MEDICAL EXECUTIVE COMMITTEE	09/07/2022
BOARD OF DIRECTORS APPROVAL	
	09/27/2022
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
September 27, 2022 BOARD APPROVAL

The following Policies/Procedures/Protocols/Plans/Forms have been reviewed by the Medical Executive Committee and are being submitted to the Board of Directors for approval:

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SUBJECT:	SECTION:
ADMINISTRATION OF TETANUS-DIPTHERIA TOXOIDS & PERTUSSIS VACCINE TO ADULTS (Employees)	***Surveillance, Prevention, Control of Infection (IC)***

POLICY

PURPOSE: To assure that a standard procedure is in place for the administration of the Tetanus-Diphtheria Toxoids and Pertussis (**Tdap**) Vaccine for adult employees who meet criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

A. **BACKGROUND:** Diphtheria, pertussis (whooping cough) and tetanus are 3 devastating diseases that are no longer common in the U.S. due to the availability of vaccines. Two of these diseases (diphtheria and pertussis) are spread from person to person by respiratory droplets while the other, tetanus, enters the body through cuts or wounds. Because of the mode of transition for these 3 diseases, the Tetanus, Diphtheria and Pertussis (**Tdap**) vaccine is used to protect adults, especially healthcare professionals (HCP) within the healthcare setting.

B. **PREREQUISITES:** According to the Centers for Disease Control and Prevention (CDC), adults/HCP who meet the following criteria are eligible for **Tdap** vaccination or a booster (**Table 1**):
   1. Adults who have *never* received **Tdap** vaccination
   2. If 10 years have passed since your last **Tdap** vaccination/booster
   3. If you have had a severe or dirty wound or burn and it's been 5 years or more since your ~~last~~ **Tdap** vaccination/booster
   4. If pregnant and due for 10 year booster, vaccinate, preferably in the 3rd trimester, to help protect the newborn infant from pertussis. If prior dose was given within the last 10 years, vaccinate in the immediate postpartum period

C. **PRECAUTIONS:** The following should be taken into consideration before a **Tdap** vaccination:
   1. The HCP should wait to be vaccinated if moderately or severely ill. However, the individual may be vaccinated if the illness is minor, such as a cold
   2. The HCP should wait to be vaccinated if your health care provider decides to postpone the **Tdap** vaccination/booster

D. **CONTRAINDICATIONS AND RISKS**: Tell your vaccination provider if:
   1. The person receiving the vaccination/booster has had an allergic reaction after a previous dose of any vaccine that protects against tetanus, diphtheria or pertussis, or has any severe, life-threatening allergies
   2. The person receiving the vaccination/booster has had a coma, decreased level of consciousness or prolonged seizures within 7 days after receiving any pertussis vaccine (DTP, DTaP, or **Tdap**)
   3. The person receiving the **Tdap** vaccination/booster has had seizures or another nervous system problem

4. The person receiving the vaccination/booster has had Guillain-Barre Syndrome after a previous dose of *any* vaccine that protects against tetanus or diphtheria
5. Lesser risks of a vaccine reaction include pain, redness or swelling where the injection was given, mild fever, headache, feeling tired, nausea, vomiting or stomachache after **Tdap** vaccination/booster

E. **RESPONSIBILITIES**:

1. Any of the following health care professionals with current California licenses may administer the vaccine: Licensed Vocational Nurse (LVN), Registered Nurse (RN), or a physician (MD or DO).
2. A copy of the most current Vaccine Information Statement (VIS) in the appropriate language, must be proved to the vaccine recipient and recorded, along with the publication of the VIS, in the medical record or office log. (See References for URL and the PDMS Link for the most current VIS.)

PROCEDURE:

A. **Assess** the employee for the need of **Tdap** vaccination (see Prerequisites above). This is accomplished by authorized personnel reviewing employee records and via interview with the employee.
B. **Screen** the candidate employee for **precautions** and **contraindications** (see full list above) against **Tdap** vaccination, which includes but is not limited to:
   a. **Precautions**
      i. Moderate or severe acute illness (with or without fever)
   b. **Contraindications** (examples)
      i. A history of a severe allergic reaction (*e.g.* anaphylaxis) to a vaccine components or excipients such as aluminum, etc. (Appendix B, *The Pink Book*, for Tdap excipients)
      ii. A history of a serious reaction to any similar vaccines or following a prior dose of the same vaccine
      iii. A history of encephalopathy within 7 days following vaccination given at 7 years or older
      iv. A history of Guillain-Barre Syndrome within 6 weeks after any vaccination
C. **Education** of patient – provide each vaccinated adult patient the VIS in the appropriate language if available and document in the electronic medical record (EMR) that the VIS was reviewed and given
D. **Prepare** materials and injection site to administer vaccine to HCP
   a. See **Table 2** to select the appropriate needle gauge, length and injection site
E. **Administer** the vaccine
   a. See **Table 3** for criteria and guidance on dosage, route and vaccination schedule

F. Be prepared to manage any **medical emergency** related to the administration of the vaccine. The recipient should be monitored for at least 15 minutes after administration of the vaccine. The following items should be available at the time of vaccination:
   a. A written emergency protocol specifically for vaccination reactions
   b. Equipment and/or medication described in the written emergency protocol

G. **Documentation** - the following items should be documented in the medical record:
   a. Date of vaccination and number of the series
   b. The manufacturer and lot number
   c. The vaccination site and route
   d. The name and title of the person administering the vaccine
   e. Note of the VIS was provided to the recipient. Also include the language and publication date of the VIS
   f. Record if the vaccine was not administered, record the reasons(s), and discuss the need for vaccination with the candidate employee

~~A. Definition: Eligible nurses will utilize the following parameters to identify adult(s) in need of Tetanus-Diphtheria toxoids and Pertussis Vaccine and subsequently vaccinate these persons.~~

~~B. Data Base:~~

~~1. Subjective: n/a~~

~~2. Objective: Identify adults in need of vaccination against tetanus, diphtheria, and Pertussis based on any of the following criteria:~~

~~a. Lack of documentation of Tdap adult booster~~

~~b. Screen all adults for contraindications and precautions to tetanus and diphtheria toxoids (Td) and, if applicable, Pertussis vaccine (Tdap).~~

~~3. Contraindications:~~

~~a. A history of a serious reaction (e.g. anaphylaxis) after a previous dose of Td or to a Tdap component. For a list of vaccine components, go to www.cdc.gov/nip/publications/pink/appendices/b/excipient-table-2.pdf.~~

~~b. For Tdap only, a history of encephalopathy within 7 days following DTP/DTaP given age 7 years~~

~~4. Precautions:~~

a. History of Guillain-Barré syndrome within 6 weeks of previous dose of tetanus toxoid-containing vaccine

a. An unstable neurologic condition

b. Pregnancy: if due for 10 year booster, give Td; if prior dose within previous 10 years and has no history of Pertussis-containing vaccine given since the age of 10 years, give Tdap in the immediate postpartum period

c. Moderate or severe illness with or without fever

A. Diagnosis: n/a

B. Plan: Establish immunization from Tetanus-Diphtheria toxoids and Pertussis by vaccinating all adults who are in need vaccination, and meet the criteria for vaccination.

1. Treatment:

a. Screen all adults for contraindications and precautions to Tetanus-Diphtheria toxoids and Pertussis vaccine.

b. Administer 0.5 mL Tdap vaccine IM (22-25g, 1-1 ½" needle) in the deltoid muscle.

- To boost after primary schedule is complete: observe a 10 year interval since previous dose of Td/Tdap; if protection against Pertussis is needed, an interval of 5 years is recommended and intervals as short as 2 years or less can be observed for parents and caregivers of infants younger than age 12 months, healthcare workers having direct patient contact, and adults in a Pertussis outbreak setting.

2. Consultation Required: None

3. Education: Provide a copy of the most current federal Vaccine Information Statement (VIS). You must document in the medical record or office log, the publication date of the VIS and the date it was given. Provide non-English speakers with a copy of the VIS in their native language, if available; these can be found at www.immunize.org/vis.

4. Follow-up: Follow schedule and intervals recommended above, depending on reason for vaccination (e.g. completion of primary 3-dose schedule, boosting after primary schedule, or protection against Pertussis).

C. Documentation:

1. Medical Chart: record the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine. If vaccine was not given, record the reason(s) for non-receipt of the vaccine (e.g. medical contraindication, refusal).

2. Personal Immunization Record Card: Record the date of vaccination and the name/location of the administering clinic, as well as any necessary follow-up.

STAFF AUTHORIZED TO PERFORM THE FUNCTION: **Registered Nurse, Licensed Vocational Nurse**

REQUIREMENTS FOR ADMINISTRATION:

A. Education: Licensed Personnel (e.g. LVN, RN, MD)

B. Training: As required by specific licensing board

C. Experience: N/A

D. Initial Evaluation: Review of CDC immunization criteria, SVMC Standardized Procedures for immunizations

E. Continuing Evaluation: Every two years

DEVELOPMENT & APPROVAL OF THE STANDARDIZED PROCEDURE:

A. **Method:** Approval of Infection Control Committee, Infection Control Medical Director and Infection Control Manager.

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REFERENCES:

Liang JL, Tiwari T, Moro P, et al. Prevention of Pertussis, Tetanus, and Diphtheria with Vaccines in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep 2018;67(No. RR-2):1–44. DOI: http://dx.doi.org/10.15585/mmwr.rr6702a1

Hall E., Wodi A.P., Hamborsky J., et al., eds. Epidemiology and Prevention of Vaccine-Preventable Diseases (The Pink Book), 14th ed., P 97 – 110; 239 – 252; 315 - 328. Centers for Disease Control and Prevention, Washington, D.C. Public Health Foundation, 2021.

Vaccine Information Statements (VISs), Current VISs. Vaccine Information Statements Website. Centers for Disease Control and Prevention. Last reviewed June 2, 2022. Available on the internet at: https://www.cdc.gov/vaccines/hcp/vis/index.html

Roush, S.W., Baldy, L.M., Hall, M.A.K., eds. Centers for Disease Control and Prevention. Manual for the surveillance of vaccine-preventable diseases. Retrieved May 24, 2022; page last reviewed: April 1, 2014; originally published in 1996. Centers for Disease Control and Prevention, Atlanta, GA. Available on the internet at: www.cdc.gov/vaccines/pubs/surv-manual/

Shefer, A., Atkinson, W., Friedman, C., et al. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP). Recommendations and Reports. MMWR Morb Mortal Wkly Rep 2011; 60(RR07);1-45. Retrieved May 24, 2022; Available on the internet at: https://www.cdc.gov/mmwr/indrr_2011.html

CROSS REFERENCES:

Tdap Vaccine Information Statement (Tdap VIS)

~~Centers for Disease Control and Prevention (CDC). (2015). Tdap (Tetanus, Diptheria, Pertussis) VIS. Retrieved from http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/tdap-td.html~~

TABLES:

Table 1 – Immunizing agents, schedules, indications, contraindications and special considerations
(Compiled from *Prevention of Pertussis, Tetanus, and Diphtheria with Vaccines in the United States: Recommendations of the Advisory Committee on Immunization Practices ACIP*)

TABLE 1. Immunizing Agents and Immunization Schedules for Health-care Personnel (HCP)				
Generic name	Primary schedule and booster(s)	Indications	Major precautions and contraindications	Special considerations

Tetanus and diphtheria (toxoids) and acellular pertussis (Tdap)	1 dose IM as soon as feasible if Tdap not already received and regardless of interval from last Td. After receipt of Tdap, receive Td for routine booster every 10 years.	All HCP.	History of serious allergic reaction (i.e., anaphylaxis) to any component of Tdap. Because of the importance of tetanus vaccination, persons with history of anaphylaxis to components in Tdap or Td should be referred to an allergist to determine whether they have a specific allergy to tetanus toxoid and can safely receive tetanus toxoid (TT) vaccine. Persons with history of encephalopathy (e.g., coma or prolonged seizures) not attributable to an identifiable cause within 7 days of administration of a vaccine with pertussis components should receive Td instead of Tdap.	Tetanus prophylaxis in wound management if not yet received Tdap

Table 2 – Prepare to Administer Vaccine, guide to choose the needle gauge, needle length and injection site according to the following chart (Modified from *Standing Orders for Administering Td/Tdap Vaccine to Adults)*

Gender and Weight	Needle Gauge	Needle Length	Injection site
Female or male < 130 lbs.	22 – 25	5/8* – 1"	Deltoid muscle of arm
Female or male 130 – 260+ lbs.	22 – 25	1 – 1 ½ "	Deltoid muscle of arm

* A 5/8" needle may be used in patients weighing < 130 lbs. (< 60kg) for IM injection in the deltoid muscle only if the skin is stretched tight, the subcutaneous tissue is not bunched, and the injection is

made at a 90° angle to the skin

Table 3 –Administer Vaccine, 0.5 mL, via the intramuscular (IM) route, according to the following criteria and schedule*: (Modified from *Standing Orders for Administering Td Tdap Vaccine to Adults)*

History of Previous Tdap Vaccination	Dose and Schedule for Administration
0 (zero) documented doses ***or*** none known	Give Tdap as: Dose #1, Give dose #2 at least 4 weeks later, and dose #3 6 – 12 months after dose #2.
1 previous dose (not Tdap)	Give Tdap as dose #2 at least 4 weeks after dose #1. Give dose #3 6 – 12 months after dose #2
3 or more previous doses (none Tdap)	Give Tdap as soon as possible. (You do not need to wait 10 years from previous dose.)
3 or more previous doses (including 1 dose of Tdap) booster	Give Tdap **booster** every 10 years unless patient needs prophylaxis for wound management sooner.

***During Pregnancy**: Tdap should be administered early in the third trimester of each pregnancy, preferably in the early part of gestational weeks 27 – 36.

SUBJECT:	SECTION:
ANIMAL-ASSISTED PATIENT ACTIVITIES AND ANIMAL- ASSISTED THERAPY	**Page 1 of 5**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To govern conscientious and professional involvement of animals in Animal-Assisted Activities and Therapy at Sierra View Medical Center (SVMC).

To utilize the animal/human bond to provide and enhance quality of life, non-medical and non-painful in focus, for residents and their families during their hospital stay.

Description:

Animal-Assisted Activities (AAA) provides opportunities for motivational, educational, recreational, and/or therapeutic benefits to enhance quality of life. Animal-Assisted Activities is delivered by specially trained professionals, paraprofessionals, and/or volunteers in association with animals that meet specific criteria.

Animal-Assisted Therapy (AAT) is a goal-directed intervention in which an animal that meets specific criteria is an integral part of the resident's treatment process. Animal-Assisted Therapy is directed and/or delivered by a health or human service professional with specialized expertise, and within the scope of practice and/or cognitive functioning. Animal-Assisted Therapy may be group or individual in nature. The process is documented and evaluated. Definitions are taken from Delta Society's "Standards of Practice in Animal-Assisted Activities and Therapy."

Scope:

This procedure applies to Animal-Assisted Activities / Animal-Assisted Therapy in all hospital departments excluding the Emergency Department, intensive care units, surgical areas, operating rooms, and other areas not open to the general public.

Definitions:

Animals – Currently, animals approved to be in the program are limited to dogs, birds, guinea pigs, cats and hamsters. Other animals may become registered as Pet Partners (see definition below), but the Infection Control Committee must approve the inclusion of other animals in this program.

Delta Society Pet Partners® and affiliate groups such as ***PAWS4Healing*** are nationally recognized training and registration programs for participating in AAA/T for people and their pets. All animals must pass health, skills and aptitude screenings. Handlers must demonstrate knowledge of various recipient populations by passing a written test. Handler/animal must pass evaluation by a Delta Society licensed evaluator. Volunteer handler/animal teams are covered by a $1,000,000 liability insurance policy. Sierra View Medical Center employees who become pet partners must become volunteers to be covered by the Delta Society Pet Partner liability insurance while volunteering "off the clock" for Sierra View.

Delta Society® -- A national, non-profit organization dedicated to promoting animals helping people improve their health, independence, and quality of life. The Delta Society administers the Pet Partners program and is located at 875 124th Avenue NE Ste. 101, Bellevue, WA 98005.

Objectives:

Some objectives of Animal-Assisted Activities/Animal-Assisted Therapy include, but are not limited to:

- Decrease feelings of institutionalization;
- Provide safe and pleasant tactile and sensorimotor stimulation;
- Foster patients' ability to nurture and play;
- Improve balance, postural control;
- Provide a situation of empowerment for residents within an environment where they have very little power and control;
- Divert attention from daily hospital activities in which pain and discomfort may figure prominently;
- Provide an acceptable outlet for energy, encourage activity;
- Brighten affect;
- Provide a mode of contact to enhance children's natural communication through spontaneous play and interaction;
- Provide an activity which is totally non-medical in content;
- Foster communication between the resident and caregiver;
- Provide a bridge to communication between the resident and staff;
- Provide staff an opportunity for interaction with the animals, and reduce staff stress.

POLICY:

Administration and Organization:

1. The Paws4Healing Coordinator or Delta Society Registered Pet Partner Coordinator will oversee testing and standards for both human and animal volunteers in addition to Pet Partners requirements. All Pet Partners must maintain their current legitimate registered therapy team status and PAWS4Healing and Delta. In addition, all Pet Partners are to: attend volunteer hospital orientation without their animal; be assigned to work with an experienced Pet Partner.

2. A qualified Pet Partner handler will be with their animal at all times. At no time will an animal be left alone with a patient, family, or staff member.

3. Hospital Administration and Infection Control approval and support of the program will be maintained.

4. A veterinarian must certify yearly that the animal is healthy; free of infection, contagious disease, or dermatological problems; and immunizations as recommended by Pet Partner's veterinarian must be current. The yearly exam follows requirement of Delta's "Pet Partners Animal Health Screening Form" (attached). Animal health documentation shall be kept in the volunteer's personnel file.

5. Sierra View Medical Center will not assume any liability or responsibility for the safety, health, or security of Therapy Animals.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

Pet Therapy Visitations:

1. ***Attire***: Volunteers will wear the Delta/PAWS4Healing required uniform and closed-toe, soft-soled shoes. Pets and volunteers will wear ID badges from both SVMC and Delta.

2. ***Preparation:*** Pets will be bathed the day of visit or day prior (Exception: Pets making more than one visit per week.)

   a. Thoroughly brushed prior to visit to remove loose hair.

   b. Nails will be trimmed and filed smooth.

   c. Eyes, ears and nose will be free of any matter.

   d. Free of any external parasites (e.g. fleas, ticks, etc.).

   e. No flea collars will be worn in the hospital.

3. ***Handling:*** Dogs will remain on a leash at all times. The volunteer is responsible for their animal's behavior and welfare. At no time will the animal be left unattended or under control of any person other than its Pet Partner Handler.

4. ***Scheduling:*** Visitations may be scheduled for any day of the week. No visitations will be scheduled while a patient is eating. Animals will be removed from any area where food is being served. Visits should not be longer than one hour. If they do exceed one hour, the animal is to be given a rest period every hour for 20 minutes, working no more than three hours in a day.

5. Before entering the elevator, the volunteer will inquire if any occupants object to the animal being on the elevator. If there is an objection, the volunteer and animal will wait for the next available elevator.

6. Both the volunteer and the resident will use hospital-provided hand sanitizing solution before and after each visit. When visiting groups of four or more residents, a hospital staff member will be responsible for sanitizing resident's hands.

7. Interactions:

   a. Visits will be primarily with individual residents, although some small group interactions may occur, if appropriate.

   b. Pet partners can only visit residents who have been cleared by the nurse's station. Two or more Pet Partner teams will work together. If less, they need to be accompanied by a hospital staff member. The Pet Partner team must abide by all privacy rules when asking for information about the residents. The staff will only take Pet Partner teams to residents who are open to their visits and are not allergic to the animals.

   c. Volunteer will ask the resident and roommate if the team may visit.

   d. Volunteer will introduce self and pet.

   e. Volunteer will ask the patient's preference for placement of the animal.

      - On the bed
      - If the resident requests the animal on the bed, volunteer will inquire about any special precautions (recent surgery, pain, medical or surgical equipment, etc.).
      - Volunteer will then place a clean sheet over the resident's bed, gently lift, and position the animal on the bed.
        - On a chair alongside the bed.
        - On the floor.

      - Behavior of the animal:
        - May "visit" on command (placing front paws on edge of bed, wheelchair, arm or knee), if under patient's consent.
        - May not lick the resident.
        - No eating while at the hospital.

   f. Residents, staff and visitors will be discouraged from feeding, although fresh ice and water may be provided in clean containers. Pet Partners are to clean up any dripping water from the animal's mouth or the floor.

g. On completion of visit, the animal will be removed from the bed, top sheet rolled and removed.

h. Unusual Occurrences:

Volunteers will immediately remove animal from visitation if any of the following occurs:

- Improper behavior (growling, barking, scratching, biting)
- Resident, staff or visitor's request
- Allergic response
- Medical emergency
- Animal fatigue
- The PAWS4Healing Coordinator and staff in charge of the Pet Partners will confer to see if a "Delta Incident" report is required.

8. Departures: At the conclusion of the visit, the volunteer will return to the volunteer department to complete documentation of attempted and completed visits and record observed resident and staff responses. Volunteer will then sign out and exit the hospital.

REFERENCE:

- Delta Society Pet Partners, 345 118th Ave SE #200, Bellevue, WA 98005

SUBJECT: **AURAL REHABILITATION**	SECTION: **Page 1 of 5**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose of treating patients with hearing impairment is to improve the patient's ability to engage in effective functional communication for personal, social, vocational and/or recreational needs.

POLICY:

DESCRIPTION:

Symptoms of hearing impairment may include difficulty with two-way communication, comprehension and/or behavioral problems such as an inability to follow directions, communicate effectively, and/or interact appropriately.

INDICATIONS:

1. Hearing impairment may be caused by:
   a. Acoustic trauma (noise induced hearing loss)
   b. Congenital malformations
   c. Tumors
   d. Head trauma
   e. Auditory nerve damage/disorders
   f. Toxins
   g. Acquired structural damage/disorders (ear wax, perforations of the tympanic membrane, surgical complications, cholesteatoma, Meniere's disease, etc.)
   h. Progressive diseases affecting inner, middle, or external ear (otosclerosis, tinnitus, facial palsy)
   i. Presbycusis
   j. Infections affecting inner, middle, or external ear

   NOTE: A complete audiological evaluation should be performed by a licensed, certified audiologist to rule out medical pathology prior to initiating aural rehabilitation.

CONTRAINDICATIONS:

1. Impaired cognitive function, which interferes with the ability to learn or use compensations.

2. Visual deficits, which interfere with the ability to learn speech reading techniques.

   NOTE: The following, although not contraindications, are negative indicators to the initiation of aural rehabilitation.

3. Negative indicators for the initiation of aural rehabilitation include:

   a. Normal-borderline to mild hearing loss.

   b. Profound loss/anacusis.

   c. An air-bone gap and/or eminent findings, indicating the need for medical intervention that might subsequently change hearing. Indicating the need for medical intervention that might subsequently change hearing.

   d. Speech Reception Thresholds (SRTs) or Speech Discrimination Thresholds (SDTs) that do not agree with the pure-tone data.

   e. Speech Discrimination scores that are good to excellent.

   f. Speech Discrimination scores that are very poor or poorer than expected based on pure-tone data.

   g. Poor to fair test reliability, suggesting an uncooperative, non-alert, or unwilling patient.

   h. Other unexplained discrepancies in the test findings.

PRECAUTIONS:

Medical involvement is necessary to determine etiology of hearing loss and possible medical interventions.

EQUIPMENT:

- Amplifier
- Augmentative/alternative communication devices
- Mirror

AFFECTED AREAS/ PERSONNEL: *SPEECH THERAPY*

PROCEDURE:

GUIDELINES:

1. Informal and/or formal assessment of hearing impairment may include the following areas:

   a. Acuity

   b. Hearing aid evaluation

   c. Discrimination

   d. Comprehension

   e. Non Verbal Communication

   f. Functional communication (voice, language, articulation, pragmatics, assistive device)

   g. Speechreading

   h. Assessment tools that may be used including:

      - Otoscope
      - Audiometer
      - Wepman Auditory Discrimination Test
      - Washington Speech Sound Discrimination Test
      - Test of Auditory Discrimination (TAD)
      - Auditory and visual comprehension subtests of aphasia tests (see Aphasia section)
      - Denver Scale Quick Test
      - Utley Lip Reading Test
      - Iowa Keaster Test of Lipreading Ability
      - Goldman-Fristoe Test of Articulation
      - Hearing Handicap Inventory for the elderly (HHIE) with the Nurses Handicap Assessment Scale
      - The Denver Scale of Communication Function for Senior Citizens Living in Retirement Centers

3. Treatment of hearing impairment.

The focus of treatment is determined by type and severity of hearing impairment and functional communication needs. The method of stimulation may or may not involve assistive devices (hearing aids, amplifiers, augmentative/alternative communication systems). Task-oriented activities typically involve compensatory strategies with environmental manipulation of lighting and sound.

a. Treatment areas may include:

- Traditional Aural rehabilitation
- Speechreading
- Auditory discrimination – sound awareness, identification, localization, safety skills
- Compensatory skills – seeking assistance, writing

b. Non-Traditional Aural Rehabilitation

- Assertiveness training
- Communication repair strategies
- Discourse strategies
- Reflective listening

c. Assistive devices

- Hearing aids
- Amplifies
- Augmentative/alternative communication device

d. Functional communication

- Comprehension
- Expression (verbal or signed)

e. Adjustment counseling

- Patient

- Family and Staff

REFERENCES:

- American Speech-Language-Hearing Association. (2004). Preferred practice patterns for the profession of speech-language pathology. Preferred Practice Patterns. doi:10.1044/policy.PP2004-00191.

- Tye-Murray, N. (2009). *Foundations of Aural Rehabilitation: Children, Adults, and Their Family Members* (3rd ed.). Clifton Park, NY: Delmar, Cengage Learning.

SUBJECT: **BLOOD AND BLOOD COMPONENTS-ADMINISTRATION DPSNF**	SECTION: 6 **Page 1 of 7**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide guidelines for preparation, administration and monitoring of the resident receiving a blood transfusion.

POLICY:

Follow the standard process for preparation, administration and monitoring of the resident receiving a transfusion.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES, LICENSED VOCATIONAL NURSES*

EQUIPMENT:

- IV pole and infusion pump
- Solution of 0.9% Normal Saline (500cc bag)
- IV #18 or #20 gauge needle/catheter and accompanying equipment per IV Start Procedure
- Blood administration set (Y-tubing with specific filter)
- Prepared transfusion administration form / "pick-up slip"
- Blood warmer (physician order is required for non-emergent use)
- Pressure Infusion Cuff (physician order required)
- Gloves will be worn at all times

PROCEDURE:

Packed Red Blood Cells (PRBC) and Fresh Frozen Plasma (FFP)

1. Ordering and Obtaining Blood Products

   a. A written physician order will include the component requested and number of units to be infused.

   b. Blood order is placed via Meditech system (electronic medical record).

   c. Explain the procedure to the resident and obtain written authorization.

   d. In accordance with the College of American Pathologist (CAP), the laboratory will draw a second sample of blood for Type and Cross Match at a separate site to reduce the risk of mis-transfusion for non-emergent red cell transfusions, when residents have been ordered

to receive packed cells and have no prior history of receiving blood. In the event of an emergent need for blood, the emergency release protocol will be followed (See Lab policy on Comparison of past blood bank records).

2. Obtain blood product(s) from the lab.

   a. Ascertain from Meditech that blood product is ready for use. Take the request for blood component slip or "pick-up slip" to the lab.

   b. Verify with the Blood Bank Tech that the resident ID number, BBK#, name, blood type and Rh is correct along with the expiration date of the blood product. The Lab Tech and nursing personnel must sign the computer-generated verification slip. This slip becomes part of the medical record.

   c. The RN/LVN will legibly complete the "pick-up slip" form/transfusion record.

      - Stamp the Transfusion Record
      - Give name of the physician ordering the transfusion
      - Reason for the transfusion
      - Identify the blood component to be obtained

   d. A clinical representative, defined as an employee in a clinical service and designated by the Charge Nurse, can pick up the blood and will double check the following with the blood bank technologist: If any of the information is missing or does not match, the blood cannot be released. (Exception: type compatible but not type specific units)

      - Resident's name
      - Identification number
      - BBK#
      - Blood group, Rh type and antibody screen
      - Donor number
      - Donor blood group and Rh type
      - Expiration date and time
      - Blood product ordered

e. Blood Bank Technologist, clinical representative, RN/LVN will sign the Blood Bank computer generated Verification Sheet, which becomes a part of the Medical Record. The record will be printed with all the pertinent resident blood bank information. There must be exact verification of all information before the unit leaves the blood bank.

NOTE: No more than 1 unit is to be removed from the Blood Bank at a time; with the exception of a massive bleed or surgical patient with monitored refrigeration available for storage.

3. Preparing the resident

   a. Provide transfusion reading material to resident and/or family member(s) and allow for questions.

   b. Obtain transfusion informed consent after the physician has spoken to the resident.

      - Resident must agree and sign consent to the administration of blood/blood product(s) prior to the transfusion and prior to staff picking up the blood from the Blood Bank. If the patient refuses the transfusion, the refusal form must be completed (See Appendix C).

   c. Establish IV access with #18 gauge catheter (preferred) prior to obtaining blood from blood Bank. A #20 gauge catheter may be used in the event that a larger vein is not accessible.

4. Vital signs, including temperature, will be taken and recorded on the Blood Transfusion Form prior to start of transfusion.

5. At the bedside

   a. The blood product is verified with two (2) qualified licensed staff against the "Blood Administration Record" at the bedside. The one individual conducting the identification verification must be the qualified transfusionist who will administer the blood or blood component to the resident. At least two unique identifiers are used in the verification process and is conducted after the blood or blood component that matches the order has been issued or dispensed. The following information will be verified:

      - Resident's name
      - DOB
      - Resident Account Number
      - BBK#
      - Blood unit number

- Donor blood group and Rh type

b. The resident's identification is verified by checking the name, date of birth and BBK.

c. The two (2) licensed staff sign in the space provided on the "Transfusion Record"

6. Preparation for Transfusion

a. Wash hands thoroughly. Put on gloves.

b. Run 0.9% Normal Saline solution through the "Y" tubing to remove air and clamp tubing. Make sure the fluid level in the drip chamber is above the entire filter.

c. Gently agitate the unit of blood to distribute all the cells.

d. Gently open either outlet of the plastic blood container.

e. Insert the "Y" tubing into the blood container.

7. Administration

a. Check the resident's vital signs and record on the Blood Administration Record.

b. Check to make sure that the IV site is patent. Apply arm board if necessary and then begin transfusion.

c. Check IV insertion site, rate of flow, and monitor for side effects.

d. Vital signs are taken initially before start of transfusion, then every 15 minutes times two and at the completion of the transfusion.

e. Observe the resident closely for signs of reaction, e.g. fever, chills, rash, abdominal, chest or back pain, SOB and condition of infusion site. ***Stop the transfusion if a reaction is suspected.*** Review Transfusion Reaction Policy.

NOTE: If a hemolytic reaction or anaphylactic reaction is going to occur, it usually will happen after a very small volume of blood enters the resident's circulation. A febrile reaction may occur at any point during the transfusion or even after the transfusion.

8. Completion of Transfusion

a. Clamp blood component bag

b. If another unit of blood is to be transfused, obtain from the laboratory and repeat above steps. If transfusion is completed, flush the line with solution of 0.9% Normal Saline and resume parenteral infusion or maintain IV lock.

c. Remove blood products and tubing

- Dispose of blood bag and tubing in appropriate biohazard container.
- Return blood bags to the Lab only when a reaction is suspected.
- The unit issue card is affixed to the patient's lab sheet in the medical record.

d. Document the resident's response to the transfusion.

PLATELETS

- Platelets should be infused rapidly due to loss of viability (1.5 to 2 hours, but less than 4 hours).
- Use the same procedure as when ordering and verifying PRBC's.

FRESH FROZEN PLASMA

- Use same procedure as when ordering and verifying PRBCs.

NOTE: Laboratory will need 30 minutes advance notification to thaw the unit.

- Administration rate for adult infusion of FFP should be at 200 cc/hr. Give slowly if circulatory overload is a potential problem.

SPECIAL CONSIDERATIONS

1. Blood components must be started within 30 minutes after being signed out from Blood Bank, and should be completely infused within 4 hours.

   a. Unused blood should be returned immediately to the Blood Bank within 30 minutes of issue.

   b. If the blood is returned after 30 minutes, it may not be re-issued and must be discarded by the Blood Bank.

   c. Blood should not be laid in the sunlight, on top of microwave units, or near a heat source that could result in prolonged warming.

   d. No drugs or fluids other than 0.9% NaCl should be given through the IV port where the blood is infusing.

2. Informed consent must be signed prior to administration of blood component(s).

3. Reading material must be provided to the resident and/or family. A "Patient's Guide to Blood Transfusions" by the California Department of Health Services will be provided in English. Pamphlets will also be available in Spanish.

4. The resident has the right to refuse the transfusion.

5. Type and screen is good for 72 hours but still requires a cross match before blood is made available.

6. Massive Bleed Protocol and initiation of process to obtain rapidly, large amounts of blood:

   a. Blood bank will issue 2-4 units of PRBCs and 1 unit of FFP upon request, per specific situation and will work closely with nursing services to provide continued blood products as needed. Cross matched blood will be utilized upon availability.

   b. Responsible physician will sign for release of uncross matched blood upon completion of the procedure.

DOCUMENTATION

1. Complete all information on the "Blood Administration Record" form. Make sure all signatures are present.

2. Make sure blood transfusion is documented on the I&O Record; note amount infused, i.e. 250cc/unit of PRBCs.

3. Documentation in Nursing Notes should state when administration began, resident's tolerance, time the transfusion ended, and any pertinent observations. Refer to Blood Transfusion Record for vital signs.

4. Place the "Transfusion Record" in the resident's chart under Lab.

REFERENCES:

- Health & Safety Code, Division 2, Licensing Provisions, Chapter 2.4, Quality of Long Term Health Facilities 1418.8 (2019) California Code.

- Blood Transfusion, Patient Care and Health Information, Tests and Procedures, Sandhya, Pruthi, MD Mayo Clinic (April 15, 2020).

CROSS REFERENCES:

- Nursing Administrative Policy and Procedure Manual, "BLOOD & BLOOD COMPONENTS, TRANSFUSION REACTION " Laboratory Policies.

SUBJECT: **BLOOD AND BLOOD COMPONENTS- TRANSFUSION REACTION- DP/SNF**	SECTION: **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish guidelines for the handling, determining and reporting of adverse transfusion reactions.

POLICY:

All transfusion reactions shall be handled as an emergency and documented accordingly on the specified transfusion reaction form and submitted to the laboratory.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RNs), LICENSED VOCATIONAL NURSES (LVNs)*

EQUIPMENT:

- 500 cc 0.9% Normal Saline Solution
- Primary IV tubing set

PROCEDURE:

1. If a transfusion reaction is suspected, immediately clamp off the blood unit.
2. Keep blood unit and tubing set intact, but disconnect from the IV port.
3. Connect a 500 cc bag of 0.9% Normal Saline with new primary tubing set to the injection port closest to the patient.
4. Regulate the IV to keep a vein open rate (25cc/hr).
5. Report symptoms to the physician and notify the blood bank.
6. If the physician elects to stop the transfusion:
    a. Complete the blood transfusion reaction form and call the lab to draw a blood sample.
    b. Prepare the blood component bag and blood tubing and return to Blood Bank.
    c. Collect a urine sample properly labeled and send to the Lab.
    d. Return a copy of the completed "Transfusion Record" form with blood component bag and tubing.
    e. Write and administer orders as given by the physician.
    f. Complete an Occurrence Report.

7. If the physician elects to continue the transfusion:

   a. Notify the Blood Bank of the physician's decision.

   b. Write the order that physician elects to continue transfusion.

   c. Administer medications (if ordered).

   d. Observe the patient and continue to take and record the patient's vital signs.

Documentation:

1. On the "Transfusion Record"

   a. Note the reactions in the portion entitled "Patient Response to Transfusion"

   b. The most common symptoms are:

   - Fever (2 degree increase from baseline) with or without chills
   - Chest pain
   - Hypotension
   - Nausea
   - Flushing
   - Dyspnea
   - Bleeding
   - Hemoglobinuria
   - Rapid onset of rales

   ***The above common symptoms often occur within the first 15 minutes.**

2. Nurses Progress Notes should include:

   a. Date and time of the reaction.

   b. Description of objective and subjective symptoms of the patient

   c. Condition of the patient

d. M.D. notified

e. Vital signs every 15 minutes until stable or as ordered by the physician

f. Persons contacted and time contacted

g. Samples drawn, e.g. urine/lab draws with times taken

h. Patient's response to the reaction and to interventions, if taken

3. Complete the Occurrence Report

a. Submit to the Department Director

REFERENCE:

- Blood Transfusion Reactions: Symptoms and Treatment-Medical News Today, Joy Choquette: July 31, 2020. https://www.medicalnewstoday.com.

CROSS REFERENCES:

- Blood & Blood Transfusion, Transfusion Reaction
- DP/SNF policy : "Administration of Blood and Blood Components"

SUBJECT:	SECTION:
BOWEL AND BLADDER TRAINING~~BOWEL AND BLADDER TRAINING~~	Page 1 of 2

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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure attempts are made to achieve residents' highest level of independent functioning in the area of bowel and bladder control.

Note: Bowel training should be initiated prior to bladder training because residents' patterns will be easier to determine and manage.

POLICY:

It is the policy of this facility to maintain a method of bowel and bladder retraining that includes attempts to remove indwelling catheters whenever possible and to assist residents in their attempts at continence and personal hygiene so that they may maintain the highest level of personal independence.

AFFECTED PERSONNEL/AREAS: *MEDICAL DIRECTOR, REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSING ASSISTANTS (CNA)*

EQUIPMENT:

- Gloves
- Bed pan/urinal
- Appropriate call light
- Measuring device for urine
- Foley catheter clamp
- 10cc syringe

PROCEDURE:

1. Assess resident at least quarterly for readiness to begin bowel and/or bladder retraining. Notify physician of resident's progress.
2. Bowel and bladder retraining may be discontinued if resident is alert and refuses after initial assessment.
3. Attempt bowel retraining first, offering bed pan at regular intervals and utilizing bowel protocols. Make sure that appropriate call light is within reach. Make attempts for 72 hrs. Continue if progress is made by resident.
4. Assist resident as needed with skin hygiene.
5. Note pattern and type of evacuations.

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6. Foley catheter removal attempts begin with clamp/release to reintroduce bladder tone and capacity. Release clamp at regular intervals of four hours or as resident tolerates. Encourage resident to push down with abdominal muscles to expel urine if possible.

7. Continue to clamp/unclamp every four hours for 24-48 hours then remove the foley catheter (see policy for removal). Proceed as for resident without catheter. Take into account resident's ability to maintain personal hygiene. Assist with ADLs as needed.

8. If resident is placed on bowel and bladder training, every 3 months for 12 months, and remains unsuccessful, it may be discontinued for further training at that time.

9. May initiate bowel and bladder retraining if resident's condition changes.

DOCUMENTATION:

1. Maintain accurate I & O records.

2. Document incontinence episodes and ability of resident to participate in the management program.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, §72315, Section I-3, 72315 (1) (2) San Francisco, California, Title 22.

- Bladder Training Techniques- WebMD, https://www.webmd.com

SUBJECT:	SECTION:
CARE OF RESIDENTS WITH DEMENTIA ON THE DP/SNF UNIT~~CARE OF RESIDENTS WITH DEMENTIA ON THE DP/SNF UNIT~~	*Provisions of Care* **Page 1 of 4**

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PURPOSE:

To provide guidelines used to enhance the quality of life care to residents with the diagnosis of dementia in the DP/SNF unit by individualizing the residents' care to meet physical, spiritual and psychosocial needs.

DEFINITIONS:

Dementia: A syndrome or a group of symptoms that occur together; an umbrella term describing a set of memory and cognitive decline symptoms; many different conditions lead to these symptoms.

POLICY:

It is the DP/SNF unit staff's responsibility to provide a resident with dementia, a therapeutic living environment with regards to what constitutes quality of life most affected by the disease process

AFFECTED PERSONNEL/AREAS: *ANCILLARY STAFF, REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), CERTIFIED NURSING ASSISTANT (CNA), RESPIRATORY THERAPIST (RT), AND ENVIRONMENTAL SERVICES (EVS).*

PROCEDURE:

A. Obtain an initial assessment with details of the residents' cognitive and physical function before admission, if possible. Obtain input from the resident, and their family or guardian, if applicable. Some pertinent questions:

   1. What changes have been noticed with memory?
   2. Can he/she remember at intervals; is it getting worse or does it remain the same?
   3. Have there been changes in personality or behavior?
   4. Have there been declines in personality or behaviors?
   5. Have there been declines in personal care/hygiene?
   6. Is he/she a fall risk?

B. Monitor resident for episodes of dementia-related behavioral problems or changes in behavior such as:

   1. Repetitive vocalizations
   2. Psychomotor hyperactivity
   3. Physical aggression

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4. Self-neglect
5. Resisting help with personal care
6. Anger and irritability
7. Manic-like behavior
8. Disturbance of sleep cycle
9. Psychosis
10. Depression
11. Inappropriate sexual behavior
12. Pacing or wandering

C. For changes in or new dementia-related behaviors, collaborate with the physician to determine the need for the following interventions:

1. Psychiatric evaluation as needed.
2. Physical restraints for resident safety, if needed, with MD order and consent.
3. The order for restraint will include the type and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. As needed (PRN) restraint orders will be neither issued nor accepted.
4. Initiation without Physicians Order: If a physician is not available, an RN may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the resident's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 12 hours of its initiation.
5. Initial In-Person Physician Assessment Within 24-hours of Initiation: The treating physician will perform an in-person assessment of the restrained resident within 24-hours of initiation to verify that restraint is needed and that less-restrictive means are not appropriate.
6. Residents on the DP/SNF unit will be taken to the Emergency Room for full evaluation before Violent Self Destructive restraints are used, especially if the resident has a diagnosis of dementia, and/or has become violent and can harm self or others. The

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resident will not remain on the DP/SNF unit if Violent Self Destructive restraints are used.

7. Antidepressant/antipsychotic medications per MD order

8. Monitor/discuss the use of antipsychotic/psychotropic medications weekly in the Interdisciplinary Team (IDT) meetings and reduce medications as able.

9. Monitor resident closely while on antipsychotic medications using the Abnormal Involuntary Movement Scale (AIMS) tool initially. Re-evaluate using AIMS every 6 months and as indicated.

10. Pharmacy to review issues of adverse medication effects that may cause cognitive impairments and may be mistaken as worsening dementia.

D. Activities should be directed towards managing residents with all stages of dementia. These may include:

1. Reducing long periods of isolation

2. Using distractions

3. Talking/interacting frequently with resident

4. Predictable routines, avoiding frequent or sudden changes

5. Frequent reassurance, calmness

6. Structured environment

7. Orienting stimuli

8. Adequate daylight lighting, night lights, supporting normal wake/sleep cycles

E. If resident is a fall risk/wanderer, place in a low bed if available, place bed in lowest position, assign room closest to nurses' station to be monitored at all times, and place fall mats on the floor next to the bed if indicated. Complete the Bed Assessment for side rail use.

F. Monitor resident routinely for hyperglycemia, dysphasia, weight gain/ weight loss, Parkinsonism, or excessive sedation.

G. Assess resident's decision-making capacity routinely, based on degree/stages of dementia.

REFERENCES:

- ~~American Geriatrics Society.(2014). Geriatrics Evaluation and Management Tools—Dementia-related behavioral problems. Retrieved on 09-17-2014 from https://s3.amazonaws.com/ALTC-CG/GEMBehaviorProblems-alte.pdf.~~
- Annals of Long Term Care. Consuelo H. Wilkins, MD. 2022 HMP Global. *Diagnosis and Management of Dementia in Long Term Care.* http://www.hmpgloballearningnetwork.com
- Healthcare Brands (n.d.). Dementia.org. *The Difference Between Alzheimer's and Dementia.* Retrieved from http://www.dementia.org/types/the-difference-between-alzheimers-and-dementia.
- California Department of Public Health (October 7, 2017). All Facilities Letter (AFL-14-05). *Verifying informed consent for psychotherapeutic drugs before transferring patients to Skilled Nursing Facilities.* https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-14-05.aspx.
- California Association of Health Facilities (February 2020). *Guide to Long Term Care.* https://www.cahf.org/About/Consumer-Help/Guide-to-Long-Term-Care.
- Centers for Disease Control and Prevention (Updated May 12, 2020). *Considerations for Memory Care Units in Long-term Care Facilities.* https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html.
- Centers for Medicare & Medicaid Services (February 27, 2020). National Partnership- Dementia Care Resources. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-Dementia-Care-Resources.

CROSS REFERENCES:

- DP/SNF Policy and Procedure – RESTRAINTS, CHEMICAL
- DP/SNF Policy and Procedure – RESTRAINT USE – NON-VIOLENT, NON SELF-DESTRUCTIVE (NVNSD) AND EMERGENCY-VIOLENT SELF DESTRUCTIVE (VSD)

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SUBJECT:	SECTION:
CARE PLANNING~~CARE PLANNING~~	Page 1 of 3

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PURPOSE:

To ensure a coordinated, personalized and comprehensive written plan is developed based on the resident assessment instrument and on the individual needs of the resident.

POLICY:

On admission, the facility will initiate a Basic Care Plan Summary based on the resident assessment and on the individual needs of the resident. A personalized comprehensive care plan must be developed within 48-72 hours after admission. Resident care planning includes participation from all health care disciplines involved at resident care conferences with continual reassessment, and updating at least quarterly, and upon change of condition, until resident's discharge.

AFFECTED PERSONNEL/AREAS: *INTERDISCIPLINARY TEAM*

PROCEDURE:

1. Resident Care Plan forms will be maintained as part of the resident health record.
2. Each diagnosis will be listed and updated as necessary.
3. The long term goal is stated in relation to the expected outcome of the resident's condition and is determined collectively by the health care team as part of the review of the care plan. Reviews will be recorded by date in number sequence.
4. Identify the problems or needs. After information has been gathered, the data is analyzed to determine what problems and needs exist.
5. The following guidelines should be employed when identifying, selecting, and recording problems:
    a. The date recorded should reflect when the problem was identified.
    b. A problem is a difficulty or concern experienced by the resident.
    c. The problems include currently existing difficulties, as well as potential problems, as identified by the minimum data set:
        - The date recorded should reflect when the problem was identified.
        - Medical status measurements: labs, diagnostic reports, vital signs, etc.
        - Functional status
        - Sensory and physical impairments

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- Nutritional status/requirements
- Special treatments
- Psychosocial status
- Dental condition
- Activity potential
- Rehabilitation potential
- Cognitive status
- Drug therapy

6. Problem statements should be followed with a "related to" or secondary phrase, which relates to the problem when appropriate.

7. The "FOCUS" (goals) are expectations, within the residents' abilities, that can be realistically achieved. Each problem should have a FOCUS goal that is simple, specific and measurable within a specified time frame.

8. Select actions/approaches. When selecting appropriate actions or approaches toward resolving the resident's problems, the following must be remembered:

   a. Actions must be clearly stated and be specific as to "how."

   b. Some actions or approaches may be more appropriate to defer, or may be medically deferred until a later time.

   c. Although specific actions are performed by individual disciplines, the interdisciplinary team's collective actions provide the most effective effort toward resolution of the resident's problems.

9. Determine the responsible discipline. The discipline with expert knowledge is the one that can best meet the resident's needs or accomplish the selected actions.

10. Evaluating the Plan. When evaluating and reassessing the plan of care for the resident, the following shall be considered:

    a. Are the resident's problems still current? Are there new problems?

    b. Are the actions/approaches appropriate and effective?

    c. Are the objectives being met within the designated time frames?

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d. Are all appropriate members of the interdisciplinary team involved in the plan of care as needed?

11. Document resolution of the problem. When a problem is resolved, the appropriate date will be indicated on the resident care plan, written on the blue "discontinued care plan " form in the chart and then removed from current chart and placed in the overflow file in DP/SNF Medical Records.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 (D) (K)United States of America, Med Pass Inc.
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72311 (a), (1A-C), San Francisco, California, Title 22.

SUBJECT: CARE PLANNING, SOCIAL SERVICE	SECTION: *Social Services* Page 1 of 2

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the role of Social Service in planning care for facility residents.

POLICY:

The interdisciplinary team shall develop a comprehensive Care Plan for each Resident. The Social Service Designee is responsible for specific areas, as assigned.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICE, NURSING*

PROCEDURE:

1. A comprehensive Care Plan is developed within seven (*=7) days of completion of the Resident Minimum Data Set (MDS).

2. The Care Plan is developed by the interdisciplinary team which includes, but is not limited to the following professionals:

   a. The attending physician

   b. The registered nurse responsible for the Resident

   c. Dietary Supervisor/Dietitian

   d. Social Services staff member responsible for the Resident

   e. Activity staff member responsible for the Resident

   f. Rehabilitation specialist, and physical, occupational, and/or speech therapists as indicated

   g. Consultants (as appropriate)

   h. Director of Nursing (as applicable)

   i. Nursing assistants responsible for Resident care

   j. Respiratory staff member as indicated

   k. Others as necessary or indicated

3. To the extent possible, the Resident, the Resident's family and/or responsible party, should participate in the development of the Care Plan.

4. Every effort will be made to schedule Care Plan meetings to accommodate the availability of the Resident and family or responsible party.

5. When the Resident has no family or responsible party, and is unable to make his/her own health care decisions, the Interdisciplinary Team (IDT) will act as surrogate decision makers.

6. Scheduling and preparation of the Care Plan meeting calendar is completed by the MDS Coordinator or Social Service Designee

7. The MDS Coordinator, assisted by Social Services, will notify the Resident, family, and/or responsible party, and other interested parties designated by the Resident, of the date and time of the Care Plan Conference at least a week prior to the meeting.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.20 (k), 483.20(1), 483.10(d)(3), 483.20(k)(2). United States of America, Med Pass Inc.

CROSS REFERENCE:

- INTERDISCIPLINARY ASSESSMENT AND REASSESSMENT DPSNF

SUBJECT: **CHANGE IN CONDITION- SIGNIFICANT**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To recognize significant changes in condition which require initiation of new Minimum Data Set (MDS) and Protocol information.

POLICY:

It is the policy of Sierra View Medical Center Distinct Part Skilled Nursing Facility (DP/SNF) that all significant changes of condition will trigger a new Minimum Data Set to be completed and Care Area Assessment (CAA) review of triggered sections.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), MDS COORDINATOR, SOCIAL SERVICES*

PROCEDURE:

1. Document, in the progress notes, the significant change in condition, date and time.
2. Notify physician using SBAR (Situation, Background, Assessment, Recommendation) report format.
3. Notify the responsible party.
4. Initiate new Minimum Data Set form and complete within 14 days. Complete Care Area Assessment review on triggered areas.
5. Update the care plan to reflect the resident's current status.

A significant change in condition is identified as:

- An acute condition (i.e., stroke, broken hip).
- Deterioration in health condition which is life threatening, such as congestive heart failure (CHF) or cancer.
- Clinical complications, such as advanced skin breakdown.
- Recurrent urinary tract infections.
- Deterioration in two or more activities of daily living (ADLs), communication, and/or cognitive abilities.
- Permanent loss of ability to freely ambulate or to use hands.
- Deterioration in behavior, mood or relationships not reversed by interventions.

- A new diagnosis likely to affect the resident's physical, mental, and psychosocial wellbeing over a prolonged period of time (e.g. Alzheimer's disease, diabetes).
- Significant weight loss (3% in 1-2 weeks, 5% in 30 days or 10% in 6 months).
- Marked and sudden improvement in resident's status (e.g. a comatose resident regaining consciousness).

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.20 (b) (2) United States of America, Med Pass, Inc.
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72311 (3-B) , San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **CHANGE IN RESIDENT CONDITION**	SECTION: **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To clearly define guidelines for timely notification of a change in resident condition.

POLICY:

It is the policy of this facility that all changes in resident condition will be communicated to the physician and family or legal representative.

AFFECTED PERSONNEL/AREAS: *NURSING STAFF (RN, LVN)*

PROCEDURE:

1. Acute Medical Change

   a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician using SBAR (Situation, Background, Assessment, Recommendation) report format with a request for prompt physician visit and/or acute care evaluation. The licensed nurse in charge will notify the physician AT ONCE.

   b. If unable to contact attending physician or alternate physician IN A TIMELY MANNER, NOTIFY MEDICAL DIRECTOR FOR FOLLOW–UP TO CHANGE IN RESIDENT CONDITION.

   c. The responsible party for making medical decisions regarding the resident will be notified that there has been a change in the resident's condition and what steps are being taken. (The resident may be the responsible party.)

   d. All nursing actions will be documented in the licensed progress notes as soon as possible after resident needs have been met.

2. Routine Medical Changes/Need to Alter Treatment Significantly

   a. All symptoms and unusual signs will be communicated to the physician promptly. Routine changes are minor changes in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening, and weight loss or gain.

   b. The nurse in charge is responsible for notification of physician and family or legal representative prior to end of assigned shift when a change in a resident's condition is noted.

   c. If unable to reach physician, all calls to physicians or exchanges requesting callbacks will be documented on the Nursing Notes.

d. If the physician has not returned the call by the end of the shift, the oncoming nurse will be notified for follow-up.

e. If unable to contact attending physician or alternate IN A TIMELY MANNER, notify Medical Director and Nursing Director for response and follow-up to change in resident status.

f. Document resident change of condition and response in Nursing Notes, and update resident care plan as indicated.

g. All attempts to reach the physician and responsible party will be documented in the Nursing Notes. Documentation will include time and response.

3. Accident with Injury

a. Any injury that occurs as the result of an accident will be communicated to the physician and the family or legal representative promptly. A request for a prompt physician visit and/or acute care evaluation will be made by the licensed nurse in charge.

b. If unable to contact attending physician or alternate physician IN A TIMELY MANNER, NOTIFY MEDICAL DIRECTOR FOR FOLLOW–UP TO CHANGE IN RESIDENT CONDITION.

c. The responsible party for making medical decisions regarding the resident will be notified that there has been a change in the resident's condition and what steps are being taken. (The resident may be the responsible party.)

d. All nursing actions will be documented in the licensed progress notes as soon as possible after the resident needs have been met.

e. Notify State of California Health and Human Services Agency within 24 hours and fill out the SOC341 form (see Abuse Binder).

4. Decision to Discharge or Transfer

a. If a decision to transfer or discharge a resident is made, the charge nurse will notify the family or legal representative promptly.

b. All attempts to notify the family or legal representative will be documented in the Nursing Progress Notes. The documentation will include time and response.

5. Change in Room or Roommate

a. Refer to Social Service Policy Changes in Room/Roommate.

6. Change in Resident Rights

a. See Social Service Policy Notification and Excision of Rights and Responsibilities.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72311 (3-E), San Francisco, California, Title 22.
- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 (lli) United States of America, Med Pass Inc.

SUBJECT: **CHANGE OF SHIFT REPORT**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide communication and continuity of resident care.

POLICY:

It is the policy of this facility that a resident status report will be given at each change of shift.

AFFECTED PERSONNEL/AREAS:

RN, LVN, CNA

PROCEDURE:

LICENSED

1. On-duty nurse prepares the nursing report which includes pertinent information:
   a. Change of condition
   b. Transfers, discharges
   c. Admissions
   d. Medications/treatment changes
   e. Any unusual occurrence or event
   f. Resident/family complaints
2. Report is given to the on-coming nurses for the next shift, during walking rounds.
3. This cycle is repeated every shift.

LICENSED TO NON-LICENSED (CNA)

1. Non-licensed staff will meet with the licensed staff at the designated time for report.
2. CNA staff going off duty will do walking rounds/ ADL Care with the oncoming CNA staff.
3. Licensed staff will give information pertaining to their specific assignments, which will include:
   a. Special needs
   b. Change of condition

4. This cycle is repeated every shift.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, 2547, San Francisco, California, Title 22.

SUBJECT: CHARTING~~CHARTING~~	SECTION:
	Page 1 of 2

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PURPOSE:

The purpose is to provide consistency in documentation of resident status and care given by Nurse Assistant staff.

POLICY:

It is the policy of this facility that the Certified Nurse Assistant (CNA) will document the care given to their assigned residents on a daily basis. He/she will complete the CNA Activities of Daily Living (ADL) Record in the electronic medical record (EMR), which indicates the resident's level of independence or dependence in functional activities of daily living, their behavior and general nursing care given. General observations of the resident's response to care may be documented on the designated area of the ADL Record. The Nurse Assistant will encourage each resident to participate in completion of ADL tasks to the greatest extent possible to foster resident independence in accordance with the resident's plan of care.

AFFECTED PERSONNEL/AREAS: *CERTIFIED NURSE ASSISTANTS (CNAs)*

PROCEDURE:

1. Each Nurse Assistant will complete the CNA ADL Record for their shift on each resident assigned to their care.

2. Daily care will include, but is not limited to:

   a. Feeding – Percentage of each meal consumed, substitutes offered and amount eaten, the level of assistance required, where the resident takes their meals, and nourishments and fluids offered or if independent in taking fluids.

   b. Body Care – Personal hygiene care including bathing, oral care, hair and nail care, skin care, bed mobility and repositioning and pressure reducing devices used. Indicate level of independence and/or assistance required.

   c. Bowel and Bladder – Toileting methods used, level of contingency (includes presence of indwelling catheters), number of continent or incontinent voiding or eliminations, special care rendered peri care, catheter care, enema.

   d. Behavior – Resident behavior patterns.

   e. General Nursing Care – General nursing measures which are provided on a daily basis and may vary with resident. Indicate level of independence and/or assistance required.

3. Any new or significant change in the resident's condition will be reported to the licensed nurse immediately to enhance nursing intervention.

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4. Bowel and bladder retraining will be documented on the appropriate form(s) according to policy and procedure.

5. Explanation for charting in the Electronic Medical Record:

6. Use care item choices as indicated for:

   a. DP/SNF VITAL SIGNS
   b. SHOWERED WITH ASSISTANCE
   c. INTAKE AND OUTPUT
   d. ORAL CARE
   e. AMBULATE WITH ASSISTANCE
   f. BED BATH PROVIDED
   g. DP/SNF NEUTRASHIELD
   h. NON-SKID FOOTWEAR
   i. CHANGE WATER PITCHER LINING
   j. TRANSFER WITH ASSIST
   k. TOILETING WITH ASSIST
   l. ELIMINATION RECORD
      i. GU SYMPTOMS
      ii. URINE CHARACTERISTICS
      iii. BOWEL PATTERN
      iv. STOOL
   m. FALL PADS
   n. WAFFLE CUSHION OR PRESSURE RELIEF DEVICE

REFERENCES:

- California Code of Regulations (2019). Title 22, Division 5, Chapter 3, Article 5, Section §72547. Retrieved from https://govt.westlaw.com/calregs/Document/I4E75E6D05F7B11DFBF84F211BF18441D?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default).

SUBJECT: **CLEANING AND STORAGE OF BEDSIDE COMMODES AND BEDPANS**	SECTION: **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure adequate cleaning and storing of the residents' bedside commodes and bedpans.

POLICY:

Proper procedures must be followed and appropriate agents used when cleaning bedside commodes and personal resident bedpans.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSING ASSISTANTS (CNA), ENVIRONMENTAL SERVICES (EVS)*

PROCEDURE:

Cleansing and Decontamination:

1. It is Nursing's responsibility to empty contents of commode and bedpans.
2. The commode/bedpan is removed from the patient care area and taken to the dirty utility room or bathroom.
    a. Bedpan or commode receptacle contents are rinsed into toilet.
    b. Receptacle or bedpan is wiped thoroughly with a clean, damp cloth or hospital-approved disinfectant only and allowed to air dry.
    c. The bedpan should be marked with the resident's name, room number and dated. Keep in bathroom away from other personal equipment.
    d. Bedpans are to be changed weekly every Sunday on day shift and as needed.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, §72323, San Francisco, California, Title 22.

SUBJECT: CLOSED TRACH SYSTEM~~CLOSED TRACH SYSTEM~~	SECTION: Page 1 of 3

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PURPOSE:

To provide tracheal suction without interrupting mechanical ventilation and reduce the risk of respiratory infection.

PATIENT POPULATION:

21 years and older

AFFECTED PERSONNEL/AREAS:

REGISTERED NURSE, RESPIRATORY CARE PRACTITIONER

PROCEDURE:

FORMAT	RATIONALE/PRECAUTIONS:
1. Select equipment • Trach care suction catheter • Suction regulator, tubing • Oxygen adjuncts • Oximeter • Normal saline for instillation	Ventilator, trach mist, etc. Provide 100% oxygen, if indicated. Monitor saturation during procedure.
2. Prepare equipment • Wash hands and wear gloves.	Prevention of transmission of infection.
3. Turn on suction. • Adjust suction regulator.	120-150mm Hg for adults. Pressures greater than 150mm Hg greatly increase the risk of trauma.
4. Prepare resident. • Introduce yourself to resident; explain procedure and purpose.	Professional courtesy reassures resident.
5. Begin procedure. • Attach Trach Care T-piece to ventilator circuit, using flex tube, if desired.	Prevents inadvertent interruption of suctioning. Suctioning cannot be accomplished when valve is locked. Blue line on catheter indicates direction catheter tip

• Attach system to resident. • Make sure all connectors are secure; i.e., T-piece to trach tube, suction tubing to control valve, wall connector to container. • Lift and turn control valve to unlocked position. • With resident's head in the 12 o'clock position, advance catheter to black square indicator mark on the catheter. • Reassure resident. • Depress suction control valve, gently withdrawing the catheter to its fully extended length.	will follow. One o'clock position will assist with access to left lung; eleven o'clock position will assist with access to right lung. Suctioning is a very traumatic procedure for some residents; provide reassurances and explanations throughout the procedure. ~~Use intermittent suction only.~~ Monitor saturation during procedure. Catheter is fully withdrawn when black mark is visible at back of T-piece. Do not allow suction procedure to last longer than 15 seconds.
6. Lavage • Advance catheter to the black square indicator mark on the catheter into the tracheostomy tube. • Instill 3-5cc lavage solution into irrigation port. • Suction as above.	Do not apply suction during lavage procedure. Close irrigation port. Use lavage practice sparingly • Contraindications to lavage 1. Decreased O2 saturations 2. Excessive coughing 3. Bronchospasms 4. Tachycardia 5. Dyspnea
7. Cleansing catheter. • After suctioning, flush catheter by depressing control valve and slowly introducing 3-5cc flush solution into irrigation port.	Catheter must be in fully withdrawn position. Make sure irrigation port is closed when not in use.
8. Lift and turn control valve 180° to locked position.	Prevents inadvertent suction.

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9. Chart procedure in resident progress notes and department records.	

REFERENCES:

- American Association of Respiratory Care. AARC Clinical Practice Guidelines>2014/08>06.10.0758.PDF (2010). Retrieved from https://www.ncbi.nlm.nih.gov>pub.
- American Association of Respiratory Care. AARC Clinical Practice Guidelines: Artificial Airway Suctioning (2022). Retrieved from https://doi.org/10.4187/RESPCARE.09548 ~~>2014/08>06.10.0758.PDF (2010). Artificial Airway Suctioning. DOI: 10.4187/respcare.09548 Retrieved from https://www.ncbi.nlm.nih.gov>pub.~~
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SUBJECT: **CLOSETS- ORGANIZING/CLEANING**	SECTION: **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To control infection and to enable residents and staff access to personal belongings stored in resident closets.

POLICY:

It is the policy of this facility to maintain the organization and cleanliness of the resident closets.

AFFECTED PERSONNEL/AREAS: *CERTIFIED NURSING ASSISTANTS (CNA), LICENSED VOCATIONAL NURSES (LVN)*

PROCEDURE:

1. The Nurse Aides/ Shower Team will organize and clean the resident's closets on a daily basis.
2. Reorganization and cleaning shall include proper hanging of resident clothing, shoes stored appropriately, and the removal of inappropriately stored items from the closet.
3. The Nurse Aide will monitor that laundry hampers for personal clothing laundered by families are clean and have tightly sealed lids. Those requiring cleaning or lids shall be reported to the Charge Nurse for communication to Social Services for family notification.
4. The Nurse Aide will ensure that only personal laundry hampers and resident shoes/slippers are stored on the floor of the closet.
5. The Nurse Aide on duty at the time of a resident's transfer/discharge will empty the resident's belongings from the closet and follow facility policy and procedures for the care of the residents' belongings during transfer/discharge.
6. Housekeeping will provide terminal unit cleaning upon transfer/discharge of a resident, per housekeeping policies and procedures

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.70(1) (2) (iv) United States of America, Med Pass Inc.

SUBJECT: **COMMUNICATION BARRIERS, REDUCTION OF**	SECTION: **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To assist residents in communicating their needs.

POLICY:

Residents will be provided methods of communication to ensure adequate communication between residents and staff.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICES, ANCILLARY STAFF*

PROCEDURE:

1. The facility will make arrangements for interpreters or alternate means of communication, such as pictures, sign language, Braille, etc., to enhance communication between residents and staff.
2. Certified bilingual employees, HCIN, TDD phone for the deaf and disabled family members, clergy, or other outside resources may be used in this capacity to reduce communication barriers.
3. Methods instituted to assist residents in communicating their needs will be identified in the residents' plan of care.
4. A list of facility interpreters will be maintained on the unit.
5. Telephone and mail service are available to all residents

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 (1) United States of America, Med Pass Inc.
- Thompson, S. (2017). Overcoming Communication Barriers to Healthcare for Culturally and Linguistically Diverse Patients. Retrieved from https//www.sth.nhs.uk.

SUBJECT:	SECTION:
CONDUCT METHICILLIN RESISTANT STAPHYLOCOCUS AUREUS (MRSA) SCREENING~~INPATIENT METHICILLIN RESISTANT STAPHYLOCOCUS AUREUS (MRSA) SCREENING~~	**Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

PURPOSE: To reduce overall Hospital Acquired Infections (HAIs) and improve in patient outcome by identifying patients at risk for known HAIs, and in this instance, specifically for methicillin resistant *Staphylococcus aureus* (MRSA) infections through active surveillance testing (AST).

BACKGROUND: Although many innovations and improvements have been made in treating patients for various types of conditions and diseases, it is crucial to monitor and prevent HAIs as they may be a major threat to patient safety. Of the various known HAIs, (CLABSIs, CAUTIs, VAPs and others) MRSA infections are easily monitored. Approximately 2 - 5% of all patients in U.S. hospitals carry MRSA bacteria in their nose or on their skin but most do not develop serious infections. MRSA is spread by contact with infected people or fomites carrying the bacteria. In facilities that care for vulnerable individuals such as GACH or SNF, MRSA infections may cause severe problems such as bloodstream infections, pneumonia, sepsis and even death. For this reason, the State of California passed legislation (CA SB 1058, Nile's Law, and SB 158) which aligns with guidelines from the CDC, and requires specific conditions be met for disease surveillance of patients, including the screening for MRSA infections.

A. **DEFINITIONS:** AST, active surveillance testing; CDC, The Centers for Disease Control and Prevention; EMR, electronic medical record; HAI/HAC, hospital acquired infections/conditions; CAUTI; catheter associated urinary tract infection; CLABSI, central line associated bloodstream infection; GACH, general acute care hospital; MRSA, methicillin resistant *Staphylococcus aureus*; SNF, skilled nursing facility; VAP, ventilator associated pneumonia;

B. **SCREENING CRITERIA:** Eligible healthcare professionals (See D. RESPONSIBILITIES) will use the following parameters to identify inpatients in need of MRSA AST and then test these inpatients. According to CA SB 1058, inpatients must be screened upon admission to determine the need for an MRSA swab test (see Figure 1). The test should be conducted within 24 hours of the patient's admittance. The MRSA bundle criteria section in the EMR is meant to assess if:

1. This is a pre-operative patient who is having hip or knee replacements. The patient is to be retested when discharge is ordered. Any patient that tests positive will be notified and educated about MRSA
2. The patient is being admitted to the ICU

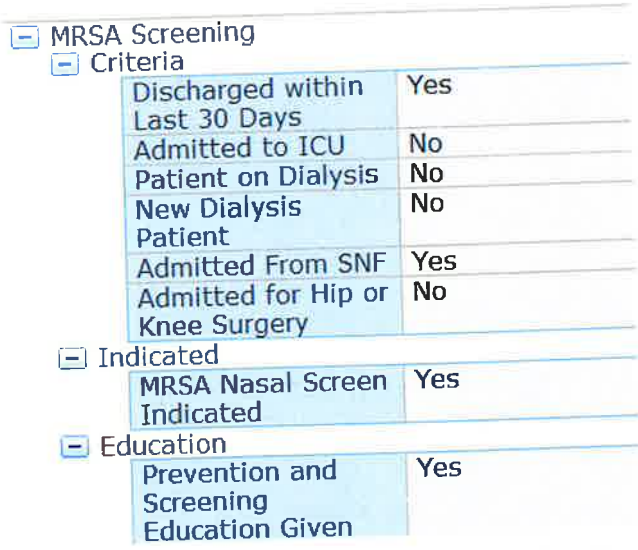

Figure 1: MRSA AST and nasal screen should be administered within the patient's first 24 hours of admission.

3. The patient is discharged from an acute care facility within the past 30 days
4. The patient is or will be receiving inpatient dialysis
5. This is a dialysis patient entering the facility that shows evidence of increased risk of invasive MRSA. If so, the patient shall be tested for MRSA immediately prior to discharge from the facility (this does not apply to a patient who has tested positive for MRSA infection or colonization upon entering the facility)
6. The patient is admitted from a SNF

C. CONTRAINDICATIONS FOR SCREENING: A physician's order is required to withhold MRSA screening, swab testing and culture

D. RESPONSIBILITIES: Any of the following health care professionals with current California licenses may perform MRSA swab tests – Licensed Vocational Nurse (LVN), Registered Nurse (RN), Family Nurse Practitioner (FNP), Physician's Assistant (PA), Laboratory Technician, MD or DO.

E. PROCEDURE:

1. Conduct MRSA AST questionnaire entitled Criteria within the EMR
2. Inform the inpatient of the purpose for performing a swab for laboratory culture
3. A single 'yes' response within the Criteria section of the MRSA Screening questionnaire is sufficient to require an MRSA swab test
    a. Use a single regular culture swab,
    b. Peel open and carefully remove the swab
    c. Insert the swab into the nostril at least 1 cm and swab the inside of the nose by rotating the swab against the anterior nasal mucosa for 3 seconds
    d. Repeat this procedure using the same swab in the second nostril
    e. Carefully place the swab into a labeled transport tube that has the inpatient's information for transport to the laboratory for culture
    f. Record the date that the screening culture collection was completed into the EMR
4. If an inpatients tests positive for MRSA:
    a. The physician should inform the patient or the patient's representative immediately or as soon as is feasibly possible
    b. The inpatient and/or caregiver shall receive verbal and written instructions regarding aftercare and precautions to prevent the spread of MRSA to others (Refer to ***Krames On Demand*** in SVMC Intranet, Infectious Disease, Diseases & Conditions, Methicillin-Resistant Staphylococcus aureus (MRSA) Infection, to print out an information sheet that may be personalized with patient name and special instructions)

REFERENCES:

- California Senate Bill 158 (2008), California State Legislature. SB 158
- California Senate Bill 1058 (2008), California State Legislature. SB 1058

SUBJECT:	SECTION:
CONDUCT METHICILLIN RESISTANT STAPHYLOCOCUS AUREUS (MRSA) SCREENING~~INPATIENT METHICILLIN RESISTANT STAPHYLOCOCUS AUREUS (MRSA) SCREENING~~	**Page 3 of 3**

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- CDC Interim Guidance for a Public Health Response to Contain Novel or Targeted Multidrug-resistant Organisms (MDROs) 2019. Page last reviewed July 10, 2019 and information retrieved July 29, 2022. https://www.cdc.gov/hai/containment/guidelines.html

- Methicillin-resistant *Staphylococcus aureus* (MRSA) in Healthcare Settings, 2019. Content Source: Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Healthcare Quality Promotion (DHQP). Page last reviewed February 28, 2019 and information retrieved July 29, 2022. https://www.cdc.gov/mrsa/healthcare/index.html

- Noorani HZ, Adams E, Glick S, et al. Screening for Methicillin-Resistant Staphylococcus aureus (MRSA): Future Research Needs: Identification of Future Research Needs From Comparative Effectiveness Review No. 102 [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2013 Jun. (Future Research Needs Papers, No. 40.) Retrieved July 29, 2022. Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK154512/

CROSS REFERENCE

- Isolation & Standard Precautions Policy & Procedure

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SUBJECT:	SECTION:
CONFIDENTIALITY OF COMPLETION OF MDS DATA~~CONFIDENTIALITY OF COMPLETION OF MDS DATA~~	Page 1 of 1

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PURPOSE:

To provide for and ensure the resident's right to confidentiality as it relates to the completion and transmission of the Minimum Data Set (MDS) data from persons not authorized by law to obtain this information.

POLICY:

The facility will make reasonable efforts to protect and promote the resident's best interests. The resident or responsible party will be informed at the time of admission of the requirement of the electronic transmission of the Minimum Data Set information. The facility's handling of resident information will be in compliance with state law, resident advocacy and regulatory standards for long-term care.

AFFECTED PERSONNEL/AREAS: *MDS COORDINATOR AND SOCIAL WORKER*

PROCEDURE:

1. The Minimum Data Set assessment information will be entered on the Minimum Data Set form by the Interdisciplinary Team.

2. The MDS Coordinator will input the assessment data into the computer. The information will be processed and transmitted according to Federal requirements outlined in the Resident Assessment Instrument (RAI) Guidelines.

3. When assessment information is entered into the computer, the confidentiality of this information will be maintained under the provisions of the Federal Privacy Act. The completed demographic and signature page with electronic signatures of the ~~and signed~~ Minimum Data Set will be placed in the resident's MDS Chart at the nurses station ~~medical record~~ and is covered under all the confidentiality regulations governing long-term care.

REFERENCES:

- MDS 3.0 RAI Manual v1.15 (October 2017). Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Retrieved from https://downloads.cms.gov/files/mds-30-rai-manual-v115-october-2017.pdf.

- MDS 3.0 RAI Manual v1.16 (October 2018). Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Retrieved from https://downloads.cms.gov/files/1-MDS-30-RAI-Manual-v1-16-October-1-2018.pdf.

SUBJECT: **CONSUMER INFORMATION**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure residents, families and visitors are provided information regarding rights, services, support resources and rules and regulations of the facility in accordance with regulatory guidelines.

POLICY:

The facility will post consumer information for public view as required by law. The Social Worker and Director of DP/SNF shall be responsible for ascertaining that all such consumer information is accurate and conspicuously posted at all times.

AFFECTED PERSONNEL/AREAS: *SOCIAL WORKER, DIRECTOR OF DP/SNF*

PROCEDURE:

1. The Social Worker or designee posts required information as it is received by the facility.
2. The Social Worker or designee and Clinical Director checks the posting periodically to ensure that they are current, accurate, correctly, and conspicuously posted.
3. Should any of the required information be inaccurate or otherwise require change, the Social Worker or designee removes the posting and replaces them with the correct information.
4. All staff members are instructed at the time of hiring to direct all inquiries regarding consumer information to the Director of DP/SNF or Social Worker or designee.
5. The following is a list of articles/information to be posted in public view:
    a. Existing facility license
    b. Previous survey reports. (*DHS 2567 form)*
    c. Any notices of action taken by the Department of Health Services (DHS)
    d. DHS address and phone number. (*Local Field office and State office)*
    e. Ombudsman name, address and phone number (*A poster should be obtained from the ombudsman for this purpose.*)
    f. Consumer information regarding Medicare/ Medi-Cal application, office address and phone number (*how to apply, supplemental financial benefits information, covered and non-covered services)*
    g. Activity calendar

h. Residents' rights (*It is recommended that these be in large print, at eye level, and in several languages, if possible.)*

i. Medicare, Medicaid and Medi-Cal fraud telephone numbers

j. Resident state and local advocacy and support agencies addresses and telephone numbers

k. Resident trust banking hours

l. DHS complaint filing statement

m. Name of Unit Director and Clinical Manager and how to contact them

n. Name and License number of the DP/SNF Administrator

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72503, §72207, §72209, San Francisco, California, Title 22.
- Med Pass, Inc.,(Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 (10) (iii) United States of America, Med Pass Inc.

SUBJECT: DP/SNF ROOM CHANGE	SECTION: Page 1 of 1

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the process of notification of change of room or roommate.

POLICY:

The resident's right to notification of any change in room assignment or roommate will be respected.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICE*

PROCEDURE:

1. A written notification form will be completed by the Social Service Designee to notify the Resident or responsible party that there will be a change in room or roommate.
2. The form must be acknowledged by the resident or responsible party signature or telephone consent prior to the change occurring.
3. The form is filed in the resident's medical record.

REFERENCE:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, Appendix PP 483.15 (e) (2) United States of America, Med Pass Inc.

SUBJECT: **DEATH OF A RESIDENT**	SECTION: **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The care given a body after death, post-mortem care, maintains the dignity of the resident, prepares the body for viewing by the family and properly identifies the body for transfer.

POLICY:

It is the policy of this facility that all residents who expire will be given post mortem care.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSING ASSISTANTS (CNA)*

PROCEDURE:

A. Administrative

1. All residents with Do Not Resuscitate (DNR) status can be pronounced dead by a physician or certified personnel. If a physician is unable to come to the facility to pronounce the resident, the certified personnel will record appropriate information to reflect that "no signs of life" are apparent. For example, "No blood pressure or respirations are obtainable. No pulses felt and no signs of life present." All others must be pronounced by a M.D.

2. Obtain physician's order to release body. If no mortuary is listed and family/responsible party is not available, call the mortuary on call.

3. Notify the family (by physician or licensed nurse) of the resident's death.

4. Notify the coroner if the death is a coroner's case. The body will be released or held for autopsy on the coroner's order. Coroner's office will advise where to send the body. (See Policy on Deaths Reportable to the coroner.)

5. Check with the physician before removing any drains or tubes from the body. They may be left in place if an autopsy is to be performed. Notify Organ Donor Network.

6. Have the mortuary or coroner's representative sign mortuary release form.

7. Notify appropriate departments (pharmacy, business office, dietary).

B. Care of the Body

1. Screen the unit for privacy.

2. Straighten the body and elevate head on one pillow to prevent hypostasis which might discolor the face.

3. Provide dentures in a labeled cup to mortuary.

4. Close eyes by gently pulling down on lashes.

5. Jewelry left with the body must be accounted for on the personal inventory sheet and signed for by mortuary representative.

6. If an autopsy is ordered, leave any tubes in place unless Coroner's office says they can be removed. If no autopsy is anticipated, remove all tubes after checking with the physician.

7. Bathe the body and comb hair.

8. Change dressings if needed.

9. Place body in supine position.

10. Place disposable pads under buttocks and over perineum.

11. Identification bracelet must be on.

12. Extend the arms at sides. Cover body to neck with a sheet.

13. Provide for family privacy.

C. Preparation

1. Assemble all the resident's belongings and check for valuables.

2. If the belongings are given to the family, note items given and to whom. Have the recipient sign for receiving clothing, valuables, and other possessions of the resident on the inventory list. If family is not available, send deceased's personal property to a designated storage area.

3. If the resident's family needs to go to the Social Service office to pick up valuables, escort them and help them obtain the items.

D. Documentation

1. Resident's condition prior to death.

2. Administration of Last Rites of church or attendance of clergy.

3. Time resident was pronounced dead and by whom or name of physician notified.

4. Presence of family and/or notification to them of resident's death and by whom.

5. Time body was transferred to mortician or County coroner representative. Include signed slip from mortician. Notification of Organ Donor Network and referral number.

6. If a coroner's case, record the date and time the coroner's office was notified, name or coroner's representative, the assigned case number, the receiving mortuary and any other instructions.

REFERENCES:

- Nursing Home Practices Following Resident Death, Adrita Barooah, MS, Kathrin Boerner, PhD, 2015, Geriatric Nursing online at www.ncbi.nlm.nih.gov.
- National League for Nursing, 2022, How to Perform Post-Mortem Care, CNA Plus Academy, Retrieved from: https://m.cna.plus

SUBJECT: **DISCHARGE MEDICAL SUMMARY**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure there is a written discharge summary completed by the physician for all residents at discharge.

POLICY:

Each physician will complete and sign a discharge summary within 7 days following the discharge of the resident. The Discharge Summary may be written or dictated per facility policy.

AFFECTED PERSONNEL/AREAS: *ATTENDING PHYSICIAN*

PROCEDURE:

1. The physician or his/her alternate will give discharge orders for the immediate care of the resident.
2. The physician will complete his/her part of the medical record, inscribe the final diagnosis and sign the records.
3. The discharge summary will be released to authorized persons/agencies with consent of the resident/legal representative in accordance with facility policy.
4. Key elements of the Discharge Medical summary include:
   a. Dates of admission and discharge
   b. Reason(s) for admission to DP/SNF Unit
   c. Course in medical and rehabilitation until recapitulation of residents stay and prior treatment.
   d. Admitting diagnosis
   e. Final diagnosis
   f. Discharge functions status/rehab potential, medical condition and prognosis at discharge
   g. Relevant laboratory/imaging results
   h. Discharge location – support – home, care, etc.
   i. Discharge medications
   j. Follow-up plans
   k. Next physician appointments

1. Visiting nurse/home/care/other support service

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 (1), 483.12 (a) (3). United States of America, Med Pass Inc.

SUBJECT: **DISCHARGE PLANNING DPSNF**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

Discharge planning provides:

- Evaluation of all residents for potential care at alternative levels of care including acute rehab, home care, long-term skilled nursing, or other lower level of care (i.e., residential care facility).
- Establishment of discharge plans and post discharge care prior to discharge to enhance continuity of the resident's care.
- Involvement of resident/responsible party in the discharge planning process for each resident anticipating discharge.

POLICY:

It is the policy of this facility to provide ongoing evaluation and discharge planning for all residents while in the facility.

AFFECTED PERSONNEL/AREAS: *NURSING AND SOCIAL SERVICES*

PROCEDURE:

NOTE: If discharge is facility initiated, see Facility Admission Agreement for notice and requirements prior to completing Assessment and Post Discharge Plan of Care forms.

1. This facility uses a Social Worker or *designee* who is familiar with community resources needed to provide appropriate discharge planning.
2. The Interdisciplinary Team and Social Worker or designee are actively involved in planning for the residents who are about to be discharged.
3. Throughout the active discharge planning phase, appropriate disciplines will assist in education and preparation for discharge (i.e., a self-medication program may be initiated).
4. Coordination of discharge planning with the resident and/or responsible party regarding the home environment, equipment, medications, treatments, supervision and/or referral for community services in the home is an integral part of the discharge planning process.

DOCUMENTATION REQUIREMENTS:

1. The social worker or designee will document the discharge planning level of care required for residents. The level of care required shall be documented within seven (7) days of admit and updated as needed, weekly at the Interdisciplinary Team Meeting, quarterly and upon change of condition.

2. The Social Worker or designee shall initiate the Discharge Planning Assessment when it is known that a resident anticipates being discharged. This may be on admission or any time a discharge to home, another SNF, lower level of care (i.e., board & care, nursing facility, residential setting, etc.) is indicated.

3. Once the need for discharge planning has been determined, the Social Worker or designee is responsible for coordinating with the resident/responsible party and appropriate disciplines/services (i.e., physician, home health coordinator, dietary, therapy, nursing, etc.) and to chart in the appropriate location of the medical record.

4. Nursing will play a primary role in the completion of the Post Discharge Plan of Care Summary with additional input from other appropriate disciplines. Attach additional discharge planning notes when appropriate.

5. While completion of the Post Discharge Plan of Care involves all appropriate disciplines, Social Services will ensure that it has been prepared prior to resident discharge.

6. Ensure that the release of information consent has been obtained from the resident upon admission to the facility.

7. Provide resident or responsible party with the Post Discharge Plan of Care Summary prior to discharge. The facility will provide the Post Discharge Plan of Care Summary and Inter-facility Transfer Summary to other long-term health care facilities admitting the resident. Copies of both discharge forms are kept in the resident's medical record.

8. If resident is not discharged as anticipated, indicate reason and continue to document status in Social Services notes. Review discharge status in Resident Care Conference until finalized. Document status in discharge planning section of Care Plan.

9. Home Care Coordinators, when available, should be involved in completing the Discharge Planning Assessment and/or the Post Discharge Plan of Care in conjunction with other disciplines.

10. When transferring a resident to an acute hospital, use only standard Inter-facility Transfer Form.

11. Upon discharge, the completed discharge forms will be retained in the medical record after they are faxed to the physician who will continue care of the resident.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 (1)(3), Title 22, #72433 (5) United States of America, Med Pass Inc.
- California Health and Safety Code 1262.5: Section 1262.5: 2011 California (2015). Retrieved from https://calhospital.org/sites/main/files/file-attachments/lnc-afl-15-25.pdf.

SUBJECT: **DISCHARGE TO HOME**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To adequately prepare the resident and family for discharge and to ensure appropriate home care arrangements have been made.

POLICY:

It is the policy of this facility that residents will be discharged from the facility as per physician order. Pursuant to the physician's orders and discharge planning, a review of the resident's home care needs and medications are completed with the resident/family. If necessary, help will be provided to the resident in making arrangements for transportation when he/she is discharged.

AFFECTED PERSONNEL/AREAS: *NURSING (RN, LVN, CNA), SOCIAL SERVICES*

PROCEDURE:

1. Social Worker or designee and nursing will collaborate with the Interdisciplinary Team, including the resident and/or responsible party, in formulating discharge plans and completing the Discharge Evaluation and Plan of Care, Review and Summary.

2. Obtain physician order for discharge, preferably 24 hours before discharge. The physician order will specify any medications that will not be sent home with the resident.

3. Obtain the name of the attending physician who will take over care once the resident leaves and make a follow-up appointment with this physician. Fax all information needed to the attending physician, (i.e., progress notes, discharge summary form, medication reconciliation sheet, history and physical, physical therapy notes, speech therapy notes, dietary notes, etc.)

4. Nursing will order any discharge medications needed. The social worker or designee will arrange for take-home equipment as ordered by the physician or as needed.

5. Once the discharge order has been obtained, nursing will notify the business office of pending discharge.

6. Nursing will complete the Discharge Plan of Care form and review with the resident and family.

7. Active Discharge

   a. Nursing will check the residents' Personal Inventory List to ensure all belongings are accounted for. Once reconciled, the resident or responsible party will sign the Inventory List to verify receipt of belongings, valuables, and monies. Assist resident with packing belongings. Check closet, drawers, bedside stand and windowsills for any belongings.

   b. Nursing will provide resident and/or family with the final review of the Post Discharge Plan of Care form including any follow-up appointments and discharge medications. Ensure resident/family understand instructions clearly. Obtain signatures. Send original

Post Discharge Plan of Care form with resident/responsible party. Maintain copy of Post Discharge Plan of Care and original Discharge Planning Assessment form in chart.

c. Nursing will escort the resident from the facility, assist into transportation vehicle and assist with transferring belongings to the vehicle.

d. Nursing will ensure that the linen and personal care utensils are removed from the resident's unit.

e. Nursing will notify Housekeeping that the room is ready to be cleaned.

f. Nursing will notify the Dietary Department of discharge.

DOCUMENTATION REQUIREMENTS:

1. See Documentation Requirements – Discharge Planning.

2. Nursing Notes: Record date, time of discharge, manner in which resident left the facility, condition of the resident, who accompanied, and mode of transport. Include any instructions or appointments given in the Electronic Medical Record.

3. Nursing will gather all medical record documents for the resident and send complete chart to Medical Records.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 (1) (3), AHCA 483.12 United States of America, Med Pass Inc.

SUBJECT: **DOCUMENTATION NURSING DPSNF**	SECTION: **Page 1 of 4**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide guidelines for appropriate use of nursing and interdisciplinary documentation.

POLICY:

Documentation will provide an accurate description of a patient's condition, clear and concise communication between healthcare disciplines and meet legal requirements through proper use of nursing and interdisciplinary forms and Electronic Health Records Interventions. ***Ink color must be blue or black and handwriting legible. All signatures will include first initial, last name and license or certification title (i.e. N. Nurse, RN)***

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSES VOCATIONAL NURSE (LVN), CERTIFIED NURSING ASSISTANT (CNA), LICENSED TRAVELERS AND REGISTRY STAFF, RESTORATIVE NURSING AID, UNIT CLERKS, RESPIRATORY THERAPY, NUTRITIONAL SERVICES, PHYSICAL THERAPY, SOCIAL SERVICES, SPEECH THERAPY, OCCUPATIONAL THERAPY.*

PROCEDURE:

INITIAL ASSESSMENT FORMS:

1. The initial assessment documentation will be completed on all patients at the time of admission.

   a. The Registered Nurse (RN) will complete the DP/SNF General Admission Questions and Past Medical History if able (family or history available if resident unable to speak) in Meditech (electronic health record).

   b. All screenings will be completed upon admission and the appropriate referrals made as applicable. The unit clerk will initial, date and time referrals, and enter into Meditech as applicable. (i.e., Physical Therapy, Registered Dietitian, Speech Therapy, Occupational Therapy.)

   c. The RN is responsible for documenting the date and time once all data is collected and the RN has assessed the patient. The RN will document the RN Assessment, Fall Risk and Skin Risk in Meditech.

INTERDISCIPLINARY PLAN OF CARE:

1. Upon completion of the Initial Assessment, the RN or LVN will initiate the appropriate Baseline Care Plan and then the Comprehensive Person Centered Care Plans will be initiated within 48 hours after admission. A copy of the Baseline Care Plan will be reviewed with the family, significant other, or whomever is the guardian and they will sign the form stating it was received.

2. Other healthcare providers involved in the patient's care may also initiate the initial assessments and their corresponding care plans as they deem necessary for the current condition of the patient. These providers include; Respiratory Therapists, Activity Director, Physical Therapists, Speech Therapists, Physicians, Occupational Therapists, Social Service Workers, and Dietitians. It is the responsibility of the healthcare providers to communicate and collaborate with the RN on those care plans they initiated.

3. The Plan of Care will be based upon the age and developmental needs of all residents, and will be consistent with the therapies of other disciplines. Communication among disciplines may occur by review of documentation, referrals via Meditech, interdisciplinary meetings, direct conversation(s) or other appropriate means.

4. To initiate a problem number on the Person Centered Plan of Care, the healthcare provider will enter the following information:

   a. Column #1 – Start Date

   b. Column #2 – Care Plan #

   c. Column #3 – Focus

      - Mark each applicable problem and what it is related to
      - If necessary, mark "other" and write in the specific problem

   d. Column #4 – Residents Goals, must be "SMART" meaning: Specific, Measurable, Achievable, Realistic and Time Frame.

   e. Column #5 –Approach Plan/ Interventions

      - Mark all applicable interventions

   f. Column #6 – Discipline

      - Mark all that apply

   g. Column #7 – Re-eval Date

      - The RN or LVN will date, initial and mark the appropriate outcome

   h. Column #8- Goal Resolved

- Once problem is resolved, the nurse will date and sign. Then, the Care Plan will be removed from the chart, documented on the Blue Discontinued Care Plan form, and given to Medical Records for filing.

5. All healthcare providers that document on the Interdisciplinary Plan of Care will date, initial, and sign the form.

6. The Person Centered Plan of Care is reviewed, updated and/or revised monthly and as the patient's condition warrants.

NURSING EVENT NOTES IN MEDITECH SYSTEM

1. The Notes section in the EMR allows for the documentation of events that requires additional narration. When an event occurs, the RN or LVN must document an entry in Notes, including an assessment of the problem, the interventions that were done to correct or help the problem, and the patient outcome and the notification of the MD and family/significant other.

2. The RN or LVN will document appropriate assessment, interventions followed and the patient outcome using brief and concise wording for each event/problem that occurs during their shift.

3. Sometimes the patient outcome from a previous problem may not be known for some period of time. In this instance, a patient outcome may not be documented with the problem entry. Once the outcome is known, the RN or LVN will document the time and what the outcome was for the previous problem.

4. Pain is an event that will be documented on the back of the Medication Administration Notes, if pain medication was administered and will be monitored on the nurses Pain Assessment Intervention in the EHR three times a shift.

5. The pain assessment on the Medication Administration Record (MAR) will include:

   a. Initials

   b. Location

   c. Time/Date

   d. Description

   e. Pain Scale Number (0-10)

   f. Intervention

   g. Time of Reassessment (after intervention)

h. Response after intervention (0-10)

RN ASSESSMENT AND DOCUMENTATION

1. The RN will document the Weekly Summary and update the Care Plans of scheduled residents per the Weekly Summary Calendar each shift.

LVN NOTES/ASSESSMENT IN PCS

1. The LVN Shift Evaluation in Meditech is for documenting the routine shift assessments performed by the nurse. The LVN is responsible for completing this section every 12 hours.

CNA DOCUMENTATION IN MEDITECH

1. The CNA will document in Meditech, the CNA ADL Record- once a shift, Positioning- in real time, Activities of Daily Living (oral care, baths/showers, pericare ability as indicated) and Elimination Record each time of occurrence.

MEDITECH DOWNTIME

1. In the event of an EMR downtime, follow the policy: Meditech Downtime-Clinical documentation.

REFERENCES:

- Thomson Reuters: (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, §70213, §72547, San Francisco, California.

CROSS REFERENCES:

- MEDITECH DOWNTIME - CLINICAL DOCUMENTATION

SUBJECT:	SECTION:
FALL PREVENTION (ADULT AND GERIATRIC)	**Page 1 of 5**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To identify residents who may be at risk of falling and the implementation of interventions to ensure a safer and protective environment for all residents.

DEFINITIONS:

1. **Fall** - a sudden, uncontrolled, unintended, assisted or unassisted event resulting in a person coming to rest on the ground/floor
2. **Unwitnessed Fall** - a report of a person who has landed or been found on the floor that is unwitnessed
3. **Fall Risk Screening Tool** - a documentation tool used to determine the level of fall prevention interventions initiated that are specific to each resident based on risk
4. **Risk Stratification** – for the purposes of this procedure, assigning a level of risk for a fall, based on an assessment of fall risk factors

POLICY:

Residents who are assessed will be screened using the Fall Risk Screening Intervention in the Electronic Health Record to determine their risk of falling. This screening will be completed upon admission, once per shift, after any fall, post procedure as needed, upon transfer to another level of care, or more frequently based on nursing judgment. The Fall Risk Screening Tool is used to determine the level of fall prevention interventions to be used that are specific to each resident. When a resident is identified as "at risk", resident specific interventions will be implemented.

EXCEPTION: A resident designated as requiring intensive care services, until transferring to another level of care and reevaluated, are considered "at risk" for falls. All residents on the DP/SNF Unit who are total dependence or neurologically impaired are considered "at risk" for falls. All staff will be responsible for maintaining a safe environment and employing the full protection interventions as appropriate.

AFFECTED PERSONNEL/AREAS: *ALL DP/SNF STAFF*

PROCEDURE:

GENERAL PROCEDURES & DOCUMENTATION:

1. All residents are potentially at risk for falling during their hospital stay. A resident's fall risk factors are identified when the fall risk screening tool is completed.
2. Fall risk factors include:
   a. Age

b. Fall history

c. Mobility

d. Elimination

e. Mental status changes

f. Medications

g. Patient care equipment

3. Residents who score 11 or more points on the fall risk screening tool are considered to be a "Fall Risk". Critical thinking and nursing judgment continue to be an essential aspect of nursing care. Therefore, if a resident's fall risk score is less than 11 but nursing judgment indicates that a resident should receive more interventions, the nurse should initiate fall risk strategies in addition to other appropriate fall risk interventions based on the resident's needs.

INTERVENTIONS TO PREVENT PATIENT FALLS:

1. There are two levels of interventions:

a. **Fall Safety Protection** – to be initiated on admission *on all residents.* These interventions include:

- Call light within reach
- Orientation to environment
- Bed or chair in low position with brakes on
- Appropriate footwear
- Personal items within reach
- Bed rails up if indicated by the Bed Assessment for use of Side Rails
- Patient and/or family educated on fall protection
- Maintain clear pathways
- Appropriate lighting
- Assistive devices will be used as appropriate

b. **Fall Risk Interventions** – to be initiated on a resident who scores 11 or more points on the fall risk screening tool ("Fall Risk") or as nursing judgment deems necessary.

- Bed or chair alarm activated
  - When out of bed or chair, resident will be monitored at all times
  - When toileting, staff will remain within arm's reach
- Side rails up (with physician order and Consent) -- **or**
- Bed in lowest position. (Low beds used on residents in the DP/SNF Unit who are alert/ neurologically impaired and can move self out of bed.)
- Fall Mats at bedside if indicated
- Fall Risk indicator near door
- Toileting, offering food/drink, position change every two hours
- Ambulate with assist (if applicable)
- Fall Risk on Person Centered Care Plan

Additional interventions may be implemented as appropriate:

- Physical Therapy/ Occupational Therapy evaluation (requires physician order)
- Restraints (requires physician orders and Consent)
  NOTE: Avoid use of restraints if at all possible.

INTERVENTIONS FOR PATIENT WHO FALLS

1. Assess for injuries (i.e. abrasions, contusion, laceration, fracture, head injury) and provide appropriate aide.
2. Obtain and record vital signs/ neuro checks for 72 hours minimum.
3. Assess for change in range of motion and level of consciousness.
4. Notify physician/family/conservators.
5. Diagnostic tests per physician order.
6. Continue to monitor patient as condition warrants.
7. Document circumstances in medical record.

Complete electronic incident report.

8. Assess physiologic and environmental factors that contributed to the fall.

9. Designate patient as a fall risk for the duration of their stay and initiate Fall Risk Interventions as appropriate.

10. Charge Nurse will conduct a "HUDDLE" with all staff after a fall has occurred and interventions have been implemented and present occurrence at the huddles twice a shift for several days to ensure all staff is informed and aware.

11. Consider assistive devices to prevent repeat fall.

12. Notify California Department of Public Health (CDPH) if the fall resulted in any type of injury to the resident.

ASSISTED FALLS

1. Assess for injuries.
2. Notify physician, family, and conservator.
3. Resident Assessment for pain/discomfort will be reflected via the routine nursing assessment in the EMR.
4. Complete electronic incident report.

PRECAUTIONS, CONSIDERATONS AND OBSERVATIONS

1. One of the primary reasons for falling involves toileting issues. Elimination rounds for assistance with elimination needs are a basic and effective way of reducing the resident risk for falling.

2. Changes in mental status from an oriented baseline are significant contributing factors in resident falls and intervention is essential.

3. The majority of resident falls occur in the residents' rooms.

4. Poly pharmacy (four or more medications) increases the risk for patient falls; risk also increases with titration of medication.

5. Upper side rail use offers handholds/stabilizers for the patient to exit the bed (if indicated in the Bed Assessment for side rail use). A third lower rail can be used on the side where the patient tries to exit the bed without assistance and is a risk for falls. (This requires a physician's order and consent from family or conservator).

6. Preventing resident falls is challenging. Research of the effectiveness of a single intervention is limited. Interventions to reduce the risk of falling must be multifactorial, addressing residents' specific risk factors (i.e. altered elimination, altered mentation and altered mobility).

REFERENCES:

- Tool 3H: Fall Scale for Identifying Fall Risk Factors. Content reviewed 2018, February 20, Agency for Healthcare Research and Quality, Rockville, MD
  Retrieved from http:www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3h.html.

- ~~Strategies for Reducing Falls in Long Term Care, Population Health Learning Network, Vol 22-Issue1-January 2014-ALTC, Betty Willy, PT, MA, CWS, Christine M. Osterburg, RN, BSN. Retrieved from https://www.managedhealthcareconnect.com/articles/strategies-reducing-falls-long-term-care.~~
- Centers for Disease Control and Prevention. STEADI. Older Adult Fall Prevention. July 26, 2021. Retrieved from: *cdc.gov/steadi*
-
- ~~Preventing Falls in a Nursing Home. Wells P. Doctoral Dissertation. A.T. Still University of Health Sciences; Kirksville, MO, USA: 2017.~~
- American Nurse, 2020. *Preventing Falls In Long Term Care Facilities*, Sara Lewandowski DNP, MS, BA, BS, RN, CNE, HNB-BC., Retrieved from:https://www.myamericannurse.com

- Original Research Exploring Clinicians' Perceptions About Sustaining an Evidence –Based Fall Prevention Program, AJN, *American Journal of Nursing 2018; 118(5): 24-33.*

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SUBJECT: **FEEDING, TRANSITIONAL-ENTERAL TO ORAL INTAKE**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure that each resident is appropriately weaned from a tube feeding and is an appropriate candidate for oral intake only.

POLICY:

It is the policy of this facility to safely wean tube fed residents to oral intake under the direction of a physician with supervision provided by appropriate members of the interdisciplinary health team.

AFFECTED PERSONNEL/AREAS: *NURSING (RN, LVN), SPEECH THERAPY, DIETARY, NUTRITION SERVICES*

PROCEDURE:

1. An interest is expressed to discontinue a tube feeding, such as by resident request, physician order, and/or by recommendation of a speech therapist, nursing, or registered dietitian.

2. A physician order is obtained for a Speech Therapy evaluation to determine swallowing ability.

3. In order to stimulate the resident's appetite, it is recommended the transitional feeding formula be infused in the evening hours with the feeding ending no later than 6:00 a.m.

4. If the resident passes the swallow evaluation, then the resident will be offered foods and/or fluids as best tolerated. The therapist will actively work with the resident to promote safe oral intake. In order to promote continuity, the therapist will communicate with the restorative aide and/or nursing staff additional instructions for the feeding program.

    a. Accurate documentation of the percentage of oral (po) intake must be included on the "CNA Meal and Snack Intake" Section of the Electronic Health Record.

5. During this feeding program interval, a Dietitian will monitor po intake and calculate dietary adequacy.

    a. When the % amount indicates an accepted level of intake, orders will be obtained to discontinue the tube feeding. The resident will remain in the feeding program for continual close monitoring until released to staff by the Speech Therapist.

    b. If the calorie count indicates an acceptable level of intake cannot be achieved orally, a conference should be held by the physician and dietitian to determine the feasibility of additional therapy.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.75(1) United States of America, Med Pass Inc.

- Charney, Pamela. (May 31, 2016). *Nutrition Assessment*. Momentum Press.

- **ASHA American Speech Language Association,1997-2022, *Alternative Nutrition and Hydration in Dysphasia Care,*** retrieved from: **https://www.asha.org**

- **Nutrition Care Systems, Staci Betticker, MS, RD, LDN, June 2022, Tube Feeding in a Long Term Care Facility. Retrieved from: https://www.nutritioncaresystems.com**

SUBJECT:	SECTION:
FOOD AT BEDSIDE- STORAGE~~FOOD AT BEDSIDE- STORAGE~~	Page 1 of 1

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PURPOSE:

The purpose is to maintain freshness of foods stored at bedside and prevent contamination by pests.

POLICY:

It is the policy of this facility that all food items stored at the bedside shall be kept in airtight containers labeled with the resident's name and dated.

AFFECTED PERSONNEL/AREAS: *RN, LVN, SOCIAL SERVICES, NUTRITION SERVICES*

PROCEDURE:

1. Inform the resident and family of food storage policy upon admission.
2. Airtight labeled containers are to be provided by the individual(s) supplying the food item(s).
3. Food items brought to the resident by others shall comply with physician orders regarding diet. Items needing refrigeration can be placed in the refrigerator in the pantry only if they are unopened and have not been taken into the resident's room first.
4. Dietitian will be available to discuss appropriate foods which can be kept at bedside and which will comply with physician's dietary orders.
5. Check for expiration dates. If resident refuses to follow dietary orders, it will be documented in the care plan on the chart.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §73723, §72343, San Francisco, California, Title 22.

SUBJECT: **FUNCTIONS OF SOCIAL SERVICE DEPARTMENT**	SECTION: ***Social Services*** **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the philosophy and function of the Social Service Department of the Distinct Part Skilled Nursing Facility (DP/SNF) at Sierra View Medical Center (SVMC).

POLICY:

The DP/SNF will maintain a competent Social Service Designee supervised by qualified personnel. The Social Services staff will provide all medically-related social services functions of this facility as defined by State, Federal, and Local regulatory agencies. These services include the identification, assessment and treatment of residents and families who have social, psychological and/or environmental needs related to the admission, diagnosis, treatment and discharge processes, as well as factors affecting the coping and adjustment processes such as cultural, spiritual, age-related, and language considerations.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICE/DPSNF*

PROCEDURE:

The social worker performs a variety of functions with the goal of maximizing the resident/family's ability to cope with issues that may arise, based on their individual needs and the availability of resources. Such functions include:

1. Direct Service
    a. Psychosocial assessment
    b. Counseling
    c. Discharge planning
2. Refer resident and/or authorized representative to Patient Account Specialist for financial counseling, planning and benefits acquisition
    a. Interdisciplinary team coordination and liaison
3. Consultation
4. Community networking
5. Planning
6. Education
7. Protection: Suspected child or elder/dependent adult abuse and neglect; domestic violence
8. Advocacy

9. Support needs

Social Service activities and programs in this facility are guided by the NASW Code of Ethics (following), which governs the work of all social service staff and designees.

These functions are performed collaboratively with nursing, ancillary personnel, physicians and community agencies. Services are rendered by a qualified Social Service Designee, with routine hours of availability between 8:00 AM – 4:30 PM, Monday through Friday.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.10 (6), 483.15 (g) United States of America, Med Pass Inc.

SUBJECT:	SECTION:
GUIDELINES FOR DETERMINING PRESENCE AND CLASSIFICATION OF INFECTION IN DP/SNF	**Page 1 of 7**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish infection control standards to identify, classify, and determine whether infections are nosocomial or community-acquired within the DP/SNF.

POLICY:

Infections will be determined to be nosocomial or community-acquired, by applying the criteria listed below.

AFFECTED PERSONNEL/AREAS: *DP/SNF*

PROCEDURE:

PRINCIPLES:

The definitions presented below are not all-inclusive. They focus on infections for which surveillance is expected to be useful (i.e., infections that are common and can be acquired and detected in the facility). Three important conditions apply to all of the definitions:

A. All symptoms must be new or acutely worse. Many residents have chronic symptoms, such as cough or urinary urgency that are not associated with infection. However, a change in the resident's status is an important indication that an infection may be developing.

B. Noninfectious causes of signs and symptoms should always be considered before a diagnosis of infection is made.

C. Identification of infection should not be based on a single piece of evidence. Microbiologic and radiologic findings should be used only to confirm clinical evidence of infection. Similarly, physician diagnosis should be accompanied by compatible signs and symptoms of infection.

DEFINTIONS:

A. Respiratory Tract Infection

1. Common Cold/Pharyngitis. The resident must have at least two of the following signs or symptoms:

   a. Runny nose or sneezing

   b. Stuffy nose (i.e., congestion)

   c. Sore throat or hoarseness or difficulty swallowing

   d. Dry cough

e. Swollen or tender glands in the neck (cervical lymphadenopathy)

Comment: Fever may or may not be present. Symptoms must be new, and care must be taken to ensure that they are not caused by allergies.

2. Influenza-like illness: Both of the following criteria must be met:

a. Fever (> or = 100° F~~38° C~~). A single temperature taken at any site.

b. The resident must have at least three of the following signs or symptoms: chills, new headache or eye pain, myalgias, malaise or loss of appetite, sore throat, new or increased dry cough.

Comment: ~~This diagnosis can be made only during influenza season.~~ If criteria for influenza-like illness and another upper or lower respiratory tract infection are met at the same time, only the diagnosis of influenza-like illness should be recorded.

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3. Pneumonia: Both of the following criteria must be met:

a. Interpretation of a chest radiograph as demonstrating pneumonia, probable pneumonia, or the presence of an infiltrate. If a previous radiograph exists for comparison, the infiltrate should be new.

b. The resident must have at least two of the signs and symptoms described under "other lower respiratory tract infections."

Comment: Noninfectious causes of symptoms must be ruled out. In particular, congestive heart failure may produce symptoms and signs similar to those of respiratory infections.

4. Other lower respiratory tract infection (bronchitis, tracheobronchitis): The resident must have at least ~~two~~ three ~~three~~ of the following signs or symptoms:

a. New or increased cough

b. New or increased sputum production

c. Fever (> or = 100° F ~~38° C~~)

d. Pleuritic chest pain

e. New or increased physical findings on chest examination (rales, rhonchi, wheezes, bronchial breathing)

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~~e.~~f. Leukocytosis

g. One of the following indications of change in status or breathing difficulty: new/increased shortness of breath or respiratory rate > 25/minute or worsening mental or functional status (significant deterioration in the resident's ability to carry out the activities of daily living or in the resident's cognitive status, respectively.)

~~f.~~h. Reduction of O_2 Saturation <92%, on room air.

B. Urinary Tract Infection- UTI includes only symptomatic urinary tract infections. Surveillance for asymptomatic bacteria, defined as the presence of a positive urine culture in the absence of new signs and symptoms of UTI, is not recommended, as this represents baseline status for many residents.

1. Symptomatic UTI: One of the following criteria must be met:

a. The resident does not have an indwelling urinary catheter and has at least three of the following signs and symptoms:

~~b.~~• Acute dysuria

- Fever (100° F ~~38° C~~or more), or leukocytosis ~~chills~~
- New or increased burning pain on urination, frequency or urgency
- New flank or suprapubic pain or tenderness
- Change in character of urine (may be clinical e.g., new bloody urine, foul smell, or amount of sediment or as reported by the laboratory new pyuria or microscopic hematuria. For laboratory changes, this means that a previous urinalysis must have been negative.
- Worsening of mental or functional status (may be new or increased incontinence)

~~c.~~b. The resident has an indwelling catheter and has at least two of the following signs or symptoms:

- Fever (100° F ~~38° C~~ or more) or leukocytosis, hypotension, ~~chills~~
- New flank or suprapubic pain or tenderness
- Purulent discharge from around the catheter.

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- Change in character of urine (may be clinical e.g., new bloody urine, foul smell, or amount of sediment or as reported by the laboratory new pyuria or microscopic hematuria. For laboratory changes, this means that a previous urinalysis must have been negative.)

- Worsening of mental or functional status

- Urinary catheter specimen culture with at least 10^5 cfu/ml of any organism. Note: Urinary catheter specimens for culture should be collected following replacement of the catheter if catheter in place >14 days.

Comment: It should be noted that urine culture results are not included in the criteria. However, if an appropriately collected and processed urine specimen was sent and if the resident was not taking antibiotics at the time, then the culture must be reported as either positive or contaminated. Because the most common occult infectious source of fever in catheterized residents is the urinary tract, the combination of fever and worsening mental or functional status in such residents meets the criteria for a urinary tract infection. However, particular care should be taken to rule out other causes of these symptoms. If a catheterized resident with only fever and worsening mental or functional status meets the criteria for infection at a site other than the urinary tract, only the diagnosis of infection at this other site should be made.

C. Eye, Ear, Nose and Mouth Infection

1. Conjunctivitis. One of the following criteria must be met:

   a. Pus or drainage appearing from one or both eyes, present for at least 24 hours

   b. New or increased conjunctiva redness, with or without itching or pain, present for at least 24 hours (also known as "pink eye")

2. Ear Infection. One of the following criteria must be met:

   a. Physician's diagnosis

   b. New drainage from one or both ears (non-purulent drainage must be accompanied by additional symptoms such as ear pain or redness)

3. Mouth and perioral infection. Oral and perioral infections, including oral candidiasis, must be diagnosed by a physician or a dentist.

4. Sinusitis. The diagnosis of sinusitis must be made by a physician.

D. Skin Infection

1. Cellulitis/Soft Tissue/Wound Infection. One of the following criteria must be met:

   a. Pus or drainage present at a wound, skin, or soft tissue site.

   b. The resident must have four or more of the following signs or symptoms:

      - Fever (100° F ~~38° C~~ or more) or worsening mental/functional status;
      - And/or at the affected site, the presence of new or increasing heat, redness, swelling, tenderness or pain, serous drainage.

2. Fungal Skin Infection. The resident must have both a "maculopapular rash" and either physician diagnosis or laboratory confirmation (for Candida or other yeast, laboratory confirmation includes positive smear for yeast or culture for Candida ssp.; for herpetic infections, positive electron microscopy or culture of scraping or swab; for scabies, positive microscopic examination of scrapings).

3. Herpes Simplex and Herpes Zoster Infection. For a diagnosis of cold sores or shingles, the resident must have both a vesicular rash and either physician diagnosis or laboratory confirmation.

4. Scabies. The resident must have both maculopapular and/or itching rash and either physician diagnosis or laboratory confirmation.

   Comment: Care must be taken to ensure that a rash is not allergic or secondary to skin irritation.

E. Gastrointestinal Infection/Gastroenteritis. One of the following criteria must be met:

1. Three ~~Two~~ or more loose or watery stools above what is normal for the resident within a 24- hour period.

2. Two or more episodes of vomiting in a 24-hour period

3. Both of the following:

   a. Stool culture positive for a pathogen (Salmonella, Shigella, E. coli 0157:H7, Campylobacter) or a toxin assay positive for C. Difficile toxin)

   b. At least one symptom or sign compatible with gastrointestinal tract infection (nausea, vomiting, abdominal pain or tenderness, diarrhea)

Comment: Care must be taken to rule out noninfectious causes of symptoms. For instance, new enteral feeding or new medications may cause both diarrhea and vomiting; vomiting may be associated with gallbladder disease.

F. Systemic Infection/Primary Bloodstream Infection. One of the following criteria must be met:

1. Two or more blood cultures positive for the same organism

2. A single blood culture documented with an organism thought not to be a contaminant and at least one of the following:

   a. Fever (100° F ~~38° C~~ or more)

   b. New hypothermia (less than 34.5° C)

   c. Drop in systolic blood pressure of > 30mm Hg from baseline

   d. Worsening mental or functional status

Comment: Bloodstream infections related to infection at another site are reported as secondary bloodstream infections and are not included as separate infections. Unexplained febrile episode: the resident must have documentation in the medical record of fever (100° F ~~38° C~~ or more) on two or more occasions at least 12 hours apart in any 3-day period, with no known infectious or noninfectious cause.

Commentary: The identification of infections in residents of long-term care facilities is often difficult, and several of these definitions may be found to lack sufficient validity and/or reliability for use in many surveillance programs (McGeer, 1991). See original document for further discussion.

REFERENCES:

- Association for Professionals in Infection Control and Epidemiology (APIC) (2019). *Infection Prevention Guide to Long Term Care* (~~-~~2nd Edition)~~.~~ APIC~~.~~ ~~2019.~~
- ~~Janet Nau Frank MBA,MSN,CIC,FAPIC, Mandy Bodily Bantrum, DNP,MPH,RN,CIC,FAPIC.~~
- Centers for Disease Control and Prevention (2020). ~~Prevention Tools/~~ Nursing Homes and Assisted Living (~~LTC~~ Long-term Care Facilities [LTCFs]): Infection Prevention Tools. Retrieved from https://www.cdc.gov/longtermcare/prevention/index.html. ~~CDC. Retrieved from https://www.cdc.gov >longtermcare.~~

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- Med Pass, Inc., (U-updated February 6, 2015). Facility Guide to OBRA Regulations, 483.65 United States of America, Med Pass Inc.

- McKesson Medical-Surgical Inc. (-2021). Universal/-Standard Precautions. ~~-Mckesson Infection Prevention. retrieved url.~~Retrieved from http://uprevent.mckesson.com/universalstandardprecautions/#:~:text=Universal%2FStandard%20Precautions%20are%20a,from%20contact%20with%20infectious%20agents. ~~https://uprevent.mckesson.com~~~~APIC Principles and Practi~~

SUBJECT: **HAIR AND SCALP, CARE OF**	SECTION: **Page 1 of 5**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide comfort, increase circulation, maintain cleanliness, provide an attractive appearance, and improve a resident's self-image.

POLICY:

It is the policy of this facility to provide hair and scalp care as a component of a resident's hygienic program as necessary.

Shampooing of the hair shall be performed as part of a resident's bathing program per facility schedule. Residents who have physician orders for therapeutic shampoo will have them administered per order.

AFFECTED PERSONNEL/AREAS: *CNA, LVN, RN*

PROCEDURE:

A. DAILY GROOMING

EQUIPMENT:

1. Comb and brush
2. Towel

B. PROCEDURE:

1. Explain the procedure to the resident and bring equipment to the bedside. Provide privacy. Wash hands thoroughly/wear gloves.
2. Assist resident to a comfortable position.
3. Begin combing/brushing at end of hair and work toward head.
4. Observe condition of hair and scalp.
5. If hair is tangled, cream rinse may be used to assist with removal.
6. Comb hair to desired style.
7. Hair may only be trimmed by a facility-contracted, licensed and insured cosmetologist with resident/family consent.
8. Report any unusual observations to the licensed nurse for follow up.

9. Document on the nurse assistant Activities of Daily Living (ADL) Care in the electronic health record (EHR).

C. ROUTINE SHAMPOO

1. Coordinate with the resident's shower schedule.
2. Collect shampoo and towel.
3. Wet the hair and apply shampoo.
4. Lather shampoo and massage into hair and scalp.
5. Rinse hair thoroughly and towel dry.
6. Comb or brush hair to desired style.
7. Return shampoo to designated area.
8. Place soiled linen in laundry hamper.
9. Ensure the resident is comfortable.
10. Report any unusual observations to the licensed nurse for follow up.
11. Document in the nurse assistant flow sheet.

D. THERAPEUTIC SHAMPOO

PURPOSE:

1. To soothe an irritated scalp.
2. To remove scales and debris, ointments, or creams previously applied.
3. To administer medication.

EQUIPMENT:

1. Medicated shampoo, with physician's order
2. Towels
3. Washcloth
4. Other linen as needed

PROCEDURE:

1. Coordinate shampoo with other procedures such as resident shower schedule or per physician orders.
2. Collect materials needed.
3. Explain procedure to resident.
4. Wet the hair and apply medicated shampoo.
5. Leave medicated shampoo on hair for prescribed length of time.
6. Rinse hair thoroughly. Last rinsing should be tepid to cool.
7. Remove scales and debris using comb.
8. Towel-dry hair.
9. Apply cream or ointment as prescribed.
10. Comb or brush hair to desired style.
11. Return shampoo to designated area.
12. Dispose of used linens appropriately.
13. Ensure the resident is comfortable.
14. Report any unusual observations to licensed nurse for follow up.
15. Document in nurses' ADL care in the EHR.
16. Licensed nurse will document treatment on the resident's treatment sheet and record the effectiveness of the treatment.

SHAMPOO IN BED:

A cleansing or therapeutic shampoo may be done in the resident's bed if the resident is confined to the bed or refuses to go to the shower.

EQUIPMENT:

1. Large pitcher

2. Shampoo/ non-rinse or Redibath Cap (shampoo cap-no rinse)
3. Absorbent peach pads
4. Towels
5. Comb and brush

PROCEDURE:

1. Explain the procedure to the resident and bring equipment to the bedside. Provide privacy. Wash hands thoroughly.
2. Remove pillow and place absorbent peach pads under resident's head.
3. Fill pitcher with warm water.
4. Place waterproof sheeting under pail at the head of bed.
5. Lower head of bed to comfortable position. Make sure resident does not have respiratory difficulty.
6. Unfasten gown and bring down to resident's shoulders.
7. Wet hair with water; apply shampoo, massaging scalp and hair well. Rinse with clear water. Repeat shampoo and rinse well until all shampoo has been removed unless a no-rinse shampoo is used.
8. Towel dry hair.
9. Comb hair to desired style. Blow dry hair if necessary.
10. Assist resident to comfortable position.
11. Make sure linen is dry. Change bed linens if needed.
12. Report any unusual observations to a licensed nurse for follow up.
13. Record in the nurses' ADL care in the EHR .
14. If using the Redibath Cap, warm cap as instructed by manufacturer, place on head, massage onto head and leave for 10 minutes. Remove cap and comb hair.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, §72315 (d), San Francisco, California, Title 22.

SUBJECT: HAND CARE OF, CONTRACTURE	SECTION: Page 1 of 2

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To maintain cleanliness, prevent injury or skin breakdown, and to prevent progression of the contracture.

POLICY:

It is the policy of this facility to provide for cleansing of the contracted hand on a daily and as needed basis, and to provide measures to prevent injury, skin breakdown or contracture progression on all shifts.

AFFECTED PERSONNEL/AREAS:

RNA, LICENSED NURSES

EQUIPMENT:

- Basin
- Soap
- Warm water or warm soapy water
- Washcloth
- Towel
- Hand roll
- Nail clippers
- Nail file

PROCEDURE:

1. Wash hands thoroughly and don gloves. Explain procedure to the resident. Provide privacy.
2. Fill basin with warm water not to exceed 105 degrees F.
3. Soak the affected hand for 5 minutes.
4. Wash hand with washcloth.
5. Gently lift fingers to wash underneath. Do not force fingers beyond range of easy mobility. This procedure can cause pain to the resident and forced movement could result in injury to the resident.

6. Spread the fingers to wash between each finger. Do not force fingers apart. Gentle movement and washing is essential to this procedure.

7. Rinse the hand well.

8. Dry the hand well with the towel. Gently dry beneath and between the fingers.

9. Clip nails to prevent injury to the hand.

10. Clean beneath the nails as necessary and file all rough areas of the nail.

11. Apply hand roll appropriately if used. Ensure that Velcro strap holding hand roll in place is not binding the skin or impairing skin or circulation if used. Ensure that the hand roll is properly placed for maximum efficiency.

12. Empty basin, wipe dry and store appropriately.

13. Place soiled linen in laundry hamper. Clean nail care items and return to appropriate storage area.

14. Ensure resident is comfortable.

15. Each shift will check all residents with contracted hands to ensure hand rolls are in place and are appropriately applied.

16. Report pertinent observations noted during cleansing procedure and check of hand rolls each shift.

DOCUMENTATION:

Report and/or document any unusual observations in the medical record.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72315 (f), San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **HAND ROLLS**	SECTION: **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To help maintain correct hand position of residents suffering loss of hand sensation, loss of hand mobility, or a resident who is in a persistent vegetative state or loss of use of an extremity.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to provide for the use of hand rolls for those residents assessed as needing them.

AFFECTED PERSONNEL/AREAS: *RNA, CNA*

EQUIPMENT:

- Factory manufactured hand rolls, either hard or soft, with or without straps
- Improvised hand roll, made of rolled washcloth

PROCEDURE:

1. Explain the procedure to the resident.
2. Wash hands thoroughly. Wear gloves.
3. Wash and dry resident's affected hand/hands.
4. Provide range of motion to affected hand/hands.
5. Position hand roll within affected hand/hands. Ensure that Velcro strap holding hand roll in place is not binding the skin or impairing skin or circulation if used.
6. Record the use and effectiveness of assistive devices in the medical record, the resident's electronic health record (EHR) each shift, and in their person centered care plan. Evaluate the effect of these on the resident care goals.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, §72315, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **IDENTIFICATION OF RESIDENT**	SECTION: **Page 1 of 2**

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PURPOSE:

To define a process that reliably identifies the resident as the person for whom the service or treatment is being rendered: second, to match the service or treatment to that individual.

POLICY:

Two patient identifiers will be used when administering medications, blood or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures.

AFFECTED PERSONNEL/AREAS: *ALL DP/SNF STAFF, ALL HOSPITAL PERSONNEL PROVIDING SERVICES TO THE RESIDENT*

PROCEDURE:

Resident's Picture:

1. A picture will be inside the cover of every resident's chart, medication and treatment book, and in the IV administration binder.
2. Pictures will be updated annually and as needed.

Hospital Arm Band:

1. A nontransferable identification band shall be prepared and affixed to the resident during the registration/ admit process.
2. The ID band will be fixed to the bed if resident refuses to have an armband on and will be care planned.
3. The identification band shall be checked by the care provider for the following **two** identifiers to ensure that the right resident is involved:
   a. Resident's name
   b. Resident's date of birth
4. Whenever possible, staff should also verbally assess the resident to assure proper identification, asking the resident's name and date of birth and matching the verbal confirmation to the written information on the identification band.
   a. If the resident's date of birth is **not** available, the second identifier will become the resident's **medical record number.**
   b. Blood Bank (BBK) numbers will be referenced when specimens are obtained for cross match.

c. Blood Bank numbers will be referenced during the administration of blood or blood components.

4. Resident identification must be confirmed using the **two-identifier** system:

   a. No procedure shall be conducted when the resident's identity cannot be verified because the imprinted band is illegible or missing.

   b. Defective or missing bands shall be replaced immediately with new bands.

5. Each healthcare provider conducting assessments on the residents shall include a check of the identification band to assure the band is present and legible, as a routine component of the assessment process.

6. The daily nursing staff rounds shall include spot checking the residents to ensure that they are wearing identification bands and that the information is legible.

Room Identification:

As an additional customary identification measure, room assignment reflecting the patient's/resident's last name, will be placed outside by the (assigned room) door entry for each respective patient/resident immediately during admission.

Same Name Alert:

"NAME ALERT" will be documented on the front of the chart, using "NAME ALERT" labels when residents are present on the same nursing unit with the same last name.

Chart Forms:

All chart forms must have at least two resident identifiers for processing.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §70717, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **INCIDENTAL MEDICAL SERVICES**	SECTION: *Social Services* **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the Social Service Designee's role in ensuring that residents receive dental, optometry, and podiatry services during their stay in the facility.

POLICY:

It is the policy of the Distinct Part Skilled Nursing Facility (DP/SNF) that the Social Service Designee is primarily responsible to maintain, monitor, and coordinate the scheduling of resident services by providers of dental, optometric, podiatric care, and speech therapy.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICES/ DPSNF*

PROCEDURE:

1. Social Services will maintain a system to monitor the dental, optometry and podiatry (others, e.g. speech therapist, as needed) evaluations.
2. Evaluations will be scheduled on an annual basis and/or as needed.
3. Evaluation dates will be documented in the Electronic Medical Record and on logs maintained separately as agreed upon with nursing.
4. Social Services will notify resident or authorized representative of any recommendation for medical services/ evaluations made by a consultant. prior to scheduling the appointment.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990). Barclay's California Code of Regulations, 72423, 72031, 72089, 72401 San Francisco, California, Title 22.
- Long Term Care State Operations Manual, F636 Comprehensive Assessment Timing, Intent 483.20(b) (1) (2) (i) & (iii), November 28, 2017.

PURPOSE:

To establish guidelines for the contents, maintenance, and confidentiality of patient Medical Records that meet the requirements set forth in Federal and State laws and regulations, and to define the portion of an individual's healthcare information, whether in paper or electronic format, that comprises the medical record. Patient medical information is contained within multiple electronic records systems, in combination with financial and other types of data. This policy defines requirements for those components of information that comprise a patient's complete "*Legal Medical Record.*"

DEFINITIONS:

Medical Record: The collection of information concerning a patient and his or her healthcare that is created and maintained in the regular course of Sierra View Medical Center (SVMC), in accordance with hospital policies, made by a person who has knowledge of the acts, events, opinions or diagnoses relating to the patient, and made at or around the time indicated in the documentation.

- The medical record may include records maintained in an electronic medical / record system, e.g., an electronic system framework that integrates data from multiple sources, captures data at the point of care, and supports caregiver decision making.

- The medical record excludes health records that are not official business records of SVMC as personal health records managed by the patient.

Each Medical Record shall contain sufficient, accurate information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers. The information may be from any source and in any format, including, but not limited to, print medium, audio/visual recording, and/or electronic display.

The Medical Record may also be known as the "*Legal Medical Record*" or "*LMR*" in that it serves as the documentation of the healthcare services provided to a patient by a SVMC service area, physician or provider and can be certified by the SVMC Record Custodian(s).

The Legal Medical Record is a subset of the *Designated Record Set* and is the record that will be released for legal proceedings or in response to a request to release patient medical records. The Legal Medical Record can be certified by SVMC in a court of law.

Designated Record Set ("DRS"): A group of records that include protected health information (PHI) and that is maintained, collected, used or disseminated by, or for, a covered entity for each individual that receives care from a covered individual or institution. The DRS includes:

1. The medical records and billing records about individuals maintained by or for a covered health care provider (can be in a business associate's records);

2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

3. The information used, in part or in whole, to make decisions about individuals.

Any research activities that create PHI should be maintained as a part of the DRS and are accessible to research participants unless there is a HIPAA Privacy Rule permitted exception.

Protected Health Information ("PHI"): PHI is individually identifiable health information that is transmitted or maintained in any medium, including oral statements.

Authentication: The process that ensures that users are who they say they are. The aim is to prevent unauthorized people from accessing data or using another person's identity to sign documents.

Signature: A signature identifies the author or the responsible party who takes ownership of and attests to the information contained in a record entry or document.

Clinic Record / Shadow File: A folder containing COPIES ONLY of information from the medical record used primarily by clinicians in their office or clinic setting. These COPIES of the relevant documents from the original medical record are NOT part of the legal medical record.

Macros: Macros allow a provider to record and replay a series of typed characters or other keystrokes (e.g., hot keys, one or more keys at the same time, or one-word commands) in a manner that makes it possible for a physician or a provider to quickly document an entire medical note while avoiding the cost of transcription and/or the time of repetitive documentation.

POLICY:

I. Maintenance of the Medical Record

A. A Medical Record shall be maintained for every individual who is evaluated or treated as an inpatient, outpatient, or emergency patient of SVMC.

B. Currently, the Medical Record is considered a hybrid record, consisting of both electronic and paper documentation. Documentation that comprises the Medical Record may physically exist in separate and multiple locations in both paper-based and electronic formats. (See Appendix A).

C. The medical record contents can be maintained in either paper (hardcopy) or electronic formats, including digital images, and can include patient-identifiable source information, such as photographs, films, digital images, and fetal monitor strips and/or a written or dictated summary or interpretation of findings.

D. The current electronic components of the Medical Record consist of patient information from multiple Electronic Health Record source systems. The intent of SVMC is to integrate all electronic documents into a permanent electronic repository.

E. Original Medical Record documentation must be sent to the designated Medical Records department or area. Whenever possible, the paper chart shall contain original reports.

Shadow files maintained by some clinics or care sites contain copies of selected material, the originals of which are filed in the patient's permanent Medical Record.

PROCEDURE:

II. Confidentiality

The Medical Record is confidential and is protected from unauthorized disclosure by law. The circumstances under which SVMC may use and disclose confidential medical record information is set forth in the Notice of Privacy Practices and in other SVMC Privacy Policies and Procedures.

III. Content

A. Medical Record content shall meet all state and federal legal, regulatory and accreditation requirements including, but not limited to, Title 22 California Code of Regulations, sections 70749, 70527 and 71549, and the Medicare Conditions of Participation 42 CFR Section 482.24. Appendix A contains a listing of required Medical Record documentation content, and current electronic or paper format status.

B. Additionally, all hospital records and hospital-based clinic records must comply with the applicable hospital's Medical Staff Rules and Regulations requirements for content and timely completion.

C. All documentation and entries in the Medical Record, both paper and electronic, must be identified with the patient's full name, SVMC Unit number, and SVMC account number. Each page of double-sided or multi-page forms must be marked with both the patient's full name, SVMC Unit number and SVMC account number, since single pages may be photocopied, faxed or imaged and separated from the whole.

D. All Medical Record entries should be made as soon as possible after the care is provided, or an event or observation is made. An entry should never be made in the Medical Record in advance of the service provided to the patient. Pre-dating or backdating an entry is prohibited.

IV. Medical Record vs. Designated Record Set

A. Under the HIPAA Privacy Rule, an individual has the right to access and/or amend his or her protected health (medical record) information that is contained in a "designated record set." The term "designated record set" is defined within the Privacy Rule to include medical and billing records, and any other records used by the provider to make decisions about an individual. In accordance with the HIPAA Privacy Rule, SVMC has defined a "designated record set" to mean the group of records maintained for each individual who receives healthcare services delivered by a healthcare provider, which is comprised of the following elements:

- The Medical Record, whether in paper or electronic format, to include patient identifiable source information such as photographs, films, digital images, and fetal monitor strips when a written or dictated summary or interpretation of finding has not been prepared;
- Billing records, including claim information; and
- All physician or other provider notes, written or dictated, in which medical decision-making is documented, and which are not otherwise included in the Legal Medical Record (e.g., outside records, email, when applicable for treatment).

B. The Medical Record generally excludes records from non-SVMC providers (i.e., health information that was not documented during the normal course of business at SVMC or by a SVMC provider). However, if information from another provider or healthcare facility, or personal health record, is used in providing patient care or making medical decisions, it may be considered part of the SVMC Designated Record Set, and may be subject to disclosure on specific request or under subpoena. Disclosures from medical records in response to subpoenas will be made in accordance with applicable Campus policies.

V. Who May Document Entries in the Medical Record

Only the following types of SVMC employees and/or employees of SVMC-contracted clinical and social services providers may document entries in the Medical Record:

1. Child Life Specialists
2. Clinical Social Workers/Social Service Providers
3. Dentists
4. Dietitians/Diet Technicians
5. Emergency Trauma Technicians
6. Fellows
7. Home Health Coordinators
8. Clinical Care Partners
9. Hyperbaric Technicians/Observers
10. Interns
11. Interpreters (Employees of SVMC)
12. Lactation Specialists
13. Licensed Vocational Nurses
14. Medical Assistants
15. Medical Ethicists
16. Nurse Practitioners
17. Nurses employed by physicians (exceptions)
18. Occupational Therapists
19. Osteopathic Students
20. Pastoral Care Providers
21. Pharmacists

22. Physical Therapists
23. Physician Assistants
24. Physicians, including MD's and DO's
25. Podiatrists
26. Psychologists
27. Registered Nurses
28. Mental Health Practitioners
29. Licensed Psychiatric Technicians
30. Midwives
31. Residents
32. Respiratory Therapists
33. ~~School Teachers~~ Clinical/Ancillary Faculty
34. Speech Pathologists
35. Students, e.g., MD, RN, Occupational Therapy, etc. (Notations in the record must be co-signed by a supervising clinician)
36. Students, e.g., MD, RN
~~36.~~37. Certified Nurse Assistants (CNA)
~~37.~~38. Others as designated by Medical Center Policies and /or Medical Staff Bylaws

VI. Completion, Timeliness and Authentication of Medical Records

A. All inpatient Medical Records must be completed within 14 days from the date of discharge (California Code of Regulations, Title 22, section 70751). Additional requirements may also be included in the applicable SVMC hospital Medical Staff By-Laws and/or Rules and Regulations.

B. All operative and procedure reports must be completed immediately after surgery.

C. All Medical Record entries are to be dated, the time entered, and signed.

D. Certain electronic methods of authenticating the Medical Record, including methods such as passwords, access codes, or key cards, may be allowed provided certain requirements are met. The methodology for authenticating the document electronically must comply with SVMC electronic signature standards (See Section XII below: Authentication of Entries). The entries may be authenticated by a computer key, in lieu of a medical staff member's signature, only when that medical staff member has placed a signed statement with the Medical Staff Office to the effect that the member is the only person who will use the key (or sequence of keys). The use of signature stamps is not allowed within the medical record.

E. Fax signatures are acceptable.

VII. Routine Requests for Medical Records for Purposes of Treatment, Payment and Healthcare Operations ("TPO")

The Health Information Management Services staff will process routine requests for Medical Records. All charts physically removed from the Medical Record storage areas will be logged, e.g., using a computerized tracking system.

Only authorized SVMC workforce members may access Medical Records. SVMC Workforce members who access Medical Records for payment or healthcare operations are responsible to access only the amount of information in medical records which is necessary to complete job responsibilities.

A. Access to Medical Records for Treatment Purposes.

B. Healthcare providers who are directly involved in the care of the patient may access the full Medical Record.

C. Payment Purposes.

D. Authorized and designated SVMC workforce members may access the patient's medical record for purposes of obtaining payment for services, including the following uses:

1. Coding and abstracting;
2. Billing, including claims preparation, claims adjudication and substantiation of services;
3. Utilization Review; and
4. Third Party Payer Reviews (including Quality Improvement Organization reviews).

E. Healthcare Operations. Patient medical records may be accessed for routine healthcare operation purposes, including, but not limited to:

1. Peer Review Committee activities;
2. Quality Management reviews, including outcome and safety reviews;
3. Documentation reviews; and
4. Teaching.

F. Requests for Electronic Components of the Medical Record.

Personnel who access the electronic Medical Record are required to have a unique User ID and password, and access to information is limited according to the minimum necessary rule and managed by role, as approved by designated management personnel.

VIII. Ownership, Responsibility and Security of Medical Records

A. All Medical Records of SVMC patients, regardless of whether they are created at, or received by, SVMC, and patient lists and billing information, are the property of SVMC. The information contained within the Medical Record must be accessible to the patient and thus made available to the patient and/or his or her legal representative upon appropriate request and authorization by the patient or his or her legal representative.

B. Responsibility for the Medical Record. The SVMC Director of Health Information Management (Medical Records) is designated as the person responsible for assuring that there is a complete and accurate medical record for every patient. The medical staff and other health care professionals are responsible for the documentation in the medical record within required and appropriate time frames to support patient care.

C. **Original records may not be removed from SVMC facilities and/or offices except by court order, subpoena, or as otherwise required by law.** If an employed physician or provider separates from or is terminated by the hospital for any reason, he or she may not remove any original Medical Records, patient lists, and/or billing information from SVMC facilities and/or offices. For continuity of care purposes, and in accordance with applicable laws and regulations, patients may request a copy of their records be forwarded to another provider upon written request to SVMC.

D. Medical records shall be maintained in a safe and secure area. Safeguards to prevent loss, destruction and tampering will be maintained as appropriate. Records will be released from Health Information Management only in accordance with the provisions of this policy and other SVMC Privacy Policies and Procedures.

E. Special care must be exercised with Medical Records protected by the state and federal laws covering mental health records, alcohol and substance abuse records, reporting forms for suspected elder/dependent adult abuse, child abuse reporting, and HIV-antibody testing and AIDS research.

F. Chronology is essential and close attention shall be given to assure that documents are filed properly, and that information is entered in the correct encounter record for the correct patient, including appropriate scanning and indexing of imaged documents.

IX. Retention and Destruction of Medical Records

All Medical Records are retained for at least as long as required by state and federal law and regulations, and SVMC policies and procedures. The electronic version of the record must be maintained per the legal retention requirements as specified in or consult with Legal Counsel.

X. Maintenance and Legibility of Record

All Medical Records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted from the record, except in accordance with the Record Management policy.

Handwritten entries should be made with permanent black or blue ink, with medium point pens. This is to ensure the quality of electronic scanning, photocopying and faxing of the document. All entries in the medical record must be legible to individuals other than the author.

XI. Corrections and Amendments to Records

When an error is made in a medical record entry, the original entry must not be obliterated, and the inaccurate information should still be accessible.

The correction must indicate the reason for the correction, and the correction entry must be dated and signed by the person making the revision. Examples of reasons for incorrect entries may include "wrong patient," etc. The contents of Medical Records must not otherwise be edited, altered, or removed. Patients may request a medical record amendment and/or a medical record addendum.

A. Documents created in a paper format:

1. Do not place labels over the entries for correction of information.

2. If information in a paper record must be corrected or revised, draw a line through the incorrect entry and annotate the record with the date and the reason for the revision noted, and signature of the person making the revision.

3. If the document was originally created in a paper format, and then scanned electronically, the electronic version must be corrected by printing the documentation, correcting as above in (2), and rescanning the document.

B. Documents that are created electronically must be corrected by one of the following mechanisms:

1. Adding an addendum to the electronic document indicating the corrected information, the identity of the individual who created the addendum, the date created, and the electronic signature of the individual making the addendum.

2. Preliminary versions of transcribed documents may be edited by the author prior to signing. A transcription analyst may also make changes when a non-clinical error is discovered prior to signing (i.e., wrong work type, wrong date, wrong attending assigned). If the preliminary document is visible to providers other than the author, then this document needs to be part of the legal health record.

3. Once a transcribed document is final, it can only be corrected in the form of an addendum affixed to the final copy as indicated above. Examples of documentation errors that are corrected by addendum include: wrong date, location, duplicate documents, incomplete documents, or other errors. The amended version must be reviewed and signed by the provider.

4. Sometimes it may be necessary to re-create a document (e.g., wrong work type) or to move a document, for example, if it was originally posted incorrectly or indexed to the incorrect patient record.

C. When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:

1. Identify the new entry as a "late entry"

2. Enter the current date and time – do not attempt to give the appearance that the entry was made on a previous date or an earlier time. The entry must be signed.

3. Identify or refer to the date and circumstance for which the late entry or addendum is written.

4. When making a late entry, document as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapse, the less reliable the entry becomes.

D. An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry.

1. Document the date and time on which the addendum was made.

2. Write "addendum" and state the reason for creating the addendum, referring back to the original entry.

3. When writing an addendum, complete it as soon as possible after the original note.

E. Errors in Scanning Documents

If a document is scanned with wrong encounter date or to the wrong patient, the following must be done:

1. Reprint the scanned document.

2. Rescan the document to the correct date or patient, and void the incorrectly scanned document in the permanent document repository.

F. Electronic Documentation – Direct Online Data Entry

Note: The following are guidelines for making corrections to direct entry of clinical documentation, and mechanisms may vary from one system to another.

1. In general, correcting an error in an electronic/computerized medical record should follow the same basic principles as corrections to the paper record.

2. The system must have the ability to track corrections or changes to any documentation once it has been entered or authenticated.

3. When correcting or making a change to a signed entry, the original entry must be viewable, the current date and time entered, and the person making the change identified.

G. Copy and Paste Guidelines

The "copy and paste" functionality available for records maintained electronically eliminates duplication of effort and saves time, but must be used carefully to ensure accurate documentation and must be kept to a minimum.

1. Copying from another clinician's entry: If a clinician copies all or part of an entry made by another clinician, the clinician making the entry is responsible for assuring the accuracy of the copied information.

2. Copying test results/data: If a clinician copies and pastes test results into an encounter note, the clinical-provider is responsible for ensuring the copied data is relevant and accurate.

3. Copying for re-use of data: A clinician may copy and paste entries made in a patient's record during a previous encounter into a current record as long as care is taken to ensure that the information actually applies to the current visit, that applicable changes are made to variable data, and that any new information is recorded.

XII. Authentication of Entries

A. Electronic signatures must meet standards for:

1. Data integrity to protect data from accidental or unauthorized change (for example "locking" of the entry so that once signed, no further untracked changes can be made to the entry);

2. Authentication to validate the correctness of the information and confirm the identity of the signer (for example, requiring signer to authenticate with password or other mechanism);

3. Non-repudiation to prevent the signer from denying that he or she signed the document (for example, public/private key architecture).

At a minimum, the electronic signature must include the full name and either the credentials of the author or a unique identifier, and the date and time signed.*

B. Electronic signatures must be affixed only by that individual whose name is being affixed to the document and no other individual.

C. Countersignatures or dual signatures must meet the same requirements, and are used as required by State law and Medical Staff Rules and Regulations.

D. Initials may be used to authenticate entries on flow sheets or medication records, and the document must include a key to identify the individuals whose initials appear on the document.

E. Rubber stamp signatures: *Refer to Section VI (D).*

F. Documents with multiple sections or completed by multiple individuals should include a signature area on the document for all applicable staff to sign and date. Staff who have completed sections of a form should either indicate the sections they completed at the signature line or initial the sections they completed.

G. No individual shall share electronic signature keys with any other individual.

H. *Macros & Checklists*. Pre-printed forms, checklists, patient questionnaires, and word-processing macros can be used to supplement written or dictated notes. When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation, if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician's macro, either the resident or the teaching physician must provide customized, patient-specific information that is sufficient to support a medical necessity determination. The note in the record must sufficiently describe the specific services furnished to the specific patient on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros which do not contain patient-specific information. Medical record macros and checklists may be used to supplement provider written or dictated notes.

XIII. Designation of Secondary Patient Information

The following three categories of data contain secondary patient information and must be afforded the same level of confidentiality as the LMR, but are not considered part of the legal medical record.

A. Patient-identifiable source data are data from which interpretations, summaries, notes, etc. are derived. They often are maintained at the department level in a separate location or database, and are retrievable only upon request. Examples:

1. Photographs for identification purposes
2. Audio recordings of dictation notes or patient phone calls.
3. Video recordings of an office visit, if taken for other than patient care purposes

** Acknowledge that there may be older systems that do not have this capability. There are future plans for all systems to meet this minimum requirement.*

4. Video recordings/pictures of a procedure, if taken for other than patient care purposes
5. Video recordings of a telemedicine consultation
6. Communication tools (i.e., Kardex, patient lists, work lists, administrative in-baskets messaging, sign out reports, FYI, drafts of notes, or summary reports prepared by clinicians, etc.)
7. Protocols/clinical pathways, best practice alerts, and other knowledge sources.
8. A patient's personal health record provided by the patient to his or her care provider.
9. Alerts, reminders, pop-ups and similar tools used as aides in the clinical decision making process. The tools themselves are not considered part of the legal medical record. However, the associated documentation of subsequent actions taken by the provider, including the condition acted upon and the associated notes detailing the exam, are considered a component of the legal medical record. Similarly, any annotations, notes and results created by the provider as a result of the alert, reminder or pop-up are also considered part of the legal medical record.

Some source data are not maintained once the data has been converted to text. Certain communication tools are part of workflow and are not maintained after patient's discharge.

B. Administrative Data is patient-identifiable data used for administrative, regulatory, healthcare operations and payment purposes. Examples include, but are not limited to:

1. Authorization forms for release of information
2. Correspondence concerning requests for records.

3. Birth and death certificates.

4. Event history/audit trails.

5. Patient-identifiable abstracts in coding system.

6. Patient identifiable data reviewed for quality assurance or utilization management.

7. Administrative reports.

C. Derived Data consists of information aggregated or summarized from patient records so that there are no means to identify patients. Examples:

1. Accreditation reports

2. Best practice guidelines created from aggregate patient data.

3. ORYX reports, public health records and statistical reports.

4. Draft Documents / Work in Progress. Electronic processes and workflow management require methods to manage work in progress. These work-in-progress documents often are available in the system as "draft documents, viewable to a limited number of users. They generally are not viewable to clinicians until the document is sent for final signature. Draft documents are not considered an official medical record document until it has been signed by an authorized signer.

XIV. ENFORCEMENT, CORRECTIVE & DISCIPLINARY ACTIONS

Compliance with the above policy is monitored by SVMC Department of Health Information Management (HIM). Violations of any of the above policy will be reported to the appropriate supervising authority for potential disciplinary action, up to and including termination and/or restriction of privileges in accordance with SVMC Medical Staff By Laws, and Human Resource / Personnel Policies.

RELATED POLICIES

- Designated Record Set Policy
- Notice of Privacy Practices Policy
- Patient Privacy – Patient's Right to Amend
- Authorization for Uses and Disclosures of Protected Health Information (PHI)
- Verbal & Telephone Orders – Persons Permitted to Accept, Read Back, and Authentication of
- Documentation and the Use of Abbreviations, Acronyms and Symbols
- Medical Record Retention and Destruction: Disposal of Protected Health Information
- Medical Record- Unacceptable Abbreviations & Symbols

- Ownership of Medical Records
- Patient Access to Medical Records
- Records Management
- Release of Patient Information
- Signature, Initials or Computer Key Identification

REFERENCES:

- Health Insurance Portability and Accountability Act (HIPAA) Privacy & Security Rule, 45 CFR 160-164 (2013). https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/administrative/combined/hipaa-simplification-201303.pdf.

- California Medical Information Act, California Civil Code Section 56 et seq. (1988). https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=56.10.&lawCode=CIV.

- Medicare Conditions of Participation, 42 CFR Section 482.24 (2020). https://www.law.cornell.edu/cfr/text/42/482.24.

- Title 22 California Code of Regulations, Sections 70749, 70527, and 71549 (2020). https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Business Records Exception, Federal Evidence 803(6) (2014). https://www.law.cornell.edu/rules/fre/rule_803.

- California Code of Regulations, Title 22, Section 70751 (2020). https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- California Hospital Association Consent Manual – Authentication sections (2019). https://www.sierra-view.com/documents/consent2019_enterprisenew.pdf

- The Joint Commission. (2020) Comprehensive Accreditation Manual. National Patient Safety Goal 15. Oakbrook Terrace, IL.

Appendix A
Documentation Contents of the Medical Record

The medical record shall include, at a minimum, the following items (if applicable):

A. Identification information, which include, but are not limited to, the following:

1. Name
2. Address on admission
3. Identification number (if applicable)
   - Medicare Number
   - Medi-Cal
   - Hospital Number
   - Social Security Number
4. Age
5. Sex
6. Marital status
7. Legal status
8. Mother's Maiden name
   - Patient's Mother's maiden name
   - Place of Birth
9. Legal Authorization for admission (if applicable)
10. School Grade, if applicable
11. Religious Preference.
12. Date and time of admission (or arrival for outpatients).
13. Date and time of discharge (departure for outpatients).
14. Name, address and telephone number of person or agency responsible for patient.
15. Name of patient's admitting/attending physician.
16. Initial diagnostic impression.
17. Discharge or final diagnosis and disposition.
18. Allergy records.
19. Advance Directives (if applicable).
20. Medical History including, as appropriate: immunization record, screening tests, allergy record, nutritional evaluation, psychiatric, surgical and past medical history, social and family history, and for pediatric patients, a neonatal history.
21. Physical examination.
22. Consultation reports.
23. Orders, including those for medication, treatment, prescriptions, diet orders, lab, radiology and other ancillary services.
24. Progress notes, including current or working diagnosis (excluding psychotherapy notes).
25. Nurses' notes, which shall include, but not be limited to, the following:
    - Nursing assessment including nutritional, psychosocial and functional assessments.
    - Concise and accurate record of nursing care administered.
    - Record of pertinent observations, including psychosocial and physical manifestations and relevant nursing interpretation of such observations.

- Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration.
- Record of type of restraint and time of application and removal.
- Record of seclusion and time of application and removal. (NPH)

26. Graphic and vital sign sheet.
27. Results of all laboratory tests performed.
28. Results of all X-ray examinations performed.
29. Consent forms for care, treatment and research, when applicable.
30. Problem List (outpatient records only).
31. Emergency Department record.
32. Anesthesia record, including preoperative diagnosis, if anesthesia has been administered.
33. Operative and procedures report, including preoperative and postoperative diagnosis, description of findings, technique used, and tissue removed or altered, if surgery was performed.
34. Pathology report, if tissue or body fluid was removed.
35. Written record of preoperative and postoperative instructions.
36. Labor record, if applicable.
37. Delivery record, if applicable.
38. Physical, occupational and/or respiratory therapy assessments and treatment records, when applicable.
39. Patient/Family Education Plan (NPH Only)
40. Clinical Data Set from other providers.
41. Master Data Sets (as applicable to record type) including but not limited to: MDS (Skilled Nursing).
42. Patient photographs when used for identification or treatment.
43. Master Treatment Plan and Reassessment (NPH only).
44. Discharge Instructions
45. A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, final diagnoses, his/her condition on discharge and the recommendations and arrangements for future care. If applicable, it shall include diet and self-care instructions.
46. Copies of letters to patients.
47. Email communications between the patients and the provider regarding the care and treatment of the patient.
48. Telephone Encounters. Documentation is required for telephone encounters with patients and/or their caregivers, or other care providers that:
    - Provide new or renewal of prescription for medications
    - Alter the current plan of care, including treatments and medications
    - Identify a new system or problem and provide a plan of care
    - Provide home care advice for symptom/problem management
    - Provide authorization for care
    - Provides or reinforces patient education

    Documentation should include the date and time of call, name of caller and relationship to patient (if different from patient), date and time of the response (or attempts to return call),

the response given, and the signature and professional title of provider or clinic staff handling the call

49. Primary Language

SUBJECT: **MAINTAINING PATENCY OF FEEDING TUBE**	SECTION:

PURPOSE:

To dissolve coagulated formula that may be occluding the feeding tube.

POLICY:

Occluded percutaneous endoscopic gastrostomy tube (PEG) feeding tubes will be reported to the physician, and an order obtained for a surgical consult for removal.

Note: Foley feeding tubes will be changed as needed by licensed nursing staff. Nursing staff are not to remove a PEG tube.

Agents:

- Warm Water

AFFECTED PERSONNEL/AREAS:

RN, LVN

EQUIPMENT:

- 60cc Syringe
- Warm Water
- Container

PROCEDURE:

1. Wash hands thoroughly.
2. Explain procedure to resident.
3. Draw up 20-50cc of warm water.
4. Attach syringe to tube, alternately push in and pull back on the plunger to avoid continued excessive pressure.
5. If unsuccessful, instill 10-20cc of H2O; clamp tube for about 20 minutes.
6. Check tube as per #4.
7. If unsuccessful, repeat 5 and 6.

8. If unable to unclog tube – replace per physicians orders. If the resident has a permanent tube which cannot be removed (PEG), notify the physician.

RECORDING:

1. Record procedure and results in resident's electronic medical record.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.30 United States of America, Med Pass Inc.
- American Society for Parenteral and Enteral Nutrition (ASPEN). (Mar 22, 2019). *Combat the Clog: Tips for Keeping Feeding Tubes Clear*. Tubefed.com by AVANOS. Retrieved from https://tubefed.com/newsletter/combat-the-clog-tips-for-keeping-feeding-tubes-clear/.

SUBJECT:	SECTION:
MDS TRACKING FORM~~MDS TRACKING FORM~~	Page 1 of 3

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

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PURPOSE:

Track Minimum Data Set (MDS) dates to assure that all time frames are met timely for change of condition annual and quarterly reviews by the Interdisciplinary Team (IDT).

POLICY:

All MDS time frames will be accurate for change of condition, annual and quarterly reviews.

AFFECTED PERSONNEL/AREAS:

MDS COORDINATOR

PROCEDURE:

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- The Resident's ~~A~~ individual charts with printed MDS demographic information and the Signature page ~~n MDS book~~ should be placed at the nurses' station. ~~This book should have alphabetized tabs in it so that the MDS Coordinator can place the resident's MDS to be completed alphabetically. When the IDT team completes the assessments they are to be placed back in the book for access by the entire team.~~
- MDS Coordinator will prepare the MDS tracking forms the 1st of each month.
- The form will be placed in the MDS book the 1st of each month so it is available for the IDT. This allows the IDT to plan their schedule for assessments.
- To determine timely dates, if a change of condition assessment is due, an addendum note is placed in the chart on the date the change is identified. That date is put in the "Type of MDS" column.
- The next column identifies the 7-day assessment period (assessment reference date).
- The next column identifies the documentation start date for the IDT assessment to be completed. The team members are to ~~place the~~ complete their section of the ~~d~~ assessment in Net Solutions. ~~the book for the MDS Coordinator to input into the computer~~. The computerized assessment will be put in the book so the IDT can do their appropriate RAP modules and sign the assessment. On the 13th day, the MDS coordinator will review the process and sign off appropriately by the 14th day.
- For annual assessments, MDS Coordinator should count back 14 days from the last quarterly assessment date and repeat the time frame in steps 5 and 6.
- For quarterly assessments, MDS Coordinator should identify the last assessment date and count back 11 days and then forward 7 days. These 7 days will constitute the observation period for the IDT and this date would be entered in the referenced date column. The next 2 days are for the

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team to complete the assessment and the next 2 days for the MDS Coordinator to input the assessment into the computer and the team to sign it off.

- Less time is required for the quarterly assessment as there are no RAP modules to complete.

Example:

1. Last quarterly completed on *September 15.*
2. Count back to *September 4.*
3. Count forward to *September 4 to September 11.*
4. The assessment period will be *September 12 and 13.*
5. The input time and sign off will be *September 14 and 15.*

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1	2	3	4 11 days to start for 7 days observation	5 OBSERVATION ←----------	6 PERIOD ----------	7 ----------
8 FOR	9 ASSESSMENT IDT	10 BY	11 Reference date to put on MDS	12 COMPLETE ---------- --	13 ASSESSMENT BY	14 Input in computer by MDS Coordinator
15 Last quarterly date 9/15 Sign off by team	16	17	18	19	20	21
22	23	24	25	26	27	28

This form is to be used in conjunction with the Minimum Data Set (MDS) Log and schedule form that is in the Nursing Policy and Procedure Book.

When the MDS is locked in the computer and transmitted, the MDS nurse will document this date on the MDS Tracking Form.

REFERENCES:

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- Centers for Medicare/Medicaid Services. MDS 3.0 RAI Manual (2019). Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.
- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 United States of America, Med Pass, Inc.

SUBJECT: **MEDICATION ADMINISTRATION - DP/SNF**	SECTION: **Page 1 of 20**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To assure the most complete and accurate implementation of physicians' medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe, timely, and sanitary manner.

POLICY:

1. ORDERING MEDICATIONS – Medications and treatments shall be administered only upon the written order of a medical provider. No standing orders shall be employed.

2. TELEPHONE ORDERS – The prescriber's complete order, date, time, name of prescriber, and signature of the nurse receiving the order shall be transcribed on the physician's order sheet. Licensed nurses and pharmacists may take telephone orders, using telephone order, read back format.

3. IMPLEMENTATION ("NOTING") – The nurse who receives the prescriber's order shall be responsible for its complete implementation. This includes proper transcribing, ordering of medications and all other steps involved in carrying out of the order, and care plan as needed, whenever pertinent.

4. INITIATION OF NEW MEDICATION ORDERS – New medication orders shall begin timely. Routine orders shall begin on the same day ordered, unless the next dose would normally be given on another day. New PRN drug orders shall be available on the same day ordered.

5. ADMINISTRATION – All medications and treatments shall be administered by licensed health care professionals as allowed by state law.

Pre-pouring of medications shall not be permitted in this facility. The pre-pouring of medications is defined, as the preparation of all resident's medication doses prior to the medication pass.

AFFECTED PERSONNEL/AREAS: *RN, LVN*

PROCEDURE:

PREPARATION OF DOSES – GENERAL INSTRUCTIONS:

1. Doses shall be prepared immediately prior to administration to each resident and shall be administered within one (1) hour before or (1) hour after the scheduled dose time.

2. On the DPSNF unit when using the cassettes system, doses(s) will be removed, using sanitary technique, and placed in a receptacle such as a disposable cup. When using the punch card system, the dose(s) will be removed from the card using pressure on the "bubble" and placed in a receptacle such as a disposable cup.

3. Sanitary techniques shall be used in the preparation of any medication:

   a. Hand washing shall be done immediately prior to preparation for each dose time and whenever the nurse has contact with body secretions (i.e., eye needs, N/G tube). Alternatives to hand washing such as isopropyl alcohol gel or foam may be used between residents, and when the nurse has not come in contact with any body secretions.

   b. Oral medication shall not be touched.

   c. Sterile syringes and needles shall be used for all injections.

   d. Topical ointments and creams shall not be touched, ordered amount placed in disposable cup (Do NOT take tubes, bottles into residents' room.)

4. The nurse shall maintain the security of the medications during the preparation of doses, and while medications are being administered. A licensed nurse or pharmacist must attend an unlocked medication or treatment cart (within view).

5. The medication label shall be verified against the medication sheet for accuracy of resident, drug and dose, and for strength of medication, route, frequency and duration of therapy, if applicable, and for allergies.

6. The nurse shall read and follow precautionary or additional instructions available on the prescription label "Shake Well", "Give on an Empty Stomach").

7. The licensed nurse will bring the resident's MAR to the Medication Room for verification purposes before signing out narcotics.

8. During the licensed nurses' medication pass, the medication cart will be brought to an easily accessible area near the resident to maintain contact with the medication cart and medications, and for verification purposes.

ADMINISTRATION OF DOSES:

1. Each resident shall be appropriately identified prior to the administration of any medication, using two means of identification, (i.e., birthdates, picture, name, armbands.)

2. If applicable, vital signs or tests shall be done prior to the administration of a dose (ex: pulse with antihypertensive, and urine or blood sugars with insulin, if ordered) by nurse administering medication.

3. Adequate fluid will be offered with oral medications, unless on fluid restrictions per physician's order.

4. Residents will be observed swallowing their oral drugs. Medications shall not be left with residents to self-administer unobserved (unless bedside medication administration procedures are followed).

5. Medications will be dissolved with the appropriate amount of H_2O/ fluid as per MD order/ manufacturer's recommendation.

6. Medications shall be charted immediately after being administered.

7. Crushing of medications or allowing residents to chew the medication shall be done appropriately for the medications(s) concerned.

   a. Medications shall be reviewed for appropriateness of crushing (see List of Medications Which Should Not Be Crushed or Chewed). Specific questions should be addressed to the pharmacist.

   b. Sanitary techniques shall be used when crushing or breaking medications.

   c. Proper crushing instruments shall be used.

   d. Any medication which appears on the "List of Medications Which Should Not Be Crushed or Chewed" that cannot be provided in another form and cannot be administered without crushing or chewing, requires a specific physician order authorizing its administration by crushing or chewing.

8. Adequate supplies shall be maintained in the facility at all times (disposable cups, portion cups, drinking cups, counting tray, crusher, syringes, needles, scalpel or medication/tablet cutter-for breaking tablets).

9. Supplies shall be disposed of properly; according to policies and procedures listed in the Infection Control Manual.

NASAL AEROSOLS (INHALERS):

1. Follow preparatory steps for ointments.

2. Verify that the medication is for the NOSE and verify right, left or both nostrils.

3. Nasal Drops

   a. Position resident so that drops flow toward the sinuses and Eustachian tube.

   b. Push tip of nose up slightly and position dropper just inside nostril and in a manner such that drops flow down the inside wall of the nasal cavity or along the septum.

c. Do not touch dropper to nostril.

d. Instill the prescribed number of drops and have the resident remain in the position for several minutes to allow full penetration of the drops.

e. After repositioning the resident comfortably, wipe excess drops from the nose. Some residents will need to expectorate so an emesis basin may be needed.

f. Wash hands.

g. Wear gloves at all times during procedure.

4. Nasal Sprays

a. Position resident upright with head tilted back slightly.

b. Occlude one nostril with finger and insert the tip of the sprayer into the nostril.

c. Instruct the resident to inhale gently while the container is squeezed.

d. Repeat the prescribed number of times in the nostril(s).

e. Instruct the resident to keep head tilted back for several minutes to allow complete penetration of the medication.

f. Wash off the tip of the sprayer and replace cap.

g. Wash hands.

h. Wear gloves at all times during administration of medication.

OPHTHALMIC MEDICATIONS:

1. Verify that the medication is for the EYE and verify right or left eye or both eyes.

2. Using gloves, when appropriate, remove any dressing or encrustation from eye and cleanse area with warm water.

3. Use a clean gauze pad for each stroke and wipe the eye from inside to outside (inner canthus).

4. Position resident so that the head is tilted back to side of affected eye so that medication flows away from tear duct.

5. While resident looks up and away, hold lower lid down to expose the conjunctival sac.

6. For eye drops, keeping the tip of the dropper clean, drop the prescribed number of drops into the sac.

7. For eye ointments:

   a. Apply thin ribbon of the ointment along the length of the lower lid.

   b. Have resident blink several times to distribute the medication.

   c. Twist tube to cut ribbon. Do not touch tube to eye.

8. After instillation, wipe any excess medication from the outer eye with a clean tissue for each eye.

9. Apply a new dressing, if necessary.

10. Dispose of supplies appropriately.

11. Wash hands.

12. Document administration of medication and record in licensed nursing notes any pertinent observations of the condition of the eye(s).

ORAL INHALERS

1. For hand-held nebulizer:

   a. Assemble canister and clean mouthpiece. If aerochamber is ordered, attach to canister.

   b. Shake well.

   c. Instruct resident to exhale, close lips, cover mouthpiece and tilt head back.

   d. Instruct resident to inhale slowly and completely as the medication is sprayed into the mouth.

   e. Have resident hold breath for 4 to 5 seconds, and then exhale slowly through pursed lips.

2. For Hand Held Inhaler

   a. Per manufacturer's directions, insert canister into the device and re-assemble.

   b. Instruct resident to exhale, close lips over the inhaler and tilt head back.

   c. As medication is released, have resident inhale quickly and deeply.

d. Instruct resident to hold breath for 4 to 5 seconds, then exhale as much as possible.

e. Repeat procedure until capsule contents are consumed.

f. After administration, the resident may remove medication from the mouth and throat.

g. Wash the mouthpiece in warm water and dry thoroughly.

h. Supplies should be discarded properly.

Document administration of the medication and record any observations of the resident's condition in the licensed nursing notes.

OTIC MEDICATIONS:

1. Verify that the medication is for the EAR and verify right or left ear or both ears.
2. Using gloves, when appropriate, remove any dressing or encrustation from the ear canal and clean the area with warm water.
3. Position the resident so that the affected ear is facing up and gently pull back on the auricle to straighten the ear canal.
4. Examine the canal with adequate light and clean any excess drainage from the canal with a cotton-tipped applicator or tissue.
5. Withdraw the proper amount of medication from the container and instill the proper number of drops. Drops should be directed to avoid dropping directly onto the eardrum.
6. Instruct the resident to remain in the same position for several minutes to allow penetration of the medication.
7. A cotton ball may be placed in the canal after this period to prevent leakage.
8. Assist the resident to a comfortable position. Discard used supplies appropriately.
9. Wash hands.
10. Document administration of the medication and record any pertinent observations of the ear in the licensed nursing notes.

ORAL ADMINISTRATION:

1. Special Considerations – Crushing

   a. The manufacturer formulates some tablets for "Timed Release" of the medication throughout the gastrointestinal tract. Some other tablets are coated for a variety of reasons (enteric coat, or to prevent staining of the mouth and tongue, etc.). These two types of tablets should not be chewed or crushed. Other categories and alternatives are listed on the list of "DO NOT CRUSH MEDICATIONS" which are listed in clinicalpharmacology-ip.com, and can also be accessed via the SVMC intranet under tab Physicians, then tab Pharmacology.

   b. Sanitary handling of medications to be crushed will be maintained.

2. Special Considerations – Sublingual/Buccal:

   a. Sublingual and buccal tablets should not be crushed or swallowed.

   b. Some common buccal medications are:

      - Cardilate (erythrityl tetranitrate)
      - Oreton Propionate (testosterone)
      - Oreton Methyl (methyl testosterone)

   c. Some common sublingual medications are:

      - Nitroglycerin
      - Isordil (isosorbide dinitrate)
      - Isuprel Glosserts (isoproterenol HCl)
      - Hydergine S.L. (HEA)

3. Definition of Liquids

   a. Solution – medication dissolved in water usually forming a transparent liquid.

   b. Suspension – medication is not dissolved but is "suspended" within the liquid vehicle forming a cloudy liquid. The suspended powder will settle to the bottom of the container with time. Suspensions should be shaken well before each administration.

c. Elixir – medication dissolved in alcohol solution resulting in a clear liquid. Measuring of all liquids is done by reading the volume at the lowest level of the meniscus while holding the container at eye level. The reading is taken at the center of the line of liquid. Volumes may be expressed in terms of different measuring systems, but generally metric or apothecary measurements are used. The metric system is the preferred system. Measurements such as "teaspoonful" or "tablespoonful" are discouraged. Conversions between systems must be done accurately to ensure proper dosing.

4. Oral Administration of Solids and Liquids

a. Prepare doses (see Preparation of Doses-General Instructions).

b. Pour the proper dose of each medication into appropriate medication cup (paper-souffle for solids, plastic graduated for liquids), from vial, bottle or punch card.

c. When all doses for a resident are prepared, identify the resident by name and armband and explain the procedure.

d. Inform the resident of any changes in doses, dosage form, color, etc.

e. Hand the medication cup(s) to the resident or pour the contents into the resident's mouth.

f. Offer plenty of drinking water or juice after medications, unless contraindicated.

g. Observe that medications are taken. It may be necessary to double-check the resident's mouth or cheek pockets.

- Dispose of supplies.
- Document administration of medication.

5. Oral Administration of the Sublingual/Buccal tablets.

a. Prepare doses (see Preparation of Doses-General Procedures).

b. Pour the dose into the medication cup. A separate cup should be used if the resident receives other medications, which should be swallowed. The sublingual or buccal tablets should be given last in that case.

c. Identify the resident by name or picture and armband, then explain the procedure and any changes in medications.

d. For sublingual medication, have the resident hold the tablet under the tongue until dissolved completely.

e. For buccal tablets, instruct the resident to hold the tablet in any one of the four buccal pouches between the gum and cheek and keep it in place until completely dissolved.

f. Some tablets require several minutes to dissolve completely so the resident should be checked for proper and complete dissolution of the tablet after several minutes.

g. Alternating the buccal pouch used during each dose of administration can minimize mucosal irritation from buccal tablets.

h. Water or juice should be offered only after the tablets have been completely dissolved.

i. Dispose of supplies.

j. Document administration of medication.

PARENTERAL ADMINISTRATION:

1. Intramuscular (IM)

a. Wash hands/wear gloves.

b. Select appropriate syringe and needle size; IM injections are best administered using a 20G to 23G needle, 1" to 11/2 " in length, and with a medium bevel; volume per injection should not exceed 2.5 ml.

c. Prepare medication; verify directions on vial with medication administration record.

- Reconstitute powders with proper diluents, as specified in product information.
- If refrigerated, warm the medication slightly to minimize pain on injection.

d. Swab stopper or wipe break point of ampoule with alcohol swab and withdraw the proper dose using a filtered needle, then change to appropriate needle gauze.

e. Identify resident by name and wristband.

f. Provide privacy and position the resident to expose the chosen injection site.

g. Explain the procedure to the resident and provide reassurance and minimize anxiety, if needed.

h. Clean the site with an alcohol swab, moving in a circular pattern out about 2 inches from the center. Allow to dry.

i. After the alcohol has dried, stretch the skin around the injection site with one hand. This makes insertion of the needle easier and helps disperse the medication. For deltoid muscle, grasp the flesh and lift up and away from the bone.

j. With needle and syringe held at 90-degree angle to the skin, insert the needle with a quick, dart-like thrust.

k. Check needle placement by withdrawing the plunger slightly, checking for blood. If blood appears in the needle hub or syringe barrels, withdraw the needle, affix a new needle onto the syringe and select a new site.

l. Holding the syringe and needle steady, inject the medication at a slow even rate until entire dose is administered.

m. Quickly withdraw the needle and apply gentle pressure to the site.

n. Discard used materials according to facility policy.

o. Wash hands.

p. Document administration of the medication, dose, date, time and injection site. Note the resident's tolerance of injection and its effects.

2. Z Track Technique (for Iron Dextran-inferon)

a. Wash hands.

b. Verify directions on vial with medication administration record.

c. Draw a proper dose of medication and on 0.2 to 0.3 ml of air into the syringe.

d. Replace needle with a sterile 3" needle (replacing needle prevents leakage into the subcutaneous tissue as the needle is inserted). Follow facility policy and procedure to prevent needle stick injuries.

e. Identify resident. Explain the procedure and provide privacy.

f. Place resident in the lateral position exposing the opposite gluteal muscle to be used as the injection site. The resident may also be placed in the prone position.

g. Displace skin literally by pulling it about 1/2" (1cm) away from the injection site.

h. Insert the needle into the muscle at a 90-degree angle.

i. Aspirate for blood return. If none appears, inject the drug slowly, followed by the air. (Injecting air after the drug helps clear the needle and prevents tacking of the medication through subcutaneous tissues as the needle is withdrawn.)

j. After the volume has been injected, leave the needle in place for about 10 seconds to prevent seepage from the site.

k. Withdraw the needle and allow the skin to return to its normal position. This will seal the site.

l. Do not massage the site, but encourage physical activity.

m. Use alternate buttocks for subsequent injections.

n. Document administration of medication, dose, date, and site on the medication administration record. Include resident's response, if appropriate.

3. Intradermal

a. Prepare as for I.M. injections, steps 1 through 7(select a tuberculin syringe and 26G x 5/8" needle).

b. Locate an injection site several finger widths forward of the antecubital space. Avoid areas with dense hair/blemishes.

c. Cleanse the site with alcohol and allow to dry.

d. Withdraw the proper dose of medication into the syringe and expel any excess air.

e. Hold the resident's forearm in one hand with the injection site facing up and stretch the skin around the site with thumb. Position the needle nearly flat against the surface of the skin with the bevel facing up and insert the needle into the skin until the tip rests about 1/8" (3mm.) below the surface. At this point, the needle tip will rest between the epidermis and the dermis.

f. Slowly inject the medication. Resistance to flow indicates proper placement of the needle. Ease of flow may indicate that the needle tip is into the dermis.

g. When a small wheal appears at the surface of the skin, withdraw the needle and apply gentle pressure at the site. Do NOT massage.

h. A control wheal may be made on the opposite arm using a like volume of normal saline of test diluent.

i. Discard used materials properly.

j. Wash hands.

k. Document administration of medication.

Special Notes on Intradermal Skin Testing

Follow the instructions supplied with the testing agent regarding the proper technique for reading the results of the test. It is important to wait the proper length of time between the injection and the reading of the result. Consult the manufacturer's instructions, and document accordingly.

1. Subcutaneous (S.C.)

a. Prepare as for I.M. injections.

b. Swab the site with alcohol, using an outwardly spiraling motion, starting at the center and moving out about 2".

c. Grasp the skin at the chosen site between the thumb and index finger, pinching slightly to elevate the subcutaneous layer.

d. Position the needle with the bevel up: a 1/2" needle should be positioned at 90 degrees, a 5/8" or longer needle should be positioned at 45 degrees.

e. Insert the needle in one quick motion and release the grip on the skin.

f. Draw back the plunger to assure that a vein has not been entered, and slowly inject the medication. If a vein is entered, signaled by a backflow of blood into needle hub and barrel, attach a new needle and start again.

g. With an alcohol swab over the site, quickly withdraw the needle along the same angle as it was inserted, and apply slight pressure to the site.

h. Massage the site gently for several seconds.

i. Discard used materials properly.

j. Wash hands.

k. Document administration of medication, date, dose, time and site. Note the resident's response, if appropriate.

2. Insulin Pens

a) Verify MD order and pen to resident