HealthWest
Muskegon's Behavioral Wellness Connection

Procedure Title: Nursing Guidelines	**Procedure #: 12-007**	**Review Dates**	
Category: Medical **Subject:** To provide education and direction to individuals in order to promote consistent skills for healthy living.	**Prepared by**: Name: Greg Green, MD Title: Medical Director **Approved by:** DocuSigned by: Rich Francisco AA7FBD48ABB04A3... Rich Francisco, Executive Director	08/19/2025	
	Effective Date: 08/01/2005	**Last Revised Date:** 08/29/2024	

I. PRACTICE GUIDELINE

Nursing Guidelines

II. PURPOSE

To provide education and direction to individuals in order to promote consistent skills for healthy living.

III. APPLICATION

This practice guideline applies to all HealthWest employees, contracted providers, consumers, and caregivers (family members, AFC home operators, etc).

IV. PROTOCOL/GUIDELINE

The Nursing Guidelines are attached.

HealthWest

NURSING GUIDELINES

HEALTHWEST

Nursing Guidelines

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Documentation Guidelines

Example: Incident Report, Head Protocol, Seizure Log

1. Print or write clearly.
   - *Use correct spelling and punctuation*
   - *Clearly state what you mean*
   - *Write legibly*

2. Always use ink
   - *Always use black or blue ink*
   - *Sign entries with first and last name and title*
   - *Do not leave blank lines or spaces*

3. Document time and date.
   - *Specific incident charting-chart the time you are doing the charting and the actual time the incident occurred.*

4. Be brief, specific, objective.
   - *Use specific words to make a clear statement*
   - *Use complete sentences*
   - *Avoid slang*
   - *Avoid abbreviations, unless on approved list of abbreviations*
   - *Avoid opinions.*

5. Chart as soon after an incident happens as possible
   - *Important details are not forgotten if you chart immediately*
   - *When you chart an incident, chart what you did about it and whom you reported it to.*

(Example: if you write that a client complained of a headache, chart what you did to help the client relieve his headache, such as administered PRN Tylenol. Record whether you notified anyone, and if the PRN was effective in relieving the headache.)

6. Record any accident or unusual incident.
   - *Complete an Incident Report*
   - *Document in the progress notes expanding on the incident or accident*
   - *Document what first aid or medical advice was given, and how tolerated*
   - *Document any unusual incident reported to you by day program, family, etc.*

7. Avoid generalizations
   - *Describe what you see and hear*
   - *Avoid statements such as “Looks Depressed”*
   - *Use descriptions such as, moving slowly, mumbling under breath, head hanging down*

8. Use "non-judgmental" charting

- *Write what happened in objective terms*
- *Write what the client actually said or did*
- *Be descriptive and use quotes*

9. Never erase, scribble over or use white-out
    - *If a correction must be made, cross out word or phrase with one line, write error above it and your initials, then proceed with charting.*

10. Document follow-up.
    - *If client has been experiencing a problem, i.e., has been ill - be sure to address this in your charting*
    - *When a client starts a new medication*
        - *Chart effectiveness*
        - *Chart any unusual response or possible side effects you may see*
            - *Chart who you reported to*

11. Medical appointments
    - *Chart why client went to the Doctor*
    - *Chart what medication or treatment the doctor prescribed*
    - *Chart any comments made by the doctor that you feel may be important*
    - *Chart if prescription was taken or faxed to the pharmacy*
    - *Notify assigned HealthWest nurse of new physician orders*
    - *Document that you notified the RN*
    - *Record any other medical appointments, lab visits, and dental or podiatrist appointments, wheelchair clinic, brace clinic, etc.*

12. When referring to another person in your charting:
    - *If a client, use first name and case number*
    - *If not another client, use full name and title*

SPECIFIC EXAMPLES:
Include clear information in your charting and when writing an Incident Report: what you observed, what you did about the problem, who you reported it to, and any other pertinent information.

Wounds/Infections/skin breakdown:
Do you note drainage from the wound? What color? How much? Is there redness, swelling, or anything else unusual? Did you treat the wound with cleansing, a PRN ointment, a dressing, or any other treatment you were instructed to do when you reported it to the RN? Do you know how the injury happened?

Rashes:
Is the rash flat or raised? Is it all-over or scattered? Blotchy? Do you think the client came in contact with a substance that may have caused the rash? Did you treat the rash with a PRN as ordered? (See med sheets) Who did you notify about the rash? Was it reported to the RN?

Falls:
Do you know how the fall happened? Did you witness the fall?
Describe the fall: how the client landed, whether they struck a body part on an object, such as a table. Does it involve a head injury? Is there loss of consciousness? Do a body check immediately for any evidence of injury and document what you find. Take vital signs so that when you notify the RN, you can report these. Document what you did.

Remember that an injury may not be evident until later - chart who you reported it to for follow-up if you are leaving your shift. Is the client favoring any limbs? Is there complaint of pain or discomfort, or behavior changes that would make you suspect pain or discomfort such as facial grimacing or crying out? Is there swelling, warm to touch, unusual movement or redness of any area?

Vomiting:
How soon after medications were administered? Do you see any intact meds in the vomitus? What color is the vomitus? Texture? How soon after a meal? Are there any other symptoms? Take the clients temperature and be ready to report this when you report the vomiting. Document any instructions given. Did you follow the vomiting protocol?

Diarrhea:
What color? How much or how many loose or watery stools? If black and tarry or contains red blood, did you report it to the RN immediately? Unusual odor? Did you check the client's temperature? Are you holding any stool softeners/laxatives for the day?

Coughing/cold symptoms:
Is the cough productive or non-productive? Does it sound loose, dry, hacking, barking, or wheezing? What color is the sputum or nasal discharge? Is the client having any unusual respirations? Noisy or fast? Did you check vital signs or temperature? Do you note any other symptoms? Did you give a PRN med? Did you report the symptoms to the RN?

Seizures:
Did you document all observed seizures on the seizure record? Did you also document any that were reported to you by family members or others if client was on Leave Of Absence from the home or on an outing with others (record that they were reported to you, that you did not observe the seizure) in notes as well as on seizure record? Did you follow the seizure protocol for PRN medication such as Diastat? Did you report the seizure (s) to anyone? Did you check the client over for any injuries? Was there anything unusual about the seizure activity?
If the client has no history of having seizures, report seizure immediately to RN.

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Information Needed When Calling the Doctor or Nurse

The more information you can provide, the more helpful we can be! Have medication administration record on hand.

When you call the nurse or the doctor's office for help in making a health care judgment, have the following information available:

Key in on what's different from the client's normal.

"Cold" Symptoms-

- When did symptoms start?
- Temperature
- Nasal drainage? (amount, color)
- Cough (frequency, loose, tight, mucus, color of mucus)
- Appetite (normal, low)
- Fluid intake (normal, low, increased, forcing fluids)
- Other symptoms (tired, pain, etc.)
- What prn orders are available?
- What have you done so far? Response?

Vomiting/ Diarrhea-

- When did it start?
- How many times?
- How much?
- What does it look like?
- What was eaten in the last 24 hours?
- Are they taking fluids? How much?
- Temperature? Other vital signs?
- Other symptoms?
- Is there a program or prns available?
- What have you done so far? Response?
- Were medications vomited?

Fever-

- What are the trends in temperature for this consumer?
- How was the temp taken?
- What is the number on the thermometer?
- How long?
- Other symptoms (aches, sore throat, pulling ears, etc?)
- Did you remove heavy clothing/blankets?
- Have you given prn Tylenol? When? Response?

Cut, Scrape, Scratch, Bruise-

- How did it happen?
- How long ago?
- How long, how wide?
- Where?
- Swelling?
- Bleeding?
- Red streak? Drainage? What color?
- When was last tetanus?
- Are there prn orders or a program available?
- What have you done so far? Response?

Pain-

- Where does it seem to be?
- What is client doing/saying to indicate pain?
- How long has it been going on?
- Swelling or redness?
- Possible reasons or causes?
- Vital signs?
- Are there prn orders for pain?
- What have you done so far? Response?

Rash-

- Where?
- How long?
- What does it look like?
- Itching?
- Ever had it before?
- Does anyone else have it?
- New product for laundry or hygiene?
- Something new in diet?
- New/current medications?
- Other symptoms of illness? (cough, runny nose, etc)
- Are there prn's or a program?
- What have you done so far? Response?

Other Situations-

- When did it happen or start?
- Contributing factors (why?)
- Where?
- What does it look like?
- What have you done so far?
- The more information, the better!

Emergencies-

Call 911 - Call ambulance or go immediately to the Emergency Room, When:

- No breathing and/or no pulse rate > Begin CPR immediately

- Uncontrolled bleeding- Apply direct pressure and elevate when possible

- Unconscious or losing consciousness

- Accident resulting in severe injury-
    - Suspected fractures of limbs
    - (Swelling, Severe bruising, Favoring or refusal to move a limb)

- Uncontrolled behavior– that is dangerous to others or life threatening to self

*Check behavior plan

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Six Right of Medication Administration

1. **Right patient**
   - Ask the patient their first and last name
   - Does the order match the patient?

2. **Right medication**
   - Does the medication label match the order?
   - Be vigilant with look-alike and sound-alike medications

3. **Right dose**
   - Does the strength and dosage match the order?
   - Is it half, whole or multiple tablets?

4. **Right time**
   - Does the administration time match the order?
   - Before administering a PRN medication, ensure specified time interval has passed

5. **Right route**
   - Does the route match the order?
   - Can this be crushed or mixed in other substances?

6. **Right documentation**
   - Document immediately after the medication is administered

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Diarrhea / Vomiting Guideline

LOOSE STOOLS OR DIARRHEA

If two or more loose stools occur within a two-hour period:

Check temperature initially and at least every 4 hours while condition persists.

1. Clear to full liquid diet for 4-6 hours.

Laxatives should be held for 24 hours after last stool.

2. Small amounts of soft foods may be used with medications.
3. If liquid diet is tolerated without further loose stools, progress to a BRATT diet. (Bananas, Rice, Applesauce, Toast or Tea – in any combination.)
4. Progress to scheduled menu meal at the next scheduled meal time. Avoid spicy or difficult to digest foods.

Call RN or nurse on call if loose stools persist or progress to diarrhea (watery stools), if stool is red, coffee ground, black, or if temperature is over 100°F.

VOMITING

If vomiting occurs, check temperature. If taking oral temp, wait 5 minutes after vomiting occurs. Give nothing by mouth for 2-4 hours.

After 2-4 hours, offer clear liquids. Progress to BRATT diet, bland diet, and then normal menu.

If vomiting recurs, repeat the cycle.

Check temperature at least every 4 hours while condition persists.

Call RN or nurse on call immediately if temperature is over 100°, vomiting occurs, or if emesis contains blood or coffee ground material, or medication.

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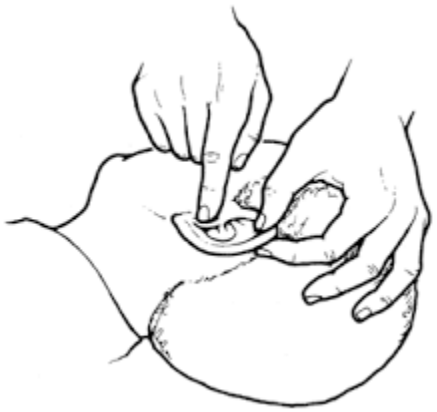
Ear Drop Guideline

Instilling Ear Drops

1. Follow rights to medication administration
2. Wash hands and apply gloves
3. Turn the affected ear up toward the ceiling, best accomplished by lying down
4. For Adults: Hold the upper, outer ear and gently pull upward and backwards

For Children: Hold the lower, outer ear and gently pull down and backwards

5. Place prescribed amount of solution into that ear canal
6. Massage the tragus for 15 seconds.
7. Wait for 3 minutes with that same ear toward the ceiling
8. Now turn that same ear down toward the floor. Allow 3 minutes for drainage
9. Wipe off the spillage of drops with a dry cloth
10. Repeat this procedure on the opposite ear, if necessary
11. Repeat procedure following times of the administration



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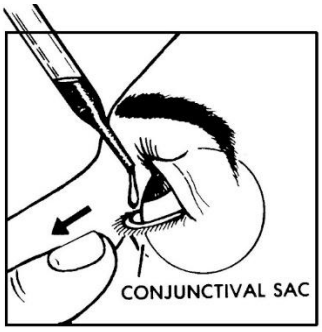
Eye Drop Guideline

Instilling Eye Drops

1. Follow rights to medication administration
2. Shake well before using
3. Wash hands and apply gloves
4. Tilt head backward or lie down and have the consumer gaze upward
5. Gently grasp lower eyelid below eyelashes and pull the eyelid away from the eye to form a pouch
6. Place dropper directly over the eye. Avoid contact of the dropper with the eye, finger or any surface
7. Gently apply prescribed amount of drop(s)
8. After releasing the drop(s), look downward for several seconds
9. Release the lid slowly
10. Close eyes gently for 1-2 minutes. Closing the eyes tightly may cause the drug to spill out of the eye
11. Apply gentle pressure with fingers to the bridge of the nose (inside corner of eye). This prevents drainage of solution from the intended area
12. Pat excess, Do Not Rub the eye. Minimize blinking
13. Do not rinse the dropper
14. Do not use eye drops that have changed color
15. If more than one type of eye drop is to be used, wait at least 5 minutes before using the second agent unless otherwise indicated.
16. When the administration of eye drops is difficult (children, adults with particularly strong blink reflex), the close-eye method may be used. This involves lying down, placing the prescribed number of drops on the eyelid in the inner corner of the eye, then opening the eye so that drops will fall into the eye by gravity.

Gels/Ointments: Use solutions before ointments. Ointments prevent entry of subsequent drops. Apply ointment as above, placing the line of ointment in the pocket formed by the lower lid.



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Food Safety

Separate, don't cross-contaminate. Always thoroughly wash cutting boards, utensils and dishes in between uses for raw animal foods (meat, poultry, fish, pork, and eggs) and fresh produce or other foods that will not be cooked before serving. Another option is to use separate cutting boards, utensils and dishes for raw animal foods and other fresh foods.

- Cut your losses with old cutting boards. Discard any cutting boards with deep grooves, cuts or cracks. These crevices make good hiding places for bacteria.

- Follow the thaw law. Only thaw frozen foods in the microwave or refrigerator. Do not thaw on the kitchen counter; room temperature puts food at risk for bacterial growth.

- To marinate, refrigerate and separate. Do not marinate raw meat at room temperature (put it in the refrigerator), nor reapply marinade to foods after they are cooked.

When cooking food: Follow minimum internal temperature chart

Cooking		
Product	**Type**	**Minimum Internal Temperature & Rest Time**
Beef, Pork, Veal & Lamb	Ground	160 °F
	Steak, chops, and roasts	145 °F and allow to rest for at least 3 minutes
Chicken & Turkey	Breasts	165 °F
	Ground, stuffing, and casseroles	165 °F
	Whole bird, legs, thighs, and wings	165 °F
Eggs	Any type	160 °F
Fish & Shellfish	Any type	145 °F
Leftovers	Any type	165 °F
Ham	Fresh or smoked (uncooked)	145 °F and allow to rest for at least 3 minutes
	Fully cooked ham (to reheat)	Reheat cooked hams packaged in USDA-inspected plants to 140 °F and all others to 165 °F.

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Head Injury Protocol

Head Injury = Any injury to the head, including lacerations and bruises to the head, scalp or face or any fall that was not witnessed.

If a person experiences a head injury, check level of consciousness, amount of bleeding, overall condition. If the person loses consciousness, or if it is a serious emergency, 911 should be called first.

If there is a laceration, attempt to stop bleeding with direct pressure. If there is heavy visible bleeding or spurting blood that does not slow significantly with direct pressure for 30 seconds or less, **call 911.** This is a serious emergency and the person should be transported to the emergency room by ambulance.

A wound that is deep enough to gape open even though the bleeding stops should be evaluated for sutures at the doctor's office, the urgent care, or the emergency room.

If there is noticeable swelling, apply ice.

Check Vital Signs: Blood pressure, Pulse, Respirations

Call on-call nurse for all head injuries, R.N. should be contacted within ½ hour of injury.

Treatment protocol: (may be modified by R.N. or Physician based on consumer needs)

- Close observation every 15 minutes for one hour, then every hour for 8 hours, then every 4 hours for the next 16 hours. Observations should be documented in progress notes.
- If client is leaving the place the injury occurred, a responsible care giver (such as: school staff, family, home staff, etc.), should be informed of the head injury.

As requested by the nurse:

- Check blood pressure, respirations, and pulse. Initially every hour for four hours, and then every two hours for the first eight hours after the injury.
- Provide quiet environment and rest.
- Keep head and shoulders elevated.
- Tylenol as ordered. No aspirin.
- Apply ice pack 20 minutes on the site, 20 minutes off, as tolerated by the client, during wake hours for the first 24 hours to reduce swelling and relieve discomfort.

Observe for and call RN immediately if:

1. Change in consciousness or increased confusion.

2. Any change in normal behavior or appearance.
3. Severe and persistent headache.
4. Tingling, numbness in extremities.
5. Loss of movement in any body part.
6. Unusual bump or depression in head.
7. Blood or fluid from ears or nose. (Do not plug nose or ears.)
8. Onset or increase in seizures.
9. Impaired breathing.
10. Vision or speech disturbance.
11. Unsteady gait.
12. Bruising around eyes or behind ears.
13. Abnormality of pupils or eyes.
14. Nausea or vomiting.

ATTACHMENTS

A. Incident Report C260
B. Head Protocol C282

HEALTHWEST

Guidelines for minor cuts, abrasions, and human/animal bites

Follow Standard Precautions

Most minor cuts and abrasions can be treated at home.
If injury is the result of a bite, a nurse must be notified immediately.

PROCEED TO EMERGENCY CARE IF ANY OF THE FOLLOWING OCCUR:

- Blood is spurting from the wound
- The injury is deep, exposing muscle or bone
- A cut that is longer than an inch
- Bleeding does not stop after 20 minutes of pressure

If none of the above conditions apply, follow the guidelines below for minor cuts and abrasions:

- Use gauze or a clean cloth to cover the wound. Apply pressure to the wound if necessary to stop the bleeding.
- Clean the wound with soap and water.
- Following the consumer's physician's order, apply specified cream/ointment on the clean, dry wound.
- Cover the wound completely with a gauze dressing or regular bandage.
- The dressing should be changed daily, or whenever it appears soiled.
- An ice pack may be applied, (20 minutes on the site, 20 minutes off, as tolerated by the client, during wake hours for the first 24 hours), to relieve initial pain if necessary.
- Notify the nurse of the injury and document it in the staff progress notes and fill out an incident report.
- If the consumer develops increased redness, continued drainage, increase in swelling, a fever or streaking redness, notify the nurse immediately. These are signs of infection that need to be addressed immediately.

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Nosebleeds Guidelines

NOSEBLEEDS

1. Have the consumer gently blow their nose
2. Flex the neck having them put their chin to their chest
3. Firmly pinch the soft, fleshy tip of the nose and hold it for 5 minutes
4. Release the tip and observe for 2 seconds to see if bleeding recurs
5. If bleeding resumes, repeat Step 3
6. Release again and, if bleeding resumes, hold onto the nasal tip and call on call nurse
7. If, while pinching the nasal tip, bleeding continues and fills the back of the mouth or blood runs out of the mouth, go immediately to the hospital for treatment; likely, nasal packing will occur.

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Nursing Consultation Guidelines

Purpose

To provide nursing consultation guidelines and examples of situations they are authorized to resolve.

Application

These guidelines apply to all HealthWest staff and contracted staff/providers working within the HealthWest network requiring consultation with the HealthWest nurse.

Definition

"PRN per protocol": Applies only to a medication prescribed by a HealthWest prescriber when the order is written for "prn use per protocol". "PRN" refers to as needed. "Protocol" is a specific plan written for staff to refer to for specific criteria to be considered prior to administration of the "prn" medication. When it has been determined that there is a need for a behavioral plan, the protocol for the administration of the PRN behavioral medication will be included. When it has been determined that there is no need for a behavioral plan, a protocol with instructions for the administration of the PRN behavioral medication is written on the order. This applies to a unique population of clients served at HealthWest to give guidance to HealthWest staff and contracted staff for specific behavioral issues.

Procedure

1. Consultation with HealthWest nursing staff is always allowed and encouraged if in doubt about any medication or medical condition.
2. Consultation should occur with the assigned nurse during HealthWest regular business hours whenever possible.
3. All after hour telephone calls to the on-call nurse for consultation.
4. On-call nursing staff can be consulted to determine if an emergency room visit is warranted in the case of injury or illness. The on call nurse will determine if the client needs to be transported to the Emergency Room for medical intervention. The home supervisor will notify/communicate with the guardian regarding the client's Emergency Room visit prior to treatment and to report findings and treatment after the visit.
5. Consultations must be documented in the client's record on a progress note, or Incident Report if appropriate, written by the person who initiated the consultation. The note must include the reason for the call, the information received from the nurse, and the subsequent action taken by the caller.
6. The nurse must document the call within the first business day after receiving the call.
7. A nursing consultation should occur and be documented in the following situations:
    A. Medical Issues:
        i. A client reports or staff observes a medical issue that, if left untreated could endanger the client if left until the nurse is available during regular working hours, and staff are unsure what action to take.
        ii. The client has an elevated temperature greater than 100 degrees axillary for more than 24 hours that is not relieved with medications.
        iii. The client has cold symptoms, vomiting, and/or fatigue for more than 24 hours.

iv. The client is noted with any rectal, vaginal (other than menses), or penile bleeding.
v. The client is noted to be vomiting red blood, coffee ground, or vomitus contains medications.
vi. The client is noted with swelling of the genital area.
vii. The client is noted with a rash especially after starting a new medication.
viii. The client may be having a possible medication reaction.
ix. The client is noted with any respiratory problems including shortness of breath, cyanosis, congestion, or persistent cough not relieved with medication.

B. Trauma Issues:
i. The client has received an injury to the head.
ii. The client is noted with a bruise larger than the diameter of a baseball.
iii. The client is noted with a bruise that includes swelling to the area.
iv. The client is noted with any new swelling of the limbs.
v. The client is noted to be favoring or limiting the use of his/her limbs; possible fracture.

C. Pharmacy Issues:
i. A prescribed medication was not administered within one half hour before or one-half hour after the designated time and now staff wants to administer the dose or the resident requests taking the dose.
ii. The staff has contacted the pharmacy and cannot obtain an adequate supply of medication and this will result in the client going without medication.
iii. Staff administering the medication needs clarification on the correct dose, strength, dispensing time or name of medication.
iv. The client has missed a dosage of medication due to vomiting or refusal.

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Physician Appointment Instructions

1. Know what you are taking the consumer to the doctor for. If you don't know, call your supervisor or nurse to find out.

2. Arrive at the doctor's office at least 15 minutes early

3. Bring with you:

    - Physician's Appointment/Communication Form
    - List of allergies
    - Current medication administration record, so you can show what medications the client is currently taking
    - Any other pertinent information (current lab reports, seizure records, blood sugar records, etc)
    - Medicaid/Medicare/private insurance cards

4. If the doctor orders a new medication, lab, or procedure:

    - Remember - you can't take a verbal order - make sure the doctor sends a script to the pharmacy.
    - Ask the doctor or nurse to write on the Physician Appointment/ Communication Form.
    - You may be asked to write or add an order on the Medication Administration Record from the pharmacist's label on the bottle.
    - Read the teaching sheet delivered with the medication from the pharmacy. Check med sheet for listed allergies. Notify RN if you have a question or see a med has been ordered that the client is allergic to. Monitor for possible side effects. Notify RN if you see any of the listed side effects or note anything unusual after starting a new medication.
    - Monitor temperature and vital signs as instructed. Anyone starting a new antibiotic will need their temperature checked once a shift while on the antibiotic.

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Razor Use

- Do not share razors. Each client must have their own.
- Never attempt to shave a client when they are agitated.
- All razors must be kept locked away out of the reach of clients.
- All used, disposable razors must be disposed of according to licensing guidelines. If a Sharps Container is available, place the used razor in the container and this container must be kept locked away and out of the reach of clients.

HEALTHWEST

Responding to Medical Emergencies/ Unusual Medical Events

No. 06-018

Prepared by:

Effective: August 1, 2005
Revised: April 8, 2024

Cyndi Blair, RN, PMH-BC
Chief Clinical Officer

Approved by:

Subject: Responding to Medical Emergencies/ Unusual Medical Events

Rich Francisco
Executive Director

I. PURPOSE

To establish clear guidelines that will enable HealthWest and contract staff to respond promptly and effectively to medical emergencies and unusual medical events that may occur in HealthWest facilities or under contract with HealthWest.

II. APPLICATION

All HealthWest staff and contracted providers

III. DEFINITIONS

Medical Emergency: A potentially life-threatening injury or illness.

Unusual Medical Event: Any incident that could or does result in the need for medical treatment, including those related to the use of medication.

Residential Facility: A residential facility run or contracted by HealthWest that has an on-call nurse available.

HealthWest Outpatient Service Sites: HealthWest operated facilities providing outpatient services. These sites include Assertive Community Treatment, Club Interactions, County Mental Health Center, Youth Services, Autism Services, Correctional Services, Youth and Adult Out Patient Services at Terrace Street, Occupational Therapy, Physical Therapy and Speech Therapy at Moka.

Health Care Professional: Physician, Physician Assistant, Nurse, or Nurse Practitioner.

Potential Poison: Anything that a person eats, breathes, or touches that could cause illness or death.

STAT: A universal term that is taught to Health Care Professionals that a medical situation that requires immediate attention has been identified.

IV. PROCEDURE

A. Medical Emergencies:

1. The first person on the scene will:

a. Survey the area to determine if it is safe and then check the victim. Immediately call 911 or designate a bystander to do so. *Do Not call 911 if the event is a drill and not an actual event*.

b. If possible, designate someone to meet the First Responders to direct them to the location of the ill or injured person.

c. Perform First Aid if needed and trained in it, otherwise attempt to find someone who can. If a healthcare professional is available, summon them. Use Universal Precautions at all times.

d. Stay with the individual and reassure them as much as possible. Do not move them unless the location becomes unsafe.

B. Unusual Medical Events:

1. Determine if any treatment is needed and, if possible, provide treatment within the scope of one's training.

2. Instruct the individual/caregiver to monitor for signs and symptoms related to the illness/injury.

C. Documentation and Reporting:

1. Notify your supervisor.

2. Document actions on the appropriate forms (Progress Notes, Incident Report Form, Muskegon County General Accident Form).

D. Residential Facilities

1. In the case of a medical emergency concerning an individual who resides in a HealthWest residential facility, staff will also notify the primary worker, nurse and appropriate supervisor.

2. In the case of an unusual medical event concerning an individual who resides in a HealthWest residential facility, the staff will immediately inform the nurse/on-call nurse and appropriate supervisor. The nurse will take appropriate action per procedure. Residential staff will also notify the primary worker.

3. In the case of an unusual medical event/medical emergency occurring in a residential home, the home supervisor or the primary worker will notify the individual's legal representative.

E. HealthWest Outpatient Service Sites:

1. In the case of a medical emergency, the Healthcare Professional will notify appropriate staff and/or significant persons involved (i.e., parent, spouse, family, friend).

2. In the case of an unusual medical event, staff will notify a HealthWest nurse on site or call the on-call nurse. The nurse will take appropriate action per procedure. The nurse will notify the appropriate worker and/or significant others (i.e. parent, spouse, family, friend).

F. If HealthWest staff or Contracted Providers are in a situation where they have to make a judgment call, they are urged to error on the side of caution until the event is completely investigated and/ or resolved.

G. Nursing Guidelines

1. In the case of Medical Emergencies, the HealthWest nurse shall:

a. Assess and determine necessary treatment.

b. Provide necessary treatment within the scope of their training.

c. Provide emergency medical services pertinent information when they arrive on the scene.

d. Document actions taken on all appropriate forms (Nursing Progress Notes, Incident Report, Accident Report, etc.).

2. In the case of Unusual Medical Events the HealthWest nurse shall:

a. Assess and determine necessary treatment.

b. Provide necessary treatment within the scope of their training.

c. Instruct individual/care giver to monitor for signs/symptoms related to the suspected injury/illness.

d. Coordinate care with appropriate medical services as deemed necessary.

e. Document actions taken on all appropriate forms (Nursing Progress notes, Incident Report, Accident Report, etc.).

f. The nurse will attempt to notify the legal representative of the individual receiving services if the medical situation is emergent.

3. Nursing Consultation Guidelines as attached.

H. Poison Control

1. HealthWest staff will follow the Emergency Action Guidelines for Poisoning as follows:

a. Inhaled Poison:
Immediately get the person to fresh air. Avoid breathing fumes. Open doors and windows wide. If victim is not breathing, start artificial respiration.

b. Poison on the Skin:
Remove contaminated clothing and flood skin with water for 10 minutes. Then wash gently with soap and water and rinse.

c. Poison in the Eye:
Flood the eye with lukewarm (not hot) water poured from a large glass 2 or 3 inches from the eye. Repeat for 15 minutes. Have patient blink as much as possible while flooding the eye. Do not force the eyelid open.

d. Swallowed Poison:

- Medicine: Do not give anything by mouth until calling the Regional Poison Center for advice.

- Chemical or Household Products: Unless patient is unconscious, having convulsions, or cannot swallow—give milk or water immediately—then call for professional advice. about whether you should make the patient vomit or not.

2. After emergency actions, call **Regional Poison Center at (800) 222-1222.** *Do not call if the event is a drill and not an actual event.*

3. When you call the Poison center, have the following information ready:

- Age and weight of the poisoning victim.

- Name of the poison product, and amount involved in the exposure.

- Time the exposure happened.

- Any symptoms occurring right now.
- Any first-aid measures you have already given the victim.
- Your name and telephone number.

4. Regional Poison Center phone number and Poison Safety Guide information will be readily available to HealthWest staff and contracted providers via the HealthWest Intranet and posted in nurses' offices and medication administration rooms.

5. Regional Poison Center phone number and Poison Safety Guide information will be readily available to all HealthWest recipients in all HealthWest sites' waiting rooms.

V. REFERENCES:

Devos Children's Hospital Poison Safety Guide

HEALTHWEST

Seizure

I. Partial Seizures (also called focal seizures):

A. Simple Partial seizures: No change in level of consciousness. May have weakness, numbness, dizziness, muscle twitching and / or unusual smells.

B. Complex Partial Seizures: Consciousness is altered. Symptoms may be similar to a simple partial seizure, but persons may have trouble interacting in the environment. May have repetitive behavior, lip smacking, unusual thoughts, uncontrollable laughing, visual hallucinations, and/or unpleasant odors.

II. Generalized Seizures**:**

A. Grand Mal: Also called “clonic tonic” seizures. Patients may experience an aura (unusual taste or smell) prior to the seizure. The person may abruptly fall and begin to have jerking movements of their arms, legs and head. Drooling, biting of the tongue, foaming at the mouth and loss of control of urine and bowels may occur. The person may be unconscious for a period of time. Person’s may awaken and be confused for a period of time after a grand mal seizure. Persons may experience prolonged weakness after a grand mal seizure.

B. Petit Mal Seizures: Also called “absence seizures”. Only loss of consciousness occurs without associated motor movements. There usually is no aura (unusual taste or smell that precedes a seizure). Subtle motor movements may accompany the alteration in consciousness.

C. Myoclonic Seizures: Brief jerking movement that involves both sides of the body. The movement may be small or very dramatic.

III. Status Epilepticus: This is a prolonged repetitive seizure that lasts longer than 5 minutes or greater than two in an hour in which the person is unconscious. This is a medical emergency and 911 must be called. *Unless different than neurologist recommendation.

Seizure Guidelines

During the seizure:

A. Remain calm. Stay with the person having a seizure. Do not try to stop the seizure, restrain movement, or insert anything into the person's mouth.
B. Keep the person safe. Keep the airway opened. Assist the person to the floor in a sitting or lying position. Remove the person's glasses. Remove any items that may be harmful to the person. Do not put anything in the person's mouth. Stay with the person until the seizure ends.
C. Keep the person comfortable. If the person is not convulsing loosen tight clothing if possible and cushion the person's head.

After the seizure:

A. Turn the patient to the side and allow the mouth to drain.
B. The person may remain tired and sleepy for a period of time after the seizure. Allow rest. Continue to observe the person's level of consciousness.
C. Take vital signs within 5 minutes after the seizure stops and every 30 minutes for 1 hour after.
D. Follow seizure care plan of when to notify nurse or give PRN medications.
E. Do not give the person anything by mouth until they are fully awake.
F. Never leave person alone.
G. Call 911 if: the person has diabetes or is pregnant, the seizure happened in water (seizure occurred in shower, tub, pool, and person was submerged or suspected to have went under), the seizure lasted longer than 5 minutes, the person stops breathing, this is the first seizure for this person, or the person does not regain consciousness in 15 minutes (unless nursing care plan states otherwise).
H. Document on the seizure log / progress note (If a seizure log is used, also document in the progress notes). If there is any injury complete an Incident Report and notify the RN if a head injury is involved.

ATTACHMENTS

A. Seizure Log C242

HEALTHWEST

Skin Care

Personal Care Practices

- Maintain the water temperature at about 90°F to 100°F.
- Make sure skin is rinsed well.
- Whirlpool bathing stimulates circulation, but the temperature should not be too hot.
- Apply emollient products after bathing, rather than using them in the bath water, to minimize the risk of falls on oily surfaces and to maximize the benefits of the emollient.
- Use emollient products containing petrolatum or mineral oil (e.g., Keri, Eucerin Aquaphor).
- If emollient products are applied to the feet, put on non-skid slippers or socks before walking.
- Make sure the skin is dried thoroughly, especially between the toes and other areas where the skin rubs together.
- When drying the skin, use gentle, patting motions, rather than harsh, rubbing motions.

Avoiding Sun Damage

- Wear wide-brimmed hats, sun visors, sunglasses, and long-sleeved garments when they are out in the sun.
- Cotton materials provide better protection from the sun than polyester fabrics because ultraviolet rays can penetrate polyester.
- Apply sunscreen lotions frequently, beginning 1 hour before sun exposure.
- Use sunscreen lotions with a sun protection factor (SPF) of at least 15.
- Avoid exposure to the sun between 10AM and 3PM.
- Protect the consumer from ultraviolet rays even on cloudy days and when they are in the water.

HEALTHWEST

Diabetes

1. Perform blood sugar testing as ordered.

2. Administer medication as ordered.

3. Monitor for signs and symptoms of hypo/hyperglycemia. Check blood sugar outside of scheduled times if symptoms are noted. Call RN for blood sugar less than 70 or greater than 350. Follow guidelines below for high and low blood sugars.

4. Notify the RN if ever in doubt about what approach to take regarding treatment.

Low Blood Sugar (Hypoglycemia)

Signs and symptoms: sweating, pale skin, confusion, irritability, lack of coordination, increased hunger, increased thirst, general feeling of not feeling well.

What to do:

- *If the blood sugar is below 50 and they are without symptoms:*
    a. Give a ½ cup of regular orange juice, soda (not diet), or sugar water.
    b. Also offer them a meal if it is the scheduled mealtime.
    c. Re-check the blood sugar every 15 minutes until it reaches 70.
    d. **Notify the RN.**

- *If the blood sugar is below 50 and they are unresponsive or has symptoms:*
    a. **Call 911 first**
    b. If alert, give a ½ cup of regular orange juice, soda (not diet), or sugar water. If they are not alert, DO NOT GIVE THEM ANY FOOD OR LIQUIDS.
    c. Re-check the blood sugar every 5 minutes until it reaches 70 or until emergency personnel arrive.
    d. Notify the RN.

- *If the blood sugar is below 70 but above 50 and they are without symptoms:*
    a. Give a ½ cup of regular orange juice, soda (not diet), or sugar water.
    b. Also offer them a meal if it is the scheduled mealtime.
    c. Re-check the blood sugar after 30 minutes to ensure that it is elevating.

Notify the RN if the blood sugar does not reach 70 after 30 min.

High Blood Sugar (Hyperglycemia)

Signs and symptoms: dry mouth, weakness, blurred vision, headache, frequent urination, increased thirst, general feeling of not feeling well.

What to do:

- *If blood sugar is 350 or greater:*
    a. Call nurse.
    b. Offer one full 8oz glass of water. Recheck blood sugar in one hour.
    c. If blood sugar is still 300 or higher, call nurse again and notify of results.

- *If blood sugar is 500 or greater and they are without symptoms:*
    a. The home can transport them to ER as long as they are able to be transported within the hour.

- *If blood sugar is 500 or greater and they are unresponsive or have symptoms:*
    a. Call 911.

Instruction for giving insulin injections

1. Check client's blood sugar and record it.
2. Check insulin order and verify the 6 R's of med administration.
3. Gather supplies and wash your hands.
    a. Insulin
    b. Syringe
    c. Alcohol swabs
    d. Gloves
4. Follow administration guidelines on insulin package.

Dos and Don'ts

1. Don't mix different types of insulin. Call an RN if unsure.
2. Don't give insulin to someone who can self-administer.
3. Do report a needle stick immediately.
4. Do not recap syringes.
5. Don't set the syringe down after it is used. Put directly in "sharps" container.
6. Do know the signs and symptoms of hypoglycemia.
7. Do make sure that the client will be eating shortly after giving the insulin.

Steps for preparing a single dose of Insulin

Follow these steps when preparing a single type of insulin for an injection.

1. Roll the bottle (vial) gently between your hands. This will warm the insulin if you have been keeping the bottle in the refrigerator. Roll a bottle of cloudy insulin until the white powder has dissolved.

2. Wipe the rubber lid of the insulin bottle with an alcohol wipe or a cotton ball dipped in alcohol. If you are using a bottle for the first time, remove the protective cover over the rubber lid.

3. Remove the plastic cap covering the needle on your insulin syringe (without touching the needle).

4. Pull the plunger of the syringe back and draw air into the syringe equal to the number of units of insulin to be given.

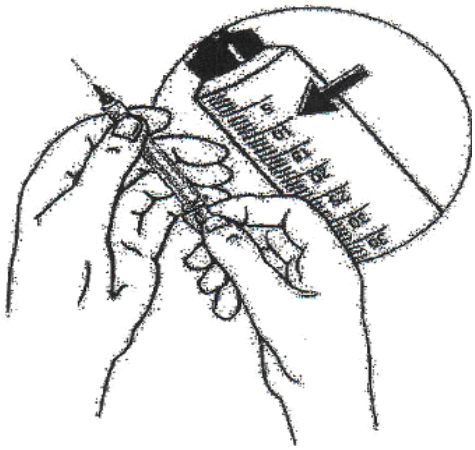


Illustration of Step 4

5. Insert the needle of the syringe into the rubber lid of the insulin bottle. Push the plunger of the syringe to force the air into the bottle. This equalizes the pressure in the bottle when you remove the dose of insulin. Leave the needle in the bottle.

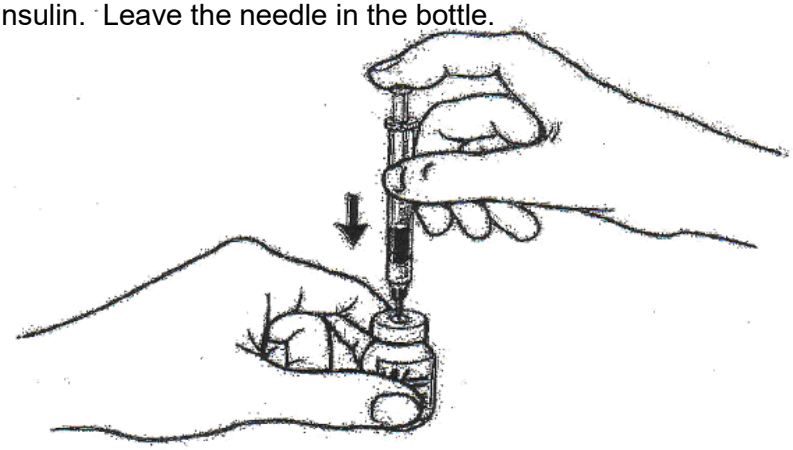


Illustration of Step 5.

6. Turn the bottle and syringe upside down and hold them in one hand. Position the tip of the needle so that it is below the surface of insulin in the bottle. Pull back the plunger to fill the syringe with slightly more than the correct number of units of insulin to be given.

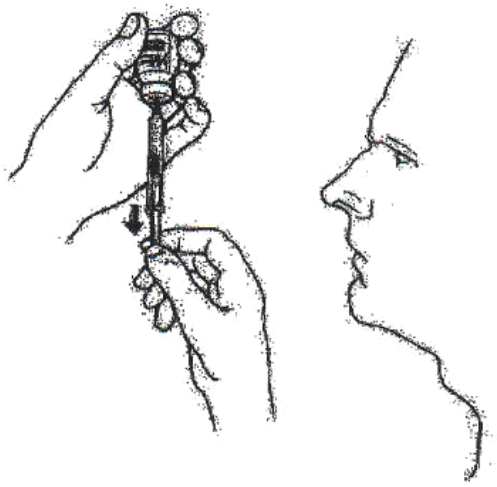


Illustration of Step 6.

7. Tap the outside (barrel) of the syringe so that trapped air bubbles move into the needle area. Push the air bubbles back into the bottle. Make sure you now have the correct number of units of insulin in your syringe.

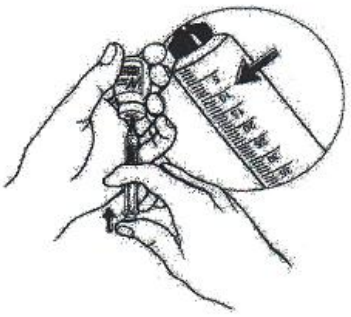


Illustration of Step 7.

8. Remove the needle from the bottle. Now you are ready to give the injection.

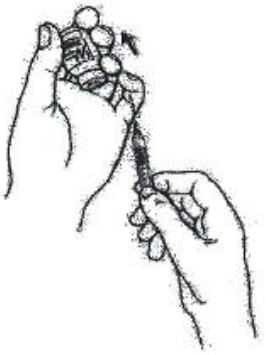
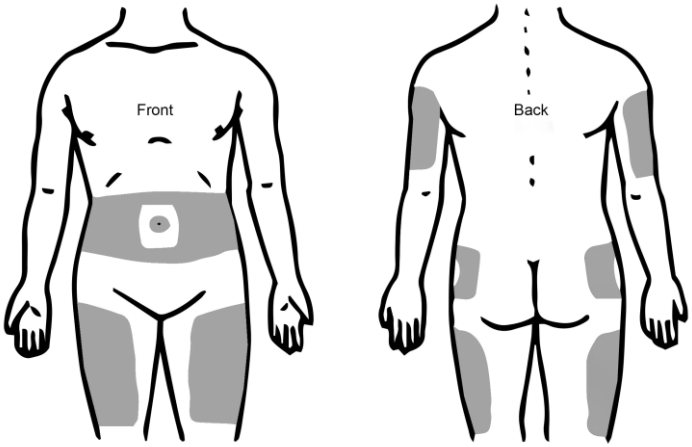


Illustration of Step. 8

Choosing the Site for an Insulin Shot

Choosing exactly where on your body you will give your shot(s) each day is very important.



These drawings show areas for your insulin shots. You may need a family member to give your shot in some of them

The areas are divided into squares. Each square is a site, an exact place to give a shot. To keep skin, fat and muscle health, use a different site for each shot.

When you use all of the areas and the sites inside them, no one site has to be used too often.

Rotating Injection Sites

Rotating sites means following a regular plan of moving from site to site as you take your shots.

- Use all the sites in one area before changing to another. For example, use all the sites in both arms before moving to your legs. This will help keep your blood sugar more even from day to day.

- If you take more than one shot each day, use a different area for each shot.

- Starting in a corner of an area, move down or across the sites, in order. Jumping from site to site makes it hard to remember where you gave your last shot.

- When you have used all the sites in an area, move to another.

HEALTHWEST

Psychiatric Medication Side Effect Protocol

1. Administer medications as ordered by physician.

2. Periodically review and be familiar with medication side effects. Refer to medication teaching sheets as provided by the pharmacy.

3. Monitor consumer for possible side effects and report any concerns to RN immediately.

4. Be familiar with the purposes of each of consumers' medication. If it is noted that the medication does not seem to be effective for its intended use, notify home RN.

5. EPS symptoms should be monitored for and reported immediately. These are potential side effect of Seroquel and Clozapine and include:

    a. Pseudoparkinsonism (muscle rigidity slow shuffling gait, tremor, slow movements, difficulty chewing and swallowing).
    b. Akathisia (inability to sit still, an inner restlessness).
    c. Dystonia (odd muscle movements often involving the face, neck, tongue).
    d. Tardive dyskinesia (involuntary, repetitious muscle movements of the face, limbs or trunk).
    e. Neuroleptic malignant syndrome (characterized by stiffness, pale, problems with movement, confusion, high temperature, incontinence, unstable blood pressure, pulmonary congestion). *This side effect is potentially lethal and must be reported to RN immediately. If unable to contact RN, call 911.*

HEALTHWEST

Hypertension/ Heart Attack/ Stroke

1. Administer blood pressure medication as ordered.

2. Check blood pressure as ordered by your provider. Minimum of monthly. Record on MAR.

3. If abnormal reading is obtained, re-check in one hour. Report blood pressure greater than 150/90 or less than 90/60 to RN.

4. Observe for and report the following to RN:

    a. cyanosis around mouth/nailbeds or generally blue gray or ashen color
    b. cold, clammy skin
    c. profuse sweating
    d. complaints of chest, back or abdominal pain
    e. dizziness, severe headache, or blurred vision
    f. nausea or vomiting
    g. swelling of legs, ankles, or hands
    h. frequent, prolonged, or persistent cough

5. Consumer should go to ER by ambulance if they complain of chest pain or become cyanotic.

Identifying a Stroke F.A.S.T

F - Face Drooping: Does one side of the face droop or is it numb? Ask the person to smile. Is the person's smile uneven or lopsided?

A - Arm weakness: Is one arm weak or numb? Ask the person to raise both arms. Does one arm drift downward?

S - Speech: Is speech slurred? Is the person unable to speak or hard to understand? Ask the person to repeat a simple sentence.

T - Time to call 911: if the person shows any of these symptoms, even if the symptoms go away, call 911 and get them to the hospital immediately.

HEALTHWEST

Constipation Protocol

1. Encourage drinking 8 – 10 glasses of fluids daily.

2. Provide a high fiber diet, following dietary guidelines.

3. Administer stool softeners/evacuants as ordered.

4. *It is the staff's responsibility to monitor bowel function EVERY DAY, EVERY SHIFT.* All staff are to check BM chart when administering medications. A BM chart/flowsheet must be kept in the med book and documented on for every shift. Include the size of the BM If possible. If they do not have a BM on your shift, indicate so in your documentation. Do not leave it blank. Small BM's do not count when determining the number of days without a BM. A small BM is equal to no BM.

5. Monitor for constipation. Signs of constipation include:

    a. Leaking small amounts of soft or loose BM
    b. Hard, round balls of BM
    c. Large, hard stools
    d. Straining when having a BM
    e. Increased gas
    f. Vomiting
    g. Decreased appetite
    h. Abdominal distention/firmness

6. Follow prescribed bowel regimen, but also use foods such as prunes (prune juice), fruits, vegetables, and water to naturally prevent constipation.

7. After 3 days of no bowel movements and no reaction to bowel medications, call the nurse.

Authors Initials /

INCIDENT REPORT

ATTACHMENT A

REPORT DATE	REPORTING AGENCY	REPORTING PROGRAM/ HOME
INDIVIDUAL NAME:	CASE NUMBER:	REPORT TIME:

WHEN DID YOU DISCOVER INCIDENT (Date & Time) ☐AM ☐PM	WHEN DID IT HAPPEN (Date & Time) ☐AM ☐PM	WHERE DID INCIDENT HAPPEN (Specific Location)

INDIVIDUAL(S) INVOLVED

EMPLOYEE(S) INVOLVED AND/OR PRESENT

EXPLAIN WHAT HAPPENED

ACTION TAKEN BY STAFF

REPORTING PERSON'S NAME & TITLE:	REPORTING PERSON'S SIGNATURE:

PHYSICAL INJURY APPARENT? YES: ☐ NO: ☐	DURATION OF PHYSICAL INTERVENTION (if used):	DATE:

REVIEW/COMMENTS FROM PRIMARY WORKER:

ASSIGNED PRIMARY WORKER NAME:	SIGNATURE:	DATE:

CURRENT BEHAVIOR PLAN: YES: ☐ NO: ☐	DATE OF DEBRIEF:	PREVIOUS IR IN LAST 30 DAYS (Physical Management or Law Enforcement): YES: ☐ NO: ☐

IF RELATED TO BEHAVIOR PROGRAM AND/OR P.I., REVIEW AND COMMENTS BY PSYCHOLOGIST:

ASSIGNED PSYCHOLOGIST NAME (PRINT CLEARLY):	SIGNATURE:	DATE:

IF INJURY, DESCRIPTION OF INJURY AND CARE/TREATMENT GIVEN BY PHYSICIAN OR R.N.:

DATE & TIME CARE GIVEN ☐AM ☐PM	EXTENT OF INJURY AT THIS TIME ☐SERIOUS ☐NONSERIOUS		
IF SERIOUS INJURY: DATE & TIME DIRECTOR OR DESIGNEE NOTIFIED ☐AM ☐PM	IF SERIOUS INJURY: DATE & TIME RIGHTS OFFICER NOTIFIED ☐AM ☐PM	PHYSICIAN'S OR R.N. SIGNATURE:	DATE:

DESIGNATED SUPERVISOR (State program or administrative action to remedy and/or prevent reoccurrence of incident, including disciplinary action):

NAME OF EMPLOYEE ASSIGNED TO CONSUMER AT TIME OF INCIDENT:	DESIGNATED SUPERVISOR'S SIGNATURE:	DATE:

WITHIN 24 HOURS EMAIL OR FAX REPORT TO: INCIDENTREPORTS@HEALTHWEST.NET **or (231) 724-3314**

C260 (Rev. 10/04/2022)
(Incident Report) (Rev. 10/04/2022)

HEALTHWEST
HEAD INJURY PROTOCOL DOCUMENTATION

DATE: _____ NAME: _____ CASE # _____

Was nurse contacted? YES NO

Did the consumer sustain a wound? YES NO

If so, describe the injury (include location, size, color, drainage): _____

_____

_____

NEURO/WELLNESS CHECKS (Q15min X 1hr, Qhr X 8hr Q4hr X 16hr)
DOCUMENT ABNORMALS UNDER COMMENTS

TIME	INIT		ALERT	VERBAL	PUPILS	GAIT	MOOD	COMMENTS
		15min						
		15min						
		15min						
		15min						
		1hr						
		1hr						
		1hr						
		1hr						
		1hr						
		1hr						
		1hr						
		1hr						
		1hr						
		4hr						
		4hr						
		4hr						
		4hr						

VITALS (Initial set, Qhr X 4hr, Q2hr X 8hr)

TIME	INIT		BP		PULSE	RESP	COMMENTS
		Initial					
		1hr					
		1hr					
		1hr					
		1hr					
		2hr					
		2hr					
		2hr					
		2hr					

INITIAL/SIGNATURE _____

INITIAL/SIGNATURE _____

INITIAL/SIGNATURE _____

The consumer is leaving the place of injury, and the successive caregiver has been notified that this protocol has been initiated.

Signature of Protocol Initiator	Facility	Date
Signature of Successive Caregiver	Facility	Date

HEALTHWEST
Seizure Log

Name: _____ **Birthdate:** _____ **Case No:** _____
Home: _____

Date:							
Time (start and end)							
Duration of Stiffening (upper/lower/generalized)							
Initial Sign of Seizure							
Activity Involved In							
Jerking (Explain)							
Frothing At Mouth?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Rolling of Eyes or Face Twitching?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Change In Color?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Urination?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Defecation?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Deep Sleep? How Long?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Injuries Sustained (Describe)							
Return to Normal Activities Timeline (3 Min, 5 Min, Etc.)							
Post Seizure Temp. (Axillary °1 After If Indicated)							
PRN Med Given?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Signature and Title							

HEALTHWEST
Physician's Appointment / Communication Form

Date _____ Name _____ Case No. _____

Date of Birth _____

☐ Nursing – 376 E. Apple Ave., 724-3699, Fax 724-3327
☐ HealthWest Crisis Residential, 1364 Terrace Street, 724-6040, Fax 724-6042

Appointment Date _____ Time _____ Physician _____

Location _____

Current Medications: ☐ See Attached Medication Sheet

_____
_____
_____

Reason for Appointment / Communication / RN Comments:

_____ _____
Staff Signature Date

Findings / Plan / Restrictions/Medication Changes:

Follow up Appointment? _____ Keep home from school/work? ☐Y ☐N ☐N/A

_____ _____
Physician Signature Date

C204 (Rev. 2/14/2024)
(Medical)