STANDARD of CARE GUIDE

PALLIATIVE CARE SOC

- Goal of care is the best quality of life, to focus on comfort rather than cure
- Involved IDT, resident and family
- Encourage advanced directive planning
- Plan is individualized for each resident according to wishes
- Provide pain & discomfort relief
- Consider referral to Hospice

BEHAVIOR SOC

- All IDT report changes in resident's behavior
- Assess behavior daily and prn
- Recognize behavior as a form of communication
- Approach from the front
- Distract/ redirect with resident specific conversation
- Do not rush, limit choices
- Identify triggers to behaviors
- Remove or redirect away from situation, stimulus

CONTINENCE SOC

- Provide highest level of care to maintain dignity
- All member IDT report changes in continence
- Limit dietary irritants, coffee
- Adjust timing of fluids
- Encourage/assist resident to toilet as per CCP
- Keep clean and dry
- Modify environment to facilitate continence

ADJUSTMENT TO FACILITY- TR SOC & SW POLICY

- SW meets with resident/family to establish trust, build rapport
- Encourage to attend TR programs & meet peers
- Provide info on resident /family council
- Determine activity preferences

NUTRITION

- Diet, labs & diet per medical order
- Observe for adequate food and liquid intake
- See ADL for assistance with meals
- Weight as per facility policy
- Provide preferences, provide substitutes prn
- Verbal cueing prn
- Offers HS Snack

STANDING ORDERS

- Tylenol 650mh X1 for pain 1-4 if >call MD
- Start emergency 02
- Routine nursing procedures & standards
- Hypoglycemia Protocol-see policy

PAIN SOC

- All members of IDT will report pain symptoms to nurse
- Pain is evaluated daily and prn
- Interventions include medication, massage, relaxation, positioning
- Use 1-10 scale for cognitive residents
- Use CPAT for dementia residents
- CPAT pain indicators are moaning, scared/fearful expression, tense body position
- Record pain scale before and after medication
- Evaluate for pain before and after treatments

FALL PREVENTION SOC

- All IDT report potential resident hazards
- Keep environment free of potential fall hazards
- Keep call bell within reach
- Maintain adequate lighting
- Toilet resident per plan
- Provide ROM, ambulation & transfer as per CCP
- Apply dycem on chairs
- Keep bed in low position
- Lock bed all times
- Lock w/c for transfers
- Evaluate for bed/chair alarm

SKIN INTEGRITY SOC

- All IDT report changes in skin integrity
- Skin evaluation every shift
- Keep skin clean and dry
- Moisturize dry skin
- Elevate HOB to 30 to prevent friction and shear
- Immobilize residents to be place on a turning program
- Use skin barrier for incontinent/ immobilize residents
- Float heel if at risk

ADL

- Provide hygiene daily and prn
- Check Q2 hours for wetness
- Oral hygiene daily
- Shave daily, keep finger nails trim
- Bath minimum of 2X per week
- OOB unless otherwise instructed
- Provide AROM during care
- Encourage self-performance, if able
- Check bed & chair alarm

DISCHARGE PROTOCOL

- Coordinate plan with resident, family & IDT
- Connect with services & DMG as needed
- Coordinate d/c summary & RX with MD & IDT

MEDICATION

- Observe for adverse effects
- Check ordered labs

ANTICOAGULANTS

- Assess for GI bleeding & bruising
- Bleeding precautions – electric razor
- Cautions during teeth brushing, nail clipping procedures

FOLEY CATHETER

- Monitor for output, color, odor
- Foley care q shift
- Change q month and prn to maintain patency
- Encourage between meal fluids

FULL SOC IS FOUND ON THE INTRANET UNDER INTERDEPARTMENTAL POLICIES