Document Use
in Entry Level Healthcare Occupations

Essential Skills Resources for Aboriginal Learners

Career Enhancement Programs
Business Division
SIAST Wascana Campus

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Welcome
Welcome to a course that will help you sharpen your document use skills. Documents play an important role in healthcare settings where Aboriginal persons are employed or are patients/clients. This course provides a unique opportunity to learn how much you already know about document use and improve your ability to work with different types of healthcare documents.

What’s this guide about?
This guide is about the displays of information found in healthcare work. We see displays of information—signs, lists, graphs—around us all the time. Nature and the man-made world have a variety of displays that we read and respond to in different ways every day. This guide is about displays of information that man has made to help guide what people do as healthcare workers. You will learn, however, that there are similarities between the information displays that are man-made and the ones found in nature.

What’s the purpose of this guide?
This guide contains ideas and exercises to help you learn how to use different kinds of healthcare documents. Many different types of documents are used in healthcare occupations today, and healthcare workers have to know how to read and use them properly.

What do we mean by “healthcare documents”?
Healthcare documents are often the paper (or computer) displays of information that healthcare workers use as they do their jobs. Some examples are:

- attendance or work schedules,
- equipment gauges,
- how to work safely (occupational health and safety signs),
- steps to operate equipment,
- lists of tasks to be completed,
- information sheets about the chemical products that are being used, and
- patient information sheets and patient charts.

Some information displays in healthcare are used to remind you of things to be done. Some are used to warn you of hazards in the work environment. Some explain how to do things. There are many different healthcare occupations in which documents are used, and many different documents are used in each occupation.

You are reading this guide because you may be considering work in a healthcare occupation. Or you may be working in a healthcare occupation right now. Or you may be preparing to take training for future work in a healthcare occupation. This guide focuses on the documents used in entry level positions in healthcare, such as continuing care aide, licensed practical nurse, emergency medical technician, and housekeeping.
**Document Use as a Skill**

“Document Use” is one of the 9 Essential Skills that employers have said are important for workers to do their jobs. The 9 Essential Skills are:

- Reading Text
- Document Use
- Numeracy
- Writing
- Oral Communication
- Working with Others
- Continuous Learning
- Thinking Skills
- Computer Use

Document use involves the skills you need to work with information displays. Examples of document use are as follows:

- reading or making lists, labels or signs;
- entering information on forms, such as schedules;
- reading tables and using their information;
- figuring out the meaning of the information that appears on graphs or charts; and
- reading diagrams and drawings of how to put things together or how they work.

Often, when healthcare workers use documents, they are both reading them and adding information to them. And they also report what they see on documents to others, such as supervisors, head nurses and doctors. Clear handwriting is essential to accurately record and communicate information on healthcare documents.

**How can I benefit from using the Learner’s Guide?**

You benefit from using this guide because it will help you to do your job in a better way. You may also benefit from using it in a course that is training you to work in healthcare. At the very least, you will learn a variety of the words and expressions used in healthcare workplaces. It is more likely, however, that you will develop your skills in using documents. In the future, you will orient to documents faster and be more comfortable managing the information on them.

**What’s in this guide?**

This guide contains exercises with documents used by different healthcare workers in their jobs. Many of the documents come from actual healthcare workplaces; others come from training programs.

The reading pack is part of this guide. It provides ideas and tips on how to approach and use healthcare documents.

In the exercises, you will see documents and “read them” to find information or to fill in information. After you have completed each exercise, you can compare your answers with the correct answers. You can see how well you did and if you need to improve in some areas.
How will I learn to work with documents more effectively?

Your instructor will give you ideas about how to approach documents, how to view them and how to understand and use them. Once you learn what to look for, you will be able to approach documents and use them more easily and effectively. Learn and practise the strategies your instructor suggests.

What’s the connection between document use and traditional Aboriginal culture?

In the traditional way of life, survival depended on understanding the displays of information in nature. Being able to observe and interpret signs in the natural environment meant a successful hunt or a safe journey. Being able to perceive change in the information displays of nature was critical to success in everyday life.

Similarly, healthcare workers caring for patients need to be able to read displays of information. Recording the correct information and communicating it to others when they need it affects what happens to patients—whether patients get the right treatment at the right time. Document use in healthcare helps everyone do their job for the patient. Likewise, reading the displays of nature correctly in traditional culture helped all members of the group or tribe to survive, be healthy and prosper.

Your instructor or trainer will help you see more connections between using documents and the traditional ways of life in your community. You will be surprised how much you already know and can help your instructor learn about Aboriginal culture and healthcare, past and present.

You will now start on an exploration of document use within the context of Aboriginal culture.
### Understanding Documents

1. **When approaching a new document, look at the display of information. Answer the following questions:**
   - What are the parts of the document?
   - How is the information organized on the document? What categories are used?
   - Are there headings, tables, other dividers?
   - How much white space (i.e., space on the page where there are no words or lines) is there? How is it used?
   - Are there special terms that need to be understood?

   Draw a parallel between this view of documents and reading the environment in traditional life. Answer the questions: “What are some things you might look for in the environment?” “What’s in the background?” “What causes you to focus on one thing rather than another?”

2. **Identify the purpose of the document.**
   - What is it used for?
   - Who is involved in using this document and how do they use it?
   - Who receives the information and what decisions will that person make?

   The purpose of a document may be explained in its title. In healthcare settings documents may have purposes such as:
   - collecting patient information;
   - recording patients’ vital signs (e.g., pulse, temperature)
   - recording the amount of medication administered and the time it was given to the patient (i.e., on the “Medical Administration Record” (MAR);)
   - ensuring that all the necessary treatments are being applied on schedule; making decisions about what the patient needs next (i.e., on the “Patient Care Plan” (PCP); and
   - following the instructions to use a particular piece of equipment.

   The value of any document in healthcare depends on how it benefits the patient, caregiver or the healthcare system itself. Does it support what certain healthcare workers do? Does it aid a patient in a certain way? Does it aid a patient in a critical way or in a way that simply helps them move through the medical treatment system? It is important to know the purpose and the benefits of each healthcare document you use.
Main Tasks in Document Use

Here is a list of the tasks involved in working with documents generally.

1. Read the document (skim and scan).
2. Focus on key information.
3. Add/enter information or complete the document.
4. Do a calculation using the document.
5. Interpret the information (Answer the question: “What does this information mean?”)
6. Communicate the information to other people (Decide who needs to know and the most effective way to let them know.)

A Strategy for Working with Documents

Here is a specific strategy that you can use to work with the sample healthcare documents in this guide.

1. Identify
   - Identify the information that is given.
   - Identify the information that is requested.
   - Identify the key words in the question.

2. Scan
   - Look for specific key words and/or similar words (Don’t read line-by-line, use headings, bold text, start at the top of the page, scan in a zigzag pattern.)

3. Locate
   - Find the data, word or phrase you are scanning for, stop scanning and read a few words, the sentence or the paragraph.

4. Decide
   - Read the question again.
   - Look at the information you have found. Is it the information that is requested?
   - Do you need to scan further for other information or more information?

Skimming and Scanning

Skimming and scanning are two ways of searching for information in documents.

Skimming

Skimming is a technique that can help you to:

- Read more quickly (skimming is done three to four times faster than normal reading), and
- Get the gist (the main idea) of a page of a document. The gist helps you to decide whether you should read the document more slowly and in more detail.

Don’t read the whole document word-for-word. Use as many clues as possible to give you some background information. Read the title, subtitles and subheadings to find out what the text is about. Look at the illustrations or pictures to give you further information about the topic.

Read the first and last sentence of each paragraph. Let your eyes skim over the surface of the text and, while thinking about any clues you have found about the subject, watch for key words. Continue to think about the meaning of the document.
**Scanning**

After you have skimmed a document, you may decide to use scanning techniques to locate specific information. Scanning is used, for example, to find a particular number in the telephone directory or find out the dosage of medication that was administered on the last shift.

Scanning involves moving your eyes quickly down the page seeking specific words or phrases. In most cases, you know what you are looking for, so you are concentrating on finding specific information.

When scanning, look for how organizers such as numbers, letters, steps, or the words, “First,” “Second,” or “Next” are used. Look for words that are bold-faced, italics, or in a different type size, style, or colour. Sometimes authors also put key ideas in the margin.

*Skimming and scanning is an art in itself. It takes practice to know and understand what you should be looking for. It is possible to pull information from documents that is not so useful and skip over the important stuff. Take time to practice skimming and scanning and develop these skills.*
Document Exercises

This section has 19 exercises with documents used in healthcare. The correct answers follow each exercise. Fifteen exercises are listed below.

Before you begin an exercise, your instructor or trainer will help you to learn the meaning of the words you need to know in the document. If your instructor or trainer forgets to do this, remind him or her to do so. She or he may direct you to a resource (dictionary or the Internet), or provide you with the meanings of words you need to know.

Documents that people use in the workplace are not always easy to read. Some of the reasons for this are poor handwriting, faded copies and small print. In the document exercises you may have trouble reading some text and handwriting. It is quite acceptable to use a magnifying glass. Use one if it will help.

The Patient Care Report for Emergency Medical Professionals (pages 22, 25 and 27) is difficult to read because of the small size of the print. At the end of this Guide there are larger 8.5”x14” copies for you to work on.

LIST OF DOCUMENT EXERCISES

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<tr>
<th></th>
<th>Document Category</th>
<th>Document Title</th>
</tr>
</thead>
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<td>Eating Well with Canada’s Food Guide</td>
<td>(1) First Nations, Inuit and Métis</td>
</tr>
<tr>
<td>14</td>
<td>Aboriginal Cancer Prevention Newsletter</td>
<td>(2) Provided by “Cancer Care Ontario” (<a href="http://www.cancercare.on.ca">www.cancercare.on.ca</a>)</td>
</tr>
<tr>
<td>18</td>
<td>Health Care Professionals</td>
<td>(3) 7 Steps of Handwashing</td>
</tr>
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<td>21</td>
<td>Emergency Medical Services Professionals</td>
<td>(4) Patient Care Report (A)</td>
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<td>Emergency Medical Services Professionals</td>
<td>(4) Patient Care Report (B)</td>
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<td>Continuing Care Assistant</td>
<td>(5) Graphic Record (A)</td>
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<td>(6) Patient Care Plan (A)</td>
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<td>Continuing Care Assistant</td>
<td>(6) Patient Care Plan (B)</td>
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<td>43</td>
<td>Licensed Practical Nurse</td>
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<td>Licensed Practical Nurse</td>
<td>(9) Adult Neurosciences Watch Sheet</td>
</tr>
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<td>Licensed Practical Nurse</td>
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<td>Licensed Practical Nurse</td>
<td>(10) TLR Symbols – Indications for Use (B)</td>
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<td>63</td>
<td>Health Care Professionals</td>
<td>(e.g., Nurses) (11) Admission Assessment &amp; History Form</td>
</tr>
<tr>
<td>70</td>
<td>Health Care Professionals</td>
<td>(e.g., Nurses) (12) Patient Medication Form</td>
</tr>
<tr>
<td>73</td>
<td>Health Care Professionals</td>
<td>(e.g., Nurses) (13) Clinical Record</td>
</tr>
<tr>
<td>81</td>
<td>Health Care Professionals</td>
<td>(e.g., Nurses) (14) Discharge Care Plan</td>
</tr>
<tr>
<td>85</td>
<td>Housekeeping Staff</td>
<td>(15) Discharge/Transfer Cleaning Checklist for All Rooms</td>
</tr>
</tbody>
</table>
Eating Well with Canada’s Food Guide (1)  
First Nations, Inuit and Métis

Canada’s Food Guide recommends the number of servings per day for different age groups. Look at Canada’s Food Guide.

Canada’s Food Guide

1. What are the four food groups?

2. Name three milk alternatives.

3. How many servings of milk and alternatives are recommended for an adult 19-50 years of age?

4. Name three traditional or wild game meats.

5. What is recommended to have more often than juice?
How to use Canada’s Food Guide
The Food Guide shows how many servings to choose from each food group every day and how much food makes a serving.

### Recommended Number of Food Guide Servings per day

<table>
<thead>
<tr>
<th>Food Group</th>
<th>Children 2-3 years old</th>
<th>Children 4-13 years old</th>
<th>Teens and Adults (Females)</th>
<th>Teens and Adults (Males)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vegetables and Fruit</td>
<td>4</td>
<td>5-6</td>
<td>7-8</td>
<td>7-10</td>
</tr>
<tr>
<td>Fresh, frozen and canned.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grain Products</td>
<td>3</td>
<td>4-6</td>
<td>6-7</td>
<td>7-8</td>
</tr>
<tr>
<td>Milk and Alternatives</td>
<td>2</td>
<td>2-4</td>
<td>Teens (3-4 adults 19-50 years)</td>
<td>Teens (3-4 adults 19-50 years)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Adults (25+ years) 2</td>
<td>Adults (25+ years) 3</td>
</tr>
<tr>
<td>Meat and Alternatives</td>
<td>1</td>
<td>1-2</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### What is one Food Guide Serving?
Look at the examples below.

- **Eat at least one dark green and one orange vegetable each day. Choose:**
  - Dark green and orange vegetables 125 mL (1/2 cup)
  - Other vegetables 125 mL (1/2 cup)

- **Make at least half of your grain products whole grain each day. Choose:**
  - Bread 1 slice (35 g)
  - Bannock 35 g (2” x 2” x 1”)

- **Drink 500 mL (2 cups) of skim, 1% or 2% milk each day. Select lower fat:**
  - Milk Powdered milk, mixed 250 mL (1 cup)

- **Have meat alternatives such as beans, lentils and tofu often. Eat at least:**
  - Traditional meats and wild game 75 g cooked (2 1/2 oz)/125 mL (1/2 cup)
  - Fish and shellfish 75 g cooked (2 1/2 oz)/125 mL (1/2 cup)

### When cooking or adding fat to food:
- Most of the time, use vegetable oils with unsaturated fats. Include canola, olive and soybean oils.
- Aim for a small amount (2 to 3 tablespoons or about 30-45 ml) of fat each day. This amount includes oil used for cooking, salad dressings, margarine and mayonnaise.
Eating Well Every Day
Canada’s Food Guide describes healthy eating for Canadians two years of age or older. Choosing the amount and type of food recommended in Canada’s Food Guide will help:

• children and teens grow and thrive
• meet your needs for vitamins, minerals and other nutrients
• lower your risk of obesity, type 2 diabetes, heart disease, certain types of cancer and osteoporosis (weak and brittle bones).

Every day, choose vegetables and fruit prepared with little or no added fat, sugar or salt. Have vegetables and fruit more often than juice.

- Leafy vegetables and wild plants
  cooked 125 mL (1/2 cup)
  raw 250 mL (1 cup)
- Berries
  125 mL (1/2 cup)
- Fruit
  1 fruit or 125 mL (1/2 cup)
- 100% juice
  125 mL (1/2 cup)

Every day, choose grain products that are lower in fat, sugar or salt.

- Cold cereal
  30 g (see food package)
- Hot cereal
  175 mL (3/4 cup)
- Cooked pasta
  125 mL (1/2 cup)
- Cooked rice
  White, brown, wild
  125 mL (1/2 cup)

Lower fat milk alternatives. Drink fortified soy beverages if you do not drink milk.

- Fortified soy beverage
  250 mL (1 cup)
- Canned milk (evaporated)
  125 mL (1/2 cup)
- Yogurt
  175 g (3/4 cup)
- Cheese
  50 g (1/2 oz.)

Eat at least two Food Guide Servings of fish each week.* Select lean meat and alternatives prepared with little or no added fat or salt.

- Fish and shellfish
  75 g (3 oz)
  125 mL (1/2 cup)
- Lean meat and poultry
  75 g cooked (2 1/2 oz)
  125 mL (1/2 cup)
- Eggs
  2 eggs
- Beans – cooked
  175 mL (3/4 cup)
- Peanut butter
  30 mL (2 Tbsp)

Limit saturated fats. These fats are solid at room temperature, such as coconut and palm oil, lard, and butter. Use less than 7% of your total daily calories from saturated fats.

- Limit trans fats. These are artificial fats that are liquid at room temperature, such as seed and nut oils, and are often added to margarines, shortening, salad dressings, and snack foods. Use less than 1% of your total daily calories from trans fats.

- Traditional fats that are liquid at room temperature, such as seal and whale oil, or ooligan grease, also contain unsaturated fats. They can be used as all or part of the 2-3 tablespoons of unsaturated fats recommended per day.

- Choose soft margarines that are low in saturated and trans fats.
- Limit butter, hard margarine, lard, shortening and bacon fat.

*Health Canada provides advice for limiting exposure to mercury from certain types of fish. Refer to www.healthcanada.gc.ca for the latest information. Consult local, provincial or territorial governments for information about eating locally caught fish.
How to use Canada’s Food Guide

The Food Guide shows how many servings to choose from each food group every day and how much food makes a serving.

1. Find your age and sex group in the chart below.
2. Follow down the column to the number of servings you need for each of the four food groups every day.
3. Look at the examples of the amount of food that counts as one serving. For instance, 125 mL (1/2 cup) of carrots is one serving in the Vegetables and Fruit food group.

Recommended Number of Food Guide Servings per day

<table>
<thead>
<tr>
<th>Food Group</th>
<th>Adults (0–34 years)</th>
<th>Adults (35+ years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grains and Alternatives</td>
<td>1</td>
<td>1–2</td>
</tr>
<tr>
<td>Milk and Alternatives</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Meat and Alternatives</td>
<td>1–2</td>
<td>1–3</td>
</tr>
<tr>
<td>Vegetables and Fruit</td>
<td>2</td>
<td>2–3</td>
</tr>
</tbody>
</table>

What is one Food Guide Serving?

Look at the examples below.

Traditional meats and wild game
75 g cooked (2 1/2 oz)/125 mL (1/2 cup)

When cooking or adding fat to food:
- Most of the time, use vegetable oils with unsaturated fats. Examples include canola, olive and soybean oils.
- Aim for a small amount (2 to 3 tablespoons or about 30-45 mL) each day. This amount includes oil used for cooking, salad dressing, margarine and mayonnaise.

Select lower fat

Milk
Powdered milk, mixed
250 mL (1 cup)

Vegetables
Beans
1 cup (1/2 cup)

Fruits
Strawberries
1 cup (1/2 cup)
Eating Well with Canada’s Food Guide (1)
First Nations, Inuit and Métis

Canada’s Food Guide recommends the number of servings per day for different age groups. Look at Canada’s Food Guide.

Canada’s Food Guide

1. What are the four food groups?
   - vegetables and fruit
   - grain products
   - milk and alternatives
   - meat and alternatives

2. Name three milk alternatives.
   - soy beverage
   - yoghurt
   - cheese

3. How many servings of milk and alternatives are recommended for an adult 19-50 years of age?
   - 2

4. Name three traditional or wild game meats.
   - beaver
   - elk
   - rabbit
   - turkey, goose, or other wild bird
   - moose
   - seal
   - deer

5. What is recommended to have more often than juice?
   - vegetables and fruit
Aboriginal Cancer Prevention Newsletter (2)
Issue 1.2009-2010 Provided by “Cancer Care Ontario” (www.cancercare.on.ca).

Researchers and cancer health professionals record data for statistical purposes. They gather information about the rate of breast cancer in women.

Look at the graph and read the text in the Aboriginal Breast Cancer Study: Research Towards Improving Cancer Care in Ontario.

Graph
1. What is the percentage of First Nations women who are alive after five years?

2. How does that compare to non-First Nations women?

3. Why is the survival rate lower in First Nations women?
Aboriginal Breast Cancer Study: Research Towards Improving Cancer Care in Ontario

Breast cancer is the most common cancer among women, regardless of ethnicity. Although breast cancer occurs more often among the general population than among First Nations women in Ontario, First Nations women do not live as long after diagnosis. (Figure 1)

Researchers and breast health professionals at Cancer Care Ontario (CCO) and provincial Regional Cancer Centres collaborated on an Aboriginal Breast Cancer (ABC) Study that examined reasons for the survival difference between First Nations women and the general population in Ontario after a breast cancer diagnosis.

For this work, 287 First Nations and 671 non-First Nations women with a breast cancer diagnosis between 1995-2004 were matched according to 3 factors: Regional Cancer Centre attended, age at diagnosis and period of diagnosis. This ‘matching’ is done to account for differences in survival that may be due to these 3 factors, so that other factors which may be actionable can be focused on.

In summary, the study revealed that First Nations women are being diagnosed with breast cancer at a more advanced stage at diagnosis compared to other Ontario women. Not being screened for breast cancer, having a higher Body Mass Index (BMI) or having other health conditions, all contributed to diagnosing the cancer at a later stage, in turn, contributing to an increased risk of death.

As Canada’s population ages, more families and communities will become affected with breast cancer. It is vital to establish health care pathways to lengthen and improve life after a diagnosis. The results of this study may support improvements in cancer care for First Nations people.

The findings from this study were at the Aboriginal Breast Cancer Workshop, April 2009 in Toronto, Ontario.

Amanda J. Sheppard, B.Sc, M.Sc.
This research is supported by the Canadian Breast Cancer Foundation – Ontario Region.
Amanda Sheppard is supported by a Canadian Breast Cancer Foundation – Ontario Chapter Doctoral Fellowship."

For more information on this study please contact: amanda.sheppard@cancercare.on.ca

Feature Recipe - Lightened Up Hummus

3/4 cup (175 mL) fat-free plain yogurt
1 can (19 oz/540 mL) chickpeas, drained and rinsed
2 tbsp (25 mL) lemon juice
1 tbsp (15 mL) sesame oil
1 tsp (5 mL) ground cumin
1/4 tsp (1 mL) salt
Pinch cayenne pepper
2 cloves garlic, minced
1 tbsp (15 mL) extra virgin olive oil
Pinch paprika

Preparation: Line small sieve with cheesecloth; set over bowl. Add yogurt; drain in refrigerator until reduced by half, about 2 hours. In food processor, puree yogurt, chickpeas, lemon juice, sesame oil, cumin, salt and cayenne pepper until smooth; scrape into bowl. Stir in garlic. (Make ahead: Cover and refrigerate for up to 3 days.) Drizzle oil over top; sprinkle with paprika.

Nutrition Corner

A new study conducted by the Risk Factor Modification Centre at St. Michael’s Hospital in Toronto shows adding beans to your diet can improve glucose control. They are foods with big health benefits — legumes, chickpeas, kidney beans, black beans, navy beans and lentils — all help regulate blood sugar, lower cholesterol and blood pressure and guard against heart attack and cancer.

To learn more about this study visit: http://www.theglobeandmail.com/life/health/beans-good-for-your-heart-and-blood-sugar/article1241208/
Aboriginal Breast Cancer Study: 
Research Towards Improving Cancer Care in Ontario

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Researchers and breast health professionals at Cancer Care Ontario (CCO) and provincial Regional Cancer Centres collaborated on an Aboriginal Breast Cancer (ABC) Study that examined reasons for the survival difference between First Nations women and the general population in Ontario after a breast cancer diagnosis.

For this work, 287 First Nations and 671 non-First Nations women with a breast cancer diagnosis between 1995-2004 were matched according to 3 factors: Regional Cancer Centre attended, age at diagnosis and period of diagnosis. This ‘matching’ is done to account for differences in survival that may be due to these 3 factors, so that other factors which may be actionable can be focused on.

In summary, the study revealed that First Nations women are being diagnosed with breast cancer at a more advanced stage at diagnosis compared to other Ontario women. Not being screened for breast cancer, having a higher Body Mass Index (BMI) or having other health conditions, all contributed to diagnosing the cancer at a later stage, in turn, contributing to an increased risk of death.

As Canada’s population is aging, healthcare pathways and funding for cancer care for First Nations women in Ontario become increasingly important.

The findings from this study are informing cancer care improvement strategies in the province.

Amanda J. Sheppard, B.Sc.
This research is supported by the Canadian Cancer Society – Ontario Region
Amanda Sheppard is supported by the Innovation Fund of the Canadian Cancer Society – Ontario Region.

For more information on the Aboriginal Breast Cancer Study, visit: http://www.cancer.ca/breastcancer/factsheet

Feature Recipe

3/4 cup (175 mL) fat-free plain yogurt
1 can (19 oz/540 mL) black beans
2 tbsp (25 mL) lemon juice
1 tbsp (15 mL) sesame oil
1 tsp (5 mL) ground cumin
1/4 tsp (1 mL) salt
Pinch cayenne pepper
2 cloves garlic, minced
1 tbsp (15 mL) extra virgin olive oil
Pinch paprika

Preparation: Line small, shallow dish with non-stick cooking spray. Place black beans in dish. In a large bowl, combine yogurt, lemon juice, cumin, salt and cayenne pepper. Add garlic and olive oil. Pour mixture over beans. Cover and refrigerate up to 5 days. Drizzle oil over top; sprinkle with paprika.

Per 1 tbsp (15 mL): cal 5• protein 1• total fat 1• sat fat trace• carb 1• fibre 1• chol 0• sodium 55
Source: Canadians Living Magazine- October 2004

To learn more about this study visit: http://www.theglobeandmail.com/life/health/beans-good-for-your-heart-and-blood-sugar/article1241208/
Aboriginal Cancer Prevention Newsletter (2)
Issue 1.2009-2010 Provided by “Cancer Care Ontario” (www.cancercare.on.ca).

Researchers and cancer health professionals record data for statistical purposes. They gather information about the rate of breast cancer in women.

Look at the graph and read the text in the Aboriginal Breast Cancer Study: Research Towards Improving Cancer Care in Ontario.

Graph

1. What is the percentage of First Nations women who are alive after five years?
   • 72 or 73%

2. How does that compare to non-First Nations women?
   • 81 or 82%

3. Why is the survival rate lower in First Nations women?
   • First Nations women are being diagnosed with breast cancer at a more advanced stage at diagnosis compared to other Ontario women.
Health Care Professionals (3)

All Health Care Professionals are required to follow hand washing procedures. Look at the seven steps of hand washing.

7 Steps of Handwashing

1. What song do you sing to yourself to indicate 15 seconds?

2. When should waterless hand cleansers not be used?

3. How many pumps of waterless hand cleanser are needed to cover all surfaces?

4. What do you use to turn the taps off?
7 STEPS OF HANDWASHING

• REMOVE RINGS AND OTHER HAND JEWELRY
• TURN ON WATER AND WET HANDS
• APPLY SOAP
• FRICTION TO ALL SURFACES FOR MINIMUM OF 15 SECONDS (SING HAPPY BIRTHDAY TO YOURSELF)
• RINSE WELL UNDER RUNNING WATER
• PAT HANDS DRY WITH CLEAN PAPER TOWEL
• TURN TAPS OFF WITH DRY PAPER TOWEL

WATERLESS HAND CLEANSERS

• KNOW THE PRODUCT
• **DO NOT** USE OF HANDS ARE VISIBLE SOILED
• **DO NOT** USE ON GLOVED HANDS
• **DO NOT** USE WHEN THERE IS CONTACT WITH C. DIFF.
• APPLY ENOUGH PRODUCT ON PALM OF HAND TO COVER ALL SURFACES (2 FULL PUMPS)
• RUB VIGOROUSLY OVER ALL SURFACES OF HANDS UNTIL HANDS ARE DRY
Health Care Professionals (3)

All Health Care Professionals are required to follow hand washing procedures. Look at the seven steps of hand washing.

7 Steps of Handwashing

1. What song do you sing to yourself to indicate 15 seconds?
   - Happy Birthday

2. When should waterless hand cleansers not be used?
   - on visibly soiled hands
   - on gloved hands
   - when there is contact with C. Diff.

3. How many pumps of waterless hand cleanser are needed to cover all surfaces?
   - 2 full pumps

4. What do you use to turn the taps off?
   - dry paper towel
Emergency Medical Services Professionals (4)

Emergency Medical Services Professionals complete Patient Care Reports in a timely manner before handing patients off to the next care level. Look at the Patient Care Report.

Patient Care Report (A)

1. Where did EMS find the patient?

2. Circle or highlight the position in which the patient was found?

3. Describe the patient’s first reaction when EMS first arrived.

4. In what body part did the patient have pain after the fall?

5. Where did EMS take the patient?

6. Who was the receiving physician?

7. Circle or highlight one medication EMS administered to the patient.
### Patient Information

<table>
<thead>
<tr>
<th>Name</th>
<th>First</th>
<th>Last</th>
<th>Middle</th>
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<tbody>
<tr>
<td>John</td>
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<td>Smith</td>
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<table>
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<table>
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</thead>
</table>

### Emergency Health Care Department

**Patient Care Report**

**Date of Birth:** 01/03/2010

**Sex:** Male

**Height:** 6'0"

**Weight:** 160 lbs

**Allergies:** None

<table>
<thead>
<tr>
<th>Medication</th>
<th>Type</th>
<th>Dose</th>
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</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>Tablet</td>
<td>325 mg</td>
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</tbody>
</table>

### History

**Chief Complaint:** Shoulder pain after fall

- Patient fell from a height, became dizzy and blacked out.
- BP: 120/80, HR: 72, RR: 12, O2 Sat: 98%
- Temperature: 98.6°F

**Past Medical History:** None noted

**Medications:** Aspirin

### Onset

- **Onset of Symptoms:** 21 July 2023 at 08:00 AM

### Vital Signs

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<th>Value</th>
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<td>RR</td>
<td>12</td>
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<tr>
<td>BP</td>
<td>120/80</td>
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</tbody>
</table>

### Treatment

- **Diagnosis:** Shoulder pain

- **Medication:** Aspirin 325 mg

- **Procedure:** Assessing for fractures

- **Assessment:** No obvious signs of trauma

### Procedure/Treatment

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<th>Item</th>
<th>Description</th>
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<tbody>
<tr>
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<td>Vitals checked</td>
</tr>
<tr>
<td>2</td>
<td>Assessing for fractures</td>
</tr>
</tbody>
</table>

---

### Footnotes

- Patient is alert and oriented to person, place, and time.
- Pain relieved with Aspirin 325 mg.
- Patient to be followed up with orthopedic specialist.

---

### References

- American Academy of Orthopedic Surgeons
- Orthopaedic Trauma Association

---

**Signature:**

Dr. Jane Smith
Orthopedic Surgeon

---

**Date:** 21 July 2023
Emergency Medical Services Professionals (4)

Emergency Medical Services Professionals complete Patient Care Reports in a timely manner before handing patients off to the next care level. Look at the Patient Care Report.

Patient Care Report (A)

1. Where did EMS find the patient?
   - at her residence, house

2. Circle or highlight the position in which the patient was found?
   - laying on left hand side in fetal position

3. Describe the patient’s first reaction when EMS first arrived.
   - she did not react when we banged on the door and called to her

4. In what body part did the patient have pain after the fall?
   - shoulder

5. Where did EMS take the patient?
   - RGH ER

6. Who was the receiving physician?
   - Scott

7. Circle or highlight one medication EMS administered to the patient.
   - 25 mg. Gravol, or
   - 25 mg. Morphine
**Emergency Medical Services Professionals (4)**

Emergency Medical Services Professionals complete Patient Care Reports in a timely manner before handing patients off to the next care level. Look at the Patient Care Report.

**Patient Care Report (B)**

Enter the following information on the blank Patient Care Report:

EMS attended Mavis Delorme, female, born July 28, 1974. She had been cleaning a recreational area on her reserve using a tractor and other equipment. The tractor had turned over on a hillside, pinning her beneath a wheel. Others working with her had lifted the tractor off her before EMS arrived. She was experiencing severe abdominal pain and exhibited lacerations of the soft tissue of her chest, abdomen and both arms. This was an emergency response with the patient in a life threatening situation. One of the attending EMS personnel was: Derek, 002374.

On the form, enter the following:

- first name and last name
- sex
- type of call (circle the number)
- patient number
- where the accident happened (circle the numbers)
- appropriate major and minor trauma codes (circle the numbers)
- the name and number of the EMS personnel
- information on priority and responses
- a short description of what happened in history
### Patient Care Report Form

#### Patient Information
- **Name:**
- **Relationship:**
- **Phone:**
- **Address:**
- **Diagnosis:**
- **Allergies:**
- **Medications:**

#### Trip Record
- **Onset:**
- **Assessment Codes:**
  - Trauma Injuries
  - Head Injury
  - Spinal Injury
  - Other Injuries
- **History:**
  - **Past:**
  - **Present:**
- **On Exam:**
  - **Head:**
  - **Neck:**
  - **Vital Signs:**
  - **Blood Pressure:**
  - **Heart Rate:**
  - **Respiratory Rate:**
  - **Temperature:**
- **Procedure/Treatment:**
- **Fluids/Medications:**

#### Ambulance Time Record
- **En Route: 11:59 AM**
  - **Transport:**
  - **Assessment:**
  - **Diagnosis:**
  - **Treatment:**
  - **Disposition:**

#### Treatment Description/Comments

---

**Essential Skills Resources for Aboriginal Learners / 25**
Emergency Medical Services Professionals (4)

Emergency Medical Services Professionals complete Patient Care Reports in a timely manner before handing patients off to the next care level. Look at the Patient Care Report.

Patient Care Report (B)

Enter the following information on the blank Patient Care Report:

EMS attended Mavis Delorme, female, born July 28, 1974. She had been cleaning a recreational area on her reserve using a tractor and other equipment. The tractor had turned over on a hillside, pinning her beneath a wheel. Others working with her had lifted the tractor off her before EMS arrived. She was experiencing severe abdominal pain and exhibited lacerations of the soft tissue of her chest, abdomen and both arms. This was an emergency response with the patient in a life threatening situation. One of the attending EMS personnel was: Derek, 002374.

On the form, enter the following:

- first name and last name: Mavis Delorme
- sex: F
- type of call: 01 Injury/Trauma
- patient number: 1 of 1
- where the accident happened: 16 Reserve, 03 Recreational Area
- appropriate major and minor trauma codes: 009 Other Major Trauma
  018 Soft Tissue Injury
- the name and number of the EMS personnel: Derek, 002374
- information on priority and responses: priority 4, responses 4
- a short description of what happened in history: Severe abdominal pain and soft tissue lacerations after being pinned under tractor.

Refer to completed form.
**Continuing Care Assistant (5)**

A Continuing Care Assistant provides personal care and activities of daily living for clients (patients, residents) to encourage an optimum level of functioning. They support clients in meeting their physical, emotional and spiritual needs. A Continuing Care Assistant is sometimes called a Special Care Aide or a Home Care Aide. They work with a variety of documents.

Continuing Care Assistants record clients’ vital signs, weight, intake and output. Look at the Graphic Record. The initials B.P. refer to blood pressure. The arrow pointing down refers to “systolic” blood pressure. The arrow pointing up refers to “diastolic” blood pressure.

**Graphic Record (A)**

1. What are the two vital signs that are plotted on the graph?

2. On what day and at what time was Maggie McGee’s systolic blood pressure the highest?

3. On what day and at what time was Maggie McGee’s diastolic blood pressure the lowest?

4. What was Maggie McGee’s highest and lowest temperature over the two days?
<table>
<thead>
<tr>
<th>Other</th>
<th>Temp</th>
<th>Vital Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Apical Pulse</td>
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</table>

Legend:
- Temp X
- Pulse

Graphic Record

Mcpee, Maggie
Continuing Care Assistant (5)

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Graphic Record (A)

1. What are the two vital signs that are plotted on the graph?
   - Apical Pulse
   - BP

2. On what day and at what time was Maggie McGee’s systolic blood pressure the highest?
   - May 14
   - 0600 hours

3. On what day and at what time was Maggie McGee’s diastolic blood pressure the lowest?
   - May 14
   - 10 o’clock

4. What was Maggie McGee’s highest and lowest temperature over the two days?
   - 39
   - 38
Continuing Care Assistant (5)

A Continuing Care Assistant provides personal care and activities of daily living for clients (patients, residents) to encourage an optimum level of functioning. They support clients in meeting their physical, emotional and spiritual needs. A Continuing Care Assistant is sometimes called a Special Care Aide or a Home Care Aide. They work with a variety of documents.

Record the information below on a blank copy of the Graphic Record.

**Graphic Record (8)**

<table>
<thead>
<tr>
<th>Name of Client:</th>
<th>McGee, Maggie (top right corner)</th>
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<tbody>
<tr>
<td>Date:</td>
<td>May 15 and 16</td>
</tr>
<tr>
<td>Times:</td>
<td>May 15: 06, 11, 16</td>
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<td>May 16: 16, 06, 10</td>
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<tr>
<td>BP:</td>
<td>May 15: 06 – 160/100</td>
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<tr>
<td></td>
<td>11 – 190/80</td>
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<tr>
<td></td>
<td>16 – 155/75</td>
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<tr>
<td>Temperature:</td>
<td>May 16: 06 – 37.5</td>
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<tr>
<td></td>
<td>16: 10 – 39.5</td>
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<tr>
<td>Pulse:</td>
<td>May 16: 06 – 80</td>
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<td></td>
<td>16: 10 – 70</td>
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</table>
**Graphic Record**

**Legend**

- B.P. ▲ Temp X Pulse ●

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**Vital Signs**

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**Temp**

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**Respirations**

**Other**

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*Essential Skills Resources for Aboriginal Learners / 33*
### Answers

#### Graphic Record

**Legend**
- B.P. ▲ Temp x Pulse ●

<table>
<thead>
<tr>
<th>Date</th>
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**Vital Signs**
- BP

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**Temp**

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**Respirations**

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<tr>
<td>Other</td>
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</tbody>
</table>
Continuing Care Assistant (6)

Continuing Care Assistants record, update and read the Patient Care Plan. Look at the Patient Care Plan. Transfer the information below to the first page of the Patient Care Plan.

Patient Care Plan (A)

- Maggie McGee is the client’s name.
- She is 74 years old.
- She has a rose coloured tattoo on her right ankle.
- Her previous address was Box 473, Timbuk, SK
- Her interests are playing the piano, singing and reading.
- She belongs to the United Church, where the pastor is Reverend Dickson.
- She attends that church every Sunday at 9:00 a.m.
- She was admitted to the hospital February 7, 2010.
- Her subsequent diagnosis was 1) aspiration pneumonia, 2) obesity, and 3) hypertension.
- She is allergic to penicillin.
Patient Care Plan

Code Status: __________ Date: ______
Eye color: __________ Hair color: __________

Other identification (scars, tattoos, etc.):

Previous Address: ________________________________________________

Next of kin: _____________________________________________________

Hobbies/interests/activities

Religion: __________ Pastor: ________________________________

Church Attendance: Day ____ Time ____ Frequency: __________________

__________________________

Health Care status

Admission Date: ______________ Transfer Date: _________________

Admission
Diagnoses

Subsequent Diagnosis/Date: ______________________________________

1. 3.
2. 4.

Hospitalization/Date:

1.
2.
3.

Allergies: None known (circle) or list:

__________________________
Answers

RM. __________
Client name: McGee, Maggie
Age: 74

Code Status: __________ Date: ________

Eye color: ________ Hair color: __________

Other identification (scars, tattoos, etc.): Tattoo - Rose Right Ankle

Previous Address: Box 473, Timbuk, SK

Next of kin:

Hobbies/interests/activities
Playing piano
Singing
Reading

Religion: United Pastor: Rev. Dickson

Church Attendance: Day: Sun Time: 9 AM Frequency: Weekly

Health Care status

Admission Date: Feb. 7, 2010 Transfer Date: __________

Admission
Diagnoses

Subsequent Diagnosis/Date:
1. Aspiration pneumonia 3. Hypertension
2. Obesity 4.

Hospitalization/Date:
1.
2.
3.

Allergies: None known (circle) or list: Penicillin

_________________________________________________________

_________________________________________________________

_________________________________________________________
Continuing Care Assistant (6)

Continuing Care Assistants record, update and read the Patient Care Plan. Look at the second and third pages of the Patient Care Plan. Answer the questions below.

Patient Care Plan (B)

1. What does Maggie McGee do when she’s frustrated?

2. Describe her ability to communicate.

3. What kind of restraints does she need?

4. What are staff expected to do when she becomes frustrated and teary?

5. Why are staff expected to watch her “food pocketing”?
   (Food pocketing means hiding food to eat later when she is alone.)
# Patient Care Plan

## I. ACTIVITIES OF DAILY LIVING

### PERSONAL HYGIENE:
- **AM care:** Self ❌ Partial Assist ❌ Total Assist ✅
  - Assist: one person ✓ Two person ❌
  - **Needs encouragement to wash own hands and face.**
- **PM Care:** Self ❌ Partial Assist ✅ Total assist ❌
  - Assist: one person ✓ Two Person ❌
  - Comments: ____________________________

### Bathing
- Whirlpool ✓ Tub ❌ Bed ❌
- Day and Time: ❌ Friday ❌ evening
  - Comments: ____________________________

### Dressing/Undressing
- Self ❌ Partial assist ✅ Total Assist ❌
  - **Needs encouragement.**

### Hair
- Wash ❌ Set ❌ Special Shampoo ❌
  - Beauty Parlour: Day and Time: ❌ 5th Am
  - Comments: ____________________________

### Skin/Nail Care
- Rash ❌ Fragile ❌ Open Areas ❌
  - Clip Nails Self ❌ Assist ❌
  - Special Treatments: Specify Type and Times
  - **Skin folds reddened and excoriated.**

### Oral Care
- Dentures; Upper ✓ Lower ✓ Partial ❌
  - Own Teeth ✓ Brushes; Self ❌ assist ❌
  - Requires mouth care: Yes ✓ No ❌
  - Comments: Uses own denture paste.

## Elimination
- Continent ❌ Incontinent ✓
- Regular toileting: Times: ❌
  - On Toilet ❌ with supervision ❌
  - On Commode ❌ with supervision ❌
  - **Wears X to Attend.**

### Catheter
- Leg bag ❌ Continuous drainage ❌
  - Comments: ____________________________

### Bowel care regime: ❌ 3 day plan
- Incontinence Product: Soaker, pull-ups, etc)
  - In chair: ❌
  - In bed: ❌
  - **SEE ABOVE.**

### Colostomy
  - Comments: ____________________________

### Restraints
- Side rails: day- up ❌ down ❌
  - Night- up ❌ down ❌
  - Jacket Restraint ❌ Lap Restraint ❌
  - w/c seat belt ✓ w/c/gerichair table ✓
  - Other (specify): ____________________________
  - Chair ❌ bed ❌ all times ❌
  - Comments: ____________________________

### Nutrition
- Diet: Dental Soft
  - Eats: self ❌ partial assist ✓ total assist ❌
  - Appetite: Good ✓ Fair ❌ poor ❌
  - Food Supplement required: Yes ❌ no ✓
  - Seating: Dining Room ✓ Lounge ❌ other ❌
  - Gastric Feeding ❌
  - **Watch for pocketing food.**
  - Chokes easily
## Patient Care Plan

### Sleep/Rest
- Sleeps: good __ Fair __ Poor ✓
- Time to go to bed: 20:00
- Time to get up: 06:30
- Positioning: yes ✓ no
- Sliding sheet: yes ✓ no
- Assist one person __ Two person ✓
- Afternoon nap: yes ✓ No __
- Comments: __________________________

### Mobility
- Walks: independently __ with assist __
- Aids: Cane __ Walker __
- Walking Program: Day & Time __________
- Comments: __________________________

### Transfer Assessment/TLR
- Independent __ supervision __
- Assist __ One person __ Two person __
- Sit/stand ✓ Mechanical lift __
- Comments: __________________________

### II. SENSORY ABILITY
- Hearing: good __ Limited ✓ deaf __
- Wears hearing aid: yes __ no ✓
- Vision: Good __ Limited ✓ Blind __
- Wears glasses: yes ✓ no __
- Comments: __________________________

### Communication
- Speech: normal __ hard to understand ✓
- Unintelligible __ language barrier __
- Comments: __________________________

### III. PSYCHOSOCIAL
#### Emotional Status
- Normal __ Depressed ✓ Niosy __
- Delusional __ Hallucinations __
- Frequent agitation __
- Aggressive: verbally ✓ Physically __
- Assist: one person __ two person __
- Comments: When frustrated, tends to swear at staff.

#### Memory/orientation
- Orientated (time, place, person) ✓
- Forgetful __ Occasional Confusion __
- Total confusion __
- Tendency to wander: Yes __ no ✓
- Comments: __________________________

### Activities
- Group: one-to-one ✓
- Attends church: yes __ no __
- Catholic Mass __ Protestant services ✓
- (Outside) in community __
- Comments: __________________________

### Special Needs
- I.D. Bracelet: yes ✓ no __
- Uses Tobacco: yes __ no ✓
- Uses alcohol: yes __ no __ Occasional
- Takes Leader Post: yes ✓ no __
- Own Telephone: yes ✓ no __

### Special Needs
- Transportation: Yes __ no __
- Other (specify): Para transit __
- Comments: outlying __

### Additional Information
- When becomes frustrated and tearful, still son as per his request.
**Continuing Care Assistant (6)**

Continuing Care Assistants record, update and read the Patient Care Plan. Look at the second and third pages of the Patient Care Plan. Answer the questions below.

**Patient Care Plan (B)**

1. What does Maggie McGee do when she’s frustrated?
   - She tends to swear at staff.

2. Describe her ability to communicate.
   - She is hard to understand.
   - Her speech is slurred.
   - She becomes frustrated easily.
   - She responds slowly.

3. What kind of restraints does she need?
   - She needs the side rails up day and night.
   - She needs a gerichair table.

4. What are staff expected to do when she becomes frustrated and teary?
   - Staff are expected to call her son.

6. Why are staff expected to watch her “food pocketing”?
   - Because she chokes easily.
**Licensed Practical Nurse (7)**

Licensed Practical Nurses administer drugs to patients in a safe manner. They read and interpret labels. Read “Reconstituting a Powdered Drug”, and then look at the Ampicin label.

**Ampicin Label**

1. Write down the weight of Ampicin powder indicated on the label.

2. How much sterile water is added to the Ampicin powder when administering intravenously (i.e., for IV use)?

3. After reconstituting the Ampicin powder, during what period of time should it be used?
**Licensed Practical Nurse (7)**

Licensed Practical Nurses administer drugs to patients in a safe manner. They read and interpret labels. Read “Reconstituting a Powdered Drug”, and then look at the Ampicin label.

**Ampicin Label**

1. Write down the weight of Ampicin powder indicated on the label.
   - 500 mg

2. How much sterile water is added to the Ampicin powder when administering intravenously (i.e., for IV use)?
   - 5 ml

3. After reconstituting the Ampicin powder, during what period of time should it be used?
   - 1 hour
Licensed Practical Nurse (8)

Licensed Practical Nurses are required to be licensed with the provincial licensing agency. Look at the Saskatchewan Association of Licensed Practical Nurses Renewal Form as an example.

Renewal Form
1. When do Licensed Practical Nurses in Saskatchewan need to renew their license?

2. What is the membership fee for a practicing Licensed Practical Nurse?

3. Name four categories in which Licensed Practical Nurses can earn continuing education points.

4. Sally’s primary place of employment is a hospital. What code does she use to indicate her place of work?

5. Sally’s primary area of responsibility in direct patient care is in medical/surgical. What code does she use to indicate her primary area of responsibility?
**2010 RENEWAL FORM**

**MEMBERSHIP FEE:**
- **PRACTICING:** $400.00
- **NON-PRACTICING:** $50.00

**HAVE YOU BEEN CONVICTED OF A CRIMINAL OFFENSE IN THE PAST 12 MONTHS?**
- **YES**
- **NO**

**WHAT REGIONAL HEALTH AUTHORITY IS YOUR PRIMARY EMPLOYER?**
- **Regina Qu'Appelle Health Region**

**SECOND EMPLOYER**
- **Regina General Hospital**
- **Address:** 1440 14th Ave, Regina, Sask. 3SK 0X7

**THIRD EMPLOYER**
- **Address:** 1440 14th Ave, Regina, Sask.

**JOINING YEAR:**
- **2009**
- **2007**
- **2006**

**PLACES OF WORK**
<table>
<thead>
<tr>
<th>PRIMARY EMPLOYER</th>
<th>SECOND EMPLOYER</th>
<th>THIRD EMPLOYER</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>02</td>
<td></td>
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<tr>
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<td></td>
<td></td>
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<td>05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**POSITION**
- **CPN/STAFF NURSE**
- **LPN/STAFF NURSE**
- **NURSE AIDE**
- **NURSE AIDE/STAFF NURSE**
- **NURSE, REGISTERED**
- **NURSE, LICENSED**

**PRIMARY AREA OF RESPONSIBILITY**
- **DIRECT PATIENT CARE**
- **NURSING SERVICE**
- **NURSING EDUCATION**
- **NURSE, LICENSED**

**ARE YOU LICENCED IN ANOTHER JURISDICTION?**
- **YES**
- **NO**

**LATE PENALTY FEE OF $20.00 WILL BE CHARGED FOR REGISTRATIONS RECEIVED IN THE SALPN OFFICE BETWEEN DEC. 2 AND DEC. 31, 2009. REGISTRATIONS NOT RECEIVED ON TIME WILL BE SUBJECT TO THE LATE FEE PENALTY.**

**RENEWALS RECEIVED JANUARY 1, 2010 OR LATER WILL ALSO BE SUBJECT TO A REINSTATEMENT FEE OF $200.00.**
CONTINUING EDUCATION PORTFOLIO
See the 2010 Renewal Guide for important information regarding registration audits.

RECORD OF EDUCATION POINTS 2009
Total of 5 Continuing Education Points is required annually.

LPNs that successfully complete SIAST completer courses (Administration of Medication, IM’s, IV’s, Catheterization, Wound Care) and Nursing 227 or equivalent will earn 3 CEP points plus be credited with an additional 3 points per course to be used against next year’s CEP requirements.

EDUCATION COURSES/IN-SERVICES

<table>
<thead>
<tr>
<th>COURSE LENGTH</th>
<th>NAME OF COURSE</th>
<th>EDUCATIONAL PROVIDER</th>
<th>DATE(S)</th>
<th>POINT(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVER 2 DAYS (3 POINTS)</td>
<td>Administration of Medications</td>
<td>SIAST</td>
<td>Jan-Mar</td>
<td>5</td>
</tr>
<tr>
<td>OVER 1 TO 2 DAYS (1 POINTS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OVER 1/2 TO 1 DAY (2 POINTS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/2 DAY OR LESS 1 HR MIN (1 POINT)</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Carry over points for 2011

PROFESSIONAL NURSING PARTICIPATION (Maximum 2 points)

<table>
<thead>
<tr>
<th>ACTIVITY TITLE/DESCRIPTION</th>
<th>MEMBER'S ROLE</th>
<th>CONTACT PERSON &amp; PHONE #</th>
<th>MEETING DATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 OR MORE MEETINGS PER YEAR (2 POINTS)</td>
<td>SALPN AGM</td>
<td>Phone: 306-725-3689</td>
<td>April 26-28</td>
</tr>
<tr>
<td>6 TO 9 MEETINGS PER YEAR (1 POINT)</td>
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</tbody>
</table>

PRECEPTORSHIP – LPN’s who preceptor practical nurse students attending a qualified educational institute. (Maximum 2 points)

<table>
<thead>
<tr>
<th>STUDENT NAME</th>
<th>NAME OF PROGRAM</th>
<th>LENGTH OF PRECEPTORSHIP</th>
<th>EDUCATOR CONTACT &amp; PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRECEPTOR 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRECEPTOR 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRECEPTOR 3</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

ARTICLES, AUDIO-VISUAL, INTERNET – All material must be from a health or nursing source recognized by the SALPN. (Maximum 1 point)

<table>
<thead>
<tr>
<th>TITLE</th>
<th>AUTHOR</th>
<th>SOURCE (DETAILED)</th>
<th>DATE/ISSUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.25 POINT</td>
<td></td>
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<td>0.25 POINT</td>
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<td>0.25 POINT</td>
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</tr>
<tr>
<td>0.25 POINT</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT

May 5, 2010
306 725-2569
306-537-8962
786-4444

Sally Brown
sbrown@sasktel.net
Licensed Practical Nurse (8)

Licensed Practical Nurses are required to be licensed with the provincial licensing agency. Look at the Saskatchewan Association of Licensed Practical Nurses Renewal Form as an example.

Renewal Form

1. By what date do Licensed Practical Nurses in Saskatchewan need to renew their license?
   - Renewal deadline is Dec. 1, 2009.

2. What is the membership fee for a practicing Licensed Practical Nurse?
   - $400.00

3. Name the four categories in which Licensed Practical Nurses can earn continuing education points.
   - Education Courses/In-Services
   - Professional Nursing Participation
   - Preceptorship
   - Articles, Audio-Visual, Internet

4. Sally’s primary place of employment is a hospital. What code does she use to indicate her place of work?
   - 01

6. Sally’s primary area of responsibility in direct patient care is in medical/surgical. What code does she use to indicate her primary area of responsibility?
   - 01
**Licensed Practical Nurse (9)**

Licensed Practical Nurses assess clients’ level of consciousness by observing and giving a numeric value. Look at the Adult Neurosciences Watch Sheet.

*Adult Neurosciences Watch Sheet*

1. What three main categories does the coma scale include?

2. Describe the client’s responses at 1400 hours.

3. Plot the client’s eye responses on the COMA SCALE from 1600 hours to 600 hours as follows:

   - 1600   eyes open to pain
   - 1800   eyes open to pain
   - 2000   eyes open to pain
   - 2200   eyes open to pain
   - 2400   eyes open to speech
   - 0200   eyes open to speech
   - 0400   eyes open spontaneously
   - 1600   eyes open spontaneously

4. Complete the coma scale scores.
## Adult Neurosciences Watch Sheet

**Date:** May 4, 2010

### COMA Scale

<table>
<thead>
<tr>
<th>Time</th>
<th>9:00</th>
<th>10:00</th>
<th>11:00</th>
<th>12:00</th>
<th>13:00</th>
<th>14:00</th>
<th>15:00</th>
<th>16:00</th>
<th>17:00</th>
<th>18:00</th>
<th>19:00</th>
<th>20:00</th>
<th>21:00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes Open</td>
<td>Spontaneously (4)</td>
<td>To Speech (3)</td>
<td>To Pain (2)</td>
<td>No Response (1)</td>
<td>Orientated (5)</td>
<td>Confused (4)</td>
<td>Inappropriate Words (3)</td>
<td>Incomprehensible Sounds (2)</td>
<td>None (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best Verbal Response</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best Motor Response</td>
<td>Obey Commands (6)</td>
<td>Localize Pain (5)</td>
<td>Withdraws (4)</td>
<td>Flexor Response (Dorsocutaneous Posturing) (3)</td>
<td>Extension Response (Dorsocutaneous Posturing) (2)</td>
<td>No Response (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### COMA Scale Score

**Limbs**

- **Arms**
  - Normal Power
  - Mild Weakness
  - Severe Weakness
  - Spastic Flexion
  - Extension
  - No Response

- **Legs**
  - Normal Power
  - Mild Weakness
  - Severe Weakness
  - Spastic Flexion
  - Extension
  - No Response

**Pupils:**

- **Size Reaction**
  - Right
  - Left

### Initials

- **Reacts**
- **No Reaction**
- **Eye Closed**

**Pupil Scale (mm):**

- 2
- 4
- 6
- 8

---

Essential Skills Resources for Aboriginal Learners / 51
Licensed Practical Nurse (9)

Licensed Practical Nurses assess clients’ level of consciousness by observing and giving a numeric value. Look at the Adult Neurosciences Watch Sheet.

Adult Neurosciences Watch Sheet

1. What three main categories does the coma scale include?
   - eyes open
   - best verbal response
   - best motor response

2. Describe the client’s responses at 1400 hours.
   - eyes open—to pain
   - best verbal response—incomprehensible sounds
   - best motor response—withdraws

3. Plot the client’s eye responses on the COMA SCALE from 1600 hours to 600 hours as follows:
   - See Adult Neurosciences Watch Sheet.

4. Complete the coma scale scores.
   - See Adult Neurosciences Watch Sheet.
## Adult Neurosciences Watch Sheet

**Jane Tree**  
**DOB September 3, 1954**  
**SHSP # 123456789**

<table>
<thead>
<tr>
<th>Date:</th>
<th>May 4, 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Eyes Open</strong></td>
<td></td>
</tr>
<tr>
<td>Spontaneously</td>
<td>4</td>
</tr>
<tr>
<td>To Speech</td>
<td>3</td>
</tr>
<tr>
<td>To Pain</td>
<td>2</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
</tr>
<tr>
<td><strong>Best Verbal Response</strong></td>
<td></td>
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<tr>
<td>Orientated</td>
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<tr>
<td>Confused</td>
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<td>Inappropriate Words</td>
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<td>Incomprehensible Sounds</td>
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</tr>
<tr>
<td>Localize Pain</td>
<td>5</td>
</tr>
<tr>
<td>Withdraws</td>
<td>4</td>
</tr>
<tr>
<td>Feyer Response (Decorticize)</td>
<td>3</td>
</tr>
<tr>
<td>Extensor Response (Decorticize)</td>
<td>2</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
</tr>
</tbody>
</table>

**COMA SCALE SCORE**  

7 7 7 8 8 8 10 11 15 15

**Arms**  
- Normal Power
- Mild Weakness
- Severe Weakness
- Spastic Flexion
- Extension
- No Response

**Legs**  
- Normal Power
- Mild Weakness
- Severe Weakness
- Spastic Flexion
- Extension
- No Response

**Pupils:**  
- Size Reaction  
  - Right
  - Left

**Initials:**  

- Reacts
- No Reaction
- Eye Closed

---

Essential Skills Resources for Aboriginal Learners / 53
Licensed Practical Nurse (10)

Licensed Practical Nurses are required to move and lift clients safely. Look at the Transfer, Lifting and Repositioning (TLR) Mobility Record.

**TLR Mobility Record (A)**

1. What are the five risk factors that must be assessed for each client?

2. Name one item under “Health Information – Emotional/Behavioral Status,” which Licensed Practical Nurses evaluate? Emotional/Behavioral Status is the third category in Health Information.

3. Which item under Standing Abilities makes a reference to “time”?

4. Which item has to do with the patient’s “hands”?

5. “Walking on the spot” is used to evaluate which ability?
# Mobility Record

**Level of Assessment:**
- G - General Client Mobility Assessment
- O - Ongoing Client Mobility Assessment

Initial if criteria met
- ✔️ if criteria met but written note required
- ✗ if criteria not met, written note required
- NA or / if criteria not applicable

<table>
<thead>
<tr>
<th>Date (Y/M)</th>
<th>Day</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Level of Assessment

### Communication Status
- Is able to communicate needs

### Vision Status
- Vision is adequate (**specify device(s) on side 2**)

### Hearing Status
- Hearing is adequate (**specify device(s) on side 2**)

### Cognitive Status
- Is able to remember instructions related to the move

### Emotional/Behavioral Status
- Is able to judge own capabilities in moving
- Is able to make decisions

### Health Information
- Displays stable moods
- Demonstrates predictable/cooperative behaviours

### Medical Status
- Is able to participate in move despite medical condition
- Is aware of own body position in space
- Is able to move with attachments/appliances
- Is able to move despite pain/fatigue
- Is able to participate in the move despite effects of medication

## Risk Factors

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Pre-Mobilization Abilities</th>
<th>Abilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Can grip, push &amp; pull hand in a handshake</td>
<td>Rt, Lt</td>
</tr>
<tr>
<td></td>
<td>Can bend knee and lift leg</td>
<td>Lt, Lt</td>
</tr>
<tr>
<td></td>
<td>Can move foot up &amp; down at the ankle</td>
<td>Lt, Lt</td>
</tr>
<tr>
<td></td>
<td>Can roll from side to side in bed</td>
<td>Lt, Lt</td>
</tr>
</tbody>
</table>

## Sitting Abilities
- Can get into sitting position
- Can sit unassisted for 15 seconds
- Can right self when gently tipped in all four directions

## Standing Abilities
- Can position self for standing
- Can lift body weight off buttocks/hips
- Can stand independently
- Can remain standing for 15 seconds
- Balanced when lifting one arm at a time to front and side

## Walking Abilities
- Can shift weight from one foot to another
- Can walk on the spot
- Can walk from one location to another

© SAHO, Dec 2005

Essential Skills Resources for Aboriginal Learners / 55
Licensed Practical Nurse (10)

Licensed Practical Nurses are required to move and lift clients safely. Look at the Transfer, Lifting and Repositioning (TLR) Mobility Record.

TLR Mobility Record (A)
1. What are the five risk factors that must be assessed for each client?
   - walking abilities
   - standing abilities
   - sitting abilities
   - pre-mobilization abilities
   - health information

2. Name one item under Health Information – Emotional/Behavioral Status, which Licensed Practical Nurses evaluate? Emotional/Behavioral Status is the third category in Health Information.
   - displays stable moods, or
   - demonstrates predictable/cooperative behaviours

3. Which item under Standing Abilities makes a reference to “time”?
   - can remain standing for 15 seconds

4. Which item has to do with the patient’s “hands”?
   - can grip, push & pull hand in a handshake

5. “Walking on the spot” is used to evaluate which ability?
   - walking ability
**Licensed Practical Nurse (10)**

Licensed Practical Nurses are required to move and lift clients safely. Look at the “Indications for Use” descriptions. Match each description with its corresponding symbol on the following pages. Write the correct number next to the symbol.

**TLR Symbols – Indications for Use (B)**

1. An **independent transfer** is used by the client to move from one surface/location to another surface/location with or without the use of assistive devices such as a cane or walker (e.g., from a bed to a wheelchair, or from a wheelchair to the bathroom/toilet).

2. A **minimum assistance transfer** is used to move the client from one surface/location to another surface/location with or without the use of assistive devices such as a cane or walker.

3. A **one-person transfer with belt** is used to move the client from one surface/location to another surface/location with or without the use of assistive devices such as a cane or walker.

4. A **one-person transfer with belt and assistant** is used to move the client from one surface/location to another surface/location with or without the use of assistive devices such as a cane or walker.

5. A **two-person transfer with belt and assistant** is used to move the client from one surface/location to another surface/location with or without the use of assistive devices such as a cane or walker.

6. A **sit/stand lift** is used to move the client from one seating surface to: another seating surface (e.g., from a bed to a wheelchair) or to a bathroom adjacent to the client’s room.

7. A **total lift** is used to move the client:
   - To a bathroom adjacent to the client’s room
   - In and out of bathtubs using “bathing” mesh slings, if the life base is compatible with the tub base/supports
   - In bed, if repositioning devices are inaccessible or inappropriate for the client

8. **Bed rest** is appropriate for the client who has been confined to bed by their physician or by the nature of their medical condition (e.g., the client with a back injury or fracture, or the palliative patient).
TLR Symbols - Indications for Use
TLR Symbols - Indications for Use

1. [Diagram of three individuals]

2. [Diagram of two individuals]

3. [Diagram of two individuals with a child]

4. [Diagram of two individuals with a child]
7. a total lift

8. bed rest

6. a sit/stand lift

3. a one-person transfer with belt
TLR Symbols - Indications for Use

1. an independent transfer

5. a two-person transfer with belt and assistant

4. a one-person transfer with belt and assistant

2. minimum assistance transfer
**Health Care Professionals (e.g., Nurses) (11)**

Health Care Professionals are required to obtain and record patient information when someone is admitted to a health facility for surgery. Look at the Admission Assessment & History form. If you don’t know the meaning of certain words, ask your instructor/trainer before answering the questions below.

**Admission Assessment & History Form**

1. Who is the patient?

2. Enter the following information about the patient.
   - May Harris – wife
   - Penicillin allergy
   - Lower dentures
   - Wears reading glasses

3. What is Jeff’s diagnosis?

4. What treatment procedure will Jeff receive?

5. How many calories should Jeff have?

6. What food intolerance does Jeff have?
   (A “food intolerance” means that a person will get sick or have an allergic reaction if he or she eats or drinks a particular food.)
**ADMISSION ASSESSMENT & HISTORY**

**MEDICINE/SURGERY**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Personal care assistance (bathing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal care assistance (grooming)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal care assistance (oral care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal care assistance (dressing)</td>
<td></td>
<td></td>
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<tr>
<td>Devices with patient</td>
<td></td>
<td></td>
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</tbody>
</table>

**Test(s)/X-ray(s) completed to date**
- CBC
- Electrolytes
- UA
- CXR
- ECG
- Crossmatch

**Next of Kin**
- Name:
- Relationship:
- Designated Contact: as above
- Relationship:

**Phone (H):** 306-524-2160 (C)

**Pre-op bath done**
<table>
<thead>
<tr>
<th><strong>ELIMINATION</strong></th>
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<tbody>
<tr>
<td>Difficulty with bowel care  (describe problem and help needed)</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td>☐</td>
<td></td>
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<tr>
<td>Diarrhea</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Incontinence</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Bowel Pattern:</td>
<td>☐</td>
<td>OD</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>EOD</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>q 3 days</td>
</tr>
<tr>
<td>Other:</td>
<td>☐</td>
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<tr>
<td>Date of last BM:</td>
<td><strong>Oct 26/07</strong></td>
<td></td>
</tr>
<tr>
<td>Difficulty with bladder care  (describe problem and help needed)</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Incontinence</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Frequency (how often)</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Nocturia (nights up)</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>1-2 times</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Toileting regime:</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Intermittent catheter</td>
<td>☐</td>
<td>q</td>
</tr>
<tr>
<td>Frequency of change:</td>
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<tr>
<td>Date of last change:</td>
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<tr>
<th><strong>NUTRITION</strong></th>
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<tbody>
<tr>
<td>Specific diet  (specify):</td>
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<tr>
<td>Regular</td>
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<td></td>
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<tr>
<td>Other:</td>
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<td>Diabetic – approximately 1800 calories</td>
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<td>Nutritional Pattern:</td>
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<td>6 small meals</td>
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<td></td>
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<tr>
<td>hs snack</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Food intolerance  (specify):</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Spicy foods cause gas</td>
<td>☐</td>
<td></td>
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<tr>
<td>Difficulty eating/drinking</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Difficulty chewing</td>
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<tr>
<td>Recent weight gain</td>
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<td></td>
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<tr>
<td>Dysphagia</td>
<td>☐</td>
<td></td>
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<tr>
<td>Recent weight loss</td>
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<td></td>
</tr>
<tr>
<td>☑ NPO</td>
<td>☐</td>
<td>Last ate:</td>
</tr>
<tr>
<td>☑</td>
<td>☐</td>
<td>Last drank:</td>
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<tr>
<th><strong>MOBILITY</strong></th>
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<tbody>
<tr>
<td>Devices used:</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Walker</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Cane</td>
<td>☐</td>
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<td>Orthopedic:</td>
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<td>(Specify)</td>
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<td>Prosthesis:</td>
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<td>(Specify)</td>
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<td>Other:</td>
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<tr>
<td>☐ With Patient</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ At Home</td>
<td>☐</td>
<td></td>
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</tbody>
</table>
Health Care Professionals (e.g., Nurses) (11)

Health Care Professionals are required to obtain and record patient information when someone is admitted to a health facility for surgery. Look at the Admission Assessment & History form. If you don’t know the meaning of certain words, ask your instructor/trainer before answering the questions below.

**Admission Assessment & History Form**

1. Who is the patient?
   - Jeff Harris

2. Enter the following information about the patient:
   - May Harris – wife
   - Penicillin allergy
   - Lower dentures
   - Wears reading glasses

3. What is Jeff’s diagnosis?
   - Non functioning Lt Kidney

4. What treatment procedure will Jeff receive?
   - Lt. Nephrectomy

5. How many calories should Jeff have?
   - 1800

6. What food intolerance does Jeff have?
   - Spicy foods cause gas
**ADMISSION ASSESSMENT & HISTORY**

**MEDICINE/SURGERY**

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<thead>
<tr>
<th>Pre-Admission - Date &amp; Time</th>
<th>Admission - Date &amp; Time</th>
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<tr>
<td>○ See Notes</td>
<td>Oct 05/07 - 0045</td>
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<tr>
<td>Oct 11/07 - 0045</td>
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<th>Reviewed and completed by:</th>
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<tr>
<td>○ See Notes</td>
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<table>
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<tr>
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<tbody>
<tr>
<td>○ English</td>
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<td>○ Retired Teacher</td>
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<th>Source of Information</th>
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<tr>
<td>○ Self</td>
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<tr>
<td>○ Other</td>
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<table>
<thead>
<tr>
<th>Age</th>
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<tbody>
<tr>
<td>JEFF HARRIS</td>
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<table>
<thead>
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<th>Diagnosial Procedure</th>
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<tr>
<td>○ Non functioning Lt Kidney - Lt. Nephrectomy</td>
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<th>Date Booked:</th>
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| Consult                    |
|○ consent on pt record      |

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<tr>
<td>○ CBC</td>
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<tr>
<td>○ Electrolytes</td>
</tr>
<tr>
<td>○ UA</td>
</tr>
<tr>
<td>○ CXR</td>
</tr>
<tr>
<td>○ ECG</td>
</tr>
<tr>
<td>○ Crossmatch</td>
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<tr>
<td>○ Other</td>
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<th>Allergies:</th>
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<td>○ None Known</td>
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<tr>
<td>○ Medi Alert on</td>
</tr>
<tr>
<td>○ Agency Alert on</td>
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<table>
<thead>
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<td>○ Drug:</td>
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<tr>
<td>Penicillin</td>
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<th>Food:</th>
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<tbody>
<tr>
<td>○ Latex</td>
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<tr>
<td>○ Other</td>
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<table>
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<tr>
<th>Next of Kin: Name:</th>
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<tr>
<td>○ May Harris</td>
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<tr>
<td>Wife</td>
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<table>
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<th>Designated Contact:</th>
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<tr>
<td>○ as above</td>
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<table>
<thead>
<tr>
<th>Phone (H):</th>
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<tr>
<td>○ 306-524-2160 (C)</td>
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<table>
<thead>
<tr>
<th>PATIENT’S RESPONSE and INTERVIEWER’S COMMENTS</th>
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<tr>
<td>○ Pre-op bath done</td>
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<thead>
<tr>
<th>QUESTIONS</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Personal care assistance</td>
<td>bathing</td>
<td>✓</td>
</tr>
<tr>
<td>grooming</td>
<td>Ø</td>
<td></td>
</tr>
<tr>
<td>oral care</td>
<td>Ø</td>
<td></td>
</tr>
<tr>
<td>dressing</td>
<td>Ø</td>
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<table>
<thead>
<tr>
<th>PERSONAL HYGIENE</th>
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<tbody>
<tr>
<td>assistance provided</td>
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<tr>
<td>Family</td>
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<tr>
<td>Home Care</td>
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<tr>
<td>LTC</td>
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<td>Day Care</td>
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<th>devices with patient</th>
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<td>Hearing aid (es)</td>
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<td>Ø</td>
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<td>Lower</td>
<td>Ø</td>
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<tr>
<td>Partial</td>
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<td></td>
</tr>
<tr>
<td>Caps</td>
<td>Ø</td>
<td></td>
</tr>
<tr>
<td>With Patient</td>
<td>Ø</td>
<td></td>
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<tr>
<td>At Home</td>
<td>Ø</td>
<td></td>
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<tr>
<td>Glasses</td>
<td>reading</td>
<td>Ø</td>
</tr>
<tr>
<td>Contact lens</td>
<td>Ø</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Ø</td>
<td></td>
</tr>
<tr>
<td><strong>Elimination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Difficulty with bowel care (describe problem and help needed)</td>
<td>√</td>
<td>☐ Constipation ☐ Diarrhea ☐ Incontinence Aids used: ☐ Pads ☐ Liners ☐ Briefs/Pull-ups ☐ Other:</td>
</tr>
<tr>
<td>Bowel Pattern:</td>
<td>☐ OD ☐ EOD ☐ q 3 days</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of last BM:</td>
<td>Oct 26/07</td>
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<table>
<thead>
<tr>
<th><strong>Elimination</strong></th>
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<tbody>
<tr>
<td>Difficulty with bladder care (describe problem and help needed)</td>
<td>√</td>
</tr>
<tr>
<td>☐ Incontinence</td>
<td>☐ Indwelling Catheter: (size &amp; type) Aids used: ☐ Pads ☐ Liners ☐ Briefs/Pull-ups ☐ Other:</td>
</tr>
<tr>
<td>☐ Frequency (how often)</td>
<td>☐ Intermittent catheter q</td>
</tr>
<tr>
<td>☐ Nocturia (no of times up) 1-2 times</td>
<td>☐ Freq. of change: q</td>
</tr>
<tr>
<td>Toileting regime:</td>
<td>☐ Date of last change:</td>
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<thead>
<tr>
<th><strong>Nutrition</strong></th>
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</thead>
<tbody>
<tr>
<td>Specific diet (specify)</td>
<td>√</td>
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<tr>
<td>☐ Regular ☐ Other: Diabetic – approximately 1800 calories</td>
<td></td>
</tr>
<tr>
<td>Nutritional Pattern:</td>
<td></td>
</tr>
<tr>
<td>☐ 3 regular meals ☐ 6 small meals ☐ hs snack ☐ between meal snacks ☐ Other:</td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Nutrition</strong></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Food intolerance (specify)</td>
<td>√</td>
</tr>
<tr>
<td>Spicy foods cause gas</td>
<td></td>
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<table>
<thead>
<tr>
<th><strong>Mobility</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty eating/drinking</td>
<td>√</td>
</tr>
<tr>
<td>☐ Difficulty chewing ☐ Recent weight gain ☐ Dysphagia ☐ Recent weight loss</td>
<td></td>
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<table>
<thead>
<tr>
<th><strong>Mobility</strong></th>
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</thead>
<tbody>
<tr>
<td>Physical disabilities (describe help needed):</td>
<td>√</td>
</tr>
<tr>
<td>☐ NPO ☐ Last ate: ☐ Last drank:</td>
<td></td>
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<thead>
<tr>
<th><strong>Mobility</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Devices used:</td>
<td>√</td>
</tr>
<tr>
<td>☐ Walker ☐ Prosthesis: (leg) ☐ With Patient</td>
<td></td>
</tr>
<tr>
<td>☐ Cane ☐ Orthopedic: (leg) ☐ At Home</td>
<td></td>
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<tr>
<td>☐ Wheelchair ☐ Other:</td>
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</tr>
</tbody>
</table>
**Health Care Professionals (e.g., Nurses) (12)**

**Patient Medication Form**

Registered nurses administer medications on physician’s orders. Look at the medication administration record.

1. Who is the patient?

2. Name two medications that were administered at 10 AM.

3. What are the patient’s allergies?

4. What should the nurse do to medication before administering it?

5. How often should acetaminophen be administered?
   
   - PRN means as required
   - q means how often something should happen
   - h means hour(s)
<table>
<thead>
<tr>
<th>Medications</th>
<th>00 02 04 06 08 10 12 14 16 18 20 22</th>
<th>01 03 05 07 09 11 13 15 17 19 21 23</th>
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</thead>
<tbody>
<tr>
<td>DIGOXIN 0.25 mg</td>
<td>PO</td>
<td>10</td>
</tr>
<tr>
<td>1 TAB PO OD</td>
<td>RX 2898</td>
<td></td>
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<tr>
<td>STOP: MAR 24 23:59</td>
<td></td>
<td></td>
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<tr>
<td>FUROSEMIDE 40 mg</td>
<td>PO</td>
<td>10</td>
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<tr>
<td>1 TAB PO OD</td>
<td>RX 2913</td>
<td></td>
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<tr>
<td>STOP: MAR 24 14:38</td>
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<tr>
<td>DIAZEPAM 5 mg</td>
<td>PO</td>
<td>10 22</td>
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<tr>
<td>1 TAB PO BID</td>
<td>RX 2907</td>
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<td>STOP: MAR 6 22:00</td>
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<table>
<thead>
<tr>
<th>PRN Medication</th>
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<tbody>
<tr>
<td>ACETAMINOPHEN 325 mg</td>
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<tr>
<td>1-2 TAB PO q3h</td>
<td>RX 2908</td>
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<tr>
<td>STOP: MAR 6 22:00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Health Care Professionals (e.g., Nurses) (12)

Patient Medication Form

Registered nurses administer medications on physician’s orders. Look at the medication administration record.

1. Who is the patient?
   - Mr. Albert Huff

2. Name two medications that were administered at 10 AM.
   - two of the following:
     - digoxin
     - furosemide
     - diazepam

3. What are the patient’s allergies?
   - penicillin, smoke

4. What should the nurse do to medication before administering it?
   - crush it

5. How often should acetaminophen be administered?
   - every three hours as required
**Health Care Professionals (e.g., Nurses) (13)**

Health Care Professionals record patients’ vital signs. Look at the clinical record for Jeff Harris.

**Clinical Record**

1. Who recorded the patient’s vitals on October 28, 2007?

2. What was Jeff Harris’ temperature at 10 p.m. on October 28th?

3. How much did Jeff Harris’ temperature increase on October 28th from 1400 hours to 2200 hours?

4. Plot the following vitals for Jeff Harris on October 29th:

<table>
<thead>
<tr>
<th>Vital</th>
<th>Time</th>
<th>Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature</td>
<td>1400</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>1800</td>
<td>36.8</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>1400</td>
<td>140/83</td>
</tr>
<tr>
<td></td>
<td>1800</td>
<td>135/79</td>
</tr>
</tbody>
</table>

Use the tip of the small triangle to show the the patient’s blood pressure.

<table>
<thead>
<tr>
<th>Vital</th>
<th>Time</th>
<th>Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse</td>
<td>1800</td>
<td>85</td>
</tr>
<tr>
<td>Respiration</td>
<td>1800</td>
<td>18</td>
</tr>
<tr>
<td>SaO2</td>
<td>1800</td>
<td>98.2</td>
</tr>
<tr>
<td>Intake</td>
<td>1800</td>
<td>Ice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IV/Blood 250</td>
</tr>
<tr>
<td>Output</td>
<td>1800</td>
<td>Urine 175</td>
</tr>
</tbody>
</table>
Health Care Professionals (e.g., Nurses) (13) Answers

Health Care Professionals record patients’ vital signs. Look at the clinical record for Jeff Harris.

Clinical Record

1. Who recorded the patient’s vitals on October 28, 2007?
   • JM

2. What was Jeff Harris’ temperature at 10 p.m. on October 28th?
   • 37.2 (degrees)

3. How much did Jeff Harris’ temperature increase on October 28th from 1400 hours to 2200 hours?
   • 1 (degree)

4. Plot the following vitals for Jeff Harris on October 29th:
   • Check the plot on the following page.
| Blood Pressure | 22 20 18 18 18 22 20 | 18 |
| Respiration / min | 98.3 98.4 98.1 98.3 98.2 98.1 98.4 | 98.2 |
| SaO2 % | 80 70 60 50 40 30 20 |
| Weight (kgs) | 250 |
| Oral / Tube Intake | NPO NPO Ice Ice Ice Ice |
| IV / Blood | 250 250 250 275 250 |
| Shift Total | 250 250 250 275 |
| 24 Hr Total | 500 |
| Urine | 100 100 175 200 175 |
| Enuresis | |
| Stool / Drain | |
| Shift Total | 100 100 175 200 |
| 24 Hr Total | 200 |

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Health Care Professionals (e.g., Nurses) (14)

Health Care Professionals complete discharge care plans for patients. Look at Jess Harris’ discharge care plan.

**Discharge Care Plan**

1. What nutritional restrictions does Jeff Harris have?

2. What signs of infection in his incision does Jeff Harris need to look for?

3. When should Jeff Harris notify his doctor?

4. What should Jeff Harris watch for in his urine?

5. Who completed the discharge plan?

6. How long should Jeff avoid heavy lifting?
**DISCHARGE CARE PLAN**

☐ From In-patient agency

☐ From Home Care

Referral to Home Care for:

☐ None

☐ Nursing Care

☐ Personal Care

☐ Home Maintenance

☐ Meals

☐ Physiotherapy

☐ Occupational Therapy

☐ Other.

Jeff Harris

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**INSTRUCTIONS FOR CARE**

**PERSONAL HYGIENE**  ☑ Independent  ☐ Handout (name & dept):

*Shower until suture line is well healed*

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**ELIMINATION**  ☑ Independent  ☐ Handout (name & dept):

*Watch for any blood in urine, pain on voiding or foul odor. Notify doctor if any excess pain, sudden pain on left side or any problem voiding.*

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**NUTRITION**  ☑ Independent  ☐ Handout (name & dept):

*Follow your previous Diabetic diet.*

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**MOBILITY**  ☑ Independent  ☐ Handout (name & dept):

*Gradually increase activity level for next 6 weeks until back to usual activities.*

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**OBSERVATIONS AND MEASUREMENTS**  ☐ Handout (name & dept):

*Watch for signs of infection in incision – redness, drainage, odor and report to Dr. immediately.*

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**MEDICATIONS**  ☐ Handout (name & dept):

Prescription  Yes ☑  No ☐  Own Medications Returned  Yes ☑  No ☐
Resume usual routine for glucose monitoring or checking your blood sugar.

No heavy lifting or shoveling etc. for the next 6 weeks.

HOME CARE PLAN

APPOINTMENTS

<table>
<thead>
<tr>
<th>NAME</th>
<th>LOCATION</th>
<th>TIME/DATE</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Brown</td>
<td>Clinic</td>
<td>Nov 16/07 at 1pm</td>
<td>345-6789</td>
</tr>
</tbody>
</table>

SHOW THIS PLAN TO YOUR HOME CARE PROVIDER(S) AND TAKE IT TO YOUR NEXT DOCTOR'S APPOINTMENT

The above information has been reviewed with the patient/family/significant other

SIGNATURE: [Signature]

DATE: Nov 5/07
ID: WL
**Health Care Professionals (e.g., Nurses) (14)**

Health Care Professionals complete discharge care plans for patients. Look at Jess Harris’ discharge care plan.

**Discharge Care Plan**

1. What nutritional restrictions does Jeff Harris have?
   - Follow your previous diabetic diet.

2. What signs of infection does Jeff Harris need to look for?
   - redness, drainage, odor

3. When should Jeff Harris notify his doctor?
   - if any excess pain, sudden pain on left side or problem voiding

4. What should Jeff Harris watch for in his urine?
   - blood

5. Who completed the discharge plan?
   - WL

6. How long should Jeff avoid heavy lifting?
   - for the next 6 weeks
Housekeeping Staff (15)

Housekeeping staff must clean rooms when a patient is discharged. Look at the Discharge/Transfer Cleaning Checklist for All Rooms.

Discharge/Transfer Cleaning Checklist for All Rooms

1. Name four additions that must be completed in a room of a patient on precautions.

2. Name one thing housekeeping staff should report to nursing.

3. What items must a housekeeper remove in a regular cleaning?

4. What items must be cleaned thoroughly before use by another patient?
Discharge / Transfer Cleaning Checklist for All Rooms

**Use regular cleaner**

1. All dirty/used items removed?  
   - Yes  
   - No  
   Suction container, etc.  
   - Yes  
   - No  
   Disposable items (Kleenex, bar soap tossed out)  
   - Yes  
   - No  

2. Are curtains removed before starting to clean if visibly soiled?  
   - Yes  
   - No  

3. Are clean cloths, mop (all supplies) and solution used to clean the room?  
   - Yes  
   - No  

4. Are mattress/pillows/chairs in room torn?  
   - Yes  
   - No  

5. If torn, did you report to supervisor to have replaced?  
   - Yes  
   - No  

6. No double dipping with used cloth?  
   - Yes  
   - No  

7. Were several cloths used to clean room?  
   - Yes  
   - No  

8. Do you always work from top to bottom?  
   - Yes  
   - No  

9. Do you clean all surfaces and allow for the appropriate contact time (10 minute contact time)  
   - Mattress/cover  
     - Yes  
     - No  
   - Pillow – Always replace protective pillow cover  
     - Yes  
     - No  
   - BP cuff  
     - Yes  
     - No  
   - Bedrails and bed controls  
     - Yes  
     - No  
   - Call bell  
     - Yes  
     - No  
   - Stethoscope and column  
     - Yes  
     - No  
   - Flow meters  
     - Yes  
     - No  
   - Suction tube and outer container  
     - Yes  
     - No  
   - Pull cord in washroom  
     - Yes  
     - No  
   - Overbed table  
     - Yes  
     - No  
   - Inside drawers  
     - Yes  
     - No  
   - TV control/T.V. – remotes wrapped in plastic  
     - Yes  
     - No  
   - Soap dispenser  
     - Yes  
     - No  
   - Door handles  
     - Yes  
     - No  
   - Light switches  
     - Yes  
     - No  
   - Light cord  
     - Yes  
     - No  
   - Chair  
     - Yes  
     - No  

10. Did you clean phone well?  
    - Yes  
    - No  

11. Are the following cleaned thoroughly before being used by another patient?  
    - Commodes/high toilet seat  
      - Yes  
      - No  
    - Wheelchairs  
      - Yes  
      - No  
    - IV poles/machines – once bag & tubing removed by nursing  
      - Yes  
      - No  

12. Let nursing know if sharps container needs replacing?  
    - Yes  
    - No  

13. Is the outer canister of the suction container and tubing cleaned?  
    - Yes  
    - No  

14. Is the new cloth bag in place over ziplock bag on suction?  
    - Yes  
    - No  

15. Is all tape removed from all surfaces?  
    - Yes  
    - No  

16. Is sheepskin washed between patients?  
    - Yes  
    - No  

17. Is the lift mesh or sheet washed between patients?  
    - Yes  
    - No  

**Additions When Cleaning A Room For A Patient On Precautions**

1. Are curtains removed before starting to clean the room that was used for additional precautions?  
   - Yes  
   - No  

2. Is glove box discarded?  
   - Yes  
   - No  

3. Are the following discarded:  
   - Soap  
     - Yes  
     - No  
   - Toilet paper  
     - Yes  
     - No  

4. Is the sharps container wiped? If ¼ full notify nursing  
   - Yes  
   - No  

**AVOID STOCKPILING IN ROOMS TO PREVENT WASTAGE**
Housekeeping Staff (15)

Housekeeping staff must clean rooms when a patient is discharged. Look at the Discharge/Transfer Cleaning Checklist for All Rooms.

Discharge/Transfer Cleaning Checklist for All Rooms

1. Name four additions that must be completed in a room of a patient on precautions.
   - curtains are removed before starting to clean the room
   - glove box is discarded
   - soap and toilet paper are discarded
   - sharps container is wiped

2. Name one thing housekeeping staff should report to nursing.
   - if sharps container needs replacing, or
   - if sharps container is ¾ full

3. What items must a housekeeper remove in a regular cleaning?
   - dirty/used items
   - suction container
   - disposable items (Kleenex, bar soap)
   - all tape is removed from surfaces

4. What items must be cleaned thoroughly before use by another patient?
   - commodes/high toilet seat
   - wheelchairs
   - IV poles/machines