTS**

- Heel
- Scrotum
- Elbow
- Shoulder blades
- Back of head
- Malleolus
- Knees
- Greater trochanter
- Hip
- Shoulder
- Ear
- Spine
- Breast
- Anus
- Nipple
- Cheek
- Nose
- Heel
- Ischial
- Sacrum
- Spine
- Supine position
- Prone position
- Fowler's position
- Sitting position

**“RED REPORT”**

Don’t FORGET!
Risk factors for falls

- Age - older than 65
- Gender - Women
- Race - White
- Previous history of falling
- Secondary diagnoses of: diabetes, stroke, depression, malnutrition, Parkinson’s, or other movement disorders
- Sensory perception problems
- Multiple medications
- Psychological factors; impulsivity, desire for independence beyond ability, impaired judgment

Ways we prevent falls

- Hourly rounding including
- Keep environment free of clutter
- Scheduled toileting—take at least every 3 hours
- Don’t leave them alone in bathroom
- Non skid slipper socks
- Communicate concerns with RN; fall risk assessed

Patient Falls - What do I do?
- Make sure patient is safe.
- Communicate with RN

Charge Nurse:
- Initiates post fall huddle

USE OF ONE TO ONE SITTERS see below:

One to one sitter is a delegated responsibility based on the RN assessment of patient safety.

Need to know reasons for 1 to 1 sitter:

- Fall prevention
- Elopement
- Suicide precaution

Expectations of the one to one sitter where the focus should be on the patient at ALL times.

- Provide a safe environment
- Provide cares within your scope of practice
- Must be able to SEE the patient at all times
- Do not eat or drink while in the room
- Intervene in event of an unsafe situation
- Stay awake! Ask the RN for direction if you are having

FALLS PREVENTION

Yellow means SLOW DOWN! Place on patients who are at a high risk for falling.

Tips for working with patients who are confused / have dementia

Best way to communicate with people with dementia is: TREAT WITH RESPECT!

Environmental stimuli
- Keep objects away from patient
- Use clock & calendars
- Bring in familiar items from home like picture, personal items
- Decrease noise & stimuli e.g. soft lighting

Communication & Approaches
- Give short explanations
- Speak quietly & slowly, short & simple words
- Be clear! Do not ask confusing questions
- Reorient as needed
- Do not personalize negative comments or outbursts

Falls Risk = Confusion or unsteady gait

Characteristics

- Patient may not understand consequences of behavior
- Understand what is appropriate to the current situation
- Be in control of their behavior
- Have their usual attention span

Patient may

- Be frightened or suspicious
- Have alteration in thought process
- Have problems with thought & comprehension
- Act impulsively, not comprehend consequences of action
- Wander
- Injure self or others
- Be anxious
- Be combative or argumentative

Confusion or unsteady gait
Philosophy: Patients have a right to be free from restraints of any form that are not necessary. A restraint will be used only when less restrictive interventions have been determined to be ineffective.

Monitoring for safety is critical! Review your patient’s plan of care and ask the RN for specific needs of the patient. Check adult patients at a minimum of every 2 hours.
VTE - VENOUS THROMBOEMBOLISM

DVT + PE = Venous thromboembolism (VTE)

What to watch and report:
- Calf/arm - pain, swelling, warmth, redness or discoloration
- Respiratory and Heart Rate
  - Respiratory Rate > 20, Heart Rate > 100, Complaints of central chest pain

Prevent VTE:
- Early Ambulation

Correct application of TEDs or SCD (Sequential Compression Device)

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ORAL HYGIENE

Oral care includes brushing, flossing and inspecting the mouth. Good oral hygiene removes soft plaque deposits and calculus from teeth, cleans and massages gums, reduces mouth odor by killing bacteria, and helps prevent infection.

Patient groups that are at risk for oral hygiene problems

- Dehydrated patients
- Patients with NG tubes, tracheal tubes, or oral airways
- Confused and combative patients
- Comatose patients
- Patients on ventilators
- Patients with dentures

Lippincott procedures online has information on ORAL CARE for all types of patients

Enter ORAL CARE in search to find more information on caring for patients that are unconscious.
Unbalance input and output can signal a problem such as:

- Dehydration
  - Low Urine Output
  - Constipation
  - Dry mucous membranes
- Kidney failure
  - Low Urine Output
  - Edema (Swelling)
- Infection
  - Urinary - frequent and small amounts
  - Gastro intestinal - loose stools
- Bowel obstruction
  - Abdominal distention
  - Firm abdomen

**INTAKE**
- Oral food and fluids
- IV fluids & blood products
- Tube feedings

**OUTPUT**
- Urine and stool
- Emesis
- Drains
- Perspiration

**What is normal?**
Fluid intake in a healthy person is usually a little more than the output due to fluid loss from perspiration and breathing that is not collectable.

Clear yellow urinary output report amount to RN

**MEALTIME PREPARATION**

Good nutrition is a staple to good care and the healing process for patients. Meeting patients nutritional needs include conducting meal time in a friendly, unhurried, calm and quiet manner.

PREPARE PATIENT FOR MEAL TIME PRIOR TO DELIVERY OF THE TRAY BY:

- Clear off bedside table, especially of reminders of treatments completed or yet to come and odorous items
- Offer toileting
- Offer a warm washcloth to wipe off face and hands
- Position for maximum comfort and independence
- Mouth care when necessary to remove unpleasant tastes
NA Skills

VITAL SIGNS

<table>
<thead>
<tr>
<th>Normal Range</th>
<th>Tell Nurse NOW if higher</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature</td>
<td>98.6</td>
<td>Retake if under 97.4</td>
</tr>
<tr>
<td>Pulse</td>
<td>60-100</td>
<td>Under 60</td>
</tr>
<tr>
<td>Respirations</td>
<td>16-22</td>
<td>Under 12</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>120/80</td>
<td>Under 90/50</td>
</tr>
</tbody>
</table>

Daily routines on the unit may include:

1. Vital signs and weights
2. Call lights and rounding
3. Meeting patient hygiene and mobility needs
4. Stocking and resupplying of patient rooms
5. Tasks as delegated and supervised by the RN

Be a team player

Remember that you are a part of the team delivering care to the patient.
Communicate often, ask question if not clear and be ready to learn.

DELEGATION Definition: “Transferring to a competent individual the authority to perform a specific nursing task in a specific situation.” The National Council of State Board of Nursing

**Five Rights of Delegation**
- Right Task
- Right Circumstances
- Right Person
- Right Direction/Communication
- Right Supervision
Safe Patient Handling

Equipment Use:

- Determine by patient’s level of mobility
- Task to be performed
- Provide clear, simple directions to patient for their assistance, when possible.
- Apply brakes firmly and properly.
- Use your legs to do the work, saves work on your back.
- Replace soiled or broken equipment and pieces immediately.

Purpose:

- Improve the quality of patient care and comfort with transfers
- Reduce physical stresses and injuries to staff related to manual lifting, handling, transferring and repositioning patients.
- Ensure devices and tools are available and used in patient care.

Ceiling Lifts for transfers and repositioning are available throughout the HealthEast facilities

Determine the correct sling size for the client and task.
Standard sling - up to 625 lbs.
Bariatric sling - up to 800 lbs.

2 staff required for transfer

Repositioning Sling for boosting and transferring to cart (flat sheet with loop handles)

Chair Sling for transfers (crisscross straps in front, between legs, shorter loops by head so patient is in reclined position).

Procedure:
1. Explain procedure to client.
2. Place sling under client, careful not to twist.
3. Position and lower ceiling lift over client.
4. Attach color coded loops to 4 point hook up. (Color codes correspond to different client positions).
5. Use remote to raise patient.
6. Position patient over chair/bed.
8. Disconnect straps from sling support hooks.

Emergency Troubleshooting Tips

Pull red cord and patient will lower.

Lift does not work: Check red emergency cord. Manually reset emergency cord by resetting into base
* Always dock when not in use for charging (white box on wall is power pack)

* Problems? Call Engineering or Occupational Health
**Hovermatt Air Transfer System**

Uses a bed of air to assist with transfer
Requires a 2 person minimum for use

Directions:
1. Explain procedure to patient.
2. Place Hovermatt under patient, feed symbol at the bottom.
3. Snap air supply in place on either side at bottom.
4. Close belts around patient loosely fitting around patient, (it will tighten as it inflates).
5. Turn on air by touching button on canister.
6. With staff on either side of matt, carefully move patient with one side guiding the movement across and the other lightly pulling toward self.
7. Once patient is in correct position, deflate mattress by pushing in button on canister once more.
8. Clean/disinfect after each patient use.

**TROUBLESHOOTING HOVERMATT USE:**
- Make sure that air supply is securely snapped in place.
- MRI / CT Compatible
- Never operate with less than 2 people

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**ZOOM Cart Motorized Stretcher**

**Prior to Use:**
1. Unplug cart and press and hold buttons on handles to confirm readiness. (Holds charge for 6 hours).
2. Engage DRIVE wheel and verify that switch is ON.

**For Use:**
1. Always make sure side rails are up, backrest engaged, and IV pole is secure prior to moving.
2. Cart is powered by your walk/pace. Maintain good control by anticipating corners, stopping a starting.

**After Use:** Make sure the zoom cart is plugged in for charging.

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**Risk factors related to staff injury:**
- Forceful exertion - amount of force used and how long it is sustained.
- Repetition - performing the same motion over and over again.
- Awkward postures - repeat bending, twisting, reaching, or holding.
## Clinical Resources

<table>
<thead>
<tr>
<th>RESOURCES</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance Hotline</td>
<td>232-5420</td>
</tr>
<tr>
<td>EMERGENCY - In-Hospital</td>
<td>232-1111</td>
</tr>
<tr>
<td>IS Help Desk</td>
<td>232-1227</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
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<tr>
<td>St. Joseph’s Hospital</td>
<td>232-3058 or 326-3253</td>
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<tr>
<td>Saint John’s Hospital</td>
<td>232-7097</td>
</tr>
<tr>
<td>Woodwinds Hospital</td>
<td>232-0023</td>
</tr>
<tr>
<td>Bethesda Hospital</td>
<td>232-2198</td>
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<tr>
<td>Injury Hotline</td>
<td>232-2939</td>
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<tr>
<td>Equipment Hotline</td>
<td>232-1070</td>
</tr>
</tbody>
</table>