

Application of Dry Dressing Instructions

(Name of Client)

Procedure

Review care plan or medical orders for procedure.

- Gather supplies.
 - Clean or sterile gloves
 - Sterile dressings
 - Tape
 - Antiseptic swab sticks or other cleanser as prescribed on care plan or medical orders
2. Explain procedure to client and instruct the client not to touch the area or supplies.
 3. Provide for privacy and comfort. Drape to expose only area to be dressed.
 4. Wash hands and put on clean gloves.
 5. Remove tape, pulling parallel to skin and toward dressing. Carefully remove old dressings, taking care not to dislodge drains or tubes.
 6. Observe any drainage on old dressings. Dispose of dressings in disposable bag.
 7. Remove gloves by pulling them off inside out and dispose in bag.
 8. Open new dressing and antiseptic swab sticks.
 9. Put on clean or sterile gloves.
 10. Cleanse area with antiseptic swab sticks.
 - Use a separate swab for each cleansing stroke.
 - Clean from least contaminated area to most contaminated.
 - Use dry gauze to dry area.
 11. Apply antiseptic ointment as prescribed in care plan or medical orders.
 12. Apply dry sterile dressings to site. Use cut 4 X 4 gauze to fit flat around drain or tubing, if present.
 13. Apply tape over dressing.
 14. Remove gloves and dispose in bag.
 15. Assist client to comfortable position.
 16. Dispose of all supplies and wash hands.
 17. Record appearance, drainage, client's tolerance and type of dressing applied as instructed.

Additional Instructions _____

RN Contact Information:

Names of Caregiver(s) oriented/trained/date with client: _____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

Application of Elastic Stockings
Written Instructions

Client Name _____

Procedure

1. Review care plan or instruction sheet regarding use of stockings
2. Explain procedure to client
3. Wash hands
4. After legs have been washed and dried, apply a small amount of powder to each leg and foot.
5. Turn elastic stockings inside out.
6. Place client's toe into foot of stocking, making sure stocking is smooth.
7. Slide remaining portion of stocking over the client's foot, being sure that toes are covered. Sock will now be right side out.
8. Slide stocking over client's calf until it is completely extended. Be sure that stocking is smooth with no ridges.
9. Wash hands.
10. If stockings are worn all day and night, be sure that they are removed at least once a shift for twenty (20) minutes.
11. Stockings may be washed in the sink using a mild detergent or shampoo. Rinse well and hang them up to dry. Do not use a clothes dryer.

Additional Instructions _____

RN Contact Information:

Names of Caregivers oriented/trained/date with client: _____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

Blood Glucose Monitoring

Written Instructions

Client Name _____

Refer to specific instructions with blood glucose meter purchased. The following procedure is for the Sure Step (Life Scan) blood glucose meter.

1. Review the care plan or medical orders for procedure
2. Gather supplies.
 - Sure Step meter
 - Penlet II or blood sampler device and lancets
 - Sure Step meter test strips
 - Sure, Step meter control solution
 - Soap and water, washcloth and towels
 - Sharps Container
 - Clean disposable gloves

Control Test

1. Press the on/off button on the meter.
2. A code and number will appear on the display. Press the C button until the code number on the meter matches the code number on your current test strip package.
3. Remove the test strip from the vial or foil package. If vial, replace the cap immediately.
4. After shaking the control solution vial, apply one drop of control solution to the pink test square on the test strip.
5. Check to see that the confirmation dot on the back of the test strip has turned completely blue to ensure enough control solution has been applied.
6. Within 2 minutes after applying the control solution, insert the test strip into the meter, pink side up, and read the results (takes about 30 seconds to appear).
7. Compare the control solution test result with the control range printed on the Sure Step test strip package. When the control solution test result is within the control range, test the blood sample.
8. The meter automatically turns off within 2 minutes after control solution testing or 3 minutes after the meter displays a blood glucose reading. **Blood Sample Test**
1. Explain procedure to client. Provide for comfort and privacy.
2. Assist the client to wash hands with soap and warm water. Rinse and dry. If using an alcohol wipe, let the area dry before obtaining a blood sample.
3. Wash hands and apply gloves.
4. Turn on the Sure Step glucose meter. Symbols indicating to (1) apply blood to the test strip and (2) to insert the test strip into the meter will alternate on the display. You have 2 minutes to insert the test strip before the meter automatically turns off.
5. Obtain a blood sample by pressing the lancet loaded Penlet II or a blood sampling device against the pad side of the finger (the harder you press, the deeper the puncture). Press the release button.
6. Squeeze the finger to get a large, hanging drop of blood.
7. Hold the test strip under the finger, and touch the drop of blood to the pink test square.
8. After a few seconds, look at the confirmation dot on the back of the test strip. If it is completely blue, go on with the test.
9. Slide the test strip into the test strip holder, pink side up. Insert the test strip within 2 minutes to obtain an accurate result. Turn off the meter after obtaining the reading.

10. Dispose of the lancet into the sharps container.
11. Remove and dispose of gloves
12. Assist client to comfortable position
13. Dispose of all supplies and wash hands.

Additional Instructions: _____

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RN Signature: _____ **Date** _____

RN Contact Information:

Blood Pressure
Written Instructions

Client Name _____

Procedure

Review care plan or medical orders for procedure

1. Determine which arm to use for blood pressure check. Avoid using arm with an intravenous catheter or shunt in place, when breast or axillary surgery has been performed on that side or when the arm or hand has been traumatized or diseased.
2. Gather supplies

Blood pressure cuff of correct size for client. The blood pressure bladder should completely encircle the arm without overlapping; the cuff should be long enough to encircle the arm several times. Stethoscope

3. Position client comfortably in sitting or lying position. Be sure room is warm and quiet.
4. Explain procedure to client. Have client rest at least 5 minutes before measurement.
5. Wash hands
6. Expose upper arm fully by removing constricting clothing. Support client's bare upper arm at heart level with palm turned up.
7. Palpate brachial artery. Position cuff 1 inch above brachial pulse in antecubital space. Center bladder above artery.
8. With cuff, fully deflated, wrap cuff evenly and snugly around upper arm. Be sure the dial is at your eye level and no further away than 1 yard.
9. Place stethoscope to ears and be sure sounds are clear, not muffled.
10. Close valve of pressure bulb clockwise until tight.
11. Rapidly inflate the cuff to 30 mm Hg pressure above normal systolic pressure.
12. Slowly release the valve and allow mercury to fall at rate of 2-3 mm Hg/second. Note points on dial when the first clear sound is heard and when the sound disappears.
13. Deflate the cuff rapidly and completely. Remove from arm.
14. Assist client in returning to a comfortable position and cover upper arm if previously clothed.
15. Wash hands.
16. Record blood pressure and report abnormal findings immediately.

Additional Instructions _____

RN Contact Information:

Names of Caregivers oriented/trained/date with client: _____

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RN Signature _____ Date _____

Care of the Diabetic Client
Written Instructions

Client Name _____

Procedure

1. Blood Glucose Monitoring (Blood Sugar Checks)

- a. Glucometers are available for clients to monitor their blood sugar results and make necessary adjustments with medication, diet or exercise as instructed by their physicians. Blood sugars are checked regularly on these portable instruments according to the physician's recommendations and when a client is concerned that his or her blood sugar level is abnormal.
- b. Fasting blood sugars are drawn in the morning before the client eats or drinks anything. The fasting blood sugar (FBS) should be measured because the blood sugar level will increase as soon as the client eats.
- c. Normal blood sugar is 70-110. ○ Hypoglycemia: Hypoglycemia means a low blood sugar (below 70) and is also called an insulin reaction. It results from too little food, too much insulin and/or extra exercise.
 - The onset is sudden
 - Symptoms vary with individuals, but generally include ○ Cold, clammy skin ○ Anxiety ○ Shakiness ○ Sweatiness (diaphoresis) ○ Irritability

Action: Treatment is urgent!

- 1. If possible immediately check the blood sugar of a client you suspect has hypoglycemia. However, If you do not have a machine nearby, do not delay treatment to check a blood sugar.
- 2. Give the client a cup of orange juice or several hard candies (simple sugar).
- 3. If your client will not be eating a meal in the next ½ hour, give a snack with carbohydrates such as crackers or a peanut butter sandwich and milk.
- 4. Contact the nurse and chart what happened and your treatment.
- 5. Continue to monitor the client frequently and recheck her blood sugar as instructed by the nurse (generally, 30 minutes after eating).

Hyperglycemia: Hyperglycemia means high blood sugar (over 200). It results from too much food, too little insulin or other diabetic medication, illness, or stress.

Additional Instructions _____

RN Contact Information:

Names of Caregivers oriented/trained/date with client: _____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

Care of Client with Indwelling Catheter
Written Instructions

Client Name _____

General Guidelines

1. The inside of the catheter and drainage system is sterile and should never come in contact with other objects. Do not insert anything into the catheter or drainage tubing or let any part of the system come in contact with the floor. Keep the collection bag below the level of the urinary bladder to prevent backflow of urine into the bladder.
2. Use standard precautions. Wear gloves when there is a chance of coming in contact with body fluids.
3. Make sure urine is draining freely into the collection bag. Check for kinks in the tubing.
4. Provide perineal and catheter care as indicated in the care plan. Keep the catheter and tubing clean.
5. Report the following to your supervisor.
 - Leakage of urine around the catheter
 - Complaints of pain, burning, irritation or feeling the urge to void
 - Discharge from the urinary meatus or vagina.
 - Abnormal quantity or appearance of urine
 - Leaks in the drainage tubing or collection bag
6. Whenever the catheter is separated from the drainage tube, it must be handled in a manner that will prevent it from being contaminated.

When changing from a night bag to a leg bag or visa versa, use the following procedure.

1. Review the care plan or medical orders for procedure.
2. Gather supplies
 - Clean gloves
 - Clean leg bag
 - Alcohol wipe
 - Clean cap for tubing
3. Explain procedure to client. Provide for privacy and comfort.
4. Be sure that urine is drained through tubing into collection bag.
5. Wash hands
6. Open alcohol wipe.
7. Put on clean gloves.
8. Separate catheter from tubing. Do not let ends of catheter or tubing touch anything.

9. Place clean cap onto end of tubing from night bag.
10. Cleanse the end of catheter with alcohol wipe.
11. Remove cap from end of tubing for leg collection bag and cleanse with alcohol wipe.
12. Connect catheter with leg bag tubing.
13. Position leg bag.
 - Assist client to sitting position and secure to lower leg with straps.
 - If night bag, connect the collection bag to the bed and arrange the tubing in a coil to prevent dangling.
14. Remove gloves and wash hands.
15. Assist client into comfortable position
16. Put on clean gloves to empty the urine from the night bag. Measure and record output as instructed on care plan.
17. Open all clamps and wash the night bag in mild soap and water. Rinse well and soak in a vinegar and water solution (1:3) for 15 minutes. Air dry.

You may make a vinegar solution using white vinegar and water. After washing your hands, measure and pour 3 cups of water into a container followed by 1 cup of white vinegar. Cover and shake to mix the solution. If you do not use all the solution, label it clearly and store it in an enclosed cabinet away from children and food. The tips and caps of the catheter tubing should be cleaned with alcohol and kept covered.

18. Document procedure according to policy.
- Additional Instructions

RN Contact Information:

Names of Caregivers oriented/trained/date with client: _____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

colostomy Bag Change
Written Instructions

Client Name _____

Procedure

1. Review care plan or medical orders for procedure.

Gather supplies.

- Clean gloves
 - Colostomy bag/appliance
 - Kara powder: paste or wafer
 - Skin preparation packets
 - Paper towels cut to size 4x4 or non sterile 4x4 gauze pads
 - Basin of warm water and mild soap
 - Clean colostomy bag belt
 - Bag for garbage
2. Wash hands and apply gloves.
 3. Remove colostomy belt. This may be cleaned and reused.
 4. Remove old colostomy bag and check skin around stoma for redness, breaks or bleeding.
 5. Clean skin with warm water and mild soap using 4x4. Stoma may expel some stool during process.
 6. Pat dry with paper towels or gauze.
 7. Apply Kara, if needed.
 - If paste is used, place the tube at edge of the stoma where it meets the skin of the abdomen and squeeze a thin bead around the edge of the stoma.
 - If a sheet of Kara is used, cut the center out of a 4x4 sheet so the inner circle fits tightly to the stoma and covers all the skin of the abdomen. A paper pattern may be effective for testing the size of the hole needed.
 8. Hold in place for several minutes so that the Kara warms and stays in place.
 9. Apply the new colostomy bag.
 10. Remove gloves and wash hands.
 11. Attach belt.
 12. Throw away old supplies into garbage bag. Secure the bag closed.
 13. Wash hands.
 14. Reorder needed supplies.
 15. Document colostomy bag change and observations.
 16. Call the supervising nurse if any of the following is noted.
 - Bleeding of the stoma
 - Skin breakdown
 - Pain
 - Blood in stool
 - Dark blue or black spots on stoma or skin

Additional Instructions _____

RN Contact Information:

Names of Caregivers oriented/trained/date with client: _____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

Ear Drops
Written Instructions

Client Name _____

1. Provide privacy
2. Identify client (ask client his/her name)
3. Wash hands (assist client with hand washing if taking own medication)

Check medication profile

- | | |
|----------------------------------|-------------------------|
| A) Right client | E) Right dose |
| B) Right day | F) Correct ear/ears |
| C) Right time | G) Check for additional |
| D) Right medication instructions | |

4. Get supplies
5. Obtain the correct medication
6. Compare the medication with medication profile
7. Position client correctly
8. Compare the medication with medication profile
9. Pull ear up and back
10. Administer correct number of drops in correct ear:
11. Avoid contact of ear with dropper
12. Instruct client to remain in position for approximately 5 minutes
13. Repeat for other ear if ordered
14. Return medication to storage place and lock, if applicable
15. Wash hands
16. Document on appropriate charting sheet
17. Report any questions or concerns to the nurse immediately

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

RN Contact Information:

Enemas
Written Instructions

Client Name: _____

1. Provide privacy
2. Identify client (ask client his/her name)
3. Wash hands
4. Check medication profile A) Right client B) Right route C) Right day D)
Right type of enema E) Right time
F) Right dose G) Check for additional instructions
5. Get supplies such as gloves, lubricant, protective pad for the bed
6. Obtain or prepare the correct enema; compare it with medication profile
7. Put on gloves and place a protective pad on bed
8. Assist client to undress
9. Position client on left side lying position or as indicated below
10. Compare enema with medication profile
11. Administer enema: Administer at room temperature unless otherwise indicated otherwise
on instructions
 1. Remove tip protector 2. Gently insert into rectum
 3. Lubricate if not pre-lubricated 4. Squeeze container/expel correct amount
12. Inform client of instructions on enema retention
13. Remove gloves and wash hands
14. Assist client to dress if applicable
15. Clean and return enema container to storage place and lock, if applicable
16. Wash hands
17. Document on appropriate charting sheet
18. Report any questions or concerns to the nurse immediately

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

RN Contact Information:

Eye Drops
Written Instructions

Client Name: _____

1. Provide privacy
2. Identify client (ask client his/her name)
3. Wash hands (assist client with hand washing if taking own medication)
4. Check medication profile A) Right client B) Right day
5. C) Right time D) Right medication E) Right dose
6. F) Correct eye/eyes G) Check for additional instructions
7. Get supplies such as gloves and tissue
8. Obtain the correct medication
9. Compare the medication with medication profile
10. Shake the bottle PRN
11. Position client correctly
12. Compare medication with medication profile
13. Pull lower eyelid down
14. Administer correct number of drops in correct eye/eyes
15. A) Outer aspect of lower lid B) Avoid contact of eye with dropper
16. Provide tissue to wipe excess moisture
17. Return medication to storage place and lock, if applicable
18. Return medication to storage place and lock, if applicable
19. Wash hands
20. Document on appropriate charting sheet
21. Report any questions or concerns to the nurse immediately

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

RN Contact Information:

Eye Ointment
Written Instructions

Client Name: _____

- Provide privacy
- Identify client (ask client his/her name)
- Wash hands (assist client with hand washing if taking own medications)
- Check medication profile A) Right client B) Right day
- C) Right time D) Right dose E) Correct eye/eyes
- F) Right medication G) Check for other instructions
- Get supplies such as gloves and tissue
- Obtain the correct medication
- Compare the medication with medication profile
- Position client correctly
- Compare medication with medication profile
- Pull lower eyelid down
- Apply ointment to correct eye/eyes: Apply thin strip (generally one inch or as directed) to lower lid. Avoid contact of eye with tube tip
- Advise client to gently close eye for a moment
- Provide tissue to wipe excess moisture
- Return medication to storage place and lock, if applicable
- Wash hands
- Document on appropriate charting sheet
- Report any questions or concerns to the nurse immediately

Additional Instructions: _____

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RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

RN Contact Information:

Falls Protocols
Written Instructions

Client Name _____

When you encounter a client, who has fallen:

1. **Calmly ask, "Are you OK? What happened?"** This checks his or her LOC (level of consciousness) and orientation. Is it normal for the client? If the client is not okay, unconscious, or newly disoriented, do not move the client and call 911. Then call the On-Call Nurse. Otherwise, continue to the next step.
2. **Ask, "Where does it hurt?"** Check for pain. Look at the area identified for injury. If there is a serious injury (such as a head injury or laceration), do not move the client and call 911. Then call the On-Call Nurse. Otherwise, move to the next step.
3. **Ask the client to move each arm and leg.** This checks the function of all extremities. If the client is unable to move an extremity, do not move the client and call 911. Then call the On-Call Nurse. Otherwise, move to the next step.
4. **If the client appears to be uninjured, assist to a sitting position. Look for open areas, bleeding, swelling, redness and areas of pain.** If any of these problems are evident, call the On-Call Nurse. Otherwise, move to the next step.
5. **Assist the client to a comfortable location.** Check vital signs and blood sugar (if diabetic). Treat any cuts or minor injuries using standard first aid protocols.
6. **If the vital signs are within normal range for the client, position him or her safely and comfortably and recheck his or her status and vital signs in 30 – 60 minutes.** Continue to monitor the client during the next 8 hours for changes or signs/symptoms of injury.
7. **Note the cause** of the fall and implement steps to avoid future falls.
8. **Document** the fall in the communication book.
9. **Fill out an Incident Report.**

If the client is sent to the emergency room because of a serious injury, contact the on-call nurse. Home Health Aides should not contact family members without instructions from the on-call nurse.

If you are unsure about any findings, call the on-call nurse.

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

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_____	_____	_____
_____	_____	_____
_____	_____	_____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

RN Contact Information:

Gastrostomy Tube Feedings
Written Instructions

Client Name _____

Procedure:

To start feeding:

1. Verify correct formula, rate, route, and frequency
2. Wash hands and apply clean gloves
3. Assemble equipment
 - Feeding bag and tubing (use new bags and tubing as instructed per nurse or supplier)
 - 60 ml catheter-tipped syringe
 - Formula
 - Infusion pump
4. Connect tubing to bag
5. Fill bag and tubing with formula
6. Explain procedure to client and elevate head of bed to 30 degrees
7. Verify placement of tube as instructed by RN
 - Aspirate gastric secretions and check residual (call RN for residual amount as instructed on Care Plan)
 - Place stethoscope over stomach (upper quadrant) and inject 10-20 ml of air into tube
8. Hang feeding bag on pole
9. Unclamp end of gastrostomy tube and connect to syringe or tubing
10. Using syringe, slowly inject water (amount as instructed on Care Plan) before connecting tube feeding, if ordered by RN
11. Connect infusion pump and set rate
12. Assure normal operation of pump and feeding
13. Wash hands
14. Chart start of feeding **At end of feeding:**

1. Wash hands and apply clean gloves
2. Turn off pump and disconnect feeding tube
3. Using syringe, slowly inject water (amount as instructed on Care Plan), if ordered by RN
4. Clamp end of gastrostomy tube
5. Rinse bag and tubing with warm water if they are to be reused
6. Wash hands
7. Chart amount and type of feeding and client's response **Watch for the following:**
 - Skin breakdown or irritation • Bleeding or drainage at insertion site
 - Feeding tube dislodged • Choking
 - Difficulty breathing • Upset stomach that lasts 24 hours
 - Vomiting • Diarrhea • Constipation
 - Other (specify) _____

If you observe any of the above symptoms, contact your supervising nurse.

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RN Signature _____ Date _____

RN Contact Information:

Inhalants
Written Instructions

Client Name _____

1. Provide privacy
2. Identify client (ask client his/her name)
3. Wash hands (assist client with hand washing if taking own medication)
4. Check medication profile:
A) Right client B) Right day C) Right time D) Right dose
E) Right route F) Right medication G) Check for other instructions
5. Obtain correct medication
6. Compare the medication with the medication profile
7. Shake PRN
8. Assemble equipment:
A) Inhaler or nebulizer with tubing
B) Prescribed amount of medication poured or dropped into nebulizer
C) Compressor plugged in
9. Compare the medication with medication profile
10. Position client correctly (Standing or sitting)
11. Administer medication: Instruct client to:
A) Exhale B) Place mouthpiece in mouth
C) Inhale while pressing inhaler once D) Hold breath (3 seconds)
E) Exhale slowly F) Repeat until all medication is delivered as prescribed
12. Clean and dry nebulizer and tubing daily
13. Return medication to storage place and lock, if applicable
14. Wash hands
15. Document on appropriate charting sheet
16. Report any questions or concerns to the nurse immediately

Additional Instructions: _____

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RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

RN Contact Information:

Liquid Medications
Written Instructions

Client Name _____

1. Provide privacy
2. Identify client (ask client his/her name)
3. Wash hands (assist client with hand washing if taking own medications)
4. Check medication profile A) Right client B) Right day
C) Right time D) Right route E) Right medication
F) Check for additional instructions
5. Get supplies such as dropper, medication cup or other measuring device
6. Obtain the correct medication
7. Compare the medication with the medication profile
8. Shake the bottle PRN
9. Pour the correct amount of liquid
10. Compare medication with medication profile
11. Give medication to client and watch the client swallow it
12. Return medication to storage place and lock, if applicable
13. Wash hands
14. Document on appropriate charting sheet
15. Report any questions or concerns to the nurse immediately

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

_____	_____	_____
_____	_____	_____
_____	_____	_____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

RN Contact Information:

Mechanical Lift
Written Instructions

Client Name _____

Procedure

1. Review the Care Plan or medical orders for procedure
-Gather supplies
2. Hoyer or other mechanical lift device
3. Wheelchair or Chair
4. Explain procedure to client. Provide for privacy and comfort.
5. Wash hands
6. Position the client in the center of the bed. Roll the client toward you.
- 6, Fold the Hoyer lift sling halfway under the client so that the lower edge of the sling is slightly below the client's knees.
7. Go to the opposite side of the bed and roll the client over the sling, pulling the sling out flat.
8. Position the Hoyer lift with the arms perpendicular to and directly over the client. The Hoyer lift base legs should be spread wide apart.
9. Connect the Hoyer lift chains to the sling and the other ends of the Hoyer lift chains to side arms of the lift (shorter chains toward the head). The hook ends of the chains should face away from the client.
10. Instruct the client to keep his or her arms inside the chains with the arms folded across the chest.
11. Will ensure that each strap is properly attached by examining each strap to ensure it is locked in place before is lifted. .
12. Slowly pump the Hoyer lift hydraulic handle to raise the client from the bed.
13. As soon as the client is clear of the bed, swing him or her away from the bed. Position the client over the wheelchair or chair.
- 14 Press the Hoyer lift hydraulic release valve, and stabilize the client while slowly lowering him or her into the wheelchair/chair.
- 15 Remove the Hoyer lift hooks and chains; keep the client seated on the Hoyer lift sling. Position client comfortably.
- 16, If Client is unable to stand, KEEP Sling in wheelchair
- 17 Clean and replace equipment.
18. Wash hands.
19. Document Hoyer transfer.

Make sure #11 is in the care plan

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

_____	_____	_____
_____	_____	_____
_____	_____	_____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

RN Contact Information:

Nasal Drops/Sprays
Written Instructions

Client Name _____

1. Provide privacy
2. Identify client (ask client his/her name)
3. Wash hands (assist client with hand washing if taking own medication)
4. Check medication profile A) Right client B) Right day
5. C) Right time D) Right medication E) Right dose
6. F) Correct nostril/nostrils G) Check for additional instructions
7. Get supplies such as gloves and tissue
8. Obtain the correct medication
9. Compare the medication with medication profile
10. Shake the bottle PRN
11. Position client correctly
12. Compare medication with medication profile
13. Have client blow nose if needed
14. If drops, tip head back and place drops into nostril
15. If spray, have client hold head upright, place nozzle into nostril and depress
16. Administer correct number of drops in correct nostril/nostrils
17. Provide tissue to wipe excess moisture
18. Return medication to storage place and lock, if applicable
19. Return medication to storage place and lock, if applicable
20. Wash hands
21. Document on appropriate charting sheet
22. Report any questions or concerns to the nurse immediately

Additional Instructions: _____

RN Contact Information:

Names of Caregivers oriented/trained/date with client: _____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

Oral Medications
Written Instructions

Client Name _____

1. Provide privacy
2. Identify client (ask client his/her name)
3. Wash hands (assist client with hand washing if taking own medications)
4. Check medication profile.
 - A) Right client B) Right day C) Right time
 - D) Count number of pills for day/time E) Check for additional instructions
5. Check medication box
 - A) Right client B) Right day C) Right time
 - D) Right number of pills for day/time
6. Provide client with water, milk or juice unless otherwise instructed on medication profile
7. Give medication to client and watch client swallow it
8. Return medication to storage place and lock, if applicable
9. Wash hands
10. Document on appropriate charting sheet
11. Report any questions or concerns to the nurse immediately

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

Signature _____ Date _____

RN Contact Information:

Oxygen Therapy
Written Instructions

Client Name _____

Applying a Nasal Cannula

A nasal cannula is a simple, comfortable device used for oxygen delivery. Two cannulas, approximately ½ inch long, protrude from the center of a disposable tube and are inserted in the client's nostrils. Oxygen is delivered via the cannulas according to the flow rate ordered by the physician.



Procedure

12. Review Care Plan or instruction sheet regarding use of oxygen
13. Explain procedure to client
14. Wash hands
15. Gather equipment:
 - a. Nasal cannula
 - b. *Humidifier, if indicated
 - c. *Sterile water for humidification, if indicated
 - d. Oxygen source
 - e. Flow-meter
16. Attach nasal cannula to oxygen tubing and attach to humidified (if indicated) oxygen source adjusted to prescribed flow rate
17. Place tips of cannula into the client's nostrils and adjust the elastic headband until the cannula fits snugly and comfortably.
18. Maintain sufficient slack on oxygen tubing and secure it to the client's clothing
19. Wash hands
20. Document the procedure, including administration of oxygen and flow rate.
21. Check cannula regularly. Keep humidification jar filled at all times.
22. Check oxygen flow rate compared to physician's orders regularly.
23. Check tubing regularly to be sure that it is not kinked and that it is securely attached to the oxygen flow-meter.
24. Inspect the skin over the ears and in the nostrils for any redness or breakdown from too tight an application of the cannula.

25. Contact the nurse supervisor if any of the following occurs.
- Increased respiratory rate,
 - Change in level of consciousness
 - Increased confusion
 - Pain

The flow-meter should be adjusted to the prescribed oxygen flow rate. Several home oxygen systems are available, including compressed gas cylinders, liquid oxygen systems and oxygen concentrators. Be familiar with that used by your client. Be sure that the phone number and contact information for the home oxygen supplier is readily

Precautions

- Oxygen is flammable. **There should be no smoking in the vicinity when a client is receiving oxygen therapy.**
- Clients on oxygen therapy may not smoke when on oxygen therapy or in the vicinity of the oxygen equipment.
- Electrical equipment must have special grounding adaptors on plugs to avoid sparks. The client and family should be warned of the dangers involved in using oxygen at home, such as exercising care when using oxygen near stoves, portable heating units, and ungrounded electrical equipment. Post signs, if possible.
- Oxygen cylinders must be placed in a cart or base to avoid dropping or bumping the tank.
- Oxygen tanks or compressors should be turned off when not in use and oxygen

valves should be checked routinely to be sure that they are secure.

- Oxygen levels in reserve tanks should be monitored to ensure continuous therapy.

*If the oxygen flow rate is greater than 4L/min, humidification may be indicated to prevent dry nasal and upper airway passages.

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

RN Contact Information:

PRN Medications
Written Instructions

Name of Client _____

1. Provide privacy
2. Identify client (ask client his/her name)
3. Identify reason for requesting medication
4. Wash hands (assist client with hand washing if taking own medications)
5. Check medication profile: A) Right client B) Right day
C) Right time D) Right medication E) Right dose
F) Right number of pills G) Check for other instructions
6. Check PRN medication administration record to see when it was last given
7. Obtain the correct medication envelope or follow medication protocol sheet for appropriate route of medication
8. Compare the medication with the medication profile/PRN instruction sheet
9. Provide client with water, milk, or juice (unless otherwise instructed)
10. Give medication to client and watch client swallow it
11. Return medication to storage place and lock, if applicable
12. Wash hands
13. Document on appropriate charting sheet
14. Report any questions or concerns to the nurse immediately
15. Check back with client to see if the medication was effective. Chart results.

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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RN Signature _____ Date _____

RN Contact Information:

Pulse Oximeter
Written Instructions

Client Name _____

Procedure

1. Review care plan or medical orders for procedure.
2. Obtain pulse oximeter machine.
3. Position client comfortably in sitting or lying position.
4. Wash hands.
5. Explain procedure to client and assist client to wash hands, if dirty.
 - Turn on the oximeter.
6. Open clip and place the sensor probe over the fingernail, using the pointer finger, if possible.
 - Instruct the client to remain still while getting the reading.
 - Read the display.
 - a) A notation of SpO2 will identify the client's oxygen saturation level
 - b) A heart symbol will indicate the client's pulse rate
7. Remove the oximeter from the finger.
8. Clean the oximeter and sensor probe with a mild detergent solution or alcohol pad (70% isopropyl alcohol solution).
9. Be sure that the oximeter is dry before putting it away.
10. Wash hands.
 - Record the oxygen saturation level and pulse rate.
11. Report abnormal findings to the nurse immediately.

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

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RN Signature _____ Date _____

RN Contact Information:

Rectal Suppositories

Written Instructions

Name of Client _____

1. Provide privacy
2. Identify client (ask client his/her name)
3. Inform client of procedure
4. Wash hands
5. Check medication profile:
 A) Right client B) Right day C) Right time D) Right dose
 E) Right route F) Check additional instructions
6. Get supplies such as gloves, lubricant, protective pad for bed and tissue to clean rectal area
7. Obtain the correct medication and compare the medication with medication profile
8. Put on gloves and place protective pad on bed
9. Assist client to undress
10. Position client on left side lying position or as instructed
11. Compare medication with medication profile
12. Administer suppository:
 A) Administer at room temperature; if too soft and suppository is unwrapped, refrigerate 30 minutes **OR** if wrapped, run under cold water
 B) Remove foil, if applicable
 C) Lubricate suppository with water-soluble jelly or cold water on smooth round end
 D) Gently insert rounded end into anus along the wall of the rectum approximately 4 inches (adult)
13. Inform client of instructions on suppository retention
14. Remove gloves and wash hands; assist client to dress if applicable
15. Return medication to storage place and lock, if applicable.
16. Document on appropriate charting sheet
17. Report any questions or concerns to the nurse immediately **ADDITIONAL INSTRUCTIONS:**

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

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RN Signature _____ Date _____

RN Contact Information:

Suprapubic Catheter Care
Written Instructions

Client Name: _____

Definition: A suprapubic catheter is a tube inserted into the bladder through a hole in the abdomen called a stoma. The catheter is used to empty the bladder. It is held in place with a balloon which is inflated inside the bladder.

Procedure

1. Gather supplies:
 - Antiseptic ointment
 - Clean Q tips
 - 2 pairs of gloves
 - Bowl of warm water, soap, washcloth and hand towel
 - Tape
 - 4X4 gauze or pre-cut gauze pad
 - Scissors
 - Waterproof pad to protect bedding
2. Explain procedure to client.
3. Provide for privacy.
4. Wash hands.
5. Position client on his/her back.
6. Place a waterproof pad under the client to keep the bedding dry.
7. Apply gloves
8. Remove and dispose of old dressing
9. Check for any redness or drainage around insertion site.
10. Remove gloves, wash hands and apply clean gloves
11. Clean the site around the stoma.
 - Gently wash using a clean washcloth with warm water and soap using a circular motion outward from the stoma

- Holding the catheter tube to prevent it from being pulled out, wash the catheter to remove any blood or other materials
 - Rinse the stoma and surrounding skin
 - Pat dry
12. Using the Q tips, put a small amount of antiseptic around the stoma.
 13. Cut a clean 4X4 gauze sponge to the center on one side to fit around the catheter like a collar OR use a precut gauze sponge.
 14. Apply the gauze bandage to the stoma site and tape the edges of it securely.
 15. Secure the catheter with a pin or tape, as instructed by the nurse, to prevent any tension on it.
 16. Remove gloves and wash hands
 17. Document the catheter care.
 18. Notify the nurse of the following.
 - Redness or drainage at insertion site
 - Leakage
 - Cloudy urine
 - Presence of mucous or red specks in urine
 - Strong smelling urine
 - No urine output within 6-8 hours
 - Pain or burning in area
 - Chills or fever

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

_____	_____	_____
_____	_____	_____
_____	_____	_____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

RN Contact Information:

Topical
Written Instructions

Name of Client _____

1. Provide privacy
2. Identify client (ask client his/her name)
3. Inform client of procedure
4. Wash hands
5. Check medication profile:
 - A) Right client B) Right day
 - C) Right time D) Right medication E) Right application site
 - F) Right dose G) Check for additional instructions
6. Obtain the correct medication
7. Compare the medication with the medication profile
8. Put on gloves
9. Apply to correct site with appropriate applicator according to procedure, if applicable
10. Clean or discard applicator if used
11. Remove gloves and wash hands
12. Return medication to storage place and lock, if applicable
13. Document on appropriate charting sheet
14. Report any questions or concerns to the nurse immediately

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

RN Contact Information:

Vaginal Suppository/Creams

Written Instructions

Name of Client _____

1. Provide privacy and identify client (ask client her name)
2. Inform client of procedure
3. Wash hands
4. Check medication profile: A) Right client B) Right day C) Right time D)
Right dose E) Right route
F) Check for additional instructions
5. Get supplies: gloves, protective pad for bed, applicator, tissue to clean vagina
6. Obtain the correct medication and compare it with the medication profile
7. Apply gloves and place protective pad on bed
8. Assist client to undress and position client in back-lying position with knees bent or as instructed
9. Compare medication with medication profile
10. Administer suppository
 - If too soft, run under cold water
 - **Unwrapped: refrigerate 30 minutes** ● **Remove foil if applicable**
 - Lubricate suppository with water-soluble ● Insert 2 inches into vagina ● Push the plunger ○
 - Dispose of or clean the applicator.

Administer cream

- A) Fill applicator with prescribed amount of cream if applicable
- B) Gently Insert end into vagina back wall 3-4 inches or as far as it will go
- C) Push the plunger
- D) Dispose of or clean the applicator.

Inform client of instructions on suppository/cream retention; wipe vaginal area with tissue

11. Remove gloves and wash hands; assist client to dress if applicable
12. Return medication to storage place and lock, if applicable
13. Document on appropriate charting sheet
14. Report any questions or concerns to the nurse immediately

Additional Instructions: _____

Names of Caregivers oriented/trained/date with client: _____

RN should initial & date next to caregiver name. (Copy in client file & copy in each CG file)

RN Signature _____ Date _____

RN Contact Information: