



NURSING RESPONSIBILITIES IN ASSISTED LIVING

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Overview

- **Discuss the responsibilities of the RN according to RALF state rules.**
- **Discuss nursing assessments and change of condition assessments.**
- **Wound assessment & staging.**

Nursing Requirements

- **300.01 licensed professional nurse (RN)**
- **Must visit the facility every 90 days.**
- **Must visit the facility when there is a change in condition.**
- **Must delegate nursing functions in accordance with BON rules.**

True or False?

- **The facility has hired a new RN. All med aides have passed the medication assistance course and were delegated by the previous RN; therefore, the new RN does not have to re-delegate staff to assist with medications.**

300.02 Licensed Nurse

- **The facility must assure a licensed nurse is available to address changes in a resident's health status.**
- **The licensed nurse must be available to review and implement new orders.**
- **The licensed nurse must be available by telephone 24/7.**

RN Involvement

Mr. Smith goes to the MD and receives a new order for Novolog insulin. He gives the order to the house manager, she faxes it to the pharmacy. The insulin pen arrives and caregivers assist the resident with the medication.

305. RN Responsibilities

- **01. Resident response to medication and therapies.**
- **02. Current medication orders:**
 - Orders, mar, medication label.
 - Copy of current signed physician orders.

Rule Violation?

- **Surveyors discover that Mr. Smith has PRN orders for Benadryl, Imodium and Colace. The caregiver states the medications are not at the facility, but if the resident were to need them, they could be obtained within two hours.**

305. RN Responsibilities

- **03. Resident health status - initial assessment, 90 day assessment, and change of condition assessment.**
- **What is a change of condition?**
- **A change of condition is anything which deviates from the resident's baseline.**

Nursing Progress Note or Nursing Assessment

- Resident A has experienced a 10 pound weight loss since her last assessment.
- Resident B woke up this morning with left sided facial droop, was drooling and had trouble speaking.
- Resident C had a bruise of unknown origin on her right upper forearm and right inner thigh.

305. Continuation

- **04. Recommendations.**
- **05. Progress of previous recommendations.**
- **06. Self-administration medication assessment.**
- **07. Medication interaction and usage.**

Scenario

- **Surveyors walk into Mrs. Jones room. Tylenol, St. John's wort, Bengay and Milk of Magnesia are present in her medicine cabinet. What would the surveyors want to see in this resident's record?**

305 Continuation

- **08. Resident and facility staff education.**
- **What training do staff need in order to carry out the care described in the NSA?**
- **What training do staff need in order to implement MD orders?**
- **What education should be provided to the resident?**

Pressure Ulcers

Why is it important to stage pressure ulcers?

- **Pressure injuries are staged to indicate the extent of tissue damage.**
- **All wounds should show improvement bi-weekly.**

Stages I & II

Stage I: Skin is intact with an area of nonblanching erythema. This is usually over a bony prominence.



Stage II: Partial-thickness skin loss with loss of the epidermis and some of the dermis. It appears as a shallow ulcer with a red-pink color. No slough or necrotic tissue is present in the base. It may also appear as an enclosed or open serum-filled blister.



Stage III

Stage III: Full-thickness loss of skin with the epidermis and dermis gone and damage to or necrosis of subcutaneous tissues. Damage extends down to but not through the underlying fascia. Subcutaneous fat may be visible, but muscle, tendon, or bone is not seen. Slough may be present but does not hinder estimation of the extent of tissue loss. Tunneling or undermining may be present.



Stages IV/Unstageable

Stage IV: Full-thickness loss of skin with extensive destruction, tissue necrosis, and damage to bone, muscle, or other supporting structures that are exposed.



Unstageable Pressure Ulcers: Full-tissue thickness loss where the base of the ulcer is covered by slough or an eschar. The true depth of the damage cannot be determined until the necrotic tissue is cleared away or the eschar removed and the base of the pressure ulcer is visible. (Debridement should be avoided in the case of a stable eschar on the heels.)



Pressure Ulcers

- **Administrators - this is important because without the nurses assessment and input, the administrator cannot make an informed decision on whether or not the facility can admit or retain the resident.**
- **The focus should be on prevention.**

Pressure Ulcers

- The national pressure ulcer advisory panel is a multi-disciplinary group of experts in pressure injury. The NPUAP serves as the authoritative voice for improved patient outcomes in pressure injury prevention and treatment through public policy, education and research.
- Contact NPUAP at: npuap@npuap.org

305.08 Example

- **During an assessment, the nurse notices a stage one pressure ulcer on the resident's left heel. What interventions should be implemented to prevent further skin breakdown?**

What general training to staff and the resident might the nurse recommend to the administrator?

Questions?

- **Call 208-364-1962 and an office surveyor will be happy to help you.**
- **Email: ralf@dhw.idaho.gov**

Terminology

- **Bony prominence** – Skin closest to the bone and are areas of the body that are at the greatest risk for developing pressure sores.
- **Debridement** – The removal of damaged tissue or foreign objects from a wound.
- **Dermis** – The thick layer of living tissue below the epidermis that forms the true skin, containing blood capillaries, nerve endings, sweat glands, hair follicles and other structures.
- **Epidermis** – The outer layer of the two main layers of cells that make up the skin – it overlies the dermis or inner layer of skin.
- **Erythema** – Redness of the skin caused by increased blood flow in superficial capillaries, which occurs with any skin injury.
- **Eschar** - Dead tissue which is dry, hard tissue found in a full-thickness wound, which should not be removed. Blood flow in the tissue under the eschar is poor and the wound is susceptible to infection.
- **Fascia** - A thin sheath of fibrous tissue enclosing a muscle or other organ, primarily collagen, beneath the skin that attaches, stabilizes, encloses and separates muscles or organs
- **Necrotic tissue** – Non-viable tissue due to reduced blood supply – dead tissue, usually cream or yellow in color or eschar, which is dry, black, and hard. Impedes healing.
- **Nonblanching** - Includes changes in skin temperature (warmth or coolness); tissue consistency (firm or boggy feel) as compared to the adjacent or opposite area on the body – persistent redness in lightly pigmented skin. In darker skin the ulcer may appear with persistent red, blue or purple hues.
- **Serum-filled blister** – Fluid filled blister can be serous (pale yellow and transparent – benign nature), serosanguineous (yellowish with small amounts of blood) or blood filled blister which can be intact or open/ruptured.
- **Slough** – Yellow fibrinous tissue that consists of fibrin, pus and proteinaceous material, thought to be associated with bacterial activity.
- **Subcutaneous** - Situated or lying under the skin, the layer of skin directly below the dermis and epidermis.
- **Tunneling** – A narrow opening or passageway underneath the skin that can extend in any direction through soft tissue and results in dead space with potential for abscess formation. Tunneling wounds are among the most difficult to heal, as they often do not respond to a variety of wound dressings.
- **Undermining** – Is deep tissue (subcutaneous fat and muscle) damage around the wound margin. Tunneling is just under the skin surface and doesn't involve deep tissue.