

Procedure No. 5-10-8

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Issued: 08-15-08

SUBJECT: WHEN TO CONTACT HEALTH SERVICES - THIS LIST IS NOT INCLUSIVE

PURPOSE: TO ENSURE THE HEALTH AND SAFETY OF INDIVIDUALS

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Nurses are available for staff to contact regarding questions or concerns that they may have regarding the individuals that they support. However, during an emergency Staff should **ALWAYS call 911 first. Direct Support staff do not need permission to contact 911.** Once the help has arrived, contact your supervisor. Supervisor will update assigned nurse when it is feasible to do so.

A. **Emergencies**-can include the following, but are not limited to items listed:

- Cardiac Event
- Breathing Difficulties
- Accident with serious injuries
- Unresponsiveness
- Severe bleeding
- Choking
- Orthopedic injuries
- Fall with injuries

B. **Contacting the RN on-call**

- Nurses are on-call for the agency from 8am-10:30 pm Monday-Thursday and 8am-6:30pm on Fridays. Station MD is to be utilized as medical on call stand in from Friday 6:30PM-Monday 8AM. Please contact your supervisor if you have a question on the overnight or call 911 if it is an emergency.
- During regular business hours (8:30AM-4:30PM) Monday through Friday, please contact the nurse that is assigned to the individual for needs.
- On-call Nurses are expected to respond to calls in 15 minutes. For non-emergent needs not requiring a fast response, texts are welcomed. Please contact your supervisor if you do not hear back from the nurse in a timely manner. Follow the chain of command if necessary. (HC/PM/DP)
- Provide the most detailed information possible regarding the individual to the nurse so that an appropriate evaluation and recommendation can occur. **Be prepared to provide the pulse, respiration and temperature + BP + O2 Sats of the individual when calling.**
- Always document in your daily notes the recommendation from the nurse. Make sure the information is passed along to additional staff members working in the home or during shift change.
- If the nurse recommends that the individual receive treatment by the Primary Care Physician, Urgent Care, Station MD or ER, the nurse must be made aware of when the visits will be occurring to assure that they are within an acceptable time frame.
- All recommendations received from Station MD are physician orders and thus must be followed.
- Any direct support person, home coordinator or program manager may contact the community RN or Health Services Manager to discuss concerns regarding the well-being of an individual supported.
- If at any time a Home Coordinator or Program Manager feels like an individual supported needs an assessment by their Primary Care Physician, Urgent Care or Emergency Room physician, arrangements may be made for this to occur and Health Services notified of the decision
- Always call the nurse on-call cell phone, which is posted in the home with the on-call schedule. Calls to office line or a nurse whom is not on call will delay response.

C. **Medication Errors:** Contact the RN on-call for medication errors, including the following:

- Failure to administer
- Wrong Dose
- Wrong Time
- Wrong Individual
- Wrong Medication
- Wrong Route

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D. **Illnesses:** Minor concerns may be reported to the HC initially, either the HC or the DSP will contact the nurse for the following issues.

- Any temperature less than 97.0 or greater than 99.0
- O2 Saturation below 92%
- Nausea/Vomiting
- Diarrhea (Watery stools occurring 2+ times in a day)
- Constipation (More than 2 days without a bowel movement- unless protocol states otherwise)
- Swelling (Any area of the body where swelling is new or an increased in swelling from the client's baseline)
- Hives/Rash
- Fainting / Dizziness
- Minor coughs or runny noses - contact health services during normal business hours.
- Urination problems
- Distended abdomen
- Blood in stool
- Blood pressure reading Systolic greater than 140 or less than 100 (unless directed differently by physician)
- Blood pressure reading Diastolic Greater than 90 or less than 60 (unless directed differently by physician)
- Pulse Less than 60 or greater than 100 (unless directed differently by physician)
- Respirations less than 12 or greater than 22
- Signs or Symptoms of aspiration/pneumonia (see handout)

**NOTE:** The Acute Illness Form (located on Program Manager Forms) needs to be started when a person has an elevated temperature or cold-like symptoms as directed by an RN. Follow the parameters on the bottom of the form in regards to notifying a nurse or doctor. All vitals listed on the form must be filled out and reported. Vitals need to be entered into Therap as well during the use of the Acute Illness Form.

**Note:** The Parameters listed in this procedure should be followed **UNLESS** a physician gives specific parameters to follow. In that case the parameters set by the physician should be followed for that individual. If a vital sign form is being used with parameters listed that are not physician ordered, the parameters listed in this procedure will be the parameters that need to be followed.

\* Prescribed PRN medications used for purposes other than behavior (coughing, running noses, slightly elevated temperature) may be given to a client according to the parameters set by the physician **without** calling the P.M. or RN prior to administering the medication. Nurses will review all PRN dosing frequency at each monthly nurse's visit.

#### E. **Seizures**

**Always follow the seizure protocol individualized per client before calling the nurse.**

- If a client does not have a seizure history and experiences a seizure, call 911. Notify your supervisor, who will update the on-call nurse.
- If a client has a history of seizures with multiple seizures per month and the client's seizure is similar in type and duration as his/her previous seizures, document on seizure log and send an s-comm to the assigned nurse for your home.
- Follow the protocol if a person hasn't had a seizure in over a year, if they no longer have a protocol then call 911

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F. **Hospital Admission and Discharge procedures**

- Nurse must be notified of all hospital admissions by the Home Coordinator or Program Manager.
- Nurse must be notified PRIOR to all hospital discharges as several items are needed.
  - Hospital Discharge form must be given to the inpatient RN (This form can be found in the Program Manager Forms)
  - A nurse to nurse discharge report must be completed before discharge
  - Discharge paperwork and orders must be faxed to health services. 573-876-7319
- Delegations: all new delegation needs must be met PRIOR to an individual returning home. It is the nurse's responsibility to determine what delegations are needed. It is the Home Coordinator's responsibility to coordinate the staff and RN for this training.
- Medications: All new medication orders must be called in and ordered prior to discharge.
  - Regardless of the pharmacy to be used to fill the medication, Neighborhood pharmacy must be notified immediately to ensure eMAR is updated.
- Woodhaven has the right to refuse/postpone a hospital discharge if lack of weekend nurse availability interferes with a safe discharge.
- Woodhaven has the right to refuse/postpone a hospital discharge if delegation, medication and staffing needs cannot be met by the time of anticipated discharge.
- RN is required to complete a face to face hospital discharge assessment within 24 hours of discharge as able with weekend availability.
- **NOTE:** The acute illness form will be completed for 24 hours post hospital discharge or until vitals are WNL.

G. **Injuries: (Staff or Consumers)**-Staff have been trained in first aide and may deal with minor cuts/scratches and abrasions. They will need to notify their supervisor, who will email an update to the nurse. Nurses must still be contacted regarding the following types of injuries and staff can always call if unsure.

- a. If staff is hurt on shift, staff must notify Health Services within 24hours of the injury. If injured during the weekend- forms are located on the medication room door in the HS office in a neon folder. Complete and slide under the medication room door.
  - b. If deemed a physician clearance is necessary, staff are not allowed to return to work until cleared by a physician unless treatment is refused.
- Lacerations
  - Falls
  - Bites, including person, animal, spider or bug
  - Stings, including bees and wasps
  - Limping
  - Bleeding
  - Burns

H. **Behavior:**

The HC will email Nurse AFTER behavior protocol has been followed:

- Changes in normal behavior
- Use of Restraint on Individual
- Threat to harm self or other
- Injuries to the Individual
- Injuries to staff or other Individuals

\* **Note:** The ISP shall include methods to address the situation surrounding the need for PRN psychotropic medications. If PRN medications are indicated, **the Program Manager should be notified and can give permission for the use of the PRN medication.** Follow the chain of command and contact the Director of Residential and Community Services or her designee if unable to reach the Program Manager. The supervisor will follow up with an email to the assigned nurse that a PRN medication for behavior was administered.

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I. **Communication**

- **Nurse to Nurse Communication:** When the nurse on-call receives a call regarding the individuals on another nurse's caseload, the on-call nurse will follow up the next business day with an email to the nurse that is assigned to the home to share all relevant information regarding the call.
- **Home Coordinator to Nurse Communication:** If an event occurred overnight or over the weekend, health services must be emailed details of the event such that they can be up to date by the next business day. This includes ER visits, Urgent Care visits, Hospital admissions, and changes in condition.

Signed: \_\_\_\_\_  
Director of Community Connections & Nursing

Date: \_\_\_\_\_

## Aspiration and Aspiration Pneumonia (page 1)

### Choking (page 2)

Every year, people with DD die because they have choked or aspirated. If we **educate, advocate, and take precautions**, some deaths may be prevented. When people think of leading causes of death it is generally heart disease/cancer/stroke that is thought of first. **Did you know a leading cause of death in people with DD is Aspiration Pneumonia?**

**Aspiration:** Aspiration occurs when food, saliva, liquids, or vomit enters into the lungs. Aspiration is more common in people with DD, because they are more prone to conditions that can affect the muscles and nerves involved in swallowing. *(Swallowing is very complex and according to Mayo Clinic, there are 50 pairs of muscles and nerves used to help you swallow. In other words, there are a lot of things that can go wrong and lead to problems swallowing; another medical name for swallowing difficulty is dysphagia.)* Aspiration may occur without signs or symptoms, the term for this is Silent Aspiration.

#### **Risk factors for aspiration include but are not limited to:**

- Dysphagia, immobility, tongue thrust, spinal deformities, gastro-esophageal reflux disease (commonly known as GERD). People with G-tube/J-tube who have physician orders for nothing by mouth are not excluded from aspiration from saliva or stomach content. They are at high risk for aspiration; the head of the bed should always be elevated to at least 30 degrees to help decrease this risk.

#### **Symptoms of aspiration may include but are not limited to:**

- Drooling, pain when swallowing, coughing or gagging before/during/after swallowing, pocketing food in the cheeks, food or acid backing up in throat (regurgitation), unexpected weight loss, tiring or not finishing meals, refusal to eat certain foods or liquids, feeling like something is caught in the throat, gurgled voice during a meal, a lot of throat clearing, choking on certain foods; example white bread, trouble chewing or swallowing, fevers that come and go, coughing when lying flat.

#### **Prevention:**

- Be alert and watchful for any signs and symptoms that may be related to aspiration. Report symptoms to your supervisor and or physician, it can possibly save a life.
- A speech language pathologist (also commonly known as a speech therapist) evaluation may be ordered
- Other testing such as a barium swallow (commonly known as a cookie swallow test) or an endoscopic procedure may be ordered and completed to determine the cause and treatment necessary.

**Aspiration Pneumonia can be life threatening and should be considered an emergency:**

Symptoms can be sudden or they may take up to a few days to appear.

Symptoms of aspiration pneumonia include (in any combination) but are not limited to: wheezing, chest pain, shortness of breath, fever, chills, feeling anxious, watery eyes, confusion, lightheaded or dizzy, bluish tint to skin or nails, and/or coughing with colored or foul odor sputum. **For persons with risk for aspiration, be alert to all changes, especially if they have had a vomiting or choking episode and then begin to "not act like themselves".**

**Choking:** Choking occurs when a foreign object becomes lodged in the throat or windpipe, blocking the flow of air.

### **Risk factors and examples of prevention measures for choking:**

- Unsafe eating habits: Stuffing mouth, taking too large of bites, not chewing well, or laughing/talking during meals (The epiglottis, the hinge like flap at the base of your tongue that keeps food from entering your windpipe doesn't know whether to open or close because it doesn't know whether food or air is coming when laughing or talking), rushing during mealtime, pocketing food in cheeks. **Prevention** - Line of site during meals for reminders to eat safely and monitor for complications, cutting food into smaller pieces, use of smaller utensils, making sure plenty of time is allotted to eat before work/outing/program, checking and cleaning the mouth after meals.
- Drowsiness/fatigue during meals: Some medications can cause drowsiness and/or decreased response time. **Prevention** - Report to the prescribing physician that the meds are causing problems during mealtime.
- Some conditions or diseases can also cause tiredness. **Prevention** - Allow frequent rest periods, a person may need to eat their meal in intervals.
- Slow eater: This may be caused by things such as; mouth pain, difficulty chewing, dry mouth, problems concentrating. **Prevention** - Talk with the PCP, find the cause and treat as necessary.
- Improperly fitted dentures or decayed/missing teeth: Many people with DD have had a history of poor oral health due to long term use of certain drugs such as seizure meds, improper hygiene, lack of proper dental care, etc. **Prevention** - Ensuring proper dental hygiene and checkups/cleanings are completed on a regular basis and treatments of new problems are addressed. Realigning dentures, if necessary.
- Improper body positioning with meals: Many people with DD have difficulty sitting upright during meals due to contractures, curvature of the spine or kyphosis, muscle weakness or spasms, etc. **Prevention** - Try obtaining a professional evaluation by a physical and/or occupational therapist to assess modalities that can be helpful for proper body position during mealtime.
- Some signs of difficulty eating and/or swallowing are:
- Refusal to eat certain foods. Having food or liquid leaking from their mouths. Coughing after swallowing or with meals. Regurgitating during meals. Having trouble breathing when eating. Weight loss without trying.

**Always-** All swallowing difficulties and choking risk should be discussed with the primary care physician and risks/prevention should be discussed in the ISP.

## **Resources:**

**CHOKING - video** <http://www.safekids.org/video/choking-prevention-families-children-special-needs>

asha.org ( see page # 9 for Dining Guidelines for choking/aspiration prevention)  
[https://www.google.com/search?q=zimmerman-barlow-kieweg-wang&sourceid=ie7&rls=com.microsoft:en-us:IE-Address&ie=&oe=&safe=active&gws\\_rd=ssl](https://www.google.com/search?q=zimmerman-barlow-kieweg-wang&sourceid=ie7&rls=com.microsoft:en-us:IE-Address&ie=&oe=&safe=active&gws_rd=ssl)

## **ASPIRATION PNEUMONIA**

<http://www.drugs.com/cg/aspiration-pneumonia.html>

<https://www.nlm.nih.gov/medlineplus/ency/article/000121.htm>

## **DYSPHAGIA**

<http://www.mayoclinic.org/diseases-conditions/dysphagia/basics/causes/con-20033444>

<http://www.swallowingdisorders.org/>

<https://patienteducation.osumc.edu/Documents/dyspha.pdf>

[http://www.pdf.org/search/t/dysphagia/c/PDF\\_All](http://www.pdf.org/search/t/dysphagia/c/PDF_All)

## **PUREED FOODS**

<http://www.netwellness.org/healthtopics/diet/pureedfoodguidelnes.cfm>

“Swallow Safely” A book with simple reading & low cost – good resource for training and instruction. (\$15.00) <http://www.swallowsafely.com/about>

“Tool-Kits” for health/safety

<http://dodd.ohio.gov/HealthandSafety/Pages/Tool-Kits.aspx>