Bedridden Resident Care

4 CEU's for ARF's and RCFE's

Course Objectives

1. Define “bedridden”
2. Discuss how to deliver proper care to residents who are bedridden
    1. Repositioning
    2. Proper transferring techniques
    3. Personal hygiene and toileting
    4. Making the bed
    5. Bathing
    6. Oral care
    7. Grooming
    8. Assisting with emotional and social needs

Course Objectives

3. Discuss dangers and complications for bedridden residents
   - Ulcers
   - Blood clots
   - Pneumonia
   - Depression
   - Nutrition
4. Learn about equipment and devices that can be utilized
   - Hoyer Lifts and other devices

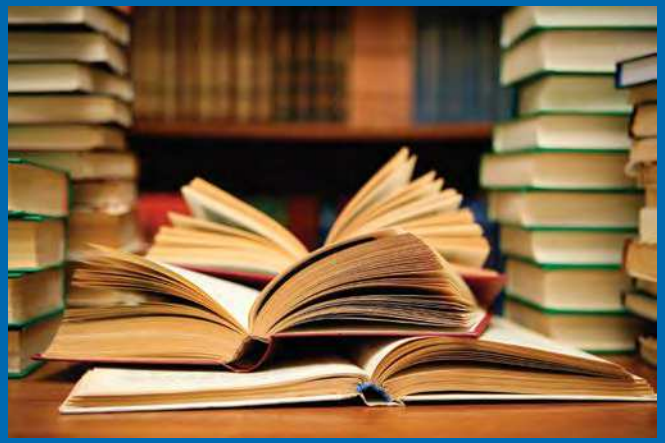
Course Objectives

5. Emergency evacuations
   - How to properly evacuate a bedridden resident
     - Types of methods, like the 2 person carry
6. Utilizing outside services
   - Home Health
   - Hospice
   - Limitations

Sources

Many sources were consulted to prepare this course.

At the end of the course, these sources are listed.



Definitions

“DSS” =	Department of Social Services
“RCFE” =	Residential Care Facility for the Elderly
“ARF” =	Adult Residential Facility
“SNF” =	Skilled Nursing Facility
“LPA” =	Licensing Program Analyst
“AB” =	Assembly Bill
“SB” =	Senate Bill

Being Bedridden

Imagine this – a WHOLE day to spend in bed, watching all of those shows you DVR'd, catching up on the latest magazines, having someone deliver your coffee to you!

Being Bedridden

Day 4: You've watched an entire season of Law & Order. Your back hurts from lying in bed. Your spouse says you are grouchy and doesn't want to bring you coffee in bed anymore.

Day 7: You are done. This is so boring!

Now – can you imagine 10 months of this? Can you imagine *NOT* being able to get up and get out of the bed? This is how a bedridden person feels.

Being Bedridden

Nursingtimes.net about “bedrest”:

The human body has evolved to function optimally in the upright position for around 16 hours a day. The average adult will sleep 8-9 hours a day, usually in a supine position. Consistently sleeping for more than 9 hours or fewer than 8 hours a day has a negative impact on physiological, psychological and cognitive functions.

Being Bedridden

What would cause a person to be bedridden?

- Illness, such as fibromyalgia or cancer
- Injury, such as a broken hip
- Advanced age and immobility
- Paralysis
- Developmental or mental disability

Being Bedridden

A bedridden state could be temporary or permanent.

Temporary = possible candidate for an RCFE or ARF

Permanent = most likely would need to reside in a long-term care facility, like skilled nursing.

Bedridden Definitions

Adult Residential Facilities:

Health & Safety Codes 1566.45: "bedridden" means requiring assistance in turning and repositioning in bed or being unable to independently transfer to and from bed, except in a facility with appropriate and sufficient care staff, mechanical devices, if necessary, and safety precautions, as determined by the director in regulations."

ARF's are only allowed to retain residents that are bedridden if they are on hospice. Note: Per the Evaluator's Manual, "A client whose condition persists for fourteen days or less is not considered to be bedridden, pursuant to Health and Safety Code Section 1566.45(a)(3)."

Bedridden Definitions

A bedridden person may be admitted to, and remain in, a residential facility that secures and maintains an appropriate fire clearance. A fire clearance shall be issued to a facility in which one or more bedridden persons reside if either of the following conditions are met:

1. The fire safety requirements are met. Clients who are unable to independently transfer to and from bed, but who do not need assistance to turn or reposition in bed, shall be considered non-ambulatory for purposes of this paragraph.
2. Alternative methods of protection are approved.

Bedridden Definitions

Residential Care Facilities for the Elderly:

According to Health & Safety Code 1569.72, "bedridden means requiring assistance in turning and repositioning in bed or being unable to independently transfer to and from bed.

Residents who are unable to independently transfer to and from bed, but who do not need assistance to turn or reposition in bed, shall be considered non-ambulatory."

Bedridden Definitions

Bedridden is defined in in the H&S Codes - (b) (1). However, for purposes of fire and life safety, and provided fire safety requirements are met, individuals who can turn and reposition in bed, but are unable to independently transfer are considered non-ambulatory.

Bedridden Definitions

Temporary bedridden status may result from surgery, strokes, fractures, sprains and other traumas; acute episodes of chronic conditions, such as lower back pain or a flare-up of rheumatoid arthritis; and other conditions that temporarily make the person unable to independently turn and reposition in bed.

Notifying the Fire Department

- Per DSS regulations, if the resident will be bedridden for 14 days or less, the licensee is not required to obtain and maintain a fire clearance.
- The licensee must notify the local fire authority, as required by Health and Safety Code sections 1569.72 (f) and 1569.73 (h), within **48** hours of admitting or retaining a resident who is bedridden, regardless of the length of time the resident will be bedridden.
- These requirements apply even if a resident is on hospice.

Bedridden Definitions

Temporary bedridden status may be extended up to 60 days provided the physician indicates that the individual may improve or recover.

A resident bedridden in excess of 60 days is considered bedridden, and the licensee must meet the additional requirements necessary to secure an exception, including a fire clearance from the local fire authority.

Bedridden Definitions

"Repositioning" means that when a resident is lying in bed, he/she is able to change position in the bed, to cross or uncross the legs, to curl up or stretch (fully extend) the limbs and body, to shift, wiggle or push the body up and down in the bed.

Bedridden Definitions

A bedridden resident may be retained in an RCFE in excess of 14 days if all of the following requirements are satisfied:

1. The facility notifies DSS in writing regarding the temporary illness or recovery from surgery.

2. The facility submits to DSS, with the notification, a physician and surgeon's written statement to the effect that the resident's illness or recovery is of a temporary nature. The statement shall contain an estimated date upon which the illness or recovery will end or upon which the resident will no longer be confined to a bed.

Bedridden Definitions

A bedridden resident may be retained in an RCFE in excess of 14 days if all of the following requirements are satisfied (cont'd):

3. DSS determines that the health and safety of the resident is adequately protected in that facility and that transfer to a higher level of care is not necessary.

4. This section does not expand the scope of care and supervision of a residential care facility for the elderly.

Bedridden Definitions

How do Administrators know what they can do and when they have crossed in to a nursing scope of practice? If the answer is “yes” to any of the below, then they have crossed into nursing:

1. Has the resident developed a prohibited health condition?
2. Does the resident need more than our regulations state we can provide?
3. Does this resident have a skilled nursing need?

Bedridden Residents

OK, so now you have a bedridden resident.

How do you care for them properly?

Repositioning and Transferring

It is extremely important for your resident to be repositioned often. Why?

1. Prevent decubitus ulcers
2. Prevent pneumonia
3. Comfort – reduce pain
4. Prevent blood clots

Repositioning and Transferring

Bedridden residents may range from being independent, or needing just minimal help to reposition, to totally dependent.

Those who are totally dependent cannot move out of bed without help so staff must be trained properly to assist them.

Let's discuss transferring first.

Repositioning and Transferring

Why is it so important to do bed transfers correctly? Per Drugs.com:

1. You can hurt a bedridden resident when a transfer is not done properly. Transfers not done properly can tear, shear or bruise skin. Worse, the person's bones may fracture or dislocate.

Repositioning and Transferring

Why is it so important to do bed transfers correctly (cont'd)?

2. You can injure yourself when a bed transfer is not done properly. If the resident resists or become unsteady, you may end up hurting your back, spine, shoulders or other body areas.

Repositioning and Transferring

Preparing for a transfer from a bed to a wheelchair:

1. Assess the resident. Can the person help with the bed transfer? Assess their arm and leg strength. Can they sit or stand up? Can they follow directions? Do they have any wounds or other issues?
2. Make sure the floor around the bed is free of clutter, such as throw rugs.

Repositioning and Transferring

3. Work with another caregiver, if necessary.
4. Use correct form. Do not stretch your back or turn at your waist during the transfer. Your body should be in a straight line, with a straight back and bent knees.
5. If the resident you are moving grabs you by the neck or shoulders, this could cause a back or neck injury.
6. Gait belts can be used by only if you have received proper training on their use.

Repositioning and Transferring

Here is an eHow video that demonstrates proper transfer techniques:

https://www.youtube.com/watch?v=4BUlu0TNs_8

Repositioning and Transferring

Repositioning residents:

According to HeadtoToeCare.com, here are the steps to follow:

1. Turning and repositioning of a bedbound person should occur every 2-3 hours.
2. Discuss the process with the resident before and during the process.
3. Remove all pillows. If a hospital bed is in use, return the bed to a flat position and lower the sidebar closest to you.

Repositioning and Transferring

Repositioning residents (cont'd):

Here is a short video that shows step by step how to reposition a resident:

https://www.youtube.com/watch?v=esUDO_IZj2I

Personal Hygiene - Bathing

Can you imagine lying in bed for days and days with no shower? Yuck.

- If a resident is completely bedridden and require baths in bed, try to give them a sponge bath *at least* three times a week so that they will feel clean and comfortable.
- A Home Health or Hospice nurse is a great resource to train your staff – just ask them!

Personal Hygiene - Bathing

Wikihow.com gives you step by step instructions on how to give a sponge bath:

1. Fill two basins or washtubs with warm water. One is used for washing, and the other for rinsing. The water temperature should be 115 degrees F (46 degrees C) or less. You want it to be comfortable to the touch, but not too hot.

Personal Hygiene - Bathing

2. Choose soap that is easy to rinse away. Most bar soaps are fine to use; body washes are also acceptable as long as they do not leave a residue. You may add soap to one of the basins to create a bowl of warm, soapy water for washing, or keep the soap separate and apply it directly to the patient's skin.
    a. Avoid using soap that has exfoliating beads or other substances that could end up staying on the resident's skin and causing irritation.
    b. No-rinse soap is a convenient solution for a quicker cleanse, but they leave a residue so you will still need to rinse the resident's body from time to time.

Personal Hygiene - Bathing

3. If you plan to shampoo the resident's hair, you'll need shampoo that's easy to rinse out (such as baby shampoo) and a special basin designed for washing hair in bed. You can find one at a medical supply store, and it's a big help when it comes to washing hair in bed without getting water everywhere. (If you don't have a special basin, you can make do by placing an extra towel or two under the resident's head to protect the bed from getting too wet.)
4. Have a stack of clean towels and washcloths ready. 3 of each is a good number.

Personal Hygiene - Bathing

5. Place two towels under the resident. This will prevent the bed from getting wet and keep the resident comfortable during the process. To place the towels under the patient, lift the resident onto their side and scoot the towel under, then carefully lower the resident and do the same on the other side.
6. Cover the resident with a clean sheet or towel. This will ensure the resident stays warm during the bath as well as providing some privacy. The sheet or towel will stay on the resident's body the whole time.

Personal Hygiene - Bathing

7. Remove the resident's clothes and cover them with the towel or sheet.
8. Use the same cleansing and rinsing method for the whole body. First apply soap or soapy water to the resident's skin. Scrub it gently with a washcloth to remove dirt and bacteria, then place the washcloth in the soapy basin. Dip a second washcloth into the rinsing basin and use it to rinse away the soap. Pat the area dry with a towel. If the cloths become soiled, switch to clean ones.

Personal Hygiene - Bathing

9. Replace the water in the basins as necessary.
10. When washing the resident's hair, gently lift their head into the shampooing basin. Wet the hair by pouring water over the resident's head, taking care not to get it in their eyes. Apply shampoo, then rinse it away. Pat the hair dry with a towel.
11. Make sure the genital and anal areas are washed and dried thoroughly.

Personal Hygiene - Bathing

12. When you are finished and the resident is thoroughly dry, dress the resident in clean clothes or a robe.
13. Elderly skin tends to get dry, so you may want to apply lotion to the arms and legs before putting their clothes back on.
14. Remove all of the personal hygiene items, such as shampoo, from the room, if required.

Personal Hygiene – Oral Care

Dental care:

- Make sure the resident brushes their teeth at least twice a day.
  - If the resident is not able to brush their teeth themselves, then you must do it for them.
- Clean their dentures daily, if applicable.

Personal Hygiene – Other

- Shaving – wear gloves when shaving a resident.
- If the resident wants to wear make up, assist them in applying it or apply it for them.
- Comb or brush the resident's hair daily.
- File the resident's nails on a regular basis.

Toileting

You may have choices when it comes to toileting the resident, depending on their abilities.

The best scenario is that you assist them to the bathroom to use the toilet. If they are unable to do so, bedpans and/or incontinence supplies (such as Depends) can be used.

Toileting

If the resident is unable to get to the bathroom, briefs may be used.

Here is a short video that shows how to change a resident's brief while lying in bed:

https://www.youtube.com/watch?v=NMlw5dBk9LE

Toileting

After the resident goes to the bathroom, make sure that they are cleaned properly and dry before a new product is put on.

Remove the soiled product from the room immediately and discard in a sealed bag in a covered garbage can.

Toileting

How often are you going to check on and/or change a resident's briefs?

At least every 2 hours, or more often, if necessary. Do not let them lay in a wet or soiled brief – this will cause skin breakdown or a urinary tract infection.

Linens and Bedding

As the resident spends almost all his/her time in bed, the sheets get dirty due to food particles, hair and skin flakes - change the linens regularly*, including pillow covers. Ask your home health or hospice nurse to demonstrate how to change a bed properly with a resident in it.

*How often is “regular”? This might be daily or once a week, depending on the needs of the resident.

Linens and Bedding

Protect the bed with a waterproof covering and a cotton pad for the resident's comfort.

Be sure to allow toe space when tucking in the top sheet and blanket; this could cause ulcers to form on the tops of the feet.

Covers should be warm and light-weight.

Linens and Bedding

Here is a short video that shows how to change a bed properly:

https://www.youtube.com/watch?v=zZ4zoIfUgc4

Eating

If the resident is able to join the other residents in the dining room, this is preferred, but many residents cannot leave their bed to do this.

If your resident is bedbound:

1. Try smaller, more frequent meals, and if prescribed by the physician, a dietary supplement high in protein.

Eating

2. Keep the resident well hydrated to reduce the risk of constipation.
3. Serve foods that are easier to consume in a semi-lying position.
4. Never leave a resident alone while they eat – they may choke and not be able to notify you.
5. Order a tray table that slides over bed so the food is easily accessible to the resident.

Eating

6. Notify the physician immediately if the resident experiences rapid weight loss or if the resident consistently refuses to eat any food, or is not able to swallow.
7. Find out what types of food the resident loves and serve them!

Activities

Leaving the television on all day for a resident is NOT an appropriate activity. Just because the resident is in their room and unable to participate in group activities does NOT mean that you ignore them.

You must engage the resident in daily activities.

Activities

Good activities:

1. Spend time just talking with them!
2. Read them a book out loud if they are unable to do so themselves.
3. Do your best to encourage the resident to exercise to maintain their muscles, mobility and flexibility. If a physical therapist prescribes exercise, do your best to encourage them to do the exercises.
4. Show them how to use Google and Facebook.

Activities

Good activities (cont'd):

5. Play board games, such as Monopoly or checkers.
6. Do something creative – drawing, knitting, arts and crafts, etc.
7. Listen to music.
8. Watch old movies or TV shows together.
9. Have their clergy visit.

Complications and Challenges with Bedridden Residents

Note

- With any medical condition, it is imperative to contact the physician and work with home health or hospice (as appropriate). If the facility employs a skilled medical professional, then include this individual.

- Anytime there is a significant change in a resident's condition (such as the formation of a decubitus ulcer), the physician and responsible parties must be contacted.

Decubitus Ulcers

Decubitus Ulcer (aka bedsore, decub, pressure ulcer, ulcer) = An erosion in the SKIN that results from the pressure of remaining in one position for an extended period of time, commonly called a bedsore or pressure sore.

Two thirds of pressure sores occur in patients older than 70 years.

Source: https://www.clinicalkey.com/topics/infectious-disease/pressure-ulcer.html

Decubitus Ulcers (cont'd)

Decubitus ulcers can range from a very mild pink coloration of the skin, which disappears in a few hours after pressure is relieved on the area, to a very deep wound extending to and sometimes through a bone into internal organs.

These ulcers, as well as other wound types, are classified in stages according to the severity of the wound.

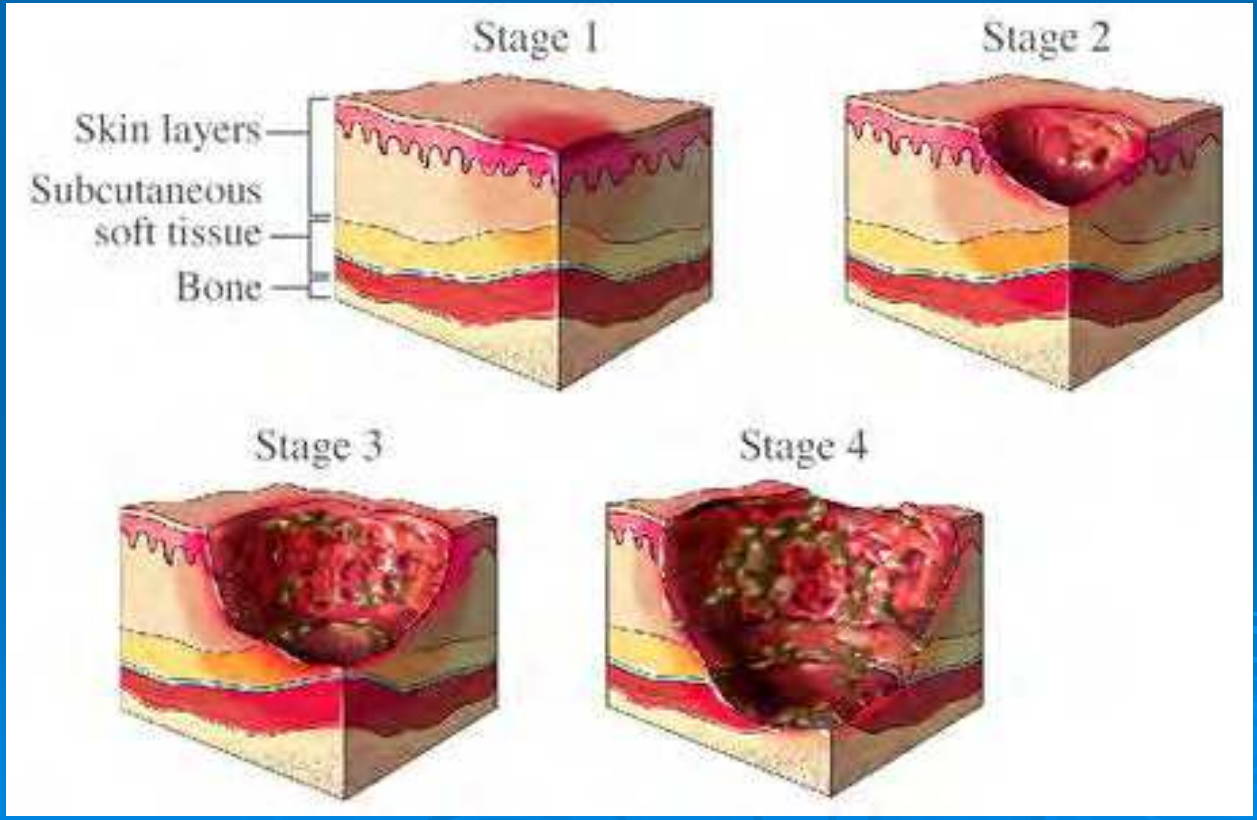
Source: http://expertpages.com/news/decubitus_ulcer.htm

Decubitus Ulcers (cont'd)

The typical way a decubitus ulcer forms is from pressure, but they can also occur from friction by rubbing against something such as a bed sheet, cast, brace, etc., or from prolonged exposure to cold.

Decubitus Ulcers (cont'd)

The stages:



Decubitus Ulcers (cont'd)

STAGE 1

- Reddening of the skin.
- The skin is unbroken and the wound is superficial (looks like a light sunburn or a first degree burn as well as a beginning decubitus ulcer).
- This should quickly fade when pressure is relieved on the area.

Decubitus Ulcers (cont'd)

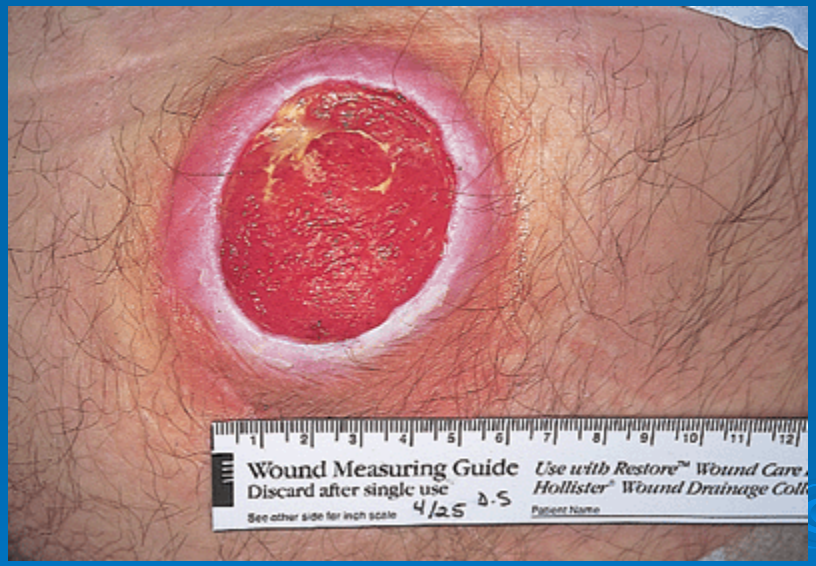
STAGE 1

- Treatment: turning or alleviating pressure in some form or avoiding more exposure to the cause of the injury as well as covering, protecting, and cushioning the area.
- Soft protective pads and cushions are often used for cushioning and protecting.
- An increase in vitamin C, proteins, and fluids is recommended.
- Increased nutrition is part of prevention.

Decubitus Ulcers (cont'd)

STAGE 2

- A blister that is either broken or unbroken.
- A partial layer of the skin is now injured.
- This is no longer just a superficial wound.



Decubitus Ulcers (cont'd)

Per the California Code of Regulations, Title 22, Division 6, Chapter 8, Stage 1 and Stage 2 decubitus ulcers are ***restricted conditions***.

Stage 3 and 4 are ***prohibited conditions***.

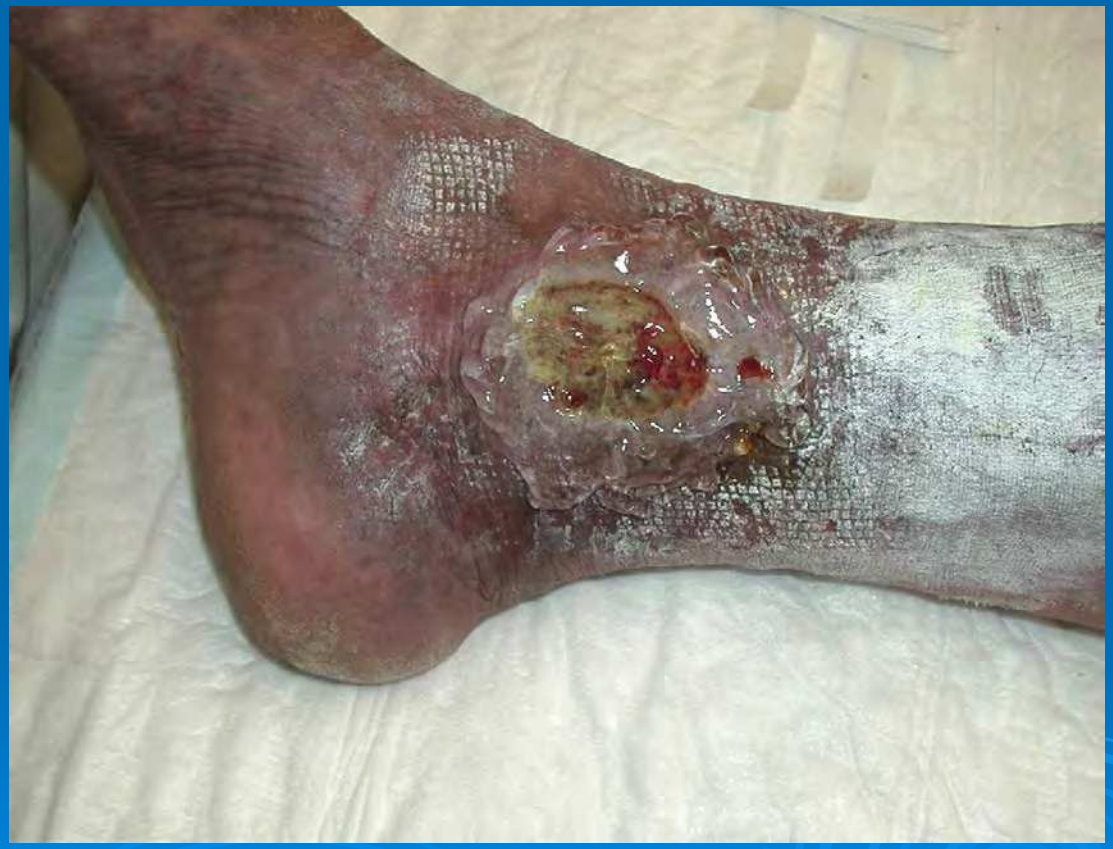
Decubitus Ulcers (cont'd)

STAGE 3

- The wound extends through all of the layers of the skin.
- It is a primary site for serious infection to occur.
- This must be treated by a physician.

Decubitus Ulcers (cont'd)

STAGE 3



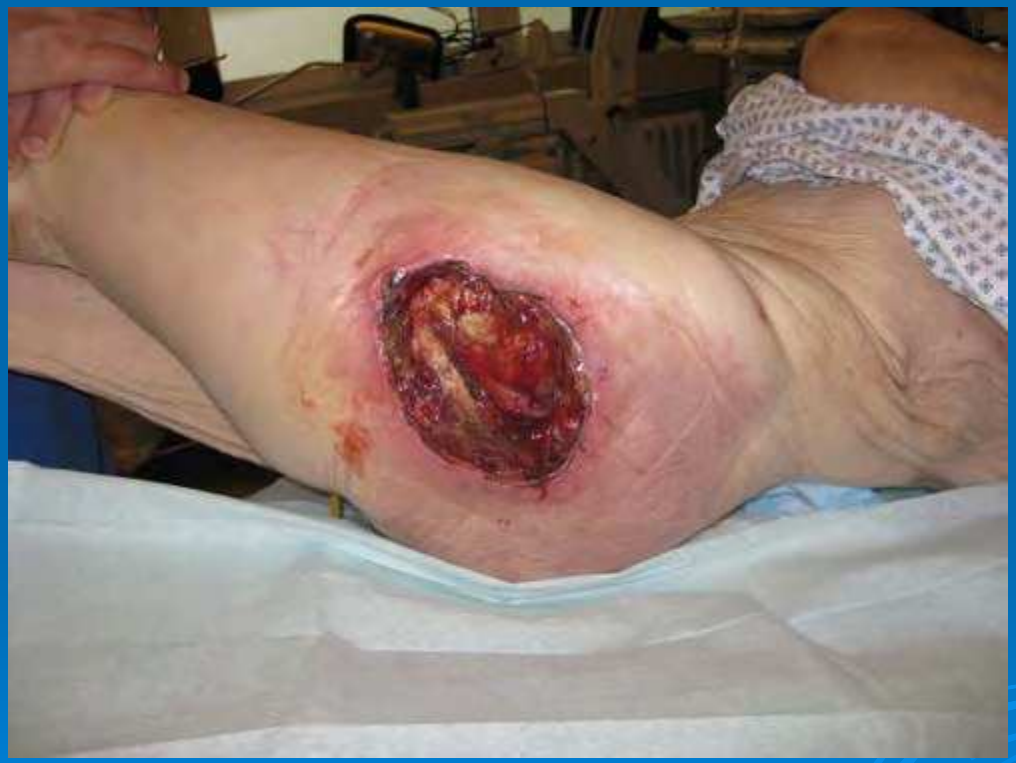
Decubitus Ulcers (cont'd)

STAGE 4

- This extends through the skin and involves underlying muscle, tendons and bone.
- The diameter of the wound is not as important as the depth.
- This is very serious and can produce a life threatening infection, especially if not aggressively treated.

Decubitus Ulcers (cont'd)

STAGE 4



Decubitus Ulcers (cont'd)

Here is a rhyme to help you remember the regulations about ulcers:

1 AND 2, YOU CAN DO;

3 AND 4, OUT THE DOOR!

Decubitus Ulcers (cont'd)

Caring for ulcers:

- Changing position* every 2 hours or more frequently if needed when in bed (state in the resident's Care Plan who will be doing this)
- Changing position* every 15 minutes or more frequently when sitting (again, state in the Care Plan who will be doing this)
- Protecting and padding to prevent tissue abrasion.
- Maintaining proper hydration, nutrition and hygiene.

**See next slide for details*

Decubitus Ulcers (cont'd)

Caring for ulcers:

What does "changing position" mean?

- If the ulcer is on the coccyx, reposition from side to side, avoiding pressure on the buttocks and back.
- A doctor or nurse can train staff on how to do range of motion exercises.
- Do not raise the head of the bed too high. If the head of the bed is too high, the person may slide downward in the bed, which can cause skin damage to the lower back and buttocks areas.

Decubitus Ulcers (cont'd)

Caring for ulcers:

- air mattress with alternating compartments or air flotation mattress
- eggshell mattress or seat cushion
- sheepskin pads over bony protuberances such as the heels and elbows
- active movement at least four times a day when possible and passive range of motion exercises (i.e., stretching) when active movement is not possible
- diligent skin hygiene, including daily cleansing and complete drying

Decubitus Ulcers (cont'd)

Medical treatment for ulcers:

- Keeping the area clean and removing necrotic (dead) tissue, which can form a breeding ground for infection (done by a physician or nurse in a medical setting such as a hospital)
- The use of antibiotics, when appropriate is also part of the treatment.
- Some deep wounds even require surgical removal or debridement of necrotic tissue. In some situations amputation may be necessary.

Decubitus Ulcers (cont'd)

While about 75% of Stage II ulcers heal within eight weeks, only 62% of Stage IV pressure ulcers ever heal, and only 52% heal within one year (this is why Stage IV's are prohibited health conditions).*

This may take *more* time in the elderly.

*Source: Thomas DR, Diebold MR, Eggemeyer LM (2005). "A controlled, randomized, comparative study of a radiant heat bandage on the healing of stage 3-4 pressure ulcers: a pilot study". J Am Med Dir Assoc 6 (1): 46–9. doi:10.1016/j.jamda.2004.12.007. PMID 15871870.

Decubitus Ulcers (cont'd)

So, what do you do if you see an ulcer forming?

Get the resident to the doctor as soon as possible.

Follow the physician's directives. Utilize home health, when prescribed.

Blood Clots

Because of inactivity, blood can pool in the veins and lead to blood clots. These can lead to stroke or death by traveling to the lungs, heart or brain.

Encourage the resident to do any leg exercises their doctor or other health care provider prescribes. These may include leg lifts and gentle foot and ankle exercises.

Pneumonia

Increased pressure on the body from immobility can lead to pulmonary congestion and pneumonia.

As patients remain immobile pulmonary secretions build up in the chest and cause other complications.

Pneumonia can be a very serious illness, especially in the elderly because of their weakened immune system so it is important for caregivers to watch for signs and symptoms that may indicate pneumonia.

Pneumonia

Per WebMD, signs of pneumonia may include:

- Cough - coughing up mucus (sputum) from the lungs. Mucus may be rusty or green or tinged with blood.
- Fever.
- Fast breathing and feeling short of breath.
- Shaking and "teeth-chattering" chills.
- Chest pain that often feels worse when coughing or breathing in.
- Fast heartbeat.
- Feeling very tired or very weak.
- Nausea and vomiting.
- Diarrhea.

Pneumonia

Older adults may have different, fewer, or milder symptoms. They may not have a fever. Or they may have a cough but not bring up mucus.

The *main* sign of pneumonia in older adults may be a change in how well they think. Confusion or delirium is common. Or, if they already have a lung disease, that disease may get worse.

Pneumonia

If the pneumonia is caused by bacteria, the physician will prescribe antibiotics.

Make sure the resident takes their antibiotics according to their physician's orders. Report to the physician and responsible party if they refuse.

If the resident is not feeling better after 2-3 days of antibiotics, call the physician.

Pain

Increased pressure on the body from immobility can cause back pain.

Remaining in one position for a long period of time puts extra pressure on the spinal column which causes back pain that can be very uncomfortable for residents.

Reposition the resident every 2 hours or more often, if necessary.

Pain

If the resident is experiencing pain like sciatica pain, see if their physician will prescribe physical therapy or medications to help with the pain.

Simple exercise and movement might help relieve pain. Heating pads may provide temporary relief but should only be used for a short time and according to physician orders.

Depression

Depression is also a very common health risk for those that are bedridden.

Many residents begin to feel hopeless and dependent when they become bedridden.

Focus should be not only on the physical care, but on one's social and emotional needs as well.

Depression

Keeping the resident engaged in socialization activities can help with loneliness.

If a resident is depressed, this can cause sleep and eating issues that can lead to decline.

Ask the family and friends to visit the resident as frequently as possible (if appropriate).

Sleep Issues

Being bedridden and unable to move can also cause sleep problems in bedridden residents.

Sleep problems are very common because residents are unable to move themselves if they are uncomfortable so they are forced to lie in bed in an uncomfortable position that keeps them awake.

Constipation

Constipation can be caused by many things:

1. Side effect of narcotics and anti-depressants
2. Inactivity
3. Inadequate water intake
4. Resisting the urge to have a bowel movement
5. Depression
6. Inadequate fiber in the diet

Constipation

If your resident is experiencing the following, contact their physician right away:

- Infrequent bowel movements or difficulty having bowel movements (straining)
- Hard or small stools
- Sense of incomplete bowel movement
- Swollen abdomen or abdominal pain
- Pain

Equipment and Devices

Equipment and Devices

There are many types of equipment and devices available to assist a bedridden resident. They include:

- Hospital beds
- Egg crate mattresses (or equivalent to relieve pressure)
- Bed pans or bedside commodes
- Screens and/or curtains to ensure privacy if the resident shares a room with another resident
- Partial or full bed rails
- Over-bed tables
- Wheelchairs

Hospital Beds and Assistive Devices

Would a hospital bed be more beneficial to the resident than a regular bed? Probably, but it depends on the needs of the resident.

What about ½ or full bed rails? Both are postural supports to be used for repositioning only. Review the regulations prior to use. Full bed rails are only allowed if the resident is on hospice.

Does DSS allow a Hoyer lift? Yes

Hoyer Lifts

Due to safety issues and the potential for accidents, learning how to use a Hoyer Lift properly is essential.

HealthBleep.com has produced a video that demonstrates various Hoyer Lift procedures. Let's watch it:

https://www.youtube.com/watch?v=RRz80J3hqtI

Emergency Evacuations

Evacuating Bedridden Residents

Your Disaster Plan needs to address how you will keep your bedridden residents safe.

1. Physically evacuating them
2. Supervision while out of the facility
3. Transfer trauma
4. Relocation sites

Evacuating Bedridden Residents

EVACUATION TECHNIQUES – BOTTOM LINE:

GET VICTIMS TO SAFETY ANY WAY YOU CAN.

PROTECT YOURSELF AND THE VICTIM – MOVE QUICKLY AND CALMLY TO SAFETY.

Evacuating Bedridden Residents

Evacuating non-ambulatory or bedridden residents - methods of assisting these residents include:

- Walkers, if available.
- Wheelchairs, if available.
- Rolling the resident's bed through doorways and down hallways (if their bed has wheels and is able to move).
- HIP CARRY – One person carrying one Resident (only when necessary).

Evacuating Bedridden Residents

Evacuating non-ambulatory or bedridden residents - methods of assisting these residents include (cont'd):

- SADDLE CARRY – Two persons locking hands and wrists to form a chair.
- BLANKET CARRY – One person dragging one Resident placed on a blanket.

Note: Be very careful to keep yourself safe during the evacuation process! Ask for help if you need it.

Evacuating Bedridden Residents

Types of carries for evacuations:

SIDE-BY-SIDE COME-A-LONG: This is used for a resident who is able to walk but just needs manual assist.

a. Put the resident's weaker side next to your body; put the resident's arms over your shoulder, hold his/her wrist, wrap your other arm around his/her waist and walk.

Evacuating Bedridden Residents

Types of carries for evacuations (cont'd):

BLANKET DRAG: This is used for the resident who cannot walk. One person can perform this. Analyze the resident's size, your size and strength.

a. Lay the blanket on the floor.
b. Kneel on one knee using your other knee as a midpoint between the floor and the bed.
c. Gently lower the resident onto your raised knee and ease him/her into the lying position. Lift his/her lower body and slide him/her off your knee first - protecting his/her neck and head.
d. Grasp the blanket up around the head/shoulder area and drag him/her to safety head first.

Evacuating Bedridden Residents

Types of carries for evacuations (cont'd):

HIP CARRY: Works well for smaller residents or someone who has had abdominal surgery.

a. Grasp the resident's wrist with your hand that is the closest to the head and bring it around to your shoulder.
b. Put your other hand and arm around the resident's back and hold on tight in the auxiliary region.
c. Wrap other arm around the resident's knees and lift the resident.
d. Go sideways through the doors.
e. To ease this person down, back their buttocks against a wall and slide down the wall.

Evacuating Bedridden Residents

Types of carries for evacuations (cont'd):

TWO MAN CARRIES - Swing Carry: Assist the resident to a sitting position on the edge of a locked bed, (waist high).

a. Have a caregiver get on each side of the resident and put the resident's arms around his/her own shoulders.
b. One of the caregivers nearest the resident then goes around the resident's back (either grabs the other caregiver's wrist or grab onto the resident at the waist).
c. With your other hand, each caregiver reaches under the resident's knees and clasps the other caregiver's wrist.
d. Lift together and carry the resident to safety.
e. Lower to the floor by kneeling with the leg closest to the resident and lowering resident's feet first.

Utilizing Outside Services

Outside Services

Utilizing Home Health and Hospice:

1. Contracted *by the resident* through the Home Health or Hospice Agency;
2. The facility must be in substantial compliance with DSS;
3. A Hospice Care Waiver must be approved by DSS prior to using hospice;
4. The use of home health care does not exceed the scope of care we are allowed to give (i.e., regulations).

Outside Services

Home health nurses can be utilized for:

- Wound care
- Injections
- Bathing and care
- Staff training!

Outside Services

Note: Licensees need to be aware that they are ultimately responsible for the health and safety of residents in care – regardless of who provides the care. This includes home health and hospice care.

Also, the Licensee is responsible for understanding the scope of the license – what home health/hospice can and cannot do, and what caregivers can and cannot do.

Outside Services

The nurses from these agencies coming into our facilities do not know our regulations. Therefore, you *must* be clear with them about what can and cannot be done in a licensed facility.

For example, a un-licensed caregiver CANNOT put morphine in a resident's mouth. Insisting that the staff does this will put not only the Administrator in jeopardy, but the facility's license!!

Outside Services

If a Licensee has an issue with a home health or hospice agency, he/she should report it to the Department of Public Health Licensing and Certification unit – (they have local licensing offices) by accessing:

http://www.cdph.ca.gov/certlic/facilities/Pages/LCDistrictOffices.aspx.

Contacting them becomes important not just for complaints, but also for information on home health or hospice care.

Sources

- WebMD
- Wikipedia
- Wikihow.com
- YouTube
- eHow.com
- Drugs.com
- Carefect Home Health Care Services
- DSS Website for Regulations

Conclusion

Assisted Living Education thanks you for attending this Class.

We look forward to seeing you again at another of our Courses!