



Samples* of Standards of Care (SOC)

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***To assist in developing your own facility's SOC**

Activities of Daily Living (ADL): p. 1-2
Behavior Related to Dementia: p. 3-5
Delirium: p. 6-7
Depression: p. 8-9
Falls: p.10-11
Nutrition/Hydration in the Elderly: p.12-14
Oral/Dental: p.15-16
Pain: p.17-19
Prevention of Skin Breakdown: p.20-22
Urinary Incontinence: p.23-24

Activities of Daily Living (ADL)

Definition: Task related to personal care such as personal hygiene, toileting, feeding, ambulating, bed mobility, transfer, walking in room and in the corridor, locomotion on and off the unit, and dressing.

Background: Dependence on others for ADL assistance can lead to feelings of helplessness, isolation, diminished self-worth, and loss of control over one's destiny.

Many residents might require lower levels of assistance if provided with appropriate devices and aids, assisted with segmenting tasks, or are given adequate time to complete the task while being provided graduated promoting and assistance.

Standard of Care Activities of Daily Living

1. Assess resident's skills in performing ADLs on admission, quarterly and as needed. PT – OT will complete assessments as per policy. Compare current and previous ADL assessment, noting improvement and decline and modify care plan as appropriate. Rehabilitation/Restorative programs be developed and implemented to enhance ADL independence and address potential decline.
2. Speech Therapy evaluation will be scheduled if deemed necessary by Medical Staff.
3. Care plan will be developed to enhance independent completion of ADL's as much as possible. Care plan will be developed based on resident goals/needs and will be communicated to the resident, family and care providers.
4. The resident will be encouraged to perform self care with ADL's at the level indicated on the care plan. (Ex. supervision, independent, limited assistance, etc.) If the resident shows change in level indicated on the care plan report to the nurse and rehabilitation staff.
5. Assure resident is positioned correctly to perform eating – see that he/she is positioned upright, not leaning or tilting; position with the head & neck supported as needed to encourage slightly forward head position and to prevent tipping sideways or back.
6. Always orient the resident to the location and types of items on their meal tray as appropriate
7. Encourage the resident to make choices (i.e. clothing, time for bathing, method of bathing, time to get up, etc.)
8. Resident will be up out of bed, dressed as per the resident's choice.
9. Assist the resident to keep clean, neat and well groomed including nail care and shaving.
10. Monitor resident's ability to maintain adequate nutrition related to ADL functionality. Document as per the facility's policy
11. Assure adequate intake each meal by providing assistance and adaptive utensils as needed.
12. If a decline or improvement is noted in the ADL status of the resident, determine if a significant change of condition assessment (MDS/CAA/Careplan) review is required.

CNA Considerations:

1. Resident will perform self care with ADLs at the level on the CNA care plan. If the resident shows a change in the ADL function the nurse and rehabilitation staff will be notified.
2. Encourage the resident to make choices related to their daily living – clothing, time to get up, time for a bath, type of bath, etc.
3. Resident will be OOB and dressed appropriately each day per the resident's choice.
4. Assist the resident to be clean, neat and well groomed including nail care and having. Finger and toe nails will be cut on shower days and as needed. Do not give nail care to residents with Diabetes – refer to nurse.
5. Assure adequate intake at each meal by encouraging, cueing, prompting and or feeding as needed. Notify nurse of changes in resident's normal intake.
6. If resident requires set up for meals: Position in an upright position, not leaning or tilting; Position with head & neck supported as needed to encourage slightly forward head position and to prevent tipping sideways or back.
7. Orient resident to location of items on tray as appropriate.
8. See that the meal is as close to waist level as possible. Make sure sensory devices and dentures are in place.
9. Document ADL support and performance as per the facility's policy

References

Resident Assessment Instrument User Manual Version 3.0 (2012). Med-Pass Heaton Resources. Miamisburg, OH.

Geriatric Nursing Resources for Care of Older Adults. (2008). Hartford Institute for Geriatric Nursing. <http://consultgerirn.org>

Behavior Related to Dementia

Dementia – characterized by a progressive impairment of cognitive function, personality, and behavior. Person with dementia experiences loss of memory, orientation, language skills, concentration and judgment. Advanced stages a person experiences behavior and personality changes such as aggressiveness, mood swings, wandering and confusion.

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| Common Risk Factors: | Impaired perception of reality | Decreased self-esteem |
| | Impaired frustration tolerance | Perceived threat to self |
| | Alteration in sleep/rest pattern | Overstimulation |
| | Anxiety | Impaired Coping Skills |
| | Physical Discomfort | Drug reaction |
| | Impaired self expression | Decreased sense of personal |
| | (verbal and nonverbal) | boundaries. |

Standard of Care Behavior

1. Assess cognitive factors that may contribute to development of behaviors. Document and care plan appropriately as per care plan.
 - Decreased ability to solve problems
 - Alteration in sensory and perceptual capacities
 - Impairment in judgment
 - Psychotic or delusional thought patterns
 - Impaired concentration or decreased response to redirection
2. Assess physical factors that may foster behaviors – physical discomfort – being wet or cold, sensory overload such as noise.
3. Assess emotional factors that can lead to behaviors; Document as per facility policy.
 - Inability to cope with frustrating situations
 - Expressions of low self esteem
 - Non-compliance with care plan
 - History of aggressive behaviors as means of coping with stress
4. Evaluate impact of medication regimen on behaviors in relation to contribution to agitation. Document observations.
5. Encourage resident involvement, allow time to process and respond.
6. Observe for potential triggers that produce or could potentially produce behavior issues.
7. Rule out delirium if new behaviors are observed (see standard for delirium)
8. Keep resident, staff and other safe. Separate from other residents as needed.
9. Educate resident related to appropriate social conduct with staff and peers as needed.
10. Approach resident calmly, unhurriedly, allowing him or her the time to process question or direction.
11. Reinforce positive statements.

12. Encourage and assist resident in mutual problem solving.
13. Monitor and document any concerns with resident's behavior, interventions used and effectiveness as per facility policy.
14. Review and assess past behavioral interventions, modify care plan utilizing interventions that have previously been successful.
15. Refer to mental health as needed.

Nonaggressive behaviors – wandering, pacing, restlessness or increased motor activity, climbing out of bed, changing clothes or disrobing, wringing hands.

1. Provide verbal feedback and initiate interpersonal approaches
2. Initiate measures such as validation, reorientation, reduced stimuli, and consistent schedules. Document specific behaviors, approaches used and effect on behavior. Attempt to determine triggers that caused behavior.
3. Complete documentation as per facility's policy.
4. Utilize slow, clear, soothing tones in speaking to the resident. Use brief comments, repeat if needed.
5. Use distractions.

Verbally aggressive behaviors – may include cursing, yelling, screaming, unintelligible or repetitious speech, threats or accusations.

1. Attempt verbal control; distraction, if possible allow for more personal space.
2. Acknowledge fear of loss of control; evaluate use of touch and hand holding.
3. If resident wanders or paces, consider need for visual supervision, especially if expressing desire to leave.
4. Provide divisional activity – folding towels handling beads, walking with resident.
5. Document behaviors, approaches used and effect on behavior. Attempt to determine triggers that caused behavior.
6. Complete documentation as per facility's policy.

Physically aggressive behavior – may include hitting, kicking, spitting or biting, throwing objects, pushing or pulling others or fighting.

1. Permit verbalization of feelings associated with agitation.
2. Offer acceptable alternatives to unacceptable behaviors – instead undressing in public – undress in own room; allow resident to select clothing
3. Provide reassurance, redirect, diversion, separate resident from others, assist in problem solving. If possible leave the room briefly, reproach.
4. Refer to appropriate mental health professionals as indicated

5. Document behaviors, approaches used and effect on behavior. Attempt to determine triggers that caused behavior.
6. Complete documentation as per facility's policy.

CNA Considerations:

1. Observe for triggers that produce or could potentially produce behavior issues.
2. Keep resident and others safe; Separate from other residents as needed.
3. Assess for unmet need – pain, hunger, toileting needs, cold/hot, etc. and attempt to address.
4. Address resident calmly, speak slowly, allowing the resident time to respond to one question or direction at a time.
5. If behavior is escalating during ADLs, reproach if possible at a later time; Keep resident and others safe.
6. Provide positive reinforcement, provide one simple direction at a time, break down task in small simple steps allowing the resident to complete if possible.
7. Provide a positive dining experience.
8. Document all behaviors as per facility policy and report to nurse.
9. Document all behaviors even if they occur daily. Do not minimize or rationalize behavior. If the behaviors occur document them.

References

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Geriatric Nursing Resources for Care of Older Adults. (2008). Hartford Institute for Geriatric Nursing. <http://consultgerirn.org>

Gulanick, M & Myers, J. (2011). *Nursing Care Plans – Diagnoses, Interventions and Outcomes*. 7th Edition. Elsevier Mosby, St. Louis, Missouri

Delirium

Definition: An acute disturbance of consciousness and a change in cognition that develops over a brief period.

- Common syndrome
- Can be reversible
- Is associated with increased mortality, increased hospital costs and long term cognitive and functional impairment
- Can be prevented with recognition of high risk residents and implementation of standard protocol
- Often under recognized

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| Risk Factors: | Advanced Age | Male Gender |
| | Dementia | Poor functional status |
| | Medical illness | Depression |
| | Multiple medications | Pain |
| | Alcohol abuse | Sensory Impairment |
| | Increased BUN/Creatinine ratio | |

Standard of Care

1. Assess vital signs (TPR & B/P) – compare with baseline and document.
2. Assess for change in baseline behavior and new onset of altered mental status. Utilize Brief Interview of Mental Status/CAM as assessment tool. Compare with previous scores.
3. Notify Medical staff to rule out potential reversible causes of delirium versus extension of existing diagnosis/condition.
4. Reversible causes may (not inclusive) include illness, infections, dehydration, medications, sensory loss, psychosocial issues, pain, and impaired mobility.
5. Notify responsible party as per Facility's policy related to communicating resident's status change. Update family on presenting symptoms and interventions ordered by Medical and effects on resident.
6. Modify care plan to address acute changes; if significant change in condition is identified as per RAI User manual, Interdisciplinary Team (IDT) will conduct a care plan meeting with family and/or responsible party.
7. Eliminate and/or minimize risk factors.
8. Assessments for falls, skin, elopement, pain, and mental status will be updated; Modify CNA care plans as needed.
9. Ensure adequate nutrition
10. Monitor intake and insure urinary and bowel output.
11. Communicate change in intake to Dietician.
12. Insure use of sensory aids as appropriate (glasses, hearing aids, etc.)

13. Foster orientation, reassurance – carefully explain all activities, communicate slowly, clearly and provide explanation.
14. Provide appropriate sensory stimulation – quiet room, utilize noise reduction techniques.
15. Facilitate rest/sleep – back massage, warm drinks (not caffeine) at bedtime, relaxation music or videos, avoid awakening.
16. Foster familiarity – utilize familiar objects from home, care giver consistency.
17. Maximize mobility – ambulation, active range of motion, etc.
18. Consider psychotropic medications as a last resort.
19. Reassure/educate family – encourage their involvement.

CNA Considerations

1. Notify nurse of any change in mental status or change in resident's usual behavior. Collect vital signs as directed – report and document.
2. Check CNA care plan for any changes related to current status.
3. Provide verbal reminders/reality orientation/validation during care.
4. Report to nurse any significant changes in intake or output.
5. Notify nurse of any observed behaviors and document as per Facility's policy.
6. Maintain a safe environment;
7. Place resident in quiet, low stress environment with frequent
8. Checks. Utilize relaxation music and or videos.
9. Provide ROM, transfer, ambulation, exercise program as per the care plan. Record and document program as per facility's policy.
10. Insure sensory aids are in place.
11. Break tasks into smaller tasks – do one step at a time.
12. Keep environment quiet, well lit and place familiar objects in sight.
13. Communicate clearly and slowly.

References

Lippincott Manual of Nursing Practice. (2010). Wolters Kluwer Health/ Lippincott, Williams & Wilkins. Ambler, PA.

Resident Assessment Instrument User Manual Version 3.0 (2012). Med-Pass Heaton Resources. Miamisburg, OH.

Geriatric Nursing Resources for Care of Older Adults. (2008). Hartford Institute for Geriatric Nursing. <http://consultgerirn.org>.

Waszynski, C. (2007). How to try this: detecting delirium. *American Journal of Nursing*. 107(12). Pp 50-59.

Depression

Background: Highly prevalent in nursing home residents; Not a natural part of aging; Consequences of depression – amplification of pain and disability; delayed recovery from surgery or illness; worsening of drug side effects; cognitive impairment; subnutrition, increased suicide potential and nonsuicide related death. Tends to be long lasting and recurrent;

Risk Factors:

- Current Alcohol/substance abuse problem
- Medical comorbidity – dementia, CVA, cancer, arthritis, hip fracture, MI, COPD and Parkinson's disease.
- Functional disability – especially new loss, new medical diagnosis, poor health status, older age.
- Social isolation/absence of social support
- Psychosocial causes – cognitive distortions, stressful life events, chronic stress

Standard of Care Depression

1. Assess residents using a standardized depression screening tool such as PHQ9 Resident Mood Interview on admission, at least quarterly and as needed. Compare previous results and determine improvement or worsening of depression. Document results as per facility's policy.
2. Review medical history and physical/neurological examinations.
3. Assess for depressogenic medications such as– narcotics, steroids, antihypertensives, benzodiazepines, beta-blockers, antipsychotics, etc.
4. Assess for related systematic and metabolic processes potentially contributing to depression such as infections, anemia, hypo or hyperthyroidism, hyponatremia, hypocalcemia, hypoglycemia, CHF, kidney failure.
5. Assess for cognitive dysfunction
6. Assess level of functional ability.
7. Provide an individualized care plan to address depression; Communicate plan to all care providers and family.
8. Initiate safety precautions for suicide risk as per the facility policy; Notify Medical and Social Work staff. Refer to appropriate mental health person.
9. Treat metabolic/systemic disturbances.
10. Monitor and promote nutrition, elimination, sleep/rest patterns, physical comfort.
11. Review medications – revised as needed.
12. Enhance physical function – encourage participation in exercise programs, activities, rehabilitation and restorative programs. Develop a consistent daily schedule. Provide copies of facility activity schedule.
13. Maximize autonomy, personal control and self efficacy – includes resident's participation in making daily schedules, involvement in goal planning and care planning. Provide
14. Identify and reinforce strengths and capabilities with the resident.

15. Structure and encourage daily participation in relaxation and other therapies
16. Provide emotional support – listening, expression of feelings, hope instillation, coping, encourage pleasant reminiscences, support adaptive coping.
17. Educate resident/family regarding depression, treatment and the importance of adherence to prescribe treatment regimen.
18. Observe and document for changes in mood; address and resolve if possible. Report any changes to nurse. Document as per facility policy. Modify care plans as needed.
19. Encourage socialization. Encourage the resident to ask questions and allow time to discuss feelings.
20. Instruct staff to maintain consistent approach when dealing with the resident.
21. Utilize familiar items in resident room to assist with identification and comfort.
22. Monitor and document any concerns with resident's mood, interventions used, their effectiveness as per the facility policy.
23. Encourage the resident to eat in the dining room to promote socialization.

CNA Considerations:

1. Introduce self to the resident.
2. Introduce resident to others and encourage relationship building.
3. Encourage socialization; Encourage the resident to ask questions and allow time to discuss feelings.
4. Utilize familiar items in resident room to assist with identification and comfort.
5. Encourage resident to eat meals in dining room to promote socialization.
6. Check activities calendar and daily program offerings. Allow resident the opportunity to attend activities of their choice.
7. Provide 1:1 visits with recreation if resident prefers.
8. Attempt to determine resident's mood changes, report to nurse, resolve if possible.
9. Observe for and document all mood changes as per policy; Notify nurse.
10. Immediately notify nurse if resident is expressing thoughts that they would be better off dead or having self harming thoughts. Maintain observation of the resident; Document as per facility's policy

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FALLS

Definition: Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface. May be witnessed, reported by the resident or observer or identified with a resident is found on the floor or ground. (includes an intercepted fall in which the resident would have fallen if they had not been caught by another person).

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| Risk Factors: | History of Falls | Wheelchair use |
| | 65 years of age or + | Female (if older) |
| | Use of assistive device for mobility | Presence of acute illness |
| | Orthostatic Hypotension | Visual/hearing difficulties |
| | Incontinence | Impaired mobility |
| | Diminished mental status | Multiple medications |
| | Cluttered environment | Poor lighting |
| | Difficulty with gait | Impaired imbalance |
| | Neuropathy | Sleeplessness |
| | Decreased lower extremity strength | Uneven/slippery surfaces |
| | Inappropriate footwear | |

Standard of Care Safety/Prevention of Falls

1. Assess the resident care environment routinely for potential hazards (spills, clutter, lights out, loose safety bars, etc.) Take appropriate corrective action.
2. Assess resident for risk for falls utilizing standardized fall risk tool such as the Morse Fall Scale on admission and as indicated; communicate findings to staff, document results.
3. Educate resident and family identified risk factors and prevention measures.
4. Educate resident on how to summons help by using the call bell and assure the resident has the skill and understanding on how the bell works. Use specialty bells as needed.
5. Keep call light within resident's reach.
6. Assure resident has foot wear that is well-fitting, sturdy with non-slip soles.
7. Monitor for side effects of medications or potential interactions that may increase the risk of falls.
8. Encourage routine mobility – walking, exercise, falls programs, range to promote and maintain resident's current level of strength and balance.
9. Encourage appropriate use of mobility assistive devices/aids issued for the resident.
10. Referrals to PT – OT therapy as indicated for evaluation and recommendations for appropriation interventions and/or programs as per facility policy.
11. Assess resident's functional status on admission and as needed.
12. Follow the recommendations for transfer and ambulation status as per PT – OT – Nursing recommendations.
13. Monitor during activities/programs.
14. Assure staff awareness of resident's safety needs.
15. Assure initiation of safety precautions such as low bed with fall mattress, alarms, nursing observations, scheduled toileting, etc.
16. Identify residents at risk for falls and interventions – insure documentation on CAN care plan.

17. Avoid use of physical restraints.

Following Resident's Fall:

- Assess/monitor for injury, monitor vital signs, level of consciousness, neurological checks and functional status per facility protocol. Determine need for further diagnostic testing, clinical monitoring, etc.
- Assess for cause of fall – intrinsic and extrinsic causes.
- Document fall and fall investigation as per facility policy; modify care plan as needed.
- Assess pain post fall.
- Assess psychological effects of fall – fear of falling and impact on mobility.

CNA Considerations:

1. Keep resident's environment free of potential fall hazards – clutter, spills, tripping hazards, poor lighting, etc.
2. Keep call light in resident's reach.
3. Keep bed locked.
4. Assure foot wear is well fitting, sturdy and has non-slip soles.
5. Follow recommendations for transfer, positioning, ambulation status as per the CNA care plan. Report to charge nurse any problems/issues observed.
6. Follow recommendations for safety devices – low bed, floor mats, alarms, etc as per CNA care plan. Place walkers and wheelchairs as directed by care plan.
7. Provide ROM, ambulation, transfer programs as per the care plan. Record and document program as per facility's policy.
8. Toilet resident as per the scheduled program.
9. Communicate any problems with facility equipment such as lifts, rails, brakes (wheelchair and bed) etc.
10. If resident is found on floor or assisted to floor – advise nurse. DO NOT MOVE resident until assessed by RN.
11. Following assessment after fall, utilize RN direction to move the resident.
12. Monitor and report any pain or discomfort post fall.

References

Lippincott Manual of Nursing Practice. (2010). Wolters Kluwer Health/ Lippincott, Williams & Wilkins. Ambler, PA.

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Nutrition/Hydration in the Elderly

Definitions:

Hydration Management –promotion of adequate fluid balance that prevents complications resulting from abnormal or undesired fluid levels.

Malnutrition: Any disorder of nutritional status, including disorders resulting from a deficiency of nutrient intake, impaired nutrient metabolism or over nutrition.

Protein-energy under-nutrition: Presence of clinical (i.e. signs of wasting, low BMI) and biochemical (i.e. low albumin or other serum protein) evidence of insufficient intake.

Risk Factors: **Dietary Intake** – decreased appetite, problems eating/swallowing, eating inadequate servings of nutrients, eating fewer than two meals/day.

Isolation – loss of spouse, loneliness

Chronic illness – depression, poor oral health, dry mouth due to medication side effects, inability to ingest foods or independently eat, inability to focus.

Physiological changes – change in taste due to medications, nutrient deficiencies or tastebud atrophy, decrease in lean body mass and redistribution of fat leads to decreased caloric requirements

Standard of Care Nutrition/Hydration

1. Interview and assess resident/family for diet history, food preferences, food allergies, meal/hydration customary routines, alcohol use, past medical/surgical history and comorbidities. Review medications – identify any potential drug-nutrient interactions.
2. Complete nutritional assessment and document upon admission, with quarterly review and as needed with condition change.
3. Monitor intake via observation at meals and documentation in medical record. Encourage resident to complete meal including food and fluids. Adjust meal plans as needed. Record meal/fluid consumption as per facility's policy.
4. Obtain admission weight, and then weigh weekly the first 4 weeks following. Establish weight schedule as per the IDT.
5. Obtain height on admission then annually.
6. Monitor the resident for swallowing/chewing difficulties including mouth pain, ill fitting dentures, coughing, etc.
7. Ensure resident has sensory devices in place at meals; dentures are in place and secure.

8. Refer to Speech Pathologist, Dentist or other consultants as indicated. PT-OT provide adaptive equipment/utensils; develop programs to enhance mobility and independent functioning to promote appetite increase and functional independence.
9. Complete ordered laboratory tests to monitor nutritional status – modify care as needed.
10. Provide required diet as recommended by Dietician; ordered by Medical.
11. Nurses and CNAs will monitor and accurately document food and fluid intake as per facility's policy. Encourage family involvement at meal time, bringing favorite foods from home.
12. Nurse Manager/RN supervisors will monitor resident's 24 hour fluid intake report and modify care as needed; communicate decreased intake to Nutrition/Medical.
13. Report and document resident refusal to eat, decline in intake and hydration. Modify care plan, Communicate to Nutrition/Medical.
14. Monitor for signs and symptoms of dehydration, foods causing G-I distress.
15. Monitor for signs and symptoms of Hyper or Hypoglycemia when indicated.
16. Encourage intake. Alert Nutrition staff when pattern of intake changes.
17. Honor food/fluid preferences. Offer alternative choices if meals refused.
18. Provide nutritional supplements and snacks as needed.
19. Monitor for tolerance to diet – adjust as needed.
20. Modify resident's diet consistency following order from medical staff.
21. Provide adequate nutrition to meet estimated needs.
22. Provide a conducive environment for meals – encourage residents sitting in dining chairs, utilizing napkins, colorful table settings, proper positioning, etc.
23. Assist residents with eating as per their plan of care – if feeding sit with the resident at eye level and make eye contact during feeding.
24. Do not interrupt resident for non-urgent procedures or clinical rounds during meals.
25. Utilize nutritional supplements/snacks between meals but not within an hour preceding a meal and at bedtime.

CNA Considerations:

1. Encourage adequate intake each meal. Record all fluid and meal intake as per facility's policy.
2. Assist residents as needed. Report changes in ability to eat/swallow to nurse.
3. Report any hoarding, stealing from other residents, throwing foods, or eating of non food items.
4. Offer alternatives if meal is refused.
5. Call nurse to evaluate any pocketing (holding food in mouth for an extended period of time) or swallowing difficulties.
6. Check care plan, if resident wears sensory devices and dentures – ensure they are in place.

7. Weigh resident on admission and weekly for 4 weeks. Follow weighing schedule as documented on CNA care plan. Utilize same scale, consistent process each time weight is taken. Document as per the facility's policy.
8. Obtain height on admission and then annually. Document as per facility's policy.
9. Administer nourishments as scheduled and document as per the facility's policy.
10. Offer water/fluids on all shifts as per the facility's policy. Beware of residents on fluid restrictions and altered consistencies such as thickened fluids. (Nectar, Pudding or Honey thickened). Document fluid consumption as per facility's policy.
11. Observe and report to nurse any signs and symptoms of dehydration, decreased intake and output, and any issues/problems related to eating or drinking. Document as per policy.
12. Promote independent skills in eating/drinking – provide adaptive utensils, allow time to eat, cuing, etc. Develop restorative programs to re-teach independent skills.
13. Ensure residents are provided with napkins, condiments as desired, and the environment is pleasant for meal consumption.

References

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Oral/Dental

Oral Hygiene Background:

Directly linked with systemic infection, CVA, cardiac disease, acute MI, glucose control in diabetes, nutritional intake, comfort, ability to speak, and a resident's self esteem and overall well being.

Definitions: Oral – refers to mouth (natural teeth, gingival and supporting tissue, hard and soft palate, mucosal lining of the mouth and throat, tongue, salivary glands, chewing muscles, upper and lower jaw, lips).

Oral Cavity – includes cheeks, hard and soft palate.

Oral hygiene – prevention of plaque related disease; destruction of plaque through mechanical action of tooth brushing and flossing or use of other oral hygiene aides.

Standard of Care Oral/Dental Care

1. Conduct an assessment/evaluation of oral cavity on admission, quarterly and as indicated.
2. Assess condition of:
 - Oral cavity – lips, oral mucosa and tongue; should be pink, moist and intact.
 - Absence or presence of natural teeth and/or dentures; Natural teeth should be intact; dentures should fit comfortably, should not move while person speaks.
 - Ability to function with or without teeth or dentures.
 - Resident's ability to speak, chew and swallow.
 - Look for abnormal findings such as dryness, swelling, sores, ulcers, bleeding, white patches, broken or decayed teeth, halitosis, difficulty swallowing, signs of aspiration and pain.
3. Document assessment and develop a care plan to address abnormal findings. Document as per facility's policy.
4. Refer to Medical, Dental, Speech Therapist and other specialists as indicated.
5. Develop an oral hygiene plan of care. Document the plan and communicate to resident, family and care givers.
6. Encourage resident self care with oral hygiene if possible.
7. Provide oral care at least twice per day and when additionally needed.
8. Remove dentures morning and night, clean with toothpaste. Brush the residents tongue; Rinse off and reinsert dentures as per the resident.
9. Monitor for any difficulty with chewing related to poor dentition and modify diet consistency as needed.
10. Ensure annual dental examination and as needed.

CNA Considerations:

1. Check CNA care plan follow the oral hygiene care plan, to determine if resident has dentures, or any mouth/swallowing problems.
2. Provide mouth care as per the CNA care plan – encourage resident assisting with process.

3. Store resident dentures in appropriately labeled containers in water.
4. Check meal trays before discarding to assure dentures are not on tray.
5. Brush teeth minimally two times per day, assist resident with flossing as needed.
6. Report any dental concerns, complaint of pain, etc. to nurse and document as per facility's policy.

References

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PAIN

Definition: Unpleasant sensory and emotional experience and is “whatever the person experiencing pain says it is”. Is highly subjective. Pain may be a symptom of injury or illness but al well may arise from emotional, psychological, cultural or spiritual distress. Approximately 85% of nursing home residents experience pain.

- **Acute** – pain results from injury, surgery or tissue damage. Usually time-limited and subsides with healing.
- **Persistent** – continues for a prolonged period (usually 3 – 6 months) May or may not be associated with a diagnosable disease process. Often associated with functional loss, mood and behavior changes and reduced quality of life.
- **Nociceptive pain** – caused by stimulation of specific peripheral or visceral pain receptors. Results from disease process (osteoarthritis), soft tissue injury (falls) and medical treatments (surgery, venipuncture, etc.) Generally localized and responsive to treatment.
- **Neuropathic** – Caused by damage to the peripheral or central nervous system. Associated with diabetic neuropathies, post-herpetic and trigeminal neuralgias, stroke and chemotherapy. Generally more diffuse and less responsive to analgesic medications.

Standard of Care Pain and Comfort Management

1. Determine contributing factors related to pain by conducting a pain interview with resident, review of medical history, physical exam, diagnostic information, etc.;
2. Assess resident present pain including intensity, character, frequency, pattern, location duration and precipitating and relieving factors. Utilize a standardize pain assessment tool such as 0-10 Numerical Descriptive Pain Intensity scale or Wong-Baker Faces pain scale. Document results as per facility’s pain assessment policy. Utilize consistent pain scale tool.
3. Review previous and current medications with resident/family – include prescription, over the counter drugs and home remedies used. Determine pain control methods that have been effective. Assess residents attitude and beliefs related to pain, use of pain medication and non-pharmacological treatments.
4. Assess pain frequently and regularly- at least every 4 hours. Respond immediately to complaints of pain.
5. Monitor pain intensity after administering medications to evaluate effectiveness.
6. Observe resident for nonverbal and behavior signs of pain – facial grimacing, withdrawal, guarding, rubbing, limping, shifting of position, aggression, agitation, depression, vocalizations and crying. Observe for changes in behavior. Obtain input from family

regarding verbal and nonverbal/behavior pain expressions, particularly in those with dementia.

7. Anticipate and aggressively treat for pain before, during and after painful diagnostic or therapeutic treatments (wound care, therapy session, restorative programs, etc). Educate resident and family.
8. Educate resident and family on medications, benefits, adverse effects. Educate on the need to take medications regularly and to avoid allowing pain to escalate.
9. Monitor medication closely – avoid under or over medicating;
10. Administer pain medications on a regular basis to maintain therapeutic levels, avoid PRN medications.
11. Clearly document the pain care plan to maintain consistency across shifts and with all care providers.
12. Provide nonpharmacologic pain treatment strategies such as relaxation therapy, guided imagery, breathing exercises, distraction, heat, cold, message, position change, therapeutic activities, etc. Combination of both pharmacological and nonpharmacological pain treatment are generally most effective. Document effects of all treatment for pain management.
13. Provide rest periods to facilitate comfort, sleep and relaxation.
14. Monitor resident during activities and or programs for signs of pain and discomfort.
Report pain to nurse.
15. Coordinate pain medication schedules prior to PT-OT, Restorative nursing programs, Therapeutic recreations, etc. to enhance resident's involvement and comfort.
16. Monitor, report and document side effects of pain medications such as sedation, confusion, constipation, loss of appetite, nausea, etc.
17. Ensure pain management care plan is communicated to the resident, family and care providers.

CNA Considerations:

1. Observe, report to nurse, and document resident's complaint's of pain as soon as possible.
2. Observe and report to nurse non-verbal signs of pain such as facial grimacing, rubbing, guarding, etc. as soon as possible. Changes in behavior such as aggression, irritability, crying, vocalizations, sleep disturbances, restlessness, decreased appetite, etc. all could be pain related – if observed – report.
3. Allow the resident to move at his or her own speed or pace.
4. Follow recommendations for position as per the CNA care plan to enhance comfort.
5. Maintain a quiet, calm, relaxing environment for resident's experiencing pain.
6. Encourage rest periods to facilitate comfort – provide relaxation music, diversion, breathing exercises etc. to aid in comfort as per the resident's care plan.

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Prevention of Skin Breakdown

Definition: Nursing interventions designed to prevent pressures ulcers for residents identified as at risk for developing them.

| | | |
|----------------------|--|---|
| Risk Factors: | Immobility Incontinence Friction Shear Chronic Disease state Impaired circulation Edema, anemia, hypoxia, or hypotension History of prior ulcer | Decreased mental status Exposure to moisture Device related pressure Inactivity Impaired sensation Pronounced bony prominences |
|----------------------|--|---|

Standard of Care Prevention of Skin Breakdown

1. Use a valid, reliable, and standardized and age appropriate method of skin assessment such as the Braden Scale to identify risk factors.
2. Document risk assessment subscale scores and total scores; implement a risk based prevention plan.
3. Assess skin on admission, weekly for four weeks, then quarterly and whenever the resident's condition changes.
4. Identify all individual risk factors to guide specific preventative treatments. Modify care based on identified risk factors.
5. Inspect skin minimally on a weekly basis, document as per the facility's policy.
6. Monitor skin condition with daily care and with each episode of incontinence.
7. Individualize bathing frequency – use mild cleansing agent; Avoid hot water and excessive rubbing.
8. Moisturize skin after bathing.
9. Cleanse skin after episodes of incontinence – use topical barrier to protect the skin.
10. If indicated utilize briefs and/or under pads that are absorbent and provide a quick drying surface to the skin.
11. Identify and correct factors compromising protein/calorie intake consistent with overall goals of care/advanced directives.
12. Monitor intake and provide nutritional supplements as recommended by Dietician/ordered by Medical such as multivitamins, Vitamin C, zinc, etc.
13. Request albumin levels as needed.
14. Offer hydration as appropriate; encourage meal/snack/fluid completion.
15. Encourage early mobility – ROM, ambulation, transfer and positioning programs.
Encourage resident to shift weight. Teach residents who are able to shift weight every 15 minutes.

16. Reposition bed bound persons at least every two hours and chair bound persons every hour consistent with overall care goals.
17. Place at risk residents on pressure redistributing mattress and chair cushion surfaces.
18. Utilize lifting devices (trapeze, slide sheets, bed linens) to move persons during transfers and position changes.
19. Utilize pillows or foam wedges to keep bony prominences from direct contact with each other.
20. Eliminate pressure on heels.
21. Avoid positioning directly on trochanter when side lying positioning; maintain the head at lowest degree of elevation consistent with resident's medical condition.
22. Initiate a rehabilitation or restorative nursing program to maintain or improve mobility/activity status.
23. Educate the resident/family on pressure ulcer prevention, risk factor management and interventions.
24. Medical consultations as needed.

CNA Considerations:

1. Monitor skin daily with care and with each episode of incontinence/toileting.
2. Apply barrier cream following each incontinent episode as per the facility's policy.
3. Keep skin clean, dry, and well moisturized as per facility policy.
4. Encourage meal/snack/fluid completion. Report and document decline in intake.
5. Turn and position every two hours or per the residents individual schedule. Ambulate or reposition as scheduled/as needed.
6. Notify nurse and chart any new skin issues as per facility's policy.
7. Follow the recommendations for position as per the CNA care plan.
8. Use lifting devices (slide sheets, linens, trapeze) to move persons during transfers or positioning.
9. Utilize positioning devices as recommended by PT – OT.

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Urinary Incontinence

Definition: Involuntary loss of urine sufficient to dampen undergarments, brief or pad, during day or night time. Can be transient (acute) or established (chronic).

Types: **Stress-** involuntary loss of urine associated with activities that increase intra-abdominal pressure (coughing, laughing, sneezing).

Related Factors: Multiple vaginal deliveries, Diabetic Neuropathy, Obesity, Aging, Menopause

Urge- involuntary urine loss associated with strong desire to void (urgency).

Related Factors: Caffeine intake, Diuretic use, CVA, Alcohol intake, Parkinson's disease, Infections, Multiple Sclerosis

Overflow- involuntary loss of urine associated with over distention of the bladder and may be caused by under active detrusor muscle or outlet obstruction leading to over distention of the bladder and overflow of urine.

Related Factors: Bladder outlet obstruction, fecal impaction, severe pelvic prolapsed, side effects of anticholinergic meds, side effects of calcium channel blockers, side effects of decongestant meds, and urethral obstruction.

Functional – person able to recognize the urge to void – barriers in the environment – resident unable to toilet independently (ex. need assistance to walk to the toilet).

Related Factors: limited physical mobility and altered environmental factors.

Standard of Care Urinary Incontinence

1. Assess the resident for presence and/or absence of urinary incontinence on admission and as needed. Follow facility's protocol for documentation.
2. Investigate whether incontinence is transient or established. Develop and document possible etiologies of urinary incontinence.
3. Referral to G-U specialist as needed.
4. Discuss with resident/family strategies for successful management of incontinence.
5. Develop an individualized plan of care utilizing urinary assessment, voiding pattern, etc. and communicate program to resident/family and care providers for consistent implementation. Utilize toileting schedule or bladder training as indicated.
6. Utilize treatments, exercise programs, etc to plan care for specific types of incontinence.

7. Avoid medications that contribute to incontinence if possible.
8. Limit dietary bladder irritants – ex. caffeine.
9. Monitor fluid intake and maintain an appropriate hydration schedule.
10. Modify the environment to facilitate continence.
11. Keep resident clean and dry, observing skin for changes such as reddened areas with each incontinent/toileting episode.
12. Barrier creams to be used on all incontinent resident's as per facility's protocol.
13. Develop Rehabilitative and or Restorative programs to enhance resident's mobility, to foster continence and to learn to independently manage incontinence.
14. Encourage resident to utilize clothing that can be easily removed for toileting.
15. Provide appropriate incontinence products to maximize resident's independence in managing episodes of incontinence (stress pads, liners, pull ups, briefs). Develop restorative programs to teach or manage incontinence.

CNA Considerations:

1. Encourage or assist resident to toilet as per their individualized care plan; Document results as per facility's policy.
2. Check residents and change as needed per the CNA care plan.
3. Report and document changes in level of continence to the nurse – increased/decreased frequency, dark concentrated urine, pain on urination, etc.
4. Keep resident clean and dry; observe skin for changes such as reddened areas with each toileting/incontinent episode. Document any skin issues as per the facility's policy and report to the nurse.
5. Apply barrier cream following each episode of incontinence per the facility's policy.
6. Encourage/Assist resident to be as independent as possible with toileting and/or incontinence care.
7. Utilize appropriate incontinence products as per the CNA care plan.
8. Assist/Encourage resident to utilize clothing to foster independence with toileting.

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