b) Don gloves

c) Take lid off pen and clean tip with alcohol

d) Place special needle on tip made for the pen

e) Click pen twice to remove air and move insulin up into needle

f) Enter the amount of insulin to be given into the window on pen

g) Verify amount of insulin on pen with a second licensed nurse before administration

h) Clean area with alcohol where injection will be given, let dry

i) Inject insulin, needle will automatically retract.

j) Remove needle and place in needle disposal box.

k) Wash hands.

l) Document administration of medication, date, dose, time and site. Ensure verifying licensed nurse countersigns on MAR. Note the resident's response, if appropriate.

TUBE ADMINISTRATION (NASOGASTRIC, GASTRIC AND JEJUNOSTOMY):

1. Medication shall be ordered from the pharmacy specifying the tube type so that the most appropriate dosage form of the medication ordered is dispensed.

2. Prepare doses (see Preparation of doses-General Procedures).

3. Prepare each dose of medication in separate cups.

   a. Crush medications, if allowable (see List of Medications Which Should Not be Crushed)

   b. Crushed tablets or capsule contents should be mixed with a small volume of water (20ml) or the amount stated in the MD order/ manufacturer's recommendation.

4. When all doses are prepared, identify the resident by name or picture and armband and explain the procedure. Inform the resident of any changes in medication.

5. Have the resident placed in a Fowler's or semi-Fowler's position.

6. Stop enteral pump, if applicable, and clamp the administration set tubing.

7. Disconnect the administration set tubing from the resident's tube.

8. Check for proper placement of tube by administering air and auscultation with a stethoscope or by aspirating gastric contents.

9. Flush the tube with approximately 30 ml of water using a catheter-tipped syringe prior to administering medications.

10. Draw the liquefied medications into the feeding syringe or pour into connected feeding syringe by gravity. Allow medications to flow by gravity through the enteral tube. Gentle pressure with the syringe plunger may be used, if necessary. Never "force" medications/fluids through tubing.

11. Rinse medication cup and administer rinsing to assure complete dose.

12. Flush tube with minimum of 15 ml of water after each medication.

13. Flush tube with 30 ml of water after medication administration is complete.

14. Reconnect the administrations set tubing, unclamp and start the enteral pump, if needed, and double check the flow rate.

15. Confirm that the formula is flowing properly through the tubing.

16. Clean or dispose of syringe according to facility policy and procedure and discard all other supplies appropriately.

17. Wash hands.

18. Document administration of medications.

TOPICAL ADMINISTRATION:

1. <u>Ointments, Creams, Lotions and Solutions</u>

   a. Prepare treatment (See Preparation of Doses – General Procedures).

   b. When all treatments are prepared, identify the resident by name and armband and explain the procedure.

   c. Provide privacy.

   d. Verify the site to be treated and properly position the resident and expose the area.

   e. Wear gloves as appropriate.

f. Examine area to be treated and remove any existing dressing.

g. Clean the area as needed.

h. Medication should be removed from the container in a sanitary manner to prevent contamination of the remainder of the contents.

- Use a tongue blade to remove an amount from a large jar or squeeze from a tube onto the tongue blade.
- Lotions or solutions may be applied directly to the area, being careful not to touch the tip of the container to the resident.

i. Ointments and creams may be dabbed in several spots within the area to be treated. This will provide an even application over the entire area.

j. On the surface of the skin, medication should be rubbed in the direction of hair growth (use stroking motion) to minimize irritation of hair follicles.

k. For areas below the skin surface, medications should be applied gently and evenly.

l. Dress with sterile gauze, if appropriate.

m. If the entire body is treated, have a resident wear loose cotton gown or pajamas.

n. Document application of the medication, and progress of the treated area in the licensed nursing notes.

2. Debriding Agents

a. Those debriding agents which are creams or ointments should be applied as described above, taking care to apply the medication only to the area of necrotic tissue and not to the surrounding skin.

b. Agents that need mixing should be mixed prior to application according to the instructions (per pharmacist).

c. Any excess medication should be wiped off of the surrounding skin prior to dressing. Petroleum jelly may be applied to healthy surrounding tissue to protect it.

d. Avoid taping of bandages to the skin to minimize irritation.

3. Rectal Medications (Suppositories)

a. Position the resident in the Sims position on his or her side and drape to expose rectal area.

b. Wear gloves.

c. Remove suppository from wrapper and lubricate it with water-soluble lubricant.

d. With the opposite hand, lift the opposite buttock to expose the anus.

e. If necessary, instruct the resident to take several deep breaths through the mouth. This helps relax the anal sphincter and relieve anxiety.

f. With the gloved finger insert the suppository, tapered end first, into the rectum about 1" to 1-1/2". This will place the suppository past the rectal sphincter.

- Instruct the resident to lie quietly and retain the suppository the appropriate length of time.
- Discard all supplies appropriately.
- Document administration of the medication.
- Reposition the resident comfortably.

4. Vaginal Medications (suppositories, creams ointments, gels)

a. Ask resident when would he/she prefer to administer the medication herself and provide proper instruction, if necessary.

b. Ask resident to void.

c. Have resident positioned in the lithotomy position.

d. Expose the perineum and drape other areas.

e. For suppositories:

- Remove the suppository from the wrapper and lubricate it with a water-soluble lubricant.
- Put on gloves.
- Expose the vagina with one hand.

- With free hand, insert the suppository about 2" (5cm.) by first directing it downward, then up and back, toward the cervix.
- If an applicator is provided with the medication, insert the suppository and applicator tip. Insert into the vagina, depress plunger and remove the applicator with the plunger.

f. For ointments, creams, gels

- Affix applicator onto the tube of medication with plunger depressed.
- Squeeze the tube to fill the applicator.
- Lubricate the applicator.
- Put on gloves.
- Expose the vagina with one hand.
- With free hand, insert the applicator into the vagina about 2" (5cm.) and depress plunger.
- Withdraw the applicator with the plunger depressed.
- Remove and discard gloves and supplies appropriately.
- Provide sanitary pad to resident to prevent soiling of clothes or bedding.
- Return resident to a comfortable position.
- Wash applicator, if used, and dry thoroughly.
- Wash hands.
- Document administration of the medication.

5. Medicated Shampoos

a. If lindane is used, also follow facility isolation procedures, as applicable.

b. Wet resident's hair thoroughly.

c. Apply proper amount of shampoo and massage thoroughly into hair.

d. Specific instructions:

- Selenium: Rinse thoroughly; repeat.
- Coal Tar: Rinse, repeat and leave on 5-10 minutes as directed on label.
- Keratolytic: Lather; leave on 5-10 minutes as directed on label.
- Lindane: Lather scalp and hair thoroughly for 5-10 minutes as directed on label.

e. Rinse hair and scalp thoroughly.

f. Dry hair with a clean towel and comb out tangles.

- When treating for lice, after lindane shampoo, comb through hair carefully with a fine-toothed comb to remove nits.
- A thorough removal of dead lice and nits can be done using tweezers.

TRANSDERMAL MEDICATIONS:

1. <u>For nitroglycerin ointment:</u>

   a. Take resident's blood pressure, if indicated.

   b. Measure the prescribed length of ointment onto measuring paper provided.

   c. Fold the paper in half to spread the ointment side onto a non-hairy area of the resident's skin.

   d. If indicated, check the resident's blood pressure again and notify the physician of any adverse effects of the ointment.

   e. Wash hands/ wear gloves during administration of medication.

   f. Document administration of dose and blood pressure, if applicable.

   g. For subsequent applications, remove previous measuring paper, wipe off residue and select alternate site of application.

2. <u>For transdermal patches:</u>

   a. Prepare patch by removing any backing paper, date and initial patch before applying.

   b. Remove previous patch, if applicable.

c. Affix new patch to an alternate, hairless site.

d. Dispose of supplies appropriately.

e. Wash hands.

f. Document administration of the medication and record observations of the application site as appropriate in the licensed nursing notes.

DOCUMENTATION REQUIREMENTS:

1. General Policy

a. Licensed personnel shall make all entries in the health record involving medications.

b. All entries shall be made in black or blue, permanent ink.

c. Two staff are required to check and sign for certain medications, i.e.: Lovenox, Insulin as per pharmacy protocol.

d. Documentation of medication doses administered shall be charted as soon as possible after administration to any individual resident.

e. Documentation errors shall be corrected either by:

- Circling the incorrect recorded initials and explaining fully on back of the medication or treatment sheet.
- Lining through the error with a single line, initialing above the line, writing the word "ERROR" and documenting correctly or providing an explanation on the back of the medication or treatment sheet.

2. Injectable Mediations

a. Initial for administration of drug and document site of injection either by number referenced to sites listed on medication sheet or by abbreviation.

b. Anticoagulants– Abdominal site shall be described on the medication administration record (may be done by numbered diagram or narrative).

3. PRN Medications

a. The date, time, drug, dose, reason and nurse's initials shall be recorded when the drug is administered, and results charted at a later time. Another nurse may document results, if necessary.

b. If a drug is ordered both routinely and PRN, there should be at least one hour between doses unless otherwise ordered.

4. Drugs Not Given as Prescribed

a. When doses are refused or not given for other reasons, or given at a time other than that prescribed, the nurse shall circle her initials and explain reason on back of medication administration record.

b. Physician should be notified of missed doses, as appropriate.

REFERENCES:

- Thomson Reuters: (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, §72313 (a 1-8), §72067 San Francisco, California. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Clinicalpharmacology-ip.com. *List of Do Not Crush or Chew Products* (2021) Elsevier/Gold Standard. https://www.clinicalpharmacology-ip.com/Forms/AdvSearch/msearch.aspx?s=dcc.

SUBJECT: **MEDICATION ADMINISTRATION THROUGH A FEEDING TUBE**	SECTION: **Page 1 of 2**

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

PURPOSE:

To administer medications via the nasogastric, gastrostomy, or jejunostomy tube in those residents who are unable to take medications orally.

POLICY:

Medications will be administered via the feeding tube by a Registered Nurse (RN) or Licensed Vocational Nurse (LVN).

AFFECTED PERSONNEL/AREAS: *RNs, LVNs*

EQUIPMENT:

- Medication
- 60 cc syringe with Luer tip
- Gloves
- Protective cap for feeding bag tubing
- Medicine cups
- Warm water

PROCEDURE:

1. Assemble supplies/equipment.
2. Wash hands. Wear gloves.
3. Explain the procedure to the resident.
4. Auscultate abdomen for gastrostomy tube placement.
5. Crush pills, tablets, or empty contents of capsules into small medicine cup and mix with water. Dilute liquid medications with warm water. Use a minimum of 15cc water for each medication. (Check with the pharmacist if there are questions as to whether to crush a particular pill or tablet.)
6. Put continuous tube feedings on hold. Check the residual and tube placement.
7. Close Lopez valve to the "off" position to feeding bag/bottle.

8. Put protective cap onto adapter of feeding bag tubing, if disconnected, to protect tubing and feeding from contamination.

9. Insert syringe to Lopez valve and check for gastric residuals and placement of the gastric tube.

10. Remove the plunger from the syringe and pour 30 ml H_2O into the syringe and let it flow by gravity, then pour each medication separately into the syringe and let it flow by gravity also (flush with a minimum of 15 ml H_20 as indicated in between meds given).

11. Flush tubes with 30ml water after all medications are given.

12. Turn the Lopez valve to "open" to feeding/bottle.

13. Resume feeding as ordered.

RECORDING:

Chart medications given on Medication Administration Record. Chart fluids administered with medication on the I & O record, on PCS in the computer.

SPECIAL CONSIDERATIONS:

May gently use pressure to instill medications if gastric tube is sluggish and has some resistance.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.60, 483.25 (1) United States of America, Med Pass Inc.
- U.S. National Library of Medicine. National Institutes of Health (n.d.). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/.
- Pharmacy Management of Long Term Medical Conditions, March 2021, Ross Ferguson, Jonathan Burton, Pharmaceutical Press.

SUBJECT: **NASAL CARE FOR NASOGASTRIC TUBE FED RESIDENTS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To prevent excoriation of the nose and to assess nose for pressure from the nasogastric tube.

POLICY:

Nasal care will be provided at least once per shift and as needed to the resident with a nasogastric tube.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSE VOCATIONAL NURSE (LVN)*

EQUIPMENT:

- Gloves
- Cotton tipped applicators
- Container with warm water
- Washcloth
- Soap and water
- Inch paper or silk tape (if needed)

PROCEDURE:

1. Assemble equipment.
2. Wash hands thoroughly/wear gloves.
3. Provide privacy.
4. Explain the procedure.
5. Assess the taped areas to determine if re-taping is needed:
   a. Carefully remove tape.
   b. Wash skin with warm soapy water, rinse, and dry well.
   c. Re-tape area.
6. Clean outer edges of both nostrils with warm water using cotton swabs.
7. Assess the nares for pressure areas, encrusted areas, or bleeding.

8. Water soluble lubricant may be used to lubricate the nostrils if needed.

SPECIAL CONSIDERATIONS:

Take into consideration that if a resident is going to be a long term tube feeder and can tolerate placement of gastrostomy tube, this should be discussed with the resident (where applicable), and with family or guardian by the physician.

RECORDING:

Nasal care should be done and documented at least once each shift. This is recorded in Meditech on the LVN Intervention GT/NG section.

Record any pressure areas or bleeding on the resident's chart, as well as the interventions.

If nasal irritation occurs, assess and consider changing the nasogastric tube to the other nostril.

REFERENCE:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, §483.25 (g) United States of America, Med Pass Inc.
- Nettina, S.M. (2018). Lippincott Manual of Nursing Practice (11th ed.) Lippincott Williams and Wilkins.

SUBJECT: **NOURISHMENTS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To meet the nutritional needs of identified residents.

POLICY:

It is the policy of this facility that residents may be given nourishments without obtaining a physician's order, following appropriate diet as recommended by the registered dietitian or licensed nurse.

AFFECTED PERSONNEL/AREAS: *RN, LVN, CNA, NUTRITION SERVICES, DIETITIAN*

SCOPE:

Provision of nourishments is the responsibility of the Nutrition Services Department. The Dietitian will initiate nourishment service whenever it has been determined that a resident requires additional nutritional support. Nourishments are not a replacement for routine meals.

PROCEDURE:

1. ORDERING AND DISCONTINUING – The Dietitian will coordinate with nursing regarding residents who require nourishments. If initiated by nursing, the Charge Nurse will order and/or discontinue via Meditech.

2. IMPLEMENTATION – The food service staff and Dietitian will maintain a current "Nourishment List- Dietary Special Needs."

3. MONITORING – The Dietitian will review the need for the nourishment with Charge Nurse monthly for continuance. The Registered Dietitian will review the list of residents routinely.

4. NOURISHMENT COST – Nourishments will be included in the food cost and will not be charged to residents.

5. NOURISHMENT TIME AND DISTRIBUTION

   a. Routine Nourishments (Snacks)

   - Routine nourishments will be offered at bedtime (H.S.) unless contraindicated by diet or condition. Items available for H.S. nourishments will be recommended by the Registered Dietitian.

     Schedule is as follows:

     a. 0800 – 1000 (coordinated with activities)
     b. 1400
     c. 1900

- Bedtime (H.S.) nourishments will be provided by Nutrition Services and will be delivered by the staff to each nursing station before closing the kitchen each night.

b. Recommended Nourishments

- Recommended nourishments will be served at the designated times and frequency. They will be labeled with the resident's name and room number and delivered by dietary to the nursing station.

- The Nursing Staff will be responsible for nourishment distribution each time and will document intake in the appropriate notes.

REFERENCE:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72335 (2), 72351, San Francisco, California, Title 22.

SUBJECT: **NURSING DOCUMENTATION OF ENTERAL FEEDING**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide complete documentation of enteral feeding.

POLICY:

Nursing documentation of enteral feeding will be compliant with all State and Federal regulations; and will reflect all aspects of enteral feeding as required and as ordered by the physician.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN)*

PROCEDURE:

1. Administration of enteral feeding and all related procedures will be recorded daily on the Medication Administration Record and the Intake and Output Record in the EMR according to facility documentation policies. This documentation is required for each shift.

2. Additional information is to be recorded as follows:

   a. The Licensed Nurses' Notes must include any feeding omitted and why, complications from feeding, tube changes and why, and any resident or family instructions.

   b. Care plans must address all resident nutritional needs, enteral interventions, tube care, and potential problems. (Note that feeding tubes are an automatic trigger on the MDS/RAI.)

   c. Nursing Weekly Summaries must reflect all aspects of the nutrition/enteral care plan.

RECORDING:

As indicated above.

SPECIAL CONSIDERATIONS:

REFERENCE LIST COMPLICATIONS OF TUBE FEEDINGS

1. Fluid and electrolyte disturbances can be caused by excessive protein intake accompanied by inadequate fluid intake, frequent suctioning, vomiting, diarrhea, fever, infection

   a. Dehydration

   b. Hypernatremia (increased sodium, normal 135-145 mEq/L)

   c. Azotemia (increased urea-nitrogenous waste products) Renal failure

d. Glycosuria (increase urine sugar)

2. Aspiration pneumonia – possible causes include:

a. Large bore tubes (increased risk of reflux and aspiration)

b. Decreased level of consciousness

c. Decreased GI motility

d. Pulmonary disease

e. Diminished or absent gag reflex

f. Incorrect resident position and tube placement

3. Diarrhea – the most common complication of tube feedings. Possible causes include:

a. Rapid infusion rate

b. Infusing cold formula

c. Bacterial contamination of formula

d. Hyperosmolar formula

e. Low residue formula

f. Lactose intolerance

g. Not rinsing bag and tubing between feedings and adding new formula

Note: Other causes such as illness, flu, impaction or antibiotic therapy must be ruled out.

4. Constipation – possible causes:

a. Elderly bedridden resident

b. Residents with history of constipation

c. Chronic laxative abuse

d. Long term maintenance on tube feeding

e. Dehydration

5. Bloating and retention – causes include:

   a. Large volume feedings

   b. Intolerance to feedings

   c. Decreased gastric motility

   d. Constipation

   e. Bowel obstruction

   f. Ileus

6. Erosion of esophageal, tracheal, nasal and oral mucosa. Causes include long term tube placement, use of large bore PVC tubes, dehydration, improper nasal and mouth care.

   a. Skin pressure, excoriation of nose

   b. Sinusitis

   c. Esophagitis

   d. Esophageal – tracheal fistula

   e. Gastric ulceration

   f. Pulmonary and oral infections

   g. GI bleeding

   h. Increased mucous secretions

Xerostomia (decreased salivation,)

7. Vomiting – causes might include:

   a. Clogged tube

   b. Improper infusion of feeding

   c. Initiation of enteral therapy

   d. Constipation – bowel obstruction – impaction

   Note: Other causes such as illness, flu, and medications must be ruled out.

REFERENCE:

- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.75 (1), 483.20 (k) (2) (iii) United States of America, Med Pass Inc.

SUBJECT: **NURSING WEEKLY SUMMARY**	SECTION: **Page 1 of 2**

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

PURPOSE:

- To address the resident's progress toward resolution of care plan problems.
- To evaluate the outcomes expected from care plan approaches and interventions.

POLICY:

- Weekly Nursing Summaries will be written on each DP/SNF resident in the unit in accordance with State and Federal regulations.
- The Weekly Summary will address all care plan problems, resident tolerance of care and procedures, resident progress and goals.
- The Weekly Summary will be done in PCS or in accordance with facility documentation policies.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RNs)*

PROCEDURE:

1. Review the resident personalized care plans, nurses' notes, ancillary progress notes, intake and output record, physician's orders, medication and treatment records, lab and radiology reports for the last seven days.
2. Assess the resident.
3. Complete the weekly summary, addressing all personalized care plan problems. Problems may be referred to by number when completing the summary.
4. Be sure to include resident status and progress in the following basic areas of focus:
    a. Nutrition
    b. Skin Integrity
    c. Intake and Output
    d. Activities of Daily Living (ADLs)
    e. Elimination
    f. Mobility
    g. Skin Risk
    h. Neurological Evaluation

i. Psych/Social Evaluation

j. HEENT Evaluation

k. Cardiovascular Evaluation

l. Gastrointestinal Evaluation

m. Genitourinary Evaluation

n. Integumentary Evaluation

o. Musculoskeletal Evaluation

p. Male/Female Reproductive Evaluation

q. Airway (if diagnosis warrants, or if tracheotomy patient)

r. Restraints, if present

s. Infection, if present

Update the care plans at the time the Weekly Summary is completed in the electronic medical record (EMR).

REFERENCE:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72071, §72315 (3) San Francisco, California, Title 22.

SUBJECT:	SECTION:
ORAL CARE FOR THE RESIDENT WITH SPECIAL NEEDS~~ORAL CARE FOR THE RESIDENT WITH SPECIAL NEEDS~~	Page 1 of ~~3~~ 2

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PURPOSE:

To promote oral and dental health.

POLICY:

It is the policy of this facility to provide oral care for residents with special needs every shift and as needed. These residents include those who are unable to care for themselves, those who have tracheostomy tubes, and those with other special needs.

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

EQUIPMENT:

- Gloves
- Lemon glycerin swabs or toothettes
- Warm water
- Mouthwash
- Tongue blade
- Emesis basin
- Towel or disposable washcloths
- Placvac, Evacu toothbrush, or other oral evacuation tool such as a Yaunker.
- Regular toothbrush, if not using special brush as described above
- Toothpaste
- Clean 4x4 gauze sponges
- Lubricant for lips

PROCEDURE:

1. Arrange equipment within reach on the overbed table.
2. Wash hands and don gloves.
3. Explain the procedure to the resident.

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4. Elevate the head of the bed at least 45 degrees.

5. Spread towel or disposable washcloth across patient's chest, taking care not to obstruct the tracheostomy tube if present.

6. Attach the Placvac, Evacu toothbrush, or oral evacuation tool to the extension tubing and activate the suction.

7. Brush the resident's teeth using a brush moistened with water and toothpaste, holding the brush at a 45 degree angle to the gum and using a circular motion.

8. Brush all teeth thoroughly using gentle pressure for at least several minutes.

9. Gently brush the tongue, if able.

10. If using a regular toothbrush, use the Yaunker continually on the residents with a vent or have dysphagia to prevent the resident from swallowing or choking on the water and toothpaste (to be done by licensed staff only).

11. Cleanse the entire mouth after brushing with toothettes or a gauze wrapped tongue blade moistened with diluted mouthwash, following brushing. Use oral evacuation tool continually to prevent the resident from swallowing or choking on any accumulated liquid in the oral cavity.

12. Moisten the mouth with lemon glycerin swabs following cleansing, and as needed.

13. Apply lubricant to lips as needed.

14. Discard waste, wash utensils, and return equipment to proper storage.

15. Wash hands.

DOCUMENTATION:

Document oral care provided in the resident record on the CNA Activities of Daily Living (ADL) record in the electronic medical record (EMR). Document and report any unusual conditions or problems of the mouth to the licensed nurse.

REFERENCE:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72315 (d), San Francisco, California, Title 22.
- **American Association of Critical Care Nurses (2017). *Oral Care for acutely and critically ill patients. Critical Care Nurse,* 37(3): e19-e21. doi:10.4037/ccn2017179.**

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SUBJECT: **ORAL/NASAL TRACHEAL SUCTIONING WITHOUT AN ARTIFICIAL AIRWAY**	SECTION: **Page 1 of 3**

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

PURPOSE:

To ensure that oral/nasal suctioning is performed in a consistent manner while maximizing patient safety.

POLICY:

- Oral/Nasal suctioning will be performed as needed to remove secretions from the airways of patients that are unable to cough effectively.

AFFECTED AREAS/PERSONNEL: *RESPIRATORY CARE PRACTITIONER, RN*

PROCEDURE:

1. Gather all equipment and bring to the bedside.
2. Pour sterile rinse solution into sterile rinse container.
3. Open sterile suction catheter package.
4. Wash hands.
5. Put on sterile glove.
6. Maintaining sterility, attach sterile suction catheter to suction connecting tubing.
7. With ungloved hand, you may touch only that portion of the catheter containing the control vent.
8. Choose correct suction pressure:
   a. Neonates 60 – 80 mm. Hg
   b. Infants 80-100 mm. Hg
   c. Children 100 - 120 mm. Hg
   d. Adults 80 – 120 mm. Hg

   Efforts to set the suction pressure as low as possible and effectively clear secretions should be made.
9. Choose correct size of suction catheter:
   a. Infant 5 – 6 French

b. Small child (2-5 yrs.) 6-8 French

c. School Age Child (6-12 yrs.) 8-10 French

d. Adolescent to Adult 10-16 French

10. Explain the procedure to the patient.

11. Correctly position the patient. Elevate head of the bed 45 degrees unless contraindicated by the patient's condition.

12. Lubricate the catheter with sterile lubrication.

13. Apply oxygen to patient if not present and have the patient take a few deep breathes to hyper oxygenate.

14. Pass the suction catheter nasally into the nasopharynx with a downward and an inward pressure on the catheter toward the septal wall of the nares. Orally, pass the suction catheter to the rear of the oropharynx.

15. Pass catheter into the trachea during active inspiration.

16. The cardiac monitor should be observed, if present. If dysrhythmias, bradycardia or other signs of distress occur, procedure must be stopped immediately. If no cardiac monitor is present, use continuous pulse oximeter to monitor saturations and heart rate.

17. When you reach the carina, you can expect to meet an obstruction and initiate a cough reflex.

18. Apply suction by closing the vent with the ungloved hand and slowly remove the catheter, utilizing a twisting or rotating motion with the gloved hand.

19. Active suctioning should last no more than 10 seconds.

20. Draw sterile rinse solution through the catheter in between each insertion.

21. Instruct the patient to take several deep breaths before repeating this procedure. If the patient is using oxygen, replace the oxygen apparatus on the patient allowing him/her to re-oxygenate.

22. Repeat above steps until all secretions have been aspirated and the airway seems clear.

23. Dispose of rinse solution container, wrap suction catheter around the gloved hand and with opposite hand, peel glove back over catheter and off the hand. Dispose of glove and catheter.

24. Empty and clean suction canister at the end of each shift or as necessary.

25. Be sure a new catheter is located at the bedside for the next procedure.

26. Remove gloves and wash hands.

27. Chart results and patient's reaction.

CARE OF EQUIPMENT:

- Check to make sure that the ON/OFF valve is functioning properly. Test the system upon replacement of the bottle.

REFERENCES:

- Bell, L. (2017). AACN Procedure Manual for High Acuity, Progressive, and Critical Care, Seventh Edition. Critical Care Nurse, 37(2), 108-109. doi:10.4037/ccn2017256 Page 70 and 71
- AARC Clinical Practice Guideline - Respiratory Care. (n.d.). Retrieved from https://rc.rcjournal.com/content/respcare/67/2/258.full.pdf
- Suctioning - Home | Children's Hospital of Wisconsin. (n.d.). Retrieved from https://www.chw.org/-/media/files/medical-professionals/nursing-students/post-conferences/suctioning-pediatric-patients.pptx?la=en Infant Catheter Size

SUBJECT: **ORDERS- PHYSICIAN NOTING**	SECTION: **Page 1 of 2**

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

PURPOSE:

To ensure accuracy and clarity in the noting of physician orders.

POLICY:

It is the policy of this facility that each physician order will be noted and verified by the licensed nurse.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN)*

PROCEDURE:

1. The nurse shall verify each order for completeness, clarity, and appropriateness of dose and allergies.
2. Monitoring criteria for the medications (vital signs, behavior, laboratory tests, etc. are instituted onto the Medication Administration Record (MAR) by the LVN or RN.
3. The RN or LVN will note any applicable automatic stop orders. (See Pharmacy Policy and Procedure Manual)
4. Orders are entered onto the Medication Administration Record or the Treatment Administration Record.
5. Appropriate doses and administration times are established for each medication. (See MEDICATION ADMINISTRATION TIMES)
6. All new orders are phoned or faxed to the contracted drug company and SVMC.
7. If applicable, signal labels are affixed to current containers of medication (Order Change, Discontinued, and Hold).
8. The order is "noted" when the above steps, and any other appropriate actions, are taken. To note an order the nurse shall:
   a. Bracket the order(s);
   b. Write "noted" beneath the order; and
   c. Date, time and sign the order with TORB (Transcribed Order Read Back).

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 (a) United States of America, Med Pass Inc. Thomson Reuters: (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, San Francisco, California.

- American Health Information Management Association, 2019, Documentation in the Long–Term Care Record-AHIMA Body of Knowledge, Physicians Orders (F271).

CROSS REFERENCES:

- MEDICATION ADMINISTRATION TIMES

SUBJECT: **ORDERS- PHYSICIAN RECAPPING**	SECTION: **Page 1 of 1**

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

PURPOSE:

To ensure accuracy and clarity of physician orders and accurate administration of medications, treatments and resident care per physician order.

POLICY:

It is the policy of this facility to review all physician orders for accuracy on a monthly basis.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN)*

PROCEDURE:

1. The Registered Nurse will review the physician orders on the last day of each month to ensure that all new orders have been carried over and discontinued orders have been removed from the printed orders for the upcoming month. Accuracy is essential and all orders will have original dates on the printed orders.

2. The Medication Administration Sheets and Treatment Sheets for the upcoming month are compared to current physician order sheets and current MAR/TAR for all changes. All new orders not included on the new physicians orders, MAR and TAR will be added at this time, and discontinued orders will be removed. The licensed nurse needs to make sure all medications have an administration time in the appropriate column.

3. Once all physician orders have been reviewed, the physician's order sheet is signed and dated by the Registered Nurse reviewing that record in the area designated "Reviewed By" and placed into the resident's chart after midnight on the first day of the month, but before day shift starts at 0645.

4. Once the Medication Sheets and Treatment Sheets have been reviewed by the Licensed Nurses, they will be placed into the appropriate binders and the old sheets will be removed and given to the Medical Records Department.

REFERENCES:

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

SUBJECT: **ORDERS- PHYSICIAN TELEPHONE / VERBAL**	SECTION: **Page 1 of 1**

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

PURPOSE:

To document all orders received by telephone/or verbally from the physician.

POLICY:

It is the policy of this facility to obtain a signed order from the physician within 5 days from the time that the initial order was received by telephone or verbally.

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

PROCEDURE:

1. When a telephone/verbal order is received by licensed staff, it is recorded on the physician's telephone order sheet with date, time and using T.O.R.B. (Telephone Order Read Back) or V.O.R.B. (Verbal Order Read Back) with the signature of the nurse receiving the order.
2. The order is then flagged.
3. The unit clerk maintains audits to monitor the timely signing of physician's orders with the ultimate responsibility for compliance.

REFERENCES:

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

SUBJECT: **OXYGEN PROTOCOL FOR RESIDENT TRANSPORT**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define a process to ensure that supplemental oxygen is administered appropriately according to the patient's condition and status while in transport.

POLICY:

The oxygen therapy protocol will be instituted by a physician order, which indicates:

- Initial flow rate
- Type of delivery appliance
- Target $Sp0_2$ [if other than 92%] or target $Pa0_2$ [if other than 60 mmhg]

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), RESPIRATORY THERAPISTS (RT)*

PROCEDURE:

1. Oxygen therapy will be titrated as appropriate whenever residents are in transport to the Activity Room, shower, or off the unit to another department.
   a. Cardiopulmonary stability including vital signs and respiratory pattern.
   b. Adequate tissue perfusion based upon clinical assessment which includes, but is not limited to:
      - Level of consciousness or neurological changes
      - Respiratory rate and pattern
      - SpO_2 monitoring as indicated
2. For COPD residents with documented $C0_2$ retention, oxygen will be titrated from 0-2 LPM via nasal cannula or <28% via venti-mask, or via venturi device via trach to maintain a $SP0_2$ between 88-92%, unless the physician specifies a different target $SP0_2$.
3. For all residents on a blow-by mist via trach, oxygen will be titrated <40% via venturi device to maintain an $SP0_2$ > 92% =>60 mmhg, unless the physician specifies a different target $SP0_2$ or $Pa0_2$.
   a. If a resident is on oxygen of 28% or less, prior to transport, take off O_2 for five minutes and then check O_2 saturation on room air. If the O_2 saturation is 88% and above on room air, and resident is clinically stable (vital signs, temp), resident may be transported to the shower or activities without O_2 supplement.

4. All residents on a mechanical ventilator will be oxygenized via ambu-bag by a licensed nurse (RN, LVN, RT) while being transported and taken off the ventilator for any length of time.

5. The physician will be notified immediately for any patient who cannot maintain an adequate $SP0_2$ or $Pa0_2$ based upon this protocol.

6. All residents scheduled for transport (internally and externally) will be evaluated by Respiratory Therapy Staff and/or Licensed Nursing Staff for the following:

   a. Stable vital signs

   b. Type of delivery appliance

   c. Initial flow rate

   d. Adequate oxygen source for transport

Special Note: When resident on a ventilator/oxygen is being transported, they will have a licensed staff member in attendance.

REFERENCES:

- CMS Department of Health and Human Services, Dec 10, 2018, *Updated Guide for Long Term Care Participation: Oxygen Therapy Guidelines*. Retrieved from https://www.cms.gov.
- American Association for Respiratory Care, 2021, Oxygen Protocol. Retrieved from www.aarc.org.

CROSS REFERENCES:

- Respiratory Care Services Policy: "Oxygen Administration"
- Respiratory Care Services Policy: "PULSE OXIMETRY"

SUBJECT: **PACEMAKER- PERMANENT CARE OF**	SECTION:

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

PURPOSE:

To have a system of monitoring residents with permanent pacemakers.

POLICY:

It is the policy of this facility that residents with permanent pacemakers will be checked on a periodic basis to ensure that implanted pacemaker is functioning properly.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), UNIT CLERK*

PROCEDURE:

1. Shape all routines around the physician's orders.
2. Pacemaker will be checked every 3-6 months per company policy using the telephone and the appropriate device.
3. Include an entry for pacemaker on the resident care plan.
4. Enter on resident care plan the type of pacemaker, date of insertion, rate, and pacemaker check lab and phone number (or keep info packet in the chart).
5. Report to physician any rate change of more than five impulses per minute, missed beats or any unaccustomed sensations associated with the pacemaker.
6. Advise resident to report signs/symptoms of dizziness or weakness.
7. Observe for pain, swelling or discoloration at pacemaker site.
8. If pacemaker does not need to be checked, identify that on the resident care plan.
9. Do not use any electrical appliances (i.e., electric razors) that come in contact with the resident's skin.
10. Monitor electrical appliances close to the resident (i.e., microwave ovens) for signs of electrical interference and leakage.
11. Obtain plastic card that comes with the pacemaker and affix to the inside of the resident's chart cover.

REFERENCE:

- National Heart, Lung, and Blood Institute (NHLBI) (n.d.). *Pacemakers*. Retrieved from https://www.nhlbi.nih.gov/health-topics/pacemakers.

SUBJECT: **PATIENT FOOD FROM HOME - DPSNF**	SECTION:

PURPOSE:

To establish a policy regarding use and storage of foods brought to Sierra View Medical Center Distinct Part Skilled Nursing Facility (DP/SNF) residents by family and other visitors to ensure safe and sanitary storage, handling and consumption.

POLICY:

It is the policy of the Food & Nutrition Services (FNS) Department to prepare and deliver food safely to our residents, families and staff. This policy will ensure proper handling, serving and storage of any food items brought in to our residents from all outside sources.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, PATIENT CARE AREAS*

PROCEDURE:

1. It is a resident's right to obtain foods from outside sources such as ordering takeout and to receive foods brought in by the resident's family and friends. The FNS and the unit's nursing staff will make every effort to advise the residents of foods that are permitted within their diet restriction. However, the resident has the right to make food choices that may not follow their diet restriction.

2. All food or beverages brought into the unit for resident consumption will be checked by a staff member before being accepted for storage. Any suspicious or obviously contaminated food or beverage will be discarded immediately.

3. Foods and beverages brought in from the outside will be labeled with the resident's name, room number and dated by staff with the current date that the item(s) are brought into the facility for storage.

4. Residents with dietary restrictions, texture modifications and adaptive equipment needs will be advised and assisted as necessary to ensure the resident's diet/devices are being followed/provided.

5. Food or beverage items may be stored in the designated patient refrigerator, freezer or pantry. Items may be stored in the resident's room or their personal room refrigerator.

    a. Food or beverage in the original container that is past the manufacturer's expiration date will be discarded by staff.

    b. All cooked or prepared food brought in from outside will be dated when accepted for storage and discarded after three (3) days. No home-prepared foods that are home canned or preserved will be permitted.

6. In support of our residents, families and visitors, and in understanding of safe food handling practices, a copy of the food handling safety guidelines will be included in our admission packets and reviewed annually with resident and/or family during the interdisciplinary team meeting.

REFERENCES:

- Centers for Medicare and Medicaid Services, Conditions of Participation (2021). §483.60(i)(3). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2021). Hospital accreditation standards. PC.02.02.03. Joint Commission Resources. Oak Brook, IL.
- Med Pass, Inc. (Updated Feb 6, 2015) Facility guide to OBRA Regulations, 483.10.
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of regulations 72343, 72335 (6), San Francisco, California. Title 22.
- Food From Home handout. Tips for Family Members 2022.
- https://www.cahf.org/Portals/29/Clinical-Quality/Food%20From%20Home%20Handout.pdf?ver=2022-03-29-180723-740

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SUBJECT: **PHYSICAL EXAMINATIONS POSITIONING AND DRAPING**	SECTION: **Page 1 of 2**

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

PURPOSE:

The purpose is to allow adequate expose while preserving the resident's modesty and comfort during an examination by a physician.

POLICY:

It is the policy of this facility to ensure the resident's privacy will be protected by being well draped for any examination. A nurse should be present during internal examination of a female resident.

AFFECTED PERSONNEL/AREAS:

RN, LVN

PROCEDURE:

1. HORIZONTAL RECUMBENT OR SUPINE POSITION (ADMISSION AND GENERAL EXAMINATIONS):
   a. Explain procedure to resident.
   b. Position resident flat on back with legs extended or slightly flexed.
   c. Replace top bedding with bath blanket, and fan fold bedding at bottom of bed.
2. DORSAL RECUMBENT POSITION (VAGINAL AND PERINEAL EXAMINATIONS):
   a. Explain procedure to resident.
   b. Position resident flat on back with knees flexed and relaxed out to side.
3. SIMS' POSITION (RECTAL OR VAGINAL EXAMINATION):
   a. Explain procedure to resident.
   b. Place resident on left side with back close to edge of bed.
   c. Place bath blanket folded lengthwise over resident.
   d. Draw both knees up slightly. Help resident flex right knee and thigh to acute angle so both knees are resting on bed.
4. STANDING OR ERECT POSITION (SPINE OR BACK EXAMINATION):
   a. Explain procedure to resident.

b. Provide bath towel or mat for resident to stand on.

c. Loosen gown to expose entire spine.

d. A bath blanket may be pinned to gown and draped over shoulders.

5. DOCUMENTATION:

a. Record type of examination, physician performing and resident's tolerance in the Nurse's Notes in the electronic medical record (EMR).

REFERENCE:

- Davis, F.A. (2019). *Draping for Minimum Exposure and Maximum Dignity*, Chapter 6. Retrieved from: https://fadavispt.mhmedical.com

SUBJECT: **PHYSICIAN'S ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)**	SECTION: **Page 1 of 3**

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

PURPOSE:

To ensure the process for the resident/responsible party to determine the level/intensity of care and treatment options preferred while residing in the facility.

POLICY:

The resident or responsible party/surrogate decision-maker will exercise the right of self-determination in making informed decisions regarding medical treatments to be provided. The facility will acknowledge the resident's advanced directive, which designates the resident's wishes and/or alternate decision-maker. The facility will utilize the Physicians Orders for Life-Sustaining Treatment (POLST) form to document the review of treatment options with the resident/responsible party and the intensity of care electives for medical treatments.

AFFECTED PERSONNEL/AREAS: *PHYSICIAN, SOCIAL SERVICES, NURSING, INTERDISCIPLINARY TEAM (IDT)*

PROCEDURE:

1. At the time of admission, the Social Worker or designee will inform the resident or surrogate decision-maker of the options available in determining the level of care, withholding treatment, limiting treatment, or consenting to available treatments.

2. The physician will determine and document the mental capacity of the resident to understand the nature and consequences of the diagnosis, prognosis, and treatment options.

3. The physician will discuss the treatment plan with the health care team and the resident or the surrogate if the resident is determined to lack the mental capacity to understand the nature and consequences of the diagnosis, prognosis, and treatment options.

    a. If the physician determines that the resident lacks the mental capacity to make healthcare decisions and the resident does not have an advance directive or legal representative/surrogate, the physician, in consultation with the resident's family members or involved parties, will identify the person who will assume the responsibility of surrogate decision-maker.

    b. If there is no family, friend, or involved party who is willing to assume responsibility for the medical decision-making, the physician will utilize the facility's Interdisciplinary Team and/or the Hospital Bioethics committee to provide consultation for healthcare decision-making.

    c. The resident will be given the opportunity to participate in his/her health care decisions and intensity of care electives to the extent possible.

4. The Social Worker or designee will assist the resident or surrogate decision-maker in the following:

   a. Ensuring that a copy of the advanced directive is obtained and the Interdisciplinary Team is informed of the resident's wishes.

   b. Completing the facility's Physicians Orders for Life-Sustaining Treatment (POLST) form, which documents the intensity of care elected while residing in the unit.

   c. Informing nursing staff of treatment preferences elected by the resident or surrogate, obtaining nursing assistance as needed to provide additional clinical information and counsel regarding treatment options, and seeking nursing follow-up with physician to obtain consultation and orders for the intensity of treatments to be provided.

   d. Ensuring physician discussion of the diagnosis, prognosis, and treatment options with the resident or surrogate decision-maker, and completion of the Physicians Orders for Life-Sustaining Treatment (POLST) Form.

   e. Assisting in the establishment of surrogate decision maker.

   f. Assisting in the resolution of disagreements between the resident, surrogate and/or physician regarding intensity of treatment decisions, including advisement and/or assisting referrals to Bio Ethics Committee, public guardian, Ombudsman, legal services, advocacy groups, change of physician, and change of facility.

5. The physician and IDT will periodically do the following with the resident or surrogate decision-maker:

   a. Inform of any changes in medical condition and prognosis.

   b. Assist in determining any changes in treatment options or level of care provided.

   c. Assist in determining the resident's ongoing capacity to make informed decisions about intensity of medical treatments.

   d. Ensure the designation of a decision-maker.

   e. Ensure that decisions made on behalf of the resident are in his/her best interest or well-being.

   f. Review and revise the advance directive and intensity of care preferences as requested for change of condition or annually at Interdisciplinary Team Meeting.

   g. Review and update all care plans.

6. The Social Worker or designee and nursing staff will monitor to ensure the Intensity of Care Form is completed correctly by the physician and the treatment electives are consistently documented by relevant disciplines throughout the resident's medical record (i.e., Physicians Orders for Life-Sustaining Treatment (POLST) form, orders, Minimum Data Set, care plan, Interdisciplinary Team Meeting form and notes, etc.).

7. Nursing staff will ensure the resident's code status is clearly delineated in the medical record and will readily identify residents who are "NO CODE/Do Not Resuscitate" status on charts.

8. The physician and nursing staff will also notify the Social Worker or designee when there is a change in the resident's intensity of care preferences in order for the Social Worker or designee to ensure that a new Physicians Orders for Life-Sustaining Treatment (POLST) Form is completed which reflects the changes.

9. When the resident is transferred or discharged from the unit, nursing staff will ensure that the resident's advance directive and/or intensity of care preferences are forwarded to the receiving facility.

REFERENCES:

- California Code of Regulations (2019). Title 22, 483.10 (8), §72528. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

CROSS REFERENCES:

- Physicians Orders for Life-Sustaining Treatment Form (POLST)
- SVMC Policy and Procedure: RESIDENT SELF-DETERMINATION IN MEDICAL DECISION MAKING (PSDA)
- SVMC Policy and Procedure: SURROGATE DECISION MAKER, SELECTION OF

SUBJECT: **PM CARE**	SECTION: **Page 1 of 1**

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

PURPOSE:

The purpose is to prepare resident for the night by providing cleanliness and comfort.

POLICY:

It is the policy of this facility to provide P.M. care to each resident daily.

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

PROCEDURE:

1. Wash hands thoroughly/wear gloves. Explain procedure to the resident. Provide privacy.
2. Offer bed pan, urinal or take to the bathroom.
3. Assist residents in areas of oral hygiene, care of dentures and peri-care (CHANGE GLOVES & WASH HANDS WITH EACH ACTIVITY OF DAILY LIVING (ADL) DONE).
4. Assist residents to undress and put on night clothes.
5. Assist residents to bed, make comfortable, and utilize any positioning devices needed according to the plan of care.
6. Offer fluids if indicated or as prescribed.
7. Apply postural support if indicated.
8. Position side rails as indicated in the plan of care.
9. Place call lights within easy reach of resident.

DOCUMENTATION:

1. Report and document any unusual observations.
2. Document care given on nurse assistant flow sheet.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, § 72315 (d), San Francisco, California, Title 22. Register 2022, No.23

SUBJECT: **PRIORITIZING SOCIAL SERVICE REFERRALS**	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 provide guidelines for the prioritizing of social service referrals in order to facilitate timely response based on resident needs and risk factors.

POLICY:

All residents of the Distinct Part Skilled Nursing Facility (DP/SNF) receive social work services during their stay in the facility without any specific referral process In the event that a referral for Social Service requires intervention outside the scope of services provided by the Social Service Designee, the Unit Director will be contacted to facilitate arrangement for appropriate consultation.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES / DP/SNF*

PROCEDURE:

To facilitate appropriate triage of multiple needs, the following priorities will be observed.

1. Residents who are a danger to themselves or others
2. Residents suspected to be victims of abuse or neglect.
3. Requests from resident/family to see Social Service staff.
4. Residents lacking finances/insurance/benefits or other material assistance or need for financial security.
5. Residents who may require additional services or care due to sensory impairments, mental illness, substance abuse, or developmental delay.
6. Residents who need discharge planning services.
7. Residents with terminal illness or infectious disease.
8. Residents with newly diagnosed or poorly controlled disease.
9. Referral from physician.
10. Referral from interdisciplinary team.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, 72445, San Francisco, California, Title 22.

PURPOSE:

To establish appropriate standards for administering and monitoring patients receiving procedural sedation.

POLICY:

All patients at Sierra View Medical Center receiving procedural sedation, IV/PO/IM, for short term diagnostic, therapeutic or invasive procedures will be cared for as stated in this policy.

Exceptions:

This policy applies to the use of analgesia and/or sedation in all hospital departments and areas except as stated below:

1. Those patients in the Intensive Care or Post Anesthesia Care Unit under a 1:2 nurse to patient ratio who are mechanically ventilated or whose cardiovascular and respiratory status are continuously monitored by the same monitoring devised as specified in this policy. These patients are excluded because their care always includes continuous monitoring of vital signs and are documented according to ICU and/or PACU protocol based on patient acuity.

2. Single dose drugs used as pain control and anxiolysis (where the patient retains a normal response to verbal stimulation and airway ventilation is unaffected) with a local infiltration analgesia to perform minimal procedures, e.g. episiotomies, simple lacerations, closed reductions, lumbar puncture, dressing change, bone marrow aspiration.

3. Medications given for procedure-related anxiolysis or deep sedation.

4. Those patients requiring emergency tracheal intubation.

5. An adult patient receiving strictly a one time pre-diagnostic PO sedative will be exempt from the documentation and monitoring of this policy if in the judgment of the prescribing physician, the dosage and drug given would not result in impairment of protective or airway reflexes. The provider assumes responsibility of ensuring the patient is accompanied by an escort, instructions are given regarding when the patient may resume normal activities, and counseling regarding possible side effects is given. This exception does NOT apply to children. It also does not apply if any additional PO, IM or IV sedation/analgesia is given.

6. Pre-operative medications, pre-procedural management of anxiety or pain management medications.

7. Deep sedation under by IV Ketamine ~~or Propofol~~ administered by physicians or IM Ketamine.

DEFINITIONS:

Levels of Sedation:

Sedation occurs in a dose related continuum, is variable, and depends on each patient's response to various drugs. The definitions below progress on a continuum from a high state of consciousness to unconsciousness.

Table 1. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia (2014)

	Minimal Sedation (Anxiolysis)	**Moderate Sedation/ analgesia (Conscious Sedation)**	**Deep Sedation/ Analgesia**	**General anesthesia**
Responsiveness	Normal response to verbal stimulation	Purposeful* response to verbal or tactile stimulation	Purposeful* response following repeated or painful stimulation	Unarousable, even with painful stimulation
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous Ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular Function	Unaffected	Usually maintained	Usually maintained	May be impaired

*Reflex withdrawal from a painful stimulus in NOT considered a purposeful response.
American Society of Anesthesiologists. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/ Analgesia, 2014.

NOTE: Anesthesiologists, CRNA's or physicians who are residency trained and board certified in Emergency Medicine or emergency physicians with 10+ years active practice in a current emergency room environment or physician assistant in the ED may provide sedation for patient's assessed as being ASA Class 4 or 5 and any patient requiring deep sedation. ***EXCEPT in emergent situations with an ER physician present.***

AFFECTED AREAS/PERSONNEL: *MAIN OPERATING ROOM (OR); OBSTETRICS (OB)OR; ENDOSCOPY SUITE; EMERGENCY DEPARTMENT; INTENSIVE CARE UNIT (ICU); INTERVENTIONAL RADIOLOGY; POST ANESTESIA CARE UNIT (PACU), AMBULATORY SURGERY DEPARTMENT (ASD), CARDIAC CATHETERIZATION LAB*

MEDICATIONS APPROVED FOR PROCEDURAL SEDATION:
(See Addendum A for Procedural Sedation Dosing Guidelines)

1. Minimal or Light Sedation

a. Ativan

b. Diazepam (Valium)

2. Moderate Procedural Sedation

a. Midazolam (Versed)

b. Fentanyl (Sublimaze)

c. Meperidine (Demerol)

d. Morphine Sulfate

3. Reversal Agents

a. Benzopdiazepines – Flumazenil (Romazicon)

b. Opiods – Naloxone (Narcan)

Only anesthesiologists, anesthesia providers (i.e. Certified Registered Nurse Anesthetists), physicians who are residency trained and board certified in Emergency Medicine or emergency physicians with 10+ years active practice in a current emergency room environment may administer the following (deep sedation) anesthetics:

- Ketamine
- Sodium Thiopental
- Propofol
- Etomidate
- Nitrous Oxide

PATIENT ASSESSMENT AND CRITERIA FOR SELECTION:

1. Registered Nurses who have successfully completed the Moderate Procedural Sedation competency may provide care to the following types of patients:

a. Patients who are to have minimal or moderate sedation.

b. Patients who are assessed as ASA 1, ASA 2, or ASA 3 as designated by the American Society of Anesthesiologist (ASA) Classifications. (Note: ASA 3 patients may be appropriate, but need to be evaluated on an individual basis.):

- *ASA 1: A normal healthy patient.*
- *ASA 2: A patient with mild systemic disease.*
- *ASA 3: A patient with severe systemic disease.*
- *ASA 4: A patient with severe systemic disease that is a constant threat to his/her life.*
- *ASA 5: A moribund patient who is not expected to survive 24-hours with/without an operation.*

2. Anesthesiologists, CRNAs or physicians who are residency trained and board certified in Emergency Medicine or emergency physicians with 10+ years active practice in a current emergency room environment are required to provide care to the following types of patients:

   a. Patients who are to have deep sedation or analgesia

   b. Patients who are assessed as ASA 4 or ASA 5

3. It is the responsibility of the physician to select only those patients who can safely undergo the required procedure with the use of moderate sedation.

4. An anesthesiologist or anesthetist should be consulted for the following patients:

   a. Significantly compromised patients; e.g., severe obstructive pulmonary disease, coronary artery disease, congestive heart failure
   b. Morbid obesity

   c. Significant risk of aspiration

   d. Pregnancy

   e. Difficult airway

   f. If it appears likely that sedation to the point of unresponsiveness or general anesthesia will be necessary to perform the procedure

   g. History of symptoms of obstructive sleep apnea (OSA), or diagnosed OSA.

5. Patients must be screened for potential risk factors of receiving any pharmalogical agents selected. The decision as to which agent and dosage to use, will be based on the goals of sedation, the type of procedure being performed, and the age and physiologic condition of the patient.

6. NPO Guidelines:

a. Clear liquids(not to include alcohol) > 2 hours is advisable

b. Solids > 6 hours is advisable

Fasting recommendation to reduce the risk of pulmonary aspiration:

- Clear liquids(not to include alcohol) 2 hours
- Breast milk 4 hours
- Infant formula 6 hours
- Non human milk 6 hours
- Light meal 6 hours
- Regular meal 8 hours

NOTE: NPO status exempt in emergency situations.

PROCEDURE:

PRE-PROCEDURE PREPARATION:

1. Physician's responsibility

a. Prior to the procedure, it is the physician's responsibility to complete and record the following in the patient's medical record

- Focused physical examination (performed within 30 days and 24 hour update), including pertinent medical history, auscultation of the heart and lungs, and evaluation of the airway.
- ~~Indicated diagnostic test(s), including pregnancy test if female age 12-50 years unless sterilized:~~
- Indicated diagnostic test(s), including pregnancy test for female patients between the onset of menses and post-menopause, typically between the ages of 10-55 years, unless sterilized
-
- Informed consent of sedation risks, benefits and options as discussed with the patient and/or family prior to administration.

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- Pre-procedure diagnosis
- Pre-sedation assessment and ASA category;
- Order for sedation medications
- Procedure/sedation plan.
- Sedation goal using the Ramsay Sedation Scale below;
  - Anxious and/or restless
  - Cooperative, oriented, tranquil
  - Responds to commands
  - Brisk response to stimulus
  - Sluggish response to stimulus
- Determination of patient's appropriateness for the planned sedation, and
- Time-Out with RN and team prior to sedation to confirm patient identity, procedure and site, plus agreement on patient status, planned sedation level and recommended dosages of medications.

2. RN Responsibilities:

~~2.~~a. Two perioperative RNs will be assigned to care for the patient receiving procedural sedation. One RN will administer the sedation medication and monitor the patient and the other RN will perform the circulator role.

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~~a.~~b. Validate the following:

- Physician orders for sedation medications
- Presence of the current H&P, updated if not done on day of procedure
- Signed Informed Consent for procedure and moderate sedation

~~b.~~c. Provide pre-procedural patient education, including the following:

- To anticipate drowsiness/sleep lasting a short time
- That conscious awareness of activity will be limited

- That ability to hear will remain; nurse will communicate throughout procedure
- That BP cuff and pulse oximeter will remain on during the procedure
- To advise the nurse if pain, itching, or difficulty breathing occurs
- To advise nurse if pain is not tolerated
- That recovery period will remain relatively short
- Addressing any questions the patient may have at that time

~~c.~~d. Confirm patent IV access

~~d.~~e. Validate presence of emergency equipment:

- Oxygen set-up with tubing and face mask/nasal cannula
- Suctioning equipment
- Pulse oximetry
- Cardiac monitor
- Non-invasive, automatic blood pressure cuff/machine
- Code cart immediately accessible
- Sedative and analgesic antagonists

3. All team members participate in pre-procedure Time Out (following Universal Protocol) to confirm patient identity, procedure and site, plus agreement on patient status, planned sedation level and recommended dosages of medications.

IMMEDIATELY PRIOR TO DRUG ADMINISTRATION

1. RN conducts and documents a baseline assessment to include the following:

   a. Respiratory rate;

   b. Oxygen saturation via pulse oximetry;

   c. Blood Pressure;

   d. Heart rate;

e. Pain assessment

f. Level of consciousness

2. Physician delivers or directs the RN to deliver the initial and subsequential doses of moderate sedation medications.

3. Immediately prior to start of procedure, the RN verbally confirms drug and dosage with physician, repeating sedation medication orders prior to administration.

THROUGHOUT THE ADMINISTRATION OF THE AGENT(S) AND DURING THE PROCEDURE

1. During the procedure with sedation the physician must be present and continuous monitoring will begin at the time the sedation medication is administered. Every 5 minutes throughout the procedure and for at least 15 minutes after the last dose of medication, the patient will be monitored , and the following will be documented:

   a. Oxygen saturation (pulse oximetry);

   b. End Tidal CO2;

   c. Blood pressure;

   d. Rate and quality of respirations;

   e. Level of consciousness;

   f. Response to verbal commands;

   g. ECG Monitoring;

   h. Vital signs.

2. Verbally confirm drug and dosage with physician, repeating sedation medication orders prior to administration.

3. Notify physician if patient-specific maximum dosage of sedative or analgesic has been administered. (Note: Administration of procedural sedation medication above the recommended dosages for the patient's age, status and desired level of sedation (as outlined by the Procedural Sedation Dosing Guidelines, Appendix A) will be done at the physician's discretion and documented as such.

4. During the procedure and during post-procedure observation, the RN will verbally notify the physician of any signs or symptoms of adverse reaction or physiologic compromise. These include, but are not limited to:

a. Variation of 20% in blood pressure or heart rate

b. Oxygen saturation drops more than 2% from baseline.

c. Dyspnea, apnea or hypoventilation

d. Chest pain or cardiac arrhythmia

e. Diaphoresis

f. Inability to arouse the patient

g. The need to maintain the patient's airway mechanically

h. Any other untoward or unexpected patient responses.

5. The RN must have no other responsibilities that would leave the patient unattended or would compromise continuous monitoring until the patient recovers.

IMMEDIATELY POST PROCEDURE:

1. The physician and team do a "Sign-Out", reviewing the name of the procedure, specimens are identified and labeled, equipment problems are addressed, and any concerns for the continued management of the patient to be communicated to the next care-providers

2. The physician will remain available (within hearing distance) and the pulse oximeter and ECG monitor will remain in place until the patient recovers protective airway reflexes, responds to verbal stimulation and moves extremities appropriately.

3. The physician will complete the Post Procedure Assessment Note including: procedure performed, post-operative diagnosis, findings, EBL, specimens removed and if there was an assistant.

4. One set of vital signs will be recorded in the procedural area before transfer to the PACU or immediate post-procedure area for continued recovery from procedural sedation if the patient remains in the procedural area longer than 15 minutes.

5. Patient status will then be monitored for a minimum of 30 minutes after the last dose of medication by a qualified RN until the patient has reached baseline status or acceptable level according to the Aldrete scoring system in the following parameters:

a. Level of consciousness;

b. Oxygen saturation;

c. Movement of extremities;

d. Vital signs stable for 30 minutes;

e. Maintenance of airway; and

f. Pain assessment.

6. The Aldrete score is to be recorded in the immediate post-procedure recovery period, repeated every 15 minutes until criteria is met. (see below)

ALDRETE SCORE

SCORE	ADD 2	ADD 1	ADD 0
Activity	Moves 4 extremities voluntarily or upon command.	Moves 2 extremities voluntarily or upon command.	Moves 0 extremities voluntarily or upon command.
Respiration	Deep breathe or cough on command.	Limited or difficult respiration.	Apnea.
Circulation	BP +/- 20 mm Hg of pre-anesthetic level	BP +/- 20-50 mm Hg of pre-anesthetic level.	BP +/- 50 mm Hg or more of pre-anesthetic level.
Consciousness	Fully awake.	Responsive to voice stimuli.	Not responsive.
Oxygenation	Maintain SaO2 > 92%.	Maintain SaO2 > 90%	Sa02 < 90% even with O^2

7. IV access will be maintained throughout the post-procedure recovery until the LOC returns to the baseline, unless otherwise ordered by the MD.

8. A physician will be available to discharge the patient in accordance with hospital policy.

9. Patients may be recovered in the following areas only:

a. PACU

b. ICU/CCU

c. ER

d. Radiology

e. Endoscopy

f. ASD

g. Cardiac Catheterization Lab

10. The patient must be accompanied by an RN if transported prior to the return to baseline status with O2 available. Transportation mode is determined based upon patient status and need.

11. Patients may be discharged from the recovery phase after the hospital-approved discharge criteria is met.

Inpatients:

a. It has been at least 30 minutes since the last dose of sedation (or *1 hour if a reversal agent was used.*)

b. The patient has an Aldrete score within 2 points of pre-procedure baseline level.

EXCEPTION: Patient admitted to or currently in ICU.

c. Vomiting is absent or controlled with ordered medications.

d. Pain is managed via ordered medications after alternative methods are attempted; i.e., repositioning.

Outpatients

a. Discharge criteria (Post-Anesthesia Recovery or PAR), including level of consciousness, should be met for a 30 minute period before discharge. (See Outpatient Discharge Criteria Standardized Procedure.)

b. It has been at least 30 minutes~~1 hour~~ since last dose of sedation medication and 2 hours after a reversal agent was used.

c. The patient has an Aldrete score within 2 points of pre-procedure level.

d. Pain and nausea are controlled.

e. The patient is able to ambulate with assistance consistent with age and procedure.

f. The patient will be accompanied by a responsible adult who will be able to report any post-procedure complications.

g. Discharge instructions are given, including resources to contact if any problems arise.

h. Patient and/or responsible adult verbalize understanding of discharge instructions.

DOCUMENTATION:

1. The Procedural Sedation Flow Sheet and the electronic medical record will be utilized for documentation before, during and after the procedure.

2. Documentation will include, but will not be limited to:

   a. The patient's status before, during and after the procedure;

   b. Dosage and route of all drugs and agents used;

   c. Type and amount of intravenous fluids administered;

   d. All assessment data;

   e. Unusual events during the procedure.

COMPETENCY REQUIREMENTS

NURSING STAFF

1. All RNs administering medications to produce moderate procedural sedation are required to demonstrate competency in management of the patient. At the end of the initial training program, the nurse will be able to:

   a. State the pharmacological agents used for local analgesia and procedural sedation, their dosages, route, desired effects and adverse reactions.

   b. Identify the pharmacologic agents used as antagonists to opioids and benzodiazepines and their dosages.

   c. Describe the procedure for procedural sedation including benefits and potential complications.

   d. Demonstrate appropriate assessment parameters prior to, during and after the procedure.

   e. Identify basic dysrhythmias

   f. Demonstrate ability to recognize and treat an obstructed airway

   g. Describe reportable conditions and appropriate nursing interventions.

2. Both cognitive and psychomotor skills, including airway management, will be validated initially and annually through the E-Learning Module and annual nursing competency fair.

3. All RNs who do procedural sedation monitoring must have valid and current BLS and ACLS certifications. Emergency Department RNs must also have PALS certification.

PHYSICIAN TRAINING AND COMPETENCY

1. Minimum formal training requirements are delineated on Procedural Sedation Privilege Request form.

2. Current ACLS is required for non-anesthesiologists who are not Board Certified in Emergency Medicine, Pulmonology or Cardiology. Physicians who have completed a residence training in Emergency Medicine and are not Board Certified, will be exempt from the ACLS or ATLS requirements if they have had 10+ years current consecutive practice in an emergency department environment.

3. Completion of the tutorial on Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, Airway Management Tutorial, and is passing the exam by no less than 80%.

4. Competency re-exam is waived for the reappointment applicant that has documented satisfactory performance of 10 cases within the last twenty-four months.

5. The privilege to perform moderate procedural sedation will be granted upon recommendation by the Department of Anesthesiology and approved by the Credentials Committee, the Medical Executive Committee and the Governing Board.

6. Only those practitioners who have been granted appropriate clinical privileges by the Governing Board are permitted to order and/or supervise the administration of moderate procedural sedation.

QUALITY ASSURANCE and RISK MANAGEMENT

1. Outcomes for patients undergoing sedation are collected and analyzed in the aggregate to identify opportunities to improve care.

2. The following events are reported through the QM/RM module and are evaluated for Risk Management and Performance Improvement Services. A summary of the findings are reported to the Anesthesia Services quarterly, including cases appropriate for peer review.

   a. Cardiac or respiratory arrest

   b. Use of reversal agents

   c. Need for assisted ventilation (ambu)

d. Sedatives or analgesic dosing outside of the dosing guidelines

e. Transfer to a higher level of care after sedation

REFERENCES:

- Practice Guidelines for Moderate Procedural Sedation and Analgesia 2018: **A Report by the American Society of Anesthesiologists Task Force on Moderate Procedural Sedation and Analgesia, the American Association of Oral and Maxillofacial Surgeons, American College of Radiology, American Dental Association, American Society of Dentist Anesthesiologists, and Society of Interventional Radiology**. *Anesthesiology* 2018; 128:437–479 doi: https://doi.org/10.1097/ALN.0000000000002043~~American Society of Anesthesiologist – The Joint Commission Model Policy~~
- ~~Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. An Updated Report by the American Society of Anesthesiologists Task Force on Sedation and Analgesia by Non-Anesthesiologists: 2002~~
- American Society of Post Anesthetic Nurses. 2021-2022. Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements. Pg 73.~~*The Role of the Registered Nurse in management of Patients Receiving IV Procedural Sedation for Short-Term Therapeutic Diagnostic or Surgical Procedures:*~~
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- ~~Clinical Pharmacology Online, accessed July 2012.~~
- ~~Emergency Medicine Report, Vol 23, No. 21 – October 7, 2002~~
- ~~Emergency Medicine Report, Vol 23, No. 22 – October 21, 2002~~
- American Society of Anesthesiologists. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/ Analgesia, 2010~~04~~
- The Joint Commission. (2022~~17~~). ~~Hospital accreditation standards. Oakbrook Terrace, Illinois~~Sedation and Anesthesia-Understanding the Assessment Requirements.
- ~~King, C. (2010) *Moderate Sedation/Analgesia: Competency Assessment Module. Competency and Credentialing Institute.*~~
- ~~Lexi-Comp Online, accessed July 2012.~~

- ~~"Model Sedation Protocol for Moderate Sedation and Analgesic Performed by Non-Anesthesia Practitioners." California Society of Anesthesiologists. May 2010.~~
- ~~Orlewicz, Marc MD. Procedural Sedation. Emedicine.medscape.com. updated 11/8/11. Accessed July 2012.~~

CROSS REFERENCES:

- Assessment of Patients for Surgical/Invasive Procedures Policy – SVMC
- Intrafacility Transfers Policy- SVMC
- ~~lity Transfers Policy - SVMC~~

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APPENDIX A: Procedural Sedation & Analgesia Guidelines (Adult & Pediatric)

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	MEDICATION	PEDIATRICS < 12 years	ADULTS PEDS ≥12 years	GERIATRIC > 60 years	ONSET	DURATION	COMMENTS
Moderate (Conscious) Sedation	FENTANYL (Sublimaze®)	1 mcg/kg/dose IM or slow IV push, if needed, may repeat by 1 mcg/kg increments; not to exceed a cumulative dose of 4mcg/kg	1-2 mcg/kg slow IV push (over 1-2 min); may repeat dose after 30 min	Same as adult dosing unless renal impairment	1 – 2 min	30 – 60 min	• **Reversal with Naloxone if respiratory depression occurs** • IV push slowly • Risk of skeletal and thoracic muscle rigidity with rapid injection. Risk of respiratory depression • ***(If patient is pre-medicated with opiate or other CNS depressant, reduce dose by 50%.)*** • **Use lowest possible dose in patients with renal impairment. Modify dose based on clinical response and degree of renal impairment**
	HYDROMORPHONE (Dilaudid®)	**Not recommended**	Incremental doses of 0.5 mg – 1 mg; **not to exceed 6 mg maximum**	Incremental doses of 0.5 mg – 1 mg; **not to exceed 6 mg maximum**	3 – 5 min	1 – 4 hours	• **Reversal with Naloxone if respiratory depression occurs** • Risk of respiratory depression • Monitor for 45

							minutes after last dose. Watch for delayed respiratory depression • **Use lowest possible dose in patients with renal impairment. Modify dose based on clinical response and degree of renal impairment**
	LORAZEPAM (Ativan®)	**For infants and children:** 0.05 mg/kg PO, IM, or IV (range: 0.02-.09 mg/kg) one hour prior to procedure. **Not to exceed 2 – 4 mg/dose.** Alternatively, for slow titration to effect, 0.01—0.03 mg/kg IV initially, may repeat every 20 minutes to titrate to desired effect within the hour before procedure.	0.044 mg/kg IV 15-20 min before procedure. **Max dose of 2 mg IV.** Alternative: 0.05 mg/kg IM 2 hours before procedure. **Max IM dose of 4 mg.**	Refer to adult dosing. Increased sensitivity to lorazepam in this age group.	5 – 20 min	6 – 8 hours	• **Reversal with Flumazenil if respiratory depression occurs** • Use of this in infants and children is an off-label indication and safety and efficacy has not been established • **Dosage should be modified depending on clinical response and degree of renal impairment, but no quantitative recommendations are available**

	DIAZEPAM (Valium®)	0.2 – 0.4 mg/kg PO. **Not to exceed a total dose of 0.4 mg/kg. (Max dose is 20 mg PO)** or Incremental dose of 0.05 – 0.1 mg/kg IV. **Not to exceed a total dose of 0.25 mg/kg**	5-15 mg IV 5-10 min before cardioversion or titrated up to 20 mg IV for endoscopy. Alternative: 10 mg PO 45-60 minutes before procedure.)	Refer to adult dosing. Increased sensitivity to diazepam in this age group.	IV: 1 – 5 min Oral: rapid	IV: 20 – 30 min Oral: variable	• **Reversal with Flumazenil if respiratory depression occurs** • **Dosage should be modified depending on clinical response and degree of renal impairment and/or hepatic impairment but no quantitative recommendations are available**
	MEPERIDINE (Demerol®)	Pre-op sedation induction: SC/IM: 1.0 - 2.2 mg/kg 30-90 min. before beginning of anesthesia. **Not to exceed max adult dose (100mg)**	Pre-op sedation induction: 50—100 mg SC/IM 30—90 minutes before the beginning of anesthesia. **Not to exceed 100mg**	Pre-op sedation induction: 50 mg SC/IM 30—90 minutes before the beginning of anesthesia. **Not to exceed 50mg.**	SC: 10 – 15 min IV: 5 min	2 – 4 hours	• **Reversal with Naloxone if respiratory depression occurs** • Note: Naloxone does not reverse, and may even worsen, neurotoxicity (anxiety, tremors, seizures) • Avoid use in the elderly if possible • **Avoid use in renal impairment** • **Use caution in hepatic impairment**

	MIDAZOLAM (Versed®)	**Infants under 6 mos:** DO NOT GIVE 6 mos. – 5 years: Initial dose of 0.05-0.1 mg/kg IV, up to 0.6 mg/kg may be necessary. **Max dose = 6 mg** **6 – 12 years**: Initial dose of 0.025 – 0.05 mg/kg IV, up to 0.4 mg/kg may be necessary. **Max dose = 10 mg.** **12 – 16 years**: Dose as adults **Max dose = 10 mg**	Initial: Incremental doses of 0.5 – 2 mg slow IV over at least 2 minutes. Slowly titrate to effect by repeating doses every 2 – 3 min if needed. Usual total dose needed is 2.5 – 5 mg. Maintenance: 25% of the dose needed to reach sedative effect	Initial: 0.5 mg slow IV; give no more than 1.5 mg in a 2 minute period. If additional titration is needed, give no more than 1 mg over 2 min, waiting another 2 min or more to evaluate sedative effect. A total dose of > 3.5 mg is rarely needed	3 – 5 min	< 2 hours	• **Reversal with Flumazenil if respiratory depression occurs** • IV push slowly • Wait ≥ 2 min to assess sedative effect prior to administering additional doses • NOTE: Children < 6 years old may require higher doses and closer monitoring than older children. • **If patient is pre-medicated with opiate or other CNS depressant, reduce dose by 50%**
	MORPHINE Dilute to 1 mg/mL	Infants, children & adolescents: 0.1 - 0.2 mg/kg IV with onset of action 2 - 5 mins. Neonates: 0.05 - 0.2	**Off label** dosing for sedation induction: 2 mg IV *Reduce dose if patient is pre-medicated with benzodiazepin	Increased risk of respiratory depression in elderly. Use with caution.	5 – 10 min	2 – 4 hours	• **Reversal with Naloxone if respiratory depression occurs** • Use fluids and trendelenburg position if hypotension occurs • IV push slowly over 4 to 5

	mg/kg IV. Onset of action 5 mins. Use lower end of range for opiod-naïve neonates. Use preservative free formulation.	e				minutes • Monitor for 45 minutes after last dose. Watch for delayed respiratory depression • **If patient is pre-medicated with benzodiazepine reduce dose by 50%.** • **Prolonged half-life and/or accumulation in hepatic and renal impairment & pre-term neonates. Use with caution.**
KETAMINE	6 – 10 mg/kg PO for one dose. (mixed in Cola or another beverage). Given 30 min. before procedure. 0.5 – 1.0 mg/kg/dose IV (given slowly over 60 seconds). **Not to exceed 0.5 mg/kg/min.**	Off label use: IM: 2 – 4 mg/kg IV: 0.2 – 0.75 mg/kg Titrate dose to effect	Refer to adult dosing	IV: 30 sec IM: 3 – 4 min PO: 15 – 20 min	IV: 5 – 10 min IM: 12 – 25 min	• In children, drink oral dose immediately after mixing with cola or other beverage. • Can cause emergence psychosis. Pre-treatment with a benzodiazepine can decrease psychosis by > 50% • **No renal adjustment appears to be necessary.**
NALOXONE (Narcan®)	**Post-operative opiate agonist induced**	0.1 – 0.2 mg IV push every 2-3 min. until desired response	Refer to adult dosing.	2 min	20-60 min	• Reversal agent for opioids o Fentanyl o Hydromorph one

		respiratory depression: Initially, 0.005 – 0.01 mg/kg IV at 2 – 3 min intervals until desired response obtained.	obtained.				o Meperidine o Morphine • Administer over 30 seconds • Use in caution in patients with CVD and liver impairment • Additional doses may be necessary at 1–2 hour intervals depending on patient response as well as dosage/duration of action of the opiate agonist. • **It appears that no renal adjustment is necessary.**
	FLUMAZENIL (Romazicon®)	<u>For Adolescents and Children:</u> Dosage has not been definitively established. Initial dose of 0.01 mg/kg (max = 0.2 mg), followed by 0.005 – 0.01 mg/kg (max = 0.2 mg) every minute. **Not to exceed a total cumulative dose of 1 mg.**	0.2 mg IV initial, then repeat dose after 45 seconds, then every 1 minute until desired level of consciousness achieved. **Max Total Cumulative Dose: 1 mg over 5 min** If resedation occurs, repeat the regimen at 20 minute intervals, up	Refer to adult dosing, however, increased sensitivity may occur in some elderly patients	1 – 3 min	~ 1 hour	• Reversal agent for benzodiazepines o Midazolam o Lorazepam o Diazepam • Administer over 15 seconds • May induce seizure • CAUTION: the effects of flumazenil may subside prior to those of the Benzodiazepine and therefore, the patient may require additional ventilator support. DO NOT USE in

			to a maximum of 3 mg/hour.				patients requiring benzodiazepine for control of a potentially life-threatening condition or in patients with serious concurrent cyclic antidepressant overdose. • Safety and efficacy has not been established in children less than 1 year old • **It appears that no renal adjustment is necessary.** • **In hepatic impairment, no adjustment to the initial dose but subsequent doses should be reduced in size or frequency**

SUBJECT: **PROCEDURE FOR MOUTH CARE OF THE TUBE FED RESIDENT**	SECTION: **Page 1 of 3**

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

PURPOSE:

The purpose is to prevent dryness of mouth and lips, and also increase resident comfort and dignity.

POLICY:

Mouth care will be given every shift and PRN to the tube fed resident.

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

EQUIPMENT:

- Water
- Emesis basin
- Towel or linen saver pad
- Toothbrush and toothpaste
- Disposable gloves
- Mouthwash
- Toothettes swab or lemon-glycerine swab
- Water soluble lubricant

Edentulous resident:

- Denture cup
- Denture cleaner
- Denture brush

Comatose or debilitated resident:

- Cotton tipped swabs
- Evacu-toothbrush or oral suction handle
- Gauze sponges

PROCEDURE:

1. Assemble equipment pertinent to individual resident needs.
2. Provide privacy.
3. Wash hands thoroughly, put on gloves.
4. Elevate head of bed (semi-Fowlers position).
5. Drape towel or pad under resident's chin.
6. Gently brush resident's teeth and gums with small amount of toothpaste or diluted mouthwash and toothbrush.
7. For the edentulous resident, cotton tipped applicators, 2x2 gauze sponges, or toothettes dipped in half mouthwash and water may be used to clean the mouth.
8. Hold emesis basis under the resident's chin.
9. Rinse and swab mouth (including tongue, palate and gums with toothettes dipped in warm water).
10. Observe the residents mouth for cleanliness, tooth and tissue condition.
11. For the comatose resident, oral suctioning may be required for excess fluid in the mouth.
12. Apply water soluble lubricant to the resident's lips.
13. Dentures should be soaked in warm water with a denture cleanser, then brushed with a denture brush and rinsed.

RECORDING:

1. Mouth care is recorded on the activities of daily living (ADL) flow sheet or treatment record.
2. Record any unusual conditions such as bleeding, edema, mouth odor, excessive secretions or encrusted membranes on the nurses' notes in the EMR. Record interventions.

REFERENCES:

- Brevda, Michael. (2018, October 28). *What is Proper Oral Care For An NPO Resident?* Senior Justice Law Firm. Retrieved from https://seniorjustice.com/what-is-proper-oral-care-for-an-npo-resident/#:~:text=Proper%20oral%20care%20for%20an%20NPO%20resident%20involves%3A,2%20hours%20for%20moisture%20relief.

- Shepherd Center (2020). *Tube Feeding Guide*: *About Tube Feeding*. Shepherd Center. https://www.myshepherdconnection.org/tube-feeding-guide.

SUBJECT:	SECTION:
PROVISION OF 24 HOUR NURSING ACCESSIBILITY GUIDELINES	***DP/SNF STAFFING REQUIREMENTS***

PURPOSE:

To ensure that quality medical care is being provided to the Residents through the accessibility of nurses 24 hours a day.

POLICY:

The facility will provide 24 hour nursing care for residents, per Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH) requirements for the sub-acute program and the criteria as described in facility nursing standards.

AFFECTED PERSONNEL/AREAS:

CLINICAL DIRECTOR, MANAGER, REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), CERTIFIED NURSING ASSISTANT (CNA), RESTORATIVE NURSING ASSISTANT (RNA), UNIT CLERK

PROCEDURE:

The facility will utilize the following staffing and skill mix for the sub-acute unit.

Skill Mix

- Clinical Nurse, Director/Manager, Registered Nurses, Licensed Vocational Nurses, Certified Nursing Assistants, Staff Developer and MDS Coordinator, Activity Director, Social Worker Designee, Unit Clerk and Restorative Nursing Assistant.

Augmentation to Core Staffing

- Core Staffing may be augmented as census increases.

DISTINCT PART SUBACUTE STAFFING REQUIREMENTS PER DEPARTMENT OF HEALTH CARE SERVICES

The Monthly Sub Acute Staffing Report must be completed and submitted to the Department of Health Care Services **by the 16th of the month**, for the previous month.

Daily Minimum Requirements:

- RN and LVN Daily Minimum Requirement hours per patient day for Distinct Part Adult Subacute Unit (Staffing Factor) is 4.0
- CNA Daily Minimum Requirement hours per patient day for Distinct Part Adult Subacute Unit (Staffing Factor) is 2.0

Additional Requirements:

- Each subacute unit ***must*** have a minimum of one RN assigned to the subacute unit per shift.
- Nursing staff assigned to the sub-acute unit shall ***not*** be assigned other duties outside the sub-acute unit during any given shift.

Cautionary notes:

- The required hours are to be met on a daily basis. Therefore, "excess" RN/LVN and CNA hours cannot be carried over to the next day. These hours ***cannot*** be averaged over a week or month.
- CNA hours ***cannot*** be used to supplement RN/LVN hours.

Included/Excluded Staffing Hours:

The following information identifies subacute staffing hours that will either be included or excluded from the ***Monthly Subacute Staffing Report*** for the adult subacute program.

Action	Who
Include staffing hours for:	-RNs, LVNs who provide actual subacute patient care -CNAs who provide actual subacute care -Director of Nurses, Nurse Supervisors, Clinical Directors when providing actual subacute patient care. -Registry Nurses who provide actual subacute patient care -Minimum Data Set (MDS) Nurses – who perform assessments for subacute patients (*not including data entry functions*) -Wound care and follow-up wound care
Exclude staffing hours for:	-Director of Nurses, Nurse Supervisors, Clinical Directors when ***not*** providing actual subacute patient care -Director of Staff Development (DSD) Nurses when performing the duties of this position as specified in California Code of Regulations, Title 22, Section 71829 -Respiratory Therapists (RTs) -Special duty nurses or nurse assistants who are privately funded -RNs, LVNs, and CNAs who are in training or on meal breaks -Staff time spent in non-nursing functions such as administration, maintenance of health records, laundry, kitchen, etc. -Staff time spent on patient care outside of the subacute unit -RNs, LVNs and CNAs on vacation/sick leave -Activity Directors

	-Technicians or other therapists -Qualified Mental Retardation Professionals (QMRP)

Information Needed Prior to Completing the *Monthly Subacute Staffing* Report Information to collect: Follow the table below prior to completing the ***Monthly Subacute Staffing*** Report form.

Who	What	Source
Staff Person assigned to complete the Monthly Subacute Staffing Report	Staff hours	Applicable information needed to substantiate actual daily subacute staff hours for each RN, LVN and CNA for the entire month can be taken from documentation such as: Daily staffing schedules/assignment sheets Daily sign-in sheets MDS nurse documentation substantiating time spent on subacute patients Nurse Registry sign-in sheets Payroll registers Punch detail printouts Time cards (hand-written or electronically stamped) ***Note***: If discrepancies are identified, compare documents, reconcile, and verify information for accuracy.
	Patient census	A list of <u>all</u> patients who receive daily care from designated subacute staff for the entire month. **Note**: Exclude subacute patients on "**bed-hold**" status from the daily patient census.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.30, United States of America, Med Pass Inc.
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §71829, §72082, §72319, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I

D7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT	SECTION:
QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT-DP/SNF	**Page 1 of 4**

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

PURPOSE:

The purpose of the Quality Assurance/ Performance Improvement Program is to facilitate an organized approach to improving quality patient care, maintaining patient safety and services at Sierra View Medical Center, Distinct Part Skilled Nursing Facility.

POLICY:

The Director of Nursing is responsible for maintaining the department's Quality Assurance/Performance Improvement (QA/PI) program. This includes prioritizing quality improvement activities in response to unusual or urgent events with continuous focus on patient safety and patient outcomes. The Quality Assurance/ Performance Improvement program is guided by the needs of the patient and data gathered by the MDS coordinator. QA/PI is to ensure a systematic, comprehensive, data-driven approach to care. QA/PI creates a self-sustaining approach to improving safety and quality while involving all caregivers in practical problem solving.

The program provides a comprehensive and objective assessment of aspects of care with respect to cultural sensitivity and diversity and ensures that the delivery of care is supported by evidence-based medical and healthcare research. QA /PI is a proactive and continuous study of processes with the intent to prevent or decrease problems. This is done by identifying the problem and finding new approaches to fix the underlying causes. The information is collected on an ongoing basis, is recorded, benchmarked against third party organizations empowered by regulatory agencies to gather and report on healthcare performance measures. This information is analyzed and shared with the Medical Director of the unit and employees, to foster continuous improvements.

DPSNF policies and procedures will be developed, reviewed and/or revised yearly by ~~the Patient Care Policy Committee, an ad hoc committee of the QA/PI committee. Members of the Patient Care Policy Committee may~~ to include, but not limited to one physician, the Director of Nursing Services, Clinical Manager, MDS Coordinator, Pharmacist, the Activity Director, and representatives of each required services as needed. Policies ready for approval will be forwarded through Power DMS to the Vice President of Patient Care Services for review and approval then presented at the Medical Executive Committee and Board of Directors meeting for review and approval. ~~After the approval process has been completed, the new or revised policies will be placed in the DPSNF Policy Binder. New~~ The new versions of revised policies will be published in the electronic policy management software and the old version will automatically be archived.

OBJECTIVES

To implement a planned, systematic and ongoing process of monitoring and evaluating the delivery of care in order to prioritize opportunities for improvement that support patient safety and appropriateness of care.

To support the use of best practices and form a comprehensive approach to ensuring high quality and cost effective health care.

To promote a collegial and multidisciplinary approach to all performance improvement activities, allowing for the exchange of relevant information that results in improved patient care.

MODEL

The facility utilizes PDSA (Plan, Do, Study, Act), as the model for quality. This cycle of improvement model is used for problem solving and for the design and implementation of new services. This model supports and encourages small test of change, cycles for improvement and allows for an organized process to make change that affects patient care. This process supports closing the loop and ensuring for adequate monitoring and evaluation of the actions taken.

P – Plan	The planning stage evaluates and researches the identified problem.
D –Do	This stage is implementing the change that will improve a process.
S – Study	This stage studies the results of the change by viewing data for process variation and evidence of process improvement.
A – Act	This stage is taking action needed to maintain improvements or to determine the next steps for further improvement or to maintain the gain.

REPORTING OF QUALITY DATA

QA/PI data is collected monthly and reported to the department's Quality Improvement Committee at least quarterly, or more often as necessary. Quality improvement tools are used to track and trend progress and also serve to help identify deficiencies that will need correction, address gaps in systems or processes, develop and implement a corrective plan and continuously monitor effectiveness of interventions. An example of this tool is the "Dashboard" which provides a "snap shot" view of the department's performance.

QUALITY IMPROVEMENT COMMITTEE

The Quality Improvement Committee consists of the Director of Nursing, the Medical Director, Infection Control and Prevention Officer, three other staff (one of which must be the administrator, owner, board member or other individual leadership role), the Clinical Manager, Activities Coordinator, MDS (Minimum Data Set) Coordinator, Dietitian, RNPC (Restorative Nursing Program Coordinator), Social Services Designee, Physical Therapist, Compliance RN, Respiratory Therapist, Environmental Services and any necessary discipline that participates in the care of the patients. The purpose of this committee is to prioritize performance improvement activities that maintain patient safety and provide quality patient care, and develop and improve appropriate plans and action to correct identified deficiencies. Performance Improvement activities are determined by the review of quarterly data/reports that reflect quality of patient care. The data collected is analyzed by the committee and when deficiencies are identified, actions are determined to correct the problem. Monitoring of the plan of corrections will continue until the problem has been resolved as evidenced by two quarters of meeting set benchmarks. In addition, spot checking will take place during the year to check for sustained improvements.

QA/PI ASSESSMENT AND ASSURANCE

a) Create systems to provide care and achieve compliance of regulations

b) Track, investigate and prevent recurrence of adverse events

c) Receive and investigate complaints

d) Seek feedback from residents and caregivers

e) Set targets for quality

f) Strive to achieve improvements in specific goals related to pressure ulcers, falls, restraints, or other areas.

g) Commit to balancing a safe environment with resident choices

h) Strive for deficiency-free surveys

i) Assess ~~residents~~residents' strengths and needs, to design and implement measurable and interdisciplinary care plans.

j) Perform a Root Cause Analysis to get to the heart of the reason for problems.

k) Undertake systemic changes to eliminate problems at the source.

FIVE ELEMENTS OF QA/PI

1. Design and Scope: Address all systems of care and management practices, to include, clinical care, quality of life and resident choice.

2. Governance and Leadership: Leadership should seek input from facility staff, residents, families and/or representatives. The governing body ensures staff accountability, and an atmosphere where staff are comfortable identifying and reporting quality problems as well as opportunities for improvement.

3. FEEDBACK, DATA SYSTEMS AND MONITORING: Have systems in place that monitor care, services and get data from multiple sources. Use Performance Indicators to monitor care processes and outcomes and review findings against benchmarks and/or targets. Monitor Adverse Events that must be investigated and action plans implemented to prevent recurrences.

4. PERFORMANCE IMPROVEMENT PROJECTS (PIP): This involves a team composed of interdisciplinary team members to gather information systemically to clarify problems and intervene for improvement.

5. SYSTEMIC ANALYSIS AND SYSTEMIC ACTION: Use a systemic approach to determine analysis that is needed to understand the problem, its causes and implications for change. These problems may be caused by the deliverance of the care or services. This will also serve to address the following: a) the need to develop Policies and Procedures and demonstrate proficiency in the use of Root Cause Analysis, b) the need to focus primarily on systems and processes, and c) develop and review Systemic Actions that will focus on continual learning and continuous improvement.

COMMUNICATION:

a) Make sure all residents and families/caregivers know that their views are sought, valued and considered and discussed in QAPI and Resident Council

b) Identify opportunities for improvement and let the residents and families/caregivers know how it is proactively being addressed.

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

REFERENCES:

- Thomson Reuters (2019) Barclay's California Code of Regulations, 72082, 72319, 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.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.75 (0) United States of America, Med Pass Inc.

- U.S. Centers for MEDICARE & Medicaid Services, December 1, 2021. Quality Measurement and Quality Improvement-CMS, retrieved from https://www.cms.gov

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SUBJECT: **RAZOR CLEANING- ELECTRIC**	SECTION: **Page 1 of 2**

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

PURPOSE:

To clean and maintain electric razors.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that razors will be cleaned between each use and will be maintained as per procedure.

AFFECTED PERSONNEL/AREAS:

REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), CERTIFIED NURSING ASSISTANTS (CNA)

PROCEDURE:

AFTER RESIDENT HAS SHAVED:

1. Switch razor off and unplug razor.
2. Using brush, clean head slots to remove any hair.
3. Wipe head slot thoroughly with alcohol swab.
4. Lift razor head off using thumb and index finger.
5. Clean razor head assembly inside and out with brush (over trash can).
6. Wipe thoroughly inside and out with brush (over trash can).
7. Press razor head assembly back on razor housing.
8. Wipe entire razor housing with alcohol swab and allow to dry.

NOTE:

- DO NOT operate electric razor if oxygen is being administered via nasal cannula.
- DO NOT reach for a razor that has fallen into water. Unplug immediately.
- DO NOT use while bathing or in shower.
- NEVER operate razor if it has a damaged cord or plug.

- ALWAYS unplug the razor from the electrical outlet immediately after using, except when razor is charging.

REFERENCES:

- How to Clean an Electric Shaver to Ensure It Has a Long Life. Retrieved September 2019 from https://groomandstyle.com/clean-electric-shaver/.
- Manufacturer's guide for each razor

SUBJECT: **RESIDENTS' PERSONAL CLOTHING**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish guidelines for the care of each resident's articles of personal clothing.

POLICY:

It is the policy of the Distinct Part/Skilled Nursing Facility (DP/SNF) that residents are allowed to maintain and utilize their own personal articles of clothing, separate from any provided by the facility.

AFFECTED PERSONNEL/AREAS:

NURSING STAFF; SOCIAL SERVICES; UNIT DIRECTOR

PROCEDURE:

1. All articles of personal clothing are to be noted on the resident's list of possessions which is kept in the residents chart.

2. Each article of clothing is to be labeled with the resident's name and is for the exclusive use by the resident.

3. Arrangements will be made for the laundering of the clothing articles either by the family or by the facility laundry service. If the family chooses to launder the resident's clothing themselves, they will provide a hamper for dirty clothing.

4. No alterations will be made to any personal article of clothing without the express noted permission of the resident or their representative. Any alterations made for the ease of use of the clothing article will be done in a manner that maintains the look and integrity of the piece of clothing.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72613, San Francisco, California, Title 22.

SUBJECT: **RESIDENTS' PERSONAL REFRIGERATOR**	SECTION:

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

PURPOSE:

To establish guidelines for monitoring residents' personal refrigerator temperatures and the storage of food items.

POLICY:

It is the policy of the Distinct Part/Skilled Nursing Facility (DP/SNF) unit to monitor the temperature of the residents' personal refrigerators and storage of food items on a daily basis.

AFFECTED PERSONNEL/AREAS:

NURSING STAFF, SOCIAL SERVICES, UNIT DIRECTOR

PROCEDURE:

1. The DP/SNF personnel will record the residents' personal refrigerator temperature daily. Any temperatures not within the appropriate temperature range will be reported to engineering immediately.
    a. Refrigeration Safe Zone will be below 45 degrees F.
    b. Freezer Safe Zone will be below 0 degrees F.
2. Temperature records will be maintained for one year.
3. All patient items in their personal refrigerator will be properly covered and dated.
4. All partially used items will be discarded after 72 hours. Pickled items will be discarded after 30 days.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §70273, San Francisco, California, Title 22.

SUBJECT: **RESIDENT'S RIGHTS**	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 ensure that the facility demonstrates respect for the rights of the Residents.

POLICY:

It is the policy of this facility that Social Services Designee will work to protect the following rights of each resident.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES*

PROCEDURE:

Residents shall have the right to:

1. Choose activities consistent with his or her interests.
2. Interact with members of the community both inside and outside the facility.
3. Reside in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of other Residents would be endangered.
4. Be informed or notified when there is a significant change in mental or psychosocial status or the need to alter treatment significantly.
5. Be informed or notified when there is a decision to transfer or discharge the Resident from the facility.
6. Retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights, health, or safety of other Residents.
7. Make choices about aspects of his/her life in the facility that are significant to the Resident.
8. Receive notification when there is a change in room or roommate assignment and, if known, the Resident's legal representative or interested party.
9. To be assured of confidential treatment of his/her personal and medical records and to approve/refuse their release to any individual or agency as provided by HIPAA regulations.

REFERENCES:

- The Residents Bill of Rights, Motley Rice LLC, 28 Bridgeside Blvd, Mt. Pleasant, SC 2020. Retrieved from http://www.nursinghomealert.com/residents-bill-of-rights.
- Centers for Medicare & Medicaid Services. Nursing Home Resource Center. Retrieved from https://www.cms.gov/nursing-homes.
- The National Long-Term Care Ombudsman Resource Center. *Resident's Rights*. Retrieved from https://ltcombudsman.org/issues/residents-rights.

SUBJECT: **RESTORATIVE PROGRAM**	SECTION: **Page 1 of 1**

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

POLICY:

To establish guidelines for a restorative program.

AFFECTED PERSONNEL/AREAS: RESTORATIVE NURSE AIDE (*RNA), CERTIFIED NURSING ASSISTANT (CNA)*

PROCEDURE:

1. Passive and /or active range of motion (ROM) is given 6 days a week daily by RNA/CNA to all residents needing assistance in activities of daily living (ADL).

   Hand rolls will be used whenever hands are contracted or beginning to show signs of contractures.

   Ambulation will be encouraged for all residents on a daily basis.

2. Independent ambulators:

   a. Residents who are independent in ambulation will be encouraged to ambulate to their tolerance, in their room and in the hallways.

3. Ambulatory needing assistance:

   a. Residents will be encouraged to ambulate whenever possible, including ambulation to the toilet. Commodes and bedpans will be discouraged unless physically needed by the resident.

   b. Residents will be ambulated daily in hallways as tolerated per PT orders.

   c. The distance ambulated will be documented on the Restorative Nurse Assistant Intervention in the EMR.

4. All residents are encouraged to be up in chairs, wheelchairs or Geri-chairs as scheduled, as tolerated except when contraindicated by medical conditions. All residents are encouraged to leave their room for a change of environment two (2) times a week and attend activities.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, 70557, 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:	SECTION:
RESTRAINT USE – NON-VIOLENT, NON SELF-DESTRUCTIVE (NVNSD) AND EMERGENCY-VIOLENT SELF DESTRUCTIVE (VSD)	***Provision of Care, Treatment & Services (PC)***

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

PURPOSE:

To guide the application of ***Non-Violent, Non-Self-Destructive (NVNSD)*** **and** ***Violent Self Destructive (VSD) behavior*** restraint in all settings with the goal of minimizing the frequency/duration of restraint use to that which is absolutely necessary for resident care and resident and provider safety.

SCOPE:

The following are not considered restraint under this policy:

- Standard healthcare practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes.
- Adaptive support in response to assessed resident need.
- Forensic or correctional restrictions used for security purposes.

POLICY:

1. Seclusion will not be employed at this hospital.
2. Physical restraint may be used according to this policy when warranted by the resident's condition and therapy, and when less-restrictive means of protecting the resident are not indicated.
3. All staff assigned to apply or monitor restraint will demonstrate corresponding competence.
4. Staff will ensure that residents are treated with dignity and privacy, including during periods of restraint.

AFFECTED PERSONNEL/AREAS:

NURSING, MEDICAL, ADMINISTRATION, DP/SNF

PROCEDURE:

NON – VIOLENT- NON SELF DESTRUCTIVE RESTRAINT

1. ***Definition:*** ***Non-violent, non-self-destructive (NVNSD)*** restraint means restricting a resident's movement to assist with the provision of medical or surgical care. Resident immobilization that is a normal component of a procedure (e.g., magnetic resonance imaging, surgery, etc.) is not considered restraint.

2. ***Indications:*** Prior to the initiation and continuation of ***NVNSD*** restraint, the resident must be assessed every 2 hours and documented in Meditech (EMR), to determine whether he/she requires restraint to prevent interference with his/her treatment plan.

3. ***Consideration of less-restrictive means:*** Prior to the initiation and continuation of restraint, alternative means of protecting the patient will be considered.

4. ***Conversation with Resident and Family:*** To the extent practical, the issue of restraint will be discussed with the resident and family prior to its use. Resident/family education will be documented. Consent will be obtained from appropriate resident representative before use of the restraint if able or as soon as possible, within 48 hours.

5. ***Orders:*** Restraint will be initiated or continued at the order of the physician. 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. If a resident has been removed from restraints but a valid order is still in effect, the registered nurse may reapply the restraint without obtaining a new order, as long as the resident is exhibiting the same behaviors that met the original indication.

6. ***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.

7. ***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.

8. ***Early Discontinuation of Restraint:*** Restraint will be discontinued as soon as it is no longer warranted by the resident's actions or the nature of the resident's treatment plan. Restraint may not be reapplied without a new order.

9. ***Resident Monitoring:*** Residents will be observed at least every two *(2)* hours to ensure that restraint remains necessary, that restraining devices remain safely applied, and that the resident remains safe and as comfortable as possible.

10. ***Documentation:*** The following will be documented in the medical record whenever medical restraint is applied:

    a. The resident's actions or condition that indicated the initial and continued use of restraint

    b. The less-restrictive alternative(s) to restraint considered

    c. Restraint orders

d. Resident monitoring

e. Significant changes in the resident's condition

f. Discussions and education with the resident and family (as appropriate) regarding restraint

g. The resident's plan of care will be updated any time a restraint is used

h. Record of Consent

VIOLENT AND SELF DESTRUCTIVE BEHAVIOR RESTRAINT (VSD)

1. ***Definition:*** ***Violent and Self Destructive Behavior Restraint*** is the restriction of a resident's movement in response to severely aggressive, destructive, violent, or suicidal behaviors that place the resident or others in imminent danger.

2. ***Consideration of Less Restrictive Means:*** Prior to the initiation and continuation of ***VSD*** restraint, alternate means of protecting the resident and others will be considered.

3. ***Conversation with Resident and Family:*** To the extent practical, the issue of restraint will be discussed with the resident and the family prior to its use and resident being sent to the Emergency Department. Resident and family education will be documented, as appropriate.

4. ***Discontinuation of Restraint:*** ***VSD*** restraint will be discontinued as soon as it is no longer indicated by the resident's behavior or the nature of the resident's treatment plan.

5. ***Orders:*** ***VSD*** restraint will be initiated or continued upon the order of a treating physician with current privileges at this institution. The order for restraint will include the type of restraint to be applied and will be based on specific violent/self-destructive behaviors that indicate restraint. PRN restraint orders will not be issued or accepted. ***VSD*** restraint may not be ordered for longer than four (4) hours for adult residents. Residents on the DP/SNF unit will be taken to the Emergency Room for full evaluation before VSD restraints are used, especially if the resident has a diagnosis of dementia, and/or has become violent and can harm self or others. The resident will not remain on the DP/SNF unit if VSD restraints are used.

6. ***Initiation without Orders:*** An RN may initiate ***VSD*** restraint in an emergency in advance of a physician's order. In such cases, the resident will be sent to the ER for evaluation and a treating physician will perform a face-to-face assessment of the resident within one *(1)* hour of its application.

7. ***Notification of the Nurse Manager:*** The nurse manager on duty will be notified:

   a. of any ***VSD*** restraint that continues to be applied for more than eight hours

b. any reapplication of VSD restraint within 12 hours after discontinuation

8. Patient Monitoring: After initial observation in the Emergency Department and continual use of the VSD restraint is identified, the resident will be placed in ICU where staff will continuously observe the resident. Such monitoring will be documented at least every 15 minutes.

Documentation: Document the following in the medical record whenever VSD restraint is applied: The patient's actions or condition that indicated the initial and continued use of restraint;

a. The less-restrictive alternative(s) to restraint considered

b. Restraint orders

c. Patient monitoring

d. Significant changes in the patient's condition.

e. Discussions and education with the patient and family (as appropriate) regarding restraint.

f. The residents' plan of care will be updated any time a restraint is used.

g. Transfer to Emergency Room order.

CHEMICAL RESTRAINT

1. ***Definition:*** A chemical restraint is any medication used as a restriction to manage the resident's behavior or restrict the resident's freedom of movement that is not a standard treatment or dosage for the resident's condition. Therefore, administration of an antianxiety or antipsychotic drug to alleviate symptoms of mental illness need not be considered a chemical restraint. Routine scheduled use of medications or PRN use, either oral or IM, of these same medications for approved indications does not need to be considered a chemical restraint.

2. On the rare occasion that chemical restraint is used in the acute setting, and also accompanies the initiation of ***VSD*** restraint, the protections afforded to the resident for this physical restraint *(See Non-violent, Non-Self Destructive details)* also ensures the resident's rights in the event of use of chemical restraint. Immediate transfer to the ER precedes the initiation of both VSD and chemical restraints.

REPORTING DEATHS RELATED TO RESTRAINT

Staff will promptly notify management of the death of any resident during or within 24 hours of the end of an episode of restraint use.

Management, in consultation with the department of quality, member and regulatory services, will notify the California Department of Public Health (CDPH) (on behalf of the Centers for Medicare & Medicaid Services [CMS]) of any resident who dies during restraint use.

STAFF EDUCATION:

1. During the initial orientation period, all levels of staff that have direct resident care responsibilities are oriented to this policy and procedure and trained in the proper and safe application and use of restraints.

2. Competency validation related to the proper and safe application and use of restraints is documented prior to the independent performance of the application or monitoring of a resident requiring restraint.

3. Only Registered Nurses (RN), who have demonstrated competence, or physicians may apply restraints in an emergency situation.

Contract/agency staff with direct resident care responsibilities will have documented competency in the hospital's restraint policies and procedures prior to caring for residents in restraints

REFERENCES:

- Thomson Reuters (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, §72082, §72319, San Francisco, California, Retrieved from: https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- MedPass, Inc. (Updated February 6, 2015) *Facility Guide to OBRA Regulations,* 483.13 (a) United States of America, Med Pass Inc.

CROSS REFERENCES:

- DP/SNF Policy & Procedure Manual RESTRAINTS, CHEMICAL

- DP/SNF Policy & Procedure Manual CARE OF RESIDENTS WITH DEMENTIA ON THE DP/SNF UNIT

SUBJECT: **RESTRAINTS, CHEMICAL**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 6**

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

PURPOSE:

To establish set guidelines for the proper use of chemical restraints in the DP/SNF

POLICY:

When psychoactive medications are ordered, the assessment process will be utilized to ensure:

1. Environmental causes of resident's distress or behavior have been ruled out.
2. Alternative behavioral management programs have been attempted prior to the use of psychoactive medication.
3. Early identification and reporting of drug side effects are documented.
4. Physician is provided with summaries of resident's behavioral manifestation, frequency, response to behavioral programs and medications, as well as recommendations for changes in medication.
5. Psychoactive medications are used in the lowest possible dose, and are discontinued when no longer required to treat a mood or behavior problem, unless the medication is used to maintain a resident with a psychotic diagnosis, or organic mental disorder.
6. Psychoactive medications are given only after the physician has obtained informed consent from the resident/surrogate decision maker.
7. Facility staff has verified that informed consent has been obtained.
8. Residents with dementia on antipsychotic/psychotropic medications will be reviewed by Pharmacy for any issues of adverse medication effects that may cause cognitive impairments and may be mistaken as worsening dementia.

POLICY:

1. Residents will be enabled to achieve the highest level of functioning, and will receive psychoactive medications only when they are necessary to treat medical, mood, behavioral, or psychiatric symptoms. These medications will not be used for the convenience of staff. Informed consent will be obtained by the physician from the resident, unless the resident lacks decisional capacity, in which case, consent will be obtained from the surrogate. In the absence of surrogate, the Interdisciplinary Team will make the recommendation regarding the use of the medication. Consent will also be obtained for any change of dosage.
2. <u>Antipsychotic Medications</u>

a. Anti-psychotic medications will not be initiated for residents who have not used them previously, unless the clinical record documents the medication is necessary to treat a "specific condition".

b. Non-pharmacological interventions will be initiated and documented prior to the use of antipsychotic medications.

c. Psychologist consults as per MD order.

d. In the event that non-pharmacological interventions are ineffective, and a pharmacological intervention has been initiated secondary to consult, licensed nursing staff will document the frequency of incidents of the targeted behavior each shift, in order to demonstrate the necessity for treatment with anti-psychotic medications.

e. Continued aggravation or deterioration in status will be reported to the physician.

f. Anti-psychotics will be given in the lowest effective dose to start, and increased as needed by physician order.

g. Use of a one-time only dose of anti-psychotics more than two times in seven days will be assessed by the Interdisciplinary Team for side effects and continued use.

h. Gradual dose reductions will be attempted twice in a year unless the physician documents that it is clinically contraindicated.

i. The medication's effectiveness will be reevaluated by the physician on a weekly basis during the Interdisciplinary Team Meeting.

3. Anti-anxiety Medications

a. Nursing will document the frequency of incidents of the targeted behavior each shift, in order to demonstrate the necessity for treatment with anxiolytics.

b. Anti-anxiety medications will be administered only when the appropriate indications/diagnoses are present:

- Generalized anxiety disorder
- Organic mental syndrome associated with agitated states
- Panic disorder
- Symptomatic anxiety that occurs in residents with another diagnosed psychiatric disorder (e.g., depression, adjustment disorder).

c. Long acting benzodiazepines will not be used unless the short acting benzodiazepines have failed.

d. Daily use will be reevaluated every 6 months unless a dose reduction is attempted and is unsuccessful.

4. Antidepressant Medications

a. Residents with symptoms of depression (e.g., withdrawn behavior, refusal to speak, poor appetite, and/or loss of interest) will be provided appropriate non-pharmacological interventions such as altered lighting, distractions with activities, relaxation techniques, calming music, repositioning, sit and conversing with resident, etc. These non-pharmacological interventions will be attempted prior to the initiation of any drug therapy.

b. Any use of an antidepressant medication outside the Diagnostic and Statistical Manual of Mental Disorders (DSM V) guidelines will be justified by a physician's note explaining why the medication is clinically appropriate, and this should be supported by a psychiatrist/psychologist consultation.

c. Behavioral monitoring charts via MAR will be used for residents receiving antidepressant medications.

5. Sedative/Hypnotic Medications

a. All environmental factors for insomnia will be ruled out before pharmacological interventions will be initiated to assist a resident to sleep.

b. Daily use of drugs for sleep induction will be less than ten consecutive days or as the physician deems necessary, unless an attempt at a gradual dose reduction has been unsuccessful.

c. Barbiturates will not be used except as a single dose for dental or medical procedures, and phenobarbital will be used only for seizure disorder.

d. When resident is admitted with barbiturates, or miscellaneous hypnotic, sedative, or anxiolytic drugs, there will be a gradual dose reduction at least two times in one year before dose reduction is determined to be "clinically contraindicated".

e. Neither barbiturates, nor miscellaneous sedative, hypnotic, anxiolytic drugs will be initiated in the facility as part of an initial therapeutic treatment program.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICES, INTERDISCIPLINARY TEAM*

PROCEDURE:

1. Residents who are admitted with a psychoactive medication will have an assessment of the continued need, dosage, and indications for the medication.

   a. The physician's admitting order for psychoactive medication will state the behavior or mood problem being treated.

   b. The physician is to obtain the informed consent.

   c. The behavior or mood problem will be entered on the care plan with the side effects of the drug and non-drug interventions.

   d. The Interdisciplinary Team will complete the "Psychoactive Medication Assessment" at the first Team Conference Meeting following admission, review the treatment progress in the monthly Team Conference Meeting, and reevaluate in a quarterly assessment the appropriateness of continued treatment with psychoactive medications.

   e. Nursing and Social Service Designee will document in their progress notes the interventions provided, and resident's response to treatment.

   f. Nursing will stop the medication and notify the physician if medication side effects are suspected.

2. When psychoactive medications are initiated on the unit, the resident's medical record will contain completed assessments, documented interventions, and appropriate consents, before the drug is administered.

   a. The physician's order for psychoactive medication will identify the mood or behavior problem being treated and order behavioral monitoring when behaviors are targeted.

   b. The physician will then complete the appropriate consent form for the medication with the resident.

   c. If the resident is not capable of giving informed consent, consent will be obtained from the resident's surrogate.

   d. Nursing will have documentation in regards to the non-drug interventions that have been unsuccessfully implemented.

   e. A care plan will be completed noting the behavior or mood problem being treated, non-drug interventions, and drug side effects.

3. Informed consent, assessment, and response to psychoactive medications will be documented in the medical record.

a. Prior to the administration of any psychoactive medications initiated on the unit, the consent for the specific medication will be documented in the medical record.

b. When a resident, or the resident's surrogate refuses a psychoactive medication that has been ordered, the Refusal of Medication will be documented in the medical record. Documentation will state that the resident was informed, inclusive of details, regarding the risk and benefits of the medications ordered.

c. The Interdisciplinary Team will review the use of psychoactive medications in the Interdisciplinary Team Conference meeting, and will document in the Team Conference notes a re-evaluation of the medication's effectiveness, with recommendations for the continued usage, dose reduction, or discontinuance of the medication.

d. When resident is receiving a psychoactive medication and dosage reduction is "clinically contraindicated," the physician will document the reason as to why the medication is necessary on a Risk vs. Benefits form.

e. When medications are ordered outside the "Unnecessary Drug Guidelines," the physician will document the reason for the medication and the psychiatric condition necessitating the medication. The physician's documentation should be supported by a psychiatric/ psychologist consultation.

f. Nursing will document frequency of incidents of the behavior on each shift, when a resident is receiving any psychotropic medication for a disorder, which is manifested by inappropriate behaviors.

g. Nursing will document responses to dosage reduction attempts.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) *Barclays California Code of Regulations,* 72319 (j) 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.

- Stones, MJ (2019). *Psychotropic Medication Use and Mortality in Long Term Care Residents.* Retrieved from https://www.intechopen.com/books/aging-life-span-and-life-expectancy/psychotropic-medication-use-and-mortality-in-long-term-care-residents.

- Medicare State Operations Manual for Long Term Care Facilities, Department of Health and Human Services, September 2000 , Tag F221, F222, Appendix PP.

CROSS REFERENCES:

- DP/SNF Policy and Procedure: CARE OF RESIDENTS WITH DEMENTIA ON THE DP/SNF UNIT .

SUBJECT: **RESTRICTED AREAS ON THE NURSING UNIT**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish guidelines and boundaries for the unit and to assure the work environment is operated in a safe and orderly manner.

POLICY:

The facility will maintain the confidentiality of residents, and rights of residents and employees. In order to assure this, some areas are restricted at all times from resident, family and visitors.

AFFECTED PERSONNEL/AREAS:

ALL FACILITY STAFF

PROCEDURE:

1. All staff are to politely enforce this restriction.
2. The following areas are off-limits to non-staff:
   a. Nurse's Lounge
   b. Behind Nurse's desk
   c. Medication Room (restricted to Licensed Nurses only)
   d. Utility Rooms (clean and soiled)
   e. Residents' Pantry

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 72325, San Francisco, California, Title 22.

SUBJECT: **SCOPE OF OCCUPATIONAL THERAPY**	SECTION: *[Enter manual section here]* **Page 1 of 2**

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

PURPOSE:

To establish guidelines for the scope of Occupational Therapy Practice in Sierra View Medical Center Distinct Part Skilled Nursing Facility (DPSNF).

POLICY:

DEFINITIONS:

1. Scope of Practice:

a. Occupational Therapy is a profession which develops, coordinates and utilizes select knowledge and skills in planning, organizing and implementing programs for the care of individuals whose ability to function is impaired or threatened by disease or injury.

b. This leads to the selection and implementation of appropriate therapeutic procedures to maintain, improve or restore these functions. Services are provided to outpatients and inpatients on acute and sub-acute.

2. Types of Patients:

All types of orthopedic conditions and soft tissue injury, neurological conditions, wound care for diabetic and venous stasis ulcers and medical conditions, if the condition impacts activities of daily living (ADLs).

3. Age of Patients:

Middle Adult: 21 - 65 years

Late Adult: Over 65

4. Services:

Occupational Therapy services include, but are not limited to:

a. Evaluation and assessment prior to the provision of services.

b. Determination and development of a treatment program established to prevent or reduce disability or pain and to restore loss of function.

c. Interventions that focus on posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, pain and activities of daily living.

d. Procedures that include application of heat or ice, ultrasound, massage, mobilization and therapeutic exercises.

e. Wheelchair training and assessment, including application of assistive or prosthetic devices as appropriate.

5. Hours of operation:

Occupational Therapy consult/services are provided on an as needed basis.

6. Department Goals:

a. Goals are to provide effective and efficient patient care, increase professional and lay awareness and encourage on-going education and research in the field of physical therapy.

b. Occupational Therapy incorporates a broad spectrum of activities such as direct patient care, multidisciplinary interchange, supervision, teaching, administration, research and community service.

c. It also accepts responsibility for education at many levels, recruitment of personnel and ethical standards of practice for the welfare of patients and its own members.

7. Staffing Plan:

a. Services are provided by a per diem employee on a per consult basis.

b. Restorative Nursing Aide to collaborate with Occupational Therapist for compliance with the OT program.

8. Qualification of staff

a. Fulfill state requirements for licensure, certification or registration. Internationally educated occupational therapists must complete occupational therapy education programs that are deemed comparable (by the credentialing body recognized by the state occupational therapy regulatory board or agency) to entry-level occupational therapy programs in the United States.

b. **Occupational Therapy staff will have Basic Life Support (BLS) certification.**

AFFECTED PERSONNEL/AREAS: *ALL OCCUPATIONAL STAFF*

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, Article 4, §72413, §72415, §72417, San Francisco, California, Title 22.

SUBJECT:	SECTION:
SCOPE OF PRACTICE – LICENSED VOCATIONAL NURSE	***DP/SNF***

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

PURPOSE:

To clarify the *Scope of Practice* for Licensed Vocational Nurses (LVNs) working for Sierra View Medical Center within the DP/SNF.

POLICY:

A. Nursing staff members licensed in the State of California as Vocational Nurses shall adhere to all statutes defining their scope of practice as published by the Board of Vocational Nurses and Psychiatric Technicians.

B. Licensed Vocational Nurses (LVNs) shall adhere to the LVN Job Description, practice guidelines, policies and procedures, and competencies as established by Sierra View Medical Center in compliance with the acute care hospital, DP/SNF, and outpatient departments, in regard to all patient care practices, including IV certification and administration of medications to patients under the care of the LVN.

C. Only LVNs who have successfully completed an IV certification, completed competency validation course and passed the Medication Math testing, may start peripheral IVs and superimpose intravenous solutions of electrolytes, nutrients, vitamins, blood, and blood products.

D. LVNs are directly supervised by a registered nurse.

REFERENCE:

- Vocational Nursing Practice Act with Rules and Regulations (Includes amendments through July 31, 2015). Retrieved on Oct 4, 2017 from https://www.bvnpt.ca.gov/about_us/laws.shtml.

SUBJECT: **SCREENING OF LONG-TERM CARE RESIDENTS FOR TUBERCULOSIS (TB)**	SECTION: **Page 1 of 2**

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

PURPOSE:

To screen residents for latent and potentially active tuberculosis (TB) in accordance with epidemiologic principles and local/state/federal regulations.

POLICY:

- The Manager of Infection Control will assist the staff with TB surveillance in the Distinct Part Skilled Nursing Facility (DP/SNF) Unit.
- In accordance with Centers for Disease Control and Prevention (CDC) guidelines, Sierra View Medical Center (SVMC) will screen all new residents of DP/SNF without a known history of TB skin test (within one year) for the TB infection using the two-step Mantoux (PPD) skin test.
- Residents with positive PPD skin test results will be evaluated for active TB and considered for preventive treatment.

AFFECTED AREAS/PERSONNEL: *DP/SNF RESIDENTS*

PROCEDURE:

1. Residents with a known history of positive PPD reaction will be screened for TB with an annual chest x-ray.
2. Residents with no known history of positive PPD reaction will be screened for TB on admission with a questionnaire /chest x-ray and the two-step Mantoux test as follows:
   a. Intracutaneous administration of 5 units of purified protein derivative tuberculin (PPD).
   b. Read skin test within 48-72 hours of administration.
   c. If the skin test induration is = or > 10mm, the reaction is considered positive. Anything less than 10mm induration is considered negative unless clinical/historical information is significant. Record the results.
   d. Residents with a negative PPD skin test initially shall have a repeat skin test the following week to identify the booster phenomenon. The method of administration and reading is the same as the initial skin test.
3. PPD skin test results will be recorded on the resident's chart. Staff caring for residents with a positive PPD test result shall consider active TB as a differential diagnosis should the resident develop the signs/symptoms of active TB (persistent cough, night sweats, fever, weight loss, etc.)
4. All residents will be screened annually for TB. Residents with positive PPDs will have a chest X-ray completed annually.

5. A skin test conversion on repeated skin tests is defined as an increase = or > 15mm for a person > or = 35 years of age and = 10mm for a person < 35 years of age.

6. Residents with skin test conversions and/or residents with symptoms suggesting TB, regardless of size of reaction, shall have a chest X-ray within 72 hours.

7. Residents with abnormal chest X-rays and/or symptoms compatible with TB should be evaluated for airborne isolation precautions, transferred to a negative pressure room, AFB sputum, and other medical evaluations.

8. Residents with positive PPD skin test results and skin test converters shall be considered for preventive therapy by their physician.

9. All skin test converters shall be reported to the Director of Infection Control or Designee and will be investigated.

10. When an active case of TB is identified in the DP/SNF Unit, all residents and staff having close contact will be given baseline screening (PPD test for negative skin reactors and symptom review of positive skin reactors). Screening will be repeated in 12 weeks.

REFERENCES:

- National Library of Medicine (2020). *WHO Consolidated Guidelines on Tuberculosis*. Geneva: World Health Organization. Retrieved from https://pubmed.ncbi.nlm.nih.gov/32186832/#:~:text=The%20WHO%20consolidated%20guidelines%20on,upon%20TB%20elimination%20(9).

- California Department of Public Health, (CDPH) California Tuberculosis Controllers Association (CTCA). (June 2019) *Guidelines for the Assessment of Tuberculosis Patient Infectiousness and Placement into High and Lower Risk Settings*.

- The Joint Commission Center for Transforming Healthcare. (2020) IC.4, IC.5, I. Retrieved from https://www.centerfortransforminghealthcare.org/.

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, Chapter 3, §72523, San Francisco, California, Title 22.

SUBJECT: **SHAVING**	SECTION: **Page 1 of 2**

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

PURPOSE:

The purpose is to increase cleanliness and improve the resident's self-image.

POLICY:

- It is the policy of this facility to provide for the removal of facial hair as a component of the resident's hygienic program.
- Male residents will be shaved at least every other day and female residents will be shaved as needed.

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

EQUIPMENT:

- Safety razor or rechargeable razor
- Basin
- Bath towels
- Washcloth
- Soap or shaving cream
- Tissues
- After shave lotion (optional)
- Gloves

PROCEDURE:

1. Explain procedure to resident. Provide privacy. Wash hands thoroughly.
2. Assist resident to comfortable position.
3. Place towels over chest and under head.

WHEN USING SAFETY RAZOR:

a. Fill basin half full of warm water

b. Apply gloves

c. Apply moderately warm washcloth to face

d. Apply shaving cream

e. Pull skin tight in opposite direction to razor and shave

f. Rinse blades frequently

g. Rinse face, dry and apply after shave lotion as desired

h. Remove gloves

i. Wash hands thoroughly

DOCUMENTATION:

1. Report any unusual observations to licensed nurse for follow up.
2. Document procedure of resident's refusal to shave on nurse assistant activities of daily living (ADL) Intervention in the electronic medical record (EMR).

REFERENCES:

- Thomson Reuters (2019) Barclay's California Code of Regulations, 72315 (d), 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: **SIDERAILS**	SECTION: **Page 1 of 1**

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

PURPOSE:

The purpose of this policy is to provide a device to assist residents in independent bed mobility, to provide a safety device for preventing residents from falling from bed, or as a restraint to prevent injuries for those residents who have been screened for the use of restraints and for whom the use of siderails has been determined to be the appropriate, least restrictive type of restraint. An Informed Consent from the family/responsible party and a physician's order has also been obtained for their use and must be obtained before they are used.

POLICY:

It is the policy of this facility to assess all residents for the appropriate use of siderails.

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

PROCEDURE:

1. Upon admission, all residents will be assessed for functional and cognitive levels.
2. The appropriate use of siderails will be determined by the resident Bed/Siderail Assessment.
3. Residents for whom siderails are determined appropriate for assistive or safety reasons will have care plan entries identifying the reason for use.
4. Residents for whom siderails are determined appropriate will have an appropriate personalized care plan completed and informed consent signed by the resident, family, significant other or guardian.

REFERENCES:

- Thomson Reuters (2019). Barclay's California Code of Regulations, 72319, 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.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.25(n), (2) (3) (4) United States of America, Med Pass Inc.

SUBJECT: **SPLINT APPLICATION AND USE**	SECTION: **Page 1 of 2**

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

PURPOSE:

The purpose of this policy is to maintain optimal quality of life and prevent the progression of contractures.

POLICY:

The facility will utilize splints to prevent contractures or the progression of contractures.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), CERTIFIED NURSING ASSISTANT (CNA), RESTORATIVE NURSE ASSISTANT (RNA), PHYSICAL THERAPIST, AND OCCUPATIONAL THERAPIST*

PROCEDURE:

1. Splints are to be worn according to the schedule determined by written order of the physician.
2. The Occupational Therapist assists in determining the need for and coordinating a referral for splint fabrication, if needed, or a pre-made splint, if appropriate.
3. The Physical Therapist or Occupational Therapist assesses for proper fit and instructs the CNA in proper application.
4. CNA and/ or RNA monitors the patient every 2-3 hours for proper positioning, fit, and resident's tolerance of the splint.
5. Resident's refusal for splint application will be documented promptly by the RNA or CNA per the department's documentation system. A care plan regarding this concern will be written accordingly and reviewed as appropriate.
6. The skin will be checked for redness, irritation, or pressure marks during care at least every 2-3 hours.
7. Any problem with fit or resident tolerance is relayed to the Physical Therapist or Occupational Therapist for reassessment.
8. The fit and effectiveness of the splint is reassessed monthly at Interdisciplinary Team (IDT) and PRN by the Physical Therapist or Occupational Therapist. Any need for adjustment or modification of the splint is made to the appropriate vendor.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72319 (k) (1) (5) (2A & 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: **SWALLOWING ASSESSMENT AND RESIDENTS' RIGHTS – DP/SNF**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish collaborative guidelines between resident, physician and other healthcare professionals in order to deliver safe and effective healthcare.

To define the rights and responsibility of the residents receiving care and the safety issues involved in those decisions made by the resident.

POLICY:

The Physician and Speech Therapist will define the safety issues to the resident who is willing to exercise their rights and responsibility to take oral meals when the swallowing evaluation establishes the potential for aspiration.

AFFECTED PERSONNEL/AREAS:

PHYSICIAN, SPEECH THERAPIST, REGISTERED NURSE (RN), REGISTERED DIETITIAN

PROCEDURE:

1. All residents will receive an evaluation conducted by the speech therapist on admission to the DP/SNF Unit.

2. The physician and nursing staff will be notified of the results of the evaluation.

3. If the resident does not meet criteria for a swallow evaluation at the time of admission, a re-evaluation will be written when the nursing staff and physician see the resident has shown improvement to warrant such evaluation.

4. If the resident does receive a swallow evaluation and does not pass, the resident will be re-evaluated when the speech therapist and physician see the resident has shown improvement or the resident themselves requests it and is ordered by the physician.

5. If the resident does not pass their swallow evaluation and insists, per their patient rights, to have oral meals, then the following must be met.

    a. The physician will speak to the resident and fully disclose to him/her the risks entailed with eating meals and the possibility of aspiration.

    b. The resident will be placed at a 35-90 degree angle in bed during meals.

    c. The resident will be monitored during meals by licensed nursing staff as per the order of 100% supervision by the speech therapist and physician.

    d. A comprehensive care plan will be maintained in the residents' chart, on the potential for aspiration, and the residents' right to eat meals against the medical advice of the

physician. Per SVMC Policy & Procedure: Patient Rights and Responsibilities, "The resident is responsible for his/her actions if she/he refuses treatment or does not follow the practitioner's instructions."

e. The resident must have an adequate decision making capacity, and the level of his/her decision-making capacity must be evaluated by the physician.

Per CMS and the New Dining Practice Standards, "It is ethically and legally permissible for patients with decision making capacity to refuse unwanted medical interventions and to ignore recommendations of the clinician. If the patient is sufficiently informed about the risks and benefits of acceptance (informed consent) or refusal (informed refusal) of a proposed intervention or treatment and refuses, the clinician should respect the patient's decision".

REFERENCES:

- California Department of Public Health, updated Oct 6, 2017, Nursing Home Residents Rights, retrieved from: https:www.cdph.ca.gov
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72527, San Francisco, California, Title 22.
- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.10. United States of America, Med Pass Inc.

CROSS REFERENCES:

- SVMC House Wide Policy & Procedure: "PATIENT RIGHTS AND RESPONSIBILITIES "

SUBJECT: **THEFT AND LOSS**	SECTION: **Page 1 of 4**

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

PURPOSE:

The purpose of this policy is to ensure reasonable efforts are made by Sierra View Medical Center (SVMC) to safeguard resident property and to reimburse a resident for or replace stolen or lost property at its then current value.

POLICY:

SVMC will prevent theft or loss of resident valuables and possessions in consideration for providing a safe and secure environment for addressing the resident's medical and social needs. The facility will comply with all applicable regulations and laws, including California Health and Safety Code Section 1289, 1289.3, 1289.4, 1289.5.

The administrator is responsible for the overall monitoring and implementation of the Theft and Loss Policy and Procedures.

AFFECTED PERSONNEL/AREAS:

SOCIAL SERVICES, LICENSED NURSING STAFF, CLINICAL DIRECTOR, CLINICAL MANAGER

PROCEDURE:

1. The Social Service Designee will provide information regarding the facility's policies and procedures relating to theft and loss prevention program to residents and responsible parties upon admission.

2. All new employees shall undertake an orientation program within 90 days of employment which shall include a review of the facility's theft and loss policy and procedures. Existing staff shall receive this information during annual orientation, and updated annually during in-services/staff meetings.

3. For recording and tracking, the facility shall utilize a Theft and Loss Monitoring Report and a Theft and Loss Log. The Social Service Designee shall be responsible for the maintenance of the reports and the log. Theft and loss reports should be completed by any staff when a report is received from a resident/family. Staff shall ensure the reports are provided to the Director for follow up and timely resolution.

4. Lost or stolen property shall be documented and reported to the administrator and/or designee and also reported to the California Department of Public Health, Law Enforcement, and the Long Term Care Ombudsman, Risk Management, and Hospital Security.

5. Any theft or loss determined to be $100.00 or greater will be documented and reported to the California Department of Public Health, and to the Office of the State long-term care Ombudsman in response to a specific complaint. Theft and loss records need only be provided upon request, for the prior twelve months.

6. The Theft and Loss Monitoring Report will include the following information and the Social Worker Designee / Nursing Staff will attempt to have the form filled out as completely as possible to facilitate review and possible recovery of losses.

   a. A description of the article;

   b. The article's estimated value;

   c. The date and time the theft or loss was discovered;

   d. If determinable, and the date and time the loss or theft occurred;

   e. The action taken.

7. When items are reported lost or stolen by a resident/family, the Social Worker Designee and Nursing staff will do the following:

   a. Determine whether items were removed from the facility;

   b. Search the immediate area, facility laundry, and areas on the unit to determine whether items may have been misplaced;

   c. Determine value of items (obtain receipts as possible);

   d. Submit report of theft and loss to the Social Service Designee and Director.

8. Resident's personal property inventory. (Cross reference: Policy re: Inventory/Personal Effects)

   Upon Admission:

   a. Upon admission to the facility, the Social Service Designee initiates the completion of the Resident's Personal Belongings form # 014897, Attachment M –Theft and Loss Prevention Program Requirements Health and Safety Code Sections 1289.3-5.The Social Service Designee and Licensed Nursing Staff then completes the resident's personal property inventory form #013048.

   b. This inventory form is retained by the facility and a copy provided to the resident and/or resident's representative upon admission if requested.

   During the resident's stay:

   a. Additions to and deletions from the resident's personal inventory form will be completed by Licensed Nursing Staff and/or Social Services Designee on the inventory form, which accompanies the original form in the resident's medical record. Upon request from the

resident or resident's family, items brought in or taken out shall be recorded on the inventory form to properly maintain an accurate record of items retained in the facility.

b. The facility shall not be liable for items which have not been requested to be included in writing on the inventory form or for items which have been deleted from the inventory form.

c. A copy of the current inventory shall be made available upon request to the resident, responsible party, or other authorized representative.

d. The resident's family or a responsible party is responsible for items which are subject to frequent removal from the facility and not signed in or out, such as personal clothing or laundry.

e. If an item is on the inventory list and after investigation, the facility was determined to be at fault for the loss, the item will be replaced by the facility.

Upon Discharge:

a. Nursing Staff shall inventory and surrender the resident's personal effects and valuables upon discharge to the resident or authorized representative in exchange for a signed inventory form.

b. Upon the death of a resident without a representative or known next of kin as specified by Section 7600.5 of the California Probate Code, the facility will provide immediate written notice to the public administrator of the county.

9. The facility shall establish a method of marking, to the extent feasible, personal items for identification purposes upon admission or as items are added to the property list, including engraving or marking of Dentures, Eyeglasses, Hearing aids, and other prosthetics. This will be carried out by Nursing and Social Services Staff.

10. The facility shall report to the local law enforcement agency within thirty-six (36) hours when the Administrator of the facility has reason to believe resident property with a then current value of one hundred dollars ($100) or more has been stolen. The administrator or designee will oversee the reporting process to a Law Enforcement Agency.

11. The facility will make a referral within 3 calendar days and if not possible, document why dentures are missing or broken. The facility will get a dietary consult to maintain adequate hydration and nutrition. Hearing, glasses or other prosthesis referrals will be made within 3 working days.

12. The facility shall make available and maintain a secured area for the safekeeping of resident property upon the request of the resident or resident's responsible party.

a. A locked area will be kept in the facility to provide security for items that can be accommodated. All items provided for the safe keeping shall be properly receipted when accepted by facility staff and when returned.

13. The facility will accept residents' funds for safe keeping, upon residents' request. Such residents' funds will be maintained in a resident trust account pursuant to Title 22 Section 72529 or 73557.

14. A copy of Sections 1289.3, 1289.4, 1289.5 of Health and Safety code will be provided by the Social Worker Designee to all residents and their responsible parties, during the admission process, and available upon request, to prospective residents and their responsible parties.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 1289.3, 1289.4, 1289.5. United States of America, Med Pass Inc.

- Thomson Reuters (2019) Barclay's California Code of Regulations, 72529, 73557, 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.

CROSS REFERENCES:

- RESIDENTS' FUND POLICY

SUBJECT: **TRANSFER, INTERFACILITY RESIDENT**	SECTION:

PURPOSE:

Interfacility transfer planning provides for continuity of care when a resident is transferred to acute or another health care facility. To ensure continuity of nursing care when a resident is transferred to a new health care facility, discharge planning forms are completed to assess and communicate resident's needs.

POLICY:

It is the policy of this facility that:

- Residents may be transferred only with a physician's order.
- The resident family, responsible party, or public agency must be notified of transfer.
- A completed Interfacility transfer form, medication reconciliation list and other pertinent information must accompany resident on transfer to an acute health care area.
- A completed Post Discharge Plan of Care form must accompany the resident on transfer to a long-term care health facility or when discharged to home.
- Call the receiving facility or acute floor prior to transfer in order to inform the facility of resident's immediate needs.
- Only personal items should be sent with the resident when transferred to an acute care facility. Clothing and other articles should be reconciled with the Personal Inventory List and the belongings secured until the resident returns or until claimed by the resident/family/responsible party.

AFFECTED PERSONNEL/AREAS:

ALL

PROCEDURE:

1. Obtain physician order for transfer.
2. Notify resident/family of impending transfer.
3. For transfer to an acute health care facility, initiate the Interfacility Transfer Form and complete. Include diagnosis, prognosis, rehabilitation potential, allergies and current significant findings with complete vital signs. Copies of physician orders and medical record face sheet should accompany transfer form but these do not replace information which must be documented on transfer form.

4. For transfer to a long-term health care facility, the Interdisciplinary Team will initiate and complete the interdisciplinary Discharge Planning Assessment and Post Discharge Plan of Care. Copies of physician orders and medical record face sheet should accompany the Post Discharge Plan of Care Summary, but these do not replace information which must be documented on the discharge form (see Discharge Planning Policy).

5. When resident is transferred, maintain a copy of the Interfacility Transfer Form, Discharge Planning Assessment and Post Discharge Plan of Care in the resident's medical record.

6. Notify the Business Office, Housekeeping, and Dietary Departments.

DOCUMENTATION:

Nursing notes must include the following discharge information:

1. Date and time of resident transfer or discharge.

2. Date and time of persons notified, including responsible parties and/or public agency.

3. Condition of resident when transferred.

4. How resident was transferred and by whom.

5. Disposition of the resident's itemized personal belongings.

REFERENCE:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72519, 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.

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

SUBJECT: **TRANSFER OF RESIDENT TO-FROM BED**	SECTION:

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

PURPOSE:

The purpose of this policy is to set forth a procedure to assess the resident's capabilities and provide the form of transfer best suited to his/her needs and to maintain resident safety during the procedure.

POLICY:

It is the policy of this facility to assess and provide appropriate and safe transfer techniques for each resident based on individual need.

AFFECTED PERSONNEL/AREAS: *RNs, LVNs, CNAs, PTs*

EQUIPMENT:

- Wheelchair
- Geri chair
- Hoyer Lift
- Gait Belt
- Maxi Lift
- Steady

PROCEDURE:

ASSISTING TO CHAIR:

a) One Person Pivot Transfer (resident must be able to bear weight):

a. Place the chair on the convenient side of the bed with the back of the chair parallel to the foot of the bed and facing the head of the bed.

b. If using wheelchair, make sure footrests are not in the way and wheels are locked.

c. Place appropriate pressure reducing devices into chair.

d. Adjust bed to appropriate level for resident. Raise the head of the bed.

e. Turn resident on his side and pivot him to a sitting position, with legs dangling over side of bed.

f. Assist resident into daily attire.

g. Apply gait belt (unless contraindicated) around resident's waist securely enough to prevent sliding up over ribs.

h. Make sure resident's feet are flat on the floor.

i. Facing resident, establish a broad base with feet spread and one foot slightly in front of the other and grasp the gait belt with thumbs down on either side of the resident and slightly to the back. Pull the resident to a standing position, bracing the resident's knees with yours, if necessary, to prevent buckling.

j. Turn or pivot resident around with his back to the chair. Flex your knees and lower resident into chair. Remove gait belt.

k. Cover lap and knees with lap robe and make sure he/she is comfortable. Utilize postural support and/or positioning devices per physician order and resident need. Make sure call bell is within resident's reach before leaving.

b) Two-Person Assisted Transfer (heavy resident who must be able to bear weight):
(Use Sara 3000 or Steady where indicated)

a. Place the chair parallel to the bed, and facing the head of the bed with wheels locked.

b. Adjust bed to convenient level for resident. Raise the head of the bed.

c. With resident properly attired, assist to a sitting position, legs extended over side of bed and feet resting firmly on the floor. Apply gait belt around resident's waist unless contraindicated.

d. Each person will stand facing the resident with one on either side of the resident.

e. Provide a broad base of support by spreading feet and placing foot farthest from the resident slightly in front of the other.

f. Each person will extend the arm closest to the resident forward between the resident's side and elbow. With fingers pointing downward, grasp the gait belt firmly. Have resident place his hand between your body, the arm grasping the gait belt and holding onto the back of your upper arm.

g. On a verbal command, draw the resident gently but firmly forward and upward to a standing position. Brace his knee with yours to prevent buckling.

h. Pivot or turn resident so that their back is towards the chair. Gently lower resident into chair. Remove gait belt.

i. Cover lap and knees with lap robe and make sure resident is comfortable. Utilize postural supports and/or positioning devices per physician order and resident need. Make sure call bell is within resident's reach before leaving.

c) Two-Person Total Lift (resident unable to bear weight):
No lift facility; always use Hoyer Lift/ Maxi Lift for these types of residents.

TRANSFER TO BED:

1. Select appropriate level of transfer utilized for resident transfer to chair:

   a) Physical therapist assist
   b) Mechanical Devices

2. Utilizing proper body mechanics, reverse the procedure steps to return resident to bed.

3. Make sure resident is comfortable and adjust bed linens. Raise side rails when appropriate for resident safety. Make sure call bell is within resident's reach before leaving resident.

4. Return bed to lowest level after transfers before staff departure.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 483.25(a)(1)(ii), San Francisco, California, Title 22.
- Occupational Safety and Health Administration. *Safe Patient Handling Programs: Effectiveness and Cost Savings* (n.d.). https://www.osha.gov/dsg/hospitals/documents/3.5_SPH_effectiveness_508.pdf.
- Matz, M.W. (2019) *Patient Handling and Mobility Assessments* (2nd Ed.). The Facility Guidelines Institute.

SUBJECT: **TRANSFER WITHIN FACILITY- CHANGE OF ROOM/ROOMMATE**	SECTION: **Page 1 of 3**

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 and/or representative will be provided a written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES DESIGNEE*

PROCEDURE:

Administrative:

1. Changes in resident's room or roommate will be based on nursing/medical care needs and/or resident request. The resident's cultural, spiritual, and age related needs will be considered whenever a room or roommate change is necessary.

2. No resident will be involuntarily transferred within the facility without reasonable notice in writing (as required by law), except in an emergency, which necessitates transfer to acute level for health reasons, or safety and regulatory compliance reasons.

3. The resident's right to refuse certain transfers (per regulatory standards) and his/her wishes regarding transfer will be considered and complied with when they do not interfere with the resident's care and safety needs, and/or the rights and needs of other residents.

4. If the resident lacks the capacity to make decisions or to participate in his/her care, the responsible party will be contacted for notification of room or roommate changes. Written notice will be sent via one of the following options: certified mail, e-mail, fax. Acknowledgement of receipt of notification will be confirmed via phone call and will be documented as appropriate.

5. Documentation of verbal and written notice of changes in the resident's room or roommate will be maintained in the resident's record.

6. The Ombudsman's Office will be contacted to serve as advocate and liaison as needed to assure the resident's rights, when refusal of certain transfers occur, and to assist the resident/responsible party and facility to resolve concerns regarding room or roommate changes.

Preparation for Transfer:

1. The Social Services Designee will discuss the room change with the resident, responsible party and affected roommates, and complete charting needs related to the notification for transfer.

2. The licensed nurse will assemble current health records and all medication and treatment supplies.

3. The nursing assistant will assemble all resident's belongings, verify belongings against the personal inventory form, and date and initial upon completion; complete current charting needs; and, assemble all resident information forms located in the resident's room.

Transfer:

1. The licensed nurse and nursing assistant will transfer the resident with all belongings, records, medications and treatment supplies, after verification of the new room assignment.

2. The nursing assistant will assist resident adjustment through introductions to the new nursing assistant and review of the resident's ADL needs. The new assistant will introduce the resident to his/her new roommate(s) and orient the resident to the new room.

3. The licensed nurse will give verbal report to the receiving nurse (medication and care orders, resident care plan information, general condition and vital signs, medications administered and treatments done), will transfer all medications and treatment supplies, and will document that the transfer of the resident and all belongings has occurred and include the new room and bed number.

Post-Transfer:

1. The nursing assistant receiving the resident will complete admission to the room, safely store resident belongings and appliances for use, and will implement appropriate records maintained in the resident's room.

2. The licensed nurse receiving the resident will introduce self, document the admission in the Electronic Health Record, and notify the Dietary Department of the change in room.

3. The nursing assistant transferring the resident will check the resident's old room for any overlooked belongings (ensure that the bedside stand, closet and drawers are empty), and will remove all linen from the resident's old bed to prepare for cleaning.

4. The licensed nurse transferring the resident will document completion and assignment change in the Electronic Health Record, and will notify Housekeeping of the need to terminally disinfect the resident's old room.

5. Social Services and Nursing will monitor and assist in the adjustment of the resident and roommate(s) to the change, as well as the responsible parties.

GUIDANCE 483.10(e)(4)-(6)

Residents have the right to share a room with whomever they wish, as long as both residents are in agreement. These arrangements could include opposite-sex and same-sex married couples or domestic partners, siblings, or friends.

There are some limitations to these rights. Residents do not have the right to demand that a current roommate is displaced in order to accommodate the couple that wishes to room together. In addition, residents on DP/SNF are not able to share a room if one of the residents elects to pay privately for his or her care, or one of the individuals is not eligible to reside in a nursing home.

Moving to a new room or changing roommates is challenging for residents. A resident's preferences should be taken into account when considering such changes. When a resident is being moved at the request of the facility staff, the resident, family, and/or resident representative must receive an explanation in writing of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move.

A resident receiving a new roommate should be given as much advance notice as possible. The resident should be supported when a roommate passes away by providing time to adjust before moving another person into the room. The length of time needed to adjust may differ depending upon the resident. Facility staff should provide necessary social services for a resident who is grieving over the death of a roommate.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10(e)(4)-(6) United States of America, Med Pass Inc., Rev 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17.

SUBJECT: **TRAPEZE- OVERBED**	SECTION: **Page 1 of 1**

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

PURPOSE:

The purpose of this policy is to ensure residents are enabled to improve independence in bed mobility.

POLICY:

It is the policy of this facility to provide an over bed trapeze for all residents who are assessed as being able to utilize and are in need of a device to increase bed mobility.

AFFECTED PERSONNEL/AREAS: *NURSING (RNs, LVNs)*

PROCEDURE:

1. Nursing will assess each resident upon admission for level of mobility and mental status.
2. Those residents assessed as alert and able to utilize an over bed trapeze as well as in need of improved bed mobility will be provided with an over bed trapeze.
3. Nursing will request the Engineering Department to attach the trapeze to the bed.
4. Nursing will instruct the resident on the use of the trapeze.
5. Once a resident becomes independent in bed mobility or no longer has a need for the trapeze, nursing will notify the Maintenance Department of the need to remove the trapeze and to clean and store it.
6. The use of an over bed trapeze to improve bed mobility will be included as an approach on the resident's personalized care plan.

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: **TREATMENTS RELATED TO MEDICATION-CNA**	SECTION: **Page 1 of 1**

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

POLICY:

It is the policy of this facility that a Certified Nurse Assistant may administer medicated shampoos (OTC only) and non-prescription, topical ointments, creams, lotions, and solutions to areas of unbroken skin.

AFFECTED PERSONNEL/AREAS:

DIRECTOR OF STAFF DEVELOPMENT, CERTIFIED NURSE ASSISTANTS (CNAs)

PROCEDURE:

1. CNA will follow the procedure in the Nursing Policy and Procedure Manual (Medication Administration).
2. CNA will be in-serviced by the Director of Staff Development (DSD) on the procedure.
3. CNA will give a satisfactory return demonstration to the Director of Staff Development or another licensed nurse.
4. Documentation of a satisfactory level of performance will be kept in an Education Binder with the DSD.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72313, 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: **TRUST ACCOUNT-SOCIAL SERVICE POLICY**	SECTION: **Page 1 of 2**

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

PURPOSE:

To assure a system for the facility to hold, safeguard, manage and account for the personal funds of the resident when deposited with the facility. To assure a system which allows the resident access to their monies and provides a means for the reimbursement of their personal debts.

POLICY:

The resident or responsible party will have the right to manage his/her own financial affairs. The resident my delegate this responsibility to the facility in writing. The facility will accept the resident's funds and merge them in an interest bearing trust account, in accordance with the requirements of Federal and State law. The facility may not require residents to deposit their personal funds with the facility.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES, PATIENT ACCOUNTING*

PROCEDURE:

1. The Social Service Designee will advise the resident or responsible party at the time of admission, and/or when changes occur in financial status, of the availability of trust account services.

2. When trust account services are needed, the resident or surrogate will sign the authorization for the facility to establish and manage the trust account. The social service designee will ensure that the authorization is obtained and forwarded to the trust account manager.

3. When a resident is incapable of managing his/her personal funds and has no one to assume this responsibility, the Social Service Designee will notify the Ombudsman and request authorization for the facility to establish a trust account for the resident. When the Ombudsman does not provide this service, the facility will establish an account and the circumstances documented in the medical record by the Social Service Designee. The Designee will also refer residents to the Public Guardian's office when their funds are in excess of routine m monthly benefits and/or financial resources.

4. When requested, or in the absence of a responsible party, the patient account specialist coordinates the funds being directly deposited into the Resident Trust Account and monitors the balance to ensure continuance of benefits when applicable.

5. The Patient Accounting Specialist will establish and maintain a system to assure notification of the resident/responsible party and/or Social Service Designee when the amount in the account of a Medi-Cal beneficiary reaches $200 less than the SSI resource limit. The Social Service Designee will assist the resident with spending down funds in the trust account in accordance with guidelines established by SSI/Medi-Cal for the purpose of maintaining eligibility.

6. The Patient Accounting Specialist will establish and maintain a system for the timely withdrawal and reconciliation of the funds from the trust account to meet resident's monthly share of cost payments and non-covered charges.

7. The Social Service Designee (SSD) will assist the resident or responsible party with making withdrawals from the trust account to purchase personal items, to pay debts, and other person expenditures. The SSD will assure that receipts are obtained and provided to the Trust Account Manager, in order to maintain accurate accounting and monitoring of the residents' funds.

8. The Social Service Designee and Patient Account Specialist will each maintain records of resident authorizations, financial notices, and relevant financial interactions made on behalf of the resident; SSD records will be maintained in the social service files.

9. The SSD will monitor trust account activity and assure the resident or responsible party receives statement at least quarterly of his/her financial records/trust account balance including accrued interest and expenditures made, in accordance with the facility's trust account policy and regulatory requirements.

10. The Patient Account Specialist will monitor to assure that trust account balance and property held by the facility are forwarded to appropriate parties in a timely manner, upon request and at the resident's discharge or death.

11. The Social Service Designee will monitor to assure that the facility Patient Account Specialist maintains a surety bond for the protection of all residents' trust account funds and financial security, in accordance with affidavits filed with regulatory agencies that establish the amount of funds the facility anticipates handling.

REFERENCES

- California Code of Regulations (2020). Title 22. §72445 Special Treatment Program Service. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Botek, Anne-Marie (2020). *7 Things to Know About Nursing Home Resident Trust Funds.* Aging Care 2020 Newsletter. Retrieved from https://www.agingcare.com/articles/things-to-know-about-nursing-home-trust-funds-162627.htm.

- CMS Compliance Group, Inc, F567, Protection/ Management of Personal Funds, Resident's Rights, Dec 7, 2018, Brandie Elizaitias MS, CDP, CDS, Director of Operations.

SUBJECT: **TUBERCULOSIS CONTROL PLAN**	SECTION: **Page 1 of 32**

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

PURPOSE:

The Tuberculosis Control Plan (TCP) integrates Centers for Disease Control and Prevention (CDC) evidence-based research and guidelines across all entities and provides Sierra View Medical Center (SVMC) staff a comprehensive plan for the management, early detection, isolation and treatment of persons with active tuberculosis (TB). Adherence to the policies and procedures addressed in this TB Control Plan will assist in reducing the risk of exposure to patients, visitors and staff within the District environment. This Tuberculosis Control Plan includes:

TB CONTROL PLAN – TABLE OF CONTENTS

POLICY:

Sierra View Medical Center (SVMC) is committed to providing a safe and healthful work environment for our staff, caregivers, and patients. In pursuit of this endeavor, the following TCP is provided to eliminate or minimize occupational exposure to TB in accordance with the 2005 CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities. It is the intent of SVMC to comply with California Code of Regulations Title 8, Section 5144, Subchapter 7 concerning respiratory protective equipment and OSHA Standard 29 CFR 1910.139 concerning respiratory protection for Mycobacterium tuberculosis (MTB).

AFFECTED AREAS/PERSONNEL: *ALL HEALTHCARE WORKERS*

SECTION I - RESPONSIBILITY FOR THE TB INFECTION PREVENTION PROGRAM

A. The fundamentals of a TB Control Plan should consist of administrative controls, environmental controls, and a respiratory protection program.

1. Administrative Controls: These are management measures that are intended to reduce the risk or exposure to persons with infectious TB.

- Assigning someone the responsibility for TB infection control in the health care setting;
- Conducting a TB risk assessment of the setting;
- Developing and implementing a written TB infection-control plan;
- Ensuring the availability of recommended laboratory processing, testing, and reporting of results;
- Implementing effective work practices for managing patients who may have TB disease;
- Ensuring proper cleaning, sterilization, or disinfection of equipment that might be contaminated (e.g., endoscopes);
- Educating, training, and counseling health care personnel, patients, and visitors about TB infection and TB disease;
- Screening, testing, and evaluating personnel who are at risk for exposure to TB disease. Early identification, isolation, and treatment of persons with TB, (e.g., provide and practice early patient screening in the Emergency Department, to identify potentially infectious patients, and prevent employee exposures).
- Using posters and signs to remind patients and staff of proper cough etiquette (covering mouth when coughing) and respiratory hygiene; and
- Coordinating efforts between local or state health departments and high risk healthcare and congregate settings.

2. Environmental Controls: The use of environmental controls to prevent the spread and reduce the concentration of infectious droplet nuclei.

    - Primary environmental controls consist of controlling the source of infection by using local exhaust ventilation (e.g., hoods, tents, or booths) and diluting and removing contaminated air by using general ventilation.
    - Secondary environmental controls consist of controlling the airflow to prevent contamination of air in areas adjacent to the source airborne infection isolation (AII) rooms; and cleaning the air by using high efficiency particulate air (HEPA) filtration.

3. Respiratory-Protection Controls: Consists of the use of personal protective equipment in situations that pose a high risk of exposure to TB disease.

    - Implementing a respiratory protection program;
    - Training healthcare personnel on respiratory protection; and
    - Educating patients on respiratory hygiene and the importance of cough etiquette procedures.

B. The Tuberculosis Control Plan was developed and approved by the Administrative staff and the Board of Directors, who have ultimate responsibility for the development of programs that create a safe work environment for the employees.

The Infection Prevention and Control Committee has the authority for implementation and ongoing evaluation of the TB Control Plan. Leadership is responsible for monitoring compliance with the plan. All employees are expected to follow the policies and procedures contained in the TB Plan.

Risk assessment includes:

A. Analysis of the number of infectious TB patients admitted to the facility and each area in the facility
B. Analysis of Healthcare Worker (HCW) Tuberculin Skin Test (TST) conversion and possible patient-to-patient TB transmission.
C. Analysis of the management of infectious TB patients in the hospital, drug susceptibility patterns, and adequacy of treatment of TB patients.
D. Analysis of relevant current epidemiological information for the geographic area (locally, statewide and nationally)

SECTION III - PROTOCOL FOR EARLY DETECTION

In order to protect healthcare workers, patients and visitors from exposure to tuberculosis, patient (across all SVMC entities) with known or suspected infectious tuberculosis will be promptly screened and identified. Control measures will be employed in accordance with this policy and local, state, and federal regulations. *See other SVMC entity-specific policies as appropriate.*

Characteristics of TB:

Symptoms of TB disease depend on where in the body the TB bacteria are growing. TB bacteria usually grow in the lungs (pulmonary TB). TB disease in the lungs may cause symptoms such as:

A. Signs and symptoms of active TB:
    1. Productive, persistent cough of 3 weeks (or longer) duration (unclear etiology)
    2. Purulent of bloody sputum/phlegm from deep inside the lungs (hemoptysis)
    3. Night sweats
    4. Pleuritic chest pain
    5. Unexplained weight loss
    6. Loss of appetite (anorexia)
    7. Easy fatigability
    8. Fever of unknown origin

Symptoms of TB disease in other parts of the body depend on the area affected.

B. Certain groups experience disease and infection rates substantially in excess of the general population. These groups include:

1. Persons with certain comorbid medical conditions: diabetes, cancer, and HIV infection alter the immune system's ability to fight TB
2. Babies and young children with weak immune systems
3. Geographic disparities:
    a. Foreign-born persons from high prevalence countries
    b. Medically underserved low-income populations, including high risk minority, African American, Hispanics, Native Americans and Southeast Asians
    c. Certain other populations that have been identified locally as having an increased prevalence of TB
4. Close contacts with known infectious TB cases
5. Alcoholics and intravenous drug users
6. Resident of high-risk congregated settings:
    a. Long-term care facilities (e.g., correctional facilities, skilled nursing)
    b. Homeless

C. Medical Risk Factors:

1. Persons with HIV infection
2. Silicosis
3. Abnormal chest radiograph showing fibrotic lesions
4. Prolonged corticosteroid therapy
5. Organ transplants
6. Immuno-suppressive therapy
7. Hematologic and reticuloendothelial diseases
8. End-stage renal disease
9. Intestinal by-pass
10. Post-gastrectomy
11. Chronic malabsorption syndromes
12. Carcinomas of the oropharynx and upper GI tract or more below bodyweight
13. Ten percent (10%) or more below ideal bodyweight

SECTION IV - SCREENING AND DIAGNOSIS

Diagnostic measures/assessment should be initiated on any person with suspected TB. The nursing staff shall notify the primary physician/hospitalist of any symptoms suggestive of TB upon initial patient assessment.

A. Diagnostic measures may include:

1. History and physical examination
2. Tuberculin Skin Test (TST)
3. Blood Assay for Mycobacterium tuberculosis (BAMT); Interferon Gama Release Assay (IGRA) or QuantiFERON-TB Gold test
4. Chest X-Ray
5. AFB sputum smear and culture
6. Others as prescribed

B. Tuberculin Skin test (TST): *See TST – ADMINISTRATION AND INTERPRETATION OF TB SKIN TEST POLICY*

1. Only designated personnel who have completed documented in-service training and have been shown to be competent will be permitted to administer and interpret the TST. Test may be given to employees, healthcare providers, and patients. Patient results will be entered into the medical record.

2. Two-step TST Testing is used for new employees

C. Notification of the Nursing Unit and Infection Prevention Department

1. In addition to notifying the nursing unit, the Infection Prevention Department shall be notified (ext. 37812795 or 47222781; Fax at 791-38719) by any person on the healthcare team in a timely manner of any suspect or confirmed TB diagnosis.

2. Notification can be accomplish by:

   a. The **nursing units** should notify Infection Prevention **ASAP** when placing a patient in Airborne Precautions
   b. **Physicians** can notify the nursing units/IP Department
   c. The interpreting **radiologist** (or Imaging designee) shall be responsible for immediately notifying attending imaging staff, who will inform the nurse and Infection Prevention of any abnormal radiological findings suggestive of TB
   d. The **laboratory** will notify the nursing unit, physician and Infection Prevention of any **positive** results of in-patient AFB smears, cultures or TST as soon as possible.
   e. **Pharmacy** should notify the Infection Prevention Department when a patient has been placed on a new regimen of TB medications.

SECTION V - MANAGEMENT AND ISOLATION OF PATIENTS WITH POSSIBLE TUBERCULOSIS

A. Decision to place in Airborne Precautions (See Figure 1)

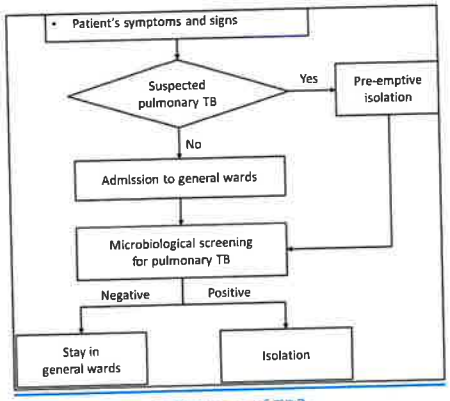
1. Signs and symptoms suggestive of TB can include:

    a. Productive, persistent cough 3 weeks duration (unclear etiology)
    b. Purulent or bloody sputum (hemoptysis)
    c. Night sweats
    d. Pleuritic chest pain
    e. Unexplained weight loss
    f. Loss of appetite (anorexia)
    g. Easy fatigability
    h. Fever of unknown origin
    i. Abnormalities (i.e., cavitation) in the chest X-Ray including apical and posterior segments of the upper lobe, in the superior segments of the lower lobe or diffuse nodular infiltrates

2. Any patient with signs and symptoms suggestive of TB, **and** any of the following circumstances will be considered suspect for TB and placed into Airborne Precautions as soon as possible:

    a. There is an order for sputum for AFB's
    b. There is an order for a Tuberculin Skin Test (TST)
    c. The physician writes "R/O suspect or confirmed TB"

Figure 1. **Decision to Place Patient in Airborne Precautions (suspect or confirm)**
Modified from Han, S., Park, J., Ji, S., *et al.*, 2021.



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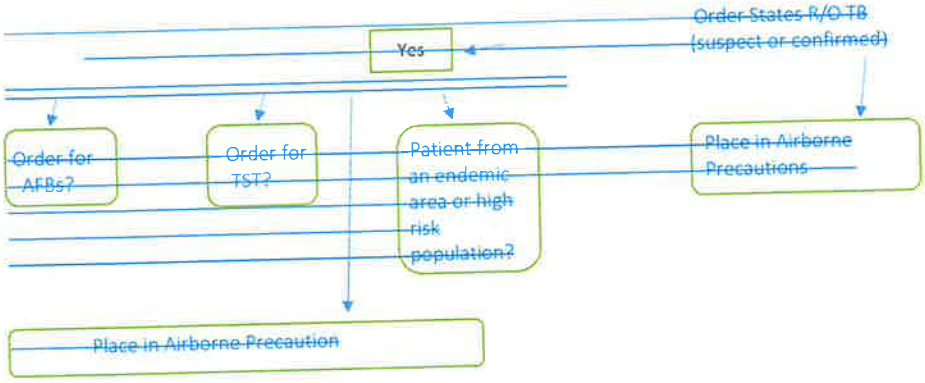

3. The physician, infectious disease physicians, nurse, nursing supervisor or infection preventionist shall have the authority to implement Airborne Isolation Precautions when signs and symptoms are suggestive of TB (suspected or confirmed). The physician and Infection Prevention Team should be consulted as part of the decision making process.

B. Airborne Precautions (Airborne Infection Isolation Room (AIIR)

When a patient is placed in Airborne Precautions, the following should take place:

1. Assure the room is negative airflow
2. An Airborne Precautions sign (caddy as needed) shall be placed on the door to the patient's room.
3. The door will remain closed, except when entering or leaving the room
4. A National Institute for Occupational Safety and Health (NIOSH) approved **respirator masks** should be donned by **all** staff (i.e., nursing, physicians, EVS, Lab, RT, Imaging, etc.) upon entering the room
5. **Standard Precautions** will be implemented in addition to Airborne Precautions (i.e., wear a gown and/or gloves if exposure to additional bod fluids is anticipated)

C. Airborne Infection Isolation Room (AIIR) Location

Designated Airborne Infection Isolation Rooms (AIIR) appropriate for the placement of patients with known or suspected TB are located in the following areas:

1. **Main Hospital:**

   a. Telemetry Department - Room 260

b. Medical Surgical Department – Room 360

2. If a room is not a designated AIIR, it may be able to be adapted with a HEPA filter.

D. Inpatients with known or suspected TB:

1. Patient must be placed in a designated room equipped with negative pressure ventilation which is exhausted to the outside or a HEPA filter unit placed at bedside.
2. Patients on treatment for infectious TB who are re-admitted to SVMC shall be placed in the above designated room until infectiousness is ruled out.
3. A care plan shall be initiated and implemented.
4. Notify the Infection Prevention Department to report all suspect and confirmed cases to Tulare County as soon as possible (Infection Prevention Department ext. 3795 or 3781).
5. Within 24 hours of diagnosis or strong suspicion of an active TB case, notification of the Tulare County TB Office must be done. The IP Team will initiate this process.
6. Adherence to Airborne Precautions/etiquette compliance by the staff and patient is mandatory.
7. Any incident of noncompliance with Airborne Precautions protocol shall be reported to the area Clinical Director/Manager.
8. The physician shall be notified if the patient will not comply with Airborne Precaution protocols.
9. The physician and/or nurse will provide the following education to the patient in respiratory precautions:
    a. Transmission of TB
    b. Reasons for respiratory precautions and importance of compliance
    c. Precautions, such as covering the mouth and nose with tissues when coughing or sneezing
    d. Importance of staying inside the patient's room
    e. Specific instructions for transportation to areas outside the patient's room

SECTION VI - OTHER CIRCUMSTANCES

A. Patient Movement to other locations:

1. A patient in Airborne Precautions shall not be routinely transported to other locations for a procedure/test unless it is deemed medically essential (and cannot be done in the patient's room).
2. If a patient in Airborne Precautions must be transported outside the patient's room for a medically essential procedure, the patient shall wear a surgical mask during the transfer and procedure. The mask should be changed if it is no longer effective (i.e., wet or soiled). If use of a mask is not possible during the procedure, the receiving department should use

Airborne Precautions. Patient should be placed in a single room with a HEPA-filter. Staff should don an N-95 respirator mask and follow other Standard Precautions (gown, face shield/goggles, gloves) if further exposure to body fluids is anticipated. Room should be exhausted for one hour (door closed) after the procedure with the HEPA-filter on.

3. If the patient requires mechanical ventilation, a HEPA-filter must be used on the expiratory side of the resuscitation bag or ventilator circuit, assuring a "closed" ventilation system. Portable ventilators are ***not*** equipped with closed circuit capability, therefore should not be used in transport of active TB ventilated patients.
4. The minimum respirator is a fitting face-piece respirator and must be selected from those approved by CDC/National Institute for Occupational Safety and Health (NIOSH) under Title 42 CFR, Part 84. It must meet one of the following specifications:
    - Non-powered air-purifying respirators (N-95)
    - Powered air-purifying respirators (PAPRs) with high-efficiency filters; or
    - Supplied-air respirators
5. Outside the patient room, during transport within the hospital or clinics, the employee does not need respiratory protection because the patient is wearing a surgical mask.
6. Staff should make **all** attempts to schedule the procedure at a time when it can be performed rapidly, when the patient is in a single room, and when waiting areas are less crowded (i.e., end of day).

B. Outpatients with known or suspected TB

1. Facility staff should be notified by physician's office staff in **advance** regarding a possible TB patient arrival.
2. Patient should be instructed to wear a mask upon entering the facility and practice appropriate respiratory etiquette (i.e., use tissues while coughing, proper disposal, etc.).
3. Place patient in a room equipped for Airborne Precautions. If not readily available, patient is to wear a mask until placed in an appropriate room.
4. When appropriate, schedule suspect TB patients at times to avoid contact with immunocompromised patients

C. Aerosol-generating (high hazard, cough-inducing) procedures (i.e., bronchoscopy, airway surgeries, intubation/extubation, non-invasive positive pressure ventilation (e.g., CPAP, BIPAP, open Suctioning of tracheostomy or endotracheal tube)

1. Minimize such procedures when possible.
2. Use the HEPA units for aerosol-generating procedures.
3. HCWs should utilize "Enhanced Airborne Precautions" during the procedure (i.e., N-95 respirator mask/PAPR, goggles/face shield, gloves and gown).

4. Following the procedure, confine the patient to the room or enclosure until coughing subsides or until patient is discharged. Have patient use tissues to contain any secretions.
5. Allow at least 1 hour following the procedure to remove any expelled droplet nuclei from the room.
6. Document precautions taken on the patient record, including area of recovery.

D. During Emergency Department/Urgent Care Services

Commented [JH1]: There is not an Urgent Care Department or services offered any longer.

1. The patient shall wear a surgical mask when being transported via emergency medical services (EMS) if TB is suspected or confirmed. Staff should be alerted to a possible TB patient.
2. The suspect patient should be provided supplies for respiratory etiquette (mask, tissues and hand sanitizer) and instructed on respiratory hygiene. This process should begin in the waiting room. The patient should be separated from other patients as soon as possible.
3. The patient should be placed in an Airborne Precaution room, if possible. If not, a separate room with HEPA filtration is recommended. Airborne Precautions should be implemented.
4. A mask should be worn at all times by the patient, until sufficient arrangements are made. The mask should be changed as necessary (i.e., when wet or soiled).
5. The patient should be processed as quickly as possible through the emergency or urgent care system.

E. Operating Room (OR):

1. Elective operative procedures shall be deferred, if possible, until TB is no longer infectious.
2. OR procedures that must be done shall be completed with the door closed and traffic minimized.
3. If possible, procedures shall be performed at the end of the day.
4. A bacterial filter shall be placed on the endotracheal tube and/or expiratory side of the anesthesia breathing circuit.
5. OR personnel shall wear an N-95 respirator mask instead of a surgical mask during the procedure.
6. HEPA filtration should **not** be used during the operative procedure due to disruptions of normal air flow.
7. HEPA filtration will be required for air scrubbing the environment post-operation after the patient has been removed from the OR suite. Note: The HEPA unit must be disinfected prior to entry into the operating room.
8. Allow the HEPA-filter unit to run for at least 60 minutes after the patient has vacated the room.

9. Recovery shall be in an individual room meeting ventilation requirements.

F. PPD Positive Obstetric Patients

1. Obstetric patients and their newborns will be provided quality effective care that meets the requirements for effective management of TB.
2. Positive PPD skin test obstetric patients should have a documented chest radiograph in their medical records to verify disease status.
3. Asymptomatic PPD positive obstetrics patients **with** a documented x-ray within the last year do not require any additional precautions related to TB upon admission
4. Asymptomatic PPD positive obstetrics patients **without** a documented chest x-ray within the last year will require a chest x-ray as soon as possible after delivery. They (as well as the infants) will not require any additional precautions related to TB upon admission until the status of the x-ray is determined.

5. **Symptomatic positive PPD** patients will require Airborne Precautions:
   a. Separation may be necessary:
      1) Mothers who are too ill to care for their infants or who need higher levels of care.
      2) Neonates at higher risk for severe illness (e.g., preterm infants, infants with underlying medical conditions, infants needing higher levels of care).
   b. If the neonate remains in the mother's room, measures that can be taken to minimize the risk of transmission from a mother with symptomatic TB to her neonate include:
      1) Mothers should wear a mask and practice hand hygiene during all contact with their neonates. **Note**: Plastic infant face shields are not recommended and masks should **not** be placed on neonates or children younger than 2 years of age.

6. If an obstetric patient is undergoing active treatment for TB, the staff will contact the Infection Prevention Department. The Infection Prevention Department will communicate with the Tulare County TB Office. A determination will be made regarding the patient's current infectious status. Precautions will be taken if necessary. The Birth Center will notify the Infection Prevention Department when the patient is discharged. The Infection Prevention Department will notify Tulare County of the discharge.

SECTION VII - ENGINEERING CONTROLS

A. Ventilation
   1. Local exhaust ventilation

a. Air from ventilation devices in the patient room is directly exhausted to the outside of the building, away from air intake vents.
b. Precaution rooms and rooms used for treatment have a minimum of twelve (12) air exchanges per hour. Air is exhausted to the outside and not recirculated.

B. Negative Pressure Rooms (AIIR)

1. Monitoring
   a. Negative airflow pressure rooms are kept at a constant "negative pressure". An alarm will notify HCW if negative pressure is disrupted. HCW may notify the Engineering Department for assistance.

C. HEPA Filtration

A HEPA air filtration unit is a portable device used to "clean" the air of a non-negative pressure patient room or area by creating high efficiency particulate air filtration (removal of respirable particles).

1. Installation of Unit

   a. Call Engineering when a HEPA unit is needed in a patient room.
   b. Engineering staff will install the unit in required area as per nursing staff and use appropriate particulate respirator and other protective equipment, as required due to patient condition.

2. Monitoring

   Negative airflow pressure check is conducted by engineering. AIIR rooms are kept at a constant "negative pressure". An alarm will notify HCW if negative pressure is disrupted. HCW may notify the Engineering Department for assistance.

3. Unit Removal

   Upon notification from nursing that the unit is no longer necessary:

   a. Engineering will be called to remove the HEPA unit.

b. HEPA unit will remain "ON" in the patient's room (to scrub the air) for at least one (1) hour, prior to being removed by Engineering (necessary only if patient had infectious TB).
c. Unit will be cleaned by Environmental Services staff.
d. Intake filter will be removed and cleaned in a non-common open area by Bio-med every 3 months.
e. Unit will be stored by Engineering.

4. Maintenance Procedure

a. HEPA filters are to be properly installed, tested, and maintained per manufacturer's instructions. HCW will maintain documentation in the patient's record indicating the time that the unit was used.
b. Filters are to be installed to prevent leakage between filter segments and between the filter bed and its frame.
c. A pressure sensing device in the filter system will determine the need for filter replacement. Changes will take place per manufacturer's recommendations by Engineering.
d. Installation should allow for maintenance without contaminating the delivery system or area served.
e. Engineering personnel are adequately trained on the installation and maintenance procedures. Respiratory protection is worn during maintenance and testing.

SECTION VIII - DISCHARGE PLANNING

A. Discontinuance of Airborne Precautions:

1. The following persons are authorized to discontinue isolation:
   a. Attending physician
   b. Infection preventionist
2. Isolation may be discontinued if the patient is:
   a. On effective therapy (usually four TB drugs)
   b. Clinically improving
   c. 3 daily consecutive sputum smears for AFB are rare or negative
   d. With permission of Tulare County Health Department
   e. When patients are found not to have infectious TB

B. TB Inpatient Notification/Discharge Planning:

Every health care provider who provides treatment for a patient with active tuberculosis must promptly report to the local health officer each diagnosis or suspected diagnosis of active TB. Also reportable are instances when the patient discontinues treatment for active TB.

A healthcare facility cannot discharge a person who is known or reasonably suspected to have active TB until after the discharge plan for the patient is approved by Tulare County.

To comply with the above regulations, the Infection Prevention Department will be the overall coordinator for the reporting process. Problems or concerns should be directed to the Infection Prevention Department. However, a team approach should be used to facilitate the initial reporting mechanism and discharge planning process between the facility and the Tulare County Health and Human Services Agency (TCHHSA) TB Office. Nursing, the patient's physician, Case Management and the Infection Prevention Practitioner will collaborate to expedite the communication of information necessary to report TB cases and to obtain approval for the patient's discharge plan.

1. Within **24 hours** of diagnosis or strong suspicion of an active TB case (i.e. patient with symptoms suggestive of TB, positive chest radiograph with positive PPD or AFB smear), notification of the Tulare County TB Office must be done. Nursing staff or the patient's physician shall notify the IP Nurse to initiate this process.

2. When the Infection Preventionist receives notice of the patient actual or suspected diagnosis, the completed TB Suspect Case Report will be faxed or input in CalREDIE by the IP.

3. The Infection Preventionist and staff will communicate with Tulare County TB Office as necessary, to facilitate patient treatment/progress. Documentation of any communication shall be recorded in the patient's medical record.

4. As soon as a projected discharge date is known and at **least one day prior to discharge,** the Tuberculosis Discharge Treatment Plan will be completed and faxed to the Tulare County TB Office by IP.

5. Notification of approval of the discharge plan will be sent from the Tulare County TB Office within approximately 24 to 48 hours after the plan was submitted as above. **The patient may not be discharged prior to receiving approval of the TB discharge plan.** If the patient refuses to wait for the facility to receive the approved discharge plan form from the Health Department, the patient must sign out AMA and the TCHHSA TB Office must be informed immediately by hospital staff.

6. For medically necessary transfers to other acute care hospitals or correctional institutions, notification of the Tulare County TB Health Officer should be done ASAP. Document in the

patient's medical record that the transfer was reported and to whom it was reported. The TB discharge plan will need to be completed.

SECTION IX - RESPIRATORY PROTECTION OF EMPLOYES/FIT-TESTING

A. All employees are required to wear a NIOSH-approved N-95 respirator mask upon the entrance into an Airborne Precautions Room (AIIR) and will be fit-tested by Employee Health Services (EHS).

B. Sealing the mask around the nose and mouth.

C. The mask must be "seal checked" for an effective seal each time before entry into an Airborne Precautions room. To do so, blow forcefully into the mask as it expands. The wearer should not feel air escaping around the edges of the mask.

D. As with any disposable mask, N-95 respirator masks shall be removed and disposed of immediately after a single use.

SECTION X - EVALUATION OF CONVERSIONS/TRANSMISSION

A. Exposure to TB in a HCW (See APPENDIX D: Employee Health Policy *Tuberculosis screening Program* and Employee Screening Form)

1. A contact investigation among other HCWs, patients, and visitors after a confirmed exposure to active TB will be initiated by Infection Prevention and Employee Health.
2. The Infectious Disease Department Chair will also be consulted.
3. Employee Health and Infection Prevention will follow current CDC recommended guidelines for exposure of employees (i.e., baseline TST and follow up at 10 weeks).
4. An employee exposure line list will be developed. Any employee converting to positive will be managed by Employee Health. Appropriate measures will be implemented based on each individual case.
5. Previous positive TST employees will be evaluated for symptoms and will be recommended for a chest x-ray.
6. The Tulare County Office will be notified for community contact investigation and consultation as required.
7. Investigation will be performed to determine the cause of transmission.
8. An evaluation of the TB exposure/TB Control Plan and processes will be conducted, with possible opportunities for improvement to be developed and recommendations implemented.
9. Summary of findings and recommendations will be presented to the Infection Prevention Committee.

B. Patient-to-Patient/Visitor TB Transmission

1. Surveillance will be conducted by Infection Prevention to determine any additional cases of TB transmission related to other patients and visitors.
2. Potential patient/visitor (as possible) exposures will be identified and the primary physician will be notified for recommended follow-up.
3. Tulare County TB Office will be notified as necessary.

C. Exposure Follow-up for Unrecognized TB at Time of Hospitalization

1. Investigation will be conducted to determine areas and persons potentially exposed.
2. All persons exposed shall be handled as above in A and B.

SECTION XI – DEFINITIONS/VOCABULARY

Acid-fast bacilli (AFB) - Bacteria that retain certain dyes after being washed in an acid solution. Most acid-fast organisms are mycobacteria. When AFB are seen on a stained smear of sputum or other clinical specimen, a diagnosis of TB should be suspected; however, the diagnosis of TB is not confirmed until a culture is grown and identified as M. tuberculosis.

Active TB - TB bacteria are dividing and multiplying within an affected individual's body, causing tissue and organ damage. A person with active TB is likely to be or soon become symptomatic.

Aerosol - The droplet nuclei that are expelled by an infectious person (e.g., by coughing or sneezing); these droplet nuclei can remain suspended in the air and can transmit M. tuberculosis to other persons.

Anergy - The inability of a person to react to skin-test antigens (even if the person is infected with the organisms tested) because of immunosuppression.

Bacille Calmette-Guérin (BCG) – The only vaccine currently used to prevent tuberculosis. It was developed by the French scientists Albert Calmette and Camille Guérin at the Institute Pasteur, Lille, between 1907 and 1921. It is a living, attenuated (weakened) variant of the bovine tubercle bacillus.

Bronchoscopy - Examination of the airways by means of a flexible or rigid tube. Modern instruments are fiber-optic and highly flexible and they enable specimens to be obtained from the lung by aspiration, washing, brushing and biopsy.

Cavity, pulmonary - A necrotic tuberculous lesion which communicates with the airways, enabling tubercle bacilli to enter the sputum and to be coughed out.

Cluster - Two or more PPD skin-test conversions occurring within a 3-month period among HCWs in a specific area or occupational group, and epidemiologic evidence suggests occupational (~~nosocomial~~hospital acquired) transmission.