**The Salvation Army – William Booth Special Care Home**

**Emergency Policies and Procedures**

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# Health Care Directives

**POLICY:**

RQHR Special Care Home Policies; Section 3.3 **Health Care Directives** (2016)

To support establishing health care directives with residents / responsible persons in special care homes.

Residents\* of The Salvation Army William Booth Special Care Home (WBSCH), Long Term Care program, Convalescent / Elective Joint / Respite program are asked to provide in writing their direction for their goals of care (Health Care Directives).

The MVLST (My Voice for Life-Sustaining Treatment) form is to be completed as a result of a guided discussion between a WBSCH health care professional and the person / proxy / personal guardian / Substitute Decision Maker. The MVLST is **not** to be completed **without** assistance of a WBSCH health care professional.

**Definitions:**

* Advance Care Plan, Advanced Directive or Living Will – Instructions given by a person in accordance with *The Health Care Directives and Substitute Health Care Decision Makers Act 1997* that deal with the person’s health care decisions and / or the appointment of a proxy or with both. Advance Care Plans are made in advance of a person’s inability to make their own health care decisions. An Advanced Care Plan is also known as a Living Will, a Directive, an Advanced Health Care Directive or Advance Directive.
* Capacity – the ability to understand information relevant to a health care decisions respecting a proposed treatment; to appreciate the reasonably foreseeable consequences of making or not making a health care decision respecting a proposed treatment; and to communicate a health care decision on a proposed treatment
* Nearest Relative – Nearest relative as described in section 15 of *The Health Care Directives and Substitute Health Care Decision Makers Act 1997*.
* The spouse or person with who the person requiring treatment cohabits and has cohabited as a spouse in a relationship of some permanence;
* An adult son or daughter;
* A parent or legal custodian;
* An adult brother or sister;
* A grandparent;
* An adult grandchild;
* An adult uncle or aunt;
* Personal Guardian – a personal guardian appointed pursuant to *The Adult Guardianship and Co-decision-making Act* who has the authority to make health care decisions for a dependent adult and who acts in accordance with the authority granted to the personal guardian pursuant to the Act.
* Proxy – A person appointed in a directive to make health care decisions for the person making the directive pursuant to *The Health Care Directives and Substitute Health Care Decision Makers Act 1997.* A Proxy must be an adult (18 years or older) and must have capacity to make health care decisions(s). A Proxy has priority over a Personal Guardian or a Nearest Relative and is obliged to follow the person’s wishes where those wishes are known. A Proxy cannot revoke or change a Specific Advance Care Plan.

**EQUIPMENT (forms):**

:

* My Voice for Life Sustaining Treatment (MVLST) Goals of Care (RQHR 993 (08/15)
* Advance Care Planning Record (ACP record) (RQHR 994 (2013)
* Advanced Care Planning – the importance of a Proxy (RQHR 1091 (11/13)
* Confirmation of Substitute Decision Maker (RQHR 1123 (07/13)

**PROCEDURE:**

The MVLST is a person order and a summary of a person’s goals of care for their health care directives.

The Resident\* documents on the MVLST Form the goals of care / life-sustaining treatment chosen.

Refer to MVLST form for description of **goals of care**:

* Full Treatment (goal is to extend life)
* Full Treatment Conditional (goal is to extend life for reversible conditions only)
* Limited Additional Interventions (goal is conservative management of medical condition)
* Comfort Measures Only (goal is maximum comfort & symptom control at the end of life)

The signed MVLST Form along with any and all Advance Care Planning documents, are placed in the Greensleeve located at the front of the health record. All Advance Care Planning documents are to remain permanently in the Greensleeve (MVLST, ACP record, Proxy, Substitute Decision Maker, Living Will).

The MVLST is to be reviewed:

* When the person is admitted to WBSCH
* When there is substantial change in the person’s health status
* When the person’s treatment preferences change
* At the time of the annual care conference.

Review of MVLST is documented on the ACP record.

* If no changes are made to the MVLST, return it to the front of the Greensleeve
* If a person’s wishes change, a new MVLST must be completed, dated, signed and placed in the Greensleeve
* The old MVLST must be voided by drawing a line through the form and writing “void” across the form with the date. Put the voided MVLST at back of the Greensleeve.

On Discharge / Transfer: **Copy** of MVLST, ACP record, and Proxy is:

* Given to the person on discharge: or
* Sent with person on transfer to another care setting / facility.

Source:

RQHR Standardized Admission Agreement 2013

RQHR Advance Care Planning Policy and Procedure 615 (March 13, 2012).

Saskatchewan Ministry of Health, Program Guidelines for SCH (2015); 3.3 Health Care Directives.

RQHR Special Care Home Policies (2016); (3.3 Health Care Directives

WBSCH Nursing Manual (2016) 1.6 CPR

**Approval/Implementation/Evaluation Process**

Initial Implementation Date: April 16, 2007

Revised Date: September 2016

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Management Of Hypoglycemia (Senior)

**POLICY:**

To follow the guidelines of the RQHR Metabolic & Diabetes Education Centre (MEDEC) for the treatment of Hypoglycemia / low blood sugar reactions for seniors.

**PROCEDURE:**

Hypoglycemia is an abnormally low level of sugar (glucose) in the blood. Hypoglycemia occurs as a result of an imbalance in food, activity, and insulin / oral agent.

**For seniors**, during the day, blood sugars less than 5.0 mmol/L should be treated. At bedtime, blood sugar less than 7.0 mmol/L should be treated.

Alert: Conscious patient, treat immediately with a fast acting sugar / carbohydrate (CHO). Unconscious patient notify EMS.

Hypoglycemia and treatment of must be documented. Reoccurring low blood glucose is to be reported to the physician.

Hypoglycemia treatment kits are available on every Nursing unit for the standardized treatment of Hypoglycemia.

**Treatment steps** (conscious patient)

1. Treat with 15g of CHO

* 1 package honey; **OR**
* 1 juice box

1. Wait 15 minutes and retest blood glucose. If blood glucose remains less than 5.0 mmol/L repeat treatment with 15g of CHO. Repeat treatment steps until blood glucose is above 5.0 mmol/L.
2. Once desired blood glucose is attained, follow-up with:

* **During the day**
* If meal or snack is less than an hour away then no further treatment is required
* If meal or snack is more than an hour away, treat with:
  + 6 soda crackers & 1 peanut butter; **OR**
  + 1 Ensure pudding
* **At bedtime** (when blood sugar less than 7 mmol/L at HS), treat with:
  + Fruit puree and glass of milk
  + ½ meat or egg sandwich
  + Serving of yogurt
  + 2 digestive cookies and cheese
  + Banana and 1 peanut butter
  + ½ cup Ensure / Glucerna / Resource

Hypoglycemia treatment kit to be available on each Nursing station. Each kit to be supplied with:

* 6 individual packages of honey
* 3 200ml unsweetened orange juice
* 3 Ensure puddings
* 18 soda crackers (9 packages of 2)
* 3 peanut butter packages
* 3 knifes
* 9 teaspoons

Maintenance of the Hypoglycemia treatment kit:

* Refill kit after each use
* 1 month prior to expiry date: exchange juices and puddings with newer supplies and mark new expiry date on top of hypoglycemia kit.

Source:

Sabrina Bovee LTC RD (2013)

RQHR MEDEC

**Approval/Implementation/Evaluation Process**

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Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Heimlich Maneuver

**POLICY:**

Choking is a life-threatening emergency. Abdominal Thrusts shall be performed for a complete airway obstruction (victim is unable to cough, breath, or speak). The universal sign for choking is the victim clutching his/her neck with one or both hands.

**PROCEDURE:**

Food can get stuck and block the trachea (causing an airway obstruction), making breathing difficult or impossible. Abdominal Thrust(s) is an emergency first aid procedure intended to expel food that is blocking the trachea.

**Air exchange – good or poor or none**

An airway can be either partially or completely blocked. With a partially blocked airway, there is either **good air exchange** or **poor air exchange.** With a:

* **good air exchange**, the obstruction is **mild** and the victim can still cough forcefully, breathe and speak.
* **poor air exchange**, the obstruction is **severe** and the victim cannot cough forcefully, has trouble breathing and speaking.
* **completely blocked airway**, there is no air exchange – coughing, breathing and speaking are impossible.

In a mild and partial obstructed airway (victim can cough, speak and/or breathe), stay **with the victim and encourage coughing.**

Conscious Choking Person

* If you suspect there might be an airway obstruction, check by asking, “Are you choking?”, “Can you speak?”
* If the victim cannot cough and/or speak or breathe, direct someone to contact EMS by dialing 911 and requesting immediate assistance for a choking victim.
* If no one else is available to assist you, shout **“HELP”**
* Stand behind the victim ready to support them should they become unconscious (place one leg between the victim’s feet)
* Make a fist with one hand and place thumb side of the fist on the middle of the abdomen, slightly above the navel and below tip of the sternum (breast bone).
* Place other hand over fist and give quick/distinct “abdominal thrusts” (inward and upward). Give each abdominal thrust with the intention of removing the object.
* Continue “abdominal thrusts” until either the object is coughed up (expelled) and the person starts to breathe / cough or the person becomes unconscious.

Conscious Choking Person - sitting in a **wheelchair**

The way you perform “abdominal thrusts” for someone in a wheelchair depends largely on the type of wheelchair. If you can reach around from behind the wheelchair, use abdominal thrusts as you would for a conscious choking victim. If you cannot reach around the wheelchair:

* Position the wheelchair against the wall
* Put the wheelchair brakes on
* Position the heel of one hand, with the other hand on top, in the middle of the abdomen
* With the heel of the hand, give quick/distinct “abdominal thrusts” (inward and upward). Give each abdominal thrust with the intention of removing the object.
* Continue “abdominal thrusts” until either the object is coughed up (expelled) and the person starts to breathe / cough or the person becomes unconscious.

Unconscious Person

Should the person lose consciousness, lower them to the ground. Confirm that EMS has already been notified (Dial 911).

* Position victim onto back, finger sweep mouth to determine if object was dislodged with move to floor.
* Open airway using head tilt / chin lift and attempt to give 2 full breaths.
* If air doesn’t go in, give 5 abdominal thrusts
  + Facing victim, straddle victim’s legs
  + Position the heel of one hand, with the other hand on top, just above victim’s navel and below tip of sternum.
  + With the heel of the hand, give quick/distinct “abdominal thrusts” (inward and upward). Give each abdominal thrust with the intention of removing the object.
* Do finger sweep and give 2 full breaths
* If air doesn’t go in, continue with 5 abdominal thrusts
* Continue sequence until object is dislodged or ambulance arrives

**AFTERCARE**

* A RQHR Confidential Occurrence Report form must be completed following a choking incident.
* Document the choking incident, emergency procedure, resident response
* Given the complication risk of aspiration, the physician must be notified following a choking incident. Temperature should be monitored for 24 hours.
* Depending on the severity of the choking incident, the choking victim may need to be transferred to Acute for monitoring.

References

www.healthatoz.com

First on the scene. Student reference guide (2006) St. John Ambulance

**Approval/Implementation/Evaluation Process**

Initial Implementation Date: July 31, 1997

Review date: July 8, 2000 / August 31, 2005 / December 1, 2010 / December 1, 2013

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# WBSCH Source Resident Risk Assessment

Source Resident / Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please ask the source resident the following questions and send / fax to the Pasqua ER (306-766-2770).  **A copy of this document is to be placed on the resident’s health record.**

1. In the past 12 months, have you had a tattoo, ear or skin piercing, acupuncture, electrolysis, needle stick injury, graft or have you come into contact with someone else’s blood? Yes No
2. Have you ever had yellow jaundice (other than at birth), hepatitis or liver disease or a positive test for hepatitis? Yes No
3. In the last 12 months, to your knowledge, have you come in close (intimate) contact with someone with yellow jaundice or hepatitis? Yes No
4. In the last 12 months, have you received blood, plasma, clotting factors or immune globulin?

Yes No

1. The following activities put you at risk for HIV/AIDS:

• If male, having sex with another male, even once

• receiving regular treatment with blood or blood products

• accepting money or drugs in exchange for sex

•being the sexual partner of someone who has taken part in any of the above activities or who has contracted HIV/AIDS or has tested positive for it

Since 1977, have you participated in any of the above activities? Yes No

1. a) Have you even once, shared needles or taken street drugs by needle? Yes No

b) In the past 12 months have you had sex with anyone who has shared needles or taken street drugs by needle? Yes No

1. In the past 12 months have you had:

• sex, even once with someone who may have participated in high risk activities (sexual background uncertain)? Yes No

• sex, even once, for which you paid money or drugs? Yes No

• an episode of syphilis or gonorrhea or any other venereal disease? Yes No

8. Have you had an HIV/AIDS test before? Yes No

If so, what was the result? Positive Negative

1. The symptoms of HIV/AIDS include:

• weight loss, night sweats, fever, diarrhea or cough

• lumps in the armpits, neck or groin

• colored patches on skin or inside mouth

In the last 12 months, have you had any of these symptoms which are continuous and unexplained?

Yes No

1. Have you been vaccinated with flu vaccine in the last 3 months?

Yes (write date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No

1. Have any of your blood relatives been diagnosed with Creutzfeldt-Jakob disease? Yes No

**I have read and understood and completed the above questions. The medical history I have given is true to the best of my knowledge.**

I am competent and hereby consent to the following:

* Release of the information on this form to the physician treating the exposed Employee
* Release of the results of my blood tests for Hepatitis B, Hepatitis C and HIV/AIDS to the exposed Employee, physician and Public Health Nurse. I understand these tests results will be kept as confidential as any other medical records.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next of Kin’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE DATE

Interviewer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Source: The above questions have been taken from the Red Cross “Donor Health Assessment Questionnaire”*

# Check List After Blood/Body Fluid Exposure to Employee

* Employee ensure first aid is done (immediately wash or flush exposure site)
* Employee notify the Nurse / Health Care Manager
* **As soon as possible, the exposed Employee should be assessed at Pasqua ER (refer to Policy 1.4 for details of high risk body fluid).**
* Nurse / Health Care Manager to complete “Source Risk Assessment” form (Appendix A). Notify ER that completed form will be sent / faxed (306-766-2770) and that the Employee will be coming for assessment.

Note original form stays on resident’s file

* Nurse / Health Care Manager inform source resident / client’s attending physician of the Employee exposure. WBSCH policy to follow RQHR policy (1.5.3.02), obtain STAT / immediate orders for blood work (Anti HIV; Anti HCV; HBs Ag).
  + All WBSCH residents / clients have given prior consent for source blood testing with the signing of the “admission agreement”:
* Complete required lab requisitions (Anti HIV, Anti HCV, HBs Ag)
* Notify lab; if lab services are not immediately available, the resident will be transported to the community lab or to the Pasqua ER department for required source blood work.
* If Health Care Manager not available, Nurse to report exposure to Healthcare Administration on call.
* The Employee and Health Care Manager will complete an Employee Report of Incident/Hazard form within 24 hours of exposure.

* Nurse / Health Care Manager to provide copy of Appendix C to exposed Employee

# Information For WBSCH Employees

# After Blood And Body Fluid Exposure

Because you have recently had an exposure to blood and/or body fluid the following is recommended for your protection:

1. As soon as possible after exposure, remove your gloves and clean the exposed area thoroughly with soap and water allowing the puncture wound to bleed freely for at least 30 seconds.
2. As soon as possible, notify the Nurse / Health Care Manager
3. As soon as possible, report to the Pasqua Emergency Department with the completed copy of **Source Resident Risk Assessment Form** if a known source.
4. As soon as possible, the Nurse / Health Care Manager will complete the **Source Resident Risk Assessment Form** and either send copy with Employee or Fax to Pasqua Emergency Department (Fax 766-2770). This assessment information is required to determine the level of risk of transmission of diseases, to obtain the appropriate lab work and to assess the need for treatment. *Exposures involving known HIV positive sources should be report to the Emergency Department immediately.*
5. Copy of completed **Source Resident Risk Assessment form** to be kept in resident’s file.
6. As soon as possible after exposure, initial blood tests for HIV, Hepatitis B and C will be done on source resident and Employee. Advise Emergency staff to label requisition: **Fax results to Public Health 306-766-7796**
7. Public Health will obtain the source resident’s blood results and notify you as soon as possible. *If you are* ***not*** *contacted by Public Health within 12 hours, then contact the Public Health-Communicable Disease office 306-766-7790*
8. Even if the source resident’s blood tests are initially negative, you should have blood retested for HIV and Hepatitis C three and six months after exposure.
9. Notify your personal physician of the exposure. Your case summary will be available through Public Health-Communicable Diseases.
10. If the source resident is unknown or at high risk for HIV, Hepatitis B or C, refrain from activities that may lead to transmission of HIV or Hepatitis until you receive negative results from your six month follow up. Don’t share toothbrushes or razors or anything that may have blood on it. Do not donate blood. Use latex condoms for sexual intercourse. Discuss with your family physician if you are pregnant or intend to breastfeed. Cover any cuts or open sores with a band-aid and clean up blood with 1 part bleach diluted with 9 parts water.
11. See your doctor immediately if you develop any of these symptoms; unexplained fever, rash, nausea, fatigue, yellow color of skin or eyes, clay colored stools or tea colored urine.

**NOTE:** Keep the source resident’s name and test results confidential except to report to the appropriate Healthcare personnel as indicated.

If you have any questions call: Health Care Manager or Public Health306- 766-7790

# Protection Of Employees From Blood-Borne Infections

**POLICY:**

WBSCH is an AFFILIATE of the RQHR. All WBSCH Employees will be treated within a RQHR FACILITY when there is exposure to blood and/or body fluids: therefore WBSCH will follow the RQHR Policy **PROTECTION FOR RHD EMPLOYEES FROM BLOOD-BORNE INFECTIONS # 1.5.3.02**

1. Utilization of routine practices in the care of all residents / clients.
2. Immunization with Hepatitis B vaccine, on a voluntary basis, of all Employees who in the normal course of their duties are at risk for exposure to blood and/or body fluids.
3. **Immediate** follow-up of the Employee when exposure to blood and/or body fluids occurs. This will include immediate HIV post exposure prophylaxis (PEP) within 1 – 2 hours after exposure with antiretroviral drugs, determined on a case by case basis.

To ensure quick access to policy documents (Appendix A, B, and C), copies will be pre-made and filed on the Units under **Blood and Body Fluid Exposure**.

**NOTE:**

On admission to WBSCH, all residents / clients / NOK have given signed consent to “*provide a blood sample for testing if a staff member or volunteer or other resident is exposed to your blood or body fluids*”;

WBSCH will assume responsibility for any financial charges related to transportation of source resident for the collection of blood work.

**PROCEDURE:**

Anyone sustaining contamination with blood/body fluids may be exposed to blood-borne pathogens such as Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), and the Human Immunodeficiency Virus (HIV).

Types of Exposure:

1. Direct or percutaneous inoculation by needle or instrument contaminated with blood/body fluids.
2. Contamination of fresh cutaneous scratches, abrasions, burns or other lesion with blood/body fluids.
3. Contamination of mucosal surfaces (such as eyes, nose, mouth, vagina, rectum, urethra) with blood/body fluids.

Any visibly bloody fluids may be associated with the transmission of blood-borne pathogens. Unless there is visible blood, there is little or no documented risk of acquiring infection with HIV or HBV following exposure to the following body substances:

* Feces
* Nasal Secretions
* Sputum
* Sweat
* Tears
* Urine
* Vomitus

ACTION FOLLOWING EXPOSURE (see enclosed Checklist):

1. Employee immediately initiates appropriate first aid:

* Allow needle stick or cut to bleed freely;
* Wash exposure site with soap and water;
* After washing site, disinfect with 70% alcohol or providone iodine;
* Flush mucous membranes with water when splashed with blood/body fluids.

1. Nurse / Health Care Manager will:

* Direct the Employee to immediately go to the Pasqua Hospital Emergency Department;
* Phone to the Pasqua Hospital Emergency Department to advise that the Employee has been contaminated with blood/body fluids;
* Complete Appendix A, Source Patient Risk Assessment and fax to Pasqua Hospital Emergency Department (306-766-2770);
* Contact the source resident’s / client’s physician to notify of the requirement for STAT / immediate blood work for Hepatitis B, Hepatitis C and HIV antibody;
* Notify lab; if lab services are not immediately available, the resident will be transported to the community lab or to the Pasqua ER department for required source blood work.
* Complete Appendix B, Checklist after Blood / Body Fluid Exposure;
* Notify the WBSCH on call Healthcare Administration person;

1. The necessary Employee blood work and counseling will be done by the Emergency Department Physician

* The lab results will be phoned to RQHR Population & Public Health, who will inform the Employee of the results;
* Any further follow-up re: blood work etc. will be done by the Employee’s family Physician. It is the Employee’s responsibility to ensure all follow up care is completed as directed by the physician.

1. The Employee will follow-up with the Health Care Manager as soon as possible following the exposure, to complete the WBSCH Incident report / WCB documentation.

Source:

RQHR Policy #1.5.3.02

**Approval/Implementation/Evaluation Process**

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Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Ensuring Timely Access To Medical Care For Potential Serious Conditions

**POLICY:**

To ensure quality and holistic care to each resident, WBSCH shall provide appropriate clinical assessments to facilitate early intervention and treatment measures.

This policy is written to direct the professional staff of the action to be taken in the event the professional staff is unable to access timely, appropriate medical care for potential serious conditions, from the resident’s physician.

All physicians providing medical care to residents within WBSCH will be aware of the policy.

Only physicians, **Active** or **Associate** with the **RQHR Practitioner Staff** will be given admission privileges at WBSCH.

**Note:** The College of Physicians and Surgeons of Saskatchewan requires its members to provide coverage for their patients outside of regular office hours (i.e.: evenings and weekends). Physicians must be available and respond to calls outside of office hours, or must make arrangements for an “on call” service to provide coverage for off-hours.

**PROCEDURE:**

1. Through appropriate clinical assessments, professional staff shall recognize potential serious conditions and alert the resident’s physician immediately by telephone.
2. If no response from the resident’s physician or “on call”, repeat the telephone call three times within a one-hour time frame (if condition is life threatening, EMS should be called immediately, if indicated by the Advance Care Directives).
3. If there is still no response, contact the WBSCH Medical Advisor and advise of the resident’s condition: **Dr. Rasmussen**.
4. If no response from the WBSCH Medical Advisor, transfer the resident to an acute care hospital.
5. Notify the on call Healthcare (DOC / designate) after hours.
6. In the progress notes, document the:

* the clinical assessment, nursing interventions
* physician’s response, or lack thereof
* time of the telephone calls and when the physician’s responses were received or not received

If the condition is life-threatening, EMS should be called immediately, if indicated by the Advance Care Directive.

Professional staff shall observe the Advance Care Directives at all times for residents. In the absence of Advance Care Directives, professional staff shall use their clinical assessment to ensure the care needs of the resident are met.

Professional staff shall contact the next of kin as soon as reasonably possible to inform them of the health status of the resident.

When the professional staff has been unable to access medical care, complete Appendix 1, Failure to Access Medical Care. Forward completed form to DOC. Documentation must include:

 The physician’s name

 The date and time of the incident

 The resident’s name

 The reason for contacting the physician

 The times of the telephone calls

 The response received from the physician

 Hospital to which resident sent

Source:

Adapted from Saskatchewan Ministry of Health, Ensuring timely access to medical care in LTC facilities. (January 2010)

**Approval/Implementation/Evaluation Process**

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Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director

# External Chest Compressions

**POLICY:**

To identify and respect the wishes of a resident and to provide direction regarding resuscitative measures in WBSCH.

Resuscitative services shall be available to all residents identifying:

* where a resident / responsible person requests resuscitative measure as part of a health care directive (i.e.: MVLST)
* where a resident has refused to take part in this discussion.

The opportunity in CPR BLS training / updating will be provided for all interested Licensed staff.

Yearly, WBSCH staff will be updated in external chest compressions (external cardiac massage).

**DEFINITION:**

* “Hands-only CPR” – external chest compressions
* Health Care Directive – also referred to as an Advanced Care Plan, is a plan that “clearly anticipates and gives direction relating to treatment for the specific circumstances that exist …” as described in Section 5(1) of *The Health Care Directives and Substitute Health Care Decision Makers Act*.
* Resuscitative - Cardiopulmonary resuscitation (CPR) includes medical intervention used by the health care team to restart the heart and / or restore the breathing of a person who suffers a cardiac or respiratory arrest.

**PROCEDURE:**

In the event of cardiac arrest or respiratory arrest, the Nurse will contact EMS emergency and follow the directions of the EMS operator (9-306-310-5000; press 1).

CPR will be commenced by BLS trained staff, as available.

If CPR has not been commenced and the EMS operator instructs that external chest compressions (external cardiac massage) be started, the Nurse / Care staff will follow the direction of the EMS operator and start external chest compressions (“hands-only CPR):

* Landmark, straight down from notch at base of neck, at nipple line
* Position heel of one hand, with the other hand on top, at landmarked area
* Position shoulders over hands, arms straight
* Compressions given thru heel of hand
* Compressions delivered downward (not sideways)
* Compressions given at a rate of 100 compressions / minutes (think about pushing to the beat of the 1970s Bee Gees song, “Staying alive”).

Sources:

RQHR SCH policy (2016) 15.7 Resuscitative Services

RQHR Long Term Care Standardized Admission Agreement (2013)

RQHR My Voice for Life-Sustaining Treatment (MVLST) September 2011

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Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_