PLAISIR 93
Reference Manual

EROS
Montreal

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Bio-psycho-social profile of clients in long term care and planning of nursing care required

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Equipe de Recherche Opérationnelle en Santé

Montreal - October 1993

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EROS - Equipe de Recherche Opérationnelle en Santé
62, Rachel Street East
Room 300
Montreal (Qc)
H2W 1C6

Phone: (514) 985-0949
Fax: (514) 985-0948

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The PLAISIR 93 documentation is printed in Canada. EROS believes that this documentation contains the information necessary to use the PLAISIR system in conjunction with the training services, validation and data processing it offers. However EROS reserves the right to update or periodically modify the contents of the documentation destined to users without direct or implicit obligation on the part of EROS to advise users of such updates or changes.

Preface

The first utilization of the PLAISIR system goes back to 1983. The publication of this revised edition marks then the system's tenth anniversary. It is difficult to specify the number of evaluations performed in Quebec with PLAISIR during this decade but we can say it is anywhere between 100 000 and 200 000. This is to say that the institutions on one hand and the research team on the other have acquired much experience with the PLAISIR system. It is this experience that has been put to work on the first major revision of the system that we publish today.

This revision's major goal was to facilitate and improve the determination of the services required by the clients presenting cognitive deficits or behavioral problems related to a chronic psychiatric illness. Furthermore, all the care actions of the section for planning services required, in the evaluation form, have been revised: certain actions have been divided, other actions have been added, the parameters or utilization modalities of certain actions have been changed. The bio-psycho-social profile of the client has been enriched (sections: psychological problems, psychological and sensorial functions, protection) to facilitate the ***validation*** *of information about services* ***required****, particularly in the two aforementioned client categories. We have added a section for rehabilitation therapy, medical rounds and specific treatments received, to complete the data base of nursing services and assistance. Finally, we have added a section: nursing rehabilitation services received, to document the attempts of rehabilitation undertaken by nursing personnel.*

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Creation and realization:

Bibiane Roussel
Charles Tilquin

Translation:

Kelley Kilpatrick

Editing:

Micheline Daigneault

Contributors, from the EROS team, to the latest edition:

Kelley Kilpatrick
Micheline Dextraze
Nancy Chartrand
Johanne Ostiguy
Daniel Bolduc

Principal contributors, from the EROS team, to earlier editions:

Diane Saulnier
Jocelyne Carle
Pierre Lambert
Estelle St-Onge
Martine Lafrance
Louise Masse
Marc Clavette

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Michèle Baker, Centre Renaissance (Outaouais Region)
Yvonne Cormier, Centre Denis Benjamin Viger (Montreal Region)
Claudine Lemieux, Manoir St-Eustache (Laurentides-Lanaudière Region)
Monique Paul, Centre Armand Lavergne - Émilie Gamelin (Montréal Region)
Jocelyne Vachon, Résidence Ste-Marie - Centres Gérontologiques de Jonquière (Saguenay - Lac St-Jean Region)

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The five dimensions of handicaps (mobility, physical independence, occupation, social integration, orientation) used in the first section of the form, as well as their descriptions are adapted from the **Code of Handicaps of the International Classification of impairments, disabilities and handicaps** of the W.H.O. The definitions of most psychological and sensorial functions (paragraph P of the first section of the form) are adapted from the **Code of Impairments** of the same classification.

For the revision of the first part of the form, we were also inspired by the U.S. Health Care Financing Administration's: **Minimum Data Set for Long Term Care Services.**

For the definitions of the categories of cognitive deficits and the descriptions of the individual supportive communication for clients with cognitive deficits we inspired ourselves from the work of Louise Lévesque, Carole Roux and Sylvie Lauzon: **Alzheimer: Comprendre pour mieux aider**, Éditions du Renouveau Pédagogique.

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1. INTRODUCTION

1.1 A tridimensional information system

The PLAISIR system is a clinico-administrative information system with regards to residents of nursing homes or extended care facilities.

The system collects two types of data concerning the resident :

- his bio-psycho-social profile;
- his profile of required nursing and assistance services.

Secondarily, one also collects certain socio-demographic data concerning the resident as well as his profile of utilization of rehabilitation (physiotherapy, occupational and speech therapies) and medical resources.*

The data are collected with the help of a form called *"FRAN"* which is filled in by a nurse evaluator specifically trained for this task. The information on the forms is entered onto a computer. According to the profile of the nursing and assistance services required by the resident and to a normative weighting of each nursing action measuring the time required to execute it, the computer then calculates the profile of nursing and assistance **resources** required by the resident.

Hence, the system allows for a tridimentional representation of the resident :

- bio-psycho-social, in terms of illnesses, impairments, incapacities and handicaps;
- services required to respond to the bio-psycho-social needs;
- resources required (measured in time) to deliver the required services.

These three dimensions correspond to the Donabedian model.

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* The routine determination of the **required** medical and rehabilitational resources according to the profile of the required rehabilitation and medical services of the resident would be much too expensive. Hence one limits oneself to collecting the profile of the resources **being used.**

1.2 A system responding to the information needs of all levels of decision makers

The system allows one to qualify and quantify the workload of dependent residents staying for varying lengths of time* (for many, until the end of their lifetime) in an institution.

This information is used by decision makers at all levels :

- by **the head-nurse** of a care unit to monitor the quality of care given on the unit and to manage personnel according to the needs of the residents.

- by **the nursing and general management** of institutions to monitor the quality of care of their institution, allocate the resources to the various units of care according to the workload of the residents, and control the admissions to the different units to attain, for example, objectives of balancing supply and demand for care or homogenizing the residents of different care units.

- in a system, such as the Quebec system, where the admissions of all the institutions are coordinated at the sub-regional level, **by the coordinating body, (Commissions d'accueil/orientation/admission)** (CAOA) to decide where to admit a given future resident.

- in a system, such as the Quebec system, where the budget is allocated to institutions according to the workload associated to their residents, by the **Regional Boards** to equitably distribute amongst all the institutions under their jurisdiction, the global regional budget put at their disposal by the Ministry of Health and Social Affairs.

- by **the Ministry or Regional Boards**, to plan and program their network of nursing homes and extended care facilities according to the needs of the population.

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* However there exists a variant of the PLAISIR system applicable to acute care hospitals; including intensive care units.

1.3 A standardized information system centered on the individual resident's needs

The PLAISIR system starts with a basic principle: that at all levels, the decisions must be oriented according to the needs of each resident and not according to the available resources.

It operationalizes this basic premise by focusing on the services **required** by the resident instead of the services which are given.

We define as required services, the nursing and assistance care required by the resident to answer his aid needs. The resident's aid needs are assessed by (a) professional(s) according to :

- the resident's (and family's) perception of his aid needs as communicated to the professional(s);

- the resident's present bio-psycho-social profile and history.

The professionals form from this starting point, their perceptions of the resident's aid need. On this basis, they determine the services required by the resident. This determination takes into account their care philosophy which translates into a certain number of rules, norms, professional standards that specify in a more or less precise fashion, the way to respond to different aid needs.

The care given does not always correspond to the care required as we have just defined it. This may be due to a lack of resources, a poor evaluation of the resident's needs or the regulations of an institution. Hence, nursing staff may assist a resident to walk once a day (care given); yet, standards of care stipulate (care required) that the resident receive help to walk three (3) times a day to activate blood flow and prevent muscular atrophy in the lower limbs. In the FRAN, one would indicate for this nursing action; ***"walk with assistance"*** at 10:00 - 15:00 -20:00 ***"every day"***, instead of ***"walk with assistance"*** at 15:00, ***"every day"***.

One will also note that the care and assistance given by significant others and/or volunteers and/or personnel not belonging to nursing and aid staff (for ex.: physio, social service), while required by the resident, are not usually noted in the form to collect the care and services required, as they are not delivered by nursing and aid staff.

As mentioned above, the philosophy of care as well as the norms and professional standards which are derived from it, influence the determination of the care required. These philosophies, norms and standards vary from one institution to the other. Hence, if one did not structure the determination of what is required with a set of rules, the required care for the same resident (in terms of services and

consequently in terms of resources) would vary from one institution to the other. This poses an important problem of equity if the results of the PLAISIR evaluations are used, as is the case in Quebec, to distribute a regional budget between the different programs or institutions of a region, according to the resources required by their residents.

Thus, in Quebec, it appeared necessary to define standards of care which all institutions must adhere to **for the purpose of the PLAISIR evaluations**.

The following standards of care and assistance correspond to current practice in the nursing homes, extended care hospitals and lodging pavilions of Quebec. There have been no studies done to establish their clinical validity. They simply stem from observations made in the facilities and, in the opinion of the nurses consulted, although they do not correspond to optimal care, they still ensure that the resident has an acceptable sense of well-being and security. Considering the presently available resources, nursing personnel are currently finding it impossible to do better in general and unfortunately, in certain cases, cannot even offer the care and assistance corresponding to these standards.

These standards are set in order to help the nurses who use the FRAN to assess the nursing care and assistance required by the resident. The nature of the standards is not prescriptive but only indicative of an average from which the nurse can move away from, providing that she **justifies** this deviation by basing it on the particular needs of the resident she is evaluating. Therefore, each time the nurse evaluator uses a frequency or an intensity that is different from the standard frequency or intensity for a particular nursing action, she must explain her reasons in writing in the FRAN.

Finally, it must be noted that if it is necessary for everyone to adhere to the same standards in order to ensure equity when allocating the resources, it is nevertheless possible that, when these resources are made available to provide resident care, each facility could set its own standards which might eventually be different from the general standards. However, the facility's own standards will certainly be regulated by the resources allocated on the basis of general standards. This is the price which must be paid in order to achieve equity in the allocation of resources.

One must however note that in the application of PLAISIR in Switzerland and Belgium, the committees of nurses of the two countries have defined the standards of care which correspond to their respective practices and are different amongst themselves and different from Quebec standards. Finally, it is important to note that the utilization of common standards of care by all the institutions of a country or region is only necessary where a **collective** application of the PLAISIR system exists, as is the case in Quebec. An institution which implements the system solely for its internal needs of information could very well use its own standards. Yet even in such a case, a certain uniformity is necessary; in fact, if one wishes to compare the units of the institution amongst themselves, it is then necessary that all adhere

to the same standards of care. Thus, even in such a situation, one cannot bypass the explicitation and the formalization of the standards of care of the institution without losing the ability to compare units amongst themselves.

One will find, below, the list of care standards currently being used in Quebec.

	Standards	**Particularities of the resident**
0010	HUMIDIFIER	
	Refill once per work shift.	The resident requires a humidifier 24/24 hours.
2070	FECAL INCONTINENCE CARE	
	Once each work shift (not each round).	Only for the resident who continually soils disposable undergarments, towels or blankets.
2090	CONDOM CARE	
	Once a day.	The resident has a condom 24 hours a day.
2110	CARE OF URINARY CATHETER	
	Twice per day.	No particularities.
	PERSONAL HYGIENE	
3030	Partial bath: five (5) days a week.	No particularities.
3040	Complete bath: two (2) days a week.	No particularities.
3040	Complete bath every day.	Resident is bedridden.

	Standards	Particularities of the resident
3050	Genital hygiene not related to incontinence: once a day.	The resident has one of the following problems: . foul-smelling vaginal discharge . redness at the groin . scrotal irritation/redness.
3090	SHAMPOO/RINSE	
	Once a week.	No particularities.
3130	BEAUTY CARE	
	Pedicure and manicure: once a week.	No particularities.
3140	SHAVING OF BEARD	
	Every day.	The resident is male and has no skin problems.
	Once a week.	The resident is female and shaving or removal of unwanted hair is required.
3170	BRUSHING OF TEETH	
	Three (3) times a day.	No particularities.
4030	ASSISTANCE NEEDED TO WALK	
	Three (3) times a day.	The resident is susceptible to muscular atrophy of lower limbs.

	Standards	Particularities of the resident
4050	RUBBING AND POSITIONING	
	Twelve (12) times a day (every two (2) hours).	The resident is bedridden.
	None.	The resident is independent and walks well.
4060	PASSIVE AND/OR ACTIVE MUSCULAR EXERCISES	
	Once a day.	The resident is mobile and is susceptible to muscular atrophy and/or circulatory problems.
	Twice (2) a day.	The resident is bedridden or does not walk.
4070	STRUCTURED MUSCULAR EXERCISES	
	Twice (2) a day.	The resident has a physical problem and would benefit from a rehabilitation program.
9070	PULSE	
	Before medication is administered.	The resident receives digoxin. (Indéral - Corgard - Lopressor).

1.4 Method

The basic tool of the PLAISIR system is the **"FRAN" form** which will be described heading by heading in a following section. This form allows one to collect very detailed information about the resident : his bio-psycho-social profile and certain services he has received (first 3 pages of the form) and his profile of nursing care and assistance required over the last 7 days (the following 29 pages of the form).

The FRAN form is filled in by a nurse evaluator. It is not necessary for the evaluator to personally know the resident. In order to fill in the FRAN, the nurse evaluator will refer to :

- the resident's chart;
- his care plan;
- the binder for treatment(s) or analysis(es);
- the binder for protocols within the institution;
- any other available data.

If need be, the evaluator will question nursing personnel responsible for the resident, other health care professionals, the resident and his family. According to the complexity of the cases, an evaluator can complete 5 to 12 FRANs (evaluations) **per day**.

The completed forms are sent to the processing centre. The information contained in the FRAN are then entered on computer. It is programmed to detect, at this stage, any missing data, impossible, incoherent or improbable responses. The computer then produces an output which is a compact yet exhaustive version of the contents of the FRANs, accompanied by messages signalling the data needing particular attention. This compact version of the FRAN is called IMPFRAN.

The IMPFRANs are submitted to a nurse-desk-reviewer who specializes in verifying the FRANs. She desk-reviews the IMPFRAN to detect any missing data, errors and incongruencies. Following this desk-review, the nurse then contacts the institution, where the resident is staying, by telephone and questions the care-giver(s) or evaluator to complete and correct the IMPFRAN of the resident. According to the complexity of the cases, a nurse-desk-reviewer can process 4 to 10 IMPFRANs per hour.

Once this step is completed, the IMPFRAN is returned to the clerk entering the data who then makes the necessary changes in the computer. The data is now ready for processing in order to produce the outputs of the PLAISIR system.

1.5 Management of the PLAISIR data base

We will now explain how an institution regularly using the PLAISIR system to evaluate its residents updates its PLAISIR data base.

When an institution starts to use the PLAISIR system, it evaluates **all** its residents. This evaluation must be obtained in the shortest time possible in order to obtain a picture of the institution's residents **at a precise moment in time.** However the number of nurse-evaluators is limited and given that an evaluator can assess 5 to 12 residents per day, obviously it is impossible to evaluate all the residents of an institution the same day. Hence, the period of evaluation of an institution varies from a few days to a few weeks. This does not cause any real problems; as the status of the residents in institutions using the PLAISIR system is relatively stable, one can still consider that one has a snapshot of the needs of the institution's residents. At the end of the evaluation process, one will date (for example: in the outputs of the PLAISIR system), the period of observation in terms of **the month** and **the year** for which the majority, if not all, of the evaluations were performed: for example: 06 - 1994. The same applies for the updating of the data base. Thus this item will not be discussed later.

Once a first image of the residents has been constructed, the institution updates it at its convenience. Different considerations may be taken into account when determining this frequency, essentially those of costs and benefits. It is more costly to update the data base frequently; however the institution that intensively uses the information of PLAISIR at a clinical or administrative level will want an updated image of their residents at all times. There is no general rule regarding the frequency of updating. We can however say that in Quebec, the choice of a frequency is most often agreed upon by all the institutions of a region. The minimal frequency of updating observed is once a year, the maximum being four times a year, the exception being transition units (mid stay care units) which may update their PLAISIR data base monthly.

When updating, one will not revaluate all the residents, only those whose status has changed or have been admitted since the last updating of the data base. One also takes advantage of the updating to remove from the data base all the closed files (transferred residents, deaths).

The initial make-up of the data base and its subsequent updating obey strict rules in order to protect the confidentiality and integrity of the data of the information system. The rules and procedures are defined in a document titled ***"Identification of Program and Evaluators - Clients Register"*** which can be found in the PLAISIR ***"Computer outputs guide"***.

1.6 Quality assurance of PLAISIR data

Numerous steps have been taken to ensure the quality of the data collected by the PLAISIR system. A certain number have already been described in previous pages, yet, given the importance of the subject, we will cover them all in this section.

The key of the evaluation process is of course the nurse-evaluator. This person generally belongs to the institution under consideration and a priori, has never completed any evaluations with a format or procedures similar to those of the PLAISIR system. She must then be trained to perform the PLAISIR evaluations. This training session has two stages. The first consists of a **group training session** (maximum of twelve participants with groups of four or five generally) lasting **two days**. This session is essentially a review of the FRAN, heading by heading. The reference manual of the system supports this whole process. The theoretical approach is followed by a practical one in which the *"students"* evaluate one imaginary resident using the FRAN.

The second step of the process consist of an **on-site individual training session** which lasts two days. This training session takes the following form.

Following the 2 day *"class"* training session, the *"student"*-evaluator returns to her institution and completes 10 PLAISIR evaluations. An instructor will then meet her in her institution. The instructor randomly chooses 3 residents among the 10 evaluated by the student, independently revaluates them and finally compares her evaluations with the student's evaluations. Finally, she *"reads over"* with the student the seven remaining evaluations. The *"student"* is then asked to perform ten other PLAISIR evaluations. Once these are done, the instructor returns to the institution, randomly chooses 6 residents among the ten just evaluated, independently assesses them and finally compares her evaluations with those of the student. This process lasts a day.

The process of desk-reviewing all the evaluations allows - as a byproduct - the identification of *"problem"* evaluators to which one offers a *"follow-up training"*, in groups or individually. The format of these follow-ups is variable. It depends on the types of problems that are detected. There are also *"refresher sessions"* which are aimed at trained evaluators who have not performed evaluations for a prolonged period (a year or more).

The number of evaluators is purposely limited. Since the system's inception in 1984, we had an objective of training one evaluator per 100 beds to ensure that each one performs a sufficient number of evaluations per year to maintain her skill. With time, we have trained an average of one evaluator for approximatively fifty beds and we have verified that this number, in most cases, allows for a good quality of data collection. The training of a larger number of evaluators than planned is due to the small size

of a number of institutions and that, in certain facilities, management wanted the head-nurses of the respective units to be responsible of the evaluations of their unit.

One of the key elements of data quality assurance is the desk-review of all the evaluations and their eventual *"correction"* following the telephone call to the evaluator/care-givers of the resident under consideration. To detect the problems, the nurse-desk-reviewers is aided by the computer's program which detects certain anomalies and signals them to the desk-reviewers in the IMPFRANs. The dual character of the PLAISIR evaluations is of great importance in the desk-reviewing process. In fact, the FRAN allows one to collect two portraits of the same resident : his bio-psycho-social profile and his profile of nursing and assistance services required. An experienced desk-reviewer rapidly detects inconsistencies in these two portraits which allows her to formulate the questions she will ask during the telephone call to the evaluator or care-givers. It is also important to note that when the IMPFRAN of a resident is received it is always compared with the previous IMPFRAN if the resident had already been evaluated with the PLAISIR system. This comparison is very helpful in detecting incongruencies. Finally, one must note that practical experience is important in such a system of data verification. Certain desk-reviewers have reviewed since 1984 several tens of thousands IMPFRANs, which helps them considerably in their task.

The process of desk-reviewing and correction is also an ongoing training experience for the evaluators as they are informed of their errors and omissions during the telephone contact with the reviewers. Furthermore, the nurses responsible of the desk-reviewing are also responsible of the training of evaluators. They are fully aware of the FRAN items that cause the most difficulties to the evaluators and can focus on these items in the training-sessions. Finally, these same nurse-desk-reviewers pilot the revision/updating process of the PLAISIR system (reference manual and form). Having knowledge of the problems within the system, they are in a position to propose pertinent solutions to these issues.

In addition to the desk-review (microscopic) of the IMPFRANs, there is the review (macroscopic) of the PLAISIR system outputs. This last step allows for the eventual detection of a systematic bias (inflated evaluations, for example) which may have gone unnoticed with the desk-review of individual evaluations. During the process of reviewing the outputs, one always compares the current outputs of a program or institution with its last outputs.

Other important elements of the quality assurance of data collection are the standards of care which were mentioned earlier and which are a necessary condition for the homogeneousness of evaluation and the reference manual which gives accurate and detailed definitions of each of the FRAN headings. Each evaluator always has at her disposal this manual.

Finally, in very rare cases, where all these measures seem insufficient to ensure validity of the data, an exceptional verification of the evaluations is done on site by nurses not belonging to the institution. They are generally nurse-instructors-desk-reviewers responsible of the PLAISIR system.

2. GENERAL DESCRIPTION OF THE FORM TO RECORD NURSING ACTIONS (FRAN)

The FRAN is divided into two sections.

The first section is used to identify the client, to describe his bio-psycho-social profile and to specify the therapies and treatments the client **receives**.

It is further divided into eighteen (18) blocs.

A- Identification
B- Rehabilitation therapy (services **received**)
C- Nursing rehabilitation/Services **received**
D- Specific treatments **received**
E- Medical rounds
F- Diagnosis/Health conditions
G- Mobility
H- Determining factor(s) for reduction or loss of mobility
I- Decrease or loss of the ability to use one or more limbs
J- Mechanical device
K- Physical independence
L- Occupation
M- Protection
N- Outside contacts
O- Social integration
P- Psychological and sensorial functions
Q- Psychological problems
R- Orientation (interactions with the environment)

The description of each of the blocs is given in chapter 3 of this guide.

The second section (II) consists of a structured list of nursing actions, grouped according to the basic needs of:

- respiration
- feeding and hydration
- elimination

- hygiene
- ambulation
- communication

and according to the needs specific to hospitalized clients such as:

- medication
- intravenous therapy
- treatments
- diagnostic procedures.

The themes are identified in the middle of the top page and the lower bottom right hand corner of the page of the FRAN.

In the guide, we will present each of the nursing actions grouped by theme, using the following format:

1. **Purpose**: describes the outcomes of the nursing action.

2. **Description**: lists and describes the activities included in the nursing action.
   This list is however incomplete as certain support activities are not listed in the description, to avoid needless repetitions. These activities have nonetheless been included in the *"time"* allotted to perform a nursing action. These acts are among the following:

   - consulting the care plan, medical orders;
   - washing hands;
   - preparing and disposing of supplies;
   - identifying the client;
   - giving general information and guidelines relative to nursing actions;
   - isolating the client;
   - positioning and making the client comfortable during and following an intervention.

3. **Instructions**: describes the different parameters to register in the form (FRAN).

4. **Level of assistance**: lists examples for each of the levels of aide that may be required by the client.

These items are a partial list and the guide does not replace the institution's policies or technical procedures binder. We have not listed, for example, all the goals of a nursing action, nor described all the technical aspects of a nursing activity. However we believe this guide will be an invaluable aide to the evaluator to choose and inscribe the nursing actions in the form (FRAN).

3. CLIENT IDENTIFICATION AND BIO-PSYCHO-SOCIAL PROFILE (SECTION I)

A. IDENTIFICATION

Region, sub-region, program, unit, client's identification number, evaluator:

- This information can be found in the form *"Identification of program and evaluators"* or *"clients register"*.

- The client's identification is a three (3) digit number. It is necessary to consult the *"clients register"* and transcribe in the available space, the three last digits attributed to the given client.

Medicare number:

- Note in the space provided the medicare number of the client.

Observation date:

- Supply the necessary information by indicating in the proper sequence: the year, the month and the day. The date correspond to the day following the seven days of observation. For example, for observations made from the 7th to the 13th inclusively, the observation date is the 14th.

Observations made for:

- The observations normally cover the period of seven (7) days. If certain clients are **regularly** absent from the institution, one or two days a week (ex: weekend pass), for these clients, the observations will cover the days they are usually present during the week. In such cases, it is necessary to specify the exact number of days (for example: 5 days/7) covered by the observations. For the clients who were **exceptionally** absent during the observation, it is necessary to evaluate the amount of care that would have been required during their absence

by referring to the care generally required for that (those) given day(s). In such cases, the observation will cover 7 days and this number must be noted in the space provided.

Sex:

- Check appropriate box.

Date of admission:

- Note the **date of admission within the institution** (program). This date remains unchanged, even if the client is temporarily hospitalized in another institution or a short stay unit within the same institution.

  If the client returns home and is readmitted to the institution within a six (6) month period, note the date of the **first admission**. If his stay at home is longer than six (6) months, note the new admission date.

B. REHABILITATION THERAPY (services received)

This section of rehabilitation therapy groups the services **received** for physiotherapy, occupational therapy and/or speech therapy. These services are given in order to maintain or increase the abilities or the physical, psychological or social functioning.

Specify the number of minutes per week received for each therapy and the number of days per week the therapies were received.

In order to determine these numbers, the assessment is generally based on the services received by the client during the week of observation. It is however possible that the frequency of a service is inferior to once weekly; for example once every two weeks. In such a case, note in the box: number of minutes/week, the number of minutes received every two weeks **divided by 2**, and inscribe in the box number of days/week: ½, **whether the client received the service or not during the last week**. Use the same rule for services received monthly.

For any service not received, it is **necessary** to note 0 (zero) in both boxes. A blank box will be considered as **a lack of information and not as an absence of services**. In the case where only the number of days/week is known, note a *"?"* in the box corresponding to the number of minutes/week.

Example: for a client who does not receive rehabilitation services.

	Number of minutes/week	Number of days/week
Physical	0	0
Occupational	0	0
Speech	0	0

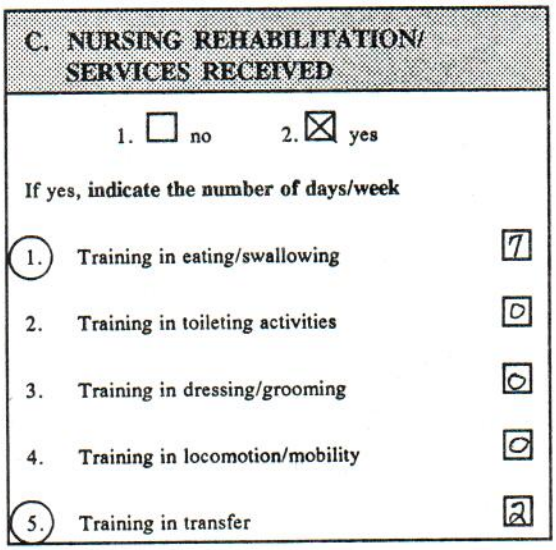
C. NURSING REHABILITATION SERVICES RECEIVED

Nursing rehabilitation refers to all interventions performed by nursing personnel for the specific purpose of **increasing the client's independence** with regards to one or more of the activities of daily living. The item also takes into account interventions performed by nursing personnel in order to **maintain the client's level of functioning.** For example, the client with cognitive deficits experiencing difficulties in accomplishing certain ADL; to orient, encourage and supervise him while **he performs** his ADL are nursing rehabilitation interventions that maintain the level of independence.

The categories of activities for which the client can receive training are the following:

- eating;
- elimination (using the bathroom, bedpan, urinal, toileting program);
- personal grooming (personal hygiene, brushing teeth) and dressing;
- locomotion (walking, using a wheelchair independently), positioning in bed;
- transfers.

Indicate if the client has **received** or not, in the period of observation, nursing rehabilitation services. In the affirmative, circle the code(s) corresponding to the category(ies) of rehabilitation activities. For **each of the categories**, indicate the number of days per week when nursing rehabilitation actions are undertaken. Note 0 (zero) in the corresponding boxes if no services were received.



In the case where no answers are given for this section, this will be treated as a lack of information, not an absence of nursing rehabilitation.

Inversely, if the section is answered yes and the boxes for number of days/week are not completed this will be treated as an absence of corresponding services and not as a lack of information.

Examples of nursing rehabilitation activities:

- assist, supervise a person learning to use adapted utensils;

- encourage, supervise a person with cognitive deficits to eat on his own. Encourage to use utensils, orient to the steps to follow but let him eat on his own;

- assist the incontinent client to the bathroom every two hours and/or offer the bedpan or the urinal to retrain the bladder;

- assist, supervise the client learning to use adapted instruments to increase his level of independence for personal care (adapted washcloth or glove and toothbrush, for example);

- orient, supervise the client with cognitive deficits at each step while dressing. Let him choose his clothes and dress himself;

- teach the client to use a wheelchair (motorized or not). Supervise him and correct his technique, as needed;

- teach the client to mobilize himself in bed by using the bedrails or a monkey bar, for example;

- teach the client to transfer from bed to chair, chair to bed, chair to toilet. Supervise him and correct his technique.

D. SPECIFIC TREATMENTS RECEIVED

Indicate if the client has received in the 7 days of observation one or more of the following treatments. If this is the case, check (✓) if the treatment was received within the institution (IN) or in another facility (OUT). For the last 3 treatments; stasis ulcer, pressure ulcers, foot care, indicate only by a check mark (✓) if the treatment was received.

D.01 **Chemotherapy:** includes all forms of treatment (including medications) given by all possible access routes, within or outside the institution.

D.02 **Radiation treatment:** includes all types of radiotherapy given within or outside the institution.

D.03 **Inhalation therapy:** includes all types of respiratory therapies **given** by the **inhalation therapist** such as: chest physiotherapy, aerosols, others.

D.04 **Dialysis:** includes peritoneal dialysis, hemodialysis, continuous arteriovenous ultrafiltration. Whether the treatment is given within or outside the institution.

D.05 **Transfusion:** includes the transfusion of blood or derivatives.

D.06 **Parenteral feeding:** includes the administration of a hypertonic solution of glucose, amino acids, electrolytes and water into a large, central vein (ex.: subclavian).

D.07 **Stasis ulcer:** open lesion, usually in the lower limbs caused by chronic venous insufficiency or peripheral vascular disease.

D.08 **Pressure ulcers:** tissue necrosis, over bony processes, caused by friction or pressure. The terms bed sores, decubitus ulcers are also used.
1° and 2° degree: redness, abrasion or vesicles.

D.09 **Pressure ulcers:** tissue necrosis, over bony processes, caused by friction or pressure. The terms bed sores, decubitus ulcers are also used.
3° and 4° degree: destruction of skin and soft tissue.
Muscles, tendons and bones are damaged at level 4.

D.10 **Foot care:** includes the treatments of a callus, wart, callosity, ingrown nail and fissures or cracking between the toes. The treatments may be performed by the nursing service (Nsg) or by a specialist not belonging to nursing personnel, a podiatrist (pod), for example.

If certain treatments are received less than once a week, do not check the item, whether the treatment was received during the last week or not, unless the treatment is received at least every fifteen days.

If no answers are given for this section, this will be treated as a lack of information not as an absence of specific treatments.

Inversely, if the section is answered yes and no further information is noted regarding any subsequent sub-title, this will be treated as an absence of the corresponding treatment and not as a lack of information.

E. MEDICAL ROUNDS

Indicate the number of doctor's visits **usually received** by the client **per month**.

If a client is seen by the doctor every **x** months, note **1/x**.

If a client is not seen by the doctor, note 0 (zero). If no answer is given in the section, this will be treated as a lack of information, not as an absence of doctor's visits.

F. DIAGNOSIS/HEALTH CONDITIONS

Circle, in the list of pathologies/health conditions, the one (those) that applies (apply) to the client. Note, in the space provided, the client's diagnoses that do not appear in the list. The number of diagnoses that can be identified for a client is unlimited. Indicate, however, their order of importance by noting 1°, 2°, 3°, 4° ... (the 1° corresponding to the **most important** diagnosis) at the right of each diagnosis.

The diagnoses considered here are those that are still active, either because they correspond to a **chronic illness** that permanently affects the client or they correspond to an **acute illness** present during the seven days of observation or they correspond to a **past illness/accident** which has left the client with sequela, presently affecting him.

General rules of assignment for the following dimensions of handicap:

G- MOBILITY HANDICAP
K- PHYSICAL INDEPENDENCE HANDICAP
L- OCCUPATION HANDICAP
O- SOCIAL INTEGRATION HANDICAP
R- ORIENTATION HANDICAP

1. The evaluator will class the person with regards to his abilities augmented by mechanical aid(s) and/or special device(s) actually being used (example: cane, eyeglasses, walker, wheelchair) and with regards to orientation, augmented with the effective use of medication(s).

2. The evaluator will class the person according to his actual degree of mobility, physical independence, social integration and orientation as well as his actual level of occupation **and not according to the level the evaluator hopes the client attains.**

3. An occasional reduction, at the time of evaluation, in mobility and/or social integration, and/or an occasional dependence for ADL and/or for orientation, or an occasional unfavourable experience with regards to the person's level of occupation should not preclude the person's classification to the less disadvantaged category corresponding to the client's usual state (i.e. category with the lowest number).

4. The five dimensions (mobility, independence, occupation, integration, orientation) apply to all individuals and the categories describing each of the dimensions are mutually exclusive. This implies that one and only one category can be chosen for each of the dimensions for each client. If doubt is experienced when classifying a person within a category of a dimension, the evaluator will rate the less favourable category (i.e. the one with the higher number).

G. MOBILITY

Mobility is defined as the person's ability to move about effectively in his surroundings. To assess this ability, the evaluator will take into account the independent use of mechanical aids (prosthesis, orthesis, cane, walker, wheelchair, etc.) **but not the aid given by another individual.** The principal indicator used to measure the client's mobility is the extent of mobility, meaning the *"distance"* to which the client can move away from a reference point, which, in this case, is the person's bed or chair. The person's extent of mobility can vary according to age and sex. In the case of persons living in an institution, the evaluator will consider as a normal extent of mobility, the distance usually travelled by persons of the same age-sex group. In the following scale, the three first categories correspond to a normal extent of mobility and the subsequent categories correspond to a slowly decreasing extent of mobility.

Circle the code of the category chosen as being the one that best describes the client's mobility. The categories are **mutually exclusive**; the evaluator can rate one and only one.

If you have selected the category *"01"*, go directly to section I if not, complete section H. *"Determining factor(s) for reduction or loss of mobility"*.

G.01 **Fully mobile:**

- This category groups the persons with a normal extent of mobility not in categories 02 and 03.

G.02 **Variable restriction of mobility:**

- This category includes persons presenting intermittent impairments or disabilities (fluctuating course of an illness, for example, in cases of rheumatoid arthritis or osteo-arthrosis, a bronchitic client with temporary seasonal impairment that limits mobility, persons suffering form severe asthma, ...). **Above and beyond these temporary impairments, these persons have a normal extent of mobility.**

G.03 **Impaired mobility (slowness):**

- This category includes persons whose extent of mobility is normal although they may take longer to get around for reasons of poor vision and insecurity, or for example, in an urban setting, the person may have difficulties using public transportation although he can **overcome any difficulties without the aid of another individual** in all circumstances.

G.04 **Reduced mobility:**

- This category regroups the persons whose mobility is reduced because of visual impairments, insecurity, frailty, debility, cardiac and/or respiratory insufficiency(ies) or, in an urbanized society because of the inability to use public transportation in all circumstances, for example. These persons can get around without the help of another individual outside the neighbourhood of their institution but **they cannot go everywhere** ***"without the help of others"***. Their extent of mobility is more restricted than what is normal.

G.05 **Neighbourhood restriction:**

- This category regroups persons who **ordinarily** move about independently in the **neighbourhood of their institution**. The persons who get around on their own only on the grounds of the institution or the surrounding streets are included in this category.

G.06 **Dwelling restriction:**

- This category regroups persons who **ordinarily** get around independently only **inside the institution,** this includes persons who cannot get out of bed on their own but who, once up, can get around independently (for example; using a wheelchair) within the institution.

G.07 **Floor restriction:**

- This category regroups persons who **ordinarily** get about independently only on the **floor of their bedroom**, this includes persons who cannot get out of bed on their own but who, once up, can move about independently (for example; using a wheelchair) on the floor of the bedroom.

G.08 **Room restriction:**

- This category regroups persons who **ordinarily** get about independently inside their bedroom; this includes persons who cannot get out of bed on their own but who, once up, can move about independently inside their bedroom.

G.09 **Total restriction of mobility:**

- This category regroups all those **ordinarily** confined to a chair or a bed and the persons incapable of moving about independently between the bed and the chair.

H. DETERMINING FACTOR(S) FOR REDUCTION OR LOSS OF MOBILITY

In this section, it is necessary to answer the question "What limits the client when he moves about?" Circle the code(s) corresponding to the factor(s) **determining the reduction or loss of physical mobility**. The factors can be:

inherent to the client, such as:

H.01 **Blindness:**

- This category regroups persons experiencing a complete loss of sight. Those with severely impaired visual fields or clients with other visual impairments are included in the factor H.13.

H.02 **Obesity**

H.03 **Loss of balance**

H.04 **Weakness, frailty**

H.05 **Psychological problems:**

- Included in this category, the clients who are limited in their ability to move about because of embarrassment, anxiety, lack of motivation; also included are the persons with cognitive deficits WITHOUT behavioral problems such as aggressiveness.

H.06 **Psychiatric problems:**

- Included in this category are persons presenting psychiatric disorders and persons experiencing cognitive deficits WITH behavioral problems such as aggressiveness.

H.07 **Coronary or cardiac insufficiency**

H.08 **Respiratory problems**

H.09 **Convalescence**

H.10 **Amputation**

H.11 **Musculoskeletal deficiencies:**

- This category regroups persons presenting a musculoskeletal deficiency following an illness such as a stroke (CVA), multiple sclerosis, or others.

H.12 **Terminal illness**

H.13 **Others:**

- Specify. Ex.: neurological deficit, visual impairment.

AND/OR inherent to the institution:

H.14 **Regulations:**

- Ex.: locked ward, nursing staff limits the client's extent of mobility.

H.15 **Architectural limitation(s)**

H.16 **Others:**

- Specify.

The evaluator will select a maximum of three determining factors and indicate their level of importance (1°, 2°, 3°) (the 1° being the most important and the 3° being the least important).

Example: H.07 Coronary insufficiency (1°)
H.03 Loss of balance (2°)

I. DECREASE OR LOSS OF THE ABILITY TO USE ONE OR MORE LIMBS

Reference chart:

- Circle, in the chart, the code(s) corresponding to the affected limb(s) or body part(s) according to the type of disability: limitation, immobility, amputation.

- If, for example, a limb is affected by a limitation, on both sides of the body (i.e. left and right) do not circle the codes corresponding to the right (ex. right hand 02) and left limbs (ex. left hand 01). It is preferable to circle the one regrouping both (ex. right and left hands 03).

- The limitation of a limb is not necessarily related to an illness or the sequela of an illness. It could be, for example, a weakness or edema of the legs that limits a person's movements.

- If a client is an **amputee** indicate, in the lower part of the chart, if he receives care (dressing) or not for the amputation. If nothing is indicated it will be interpreted as a lack of information and not as an absence of care.

- If no problem exists (i.e. no loss or decrease in the ability to use a limb or body part), specify, however, if there is a **risk of fall** in section I.1 and then go to section K. Otherwise, complete section J *"Mechanical Device"*.

- If nothing is indicated in the section *"Risk of fall"* this will be interpreted as a lack of information not as an absence of risk.

- A risk of falling that is **corrected** is considered an absence of risk.

J. MECHANICAL DEVICE

- Circle the code(s) corresponding to the device used by the client presenting a decrease or loss of the ability to use (a) limb(s) or body part(s).

- If more than one device is used, indicate their level of importance, the first being the device used most.

Example: *"02"* cane (1°) (= most of the time)
"08" wheelchair (2°) (= occasionally)

K. PHYSICAL INDEPENDENCE

The concept of independence with regards to the activities of daily living (ADL) refers to the individual's ability to complete, independently, the basic activities (personal hygiene, eating...) (BADL) and the *"Instrumental"* activities of daily living (housekeeping, cooking) (IADL).

Given that the persons, in this case, live in an institution, **the evaluator will assess the person's potential** for the abilities, without considering the institutional environment. Thus, it is possible that most clients do not have the opportunity to prepare their meals in the institution where they reside. However the evaluator will determine if the client could do it and, in the case of an affirmative response, the evaluator will consider the person's ability to perform an activity as equivalent to the ability of the person who actually performs this activity. The determination of the **actual** dependence of a client is more difficult with regards to basic activities, as certain institutions have a tendency to *"do for"* the client rather than let him do it on his own. The evaluator will assess if, in the absence of a *"do for"* policy, the person would usually be independent for the relevant activities, being careful not to idealize the client's potential (see general rule of assignment no. 2).

Complete this section by circling the code of the category that best describes the client's level of independence with regards to A.D.L. The categories are **mutually exclusive**, the evaluator will select one and only one.

K.01 **Independent:**

This category regroups persons who are independent, who do not require any mechanical aid, or special equipment, or adaptation of the environment; if there is help from others, it is not essential to accomplish the A.D.L. (i.e.: **could do without it**).

K.02 **Independent with mechanical device:**

This category groups independent persons who require special equipment (prosthesis, orthesis, cane, walker, wheelchair, ...) or mechanical aid. Those for whom such aids are available, **yet do not use them**, are not considered independent and must be classed in another category.

K.03 **Independence with adaptation / modification of the environment:**

This category regroups persons dependent with regards to the adaptation or modification of their immediate environment. In this case, the modifications are reasonable or standard adaptations such as: work surfaces, larger doorways, handrails, bath tub and washroom, ... The evaluator will class in this category a client who could be independent if he had such a modified-adapted environment at his disposal, or a client who benefits from such a setting and is independent because of it.

K.04 **Situational dependence:**

The evaluator will class in this category the persons experiencing - or would experience if they were living at home alone - **certain difficulties** meeting their personal needs **without however being largely dependent on others**; those who experience certain difficulties to move about outside the institution, difficulties that can only be countered with the assistance of others; those who experience moderate orientation problems that can only be solved with the assistance of others; those who could be independent if they used a mechanical device or special equipment (prosthesis, orthesis, cane, ...) but who refuse to use such aids - equipments.

The persons classed in this category are dependent for **predictable** needs that come up less than once a day (for example: 2 or 3 times/week).

K.05 **Dependence, long intervals (≤ once/24 hours):**

Belonging to this category are the persons who **depend - or would depend if they lived alone at home - on others to meet predictable needs that do not arise more than once per twenty-four hours**, such as housekeeping, shopping, preparing meals, cleaning, security, ... These persons need support services and/or supervision **at most** once per 24 hours at **predictable** times.

K.06 **Dependence, more than once/24 hours but at predictable times:**

Belonging to this category are the persons who depend on others morning and night, and those who require assistance to satisfy needs that manifest themselves at short intervals (every three or four hours during the day; every three or four hours during the day and occasionally at night; every three to four hours during the day and night), for example, personal hygiene, meal time, getting around in the immediate environment, transfers, changing the linen, etc. However these needs are **predictable** and **the person(s) who assist(s) does (do) not need to be available on a permanent basis,** he (they) must only be present at the predetermined times.

K.07 **Unpredictable dependence, short intervals-(quasi) permanent availability:**

Belonging to this category are the persons susceptible of requiring assistance from others to satisfy critical needs that manifest themselves at short, **unpredictable** intervals (assist to the bathroom, assist to get up, etc.); particularly, the frail or mentally unstable for whom it would be potentially dangerous to be left alone. The persons belonging to this category require **a permanent or quasi-permanent availability of others, yet this does not imply that the aid or supervision will be used.** In the case of persons who can be left alone for short periods (one or two hours), this is considered quasi-permanent availability.

K.08 **Dependent for most needs:**

Belonging to this category are the persons requiring assistance and/or continuous supervision **(not only the availability of such aid or supervision,** see category 07), in particular individuals with physical handicaps requiring help from others to answer **most** of their basic needs and/or care for them as far as customary everyday functions are concerned; or those who are sufficiently senile, confused or mentally unfit to require such a level of care. Certain individuals may be left alone for short periods (one or two hours).

K.09 **Dependent for all needs:**

Belonging to this group are the individuals **requiring aid** 24 hours a day **for all their needs**: personal hygiene, feeding, elimination, dressing, etc.

L. OCCUPATION

This concept refers to the **person's ability to occupy his time in the manner customary** for his sex and age group within the institutional environment. Included here are all activities whether related to **employment, recreation, education, creation** or customary **every day tasks** (basic or instrumental).

Circle the code of the category that best describes the client's occupation level. The categories are **mutually exclusive**, the evaluator will choose one and only one.

L.01 **Customarily occupied:**

This category regroups persons who occupy their days, in a satisfactory manner, with varied activities, appropriate for the person's age-sex group. Given that the persons considered here live in an institutional environment, it is not expected that their activities are as varied as those of persons living outside of the institution, yet they must however sustain an appropriate occupation during the day, with the exception of normal naps and rest periods. Hence, by appropriate normal activities of institutional life, we mean, in addition to the basic activities of daily living:

- instrumental activities of daily living such as shopping and, when organizational structures permit it, participating in the preparation of meals, cleaning, etc.;
- exploration activities: outing, travelling, visits;
- educational activities: various classes;
- recreational activities: board games, bingo, crafts, knitting, exercise and other sports;
- information and entertainment activities: reading, T.V., radio, music;
- various volunteer or auxiliary activities;
- socialization activities: meetings with friends, parents, birthdays, ...

The activities considered here may take place within or outside the institution that houses the client.

L.02 **Intermittently unoccupied:**

This category regroups persons who are **intermittently** unable to pursue **their usual, appropriate activities** because of the interference of conditions such as epilepsy, migraines, allergies, occasional falls. A person who temporarily suspends otherwise appropriate activities, because of a passing ailment, does not appear in this category, but rather in category 01.

L.03 **Curtailed occupation (in terms of the scope of activities):**

This category regroups persons unable to participate in the entire range of customary, appropriate activities. The person belonging to this category participates in customary, appropriate activities but is subject to certain limitations or restrictions; the person cannot participate in or execute all the activities associated with the customarily occupied, or if the person can participate in or execute all of the activities, he cannot fully complete certain of the tasks.

L.04 **Adjusted occupation:**

This category regroups persons with an inability to follow activities customary for their age-sex group but they are able to participate or execute **modified or adapted activities with regards to their impairments or disabilities**. The individual belonging to this category, while being unable to occupy himself in the same way as other members of his age-sex group, is, however, able to occupy all of his time, either because he has the same activities as his age-sex group supplemented by the help of another person and/or the adaptation of his environment and/or mechanical device, or the person has particular activities adapted to his abilities.

L.05 **Reduced occupation (in terms of time frame):**

This category regroups persons who must **limit the quantity of time for which they are occupied** because of their mental and/or physical condition.

L.06 **Restricted occupation (in terms of type):**

The individuals in this category experience severe restrictions of participation in activities customary to their age-sex group (for example, persons victims of frequent falls). These individuals must **limit themselves to certain types of activities** (for example: activities accomplished while sitting).

L.07 **Confined occupation (in terms of time frame and type):**

This category regroups persons who, simultaneously, experience limitations with regards to the **type** (category 06) and **the amount of time** devoted to activities (category 05).

L.08 **No occupation:**

This category regroups persons who, for all sorts of reasons, **are incapable of sustaining any form of activity**.

L.09 **Unoccupiable:**

This category regroups the persons who participate or realize certain activities **without a defined goal**, in such a way as that an outside observer **cannot make sense of or find any logic to the activity.** For example, the person constantly repeats the same task (often reduced to the simplest gestures) such as: constantly changing the radio stations, continually placing and replacing the same object, obsessively handling an object.

M. PROTECTION

If any means of protection were used for the client, check (✓) at which frequency **during the last week**:

R - rarely: from one to three days for short periods of time only.

S - sometimes: either, more than three days for short periods of time only;
or, from one to three days most of the time.

O - often: more than three days most of the time.

Do not check the types of protection that were never used.

Rarely will any type of protection be applied constantly. Hence the above frequencies should be interpreted according to the period for which a type of protection **could** be used. *"Most of the time"* then means *"most of the time the type of protection is likely to be used"*. For example, the bedrails can only be used when the client is in bed. In this case, most of the time would mean: the bedrails would be used most of the time the client is in bed. The use of a fireproof apron is only necessary for the client who smokes. Hence, if the fireproof apron is applied every time the client smokes, even if it is only once a day, the evaluator will check often. However, if the fireproof apron is regularly applied from one to three days a week to a client who smokes 25 cigarettes a day, the evaluator will check sometimes.

In ***"psycho-active drugs"***, we include medication administered to the client for his protection or that of others such as **antipsychotics** (hypnotics, neuroleptics, antianxiety agents, CNS stimulants, antidepressants) or **mood regulators** (mood stabilizers). If a psycho-active drug is given **less than once per week**, the evaluator will check **rarely**. If the client received psycho-active drugs from **one to three days per week**, the evaluator will check **sometimes** and if it was **more than three days per week**, the evaluator will check **often**.

If a client is cared for in a locked ward but he has the code to come and go as he pleases, the evaluator will consider that this type of protection does not apply to the client.

If, in the same train of thought, a client is cared for in a locked ward and does not have the code yet makes no attempt to leave the unit, the evaluator will also consider that this type of protection does not apply to the client.

If neither a yes or a no answer appears in the section *"Protection"* this will be interpreted as a lack of information not as an indication that the client *"never uses"* any type of protection.

Inversely, if the evaluator answers yes and no further information is inscribed next to a type of protection, this will be interpreted as the absence of use for the type of protection and not as a lack of information.

N. OUTSIDE CONTACTS

In this section, outside contacts mean receiving telephone calls, telephoning others, writing, receiving visitors, visiting others.

Estimate the frequency of all types of contacts (visits, phone calls, letters) during **the year.** If the client has absolutely no contacts, indicate 0 (zero). The absence of a zero (blank space) will be interpreted as a lack of information and not as an absence of outside contacts.

Example:	Wife's visits:	Once per week =	52
	Daughter's visits:	Twice per month =	24
		TOTAL	76
	Wife's visits:	daily =	365
	4 children each visiting about once/month =		48
	Grandson visits 3 times/year =		3
		TOTAL	416

O. SOCIAL INTEGRATION

The concept of social integration refers to the person's ability to **participate in social activities** and **maintain adequate social relations**, while taking into account that the individuals under consideration live in an institutional setting.

Circle the code corresponding to the category that best describes the person's level of social integration. The categories are **mutually exclusive**, the evaluator will choose one and only one.

O.01 **Socially integrated:**

This category includes the individuals who entertain satisfying social relationships and **participate fully in all customary social relationships** for the members of a same age-sex group (including sexual activity while taking into consideration the dissuasive policies of certain institutions). In the institutional setting, a socially integrated person easily sustains good relations with a wide circle of people (other clients, staff, visitors, ...) and participates, to the best of his abilities, in the daily life of the institution (for example: participates in activities, cooperates with care, supports other clients, etc.).

O.02 **Inhibited participation (shyness, timidity):**

This category includes the individuals whose participation in customary social relationships for their age-sex group is **inhibited by problems** such as **shyness, timidity** and other defects of self-image, mild personality problems or behaviour disabilities. The person, considered here, sustains relationships with a wide circle of people (other clients, staff, visitors, ...) and is **capable of participating in all customary social relationships** for his age-sex group but certain **personal *"obstacles"* must be overcome.**

O.03 **Restricted participation (type of social activities):**

This category includes the individuals who **do not participate in all customary social activities** for their age-sex group. However, they sustain relationships beyond the primary and secondary involvement.

O.04 **Diminished participation (primary and secondary involvement only):**

This category includes individuals who are **incapable of establishing** a relationship **with a casual acquaintance;** thus their social relationships are limited to primary and secondary involvement: family, friends, roommates, other residents, members of personnel, volunteers.

O.05 **Impoverished relationship (secondary involvement difficult):**

This category includes individuals who sustain **social relationships with only certain significant persons** either inside or outside the institutional setting, yet who **have difficulties sustaining relationships with a wider circle of people**: roommates, members of nursing staff, volunteers, and eventually family members.

O.06 **Reduced relationship (primary involvement only):**

This category includes individuals who sustain contacts **with a few significant persons: general withdrawal** in the elderly person, moderately severe behaviour disorders.

O.07 **Disturbed relationship (difficult primary involvement):**

This category includes individuals who have **difficulties initiating and sustaining relationships with significant others**, for example the clients with severe behavioral problems.

O.08 **Alienated (incapable of all involvement):**

This category includes the individuals who **are unable to relate to other people**. The clients presenting cognitive deficits **who no longer recognize family members** enter into this category.

O.09 **Socially isolated (no involvement - isolated):**

This category includes the individuals who **have been abandoned by their family** and friends, who have **no social relationships** with the members of personnel or other residents and whose potential is difficult to evaluate precisely because of the abandonment.

P. PSYCHOLOGICAL AND SENSORIAL FUNCTIONS

For the purpose of the evaluation, sixteen functions have been identified to cover the psychological and sensorial functions. The client will be evaluated for each of the sixteen functions following a four tier scale: **adequate, slight impairment, moderate impairment, severe impairment or nil.**

In case of doubt about the significance of the various functions, the evaluator will refer to the descriptions presented hereafter to avoid confusing the impairments of one function with another. Thus, it would be prejudicial to the quality of the evaluations to attribute to perception, impairments that are related to the conscious experience, or to attribute to feelings, impairments related to drive.

The assignment of the observed impairments to the proper function is not the only problem the evaluator will encounter. Once the proper function is identified, the evaluator must then decide the level to which the client's impairment belongs: adequate, slight, moderate or severely impaired/nil. It is impossible to develop infallible rules, but the following guidelines can be used to help in the decision-making process.

When deciding, the evaluator will take into account the client's age and sex and will refer to the average *"performance"* for a *"healthy"* person of the same age-sex group. The evaluator will avoid biasing the evaluation by restricting his references to the institutional setting. Hence, when referring to the average performance of *"healthy"* individuals of the same age-sex group, it is important to note that we do not only refer to healthy individuals living in an institution, but to the larger age-sex group of healthy persons particularly those living outside of the institutional setting.

The evaluator **will take into account any eventual compensations being used** by the person, meaning that a person with lower vision but whose eyesight is fully corrected by eyeglasses, will be classed, for the function sight, in the category *"adequate"*. The same is assumed if medications perfectly correct psychological impairments.

When deciding, the evaluator will also remember that the evaluation of a function is an overall assessment. Consequently, the complete loss of a sub-function within the larger function will not lead the evaluator to class for a total dysfunction but rather as a deficiency of the overall function because of the total loss of a sub-function. Thus a person experiencing *"major difficulties"* with his sleep - wake cycle (= sub-function) will not be considered totally dysfunctional (= severe/nil), but rather as impaired, for the overall function *"consciousness and wakefulness"* if this is the only problem for the function.

In case of **a temporary partial or total loss** at the time of evaluation, the evaluator will not hesitate to class the client in the category corresponding to his **usual impairment level,** less important than the one observed at the time of evaluation.

In the situation where the level of impairment fluctuates from one day to the next or changes within a given day, for example adequate to slightly impaired, or moderately to severely impaired, the evaluator will class according to the most prevalent category.

For certain functions (short term memory, decision-making, language, sight, hearing, making self understood and understanding others), it is possible to formulate definitions for the categories: adequate, slight, moderate, severe or nil. For other functions it was impossible to supply such definitions. This does not, however, pose serious difficulties for the two extreme categories corresponding respectively to an absence of impairment or a total or almost total loss of the function. If the client's state does not correspond to these two situations, the evaluator must decide between the two remaining possibilities by subjectively determining if the client's state is closer to one or the other extremity of the scale. Thus, if the evaluator feels that the client's state is closer to a full functional level than a severe impairment or loss of function, the evaluator will class the level of impairment as *"slight"* on the scale. Inversely, if the evaluator perceives the client's state as being closer to a severe impairment/loss of function than a full functional level, the evaluator will class the level at *"moderate"*.

In all cases, the evaluator must make a decision. If an indecision persists between two categories after considering the preceding instructions and consulting all possible sources of information, the evaluator will class the person in the category corresponding to the **greatest** impairment.

In the following paragraphs, we will define the sixteen dimensions under consideration and, for certain among them, define the different categories of impairments:

Short term memory:

This dimension refers to the individual's ability to store new information. It can be measured in terms of the difficulty or inability to name certain objects a few minutes after they were listed. The different levels of the short term memory function are defined as follows:

- adequate: generally the client has no more short term memory problems than the persons of the same age-sex group.

- slight impairment: the client experiences certain difficulties in naming three objects that have been mentioned or shown 5 minutes earlier. The client succeeds in naming three objects 50% of the time, then 50% of the time he is only able to name two objects.

- moderate impairment: the client succeeds in naming two objects 50% of the time, and one object 50% of the time.

- severe/nil impairment: the client names one object 50% of the time and cannot name any 50% of the time or the client forgets immediately.

Long term memory:

This dimension refers to the ability to recall information stored of past events. An impairment in this ability can translate itself by the difficulty or inability of the person to remember the house where he lived before being hospitalized, what happened the day before, his date of birth, etc...

The specific impairments of memory (for forms, words, numbers, ...) enter into this category.

Thinking:

The impairments considered here are:

1- The disturbances affecting the **speed** and **organization** of thought processes and the **ability to form logical sequences** of ideas, such as:

   - impairments of conceptualization and abstraction with regards to the ability to interpret the significance of events, integrate perceptions, relate events in a coherent manner, to abstract;

   - impairments of logical thinking seen as the ability to hierarchically structure ideas;

   - slowness or acceleration of thought;

   - obsessional or incoherent ideas, ...

2- The impairments of **thought content**: this category includes the restrictions of thought content; excessive emphasis or preoccupation with a subset of ideas to the exclusion of the critical examination of ideas; the false ideas not amenable to correction through logical thinking or reality testing; for example: poverty of thought content, overvalued ideas, paranoid delusions, jealousy, delusions of grandeur, hypochondria, ...

Perception and attention:

This dimension refers to the functions that allow the individual to **receive information**, to **process this information**, and **concentrate** on certain aspects or parts of the information, to supply a differentiated response to specific stimuli.

- **the impairments of perception** include: the disturbances of perception, the distortion of perception (optical, acoustic, tactile, kinetic illusions, ...), false perceptions (hallucinations), the disturbances of perceptions of one's own body, time, place and the difficulties to differentiate fantasy from reality;

- **the impairments of attention** are measured in terms of intensity, span, mobility and include inattentiveness, distractibility, inability to change the focus of attention, the sudden stoppage of attention, the decrease in the ability to stay alert.

Consciousness and wakefulness:

This dimension refers to:

1- impairments to the clarity of consciousness and the quality of the conscious experience including: unconsciousness, delirium, dissociative states, trance-like states, mutism, ...

2- intermittent disturbances of consciousness: epilepsy, petit mal, syncope, ...

3- disturbances of the sleep-wake cycle including disturbances of the autonomic control of bodily functions influenced by the sleep-wake cycle; difficulties in getting off to sleep, premature awakening from sleep, hypersomnia, narcolepsy, insomnia, enuresis nocturna, sleep-walking, somnolence, ...

Orientation: time/person/place

This dimension refers to the person's ability to recall the time, the day, the date, the season, to know where he lives, to find his way back to his room, to the dining area, etc.; to distinguish between staff members, other residents, strangers; to recognize family members and recognize himself.

Decision making:

This dimension refers to the person's ability to make decisions regarding certain tasks or activities of daily living.

The different corresponding levels of this dimension are defined as follows:

- Adequate: the individual makes **reasonable decisions**; he organizes his daily activities himself.

- Slight impairment: the individual organizes his daily activities. He decides on his own in familiar settings but experiences difficulty when faced with new tasks or situations.

- Moderate impairment: decision-making is poor. The individual requires help to plan and organize his day.

- Severe or nil: the individual rarely or never makes any decisions.

Drives:

This dimension refers to the increase, decrease, change of form of different behaviours related to basic **physiological needs** or instincts, such as: anorexia, bulimia, a decrease of libido, impotence, frigidity, dependence on alcohol or other substances.

Volition and motivation:

This dimension refers to disturbances in the ability to **orient one's behaviour**, to **control one's own actions**, and the ability to **pursue a goal**.

- lack of initiative;
- lack or restriction of interests;
- overcompliance, excessive cooperation, automatic submission;
- negativism;
- ambitendance;
- compulsions, rituals;
- impairment of impulse control;
- impairment of adaptability.

Emotions, affect, moods

This dimension refers to **disturbances of the intensity and quality of emotions, affect, moods** and their somatic accompaniments and the disturbances of the duration and the stability of emotions, affect, moods, such as:

- anxiety: tension, tremor, panic attacks, frightened, apprehensive, fearful attitudes;
- depression: anhedonia, tears, sadness, deep sighing, gloomy tone of voice, ...;
- blunting of affect: apathy, expressionless face or voice, disinterest, indifference, ...;
- gross excitement: includes throwing things, runs or jumps around, waves arms wildly, shouts, screams;
- excitement: euphoria, hypomania, elation, undue cheerfulness;
- irritability: including angry outbursts;
- emotional lability: lability of mood, predisposition to depression or elation;
- incongruity of affect: ambivalent affect, emotions shown not congruent with topic;
- catastrophic reactions, attempted control of affect display, restlessness, feelings of guilt, emotional immaturity, ...

Behaviours:

This item refers to patterns of behaviour that interfere with social adjustment and functioning. These patterns may be present since adolescence and throughout adult life (personality disorders), or may appear as sequela of neurological or mental illness. They manifest themselves mainly as accentuated character traits; for example:

- suspiciousness, social withdrawal, excessive shyness including excessive sensitivity and vulnerability, hypochondria, worrying, obsessional traits (insecurity, indecisiveness, compulsion) phobias (agoraphobia), hostility (aggressiveness, threats, physical abuse), perplexity, histrionic traits, self-destruction, attention seeking, ...

Language:

This dimension refers to the person's ability to express himself **verbally**. The impairments of contents are not considered here.

The different levels of the language function are defined as follows:

- Adequate: the individual pronounces clearly, verbal expression is distinct.

- Slight impairment: the individual experiences a speech impediment but it does not make speech difficult to understand (slight stutter, abnormally quiet voice, ...).

- Moderate impairment: the individual experiences a speech impediment that interferes with clear verbal expression, the client however succeeds in expressing himself (pronounced stuttering, difficulties of elocution related to a pathology such as ataxia, cerebral palsy, others).

- Severe or nil: the individual expresses himself verbally very little or not at all. He may experience aphasia, echolalia, use only very few words (yes, no, thank you).

Sight:

This dimension refers to the person's ability to **see**. To class the client in one or other of the categories, the evaluator will take into account any correction (eyeglasses) actually used by the individual.

The different levels of the sight function are defined as follows:

- Adequate: the person has normal vision, he is capable of reading *"regular print"* in a newspaper or book.

- Slight impairment: the person is unable to read *"regular print"* but can however read large print. The person may present slight visual problems such as light sensitivity, impaired night vision.

- Moderate impairment: the person cannot read, not even the large print of a newspaper. He can follow an object with his eyes.

- Severe or nil: the person is blind or can only distinguish light, certain colours and forms.

Hearing:

This dimension refers to the individual's ability to **hear**. In order to assign him to the appropriate category, the evaluator will take into account the compensating devices (hearing aid) actually used by the client.

The different levels of the hearing function are defined as follows:

- Adequate: the individual hears well. He does not experience difficulties when using the telephone.

- Slight impairment: the individual has difficulty hearing under certain conditions, for example if he is in a setting with a large amount of background noise.

- Moderate impairment: the individual only hears if spoken to loudly and if a distinct, precisely articulated speech is used.

- Severe or nil: the individual is deaf or can only hear certain words when spoken to very loudly.

Making self understood:

This dimension refers to the person's ability to express and communicate his needs, his opinions, his problems and maintain a social conversation. The evaluator will take into account the use of speech, writing, sign language or a combination of these methods.

The different levels of this dimension are defined as follows:

- Adequate: the individual expresses clearly his ideas and opinions.

- Slight impairment: the individual has difficulty finding the right words or finishing thoughts. With prompting or stimulation, he is able to express his needs, opinions and have a social conversation.

- Moderate impairment: the individual's abilities are limited. He easily expresses his basic needs such as: hunger, thirst, sleep, toilet. He expresses little or no opinions and has little or no social conversation.

- Severe or nil: the individual has great difficulty to make himself understood. Only the staff or those who know the individual very well can interpret his messages, the sounds he emits or his body language (gestures, facial expressions, others).

Ability to understand others:

This dimension refers to the individual's ability to comprehend verbal information. The emphasis here is on evaluating the individual's ability to comprehend rather than hear.

The different levels of the dimension are defined as follows:

- Adequate: the individual clearly comprehends verbal messages and demonstrates by words, actions, behaviours that he comprehends.

- Slight impairment: the individual comprehends most of the message but may miss some part or intent of the message. Generally, he demonstrates adequate comprehension with words, actions, gestures but may present periodic difficulties to integrate information.

- Moderate impairment: the individual regularly presents difficulties to integrate information. He understands and responds adequately to simple and direct messages. Simple phrases, rephrasing and gestures are used to enhance comprehension.

- Severe or nil: the resident's ability to understand messages is very limited. It is also difficult to assess comprehension as the individual does not respond (gestures, actions, behaviours) to the messages.

Q. PSYCHOLOGICAL PROBLEMS

If the client presents any of the following psychological problems, indicate if the problem is **corrected** (C) (by medication, physical restraint, a behaviour management program, etc.) or **non corrected (NC), during the period of observation.**

The problems being considered are those that **would exist** if no corrective measures were undertaken. The evaluator must not indicate as corrected a problem that does not exist.

A problem that is **in the process of being corrected** (for example: by adjustment of medication) but continues to manifest itself, is considered non corrected.

Q.01 **Physical abuse:** problem characterized by the use of hands, feet, head or body to attack another person (push, shove, scratch), by throwing or breaking objects, by spitting, etc. The physical abuse can be directed at staff, visitors or another resident.

Q.02 **Verbal abuse:** problem characterized by threats, insults, screams, curses, obscenities directed at others (staff, visitor, resident).

Q.03 **Disturbs others:** inappropriate behaviour with other residents and visitors with the **exclusion of abuse** (see Q.01 or Q.02); repeated physical or verbal demands, rummaging through other resident's rooms, pilfering, screams, etc.

Q.04 **Agitation:** problem characterized by constant attempts to get attention, multiple complaints, repeated demands. The agitated person cannot stand still, paces, walks in circles, wildly rocks himself, exhibits handwringing, ...

Q.05 **Wandering:** constant or frequent movement with no rational purpose that may or may not endanger the person's safety.

Q.06 **Persistent anxiety:** psychological uneasiness characterized by diffuse fear and uncomfortable feelings as the person senses that the situation escapes his control. The anxiety is persistent if it is present since a minimum of seven days and has not significantly decreased with active listening and support given to the individual.

Q.07 **Sadness:** a difficult, painful yet calm affective state. This state can be characterized by the following symptoms: refusal to participate in activities or personal hygiene, deep sighing, tearfulness, despondency, expressionless face, etc. By its nature, the sadness is a **permanent, lasting state.**

Q.08 **Expressions of distress:** verbal or non-verbal expressions that indicate the individual's psychological suffering. The distress does not have the same lasting component as sadness, it is, in general, related to one or several specific events, past or present.

Q.09 **Withdrawal:** a turning in on oneself, if the individual feels a need to protect himself. The individual experiencing withdrawal tends to avoid contacts and participates little in activities.

Q.10 **Suicidal thoughts:** the person expresses verbally, by his behaviours or alludes to the fact that he is contemplating suicide.

Q.11 **Frequent thoughts of death:** the person believes he is about to die: a heart attack or stroke is imminent, he has cancer, etc.

Q.12 **Early awakening with unpleasant mood:** the person awakens early without sleeping sufficiently and experiences unpleasant moods.

Q.13 **Hypersomnia (awake 7 hours or less/day):** the person suffers from hypersomnia. He sleeps seventeen hours or more per day.

R. ORIENTATION (interactions with the environment)

The concept of orientation refers to the **person's ability to orient himself within his environment, this includes his interactions or exchanges within his environment.** This concept includes the **reception of signals** from the environment, their **assimilation** and **the formulation of a response** to the message or signal received. The difficulties resulting from behavioral and communication problems are both considered here.

Circle the code of the category which best translates the client's degree of orientation. The categories are **mutually exclusive**, the evaluator will select one and only one.

R.01 **Fully oriented:**

This category regroups person's gifted with complete capabilities with regards to orientation, i.e. who **interact adequately with their environment** (receive signals - assimilate - supply a message) **without assistance of any aids** such as medications to control behavioral or communication problems or compensating aids to increase their sensorial abilities (glasses, hearing aid, cane).

The psychological and sensorial functions in section P are all adequate.

R.02 **Fully compensated impediment to orientation:**

This category regroups persons who, for example, **use aids** to see, hear, touch (cane) and/or continually use medications to control their behaviour or communication problems and the result of this correction is the **total recovery of the ability of orientation.**

The psychological and sensorial functions in section P are all adequate (the impairments are well compensated for).

R.03 **Intermittent disturbance of orientation:**

This category regroups persons **experiencing periodic episodes** that interfere with full orientation such as vertigo, symptoms associated with Menière's disease, diplopia (such as that found in cases of multiple sclerosis), intermittent changes in consciousness (epilepsy) and certain speech impediments (stuttering); the experiences that are fully corrected or controlled are excluded (category 02).

The majority of the psychological and sensorial functions are adequate (the identified deficits disturb the individual periodically).

R.04 **Partially compensated impediment to orientation:**

This category regroups persons who would otherwise belong to categories 02 or 03 but who **experience disadvantages** in certain aspects of their daily life because the disturbances of orientation that make them **vulnerable under certain circumstances**, such as: critical dependence on the level of illumination (in the case of certain visual disabilities), critical dependence on levels of background noise or other signals (in the case of listening or speaking disabilities); or those who experience disadvantages related to the use of certain medications or aids that make them ineligible to take up certain tasks, functions, activities.

One or several impairments are identified in the psychological and sensorial functions. These impairments are slight to moderate (sometimes severe or nil) but the individual is only partially disturbed.

R.05 **Moderate impediment to orientation:**

This category regroups persons who experience **appreciable difficulties** of orientation, for whom aids and/or medications do not produce a satisfying correction of the disturbances; also the persons who **require assistance from others** such as individuals with low vision, with severe hearing deficits, confusion and those experiencing appreciable impairment or insensitivity to touch.

One or more impairments are identified in the psychological and sensorial functions. The impairments are slight or moderate (severe or nil at times) and daily intervention (assistance) of staff is required to assist the individual to interact with his environment.

R.06 **Severe impediments to orientation:**

This category regroups the persons suffering from **severe disabilities** with regards to orientation and where **substitution is necessary** (which was not the case in the previous category): meaning the individual cannot usually interact with his surroundings without the frequent aid of another person.

Generally more than one psychological or sensorial function is moderately or severely impaired (sometimes nil). The intervention (doing for him) of staff is required several times during the day to assist the individual to interact with his environment.

R.07 **Orientation deprivation:**

This category regroups the persons suffering from a **severe impairment** of orientation and despite the compensation offered by others, the individual's ability to interact with the environment is very limited.

Generally many psychological and sensorial functions are moderately to severely impaired or nil.

R.08 **Disorientation:**

This category regroups the person's unable to orient themselves within their environment. Many psychological and sensorial functions are affected (severe or nil) which prevents the individual from interacting with the environment.

R.09 **Unconscious, persistent vegetative state:**

This category regroups the persons who are unable to orient themselves within their environment and who have a diagnosis of *"coma"* or *"persistent vegetative state"*. The *"semi-conscious"* are not included in this category.

4. LIST OF NURSING ACTIONS (SECTION II)

The majority of pages in the second section of the assessment form is subdivided into five (5) columns, each identifying certain characteristics of the nursing actions:

- code of the nursing action;
- name of the nursing action;
- level of assistance required by the client;
- weekly schedule of the nursing action;
- daily schedule of the nursing action.

To complete this section, the evaluator will follow these basic rules:

1. **USE A LEAD PENCIL.**

2. **DETERMINE THE WEEK OF OBSERVATION:** the FRAN allows for the collection of information over a period of seven (7) consecutive days of observation. The period of observation is determined by the institution before the start of the evaluations. All the clients are evaluated for the same period.

   An exception to the rule can be made for a client who, for example, expires on the sixth day of observation; the evaluator will move back by one day the seven (7) days of evaluation. Similarly if a client is admitted on the 3rd day of the period under observation, the evaluator will continue to observe him for 3 days after the end of the period of observation. All clients must be evaluated for seven (7) days with the exception of those who are regularly present in the institution less than seven (7) days (see page 6).

3. **COMPLETE THE FOLLOWING COLUMNS FOR EACH OF THE NURSING ACTIONS SELECTED:**

   3.1 **Code:**

   In this section, different codes are **pre-inscribed** next to each nursing action. These allow the computer to identify each nursing action required by the client. The codes must never be modified. However, certain codes must be completed by the nurse when a space (W and/or X and/or Y and/or Z) is present. The number to add to the code corresponds to the information collected under the heading "nursing actions".

3.2 **Nursing actions:**

. Circle the nursing action required.

. Complete or circle the information requested under each heading, for example:

- number of staff or nursing personnel required;
- type of ostomy.

3.3 **Level of assistance:**

Circle the code corresponding to the level of assistance required by the client. The levels of assistance (described in paragraph 7.) are the following: 1. guidance; 2. partial assistance; 3. complete assistance.

3.4 **Weekly schedule:**

Circle the letter(s) identifying the day(s) a nursing action was required by the client.

3.5 **Daily schedule:**

a) The schedule begins at 00.00h. and ends at 23:59h. This column is divided into twenty-four (24) boxes, each box representing one hour of the day.

b) If a nursing action is required once for a one hour period and begins between one (1) minute and fifty-nine (59) minutes of this hour, indicate the number *"1"* in the box corresponding to this hour.

Example:
- treatment "X" is required at 8:30h., note *"1"* in the box 8:00h.
- treatment "X" is required at 10:45h., note *"1"* in the box 10:00h.

c) If a nursing action is required more than once over a period of one hour, indicate this frequency by specifying the number of times it was executed at this given hour.

Example: treatment "X" is required at 10h., 10:45h. and at 11:30h. Indicate the number *"2"* in the box for 10h. and the number *"1"* in the box for 11h.

d) It may be difficult to specify the times at which certain nursing actions are required; for example, the precise schedule of voiding urine for which the client needs assistance to the bathroom or the schedule for the times of communication with the unit's staff. These types of cases require special attention and must be coded differently.

If an **oval** appears in the spaces reserved for the daily schedule, indicate in the ovals the frequency, i.e. the number of times a nursing action is required **for each shift.**

Example: assistance required to the bathroom, once at night, 3 times during the day shift and twice during the evening shift.

	Night	Day	Evening
F=	(1)	(3)	(2)

If a **square** □ appears in the spaces reserved for the daily schedule, indicate in these the percentages (%) of time of communication that the staff should devote to the client for each shift. The percentages indicated in the square must always total 100% for the period of 24 hours.

Example: individual supportive communication:

	Night	Day	Evening
% =	10	60	30

4. DIFFERENT MODALITIES OF EXECUTION OF THE SAME ACTION

For each of the nursing actions, several lines have been provided (if applicable) to allow for the different modes, weekly and daily schedules of execution of a nursing action during the period of observation.

Example: a client requires partial assistance to use the bathroom during the day and evening and complete assistance is required at night, for the seven (7) days of observation.

Circle the action *"Bathroom"* and complete as follows:

			N	D	E
(Bathroom)	1 (2) 3	(M T W T F s S) F=	(0)	(3)	(2)
	1 2 (3)	(M T W T F s S) F=	(2)	(0)	(1)

Example: a client has a dressing on the hip that must be changed at 10h. and 20h. on M T W Th; and after the doctor's visit on Thursday evening, the dressing must be changed at 10h., 15h. and 20h.

Circle the action *"Aseptic dressing"* and complete as follows:

			10	15	20
(Aseptic dressing)	(3)	(M T W T) F s S	1		1
	(3)	M T W T (F s S)	1	1	1

5. **AT THE END OF EACH SECTION:** respiration, feeding and hydration, elimination, hygiene, ambulation, communication, medication, treatments and diagnostic procedures, the evaluator will find the mention *"Others"*. The evaluator will indicate all required nursing actions not mentioned in the preceding enumeration while carefully completing the relevant information with regards to the level of assistance, the weekly and daily schedules according to the outline given above.

6. **CONSTANT PRESENCE:** a constant presence may be required by the client either:

   - to **observe** the client for the **entire duration** of a nursing action executed by the client himself;
   - to **assist** a health care professional, not a member of the unit's personnel, for the **entire duration** of an intervention or exam.

If a constant presence is required for **the entire duration of a nursing action**:

a) circle the nursing action
b) indicate "2" over the parameter W.

Example: $\frac{2}{W}$ hygiene / whirlpool: a client can execute part of his personal hygiene himself yet because of cognitive deficits, the client cannot be left alone in the bathtub. A **constant presence** is required for the entire duration of the bath.

In the cases where the parameter W does not appear next to a nursing action and a constant presence is required indicate the abbreviation ***"C.PR."*** next to the nursing action.

7. THE LEVELS OF ASSISTANCE

1 Support-Guidance-Orientation
The client executes the care activity. The care-giver solicits and facilitates the execution by offering a physical support and/or gives guidance or indications to the client.
2 Partial assistance
The client executes parts of the care activity. The care-giver begins, finishes or completes a part of the care activity.
3 Complete assistance
The client does not execute any part of the care activity. The care-giver executes all of the care activity.

8. MAJOR CHANGES WITHIN PLAISIR 93

The areas of needs in the evaluation form have been slightly modified. The category *"hygiene and comfort"* has been replaced by the categories *"hygiene"* and *"ambulation"*. The category *"treatments"* has been divided into three parts, as follows: *"medication"*, *"intravenous therapy"* and *"treatments"*. The areas of needs are mentioned on the top and bottom of each page in the evaluation form.

To facilitate the recording of the times of execution of the nursing actions, the daily schedule has been repeated in the middle and lower sections of each page of the form. Furthermore, to help the evaluator to remember the significance of the ovals ◯ and squares □, the letter *" F = "*, for frequency, and the sign " % ", for percentage, have been added.

Certain care activities have been transferred to other categories. This specifically concerns actions that were in the *"treatments"* section. Hence, all actions related to a *"urinary catheter"* such as: catheter insertion, bladder irrigation and others are now in the category of *"elimination"*. These actions respond to the need of elimination but may also be considered as treatments; their transfer from one section to the other was made simply to facilitate the evaluator's task.

We have also separated from the action *"meals"*, three actions that used to be included: **snacks**, **hydrations** and the action **complete the menu**. The separation of the actions permits a more adequate evaluation, particularly for the clients following a hydration program every two hours.

Other actions have also been divided. The action *"up with assistance"*, which used to include *"lie down with assistance"* is now replaced with the actions *"up with assistance"* and *"lie down with assistance"*.

The actions of the category ***"communication"*** have all been revised. As communication makes up a large part of all the activities of daily living, specifically for the clients presenting cognitive deficits or chronic psychiatric problems, two additional "individual supportive communications" have been created. For a given **client**, only **one type of individual supportive communication** can be chosen.

The actions "individual physical, psychological or social integration psychotherapy" and "individual non-verbal communication of bio-psycho-social integration" have been replaced by one action, "**preventive interaction**". It is sufficient to indicate the type of preventive interaction and to check the shift when it occurred.

The **recreational** and **therapeutic** activities have been slightly modified. The evaluator must indicate the number of nursing staff from the **unit**, the number of participants from the **unit**, the duration of the activity and the time at which it begins. Without this information, the action cannot be processed.

The two actions concerning constant "exclusive" and "shared" observations have been replaced by a single action "**constant observation**". Whereas, previously, the action was only used for a constant 24 hour observation, it is now possible to use this observation for a period of one to 24 hours and, for one or more clients.

Finally, the last action having gone through major changes is "**application of ointment**". It is no longer in the category "medication", if "less than 30%" and in the category "treatments", if "more than 30%". One single action now permits the identification of ointment application and it is in the category "treatments". It is necessary to identify the percentage (%) of total body surface for each daily schedule the ointment is applied and indicate this number over the parameter *"Z"*. This percentage may vary from 1 to 100% according to the needs of the client being evaluated.

RESPIRATION

0010 **HUMIDIFIER**

PURPOSE: To prevent dryness and irritation of the mucous membranes of the respiratory tract.

DESCRIPTION: Monitor the functioning of the humidifier.
Refill the humidifier as needed.
Provide proper maintenance.

INSTRUCTIONS: Indicate the day(s) and the hour(s) when you monitor and refill the apparatus.

STANDARD: If the humidifier is in operation 24 hrs/day, note one servicing/shift.

LEVEL OF ASSISTANCE: Mode 1: Monitor the functioning of the humidifier; the client can otherwise refill the apparatus.
Mode 3: Monitor and refill the apparatus.

RESPIRATORY EXERCISES

0020 SPIROMETRY
0030 COUGHING EXERCISES

PURPOSE: To facilitate expectoration of tracheobronchial secretions.
To improve lung capacity.

DESCRIPTION: Prepare equipment, if necessary.
Direct the client in performing exercises, correct technique as necessary.

INSTRUCTIONS: Indicate the weekly and daily schedules of respiratory exercises.

Note *"1"* over the $\overline{w}$ if the **constant presence** of staff is **not required.**

Note *"2"* over the $\overline{w}$ if the **constant presence** of staff is **required** for **the duration** of respiratory exercises.

LEVEL OF ASSISTANCE: Mode 1: Supply equipment, direct the client in performing exercises correctly, as necessary.

CHEST PHYSIOTHERAPY

0040 CLAPPING
0050 POSTURAL DRAINAGE
0060 VIBRO-MASSAGE

PURPOSE: To facilitate the drainage of tracheobronchial secretions.
To increase lung capacity.

DESCRIPTION: Perform the physiotherapy.
Remain with the client during treatment.

INSTRUCTIONS: Indicate the weekly and daily schedules of chest physiotherapy.

LEVEL OF ASSISTANCE: Mode 3: Perform the chest physiotherapy or ensure a **constant presence** when treatment is executed by another health care professional.

0070 **AEROSOL**

PURPOSE: To administer medication via the respiratory tract.
To improve respiratory status.
To facilitate the expectoration of tracheobronchial secretions.

DESCRIPTION: Prepare medication(s).
Set up and monitor apparatus and treatment.
Clean the apparatus.
Assist client, as necessary.

INSTRUCTIONS: Indicate the weekly and daily schedules of aerosol treatment(s).

Note *"1"* over the $\overline{w}$ if the **constant presence** of staff is **not required.**

Note "2" over the $\overline{w}$ if the **constant presence** of staff is **required** for **the duration** of aerosol treatment(s).

LEVEL OF ASSISTANCE: Mode 1: Prepare medication, verify the functioning of the apparatus, assist the client during the treatment(s).

SUCTIONING OF SECRETIONS

0080 ORAL
0090 NASAL
0100 TRACHEAL

PURPOSE: To facilitate the removal of tracheobronchial secretions.
To stimulate the coughing reflex.

DESCRIPTION: Wear gloves.
Suction secretions.
Provide a rest period between each suctioning.
Clean suction bottle, as necessary.

INSTRUCTIONS: Indicate the weekly and daily schedules of suctioning of secretions for each route.

LEVEL OF ASSISTANCE: Mode 1: Supply the client or another health care worker with the necessary material, clean suction bottle as necessary.

Mode 3: Suction the client's secretions.

0110 OXYGEN: CATHETER, MASK, FACIAL TENT

PURPOSE: To provide a higher concentration of oxygen.

DESCRIPTION:

Connect O_2.
Add water to the humidifier or change the disposable bottle.
Monitor O_2 concentration.
Fill the ice container, as necessary.

INSTRUCTIONS:

On line ***"B"*** indicate the day and time that O_2 therapy **begins**. If it is **already underway**, circle the letter corresponding to the **first day of observation** and mark the time 00:00.

On line ***"E"*** indicate the day and time that O_2 therapy **ends**. If it **remains in place** on the **seventh day of observation**, circle the letter corresponding to the last day of observation and mark the time 23:59.

LEVEL OF ASSISTANCE:

Mode 1: The client is relatively self-sufficient with the O_2 therapy. He adjusts the flow, removes and replaces his mask according to his needs.
Mark a **beginning** and an **end** at the hour(s) when nursing staff verify the flow or refill the water bottle.

Mode 3: The nursing personnel provide complete assistance with regards to the oxygen therapy.

TRACHEOSTOMY CARE

0120 CARE (skin, cannula, dressing, tie)

PURPOSE: To keep tracheostomy site clean.
To maintain a patent airway.
To prevent infections.

DESCRIPTION: Provide wound care.
Cleanse cannula.
Change tracheostomy dressing and ties.
Auscultate the lungs.

INSTRUCTIONS: Indicate the weekly and daily schedules for tracheostomy care.

LEVEL OF ASSISTANCE:
Mode 1: Supply the client with the material necessary for tracheostomy care.
Mode 2: Assist the client in performing his tracheostomy care; for example, clean and replace the cannula.
Mode 3: Perform all care related to the tracheostomy.

0130 INSTILLATION

PURPOSE: To maintain a patent airway.

DESCRIPTION: Instill the tracheostomy.

INSTRUCTIONS: Indicate the weekly and daily schedules of instillations.

0140 CUFF: INFLATE AND DEFLATE

PURPOSE: Increase tissue perfusion.

DESCRIPTION: Inflate and deflate the cuff.

INSTRUCTIONS: Indicate the day(s) and the hour(s) when you ***"inflate"*** the cuff.

FEEDING AND HYDRATION

Page

MEALS

1040 BREAKFAST
1050 DINNER
1060 SUPPER

PURPOSE: To provide a balanced, nutritional oral intake while respecting the prescribed diet.

DESCRIPTION:

Verify the tray with the prescribed diet.
Set up the tray.
Serve meals in the client's room, the dining area or elsewhere.
Remove the tray.
Assist the client to wash his hands and face before and after meals, as necessary.

INSTRUCTIONS:

Indicate the weekly and daily schedules of meals (breakfast, dinner, supper) which are served or assisted by nursing personnel, not those prepared by family or other services.

Note *"1"* over the $\overline{w}$ if a **constant presence** of staff is **not required.**

Note *"2"* over the $\overline{w}$ if an **individual constant presence is required** for the **duration of the meal.**

LEVEL OF ASSISTANCE:

Mode 1: Serve tray, open containers if necessary, remove tray.

Mode 2: Serve tray, open containers, cut the food, supervise the client who can feed himself and assist him to eat or drink during the meal, as necessary
or
Serve one item at a time to a client with cognitive deficits or behavioral problems during meals.

Mode 3: Feed client and assist to drink, feed with a syringe.

1070 SNACK

PURPOSE: To provide a nutritional oral intake between meals.

DESCRIPTION:

Verify the snack with prescribed diet.
Prepare snack.
Serve snack in room, dining area or elsewhere.
Clear away snack.
Help the client to wash his face and hands before and after snack as necessary.

INSTRUCTIONS:

Indicate the weekly and daily schedules for snacks that are served by nursing personnel.

Note *"1"* over the $\overline{w}$ if a **constant presence** of staff **is not required**.

Note *"2"* over the $\overline{w}$ if an **individual constant presence** of staff is **required** for the **duration of the snack.**

LEVEL OF ASSISTANCE:

Mode 1: Serve snack, open containers if necessary, clear away snack.

Mode 2: Serve snack, open containers, cut or mash food, supervise the client who can feed himself and assist him to eat or drink during his snack as necessary.

Mode 3: Feed client and assist to drink.

1080 HYDRATION

PURPOSE: To provide an oral fluid intake.

DESCRIPTION: Verify prescribed diet (fluid restriction).
Supply and refill water jug regularly.

INSTRUCTIONS: Indicate the weekly and daily schedules of hydration.

LEVEL OF ASSISTANCE: Mode 1: Supply and fill water jug or give fluids regularly.

Mode 3: Assist client to drink regularly.

NOTE: The liquids given at mealtimes are not considered in this section.

1090 COMPLETE THE MENU

PURPOSE: Choose foods according to the prescribed diet and the client's preferences.

DESCRIPTION: Verify the diet.
Offer the menu choices.
Complete the appropriate form.

INSTRUCTIONS: Indicate the day(s) and time when the form is completed.

LEVEL OF ASSISTANCE: Mode 1: Supply necessary material; the client completes his menu.
Verify his choices, if necessary.

Mode 3: Complete the menu, with or without the client.

1100 CONTINUOUS GAVAGE FEEDINGS

PURPOSE: To provide a balanced nutritional and fluid intake **by means of tube feedings.**

DESCRIPTION:

Prepare gavage feeding.
Change feeding apparatus, bottle or bag.
Check location of tube, as necessary.
Measure gastric residue, if necessary.
Set up pump and check its functioning.
Adjust rate.
Irrigate tube, if necessary.
Remove tube, if necessary.

INSTRUCTIONS:

On line *"B"* indicate the day and time the gavage **begins**. If it is **already in progress**, circle the letter corresponding to the **first day of observation** and mark the time 00:00.

On line *"E"* indicate the day and time the gavage **ends**. If it **remains in place** on the **seventh day of observation**, circle the letter corresponding to the last day of observation and mark the time 23:59.

Note *"1"* over the $\bar{x}$ if the gavage is administered **with** a pump.

Note *"2"* over the $\bar{x}$ if the gavage is administered **without** a pump.

1110 INTERMITTENT GAVAGE FEEDINGS

PURPOSE: To provide a balanced nutritional and fluid intake **by means of tube feedings.**

DESCRIPTION:

Prepare gavage feeding.
Prepare bottle, bag or syringe.
Check location of tube, as necessary.
Measure gastric residue, if necessary.
Set up feeding.
Adjust rate (if given by gravity).
Irrigate tube after feeding, if necessary.
Remove tube, if necessary.

INSTRUCTIONS:

Indicate the weekly and daily schedules of feedings.

Note *"1"* over the $\overline{w}$ is the **constant presence** of staff is **not required.**

Note *"2"* over the $\overline{w}$ if the **constant presence** of staff is **required** for the **entire period the feeding is administered.**

ELIMINATION

NATURAL ELIMINATION

2030 URINAL

PURPOSE: To meet the client's elimination needs.

DESCRIPTION: Give, remove, empty and cleanse urinal.
Change urinal cover, if necessary.
Remain near client, if necessary.
Wash and dry client, if necessary.

INSTRUCTIONS: Indicate the weekly schedule and the **number of times** per shift assistance is required by the client.

Note over the $\bar{z}$ the number of nursing staff required to assist the client.

LEVEL OF ASSISTANCE:

Mode 1: Empty and clean urinal, the client can take it, apply it and remove it himself.

Mode 2: Remove, empty and clean urinal, the client can take it and apply it himself.

Mode 3: Apply, remove, empty and clean urinal.

2040 BEDPAN

PURPOSE: To meet the client's bladder or bowel elimination needs.

DESCRIPTION: Give, apply, remove, empty and clean bedpan.
Change bedpan cover, if necessary.
Remain near client, if necessary.
Wash and dry the client's buttocks, if necessary.

INSTRUCTIONS: Indicate the weekly schedule and the **number of times** per shift assistance is required by the client.

Note over the $\bar{z}$ the number of nursing staff required to assist the client.

LEVEL OF ASSISTANCE:

Mode 1: Empty and clean bedpan, the client can take it, apply and remove it without assistance.

Mode 2: Remove, empty and clean bedpan, the client can take it and apply it herself. She may need help to wipe herself.

Mode 3: Apply, remove, empty and clean bedpan.

2050 BATHROOM OR COMMODE

PURPOSE: To meet the client's bladder or bowel elimination needs.

DESCRIPTION:

Undress and dress the client, if necessary.
Assist client to bathroom or commode.
Remain near client, if necessary.
Wash and dry client's buttocks, if necessary.

INSTRUCTIONS:

Indicate the weekly schedule and the **number of times** per shift assistance is required by the client.

Note *"1"* over the $\overline{w}$ if the **constant presence** of staff is **not required.**

Note *"2"* over the $\overline{w}$ if the **constant presence** of staff **is required** for the **duration of toileting activities**.

Note over the $\overline{z}$ the number of nursing staff required to assist the client.

LEVEL OF ASSISTANCE:

Mode 1: Guide the client to the bathroom (switch on light, indicate the toilet) or, empty the commode chair.

Mode 2: The client may need help to undress and sit on the toilet or to stand and dress. Generally the client needs help to wipe himself.

Mode 3: Assist the client to undress, sit, wipe himself, stand and dress himself.

2060 URINARY INCONTINENCE CARE

PURPOSE:

To maintain skin integrity.
To prevent urinary and skin infections.
To meet the client's hygiene and comfort needs.

DESCRIPTION:

Remove and replace incontinence pads or diapers.
Wash and dry client.
Apply cream.
Change linen, partially or completely.
Tidy the environment, if necessary.

INSTRUCTIONS:

Indicate the weekly schedule and the **number of times** per shift assistance is required by the client.

Note over the $\bar{z}$ the number of nursing staff required to assist the client.

LEVEL OF ASSISTANCE:

Mode 1: Supply diapers or incontinence pads.

Mode 2: Supply diapers or incontinence pads, assist client to wash perineal area. He can apply pad or diaper himself.

Mode 3: Remove soiled pad or diaper, execute peri-care, replace incontinence pad or diaper.

2070 FECAL INCONTINENCE CARE

PURPOSE:
To maintain skin integrity.
To meet the client's hygiene and comfort needs.

DESCRIPTION:
Remove and replace incontinence pads or diapers.
Wash and dry client.
Apply cream.
Change linen, partially or completely.
Tidy the environment, if necessary.

INSTRUCTIONS:
Indicate the weekly schedule and the **number of times** per shift assistance is required by the client.

Note over the $\bar{z}$ the number of nursing staff required to assist the client.

LEVEL OF ASSISTANCE:
Mode 1: Supply diapers or incontinence pads.

Mode 3: Remove soiled pad or diaper, execute peri-care, replace incontinence pad or diaper.

2090 CONDOM CARE

PURPOSE:
To facilitate wound healing for the incontinent client.
To maintain skin integrity.

DESCRIPTION:
Wash urinary meatus and surrounding area.
Apply condom.
Tape drainage tube and condom.
Check drainage.

INSTRUCTIONS:
Indicate the weekly and daily schedules of condom application(s).

LEVEL OF ASSISTANCE:
Mode 1: Supply the material to client, he applies condom. Assist him to tape drainage tube, if necessary.

Mode 3: Perform genital hygiene, apply and secure condom.

2100 INSERTION OF URETHRAL CATHETER

PURPOSE: To facilitate bladder emptying.

DESCRIPTION: Disinfect urinary meatus.
Insert catheter.
Secure catheter and tape drainage tube.
Remove catheter.

INSTRUCTIONS: Indicate the weekly and daily schedules of catheter insertion.

LEVEL OF ASSISTANCE: Mode 1: Supply the client with material.

Mode 2: Supply material and assist client to disinfect urinary meatus or insert catheter.

Mode 3: Insert catheter.

2110 CARE OF URINARY CATHETER

PURPOSE: To prevent urinary infections.
To meet the client's hygiene and comfort needs.

DESCRIPTION: Clean urinary meatus.
Apply cream, if necessary.
Check and secure catheter.
Check drainage.

INSTRUCTIONS: Indicate the weekly and daily schedules catheter care.

STANDARD: Twice (2) per day.

LEVEL OF ASSISTANCE: Mode 1: Supply material and ointment for care to urinary meatus.
Check drainage.

Mode 3: Execute all care pertaining to catheter.

NOTE: For a supra-pubic catheter, choose the following:

- Drainage of collection bag for the emptying of the collection bag (2120)

- For wound care choose the action that best applies:

  . Wound care (8430) or
  . Non-aseptic dressing (8480) or
  . Aseptic dressing (8490) or
  . Dressing with discharge (for significant leakage around supra-pubic catheter) (8510).

2120 DRAINAGE OF COLLECTION BAG

PURPOSE: To limit the spread of bacteria.
To prevent odours.

DESCRIPTION: Check drainage.
Empty collection bag for urethral catheter, supra-pubic catheter, condom or paediatric collection bag.
Change collection bag for a leg bag.

INSTRUCTIONS: Indicate the weekly and daily schedules for emptying collection or leg bag.

LEVEL OF ASSISTANCE: Mode 1: Supply material necessary for emptying collection bag.

Mode 3: Empty collection bag.

2130 BLADDER IRRIGATION

PURPOSE: To clean the bladder.
To facilitate drainage.

DESCRIPTION: Prepare irrigation solution.
Perform irrigation with a syringe.
Reconnect tubing, if necessary.

INSTRUCTIONS: Indicate the weekly and daily schedules of bladder irrigations.

LEVEL OF ASSISTANCE: Mode 1: Supply material necessary for irrigation.
Prepare syringe, if necessary.

Mode 3: Perform bladder irrigation.

2140 CONTINUOUS BLADDER IRRIGATION

PURPOSE:
To clean the bladder.
To facilitate drainage.

DESCRIPTION:
Prepare irrigation solution.
Set up irrigation.
Adjust rate.
Supervise irrigation.
Remove tubing, if necessary.

INSTRUCTIONS:
On line *"B"* indicate the day and time that continuous bladder irrigation **begins**. If it is **already underway**, circle the letter corresponding to the **first day of observation** and mark the time 00:00.

On line *"E"* indicate the day and time that continuous bladder irrigation **ends**. If it **remains in place** on the **seventh day of observation**, circle the letter corresponding to the last day of observation and mark the time 23:59.

LEVEL OF ASSISTANCE:
Mode 1: Supply material necessary for irrigation (bottle, irrigation tubing).

Mode 3: Set up irrigation, replace bottle, supervise irrigation.

2150 BLADDER INSTILLATION

PURPOSE:
To clean the bladder.
Apply an antiseptic solution to bladder wall.

DESCRIPTION:
Prepare syringe.
Administer solution via catheter.
Clamp/unclamp catheter.

INSTRUCTIONS:
Indicate the weekly and daily schedules for bladder instillation.

2160 RECTAL TUBE INSERTION

PURPOSE: To facilitate gas expulsion.

DESCRIPTION:
Prepare material.
Insert rectal tube.
Remove rectal tube.

INSTRUCTIONS: Indicate the weekly schedule and **number of times** per shift assistance is required by the client.

LEVEL OF ASSISTANCE: Mode 1: Supply necessary material.

Mode 3: Insert rectal tube.

2170 DISIMPACTION

PURPOSE: To facilitate the evacuation of feces.

DESCRIPTION:
Wear gloves.
Manually extract feces.
Clean and dry buttocks.

INSTRUCTIONS: Indicate the weekly and daily schedules for disimpaction.

2180 RECTAL IRRIGATION

PURPOSE: To facilitate the evacuation of feces.

DESCRIPTION:
Prepare irrigation solution.
Connect tubing, if necessary.
Perform irrigation.
Remove tubing, if necessary.

INSTRUCTIONS: Indicate the weekly and daily schedules of rectal irrigation.

Note over the $\bar{y}$ the number corresponding to the **quantity of solution** required to perform irrigation.

LEVEL OF ASSISTANCE: Mode 1: Supply material necessary for irrigation.

Mode 3: Perform rectal irrigation.

2190 RECTAL EXAMINATION

PURPOSE: Assess the contents of the rectum.

DESCRIPTION:
Wear gloves.
Insert one finger into rectum and assess contents.

INSTRUCTIONS: Indicate the weekly and daily schedules of rectal examination.

2200 ANAL STIMULATION

PURPOSE: Stimulate anorectal reflex.

DESCRIPTION: Wear gloves.
Perform circular movements around the anus.

INSTRUCTIONS: Indicate the weekly and daily schedules of anal stimulation.

OSTOMY CARE

2210 BAG REPLACEMENT

PURPOSE: To meet the client's elimination needs.
To maintain skin integrity.

DESCRIPTION: Provide skin care around ostomy.
Replace and secure appliance.

INSTRUCTIONS: Indicate the weekly and daily schedules for bag replacement.

Note over the code *"nb. 1 $\bar{x}$"* the number corresponding to the type of ostomy. If the client has 2 ostomies, use the code *"nb. 2 $\bar{x}$"* to identify the second ostomy.

For example, if a client has an ileal conduit and a colostomy, inscribe:

nb. 1: $\frac{1}{x}$; nb. 2: $\frac{4}{x}$.

LEVEL OF ASSISTANCE: Mode 1: Supply necessary material to client.

Mode 2: Supply material and assist the client in performing skin care or to replace and secure new appliance.

Mode 3: Replace ostomy appliance.

2220 CARE OF BAG WITHOUT REPLACEMENT

PURPOSE: To meet the client's elimination needs.
To maintain skin integrity.

DESCRIPTION: Provide skin care around ostomy.
Replace and secure appliance.

INSTRUCTIONS: Indicate the weekly and daily schedules for care of appliance.

Note over the code *"nb. 1 $\bar{x}$"* the number corresponding to the type of ostomy. If the client has 2 ostomies, use the code *"nb. 2 $\bar{x}$"* to identify the second ostomy.

For example, if a client has an ileal conduit and a colostomy, inscribe:

nb. 1: $\frac{1}{x}$; nb. 2: $\frac{4}{x}$.

LEVEL OF ASSISTANCE:

Mode 1: Supply material necessary for care of appliance, assess and provide skin care around ostomy, if necessary.

Mode 2: Supply necessary material, assess and provide skin care around ostomy and assist the client to either empty or clean bag.

Mode 3: Perform all care pertaining to ostomy and appliance.

2230 COLOSTOMY IRRIGATION

PURPOSE:
To empty the colon.
To remove gas.

DESCRIPTION:
Prepare irrigation solution.
Perform irrigation.
Observe for return.

INSTRUCTIONS:
Note the weekly and daily schedules of colostomy irrigation.

Note *"1"* over the $\overline{w}$ if the **constant presence** of staff is **not required.**

Note *"2"* over the $\overline{w}$ if the **constant presence** of staff **is required** for the **duration** of treatment, **until the complete return of the irrigation solution**.

LEVEL OF ASSISTANCE:
Mode 1: Prepare the irrigation solution and supply the client with necessary material.

Mode 2: Prepare irrigation solution, assist client to set up irrigation, supervise treatment at various intervals.

Mode 3: Perform all care related to irrigation.
Supervise treatment at various intervals.

HYGIENE

Page

PERSONAL HYGIENE

3030 PARTIAL BATH

PURPOSE:

To maintain or promote a healthy integumentary system.
To meet the client's comfort needs.
To refresh the client.

DESCRIPTION:

- A partial bath consists of washing the face, the arms, the thorax, the back and genital area.
- Prepare basin, sink.
- Add medication to bath water, if necessary.
- Wash client or supervise his execution of personal care.
- Apply powder or lotion, if necessary.
- Dress and undress client with nightwear (pyjamas, nightgown).
- Brush or comb hair.
- Change linen partially or completely.

INSTRUCTIONS:

Indicate the weekly and daily schedules of partial bath.

Note over the $\bar{x}$, the number corresponding to the place where the partial bath is given.

Note *"1"* over the $\overline{w}$ if the **constant presence** of staff **is not required.**

Note *"2"* over the $\overline{w}$ if the **constant presence** of staff **is required** for the **duration** of activities, while the client executes his personal hygiene.

STANDARD:

5 partial baths per week.

LEVEL OF ASSISTANCE:

Mode 1: Supply and put away the material necessary for personal care (towel, bath water). Verify that client performs his personal hygiene.

Mode 2: Assist the client to wash an area of the body, for example the back and genital area.

Mode 3: Wash all body surfaces included in partial bath.

3040 COMPLETE BATH

PURPOSE:

To maintain or promote a healthy integumentary system.
To meet the client's comfort needs.
To refresh the client.

DESCRIPTION:

- Prepare basin, sink.
- Add medication to bath water, if necessary.
- Wash client or supervise his execution of personal care.
- Apply powder or lotion, if necessary.
- Dress and undress client with nightwear (pyjamas, nightgown).
- Brush or comb hair.
- Change linen partially or completely.

INSTRUCTIONS:

Indicate the weekly and daily schedules of complete bath.

Note over the $\bar{x}$, the number corresponding to the place where the complete bath is given.

Note *"1"* over the $\bar{w}$ if the **constant presence** of staff **is not required.**

Note *"2"* over the $\bar{w}$ if the **constant presence** of staff **is required** for the **duration** of activities, while the client executes his personal hygiene.

STANDARD:

2 complete baths per week.
Every day for bedridden clients.

LEVEL OF ASSISTANCE:

Mode 1: Supply and put away the material necessary for personal care (towel, bath water). Assist client in and out of bathtub.

Mode 2: Assist client to wash an area of the body, for example the back, genital area and the legs.

Mode 3: Perform complete bath (in certain cases the client may retain the ability to wash his face).

NOTE:

If a client is self-sufficient for his personal hygiene, indicate a complete bath in the bathtub, mode 1, **once** per week for the changing of linen.

3050 GENITAL HYGIENE (not related to incontinence)

PURPOSE:

To prevent infections.
To prevent skin irritation.

DESCRIPTION:

- Prepare basin or sink.
- Add medication to bath water, if necessary.
- Wash and dry genital area **in addition** to personal hygiene.
- Apply cream, if necessary.

INSTRUCTIONS:

Indicate the weekly and daily schedules(s) for genital hygiene.

Note over the $\bar{x}$, the number corresponding to the place where the genital hygiene is executed.

Note *"1"* over the $\bar{w}$ if the **constant presence** of staff **is not required.**

Note *"2"* over the $\bar{w}$ if the **constant presence** of staff **is required** for the **duration** of activities, while the client executes his genital hygiene.

LEVEL OF ASSISTANCE:

Mode 1: Supply and put away the material necessary for genital hygiene.

Mode 2: Prepare and supply necessary material; the client can participate for example, by drying himself.

Mode 3: Perform genital hygiene.

NOTE:

The genital hygiene related to an incontinence is taken into account in the actions of *"urinary and fecal incontinence care"*.

HAIR CARE

3090 SHAMPOO/RINSE

PURPOSE: To promote the client's well being.
To promote or maintain the integrity and vitality of hair and scalp.

DESCRIPTION: Wash, rinse, dry hair with towel or hair dryer, if necessary.
Use a medicated shampoo, if necessary.

INSTRUCTIONS: Indicate the weekly and daily schedules of shampoo.

Note *"1"* over the $\overline{w}$ if the **constant presence** of staff **is not required.**

Note *"2"* over the $\overline{w}$ if the **constant presence** of staff **is required** for the **duration** of the activity, while the client washes his hair.

STANDARD: Once (1) per week.

LEVEL OF ASSISTANCE:

Mode 1: Supply necessary material.

Mode 2: Assist client by rinsing or styling hair.

Mode 3: Perform all activities related to hair care.

3100 SHAMPOO/HAIR CUT/STYLE

PURPOSE:
To promote the client's well being.
To promote or maintain the integrity and vitality of scalp.
To contribute to a positive body image.

DESCRIPTION:
Wash, rinse, cut hair or style with rollers or curling iron.
Use a medicated shampoo, if necessary.

INSTRUCTIONS:
Indicate the weekly and daily schedules of shampoo and cut or shampoo and style executed by **nursing staff.**

LEVEL OF ASSISTANCE:

Mode 1: Supply necessary material.

Mode 2: Assist the client for example, to apply rollers once she has washed her hair without help.

Mode 3: Wash and cut hair or wash and style with rollers.

3110 SHAMPOO/REMOVAL OF ADHESIONS

PURPOSE:
To promote the client's well being.
To promote or maintain the integrity and vitality of hair and scalp.

DESCRIPTION:
Wash and rinse hair repeatedly.
Comb hair strand by strand using a fine tooth comb to remove adhesions such as: lice, dry blood, soil, etc.
Wrap hair in a towel.
Dry or style hair.

INSTRUCTIONS:
Indicate the weekly and daily schedules of shampoo and removal of adhesions executed by **nursing staff.**

BEAUTY CARE

3130 MANICURE/PEDICURE

PURPOSE:
To contribute to a positive self-image.
To prevent the development of foot problems.

DESCRIPTION:
Soak limbs briefly, if necessary.
Cut, clean and file nails.
Apply nail polish, if necessary.

INSTRUCTIONS:
Indicate the weekly and daily schedules for manicure/pedicure.

STANDARD:
one (1) per week.

LEVEL OF ASSISTANCE:

Mode 1: Supply the material necessary for nail care.

Mode 2: Assist, for example, by cutting the toe nails; the client can cut the nails on his hands.

Mode 3: Execute manicure/pedicure.

3140 SHAVING OF BEARD

PURPOSE: To contribute to a positive self-image.

DESCRIPTION:

Shave beard using an electric or safety razor.
Wash face, if necessary.
Apply lotion, if necessary.

or for women:
Shave or remove hair from chin.
Shave legs or underarms or remove hair with a depilatory cream, if necessary.

INSTRUCTIONS:

Indicate the weekly and daily schedules for shaving.

Note *"1"* over the $\overline{w}$ if the **constant presence** of staff **is not required.**

Note *"2"* over the $\overline{w}$ if the **constant presence** of staff **is required** for the **duration** of shaving activities.

LEVEL OF ASSISTANCE:

Mode 1: Give, clean and put away material.

Mode 2: Assist client by shaving hard-to-reach areas, clean and put away material.

Mode 3: Shave beard.

3150 JEWELLERY/MAKE-UP

PURPOSE: To contribute to a positive self-image.

DESCRIPTION: Choose and apply make-up.
Choose and apply jewellery.

INSTRUCTIONS: Indicate the weekly and daily schedules for make-up and/or jewellery application(s).

LEVEL OF ASSISTANCE:

Mode 1: Select and give jewellery and make-up.

Mode 2: Assist client by applying part of the make-up; she can put on jewellery

or

Assist the client to put on some jewellery while she can apply her make-up.

Mode 3: Apply jewellery and make-up.

3152 REMOVAL OF MAKE-UP

PURPOSE: To promote client's well being.

DESCRIPTION: Remove jewellery and make-up.

INSTRUCTIONS: Indicate the weekly and daily schedules for removal of jewellery and make-up.

LEVEL OF ASSISTANCE:

Mode 1: Supply products necessary to remove make-up.
Put away jewellery.

Mode 2: Assist client to remove make-up; she can remove jewellery herself.

Mode 3: Remove and put away jewellery and make-up.

ORAL HYGIENE

3160 GLYCERINE SWABS

PURPOSE:

To maintain cleanliness.
To prevent oral infections and dryness of the mouth.

DESCRIPTION:

Provide mouth care using glycerine swabs.
Rinse mouth using mouth wash, if necessary.
Offer assistance to gargle, if necessary.
Apply ointment to lips, if necessary.

INSTRUCTIONS:

. Indicate the weekly and daily schedules for mouth care.

LEVEL OF ASSISTANCE:

Mode 1: Supply material necessary for mouth care.

Mode 2: Supply necessary material and assist client who performs most of his mouth care.

Mode 3: Perform mouth care.

3170 BRUSHING OF TEETH

PURPOSE:

To maintain cleanliness.
To prevent oral infections and dryness of the mouth.

DESCRIPTION:

Execute mouth care (brush teeth or dentures) using a toothbrush, water pick or other equipment.
Use mouth wash, if necessary.
Apply ointment to lips, if necessary.

INSTRUCTIONS:

Indicate the weekly and daily schedules of mouth care.

Note *"1"* over the $\overline{w}$ if the **constant presence** of staff **is not required.**

Note *"2"* over the $\overline{w}$ if the **constant presence** of staff **is required** for the **duration** of mouth care.

STANDARD:

3 times per day.

LEVEL OF ASSISTANCE:

Mode 1: Supply material necessary for mouth care.

Mode 2: Supply material and assist the client by brushing dentures while he brushes remaining teeth.

or

Supply material, put toothpaste on toothbrush, rinse and put away supplies.

Mode 3: Execute mouth care.

STREET CLOTHING

3180 DRESSING
3190 UNDRESSING

PURPOSE:

To help the client live as normal a life as possible.
To contribute to a positive self-image.

DESCRIPTION:

Prepare client's **street clothing.**
Assist client to dress.
Prepare nightwear.
Assist client to undress.
Put away clothing.

INSTRUCTIONS:

Indicate the weekly and daily schedules for dressing.

Indicate the weekly and daily schedules for undressing.

Note *"1"* over the $\overline{w}$ if a **constant presence is not required.**

Note *"2"* over the $\overline{w}$ if a **constant presence is required** for the **duration** of dressing/undressing activities.

Note over the $\overline{x}$ the number corresponding to the type of client (functional or dysfunctional).

To be considered **dysfunctional,** a client must exhibit **severe** physical limitations requiring special attention for dressing (for example: spastic client experiencing pain when mobilized, the quadriplegic client with flaccid limbs).

LEVEL OF ASSISTANCE:

Mode 1: Prepare and put away client's clothing.

Mode 2: Assist the client while he is dressing or undressing, for example, by: putting on or removing underwear, stockings or shoes, buttoning or undoing clothes.

Mode 3: Dress and undress client.

AMBULATION

Page

GET UP OR LIE DOWN

4010 GET UP WITH ASSISTANCE
4015 LIE DOWN WITH ASSISTANCE

PURPOSE:

To promote circulation.
To prevent the effects of immobility.

DESCRIPTION:

Prepare necessary material (chair, orthopedic aid).
Assist the client to:
- get out of bed;
- sit comfortably in the chair;
- get out of the chair;
- walk **INSIDE** the room;
- return to bed.

Raise and lower bed rails, if necessary.
Adjust geriatric chair table, if necessary.

INSTRUCTIONS:

Indicate the weekly and daily schedules when the client needs help to get out of bed or chair (get up with assistance).

Indicate the weekly and daily schedules when the client needs help to get into bed or sit in the chair (lie down with assistance).

Note *"1"* over the $\bar{x}$ if the client has no amputation or does **not** use **any mechanical aid** to get up or lie down.

Note *"2"* over the $\bar{x}$ if the client has an amputated limb or **uses** a **mechanical aid** (cane, walker) to get up or lie down. Specify in the available space (preceded by an X) the type of mechanical aid used, where applicable.

Note over the $\bar{z}$ the number of nursing staff required to assist the client to get up and lie down.

LEVEL OF ASSISTANCE:

Mode 1: Supply material necessary to get up (cane, walker), lower bed rails. Supervise client when getting up or lying down.

Mode 2: Assist the client to get up or lie down. The client participates actively in the process, can walk some steps if supported by staff.

Mode 3: Get client up or back into bed. The client is unable to participate (direct transfer).

NOTE:

Direct transfers from chair to toilet or commode are included in the action *"bathroom or commode"*.

4020 **GET UP WITH LIFT**
4025 **LIE DOWN WITH LIFT**

PURPOSE:

To prevent the effects of immobility.
To provide safe transfers for client and staff.

DESCRIPTION:

Prepare lift.
Assist up and to sit comfortably in the chair.
Return to bed.
Lower and raise bed rails, if necessary.
Adjust geriatric chair table, if necessary.

INSTRUCTIONS:

Indicate the weekly and daily schedules when the client is assisted up with a lift. (Get up with lift).

Indicate the weekly and daily schedules when the client is returned to bed with a lift (lie down with lift).

Note over the $\bar{z}$ the number of nursing staff required to assist client to get up and to lie down.

NOTE:

Direct transfers from chair to toilet or commode are included in the action *"bathroom or commode"*.

4030 ASSISTANCE NEEDED TO WALK

PURPOSE:

To prevent the effects of immobility.
To allow the client to participate in the activities of the institution.

DESCRIPTION:

Prepare the material needed to walk (cane, walker, ...), if necessary.
Assist the client to:
- walk OUTSIDE the room;
- go up or down the stairs.

INSTRUCTIONS:

Indicate the weekly and daily schedules when the client requires help from the nursing staff to walk in the hallway.

Note *"1"* over the $\bar{x}$ if the client has no amputation or does **not** use **any mechanical aid** to walk.

Note *"2"* over the $\bar{x}$ if the client has an amputated limb or **uses** a **mechanical aid** to walk. Specify in the available space (preceded by an X) the type of mechanical aid used, where applicable.

Note over the $\bar{z}$ the number of nursing staff required to assist the client to walk with assistance.

LEVEL OF ASSISTANCE:

Mode 1: Guide the client in his travels.
(example: blind client, client with cognitive deficits unable to find the dining area, his room, etc...).

Mode 2: Physically support the client when walking.

4040 PUSH WHEELCHAIR OR GERIATRIC CHAIR

PURPOSE: To decrease the sense of isolation.
To allow the client to participate in the activities of the institution.

DESCRIPTION: Push wheelchair outside of the room.

INSTRUCTIONS: Indicate the weekly and daily schedules for pushing wheelchair or geriatric chair.

4050 RUBBING AND POSITIONING

PURPOSE: To prevent skin irritation and the effects of immobility.
To promote circulation.

DESCRIPTION: Turn and position client while respecting proper body mechanics.
Rub and massage pressure points.
Remove or replace protective devices such as boots or sheepskin, if necessary.
Change linen partially or completely, if necessary.
Lower and raise bedrails, as necessary.

INSTRUCTIONS: Indicate the weekly and daily schedules for changing positions.

Note over the $\bar{z}$ the number of staff required for rubbing and positioning.

STANDARD: Every two (2) hours for the **bedridden client.**

LEVEL OF ASSISTANCE:

Mode 1: Guide the client to position himself at bedtime.

Mode 2: Rub the client experiencing back pain; he can position himself.

Mode 3: Rub and position client.

MUSCULAR EXERCISES

4060 PASSIVE AND/OR ACTIVE EXERCISES
4070 STRUCTURED PASSIVE AND/OR ACTIVE EXERCISES

PURPOSE:

PASSIVE OR ACTIVE: To prevent musculoskeletal atrophy.
To maintain joint mobility.

STRUCTURED: To restore muscle functioning to a client having suffered through a recent CVA or fracture.

DESCRIPTION:

Prepare the material necessary for exercising.
Encourage, guide the client (active).
Execute **passive** range of motion exercises.
Follow an individualized exercise program in view of **rehabilitation** (structured).

INSTRUCTIONS:

Indicate the weekly and daily schedules for passive or active exercises **executed by nursing staff.**

Indicate the weekly and daily schedules of structured exercises **executed by nursing staff.**

Note *"1"* over the $\overline{w}$ if the **constant presence** of staff is **not required** for the duration of the exercises.

Note *"2"* over the $\overline{w}$ if the **constant presence** of staff is **required** for the **duration** of active exercises, structured or not.

For structured exercises note *"1"* over the $\overline{x}$ if the goal is **short term** rehabilitation and *"2"* if it is **long term.**

STANDARD:

Twice (2) per day for the client who is immobile and once (1) per day for the client with limited mobility.

LEVEL OF ASSISTANCE:

Mode 1: Prepare and supply necessary material. Guide, encourage the client to practice his exercises.

Mode 2: Assist the client to mobilize certain limbs (for example: lift left arm within a certain range)
or
Encourage the client for part of his exercise session.

Mode 3: Execute passive range of motion exercises.

4080 PHYSICAL RESTRAINTS

PURPOSE: To protect the client or his surroundings.

DESCRIPTION: Apply physical restraints such as:
- vest restraint;
- abdominal band;
- mitts, gloves (for infants);
- wrist restraint.

Apply fireproof apron.

INSTRUCTIONS: Indicate the weekly and daily schedules when the restraint is **applied** (tied).

Note *"1"* over the $\bar{x}$ if the restraint is applied to a client who is **not agitated**.

Note *"2"* over the $\bar{x}$ if the restraint is applied to a client who **is agitated**.

LEVEL OF ASSISTANCE:

Mode 1: Supply client with fireproof apron.

Mode 3: Apply fireproof apron.
Apply restraint.

NOTE: The bedrails, geriatric chair table and the fixed lap belt of the wheelchair are ways to protect or restrain the client. However, they have been taken into account in the actions of *"get up/lie down with assistance"* and *"rubbing and positioning"*.

COMMUNICATION

Page

5010 INDIVIDUAL SUPPORTIVE COMMUNICATION

PURPOSE:

To promote an optimal mental health status by helping the client to maintain his bio-psycho-social equilibrium.
To reassure and comfort.
To enhance self-esteem.

DESCRIPTION:

The nursing care-giver may, according to the client's needs:
- discuss, exchange, inform, read, comment;
- offer a reassuring presence;
- encourage to participate in recreational, educational, religious or other types of activities;
- create a favorable environment;
- touch, hold, rock, stroke (especially with children).

INSTRUCTIONS:

Indicate the weekly schedule and **percentage (%) of time** per shift communication is required. The sum of the three numbers must equal 100% for the 24 hour period.

NOTE:

This type of communication is required every day for **all** clients **not** presenting cognitive deficits or psychiatric problems.

5020 INDIVIDUAL SUPPORTIVE COMMUNICATION (cognitive deficits)

PURPOSE:

To preserve dignity and self-esteem.
To maintain functional ability and mental health at their highest level possible.
To maintain, encourage or increase participation in ADL.
To increase the client's collaboration.
To decrease anxiety.
To decrease the sense of isolation.
To promote integration in the environment.
To reassure.
To decrease the risk of dysfunctional emotional reactions.

DESCRIPTION:

The nursing care-giver may, according to the client's needs:

- verbally stimulate, encourage, praise;
- discuss;
- hold the hand of an excited or anxious client;
- orient to reality by calling the client's name, telling him the day, the season, etc...;
- repeat instructions;
- reexplain, search for understandable words, gestures, facial expressions;
- establish eye contact;
- use touch;
- allow for a waiting period, to give the client time to respond;
- listen to verbal and non-verbal cues;
- decipher behaviour, focus on its meaning;
- try again later, if faced with the client's refusal to collaborate;
- redirect attention in a tense situation;
- allow the person to express feelings;
- provide a reassuring presence.

INSTRUCTIONS:

Indicate the weekly schedule and **percentage (%) of time** per shift communication is required. The sum of the three numbers must equal 100% for the 24 hour period.

Note over the $\bar{x}$ the type of **cognitive deficit**. Each of the five categories (slight, slight moderate, severe moderate, severe active/passive) are defined on the following pages.

Note over the $\bar{y}$ the degree of **collaboration** or **participation** of the client to the activities of daily living (meals, elimination, hygiene, ambulation, taking medication).

Note over the $\bar{z}$ the intensity of **stimulation** or **negotiation** required by the client to facilitate or increase his participation or collaboration with the activities of daily living (ADL).

NOTE: This type of communication is required every day for **all** clients presenting cognitive deficits.

Definitions of the categories of cognitive deficits

Cognitive deficit: This term designates a deterioration of mental functioning with regards to: memory, thought process, decision making, attention, concentration, orientation, learning abilities, etc...

SLIGHT COGNITIVE DEFICIT

Profile: The person presents minor cognitive losses, such as a greater difficulty learning or assimilating and retaining information. The person is easily distracted and the ability to concentrate is decreased, thus hindering the ability to learn and memorize. The person presents memory losses, sometimes complains of losing personal belongings or forgets where he has placed them. When communicating the person may have difficulty understanding rapid speech. The person may stray from the conversation or repeat himself. Conscious of the losses, the person may experience anxiety or depression. Certain persons, uneasy with their memory losses tend to isolate themselves. For ADL, the person may be self-sufficient or requires some aid specifically to remind him what needs to be done, where his personal belongings are or supply him with the necessary material. Generally, the person functions and interacts with his environment in spite of his cognitive losses.

Role of the care-giver: The care-giver interacts with the client at a slower pace to give the person time to assimilate information. He may remind the client **occasionally** of certain activities of the day, the time or orient the client to place. In order to maintain functional ability and prevent isolation, the care-giver will stimulate and praise the client daily.

MODERATE COGNITIVE DEFICIT

Profile: The person presents important cognitive losses which interfere with the ability to perform ADL; the losses have repercussions on social behaviour and personality. There is an overall loss of cognitive functioning. The abilities to understand and express (written or oral) are compromised. The person exhibits difficulties initiating and sustaining a conversation. He talks mostly about the past and may answer a question inadequately. The person may exhibit agitation, irritability, apathy, anxiety and signs of depression. He is still aware enough of his surroundings to participate in certain ADL, if given the chance.

SLIGHT MODERATE COGNITIVE DEFICIT

Profile: In spite of important cognitive losses, the person usually collaborates well. He may present aggressiveness or agitation at certain periods. Fatigue, over-stimulation or other factors can bring on these moments of agitation or aggressiveness. Depending upon physical abilities, the person may get around on his own but need help from others to direct him to certain areas. His wandering does not generate conflict. The care-givers consider this person as *"not or rarely disruptive"*.

Role of the care-giver: In view of the important cognitive losses, the person requires help for certain or most of the ADL. The aid is given according to the person's potential in order to preserve his dignity and self-esteem, to restore certain abilities, to prevent the development of disabilities and maintain a link with the environment. The person is sensitive to affective cues but has difficulty communicating (comprehension and expression), the care-giver is careful to establish effective communication using eye contact, touch and daily verbal exchanges in order to maintain the person's residual abilities.

The care-giver remains sensitive to the fact that the person, not always understanding the reasons behind an intervention, may experience anxiety in relation to simple activities such as: bathing, dressing, meals, etc... The care-giver will then, at each intervention, establish eye-contact, give simple and clear instructions in order to **facilitate** or **increase** the person's **participation**.

SEVERE MODERATE COGNITIVE DEFICIT

Profile: This person, in contrast with MODERATE, has a greater difficulty participating and collaborating with his care. He is generally resistant to most or all of the activities of daily living. He may also be aggressive. His wandering and behavioral problems **regularly generate conflicts** with others.

Role of the care-giver: It is in essence similar to the one for a person with a SLIGHT MODERATE cognitive deficit yet, given the person's resistance, the care-giver will offer greater "stimulation", meaning, "to reexplain" using other, more comprehensible terms (words, gestures, facial expressions), "to negotiate", trying to find a response (verbal or non-verbal) to the person's protests, without trying to reason with him. These strategies are used as a way of getting around the refusal to collaborate. This "stimulation" often takes place before an intervention as well as during the activity (meals, personal hygiene, ...) because the person forgets, during the activity, the reason of the action. The care-giver will not insist when faced with a refusal (to prevent aggressiveness), instead he will try again later. The care-giver also intervenes during conflicts and will attempt to decrease the risk of a crisis event or aggressiveness. The care-giver establishes effective communication using non-verbal cues, simple and clear instructions, appropriate terms, re-explanation and distracting the person, if necessary, in order to **increase collaboration** and **participation.**

SEVERE COGNITIVE DEFICIT

Profile: This person can no longer sustain a conversation. The content is incoherent and devoid of logic. Verbal expression is often affected; he mumbles,talks gibberish, exhibits echolalia or may even be aphasic. Socially, he has little contact, often he does not recognize family members and may even be unable to name himself. His orientation to time, place, person is very affected. For ADL, he can hardly participate; there is a loss of psychomotor abilities. In spite of these deficits, the person remains sensitive to affective cues.

SEVERE-ACTIVE COGNITIVE DEFICIT

Profile: This person presents severe cognitive deficits but is still able to accomplish certain activities. He may, for example, ambulate on his own (wander) or eat on his own. His abilities to communicate and comprehend are almost nil. He reacts by **automatic functioning.** As the person presenting a moderate deficit, he may have unpleasant moods.

Role of the care-giver: In spite of the person's major deficits, the care-giver will attempt to preserve the residual automatic functioning. He will also encourage the person to execute these residual activities.

Given the difficulties of comprehension, the care-giver will be attentive to the communication style. He will specifically use touch . As the person has difficulty grasping the purpose of an intervention, the care-giver will take the time to explain by using reassuring gestures or very simple terms.

SEVERE-PASSIVE COGNITIVE DEFICIT

Profile:

This person cannot usually accomplish an activity on his own. He is generally confined to a bed or a wheelchair. He offers little or no resistance and in view of his important deficits, stimulation is impossible. His abilities to communicate and comprehend are slight to non existent. In spite of these deficits, it is believed the person remains sensitive to affective cues although he may respond very little.

Role of the care-giver:

As the person presents few psychomotor skills, the care-giver will assist the client for all of his needs. This aid often translates into complete assistance but partial assistance may occur for an activity. The care-giver remains open to the person's abilities.

As the person is sensitive to affective cues, the care-giver particularly uses touch and eye contact to reach the person. The care-giver will also communicate verbally, using simple terms, to explain interventions.

5030 INDIVIDUAL SUPPORTIVE COMMUNICATION (psychiatric problems)

PURPOSE:

To maintain or increase self-esteem.
To maintain, facilitate or increase participation in ADL.
To increase the client's collaboration.
To decrease anxiety.
To promote integration in the environment.
To reassure.
To promote effective coping.
To prevent or decrease aggressive behaviour.
To increase insight.
To prevent crisis situations.
To prevent acting-out behaviour.

DESCRIPTION:

The nursing care-giver may, according to the client's needs:
- verbally stimulate, encourage, praise;
- discuss;
- establish a trusting relationship;
- listen to verbal and non verbal cues;
- allow the person to express his feelings;
- re-orient to reality;
- hold the hand of an excited or anxious client;
- listen to criticism;
- have a firm yet supportive attitude;
- repeat instructions;
- redirect attention in a tense situation;
- clarify expectations and set limits;
- maintain and recall limits and expectations;
- provide a reassuring presence.

INSTRUCTIONS:

Indicate the weekly schedule and **percentage (%) of time** per shift communication is required. The sum of the three numbers must equal 100% for the 24 hour period.

Note over the $\bar{x}$ the category of **psychiatric problem**. Each of the three categories (slight, moderate, severe) are defined on the following pages.

Note over the $\bar{y}$ the degree of **collaboration** or **participation** of the client to the activities of daily living (meals, elimination, hygiene, ambulation, taking medication).

Note over the $\bar{z}$ the intensity of **stimulation** or **negotiation** required by the client to facilitate or increase his participation or collaboration with the activities of daily living (ADL).

NOTE:

This type of communication is required every day for **all** clients presenting psychiatric problems. According to the pathology and the state of the client at the time of evaluation, it is possible to choose *"Individual Supportive Communication - Slight psychiatric Problem"* for 3 days and, *"moderate psychiatric problem"* for 4 days.

A preventive interaction (5090) may also be added for certain clients who require a **structured meeting**, for example, once a week.

Definitions of the categories of psychiatric problems

SLIGHT PSYCHIATRIC PROBLEMS

Profile:

The person functions well in a stable environment where the expectations, limits and roles are well defined. The person necessitates minimal structuring. He may exhibit anxiety with a new situation, a change in routine or an unexpected event. The person accepts and understands change or being turned down a request if it is accompanied by explanations. If he presents behavioral problems, they interfere little with others. The person's cognitive functions may be intact but there may be alterations of thought process, a decrease of attention and concentration. Included in this category are the persons requiring structuring in certain situations, for example, in a group activity or to effectively use problem-solving skills. Also included are those requiring some stimulation to function on a daily basis. In terms of pathology, one finds in this category, all persons who, at the time of evaluation, are stable whether they suffer from schizophrenia, paranoia, depression, mental retardation or others.

Role of the care-giver:

The care-giver will, in order to preserve the level of functioning and decrease anxiety, ensure an appropriate **safe environment**. He will also **limit as much as possible** changes in the client's routine. If a change is inevitable or a request is turned down, an explanation will be given to decrease frustration and prevent behavioral problems.

MODERATE PSYCHIATRIC PROBLEMS

Profile: The person has difficulty coping with daily events. Structuring of the environment must be personalized. There is generally a contract established between both parties (care plan developed). In terms of secondary pathologies the person may present disturbances of mood and cognition; thought process and behaviour are often affected. The relationships with others are often difficult because of withdrawal, lack of motivation or behavioral problems causing conflicts. The person retains some contact with reality and experiences much anxiety. His tolerance level is low and the person expects an immediate response or instant gratification. One finds in this category persons with behavioral problems (criticisms, constant demands), manic and depressive disorders, and psychiatric illnesses requiring a very structured environment.

Role of the care-giver: The care-giver enforces the established contract. He **listens** to criticism but adopts a **firm** yet **supportive** attitude. He must also be **patient** in view of the client's repeated demands. For certain clients, given their needs, he will explore the moral suffering and its meaning in order to help develop coping mechanisms. The care-giver listens, stimulates, supports to prevent any deterioration.

SEVERE PSYCHIATRIC PROBLEMS

Profile: The person is completely disorganized. All his functioning is disturbed. He has lost touch with reality and presents one or more of the following: psychosis, hallucinations, suicidal ideation with occasionally a serious attempt, incoherent speech patterns. The anxiety level is generally very high. Depending upon the pathology, the person may exhibit behavioral problems such as verbal and physical aggressiveness, repeated demands, up to every fifteen minutes. The person is very demanding and his tolerance level is very low. He remains very sensitive to criticism and rejection. His contacts with others are very difficult or inexistant because of aggressiveness or withdrawal (major depression). Generally, this type of person cannot stay in a nursing home or long term care facility, he is rapidly transferred to a psychiatric institution.

Role of the care-giver: The care-giver will try to establish a trusting relationship. Given the loss of touch with reality the care-giver will **reassure** and **orient the person to reality.** Active listening is very important for these clients. The care-giver will **circumvent the refusal to collaborate** by establishing a warm relationship and by trying to find answers to the person's argumentation. The care-giver will **intervene regularly** to diffuse conflicts, tense situations and control aggressiveness. Despite the person's important disturbances **contracts** are generally agreed upon and the care-giver ensures they are upheld.

DATA COLLECTION

5040 INTERMITTENT DATA COLLECTION

PURPOSE: To individualize care planning for the client.

DESCRIPTION: Collect bio-psycho-social information pertaining to the client's life style and health status on an assessment form, in an intermittent fashion, over the first days following admission.
or
Update the data collected during the initial admission history.

INSTRUCTIONS: Indicate the weekly and daily schedules for data collected with the client or family member.

NOTE: The care-plan updating is not included here, it is taken into account in the activities of "communications regarding the client (CRC)".

5050 COMPLETE INITIAL DATA COLLECTION

PURPOSE: To individualize care planning for the client.

DESCRIPTION: Collect at the time of admission bio-psycho-social information pertaining to the client's life style and health status on an assessment form.

INSTRUCTIONS: Indicate the weekly and daily schedules for data collected with the client or family members.

NOTE: The care-plan updating is not included here, it is taken into account in the activities of "communications regarding the client (CRC)".

5080 TEACHING (client or significant other)

PURPOSE:

To facilitate the acquisition of knowledge and skills according to the client's abilities.
To increase autonomy.

DESCRIPTION:

Prepare teaching material, if necessary.
Teach the client or significant other(s).

INSTRUCTIONS:

Indicate the weekly and daily schedules of teaching session(s) given to the client or significant other(s) by a member of nursing personnel.

Specify in the available space, the subject covered in the teaching session.

NOTE:

The general information given to clients in relation to nursing actions are not considered teaching.

5090 PREVENTIVE INTERACTION

PURPOSE:

To enhance the client's state of wellness.
To support the client during a problematic period.

DESCRIPTION:

Establish a trusting relationship with the client.
Use verbal or nonverbal techniques in order to help the client to:
- express his problems;
- increase self-awareness;
- accept a new situation;
- others.

These interventions may be structured or not but the client's problem is identified and explicited in the care plan unless the difficulty requires a limited intervention without a follow-up. The nursing notes should then document the problem and its evolution following the interventions.

INSTRUCTIONS:

Indicate the weekly schedule and check (✓) the **shift(s)** when preventive interaction was required by the client.

Note over the $\bar{x}$ the number corresponding to the type of preventive interaction:

1. Minimal: therapeutic communication requires less than 15 minutes/**SHIFT.**

2. Moderate: therapeutic communication requires more than 15 minutes but less than 30 minutes/**SHIFT.**

3. Intensive: therapeutic communication requires more than 30 minutes/**SHIFT.**

Specify the problem, objective and actions.

NOTE:

For a **given shift,** only one type of preventive interaction can be indicated.

For a **given day** (3 shifts), one or more types of preventive interaction can be indicated.

Example 1: Mrs Tremblay has difficulty accepting her placement, the care-giver allows time for her to express her emotions. This preventive interaction takes place for 3 days on the day and evening shift.

			N	D	E
$\frac{1}{x}$	Minimal	(M T W) T F s S	☐	☑	☑

Example 2: Mrs Roy does not accept her changed body image (recent CVA with right hemiplegia); she cries often and refuses to participate in ADL or recreational activities. She needs much support, specifically during the day.

			N	D	E
$\frac{1}{x}$	Minimal	(M T W T F s S)	☑	☐	☐
$\frac{2}{x}$	Moderate	(M T W T F s S)	☐	☐	☑
$\frac{3}{x}$	Intensive	(M T W T F s S)	☐	☑	☐

It is important to note that a *"preventive interaction"* **cannot** be chosen for clients presenting cognitive deficits or psychiatric problems as a special communication is already chosen in order to: orient to reality, decrease conflicts, increase collaboration, reassure, others... These communications and their objectives are taken into account in the specific *"individual supportive communication"* 5020 and 5030 (see purpose and descriptions).

It is however possible for a client with **slight cognitive deficits** who, aware of his memory losses and the evolution of the disease, exhibits signs of depression.

It is also possible for the client with **chronic psychiatric problems** who has planned meetings for example, once weekly, in order to establish a contract or ensure its follow-up.

5120 PREVENTIVE INTERACTION WITH SIGNIFICANT OTHER/FAMILY

PURPOSE:

To support the family during a critical period.
To assist the family to realistically view the client's situation.

DESCRIPTION:

Establish a trusting relationship with significant other(s).
Use verbal or non verbal communication techniques in order to assist the family to:
- express emotions;
- accept a situation;
- others.

These meetings may be structured or not but the problem experienced by the family member(s), the interventions and the evolution of the problem are noted in the client's chart.

INSTRUCTIONS:

Indicate the weekly schedule and check (✓) the **shift(s)** when preventive interaction was required by the significant other.

Note over the $\bar{x}$ the number corresponding to the type of preventive interaction:

1. Minimal: therapeutic communication requires less than 20 minutes/**SHIFT.**

2. Moderate: therapeutic communication requires more than 20 minutes but less than 45 minutes/**SHIFT.**

3. Intensive: therapeutic communication requires more than 45 minutes/**SHIFT.**

Specify the problem, objective and actions.

Note *"1"* over the $\bar{z}$ if the interaction takes place over the telephone.

Note *"2"* over the $\bar{z}$ if the interaction takes place within the institution.

NOTE:

For a **given shift,** only one type of preventive interaction can be indicated.

For a **given day** (3 shifts), one or more types of preventive interaction can be indicated.

It is important, here, to note that the type of communication under consideration is of an empathic, helping and therapeutic nature. The information given to the family concerning a client's health status or requests made for personal belongings are not considered here.

GROUP ACTIVITIES

5130 RECREATIONAL

PURPOSE:

To facilitate integration into a group.
To provide the client with leisure activities.

DESCRIPTION:

Check attendance.
Provide an appropriate environment.
Direct group dynamics or,
Accompany and assist the client for **all** of the recreational activity, such as:

- bingo, cards, film;
- handy work (knitting, woodwork, gardening);
- community meetings;
- others.

Adjourn the session.

INSTRUCTIONS:

Indicate the weekly schedule of the recreational activities attended by the client.

Specify in the available space, the type of recreational activity.

Note, in the appropriate boxes, the following information:

Number of staff required (nursing): this is the number of the unit's nursing staff who direct or accompany the client for the duration of the activity. The number may equal 0 if no member of the unit's staff is present for the activity.

Duration (minutes): this is the duration of the recreational activity attended by the client. The time is expressed in minutes.

Number of participants: the number of clients from the unit who participate in a recreational activity.

Beginning time: the time at which the activity begins.

5140 THERAPEUTIC

PURPOSE:

To enhance self-esteem.
To promote social integration.
To assist the client to face his behavioral problems.
To increase self-awareness through interactions with others.
To maintain or increase psychomotor skills.
To maintain or increase the ability to interact in the physical and social environment.

DESCRIPTION:

Check attendance.
Provide an appropriate environment.
Direct the therapeutic activity or,
Accompany and assist client for the **duration** of the therapeutic activity, such as:

- reality orientation;
- sensory stimulation;
- reminiscence;
- music therapy;
- therapeutic group meetings;
- therapeutic pottery, painting, carpentry;
- therapeutic community meetings;
- therapeutic swimming, broom-ball, exercise;
- others.

Adjourn the session.

INSTRUCTIONS:

Indicate the weekly schedule of the therapeutic activities attended by the client.

Specify in the available space, the type of therapeutic activity.

Note, in the appropriate boxes, the following information:

Number of staff required (nursing): this is the number of the **unit's** nursing staff who direct or accompany the client for the **duration** of the activity. The number may equal 0 if no member of the unit's staff is present for the activity.

Duration (minutes): this is the duration of the therapeutic activity attended by the client. The time is expressed in minutes.

Number of participants: the number of clients **from the unit** who participate in a therapeutic activity.

Beginning time: the time at which the activity begins.

NOTE:

This type of activity must have a **therapeutic**, not recreational, purpose.

5150 SOCIO-THERAPEUTIC OUTING

PURPOSE:

To promote or facilitate the client's integration in the community.
To promote the client's independence.

DESCRIPTION:

Check attendance.
Leave for the outing.
Provide the appropriate environment.
Direct the therapeutic group activity, such as:
- movie;
- theatre;
- shopping;
- cultural outing;
- others.

Return to nursing unit.

INSTRUCTIONS:

Indicate the weekly schedule of the therapeutic outing attended by the client.

Specify in the available space, the type of therapeutic outing.

Note, in the appropriate boxes, the following information:

Number of staff required (nursing): this is the number of the **unit's** nursing staff who direct or accompany the client for the **duration** of the activity. The number may equal 0 if no member of the unit's staff is present for the activity.

Duration (minutes): this is the duration of the therapeutic outing attended by the client. The time is expressed in minutes.

Number of participants: the number of clients **from the unit** who participate in a therapeutic outing.

Beginning time: the time at which the activity begins.

NOTE:

This type of activity must have a **therapeutic**, not recreational, purpose.

MEDICATION

Page

6010 PREPARATION OF SELF-MEDICATION

PURPOSE: To promote the client's independence regarding his medication.

DESCRIPTION:

Check medication(s).
Prepare medication and store in the appropriate containers.
Supervise self-administered medication.

INSTRUCTIONS:

Indicate the weekly and daily schedules for the preparation of medication.

Note over the $\bar{x}$ the number of medication(s) to prepare.

PREPARATION AND ADMINISTRATION OF MEDICATION

6020 MEDICATION - PO
6030 MEDICATION - NG
6040 MEDICATION - PR
6050 MEDICATION - PV
6060 MEDICATION - GTE

PURPOSE: To ensure the safe delivery and administration of prescribed medication(s).

DESCRIPTION: Prepare and administer medications by the following routes:
- oral (PO);
- gastric tube (NG);
- rectal (PR);
- vaginal (PV);
- mucous membrane (GTE).

Double check medication(s) with another nurse, if necessary.

INSTRUCTIONS: Specify the name, dose and quantity of medication prescribed.

Check appropriate box (route of administration).

Indicate the weekly and daily schedules of administration of medication.

LEVEL OF ASSISTANCE:

Mode 1: Prepare and deliver medication(s) to client.

Mode 2: Prepare, deliver and remain with client while he takes medication.

Mode 3: Prepare, crush medication(s), if necessary, and administer to client.

NOTE: For medication prescribed *"as needed"* (PRN) but not given during the seven (7) days of observation, note only the name, dose and quantity.

For **inhalers** (Ventolin, Beclovent, others), check the box *"gte"* (6060).

For ointment applied to the internal or external surface of the eyelid, check the box *"gte"* (6060).

6070 MEDICATION - IM
6080 MEDICATION - SC
6090 MEDICATION - ID

PURPOSE: To ensure the safe delivery and administration of prescribed medication(s).

DESCRIPTION: Prepare and inject the medication(s) by one of the following routes:
- intramuscular (IM);
- subcutaneous (SC);
- intradermic (IM).

Double check the medication(s) with another nurse, if necessary.

INSTRUCTIONS: Indicate the weekly and daily schedules of administration of medication(s) by the intramuscular, subcutaneous or intradermic route.

Specify, in the space provided, the name and dose of the administered medication.

LEVEL OF ASSISTANCE: Mode 1: Prepare syringe; the injection is performed by the client or another person, not included in the nursing staff.

Mode 3: Prepare and perform injection.

NOTE: If **two (2) medications** are administered in the **same syringe,** indicate the number ***"2"*** **in the schedule box.**

6100 I.V. MEDICATION - IN SOLUTION
6110 I.V. MEDICATION - IN SOLUSET/BURETROL
6120 I.V. MEDICATION - I.V. PUSH

PURPOSE: To ensure the safe delivery and administration of prescribed medication(s).

DESCRIPTION: Prepare and administer intravenous medication by one of the following routes:
- I.V. solution;
- buretrol or soluset;
- I.V. push.

Double check medication(s) with another nurse, if necessary.
Monitor the infusion of medication.

INSTRUCTIONS: Indicate the weekly and daily schedules of administration for I.V. medication(s).

Specify, in the space provided, the name and dose of the administered medication.

For medication given directly by I.V. push, note over the $\bar{y}$ the total volume in the syringe, **after dilution.**

INTRAVENOUS THERAPY

Page

INTRAVENOUS THERAPY

7010 IV INSERTION

PURPOSE: To provide fluid, electrolytes and nutrients to satisfy daily needs.
To administer medication.

DESCRIPTION: Prepare equipment necessary for IV therapy.
Perform puncture (IV or SC).
Secure the IV or SC catheter.
Adjust rate of perfusion.

INSTRUCTIONS: Indicate the weekly and daily schedules of **insertion** (or **reinsertion,** if infiltrated) of perfusion.

Specify, in the space provided (preceded by IV # 1), the type of solution administered.

Note over the $\bar{z}$ the number corresponding to the number of nursing staff required to insert IV.

7020 SURVEILLANCE - PERFUSION # 1 - PERFUSION # 2

PURPOSE: To limit the complications related to IV therapy.

DESCRIPTION:

Check IV solution.
Adjust rate of perfusion.
Adjust IV pump, if necessary.
Observe infusion site.

INSTRUCTIONS:

On line *"B"* indicate the day and time IV therapy **begins**. If it is **already in place**, circle the letter corresponding to the **first day of observation** and mark the time 00:00.

On line *"E"* indicate the day and time IV therapy **ends**. If it **remains in place** on the **seventh day of observation**, circle the letter corresponding to the last day of observation and mark the time 23:59.

An **END** to the perfusion implies the **removal** of the venous **catheter**.

NOTE:

Two codes 7020 ($\frac{1}{x}$ and $\frac{2}{x}$) appear on the form. The first is for perfusion # 1 and the second is for perfusion # 2. The second IV corresponds to a second simultaneous IV site and perfusion or to two perfusions infusing through the same IV site (piggyback); for example, mini-bags for antibiotic therapy (one vein open with two IV bags and tubings).

Use the code 7020 $\frac{1}{x}$ for the surveillance of the first perfusion and the code 7020 $\frac{2}{x}$ for the surveillance of the second perfusion (simultaneous perfusion or mini-bag).

7030 CHANGE IV SOLUTION - PERFUSION # 1 - PERFUSION # 2

PURPOSE: To maintain fluid and electrolyte balance.

DESCRIPTION: Change IV solution (bag or bottle).
Adjust rate of perfusion.

INSTRUCTIONS: Indicate the weekly and daily schedules for changing IV solution.

Use the code 7030 $\frac{1}{x}$ to document the changes of IV bags for perfusion # 1 and the code 7030 $\frac{2}{x}$ for the changes of IV bags related to perfusion # 2.

7040 CHANGE IV TUBING - PERFUSION # 1 - PERFUSION # 2

PURPOSE: To limit the complications related to IV therapy.

DESCRIPTION: Change IV tubing (without reinserting IV catheter).

INSTRUCTIONS: Indicate the weekly and daily schedules of tubing changes.

Use code 7040 $\frac{1}{x}$ for tubing changes related to perfusion # 1 and code 7040 $\frac{2}{x}$ for tubing changes related to perfusion # 2.

BLOOD AND DERIVATIVES

7050 FIRST TRANSFUSION AND CHANGE OF TRANSFUSION BAG

PURPOSE: To maintain circulating blood volume.
To replenish blood components.

DESCRIPTION: Check appropriate blood labels.
Adjust rate of transfusion.
Observe client constantly during the first fifteen (15) minutes of transfusion.
Change transfusion bag.
Discontinue transfusion.
Discard transfusion set according to protocol.

INSTRUCTIONS: Indicate the weekly and daily schedules to set up first transfusion and change transfusion bags.

NOTE: If a perfusion must be started before the transfusion, refer to code 7010.

7060 SURVEILLANCE

PURPOSE: To limit the complications related to the transfusion.

DESCRIPTION: Check the following at least every (20) minutes:
- rate;
- infusion;
- client's reactions.

INSTRUCTIONS: On line *"B"* indicate the day and time the transfusion **begins.**

On line *"E"* indicate the day and time the transfusion **ends**.

TREATMENTS

TREATMENTS
(continued)

8020 CONTINUOUS AMBULATORY PERITONEAL DIALYSIS

PURPOSE: To remove, via the peritoneum, toxic substances and metabolic wastes accumulating in acute or chronic renal failure.

DESCRIPTION:
Change necessary material (administration set, catheter adapter, drainage bag, etc.).
Add peritoneal catheter extension, if necessary.
Insert catheter adapter.
Prepare solutions.
Add medication(s) to solutions, if necessary.
Monitor the dialysis process.
Empty the drainage system.

INSTRUCTIONS: Indicate the weekly and daily schedules for each cycle.

LEVEL OF ASSISTANCE:

Mode 1: Prepare and supply to client the material necessary for dialysis.

Mode 2: Prepare and set up dialysis, the client can empty the drainage system.

Mode 3: Prepare and set up dialysis, monitor the dialysis process and empty the drainage system.

8060 GASTRIC TUBE INSERTION

PURPOSE:
Administer medication(s) or food.
Obtain a sample of stomach's contents.

DESCRIPTION:
Disinfect area.
Insert tube or catheter.
Secure tube.

INSTRUCTIONS: Indicate the weekly and daily schedules of gastric tube insertion.

LEVEL OF ASSISTANCE:

Mode 1: Prepare supplies, the client inserts his gastric tube.

Mode 3: Perform insertion.

8070 STRAIGHT DRAINAGE

PURPOSE: To facilitate the drainage of a wound, cavity or organ.

DESCRIPTION:
Secure drainage tubing.
Empty drainage bag or bottle.

INSTRUCTIONS:
Indicate the weekly schedule and **number of times** per shift that **emptying** of the drainage system is required.

Specify the type of tubing under straight drainage.

8080 UNDERWATER DRAINAGE

PURPOSE: To facilitate the drainage of a wound, cavity or organ.

DESCRIPTION:
Secure drainage tubing or container.
Empty drainage container.
Fill drainage container with water, if necessary.
Check patency of the system.

INSTRUCTIONS:
Indicate the weekly schedule and **number of times** per shift the drainage system is inspected.

Specify the type of underwater drainage system.

8090 DRAINAGE WITH SUCTION

PURPOSE: To facilitate the drainage of a wound, cavity or organ.

DESCRIPTION:

Secure drainage tubing.
Adjust the suction gauge.
Verify the functioning of the suction and drainage systems.
Empty and clean the drainage container.

INSTRUCTIONS:

Indicate the weekly schedule and **number of times** per shift the drainage system is **inspected.**

Specify the type of tubing under drainage with suction.

8100 CLAMP/UNCLAMP: TUBE AND/OR CATHETER

PURPOSE: To train the bladder.
Assess gastric emptying.

DESCRIPTION:

Clamp tube or catheter.
Unclamp tube or catheter.
Drain tube or catheter.

INSTRUCTIONS:

Indicate the weekly schedule and the **number of times** per shift the tube or catheter is **unclamped.**

Clamping includes unclamping the tube.

Specify the type of tube that requires clamping/unclamping.

IRRIGATION

8120 VAGINAL IRRIGATION

PURPOSE: To clean and disinfect the vagina.

DESCRIPTION:
Prepare the irrigation solution.
Perform irrigation.
Let liquid drain from vagina.
Dry perineal area.

INSTRUCTIONS: Indicate the weekly and daily schedules of vaginal irrigation.

LEVEL OF ASSISTANCE:
Mode 1: Prepare and supply the irrigation solution.
Put away supplies.

Mode 3: Perform the irrigation.

8130 VULVAR IRRIGATION

PURPOSE: To clean and disinfect a wound in the vulvar region.

DESCRIPTION:
Prepare irrigation solution.
Slowly pour solution over affected region.
Dry region with sterile gauzes.

INSTRUCTIONS: Indicate the weekly and daily schedules of vulvar irrigation.

8140 AURICULAR IRRIGATION

PURPOSE: To clean the external auditory canal.

DESCRIPTION: Prepare irrigation solution.
Inject solution into the ear(s).
Evacuate contents.

INSTRUCTIONS: Indicate the weekly and daily schedules of ear wash.

Note over the $\bar{z}$ the number corresponding to the number of ears requiring irrigation.

LEVEL OF ASSISTANCE: Mode 1: Prepare and supply necessary material; the irrigation is performed by another health care professional, for example, a doctor, not a member of nursing services.

Mode 3: Perform ear wash.

8150 GASTRIC IRRIGATION

PURPOSE: To supply an adequate fluid intake.

DESCRIPTION: Prepare the irrigation solution.
Perform irrigation.

INSTRUCTIONS: Indicate the weekly schedule and **number of times** per shift a gastric irrigation is required.

NOTE: A gastric irrigation related to a gavage is included in the actions *"Continuous/Intermittent Gavage"* (1100 and 1110).

8180 SOAKING OF LIMBS

PURPOSE:

To clean and disinfect a wound.
To prepare the integumentary system for treatment.

DESCRIPTION:

Add medication to water, if necessary.
Assist client to undress affected limb, if necessary.
Set up and assist client during treatment.
Dry area, as needed.

INSTRUCTIONS:

Indicate the weekly and daily schedules for soaking limbs.

Note *"1"* over the $\overline{w}$ if the **constant presence** of staff **is not required** during treatment.

Note *"2"* over the $\overline{w}$ if the **constant presence** of staff **is required** for the **duration** of limb soaking.

LEVEL OF ASSISTANCE:

Mode 1: Prepare and put away necessary material.
Supply medication.

Mode 2: Prepare soaking solution, assist client to undress or dress affected limb or dry limb.
Put away supplies.

Mode 3: Prepare solution, dress and undress limb.
Dry limb.
Put away supplies.

8190 SITZ BATH

PURPOSE: To relieve inflammation or pruritus.

DESCRIPTION:

Add medication to water, if necessary.
Assist client to undress, if necessary.
Set up and assist client during treatment.
Dry area, as needed.

INSTRUCTIONS:

Indicate the weekly and daily schedules of sitz bath.

Note *"1"* over the $\overline{w}$ if the **constant presence** of staff is not required during treatment.

Note *"2"* over the $\overline{w}$ if the **constant presence** of staff is required for the **duration** of the sitz bath.

LEVEL OF ASSISTANCE:

Mode 1: Prepare and put away necessary material.
Supply medication.

Mode 2: Prepare solution, assist client to undress or dress or dry himself.

Mode 3: Prepare solution, undress, dry and dress client.

8200 ICE PACK OR HOT WATER BOTTLE

PURPOSE:

To treat hyperthermia.
To minimize swelling.
To promote comfort.

DESCRIPTION:

Fill, cover and position ice pack(s) or hot water bottle(s), as necessary. Replace packs or bags, as necessary.

INSTRUCTIONS:

Indicate the weekly and daily schedules for applying or changing ice pack or hot water bottle.

Note over the $\bar{z}$ the number of bags required at each application or replacement.

LEVEL OF ASSISTANCE:

Mode 1: Supply necessary material (bag, towel).

Mode 3: Fill bag, cover and position it.

PROSTHESIS/ORTHESIS/STOCKINGS/BANDAGE

8260 HEARING AID - INSERT, ADJUST
8265 HEARING AID - REMOVE

PURPOSE: To correct a hearing deficit.

DESCRIPTION: Apply, adjust and remove hearing aid.
Clean apparatus.

INSTRUCTIONS: Indicate the weekly schedule and **number of times per shift the hearing** aid requires **adjustment** or **is applied** (8260).

Indicate the weekly schedule and **number of times per shift the hearing** aid is **removed** (8265).

Note over the $\bar{z}$ if application and removal of hearing **aid is required** for one (1) or both (2) ears.

LEVEL OF ASSISTANCE: Mode 1: Supply and put away hearing aid(s).

Mode 3: Apply, adjust, remove and clean hearing aid(s).

8270 EYE SHIELD OR OCULAR PROSTHESIS - APPLY
8275 EYE SHIELD OR OCULAR PROSTHESIS - REMOVE

PURPOSE: To contribute to a positive self-image.
To promote the healing process by resting the eye.

DESCRIPTION: Apply and remove eye shield.
Apply and remove ocular prosthesis.
Clean ocular prosthesis.
Apply, remove and clean contact lenses.

INSTRUCTIONS: Indicate the weekly and daily schedules for **application** of eye shield, ocular prosthesis or contact lenses (8270).

Indicate the weekly and daily schedules for **removal** of eye shield, ocular prosthesis or contact lenses (8275).

Note over the $\bar{z}$ if application and removal are required for one (1) or both (2) eyes.

LEVEL OF ASSISTANCE:

Mode 1: Supply and put away eye shield, ocular prosthesis or contact lenses.

Mode 3: Apply, clean and remove eye shield, ocular prosthesis or contact lenses.

8280 ELASTIC STOCKINGS - APPLY
8285 ELASTIC STOCKINGS - REMOVE

PURPOSE: To promote venous return in lower extremities.

DESCRIPTION: Apply and remove anti-embolic stocking(s).

INSTRUCTIONS: Indicate the weekly and daily schedules for **application** of anti-embolic stocking(s) (8280).

Indicate the weekly and daily schedules for **removal** of anti-embolic stocking(s) (8285).

Note over the $\bar{z}$ if application and removal are required for one (1) or both (2) legs.

LEVEL OF ASSISTANCE: Mode 1: Supply and put away stocking(s).

Mode 3: Apply stockings(s).

8290 BANDAGE - APPLY
8295 BANDAGE - REMOVE

PURPOSE:

To support or immobilize an injury.
To promote circulation.
To support a body part.

DESCRIPTION:

Apply and remove one of the following:
- splint;
- scrotal support;
- abdominal binder.

INSTRUCTIONS:

Indicate the weekly and daily schedules for **application** of bandage (8290).

Indicate the weekly and daily schedules for **removal** of bandage (8295).

Specify the type of bandage.

LEVEL OF ASSISTANCE:

Mode 1: Supply and put away bandage.

Mode 3: Apply, remove and put away bandage.

8300 ORTHOPEDIC PROSTHESIS OR ORTHESIS - APPLY
8305 ORTHOPEDIC PROSTHESIS OR ORTHESIS - REMOVE

PURPOSE: To correct or prevent the development of anatomical deformities.
To compensate for orthopedic deficiencies.

DESCRIPTION: Apply and remove an orthopedic prosthesis or orthesis, such as:
- a cervical collar;
- splints to maintain proper body alignment;
- Bobath splint;
- prosthesis.

INSTRUCTIONS: Indicate the weekly and daily schedules for **application** of prosthesis or orthesis (8300).

Indicate the weekly and daily schedules for **removal** of prosthesis or orthesis (8305).

Specify, in the space provided, the type of prosthesis or orthesis.

LEVEL OF ASSISTANCE:

Mode 1: Supply and put away prosthesis or orthesis.

Mode 2: Supply and assist client to secure prosthesis or orthesis; he applies it without assistance.
Put away prosthesis or orthesis.

Mode 3: Apply, secure, remove and put away prosthesis or orthesis.

8310 CERVICAL OR DORSO-LUMBAR MOULDED CORSET - APPLY
8315 CERVICAL OR DORSO-LUMBAR MOULDED CORSET - REMOVE

PURPOSE: To support the spine.
To prevent curvatures of the spine.

DESCRIPTION: Apply and remove corset.

INSTRUCTIONS: Indicate the weekly and daily schedules for **application** of corset (8310).

Indicate the weekly and daily schedules for **removal** of corset (8315).

8320 ADAPTED WHEELCHAIR - ASSEMBLE
8325 ADAPTED WHEELCHAIR - DISASSEMBLE

PURPOSE: To maintain an adequate and secure sitting position.

DESCRIPTION: Apply and remove material necessary for proper positioning, such as:
- head-rest;
- arm-rest;
- foot and leg rest;
- table;
- abutment.

INSTRUCTIONS: Indicate the weekly and daily schedules when the adapted wheelchair is **assembled** (8320).

Indicate the weekly and daily schedules when the adapted wheelchair is **disassembled** (8325).

Specify, in the available space, material necessary for proper positioning.

WOUND

8390 REMOVAL OF SUTURES OR CLIPS

PURPOSE: To promote the healing process.

DESCRIPTION: Disinfect the site, if necessary.
Remove sutures or clips.

INSTRUCTIONS: Indicate the weekly and daily schedules of removal of clips or sutures.

8400 REMOVAL OF DRESSING OR PACKING

PURPOSE: To promote the healing process.

DESCRIPTION: Remove packing or dressing **without** replacing it.
Clean wound.

INSTRUCTIONS: Indicate the weekly and daily schedules of removal of dressing or packing.

8410 INSERTION OF CATHETER IN A WOUND

PURPOSE: To facilitate drainage.

DESCRIPTION: Disinfect the site.
Insert and secure catheter.

INSTRUCTIONS: Indicate the weekly and daily schedules of catheter insertion.

8420 WOUND IRRIGATION

PURPOSE: To clean and disinfect a wound.

DESCRIPTION:
Prepare irrigation solution.
Perform irrigation.

INSTRUCTIONS:
Indicate the weekly and daily schedules of wound irrigation.

Specify the site of the wound.

8430 CLEANING AND DISINFECTING A WOUND EXPOSED TO AIR

PURPOSE: To promote the healing process of a wound exposed to air.

DESCRIPTION:
Clean and disinfect wound.
Remove discharge, if necessary.
Apply ointment, powder or other solutions.

INSTRUCTIONS:
Indicate the weekly and daily schedules for cleaning and disinfecting wound.

Specify the site of the wound.

LEVEL OF ASSISTANCE:
Mode 1: Supply the necessary material; the client performs the wound care.

Mode 3: Perform wound care.

NOTE:
Choose this action for wounds **without** a dressing. Ointment application is included in the action.

8440 SCROTAL OR VULVAR DISINFECTION

PURPOSE: To promote the healing process.

DESCRIPTION: Clean and disinfect the vulvar, scrotal or perineal area.
Dry the region with sterile gauzes.
Apply ointment, powder or other solutions.

INSTRUCTIONS: Indicate the weekly and daily schedules for vulvar, scrotal or perineal disinfection.

8450 THERAPEUTIC LAMP

PURPOSE: To promote the healing process.

DESCRIPTION: Apply therapeutic lamp.
or
Apply dryer.

INSTRUCTIONS: Indicate the weekly and daily schedules for using a therapeutic lamp or dryer.

DRESSING

8480 DRY OR MOIST NON ASEPTIC DRESSING

PURPOSE: To protect skin surface or an injection site.

DESCRIPTION:

Remove soiled dressing, if necessary.
Clean the site, if necessary.
Apply dry or moist compresses to body surface.
Example: op-site over **redness** or an injection site;
moist compresses over an inflamed region.
or
Apply Nitrol ointment.

INSTRUCTIONS:

Indicate the weekly and daily schedules for application of a non-aseptic dressing.

Specify, in the available space, the type of dressing.

LEVEL OF ASSISTANCE:

Mode 1: Prepare and supply the material necessary for dressing.

Mode 3: Apply dressing.

NOTE:

The application of ointment is included in the action.

8490 ASEPTIC DRESSING

PURPOSE: To promote the healing process.

DESCRIPTION:
Remove soiled dressing, if necessary.
Wear gloves, if necessary.
Clean and disinfect wound.
Apply ointment, powder or other solution, if necessary.
Apply and secure dressing.
Example: op-site over a wound
dressing for a second degree decubitus ulcer with discharge.

INSTRUCTIONS: Indicate the weekly and daily schedules of application of aseptic dressing.

Specify, in the available space, the type of dressing.

NOTE: The application of ointment is included in the action.

8500 ASEPTIC DRESSING - REINFORCE

PURPOSE: To absorb excess discharge.
To promote the healing process.

DESCRIPTION: Apply and secure additional compresses over existing dressing.

INSTRUCTIONS: Indicate the weekly and daily schedules for reinforcing dressing.

Specify the site of the dressing.

8510 DRESSING OF WOUND WITH DISCHARGE

PURPOSE:

To promote skin regeneration.
To remove drainage.
To prevent further wound breakdown.

DESCRIPTION:

Remove dressing or packing.
Wear gloves.
Mobilize drain or remove packing, if necessary.
Empty collection bag, if necessary.
Clean and disinfect wound.
Apply ointment, solution or powder.
Pack wound.
Apply and secure dressing.
Secure drain, if necessary.

INSTRUCTIONS:

Indicate the weekly and daily schedules of dressing application.

Specify, in the space provided, the type of dressing.

Note over the $\bar{z}$ the number of drains inserted into the wound.

NOTE:

Includes dressings for wounds with **large amounts** of discharge without drains or packing.

DRESSING FOR SKIN REGENERATION

8520 WITH BENOXYL
8530 WITH DEBRISAN
8540 WITH STOMAHESIVE
8550 WITH MOIST COTTON BALLS
8560 WITH DUODERM GRANULES

PURPOSE:

To promote skin regeneration.
To prevent the development of infections in burned areas.

DESCRIPTION:

Remove soiled dressing.
Wear gloves.
Clean and disinfect wound.
Apply ointment, powder, paste or other solutions.
Cut and apply medicated compresses.
Apply dressing.
Secure dressing.

INSTRUCTIONS:

Indicate the weekly and daily schedules for application of dressing for skin regeneration.

Specify the site of the wound.

Note over the $\bar{x}$ the number corresponding to the wound surface.

NOTE:

These dressing techniques are generally used to treat third degree decubitus ulcers with muscular and/or skeletal impairment.

8570 DEBRIDEMENT OF WOUND WITH FORCEPS AND SCISSORS

PURPOSE: To remove the accumulation of dead tissue.
To promote the healing process.

DESCRIPTION: Debride the wound using forceps (tweezers) and scissors.

INSTRUCTIONS: Indicate the weekly and daily schedules for wound debridement.

Note over the $\bar{x}$ the number corresponding to the wound surface requiring debridement.

Specify, in the space provided, the area to debride.

8580 APPLICATION OF OINTMENT WITHOUT DRESSING
8590 APPLICATION OF OINTMENT WITH DRESSING

PURPOSE: To provide relief to clients with **dermatological conditions.**

DESCRIPTION: Apply ointment to affected area.
Wrap affected area, if necessary.

INSTRUCTIONS: Indicate the weekly and daily schedules for ointment application without dressing (8580).

Indicate the weekly and daily schedules for ointment application with wrapping (8590).

Note over the $\bar{z}$ the total percentage (%) of body surface requiring an ointment applied by a **member of nursing personnel.**

LEVEL OF ASSISTANCE: Mode 1: Supply ointment, client can apply it himself.

Mode 3: Apply ointment, wrap affected area, if necessary.

NOTE: Specify the **type** of ointment (name), the **site** and **schedule** of application.

If many types of ointment are applied to different body surfaces at the same hour, calculate the total percentage (%) of body surface for each hour, thus including all ointments.

The application of cream or moisturizing lotion while performing personal care is not considered here.

EXAMPLE: 1. Hydrocortisone applied to left arm at 10:00 hrs and 20:00 hrs.
Propaderm applied to groin area at 10:00 hrs.
Z= % of total body surface
Specify:

10/z	Hydrocort-left arm 10-20	1	(3)	(M T W T F s S)	10:00
9/z	Propaderm-groins 10	1	(3)	(M T W T F s S)	20:00
-/z		1	3	M T W T F s S	

The 10% at 10:00 hrs corresponds to the ointment applied to left arm (9%) and groins (1%).

The 9% at 20:00 hrs represents the ointment applied to the arm (9%).

2. Anusol on hemorrhoids at 10:00 and 20:00
Canestin under breasts at 10:00
Celestoderm to knees (2) at 10:00, 14:00 and 20:00
Z= % of total body surface
Specify:

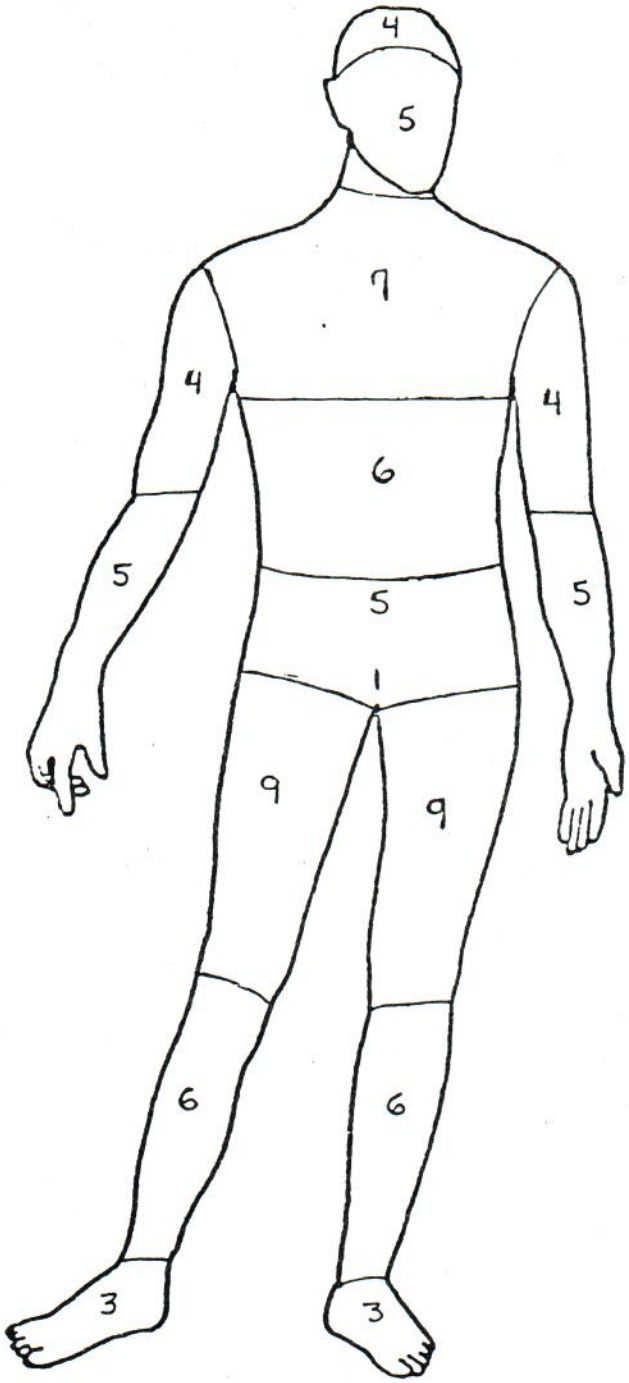
4/z	Anusol to hemorr. 10-20	1	(3)	(M T W T F s S)	10:00
2/z	Canestin under brsts 10	1	(3)	(M T W T F s S)	14:00
3/z	Celest. knees (2) 10-14-20	1	(3)	(M T W T F s S)	20:00

The 4% at 10:00 corresponds to ointment applied to hemorrhoids (1%), under the breasts (1%) and both knees (2%).

The 2% at 14:00 corresponds to the ointment applied to both knees (2%).

The 3% at 20:00 corresponds to the ointment applied to hemorrhoids (1%) and both knees (2%).

HOW TO CALCULATE PERCENTAGE OF BODY SURFACE



Consider the following surfaces **as equal to**:

- axilla :	1%
- buttocks :	5%
- coccyx :	1%
- elbows :	1%
- face :	5%
- groins :	1%
- hemorrhoids :	1%
- hip :	2%
- knee (1) :	1%
- nostrils :	1%
- scalp :	4%
- under the breasts :	1%

8630 PRECAUTIONARY TECHNIQUES: BARRIER

PURPOSE:

To prevent the development of infections.
To protect staff members during a potentially hazardous situation.

DESCRIPTION:

Scrub hands prior and following treatment.
Wear one or more of the following (sterile or non sterile):
- gown;
- mask;
- gloves;

during specific care activities.
Dispose of contaminated material in the appropriate receptacle, as necessary.

INSTRUCTIONS:

Indicate the weekly schedule and **number of times** per shift that precautionary techniques are required.

Specify **which** care activities require precautions and specify the **reason**.

8640 PRECAUTIONARY TECHNIQUES: EXTENDED

PURPOSE:

To prevent the development of infections.
To protect staff members during a potentially hazardous situation.

DESCRIPTION:

Scrub hands prior and following treatment.
Wear one or more of the following (sterile or non sterile):
- gown;
- mask;
- gloves;

for all care delivered to the client.
Dispose of contaminated material in the appropriate receptacle, as necessary.

INSTRUCTIONS:

On line *"B"* note the day and time the extended technique **begins.** If it is **already in place**, circle the letter corresponding to the **first day of observation** and mark the time 00:00.

On line *"E"* note the day and time the extended technique **ends.** If it **remains in place** on the **seventh day of observation**, circle the letter corresponding to the last day of observation and mark the time 23:59.

Specify, in the space provided, the **reason** for using extended precautionary techniques.

DIAGNOSTIC PROCEDURES

OBSERVATION

9010 BIO-PSYCHO-SOCIAL **(at intervals)**

PURPOSE: To assess client's physical, psychological or social status.
To prevent accidents or incidents.

DESCRIPTION: Examine, supervise or evaluate one or more of the following clinical parameters:

- physical status (pain, sleeplessness, edema of a limb, wound discharge, others);
- risk of falls;
- client's interrelationships (aggressiveness, isolation, others);
- behaviour (agitation, wandering, running away, others);
- risk of burns.

INSTRUCTIONS: Indicate the weekly schedule and **number of times** per shift an observation is required. Observations are performed **above and beyond** other interventions.

Specify the reason of the observation.

NOTE: An observation performed during a nursing action **(simultaneously)** - for example, observing discharge while changing the dressing - is not counted when adding up the number of observations; this type of observation is included in the action *"dressing"*.

9020 BIO-PSYCHO-SOCIAL **(constant)**

PURPOSE: To assess client's physical, psychological or social status.
To prevent accidents or incidents.

DESCRIPTION: Continuous, **uninterrupted** observation of the client.

INSTRUCTIONS: Indicate the weekly schedule when **constant observation** is required by the client(s).

Note, in the appropriate boxes, the following information:

Number of staff required (nursing): this indicates the number of nursing staff required to observe the client(s) for the observation period.

Duration: this indicates the time (in minutes) spent by nursing staff continuously observing the client(s).

Number of clients: this indicates the number of clients requiring constant observation over the stated period of time.

Beginning time: this indicates the time at which constant observation begins.

NOTE: A constant observation **is not**:

- a constant presence during a nursing care activity such as a bath, meals or others. This observation is included if mode 3 or the "constant presence" is selected.

- to be present for a recreational or therapeutic activity. This observation is included in the action "recreational or therapeutic activities".

A constant observation **is**:

- a **constant presence** for a **client** for a period of one to 24 hours a day. This observation, often called **private duty** or **constant care**, is required in view of the client's **physical** or **psychological status.**

- providing a **constant presence** for a **group of clients** for a period of one to several hours generally. This observation is usually required because of the group's **psychological status**.

Within the period of observation the care-giver may have to answer other of the client's needs such as nutrition, elimination, and others. These actions are registered in the form, in addition to the constant observation.

VITAL SIGNS

9030 ORAL TEMPERATURE
9040 RECTAL TEMPERATURE
9050 AXILLARY TEMPERATURE

PURPOSE: To obtain indicators of body temperature.

DESCRIPTION: Take temperature:
- orally;
- rectally;
- axillary.

INSTRUCTIONS: Indicate the weekly and daily schedules for temperature reading(s).

LEVEL OF ASSISTANCE: Mode 1: Give thermometer, read result.

Mode 3: Give or insert thermometer in appropriate route, remain near client and read results.

9060 RESPIRATION

PURPOSE: To obtain indicators of respiratory status.

DESCRIPTION: Calculate rate of respiration.
Assess type and quality of breathing.

INSTRUCTIONS: Note the weekly and daily schedules of evaluation of respiratory status.

9070 PULSE

PURPOSE: To obtain indicators of the cardio-vascular system.

DESCRIPTION: Take pulse.

INSTRUCTIONS: Indicate the weekly and daily schedules for taking pulse.

STANDARD: Take pulse before administering the following medications:
- Digoxin, Inderal, Corgard, Lopressor.

LEVEL OF ASSISTANCE: Mode 1: Note the pulse that has been taken by client.

Mode 3: Take pulse.

9080 BLOOD PRESSURE

PURPOSE: To obtain indicators of the cardio-vascular system.

DESCRIPTION: Take client's blood pressure when either:
- standing;
- sitting;
- lying.

INSTRUCTIONS: Indicate the weekly and daily schedules for taking blood pressure. The blood pressure may be evaluated consecutively for one or more limbs and in different positions.

Note over the $\bar{x}$ the number of limbs per position for which blood pressure was evaluated **consecutively**.

Note over the $\bar{z}$ the number of positions for which the blood pressure was measured **consecutively.**

9090 NEUROLOGICAL SIGNS

PURPOSE: To identify and assess the capability and function of the neurological system.

DESCRIPTION: Check pupil response and size.
Assess level of consciousness.
Evaluate motor, sensory and reflex functions.

INSTRUCTIONS: Indicate the weekly and daily schedules for the evaluation of neurological signs.

9100 VASCULAR SIGNS

PURPOSE: To evaluate the circulatory status of the extremities.

DESCRIPTION: Assess pulses of the limbs.
Check colour and warmth of the extremities.
Check numbness and mobility of the extremities.
Check for swelling.

INSTRUCTIONS: Indicate the weekly and daily schedules for evaluating vascular signs.

MONITOR INTAKE

9210 P.O.
9220 BY TUBE
9230 BY I.V.

PURPOSE: To assess fluid balance.

DESCRIPTION: Measure liquid intake:
- by mouth;
- by tube (gastric or others);
- by I.V. (perfusion).

Record quantities in chart.

INSTRUCTIONS: Indicate the weekly and daily schedules prescribed to monitor intake.

Indicate over the $\bar{z}$, the number of tubes (9220) and the number of perfusions (9230) to measure.

LEVEL OF ASSISTANCE: Mode 1: Record quantities in chart.
The client measures liquids ingested.

Mode 3: Measure and record in chart.

MONITOR OUTPUT

9240 NATURALLY
9250 BY TUBES OR BOTTLES

PURPOSE: To assess fluid balance.

DESCRIPTION: Measure body fluids or solid material excreted:
- naturally;
- by tube (urinary catheter, others).
Record quantity in chart.

INSTRUCTIONS: Indicate the weekly and daily schedules prescribed to monitor output.

Note over the $\bar{z}$, the number of tubes to assess (9250).

LEVEL OF ASSISTANCE: Mode 1: Record quantities in chart.
The client measures liquids excreted.

Mode 3: Measure and record in chart.

WEIGHT/MEASUREMENT

9260 WEIGHT

PURPOSE: To monitor weight gains or losses.

DESCRIPTION:
Adjust scale.
Assist client to undress and dress, if necessary.
Move tubes or other equipment.
Position client on an ordinary or metabolic scale.
Weigh client.
Reposition client.

INSTRUCTIONS: Indicate the weekly and daily schedules to weigh client.

Note over the $\bar{z}$ the number of staff required to weigh client.

LEVEL OF ASSISTANCE:
Mode 2: Adjust scale, weigh client. He does not need help to undress, dress or step on scale.

Mode 3: Adjust scale, position client on scale, weight client.

9270 MEASUREMENT

PURPOSE: To assess fluid retention.

DESCRIPTION:
Assist client to undress and dress, if necessary.
Measure one or more body parts.

INSTRUCTIONS: Indicate the weekly and daily schedules for measurement.

Note over the $\bar{z}$ the number of staff required for measurement.

COLLECTION OF 24 HOURS

9280 SPUTUM

PURPOSE: To collect sputum samples in order to determine biochemistry, microbiology, hematology or other elements.

DESCRIPTION: Label container(s).
Obtain and store specimens for the period of 24 hours.

INSTRUCTIONS: On line *"B"* indicate the day and time the collection **begins**. If it is **already in progress**, circle the letter corresponding to the **first day of observation** and mark the time 00:00.

On line *"E"* indicate the day and time the collection **ends**. If it **remains in progress** on the **seventh day of observation,** circle the letter corresponding to the last day of observation and mark the time 23:59.

LEVEL OF ASSISTANCE: Mode 1: Label and supply container.

Mode 3: Label container, collect specimens.

9290 URINE

PURPOSE: To collect urine samples in order to determine biochemistry, microbiology, hematology or other elements.

DESCRIPTION:

Label container(s).
Collect urine for a 24 hour period.
Store specimen.

INSTRUCTIONS:

On line *"B"* indicate the day and time the collection **begins**. If it is **already in progress**, circle the letter corresponding to the **first day of observation** and mark the time 00:00.

On line *"E"* indicate the day and time the collection **ends**. If it **remains in progress** on the **seventh day of observation,** circle the letter corresponding to the last day of observation and mark the time 23:59.

Note over the $\bar{x}$ the number corresponding to the method used for collection.

LEVEL OF ASSISTANCE:

Mode 1: Label and supply container.

Mode 3: Label container, collect specimens.

9300 **URINE FILTERING**

PURPOSE: To search for calculi in urine.

DESCRIPTION: Strain client's urine.

INSTRUCTIONS: Indicate the weekly schedule and **number of times** per shift the urine is strained.

SPECIMEN, SIMPLE ANALYSIS

9310 SECRETION SPECIMEN (ENT, WOUND, TRACHEOSTOMY)

PURPOSE: To collect a specimen in order to determine biochemistry, microbiology, hematology and other elements.

DESCRIPTION: Label container.
Collect sample from mouth, nostrils, ears, eyes, tracheostomy or wound.

INSTRUCTIONS: Indicate the weekly and daily schedules of specimen collection.

9320 STOOL SPECIMEN

PURPOSE: To collect a specimen in order to determine biochemistry, microbiology, hematology and other elements.

DESCRIPTION: Label container.
Collect stool sample.

INSTRUCTIONS: Indicate the weekly and daily schedules of specimen collection.

LEVEL OF ASSISTANCE: Mode 1: Label and supply container.

Mode 3: Label container and collect sample.

9350 URINE SPECIMEN (ANALYSIS)

PURPOSE: To obtain a urine sample for simple analysis.

DESCRIPTION:
Label container.
Clean perineal area.
Collect urine specimen.

INSTRUCTIONS: Indicate the weekly and daily schedules of specimen collection.

LEVEL OF ASSISTANCE:
Mode 1: Supply and label container.

Mode 2: Supply and label container, assist client to clean perineal area.

Mode 3: Label container, clean perineal area and collect specimen.

9360 URINE SPECIMEN (CULTURE)

PURPOSE: To obtain a sterile urine sample in order to determine biochemistry or bacteriology.

DESCRIPTION:
Label container.
Clean and disinfect perineal area or urinary catheter.
Collect urine aseptically.

INSTRUCTIONS: Indicate the weekly and daily schedules of specimen collection.

Note over the $\bar{x}$ if specimen is collected **with** or **without a catheter**.

LEVEL OF ASSISTANCE:
Mode 1: Label container, supply material for disinfection, explain procedure to client.

Mode 2: Label container, explain procedure, assist client to disinfect perineal area.

Mode 3: Label container, disinfect, collect sample.

9380 BLOOD SAMPLE

PURPOSE: To collect a blood sample in order to determine biochemistry, hematology or other elements.

DESCRIPTION: Disinfect site.
Perform puncture.

INSTRUCTIONS: Indicate the weekly and daily schedules for blood test.

Specify the type of exam requested.

SIMPLE UNIT TEST

9390 CLINITEST - ACETEST

PURPOSE: To analyze specimens and obtain results on the unit.

DESCRIPTION: Perform analysis, on the unit, on specimens, such as:
- urine;
- stool;
- secretions;
- blood.

Example: Sugar and Ketones;
Dextrostix;
Gastric PH.

INSTRUCTIONS: Indicate the weekly and daily schedules for testing done on the unit.

If it is a test other than "Clinitest-Acetest", specify, in the space available, "Others", the type of test.

LEVEL OF ASSISTANCE: Mode 1: Supply necessary material; the client performs the test. Note results.

Mode 3: Perform test.

9400 GLUCOMETER

PURPOSE: To evaluate blood glucose levels.

DESCRIPTION: Obtain blood specimen by micro-method (finger-prick).
Read results from glucometer.

INSTRUCTIONS: Indicate the weekly and daily schedules of glucometer readings.

LEVEL OF ASSISTANCE:

Mode 1: Supply necessary material, client performs puncture (finger prick) and test, record result.

Mode 3: Perform puncture and test.

9430 ASSISTANCE FOR EXAMINATIONS

PURPOSE:

To observe the client during an examination.
Assist physician or technician.

DESCRIPTION:

Prepare room for examination.
Prepare and position client.
Assist for part or all of the exam, such as:
- physical examination;
- gynecological examination;
- X-Ray;
- E.C.G.;
- E.E.G.

or
Execute the examination (E.C.G., gynecological exam, ...)

INSTRUCTIONS:

Indicate the weekly and daily schedules for an examination requiring the assistance of the nursing staff or executed by the nursing staff.

Specify in the space available, the type of exam.

Note *"1"* over the $\overline{w}$ if a **constant presence is not required** during an exam.

Note *"2"* over the $\overline{w}$ if a **constant presence is required** for the **duration** of the exam.

LEVEL OF ASSISTANCE:

Mode 2: Assist physician or technician.

Mode 3: Perform exam.

NOTE:

The exams performed outside of the institution are not considered here.

9440 ASSISTANCE DURING A MEDICAL INTERVENTION

PURPOSE: To assist the physician during a medical procedure.

DESCRIPTION:

Prepare room and set-up.
Prepare and position client.
Assist the physician for part or all of the intervention, such as:
- thoracentesis;
- lumbar puncture;
- paracentesis;
- venous dissection;
- insertion of a central line catheter.

INSTRUCTIONS:

Indicate the weekly and daily schedules for an intervention requiring the assistance of nursing personnel.

Specify, in the space available, the type of intervention.

Note *"1"* over the $\overline{w}$ if a **constant presence is not required.**

Note *"2"* over the $\overline{w}$ if a **constant presence is required** for the **duration** of the intervention.

NOTE:

The medical interventions performed outside the institution are not considered here.

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