Policy: Procedures for Resident When Ill

Purpose: Identify treatment plan for residents who are exhibiting increased lethargy, vomiting or fever.

Procedure:

The following are seven identified conditions with accompanying procedures. These conditions may overlap, resulting in the most cautious approach to each. The Medical Director may be contacted for further consultation regarding cases which do not fall into the following categories, yet in which any unusual medical symptoms are noted. Any time a resident exhibits the following conditions, a medical 24-Hour flow sheet will be implemented until conditions are resolved. The Occupational Therapist, Physical Therapist and Director of Nursing will identify those residents at risk for aspiration and Medical Charts will be flagged.

# CONDITION #1

All residents will be assessed by the Occupational Therapist, Physical Therapist and Director of Nursing (DON)/designee to determine whether they are at high risk for aspiration. The Medical Charts of so-identified residents will be flagged by the DON.

**CONDITION #2**

Any resident who is identified as at risk for aspiration who vomits will have his/her vital signs recorded by Nursing, who will then immediately notify a physician for orders. If, despite ordered treatment, the resident vomits again, the physician must be notified again for recommendations. Transfer to hospital will be considered.

All other residents who vomit will have vital signs recorded by Nursing. Standing orders will be referenced and administered, PRN if applicable. If resident vomits again, the Nurse will call the Medical Director for recommendations.

# CONDITION #3

When staff/Nurses notice a marked change in a resident's eating patterns, lethargy, mucus production or temperature, staff are to notify the Director of Nursing (DON). A visual assessment or phone consult will be made by the Registered Dietitian, Nurse, Occupational Therapist and Medical Director. Recommendations regarding changes in positioning, food texture, diet, and how the resident will be assisted with eating or receiving nourishment shall be made to the Coordinator of Support Services (CSS), based on the Support Team consultation. Staff are not to provide food or encourage residents to take fluids unless the Team has decided the resident is capable and guidelines are provided by the Occupational Therapist. The CSS will document conditions and procedures in a Support Team note, provide inservice training and ensure family notification is completed.

**CONDITION #4**

If a resident has a seizure or is lethargic, eating or taking of nourishment will be suspended until he/she is responsive. The Medical Director shall be notified if post-ictal (after-seizure) state exists for more than one hour.

**CONDITION #5**

If a resident has a temperature at or above 101°, prescribed treatment will be initiated (standing/PRN orders), temperature will be taken one (1) hour after treatment and results documented. Temperature will be taken every two (2) hours, blood pressure, pulse and respiration taken every shift. If the resident does not respond within 24 hours, the Medical Director is to be notified. If the resident has a rectal temperature of 102° or over, the Medical Director will be notified immediately. A chest x-ray, a stat CBC (immediate Complete Blood Count) or other appropriate treatment may be ordered. If the staff/Nurses believe a resident needs more extensive evaluation, a request may be made to the Medical Director to have the resident observed at the Emergency Room. If determined, the resident will be transferred to the hospital.

**CONDITION #6**

When a resident is producing excessive mucus, the mucus **MUST BE** removed, in one of the following manners:

⋅ Placing the resident in a prone position over wedge with his/her feet elevated;

⋅ Pulmonary drainage techniques;

⋅ Physical removal of coughed-up mucus; and

⋅ Suctioning the oral/pharyngeal airways.

If more aggressive measures are indicated as determined by the significant change in mucus production, a referral will be made to the Medical Director for consideration of appropriate interventions. Such interventions may include thickening liquids, enteral nutrition, placement of sub-clavian central line for utilization during acute episode, or admission to the hospital. A consult with a pulmonologist may be warranted and long-term follow up will be done if indicated. Residents who experience Condition #6 will be evaluated twice yearly by a pulmonologist and as needed for acute problems.

# CONDITION #7

Team will identify, develop and implement strategies for individuals with severe gastrointestinal deficits. Nursing to assess/identify contributing factors when individual experiences recurring emesis or other G.I. complications. Refer to physician for orders, test and referrals. DON will determine if an emergency IDT or scheduled ID is indicated. Team will meet to develop a plan of strategies and interventions, which may reduce risk of crisis intervention for individuals. Team will meet quarterly to review plan.