

ARKANSAS

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516 NURSING CARE REQUIREMENTS

516.1 Charting

e. The following observations must be charted upon occurrence*:

* If a flow sheet is utilized for documentation of the following, it is only necessary to document a summarization on the nurse's progress notes based on the time frequencies in item (d) above.

1. Accidents/Incidents (charting will be done every shift for at least 48 hours or until the resident returns to pre-accident status or stable condition, which ever is longer);
2. Significant changes in the residents physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). Charting will be required on every shift until the resident's condition becomes stable;
3. Any need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);
4. Use of physical restraints to include the type applied, time of application, checks, releases and exercise of resident. (Flow sheet may be used.);
5. Bedtime snacks for therapeutic diets and physician ordered supplemental feedings to include the type, amount served and amount consumed. (Flow sheet may be used.);
6. Meal consumption for residents at nutritional risk to include percentage of meal consumed. (Flow sheet may be used.);
7. PRN medications to include name, amount, route of administration, time, reason given and response. PRN "controlled" drugs must also be charted in the nurse's notes, which must also contain the condition of the patient before and after administration.
8. Foley catheters to include documentation of insertion, reinsertion, removal and catheter irrigations. The total amount of urinary output must be documented, at a minimum, every eight (8) hours. (Flow sheet may be used.);
9. Nasogastric or gastrostomy tubes to include documentation of insertion, reinsertion, removal, placement checks, care of site, type of formula, amount of formula, rate of feeding, and flushes. Total fluid intake must be documented, at a minimum, every eight (8) hours to include formula and flushes. (Flow sheet may be used.);

10. Problem skin conditions to include date of onset and weekly progress notes. Documentation must identify the skin problem, stage, size, color, odor and drainage, if any. The chart shall also document the date and time of treatments and dressings. (Flow sheet may be used.);
11. Physician visits to include date of visit;
12. Any contacts with the physician (date and time) regarding the resident's condition and the physician's response/instructions;
13. Resident's condition on discharge or transfer;
14. Disposition of personal belongings and medications upon discharge;
15. Time of death of a resident, the name of person pronouncing death and disposition of the body.

516.2 Routine Care and Services

Each patient in the home shall receive the type of nursing care including restorative nursing as required by his/her condition. Patients shall be encouraged to be active, to develop techniques for self-help, and be stimulated to develop hobbies and interests. Criteria for determining adequate and proper care includes:

516.2.1 Kind and considerate care and treatment at all times.

516.2.2 A minimum of a complete bath twice a week for all ambulatory patients with adequate assistance or supervision as needed. Patients who are incontinent or are confined to bed shall have a complete bath daily and partial baths each time the bed or clothing is wet or soiled. All soiled linen and clothing shall be replaced with clean dry ones.

516.2.3 A minimum of one shampoo every week and assistance with daily hair grooming. Patients shall not be required to pay for routine hair grooming provided by facility staff.

516.2.4 Assistance with or supervision of shaving of men patients at least every other day except when contraindicated or refused by the patient. Patients shall not be required to pay for routine shaving.

516.2.5 Oral care shall be provided at least twice a day.

516.2.6 Hands and feet shall have proper care and attention. Nails shall be kept clean and trimmed. Additional lotion shall be applied to hands and feet when indicated. Precautions shall be taken to prevent foot drop in bed patients.

516.2.7 Bed linens shall be changed weekly or more often as needed and adjusted at least daily.

516.2.8 Patients shall have clean and seasonal clothing as needed to present a neat and clean appearance, to be free of odors, and to be comfortable.

516.2.9 Measures shall be taken toward the prevention of pressure sores, and if they exist, treatment shall be given on written medical order. The position of bed patients shall be changed every two (2) hours during the day and night.

516.2.10 Each mattress and pillow shall be moisture proof or must have a moisture proof cover. Rubber or plastic sheets shall be cleaned often to prevent accumulation of odors. Clean cloth draw sheets shall be used over the rubber or plastic sheet.

516.2.11 Assistance with the use of commode, bedpan, or toilet, and keeping the commode, bedpan, and urinal clean and free of odors. Bedpans, urinals, and wash basins shall be name-labeled, cleaned after each use, properly stored in the patient's bedside cabinet, and sanitized at least weekly. Any of these utensils not name-labeled and stored in individual bedside cabinets must be sterilized after each use.

516.2.12 Each patient shall be up and out of bed for at least a brief period everyday unless the physician has written an order for him/her to remain in bed.

516.2.13 Fluids shall be offered at frequent intervals when the patient is unable to obtain them. Water pitchers shall be refilled at least once each shift and should be kept in reach of patients. Clean drinking glasses shall be kept with each water pitcher.

516.2.14 Physical findings (temperature, pulse, respiration, and blood pressure) shall be taken and recorded as ordered by the physician, but not less than one (1) time a week. All residents with indwelling catheters should have urine output recorded each shift.

516.2.15 Administration of oxygen.

516.2.16 Documentation that a continuous program of bowel or bladder training is provided when appropriate.

516.2.17 Proper bed and chair positioning.

516.2.18 Nursing equipment is in sufficient supply, in good condition, is properly cleaned and cared for, well organized, and readily available.

516.2.19 Precautions to assure the safety of patients are continuously in effect. (See, also, Section 309 regarding restraints.)

516.2.20 Bedside nursing care.

516.2.21 Administration of hypodermic medications as prescribed.

516.2.22 Rehabilitation programs such as physical therapy, occupational therapy, speech therapy, etc., as required by written physician orders. Such therapies must be administered by qualified persons.

516. 3 Skilled Nursing Facilities:

In addition, the following services will be required in Skilled Nursing Facilities:

- Intravenous feedings
- Complex dressings
- Skilled nursing care

☒ Tube feedings

There will be no administration of blood in the nursing home unless the nursing home is physically connected to a hospital. In any nursing home administering blood, a registered nurse must be on duty throughout the entire administration.

517 TREATMENT AND MEDICATIONS

517.8 Treatment of a lesion or open wound shall be done only by licensed nursing personnel.

518 REHABILITATIVE NURSING

518.1 Nursing personnel shall be trained in rehabilitative nursing measures. This shall be documented in the orientation program, and in-service on this subject shall be conducted at least annually.

518.2 The facility shall have an active program of rehabilitative nursing care which is an integral part of nursing service and is directed toward assisting each patient to achieve and maintain an optimal level of self care and independence.

518.3 Rehabilitative nursing services such as proper maintenance of body alignment, bed and chair positioning, use of foodboards, use of handrolls, range of motion exercises, elevation of extremities as indicated, assistance with ambulation, and bowel or bladder training shall be performed daily and recorded routinely for those patients who require such service.