Agency (RN, LPN, HCA) and Student Orientation Booklet

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Welcome to Carewest

For your safety and the safety of our residents, please take time to review this booklet.

As Calgary's largest public care provider of its kind and one of the largest in Canada, Carewest operates 13 locations aimed at helping people live more independent lives. Our spectrum of care is available to adults of all ages and includes long-term care, rehabilitation and recovery services, and community programs and services.

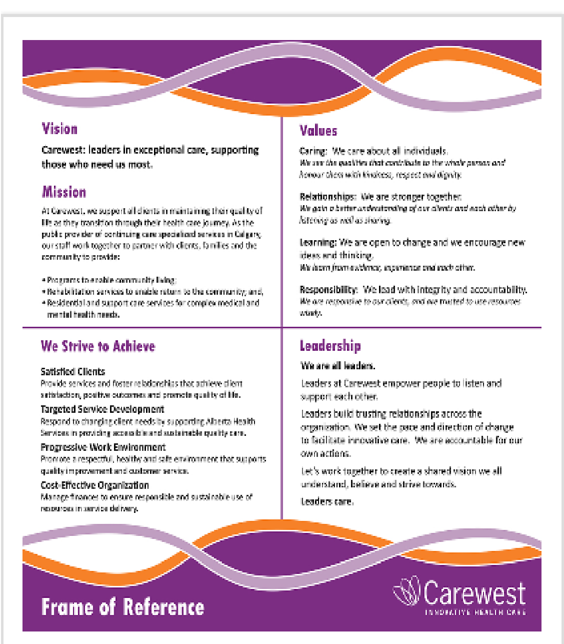
Everyone plays a role in safety. At Carewest, we all have a role to play when it comes to safety. If you see an unsafe situation or hazard, do what you can to help make it safer (e.g. cleaning up spilled water) or find a staff member to help you problem solve if you are not sure.

Expectations:

1. Refer to Care plan to find out each resident's plan of care and preferences.
2. Please ask Carewest staff in the area you are in if you have any questions.
3. Name Tags Must be worn at all times for security reasons.
4. Work with Carewest Values. We value Caring, Relationship, Learning and Responsibility.
5. English is spoken when working in all areas.

Near the main entrance, locate and review Carewest frame of reference and philosophy of Care.

Frame of Reference



Philosophy of Care

Infection Prevention and Control

Hand Hygiene is a #1 way to prevent spread of germs. Please clean your hands for 20 seconds with alcohol hand sanitizer or wash with soap and water frequently.

Due to COVID 19 pandemic continuous masking is in effect as well as 2 m distancing whenever you can. During break times, when your mask is off please ensure you are at least 2 meters away from others. Choose a non-crowded space or outdoors if possible.

Assess your risk of contracting germs depending on your task and who your client is. When appropriate, wear PPE (Personal Protective Equipment) such as gloves, gown, mask, and/or eye protection.

Clean and disinfect multi-client or multi-staff use equipment before and after each use.

Donning and Doffing steps must be followed (See right). This poster shows the steps of donning and doffing of contact and droplet precautions. Signs and posters are located outside of isolation rooms for the type of precautions and PPE required when entering room.

PPE Checklist
Contact and Droplet Precautions

Steps for putting on PPE			Steps for taking off PPE		
1		Clean hands	1		Gloves
2		Gown	2		Clean hands
3		Mask with visor or mask and eye protection	3		Gown
4		Gloves	4		Clean hands
			5		Mask with visor or mask and eye protection
			6		Hand sanitizer or soap and water

How to Wear a Procedure Mask

BEFORE

Clean hands with alcohol-based hand rub or soap and water. Open mask fully and position to cover from nose to below chin. If the mask has a nose bar, pinch around your nose.

DURING

Avoid touching the mask or your face under the mask. If the mask becomes damp or soiled, clean your hands and replace the mask.

AFTER

Clean hands with alcohol-based hand rub or soap and water. Do not touch the front of the mask. Remove using the ties or elastic loops. Discard in garbage. Clean hands with alcohol-based hand rub or soap and water. Never reuse masks.

The DOs and DONTs of masking

DO perform hand hygiene during the 4-moments of hand hygiene. It is NEVER safe to go client-to-client without changing gloves and performing hand hygiene. Hand hygiene is by far the number one practice to prevent spread of disease.

X DO NOT touch or adjust your mask. This risks contaminating your own face and hands, and increases risk of transmission to yourself and others. If you need to remove your mask (for example, to have a drink of water):

DO perform hand hygiene, and take off the mask in a manner that avoids touching the front of the mask, discard it immediately, then perform hand hygiene.

X DO NOT reuse the mask once it has been removed. You risk contaminating yourself, and the other surfaces on which your mask was placed.

X DO NOT change your mask every time you move between client rooms (unless following contact and droplet precautions).

DO change your mask when it is wet or soiled, to eat or drink, when you leave a clinical area, and at end of your shift.

DO ensure that you use a procedure mask, eye-protection, gown and gloves for all clients on full Contact and Droplet precautions.

X DO NOT use N95 respirators, unless performing an aerosol-generating medical procedure (AGMP) on a client with ILI symptoms - whether known, suspected, or at-risk (i.e. screening criteria positive) COVID client.

Emergency Codes

For all emergency codes, follow direction from a Carewest staff/emergency responder

Meaning of Code	CODE	Who can activate this Code?	What number do I call?	What do I need to do to respond to this code?
FIRE	CODE RED	Anyone discovering a fire or smoke	9-911	R - remove those in danger E - ensure door closed A - activate the fire alarm C - call 9-911 T - try to extinguish
BOMB THREAT	CODE BLACK	Anyone who receives a bomb threat or finds a suspicious package	9-911	• Alert others to the danger • Record the details • Conduct Visual inspection of area • Report any suspicious behaviour • Help search
BUILDING EMERGENCY	CODE BROWN	Anyone who encounters a building emergency, i.e.: loss of water, heat or electricity		• Remove those in danger • Notify PPS
EVACUATION	CODE GREEN	Manager / MRP, Fire, Police		• Follow instructions • Remove those in danger • Prepare to evacuate area / site
MEDICAL EMERGENCY	CODE BLUE	Anyone who finds a person in an acute medical emergency	9-911 on direction of the code leader	• Call for help • Check for unresponsiveness • Make sure scene is safe • Check Goals of Care (Green Sleeve)
VIOLENCE AGGRESSION	CODE WHITE	Anyone who encounters Violence or Aggression or the potential for bodily harm	9-911 if imminent serious danger	• Maintain safe distance • Alert others to the danger • Keep area clear • Assist as directed
MISSING CLIENT	CODE YELLOW	Manager, MRP		• Report to Manager/Person in Charge • Prepare to search for client as directed
EXTERNAL DISASTER	CODE ORANGE	Manager, MRP	Calgary Emergency Management Agency or AHS Integrated Supportive Living	• Report to manager • Support care, nourishment and monitoring as directed.
SHELTER IN PLACE / AIR EXCLUSION	CODE GREY	Manager, MRP	Calgary Emergency Management Agency	• Report to Manager • Assist as directed
HOSTAGE	CODE PURPLE	Anyone witnessing a hostage taking or a visible weapon	9-911	• Maintain your own safety • Alert others to the danger • Follow instructions

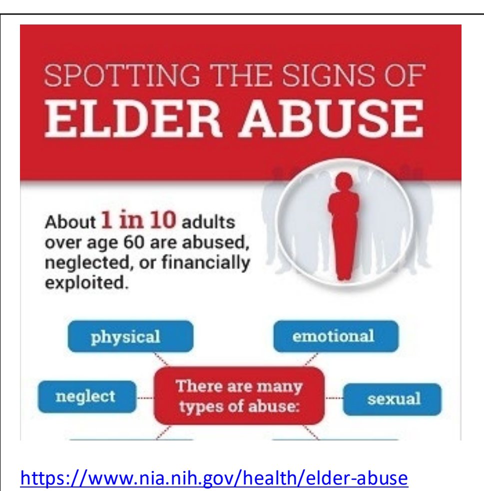
Protection in Persons Care Act

Always follow Carewest Philosophy of Care: To provide our residents and clients with quality care in safe, comfortable and supportive environments.

WHY should we report abuse? It's the law and we are responsible for the well-being of our residents and clients by controlling risks, avoiding harm and preventing abuse.

Take ACTION: If you see or hear about abuse towards our residents or clients, you MUST report it. **Abuse could be something done or something omitted:** physical, emotional, sexual, financial, neglect, or medication – by staff, family, visitors, or contractors towards someone within our care.

Failing to report abuse or maliciously or falsely reporting can result in individual fines up to **$10,000.00.** Organizations can be fined up to $100.000.00



https://www.nia.nih.gov/health/elder-abuse

PPCA

If the client is in immediate danger – Call 9-911

Website: alberta.ca/protection-for-persons-in-care.aspx

Phone: 1-888-357-9339. **Fax:** 1-780-415-8611

Email: health.ppc@gov.ab.ca

Write: Protection for Persons in Care
Station M, Box 476
Edmonton, AB T5J 2K1

You Can Get More Information:
https://www.alberta.ca/protection-for-persons-in-care.aspx

WHAT happens when you report?

1. **PPC** opens an investigation and sends a letter to: the client, legal guardian, accused, and Carewest advising they have opened an investigation.
2. **CAREWEST:** Conducts an internal investigation and takes action.
3. **ONCE DONE:** PPC will send a letter to all involved with the outcome.

YOUR JOB: Take reasonable steps to avoid abuse. Report and answer investigators questions honestly. Carewest will not take adverse action such as dismissing an employee because they report abuse or helped with an investigation. CS-03-01-07.

ABUSIVE	NOT ABUSIVE
Medicating a client for using the call bell too often	Making a mistake with a medication
Taking money from a resident or client as a loan	Sharing chocolates from a client with your team
Forcing a resident to get dressed against their wishes	Letting the resident stay in pajamas all day
Not completing a required assessment as one was 'too busy'	Waking a client up to complete neuro vital signs even if the person just wants to sleep

Restraints

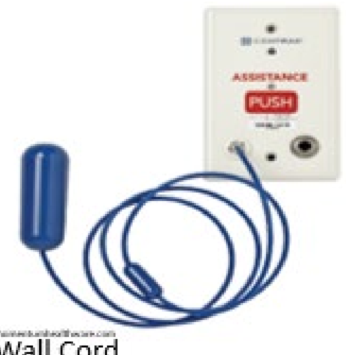
- Carewest supports a "Least Restraint" policy based on our principles and values.
- In rare cases, a resident may present with unusual safety concerns.
- Before considering use of a restraint, all possible interventions from interdisciplinary team have been reviewed, implemented, and documented.
- The specific names and type of restraint must be documented in the Care Plan.
- Please discuss with a Carewest staff member if you are caring for a resident on a restraint about the safety monitoring checks and documentation required.

Call System Overview

- Carewest facilities have different call systems.
- Ask a Carewest staff member to go over how to use the call system before you start work.
- Answer calls as soon as possible.
- If a client has a need when you answer a call, and you are unsure how to help them, please let a Carewest staff member know right away.

Centrak GPS

Client Button



Wall Cord

Staff Badge

Pager

Vital Signs: How to Take Vital Signs

Temporal Artery Thermometer

- Place the thermometer on center of the client's forehead
- Press the scanning button
- Run slowly straight across forehead, into the hairline, and then place behind the ear
- Release the button
- Read the temperature

Important tips:

- Use only the exposed side of skin (i.e. take off hat, brush hair off forehead)
- Keep sensor in FULL contact with skin (i.e. do not angle it away)
- You will get low readings from a dirty sensor, scanning too fast, sweaty forehead, or top of hair
- You can get high readings from using skin not exposed to environment (i.e. lying on that side)

Cleaning

- Clean the thermometer between every client
- Use an alcohol swab to clean the sensor and Accel Prevention wipe to clean the casing
- Clean the sensor with alcohol and a Q-tip every 2 weeks
- You will need to occasionally wipe the sensor with a wet swab to take off alcohol residue

Pulse Rate / Respiratory Rate

- Count Pulse and Respirations for one full minute
- Blood Pressure is usually taken on an automated machine-monthly and as needed

Documentation

- Record Vital signs on the Clinical Record in the client's chart. See example on the right
- Ask a Carewest staff member to show you how to correctly document if you are unsure

CLINICAL RECORD

Height (cm) 170 cm

Date (YYYY/Mon/DD)	2020/Oct/30	
Time (24 hr clock)	1000	
Temperature	36.5	
T = Tympanic, TA = Temporal Artery	TA	
Blood Pressure	112/74	
Right or Left Arm	R	
Lying		
Sitting	√	
Standing		
Pulse Rate (Automated)	83	
Pulse Rate (Manual)	85	
A = Apical, R = Radial, P = Pedal, C = Carotid	R	
Heart Rhythm	R	
R = Regular I = Irregular		
Pulse Strength	N	
B = Bounding I = Irregular N = Normal		
T = Thready W = Weak		
Respiration Rate	14	
A = Abnormal Sounds N = Normal	N	
I = Irregular S = Shallow		
U = Use of Accessory Muscles		
Pulse Oximetry SpO_2	98%	
O_2 L/min or FiO_2		
Weight (kg)	63	
Blood Glucose		
Other:		
Signature	S. Great HCA	

Reporting Tool: Changing Conditions of Client

Stop and Watch
Early Warning Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less

W Weight change
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

Patient / Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

Reporting Tool: Potential COVID-19 Signs and Symptoms

A Better Way to Care for Long Term Care Residents in Times of Medical Urgency

Stop and Watch Early Warning Tool

Potential Signs and Symptoms of **COVID-19** in Older Adults

If any of these are noted, please notify the RN immediately

Respiratory (**ST**op and wat**C**h)		Cognitive (**STO**p and w**A**tch)
• New Cough • Coughing up blood • Increased shortness of breath • Difficulty breathing • Sore throat	• Increased sputum production • Runny nose • Nasal congestion • Unable to smell • Clammy or mottled skin	• Acute or worsening confusion • New visual hallucinations • New or increased fatigue • New dizziness • Increased drowsiness or sleeping more
Pain (sto**P** and watch)		**GI** (stop **AND** watch)
• Sore muscles • New body aches • Sore throat • Abdominal pain • Chest pain		• Loss of appetite • Decrease in amount eaten • Nausea • Vomiting • Diarrhea
Other Signs (**STO**p and w**AT**c**H**)		
• Fever (greater than or equal to 37.5 degrees C OR 1 degree C above baseline temperature) • Conjunctivitis (red eyes) • Decreased participation with activities of daily activities		• New Grunting • Hoarse voice • New or More Frequent Falls • They're "just off" or "just not themselves"

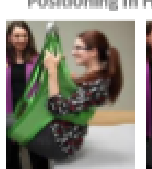
Mechanical Lifts and Slings

You MUST always have a Carewest staff member with you when using mechanical lift for transferring. You also need to follow Care Plan and have 2 staff to apply sling with a Carewest staff.

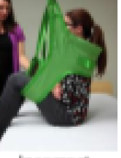
Passive Mechanical Lift Steps (Ceiling & Floor) Quick Reference*

1. **Have two (2) caregivers present**
2. **Choose correct type of sling for client's abilities/needs**
   - Must be made by the same manufacturer as the lift
     Note: Prism Medical and Waverley Glen are the same manufacturer
   - **Not all clients are safe in a hygiene sling** - refer to modules for criteria
3. **Choose correct size of sling**
4. **Make sure client's weight is within weight capacity of lift and sling**
   - If lift, carry bar and sling have different weight capacities, use the lowest weight capacity
5. **Inspect lift and sling**
   - Inspect lift, lift strap, carry bar, sling and battery strength
   - Test hand control, listening for unusual sounds and making sure lift moves smoothly
   - Check that ceiling track appears secure (ceiling lift only)
   - If sling is defective, place OUT OF ORDER tag on it and give to CSM – use a different sling
   - If lift is broken, place OUT OF ORDER tag on it and fill out maintenance requisition – use a different lift
6. **Prepare transfer area and remove all hazards**
7. **Apply sling**
   - Client's arms must be on **outside** of hygiene sling and on **inside** of Hammock, Universal and Highback slings
   - Client must be sitting when hygiene sling is applied, but may be sitting or lying when Hammock, Universal and Highback slings are applied

Positioning in Hygiene Sling



Correct



Incorrect

8. **Hook sling to lift**
   - One caregiver must have hand on carry bar **at all times**
   - Carry bar must be centred over client – do not lift at an angle
   - Always hook body support straps **before** leg support straps
9. **Decide if lift wheels should be locked or unlocked (floor lifts only)**
   - **Usually unlocked** for routine bed↔chair/commode transfers
   - Recommendations vary between manufacturers for floor→bed transfers - find out for your specific lift
     - **Liko Golvo and Viking** recommend **locked** for floor →bed transfers
10. **Test lift and sling**
    - Raise sling bar until the **straps are taut**
    - **Stop - double check** that loops/straps are securely **inside safety latches** before continuing to lift
11. **Move client**
    - One caregiver operates hand control and observes client while the other caregiver guides client along ceiling lift track or moves floor lift
12. **Lower and position client**
13. **Unhook and remove sling, make client comfortable**
    - One caregiver keeps hand on carry bar at all times
    - Always remove sling once lift is complete unless there is a clinical reason that is written in the care plan

Test: Are all loops inside safety latches?

***More information can be found in the Carewest Passive Ceiling and Passive Floor Mechanical Lift Modules**

Topical Medication Application for HCAs

Check 1 Medication Area

- Read the instructions on the Care and Clinical Flowsheet including the location and frequency of application
- Check that the name and ID number on the topical medication label matches the client's addressograph or photo with the client's name and unique ID number
- Check the expiry date(s) of the medication

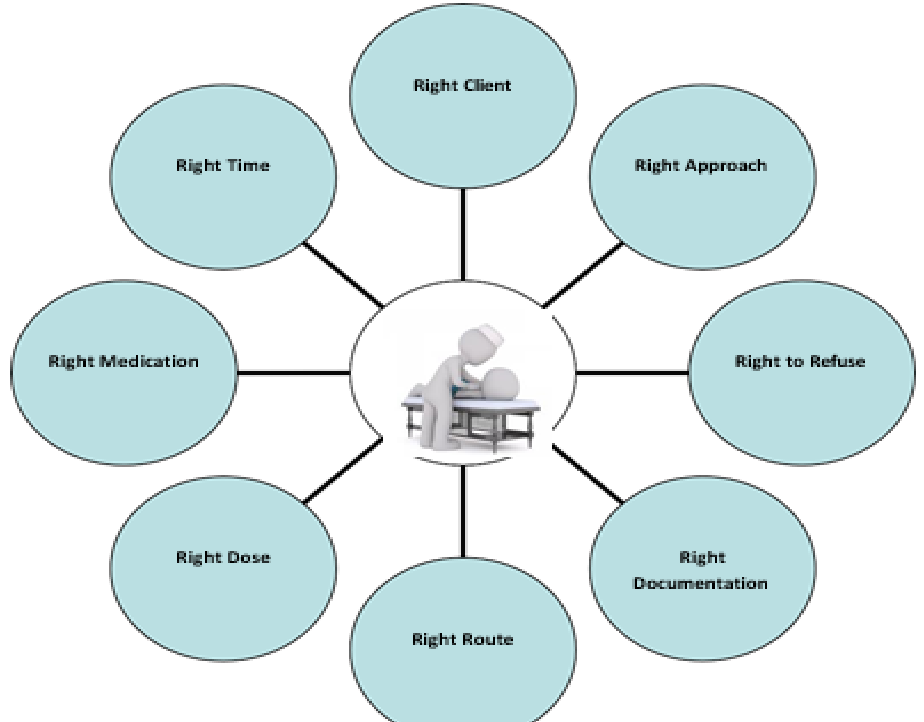
Check 2 Bedside Area

- Ask the client to identify themselves. If the client cannot self-identify, check that the name and ID number on the topical medication label matches the client's wrist band subacute or the client's identification photo (LTC) OR ask a coworker to identify the client

  **Use bedside identification photo or bring photo to the bedside if necessary

Check 3 Documentation Area

- A 'mental' check when documenting on the Care and Clinical Flowsheet



Self-Check

1. Instructions about where to apply the topical medication can be found in
   a. **Care and Clinical Flow-sheet**
   b. **Care Plan**
   c. **On Careweb**
2. You must re-read the topical medication instructions off the medication label at the bedside before applying the topical medication.
   True False
3. The client has the right to refuse topical medication.
   True False

Answers: 1.a 2.T 3.T

- Follow the instructions including where the medication should be applied
- Gather supplies and set up a clean area (paper towel, medication, applicator, gloves)
- Apply the medication correctly (squeeze medication onto an applicator, gauze or clean gloved hand, start in the middle of the application area and work outwards, no 'double dipping' into tubs/Jars)

Hazardous Medications

- Hazardous medications are medications that present a potential health risk when exposed, absorbed through skin or inhaled. This requires staff to take precautions during preparation, administration and handling bodily fluids.

- During shift report the Nurse will review if there are any clients taking hazardous medication (KNOWN risk) on the unit. This information is also found on care plans.

- There will also be a small blue white glove sticker on the door frame of any clients who are taking hazardous medications that has a KNOWN risk.

- When you are giving care to any of the listed clients you need to wear 2 pair of gloves and a gown when changing incontinent products or touching any body fluids. Depending on your task and the client, you may need other PPE such as mask, gown and eye protection.

- Please discuss with a Carewest staff member as to what PPE you will need.

- Toilets MUST be covered with a blue pad in lieu of lid and flushed twice.

- All garbage contaminated with bodily fluids goes into a yellow biohazard bin.

- If you are pregnant, breast feeding or trying to become pregnant please talk with the Nurse before handling contaminated items.

Safe bathing

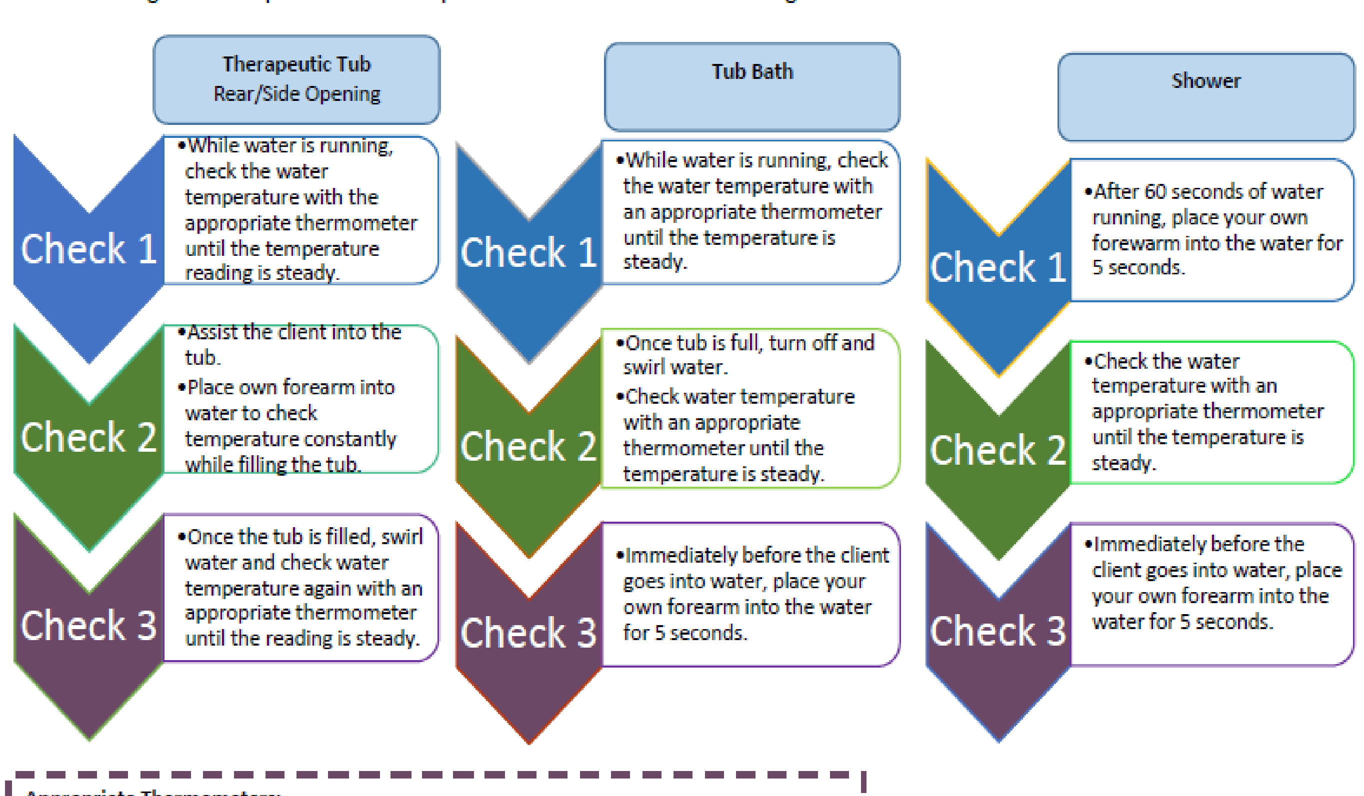
Before bathing a client, the water temperature needs to be checked to make sure the temperature is within the safe range. Bath Cards are used to check water temperature of the showers. Thermometers and/or Bath Cards can be used to check water temperature of the bath tubs. The safe range is 38° to 43° Celsius – the Bath Card will say "OK". Always follow the 3 checks before bathing our clients. You can find these posted in all the tub rooms.

Carewest
INNOVATIVE HEALTH CARE

Water Temperature Check Process

Clients 13 years and older: temperature range of **38 to 43 degrees Celsius.**

Hottest flowing water temperature for therapeutic tubs or showers in Continuing Care is maximum of **49°Celsius.**



Appropriate Thermometers:
Clients 13 years or older.
Integrated tub or shower thermometer, hand held thermometer or bath thermometer card pre-set to the acceptable water temperature range of 38 to 43°Celsius

Adapted from Alberta Health Services Water Temperature Check Process Dec. 2019

February 2020 Water Temperature Check Process

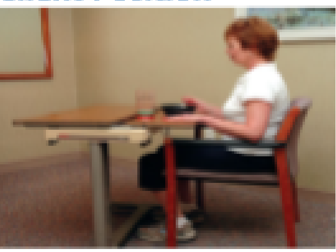
Safe Assisted Eating

Strategies for assisting clients with eating

Know Your Client

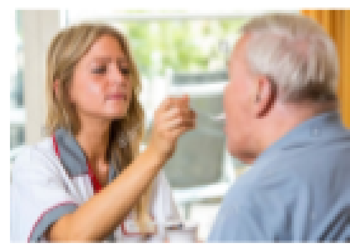
- ✓ Check care plan and diet card for correct diet and recommendations
- ✓ Perform your hand hygiene and help the client with same if needed
- ✓ Ensure client is wearing their dentures, hearing aids, or eyeglasses
- ✓ Provide client with the correct adaptive aids, if applicable

Client Position



- ✓ Before assisting with eating, make sure the client is positioned properly:
  - client is sitting fully upright with back straight, no leaning to the side
  - client's head should be upright and centred in line with the torso
  - client's head can be supported with a pillow to help keep the chin parallel to the floor if needed

Your Position



- ✓ Position yourself at eye level with the client
- ✓ Avoid standing over a client when giving assistance as this may:
  - put client's head into an unsafe position for swallowing (tilted back)
  - decrease client's sense of control
  - intimidate the client

Important Reminders

- ✓ Verbally tell client the food items included in the meal
- ✓ Offer client one level teaspoon at a time
- ✓ Ensure the client has swallowed before offering the next bite
- ✓ Do not mix the food unless asked by the client to do so
- ✓ Serve hot food hot and cold food cold, and do not blow on food to cool it
- ✓ Assist client with mouth care after meals
- ✓ Allow client to remain upright for 30-60 minutes after meals
- ✓ Report to the nurse and document any chewing or swallowing difficulties

Environment

- ✓ Ensure a quiet, calm environment with good lighting
- ✓ Remove excess distractions from the table and immediate environment
- ✓ Make meal time an enjoyable experience for the client

Diet Textures and Fluid consistencies

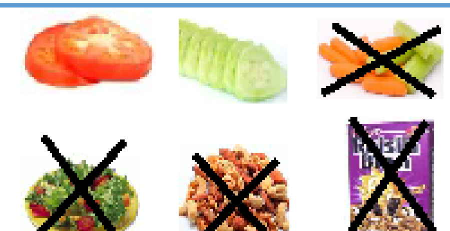
Review careplan, diet cards, serving lists etc for information about your resident's nutrition/diet.

Texture Modified Diets

Regular Texture:

Everything on the Carewest menu is allowed

Easy to Chew: Softer foods that are easier to chew

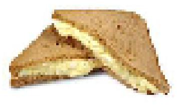


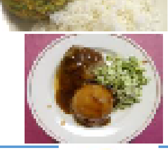
Allowed: most regular sandwiches (no lettuce)
No dry or crispy foods (e.g. bacon, deep fried meat)
No raw vegetables (e.g. carrots, celery)
(Allowed: zucchini, peeled cucumber, tomatoes)
No hard fruit (e.g. pineapple, apple)
No lettuce salad (Allowed: marinated salads, coleslaw)
No nuts, or seeds, or dried fruits (No Raisin Bran™)

Dysphagia Soft: Soft, moist foods served with gravy
Might require some minced foods

Soft breads or buns
Soft vegetables and fruits (easy to mash) or diced
Moist meat, diced, minced or shaved and diced
Finely minced fillings sandwiches (e.g. egg salad or chicken salad sandwich)
Fork-tender foods (e.g. lasagna, stews)
No raw vegetables, or salads (Allowed: coleslaw)
No nuts, or seeds, or dried fruits (e.g. no Raisin Bran™)
No bagels, raisin bread or English muffins

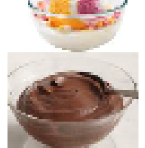
Minced: Minced, grated, or mashed foods that need little or no chewing





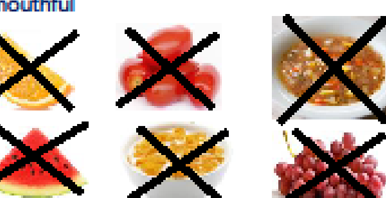
Minced, grated, or mashed meat and plain fish filet (with sauce)
Minced vegetables and fruits, (Allowed: ripe sliced banana)
Soft breads and buns
Finely minced fillings sandwiches (e.g. egg salad or chicken salad sandwich)
Allowed: short pasta (macaroni), tuna casserole (No peas)
Soups must be pureed

Puree: Texture of a pudding, smooth, doesn't separate, no lumps



All food is pureed
Oatmeal and cream of wheat allowed with very little milk
Ice cream and Jell-O are allowed unless client is on thick fluids
No Mixed Consistencies

No Mixed Consistencies: When liquid and solid are present in the same mouthful

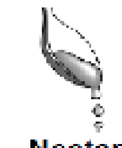


May be added to any diet
Allowed to have casseroles, stews, chili

Soups must be pureed
NO dry cereal with milk, soup with chunks, canned fruit in liquid (ok if drained), whole grape tomatoes, watermelon, grapes, orange

Thick Fluids: Nectar (Mildly Thick) **or Honey** (Moderately Thick)
Liquids or foods need to be thickened

Do NOT give thin liquids or foods
No Jell-O or popsicles or ice cream
No regular soup (unless pureed)
No thin juice, milk, or Ensure



Nectar Mildly Thick

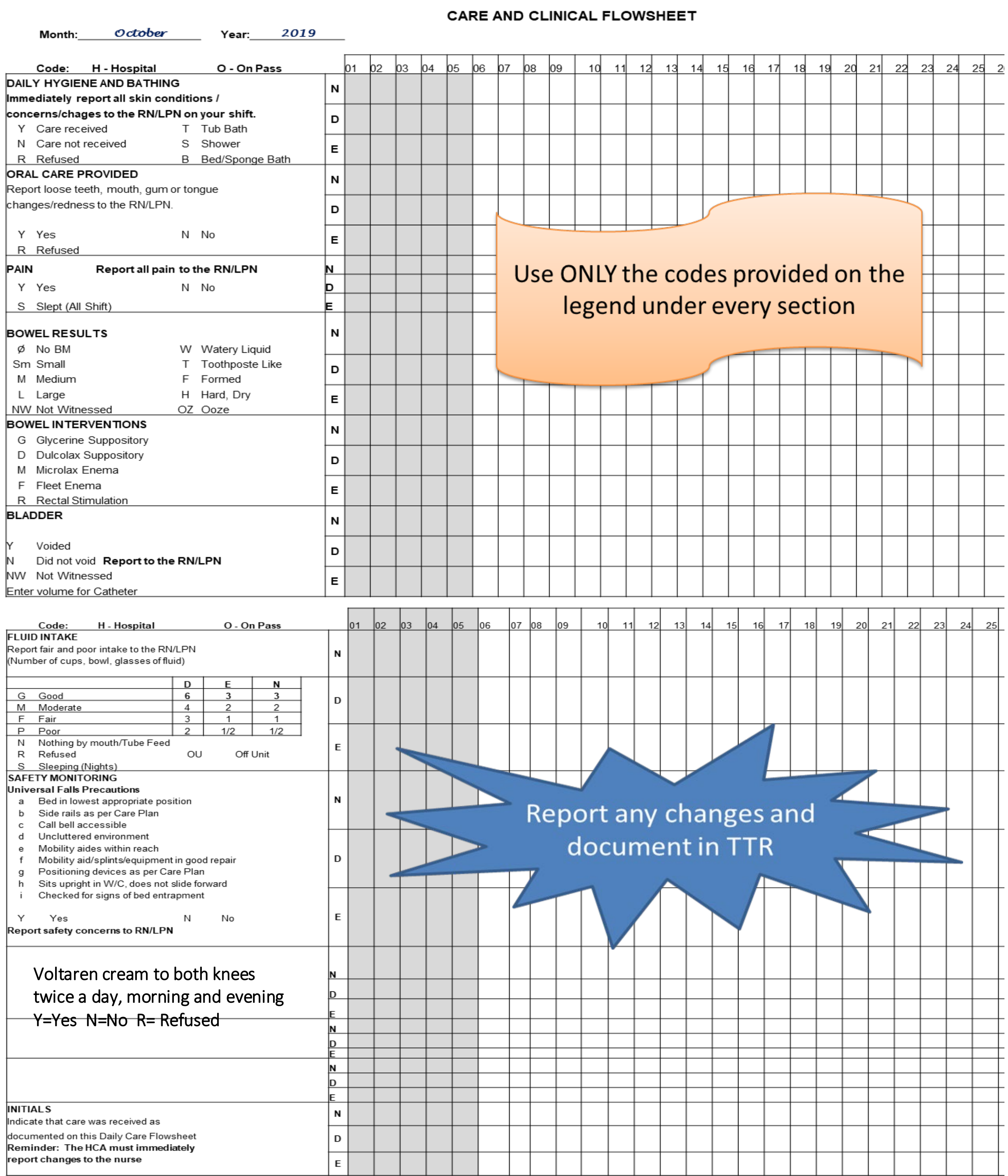
Honey Moderately Thick

Includes No Mixed Consistencies (see above for description)

Adapted by Carewest Dietitians September 2015, last update January 2020

HCA Documentation

HCAs complete the appropriate Care and Clinical Flowsheet for each client they cared for. There may be other tracking forms as well such as MDS, BSMT and TTR entries. Please ask Carewest staff for help to ensure documentation is done correctly. Example below is for long term care.



CARE AND CLINICAL FLOWSHEET

Month: *October* Year: *2019*

Code: H - Hospital O - On Pass

Days: 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 2

DAILY HYGIENE AND BATHING (N / D / E)
Immediately report all skin conditions / concerns/chages to the RN/LPN on your shift.
Y Care received T Tub Bath
N Care not received S Shower
R Refused B Bed/Sponge Bath

ORAL CARE PROVIDED (N / D / E)
Report loose teeth, mouth, gum or tongue changes/redness to the RN/LPN.
Y Yes N No
R Refused

PAIN **Report all pain to the RN/LPN** (N / D / E)
Y Yes N No
S Slept (All Shift)

BOWEL RESULTS (N / D / E)
Ø No BM W Watery Liquid
Sm Small T Toothposte Like
M Medium F Formed
L Large H Hard, Dry
NW Not Witnessed OZ Ooze

BOWEL INTERVENTIONS (N / D / E)
G Glycerine Suppository
D Dulcolax Suppository
M Microlax Enema
F Fleet Enema
R Rectal Stimulation

BLADDER (N / D / E)
Y Voided
N Did not void **Report to the RN/LPN**
NW Not Witnessed
Enter volume for Catheter

Code: H - Hospital O - On Pass

Days: 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

FLUID INTAKE (N / D / E)
Report fair and poor intake to the RN/LPN
(Number of cups, bowl, glasses of fluid)

		D	E	N
G	Good	6	3	3
M	Moderate	4	2	2
F	Fair	3	1	1
P	Poor	2	1/2	1/2

N Nothing by mouth/Tube Feed
R Refused OU Off Unit
S Sleeping (Nights)

SAFETY MONITORING (N / D / E)
Universal Falls Precautions
a Bed in lowest appropriate position
b Side rails as per Care Plan
c Call bell accessible
d Uncluttered environment
e Mobility aides within reach
f Mobility aid/splints/equipment in good repair
g Positioning devices as per Care Plan
h Sits upright in W/C, does not slide forward
i Checked for signs of bed entrapment
Y Yes N No
Report safety concerns to RN/LPN

Voltaren cream to both knees twice a day, morning and evening
Y=Yes N=No R= Refused (N / D / E)

(N / D / E)

(N / D / E)

INITIALS (N / D / E)
Indicate that care was received as documented on this Daily Care Flowsheet
Reminder: The HCA must immediately report changes to the nurse