SIERRA VIEW
MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
465 West Putnam Avenue, Porterville, CA – Board Room

AGENDA
July 25, 2023

OPEN SESSION (5:00 PM)

The Board of Directors will call the meeting to order at 5:00 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 5:05 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:30 P.M. In person attendance by the public during the open session(s) of this meeting is allowed in accordance with the Ralph M. Brown Act, Government Code Sections 54950 et seq.

Call to Order

I. **Approval of Agendas**
Recommended Action: Approve/Disapprove the Agenda as Presented/Amended

The Board Chairman may limit each presentation so that the matter may be concluded in the time allotted. Upon request of any Board member to extend the time for a matter, either a Board vote will be taken as to whether to extend the time allotted or the chair may extend the time on his own motion without a vote.

II. **Adjourn Open Session and go into Closed Session**

CLOSED SESSION (5:01 PM)

As provided in the Ralph M. Brown Act, Government Code Sections 54950 et seq., the Board of Directors may meet in closed session with members of the staff, district employees and its attorneys. These sessions are not open to the public and may not be attended by members of the public. The matters the Board will meet on in closed session are identified on the agenda or are those matters appropriately identified in open session as requiring immediate attention and arising after the posting of the agenda. Any public reports of action taken in the closed session will be made in accordance with Gov. Code Section 54957.1

III. **Closed Session Business**

A. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b): Chief of Staff Report

B. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b):

1. Evaluation – Quality of Care/Peer Review/Credentials

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54956.9(d)(2): Conference with Legal Counsel; Anticipated Litigation

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets (1 Item). Estimated Date of Disclosure – December 2023

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets; Pertaining to Service (1 Item) Estimated Date of Disclosure – October 2024

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets (1 Item). Estimated Date of Disclosure – December 2024

G. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Strategic Planning (1 Item). Estimated Date of Disclosure – February 2026

H. Pursuant to Gov. Code Section 54956.9(d)(2), Conference with Legal Counsel about recent work product (b)(1) and (b)(3)(F): significant exposure to litigation; privileged communication (1 Item)

To the extent items on the Closed Session Agenda are not completed prior to the scheduled time for the Open Session to begin, the items will be deferred to the conclusion of the Open Session Agenda.

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

Pursuant to Gov. Code Section 54957.1; Action(s) to be taken Pursuant to Closed Session Discussion

A. Chief of Staff Report
Recommended Action: Information only; no action taken

B. Quality Review

1. Evaluation – Quality of Care/Peer Review/Credentials
Recommended Action: Approve/Disapprove Report as Given

2. Quality Division Update –Quality Report
Recommended Action: Approve/Disapprove Report as Given

C. Conference with Legal Counsel
Recommended Action: Information only; no action taken

D. Discussion Regarding Trade Secret
Recommended Action: Information only; no action taken

E. Discussion Regarding Trade Secret
Recommended Action: Information only; no action taken

F. Discussion Regarding Trade Secret
Recommended Action: Information only; no action taken

G. Discussion Regarding Trade Secret
Recommended Action: Information only; no action taken

H. Conference with Legal Counsel about recent work product
Recommended Action: Information only; no action taken

VI. Public Comments

Pursuant to Gov. Code Section 54954.3 - NOTICE TO THE PUBLIC - At this time, members of the public may comment on any item not appearing on the agenda. Under state law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public may make comments at this time or present such comments when the item is called. This is the

time for the public to make a request to move any item on the consent agenda to the regular agenda. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all interested parties have an opportunity to speak with a total of thirty (30) minutes allotted for the Public Comment period. Please state your name and address for the record prior to making your comment. Written comments submitted to the Board prior to the Meeting will distributed to the Board at this time, but will not be read by the Board secretary during the public comment period.

VII. Consent Agenda
Recommended Action: Approve Consent Agenda as presented

Background information has been provided to the Board on all matters listed under the Consent Agenda, covering Medical Staff and Hospital policies, and these items are considered to be routine by the Board. All items under the Consent Agenda covering Medical Staff and Hospital policies are normally approved by one motion. If discussion is requested by any Board member(s) or any member of the public on any item addressed during public comment, then that item may be removed from the Consent Agenda and moved to the Business Agenda for separate action by the Board.

VIII. Approval of Minutes

A. **June 27, 2023 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove June 27, 2023 Minutes of the Regular Meeting of the Board of Directors

IX. CEO Report

X. Business Items

A. June 2023 Financials
Recommended Action: Approve/Disapprove

XI. Announcements:

A. Regular Board of Directors Meeting – August 22, 2023 at 5:00 p.m.

SIERRA VIEW MEDICAL CENTER

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
July 25, 2023

XII. Adjournment

PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa Mitchell, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, Monday – Friday between 8:00 a.m. – 4:30 p.m. Such request must be made at least 48 hours prior to the meeting.

PUBLIC NOTICE ABOUT COPIES

Materials related to an item on this agenda submitted to the Board after distribution of the agenda packet, as well as the agenda packet itself, are available for public inspection/copying during normal business hours at the Administration Office of Sierra View Medical Center, 465 W. Putnam Ave., Porterville, CA 93257. Privileged and confidential closed session materials are/will be excluded until the Board votes to disclose said materials.

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Senior Leadership Team	7/25/2023
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	7/25/2023

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
July 25, 2023
BOARD OF DIRECTOR'S APPROVAL

The following Polices/Procedures/Protocols/Plans have been reviewed by Senior Leadership Team and are being submitted to the Board of Director's for approval:

	Pages	Action
Policies:		Approve ↓
1. Access to Closed Circuit Surveillance System Images	1-2	
2. Code Gray | Visitor or Patient Out of Control	3-4	
3. Code Green | Missing Patient or Resident	5-6	
4. Flooding Response Plan	7-9	
5. Licenses and Permits – Required Governmental	10	
6. Participant Input of the Retirement Policy	11-12	

SUBJECT: **ACCESS TO CLOSED CIRCUIT SURVEILLANCE SYSTEM IMAGES**	SECTION: ***Security Management***

PURPOSE:

To ensure the safe and appropriate management of the Closed Circuit Surveillance System (CCSS) security system in accordance with local, state and federal laws. The CCSS system is for the prevention or detection and investigation of a crime or disorder, apprehension and prosecution of offenders (including use of images as evidence in criminal proceedings) in the interest of public and employee Health and Safety, and protection of Sierra View Medical Center property and assets.

POLICY:

Sierra View Medical Center is conscious of its responsibilities to ensure that all CCSS systems comply with local, state, and federal laws. Sierra View Medical Center is seeking to use the CCSS System to maintain optimum levels of safety and security for patients, staff, visitors and the general public. SVMC is also conscious that it must not breach issues affecting a person's civil liberties and matters of privacy. An employee representing themselves and the images may be required for investigation related to harassment, workmen's compensation, or relation to a criminal incident. The monitoring and any subsequent viewing of images must take place in a secure environment to which only authorized personnel have access. Authorized personnel may include: *Safety Officer or Designee, Security Supervisor/Officers, I.T. Data Technicians, and Risk Management. This may also include law enforcement agencies and personnel involved in a specific investigation.*

The CCSS Closed Circuit Television System will be audited by the Safety Officer.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS

PROCEDURE:

To enable Sierra View Medical Center to deal promptly with your request for access, please complete the attachment **"ACCESS TO CCSS IMAGE REQUEST FORM"** giving information such as, *dates, times and locations* as to assist in identifying your personal data.

Local, state and federal laws give any individual the right to request access to CCSS images.

1. To request a form: use any of the below listed options:

   a. Approval Data Base

   b. Safety / Security Officer

   c. Security Supervisor

d. Risk Management

e. Department Director

2. Safety Officer will review all requests.

3. All CCSS images that are requested to be removed from Sierra View Medical Center:

a. Must be approved by the Safety Officer and Risk Management

b. All copies are to be printed by the I.T. Department.

c. When CCSS images are required for evidential use in legal actions or Sierra View Medical Center disciplinary proceedings, a digital disc recording is made by the I.T. Department and placed in a sealed envelope signed and dated and held by the Safety / Security Officer or Security Supervisor until the investigation has been completed.

d. Viewing of images within the security office is controlled by the Security Supervisor or designee.

e. Only persons trained in the use of the CCSS equipment and authorized by the Security Supervisor may access image data.

Copies of all requested documentation and records related to the CCSS requests will be held within the Security Department and will be kept for a period of 10 years.

REFERENCES:

- Access to CCSS Image Request Form

SUBJECT:	SECTION:
CODE GRAY - VISITOR OR PATIENT OUT OF CONTROL	*Security Management* **Page 1 of 2**

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

PURPOSE:

To ensure a timely response to situations involving an actual or potential physical threat to patients, volunteers, students, physicians, employees, visitors or property. It is the policy of this Hospital's security program that when dealing with a confrontational and/or combative patient, personnel and/or visitor with or without a weapon, the Security Department will be called.

POLICY:

All personnel will be encouraged to recognize activities leading to actual or potential physical threats to patients, physicians, volunteers, students, personnel, visitors or property.

Prompt action will be taken to secure assistance needed to stabilize situations that could lead to bodily harm and/or property damage.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS

PROCEDURE:

- When any employee, volunteer or physician perceives that the situation may/or has become threatening verbally or physically, they should call the hospital operator. They should Dial Stat "55" and state "Code Gray" then give their location. The operator will then page overhead, three times, "Code Gray" with the location. The operator will repeat the Code Gray announcement on the hand held two way radio. Security Officers will respond to the location on a "Stat" basis.

- Employees at the Medical Office Building, Cancer Treatment Center, Urology Clinic, Wound Care Clinic and Ambulatory Surgery Department will call 911 first and inform the Porterville Police Department of the situation. The Medical Office Building, Surgery Clinic and Cancer Treatment Center will contact the operator by calling "55"; The Ambulatory Surgery Department will contact the hospital operator at 784-1110.

- When Security Department personnel arrive at the scene, they will obtain information regarding the incident from the person who has had initial contact with the individual(s) who are causing the actual or potential threat. Security Department personnel will assess the situation to see if it can be handled appropriately and safely with the number of personnel at the scene. If assistance is required, they will call the Engineering Department via the two way radio "Stat" to the location.

- Security Department personnel may take other action, which may be to call local law enforcement officers and to arrest and restrain the suspect if persons and/or property are at risk.

- The individual calling for the Code Gray will complete an electronic occurrence report documenting the situation, and security personnel shall complete a security incident report form within the immediate shift. The occurrence report form will be forwarded to Risk Management for review. The

security incident report will be sent to the Safety Officer for review. All security incident reports will be discussed at the Safety Committee for action as appropriate.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. EC 02.01.01 EP10 Joint Commission Resources. Oak Brook, IL.

SIERRA VIEW MEDICAL CENTER

SUBJECT:	SECTION:
CODE GREEN - MISSING PATIENT OR RESIDENT	***Security Management***

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

PURPOSE:

To designate the responsible positions and actions to have an organized approach for the search and retrieval of a missing patient or resident within the facility or on the grounds of Sierra View Medical Center.

POLICY:

A patient or resident not accounted for within their assigned unit will be designated as a "CODE GREEN" situation. Any time a patient or resident is determined to be absent from their assigned unit, a "CODE GREEN" will be called by the Nursing staff to quickly locate and return the patient / resident to their unit.

To reduce the potential of a "CODE GREEN" occurrence, all alarm systems and designated exterior doors will be maintained activated and locked at all times. Exterior doors will not be propped open.

AFFECTED PERSONNEL/AREAS: *GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS*

PROCEDURE:

Nursing Services:

When a patient or resident is suspected of being absent from their assigned area, Nursing staff will conduct a thorough search of the unit to locate the patient or resident. A "CODE GREEN" situation will be called immediately if the unit search is unsuccessful in locating the missing patient/resident. The code will be instituted by calling the hospital operator and informing the operator of the "CODE GREEN" situation. The operator will be provided with the name of the patient, description of the missing patient/resident, time the patient was last seen and the name of a contact person on the unit.

It is the responsibility of the Nursing staff to contact the Administrator on Call during normal business hours and the House Supervisor after hours. The Nursing staff is to keep the AOC or House Supervisor informed of the situation and the outcome. If the patient is not found by Engineering/Security during the facility/grounds search the Nursing staff is responsible for contacting the Porterville Police Department Immediately.

Hospital Operator:

Upon receiving the "CODE GREEN" call, the operator will immediately announce the "CODE GREEN" by overhead paging system, repeating the announcement three times. The operator will note the missing patient or residents first name and description to aid in the search process. The operator will then page the "CODE GREEN" over the two-way radios to Security and Engineering giving the missing patient or resident's name, description and the last time they were seen by the nursing staff on the unit.

House Supervisor:

If the missing patient/resident has a high profile or is high risk the House Supervisor is to contact the Administrator on Call; otherwise the House Supervisor is to log the situation in the 24 hour log book.

Engineering & Security Personnel:

Upon hearing the "CODE GREEN" announcement will immediately obtain the patients name and description and begin an organized search of the entire facility and grounds to locate the missing individual.

Upon locating the missing patient/resident, the Engineering or Security personnel will immediately notify the nursing unit for staff to be dispatched to assess the physical condition and return the missing individual to their assigned area.

If the patient is not willing to return to the nursing unit, and the patient is not an immediate harm to themselves or others and is able to understand the risks of leaving, they are not to be forced to return. Law enforcement is to be notified. Notification shall include: Patients Name, Description, Last Known Location, and any known safety risks associated with the patient having left prior to the completion of treatment (I.V. access, Suicidal, etc). Nursing is to document this in the patient's record.

If the missing patient/resident is not found, Engineering or Security will contact the nursing staff. Engineering or Security will also notify the operator so the code could be called ALL CLEAR. Hospital Staff is not to leave the perimeters of the facility.

Upon resolution of the "CODE GREEN" situation the Hospital will announce a "CODE GREEN" ALL CLEAR, three times. The affected department will complete a Hospital Occurrence report documenting all information related to the code situation and forward the occurrence report to Risk Management for review.

Offsite Hospital Locations:

When a patient or resident is suspected of being absent from their assigned area, Nursing staff will conduct a thorough search of the unit and the grounds outside to locate the patient.

If staff is unable to locate the patient the nursing staff must contact the Administrator on Call and inform them of the situation. In addition Nursing Staff is to contact the Porterville Police Department also.

REFERENCES:

- The Joint Commission (2023) Hospital accreditation standards. EC.02.01.01 EP10 Joint Commission Resources. Oak Brook Il.

SUBJECT: **FLOODING RESPONSE PLAN**	SECTION: *Special Circumstances* **Page 1 of 3**

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

PURPOSE:

The purpose of this plan is to provide guidance for Sierra View Medical Center staff, medical staff, volunteers and students for the protection of patients and facilities in the event of a weather related event that could result in flooding of the Sierra View Medical Center campus.

POLICY:

The response to floods will follow the "Scope of Response" approach established in the organization's Emergency Management Program and the Emergency Operations Plan. The Nursing House Supervisor and/or Administrator On Call, Safety Officer and Facilities Manager will determine the adverse impact of the weather situation on the operations of the institution and may decide to activate the Emergency Operations Plan.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS

PROCEDURE:

The Nursing House Supervisor or the Administrator On Call will contact all Senior Management personnel and implement the Hospital Incident Command System (HICS). The Hospital Incident Command System members are responsible for notifying all Department Directors. The Facilities Manager will provide continuous updates to the Incident Commander regarding the physical condition of the facilities that are being affected by rising water. The *Alert System Matrix* will be utilized by the Incident Commander and Plant Operations as an indicator for preparation of the facility.

- **Stage I** - "Flood Caution" -Flooding conditions possible. Heavy storms expected and could produce 10 – 20% chance of flooding.
- **Stage II** – "Flooding Possible"- 40 – 50% chance of flooding if storms persist. Stay in touch with emergency personnel.
- **Stage III** – "Flooding Probable"- 80 – 90% chance of flooding.

SVMC – Alert System Matrix

Alert System*	Plant Operations	Incident Commander
Stage I	1. Check supplies 2. Check & test pumps 3. Check generators 4. Obtain sand bags 5. Review call down lists & personnel rosters	1. Advise Dept. Managers 2. Review elective and outpatient scheduling for suspension of services
Stage II	1. Set up Incident Command Center (ICC) 2. Place sand bags at affected entry doors 3. Check roof and storm drains 4. Coordinate with Security Department, and dept-specific preparedness activities 5. Evacuate all hospital staff from ground level.	1. Secure non-essential departments and offices. 2. Release non-essential personnel 3. Implement specific departmental plans for departments at Ground Level and First Floor. 4. Consider de-energizing high voltage systems at ground level and first floor.

Stage III	1. Close building 2. Place remainder of sand bags at exits. 3. Shut down and secure non-essential equipment. 4. Review start-up procedures with building operations personnel. 5. Refer to Tulare County Emergency Services and City of Porterville EOC for further guidance & recommendations. 6. Make preparations for a possible evacuation of patients and personnel.	1. Incident Command is updated by Managers on condition of their department / buildings

REFERENCES:

- Alert System Matrix – See page 2 and 3 above.

SUBJECT:	SECTION:
LICENSES AND PERMITS-REQUIRED GOVERNMENTAL	*Leadership (LD)* **Page 1 of 1**

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

PURPOSE:

To establish and define Sierra View Medical Center (SVMC)'s compliance with maintaining the appropriate licenses and permits as mandated by applicable governmental agencies.

POLICY:

In accordance with applicable law and regulation, SVMC has and will maintain current and compliant those licenses and permits required for the provision of care and treatment specific to the services offered at SVMC as established by Federal, State, County and City entities. SVMC will comply with all the requirements for maintenance and posting of such documents as set forth by the authority having said jurisdiction.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

REFERENCES:

- 42 CFR § 482.11(b)(1) & 482.11(b)(2)- Condition of participation: Compliance with Federal, State and local laws. Retrieved from https://www.law.cornell.edu/cfr/text/42/482.11.

SUBJECT:	SECTION:
PARTICIPANT INPUT OF THE RETIREMENT POLICY	***Human Resources***

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

PURPOSE:

To define a method for plan participants to provide input to the Retirement Plan Administration Committee (Committee) on any plan-related issues including asset classes or investment funds that they would like the Committee to consider.

POLICY:

The Committee will examine the risk/return objectives of each asset class, the investment sophistication of the entire set of participants, and the role played by the asset class in a prudent, diversified retirement savings portfolio.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

A. The Committee will accept requests at any time and will consider all community input. Requests received by December 31 will normally be considered during the Committee's first quarterly meeting of each calendar year. The Committee may consider and discuss requests at other Committee meetings at their discretion.

B. Any plan participant can make suggestions by providing them in writing to the below contact. To be considered, each request must be accompanied by a brief written explanation of the reason, concern, and objective for the request and how the change, if implemented, would benefit the entire plan participant population. Absent this information, the request will not be brought to the Committee.

Vice President of Human Resources
465 West Putnam Avenue
Porterville, California 93257
Email: tcanales@sierra-view.com

C. For investment-related requests, the Committee will consider investments objectives for the plan, including providing exposure to a range of asset classes with varying risk/reward profiles; optimizing returns within levels of risk that are reasonable and prudent for retirement plans with diversified investments; and controlling expenses consistent with service objectives.

D. The first step in considering a fund request is to determine whether that fund's asset class is or should be included as an asset class in the plan. The Committee will then screen specific fund requests against minimum requirements within an affirmed asset class and then perform a quantitative and qualitative evaluation. Both the asset class being considered as well as the potential investment product should be consistent with the current Investment Policy Statement for the Plan.

E. Consistent with Sierra View Local Health Care District's fiduciary responsibilities, the "popularity" or number of requests for a fund shall not be a factor in the Committee's recommendation.

The process for considering non-investment requests will be dependent on the type of request.

F. The Committee will acknowledge receipt of participant requests when received. Once the Committee has considered the request (typically at their first calendar-quarter meeting), the Committee will communicate the decision to the participant who made the request, along with the rationale for the decision.

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MEDICAL EXECUTIVE COMMITTEE	07/05/2023
BOARD OF DIRECTORS APPROVAL	
	07/25/2023
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
July 25, 2023 BOARD APPROVAL

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

	Pages	Action
I. Policies:		**APPROVE**
• Aminoglycoside Protocol Per Clinical Pharmacist	1-9	↓
• Assessment – Body	10-11	
• Autopsy – Securing of	12-13	
• Blanket Warmer	14	
• Bowel Management Protocol	15-16	
• Care of Residents with Dementia on the DP/SNF Unit	17-20	
• Clinical Dietitian Scope of Practice	21-24	
• Closets – Organizing/Cleaning	25	
• Communication Barriers, Reduction of	26	
• Confidentiality of Completion of MDS Data	27	
• Consumer Information	28-29	
• Controlled Substances	30-40	
• Death of a Resident	41-43	
• Deaths Reportable to the Coroner	44-45	
• Diet Orders	46-47	
• Discharge Planning DPSNF	48-49	
• DP/SNF Room Change	50	
• Equal Access to Quality of Care	51	
• Handwashing	52-55	
• Initial Resident Assessment and Reassessment – MDS	56-61	
• Leave of Absence, Therapeutic	62-64	
• Leave of Absence, Therapeutic Outing Checklist	65-67	
• MDS, Communicating/Tracking Medicare PPS Information	68-69	
• MDS, Diagnosis Coding on MDS Assessments and UB 92 Claim Forms	70-71	
• Malignant Hyperthermia (MH), Patient Treatment Guidelines	72-82	
• Massive Transfusion	83	
• Mattress – Air	84	
• Mattress – Alternating Air	85-86	
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• Medication Administration	89-97	
• Medication Ordering	98-116	
• Medication Pass Observation	117-118	
• Medication Reconciliation	119-121	
• Medications Restricted to Areas or Personnel	122-127	
• Menu Planning	128-131	

• Naming Conventions for the Master Patient Index (MPI)	132-133	
• Neonatal Hypoglycemia	134-140	
• Nourishments	141-142	
• Nursing Care, Restorative and Supportive	143-144	
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• Patient Education for Modified Diet	150-151	
• Physician Ordered Consultation	152	
• Physician's Services	153-156	
• Propofol (Diprivan)	157-159	
• Recall of Sterilized Items/Products	160-162	
• Referrals to Social Service Department	163	
• Residents' Fund Policy	164-166	
• Restraints, Chemical	167-172	
• Scope of Services – DPSNF	173-174	
• Siderails	175	
• Smoking Cessation	176-178	
• Social Service Role in the Admission of Residents	179-181	
• Sterile Products: Education and Competency	182-188	
• Therapeutic Drug Substitution Protocol	189-199	
• Transfer within Facility – Change of Room/Roomate	200-202	
• Tube Feeding	203-206	
II. <u>Forms</u>:		
• Anesthesia Pre-Operative Orders	207-208	
• Donor Milk Consent	209-210	

SUBJECT:	SECTION:
AMINOGLYCOSIDE PROTOCOL PER CLINICAL PHARMACIST	***Drug Protocols***

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

AFFECTED AREAS/PERSONNEL: *PHARMACY; NURSING; Providers*

PROTOCOL & PROCEDURE:

A. Patient Work-Up: Clinical pharmacist to perform initial evaluation of patient based upon available data.

1. Minimum required information:
    a. Age
    b. Sex
    c. Height
    d. Weight
    e. Serum creatinine
    f. Allergy history
    g. Indication of use
2. Reason for admission
3. Past medical & medication history
4. Vital signs & pertinent physical findings
5. Co-existing disease states
6. Current medications
7. Lab Data
    a. Urinalysis
    b. Chemistries
    c. Cultures & sensitivities
8. Other pertinent tests, results, and clinical data

B. Determine therapeutic goal(s): Using physician's database, determine therapeutic goals. If unclear, contact requesting physician to clarify matters. Indicate pharmacokinetic goals on initial work-up.

C. Using available pharmacokinetic software (or standard pharmacokinetic application equations), calculate dose(s), intervals based upon the therapeutic & pharmacokinetic data from population kinetic parameters.

D. Order doses & levels as appropriate to the patient's clinical condition.

1. If patient has received dose(s), evaluate active dosing parameters.
2. If the current order does not appear to be appropriate based upon the Therapeutic & Pharmacokinetic Goals, and population data kinetics, change the dose accordingly, as calculated. Indicate on pharmacy monitoring form reason(s) for changing dose/schedule.
3. Maintenance random levels should be performed weekly at minimum.

E. Adverse Events: If the clinical pharmacist suspects an adverse event, place the aminoglycoside on hold and inform the physician immediately of the circumstances.

SUBJECT: **AMINOGLYCOSIDE PROTOCOL PER CLINICAL PHARMACIST**	SECTION: ***Drug Protocols***

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

I. Extended Interval Dosing of Aminoglycosides

This is the preferred method when dosing for gram-negative infections. Extended Interval Dosing does NOT imply 24 hour dosing, but rather the use of empiric doses.

Rationale:
Aminoglycoside bactericidal activity is concentration dependent. The high the peak/MIC ratio, the greater the rate and extent of bacterial kill. The AUC: MIC targets are for efficacy range from AUC/MIC ratios of 30-50 in non-critically ill immunocompetent patients and upwards of 80-100 for critically ill patients with infections of high bacterial burden.

Aminoglycosides have a post-antibiotic effect. (PAE) PAE ranges from 0.5 to 8 hours are reported.

Saturable aminoglycosides uptake in renal tubule cell and inner ear. This suggests that higher peaks do not result in greater risk of toxicity. A single dose results in lower renal cortical tissue concentration compared to the same total dose administered through continuous infusion or in divided doses. Data suggests extended interval dosing may be less nephrotoxic compared to traditional regimens.

SVMC will utilize the Hartford Nomogram, which generally uses a dose of 7mg/kg of either gentamicin or tobramycin. The Urban & Craig Nomogram may be used in extended interval therapy using 5 mg/kg of gentamicin or tobramycin in patient without renal dysfunction. For patients with cystic fibrosis exacerbation guidelines recommend extended interval dosing with 10 mg/kg once daily.

Exclusion criteria for extended interval dosing:

- Renal insufficiency (CrCl <30 mL/min or rapidly declining renal function)
- Pregnancy
- Synergy for G+ infections
- Ascites
- Burns (>20%)

Conventional/Traditional dosing

Traditional dosing of aminoglycoside may include lower doses with more frequent scheduling using pk parameters to determine dose & frequency to achieve target peak and trough values.

Gram-positive synergy

This is characterized by a low dose of aminoglycoside given with another antimicrobial agent that exhibits activity against the cell wall of G+ bacteria.

SUBJECT:	SECTION:
AMINOGLYCOSIDE PROTOCOL PER CLINICAL PHARMACIST	***Drug Protocols***

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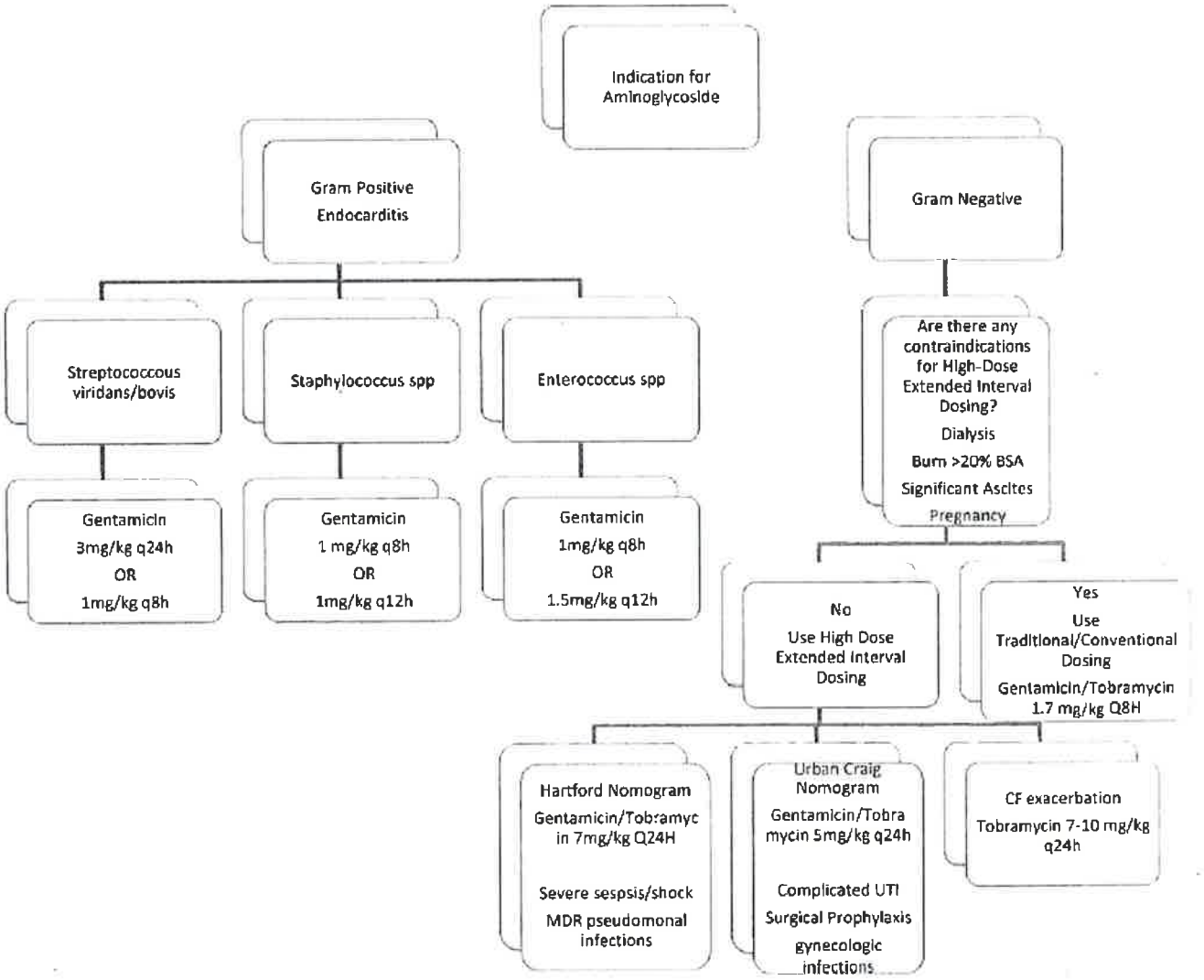

SUBJECT:	SECTION:
AMINOGLYCOSIDE PROTOCOL PER CLINICAL PHARMACIST	***Drug Protocols***

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High Dose Extended-Interval Nomogram (Gram Negative infections)

Initial Dose:

7mg/kg using actual body weight (Nomogram was developed and validated with actual body weight)
If obese use adjusted body weight. Adjusted body weight = IBW + (0.4(TBW-IBW))

CrCl (mL/min)	Gentamicin/Tobramycin	Amikacin
≥60 mL/min	7 mg/kg q24h	15 mg/kg q24h
40-59 mL/min	7 mg/kg q36h	15 mg/kg q36h
30-39 mL/min	7 mg/kg q48h	15 mg/kg q48h
<30mL/min, dialysis	Not recommended	Not recommended

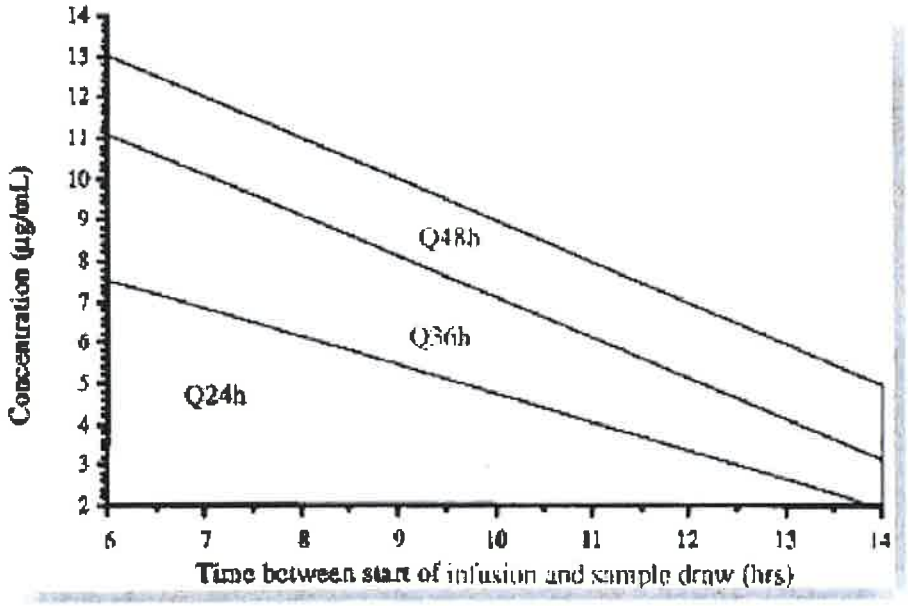
Monitoring:

Initial

- Random level drawn 8-12 hours after the first dose.
- Use Nomogram to confirm/modify dosage interval- Hartford nomogram is applicable for 7 mg/kg

Follow up trough level testing

- An early trough (6 hours prior to dose) should be considered in patients showing acute changes in renal function or suspicion of extended interval failure. Aiming for a level of <1 mcg/mL prior to next dose gives a drug free window to reduce accumulation.
- Maintenance random levels should be monitored at least once weekly



SUBJECT:	SECTION:
AMINOGLYCOSIDE PROTOCOL PER CLINICAL PHARMACIST	***Drug Protocols***

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

Urban Craig Nomogram

Initial Dosing:
Gentamicin/Tobramycin 5 mg/kg IV q24h based on actual body weight
If obese, use adjusted body weight. Adjusted body weight = IBW + (0.4(TBW – IBW)).

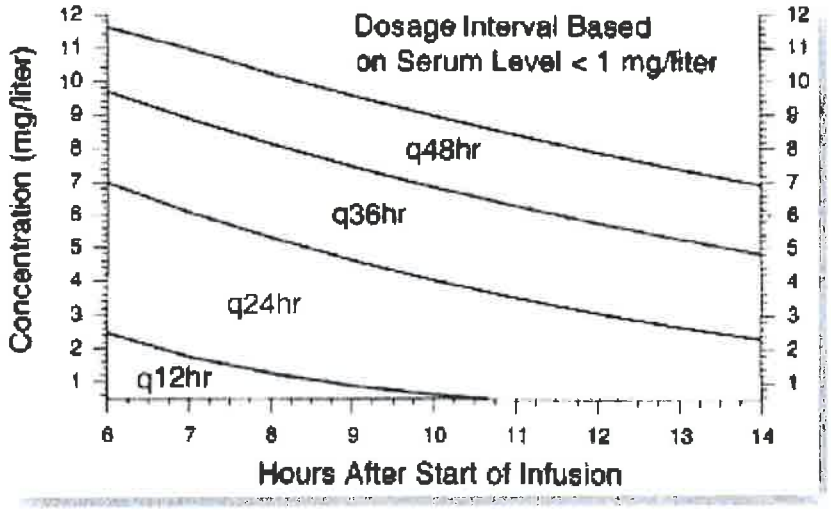
CrCl (mL/min)	Gentamicin/Tobramycin	Amikacin
>60 mL/min	5 mg/kg q24h	15 mg/kg q24h
40-59 mL/min	5 mg/kg q36h	15 mg/kg q36h
20-39 mL/min	5 mg/kg q48h	15 mg/kg q48h
<20mL/min, dialysis	Not recommended	Not recommended

Monitoring:
Initial:

- Single level drawn 8-12 hours after the first dose.
- Use nomogram to confirm/modify dosage interval.
- Only applicable for 5 mg/kg
  - Gentamicin/Tobramycin: Plot on graph
  - Amikacin: Divide level by 3, then plot on graph

Follow up monitoring:

- An early trough (6 hours prior to dose) should be considered in patients demonstrating acute changes in renal function or suspicion of extended interval failure. Aiming for a level < 1 mcg/mL ensures there is a drug free window that reduces potential for drug accumulation.
- Maintenance random levels should be performed at least weekly.



SUBJECT: **AMINOGLYCOSIDE PROTOCOL PER CLINICAL PHARMACIST**	SECTION: ***Drug Protocols***

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

Conventional/Traditional Dosing in Gram negative infections

CrCl (mL/min)	Gentamicin/Tobramycin	Amikacin	Timing of levels	
			Peaks	Troughs
>60 mL/min	1.7 mg/kg q8h	7.5 mg/kg q12h or 5 mg/kg q8h	30 min after 3rd dose	Before 4th dose
40 – 59 mL/min	1.7 mg/kg q12h	5-7.5 mg/kg q12h	30 min after 2nd dose	Before 3rd dose
30-39 mL/min	1.7 mg/kg q24h	5-7.5 mg/kg q24h	30 min after 2nd dose	Before 3rd dose
20-29 mL/min	1.7 mg/kg q24h	5-7.5 mg/kg q24h		
<20 mL/min AKI	2 mg/kg load, then dose by level	5 mg/kg load, then dose by level	30 min after first dose	Before 2nd dose
Hemodialysis	2 mg/kg load then 1.5 mg/kg post HD	5-7.5 mg/kg post HD	30 min after 1st dose	4 hr post HD OR Pre-HD levels based on indication

Monitoring

Goal Levels

Antibiotic	Indication	Target Peak	Target Trough
Gentamicin/Tobramycin	Life-threatening infection Serious infection UTI	8-10 mcg/mL 6-8 mcg/mL 4-6 mcg/mL	< 1-2 mcg/mL
Amikacin	Life-threatening infection Serious infections UTI	25-30 mcg/mL 20-25 mcg/mL 15-20 mcg/mL	< 4 – 8 mcg/mL

SUBJECT:	SECTION:
AMINOGLYCOSIDE PROTOCOL PER CLINICAL PHARMACIST	***Drug Protocols***

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Gram Positive Synergy Dosing

Initial Dosing

CrCl (mL/min)	Gentamicin Synergy Dosing	Timing of levels	
		Peaks	Troughs
>60	1 mg/kg q8h	30 min after 3rd dose	Before 4th dose
40-59	1 mg/kg q12h	30 minutes after 2nd dose	Before 3rd dose
30-29	1 mg/kg q24h	30 minutes after 1st dose	Before 2nd dose
<20; AKI	1 mg/kg x1 dose; Redose when <1mcg/mL	30 minutes after 2st dose	Before 2nd dose, redoes when Cp <1mcg/mL
Dialysis	1 mg/kg q48-72h; Re dose for pre-hd or post hd Cp <1mcg/mL	30 minutes after 1st dose	Immediately before HD; redoes for pre-HD or 4hr post HD levels <1 mcg/mL

Alternative dosing only for CrCl > 60 mL/min:

- Gentamicin 3 mg/kg q24h for treatment of endocarditis with Streptococci, Streptococcus galloyticus (bovis), Streptococcus viridans)
- Gentamicin 1.5 mg/kg q12h for treatment of endocarditis with Staphylococci; Enterococcus spp (strains susceptible to penicillin and gentamicin) endocarditis
- Refer to most recent IDSA Infective Endocarditis Guidelines for dosing in specific scenarios

Monitoring

Goal levels	Target Peak	Target Trough
Gentamicin/Tobramycin	3-4 mcg/mL	<1mcg/mL

PK Calculations

Aminoglycoside Pharmacokinetic Parameters

PK Parameter	Value
Bioavailability	Water soluble Poorly lipid soluble Poor oral absorption
Volume of distribution	0.25 L/kg (0.1-0.5 L/kg)
Fraction unbound in plasma	>0.95
Clearance Normal Renal Function Functionally anephric Hemodialysis	 Same as CrCl 0.0043L/kg/hr 1.8 L/hr
Half life Normal renal function Functionally anephric	 2-3 hours 30-60 hours

Initial Dosing

1. Determine CrCL using Cockcroft-Gault	$\text{CrCL (mL/min)} = \frac{(140 - \text{age}) \times \text{IBW}}{\text{SCr} \times 72}$ (x 0.85 for females)
2. Estimate elimination rate constant (Ke) based on PK kinetics	$Ke = (0.003 \times \text{CrCl}) + 0.01$
3. Estimate half-life (t ½)	$t\,½ = \frac{0.693}{ke}$
4. Calculate Volume of distribution (Vd) using ABW or AdjBW	Gentamicin/Tobramycin = 0.25 L/kg Amikacin = 0.3 L/kg
5. Infusion time	Gentamicin/Tobramycin = 30 minutes Amikacin = 30 minutes; 60 minutes if doses > 15 mg/kg
6. Estimated dosing interval based on goal levels Ctr = Cmin = desired trough Cpeak = Cmax = desired peak Ti = infusion time	$T = \frac{(\text{Ln}(C\,max / C\,min))}{Ke} + ti$ OR Estimated (T) = 3 x t ½
7. Maintenance dose (MD):	$MD = \frac{[(K_e) \times (VD) \times (ti) \times (C_{peak}\ desired) \times (1 - e^{-Ke\,t})]}{[(1 - e^{-Ke\,ti})]}$ OR MD = (Cpeak desired) x VD

SUBJECT:	SECTION:
AMINOGLYCOSIDE PROTOCOL PER CLINICAL PHARMACIST	***Drug Protocols***

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Individualized Dose Revisions

1. Determine elimination rate constant Use levels within the same dosing interval	$K\ (hr^{-1}) = \frac{(\text{Ln peak/trough})}{\Delta \text{ time between levels}}$ OR $k = \frac{\ln(C_{max}/C_{min})}{\tau - (t + t_{end} + t_{before})}$
2. Determine actual Cmax (if level not drawn at correct time;1 hour after the start or 30 minutes after completion of infusion)	$C_{max_{actual}} = \frac{C_{max}}{e^{-k(t_{end})}}$
3. Determine half-life	$t\,½ = \frac{0.693}{k}$ Dosing interval for traditional dosing method = ~ 3-4 times the half-life
4. Time to achieve goal trough level	Time to clearance = $\frac{\text{Ln (actual trough/ desired trough)}}{Ke}$
5. Estimate dosing interval ti = infusion time τ = interval	$\tau = \left[\frac{\text{Ln (Cmax/Cmin)}}{K}\right] + ti$ OR **Estimated $\tau = 3 \times t½$**
6. Determine Vd t1 = time from beginning infusion to Cpeak	$Vd\ (L) = \frac{Dose}{C_{max_{actual}}(1 - e^{-k(tau)})}$ OR $Vd\ (L) = \frac{[(Dose/C_{peak}) \times e^{-Kt_1}}{(1 - e^{-K\tau})]}$
7. New maintenance dose ti = infusion time τ = interval	$MD = \frac{[(k_e) \times (Vd) \times (ti) \times (C_{peak}\ desired) \times (1 - e^{-K\tau})]}{[(1 - e^{-K\,ti})]}$ OR MD = (goal peak Cmax) x Vd

8

SUBJECT: **AMINOGLYCOSIDE PROTOCOL PER CLINICAL PHARMACIST**	SECTION: ***Drug Protocols***

1.

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2. Craig WA, Ebert SC. Killing and regrowth of bacteria in vitro: a review. Scand J Infect Dis Suppl. 1990;74:63-70.

3. Moore RD, Lietman PS, Smith CR. Clinical response to aminoglycoside therapy: importance of the ratio of peak concentration to minimal inhibitory concentration. J Infect Dis. 1987;155(1):93-99.

4. Bland CM, Pai MP, Lodise TP. Reappraisal of Contemporary Pharmacokinetic and Pharmacodynamic Principles for Informing Aminoglycoside Dosing. Pharmacother J Hum Pharmacol Drug Ther. 2018;38(12):1229-1238. doi:10.1002/phar.2193

5. Zhanel GG, Hoban DJ, Harding GK. The postantibiotic effect: a review of in vitro and in vivo data. DICP Ann Pharmacother. 1991;25(2):153-163.

6. Spivey JM. The postantibiotic effect. Clin Pharm. 1992;11(10):865-875.

7. Fantin B, Ebert S, Leggett J, Vogelman B, Craig WA. Factors affecting duration of in-vivo postantibiotic effect for aminoglycosides against gramnegative bacilli. J Antimicrob Chemother. 1991;27(6):829-836.

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13. Smyth AR, Bhatt J, Nevitt SJ. Once-daily versus multiple-daily dosing with intravenous aminoglycosides for cystic fibrosis. Cochrane Database Syst Rev. 2017;3:CD002009. doi:10.1002/14651858.CD002009.pub6

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15. Daikos GL, Lolans VT, Jackson GG. First-exposure adaptive resistance to aminoglycoside antibiotics in vivo with meaning for optimal clinical use. Antimicrob Agents Chemother. 1991;35(1):117-123.

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19. Stanford Health Care Aminoglycoside Dosing Guideline. https://med.stanford.edu/content/dam/sm/bugsanddrugs/documents/antimicrobial-dosing-protocols/SHC-Aminoglycoside-Dosing-Guide.pdf; 2023

SUBJECT: **ASSESSMENT- BODY**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide an ongoing system for monitoring resident skin conditions, to implement interventions when needed, and to prevent complications.

POLICY:

It is the policy of this facility to monitor the resident's skin condition daily and provide documented licensed nurse assessments on a weekly basis and as needed.

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

PROCEDURE:

1. Body assessments will be completed upon admission of the resident by the Registered Nurse (RN). Observations will be documented in PCS. The RN will contact the physician for treatment orders and ensure treatment is initiated.

2. Nursing assistants will check each resident's skin every shift and shall report any skin integrity impairment to the licensed nurse for follow-up. The licensed nurse will observe the reported impairment and Report to the RN, who will then get a Wound Nurse consult if needed

3. The RN/ Wound Nurse shall perform weekly skin checks on all wounds and as needed for reported skin issues from the licensed nurses or CNAs.

4. The RN will notify physician for orders and follow up of treatment. Notify resident or family of changes in the resident's skin status.

5. Licensed nurse will update the resident's care plan as needed

6. Wound Nurse will initiate a weekly Pressure Sore Report and/or a weekly Non – Pressure Skin Problem Report, as appropriate for IDT.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.2 United States of America, Med Pass Inc.

- *Skin Assessment in Long Term Care,* Susan M. Cleveland, BSN, RN, WCC, CDP, NADONA.

- *Wound Source September 12, 2019*

- *Wound Care Essentials 5th Edition,* June 23, 2020, Wolters Kluwer, by Sharon Baranoski MSN, RN, CWOCN,APN, FAAN,

SUBJECT: **AUTOPSY – SECURING OF**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 2**

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

PURPOSE:

To provide guidelines for when an autopsy is ordered or the request for an autopsy is made.

POLICY:

For those cases that do not meet the coroner's criteria for an autopsy, the hospital or physician and patient's family legally consenting party may seek to secure an autopsy.

AFFECTED PERSONNEL/AREAS: *HOSPITAL STAFF AND PHYSICIANS*

PROCEDURE:

PHYSICIAN OR HOSPTIAL REQUEST FOR AUTOPSY

1. When a patient has expired and the cause of death or associated circumstances of such are indeterminate, collaboration between the physician, Senior Administration or designee of Risk Management/Patient Safety determine whether an autopsy is appropriate.

2. Care is taken to communicate with family and legally consenting party in a considerate manner respectful of their grief, values and spiritual beliefs.

3. The legally consenting party should not be made to feel obligated to consent to autopsy.

4. In the event that the legally consenting party is agreeable to an autopsy, the physician obtains and documents consent and writes an order for the autopsy.

5. The original signed consent form and a copy of the order is scanned into the patient's electronic medical record. Both copies will then be sent with the decedent to the mortuary. The department director or manager ensures the order and consent form is faxed to Premier Pathology.

6. Once the consent form and order have been faxed to Premier Pathology, the department director or manager is to notify Risk Management.

FAMILY REQUEST FOR AUTOPSY

1. In the event that the legally consenting party requests an autopsy independent of the hospital, the arrangements can be made by the family and pathologist of choice. Consent does not need to be obtained by the hospital but hospital staff can assist the family in doing so.

2. The family should be made aware that they are responsible for the cost of the autopsy.

3. Notify Risk Management of the request for autopsy.

QUALITY MONITORING

The occurrence of autopsies, requested by SVMC, will be monitored by the Risk/Patient Safety Department and findings will be reported to the appropriate Medical Staff Department Committee Chair, , usually within forth-five (45) working days. Information obtained from the autopsy will be reviewed by the medical staff during the department's peer review session, as deemed appropriate by the Department Chair

REFERENCES:

- Joint Commission on Accreditation of Healthcare Organizations. (2023). The Joint Commission Comprehensive Accreditation Manual. Oakbrook Terrace, IL: Joint Commission Resources
- Government Code §27491
- California Health & Safety Code §10250

CROSS REFERENCES:

- Patient Care Services Policy & Procedure Manual: Deaths Reportable to the Coroner

SUBJECT: **BLANKET WARMER**	SECTION: **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 ensuring the proper functioning of the Blanket Warmer on the DP/SNF Unit.

POLICY:

The facility will utilize the blanket warmer for the residents' comfort, to provide them with warm gowns, blankets, towels as per request of the resident and/or after their shower or bath. The DP/SNF unit will maintain safe usage of the blanket warmer at all times.

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

PROCEDURE:

1. The blanket warmer will be stocked on a daily basis by EVS staff or nursing when needed.

2. The RN on the unit will monitor the temperature of the unit each shift and log on the *Blanket Warmer Log Sheet* the actual temperature and the set point temperature of 125 degrees Fahrenheit. MIFU will be reviewed to its updated guidelines.

3. Each shift, the RN will monitor that the actual reading of the temperature on the unit does not read above the set point temperature of 125 degrees Fahrenheit.

4. The RN will notify Bio Med if the temperature reads above the set point and tag the unit "Out of Order" until evaluated and cleared by Bio Med.

REFERENCE:

- Venture Medical (2019). Blanket Solution Warming Cabinets. Retrieved from https://www.venturemedical.com/knowledge-center/medical-warming-cabinets/.

SUBJECT:	SECTION:
BOWEL MANAGEMENT PROTOCOL~~BOWEL MANAGEMENT PROTOCOL~~	**Page 1 of 2**

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PURPOSE:

To establish a system for bowel management / treat constipation.

POLICY:

It is the policy of this facility that the residents will be assisted in maintaining regular bowel elimination without complication.

AFFECTED PERSONNEL/AREAS: *RN, LVN*

PROCEDURE:

OBJECTIVE:

For all residents who have not had a bowel movement (BM) in 3 consecutive shifts, bowel management protocol will be followed.

1. Designated shift licensed nurse on each station will check BM record of each resident.
2. Give milk of magnesia (MOM), per MD order, if resident has had no BM x 2 days/ 5th shift.
3. If no results from MOM on the 5th shift, give Dulcolax suppository on the 6th shift.
4. If Dulcolax is ineffective on 3rd day, give Fleets enema as per MD order. Notify MD if no results from enema.
5. If no BM in three (3) days, check manually for possible impaction. If impaction is noted, remove fecal impaction as able.
6. If still no results, give second round of Milk of Magnesia, Dulcolax suppository and Fleets enema.
7. If still no results after the second round of the Bowel Protocol~~. give 200ml Golytely and hold Tube Feeding for 30 minutes after administration of Golytely. per~~ call the MD for further orders.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 72315, Section i-3, San Francisco, California, Title 22.
- Population Health Learning Network, Volume 27, Issue 8, August 2019, Management of Constipation in Long Term Care: Updates on Regulations and Treatment, Taylor Bradshaw, PharmD, BCACP, Allergan plc.

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- States Operation Manual-CMS, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, (Rev 173, 11-22-17), F540, F584, F620, CMS.gov.

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

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

PURPOSE:

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

DEFINITIONS:

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

POLICY:

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

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

PROCEDURE:

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

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

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

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

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

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

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

7. Antidepressant/antipsychotic medications per MD order

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

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

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

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

1. Reducing long periods of isolation

2. Using distractions

3. Talking/interacting frequently with resident

4. Predictable routines, avoiding frequent or sudden changes

5. Frequent reassurance, calmness

6. Structured environment

7. Orienting stimuli

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

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

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

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

REFERENCES:

- Annals of Long Term Care, Consuelo H. Wilkins, MD, 2022 HMP Global, *Diagnosis and Management of Dementia in Long Term Care*. http://www.hmpgloballearningnetwork.com
- Healthcare Brands (n.d.). Dementia.org. *The Difference Between Alzheimer's and Dementia*. Retrieved from http://www.dementia.org/types/the-difference-between-alzheimers-and-dementia.

- California Department of Public Health (October 7, 2017). All Facilities Letter (AFL-14-05). *Verifying informed consent for psychotherapeutic drugs before transferring patients to Skilled Nursing Facilities*. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-14-05.aspx.

- California Association of Health Facilities (February 2020). *Guide to Long Term Care*. https://www.cahf.org/About/Consumer-Help/Guide-to-Long-Term-Care.

- Centers for Disease Control and Prevention (Updated May 12, 2020). *Considerations for Memory Care Units in Long-term Care Facilities*. https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html.

- Centers for Medicare & Medicaid Services (February 27, 2020). National Partnership- Dementia Care Resources. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-Dementia-Care-Resources.

CROSS REFERENCES:

- DP/SNF Policy and Procedure – RESTRAINTS, CHEMICAL

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

SUBJECT: **CLINICAL DIETITIAN SCOPE OF PRACTICE**	SECTION: *Leadership (LD)* **Page 1 of 4**

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

PURPOSE:

The Registered Dietitian(s) (RD) will provide optimal medical nutrition therapy to patients of the organization to improve patient outcomes and reduce length of hospital stay.

POLICY:

The RD will be qualified through education, training, and experience in educational and clinical skills.

AFFECTED AREAS/PERSONNEL: *FOOD AND NUTRITION SERVICE S (FNS), PATIENT CARE AREAS*

Staffing: Full time RDs are available Monday- Saturday 0730-1700, and on call on Sunday for physician referrals from 0800-1630.

Qualifications: A RD is a health practitioner that meets all of the following qualifications as outlined in the Business and Professionals Code 2585-86:

- 18 years of age or older
- Satisfactory completion of appropriate academic requirements for the field of dietetics and related disciplines and receipt of a baccalaureate or higher degree from an accredited college or university.
- Satisfactory completion of a program of supervised practice for a minimum of 1000 hours of supervised practice that is designed to prepare entry level practitioners through instruction and assignments in a clinical setting.
- Satisfactory completion of the Registered Dietitian examination by the Commission on Dietetic Registration (CDR).
- Satisfactory completion of continuing education requirements established by CDR (equivalent to 75 hours per 5 year period).
- Note that after January 1, 2024, a Master's degree will be required to write the CDR registration examination for dietitians.

PROCEDURE:

The Clinical Nutrition Manager and Clinical RDs are responsible for the following:

1. Evaluates the nutritional needs of residents/patients, provides nutrition education and documents in the medical record.
2. Interprets, evaluates and utilizes current research relating to nutritional care.
3. May assist in implementing continuing education programs for FNS employees.
4. Develops interdisciplinary care planning and nutrition care plans.
5. May assist in evaluating and monitoring the meal delivery system.
6. May assist in monitoring FNS for sanitation, safety and infection control.
7. Visits residents/patients to monitor food acceptance.
8. Reviews, revises and makes recommendations as needed for the FNS policy manual.
9. Reviews, revises and makes recommendations as needed for the FNS clinical diet manual.
10. Maintains current registration, or eligible for registration, with the Academy of Nutrition and Dietetics (AND) and the Commission on Dietetic Registration (CDR).

11. Meets ongoing continuing education requirements as established by facility with evidence of current registration and current contract for services.
12. Reports concerns regarding the nutritional care of patients/residents to the FNS Director.

Communication/Collaboration:

The Physician:

1. Has direct control of patient care in all cases and at all times.

2. Will enter/write the initial diet order

3. If physician desires, he/she may enter/write order for "Registered Dietitian to recommend oral diet consistency, calorie or protein level and supplements, tube feeding or macronutrient regimen for parenteral nutrition," in the physician order section of the medical record. The physician may discontinue any RD recommendation at his/ her discretion.

4. All orders, including telephone orders, must be authenticated within 48 hours by the Licensed Independent Practitioner (LIP).

5. Diet-as-tolerated is not a diet. A specified diet texture will be ordered such as dysphagia, advanced as tolerated or clear liquid advance as tolerated, for nursing to initiate.

The Registered Dietitian:

RDs may receive a consult/referral from a physician. The RD will recommend Medical Nutrition Therapy (MNT) by calling the physician or notifying the Registered Nurse (RN) who communicates with the physician. Telephone order read back (TORB) is acceptable. The type of nutrition regimens may include:

1. Nutritional counseling and/or assessment: Estimated caloric and protein regimen. Refer to speech therapy for diet texture.

2. Lab test: RDs may order medical laboratory tests related to medical nutrition therapy when approved by the referring physician. A Registered Nurse is notified and will order the laboratory test (State dietetic practice law). Examples are:
    a. Pre-Albumin
    b. Albumin
    c. Glucose, Hemoglobin A1C
    d. Cholesterol, Triglycerides, HDL, LDL
    e. Serum Iron, Folate, vitamin B12
    f. Magnesium and Phosphorus
    g. Liver, pancreatic, and kidney related test

3. Oral Nutritional Supplements: See Oral Nutrition Supplement policy for further discussion.

4. Diets: The RD may individualize the patient's nutritional or dietary treatment when necessary by modifying the distribution, type or quantity of food and nutrients within the parameters of the diet order to provide medical nutrition therapy. Without a physician's explicit order, the RD may not adjust a calorie or protein level (i.e. 2000 calorie to 1500 calorie) or upgrade diet texture (i.e. Dysphagia to Regular).

5. Snacks: The RD may recommend adding or discontinuing snacks if on a therapeutic diet. If a patient is on a regular non-therapeutic diet, the RD can order the snacks. The Physician may order bedtime (HS) snacks, if desired, for the diabetic patient. Routine snacks are not sent. The gestational diabetic diet does include six (6) small meals and does not require Dietary Special Needs (DSN) snack order.

6. Wound Care Nutrients: The RD may receive a consult/referral by the physician or nursing staff. The RD may recommend vitamin and mineral supplements such as vitamin C, zinc, fortify diets with calories and protein, add therapeutic nutrition drink mixes (amino acids) or protein powders/liquids.

7. Tube Feedings (TF), Parenteral Nutrition (PN), Central Parenteral Nutrition (CPN) and Peripheral Parenteral Nutrition (PPN):

    a. The RD may receive a consult/referral by a physician to initiate or change the regimen. A RD may recommend the rate for a tube feeding.

    b. The RD may enter/write the initial TF/PN order when the physician defers the order to the RD to meet the metabolic needs of the patient or specifies in the physician order that RD and Pharmacy are to collaborate on appropriate macronutrients.

    c. The RN, RD or Pharmacist may discuss with the physician prior to nutrition regimen initiation.

REFERENCES:

- California Code, Business and Professions Code - BPC § 2585. (n.d.). Retrieved from: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=BPC&division=2.&title=&part=&chapter=5.65.&article=
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/CE-Associations-List/The-Commission-on-Dietetic-Registration
- Academy of Nutrition and Dietetics, Eatright Pro.org: https://www.eatrightpro.org/acend/accredited-programs/about-accredited-programs
- CIHQ Acute care Accreditation Standards: file:///C:/Users/josec/Downloads/CIHQ%20Acute%20Care%20Accreditation%20Standards%20-%20Participating%20in%20Medicare%20Rev.%201.21.pdf

  https://www.cdrnet.org/certifications/registered-dietitian-rd-certification
- The Joint Commission. (2023). Accreditation Participation Requirements (APR) Manual.

CROSS REFERENCES:

- Oral Nutrition Supplement Policy

SUBJECT: **CLOSETS- ORGANIZING/CLEANING**	SECTION: **Page 1 of 1**

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

PURPOSE:

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

POLICY:

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

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

PROCEDURE:

1. The Nurse Aides/ Shower Team will organize and clean the resident's closets on a daily basis.

2. Reorganization and cleaning shall include proper hanging of resident clothing, shoes stored appropriately, and the removal of inappropriately stored items from the closet.

3. The Nurse Aide will monitor that laundry hampers for personal clothing laundered by families are clean and have tightly sealed lids. Those requiring cleaning or lids shall be reported to the Charge Nurse for communication to Social Services for family notification.

4. The Nurse Aide will ensure that only personal laundry hampers and resident shoes/slippers are stored on the floor of the closet.

5. The Nurse Aide on duty at the time of a resident's transfer/discharge will empty the resident's belongings from the closet and follow facility policy and procedures for the care of the residents' belongings during transfer/discharge.

6. Housekeeping will provide terminal unit cleaning upon transfer/discharge of a resident, per housekeeping policies and procedures

REFERENCES:

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

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

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PURPOSE:

To assist residents in communicating their needs.

POLICY:

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

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

PROCEDURE:

1. The facility will make arrangements for interpreters or alternate means of communication, such as pictures, sign language, Braille, etc., to enhance communication between residents and staff.

2. Certified bilingual employees, HCIN, TDD phone for the deaf and disabled family members, clergy, or other outside resources may be used in this capacity to reduce communication barriers.

3. Methods instituted to assist residents in communicating their needs will be identified in the residents' plan of care.

4. A list of facility interpreters will be maintained on the unit.

5. Telephone and mail service are available to all residents

REFERENCES:

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

- Thompson, S. (2017). Overcoming Communication Barriers to Healthcare for Culturally and Linguistically Diverse Patients. Retrieved from https//www.sth.nhs.uk.

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

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PURPOSE:

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

POLICY:

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

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

PROCEDURE:

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

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

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

REFERENCES:

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

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

SUBJECT: **CONSUMER INFORMATION**	SECTION:

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

PURPOSE:

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

POLICY:

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

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

PROCEDURE:

1. The Social Worker or designee posts required information as it is received by the facility.

2. The Social Worker or designee and Clinical Director checks the posting periodically to ensure that they are current, accurate, correctly, and conspicuously posted.

3. Should any of the required information be inaccurate or otherwise require change, the Social Worker or designee removes the posting and replaces them with the correct information.

4. All staff members are instructed at the time of hiring to direct all inquiries regarding consumer information to the Director of DP/SNF or Social Worker or designee.

5. The following is a list of articles/information to be posted in public view:

    a. Existing facility license

    b. Previous survey reports. (*DHS 2567 form)*

    c. Any notices of action taken by the Department of Health Services (DHS)

    d. DHS address and phone number. (*Local Field office and State office)*

    e. Ombudsman name, address and phone number (*A poster should be obtained from the ombudsman for this purpose.*)

    f. Consumer information regarding Medicare/ Medi-Cal application, office address and phone number (*how to apply, supplemental financial benefits information, covered and non-covered services)*

    g. Activity calendar

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

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

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

k. Resident trust banking hours

l. DHS complaint filing statement

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

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

REFERENCES:

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

SUBJECT:	SECTION:
CONTROLLED SUBSTANCES	***Medication Management (MM)***

PURPOSE:

To ensure that medications defined as controlled substances under Division 10 of the Uniform Controlled Substances Act are procured, distributed and accounted for in accordance with all Federal and State laws and regulations.

DEFINITIONS:

Cactus Sink – Designated pharmaceutical waste container for all controlled substances.

POLICY:

The Department of Pharmaceutical Services shall be responsible for the organizational compliance of all laws and regulations governing the procurement, distribution and accountability of controlled substances of Schedule II, III, IV and V at Sierra View Medical Center. The Pharmacy under definition of Drug Enforcement Agency registration will not procure, retain or dispense medications that fall under definition of schedule I under the Uniform Controlled Substances Act. Systems (procedures) will be developed and maintained by the Department of Pharmaceutical services to ensure accountability, with valid audit trails and record retention.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING, ANESTHESIA*

PROCEDURE:

A. GENERAL INFORMATION

1. All controlled substances at SVMC are stored, managed, secured, and reviewed through the Pyxis C-II Safe and by the Pyxis Med Station dispensing cabinets.

B. ORDERING

Controlled substances are procured through the wholesaler by the initiation of:

1. Schedule II – Pharmacists who have been granted power of attorney shall order through the wholesaler's ordering system via CSOS (Controlled Substance Ordering System). When there are technical problems with CSOS software or internet access, then DEA 222 paper forms will be utilized.

2. Schedule III-V's are ordered through the wholesalers ordering system.

C. RECEIPT AND STORAGE

1. Controlled Substances received from vendors/other pharmacies:

   a. Vendor invoices are compared with order form, confirmed with physical count, and then signed and dated by a Pharmacist.

b. Any discrepancies are handled immediately.

2. Received inventory placed in C-II Safe by a licensed pharmacist

a. Quantity received, invoice number, date ordered, and User ID of who received them is recorded on the Vendor/Pharmacies Report. (DEA 222 number also required if Schedule II's are received).

b. These reports are filed and retained on-site for 3 years and in readily retrievable storage for no less than 7 years prior to destruction.

c. The DEA222 order form, delivery receipt from the wholesaler and CII safe report "medications received from vendors" that shows drug and quantity added to CII safe are all reviewed and signed by pharmacist checking in the medication and then reviewed and signed by the pharmacist in charge.

D. DISPENSING

1. Physician orders for medications including controlled substances are entered by the Physician via CPOE (Computer Physician Order Entry) or faxed to the Inpatient Pharmacy.

2. A Pharmacist evaluates the medication order for safety, efficacy, and appropriateness, and then verifies the approved order into the patient's profile as found in the hospital's information system.

3. Controlled substances are removed from the C-II Safe and placed into the various units Pyxis MedStations throughout the facility by the Narcotic Technician.

a. A Pharmacist checks all medications, including controlled substances, that are dispensed to Pyxis prior to the medications leaving the pharmacy.

b. The Narcotic Technician is required to run Pyxis vs. C-II Safe Compare reports prior to the end of their shift to verify that the exact quantity of each controlled substance dispensed was received by the Pyxis MedStation and that there are no discrepancies. These reports are to be given to the Technician Supervisor for review. Any open discrepancy is immediately reported to the pharmacist in charge.

4. Controlled substances removed from the units' Pyxis MedStations by Pharmacy personnel must be returned to the C-II Safe. If not, a discrepancy will show in the Compare Report until documentation is provided to clear the variance. Documentation must be provided within 24 hours to clear the variance. At the end of each shift, an "Open Discrepancy Report" is run to confirm inventory and identify any open discrepancies. All discrepancy reports are reviewed and signed and dated by the pharmacist in charge.

5. If a controlled substance is lost or is missing after an exhaustive search, a Lost Medication Report must be filed with the DEA immediately upon discovery and with the Board of Pharmacy within thirty days.

6. After the medication order is processed by the Pharmacist, the medication becomes available to the nurse for administration via the unit's Pyxis Med Station.

E. WASTING AND ADMINISTRATION

1. When a physician ordered dose is less than the unit dose stocked medication in Pyxis:

   a. The Pyxis will require a witness upon removal of all controlled medication prior to removal.

   b. The nurse and the witness will waste the excess medication in the proximally located Cactus Sink, immediately or as soon as patient has been treated, but not to exceed 1 hour without reasonable cause.

   c. The administering nurse will scan the patient's wrist band and the medication.

   d. Scanning of the medication will create documentation of the administered dose.

   e. The nurse will administer the medication. Administration will occur within 1 hr of removal for all controlled substances. Failure to do so may subject the user to review.

2. Controlled substances removed from Pyxis without authorization or review by the pharmacist via override requires a witness.

3. Override medication removals are reported and evaluated on the Pyxis override report generated daily by the inpatient pharmacy.

Unapproved removals are reported into the hospital's occurrence reporting system and the pharmacist in charge is notified immediately.

4. Wasting of controlled medication in the Pharmacy must be done by two pharmacists:

   a. Upon discovery or creation of a controlled medication requiring it to be wasted, i.e., broken vial, damaged package, creation of a unit dose medication from a bulk package, the following will occur:

      - Pyxis CII Safe is accessed and the Expiration Function is selected
      - Uncheck option for placing into "destruction bin"

1. A description for reason for wasting of medication is typed in the field provided.
2. Pharmacist will login to Pyxis and witness transaction
3. Remaining or residual drug is physically wasted in pharmacy designated Cactus Sink with witness.
4. A daily Undocumented Discrepancy Waste Report is run in the pharmacy to identify any absent documentation. Any open discrepancies are immediately reported to the pharmacist in charge.

F. MONITORING

1. The Narcotic Technician is required to perform regular patient chart audits, comparing controlled substance removal records with patient eMAR documentation.
2. The narcotic technician will review the unreconciled doses as reported in surveillance software on a daily basis (Reviews of weekends and holidays will include those days on the narcotic shift's next shift). Any unresolved unreconciled doses will have an event report submitted & notification sent to the user's manager & PIC via the surveillance software for review & disciplinary actions as needed. The user's manager shall work with the PIC to complete the investigation as soon as possible and not to exceed 24 hours.
3. Pharmacy runs a monthly Proactive Diversion Report that looks at controlled substance utilization using standard deviation determinations. Unusual usage by any nursing staff is reported to the Nursing Manager of that unit and a full comparison check of targeted controlled substance removals from Pyxis with patient eMAR documentation is required to be completed within 72 hours.
4. Based on the results of investigations from daily or monthly reports, the following will happen:
    - Nothing – the investigation reveals no problems and all documentation is confirmed
    - Progressive Discipline – The Nursing Manager finds that poor documentation issues are revealed but no evidence of diversion exists. This will result in disciplinary action that may be as basic as verbal warning but could result in termination based on that employee's past history. Progressive Discipline is coordinated in conjunction with HR (Human Resources). All errors are documented in the hospital's incident reporting system.
    - Diversion Investigation – The Nursing Manager's investigation reveals substantial deficits in documentation. At that point, Pharmacy is contacted to

assist with expansion of the employee's history via Pyxis reports. See Diversion below.

G. DIVERSION OF CONTROLLED SUBSTANCES

1. The Clinical Director of the unit where the suspected employee works will conduct a full investigation with the expanded Pyxis report from Pharmacy. Pharmacy and HR may be called to assist with this investigation.

2. Human Resources will be notified that a suspected diversion has occurred. If a diversion is validated by the investigator, HR in conjunction with Nursing Administration, will inform the CEO (Chief Executive Officer) of the hospital and file the police report. If applicable, a report will also be filed with the licensing board of the suspected diverter (Board of Registered Nurses, or the Department of Consumer Affairs for Pharmacists, and Physicians).

3. Based on the results of the investigation, any suspected diversion of controlled substances is to be reported immediately upon discovery to the DEA (Drug Enforcement Agency).

H. PYXIS ANESTHESIA SYSTEMS

All controlled substances are pulled by the Narcotic Technician according to par levels set in the Anesthesia Carts. A MedStation auto restock report is run and the meds are pulled from C-II Safe to replenish and make sure that the Anesthesia Carts are at maximum level daily. A Pharmacist will verify that all medications and quantities are correct before they are taken to the stations.

I. REMOVING OUTDATES FROM INVENTORY

When Schedule II-V medications are outdated, they are removed from inventory and placed in the drawer segregated in the C-II Safe designated specifically for controlled substance outdates and held until processed through the recover service (See "Disposition" below).

J. DISPOSITION

1. Return for manufacturer credit/destruction.

2. At regular intervals (quarterly, or more frequently as required), a Pharmaceutical Reverse Distributor that is under contract to process expired medications. Controlled substances are processed in the following manner.

   a. Expired Schedule II medications contained in the outdate drawer in the C-II Safe are inventoried by the reverse distributor personnel. The

inventory is then verified against the "dispensed" with the transaction date and the DEA Form 222 number.

b. The recovery service issues a DEA Form 222 as a registered distributor to the Hospital (supplier) for each line item medication that is being returned by NDC number, up to 10 line items per form.

c. The top copy "Supplier's Copy 1" is retained by the Pharmacy. A copy is made and placed in the "Expired C-II Safe Inventory" folder, until a "Manufacturer Return Report – Schedule Drugs" is received. Once received, it is reconciled against the DEA 222 and the original forwarded to the DEA in accordance with regulation.

d. Schedule III, IV and V

Expired Schedule III, IV and V medications contained in the outdate drawer in the C-II Safe are inventoried by the reverse distributor personnel. A "Controlled Substances Inventory and Transfer" document is generated by the recovery service and a copy retained in the "Expired C-II Safe Inventory" folder and reconciled when a "Manufacturer Return Report – Schedule Drugs" and/or a "Disposal Report – Schedule Drugs" is received and reconciled.

K. DOCUMENTATION AND RECORD RETENTION AND INVENTORY

1. All documentation regarding procurement, distribution and/or disposal of controlled substances shall be kept on-site for at least 3 years and in readily retrievable storage off-site for no less than 7 years prior to destruction.

2. A physical inventory will be conducted no less than twice a month for all Scheduled medications. All discrepancies will be reconciled and brought to the attention of the Pharmacist in Charge.

3. A biennial ~~bi-annual~~ inventory will be completed in accordance with DEA regulations and retained ON SITE for no less than 7 years.

4. Physical inventory audits are performed in all areas where controlled substances are maintained and are performed during required monthly unit/area inspections. Results of inventory audits will be monitored and reported as a performance improvement indicator to identify and trend any problems. Subsequent action and control will be implemented as deemed necessary and appropriate.

5. At least every three months, the pharmacist in charge will compile an inventory reconciliation report of all Federally Scheduled CII Drugs stored in the pharmacy. Additionally products containing the following substances in the

following strengths per tablet, capsule, other unit, or specified volume, a reconciliation report at least quarterly:
A. Alprazolam, 1 milligram/unit.
B. Alprazolam, 2 milligrams/unit.
C. Tramadol, 50 milligrams/unit.
D. Promethazine/codeine, 6.25 milligrams of promethazine and 10 milligrams of codeine per 5 milliliters of product.

For any controlled substance not identified above, an inventory reconciliation report shall be prepared for identified controlled substances lost no later than three months after discovery of the loss of that controlled substance. This report shall be completed if the loss is discovered either by inventory activities or in any other manner. The report shall cover the period from the last physical count of that controlled substance before the loss was discovered through the date of discovery. At a mimimum, any pattern(s) of loss(es) identified by the pharmacist in charge shall require an inventory reconciliation report for each pattern of loss identified, as defined by the pharmacy's policies and procedures. Any reportable loss, as specified in section of 1715.6 of CCR, shall also require an inventory reconciliation report.

An inventory reconciliation report shall require:

a. A physical count of all quantities of each federal controlled substance covered by the report that the pharmacy or clinic has in inventory. The biennial inventory required by federal law may count as one of the mandated inventories, so long as the biennial inventory was taken no more than three months from the last inventory required.

b. A review of the acquisitions and dispositions of each controlled substance covered by the report since the last inventory reconciliation report covering that controlled substance.

c. A comparison of the physical count with the acquisitions and dispositions to determine if there are any variances.

d. All records used to compile each inventory reconciliation will be maintained in the pharmacy for at least three years in a readily retrievable form.

e. Identification of each individual involved in preparing the report and possible causes of overages shall be identified in writing and incorporated into the inventory reconciliation report.

f. The inventory reconciliation report shall be dated and signed by the individual (s) performing the inventory, and countersigned by the pharmacist-in-charge and readily retrievable in the pharmacy for three

years. A counter signature is not required if the inventory was personally completed by the pharmacist-in- charge.

6. The pharmacist-in-charge shall ensure that the Pyxis Med Stations located outside of the pharmacy:

   g. All controlled substances added to the Pyxis stations are accounted for (not just CII);

   h. Access to the Pyxis machines is limited to authorized personnel

   i. Ongoing evaluations of discrepancies or unusual access associated with controlled substances is performed;

   j. Confirmed losses of controlled substances are reported to the Board of Pharmacy.

L. REPORT OF THEFT, LOSS OR SHIPPING DISCREPANCY

1. Pursuant to Division 10, Chapter 3, Article 1, Section 11103 of the State Health and Safety Code "The theft or loss of any substance regulated Pursuant to Section 11100 discovered by any licensee or any person regulated by the provisions of this chapter, shall be reported to the Department of Justice within THREE (3) days after such discovery. "Any difference between the quantity of any substance regulated pursuant to Section 11100 received and the quantity shipped shall be reported to the Department of Justice within THREE (3) days of the receipt of actual knowledge of the discrepancy.

2. Pharmacy shall submit to the Board a report containing information according to California Code of Regulations Title 16. Division 17. Article 2. Section 1715.6 no later than thirty (30) days after the date of discovery of the following:

   Any loss of a controlled substance ein one of the following categories that causes an aggregate amount of unreported losses discovered in that category, on or after the same day of the previous year to equal or exceed:

   a. For tablets, capsules, or other oral medication, 99 dosage units.
   b. For single-dose injectable medications, lozenges, fild, such as oral, buccal and sublingual, suppositories, or patches, 10 dosage unites.
   c. For injectable multi-dose medications, medications administered by continuous infusion, or any other multi-dose unit not described in subparagraph (A), two or more multi dose vials, infusion bags, or other containers.

   Any loss of a controlled substance regardless of the amount, attributed to employee theft, in addition to the reporting requirements and time frames mandated by Business and Professions Code section 4104.

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Any other significant loss as determined by the pharmacist-in-charge, including but not limited to losses deemed significant relative to the dispensing volume of the pharmacy.

All reports under section 1715.6 Reporting Drug Loss of California Code of Regulations shall specify the identity, amount and strength of each controlled substance lost, and date of discovery of the loss, for all losses that have made the report necessary.

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~~2. Pharmacy shall report identified losses and known causes to the Board within 30 days of discovery unless the cause is theft, diversion, or self-use, in which case the report shall be made in 14 days of discovery. If the cause is unable to be identified, further investigation shall be undertaken to identify the cause and actions necessary to prevent additional losses of controlled substances.~~

M. SUSPICIOUS ORDER REPORTING SYSTEM

1. Orders for controlled substances may be considered suspicious if it is an unusual size, unusual pattern or frequency.

2. The pharmacist in charge will report any suspicious orders to the DEA's Suspicious Orders Report System (SORS) online

N. LICENSED EMPLOYEE, IMPAIRMENT, THEFT AND DIVERSION: PHARMACY PROCEDURES

1. The Department of Pharmacy shall report to the Board, within 14 days of the receipt or development thereof, the following information with regard to any licensed individual employed in or working with the pharmacy.

   a. Any admission by a licensed individual of chemical, mental, or physical impairment affecting his or her ability to practice.

   b. Any admission by a licensed individual of theft, diversion, or self-use of dangerous drugs.

   c. Any video or documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs.

   d. Any video or documentary evidence demonstrating chemical, mental, or physical impairment of a licensed individual to the extent it affects his or her ability to practice.

e. Any termination based on chemical, mental, or physical impairment of a licensed individual to the extent it affects their ability to practice.

f. Any termination of a licensed individual based on theft, diversion, or self-use of dangerous drugs.

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~~f.~~ g. If the cause is unable to be identified, further investigation shall be to taken to identify the cause and actions necessary to prevent additional losses of controlled substances.

2. The report required to be submitted to the Board of Pharmacy shall include sufficient detail to inform the Board of facts upon which the report is based, including the estimate of the type and quantity of all dangerous drugs involved, the time frame of the losses, and the date of the last controlled substance inventory. All reports to the Board are immune from civil or criminal liability.

FORMS:

Form Name	*Obtained From*	*Process*
DEA Form 222	Drug Enforcement Administration	Complete and send in request form to DEA (allow 2 weeks for processing). If request forms are needed, the DEA may be contacted and additional request forms will be mailed (allow 2 weeks for processing).
Expired C-II Safe Inventory Forms	Printed Locally	Form is printed from the C-II Safe
Pyxis vs. C-II Safe Compare Reports	Printed Locally	Form is printed from the C-II Safe
MedStation Auto Restock Forms	Printed Locally	Form is printed from the C-II Safe

REFERENCES:

- California Board of Pharmacy. Retrieved -June 21, 2022, from https://www.pharmacy.ca.gov/about/news_release/board_update_may_22.pdf
- Department of Justice. Drug Enforcement Administration Diversion Control Division. Retrieved October 26, 2021, from https://www.deadiversion.usdoj.gov/21cfr/cfr/index.html.
- Nursing Practice Act. (n.d.). Retrieved October 23, 2017, from http://www.rn.ca.gov/practice/npa.shtml.

- Marquardt, K.A., Tharratt, R.S., Musallam, N.A. Fentanyl remaining in a transdermal system following three days of continuous use. *Ann Pharmacother.* 1995; 29: 969-971.

CROSS REFERENCE:

- Wasting or Returning Controlled Substances Policy

SUBJECT: **DEATH OF A RESIDENT**	SECTION:

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

PURPOSE:

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

POLICY:

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

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

PROCEDURE:

A. Administrative

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

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

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

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

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

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

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

B. Care of the Body

1. Screen the unit for privacy.

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

3. Provide dentures in a labeled cup to mortuary.

4. Close eyes by gently pulling down on lashes.

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

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

7. Bathe the body and comb hair.

8. Change dressings if needed.

9. Place body in supine position.

10. Place disposable pads under buttocks and over perineum.

11. Identification bracelet must be on.

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

13. Provide for family privacy.

C. Preparation

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

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

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

D. Documentation

1. Resident's condition prior to death.

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

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

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

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

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

REFERENCES:

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

SUBJECT: **DEATHS REPORTABLE TO THE CORONER**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 2**

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

PURPOSE:

To identify all appropriate cases that are reportable to the Coroner's Office in keeping with *California Governmental Code Section 27491.*

POLICY:

It is the duty of anyone having knowledge thereof, to report to the Coroner any death which falls into the classes herein listed:

- No physician in attendance.
- All solitary deaths (unattended by physician or other persons in period proceeding death)
- Medical attendance less than 24-hours at the receiving facility.
- Wherein the deceased has not been attended by a physician *in the twenty (20) days prior to death.*
- Following an accident or injury. (Primarily or contributory, occurring immediately or at some remote time.)
- All deaths in which the patient is comatose throughout the period of physician's attendance, whether at home or hospital.
- Drowning, fire, hanging, gunshot, stabbing, cutting, starvation, exposure, acute alcoholism, drug addiction, strangulation, or aspiration.
- Accidental Poisoning (food, chemical, drug, therapeutic agents).
- Known or suspected Homicide.
- Known or suspected Suicide.
- Involving any criminal action or suspicion of a criminal act.
- All deaths in the operating room.
- All deaths where a patient has not fully recovered from an anesthetic, whether in surgery, recovery room or elsewhere.
- Occupation diseases or occupational hazards.
- Known or suspected contagious disease, constituting a public hazard.
- Related to or following, known or suspected self-induced or criminal abortion.

- Associated with a known or alleged rape or crime against nature.
- Where the suspected cause of death is *Sudden Infant Death Syndrome.*
- All deaths of unidentified persons.
- Physician unable to state the cause of death.
- In prison or while under sentence.
- Deaths of patients in state mental hospitals serving the ***mentally*** disabled and operated by the State Department of Mental Health
- Deaths of patients in State Hospitals serving the ***developmentally*** disabled and operated by the State Department of Developmental Services.

AFFECTED AREAS/PERSONNEL: *ALL PATIENT CARE AREAS*

PROCEDURE:

When a death occurs and it has been suspected or determined by the above criteria to be a Coroner's Case, it is the responsibility of the Hospital staff to notify the County Coroner's Office:

1. Call Tulare County Sheriff's Coroner and notify them of the death. *(559) 685-2593.*
2. The body will not be released to the mortuary until the hospital staff is instructed to do so by the coroner's investigator or Deputy Sheriff.
3. Failing to notify the Coroner's Office is a *Government Code violation, a misdemeanor.*

REFERENCES:

- California Government Code Section 27491 (January 1, 2016). Retrieved from http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=27491.
- Regulations and Laws for the County of Tulare

SUBJECT: **DIET ORDERS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish the procedure for processing diet orders.

POLICY:

All diet orders, including therapeutic diets, NPO orders, tube feeding orders and parenteral nutrition orders are processed through the electronic medical record (EMR).

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

PROCEDURE:

1. Diet orders, late trays, etc. are received via the EMR. If the system is down, Food & Nutrition Services (FNS) will follow the standard operating procedure (SOP) for EMR downtime.

2. Nutrition education requests are entered as a consult in the EMR.

3. Patients that state they have special diet needs that are stricter than the current diet order will be provided their desired modifications until clarification is obtained from the attending physician.

4. The dietitian can take verbal or telephone orders from physicians for diet, tube feeding, and parenteral nutrition orders. The orders will be placed in the chart according to hospital policy to be signed by the physician.

5. Any special dietary needs known by nursing should be identified in the diet order in the EMR – under modifications, allergies, likes, dislikes, etc.

6. Any between-meal diet changes or needs should be made in the EMR.

7. All diet orders shall follow the terminology approved in the diet manual located on the intranet.

8. Diet orders for various levels of nutrients (such as calories, protein grams, sodium milligrams, etc.) will include the specific desired level.

9. Diet orders will include the desired texture consistency.

10. Dietitian will be consulted whenever the Food & Nutrition Services (FNS) staff have questions regarding diet orders.

11. When a patient requests an item not allowed on their therapeutic diet, the dietitian can be consulted. When possible, the diet will be modified to accommodate the request. If the request is unable to be accommodated within the prescribed order, the charge nurse or dietitian will consult the physician for possible diet order changes when appropriate.

12. Oral syringe feedings are not a preferred method of P.O. intake. However, if deemed appropriate by the physician, a written order will be entered into the EMR.

REFERENCES:

- California Code of Regulations (2023). Title 22. § 70273.(a), Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov.

- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). § 70273(a), § 70273(d), § 70273(e). Retrieved from https://www.cms.gov/Regulations-and-Guidance.

- The Joint Commission (2023). Hospital accreditation standards. PC.02.01.03. Joint Commission Resources. Oak Brook, IL.

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

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

PURPOSE:

Discharge planning provides:

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

POLICY:

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

AFFECTED PERSONNEL/AREAS: *NURSING AND SOCIAL SERVICES*

PROCEDURE:

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

1. This facility uses a Social Worker or *designee* who is familiar with community resources needed to provide appropriate discharge planning.

2. The Interdisciplinary Team and Social Worker or designee are actively involved in planning for the residents who are about to be discharged.

3. Throughout the active discharge planning phase, appropriate disciplines will assist in education and preparation for discharge (i.e., a self-medication program may be initiated).

4. Coordination of discharge planning with the resident and/or responsible party regarding the home environment, equipment, medications, treatments, supervision and/or referral for community services in the home is an integral part of the discharge planning process.

DOCUMENTATION REQUIREMENTS:

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

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

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

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

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

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

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

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

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

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

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

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 (1)(3), Title 22, #72433 (5) United States of America, Med Pass Inc.

- California Health and Safety Code 1262.5: Section 1262.5: 2011 California (2015). Retrieved from https://calhospital.org/sites/main/files/file-attachments/lnc-afl-15-25.pdf.

SUBJECT: DP/SNF ROOM CHANGE	SECTION:

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

PURPOSE:

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

POLICY:

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

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICE*

PROCEDURE:

1. A written notification form will be completed by the Social Service Designee to notify the Resident or responsible party that there will be a change in room or roommate.

2. The form must be acknowledged by the resident or responsible party signature or telephone consent prior to the change occurring.

3. The form is filed in the resident's medical record.

REFERENCE:

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

SUBJECT: **EQUAL ACCESS TO QUALITY OF CARE**	SECTION:

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

PURPOSE:

- To ensure all residents are treated alike when the facility is making transfer and discharge decisions.
- To ensure the facility does not distinguish between residents based on their source of payment when providing services that are required to be provided under the law.

POLICY:

The facility will maintain identical policies and procedures regarding transfer, discharge, and the provision of services under the state plan for all individuals regardless of payer source. The facility may charge any amount for services furnished to non-Medi-Cal residents consistent with the notice requirements in the Resident Rights (42 C.F.R. – 483.10(b)(5)(i) and (b)(6) describing the charges. The State is not required to offer additional services on behalf of the resident other than services provided in the State plan.

AFFECTED PERSONNEL/AREAS: *DIRECTOR OF NURSING, REGISTERED NURSES, PHYSICIANS, SOCIAL SERVICES, BUSINESS OFFICE*

PROCEDURE:

1. At the time of admission, the Social Worker or Designee will inform the resident/responsible party of their rights concerning equal access to care, statement of services provided, and the facilities' policies for handling transfer and discharge processes.
2. The Director of Nursing will oversee the IDT processes and will ensure that all Nursing Services, Specialized Rehabilitative Services, Social Services, Dietary Services, Pharmaceutical Services, or Activities that are mandated by law will be provided to residents according to their individual needs, as determined by assessments and care plans.
3. The RN and Social Worker or Designee will coordinate the reporting of changes in resident care status/needs through daily census reporting and accounts tracking systems, and will coordinate all transfers, discharges, and services according to facility policies and procedures.
4. The Director of Nursing and/or Social Worker or Designee will ensure the resident is informed by appropriate disciplines/departments of changes in care, discharge plans and services provided under the State plan or current payer source.

REFERENCES:

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

SUBJECT: **HANDWASHING**	SECTION: **Page 1 of 4**

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

PURPOSE:

Handwashing is considered the single most important measure a healthcare worker can do to reduce the risks of transmitting microorganisms. The purpose of handwashing is to remove dirt, organic material, and transient microorganisms, thereby reducing the risk of healthcare acquired transmission of infection. The Handwashing policy and procedure establishes handwashing guidelines that are to be practiced throughout the facility.

POLICY:

All employees, volunteers, contractors, medical staff, students, and instructors shall wash their hands frequently with soap, friction, and running water or alcohol-based hand rub/sanitizer to minimize the likelihood of hands serving as a mode of transmission for ***healthcare acquired infections*** (HAIs).

**** Handwashing Indications (soap and water or, if appropriate, with alcohol-based hand rub/sanitizer):***

1. Upon arriving at work
2. Before and after performing invasive procedures
3. Healthcare Personnel (HCP) need to perform hand hygiene before and after all patient contact
4. Before and after taking care of particularly susceptible patients such as those who are severely immunocompromised and newborns
5. Before and after touching wounds
6. After contact with potentially infectious material in situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood, body fluids, secretions, excretions, and/or other potentially infectious materials (OPIM).
7. After touching inanimate sources that are likely to be contaminated with virulent or epidemiologically important microorganisms (i.e. Clostridium difficile, COVID-19).
8. After taking care of an infected patient or one who is likely to be colonized with microorganisms of special clinical or epidemiologic significance (i.e. Clostridium difficile, COVID-19).
9. Before eating or drinking.
10. Before preparing or serving meals, drinks, or tube feedings
11. After using the restroom
12. After blowing one's nose

13. After the work shift

14. After handling patient equipment

15. When hands are visibly soiled or contaminated with infectious material (soap and water)

AFFECTED AREAS/PERSONNEL: *ALL STAFF*

PROCEDURES:

Handwashing with soap and water

1. Stand near the sink avoiding direct contact.

2. Turn on the water to a comfortable temperature.

3. Wet hands and wrists with running water.

4. Obtain handwashing agent from the dispenser and apply to hands. Thoroughly distribute over hands.

5. Vigorously rub hands together for 20-30 seconds, generating friction on all surfaces of the hands and fingers. Pay particular attention to fingernails and nail bed areas.

6. Rinse hands thoroughly with running water to remove residual soap. .

7. Obtain paper towel and dry hands thoroughly.

8. Discard paper towel.

* Please note that the CDC has guidelines for "hand hygiene in health care settings". Studies have indicated that an alcohol-based hand rub is an alternative to the traditional approach of handwashing with soap and water in some situations. These are listed below:

Hand Hygiene Indications (alternative to soap and water with an alcohol-based waterless hand rub)

1. If hands are **not** visibly soiled, use an alcohol-based hand rub/sanitizer for routinely decontaminating hands in all other clinical situations.

2. Decontaminate hands after contact with a patient's intact skin (as in taking a pulse or blood pressure, or lifting a patient).

3. Decontaminate hands if moving from a contaminated body site to a clean body site during patient care.

4. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.

5. Decontaminate hands before caring for patients with severe neutropenia or other forms of severe immune suppression.

6. Decontaminate hands before donning sterile gloves when inserting a central intravascular catheter.

7. Decontaminate hands before inserting indwelling urinary catheters or other invasive devices that do not require a surgical procedure.

8. Decontaminate hands before donning (putting on) and after doffing (removing) gloves and reused PPE (mask, goggles/face shields and gowns).

Hand Hygiene with waterless antiseptic agent such as an alcohol-based hand rub (at least 60% alcohol)

Procedure:

1. Apply product to palm of one hand. Adequate volume of an alcohol-based hand rub to last approximately 20 seconds for hands to dry.

2. Rub hands together.

3. Rub hands together, covering all surfaces of hands and fingers, until hands are dry. (If an adequate volume of an alcohol-based hand rub is used, it should take approximately 20 seconds for hands to dry). Apply more hand sanitizer if needed to complete required time.

Monitor and measure staff adherence to proper hand hygiene practice:

- Make use of "secret shoppers" to monitor staff.

- Conduct adherence monitoring and provide coaching and feedback to frontline staff on regular basis to assess improvement over time, increase compliance, and prevent HAIs.

Patient Handwashing

Patients shall be given the opportunity to wash their hands before eating, after using the restroom, and any other time the hands are visibly soiled.

Visitor Handwashing

Visitors shall be encouraged to wash their hands before and after visiting patients.

REFERENCES

- "Hand Hygiene." World Health Organization. World Health Organization. Accessed May 1, 2023. https://www.who.int/teams/integrated-health-services/infection-prevention-control/hand-hygiene .
- "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, November 29, 2022. Accessed May 1, 2023. https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhicpac%2Frecommendations%2Fcore-practices.html# .
- "Hand Hygiene in Healthcare Settings." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, April 28, 2023, Accessed May 1, 2023. https://www.cdc.gov/handhygiene/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Fhand-hygiene.html .
- "Healthcare Providers." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, January 8, 2021, Accessed May 1, 2023. https://www.cdc.gov/handhygiene/providers/index.html .
- California Department of Public Health. "Monitoring Adherence to Healthcare Practices That Prevent Infection." Monitoring Adherence to Healthcare Practices that Prevent Infection. Accessed May 1, 2023. https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/MonitoringAdherenceToHCPracticesThatPreventInfection.aspx .

  "When and How to Wash Your Hands." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, November 15, 2022, Accessed May 1, 2023. https://www.cdc.gov/handwashing/when-how-handwashing.html .

SUBJECT: **INITIAL RESIDENT ASSESSMENT AND REASSESSMENT- MDS**	SECTION: **Page 1 of 6**

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

PURPOSE:

To ensure that each resident is properly assessed to best meet his/her needs.

POLICY:

It is the policy of this facility that each resident admitted to the institution shall receive a complete head to toe assessment by a qualified individual so that a plan of care can be developed to best meet the needs of the resident. The assessment of the care or treatment required to meet the needs of the resident will be ongoing throughout the resident's facility stay, with the assessment process individualized to meet the needs of the resident population.

Minimum Data Set Admission assessments (comprehensive) must be completed by the 14th day of the resident's stay.

SCOPE OF PRACTICE:

All nursing personnel in the resident care units shall be qualified by the level of licensure to perform a complete assessment and reassessment of the resident. A complete assessment shall include physical, psychological, pain management, spiritual needs, social status, as well as educational and discharge preparedness/planning needs.

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

PROCEDURE:

1. At the time of admission, each resident shall have an initial physical/psychological assessment completed by a registered nurse or a licensed practical/vocational nurse under the direct supervision of a registered nurse.

2. The assessment is structured to identify facilitating factors and possible barriers to the resident reaching his or her goals, including the presenting problems and needs such as:

    a. Symptoms that might be associated with a disease, condition or treatment (such as pain, nausea or dyspnea)

    b. Social barriers, including cultural and language barriers

    c. Social and environmental factors

    d. Physical disabilities

e. Vision and hearing impairments and disabilities

f. Developmental disabilities

g. Communicative disorders

h. Cognitive disorders

i. Emotional, behavioral and mental disorders

j. Substance abuse, dependence and other addictive behaviors

3. The interim nursing plan of care will be implemented on admission to ensure the resident receives the following necessary and immediate care: Activities of Daily Living (ADL) medications, nutrition, etc.

4. The plan of care will be completed when the Minimum Data Set (MDS) and Care Area Assessment (CAA's) are completed by all disciplines.

5. The RN Resident Assessment Coordinator will ensure that the MDS assessment is completed within 14 days of admission. The RN Resident Assessment Coordinator will conduct or coordinate each assessment and will sign and certify the completion of the assessment.

6. Resident Assessment Instrument (RAI) shall be completed for any resident residing at the facility longer than 14 days. The Resident Assessment Instrument (RAI) is comprised of:

a. Minimum Data Set (MDS)

b. Care Area Assessment (CAA's)

c. Utilization Guidelines (state operations manual)

7. The sources of information for the MDS include:

a. Review of the resident's record

b. Communication with the resident

c. Observation of the resident

d. Communication with direct care staff

e. Communication with licensed professionals from all disciplines

f. Communication with the resident's physician

g. Communication with the resident's family members

8. MDS sections include:

a. Identification Sections:

- Identification of Information

b. Clinical Sections:

- Hearing, Speech, Vision
- Cognitive Patterns
- Mood
- Behavior
- Preference for Customary Routine and Activities
- Functional Status
- Bowel and Bladder
- Active Disease Diagnosis
- Health Conditions
- Swallowing/Nutritional Status
- Oral/Dental Status
- Skin Condition
- Medications
- Special Treatments, Procedures, and Programs
- Restraints

- Participation in Assessment and Goal Setting
- State Supplement
- Care Area Assessment (CAA) Summary
- Correction Request
- Assessment Administration

9. States may establish additional MDS requirements. Check with your state rules and regulations.

10. The MDS must be signed off with the following information:

    a. Name

    b. Initials of profession

    c. Date

11. The RN Resident Assessment Coordinator or designee must sign:

    a. CAA's Summary Form

    b. Quarterly Review

12. If an error is discovered within seven (7) days of the completion of a MDS and before submission to the state MDS database, the response may be corrected using standard editing procedures on the hardcopy (cross out, enter correct response, initial and date) and correction of the MDS record in the facility database. The resident's care plan should also be reviewed for any needed changes.

13. The plan of care must be based on the resident's comprehensive assessment and must be completed within seven (7) days after the comprehensive assessment is completed.

14. The MDS will trigger elements that need to be addressed in the resident's plan of care. These elements are known as Care Area Assessment (CAA's).

15. Each CAA area triggered is noted in the MDS Care Area Assessment summary and requires further assessment.

16. CAA areas include:

    a. 01 Delirium

b. 02 Cognitive Loss/Dementia

c. 03 Visual Function

d. 04 Communication

e. 05 ADL Function/Rehabilitation Potential

f. 06 Urinary Incontinence and Indwelling Catheter

g. 07 Psychosocial Well-Being

h. 08 Mood State

i. 09 Behavior Symptoms

j. 10 Activities

k. 11 Falls

l. 12 Nutritional Status

m. 13 Feeding Tubes

n. 14 Dehydration/Fluid Maintenance

o. 15 Dental Care

p. 16 Pressure Ulcers

q. 17 Psychotropic Drug Use

r. 18 Physical Restraints

s. 19 Pain

t. 20 Return to Community Referral

17. After appropriate documentation on the MDS CAA Summary, the RN Resident Assessment coordinator must date and sign to verify that all triggered CAA's have been applied.

18. Detailed care planning will be documented on the resident's plan of care.

19. Any changes in the resident's condition shall require an immediate reassessment with changes in the plan of care reflecting the change in condition.

20. Quarterly Assessment (state mandated subset or MPAF) must be completed every 92 days by the RN Resident Assessment Coordinator.

21. An MDS assessment is completed on all new resident admissions and those residents who have returned to the facility after being discharged.

22. A hardcopy of all MDS forms within the last 15 months, including signatures of the facility staff attesting to the accuracy and completion of the records, must be maintained in the resident's clinical record.

REFERENCE:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 United States of America, Med Pass Inc.
- The Medicare Learning Network®, MLN Connects®, and MLN Matters®. U.S. Department of Health & Human Services (HHS). ICN 909067 October 2017.
- CMS. Chapter 2: Assessments for the Resident Assessment Instrument (RAI). https://www.aanac.org/docs/mds-3.0-rai-users-manual/11114_mds_3-0_chapter_2_v1-12r2.pdf?sfvrs.
- *The MDS Assessment Process* by American Association of Nurse Assessment Coordination (AANAC). American Association of Post-Acute Care Nursing (AAPACN). November 08, 2017.

SUBJECT: **LEAVE OF ABSENCE, THERAPEUTIC**	SECTION:

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

PURPOSE:

Residents will be allowed short stays out of the facility to enhance their social, emotional and therapeutic well-being. Leave of absences or therapeutic outing allow the resident, interdisciplinary team and family to evaluate the resident's functional status and strengths, as well as identify problem areas for further rehabilitative or restorative programs.

POLICY:

Resident leave of absences will be authorized by the attending physician and in accordance with regulatory guidelines set forth and governing leave for residents in sub-acute and skilled nursing levels of care. All leave or outings will be allowed and conducted in accordance with standards and requirements determined by the resident's medical insurance or payer sources. All decisions regarding the appropriateness of leave of absence will be made in collaboration with the interdisciplinary health care team, the resident and family.

AFFECTED PERSONNEL/AREAS: *ALL DPSNF; SOCIAL WORKERS*

PROCEDURE:

1. Therapeutic leave or outings may be initiated by the resident, family or team members as determined essential in promoting the resident's physical and emotional well-being and quality of life.

2. An assessment of the resident's medical appropriateness, supportive care needs, caregiver capability, equipment needs, transportation resources, self-sufficiency, medications and treatment administration, supplies, diet and environmental concerns will be made by the team prior to the resident's leave. This also includes review of any information regarding the resident's destination, date and time of departure and return, and identity of persons responsible for the resident's care.

3. At the time of admission, or during the rehabilitation process, the Social Worker and/or Social Service Designee will ensure resident and/or responsible representative is aware of facility and regulatory procedures for leave. A written consent for participation in leave of absence or outings from the facility and/or a release of responsibility will be obtained prior to leave.

4. The resident and/or responsible party must receive education, training and written instructions (as appropriate), regarding procedures and information likely to be encountered during resident's absence from the facility in order to assure continuity of care.

5. Social Worker and/or Social Service Designee will work with nursing and resource persons to coordinate training and to arrange equipment and supply needs prior to leave. Documentation of all training, financial agreements and support arrangements will be entered into the medical record.

6. The resident's participation in a leave of absence should be included in the individual plan of care, including special care and dietary treatment needs.

7. The resident or responsible representative must confirm arrangements for a leave from the facility with nursing staff and the Social Worker. The resident must be signed out at the nursing station (use leave of absence form) and signed in upon return. The address of the intended leave destination and the inclusive dates of leave must be indicated.

8. Nursing staff will assure that the resident receives appropriate medication before leave commences and that medications needed during leave are reviewed and provided to resident/responsible party before signing out.

9. The facility will hold the resident's bed vacant during an approved leave. The nursing supervisor and/or Social Worker and/or Social Service Designee must be notified when the resident/responsible representative anticipates failure to return from leave within the approved period and when medical complications arise that warrant emergency treatments or hospitalizations. A Bed-Hold Notice will be provided to the resident/responsible representative when leave is anticipated to be over a 24-hour period, in accordance with the Bed Hold policy.

10. Upon return to the facility, the licensed nurse to obtain response/feedback about the outing will interview the resident or responsible party. The resident will return all unused medications, supplies and equipment.

11. Private medical insurance programs and publicly funded programs, such as Medi-Cal and Medicare, may or may not provide hospitalization benefits for the period of time during and subsequent to the time a resident is away from the hospital. If the private or public insurance program does not provide such hospitalization benefits, the resident or the person financially responsible for the resident's hospitalization expenses will remain obligated to pay the hospital for such expenses in accordance with the hospital's regular rates and terms.

12. When out overnight, the day of departure will be counted as one day of leave and the day of return shall be counted as one day of patient care. Leave is terminated if resident necessitates admission to another inpatient facility, exceeds approved period of leave, or is determined to be absent without leave. (Shall apply unless otherwise determined by medical insurance payors). Any leave that is not recommended or approved by the physician will be considered leave against medical advice (AMA) which is grounds for discharge from the facility.

13. Leave of absence for Medi-Cal beneficiaries at sub-acute or skilled nursing facility (SNF) level of care will be authorized per Title XXII regulations: Up to 18 (eighteen) calendar days per year. Up to 12 (twelve) additional days of leave per year may be approved when the request for additional days of leave is in accordance with the individual resident care plan and appropriate to the physical and mental well-being of the resident. The attending physician must approve and document in the resident's plan of care for those leaves involving the up to 12 (twelve) additional days described.

14. Leave of absence for Medicare beneficiaries at the skilled level of care will not be routinely authorized, and must be reviewed on a case by case basis to determine whether the outing constitutes a special circumstance. In some cases, outings can be allowable as short absences from the facility to handle emergent situations (i.e. funeral, wedding, need to secure residence or property in residence, discharge planning, needed to handle a special financial matter that cannot be resolved, etc.)

15. Leave of absence for private insurance residents must be approved by the medical insurance payors (i.e. case manager, physician reviewer, etc.) in order to assure continued coverage, and may be subject to short absences under special circumstances as with Medicare beneficiaries.

16. Due to the nature of disability and the complex support and skilled needs of the sub-acute resident, frequent or extended leave of absences may not be determined medically indicated by the physician and interdisciplinary team. It is recommended that the team consider leave for the sub-acute resident to return to the facility in order to resume the level and continuity of care provided within the sub-acute framework. Outings of longer daytime duration, allowing the resident to return to the facility in order to resume the level and continuity of discharge planning trial visits are recommended for the sub-acute resident as the rehabilitative processes become more eminent.

17. The Social Worker will monitor the resident's response, progress and goals, responsible party involvement and interdisciplinary planning of resident leave from the facility.

REFERENCES:

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

SUBJECT: **LEAVE OF ABSENCE, THERAPEUTIC OUTING CHECKLIST**	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 provide a reference checklist for use by the Interdisciplinary Team (IDT), in preparing for leave away from the facility.

POLICY:

Social Services will assist the resident, family and Interdisciplinary Team in the coordination of therapeutic leave of absence or outings, in accordance with policies and procedures established by the facility and regulatory standards.

AFFECTED PERSONNEL/AREAS:

SOCIAL SERVICES, NURSING, INTERDISCIPLINARY TEAM

PROCEDURE:

When resident/family request and/or it is determined by the Interdisciplinary Team that an outing would be beneficial for resident, the following steps should be taken:

Yes Or N/A	Date	
_____	_____	1. Details of the outgoing determined by Interdisciplinary Team: type of outing; medical, psychosocial and environmental appropriateness of the outing; length of time involved; responsible caregiver, staff needed, etc.
_____	_____	2. Review of hospital policies and procedures for therapeutic leave/outings to assure compliance.
_____	_____	3. Determine if outing is allowable by insurance coverage (i.e. private insurance and Medicare may not cover absence from Hospital); document approval and financial responsibility.
_____	_____	4. If determined medically appropriate, then physician's order is obtained (specify type of outing and time frame).
_____	_____	5. Develop a Care Plan regarding outing (steps necessary to achieve outing, and/or for ongoing maintenance).
_____	_____	6. Administrative approval for outing, (if necessary).
_____	_____	7. Determine whether location of outing is available or feasible for the resident to attend (prior reservations or special arrangements made, as necessary).

SUBJECT: **LEAVE OF ABSENCE, THERAPEUTIC OUTING CHECKLIST**	SECTION: **Page 2 of 3**

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

Yes Or N/A	Date	
_____	_____	8. Resident and family training provided by all necessary disciplines (documentation of training in chart notes and/or skills sheet).
_____	_____	9. Arrangements made with facility, family, insurance company, durable medical equipment to ensure resident has equipment needed for outing (i.e. portable vent, wheelchair, suctioning, etc.)
_____	_____	10. Ensure appropriate staff available and designated to accompany resident on outing (if required).
_____	_____	11. Coordinate/confirm transportation (hospital van, family car, community van, etc.) prior to outing.
_____	_____	12. Counsel and education provided to resident and/or family regarding roles, expectation of behavior during outings, compliance, emergency procedures, time frame, pass medications, etc.
_____	_____	13. Ensure consent form is signed for outings.
_____	_____	14. Ensure medications and care instructions are completed and provided to resident and/or caregiver by nursing at time of outing.
_____	_____	15. Ensure resident/caregiver signs out and in (before and after) outings.
_____	_____	16. Follow-up interview with resident/family after outing to determine and document response/outcome of outing and future goals (nursing must interview resident upon return to Facility). Social Service to provide follow-up counsel and assure education as needed ongoing.
_____	_____	17. Ensure that any twenty-four (24) hour leave of absence is noted properly on the daily census report.
_____	_____	18. Ensure a Bedhold Notification Form is completed when leave of absence is planned for over twenty-four (24) hours.

REFERENCES:

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

SUBJECT: **MDS, COMMUNICATING/TRACKING MEDICARE PPS INFORMATION**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish a timely process for communicating the MDS (Minimum Data Set) information to the Business Office for Medicare's billing requirements under PPS (Prospective Payment System) for Skilled Nursing Facilities.

POLICY:

The facility will utilize the Medicare Assessment Schedule for the completion of MDS Assessment. The facility will utilize the Medicare SNF PPS Tracking Form to communicate and monitor MDS information between the unit and the Business Office.

AFFECTED PERSONNEL/AREAS: *MDS COORDINATOR, BUSINESS OFFICE*

PROCEDURE:

1. The MDS Coordinator will complete and lock the MDS assessment according to Medicare's schedule for all patients in an SNF Part A covered stay.

2. On a weekly basis, the MDS Coordinator will complete the first four columns of the Medicare SNF PPS Tracking Form for each MDS assessment completed and locked. This should be done on the same day of the week the MDS assessments are transmitted to the state.

    a. *Column 1* – Enter the patient's name, admit date, medical record number and account number.

    b. *Column 2* – Enter the HIPPS (Health Insurance Prospective Payment system) code (i.e., SE 301). The five-digit HIPPS code consists of the three-digit RUGSIII (Resource Utilization Group) code assigned by the MDS Grouper and the two-digit modifier, which identifies the reason for the assessment. The modifier should be taken from Sections AA.8.a. and AA.8.b. of the MDS.

    c. *Column 3* – Enter the date the MDS Assessment was locked.

    d. *Column 4* – Enter the period of days the assessment and HIPPS code represents for payment (i.e. 1-14).

    e. *Columns 5 and 6* – These columns are to be used by the Business Office to calculate the expected Medicare reimbursement.

    f. *Column 7* – This column should be used to identify MDS Assessments that are completed in addition to the "normal" schedule. (i.e., Significant Change in Status Assessment and Other Medicare Required Assessment).

3. Enter the "Date Completed" and the "Completed By" sections.

4. Each week the completed Medicare SNF PPS Tracking Form will be forwarded to the Business Office Representative responsible for billing Medicare claims. In the event that there are no MDS assessments for the week, complete the form and state "No Medicare Assessment for this week."

REFERENCES:

- Long Term Care Facility Assessment Instrument 3.0 User's Manual, Version 1.16 (October 2018). Retrieved from https://downloads.cms.gov/files/1-MDS-30-RAI-Manual-v1-16-October-1-2018.pdf.

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

SUBJECT: **MDS, DIAGNOSIS CODING ON MDS ASSESSMENTS AND UB 92 CLAIM FORMS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish a process for communicating the MDS (Minimum Data Set) Assessment information to the Medical Records Department to ensure consistency of ICD-10 (Diagnosis) Coding.

POLICY:

It is the policy of this facility that the Medical Records Department provides the ICD-10 codes to the MDS Coordinator for entry onto the MDS Assessment.

AFFECTED PERSONNEL/AREAS: *MDS COORDINATOR, MEDICAL RECORDS CODER, BILLER*

PROCEDURE:

1. The MDS Coordinator will complete, lock and transmit to the State Offices the MDS Assessment for each resident in accordance with their primary funding for admission:

   a. Medicare, Medicare HMOs, and MSP (Medicare as Secondary Payors) – Completed according to Medicare's schedule for 5-day, 14-day, 30-day, 60-day, 90-day, quarterly and annually.

   b. Commercial Insurance, Non Medicare HMOs, Workers' Compensation, Medi-Cal, and Cash – Completed according to the State's Schedule for 14-day, quarterly and annually.

2. The Medical Records Coder will ensure that a valid ICD-10 code is provided to the MDS Coordinator for each diagnosis listed. The ICD-10 codes will be provided within the timeframes listed to ensure compliance with MDS completion requirements.

3. The Medical Records Coder will enter the ICD-10 codes into the computer system on the patient's account for each MDS Assessment. Additional ICD-10 codes identified on subsequent MDS Assessments will be added to the prior ICD-10 codes listed on the patient's account, to accommodate monthly interim billing.

4. The MDS Coordinator will enter the ICD-10 codes on the MDS Assessment.

5. The ICD-10 codes will print on the UB92 claim form that is used for billing Medicare, Medicare HMOs, MSP, Commercial Insurance, Non Medicare HMOs and workers' compensation claims.

6. The Biller will submit UB92 claims on an interim monthly basis, upon exhaustion of primary funding, and upon discharge.

REFERENCES:

- MDS 3.0 RAI Manual v1.16 (October 2018). Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

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

SUBJECT: **MALIGNANT HYPERTHERMIA (MH), PATIENT TREATMENT GUIDELINES**	SECTION: **Page 1 of 11**

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

PURPOSE:

- To provide nursing staff with guidelines on how to recognize the patient who may be or is known to be at risk for Malignant Hyperthermia (MH).
- To recognize the presenting symptoms and recommended treatment for a patient in MH crisis.

POLICY:

This policy/procedure is intended to provide guidelines to ensure maximum patient safety in the treatment of a malignant hyperthermia crisis.

DEFINITIONS

- Malignant Hyperthermia – a rare genetic condition characterized by a severe hypermetabolic state and rigidity of the skeletal muscles.
- Triggering agent – succinylcholine and some inhaled anesthetics (i.e. sevoflurane, isoflurane, desflurane) are agents known to elicit a MH response. The triggering agent causes a series of chain reactions in the body related to an increase in skeletal muscle intracellular calcium ion (Ca++) concentration.
- MH crisis – an overwhelming physical response to a triggering agent that may result in the death of the patient.

CONSIDERATIONS

1. The early recognition of MH symptoms is crucial. These symptoms may occur immediately after induction of anesthesia or as late as during the recovery phase in the Post-Anesthesia Care Unit (PACU). It may present with a variety of signs and symptoms during an acute phase or present in a more subtle fashion and develop over the course of several hours. (24 Hr)
2. The susceptible patient may undergo multiple uneventful episodes of anesthesia prior to the development of an episode of MH.
3. MH may also be induced by trauma, strenuous exercise or emotional stress in susceptible individuals.
4. Males develop MH reactions more frequently than females. People under 18 have the highest incidence of MH.
5. The rise in body temperature is one of the late manifestations; the temperature may rise at a rate of 1 to 2 degrees Celsius (C) every 5 minutes.

6. The following list represents symptoms that may present in the patient undergoing a MH crisis. These are not listed in any particular order.

   a. Masseter muscle rigidity due to increased intracellular Ca^{++} levels

   b. Hypercarbia - doubling or tripling when minute ventilation is constant

   c. Unexplained tachycardia - (sinus, ventricular, or even ventricular fibrillation)

   d. Whole body muscle rigidity

   e. Respiratory acidosis – (end-tidal carbon dioxide (CO2) > 55 millimeters of mercury (mmHg) or arterial partial pressure of carbon dioxide (pCO2) >60mmHg)

   f. Metabolic acidosis - (base excess < -8, potential hydrogen (pH) <7.25)

   g. Core temperature elevation – (as much as 1° C [1.8° Fahrenheit (F)] every few minutes) (increase may be early or late sign)

   h. Skin changes - generalized erythmatous flush or mottling, cyanosis, diaphoresis (lack of oxygenation to peripheral tissues due to oxygen consumption by muscle tissue; generalized vasoconstriction)

   i. Myoglobinuria – representing renal function change

   j. Sudden cardiac arrest – typically due to hyperkalemia

   k. Rhabdomyolysis - occurs when the muscle is damaged and intracellular contents begin to leak into the bloodstream.

7. During preoperative interviews, the Registered Nurse (RN) should ask all patients who will be receiving general anesthesia if they have any personal or family history of MH, or if any family members have died in surgery.

8. The RN should alert the anesthesia provider about any positive patient or family MH history, or patients who describe a history of non-surgical related incidents of heat stroke or hyperthermia.

9. The patient with MH will require continual reassurance. The clinical team is responsible to inform the patient that everyone is aware of potential problems and that an anesthesia treatment plan has been developed to avoid any MH occurrence.

GUIDELINES

1. A MH supply cart will be located in the Main Operating Room (OR), Obstetrics (OB) OR and the Ambulatory Surgery Department (ASD). Unit Crash Carts will be used in conjunction with the MH Carts during a MH crisis. Additional supplies are stocked in each individual department, including the medication refrigerators.

2. Binders containing all necessary forms will be kept on top of the MH carts. Updating of the binders will be the responsibility of each individual department.

3. Each MH cart's medications will be stocked and checked for outdates at least monthly by Pharmacy. Red breakaway locks will be used to assure drawer security. In the event that expired, or soon to be expired, medications are discovered, pharmacy will have the responsibility of replacing the item(s) and to re-lock the cart.

4. Non-pharmaceutical supplies in each cart will be stocked and checked at least monthly by the individual units. (See Addendum Cart Inventory List.) Yellow breakaway locks will be used to ensure drawer security. In the event that expired, or soon to be expired, non-pharmaceutical supplies are discovered, Central Processing Department will have the responsibility of replacing the item(s) and to re-lock the cart. (all Pharmaceutical supplies will be restocked by the Pharmacy)

5. The cart is to be checked daily (when unit is open) by Nursing Staff to assure that the locks are intact. The cart lock number is recorded in the Malignant Hyperthermia Cart logbook kept on top of the MH cart. The earliest expiration dates of medications and supplies are to be noted on the front of the drawers and checked monthly.

6. In order to assure availability, the cold intravenous (IV) fluids, ice, irrigation fluids and specified dosages of regular insulin will be labeled as "MH Use Only". (The marked insulin will be kept in the Pyxis refrigerators in the Main OR and OB, and in the medication refrigerator in Room 1 at the ASD.)

AFFECTED AREAS/ PERSONNEL:

ANESTHESIA SERVICES, SURGICAL SERVICES, ASD, MATERNAL CHILD HEALTH (MCH), EMERGENCY DEPARTMENT (ED), INTRAOPERATIVE RNs, MCH RNs, PACU RNs, INTENSIVE CARE UNIT (ICU) RNs, ED PHYSICIANS, RNs, LICENSED VOCATIONAL NURSES (LVNs), and SURGICAL TECHS

PROCEDURE:

ANESTHESIA

1. When MH symptoms are suspected during general anesthesia, the anesthesia provider must stop the administration of anesthetic gas agents except oxygen (dependent on the point of advancement of the surgical procedure; nitrous oxide or propofol are safe alternatives to maintain general anesthesia). The anesthesia circuit and the ventilator bag must be replaced immediately. The patient is hyperventilated with 100% oxygen (O_2) in an attempt to meet the requirements of the body during the crisis period.

2. The anesthetic vaporizer should be disabled as soon as possible. The machine is then flushed with 100% O_2 at 10 liters (L)/min through the circuit via the ventilator for 20 minutes.

3. The soda lime canisters will require replacement; care must be taken when changing as a patient in full blown crisis will exude so much CO_2 that these canisters will be very hot to the touch.

4. If possible, change out anesthesia machine.

NURSING

1. Call for help. In conjunction with the Charge Nurse, the staff RN will coordinate and communicate assignments of personnel responding to the crisis and assist anesthesia as needed.

2. Code Blue may be called if additional staff is needed. If after hours, the House Supervisor will be notified.

3. Should these symptoms manifest themselves while the patient is at the ASD, a call will be placed to 911 for patient transport to the ED for continued care.

4. Obtain the MH Cart, the Crash Cart and the refrigerated fluids immediately.

5. At least two other nursing staff will be needed to assist with mixing the dantrolene sodium and at least one other runner will need to fill bags with ice and bring them to the OR or PACU (where the crisis is occurring.) Another individual must be able to stand-by to transport blood gasses and other lab-draw specimens.

6. Assign one (1) RN to document. The Malignant Hyperthermia Association of the United States (MHAUS) Malignant Hyperthermia Crisis Flow Sheet will be utilized to document the MH crisis. (See attachment.) Copies of the Flow Sheet are located in the MH cart binder.) In addition, a Code Blue record is completed if the patient experiences cardiac or respiratory arrest.

7. The MHAUS hotline, at (800) 644-9737, may be utilized at any time deemed necessary to assist the staff and any non-anesthesiologist physician responding to a crisis.

8. Insert a 3-way foley catheter with a urine meter bag if the patient does not already have one in place. Report to anesthesia the color and quantity of the patient's urine. Have cystoscopy tubing ready to attach to the infusion side of the 3-way to irrigate with chilled saline.

9. Cooling the patient is of vital importance to reduce body temperature:

   a. Infusion of refrigerated IV solutions as fast as one liter/10 minutes for 30 minutes may be required. (These solutions are found in the medication refrigerators in the Main OR, OB and the ASD.) This infusion of cold IV fluid results in kidney diuresis and temperature reduction. **Do not use Lactated Ringer's Solution.**

   b. Surface cooling, utilizing automatic cooling blankets and/or ice packs to the head, neck, axilla, and groin. Instant ice packs will be available in the carts. Ice machines are located in the Main OR lounge, PACU nursing station, the OB Break Room, and in the staff lounge at the ASD. Additional ice can be obtained from the hospital kitchen 24 hours a day. If necessary, the House Supervisor has access to the ice machine after hours.

   c. Lavage of the stomach, bladder, and rectum is possible using large quantities of cold saline for irrigation (does not need to be IV saline). If fever occurs in the operating room while the peritoneal cavity is open, cold saline irrigation solution can be introduced into the peritoneal cavity.

   d. **Note: It is very important to monitor core body temperature (rectal, esophageal, tympanic membrane or bladder) as over-cooling the patient has its dangers as well. Discontinue cooling measures when the core temperature has reached 38° C (100.4° F).**

SURGEON

1. If the surgical procedure is in progress, the surgeon must begin to close the operative incision as soon as possible. He/she will assist the anesthesia provider in the care of the patient, including helping with mixing of the dantrolene sodium if needed.

PHARMACEUTICALS

1. Dantrolene sodium will be administered as soon as possible. The recommended initial dosage is 2.5 milligrams/kilogram (mg/kg) of body weight and should be administered through the largest possible vein to decrease the risk of phlebitis. (See Dantrolene Dosage Chart Addendum.) Post-crisis treatment with dantrolene sodium will continue for 24 hours at

a dose of 1 mg/kg every 6 hours; however, total dosage is to be titrated to the patient's reaction to treatment.

2. The nurse should notify Pharmacy (or the House Supervisor after hours) of the clinical diagnosis and situation so that they can bring additional dantrolene to the department immediately.

3. As a large quantity of dantrolene sodium may be necessary, a supply of 36 vials will be stocked in each of the MH carts: the Main OR, OB and the ASD. Extra vials are available in the Pharmacy. Additional vials will be obtained by Pharmacy from outside sources, if needed.

4. 60 milliliters (ml) of preservative-free sterile water for injection is required to reconstitute one vial of dantrolene sodium. Therefore, a minimum of 2,160ml of preservative-free sterile water must be available for mixing the dantrolene sodium.

5. The preferred treatment for arrhythmias is lidocaine or amidoarone as per Advanced Cardiac Life Support (ACLS) protocol. **Do not treat arrhythmias with calcium channel blocking agents when dantrolene sodium has been administered.** Calcium channel blockers may lead to life-threatening hyperkalemia and myocardial depression. Avoid parenteral potassium as well. (Avoid lidocaine or procainamide in hyperkalemic patients)

6. For the correction of acidosis not being reversed by dantrolene sodium, sodium bicarbonate is administered at 1-2 milliequivalents (mEq)/kg if blood gas values are not yet available; otherwise per physician order.

7. Place arterial and additional IV lines as time permits.

8. IV Administration of titrated mixture of 50 cubic centimeters (cc) of 50% Dextrose and 10 units of Humulin R® insulin may be ordered to provide glucose for metabolism and reduce hyperkalemia by driving potassium back into the cells. The amount of this mixture administered will be titrated based on the potassium level results. (Humulin R® is the only type of insulin that may be administered IV) by driving potassium back into the cells.

9. Administration of 10mg/kg of calcium chloride I.V. or calcium gluconate 10-50mg/kg I.V. ,Bicarbonate 1-2 mEq/kg I.V. may be ordered to treat life-threatening hyperkalemia.

10. Arrangements for an ICU bed must be made. This patient will require close observation and frequent blood gasses and other blood work for the next 36 hours at a minimum.

AFTER THE CRISIS

1. An Anesthesiologist shall provide post-crisis instruction to the patient and family as he/she will be better able to describe what occurred and what will need to happen in the future.

a. Discuss possible side effects of dantrolene sodium that they may observe in their family member post-crisis treatment; these may include nausea, diarrhea, double vision, lightheadedness, and muscle weakness.

b. Have patient follow-up with primary physician for further blood work after discharge (creatine kinase [CK] levels, coagulation profile).

c. Advise the family to contact the Malignant Hyperthermia Association of the United States (www.mhaus.org) for additional information, voluntary registration, and support. The MHAUS website also has information as to where the family can acquire muscle biopsy testing for diagnosis. English and Spanish informational handouts are available in the back of the MH cart logbook.

d. Review susceptibility of malignant hyperthermia in blood relatives.

e. Advise patient and family to notify other healthcare providers (including dentists/oral surgeons) regarding malignant hyperthermia diagnosis or susceptibility.

f. The anesthesia provider will complete the MHAUS reporting form for Adverse Metabolic Reaction to MHAUS.

2. The Charge Nurse or Circulator will submit a QM/RM report of the incident.

3. Once the patient has been transferred out of the OR and a comprehensive report has been given to the accepting nurse and physician, an assessment should be done to consider the availability of crisis management supplies to complete the remaining surgery schedule. If it is determined not safe to proceed with scheduled cases, patients may have to be rescheduled for a later time and date when mandated supplies are again available.

4. Immediate steps will be taken to reorder dantrolene and other crisis management supplies.

5. A debriefing should be held with all staff involved in the MH crisis as soon as possible to evaluate their response. The meeting should include areas in which the response team may need to improve for future cases of MH.

EDUCATION

Anesthesia Services, Surgical Services (ASD, Main OR, PACU), MCH, ICU and ED staff must participate in at least annual reviews of MH signs/symptoms and MH crisis response, including a mock MH code.

REFERENCES:

- AORN (~~2019~~) (2023) Perioperative Standards and Recommended Practices. Retrieved from ~~https://www.aorn.org/guidelines.~~ https://aornguidelines.org/glance/content?gbosid=483811
- Fielder, C. (2010). *Managing malignant hyperthermia: We were prepared when a crisis rocked our center. Can you say the same?* Outpatient Surgery Magazine, XI (2), 30-34. Unable to locate reference
- Malignant Hyperthermia pp. 1-6.Revised ~~March 3, 2019~~ 25 May 2023 from ~~http://en.wikipedia.org/wiki/Malignant_hyperthermia.~~ https://en.wikipedia.org/w/index.php?title=Malignant_hyperthermia&oldid=1157026279
- Malignant Hyperthermia Association of the United States. (2007). Malignant Hyperthermia, A Concern for OR & PACU Nurses [Brochure]. Sherburne, NY. Unable to locate reference
- Malignant Hyperthermia Association of the United States, www.medical.mhaus.org; accessed April , ~~2019~~ 2023.

Attachment A

SIERRA VIEW MEDICAL CENTER
MALIGNANT HYPERTHERMIA SUPPLY CART

Top of Cart:

Laminated poster Emergency Therapy for MH
Binder

Drawer 1

1	Temperature Probe & Cable
1	CV Pressure Kit
1	Radial Arm Cath Set
1	NS 500 ml IV
1	Pressure Bag
1	NG Tube 12, 16, 18
1	Suction Tubing
1	Feeding Tube 8
2	Toomey Syringe
2	Irrigation Tray
1	Y Connector
1	5 in 1 Connector
4	Water soluble Jelly

Drawer 2

	Alcohol Wipes
1	3 way Stopcock
1	Wrist Support
2	IV Start Kit
3	IV Cath 16, 18, 20, 22 (3 each)
2	Primary IV tubing
1	Primary IV microdrip tubing
1	Secondary IV tubing
2	Syringe 20 ml
5	Syringe 10 ml
4	Syringe 3 ml
2	Syringe Insulin
4	ABG kits
2	Red top (lab tube)

2	Blue top
2	Purple top
2	Green Top
2	Urine Spec Container
4	21 g Needle for lab draw
2	Tourniquet
1	Tape: Silk 1", Foam 2", Transpore 1" (1 each)

Drawer 3

36	Dantrolene Inj 20mg/vial
50	Sterile Water for Injection 50mL
5	Sodium Bicarb 8.4% Inj 50mL
4	Furosemide 40mg/4mL
2	Dextrose 50% 50mL
2	Calcium Chloride 10% 10mL
3	Lidocaine 2% Inj 5mL
1	Regular Insulin 100U/mL 10mL(in designated refrigerator)
10	Needle 18g blunt
10	Needle 18g
4	Syringe 60 ml
	Medication Labels

Drawer 4

1	Sterile Drape
7	Instant Cold Packs
1	Soda Lime Canister Refill (Carbon dioxide absorber)
1	Foley Cath tray
1	Urometer
1	Urine Bag
1	Bladder Irrigation Tube
1	Catheter Stabilizing Device
1	3-way Foley Catheter 22 F / 30 ml
1	3-way Foley Catheter 20 G / 30 ml
1	Foley Catheter 8, 12, 16, 18 French (1 each)
1	Enema Kit
1	Ice Bucket
4	Small Bags for Ice
4	Large Bags for Ice

Ice
Freezer @ ASD
Ice machine in OR and PACU

Ice machine in MCH

Refrigerator

6 NS IV fluid (1000 ml)
6 NS Irrigation bottles (1,000 ml)
1 NS Irrigation bags (5,000 ml)

Binder Contents

Daily Cart Checklist
MH Cart Contents List
MH Policy & Procedure
MHAUS Flowsheet
MHAUS Guidelines Therapy Info
Dantrolene Dosage Chart
SVMC Dantrolene Drug Protocol
Phone Extensions
MHAUS Adverse Medical Reaction to Anesthesia form

- ***CVP Kit supplies on Crash Cart***
- ***Art Line Cable on Anesthesia Cart, Anesthesia Room, PACU Cart***
- ***Ambu Bag on Crash Cart (Peds & Adult)***

SUBJECT: **MASSIVE TRANSFUSION**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish the criteria for activating the massive transfusion protocol.

PRINCIPLE:

Following massive transfusion, there is such a small volume of the patient's blood left that complete crossmatching has limited benefit. The pretransfusion sample no longer represents currently circulating transfused blood and sensitive AHG testing on the current specimen accomplishes virtually nothing. It is usually only necessary to confirm ABO compatibility of subsequently transfused blood.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

PROCEDURE:

1. The crossmatch can be abbreviated in those instances in which the patient has received a volume of blood approximately equal to their own blood volume within a 24 hour period. For an average adult this can be assumed to be 10 units.

2. In cases of massive transfusions as defined above, an immediate spin major crossmatch is all that is required prior to transfusion provided that the patient has had a negative antibody screen performed within the last 3 days.

3. If the antibody screen is positive and:

    a. If the antibody has been identified, units known to be negative for the target antigen may be transfused after immediate spin crossmatch only.

    b. If the specificity of the antibody has not been determined, or if the antigen has not been tested for in the donor units, then a complete major crossmatch is required.

4. This procedure applies up to 24 hours after the occurrence of a massive transfusion.

REFERENCE:

- American Association of Blood Banks (AABB) Technical Manual, 20th Edition, pg526-527, 2020.
- American Association of Blood Banks (AABB) Standards, 33rd Edition, p46, 5.19.6, 2022

SUBJECT: **MATTRESS- AIR**	SECTION:

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

PURPOSE:

The purpose is to provide pressure reduction to residents at risk for skin breakdown and to distribute body weight, relieving areas of pressure.

POLICY:

It is the policy of this facility to utilize air mattress therapy under the direction of a physician's order or when the resident's clinical condition warrants pressure-reducing devices.

AFFECTED PERSONNEL/AREAS: *CNA, LICENSED STAFF*

EQUIPMENT:

- Air mattress

PROCEDURE:

1. Place mattress on bed.
2. Be sure that mattress is inflating properly.
3. Bed making
   a. Do not use pins
   b. Do not use chux, under-pads, or sheepskin pads on the bed. Use special air flow pads.
4. Check air mattress routinely to ensure that it is working properly.

REFERENCES:

- California Code of Regulations (2019). Title 22. §72315. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **MATTRESS- ALTERNATING AIR**	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 provide stimulation and pressure relief to resident's at risk for skin breakdown and to distribute body weight relieving areas of pressure.

POLICY:

It is the policy of this facility to use pressure-relieving mattresses as indicated by the resident's physical condition.

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

PROCEDURE:

1. Explain the purpose of the mattress to the resident.
2. Wear gloves, then strip the linen from the bed. Then inspect the plug and electrical cord of the alternating pressure pad for evidence of frayed or broken wires.
3. Place the mattress on frame, with the appropriate side facing up.
4. Hang the motor on the bed if hooks are provided, near the mattress outlets. Connect the tubing securely to the motor and to the mattress outlets, and plug the cord into an electrical outlet. Turn the motor on.
5. After several minutes, observe the emptying and filling of the mattress chambers, and check the tubing for kinks that could interfere with the pad's function.
6. Place a bottom sheet over the mattress and tuck it in loosely. To avoid tube constriction, do not miter the corner where the tubing is attached. Use only an incontinent pad, if necessary, between resident and bottom sheet to maximize effect. Do not use pins.
7. Position the resident comfortably on the pad, cover him/her with the top linens, and tuck them loosely.
8. If the mattress becomes soiled, clean it with a damp cloth and mild soap, then dry well. To avoid damaging the mattress surface, do not use alcohol.
9. Record the use of the mattress and resident outcome in the resident Health Record.

REFERENCES:

- California Code of Regulations (2019). Title 22. §72315. Retrieved from **https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1**
- Wound Reference, Inc. (2019). Wound Reference. Retrieved from https://woundreference.com/.

SUBJECT: **MECHANICAL LIFT**	SECTION: **Page 1 of 2**

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

PURPOSE:

To move a resident safely and with as little physical effort as possible.

POLICY:

It is the policy of this facility that the mechanical lift will be utilized for resident transfers only. It will not be used to transport residents to another location. Assistance of two personnel will be used with mechanical lift.

AFFECTED PERSONNEL/AREAS: *LICENSED STAFF, CERTIFED NURSING ASSISTANTS (CNAs)*

EQUIPMENT:

- Mechanical lift with hooks for slings
- Canvas seat and back
- Slings with loops

PROCEDURE:

1. Explain the procedure to the resident and bring the mechanical lift to bedside. Screen resident for privacy.
2. Roll resident on the side away from the attendant. Maintain resident privacy.
3. Roll canvas seat in half with the wider section under the resident's thighs and lower edge of seat under knees.
4. Place narrow part just above the small of the back.
5. Roll resident toward attendant and pull slings through. (Like positioning a draw sheet.)
6. Position seat sling and elevate head of bed to facilitate placing back piece.
7. Move mechanical lift so that the open end of horseshoe base is slid under the bed.
8. Attach hooks of the lift to the holes in the canvas seat. Insert hooks away from the resident to outside of sling.

9. Attach hooks in the canvas back in the holes as required. Check to see that hooks are hooked all the way into the loops and that the seat is close to the knees for safety.

10. Close release valve by turning knob gently to the right. Use slight pressure.

11. Resident's arms should be inside and crossed over chest. They may hold on to the sides, if desired, and if at all possible.

12. Check loops and hooks to make sure they are properly positioned.

13. Push button for lift. Hand may be placed on steering wheel. After resident is lifted several inches off the bed, stop and reassure resident.

14. Position wheelchair and lock brakes. Swing resident's feet off bed; when resident has been lifted clear off bed, grasp steering handles and move resident over chair or shower bed. U-base of lifter fits around wheelchairs.

15. Turn release valve slowly to the left. Push gently on their knees as they are being lowered into the chair or shower bed so the correct position will be obtained. Lower resident slowly. Guide their descent.

16. When the resident is seated, open release knobs two turns and press down on the arm of the mechanical lift.

17. Detach hooks from seat and back. Resident may remain seated on seat. Be sure resident is sitting on canvas portion of sling only.

18. Permit resident to remain up according to physician's orders, unless resident complains of feeling tired or there are signs of ill effects.

19. Return the lifter to its designated area when not in use.

20. To return the resident to bed, use the same procedure in reverse. Center resident over bed and lower gently.

REFERENCES

- MAXI MOVE™ Instructions for Use ...with people in mind 001.25060. EN (Revised 11 January 2014). Retrieved from https://www.manualslib.com/manual/1292554/Arjohuntleigh-Maxi-Move.html.

SUBJECT: **MEDICATION ADMINISTRATION**	SECTION: **Page 1 of 9**

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

PURPOSE:

To establish guidelines for safe medication administration.

POLICY:

1. Medications may be administered pursuant to a provider's order or an approved hospital protocol.

2. The following employees are authorized to administer medications per their scope of practice and departmental policy as appropriate:

   a. Registered Nurses (RN)
   b. Licensed Vocational Nurses (LVN)
   c. Respiratory Care Practitioners (RCP)
   d. Radiology Technologists (RT)

3. Nursing students and Registered Nurse Interim Permittees are allowed to administer medications under the supervision of an instructor/staff nurse as part of their educational experience.

4. Sierra View Medical Center (SVMC) recognizes the "Medication Rights" as desired outcomes of medication administration. Staff authorized to administer medications will follow all established processes to ensure the following:

   a. Right Patient
   b. Right Medication
   c. Right Dose
   d. Right Route
   e. Right Time
   f. Right Documentation
   g. Right Assessment
   h. Right Education
   i. Right Evaluation
   j. Right to Refuse Medication

5. Training and Competency

   a. Upon hire, all RNs and LVNs will receive training on medication management policies and procedures and be required to take and pass with an 85% or greater a medication math aptitude written test.

   b. Annually, all RNs and LVNs will take a math medication calculation test and be required to pass with an 85% or greater. Remediation will take place for those who do not pass.

   c. Upon hire all RCPs and RTs will receive training on medication management policies and procedures as determined by their departments management. Remediation will take place for those who do not pass.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), RESPIRATORY CARE PRACTITIONERS (RCP), RADIOLOGY TECHNOLOGISTS (RT), PHARMACISTS (PHARM. D),*

PROCEDURE:

Rights of Medication Administration

Staff will adhere to established SVMC processes to ensure all "Rights" of medication administration.

Right Patient

1. Two identifiers will be used to verify the right patient. Verification of the right patient occurs at the patient's bedside.

    a. At the patient's bedside, the nurse will verify the right patient prior to administering medication by comparing patient's name and DOB on the identification band to the MAR or physician's order.

Right Medication

2. For each medication to be administered, the nurse must know the following information:

    a. Name and dose of the medication
    b. Reason for giving the medication to the patient
    c. Expected results/effects of the medication
    d. Side effects
    e. Toxic effects
    f. Incompatabilities
    g. Contraindications

3. The nurse will look up any medication that is unfamiliar to him/her by utilizing available resources.

4. The nurse will check the stability of medications by visually inspecting for particulates, discoloration and expiration date. If the medication is compromised in any way, the nurse will return the medication to the pharmacy immediately.

5. Labeling of medication will occur when any medication or solution is transferred from the original packaging to another container such as a plastic bag, syringe, bottle or box.

    a. Medication labels will include the name and strength of the medication or solution, the date, and the initials of the person preparing the medication.

b. All sterile IV products prepared outside of the pharmacy will have begun administration within one hour of preparation. No preparations shall be stored or prepared in anticipation of need.

c. Appropriate labeling is necessary in the following situations:

1. Any time one or more medications are prepared but are not administered immediately.

2. On and off the sterile field any time medication is being administered in the perioperative area or other procedural settings.

d. Any medication or solution found unlabeled will be immediately discarded.

6. The licensed professional will be careful to check the accuracy of a look alike, sound alike medication. See HIGH-ALERT MEDICATIONS AND LOOK ALIKE SOUND ALIKE MEDICATIONS .

7. Every 24 hours, the licensed professional will perform a 24-hour chart check to ensure accuracy of the eMAR.

8. The licensed professional will verify the right medication by rechecking the physician's order whenever necessary to resolve any discrepancies.

Right Dose

To determine or to double check a single medication dose, the basic formula below may be utilized:

$$\frac{\text{Dr.'s Order}}{\text{Quantity}} \times \text{Dose Have}$$

EXAMPLE: Dr.'s order 50mg Solu-Medrol. Have 125mg vial.

$$\frac{50\text{mg}}{125\text{mg}} \times 1\text{ ml} = 0.4\text{ml}$$ is the dose to be administered

1. Many medications come in varying concentrations. Prior to drawing up the ordered dose of medication, the licensed professional must verify that the correct concentration of the medication is being used.

2. The following medications require a second licensed person to verify the medications that are listed below. The second licensed person will check the medication order, the dosage calculation, the dose that is prepared, the smart pump library setting and starting dose, and then confirm that the spiked source container's IV line is in the proper pump channel and will then properly label the line with the name of the medication and place the label near the IV insertion site. Both licensed persons, one of which must be an RN, will cosign the eMAR.

a. Insulin
b. Heparin
c. Pediatric/neonatal medications that are High-Alert, IV and IM doses, excluding vitamin K and immunizations.

d. Narcotics used for Patient Controlled Analgesia (PCA)
e. Chemotherapy
f. Fentanyl and morphine continuous infusions
g. Midazolam and lorazepam continuous infusions
h. Propofol and precedex continuous infusions
i. Neuromuscular blocking continuous infusions

3. When calculating dosage, if there is any doubt or concern, the licensed professional will consult with another nurse and/or a pharmacist prior to preparing and administering the medication.

Right Route

1. A medication's rate of absorption and onset of action varies based upon what route the medication is administered. The licensed professional must check that the route of administration is correct and obtain clarification from the physician if there are any questions or concerns with the prescribed route.

Right Time

1. Routine medications will be administered per the SVMC Standardized Dosing Schedules for Non-IV and IV medications. See policy MEDICATION ADMINISTRATION TIMES.

2. When scheduling a new medication, the nurse will administer the initial dose as soon as possible. Subsequent doses will be administered per the standardized dosing schedule. Medications removed from Pyxis should be administered & documented within 1 hour of removal. Failure to comply may result in disciplinary actions or reviews.

3. Routine medications, excluding initial dose, must be given no more than 1 hour before or after the actual scheduled time, unless otherwise outlined in Medication Administration Times Policy.

4. When a medication is not administered at a specific time (i.e. medication help for a procedure or medication not available, etc.), the licensed professional will administer the medications as soon as he/she is able to document the reason for the delay or change in administration time. The time the next dose is administered is determined by referring to the appropriate standardized dosing schedule.

5. Medications ordered "Stat" are to be administered within 30 minutes of the prescribed order. See Medication Administration Times Policy for details.

6. All first dose intravenous antibiotics are to be administered within 4 hours of the prescribed order, or earlier if warranted, e.g., sepsis, etc. See Medication Administration Times Policy for details.

7. Variations in medication administration times may occur based on nursing assessment and/or judgment. For example, if the patient is to receive 10 units of NPH insulin in the evening but the patient did not eat lunch or dinner and the patient's blood sugar is only 100mg/dl, the nurse may hold and notify the physician for further orders. In such cases, the nurse must document the variation in timing, the rationale for the change and the physician notification. (Example: "NPH insulin held due to patient's lack of adequate intake and BS of 100mg/dl. Notified Dr. Smith.")

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Right Documentation

1. Medication administration is documented on the electronic medication administration record (eMAR).

2. The administering user will document medication administration on the eMAR according to the following guidelines:

   a. Medication
   b. Route
   c. Date
   d. Time
   e. Site of injection if necessary
   f. Assessment parameters
   g. Signature of caregiver that administered

3. In certain circumstances, administering medication outside of the scheduled timeframe may require the licensed professional to document a rationale in the patient's record. The following circumstances are some examples:

   a. Patient is having a procedure/test done and unavailable at the scheduled time.
   b. The medication is held due to established patient assessment parameters (i.e. digoxin held for heart rate <60bpm)
   c. Patient refused
   e. The site of intramuscular, intradermal, subcutaneous injections and medication topical transdermal patches must be documented.

4. Adverse drug reactions and allergies must be documented as per policy ADVERSE DRUG REACTIONS.

5. Special Areas for Documentation (when eMAR/EHR not used)

   a. Operating Room- The OR Anesthesiologist/Anesthetist documents the medications that he/she administers during surgery on the anesthesia record.
   b. Code Blue/White- The code form is a record of medication administration to the patient during the code process. In this instance, the notation is made under the medication section of the code form. The date, time, and notation shall serve as a reference for all medications administered during the code.

6. When the EHR/eMAR are unavailable, the downtime procedures shall be followed. See MEDITECH DOWNTIME - CLINICAL DOCUMENTATION.

7. Block Charting is defined as: A documentation method that can be used when a rapid titration of medication is necessary in specific urgent/emergent situations.

a. Emergent situations that are acceptable for block charting would include rapid responses, code blues, or a patient rapidly deteriorating with immediate life being threatened.
b. Block charting will not extend beyond a four hour timeframe, and if it needs to be continued, a new charting block will be started after the four hour limit.
c. There will be an order entered into the EMR for each medication administered during the block charting.
d. The following will be included in each block charting episode:
    a. Time of initiation of the charting block
    b. Name of the medications being administered
    c. Starting and ending rates of the titratable medications
    d. Maximum dose rate of the medications administered
    e. Time of completion of the charting block

8. Physiological parameters evaluated to determine the administration of titratable medications during the charting block

Right Assessment

1. Prior to medication administration, the administering provider will assess the following patient information in order to ensure safe medication use:

    a. Age
    b. Allergies
    c. Height & Weight
    d. Diagnosis
    e. Co-Morbidities
    f. Pregnancy status
    g. Laboratory and diagnostic values
    h. Patient's previous experience with the medication
    i. Contraindications

2. Some medications require certain physiological parameters to be met before administration. The licensed professional must assess the specific patient indicator appropriate to the medication to be administered (i.e., heart rate, blood pressure, etc.). If the patient value is outside of the established ordered parameter, the medication is held.

Right Education

1. The nurse will provide the following information to the patient during medication administration:

    a. Name of the medication
    b. The expected response (i.e., will alleviate pain)
    c. Possible side effects/adverse reactions

2. If the patient requires additional information on a newly prescribed medication, the nurse may utilize Krames notes or Lexicomp to provide more comprehensive education.

3. If the patient will be discharged on a new medication, the nurse will provide the necessary education in order to help ensure medication safety at home.

   a. Medication education may be coordinated with and provided by other healthcare disciplines as necessary (dietician, pharmacist, respiratory therapy).
   b. The nurse will provide special instructions and demonstrations, as necessary, to assist the patient in learning specific skills required to administer medication safely at home (i.e., checking blood sugars and insulin injections).

Right Evaluation

1. Ensuring medication safety requires the administering provider to monitor the patient for the effects of the medication after it has been administered. Following medication administration, the nurse will evaluate:

   a. Medication effectiveness (Did the medication have the desired response?)
   b. The presence of side effects, adverse reaction and/or allergic response
   c. Patient physiological parameters, as applicable, such as blood sugar, vital signs, urine lab values, etc.

Black Box Warnings:

The administering provider will monitor the patient for any serious side effects associated with medications that have specific black box warnings. See BLACK BOX WARNING

Right to Refuse

1. Patients have the right to refuse medication. The nurse will ascertain the reason for the refusal and discuss consequences of not taking the medication, but the patient may still refuse. Patient refusal must be documented and, in some cases, the physician may need to be notified.

Medication Procedures

MEDICATION ORDERS

1. Licensed individuals allowed to prescribe may communicate medication orders over the telephone to a registered nurse or pharmacist for immediate notation into the EHR. (In emergency situations, orders may be given verbally in person).

2. Additionally, "PRN" medication orders need to include the indication for use. (i.e. PRN pain).

3. The licensed individual will clarify all incomplete and/or ambiguous orders with the physician prior to administration.

BEDSIDE MEDICATION VERIFICATION (BMV) / ELECTRONIC MEDICATION ADMINISTRATION RECORD (EMAR)

1. Obtain medication from automated dispensing unit.

2. Administering provider will verify medication and patient with drug profile on the EMAR.

3. Scan the patient's identification band using the BMV.

4. Scan the medication using the BMV. Scanning should take place unless a delay in administration may cause harm to the patient.

5. Will confirm the five rights for accurate medication administration.

REFERENCES:

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CROSS REFERENCES:

- High-Alert Medications and Look Alike Sound Alike Medications
- Adverse Drug Reactions
- Meditech Downtime- Clinical Documentation
- Black Box Warning

SUBJECT: **MEDICATION ORDERING**	SECTION: **Page 1 of 19**

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

PURPOSE:

- To ensure medications within the organization are ordered/prescribed safely and in accordance with state and federal regulations.
- To define the conditions under which a practitioner may safely order/prescribe medications within the organization.

POLICY:

WHO MAY ORDER (PRESCRIBE)

1. The following personnel are allowed to write (prescribe) an order for a medication, provided they are members in good standing with the Medical Staff, or practitioners who have been authorized by the medical staff to practice and are acting within the scope of their professional practice:
    a. Licensed Physicians, Surgeons and Doctors of Osteopathic Medicine;
    b. Licensed Dentists;
    c. Licensed Podiatrists;
    d. Licensed Certified Registered Nurse Anesthetists;
    e. Licensed Physician Assistants; and/or
    f. Licensed Nurse Practitioners
    g. Certified Nurse Midwives
        i. In accordance with California Business and Professions Code 2746.51
2. Conditions under which a specific practitioner may write (prescribe) a chart order:
    a. Licensed Certified Registered Nurse Anesthetist (CRNA) – a CRNA may write an order for a medication in the performance of pre-anesthetic, anesthetic and post-anesthetic care, as part of an anesthesia care plan, for anesthetics, adjuvant and accessory drugs and fluids necessary to manage anesthesia and/or implementing acute and chronic pain management modalities.
        i. Student Registered Nurse Anesthetist (SRNA) – a SRNA may write an order for a medication in the performance of pre-anesthetic, anesthetic and post-anesthetic care, as part of an anesthesia care plan, for anesthetics, adjuvant and accessory drugs and fluids necessary to manage anesthesia and/or implementing acute and chronic pain management modalities. All orders must be cosigned by the supervising anesthesia provider.

b. Licensed Physician Assistants (PA) – a PA may write an order for a medication under the delegated authority of a supervising physician or surgeon in the performance of a written practice specific formulary and protocol. Orders for drugs under federal Schedule II through V may be issued only through advanced approval by a supervising physician or surgeon for a particular patient. Drug orders are to be reviewed and countersigned by a supervising physician or surgeon within seven (7) days.

c. Licensed Nurse Practitioners (NP) – Per BPC 2836.1, a NP may write an order for medication pursuant to a standardized procedure or protocol developed with a supervising physician or surgeon, provided the order is incidental to the provision of family planning services, or incidental to the provision of routine health or prenatal care or rendered to essentially healthy persons. Orders for drugs under federal Schedule II through V may be issued only through an agreed upon and specific standardized procedure between the NP and a supervising physician or surgeon. Orders for drugs under federal Schedule II must be in accordance with a patient-specific protocol approved by the treating physician or surgeon. Furthermore, they must address the diagnosis of the illness, injury, or condition for which the controlled substances are to be furnished.

WHO MAY TRANSCRIBE A VERBAL OR TELEPHONE MEDICATION ORDER:

1. Medication orders that are communicated verbally in person or via telephone from a licensed individual authorized to prescribe under section 1 of this procedure will be transcribed into the patient's medical records by the following licensed individuals:

   a. Registered Nurses;

   b. Registered Pharmacists;

   c. Licensed Vocational Nurses; and/or

   d. Respiratory Therapists may transcribe and implement the verbal order of a physician for medications pertaining to the practice of respiratory therapy, which is defined as pharmacologic, diagnostic and therapeutic agents related to respiratory care procedures necessary to implement a treatment, pulmonary rehabilitative or diagnostic regimen prescribed by a physician or surgeon.

   e. Licensed nuclear medicine technologists.

2. Written and verbally communicated, transcribed orders must have the following:

   a. Name of medication;

   b. Strength of medication;

   c. Route of administration;

d. Frequency;

e. Date and time order was received;

f. Name of the person communicating the order;

g. Name of the person transcribing the order;

h. Indication for use (PRN);

i. Additional administration details as needed.
   1. Example: If medication order is given in, weight based format, then weight is required.
      i.e. Alteplase give 0.9mg/kg. Patient's weight in KG is required.

3. Authorized prescribers MUST countersign all verbal orders within 48 hours

4. Pharmacists are only permitted to take verbal and telephone orders directly from a provider. Any verbal or telephone orders must come from an individual "WHO MAY PRESCRIBE".

WHO MAY INITIATE AND/OR ADJUST A PATIENT'S DRUG REGIMEN

A Registered Pharmacist may initiate or adjust a patient's drug regimen pursuant to an order or authorization made by the patient's prescriber and in accordance with protocols approved by the Medical Staff or pursuant to a specific written authorization by the patient's prescriber for an individual patient.

MEDICATION ORDER REQUIREMENTS:

1. ***Complete Orders*** – Orders for medications will be legible and complete and include as applicable:

   a. Name of Medication

   b. Dosage form

   c. Dose

   d. Strength

   e. Route

   f. Frequency

   g. Rate

   h. Method

i. Site of Administration

NOTE: Prior to the administration of the medication, incomplete, illegible, unclear, and ambiguous orders will be clarified.

2. ***Symbols and Abbreviations*** – Only symbols and abbreviations contained in the list of approved symbols and abbreviations will be used to document a medication order in the medical record.

3. ***Metric System*** – Quantities for medications on orders will be written in the metric system rather than the apothecary system. Exceptions are insulin, vitamins and other products that are expressed in units. The word "unit" should be spelled out rather than abbreviated "u".

4. ***Decimal Points*** – The use of decimal points should be avoided when not necessary (e.g., write 500 mg instead of 0.5 GM). A zero will be placed in front of a leading decimal point (e.g., write 0.5 mg instead of .5 mg). Unnecessary decimal points or zeros will not be used (e.g., write 25 mg instead of 25.0 mg).

5. ***"PRN" Orders*** – As needed or PRN orders must include the following:

   a. Condition for use (e.g., for nausea, for pain)

   b. Frequency not defined as a range or scale (e.g., q4h or q3h, not q3 – 4hr).

   c. Any "prn" order without a frequency or condition for use will be considered as a one-time order.

   d. Dosage "ranges" are not to be used unless specific parameters are included that specify specific doses within the range, (e.g., "25-50 mg q 3h prn pain" is not appropriate. A specific order would be 25 mg q3h prn mild pain and 50 mg q3h prn moderate pain.)

PATIENT TRANSFER AND "HOLD" ORDERS:

1. Reassessment of drug therapy and limiting duration of medication therapy in the absence of a prescriber's specific indication, including classes of drugs or individual drug entities shall occur as follows:

   a. ***Post-Op Orders***:

      All medication orders are discontinued at the time of surgery. Orders to "resume or continue as before" is not allowed.

   b. ***ICU Orders:***

      All medication orders are discontinued when admitted to or discharged from the ICU. Orders to "resume or continue as before," is not allowed.

c. ***Medication Orders > 30 days:***

Patients must have their medication orders recapped every 30 days.

d. ***Specific Drug Classes/Entities:***

The following medications have an active automatic "Stop Order," as approved by the Medical Staff.

- Antibiotics – 7 days
- DVT Prophylaxis Medications-- Heparin SQ, Enoxaparin, DOAC's– 14 days
- Ketoralac – 5 days
- Narcotics – 3-5 days
  Exceptions: Phenobarbital for seizure control: 14 days
- All other medications – 30 days

2. "Hold" orders for medications will be considered discontinued unless a time is specified. (e.g., "Hold 0900 digoxin today" – the digoxin will be held today and given tomorrow. An order written to "Hold digoxin" will be treated as a "discontinue" order).

GENERIC OR BRAND NAME:

When a medication is ordered, either generic or brand name can be used. However, when a trade name drug is ordered, the pharmacist may substitute with a generic equivalent if available, unless the prescriber specified otherwise.

ORDERING ANTINEOPLASTIC AGENTS:

Medication orders for antineoplastic agents must be ordered by an attending physician, hematologist/oncologist.

1. ***Verbal Orders***

a. Verbal orders for initial antineoplastic drug orders are NOT accepted.

b. When a patient is in the Cancer Treatment Center (CTC) for a repeat course of antineoplastic therapy, the pharmacist may accept a verbal order from the attending physician or hematologist/oncologist for the next course of antineoplastic therapy. The pharmacist must have the original order for therapy available and the repeat course must be for the same therapy. If a change in therapy is indicated, the physician must write a new order.

2. ***Requirements***

a. Any change will be rewritten as verbal order by the pharmacist or nurse after consulting with the prescriber.

b. All antineoplastic medication orders will specify the following:

- Date and time of order.
- The drug name spelled out completely (no abbreviations); the generic name is preferred.
- Strength per dose in milligrams or in units, not grams or micrograms. Calculations, such as mg/kg or mg/m2 dosages, must be shown and double checked by another licensed professional.
- Patient parameters used to calculate dose. For example, if the dose is based on mg/kg basis, the weight is required. If the dose is based on body surface area (BSA) in m2, weight and height are required.
- Route of administration.
- Frequency of dose and duration of therapy.
  - Rate of administration and infusion guidelines should be included as applicable to the drug.
  - The order should specify the number of days of therapy the patient is to receive.
  - If there are specific days that the patient receives the antineoplastic therapy, this should be indicated.
- For multiple-day treatment regimens, first list the total dose administered per 24-hour period, and secondly, list a total dose for the entire treatment period.
- The prescriber may also want to include orders for hydration fluids, antiemetic regimens, monitoring procedures, labs and any other therapy indicated in conjunction with the antineoplastic therapy as appropriate for the patient.

TEXTING ORDERS:

1. Texting of medication orders is strictly prohibited at SVMC

STANDING ORDERS:

1. Physician's standing orders used within the hospital will follow guidelines for the safe administration of medication to patients.

2. Standing orders for drugs may be used for specified patients when authorized by a person licensed to prescribe under Section 1a. (1-6) above.

3. A copy of standing orders for a specific patient shall be dated, promptly signed by the prescriber and included in the patient's medical record.

4. The standing order must specify or include:

   a. The circumstances under which the drug is to be administered.

   b. The types of medical conditions of patients for whom the standing orders are intended.

   c. Be initially approved by the Pharmacy & Therapeutics Committee.

   d. Be specific as to the drug, dosage, route and frequency of administration.

   e. When standing orders contain multiple choices on medications, or based upon circumstance, and/or medical conditions, the prescriber must circle or otherwise CLEARLY indicate their choice.

   f. Prescribers may notify the hospital in writing of their own standing orders, by submission to the Director of Pharmacy; however, the use of such is subject to prior approval of the Pharmacy and Therapeutics Committee.

   g. The Pharmacy and Therapeutics Committee will review all standing orders annually.

   h. Recommendations for clarifications and/or corrections will be forwarded to the prescriber for action.

   i. Prescribers MUST SIGN ALL ORDERS WITHIN 48 HOURS.

ADDITIONAL ORDERS

1. ***Titration Orders***

   When writing orders to titrate a medication dose, the prescriber must include the following information:

   a. Under what conditions or parameters the dose is to be titrated.

   b. The final dose the medication is to be titrated to.

c. The frequency or rate at which titration should occur.

2. ***Tapering Orders***

When writing orders to taper a medication dose, the prescriber must include the following information:

a. Under what conditions or parameters the dose is to be tapered.

b. The final dose the medication is to be tapered to.

c. The frequency or rate at which tapering should occur.

3. ***Compounding Drug Mixtures***

Orders for compounding drug mixtures that are not commercially available shall include all components of the product unless the formula is on file in the pharmacy.

4. ***Verbal or Telephone Orders***

Prescribers are encouraged to enter all orders via computerized provider order entry (CPOE) for medications, whenever possible. Verbal and telephone orders are discouraged and should be used only if it is absolutely necessary. Verbal orders from prescribers that are present in the hospital are used only in emergencies or during procedures where it is impractical for the prescriber to enter the order via CPOE, such as in surgery or the emergency department.

5. ***Resume Orders***

a. Blanket orders written to "resume all previous medications" are not acceptable.

b. The prescriber must review and re-order all orders post-operatively and upon transfer of the patient from one level of care to another.

c. The medical service responsible for the medication orders and follow-up will review and re-order the orders, when appropriate.

6. ***Medication Orders for Pediatric and Neonatal Patients***

Medication orders for pediatric or neonatal patients must be on a weight-based dosing basis as appropriate. e.g., mg per Kg per dose

7. ***Range Orders***

a. Range orders, such as Aspirin 325 mg 1-2 tablets every 6 hours as needed for headache, are not accepted.

b. "Double range" orders, that is, orders in which there is a range in both the dose and the frequency, are not accepted and should not be written.

c. The nurse or pharmacist, prior to dispensing and administration of the medication, should clarify range orders that are not clearly defined.

Medical Abbreviations

a. The following list of error-prone abbreviations, symbols, and dose designations are not approved for use when ordering medications at Sierra View Medical Center information via verbal and/or handwritten applications. If pharmacy receives written or verbal order via one of these applications & an abbreviation from the following table is used, the order must be clarified with the ordering provider and documented.

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Abbreviations for Doses/Measurement Units			
cc	Cubic centimeters	Mistaken as u (units)	Use mL
IU**	International unit(s)	Mistaken as IV (intravenous) or the number 10	Use unit(s) (International units can be expressed as units alone)
MM or M M or K	Million Thousand	Mistaken as thousand Mistaken as million M has been used to abbreviate both million and thousand (M is the Roman numeral for thousand)	Use million Use thousand
Ng or ng	Nanogram	Mistaken as mg Mistaken as nasogastric	Use nanogram or nanog
U or u**	Unit(s)	Mistaken as zero or the number 4, causing a 10-fold overdose or greater (e.g., 4U seen as 40 or 4u seen as 44)	Use unit(s)

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
		Mistaken as cc, leading to administering volume instead of units (e.g., 4u seen as 4cc)	
µg	Microgram	Mistaken as mg	Use mcg
Abbreviations for Route of Administration			
AD, AS, AU	Right ear, left ear, each ear	Mistaken as OD, OS, OU (right eye, left eye, each eye)	Use right ear, left ear, or each ear
IT	Intrathecal	Mistaken as intratracheal, intratumor, intratympanic, or inhalation therapy	Use intrathecal
OD, OS, OU	Right eye, left eye, each eye	Mistaken as AD, AS, AU (right ear, left ear, each ear)	Use right eye, left eye, or each eye
Per os	By mouth, orally	The os was mistaken as left eye (OS, oculus sinister)	Use PO, by mouth, or orally
Abbreviations for Frequency/Instructions for Use			
HS hs	Half-strength At bedtime, hours of sleep	Mistaken as bedtime Mistaken as half-strength	Use half-strength Use HS (all UPPERCASE letters) for bedtime
o.d. or OD	Once daily	Mistaken as right eye (OD, oculus dexter), leading to oral liquid medications administered in the eye	Use daily
Q.D., QD, q.d., or qd**	Every day	Mistaken as q.i.d., especially if the period after the q or the tail of a handwritten q is misunderstood as the letter i	Use daily
Qn	Nightly or at bedtime	Mistaken as qh (every hour)	Use nightly or HS for bedtime

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Q.O.D., QOD, q.o.d., or qod**	Every other day	Mistaken as qd (daily) or qid (four times daily), especially if the "o" is poorly written	Use every other day
q1d	Daily	Mistaken as qid (four times daily)	Use daily
q6PM, etc.	Every evening at 6 PM	Mistaken as every 6 hours	Use daily at 6 PM or 6 PM daily
SSRI SSI	Sliding scale regular insulin Sliding scale insulin	Mistaken as selective-serotonin reuptake inhibitor Mistaken as Strong Solution of Iodine (Lugol's)	Use sliding scale (insulin)
TIW or tiw BIW or biw	3 times a week 2 times a week	Mistaken as 3 times a day or twice in a week Mistaken as 2 times a day	Use 3 times weekly Use 2 times weekly
Miscellaneous Abbreviations Associated with Medication Use			
BBA BGB	Baby boy A (twin) Baby girl B (twin)	B in BBA mistaken as twin B rather than gender (boy) B at end of BGB mistaken as gender (boy) not twin B	When assigning identifiers to newborns, use the mother's last name, the baby's gender (boy or girl), and a distinguishing identifier for all multiples (e.g., Smith girl A, Smith girl B)
IJ	Injection	Mistaken as IV or intrajugular	Use injection
Period following abbreviations (e.g., mg., mL.)†	mg or mL	Unnecessary period mistaken as the number 1, especially if written poorly	

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
			Use mg, mL, etc., without a terminal period
Drug Name Abbreviations			
To prevent confusion, avoid abbreviating drug names entirely. Exceptions may be made for multi-ingredient drug formulations, including vitamins, when there are electronic drug name field space constraints; however, drug name abbreviations should NEVER be used for any medications on the *ISMP List of High-Alert Medications* (in Acute Care Settings, Community/Ambulatory Settings, and Long-Term Care Settings). Examples of drug name abbreviations involved in serious medication errors include:			
Antiretroviral medications (e.g., DOR, TAF, TDF)	DOR: doravirine TAF: tenofovir alafenamide TDF: tenofovir disoproxil fumarate	DOR: Dovato (dolutegravir and lami**VUD**ine) TAF: tenofovir disoproxil fumarate TDF: tenofovir alafenamide	Use complete drug names
APAP	acetaminophen	Not recognized as acetaminophen	Use complete drug name
ARA A	vidarabine	Mistaken as cytarabine ("ARA C")	Use complete drug name
AT II and AT III	AT II: angiotensin II (Giapreza) AT III: antithrombin III (Thrombate III)	AT II (angiotensin II) mistaken as AT III (antithrombin III) AT III (antithrombin III) mistaken as AT II (angiotensin II)	Use complete drug names
AZT	zidovudine (Retrovir)	Mistaken as azithromycin, aza**THIO**prine, or aztreonam	Use complete drug name
CPZ	Compazine (prochlorperazine)	Mistaken as chlorpro**MAZINE**	Use complete drug name

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
DTO	diluted tincture of opium or deodorized tincture of opium (Paregoric)	Mistaken as tincture of opium	Use complete drug name
HCT	hydrocortisone	Mistaken as hydro**CHLORO**thiazide	Use complete drug name
HCTZ	hydro**CHLORO**thiazide	Mistaken as hydrocortisone (e.g., seen as HCT250 mg)	Use complete drug name
MgSO4**	magnesium sulfate	Mistaken as morphine sulfate	Use complete drug name
MS, MSO4**	morphine sulfate	Mistaken as magnesium sulfate	Use complete drug name
MTX	methotrexate	Mistaken as mito**XANTRONE**	Use complete drug name
Na at the beginning of a drug name (e.g., Na bicarbonate)	Sodium bicarbonate	Mistaken as no bicarbonate	Use complete drug name
NoAC	novel/new oral anticoagulant	Mistaken as no anticoagulant	Use complete drug name
OXY	oxytocin	Mistaken as oxy**CODONE**, Oxy**CONTIN**	Use complete drug name
PCA	procainamide	Mistaken as patient-controlled analgesia	Use complete drug name
PIT	Pitocin (oxytocin)	Mistaken as Pitressin, a discontinued brand of vasopressin still referred to as PIT	Use complete drug name
PNV	prenatal vitamins	Mistaken as penicillin VK	Use complete drug name

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
PTU	propylthiouracil	Mistaken as Purinethol (mercaptopurine)	Use complete drug name
T3	Tylenol with codeine No. 3	Mistaken as liothyronine, which is sometimes referred to as T3	Use complete drug name
TAC or tac	triamcinolone or tacrolimus	Mistaken as tetracaine, Adrenalin, and cocaine; or as Taxotere, Adriamycin, and cyclophosphamide	Use complete drug names Avoid drug regimen or protocol acronyms that may have a dual meaning or may be confused with other common acronyms, even if defined in an order set
TNK	TNKase	Mistaken as TPA	Use complete drug name
TPA or tPA	tissue plasminogen activator, Activase (alteplase)	Mistaken as TNK (TNKase, tenecteplase), TXA (tranexamic acid), or less often as another tissue plasminogen activator, Retavase (retaplase)	Use complete drug name
TXA	tranexamic acid	Mistaken as TPA (tissue plasminogen activator)	Use complete drug name
ZnSO4	zinc sulfate	Mistaken as morphine sulfate	Use complete drug name
Stemmed/Coined Drug Names			
Nitro drip	nitroglycerin infusion	Mistaken as nitroprusside infusion	Use complete drug name
IV vanc	Intravenous vancomycin	Mistaken as Invanz	Use complete drug name

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Levo	levofloxacin	Mistaken as Levophed (norepinephrine)	Use complete drug name
Neo	Neo-Synephrine, a well known but discontinued brand of phenylephrine	Mistaken as neostigmine	Use complete drug name
Coined names for compounded products (e.g., magic mouthwash, banana bag, GI cocktail, half and half, pink lady)	Specific ingredients compounded together	Mistaken ingredients	Use complete drug/product names for all ingredients Coined names for compounded products should only be used if the contents are standardized and readily available for reference to prescribers, pharmacists, and nurses
Number embedded in drug name (not part of the official name) (e.g., 5-fluorouracil, 6-mercaptopurine)	fluorouracil mercaptopurine	Embedded number mistaken as the dose or number of tablets/capsules to be administered	Use complete drug names, without an embedded number if the number is not part of the official drug name
Dose Designations and Other Information			
1/2 tablet	Half tablet	1 or 2 tablets	Use text (half tablet) or reduced font-size fractions (½ tablet)
Doses expressed as Roman numerals (e.g., V)	5	Mistaken as the designated letter (e.g., the letter V) or the wrong numeral (e.g., 10 instead of 5)	Use only Arabic numerals (e.g., 1, 2, 3) to express doses
Lack of a leading zero before a	0.5 mg	Mistaken as 5 mg if the decimal point is not seen	Use a leading zero before a decimal point when the dose is less

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
decimal point (e.g., .5 mg)**			than one measurement unit
Trailing zero after a decimal point (e.g., 1.0 mg)**	1 mg	Mistaken as 10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
Ratio expression of a strength of a single-entity injectable drug product (e.g., **EPINEPH**rine 1:1,000; 1:10,000; 1:100,000)	1:1,000: contains 1 mg/mL 1:10,000: contains 0.1 mg/mL 1:100,000: contains 0.01 mg/mL	Mistaken as the wrong strength	Express the strength in terms of quantity per total volume (e.g., **EPINEPH**rine 1 mg per 10 mL) **Exception:** combination local anesthetics (e.g., lidocaine 1% and **EPINEPH**rine 1:100,000)
Numerical dose and unit of measure run together (e.g., 10mg, 10Units)	10 mg 10 mL	The m in mg, or U in Units, has been mistaken as one or two zeros when flush against the dose (e.g., 10mg, 10Units), risking a 10- to 100-fold overdose	Place adequate space between the dose and unit of measure
Large doses without properly placed commas (e.g., 100000 units; 1000000 units)	100,000 units 1,000,000 units	100000 has been mistaken as 10,000 or 1,000,000 1000000 has been mistaken as 100,000	Use commas for dosing units at or above 1,000 or use words such as 100 thousand or 1 million to improve readability **Note**: Use commas to separate digits only in the US; commas are used in place of decimal points in some other countries

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Symbols			
ʒ or ♏□†	Dram Minim	Symbol for dram mistaken as the number 3 Symbol for minim mistaken as mL	Use the metric system
> and <	More than and less than	Mistaken as opposite of intended Mistakenly have used the incorrect symbol < mistaken as the number 4 when handwritten (e.g., <10 misread as 40)	Use more than or less than
↑ and ↓†	Increase and decrease	Mistaken as opposite of intended Mistakenly have used the incorrect symbol ↑ mistaken as the letter T, leading to misinterpretation as the start of a drug name, or mistaken as the numbers 4 or 7	Use increase and decrease
/ (slash mark)†	Separates two doses or indicates per	Mistaken as the number 1 (e.g., 25 units/10 units misread as 25 units and 110 units)	Use per rather than a slash mark to separate doses
@†	At	Mistaken as the number 2	Use at
&†	And	Mistaken as the number 2	Use and
+†	Plus or and	Mistaken as the number 4	Use plus, and, or in addition to
°	Hour	Mistaken as a zero (e.g., q2° seen as q20)	Use hr, h, or hour
Φ or ∞†	Zero, null sign	Mistaken as the numbers 4, 6, 8, and 9	Use 0 or zero, or describe intent using whole words

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
#	Pound(s)	Mistaken as a number sign	Use the metric system (kg or g) rather than pounds Use lb if referring to pounds
Apothecary or Household Abbreviations			
Explicit apothecary or household measurements may **ONLY** be safely used to express the directions for mixing dry ingredients to prepare topical products (e.g., dissolve 2 capfuls of granules per gallon of warm water to prepare a magnesium sulfate soaking aid). Otherwise, metric system measurements should be used.			
gr	Grain(s)	Mistaken as gram	Use the metric system (e.g., mcg, g)
dr	Dram(s)	Mistaken as doctor	Use the metric system (e.g., mL)
min	Minim(s)	Mistaken as minutes	Use the metric system (e.g., mL)
oz	Ounce(s)	Mistaken as zero or 0_2	Use the metric system (e.g., mL)
tsp	Teaspoon(s)	Mistaken as tablespoon(s)	Use the metric system (e.g., mL)
tbsp or Tbsp	Tablespoon(s)	Mistaken as teaspoon(s)	Use the metric system (e.g., mL)

REFERENCES:

- List of Error Prone Abbreviations. Institute of Safe Medication Practices. https://www.ismp.org/recommendations/error-prone-abbreviations-list. Accessed January 3, 2023.
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SUBJECT:	SECTION:
MEDICATION PASS OBSERVATION~~MEDICATION PASS OBSERVATION~~	**Page 1 of 2**

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PURPOSE:

To ensure the review and monitoring of pharmaceutical services and staff performance regarding medication and medication administration.

POLICY:

The RN Clinical Manager, Compliance RN or designated Charge RN will ~~bi~~ -annually observe the administration of medications by the licensed nurses and to assure regulatory and professional standards are followed. A licensed nurse under direct supervision and/or that has been trained and deemed competent may assist in conducting the medication pass observations, when designated by the unit Clinical Director or Clinical Manager.

AFFECTED PERSONNEL/AREAS:

PHARMACIST, REGISTERED NURSE, CLINICAL DIRECTOR, CLINICAL MANAGER, COMPLIANCE RN, LICENSED VOCATIONAL NURSES

PROCEDURE:

1. The RN Clinical Manager, Compliance RN or designated Charge RN -will be involved in the medication pass observation/ Competency of -all licensed staff -annually each September when annual competencies are completed ~~every 6 months (September and March)~~ in order to better assess the unit's overall performance and staff's adherence to policy and procedure.

2. Medication pass observations will be documented by the RN Clinical Manager, Compliance RN, or Charge RN on a Medication Administration Competency Form or on an alternate format that is designated by the pharmacist/facility for reporting audits, inspections and pharmaceutical activities within the facility.

3. The RN Clinical Manager, Compliance RN or Charge RN will validate medication pass observations with the physician's order and medication administration records (MAR), to determine whether medications were managed accurately, and will assess techniques to determine whether medications were distributed appropriately.

4. Results of medication pass observations will be forwarded to the unit Director for review and follow-up with involved staff when medication errors have occurred.

5. The Director / Clinical Manager will review medication errors with the appropriate nurse, coordinate necessary training and provide performance coaching as needed to improve medication administration on the unit.

6. The Director will also share the results of medication observation outcomes with pertinent staff during regular unit processes, such as staff meetings and RN Meetings.

SUBJECT:	SECTION:
MEDICATION PASS OBSERVATION~~MEDICATION PASS OBSERVATION~~	**Page 2 of 2**

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REFERENCE:

- Med Pass, Inc.,(updated February 6, 2015) Facility Guide to OBRA Regulations, Subtask, 5E United States of America, Med Pass Inc.

SUBJECT: **MEDICATION RECONCILIATION**	SECTION: ***Medication Management (MM)*** **Page 1 of 3**

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

PURPOSE:

To maintain and communicate accurate patient medication information.

POLICY:

Care providers will create an accurate list of a patient's medications on admission to the hospital or when seen in an outpatient setting, reconcile discrepancies and ensure that accurate medication information is communicated upon discharge.

DEFINITIONS:

Medication: For the purposes of this policy, the term medication denotes any of the following:

- Prescription medications
- Sample medications
- Herbal remedies, nutraceuticals, vitamins, and over the counter medications

Licensed Personnel:

Registered Nurse, Licensed Vocational Nurse, Prescriber

AFFECTED PERSONNEL: *LICENSED PERSONNEL (R.N., L.V.N.), PHARMACY*

PROCEDURE:

Obtaining Medication List

1. To the best of their ability, licensed personnel will obtain complete information on the patient's home medication regimen before ordering medications including:

   A. Name of each medication
   B. Formulation/Strength (i.e.. extended release, 100 mg tablet)
   C. Dosage
   D. Route
   E. Frequency
   F. Date/time last taken

   The medication information will be entered into the electronic medical record. This should be done prior to ordering any medications, unless a delay in ordering may cause harm to the patient.

2. High Risk Medication Profile: Readmitted Congestive Heart Failure Patients