1. The Unit Nurse will:
   
a. Assign Nursing Assistants to:
   
   i. Take residents to/from the dining room/day room
   
   ii. Feed residents

   iii. Stay in the dining room/day room until all residents are finished eating

   iv. Answer call lights during meals, and assist residents with toileting as needed

   v. Record intakes

b. Ensure that all residents are taken to/from the dining room or day room in a timely manner.

c. Monitor the dining room/day room during meals, and remain in the dining room/day room until all residents have finished eating.

d. Inform the Kitchen Supervisor if delivery of trays to the dining room/day room is more than 15 minutes late.

e. Supervise Nursing Assistants during the meal to ensure:
   
   i. Residents are served food in accordance with prescribed diets, and assisted with feeding appropriately

   ii. Call lights are answered promptly

   iii. Intakes are recorded for all residents

   iv. Sanitary conditions and safety are maintained for all residents

   v. A therapeutic dining experience is maintained: Turn television off, and adjust temperature, noise, lighting as needed.

f. Refer residents to the Restorative Nurse for:
   
   i. Evaluation for adaptive utensils

   ii. Evaluation for a Restorative Feeding program

2. Nursing Assistants must:
   
a. Perform mealtime duties as assigned by the Unit Nurse.

   b. Assist residents to perform appropriate hygiene prior to the meal.
c. Ensure that eyeglasses, dentures, and hearing aids are in place before the meal.
d. Dress residents appropriately for dining, and offer clothing protectors/bibs as needed.
e. Seat residents properly, and adjust tables to accommodate wheelchairs.
f. Follow the dining room seating plan.
g. Notify the Unit Nurse of changes that might improve the seating plan.
h. Offer residents fluids before the meal, such as coffee, water, or tea.
i. Provide residents with required assistive devices as prescribed, such as:
   i. Plate guard
   ii. Roller knife
   iii. Weighted utensils
   iv. Two handled cups
   v. Altered handles on utensils
j. Provide residents with all necessary condiments, and assist with opening containers.
k. Serve and assist residents at the same table concurrently.
l. Serve only food to the resident that is in accordance with the menu card/prescribed diet, such as:
   Mechanically altered
   Ground meat
   Pureed
   Thickened liquids
   Thin liquids
m. Offer substitutes to any resident who refuses food.
n. Assist the resident with meals as indicated on the resident’s care plan.
o. Inform the Unit Nurse if the resident needs more help than is reflected on the plan of care. Indications that a resident may need more assistance with meals include:
   i. Unable to hold utensils
   ii. Unable to comprehend utensil use
   iii. Leaves food uneaten if not assisted
   iv. Wanders or paces
p. When feeding a resident:
   i. Refrain from making negative comments about the food. Say positive things about the food to help stimulate the resident’s appetite.
   ii. Converse with the resident during the meal, rather than with other staff members.
iii. Allow the resident to choose the order of foods when possible.
iv. Test food temperature to make sure it is not too hot for the resident.
v. Do not mix foods together.
vi. Alternate bites of food with fluids.
vii. Allow the resident ample time to chew and swallow.

q. Monitor residents during meals for chewing or swallowing difficulties, and report to the Unit Nurse immediately any occurrences of:
i. Difficulty swallowing
ii. Prolonged swallowing time or repeated swallows per bite
iii. Holding or pocketing food in mouth
iv. Coughing or throat clearing

r. When assisting the resident with a chewing and/or swallowing problem:
i. Moisten meats and vegetables with gravies or sauces when possible.
ii. Give small bites and sips.
iii. Alternate liquids with solids.
iv. Instruct the resident to eat slowly, and to chew each bite thoroughly.
v. Check the resident’s mouth after meals for pocketed food and debris.
vi. For the resident eating in bed, keep the head of the bed elevated 45 degrees during the meal and thirty minutes afterwards.

s. When assisting the visually impaired resident:
i. Describe the location of the food on the plate using the clock method.
ii. Tell the resident what the food items are.

t. Assist residents with hygiene and cleanliness after meals:
i. Clean hands and faces.
ii. Remove all clothing protectors/bibs.
iii. Clean clothing and chairs.
iv. Clean all food and debris from table tops and floors.

u. Record each resident’s intake of food and fluids as instructed by the Unit Nurse.
1. Residents who wander are considered an elopement risk, and the facility will ensure that the safety of residents who wander is maintained, and that elopement is prevented.

2. The MDS Nurse will:
   a. Complete an assessment for wandering on all residents at admission.
   b. Work with the care plan team to develop, maintain, and update a care plan for each resident who wanders.

3. The care plan team will assess causes of wandering and the effectiveness of interventions with every scheduled resident assessment and any significant change of condition.

4. The care plan team will work to identify the pattern of the resident’s wandering, asking such questions as:
   a. Is the wandering purposeful, aimless, or escapist?
   b. Is the resident looking for something?
   c. Does it indicate the need for more exercise?

5. The care plan team should consider for all residents who wander interventions:
   a. To maintain safety
   b. Modify the environment
   c. Structure activities

6. Interventions to maintain safety include:
   a. Identification band
   b. Bracelet alarm for alarm doors
   c. Assess for fall risk
   d. Monitor for fatigue and weight loss
   e. Placement in closed unit if appropriate
   f. Check resident’s location every 15/30/60 min
   g. Staff to accompany resident to__________.
7. Interventions to modify the environment include:
   a. Outside secure courtyard for safe walking
   b. Personalize room with clock, calendar, signs, or pictures
   c. Safe walking path

8. Interventions to structure activities include:
   a. Supervised walking activities
   b. Reorientation to person, place, and time as needed
   c. Toileting schedule
   d. Distract resident from wandering by offering pleasant diversions, food, conversation, television, or book

9. The Charge Nurse will ensure that:
   a. All of the unit’s staff members are aware which residents are an elopement risk, and are familiar with their care plans.
   b. The facility’s front desk receptionist has a current picture of each of the unit’s residents.
   c. All of the unit’s staff members are familiar with the plan of action in the event of a resident elopement.

10. If resident tries to follow a staff member through the door of a locked unit, the staff member should reverse direction, and then distract the resident to prevent the resident feeling locked in or confined.

11. When a resident is missing, staff members must:
   a. Notify the Charge Nurses, Director of Nursing, and Administrator immediately.
   b. Participate in a search of the facility’s building and grounds that includes a search of every room, area, and closet as instructed by the Charge Nurses, Director of Nursing, and Administrator.

12. If the resident is not found in the facility or on its grounds within twenty minutes, the Director of Nursing will inform the local police and the resident’s family member of the resident’s elopement.

13. After any occurrence of elopement:
   a. The Charge Nurse will file an incident report according to the facility’s policy.
   b. The care plan team will review the resident’s care plan and implement new interventions to prevent another occurrence of elopement.
   c. The facility’s Safety Committee will review the facility’s safety measures to assess if improvements can be made to prevent another occurrence of elopement.
   d. The Director of Nursing will inform authorities and agencies as required by state and federal laws.
1. Tracks and schedules required resident assessments per state and federal requirements.

2. Completes all Minimum Data Set (MDS) assessments and Care Area Trigger Summaries (CATs).

3. Checks the facility’s census daily, and completes Discharge and Re-entry Tracking forms as needed.

4. Monitors documentation in the facility to ensure consistency and compliance with state and federal requirements.

5. Initiates and monitors skilled nursing Medicare documentation.

6. Maintains the Medicare Utilization Review (UR) census log.

7. Attends weekly Utilization Review meetings.

8. Participates in the facility quality of care committees and meetings:
   a. Pain Care Committee
   b. Restraints Committee
   c. Safety Committee
   d. Medical Director’s meeting
   e. Quality Assurance Committee


10. Writes all chronic nursing care plans for all residents in the facility, and monitors acute nursing care plans.

11. Monitors all of the facility’s resident assessments and care plans to ensure that they:
    a. Are completed in a timely manner
    b. Are completed appropriately
    c. Meet state and federal regulations
    d. Meet standards of practice and clinical guidelines
12. Schedules and leads Care Plan Conferences. See the policy: Care Plan Conferences.

13. Reviews the daily 24 Hour Reports and telephone orders on each unit for significant changes in resident conditions that might alter assessments and care plans.

14. Completes resident assessments to capture the highest possible Resource Utilization Group (RUG) score.

15. Prints monthly Case Mix reports and Quality Indicator/Quality Measure reports, and distributes copies to the Director of Nursing and the Quality Assurance Director.

16. Prints monthly Center for Medicare and Medicaid Services (CMS) reports, and informs staff members of regulatory updates and changes.

17. Transmits completed MDS assessments to the state in compliance with state and federal regulations.

18. Educates and trains staff members about the resident assessment process.

19. Completes, or ensures that the Unit Nurses complete special care quarterly assessments such as:
   - Pain Care
   - Restraints
   - Falls
   - Hydration
   - Psychotropic Medication
   - Skin Breakdown
   - Urinary Catheter Use
   - Wandering Risk
   - Weight Loss

20. Maintains and updates the facility Falls Log, and after any fall:
    a. Enters the fall in the Falls Log with its time, date, and location.
    b. Completes a fall risk assessment which includes a full medication review.
    c. Works with the care plan team to add new interventions to the resident’s fall risk care plan.
    d. Informs the Unit Nurse of the new interventions.
1. The facility’s goal is to achieve a restraint-free environment.

2. The facility will ensure that the resident is free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

3. A restraint will be used only after other alternatives have failed.

4. A restraint assessment will be completed before any restraint is applied.

5. The underlying causes of medical symptoms will be investigated, and interventions will be implemented to eliminate those causes.

6. If underlying causes of medical symptoms cannot be eliminated, the facility will try alternative measures before the restraint is used.

7. If alternatives are unsuccessful, the least restrictive form of restraint will be applied.

8. A physician’s order will be obtained for restraint use, stating the medical symptoms requiring the restraint, what type of restraint is to be used, and when the restraint is to be used.

9. The physician’s order will include instructions to check the restraint every 30 minutes, and to release it every 2 hours for 10 minutes. These instructions will be documented in the Treatment Administration Record and the Nursing Assistant Care sheet.

10. Consent will be obtained from the resident’s family member or responsible party before applying a restraint. Obtaining informed consent includes instructing the resident’s family member about alternatives to the restraint, what potential negative outcomes there may be, and the right to refuse the restraint.

11. The Restraint Consent form will be filled out and signed for each type of restraint and for each episode of restraint use.

12. Restraint use will be reevaluated weekly or as soon as the staff has determined that a change in the resident’s condition has occurred.

13. The restraint will be discontinued as soon as possible.

14. If a resident is admitted with a restraint, a Restraint Assessment will be completed that includes evaluation of balance, strength, gait, transfer, and safety.
15. Side rail use will be addressed in the same manner as any other restraint.

16. Side rails used as an enabler will be supported by documentation.

17. During restraint use the resident will be regularly monitored for potential negative outcomes, and to make sure all of the resident’s needs are met.

18. Restraint use will be addressed on the MDS assessments, Resident Assessment Protocols, and in the care plan.

19. Care plan interventions will include measures to minimize or eliminate the medical symptom requiring restraint use.

20. Interventions will include programs to prevent functional declines, such as exercise and restorative programs for transfer, gait, and balance.

21. Restraints Committee
   a. Restraints Committee membership consists of the Director of Nursing and representatives from the Restorative Nursing, MDS, and Quality Assurance departments.
   b. The Restraints Committee will meet monthly and evaluate the restraint use of all residents in the facility.
   c. The committee will set goals to develop policies and procedures, educate staff, and develop forms to implement the restraint reduction program.
   d. The committee will assess:
      i. Restraint use policies and procedures
      ii. Restraint use practices in the facility
      iii. Restraint assessment and monitoring forms and practices
      iv. Staff, resident, and family knowledge of restraint use alternatives and potential negative outcomes of restraint use
      v. Documentation of effectiveness of restraint use practices
   e. The committee will write plans of correction to decrease the facility’s use of restraints.

22. The Quality Assurance Nurse will:
   a. Track the facility’s restraint use by month, day, location, and unit.
   b. Analyze restraints statistics to discern patterns.
   c. Investigate causes when improvement or decline in the facility rate of restraint use is noted.
   d. Perform monthly audits of the facility’s restraint use and practices to ensure that:
      i. Medical reason for restraint is documented
ii. Families and residents are instructed about alternatives to restraint use and potential negative outcomes

iii. Informed consents are obtained and signed

iv. Alternatives to restraint use are attempted

v. Appropriate physician’s order is in charts and in treatment record

vi. Restraint is the least restrictive and applied for the least amount of time

vii. Monitoring flow sheet is in treatment record

viii. Flow sheet includes observation for potential negative outcomes

ix. Restraint is checked every 30 minutes, and released every 2 hours for 10 minutes as ordered

x. Toileting needs are monitored

xi. Nutrition and hydration needs are monitored

xii. Skin is monitored for breakdown

xiii. Socialization and activity needs are monitored

xiv. Restraint care plan is completed

xv. Range of motion and mobility are addressed in care plan

e. Report all findings to the Director of Nursing.

f. Report all findings to the monthly Restraints Committee meeting and to the quarterly Medical Director’s meeting.

23. The Staff Education department will ensure that:

a. Staff is educated about the facility restraint program through orientation and regular inservices.

b. Staff education on restraints includes instructions on restraint regulations, risks, and alternatives.
1. Organizes orientation for new employees.

2. Performs evaluation of competency and training of new, non-permanent, per-diem, and leased employees.

3. Provides clinical supervision to staff members for new skills as needed.

4. Develops inservices based on staff’s learning needs.

5. Works with nursing administration to keep staff up to date on changing regulations and standards of care.

6. Provides orientation for agency and temporary staff members.

7. Collaborates with staff to maintain documentation standards.

8. Promotes awareness of legal issues related to nursing care.

9. Maintains and updates a library of inservice and training resources.

10. Schedules and announces inservices upon approval by the Director of Nursing:
    a. Posts announcements for inservices by the employee time clock and in the break room at least one full week before the scheduled learning activity.
    b. Indicates which inservices are mandatory.
    c. Schedules mandatory inservices at times convenient for staff, such as on a pay day near the end of day shift, or at the end of evening shift.
    d. If the inservice cannot be given to night shift, provides a video of the inservice for viewing on that shift.

11. Ensures that all staff members attending inservices enter on the sign-in sheet for the activity, their name, the date, and their department.

12. Maintains records of attendance for each inservice.

13. Maintains records of inservice attendance for each employee.

14. Conducts the inservice using simple learning objectives, supplemented by outlines or handouts.

15. Promotes an environment that best facilitates learning.
16. Encourages questions, participation, and feedback from staff members during learning activities.

17. Conducts a pre-test and post-test for each inservice to assess the effectiveness of the learning activity.

18. Provides an inservice at least once per year on each of the following topics:
   - Abuse Prevention
   - Activities of Daily Living
   - Catheter Care and Urinary Tract Infections
   - Cognitive Impairment
   - Constipation
   - Dementia Management
   - Falls
   - Feeding Residents
   - Infectious Diseases
   - Nutrition and Hydration
   - Pain Care
   - Range of Motion
   - Resident Rights
   - Restraints
   - Sensory and Communication Impairments
   - Sexual Harassment and Professional Communication
   - Skin Care and Pressure Ulcer Prevention
   - Standard Precautions
   - Toileting Programs
   - Transfers and Lifts
   - Urinary Incontinence
   - Wandering and Elopement Risk
   - Workplace Violence

19. Provides inservices when needed as indicated by the Director of Nursing.

20. Participates in the facility’s quality of care committees and meetings:
   a. Pain Care Committee
   b. Restraints Committee
   c. Safety Committee
   d. Medical Director’s meeting
   e. Quality Assurance Committee