BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	Care and Treatment Services		
Section: 9	Health Care Management		
Topic: 20	Nursing Guidelines		
Page: 1 of 12	**Supersedes Date:** Pol: 10-21-10 Proc: 2-21-18, 5-17-17, 3-14-16, 7-19-13, 7-19-11, 10-21-10	**Approval Date:** Pol: 10-17-13 Proc: 2-21-24	______________________ *Board Chairperson Signature* ______________________ *Chief Executive Officer Signature*
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DO NOT WRITE IN SHADED AREA ABOVE

Policy

Bay-Arenac Behavioral Health Authority (BABHA) has established protocols to be followed by individuals providing care to the people we serve regarding common medical conditions.

Purpose

This policy and procedure is designed to ensure all people we serve that are living in Specialized Residential Homes and designated apartments are given the appropriate treatment for a variety of health care issues that may arise. The guidelines are to be utilized by home staff in conjunction with the state approved Group Home Training Curriculum (GHC) they have been taught and assistance of the Nurse assigned to their home.

Education Applies to

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: Agency Nurses - Residential
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Specialized Residential Providers
  ☐ Policy Only ☒ Policy and Procedure
☐ Other:

Definitions

GHC: Group Home Curriculum
PRN: As Necessary

Revision

Revision

Background

The attached procedures are to be used as GUIDELINES. Direct care staff are to make every effort to use the skills they have been taught in the GHC to observe for signs and symptoms of illness, injury or change in behavior. Any signs or symptoms of acute illness or injury should be addressed during normal office hours when doctors and nurses are more readily available. It is always preferable that people see their own primary care professional when illness occurs. When signs and symptoms occur during non-office hours (after hours, weekends, holidays) that cannot be resolved by these Nursing Guidelines, they need to be directed to the ***Home Nurse between the hours of 8 a.m. and 5 p.m. Monday through Friday and the on-call nurse at all other times*** for evaluation and advice. **Any serious injuries or life-threatening symptoms need to be directed to the emergency room, either by home staff or by contacting EMS for evaluation and treatment.**

CALL 911

Staff are always to follow any specific guidelines or orders written by the person's own primary care professional, with the most recent ones being used. Also, the Person-Centered Plan has specific guidelines in place as well.

Procedure

(Always get vital signs prior to calling the Home Nurse)

A. Weights

1. All Consumers living in a Specialized Residential Home must be weighed monthly at a minimum.
    - **Please note that **weight gain can be a sign of heart failure and needs to be reported to the NURSE right away**.
    - *When the following symptoms are also present, there may be a medical emergency*: shortness of breath, swelling in the ankles or feet, a dry hacking cough, new or worsening dizziness, confusion, or depression, loss of appetite, increased trouble sleeping.

- **Weight loss**: Sudden, unintentional weight loss can be a cause for concern and may be a sign of malnutrition, heart failure, or other underlying medical condition.
  a. Unintentional weight loss over a 6-12 month period can also be a concern and should also be reported to the nurse and dietician.

2. Reporting weights if NOT otherwise specified in the Nursing or Nutritional Plans of Care:
   - If consumer gets weighed **MONTHLY**: Staff must report a 5 pound increase or decrease in weight to the nurse.
   - If a consumer is weighed **WEEKLY**: Report a weight gain or loss of 3 pounds in a week.
   - If a consumer is weighed **DAILY**: Report immediately if weight gain of more than 2-3 pounds in a 24 hour period.

3. Weights may be required to be monitored more frequently by the nurse or dietician. See Nutritional Care Plan and Nursing Care plan for specific instructions and reporting requirements for each consumer.

~~A.~~B. Burns

1. Immediately submerge the burned area or at least run/pour cool water on the burned area to lessen or cool down the burning process.
2. Notify the Home Nurse/On call nurse immediately after cooling the burn for any further instructions.
3. Complete any professional order if appropriate and complete an Incident Report and send to Recipient Rights per protocol.

Any burn worse than a "mild sunburn" (slight redness), should be evaluated at an Emergency Care Center. (Any blistering, deep burn, blackened area or facial burn, needs to be evaluated immediately by a health care professional)

~~B.~~C. Cough

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1. Start prn or as needed, cough syrup as ordered by primary care professional if cough is heard, especially at night (record effectiveness on back of med sheet).
2. Encourage fluids, at least five (5) ounces every hour.
3. Monitor temp and treat as above, if appropriate.
4. Monitor and document if the person coughs up any mucus (note the color and consistency of the mucous).
5. Notify the Home Nurse/On call nurse **if the PRN is not effective, or if the cough worsens**.

~~C.~~D. Cuts and Scrapes

1. Minor Cuts: Clean area thoroughly with plenty of soap and water.
2. Apply a triple antibiotic ointment to area if ointment is ordered by primary care professional, if not, attempt to obtain order as soon as possible.
3. Cover the site with bandage, as appropriate.
4. **If cut is severe enough and bleeding will not stop even after applying direct pressure, or the cut is deep, take the person to an Urgent Care Center or Emergency Room to be evaluated for further care**.
5. Complete an Incident Report and send to Recipient Rights per protocol.
6. Watch for signs and symptoms of infection (redness, swelling, heat, drainage) with any cut or scrape.
7. Notify the home nurse/On call nurse for further instruction if any signs or symptoms of infection are noted.

~~D.~~E. Diarrhea

1. Monitor temp every four (4) hours after three (3) loose stools (watery, mucus). If appropriate, treat fever per above instructions.
2. Give clear liquids for 24 hours. If no further diarrhea, you may resume regularly prescribed diet. Encourage fluids to ensure adequate hydration. (Gatorade, Powerade, or equivalent is preferred for electrolyte replacement.)
3. Check the medication administration record for PRN antidiarrheal such as Imodium, Pepto-Bismol, Kaopectate or lomotil and give as directed. If the individual is currently taking a scheduled laxative, or a stool softener such as Miralax, Colace, Docusate, etc. call the home nurse/on-call nurse for permission to hold those medications.

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4. Note: Do not give PRN antidiarrheal for the following situations: Gastroenteritis, possible food poisoning, C-Diff, bloody stool, black, tarry or maroon colored stools, or for an individual with chronic constipation.
5. Notify the Home Nurse/On call nurse after 24 hours if the above steps do not relieve diarrhea or immediately if any blood (blood can be bright red, maroon colored, or black/tarry) present in stool.

~~E.~~F. Falls:

1. Complete a body check to observe for any injury.
2. **Call Home Nurse/On call nurse and Home Manager with all falls**. Report any changes in mental status or abnormal vital signs, reports of pain, dizziness, or change in mental status from baseline.
3. Complete the Head Injury Assessment form if the fall was unwitnessed, or if the individual was observed or reports hitting their head.
4. Complete Incident Report per protocol.
5. If needed and appropriate, call 911 immediately. (Such as if the person has lost consciousness)
6. (Please note, if the individual's PCP or Nursing Care Plan outlines an exception to reporting falls please follow that plan for reporting falls.

~~F.~~G. Head Injury

1. For "jarring" injuries above the neck, initiate a head assessment (attached).
2. If severe head injury, call 911 immediately.
3. Otherwise call the Home Nurse/On call nurse immediately (or the on-call nurse if appropriate) after completing an initial head assessment.
4. Have the head assessment form readily available to review/discuss with nurse.
5. Complete an Incident Report and send to Recipient Rights per protocol.
6. Continue to complete head assessment per direction of Home Nurse.
7. Contact the Home Nurse/On call nurse with any change in status of the individual or with any questions or concerns.
8. The head assessment form will be filed with the medical record.

~~G.~~H. Fever (temp over 100)

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1. Monitor temp every four (4) hours and record.
2. Administer prn or as needed Tylenol (acetaminophen) or Motrin as prescribed by primary care professional.
3. Encourage the person to drink fluids, at least four (4) ounces every hour to prevent dehydration. (Do everything possible to get them to drink fluids).
4. Do not allow the person to attend North Bay or any other day or work program.
5. If temp is 101 or above, have the person take a bath or shower in lukewarm/body temp. water. (Note: We do not want to use cool water since this would cause the person to shiver and shivering increases body temp.)
6. The person may have chills, so dress them lightly. And if he/she are in bed, only cover with a sheet as you don't want to increase his/her heat.
7. Notify the Home Nurse (or on-call nurse) within 2 hours of the first dose of Tylenol (acetaminophen) or Motrin (ibuprofen) if temp. has not decreased at all or has increased, with above treatment.
    - PLEASE NOTE: THE TOTAL MAXIMUM DAILY DOSE OF ALL SOURCES OF ACETAMINOPHEN IS 3000 mg.

~~H.~~I. Nasal Congestion, Runny Nose

1. Monitor temp every four (4) hours and treat as above, if appropriate.
2. Start prn (as needed) antihistamine/decongestant as ordered by primary care professional.
3. Record effectiveness on back of the med sheet.
4. Monitor the color and amount of nasal secretions.
5. After 24 hours of the first dose of PRN if the condition worsens or does not show improvement, notify the on call/home nurse.

~~I.~~J. Incorrect Medication Administration or Wrong Dosage

1. Call the Home Nurse/On call nurse immediately.
2. Have a list of the wrong meds available that you gave the person.
3. Have the person's med sheets available for review.
4. Complete an Incident Report and send to Recipient Rights per protocol.

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5. Complete any professional orders that were given as soon as the person has been taken care of and is considered "safe" or okay.
6. Note: It is ***not necessary*** to notify the on-call nurse if:
   - a medication has been found on the floor, in the med basket, etc. (Complete step 4 above)
   - A medication from the previous day was missed (unless bowel protocol meds). (Complete step 4 above)

~~J.~~K. Insect Bites

Insect bites itch a lot. Due to the scratching by the person, the person is at risk for getting an infection in the area. Monitor the area closely for signs of infection until healed. If excessive scratching or signs of infection are noted, call the Home Nurse/On call nurse.

1. Insects bites can cause allergic reactions or be a source of infection to people.
2. If swelling or redness is noted, complete an Incident Report and send to Recipient Rights per protocol.
3. Apply cool cloths to the affected site as tolerated.
4. Monitor the site of the bite, it should not be any larger that 1-2 inches. If larger, monitor for signs and symptoms of allergic reaction. Watch for the following:
   a. Hives around the bite or other areas of the body.
   b. Difficulty swallowing.
   c. Difficulty breathing.
   d. Generalized weakness.
   e. Deviations in vital signs.

If any of the above are observed, the person must be evaluated at the Emergency Room right away-CALL 911

~~K.~~L. Omitted or Refused Meds, Late Meds, Missed Med while on Leave of Absence

1. Attempt to administer meds up to two (2) hours after missed, late, or refused (rule of thumb is to try to administer every thirty (30) minutes.

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2. If accepted by the person outside of the scheduled time, contact the Home Nurse to potentially alter the time of the next dose to accommodate the time frames for the med.
3. If meds are still refused after the two (2) hours or unable to give in a two (2) hour time frame, contact the Home Nurse for further direction. **IF MED IS INSULIN CALL NURSE RIGHT AWAY.**
4. If medication is a topical cream, ointment or lotion, notify the Home Manager in am if refused during the night.
5. Complete an Incident Report and send to Recipient Rights per protocol.

~~L.~~M. Pain – Muscle, Headache, Menstrual Cramps

1. Give Acetaminophen or Ibuprofen as ordered.
   - PLEASE NOTE: THE TOTAL MAXIMUM DAILY DOSE OF ALL SOURCES OF ACETAMINOPHEN IS 3000 mg.
2. Document effectiveness on back of the med sheet.
3. If medication does not relieve pain within 24 hours, or if pain worsens, notify the Home Nurse/On call nurse or primary care professional.

   Note: indications that someone non-verbal may be in pain:
   Facial grimacing, moaning or groaning, inability to move as well as they were prior to the injury, restlessness or agitation, guarding the area, limping.

~~M.~~N. PRN Psychotropic Medications

1. Prior to administration, you must contact the Home Nurse/On call nurse to obtain authorization. You need to have the following information available before calling the nurse:
   a) Copy of prn order to read to the Home Nurse/On call nurse,
   b) Date and time that last prn psychotropic med was given,
   c) Description of behavior currently demonstrated, and
   d) Alternative methods that staff utilized to resolve the behavior.

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2. Authorization from the Home Nurse/On call nurse for future administration is only good for 24 hours.
3. If needed, follow the on-call protocols for nursing consultation.

N.O. Rashes (If there is no drainage present)

1. Wash area with soap and water and dry well.
2. Apply ointment to area if primary care professional has ordered one for skin rash.
3. Use of cool cloths on the affected area will help with itching.
4. If the person is prone to rashes or skin irritation, obtain a prn or as needed order from primary care professional.
5. Notify the Home Nurse/On call nurse immediately and fill out an Incident Report and send to Recipient Rights per protocol.
6. If rash or hives appear after any new medications are given, call the Home Nurse/On call nurse immediately.
7. Never apply any topical creams or ointments around eyes or mouth. If rash appears in those areas, contact Home Nurse/On call nurse immediately.

O.P. Sprains, Strains, Large Bruises, Swelling

1. Elevate the area if the area in concern is an extremity, to reduce swelling and pain.
2. Apply cool cloths to the affected area as tolerated.
3. Rest the affected area as much as possible for at least five (5) days, may need to keep person home from day program, work etc.
4. Observe the area for further swelling/pain.
5. If caused by a fall, check the rest of the person's body for red marks, bruising swelling etc., and contact the nurse right away if the injury is related to a fall.
6. Complete an incident report as appropriate and send to Recipient Rights per protocol.
7. If signs or symptoms are initially mild, but get worse, such as swelling or pain, contact the Home Nurse/On call nurse and/or primary care professional for further instructions.
   Note: indications that someone non-verbal may be in pain:
   Facial grimacing, moaning or groaning, inability to move as well as they were prior to the injury, restlessness or agitation, guarding the area, limping.

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~~P.~~Q. Sunburn

1. Staff need to use all precautions to prevent persons from getting a sunburn.
2. Avoid prolonged exposure to the sun, especially between the hours of 11 AM - 3 PM.
3. Persons should have a prn or as needed order for sunscreen with a SPF of 30, but at least a SPF of 15.
4. Staff MUST use extra precautions for any person taking psychotropic meds or other meds that cause photosensitivity, as the person will burn even faster and more severely. Ask your Home Nurse/On call nurse to address any meds your person may have that may cause photosensitivity.
5. Cool showers/baths will help cool the burn.
6. You may also give prn or as needed acetaminophen if the person has an order for it.
7. Notify the Home Nurse/On call nurse immediately if you see: Chills/Fever, Blistering, Nausea/Vomiting or Hives (raised red area).
8. Fill out an Incident Report and send to Recipient Rights as per protocol and consult the Home Nurse/On call nurse as needed for further instructions.

~~Q.~~R. Vomiting (NOT PHLEGM)

1. Give nothing by mouth, J-tube or Peg tube to the person for two (2) hours.
2. If no further vomiting after two (2) hours, give one (1) ounce water every 15 minutes for one (1) hour.
3. If no vomiting after an additional one (1) hour, start clear liquids (any liquid you can see through, include plain jello and popsicles) and resume oral medications (may need direction by Home Nurse/On call nurse).
4. If vomiting continues, call the Home Nurse/On call nurse as soon as possible.
5. If no further vomiting in 24 hours, you may start full liquids and soft diet, (applesauce, toast, soup, scrambled eggs) and advance diet as tolerated as evidenced by no upset stomach or vomiting, etc.
6. Monitor temp and treat with above instructions for fever.
7. If vomit is black or has the appearance of having coffee grounds in it, or has blood in it, this may be a medical emergency. Call 911, notify the home/on-call nurse, and notify the home manager.

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~~R.~~S. Vomited Meds

1. **DO NOT** re-administer any medication.
2. Document what you saw in the vomit, look for actual pills, etc.
3. Contact the Home Nurse/On call nurse for instructions.
4. Complete an Incident Report and send to Recipient Rights per protocol.

Attachments

Attachment – C04-S09-T20 MDHHs Guidelines to Protect Res. Of Long-Term Care

Related Forms

BABHA Head Assessment Form (G:\BABH\Clinical Services\Master Clinical Files)

Related Materials

N/A

References/Legal Authority

N/A

Revision

SUBMISSION FORM

AUTHOR/ REVIEWER	APPROVING BODY/COMMITTEE/ SUPERVISOR	APPROVAL /REVIEW DATE	ACTION (Deletion, New, No Changes, Replacement or Revision)	REASON FOR ACTION - If replacement list policy to be replaced
M. Bartlett	MMPRC	08/24/2010	New	
M. Bartlett	MMPRC	07/19/20100	Revision	Revised to meet current practice.
M. Bartlett	MMPRC/PNLT	07/19/2013	Revision	Triennial review: revised to clarify protocols
HPC	S. Van Paris J. Kreiner	03/14/16	Revision	Triennial review: revised to clarify protocols
S. Van Paris	HPC	5/17/17	Revision	Revised to clarify protocols regarding falls and fever
S. Van Paris	HPC	2/21/18	Revision	Revised to clarify when to call nurse, added Acetaminophen total daily dose, added non-verbal signs of pain
S. Van Paris	~~HPC~~Dr. Smith	~~9/21/21~~11/2/21	~~No changes~~Revision	Triennial review- updated to include COVID-19 information on testing and quarantine
S. VanParis	Dr. Smith	2/21/2024	Revision	Revised to include weight loss/gain reporting requirements

Revision