SUBJECT: **IMMEDIATE BEDDING**	SECTION: *Emergency Department* **Page 1 of 2**

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

PURPOSE:

In order to expedite the care and treatment of Emergency Department patients while ensuring patient satisfaction, patients will be brought back to a treatment room as soon as possible.

Triage is a process, not a place. Patients should be placed in an appropriate treatment room as expeditiously as possible based on the patient's chief complaint and ESI level. If an appropriate treatment room is available, the patient should be bedded as soon a feasibly possible.

DEFINITIONS:

1. PIT – Provider at Triage area

POLICY:

AFFECTED PERSONNEL/AREAS: *EMERGENCY SERVICES AND PATIENT REGISTRATION*

A. **Registered Nurse:** Responsible for patient placement, assessment and communication with Emergency Department physicians.

B. **Director/Clinical Manager**: Distribute this information to staff and ensure compliance.

C. **Patient Registrar:** Assists in Quick Registration of the patient and then full registration as appropriate.

PROCEDURE:

A. Patient enters the Emergency Department and is quickly registered by the ED Nurse Greeter and Registration (full registration will occur at the bedside).

B. The ED Nurse Greeter will:

1. Obtain Date of Birth.
2. Obtain Patient's Name.
3. Identify patient in the Registration system or create a new patient.
4. Obtain Chief Complaint.
5. Obtain necessary information to complete triage process, including infectious disease screening questions, as appropriate.
6. Determine and document ESI Triage Level.

7. Determine if bed is available in the appropriate area. This is done in cooperation with the ED Charge Nurse.

C. Have patient escorted to the assigned area by the appropriate personnel.

D. The person escorting the patient to the bed is responsible for notifying the patient's primary nurse.

E. Appropriate Assessment is completed by the primary nurse at the bedside.

F. If no open beds are available, follow the Patient Triage (ESI and Secondary) Policy.

REFERENCES:

- Gilboy, N. et al, (2020) Implementation Handbook 2020 Edition ESI, Emergency Severity Index v4, Emergency Nurses Association.
- Farley, H MD, et al, (May 2016) Emergency Department Crowding High Impact Solutions, Emergency Medicine Practice Committee, American College of Emergency Physicians, ACEP. Retrieved from https://www.acep.org/globalassets/sites/acep/media/crowding/empc_crowding-ip_092016.pdf.

CROSS REFERENCES:

- Patient Triage (ESI and Comprehensive) Policy

SUBJECT: **INFECTION CONTROL CHAIRPERSON**	SECTION: **Page 1 of 1**

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

DESCRIPTION:

The Infection Control Chairperson will be a member of the Medical Staff. He/she is appointed to the position by the Chief of Staff and as per the Medical Staff Bylaws. The Chairperson supervises all infection surveillance programs within the hospital, determines sources of infections and consults on isolation and control of infectious diseases.

DUTIES:

1. Provides expert effective leadership in promotion of medical asepsis and oversees proper safeguards against the transmission of infection.

2. Oversees, interprets, and assists in the recommendation of isolation policies/procedures and presents modifications to the pertinent committee.

3. Responsible for giving direction and advice to the Manager of Infection Control.

4. Recommends to the pertinent committee(s) appropriate general control measures for endemic and epidemic problems.

5. Rules on questions concerning care of patients in accordance with the Hospital's Infection Control policies.

6. As a representative of the Hospital, cooperates with local, state and national health agencies in the study, prevention and control of infection.

REFERENCES:

- California Code of Regulations, Title 22, Section 70739. (n.d.) Accessed on October 8, 2023 from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=IB3A198305B6111EC9451000D3A7C4BC3&transitionType=Default&contextData=%28sc.Default%29#IB44FB28B5B6111EC9451000D3A7C4BC3
- The Joint Commission (2023). Hospital Accreditation Standards, IC.01.01.01EP1; IC.01.01.01EP3; IC.01.02.01EP1; IC.01.02.01EP3; IC.01.05.01EP2; IC.01.05.01EP6. Joint Commission Resources. Oak Brook, Il.
- The Joint Commission (2023). Laboratory and Point-of-Care Manual, IC.01.01.01EP3; IC.01.02.01EP1; IC.01.02.01EP3; IC.01.05.01EP6. Joint Commission Resources. Oak Brook, Il.

CROSS REFERENCE:

- Medical Staff Bylaws

SUBJECT: **INFECTION CONTROL IN IMAGING SERVICES**	SECTION: **Page 1 of 3**

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INTRODUCTION

The range of patients served by Sierra View Medical Center (SVMC) is a diverse population which reflects the local community. The Imaging Services Department shall protect all patients and hospital personnel who come to the department from infectious diseases by observing the principles of asepsis and putting into practice standard precautions especially proper hand hygiene by all personnel with a direct role in patient care. The practice of infection prevention principles is exceedingly important in preventing the spread of disease in the Imaging Service Department and preventing hospital associated infections (HAIs) at SVMC.

POLICY

The Imaging Services Department shall protect patients and hospital personnel who come to the department from acquiring infectious diseases from imaging equipment. The practice of asepsis principles, standard precautions, and proper hand hygiene by all personnel with a direct role in patient care, is exceedingly important in preventing the spread of disease in the Imaging Service Department.

PROCEDURE

The Imaging Services Department will follow the policies and procedures of the hospital-wide Infection Prevention Plan and all Standard Precautions.

GENERAL GUIDELINES

1. Personnel administering care shall be free from infection and should be constantly aware of sources of infection.
2. Personnel must follow the dress code and maintain good personal hygiene habits while working around infection.
3. The practice of proper hand hygiene is required and is exceedingly important in preventing the spread of infectious disease.
4. When caring for patients with communicable diseases, all personnel must adhere to the proper isolation procedures.
5. Technicians shall take special care in cases of the following:
    a. IV catheters and needles in place should not be disturbed, to avoid dislodgment or contamination, or both, of the IV site.
    b. When caring for patients with indwelling urinary catheters, care should be taken not to elevate the urine bag above the level of the bladder in order to reduce incidence of reflux back into the bladder. If there is any question about improperly placed drainage bags, notify the floor nurse on the unit from which the patient came.

c. Patient tracheostomies should not be unduly disturbed except when suctioning is absolutely necessary, in order to cut down on contamination and to facilitate proper breathing.

d. Chest tubes, if clamped, should not be unclamped. Remember to keep the container below the chest. Do not raise above the chest.

e. Sterile dressings should not be disturbed. If sterile dressing falls off the wound, replace it with a new dressing, using sterile gloves and sterile dressings to avoid contamination of the wound site. Sterile prepackaged dressings such as 4x4 in. gauze pads or ABDs should always be readily available in the Imaging Services Department.

6. Personnel will assure shared patient care equipment is appropriately cleaned before use and that all used equipment is appropriately cleaned before reuse per Alaris System Cleaning and Disinfecting policy.

7. Personnel will be educated, at least annually, on the principles and practices of Infection Prevention.

8. Personnel will notify the Infection Prevention Department (Ext. 3781) whenever a new infection is suspected or observed.

9. Personnel will follow protocol if exposed to any blood borne pathogens or other potentially infectious material.

CROSS REFERENCE:

ISOLATION AND STANDARD PRECAUTIONS

ALARIS SYSTEM CLEANING AND DISINFECTING

ATTIRE IN THE OPERATING ROOM, ENDOSCOPY, CENTRAL PROCESSING, OBSTETRICS, INTERVENTIONAL RADIOLOGY, CARDIAC CATH LAB

DRESS CODE STANDARDS

EXPOSURE CONTROL PLAN – BLOODBORNE PATHOGEN STANDARD

REFERENCES:

Ilyas F, Burbridge B, Babyn P. Health Care-Associated Infections and the Radiology Department. J Med Imaging Radiat Sci. 2019 Dec;50(4):596-606.e1. doi: 10.1016/j.jmir.2019.07.011. Epub 2019 Oct 14. PMID: 31623975; PMCID: PMC7104925. Accessed on 2023 Oct. 30, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7104925/pdf/main.pdf

The Joint Commission (2023). Hospital Standards Manual accreditation standards. Joint Commission Resources. Oak Brook, IL. IC.01.01.01, EP04; IC.01.03.01, EP1; IC.01.04.01, EP1; IC.02.02.01, EP1; IC.02.03.01

SUBJECT: **INTERDISCIPLINARY ASSESSMENT AND REASSESSMENT DPSNF**	SECTION: **Page 1 of 10**

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

PURPOSE:

To define initial resident assessment and reassessment parameters, a process to prioritize resident care, and criteria that all members of the healthcare team utilize during the assessment process.

To develop a database of information regarding the resident in order to provide the necessary information to plan, coordinate, delegate, and supervise the care of the resident.

POLICY:

1. All residents entering Sierra View Medical Center (SVMC) will receive an initial assessment, which takes into account their immediate and emerging DP/SNF needs. The data gathered will be analyzed to create information needed for care decisions concerning any need for further assessments, treatment, interventions, and reassessments.

2. Each admitted resident's initial assessment is conducted within a time frame identified by the service. Reassessment occurs throughout the care process and the purposes, key reassessment points and/or time intervals are defined.

3. Assessments are performed by each discipline within its scope of practice, state licensure laws, applicable regulations, or certification.

4. A registered nurse (RN) shall assess the patient's need for nursing care in all settings where nursing care is provided.

5. Care decisions will be based upon data and information gathered in assessments and reassessments. This data will be utilized in prioritizing patient care needs and selecting appropriate interventions.

6. Prioritizing resident care will be as follows:

    a. Emergent needs

    b. Actual needs

    c. Potential needs

    d. Educational needs

AFFECTED PERSONNEL/AREAS: *NURSING, RESPIRATORY THERAPY, NUTRITIONAL SERVICES, REHAB SERVICES, DISCHARGE PLANNING, SOCIAL SERVICES, PHARMACY, ACTIVITIES, PHYSICIAN (WHEN AVAILABLE, CHAPLAIN)*

PROCEDURE:

NURSING

1. ***Initial Assessment*** – will be performed by a Registered Nurse (RN) and other members of the Interdisciplinary Team to include the following:

   a. Physical Status (medication history and allergies)

   b. Psychological Status

   c. Social Status

   d. Spiritual Status

   e. Cultural Status

   f. Risk for Injury (Fall Risk Assessment)

   g. Nutritional Status Screen

   h. Functional Screen

   i. Skin Assessment

   j. Functional/Environmental Needs

   k. Anticipated Discharge Planning Needs

   l. Initial Anticipated Educational Needs and any Barriers to Learning

   m. Pain Assessment

   n. Abuse/Neglect Screening

2. Each nursing unit/department has established a time frame for completing the admission assessment interview, taking into consideration the following factors based on the major patient population of each department:

   a. The anticipated length of stay

   b. The complexity of nursing care needs

   c. The dynamics of the resident's condition(s)

3. Family involvement in the admission process will be encouraged /facilitated by the admitting RN whenever possible.

4. The RN can delegate data gathering aspects of the admission process to licensed vocational nurses (LVNs) and certified nursing assistants (CNAs), according to their practice guidelines, but the RN must analyze the data and formulate a nursing diagnosis and plan of care in collaboration with the resident and other clinical disciplines.

5. The RN/Social Service Designee will document or delegate documentation of the disposition of resident's valuables. This is particularly important when the resident is physically or mentally unable to keep track of personal property. The problem can be partially resolved by encouraging the resident's family to take personal belongings home.

6. The admission assessment will be documented on the Admission Intervention in the electronic medical record (EMR).

7. The scope and intensity of the assessment will be determined by:

   a. Resident diagnosis

   b. Care setting to which the resident is admitted

   c. Resident desire for care and interventions

   d. Resident response to treatment, procedures, and interventions.

9. ***Reassessment***

   a. The resident will be reassessed:

      - To determine response to treatment(s)/procedure(s)
      - When there is a significant change in condition
      - When there is a change in diagnosis
      - When there is a change in the level of care
      - Any time as deemed necessary
      - Minimally every shift and at unit specified intervals related to the care setting and course of treatment

   b. Documentation of the reassessment will be located on the RN Weekly Summary Intervention in the EMR.

c. Reassessments are completed by RNs. The information for reassessment will be gathered from residents, families, other healthcare professionals and physician input.

d. Procedural reassessment is continuous during procedures in OR, Endoscopy, and Diagnostic Radiology.

RESPIRATORY CARE

1. ***Initial Assessment***

a. Initial assessment will be initiated within 15 minutes of notification of a STAT physician order or within 2 hours of notification for routine physician order and completed within 2 hours by a Respiratory Care Practitioner (RCP).

b. The resident is evaluated by:

- Diagnosis
- History
- Physical Assessment
- Clinical Data – ABGs, Pulse Oximetry, Breath Sounds, Chest X-ray
- Resident's ability to perform ordered procedures
- Necessity for teaching home care

c. The ordered therapy is initiated and an assessment made as to the effectiveness of therapy and its appropriateness to the resident's condition and abilities. Treatments and patient's response are documented on the Respiratory Therapy Record.

2. ***Reassessment***

a. As long as the patient is receiving therapy, the therapist will reassess the resident prior to, during, and following each treatment to determine response to medication and occurrence of significant changes. The following areas will be monitored:

- Breath sounds
- Heart rate
- Respiratory rate
- Secretions

- How well treatment was tolerated
- Clinical data
- Continuing need of current therapy
- Evaluation of mode and frequency

NUTRITIONAL SERVICES

1. ***Initial Assessment***

   a. The purpose of the nutritional assessment is to evaluate the resident's nutritional status, develop a plan of nutritional care, and evaluate the efficiency of nutritional support. The need for a nutritional assessment is determined following a nutritional screening process completed by a Registered Dietitian/RN during the initial resident assessment.

   b. All inpatients are screened within 24 hours of admission, which triggers a referral to a Registered Dietitian (RD), who will assess residents in a time frame according to high, moderate or low risk identification.

   - Physician-ordered nutritional consults are completed within 24 hours of order.
   - Nursing referrals identified from the nutritional screening on nursing initial assessment form will be prioritized for nutritional risk by 48 hours.
   - All residents identified to be at high/moderate nutritional risk receive a nutritional assessment by a Registered Dietitian.

2. ***Reassessment***

   a. Residents will be reassessed by the Registered Dietitian.

   - High Risk patients, 2-3 days- TPN /PPN assessment will be completed in collaboration with lab data ordered twice weekly.

     Residents re-evaluated every 30 days or as deemed appropriate at last evaluation or Consult.

   - When ordered by a physician
   - More often as deemed necessary by the Registered Dietitian

   b. The reassessment will document the resident's response to care. At the time of reassessment, the Registered Dietitian may determine that the resident is no longer at a

certain nutritional risk level. This change of nutritional risk will be documented in the medical record.

c. All resident reassessments are documented in a narrative format on the resident's medical record in the EMR.

PHYSICAL THERAPY

1. ***Initial Assessment***

a. Residents need to be assessed by a Physical Therapist (PT) within 48 hours of receipt of physician order and may include the following:

- Resident interview
- Chart review
- Evaluation of:
  - balance/coordination
  - bed mobility
  - transfers
  - gait
  - strength
  - range of motion
  - neurological
  - posture

2. ***Reassessment***

a. Functional status and needs are reassessed with each treatment to determine the resident's response to interventions.

b. Information for reassessment will be gathered from residents, families, other healthcare professionals and physical input. Reassessment documentation will be located in the Therapy progress notes.

OCCUPATIONAL THERAPY/With Physician Order

1. ***Initial Assessment***

   a. All inpatients are screened for the need of further assessment within 48 hours of admission. Residents needing assessment will be assessed by an Occupational Therapist (OTR) within 24 hours of receipt of physician order and may include the following:

   - Resident interview
   - Chart review
   - Evaluation of:
     - ADLs
     - Upper Body Function
     - Transfer
     - Cognitive-Visual Perceptual Motor Skills

2. ***Reassessment***

   a. Reassessment of functional status and needs are ongoing with each treatment given to determine the resident's response to interventions.

   b. Information for reassessment will be gathered from residents, families, other healthcare professionals and physician input. Reassessment documentation will be located in the Therapy progress notes.

SPEECH THERAPY

1. ***Initial Assessment***

   a. All residents are screened for the need of further assessment within 5 days of admission. Residents needing immediate assessment will be performed by a Speech Therapist (SLP) within 48 hours of receipt of physician order and may include the following:

   - Resident interview
   - Chart review
   - Evaluation may include:
     - Dysphasia
     - Cognition

- Communication

2. ***Reassessment***

   a. Reassessment of the functional status and needs are ongoing with each session given to determine the patient's response to interventions.

   b. Information for reassessment will be gathered from patients, families, other healthcare professionals and physician input. Reassessment documentation will be located in the progress notes.

DISCHARGE PLANNING

1. ***Initial Assessment***

   a. A Discharge Evaluation will be done by the Social Service Designee on admission, every 6 months thereafter, and on discharge from the facility.

   b. The need for Discharge Planning Service intervention is triggered following a screening process completed by nursing during the initial patient assessment.

   c. A Social Service Designee will assess residents when given notification by nursing or upon review of the patient's medical record that indicate risk factors which warrant further discharge planning activities.

   d. The resident is evaluated for:

      - Diagnosis
      - Physical ability
      - Resident's goals for discharge
      - Social setting at place of residence (i.e.; lives alone, in Board & Care/ECF, etc.)
      - Resident's ability to safely return to previous living arrangements
      - Providing availability and education of Community Resources (assisting resident/family with discharge planning that requires specific resources).

2. ***Reassessment***

   a. The Discharge Planner reviews care and progress on assigned residents as often as deemed necessary, but no less than every 3 days, and documents discharge planning progress notes on the worksheet and medical record.

b. Coordinates multi-disciplinary communication to facilitate reassessment and revision of the plan of care when necessary.

c. Information for reassessment will be gathered from patients, families, other healthcare professionals and physician input. Reassessment documentation will be located in the medical record.

SOCIAL SERVICES

1. ***Initial Assessment***

a. The need for social service intervention is triggered following a screening process completed by nursing during the initial patient assessment.

b. Intervention will be performed by a Social Worker within 1 day for high-risk patients and within 2 days for moderate risk patients, or upon request for services.

- Residents meeting high risk criteria:
  - Domestic Violence
  - Suspected abuse/neglect
- Residents meeting moderate risk criteria:
  - Newly diagnosed catastrophic illness
  - Homelessness

2. ***Reassessment***

a. Reassessment by the Social Worker occurs at least every 3 days.

b. Information for reassessment will be gathered from residents, families, other healthcare professionals and physician input. Reassessment documentation will be located in the progress notes.

PHARMACY

1. ***Initial Assessment***

a. Assessment will be performed by a Pharmacist (Pharm. D.) within 30 days.

b. Assessment will include:

- Body Stats: Height, weight, ideal body weight (IBW), age
- Pertinent labs
- Pertinent medications
- Allergies
- Goals of treatment

c. Assessment will be performed by a pharmacist for all residents receiving medications upon physician order for therapeutic appropriateness.

d. Residents receiving parenteral nutrition are assessed upon initial order.

2. ***Reassessment***

a. Reassessment by the Pharmacist is ongoing on a monthly basis to determine the resident's response to interventions.

b. Reassessment will be performed to assure designated medications are administered to achieve therapeutic drug levels.

c. Information for reassessment will be gathered from residents, families, other healthcare professionals, and physician input. Reassessment documentation will be located in the progress notes for drug dosing/monitoring protocol.

REFERENCES:

- Centers for Medicare/Medicaid Services RAI Manual (2019). Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.
- The Improving Medicare Post- Acute Care Transformation Act (IMPACT ACT) of 2014 Data Standardized Patient Assessment Data Elements, CMS.gov
- https://www.ncbi.nlm.nih.gov>pmc

SUBJECT: **LINEN HANDLING**	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 protect against the transmission of organisms from one location to another through the use of proper linen handling techniques.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) to provide procedures for the proper handling of clean and soiled linens and to ensure procedures are followed.

AFFECTED PERSONNEL/AREAS: *LICENSED STAFF, EVS, CNA*

PROCEDURE:

CLEAN LINEN

1. Clean linen is obtained from the linen closet/cart.
2. Only the linen needed for an individual resident is taken to the resident unit.
3. Linen is to be carried in such a manner as not to have contact with the employee's uniform.
4. Clean linen may be placed at the foot of the bed when used immediately.
5. Linens considered clean and to be used by the resident at a later time may be folded neatly and stored on the shelf in the resident's closet (i.e. blanket, bedspread, pillow, etc.) or in their dresser.
6. Avoid shaking linens or fluffing them in the air, as this spreads lint and dust, which can contain microorganisms.
7. If clean linen is dropped on the floor, it will be considered contaminated and handled as soiled linen.
8. If clean linen is placed on another resident's bed or overbed table, it must be used for that resident or considered contaminated and handled as soiled linen.

SOILED LINEN

1. Soiled linen shall be placed immediately into a soiled linen hamper. If a linen hamper is not immediately available, the linen may be rolled up tightly and placed at the foot of the bed between the mattress and frame until it can be removed to the soiled linen hamper.
2. Soiled linen must never be put onto the floor.

3. Residents' soiled personal linen will be placed into the cart in the shower room for pick up by contracted service to be laundered.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.65 © United States of America, Med Pass Inc.
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, 73669, San Francisco, California, Title 22.

CROSS REFERENCES:

- Infection Prevention and Control- DP/SNF Policy

SUBJECT: **MANDATED ABUSE REPORTING- DP/SNF**	SECTION: **Page 1 of 8**

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

PURPOSE:

To define the Sierra View Medical Center (SVMC) process for handling and reporting of patient/resident suspected or actual abuse by those involved in operations of the District.

POLICY:

It is the policy of SVMC's DP/SNF to comply with the Elder Justice Act (EJA) about reporting a reasonable suspicion of a crime under Section 1150B of the Social Security Act, as established by the Patient Protection and Affordable Care Act (ACA), §6703(b)(3).

The Director of DP/SNF for SVMC will be held accountable for following the established guidelines for screening, training, preventing, identifying, investigating, protecting and reporting and/or responding to all alleged events of suspected abuse.

For the purposes of this policy, the following definitions apply:

"Abuse" - Is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish to the resident. Examples may include but not be limited to: deprivation by a caretaker of goods and services that are necessary, to attain or maintain physical, mental and psychosocial well-being. This presumes that instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.

"Alleged Violation" - Is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliant with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.

"Exploitation" - As defined at 483.5 means "taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion."

"Immediately" – Reporting must be made immediately, and no later than 2 hours, this applies to ANY abuse (whether actual, alleged or potential), including abuse resulting in serious bodily injury. All other conduct must be reported no later than 24 hours.

"Injuries of unknown source" – An injury should be classified as an "injury of unknown source" when both of the following criteria are met:

- The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and
- The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

"Misappropriation of resident property" - As defined at 483.5, means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent."

"Mistreatment" - As defined at 483.5, is "inappropriate treatment or exploitation of a resident".

"Neglect" - As defined at 483.5, means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."

"Sexual Abuse" - Is defined at 483.5, as "non-consensual sexual contact of any type with a resident".

"Verbal Abuse" - Is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

"Physical Abuse" - Includes, but is not limited to: hitting, slapping, pinching and kicking, controlling behavior through corporal punishment.

"Mental Abuse" - Includes but is not limited to: humiliation, harassment, threats of punishment or deprivation.

"Involuntary Seclusion" - Includes separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

"Covered Individual" - Refers to any individual (or staff) who is an owner, operator, employee, manager, agent or contractor of a long-term care facility (DP/SNF).

"Retaliation against an Employee" - Refers to when the employer discharges, demotes, suspends, threatens, harasses, or denies a promotion or any other employment-related benefit to an employee, or in

any other manner discriminates against an employee within the terms and conditions of employment because the employee has met their obligation to report a suspicion of a crime.

AFFECTED PERSONNEL/AREAS: *DP/SNF STAFF, CONTRACTORS, MEDICAL STAFF*

PROCEDURE:

Screening of Potential Staff:

To protect the residents/patients of SVMC, all directors will coordinate in the post-employment criminal background screening with SVMC's Human Resources Department to determine eligibility for employment or assignment. *(See: "Criminal Background Screens for Employment" – Human Resource Policy & Procedure Manual)*

Staff. Resident, and Family Education/Training:

1. All staff (e.g. "covered individuals") will annually receive a copy of their obligation to comply with the law and these policies and procedures.

2. All staff who will care for or work around the DP/SNF residents, including but not limited to, EVS, Respiratory and Floats from other departments will be given an in service on the DP/SNF Abuse Policy and will be guided to the appropriate Mandated Reporting Communication Board for information and appropriate forms.

3. All new staff, as part of their New Hire Orientation to work at SVMC, shall receive a copy of their obligation to comply with the law and this policy and procedure.

4. Staff will be taught how to identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property are more likely to occur. This in-service will be given to all employees who work with or around the residents on the DP/SNF Unit on hire and every 6 months. All staff will also be taught to document their assessment of the involved resident, initially upon report of the witness, then each shift for seven (7) days from the day of the incident, in the resident's notes via the electronic medical records. All other residents will also be assessed to ensure their safety and comfort. This assessment will be entered in the EMR on the day of the incident.

5. Residents, families, and staff will be given information on how and to whom they may report concerns, incidents and grievances without the fear of retribution/retaliation; and provide feedback regarding the concerns that have been expressed.

6. *Cameras/ Cell Phones:* Staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate a resident(s). This would include using any type of

equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and recordings on social media.

Prevention

1. Identify, correct and intervene in situations in which abuse and /or neglect and/or misappropriation of residents property is more likely to occur.

Identification of Suspected Abuse:

1. Any employee who suspects abuse of a resident by SVMC staff, who identifies any suspicious bruising, repeated occurrences, patterns and trends that may constitute abuse are to report such items to their supervisor immediately, and complete an organization Occurrence Report in the PAVISSE, which will be forwarded to the unit's department director and SVMC's Risk Management Department.

The initial report (SOC 341) of suspected abuse must be completed and reported to the Ombudsman and CDPH within 24 hours of the event. During after hours, weekends or holidays, the Nursing House Supervisor will notify the DP/SNF Unit Director or designee of the event. The SOC 341 must be faxed to both the Ombudsman and CDPH. The hard copy of the SOC 341 will be mailed to CDPH within 24 hours of completing the form.

CDPH Licensing and Certification
4540 California Avenue, Suite 200
Bakersfield, CA. 93309
(O): 661-336-0543
(F): 661-336-0529

Long Term Care Ombudsman Services
1197 S. Drive
Hanford, CA. 93230
(O): 559-583-0333
(F): 559-589-0608

Porterville Police Department
350 North D. Street
Porterville, CA. 93257
(O): 559-782-7400

2. Risk Management will coordinate with the DP/SNF Unit Director and Human Resources to initiate the investigation process.

Protection of Resident:

In order to protect the resident, the employee and/or staff member under investigation will be immediately removed from the unit.

Suspension:

If abuse is suspected and/or witnessed, the Nursing House Supervisor, Unit Director and/or the Human Resources representative will immediately suspend and remove the individual from the District grounds.

Investigation:

1. SVMC's Risk Management and Human Resources Departments will conduct a thorough investigation of the incident in collaboration with the Unit Director.

2. You must also report investigation results for all allegations – within five (5) working days of the incident. This can be done by written form.

Staff Reporting Requirements:

1. The facility administrator (or designee) is to report all incidents to CDPH Licensing and Certification and the Administrative Director of Care and Quality. If the administrator is absent, reporting is required from whoever is officially acting on the administrator's behalf.

2. Reporting should be made by telephone and /or fax copy of the SOC 341.

3. Keep a copy of the fax confirmation. Also, if the report is via phone, make sure to document who was spoken to and the time of the call.

4. When staff suspects a crime has occurred against a resident of the DP/SNF, they must report the incident to the physician, facility administrator, unit director/abuse coordinator. Appropriate state agencies will also be contacted/notified as part of the mandated reporting process.

5. Staff must report a suspicion of a crime to the state survey agency and at least one local law enforcement entity within a designated time frame by e-mail, fax, or telephone. The individual does not need to determine which local law enforcement entity to report a suspicion of crime; but, must report to at least one local law enforcement entity. This will meet the individual's obligation to report.

6. Suspected abuse not resulting in serious bodily injury by a resident with a diagnosis of Dementia:

   - Report the incident to the local Ombudsman and local law enforcement agency by telephone as soon as possible.
   - A written report must follow within 24 hours to the local Ombudsman and the local law enforcement agency.

7. If the suspected abuse does not result in serious bodily injury, the mandated reporter must:

   - Report the incident by telephone within 24 hours to local law enforcement agency

- Provide a written report to the local Ombudsman, the L & C Program and the local law enforcement agency within 24 hours.

8. If suspected abuse results in serious bodily injury, then facility must do the following:

   - Report the incident immediately and no later than 2 hours by telephone to local law enforcement. Send a written report within 2 hours to the local law enforcement agency, L & C Program and the Ombudsman.

9. Staff can either report the same incident as a single complaint, or multiple individuals may file a single report that includes information about the suspected crime from each staff.

10. If, after a report is made regarding a particular incident, the original report may be supplemented by additional staff that become aware of the same incident. The supplemental information may be added to the form and must include the name of the additional staff along with the date and time of their awareness of such incident or suspension or suspicion of a crime. However, in no way will a single or multiple person report preclude an individual from reporting separately. Either an individual or joint report will meet the individual's obligation to report.

11. To ensure correction is achieved and sustained in regards to providing evidence of investigation, an assessment entry will be made in the involved patient's note for seven (7) days from the day of the incident. This will serve as evidence of all measures undertaken and of the investigation that transpired. Such process will be an included instruction in the routine abuse training for all staff.

12. Failure to report in the required time frames may result in disciplinary action, including up to termination.

13. The Compliance RN will monitor for compliance of the investigation/monitoring process, through the nurse's daily assessment notes, for each shift x seven (7) days from the day of the incident, as documented in the EMR. The result of the monitoring will be reported on QA/PI report for the specific quarter that the incident has transpired.

***There may be instances where a report is required under 42 CFR 483.12(C) [f609], but not under 42 CFR 483.129(b) (5)/Section 1150B of the Act [F608]. The following table describes the different requirements:

	F608 42 CFR 483.12(b)(5) and Section 1150B of the Act	F609 42 CFR 483.12(C)
What	Any reasonable suspicion of a crime against a resident.	1.All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. 2.The results of all investigations of alleged violations.
Who is required to report	Any covered individual, including the owner, operator, employee, manager, agent or contractor of the facility.	The facility.
To whom	State Agency and one or more law enforcement entities for the political subdivision in which the facility is located (i.e., police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners).	The facility administrator and to other officials in accordance with State law, including to the State Agency and the adult protective services where state law provides for jurisdiction in long-term care facilities.
When	Serious bodily injury – Immediately, but not later than 2 hours after forming the suspicion. No serious bodily injury – Not later than 24 hours.	All alleged violations – Immediately, but not later than: 3) 2 hours – if the alleged violation involves abuse or results in serious bodily injury. 4) 24 hours – if the alleged violation does not involve abuse and does not result in serious bodily injury. **Results of all investigations of alleged violations will be submitted within 5 working days of the incident.

*Reporting requirements under this regulation are based on real (clock) time, not business hours.

The regulations related to Abuse were written to provide protections for the health, welfare and rights of each resident residing in the facility. The facility ensures prohibition and prevention of abuse, neglect, exploitation of residents, and misappropriation of resident property. This is achieved through implementation of the following seven (7) components within this policy, to include: Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response.

Posting Requirements:

1. The DP/SNF unit will post in an appropriate location, a sign specifying the rights of the employees under Elder Justice Act. This sign shall include both:
   - The reporting requirements of each staff member.
   - A statement that an employee may file a complaint with the state survey agency against a long-term care facility that retaliates against an employee for filing, and information how to file such a complaint to the State Agency.
2. The sign will be posted in the same area where other required employee signs are posted.

REFERENCES:

- MedPass Inc., (2001) (Updated February 6, 2015) *Facility Guide to OBRA Regulations*. 483.12(b)(5), 483.12(c), 483.13 (b). Abuse, United States of America, MedPass Inc.
- State of California (2021). Long Term Care Ombudsman. Retrieved from https://www.aging.ca.gov/Programs_and_Services/Long-Term_Care_Ombudsman/.
- Thomson Reuters (Revised edition April 1, 1990) Barclays California Code of Regulations, San Francisco, California, Title 22.
- Help Guide, *Elder Abuse and Neglect*, Lawrence Robinson. Joanna Saisan MSW, and Jeanne Segal PhD, Updated June 2019.
- FindLaw, Elder Justice Act Reporting Requirements, Updated May 17, 2021, Thomson Reuters.

CROSS REFERENCES:

- "CRIMINAL BACKGROUND SCREENS FOR EMPLOYMENT " – Human Resources Policy & Procedure Manual

SUBJECT: **MEDICAL RECORD GUIDELINES FOR PHYSICIANS**	SECTION: **Page 1 of 5**

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

PURPOSE:

To ensure a complete and accurate medical record for patients assessed, cared for, treated, or served. To ensure patient-specific information is appropriate to the care, treatment, and services provided. To ensure the medical record thoroughly documents operative or other high risk procedures and the use of moderate or deep sedation or anesthesia.

POLICY:

The quality of the medical record depends in part on the timeliness, meaningfulness, authentication and legibility of the information it contains.

PROCEDURE:

1. General Outlines:

   a. All entries must be timed, dated and authenticated.

   b. Records shall be completed and authenticated within two (2) weeks following patient discharge (See Sierra View Medical Center Bylaws).

   c. In no event shall the completion of a medical record exceed 14 days following patient discharge.

   d. Records will be considered complete when all dictated reports are transcribed and all entries authenticated.

   e. Final diagnosis and complications must be recorded without abbreviations or symbols.

2. History and Physical Examinations:

   a. A comprehensive history and physical (H&P) examination shall be completed within 24 hours of admission to inpatient services or prior to surgery by the appropriate practitioner privileged to perform H&Ps.

   b. H&P examinations by the appropriate practitioner privileged to perform H&Ps must be completed and recorded before any operative or invasive procedure is undertaken, unless the practitioner certifies in writing in the medical record that the patient's situation is emergent and any delay could lead to death or serious disability.

   c. H&P examinations may be completed ahead of time, though no more than 30 days prior to admission or readmission, and only by the appropriate practitioner privileged to perform H&Ps.

      - When the medical history and physical examination are completed within 30 days before admission, the hospital must ensure that an updated medical record entry

documenting an examination for any changes in the patient's condition is completed. This updated examination must be completed and documented in the patient's medical record within 24 hours of admission but prior to surgery or a procedure requiring anesthesia. [CMS 482.22(c)(5)]

d. Must include the following:

- Chief complaint
- Details of the present illness
- Relevant past, social and family history
- Allergies
- Review of systems
- Physical examination to include inventory of body systems and vital signs
- Pelvic, rectal, breast, and for diabetic patients, fundoscopic examination or reason for deferral, along with results if done in the hospital
- Conclusions or impressions (admitting diagnosis)
- Course of action or plan

3. Progress Notes:

a. Must be written on a daily basis.

b. Should give a pertinent chronological report of the patient's course.

c. Should reflect any change in condition.

d. Should reflect all orders.

e. Should reflect the results of treatment.

f. Should describe the patient's response to medications.

g. Must be timed and dated.

h. An Immediate Post-Operative Progress Record (to include all the components) is written upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. This Post-Operative Progress Record is to be completed in the Procedure Room or Post Anesthesia Care Unit (PACU).

4. Consultation:

   a. Should contain written opinions reflecting actual examination of the patient and the patient's medical record.

5. Physician Orders:

   a. All orders, including verbal orders, must be dated, timed and authenticated by the ordering physician or another practitioner who is responsible for the care of the patient. (42 CFR 482.12(c)).

   b. Verbal/telephone orders must be authenticated within 48 hours of giving the order. (*CoP 482.23, 482.24*)

6. Operative Reports:

   a. History and physical examination must be in the medical record prior to the surgical procedure.

   b. The operative report must be documented immediately following surgery before the patient is transferred to the next level of care.

   c. If the operative report is dictated using the telephone dictation service, an Immediate Post-Operative Progress Record (to include all the components) must be written upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. This Post-Operative Progress Record is to be completed in the Procedure Room or PACU.

   d. An operative progress note may be documented in the medical record immediately following the procedure with the stipulation that the full operative report be written or dictated within 24 hours of the procedure.

   e. Operative report must include the following:

      - The name(s) of the surgeon and any assistant
      - The name of the procedure performed
      - Date of procedure
      - Preoperative diagnosis
      - Post-operative diagnosis
      - A description of the procedure

- Findings of the procedure
- Specimens removed
- Grafts or implants
- Condition after surgery
- Estimated blood loss

f. The operative report must be signed and in the medical record as soon as possible, no later than 24 hours following surgery.

g. Informed Consent shall be documented with explanation of Risk and Benefits as provided by the physician with date, time, and signature, which shall be authenticated by the patient (or patient representative) with date, time and signature in the Medical Record.

7. Clinical Summary Reports:

a. Must contain the principal and associated diagnosis.

b. Must list all procedures performed.

c. Must be dated and authenticated.

d. Cannot contain any abbreviations or symbols.

e. In the event of death, a summation statement shall be made as to the immediate cause of death.

Discharge Summary (Inpatient and Outpatient)

a. Should be dictated within 14 days following patient's discharge. (Sierra View Medical Center Bylaws)

b. Must recapitulate the reason for the hospitalization.

c. Must include significant lab/history and physical findings.

d. Must include procedures performed, and treatment and services rendered.

e. Must include the condition and disposition of the patient at discharge.

f. Must include any instruction provided to patient and/or family relating to physical activity, medication, diet and follow-up care.

g. Must include final diagnosis.

h. Must be dictated for all deaths.

i. Final progress may be substituted for a discharge summary if:

- The patient stays under 48 hours,
- The patient was hospitalized for a minor problem (as defined by the medical staff)
- The patient had an uncomplicated obstetrical stay
- The patient was a normal newborn infant
- Final progress note should include instructions to the patient and/or family

j. Provisional autopsy results are on the medical records within three (3) days and complete the protocol within 60 days.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. RC.02.01.03, RC.01.03.01, RC.02.04.01. Joint Commission Resources. Oak Brook, IL.
- Centers for Medicare & Medicaid Services. Conditions of Participation: Medical Staff. 42 CFR §482.22(c)(5) (2019). https://www.law.cornell.edu/cfr/text/42/482.22.
- Centers for Medicare & Medicaid Services. Conditions of Participation: Medical Record Services. §482.24 (c)(2)(vii) (2020). https://www.law.cornell.edu/cfr/text/42/482.24.
- Centers for Medicare & Medicaid Services. Condition of Participation: Governing Body. 42 CFR §482.12(c). (2014). https://www.law.cornell.edu/cfr/text/42/482.12.
- Centers for Medicare & Medicaid Services. Condition of Participation: Nursing services. 42 CFR §482.23. (2019). https://www.law.cornell.edu/cfr/text/42/482.23.

CROSS REFERENCE:

- LEGAL MEDICAL RECORD STANDARDS
- Sierra View Medical Center Medical Staff Bylaws

SUBJECT: **MEDICAL RECORDS FILED AS INCOMPLETE**	SECTION: **Page 1 of 1**

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

POLICY:

Sierra View Medical Center (SVMC) shall ensure that any medical record filed as incomplete must be reviewed by the appropriate Medical Staff Committee for approval prior to being declared complete for permanent filing. Incomplete records must be reviewed by the Residency Program Director for all Residents.

PROCEDURES:

- No medical staff member is permitted to complete a medical record on a patient unfamiliar to him/her in order to retire a record that was the responsibility of another staff member who is deceased, unavailable permanently or for other reasons.

  Any medical record that may not be complete due to reasons stated in the above paragraph of this procedure will be submitted for approval to file as incomplete by the Chair of the appropriate Medical Staff Committee, the Chief of Staff, or the Residency Program Director.

- The Health Information Management Department will clear the incomplete record upon approval notification by the medical staff or residency program director.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. RC.01.02.01, RC.01.03.01. Joint Commission Resources. Oak Brook, IL.

- California Code of Regulations (2023). Title 22. § 70751,

  Retrieved from https://govt.westlaw.com/calregs/Document/IB47D04195B6111EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)&bhcp=1

- Code of Federal Regulations (2020). §482.24,
  Retrieved from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.24

SUBJECT: **MEDICATION ADMINISTRATION**	SECTION:

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 immediate use 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 expiration date & time period within which administration must begin, 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:

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

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.")

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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- Pauly-O'Neill, S. (2009) Beyond the five rights: Improving patient safety in pediatric medication administration through simulation. Clinical Simulation in Nursing, Vol 5, pg 181-186.

CROSS REFERENCES:

- High-Alert Medications and Look Alike Sound Alike Medications
- Adverse Drug Reactions
- Meditech Downtime- Clinical Documentation
- Black Box Warning

SUBJECT: **MEDICATION ADMINISTRATION - DP/SNF**	SECTION: **Page 1 of 20**

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PURPOSE:

To assure the most complete and accurate implementation of physicians' medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe, timely, and sanitary manner.

POLICY:

1. ORDERING MEDICATIONS – Medications and treatments shall be administered only upon the written order of a medical provider. No standing orders shall be employed.

2. TELEPHONE ORDERS – The prescriber's complete order, date, time, name of prescriber, and signature of the nurse receiving the order shall be transcribed on the physician's order sheet. Licensed nurses and pharmacists may take telephone orders, using telephone order, read back format.

3. IMPLEMENTATION ("NOTING") – The nurse who receives the prescriber's order shall be responsible for its complete implementation. This includes proper transcribing, ordering of medications and all other steps involved in carrying out of the order, and care plan as needed, whenever pertinent.

4. INITIATION OF NEW MEDICATION ORDERS – New medication orders shall begin timely. Routine orders shall begin on the same day ordered, unless the next dose would normally be given on another day. New PRN drug orders shall be available on the same day ordered.

5. ADMINISTRATION – All medications and treatments shall be administered by licensed health care professionals as allowed by state law.

Pre-pouring of medications shall not be permitted in this facility. The pre-pouring of medications is defined, as the preparation of all resident's medication doses prior to the medication pass.

AFFECTED PERSONNEL/AREAS: *RN, LVN*

PROCEDURE:

PREPARATION OF DOSES – GENERAL INSTRUCTIONS:

1. Doses shall be prepared immediately prior to administration to each resident and shall be administered within one (1) hour before or (1) hour after the scheduled dose time.

2. On the DPSNF unit when using the cassettes system, doses(s) will be removed, using sanitary technique, and placed in a receptacle such as a disposable cup. When using the punch card system, the dose(s) will be removed from the card using pressure on the "bubble" and placed in a receptacle such as a disposable cup.

3. Sanitary techniques shall be used in the preparation of any medication:

   a. Hand washing shall be done immediately prior to preparation for each dose time and whenever the nurse has contact with body secretions (i.e., eye needs, N/G tube). Alternatives to hand washing such as isopropyl alcohol gel or foam may be used between residents, and when the nurse has not come in contact with any body secretions.

   b. Oral medication shall not be touched.

   c. Sterile syringes and needles shall be used for all injections.

   d. Topical ointments and creams shall not be touched, ordered amount placed in disposable cup (Do NOT take tubes, bottles into residents' room.)

4. The nurse shall maintain the security of the medications during the preparation of doses, and while medications are being administered. A licensed nurse or pharmacist must attend an unlocked medication or treatment cart (within view).

5. The medication label shall be verified against the medication sheet for accuracy of resident, drug and dose, and for strength of medication, route, frequency and duration of therapy, if applicable, and for allergies.

6. The nurse shall read and follow precautionary or additional instructions available on the prescription label "Shake Well", "Give on an Empty Stomach").

7. The licensed nurse will bring the resident's MAR to the Medication Room for verification purposes before signing out narcotics.

8. During the licensed nurses' medication pass, the medication cart will be brought to an easily accessible area near the resident to maintain contact with the medication cart and medications, and for verification purposes.

ADMINISTRATION OF DOSES:

1. Each resident shall be appropriately identified prior to the administration of any medication, using two means of identification, (i.e., birthdates, picture, name, armbands.)

2. If applicable, vital signs or tests shall be done prior to the administration of a dose (ex: pulse with antihypertensive, and urine or blood sugars with insulin, if ordered) by nurse administering medication.

3. Adequate fluid will be offered with oral medications, unless on fluid restrictions per physician's order.

4. Residents will be observed swallowing their oral drugs. Medications shall not be left with residents to self-administer unobserved (unless bedside medication administration procedures are followed).

5. Medications will be dissolved with the appropriate amount of H_2O/ fluid as per MD order/ manufacturer's recommendation.

6. Medications shall be charted immediately after being administered.

7. Crushing of medications or allowing residents to chew the medication shall be done appropriately for the medications(s) concerned.

    a. Medications shall be reviewed for appropriateness of crushing (see List of Medications Which Should Not Be Crushed or Chewed). Specific questions should be addressed to the pharmacist.

    b. Sanitary techniques shall be used when crushing or breaking medications.

    c. Proper crushing instruments shall be used.

    d. Any medication which appears on the "List of Medications Which Should Not Be Crushed or Chewed" that cannot be provided in another form and cannot be administered without crushing or chewing, requires a specific physician order authorizing its administration by crushing or chewing.

8. Adequate supplies shall be maintained in the facility at all times (disposable cups, portion cups, drinking cups, counting tray, crusher, syringes, needles, scalpel or medication/tablet cutter-for breaking tablets).

9. Supplies shall be disposed of properly; according to policies and procedures listed in the Infection Control Manual.

NASAL AEROSOLS (INHALERS):

1. Follow preparatory steps for ointments.

2. Verify that the medication is for the NOSE and verify right, left or both nostrils.

3. Nasal Drops

    a. Position resident so that drops flow toward the sinuses and Eustachian tube.

    b. Push tip of nose up slightly and position dropper just inside nostril and in a manner such that drops flow down the inside wall of the nasal cavity or along the septum.

c. Do not touch dropper to nostril.

d. Instill the prescribed number of drops and have the resident remain in the position for several minutes to allow full penetration of the drops.

e. After repositioning the resident comfortably, wipe excess drops from the nose. Some residents will need to expectorate so an emesis basin may be needed.

f. Wash hands.

g. Wear gloves at all times during procedure.

4. Nasal Sprays

a. Position resident upright with head tilted back slightly.

b. Occlude one nostril with finger and insert the tip of the sprayer into the nostril.

c. Instruct the resident to inhale gently while the container is squeezed.

d. Repeat the prescribed number of times in the nostril(s).

e. Instruct the resident to keep head tilted back for several minutes to allow complete penetration of the medication.

f. Wash off the tip of the sprayer and replace cap.

g. Wash hands.

h. Wear gloves at all times during administration of medication.

OPHTHALMIC MEDICATIONS:

1. Verify that the medication is for the EYE and verify right or left eye or both eyes.

2. Using gloves, when appropriate, remove any dressing or encrustation from eye and cleanse area with warm water.

3. Use a clean gauze pad for each stroke and wipe the eye from inside to outside (inner canthus).

4. Position resident so that the head is tilted back to side of affected eye so that medication flows away from tear duct.

5. While resident looks up and away, hold lower lid down to expose the conjunctival sac.

6. For eye drops, keeping the tip of the dropper clean, drop the prescribed number of drops into the sac.

7. For eye ointments:

   a. Apply thin ribbon of the ointment along the length of the lower lid.

   b. Have resident blink several times to distribute the medication.

   c. Twist tube to cut ribbon. Do not touch tube to eye.

8. After instillation, wipe any excess medication from the outer eye with a clean tissue for each eye.

9. Apply a new dressing, if necessary.

10. Dispose of supplies appropriately.

11. Wash hands.

12. Document administration of medication and record in licensed nursing notes any pertinent observations of the condition of the eye(s).

ORAL INHALERS

1. For hand-held nebulizer:

   a. Assemble canister and clean mouthpiece. If aerochamber is ordered, attach to canister.

   b. Shake well.

   c. Instruct resident to exhale, close lips, cover mouthpiece and tilt head back.

   d. Instruct resident to inhale slowly and completely as the medication is sprayed into the mouth.

   e. Have resident hold breath for 4 to 5 seconds, and then exhale slowly through pursed lips.

2. For Hand Held Inhaler

   a. Per manufacturer's directions, insert canister into the device and re-assemble.

   b. Instruct resident to exhale, close lips over the inhaler and tilt head back.

   c. As medication is released, have resident inhale quickly and deeply.

d. Instruct resident to hold breath for 4 to 5 seconds, then exhale as much as possible.

e. Repeat procedure until capsule contents are consumed.

f. After administration, the resident may remove medication from the mouth and throat.

g. Wash the mouthpiece in warm water and dry thoroughly.

h. Supplies should be discarded properly.

Document administration of the medication and record any observations of the resident's condition in the licensed nursing notes.

OTIC MEDICATIONS:

1. Verify that the medication is for the EAR and verify right or left ear or both ears.

2. Using gloves, when appropriate, remove any dressing or encrustation from the ear canal and clean the area with warm water.

3. Position the resident so that the affected ear is facing up and gently pull back on the auricle to straighten the ear canal.

4. Examine the canal with adequate light and clean any excess drainage from the canal with a cotton-tipped applicator or tissue.

5. Withdraw the proper amount of medication from the container and instill the proper number of drops. Drops should be directed to avoid dropping directly onto the eardrum.

6. Instruct the resident to remain in the same position for several minutes to allow penetration of the medication.

7. A cotton ball may be placed in the canal after this period to prevent leakage.

8. Assist the resident to a comfortable position. Discard used supplies appropriately.

9. Wash hands.

10. Document administration of the medication and record any pertinent observations of the ear in the licensed nursing notes.

ORAL ADMINISTRATION:

1. Special Considerations – Crushing

   a. The manufacturer formulates some tablets for "Timed Release" of the medication throughout the gastrointestinal tract. Some other tablets are coated for a variety of reasons (enteric coat, or to prevent staining of the mouth and tongue, etc.). These two types of tablets should not be chewed or crushed. Other categories and alternatives are listed on the list of "DO NOT CRUSH MEDICATIONS" which are listed in clinicalpharmacology-ip.com, and can also be accessed via the SVMC intranet under tab Physicians, then tab Pharmacology.

   b. Sanitary handling of medications to be crushed will be maintained.

2. Special Considerations – Sublingual/Buccal:

   a. Sublingual and buccal tablets should not be crushed or swallowed.

   b. Some common buccal medications are:

      - Cardilate (erythrityl tetranitrate)
      - Oreton Propionate (testosterone)
      - Oreton Methyl (methyl testosterone)

   c. Some common sublingual medications are:

      - Nitroglycerin
      - Isordil (isosorbide dinitrate)
      - Isuprel Glosserts (isoproterenol HCI)
      - Hydergine S.L. (HEA)

3. Definition of Liquids

   a. Solution – medication dissolved in water usually forming a transparent liquid.

   b. Suspension – medication is not dissolved but is "suspended" within the liquid vehicle forming a cloudy liquid. The suspended powder will settle to the bottom of the container with time. Suspensions should be shaken well before each administration.

c. Elixir – medication dissolved in alcohol solution resulting in a clear liquid. Measuring of all liquids is done by reading the volume at the lowest level of the meniscus while holding the container at eye level. The reading is taken at the center of the line of liquid. Volumes may be expressed in terms of different measuring systems, but generally metric or apothecary measurements are used. The metric system is the preferred system. Measurements such as "teaspoonful" or "tablespoonful" are discouraged. Conversions between systems must be done accurately to ensure proper dosing.

4. Oral Administration of Solids and Liquids

a. Prepare doses (see Preparation of Doses-General Instructions).

b. Pour the proper dose of each medication into appropriate medication cup (paper-souffle for solids, plastic graduated for liquids), from vial, bottle or punch card.

c. When all doses for a resident are prepared, identify the resident by name and armband and explain the procedure.

d. Inform the resident of any changes in doses, dosage form, color, etc.

e. Hand the medication cup(s) to the resident or pour the contents into the resident's mouth.

f. Offer plenty of drinking water or juice after medications, unless contraindicated.

g. Observe that medications are taken. It may be necessary to double-check the resident's mouth or cheek pockets.

- Dispose of supplies.
- Document administration of medication.

5. Oral Administration of the Sublingual/Buccal tablets.

a. Prepare doses (see Preparation of Doses-General Procedures).

b. Pour the dose into the medication cup. A separate cup should be used if the resident receives other medications, which should be swallowed. The sublingual or buccal tablets should be given last in that case.

c. Identify the resident by name or picture and armband, then explain the procedure and any changes in medications.

d. For sublingual medication, have the resident hold the tablet under the tongue until dissolved completely.

e. For buccal tablets, instruct the resident to hold the tablet in any one of the four buccal pouches between the gum and cheek and keep it in place until completely dissolved.

f. Some tablets require several minutes to dissolve completely so the resident should be checked for proper and complete dissolution of the tablet after several minutes.

g. Alternating the buccal pouch used during each dose of administration can minimize mucosal irritation from buccal tablets.

h. Water or juice should be offered only after the tablets have been completely dissolved.

i. Dispose of supplies.

j. Document administration of medication.

PARENTERAL ADMINISTRATION:

1. Intramuscular (IM)

a. Wash hands/wear gloves.

b. Select appropriate syringe and needle size; IM injections are best administered using a 20G to 23G needle, 1" to 11/2 " in length, and with a medium bevel; volume per injection should not exceed 2.5 ml.

c. Prepare medication; verify directions on vial with medication administration record.

- Reconstitute powders with proper diluents, as specified in product information.
- If refrigerated, warm the medication slightly to minimize pain on injection.

d. Swab stopper or wipe break point of ampoule with alcohol swab and withdraw the proper dose using a filtered needle, then change to appropriate needle gauze.

e. Identify resident by name and wristband.

f. Provide privacy and position the resident to expose the chosen injection site.

g. Explain the procedure to the resident and provide reassurance and minimize anxiety, if needed.

h. Clean the site with an alcohol swab, moving in a circular pattern out about 2 inches from the center. Allow to dry.

i. After the alcohol has dried, stretch the skin around the injection site with one hand. This makes insertion of the needle easier and helps disperse the medication. For deltoid muscle, grasp the flesh and lift up and away from the bone.

j. With needle and syringe held at 90-degree angle to the skin, insert the needle with a quick, dart-like thrust.

k. Check needle placement by withdrawing the plunger slightly, checking for blood. If blood appears in the needle hub or syringe barrels, withdraw the needle, affix a new needle onto the syringe and select a new site.

l. Holding the syringe and needle steady, inject the medication at a slow even rate until entire dose is administered.

m. Quickly withdraw the needle and apply gentle pressure to the site.

n. Discard used materials according to facility policy.

o. Wash hands.

p. Document administration of the medication, dose, date, time and injection site. Note the resident's tolerance of injection and its effects.

2. Z Track Technique (for Iron Dextran-inferon)

a. Wash hands.

b. Verify directions on vial with medication administration record.

c. Draw a proper dose of medication and on 0.2 to 0.3 ml of air into the syringe.

d. Replace needle with a sterile 3" needle (replacing needle prevents leakage into the subcutaneous tissue as the needle is inserted). Follow facility policy and procedure to prevent needle stick injuries.

e. Identify resident. Explain the procedure and provide privacy.

f. Place resident in the lateral position exposing the opposite gluteal muscle to be used as the injection site. The resident may also be placed in the prone position.

g. Displace skin literally by pulling it about 1/2" (1cm) away from the injection site.

h. Insert the needle into the muscle at a 90-degree angle.

i. Aspirate for blood return. If none appears, inject the drug slowly, followed by the air. (Injecting air after the drug helps clear the needle and prevents tacking of the medication through subcutaneous tissues as the needle is withdrawn.)

j. After the volume has been injected, leave the needle in place for about 10 seconds to prevent seepage from the site.

k. Withdraw the needle and allow the skin to return to its normal position. This will seal the site.

l. Do not massage the site, but encourage physical activity.

m. Use alternate buttocks for subsequent injections.

n. Document administration of medication, dose, date, and site on the medication administration record. Include resident's response, if appropriate.

3. Intradermal

a. Prepare as for I.M. injections, steps 1 through 7(select a tuberculin syringe and 26G x 5/8" needle).

b. Locate an injection site several finger widths forward of the antecubital space. Avoid areas with dense hair/blemishes.

c. Cleanse the site with alcohol and allow to dry.

d. Withdraw the proper dose of medication into the syringe and expel any excess air.

e. Hold the resident's forearm in one hand with the injection site facing up and stretch the skin around the site with thumb. Position the needle nearly flat against the surface of the skin with the bevel facing up and insert the needle into the skin until the tip rests about 1/8" (3mm.) below the surface. At this point, the needle tip will rest between the epidermis and the dermis.

f. Slowly inject the medication. Resistance to flow indicates proper placement of the needle. Ease of flow may indicate that the needle tip is into the dermis.

g. When a small wheal appears at the surface of the skin, withdraw the needle and apply gentle pressure at the site. Do NOT massage.

h. A control wheal may be made on the opposite arm using a like volume of normal saline of test diluent.

i. Discard used materials properly.

j. Wash hands.

k. Document administration of medication.

Special Notes on Intradermal Skin Testing

Follow the instructions supplied with the testing agent regarding the proper technique for reading the results of the test. It is important to wait the proper length of time between the injection and the reading of the result. Consult the manufacturer's instructions, and document accordingly.

1. Subcutaneous (S.C.)

a. Prepare as for I.M. injections.

b. Swab the site with alcohol, using an outwardly spiraling motion, starting at the center and moving out about 2".

c. Grasp the skin at the chosen site between the thumb and index finger, pinching slightly to elevate the subcutaneous layer.

d. Position the needle with the bevel up: a 1/2" needle should be positioned at 90 degrees, a 5/8" or longer needle should be positioned at 45 degrees.

e. Insert the needle in one quick motion and release the grip on the skin.

f. Draw back the plunger to assure that a vein has not been entered, and slowly inject the medication. If a vein is entered, signaled by a backflow of blood into needle hub and barrel, attach a new needle and start again.

g. With an alcohol swab over the site, quickly withdraw the needle along the same angle as it was inserted, and apply slight pressure to the site.

h. Massage the site gently for several seconds.

i. Discard used materials properly.

j. Wash hands.

k. Document administration of medication, date, dose, time and site. Note the resident's response, if appropriate.

2. Insulin Pens

a) Verify MD order and pen to resident

b) Don gloves

c) Take lid off pen and clean tip with alcohol

d) Place special needle on tip made for the pen

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

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

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

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

i) Inject insulin, needle will automatically retract.

j) Remove needle and place in needle disposal box.

k) Wash hands.

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

TUBE ADMINISTRATION (NASOGASTRIC, GASTRIC AND JEJUNOSTOMY):

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

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

3. Prepare each dose of medication in separate cups.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17. Wash hands.

18. Document administration of medications.

TOPICAL ADMINISTRATION:

1. Ointments, Creams, Lotions and Solutions

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

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

   c. Provide privacy.

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

   e. Wear gloves as appropriate.

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

g. Clean the area as needed.

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

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

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

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

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

l. Dress with sterile gauze, if appropriate.

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

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

2. Debriding Agents

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

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

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

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

3. Rectal Medications (Suppositories)

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

b. Wear gloves.

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

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

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

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

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

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

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

b. Ask resident to void.

c. Have resident positioned in the lithotomy position.

d. Expose the perineum and drape other areas.

e. For suppositories:

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

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

f. For ointments, creams, gels

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

5. Medicated Shampoos

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

b. Wet resident's hair thoroughly.

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

d. Specific instructions:

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

e. Rinse hair and scalp thoroughly.

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

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

TRANSDERMAL MEDICATIONS:

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

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

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

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

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

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

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

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

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

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

   b. Remove previous patch, if applicable.

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

d. Dispose of supplies appropriately.

e. Wash hands.

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

DOCUMENTATION REQUIREMENTS:

1. General Policy

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

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

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

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

e. Documentation errors shall be corrected either by:

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

2. Injectable Mediations

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

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

3. PRN Medications

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

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

4. Drugs Not Given as Prescribed

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

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

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SUBJECT: **MEDICATION ORDERING**	SECTION: **Page 1 of 19**

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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.

   f. Medical imaging technologist and Ultrasonographers.
   Access to transcribe shall be limited to document what was administered by licensed providers during procedures & will take place once procedure is complete to prevent complications during the procedure.

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 Pharmacy Leadership; 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

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
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) Mistaken as cc, leading to administering volume instead of units (e.g., 4u seen as 4cc)	Use unit(s)
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	Use daily

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
		handwritten q is misunderstood as the letter i	
Qn	Nightly or at bedtime	Mistaken as qh (every hour)	Use nightly or HS for bedtime
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

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Period following abbreviations (e.g., mg., mL.)†	mg or mL	Unnecessary period mistaken as the number 1, especially if written poorly	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

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
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
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

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
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
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

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
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
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)

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
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 decimal point (e.g., .5 mg)**	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 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

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
			the US; commas are used in place of decimal points in some other countries
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

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
+†	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 ø†	Zero, null sign	Mistaken as the numbers 4, 6, 8, and 9	Use 0 or zero, or describe intent using whole words
#	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.
- Hospital Accreditation Standards. (2023). Oak Brook, IL: Joint Commission Resources, Inc.
- Pharmacy Law: California Edition. (2023) San Clemente, California: LawTech Publishing Group.
- The ASRT Practice Standards for Medical Imaging and Radiation Therapy https://www.asrt.org/docs/default-source/practice-standards/ps_sonography.pdf?sfvrsn=1ce176d0_32

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

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

PURPOSE:

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

POLICY:

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

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

EQUIPMENT:

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

PROCEDURE:

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

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

SPECIAL CONSIDERATIONS:

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

RECORDING:

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

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

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

REFERENCE:

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

SUBJECT: **NON-DISCRIMINATION ON THE DP/SNF**	SECTION: **Page 1 of 3**

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

PURPOSE:

To demonstrate compliance with applicable federal and state requirements pertaining to non-discriminatory practices on the DP/SNF Unit at Sierra View Medical Center (SVMC). The DP/SNF does not discriminate and does not permit discrimination, including, but not limited to, bullying, abuse, or harassment, on the basis of actual or perceived sexual orientation, gender identity, gender expression, or HIV status, or based on association with another individual on account of that individual's actual or perceived sexual orientation, gender identity, gender expression, or HIV status.

DEFINITIONS:

Senate Bill (SB) 219 Long-Term Facilities: Rights of Residents. AFL 17-24

- This bill enacts the Lesbian, Gay, Bisexual, and Transgender Long-Term Care Facility Residents' Bill of Rights. Among other things, the bill makes it unlawful, except as specified, for any long-term care facility to take specified actions wholly or partially on the basis of a person's actual or perceived sexual orientation, gender identity, gender expression, or human immunodeficiency virus (HIV) status, including, among others, willfully and repeatedly failing to use a resident's preferred name or pronouns after being clearly informed of the preferred name or pronouns, or denying admission to a long-term care facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging or evicting a resident from a facility. The bill also provides certain protections to all residents of long-term care (LTC) facilities during, among other things, physical examinations or treatments, relating to bodily privacy. The bill defines long-term care facility for purposes of these provisions to include skilled nursing facilities, intermediate care facilities, and residential care facilities for the elderly. The bill also, among other things, requires each facility to post a specified notice regarding discrimination alongside its current nondiscrimination policy in all places and on all materials where the nondiscrimination policy is posted. The bill requires a violation of these provisions to be treated as a violation under the Long-Term Care, Health, Safety, and Security Act of 1973, the California Residential Care Facilities for the Elderly Act, or specified provisions providing for the licensure and regulation of health facilities, which may include the imposition of civil penalties. By expanding the definition of existing crimes, the bill imposes a state-mandated local program.

POLICY:

1. SB 219 (Chapter 483, Statutes of 2017) prohibits LTC facility staff from taking any of the following discriminatory actions against a resident or a potential resident, on the basis of a person's actual or perceived sexual orientation, gender identity, gender expression, or HIV status:

    - Denying admission to a long-term care facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging or evicting a resident from a facility.

    - Denying a request by residents to share a room.

- When rooms are assigned by gender, assigning or refusing to assign a room to a transgender resident other than in accordance with the transgender resident's gender identity, unless at the transgender resident's request.

- Prohibiting a resident from using, or harassing a resident who seeks to use or does use, a restroom available to other persons of the same gender identity, regardless of whether the resident is making a gender transition or appears to be gender-nonconforming. Harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity.

- Willfully and repeatedly failing to use a resident's preferred name or pronouns after being clearly informed of the preferred name or pronouns.

- Denying a resident the right to wear or be dressed in clothing, accessories, or cosmetics that are permitted for any other resident.

- Restricting a resident's right to associate with other residents or visitors of the resident's choice, including the right to consensual sexual relations, unless the restriction is uniformly applied to all residents in a nondiscriminatory manner.

- Denying or restricting medical or nonmedical care that is appropriate to a resident's organs and bodily needs, or providing medical or nonmedical care in a manner that demeans the resident's dignity or causes avoidable discomfort.

2. A complaint may be forwarded to the Office of the State Long-Term Care Ombudsman if you believe that you have experienced this kind of discrimination.

Long-Term Care Ombudsman
Physical Address: 10953 14th Avenue
Armona, Ca. 93202

Mailing Address: PO Box 598
Armona, Ca. 93202

Tel (559) 852-2823
(800) 293-9714

Fax (559) 582-9627

E-mail: maribel.martinez@kccoa.org

AFFECTED PERSONNEL/AREAS: *ALL HOSPITAL PERSONNEL*

REFERENCES:

- Center for Health Care Quality, MS 0512. P.O. Box 997377. Sacramento, CA 95899-7377 (916) 324-6630. (916) 324-4820 FAX, Department Website (cdph.ca.gov).
- Health and Safety Code- HSC, Division 2. Licensing Provisions [1200-1796.63], Chapter 2. Health Facilities [1250-1339.59] Article 3. Health Facilities [1275-1289.5].
- Med Pass, Inc., (updated February 6, 2015) Facility Guide to OBRA Regulations, United States of America, Med Pass Inc.
- Senate Bill No. 21, CHAPTER 483, [Approved by Governor October 04, 2017. Filed with Secretary of State October 04, 2017.] LEGISLATIVE COUNSEL'S DIGEST SB 219, Wiener. Long-term care facilities: rights of residents.
- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 1338.4, 1439.50, 1439.51, 1439.52, 1439.53, 1439.54, and 1569.318, San Francisco, California, Title 22.

CROSS REFERENCES:

- MANDATED ABUSE REPORTING - DP/SNF

SUBJECT: **NOTIFICATION AND EXERCISE OF RIGHTS AND RESPONSIBILITIES**	SECTION: **Page 1 of 2**

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

PURPOSE:

To assure that residents are informed of his/her rights within the facility, to ensure protection in exercising rights, and to provide notification of changes in rights under federal or state law.

POLICY:

Residents will be informed both orally, using an interpreter when needed, and in writing, in a language he/she understands, of the rights and rules and regulations governing conduct and responsibilities while residing in the facility. All residents' rights information will be relayed prior to and upon admission (signed verification maintained in the medical record), periodically and when changes occur in resident rights. Residents will be encouraged and assisted in exercising his/her rights as a resident and a citizen.

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

PROCEDURE:

1. Resident rights and responsibilities will be reviewed with each resident/responsible party upon admission, a copy of the list of rights and responsibilities will be provided to the resident, and a signed verification of sufficient understanding and receipt of rights and responsibilities will be obtained (Cross Reference Policy: Resident Admission).

2. Residents' rights and responsibilities will be reviewed periodically with resident/responsible party, taking into consideration factors such as health and cognitive status, age, culture, language and educational level (resident and family council meetings, during the Interdisciplinary Team Meetings, during exercising of rights, individual contact, etc.)

3. Residents will be informed, both orally and in writing, of any changes in federal and state rights, and of changes in facility rules and regulations affecting the excision of his/her rights within the facility.

4. Residents will be informed of the Minimum Data Set (MDS) process and transmission policy, which includes review of the Privacy Act Notification Statement at the time of admission.

5. Residents will be informed of the manner of participation and assisted in exercising his/her rights within the facility with freedom from discrimination, coercion or reprisal (e.g., how resident may voice grievances and recommend changes, how they wish to organize their day, process for participation in state elections, choices and input in care procedures and activities, informed consent, notification of changes, etc.).

6. Residents' rights and responsibilities will be posted in resident areas (consumer board, bulletin boards, etc.) and included in the admission agreement, to allow direct access to rights information.

7. Residents/responsible party will be provided information regarding how to contact state and local advocacy and protection agencies for the exercise of resident rights, including the following: Ombudsman, Department of Health Services, Mental Illness and Developmental Disabilities, Adult Protective Services, Medicare/Medicaid, etc. A listing of these agencies is a part of the admission packet and will be signed by the resident/responsible party as an acknowledgement of receipt of this information. A listing of state and local agencies will be posted in the resident area, i.e., Consumer Information Board.

REFERENCE:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 United States of America, Med Pass Inc.
- California Department of Public Health (CDPH) (2017, October 6). *Nursing Home Residents' Rights.* https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/NursingHomeResidentsRights.aspx.
- California Advocates for Nursing Home Reform (CANHR) (2021, May 11). *Residents' Rights Fact Sheet: Long Term Care Justice and Advocacy*. Retrieved from http://www.canhr.org/factsheets/resrights_fs/html/fs_resrights.htm.

SUBJECT:	SECTION:
NURSING CARE OF VENTILATOR RESIDENTS ON THE DPSNF UNIT	**Page 1 of 3**

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

PURPOSE:

To assure safe, comprehensive quality care to residents requiring continuous ventilator assistance.

POLICY:

Residents who are ventilator-dependent will be cared for in a safe and competent manner.

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

EQUIPMENT:

- Bag valve maskwith adult mask at bedside at all times.
- 1 emergency trach set with ties at bedside at all times (same size or smaller). Respiratory therapist will ensure availability.
- Continuous pulse oximeter with physician order (weaning or capped).

PROCEDURE:

Licensed nurses rendering care to the ventilated resident will be competent in mechanical ventilator operations, basic lung auscultation and closed continuous tracheal suction system. The licensed nursing personnel will be aware of ventilator parameters as ordered by the physician.

Licensed nursing personnel will notify respiratory therapy (RT) personnel should ventilator alarms continue to alarm. Nursing will remove the resident from the ventilator and apply bag-valve ventilation if:

- Ventilator continues to show low pressure alarm
- Ventilator is inoperative or indicates gas pressure alarm; or
- If there is a deterioration of the resident's condition and/or status.
- Resident assessments will be done at least once every 12 hours and documented in the PCS resident's record.
- In accordance with established Respiratory Therapy Department policies and procedures, the Respiratory Therapist will regulate ventilator settings – NO EXCEPTIONS! This includes monitoring of the ventilated resident at least every 4-6 hours and maintenance of ventilator equipment and supplies.

NURSING INTERVENTIONS

1. Ensure tracheostomy tube is maintained securely.

2. Suction and clean airway apparatus as indicated to maintain patency. Suction resident every 2 hours PRN. Only suction for a 15-second period at any one time.

3. Prior to suctioning the resident, the nurse must:

   a. Instruct the resident on procedure to be performed.

   b. Comply with established suctioning policies and procedures regarding special instructions.

   c. Keep water emptied from tubing and trap. (Never turn resident without emptying first).

   d. Evaluate ventilatory pattern for rate, quality, signs of respiratory distress, or inappropriate inspiratory to expiratory ratio (should be at least 1:1). *NOTE: Resident chest movement needs to be equal for both sides of the chest. Be aware if resident has any spontaneous respirations.*

   e. Monitor resident for signs of fighting the ventilator, which indicates that the resident's respiratory cycle is inconsistent with the mechanical cycle; may be due to pain, hypoxia, secretions, fear or anxiety.

   f. Ensure that the alarms are always turned on.

   g. Carefully check all connections of the ventilator tubing to assure that they are tightly secured.

   h. Notify the RT department if alarms continue to be set off. If RT is unable to respond immediately or if any concerns arise as to the effectiveness or operations of the ventilator, remove the resident from the ventilator and manually ventilate the resident with aresuscitation bag.

   i. Assure that the ventilator is plugged in at all times when stationary.

   j. Position resident so that all lobes of the lungs are adequately ventilated and perfused.

   k. Reposition resident every two (2) hours.

   l. Monitor breath sounds for presence and quality. Assess resident's lung fields for rales, rhonchi, wheezing, and notify physician of the changes.

m. Assure resident that he/she is not alone. Let the resident know that people are near and if they need assistance, nurses will respond rapidly. Provide a call bell for immediate access and provide a means for the resident to communicate as appropriate.

n. Assure resident that adequate ventilation is being provided.

PATIENT EDUCATION

- Explain all procedures to the resident
- Answer their questions
- Involve family when applicable

DOCUMENTATION

Nursing notes to include the following elements in the resident's record:

- Problems identified and interventions provided
- Evaluation of treatment(s)
- Document respiratory assessment and characteristics of sputum

REFERENCES:

- RN Speak, May 22, 2018, Care for Patient with Mechanical Ventilator, Nursing Procedure. Retrieved from: rnspeak.com
- Mora Carpio, Andres L., Mora, Jorge I, Updated 2021, May 7; Ventilator Management, In: StatPearls{Internet] Treasure Island (FL) StatPearls Publishing; Retrieved from: ncbi.nlm.nih.gov
- Lippincott Nursing Center, September 2021, Caring for the Mechanically Ventilated Patient, retrieved from: www.nursingcenter.com

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

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

PURPOSE:

To provide complete documentation of enteral feeding.

POLICY:

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

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

PROCEDURE:

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

2. Additional information is to be recorded as follows:

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

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

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

RECORDING:

As indicated above.

SPECIAL CONSIDERATIONS:

REFERENCE LIST COMPLICATIONS OF TUBE FEEDINGS

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

    a. Dehydration

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

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

d. Glycosuria (increase urine sugar)

2. Aspiration pneumonia – possible causes include:

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

b. Decreased level of consciousness

c. Decreased GI motility

d. Pulmonary disease

e. Diminished or absent gag reflex

f. Incorrect resident position and tube placement

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

a. Rapid infusion rate

b. Infusing cold formula

c. Bacterial contamination of formula

d. Hyperosmolar formula

e. Low residue formula

f. Lactose intolerance

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

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

4. Constipation – possible causes:

a. Elderly bedridden resident

b. Residents with history of constipation

c. Chronic laxative abuse

d. Long term maintenance on tube feeding

e. Dehydration

5. Bloating and retention – causes include:

   a. Large volume feedings

   b. Intolerance to feedings

   c. Decreased gastric motility

   d. Constipation

   e. Bowel obstruction

   f. Ileus

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

   a. Skin pressure, excoriation of nose

   b. Sinusitis

   c. Esophagitis

   d. Esophageal – tracheal fistula

   e. Gastric ulceration

   f. Pulmonary and oral infections

   g. GI bleeding

   h. Increased mucous secretions

Xerostomia (decreased salivation,)

7. Vomiting – causes might include:

   a. Clogged tube

   b. Improper infusion of feeding

   c. Initiation of enteral therapy

   d. Constipation – bowel obstruction – impaction

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

REFERENCE:

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

SUBJECT: **NUTRITIONAL SCREENING AND ASSESSMENT/REASSESSMENT**	SECTION: **Page 1 of 4**

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

PURPOSE:

Sierra View Medical Center (SVMC) is committed to providing a comprehensive nutrition care program that includes medical nutrition therapy in a timely, effective and efficient manner. The nutrition care program is integrated with nursing and other appropriate disciplines as needed.

POLICY:

The nutrition assessment evaluates the patient's nutrition status, develops a plan of nutrition care and evaluates the efficiency of nutrition support.

AFFECTED PERSONNEL/AREAS:

FOOD AND NUTRITION SERVICE, PHYSICIAN, NURSING, OTHER DISCIPLINES AS REQUIRED

Food and Nutrition Service: The Registered Dietitian (RD) will prioritize the nutritional risk level of patients. The RD assesses the patient for medical nutrition therapy, develops, implements and evaluates the effectiveness of the nutrition therapy plan, identifies potential risks to the nutrition care of the patient. A diet aide will visit patients for menu selections, cultural/religious food preferences, and refers the patient to the dietitian if needed.

Physician: The physician assumes the responsibility for the overall nutrition management of the patient.

Nursing: Nursing identifies patients at nutritional risk through the general nursing admission assessment. Monitor and report the effect of nutrition care on an ongoing basis. Monitor nutrition and fluid intake.

Other Disciplines: As required. *Example: Speech Therapy will perform swallow evaluations.*

PROCEDURE:

A. NURSING NUTRITION ADMISSION SCREEN:

All patients *(see Maternal Child Health for exceptions)* will be screened for nutritional risk by nursing staff using criteria established by a Registered Dietitian.

SUBJECT: **NUTRITIONAL SCREENING AND ASSESSMENT/REASSESSMENT**	SECTION: **Page 2 of 4**

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

1. Nursing completes nutrition screening on the General Admission Assessment within 24 hours of patient admission.

2. Included in the "Nutrition Screen" section is the presence of the following, which triggers a referral to the dietitian:
   - Vomiting/Diarrhea ≥ 3 days prior to admit
   - Unintentional weight gain or loss
   - Difficulties in chewing/swallowing/feeding self
   - Enteral feeding/parenteral nutrition (PN)
   - Pregnant or Lactating and ≤ 17 years old
   - Pressure ulcer ≥ stage II
   - NPO (nothing by mouth), > 3 days
   - New onset diabetes
   - Age >80 with planned surgery
   - Recent change in diet
   - New start Warfarin

3. Included in the "Pediatric Nutrition Screen" section is the presence of the following, which triggers a referral to the dietitian:
   - Failure to thrive/malnutrition
   - Enteral feeding
   - Food allergies/intolerances
   - New onset diabetes
   - Vomiting/diarrhea >3 days prior to admit
   - Difficulties in chewing/swallowing/feeding self/delayed feeding skills
   - Weight loss in last 3 months
   - Chronic GI problems/reflux
   - Cancer
   - Metabolic disorder
   - Chronic kidney disease
   - Eating disorder

4. Maternal and Child Health patients are not automatically assessed by the RD to respect the patient's privacy during her labor. The patient will be referred to the dietitian if any of the following triggers are present:
   - Gestational DM
   - ≤17 years of age
   - Hyperemesis gravidarum
   - Nutrition education needed/requested

B. DIETITIAN NUTRITION ASSESSMENT:

1. Nutritional Prioritization Schedule
   a. Nutrition Assessment within **24 hours** of admission.
      i. Physician-ordered nutritional consults
   b. Nutrition Assessment within **48 hours** of admission.
      i. Nursing referrals identified in the nutrition admission screening via general admission assessment
      ii. Patients with the following primary medical diagnosis (high nutritional risk): malnutrition/failure to thrive, ulcerative colitis/Crohn's disease, pregnancy/lactation < 17 years old, hyperemesis gravidarum, decubitus ulcer ≥ stage II, ileus, hepatic encephalopathy, multi-system organ failure, NPO/clear liquid >/ 72 hours.
   c. Nutrition Assessment within **72 hours** of admission.
      i. Patients with the following primary medical diagnosis (moderate nutritional risk): diabetic ketoacidosis (DKA), acute respiratory failure without ventilator support, bowel surgery, cirrhosis, body mass index (BMI) <18.5 (underweight), cancer with recent chemo/radiation, 80 years old with planned surgery, pancreatitis, renal failure, gestational diabetes mellitus (GDM), peritonitis, cerebrovascular accident (CVA) with dysphagia, general dysphagia, small bowel obstruction (SBO), GI bleed, gastroparesis.
   d. Nutrition Assessment are completed for all patients within **96 hours** of admission.
      i. Patients with the following primary medical diagnosis (low nutritional risk) may include, but is not limited to: multiple food allergies, eating >50% of meals, dental difficulties, substance abuse, pneumonia, COPD, TB, coronary artery disease (CAD), congestive heart failure (CHF), hyperlipidemia, colostomy, gastritis/peptic ulcer, gall bladder disease, hypothyroidism, obesity, musculoskeletal disorder, anemia, amputation of limb, total hip arthroplasty, TKA, seizures, appendicitis, bronchiolitis, comfort measures.
2. Nutritional Assessment (Nutrition Care Process)
   a. Assessment
      i. The RD may include information collected from medical, social and dietary histories, anthropometric data, biochemical data, and review of prescribed drugs.
      ii. Where applicable, include a summary of what the current nutrition support provides and if it is appropriate
   b. Diagnosis
      i. Statement of Problem, Evaluation, Signs/Symptoms (PES)

c. Intervention
   i. Central goal or desired outcome, where appropriate
   ii. A breakdown of the nutrient composition of any recommendations for parenteral/enteral feedings
d. Monitoring and Evaluation
   i. Nutrition risk level- high, moderate or low
   ii. Appropriateness of diet

C. REGISTERED DIETITIAN & NUTRITIONAL REASSESSMENT/RE-EVALUATION:

1. Nutritional reassessment will be conducted using the following guidelines, as indicated by assigned risk level by the RD:
   a. High risk: 2-3 days (Parenteral nutrition [PN] assessments will be completed in collaboration with lab data ordered twice weekly)
   b. Moderate risk: 4-5 days
   c. Low risk: 7 days or as deemed appropriate at the last evaluation
   d. New physician order, or more often as deemed necessary by the RD
2. The reassessment will document the patient's response to care. At the time of reassessment, the dietitian may change nutritional risk level. This change of nutritional risk will be documented in the medical record.
3. Ongoing monitoring of patients occurs daily for indications of nutritional status changes. This is accomplished through monitoring the parenteral nutrition support census and diet census, as well as physician, nurse or diet aide referrals.

REFERENCES:

- California Department of Public Health (2023). Retrieved from https://www.cdph.ca.gov
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **ORAL CARE FOR THE RESIDENT WITH SPECIAL NEEDS**	SECTION:

PURPOSE:

To promote oral and dental health.

POLICY:

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

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

EQUIPMENT:

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

PROCEDURE:

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

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

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

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

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

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

9. Gently brush the tongue, if able.

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

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

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

13. Apply lubricant to lips as needed.

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

15. Wash hands.

DOCUMENTATION:

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

REFERENCE:

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

SUBJECT: **OXYGEN PROTOCOL FOR RESIDENT TRANSPORT**	SECTION:

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

PURPOSE:

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

POLICY:

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

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

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

PROCEDURE:

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

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

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

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

   a. Stable vital signs

   b. Type of delivery appliance

   c. Initial flow rate

   d. Adequate oxygen source for transport

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

REFERENCES:

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

CROSS REFERENCES:

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

SUBJECT: **PACEMAKER- PERMANENT CARE OF**	SECTION: **Page 1 of 1**

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

PURPOSE:

To have a system of monitoring residents with permanent pacemakers.

POLICY:

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

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

PROCEDURE:

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

REFERENCE:

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

SUBJECT: **PHARMACEUTICAL WASTE**	SECTION: ***Medication Management (MM)*** **Page 1 of 7**

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

PURPOSE:

To outline the methods used at Sierra View Medical Center (SVMC) to comply with federal, state, county and city regulations.

DEFINITIONS:

1. Pharmaceutical Waste: any partially used medication (more than trace amounts, i.e. visible volume) in injectable infusion containers, tubing, syringes, vials or ampules. Pharmaceutical waste also includes tablets, capsules, gelcaps, lozenges, oral dissolving films, oral/rectal solutions, suppositories, topical products, aerosols and inhalers.

2. Resource Conservation and Recovery Act (RCRA): Federal law passed in 1980 and updated in 2000 creating a multi-path hazardous waste management system that is regulated by the Environmental Protection Agency (EPA). RCRA combined with Drug Enforcement Agency (DEA) regulations resulted in ten (10) different categories of medical waste. Each of these categories has different methods of waste segregation, resulting in the use of different colored containers, with special transportation, treatment and disposal of each type.

3. RCRA Black Bin: Receptacle for designated pharmaceutical waste that is acutely hazardous (P-Listed waste); toxic (U-Listed waste); ignitable (flammable); corrosive; reactive; has toxicity characteristics; or is an endocrine (hormone) disrupter (D-Listed waste).

4. Cactus Sink: Designated pharmaceutical waste container for all controlled substances, except for liquid volumes of greater than 30mL.

5. Chemotherapy Yellow Bin: Receptacle for designated pharmaceutical waste including all chemotherapy infusion containers, syringes, and vials that contain NO visible volume /trace volume of chemotherapy after administration. Also for disposal of all Personal Protective Equipment (PPE) used in preparation and administration of these medications.

6. Biohazard Red Bin: Designated medical waste container for items that still hold blood or have been in contact with blood or body fluids and DO NOT CUT or PUNCTURE.

7. Sewer/Toilet: Designated Medical and Pharmaceutical waste method for urine, stool, emesis, peritoneal dialysis fluid, controlled substance liquids greater than 30 mL in volume and the 'Sewerable Seven', which are IV fluids containing dextrose, saline, sterile water or lactated ringer's solution as a base solution and may contain potassium (K^{+}), calcium (Ca^{++}) or magnesium (Mg^{++}) salts.

8. Pharmaceutical Blue Bin: Designated pharmaceutical waste container for all medications that cannot be disposed of in the previously listed option.

POLICY:

A. Sierra View Medical Center staff will maximize pharmaceutical safety of patients, staff and community members by ensuring that pharmaceutical waste generated by Sierra View Medical Center shall be segregated, contained, transported, treated and disposed of in accordance with federal, state, county and city regulations. The Department of Pharmacy Services shall serve as a resource for up-to-date information on pharmaceutical waste management.

B. Each patient care unit and department is responsible for appropriate handling, storage and disposal of pharmaceutical waste products that are generated from the medication use process.

C. Disposal of Chemotherapy Yellow bins, Pharmaceutical Blue bins, and Biohazard/Sharps Red bins are managed by a medical waste contractor who will haul these to a medical waste incinerator, where the contents are burned to ash and dumped into a lined non-hazardous waste landfill. In event the Chemotherapy Yellow bins are unavailable, RCRA Black bins should be used to dispose of those materials.

D. Disposal of RCRA Black bins are managed by a medical waste contractor who will dispose of these into a special federally permitted hazardous waste incinerator, where the contents are burned to ash and dumped into a special lined hazardous waste landfill.

AFFECTED PERSONNEL/AREAS: *ALL NURSING, PHARMACY, RESPIRATORY THERAPY, RADIOLOGY, LABORATORY, AND ENVIRONMENTAL HEALTH SERVICES STAFF.*

EQUIPMENT:

- Black plastic bins with white plastic lids appropriately sized for each area of collection for hazardous waste
- Yellow plastic bins with white plastic lids in 8 gallon size for chemotherapy waste
- Red plastic container with white plastic lids of appropriate size for each area of collection (biohazardous waste that may cut or puncture, i.e., "sharps")
- Sealable biohazard bags
- Blue plastic bins with blue plastic lids for pharmaceutical waste

FROM THIS POINT ON, ONLY PHARMACEUTICAL WASTE WILL BE DISCUSSED. SEE ENVIRONMENTAL SERVICES POLICIES ON WASTE MANAGEMENT.

PROCEDURE:

A. Each nursing unit and department is responsible for the appropriate disposal of pharmaceutical waste products that are generated from the medication use process.

B. Sorting of the pharmaceutical waste products shall be as follows:

1. Controlled Substance Cactus Sink: All controlled substances (tablets/capsules/injectable and oral liquids/suppositories/patches) will be placed in the Cactus Sink and witnessed as per the Wasting Controlled Substances policy.

2. Chemotherapy Yellow Bin: All empty vials, ampules, syringes, IV containers which do not contain 'visible volume' (i.e., only trace amounts) of chemotherapy and all personal protective equipment used to administer the chemotherapy.

3. Biohazardous Red Container: All empty syringes, needles and ampules (that were not used in administering chemotherapy or RCRA (black bin) medications). All human-derived medications and their containers should also be disposed of in the red container:

   a. Albumin

   b. Avonex, Betaseron (interferon)

   c. IVIG, Carimune (non-specific immune globulins)

   d. Epogen, Procrit (erythrocyte stimulating agents)

   e. HyperHep B, Hyper Rab, Hyper Tet (specific immune globulins)

   f. RhoGAM, Rhophylac (Rh^+ immune globulin)

4. Sewer/Toilet: Besides disposing of urine, stool and emesis, the following pharmaceuticals should be disposed of through flushing down the sewer:

   a. Peritoneal dialysis fluid

   b. Controlled substances in liquid dosage forms and in amounts greater than 30 mL

   c. IV fluids: Dextrose, Saline, Sterile Water, Lactated Ringer's solutions

   d. IV fluids as above in c. and containing potassium, calcium or magnesium salts

5. RCRA Black Bin AERO: All pharmaceutical items in an aerosol form (usually labeled "contents under pressure") should be returned to Pharmacy in a sealed biohazard bag for separate black bin disposal; medication such as:

a. Albuterol (Proventil/Ventolin) inhalers

b. Ipratropium (Atrovent) inhalers

c. Levalbuterol (Xenopex) inhalers

d. Albuterol and ipratropium (Combivent) inhalers

e. Beclomethasone (QVAR) inhalers

f. Fluticasone (Flovent) inhalers

g. Benzocaine (Americaine, Dermoplast or Hurricaine) sprays

h. Pramoxine and hydrocortisone (Epifoam) aerosols

i. Pramoxine (Proctofoam) aerosols

j. Nitroglycerin sublingual spray

k. Nicotine nasal spray

6. RCRA Black Bin: All of the following pharmaceutical items are for black bin disposal:

a. All chemotherapy oral (tablet/capsule) medications (drug and packaging)

b. All chemotherapy partial vials/IV containers with 'visible volume'

c. All warfarin tablets/vials (drug and packaging)

d. All nicotine gum/lozenges/patches (drug and packaging)

e. All physostigmine vials (drug and packaging)

f. All nitroprusside vials (drug and packaging)

g. All endocrine disruptors (hormones) such as:

i. All insulin vials/pens when empty or expired (drug and packaging)

ii. All oral contraceptives (birth control pills) (drug and packaging)

iii. Estrogen (Premarin) and estradiol tablets/vaginal creams/injection/patches (drug and packaging)

iv. Oxytocin (Pitocin) vials/IV containers (drug and packaging)

v. Medroxyprogesterone tablets/injection (drug and packaging)

vi. Androgen (testosterone) tablets/injection (drug and packaging)

vii. Ketoconazole (Nizoral) tablets/injection (drug and packaging)

h. All liquid (water-based) products containing $\geq$ 24% alcohol (flammable)

i. Erythromycin 2% topical solution

ii. Tretinoin (Retin-A) topical solution

i. All acids with a pH $\leq$ 2.0, such as acetic acid and phenol (carbolic acid)

j. All bases with a pH $\geq$ 12.5, such as sodium hydroxide

k. All lindane containing medications, such as Kwell shampoo and lindane spray

l. Many typical topical products:

i. Acetone

ii. Aromatic ammonia ampules

iii. Green soap tincture

iv. PhisoHex (chlorhexophene) solution

v. Mercurochrome

vi. Merthiolate

vii. Flexible collodion

viii. Benzoin compound or tincture

m. All mercury (thimerosal) preserved medications:

i. Some ophthalmic solutions/suspensions, such as Cortisporin Ophthalmic

ii. Some otic solutions/suspensions such as Cortisporin Otic Suspension

iii. Some vaccines/antidotes, such as Fluzone, Fluvirin, Tetanus Toxoid, rattlesnake (Crofab) antivenin

n. All silver containing medications:

i. Silvadene topical cream

ii. Silver Nitrate applicator sticks

o. All selenium containing products inconcentrations ≥ 10 mcg/mL:

i. Selenium sulfide (Selsun and Selsun Blue) shampoo

ii. Multiple Trace Elements (MTE-5) for TPNs

p. All chromium containing products in concentrations ≥ 5 mcg/mL or 5 mg/L

q. All iodine-containing products, including radiologic contrast dyes (Gastrografin)

r. All barium sulfate containing product

7. Pharmaceutical blue waste containers: All other medications that do NOT meet the above requirements. That is, the medication must be Non-Black, Non-Yellow, Non-BIO/Non-Red, Non-Controlled Substance and Non-Drain/Sewer to be put in WHITE.

C. Pharmaceutical waste containers (black/blue/yellow) will be segregated from other types of medical waste.

D. Environmental Services (EVS) will obtain and store pharmaceutical waste bin supplies in Materials Management, and replace the bins as needed.

E. When the pharmaceutical waste container is full, EVS will seal it with the provided seals and move the container to the secured storage area for removal and incineration by an outside vendor.

F. The sealed pharmaceutical waste containers may be stored on site at the hospital for up to 90 days before transporting to a site for incineration. The transportation of the waste must be recorded using a Department of Health Services (DHS) approved medical waste tracking document.

REFERENCES:

- American Society of Health-System Pharmacists Council on Pharmacy Practice Guideline on Pharmaceutical Waste. (2013). *Best practices for hospital and health-system pharmacy, 2013-2014 edition.* Bethesda, Maryland: American Society of Health-System Pharmacists, page 74.

- Johnson, J., Bount, G, Clemons, C, & Williams, H. (2012). Challenges in pharmaceutical waste management: "First, do no harm". *Natural Resources & Environment, 26*(4), pages 1-5. (Published by the American Bar Association.)

- Code of Federal Regulations Title 40: Protection of the Environment, parts 261 and 262. Retrieved on 10/22/17 from http:// www.ecfr.gov/cgi-bin/ retrieveECFR?gp=1&SID=c4c7e7adf468a3ab116fa53c1426f491&h=L&r=PART&n=40y26.0.1.1.2.

- EPA website. Retrieved on 1/21/2022 from https://www.epa.gov/hwgenerators/management-hazardous-waste-pharmaceuticals.

- Hospital Accreditation Standards. (2023). Oak Brook, IL: Joint Commission Resources, Inc.

CROSS REFERENCES:

- Hazardous Materials and Waste Management Plan

- Pharmaceutical Services policy on WASTING OR RETURNING CONTROLLED SUBSTANCES

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

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

PURPOSE:

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

POLICY:

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

AFFECTED PERSONNEL/AREAS:

RN, LVN

PROCEDURE:

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

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

c. Loosen gown to expose entire spine.

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

5. DOCUMENTATION:

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

REFERENCE:

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

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

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

PURPOSE:

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

POLICY:

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

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

PROCEDURE:

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

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

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

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

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

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

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

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

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

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

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

   e. Assisting in the establishment of surrogate decision maker.

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

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

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

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

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

   d. Ensure the designation of a decision-maker.

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

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

   g. Review and update all care plans.

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

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

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

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

REFERENCES:

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

CROSS REFERENCES:

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

SUBJECT: **POINT OF USE: INSTRUMENT CLEANING AND TRANSPORT**	SECTION: **Page 1 of 3**

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

PURPOSE:

This document provides guidance for **cleaning** surgical instruments, including point-of-use treatment, transport, **decontamination**, inspection, and general care of reusable medical devices (eg, surgical instruments).

POLICY:

All instruments used in a procedure will be cleaned of gross soil, sprayed with instrument spray post procedure and returned to the CPD in a red puncture proof, locking container labeled as "Bio Hazardous."

AFFECTED PERSONNEL/AREAS: *ENDOSCOPY, SURGICAL SERVICES, AMBULATORY SURGERY, RADIOLOGY, UROLOGY CLINIC, WOUND CARE CLINIC, MEDICAL/SURGICAL UNIT, TELEMETRY UNIT, EMERGENCY DEPARTMENT, MATERNAL & CHILD HEALTH UNIT, INTENSIVE CARE UNIT, ENDO/FLEX CARE/PACU, CENTRAL PROCESSING DEPARTMENT, NICU, PHYSICAL THERAPY, CARDIAC CATH LAB, CDU, RENAL SERVICES, DP/SNF, SURGERY CLINIC*

EQUIPMENT:

- Biohazard red containers
- Enzymatic instrument spray
- Closed transport carts

PROCEDURE:

1. Wear appropriate personal protective equipment (PPE), per task.
2. Begin preparation for instrument decontamination at the point of use
3. Pre-clean gross soil (to prevent the formulation of biofilm) ASAP at *point of use* (i.e., procedure room after patient leaves, operating room (OR), soiled utility room, etc.) per product recommendations and manufacturer's instructions for use (IFU).
4. After the procedure is complete, obtain instruments to be cleaned.
5. Sharp instruments must be separated from other instruments and confined in a puncture-resistant container before transport to the decontamination area.
6. Protect delicate instruments (eg, fiberoptic cords, endoscopes, microsurgical instruments, robotic instruments) from damage during transport to a decontamination area by segregating them into different containers or by placing them on top of heavier instruments.

7. Keep instruments moist until they are cleaned by using either saturation with an enzymatic pretreatment product or a towel moistened with water placed over the instruments. Do not use saline.

8. Per the Association for the Advancement of Medical Instrumentation (AAMI) Guidelines, a disposable sponge or brush soaked in water could be used to wipe gross soil.

9. All items will be placed in CPD-provided leak proof red container labeled as biohazardous, without water added.

10. Prior to transport, spray item with CPD-provided instrument spray

    a. Assure fully covered, especially around the hinges
    b. Hinged instruments to remain open

11. Arrange for transport to CPD

    a. Department with dirty instrumentation will ensure transport via CPD/courier to CPD in red biohazardous container for reprocessing.
    b. Each department will be given an appropriate quantity of red biohazardous containers to allow for an exchange from dirty to clean containers (indicated by blue containers).

12. CPD will receive items in biohazardous containers. CPD is responsible to monitor the process and assure items are received in an appropriate manner.

13. When instruments have been reprocessed, they will be delivered back to department by CPD/courier

REFERENCES:

- Association for the Advancement of Medical Instrumentation (AAMI) ST 79 (2017). *Comprehensive guide to steam sterilization and sterility assurance in healthcare facilities*. (pp.33-38).

- Disinfection (HLD) and Sterilization ~~2022~~ 2023. The Joint Commission. Sterilization, Retrieved from https://www.jointcommission.org/resources/patient-safety-topics/infection-prevention-and-control/disinfection-and-sterilization/

- Association of Operating Room Nurses. Guidelines. Instrument Cleaning. October 12, 2020. Retrieved from https://aornguidelines.org/guidelines/content?sectionid=173736661&view=book#173736661

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under

appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."