HEALTH-RELATED ACTIVITIES

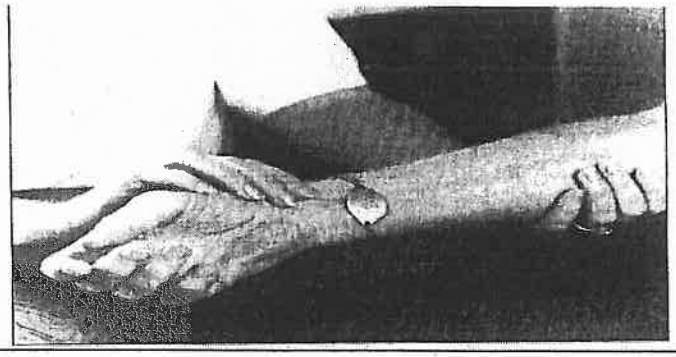
Health-related activities are defined in OAC 5123:2-6-01 as:

1. "Taking vital signs;
2. Application of clean dressings that do not require health assessment;
3. Basic measure of bodily intake and output;
4. Oral suctioning;
5. Use of Glucometers;
6. External urinary catheter care;
7. Emptying and replacing colostomy bags;
8. Collection of specimens by noninvasive means."

The health-related activities should be taught, by the nurse, according to guidelines established under OAC 4723-13. After initially teaching the health-related activities, the nurse must refer to OAC 5123:2-6-03. Guidelines related to these activities are further established within that rule.

In some settings the MR/DD personnel will be continuing these activities under nurse delegation and in other settings they will provide these services while being supervised by whomever normally supervises them without the oversight of delegated nursing. Refer to the chart on page four (4) in the main section of the manual for further details.

1. **Checking/Taking Pulse:** Place your middle and index finger on inside of individual's wrist just past the midline toward thumb side of hand approximately 1 to 1-1/2" below where hand meets arm. (See illustration on following page.) You should feel a steady beat. Count for one full minute using timepiece with second hand. It is important to count for one full minute to obtain an accurate count, as pulse can be irregular. There may be a slight difference in the exact location of pulse from individual to individual; search around. If it is difficult to find in one arm, try the other. If pulse is irregular and not previously noted, report immediately to healthcare provider.



Locate the pulse on the thumb side of the wrist with the tips of your fingers.

2. **Checking Respirations:** Count the number of breaths the individual takes in one minute's time (breathing in and then breathing out constitutes one breath). Document how the individual is breathing, e.g., breaths are regular, difficult, weak or shallow. If a person is breathing through mouth or has nasal congestion, breaths will be louder.

3. **Checking Temperature:** Most facilities now have a digital thermometer. There are various types available including ones that can still be used to take an oral or axillary (under the arm) temperature and those that are placed in the ear (otic). These newer type thermometers are very quick to get a reading. Mercury thermometers are not recommended by the Heath Department due to the potential of mercury poisoning if the thermometer breaks. Many Health Departments will accept trade-ins of old mercury thermometers for new digital thermometers. Follow the manufacture's recommendations in terms of time held in place. When documenting, make sure to note whether it was taken orally (mouth), axillary (armpit) or if you were using one of the thermometers that fit in the ear (otic), e.g., 98.6 oral, 98.6 axillary, 98.6 otic.

   Note: Demonstrations for other temperature reading devices; i.e., ear scan device, mercury thermometers, etc. may be reviewed.

4. **Checking Blood Pressure:** Wrap cuff around either upper arm (if one side has limited functioning, use other arm). The cuff should fit snugly with bottom edge of cuff 2-3 finger-widths above bend in arm. (See illustration on following page.) Tube attached to cuff is to be over brachial artery (inside of arm, slightly above the bend). Place diaphragm of stethoscope over brachial artery. Close valve and pump bulb until indicator on gauge is up to 200. Slowly release valve, listening with stethoscope located over brachial artery (at bend of elbow). The first time you hear the pulse return (usually 90-160) is the top reading (systolic). Continue listening and releasing valve until the sound of the pulse disappears (usually 60-90); this is the lower number (diastolic). The recorded blood pressure would be the point at which you first hear the pulse (120) over the point at which the volume of the pulse disappears (70). The blood pressure is recorded by placing the systolic reading over the diastolic; i.e., 120/70.

Apply cuff snuggly to arm at least 1 inch above the elbow.

Note: Normal values for these procedures may be discussed at this time with emphasis on the age and population served in specific facilities.

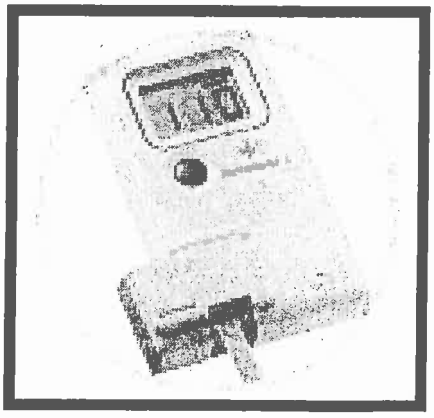
Generally Abnormal Ranges:
Pulse under 60 or over 100;
Blood pressure: Systolic is over 160 and diastolic is over 110 for one reading OR systolic is over 140 and diastolic is over 90 for two or more readings.
Blood pressure readings vary from individual to individual. For example, if 120/80, is typically normal, then 120/60 could be considered a low blood pressure for that individual.
If systolic reading is under 90 and diastolic is under 60, this is generally abnormal.
If systolic reading is under 100, and other symptoms are present, report immediately to healthcare provider.
If the primary medical provider provides specific guidelines for an individual, be sure to use those and **NOT** the ones provided in this class.

5. **Application Of Clean Dressings That Do Not Require Health Assessment:** Most dressings will be changed as indicated by a nurse. There are times when the dressing to be completed will be determined to not require a sterile procedure. In this case, once trained, MR/DD personnel may be asked to complete such dressings on regular basis to promote healing.

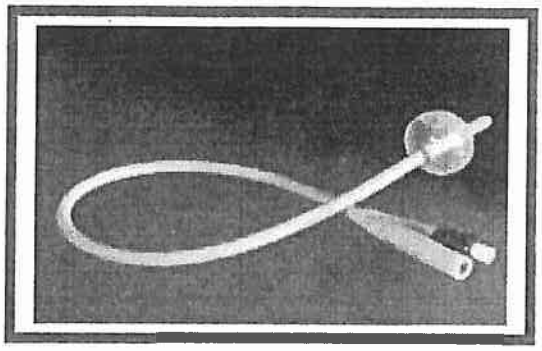
6. **Basic Measure Of Bodily Intake And Output:** Intake and output is measured to monitor the ratio of fluid a person takes in and fluid the person puts out to assure an appropriate ratio is maintained. Measure and track any fluid the person drinks such as water, coffee, tea, and soup. Also you must count any food item that would be liquid at room temperature such as Jell-o, frozen fluids, ice cream and such. Output is all the fluid that passes out of the body. This would include, urine, vomit, liquid stools, and any loss of blood or drainage from any wound. You will commonly hear this referred to as "I & O." Units of measure are cc (cubic centimeters) or ounces.

7. **Oral Suctioning:** Oral suction will be used when an individual is unable to deal with the amount of secretions in their mouth. A small plastic suction catheter (Yankaur) is placed only in the mouth to remove the secretions and prevent choking or aspiration. Do not suction for longer than 15 seconds. If there is bleeding noted during the suctioning or the person has difficulty breathing during suctioning, immediately report to healthcare provider.

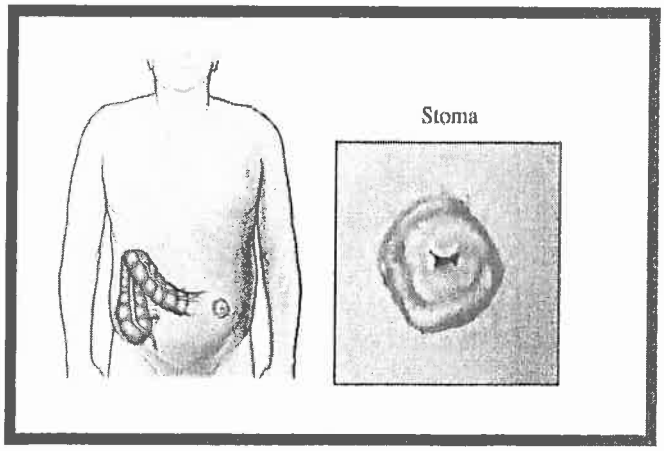
8. **Use Of Glucometers:** For diabetic individuals, there often may be a need to monitor their blood sugar and adjust their medication or diet to help maintain a better balance. The adjustment should only be done using a protocol prescribed by a physician. The MR/DD personnel may, if trained and if the procedure is ordered, use the Glucometer to test a small amount of blood from the individual to determine what the blood sugar level is. Actions after completing the test, if required, should follow the physician's orders.

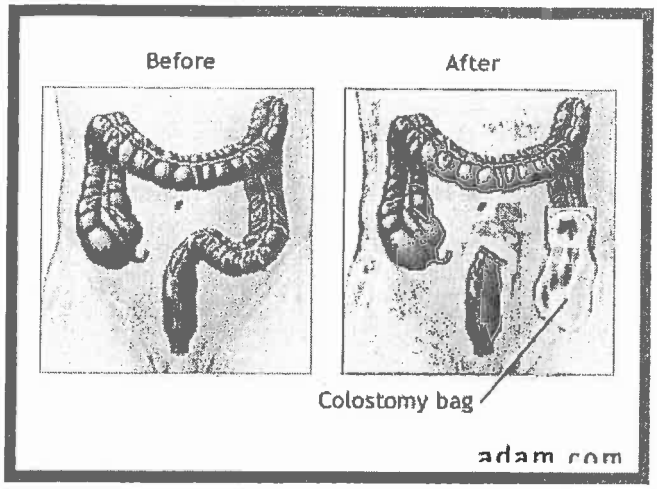


9. **External Urinary Catheter Care:** A urinary catheter may be external to the body such as a "condom catheter" used for males or internal catheters or "indwelling catheters" used for both males and females. External catheters may be taken off as necessary and replaced by anyone trained to do so. An internal catheter must be replaced using a sterile procedure and should only be done by a doctor or nurse. The internal catheter is a tube that is inserted into the bladder to drain urine. Germs can easily enter the bladder while this is in place or if it is replaced using a non-sterile procedure. Every day as a part of routine care, the entry site should be cleaned with soap and water to attempt to prevent urinary tract infections. The tubing that exits the body is attached to a drainage system. This is considered a closed system and should not be taken apart unless done under sterile procedure by the nurse. Trained MR/DD personnel may routinely empty the collection bag at times specified.



10. **Emptying And Replacing Colostomy Bags:** When a colostomy is done the intestine is cut and brought to the outside of the body. The opening created is called a stoma. This site on the abdomen is where body wastes are expelled instead through the rectum. The bag placed over the site to collect the waste products is called a colostomy bag. MR/DD personnel may need to assist with emptying the waste product from the bag or replace the bag on a routine basis.





11. **<u>Collection Of Urine Specimens By Non-Invasive Means</u>:** The individual may be experiencing some problems and the physician may order a clean catch urine sample be done and taken to the lab for testing. This will enable the physician to determine if the individual has an infection or other problems. Once trained, MR/DD personnel may complete this procedure if it is ordered.

Health-Related Activities Skills Checklist
Using A Glucometer For Blood Sugar Monitoring

YES	NO		
☐	☐	1.	Assemble equipment.
☐	☐	2.	Identify individual and explain procedure.
☐	☐	3.	Wash hands and apply gloves.
☐	☐	4.	Take out pen to hold lancet and place lancet in pen.
☐	☐	5.	Set up glucose monitor.
☐	☐	6.	Prepare the individuals finger by wiping with a cotton ball and rubbing alcohol or use a commercial rubbing alcohol wipe. Be sure to allow the finger to dry thoroughly before proceeding.
☐	☐	7.	Turn on machine and wait until ready to use.
☐	☐	8.	Pull back the trigger on the lancet pen and do the finger stick.
☐	☐	9.	Squeeze the finger to get adequate blood for the procedure.
☐	☐	10.	Place one drop of blood on the test strip. After completing this, wipe off the finger and hold cotton ball or something similar to the area that was stuck.
☐	☐	11.	Proceed by following directions as required for your specific Glucometer.
☐	☐	12.	Clean up equipment, dispose of used supplies appropriately.
☐	☐	13.	Remove gloves and dispose appropriately and wash hands.
☐	☐	14.	Record blood sugar and follow process for medication administration or requesting assistance as necessary.

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Date _____

Health-Related Activities Skills Checklist
Urinary Catheter Care (External Care Only)

YES	NO		
☐	☐	1.	Assemble supplies.
☐	☐	2.	Wash hands and apply gloves.
☐	☐	3.	Provide privacy and explain to the individual what you will be doing.
☐	☐	4.	Position the individual on his or her back exposing only a small area where the catheter enters the body.
☐	☐	5.	Using soap and warm water (other solution if ordered by the physician) wash the area surrounding where the catheter enters the body.
☐	☐	6.	Using gauze dipped in warm water or an antiseptic wipe, wipe the tube. Make only one swipe with each swab or pad. Discard after one use. **START** at the area of the urinary opening and wipe away from the body, cleaning up to the connection area. When done make sure the individual is left in a comfortable position.
☐	☐	7.	Check to make sure the tubing is not coiled or kinked and that it continues to drain appropriately.
☐	☐	8.	Clean up equipment and discard or return to storage appropriately.
☐	☐	9.	Remove gloves, discard appropriately and wash hands.

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Health-Related Activities Skills Checklist
Emptying The Collection Bag

YES	NO		
☐	☐	1.	Wash hands a put on disposable gloves.
☐	☐	2.	Gather equipment.
☐	☐	3.	Open collection receptacle(a container specified for this use) over collection container.
☐	☐	4.	Drain urine into receptacle.
☐	☐	5.	Close the drainage bag.
☐	☐	6.	Measure and record the amount of urine if required.
☐	☐	7.	Note any unusual color, unusual smell, or amounts of urine outside the norm for this individual.
☐	☐	8.	Clean equipment and return to storage.
☐	☐	9.	Remove gloves and dispose of them appropriately.
☐	☐	10.	Wash hands.

Note: Never hold the collection bag higher than the person. This will cause the urine to flow back to the body and will greatly increase the potential for a urinary tract infection.

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Health-Related Activities Skills Checklist
Emptying And Replacing A Colostomy Bag

YES	NO	
☐	☐	1. Assemble supplies
☐	☐	2. Wash hands and apply gloves.
☐	☐	3. Explain to the individual what you will be doing.
☐	☐	4. Place individual in comfortable position as instructed by a healthcare provider and provide privacy.
☐	☐	5. If emptying the colostomy bag, remove the clip and empty the contents.
☐	☐	6. Rinse bag as instructed.
☐	☐	7. Close and re-seal using clip or other provided devise.
☐	☐	8. Clean up supplies and discard as appropriate.
☐	☐	9. Remove gloves discard appropriately and wash hands.
☐	☐	10. If replacing the colostomy bag, gently remove the soiled colostomy bag from the stoma site and place in a double bag.
☐	☐	11. Clean site and if necessary apply a new wafer.
☐	☐	12. Apply new pouch
☐	☐	13. Gather wastes and dirty material being sure to secure it tightly. Discard as directed.
☐	☐	14. Remove gloves, discard appropriately and wash hands
☐	☐	15. Document procedure done, time, observations and any reactions the individual had to the procedure.

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Health-Related Activities Skills Checklist
Collection of Specimens By Non-Invasive Means
Clean Catch Urine Sample

YES	NO		
☐	☐	1.	Gather equipment.
☐	☐	2.	Wash hands and apply gloves.
☐	☐	3.	Explain to the individual what you will be doing.
☐	☐	4.	Standard procedure is to clean the genitals thoroughly with soap and water.
☐	☐	5.	Have the individual begin urinating into the toilet. After stream has begun, specimen cup is inserted into stream. Specimen obtained and cup removed before urination is completed, thus obtaining a midstream specimen.
☐	☐	6.	If this is not possible, thoroughly clean the individual's genitals with soap and water. Have individual urinate into urine hat or urinal which has been thoroughly cleaned with bleach water or a sanitized tablet solution and pour specimen into specimen cup.
☐	☐	7.	Do not touch inside of cup, underside of lid, top rim of cup or lay the lid face down on a surface. If unable to take to the lab or physician's office immediately, store specimen pursuant to physician's instructions.

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Health-Related Activities Skills Checklist
Basic Measuring Of Bodily Intake And Output

YES	NO	
☐	☐	1. Assemble supplies.
☐	☐	2. Wash hands an apply gloves if measuring output.
☐	☐	3. Measure and record all liquids taken by the individual, including that with or between meals. Liquids are measured in cubic centimeters or cc. Thirty (30) cc is equal to one (1) ounce. If an individual drank 12 oz. of pop, you need to multiply 12 (ounces) by 30 (cc) which is equal to 360 cc of fluid.
☐	☐	4. Ask the individual to use a urinal, bedpan or other receptacle besides the toilet when urinating. If the individual can use the toilet, a special plastic hat can be placed there to collect the urine.
☐	☐	5. Clean all equipment when done measuring.
☐	☐	6. Remove gloves, disposing of them appropriately and wash hands.
☐	☐	7. Record any output measured.
☐	☐	8. If feces is mixed with the urine it may cause an inaccurate measurement. Be sure to record this issue.
☐	☐	9. If an individual has vomited, document the frequency of vomiting, not necessarily the amount.

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Health-Related Activities Skills Checklist
Oral Suctioning

YES	NO		
☐	☐	1.	Place the suction machine on a sturdy surface that will support its weight. Plug the cord from the compressor into a properly grounded (three prong) electrical outlet.
☐	☐	2.	Before treatment, wash your hands with soap and water and dry completely. Put on disposable gloves.
☐	☐	3.	Connect the tubing to the outlet port on the lid of the collection bottle.
☐	☐	4.	Attach the suction catheter (Yankaur) to the other end of the connecting tubing.
☐	☐	5.	Turn on the suction machine and check for negative pressure. To do this, kink the connecting tubing with the machine running and note the reading on the gauge. The correct setting should be (3) for adults (2) for children and (1) for infants. Adjust the pressure by turning the adjustment knob on the suction machine.
☐	☐	6.	Insert the suction catheter into the mouth advancing slowly to the back. If patient starts to cough or gag, wait until the patient recovers before continuing. **NEVER SUCTION FOR LONGER THAN 15 SECONDS**.
☐	☐	7.	After suctioning the patient, suction water through the suction catheter until the catheter and tubing are clear. **NEVER ALLOW THE SUCTION CONTAINER BOTTLE TO RISE ABOVE THE FILL LIMIT LINE**.
☐	☐	8.	Turn machine off.
☐	☐	9.	Empty container bottle and clean thoroughly. Put equipment away.
☐	☐	10.	Dispose of gloves appropriately. Wash hands.

Information from:
UUUUUUUUUUUUUUUUUUUUUhttp://www.medox.org/suction.htm

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