SUBJECT:	SECTION:
PRESSURE ULCER PREVENTION PLAN ~~DPSNFPRESSURE INJURY PREVENTION PLAN~~ ~~DPSNFPRESSURE ULCER PREVENTION PLAN~~ ~~DPSNF~~	Page 1 of 11

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PURPOSE:

To define the facility's Pressure Injury~~Ulcer~~ Prevention and Wound Care Program. Sierra View Medical Center Distinct Part/ Skilled Nursing Facility (DP/SNF) will provide care, treatment, and services to promote the prevention of wound development including pressure injury~~ulcer~~ development and to promote the healing wounds including ~~of~~ pressure injuries~~ulcers~~.

This Pressure Injury~~Ulcer~~ P~~p~~revention P~~p~~lan will include:

1. The process of identifying residents at risk for pressure injury~~ulcer~~ development.
2. To identify residents at risk for developing pressure injuries~~ulcers~~ who would benefit from preventative interventions and the specific factors placing them at risk.
3. To maintain and improve tissue tolerance to pressure in order to prevent injury.
4. To protect against the adverse effects of pressure, friction, shear and moisture.
5. To reduce the incidence of pressure injuries~~ulcers~~.
6. To effectively treat existing pressure injurie~~ulcer~~s through the use of a comprehensive and research-based pressure injury~~ulcer~~ management program.
7. To provide staff guidelines for documenting, assessing, and preventing pressure injuries~~ulcers~~.
8. To provide general procedures for skin care, pressure injurie ~~ulcer~~s, and wound management.

POLICY:

It is the policy of Sierra View Medical Center DP/SNF that all residents admitted to the unit shall receive a complete head-to-toe assessment, at which time a thorough examination of the skin will be done. The following steps will be taken:

1. The "Braden Scale" will be utilized for predicting skin breakdown/pressure ulcer risk and will be used to evaluate all residents for risk of skin breakdown. This will be performed on admit, weekly thereafter for four weeks, and quarterly by the MDS nurse. If the resident is identified at risk for skin breakdown with a Braden score of 1~~8~~6 or below, implement the pressure injury~~ulcer~~ prevention plan.
2. Consult the Wound Care Specialist as indicated.
3. Complete nutritional screening by RN/LVN with appropriate referral if indicated.

4. Complete a nutritional assessment by Registered Dietitian so that the nutritional needs of the patient are met.

5. Implementing individualized, comprehensive plan of care (interventions) to attempt to stabilize, reduce, or remove underlying risk factors.

6. Maintaining and improving tissue tolerance to pressure, in order to prevent injury.

7. Protecting against the adverse effects of external mechanical forces.

8. Monitoring the effectiveness of interventions.

9. Modifying the interventions as appropriate.

10. Education will be provided to the patients and their families.

11. Staff will be provided with educational in-services regarding the prevention and treatment of pressure ulcers.

12. The assessment of care and treatment needs of the resident will be ongoing throughout the stay.

AFFECTED PERSONNEL/AREAS:

RN, LVN, CNA

DEFINITION:

1. The National Pressure Injury~~Ulcer~~ Advisory Panel (NPI~~U~~AP) defines a pressure ulcer as, "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue."

~~1. a localized injury to the skin and /or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated."~~

~~2.~~

~~3.~~2. Pressure injurie~~ulcer~~s can occur whenever pressure has impaired circulation to tissue. Pressure injuries~~ulcers~~ develop when soft tissues are compressed between a bony prominence and the surface of an object, i.e. mattress, seat of a chair, catheter compressed between patient's thighs.

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4.3. Pressure injuri~~ulcer~~s are usually located over a bony prominence, such as a sacrum, heel, the greater trochanter, fibular head, scapula, and ankle.

5.4. Pressure injuri~~ulcer~~s and non-pressure related wounds are described as:

Stage I:

a. **Non-blanchable erythema of intact skin.** Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. ~~Non-blanchable erythema of intact skin is the heralding lesion of skin ulceration. Discoloration of skin, warmth, edema, or hardness, pain or itching may be indicators of a pressure ulcer in patients.~~ These indicators will be evident after the pressure on the area has been removed for 30-45 minutes.

b. Dark pigmented skin may not have visible blanching; the color may be different from the surrounding area.

c. The area may be firm, soft, painful, warmer or cooler than the adjacent tissue.

Stage II or partial thickness skin loss:

~~a. Partial-thickness skin loss involving the dermis. The ulcer is a superficial open ulcer with a red-pink wound bed. No slough or bruising (bruising indicates suspected deep tissue injury) of the wound bed is visible. The ulcer may present clinically as an abrasion, intact or open serum-filled blister or shallow ulcer.~~

a. **Partial-thickness skin loss with exposed dermis.** Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.

b. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

~~b. According to the NPUAP, Stage II classification should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.~~

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Stage III or full thickness skin loss:

a. **Full-thickness skin loss**. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epiboly (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. ~~Full-thickness tissue loss. Subcutaneous fat may be visible. Bone, tendon or muscle is not exposed. The ulcer may include undermining and tunneling. Slough may be present but the depth of tissue loss can still be seen.~~

~~b. Stage III pressure ulcer depth is different according to anatomical location. Stage III ulcers can be shallow on the bridge of the nose, ear, occiput and malleolus due to lack of subcutaneous fat.~~

~~c. Anatomical areas where there is a significant amount of adipose tissue can develop very deep Stage III pressure ulcers.~~

~~d. Bone/tendon is not seen or directly palpable.~~

Stage IV or full thickness skin loss with exposed structures:

~~a. Full-thickness tissue loss with extensive destruction, tissue necrosis or damage to fascia, muscle, bone or supporting structures (i.e. tendon, joint capsule) is involved which may lead to osteomyelitis. Sinus tracts and undermining may be present. Slough and/or eschar may be present on areas of the wound bed but do not obscure the base of the wound.~~

a. **Full-thickness skin and tissue loss**. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury

~~b. The depth of Stage IV pressure ulcers is different according to anatomical location.~~

~~c. Exposed bone/tendon is seen or directly palpable.~~

~~Suspected~~ Deep Tissue Injury:

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~~a. Purple or maroon in color, localized area of intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or sheer.~~

a. **Persistent non-blanchable deep red, maroon or purple discoloration.** Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.

b. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

~~b. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.~~

c. Deep tissue injury may be difficult to detect in patients with dark skin tones. Evolution of the injury may include a thin blister over a dark wound bed. The wound may evolve further and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Un-stageable:

~~a. Full-thickness tissue loss.~~

a. **Obscured full-thickness skin and tissue loss.** Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.

b. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.

c. Stable eschar (i.e. dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Additional Pressure Injury Definitions: **This describes an etiology.**

a. **Medical device related pressure injuries** result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally

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conforms to the pattern or shape of the device. The injury should be staged using the staging system.

b. **Mucosal Membrane Pressure Injury**: Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.

~~b. The base of the ulcer is covered with slough which can be yellow, tan, gray, green or brown in color and/or eschar which can be tan, brown or black in color, in the wound bed.~~

~~c. Staging cannot be determined until enough of the slough and/or eschar has been removed to expose the base of the wound~~

~~Note: Stable eschar on a patient's heels should not be removed. The eschar, in this situation, acts as the body's natural cover.~~

PROCEDURE:

1. Assessments: All bony prominences of at-risk residents will be assessed once a day (i.e. occiput, sacrum, heels, ischial ~~tuberositiestuberosity's~~, coccyx, ~~trochanter~~and trochanter).

2. Changes in skin condition: Staff will remain alert to potential changes in resident's skin condition and will evaluate and document identified changes. Changes in the resident's skin condition will be reported to the attending physician when applicable.

3. Nutritional screening: Shall be done by the RN/LVN on every admission. Residents with pressure ulcers will need a referral to the dietitian.

4. Nutritional assessment: Shall be completed by a Registered Dietitian and may include, among other recommendations, an estimation of calorie, protein and fluid needs, the need for supplementation with vitamin/minerals, and/or the need for oral, enteral or parenteral feeding.

5. Interventions will be incorporated into the resident's plan of care, evaluated and revised as the condition of the resident indicates.

6. Prevention: Prevention of pressure injuries~~ulcers~~ is primarily a nursing responsibility. The most effective means of preventing skin breakdown are relief of pressure on the skin, maintenance of adequate circulation, hydration and an adequate diet.

   a. Staff will continue preventative measures when a resident has a pressure injury~~ulcer~~ to prevent the development of additional pressure injuries~~ulcers~~.

   b. Residents who are dependent on the staff for repositioning will need to be repositioned every 2 hours and as needed, depending on the resident's condition. Turning will be

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documented on the CNA flow sheet. CAUTION: Do not drag the resident across the sheets as this reduces shear forces.

7. Preventative interventions for all residents at risk:

   a. Use of pressure reduction surfaces, wheelchair/Geri-chair cushions, zero pressure boots or pillows (to off load heels) when appropriate. **Do not use donut type devices.**

   b. Place a pillow(s) under the resident's lower leg(s), suspending the heel(s), to decrease the pressure placed on the resident's heels.

   c. Apply skin protectant cream~~repair cream~~ to the resident's dry skin after each bath to decrease friction. Apply protectant/barrier~~Nutrashield~~ cream to the buttocks, perineal area of incontinent resident's skin to prevent incontinent associated dermatitis. Do not massage vigorously over bony prominences.

   d. Try to prevent moisture, diarrhea, urinary incontinence and sweating from accumulating because this may cause skin maceration and eventual breakdown

   e. Keep linen wrinkle-free to prevent uneven pressure redistribution. Limit the number of layers between the resident and the bed to a sheet, draw sheet, and pad

   f. Observe the resident for reddened or blanched areas, especially at rims of ears and bony prominences that suggest decreased circulation. If any redness is detected, remove the causative factor(s).

8. **Management of Pressure Injury/Partial thickness/full thickness wounds**: Pressure injury's/other wounds present at the time of admission or developed after admission will be identified. It is important to be aware of factors that lead to the development of a Pressure injury/other types of wounds so that appropriate interventions can be initiated.

~~8. Management of Pressure Ulcers: Pressure ulcers present at the time of admission or developed after admission will be identified. It is important to be aware of factors that lead to the development of a pressure ulcer so that appropriate interventions can be initiated.~~

   a. Nursing staff will take pictures and measure pressure injuries~~ulcers~~:

      - On admission if present or as discovered after admission.
      - Every week thereafter, until healed, on a designated day.
      - PRN changes (i.e. surgical debridement).
      - When healed, transferred to a higher level of care or discharged.

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b. The weekly wound trending record will be completed weekly by the RN/LVN on admission if present or as discovered after admission and every week thereafter, until healed. The trending record should be updated when changes are noted such as following a surgical debridement, when the injury ~~ulcer~~ is healed, or when the patient is transferred to a higher level of care or discharged.

c. The wound trending form will contain the following elements:

- Date
- Location of ulcer and stage, if applicable
- Length, Width and Depth in centimeters
- Presence, location and extent of undermining or tunneling/sinus tract
- Presence of drainage/odor
- Color content of wound bed
- Pain

d. When to call the physician: The physician should be notified when a change in the skin condition or pressure injury~~ulcer~~ requires a change in treatment ~~(see preprinted physician order set)~~.

e. When to call the Wound Specialist: The Wound Specialist is available for assistance Monday through Friday, 0~~8~~700 – 1~~6~~530.

f. Nursing staff will assess, reassess and document the injury~~ulcer~~'s characteristics and observe for infection. This includes, but is not limited to:

- Signs/symptoms of infection
- Purulent exudates
- Peri-wound warmth
- Swelling
- Induration
- Erythema

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- Increased pain or tenderness around the site
- Delayed wound healing

g. Follow physician's orders for treatment of the pressure injury ~~ulcer~~, including cleansing and dressing.

h. Avoid positioning residents on a pressure injury~~ulcer~~.

i. Daily monitoring of Pressure Injury~~Ulcers~~ includes:

- Evaluating the injury~~ulcer~~ even when no dressing is present.
- Evaluate the dressing if present; dressing intact, drainage present
- Evaluate the area surrounding the pressure injury ~~ulcer~~.
- Observe the wound for signs of increasing ulceration, soft tissue infection around the wound, or drainage.
- Pain assessment and management.
- Notify the Wound Specialist and/or physician if pressure injury~~ulcer~~ is not healing.

~~9.~~8. Plan of Care: Based upon the assessment and resident's clinical condition and identified needs, the resident's plan of care will include interventions to:

a. Redistribute pressure.

b. Minimize the resident's skin exposure to moisture

c. Keep the skin clean.

d. Provide appropriate pressure redistribution support surface if indicated (i.e. Stage III or IV on the trunk).

e. Maintain or improve nutrition and hydration status if feasible.

DEVICES:

A. **Pressure Redistribution Mattress**: Identify the need for a pressure redistribution mattress per following guidelines:

1. Stage III or IV on the trunk

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2. Stage III or IV must be greater than 2 x 2cm on the trunk, or there must be multiple stage III or IV sites on different turning surfaces.

3. CBC, Total Protein and Albumin or Prealbumin monthly until wound(s) is healed.

4. Dietitian involvement monthly.

5. Wound healing supplements per dietitian.

B. **Mechanical loading, Support Surfaces and Repositioning devices.**

1. Place the resident in a 30-degree lateral position to decrease pressure on the trochanter.

2. The head of the bed is not to be elevated more than 30-degrees unless the resident's medical condition warrants it.

3. Elevating the head of the bed or back of a reclining chair to greater than or equal to 30-degrees creates pressures comparable to that exerted while sitting.

~~SPECIAL CONSIDERATIONS:~~

~~1. The 1994 AHCPR guidelines and current literature indicate that a pressure ulcer that is clean with adequate blood supply and innervation should show evidence of healing or stabilization within 2-4 weeks.~~

~~2. If a pressure ulcer fails to present evidence of progression toward healing within 2-4 weeks, the pressure ulcer and the resident's overall clinical condition should be re-evaluated. Current treatment modalities may need to be changed or modified.~~

~~3. Pressure ulcers may progress or complications can develop such as infection of the soft tissue, infection of the bone, abscess formation, septicemia, or development of a sinus tract or chronic infection despite apparent improvement in the pressure ulcer itself.~~

DOCUMENTATION:

1. Document Braden scale on admit and weekly for 4 weeks, then every quarter thereafter.

2. Document nutritional screening on admission and implement a referral as necessary.

3. Document interventions used to prevent the development of pressure injury~~ulcers~~ on the plan of care.

1. Record nutrition and fluid intake.
2. Document wound assessment in PCS upon admission, on designated day weekly and PRN when applicable.
3. Document wound dressing changes as ordered in PCS, if applicable.

REFERENCES:

- Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide. (2019). Emily Hasler [Ed.] EPUAP/NPIA/PPPIA.
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SUBJECT: **PROCEDURE FOR MOUTH CARE OF THE TUBE FED RESIDENT**	SECTION: **Page 1 of 3**

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PURPOSE:

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

POLICY:

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

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

EQUIPMENT:

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

Edentulous resident:

- Denture cup
- Denture cleaner
- Denture brush

Comatose or debilitated resident:

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

PROCEDURE:

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

RECORDING:

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

REFERENCES:

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

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SUBJECT:	SECTION:
PROVISION OF 24 HOUR NURSING ACCESSIBILITY GUIDELINES	***DP/SNF STAFFING REQUIREMENTS*** **Page 1 of 4**

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PURPOSE:

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

POLICY:

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

AFFECTED PERSONNEL/AREAS:

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

PROCEDURE:

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

Skill Mix

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

Augmentation to Core Staffing

- Core Staffing may be augmented as census increases.

DISTINCT PART SUBACUTE STAFFING REQUIREMENTS PER DEPARTMENT OF HEALTH CARE SERVICES

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

Daily Minimum Requirements:

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

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

Additional Requirements:

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

Cautionary notes:

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

Included/Excluded Staffing Hours:

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

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

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

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

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

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.30, United States of America, Med Pass Inc.

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §71829, §72082, §72319, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I

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

SUBJECT: **RANGE OF MOTION**	SECTION: ***Physical Therapy*** **Page 1 of 8**

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

PURPOSE:

- To maintain muscle strength and tone.
- To improve muscle strength and tone.
- To prevent progression of contractures.
- To maintain circulatory integrity of the limbs.
- To enhance the utilization of a body part in physical activity.
- To prevent complications and disability attendant upon other physical/emotional dysfunctions and adverse states of well-being.

POLICY:

All residents will receive active and/or passive range of motion once daily, 6 days a week if indicated by the physical therapists/doctors' orders.

DEFINITION:

- Range of Motion (ROM) – The extent to which a particular joint is capable of being moved.
- Active range of motion – The resident independently moves his/her joints, or actively assists with the movement of joints.
- Passive range of motion – The staff performs the movement of the resident's joints.

HIGH-RISK RESIDENTS:

- Unconscious
- Acutely ill
- Unable to move head or extremities
- In severe pain and remaining immobilized
- In cast, brace or other limiting devices
- Paralyzed or having nerve weakness
- Incorrectly positioned or supported

CONTRAINDICATIONS for treatment of residents with contractures:

- Imminent death
- Ankylosis- immobility of joint
- Cancer of bone
- Osteoporosis
- Congenital anomaly
- Joint inflammation

RANGE OF MOTION EXERCISES:

TYPES OF ROM:

- Passive: For parts of the body (i.e., limbs, trunk, digits) the person cannot move for himself /herself; ROM is done for and to the person.
- Active Assisted: When the person can perform a motion with the help of an assistant or a device.
- Active: For the person who can do the motion himself /herself.

NOTE: Physician order is not required for active or passive ROM.

BODY POSITION:

- Supine: Back lying
- Lateral: Side lying

JOINT POSITIONS: (Also known as body positions)

- Extension: Straightening a flexed or bent joint.
- Flexion: Bending a joint to form an acute angle.
- Adduction: Moving arm, leg or finger toward normal resting position (i.e., normal for the patient).
- Abduction: Moving arm, leg or finger away from normal positions

AFFECTED PERSONNEL/AREAS:

RN, LVN, RNA, CNA

PROCEDURE:

1. Physiotherapy is to be called for initial evaluation, if necessary. ROM is a nursing measure; therefore, it may be instituted without physiotherapy evaluation and/or physicians' order.

2. ROM is frequently used in collaboration with other nursing and rehabilitative interventions, e.g., strengthening, gait training, ambulation, etc.

3. ROM exercise does not take the place of position change and support for dependent parts.

4. Explain each step before you do ROM and as you are doing it.

5. Gentle but firm pressure is to be applied during ROM.

6. Do not bring the joint/limb motion to the point of pain.

7. Observe the resident who is unable to communicate for signs and symptoms of discomfort such as facial grimacing, increased sweating, or increased heart rate.

8. The joint area is left free. Limbs are supported and directed through the exercises. See Protocol.

9. Each joint is moved through its range 3 – 5 times per treatment.

REASONS FOR PLACEMENT OF CAREGIVERS HANDS & BODY AS OUTLINED BELOW:

- Trust and reassurance
- Support, safety, guidance
- Observation
- Balance, direction, control of movement

EXERCISE PROTOCOL:

Motions of the Body and Trunk

A. Flexion:

   1. Bending forward from the waist

   2. Standing in front or side of patient

   3. Place both hands on shoulder or one hand on shoulder and one hand on waist

B. Extension:

1. Straightening from the flexed position to the neutral position
2. Standing to the front or side of the patient, place hand on shoulder (one hand on shoulder) and one hand on waist

C. Lateral Flexion:

1. Bending sideways from the waist, to the right and to the left.
2. Standing to front or side of the patient, place one hand on shoulder, one hand on waist or across the patient's back.

D. Rotation:

1. Turning the shoulders, keeping the hips stationary.
2. Stand in front of the patient; place one hand on the patient's hip and one hand on the opposite shoulder. Bring the shoulder gently towards you.

Motions of the Shoulder

A. Flexion and Extension:

1. Place one hand below the patient's elbow; supporting the shoulder and elbow with one hand.
2. Hold the patient's shoulder with the other hand, while ranging.
3. Lift the patient's arm up from the side of the body.
4. Next, carry the arm slowly and gently toward the patient's head as far as you can go without causing pain.
5. If the headboard prevents your carrying the straight arm all the way back, bend the arm at the elbow.
6. Finally, carry the patient's arm back to the standing position.

B. Abduction and Adduction:

1. One hand supports the patient's shoulder joint.
2. Hold the patient's elbow with your other hand.

3. Next, keeping the patient's arm straight, move it away from the patient's body.

4. Then, return to normal position against the patient's body.

C. Internal and External Rotation:

1. Start by placing the patient's arm pointed away from the patient's body, elbow bent. Hold patient's hand with your other hand.

2. Hold patient's upper arm against mattress.

3. Then, lift patient's lower arm and hand.

4. Next, move patient's lower arm and hand slowly and gently back towards the patient's head, as far as you can go.

5. Return patient's arm to starting position.

D. Cross Adduction:

E. NOTE: Important joint function and range for the hemiplegics (post stroke) patient for turning in bed and dressing by self.

1. Start by placing one of your hands on the patient's shoulder.

2. Hold patient's elbow with your hand.

3. Lift patient's arm

4. Carry patient's arm across his/her chest.

5. Return arm to starting position.

F. Elevation and Depression:

G. Lifting the shoulders towards the ears (hunching) and returning to normal position. Right, then left and/or together.

Motions of the Elbow:

A. Flexion and Extension

Note: Important for self-feeding:

1. Place one hand on elbow, one hand supporting forearm and/or hand.

2. Bend elbow, bringing forearm and hand toward shoulder.

3. Return forearm and hand to starting position.

Motions of the Forearm:

A. Supination and pronation:

1. Start by holding the patient's hand with one of your hands.

2. Place the other hand on the patient's forearm.

3. Gently rotate the hand to the right and to the left.

Motions of the Wrists and Fingers:

A. Flexion and Extension:

1. Start by holding the patient's wrist with one hand; avoid heavy pressure which can occlude the arteries and veins.

2. Hold patient's fingers with your other hand.

3. Next, keeping patient's fingers straight, bend patient's hand backward.

4. Then, straighten the hand.

5. Now, bend patient's hand forward, closing patient's fingers to make a fist.

6. Then open patient's hand to starting position.

Motion of the Knee and Hip:

NOTE: Ideally, bed should be flat. Check with the nurse. This ROM can be effective with the head of the bed raised.

A. Flexion and Extension:

1. Place one hand under the patient's knee, upper calf.

2. Place other hand under the heel of the patient's foot.

3. Then, lift leg, bending it at the knee.

4. Move patient's leg slowly back towards the patient's head as far as it will go without hurting the patient. Next, straighten the patient's knee by lifting the foot upward. Lower the patient's leg, gently, to the starting position.

Motions of the Ankle, Foot and Toe

A. Ankle Dorsiflexion and Plantar flexion:

1. Start by holding the patient's heel with your hand, letting the sole of patient's foot rest against your arm; other hand over ankle/instep.

2. Then, press your arm against the bottom of the foot, moving it back toward the leg. At the same time, pull gently on the heel. (Note: Keep the knee straight).

3. Next, move your arm back to the starting position.

4. Move your hand which was over the ankle up the area just before the toes. Push down on patient's foot to point the toes. At the same time, push up against the heel.

B. Foot inversion and Eversion:

1. Place one hand across the ankle.

2. Grasp foot with other hand.

3. Start by turning the whole foot outward.

4. Then, turn the whole foot inward.

5. Return foot to starting position.

C. Toe Flexion and Extension:

1. Pull up on the toes (one hand on sole of foot).

2. Push down on the toes (one hand on heel).

IN-SERVICE EDUCATION:

- All nursing staff are instructed in the techniques of active and passive ROM, during orientation and ongoing (classroom and on the unit), all shifts.

DOCUMENTATION:

RNA Intervention in the EMR.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.25 (e) (1), 483.25 (e) (2), United States of America, Med Pass Inc.

- California Code of Regulations (2021). Title 22. §72315. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **RAPID RESPONSE TEAM ADULT & PEDIATRIC**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 6**

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

PURPOSE:

The goal of the Rapid Response Team is to address the recognition of and response to an unexpected deterioration in a patient's condition.

POLICY:

For a patient perceived to be in distress, any individual has the ability to request a Rapid Response Team evaluation without advance consultation with the patient's attending physician. Any Sierra View Medical Center (SVMC) employee may activate an RRT. *A family member/visitor may activate an RRT.*

1. The Rapid Response Team call does not replace the Code Blue/White policy and procedure.
2. Signage in patient rooms reflects family involvement and their role in initiation an RRT.
3. Patients on comfort care are excluded from this policy.

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS*

PROCEDURE: (Adult Patients)

1. The Rapid Response Team will consist of the ER Charge/Lead RN and Respiratory Therapist (ER RR Team) or ICU Charge/Lead RN and a Respiratory Therapist (ICU RR Team).
2. In-patients that require services, such as but not limited to Lab, Echo, MRI, CT, will follow the Rapid Response policy.
3. Patient's here for outpatient services, such as but not limited to Lab, Echo, MRI, CT, will follow the Medical Response Unit (MRU) procedures under Emergency Response to on Campus Medical Emergencies policy.
4. The following objective criteria of clinical instability are provided as a general reference guide. Numerical values do **NOT** need to be reached or exceeded before requesting a Rapid Response Team consultation. The most important activation criterion remains staff/family concern or intuition.
5. Notwithstanding the RNs overall concern for changes in the patient's condition, he/she can activate the team based on the following criteria:

Respiratory Factors to Consider:

a. Unexplained acute change in respiratory rate or rate less than 8 or greater than 36 per minute.

b. Unexplained acute change in SpO2 less than 85% for more than 5 minutes.

c. New onset of difficulty breathing.

d. Difficulty speaking.

Cardiovascular Factors to Consider:

a. Unexplained acute change in heart rate- OR - heart rate less than 40 or greater than 140 beats per minute.

b. Unexplained acute change in blood pressure – OR – systolic blood pressure less than 90 or greater than 200 with symptoms.

c. Patient complaint of new onset chest pain.

Neurological Factors to Consider:

a. Unexplained acute change in level of consciousness.

b. New onset of agitation or delirium.

c. New motor/sensory function changes, seizure or sudden collapse.

d. New onset of lethargy or difficulty waking patient.

e. Difficulty speaking.

Other Factors to Consider:

a. Color change of patient or extremity (pale, dusky, gray, blue, etc.).

b. Severe uncontrolled pain.

c. Acute change in urine output: < 50 ml. in 4 hours.

d. Deterioration in condition despite treatments.

6. Activation of the Rapid Response Team

a. The Rapid Response Team is activated at the patient's bedside by dialing "55". The operator will then overhead page "Rapid Response Team to Room #"

b. The hospital encourages the patient and family to seek assistance when the patient's condition worsens.

PROCEDURE: (Pediatric Patients)

1. The Rapid Response Team will consist of the ED Charge/Lead RN and a Respiratory Therapist (ED RR Team).

2. The following objective criteria of clinical instability are provided as a general reference guide. Numerical values do NOT need to be reached or exceeded before requesting a Rapid Response Team consultation. The most important activation criterion remains staff/family concern or intuition.

3. Notwithstanding the RNs overall concern for changes in the patient's condition, he/she can activate the team based on the following criteria: (Refer to addendum A "Criteria for Activation of RRT")

   a. Staff or patient/family member concerned about the patient.

   b. Acute changes in respiratory status or a threatened airway.

   c. Acute changes in the following:

      - Oxygen saturation
        - Heart rate
        - Systolic blood pressure
        - Level of consciousness
      - Acute significant bleeding
      - Seizures (new, repeated or prolonged)
      - Refer to Addendum A for age based guidelines

4. Activation of the Rapid Response Team

   a. The Rapid Response Team is activated at the patient's bedside by dialing "55". The operator will then overhead page "Pediatric Rapid Response Team to Room #".

   b. The hospital encourages the patient and family to seek assistance when the patient's condition worsens.

COMMUNICATION AND COLLABORATION

1. Role of Bedside Nurse / Floor Staff

   a. Briefing the Rapid Response Team: SBAR

      - *Situation*
      - *Background*
      - *Assessment*

- *Recommendation*

b. Have computer for beside chart review.

c. Contacting the primary physician.

d. Administering medications and other interventions.

e. Documenting the event.

f. Assuring that emergency equipment / supplies are available if needed, e.g. Crash Cart, suction, etc.).

2. Role of Rapid Response Team

a. Assessing patient and applying critical thinking skills

b. Obtaining needed tests / labs per MD order

c. Assisting with all required interventions

d. Stabilizing patient until transfer can occur (if required)

e. Promoting effective communication with physician

f. Teaching and mentoring when appropriate

g. Calling a "Code Blue/White" if situation worsens or to obtain needed physician support

h. Utilizing standardized procedures as necessary.

DOCUMENTATION:

1. All assessments, orders and interventions will be documented in the appropriate section of the medical record.

2. The RN will initiate the RRT call sheet and hand it off completed to the ICU / ED charge nurse (CN) who responds to the RRT. The ICU / ED CN will complete their portion of the document and place it in the folder in the ICU labeled RRT.

3. The Adult or Pediatric Rapid Response Team Record form will be used for documentation of team processes and for tracking purposes.

4. The Rapid Response Team RN will place form in the Progress Notes of each patient's chart immediately after each Rapid Response Team call. A copy of the form will be placed in a binder located in the ICU and maintained by the ICU Monitor Tech.

5. After the Rapid Response Team consult is completed, the Rapid Response Team RN and bedside nurse will have a short debriefing session.

6. The call is logged into the Rapid Response Team Log Record for tracking purposes. The log will be maintained by the ICU Monitor Tech.

7. The designated unit-nursing leader or House Supervisor will attend all RRT calls and ensure all processes are followed and completed per policy. In their absence, the Charge Nurse will attend all RRT calls and ensure all processes are followed and completed per policy.

RESCUE AND RESUSCITATION (RR) COMMITTEE

Purpose:

To ensure quality emergency medical response within Sierra View Medical Center in order to improve patient outcomes through systematic review of current SVMC processes with subsequent follow-up and actions to include competency evaluation, staff education, policy and systems review and/or changes.

Procedure:

1. In-patient RRT/Pediatric RRT calls will be evaluated based on EMR committee chosen indicators.

2. Data collected on the indicators will be used for Performance Improvement reporting.

3. Additional indicators may be added as other issues are identified through chart review. The data will be used to drive performance improvements in patient care.

4. These forms will be routed to the Critical Care Monitor Technician to be reviewed by the EMR committee.

CROSS REFERENCE:

- Emergency Response to on Campus Medical Emergencies

REFERENCE:

- Institute for Healthcare Improvements. (2020). Utilization of Rapid Response Team. Improving healthcare worldwide. Retrieved 11, 2020 from http://www.ihi.org/resources/Pages/Measures/UtilizationoftheRapidResponseTeam.aspx

SUBJECT: **RESIDENT RIGHTS-MEDICAL DECISIONS**	SECTION: Social Services **Page 1 of 1**

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

PURPOSE:

To define the manner in which Sierra View Medical Center's Distinct Part Skilled Nursing Facility (DPSNF) assures the patient's ability to exercise self-determination in medical decision-making throughout their stay in the facility.

POLICY:

Each resident or surrogate completes the POLST (Physicians Orders for Life-Sustaining Treatment) document at the time of admission.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES, NURSING*

PROCEDURE:

1. The Social Service Designee shall initiate discussion with the resident/surrogate annually on the anniversary of admission, to determine whether the form still accurately reflects the treatment preferences of the resident/surrogate.

2. If the resident has an Advance Directive, the Social Service Designee shall review it annually with the resident/surrogate, to ensure that it remains current and correct, as to directives stated and any agents that are named. If not, it must be changed as soon as possible and placed in the medical record. If no changes are needed, it may be left as is.

3. When this annual review of the POLST or Advance Directive is completed, the Social Service Designee shall record it in a Progress Note in the resident's medical record.

4. If the resident/surrogate wishes to discuss medical treatment issues in order to clarify their preferences, the Social Service Designee shall refer them to the Medical Director.

5. If the resident/surrogate wishes to clarify their preferences in terms of family values, dynamics, or other psychosocial issues, the Social Service Designee should contact the unit Director to arrange for appropriate consultation.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, 72527, San Francisco, California, Title 22.

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

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

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

POLICY:

To establish guidelines for a restorative program.

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

PROCEDURE:

1. Passive and /or active range of motion (ROM) is given 3-6 days a week daily by RNA/CNA to all residents needing assistance in activities of daily living (ADL). As per the Physicians/Physical Therapy orders.

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

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

2. Independent ambulators:

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

3. Ambulatory needing assistance:

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

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

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

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

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, 70557, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1

SUBJECT:	SECTION:
RESTRAINT USE – NON-VIOLENT, NON SELF-DESTRUCTIVE (NVNSD) AND EMERGENCY-VIOLENT SELF DESTRUCTIVE (VSD)	***Provision of Care, Treatment & Services (PC)***

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

PURPOSE:

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

SCOPE:

The following are not considered restraint under this policy:

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

POLICY:

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

AFFECTED PERSONNEL/AREAS:

NURSING, MEDICAL, ADMINISTRATION, DP/SNF

PROCEDURE:

NON – VIOLENT- NON SELF DESTRUCTIVE RESTRAINT

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

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

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

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

5. ***Orders:*** Restraint will be initiated or continued at the order of the physician. The order for restraint will include the type and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. As needed (PRN) restraint orders will be neither issued nor accepted. If a resident has been removed from restraints but a valid order is still in effect, the registered nurse may reapply the restraint without obtaining a new order, as long as the resident is exhibiting the same behaviors that met the original indication.

6. ***Initiation without Physicians Order:*** If a physician is not available, an RN may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the resident's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 12 hours of its initiation.

7. ***Initial In-person Physician Assessment within 24-hours of Initiation:*** The treating physician will perform an in-person assessment of the restrained resident within 24-hours of initiation to verify that restraint is needed and that less-restrictive means are not appropriate.

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

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

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

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

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

    c. Restraint orders

d. Resident monitoring

e. Significant changes in the resident's condition

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

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

h. Record of Consent

VIOLENT AND SELF DESTRUCTIVE BEHAVIOR RESTRAINT (VSD)

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

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

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

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

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

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

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

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

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

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

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

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

b. Restraint orders

c. Patient monitoring

d. Significant changes in the patient's condition.

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

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

g. Transfer to Emergency Room order.

CHEMICAL RESTRAINT

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

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

REPORTING DEATHS RELATED TO RESTRAINT

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

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

STAFF EDUCATION:

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

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

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

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

REFERENCES:

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

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

CROSS REFERENCES:

- DP/SNF Policy & Procedure Manual RESTRAINTS, CHEMICAL

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

SUBJECT: **ROUTINE PATIENT CARE IN THE POST-ANESTHESIA CARE UNIT (PACU)**	SECTION: **Page 1 of 3**

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

POLICY:

Routine patient care will be provided to patients in the Post-Anesthesia Care Unit (PACU).

PROCEDURE:

- Start oxygen per anesthesia order on arrival to PACU. If O2 sats are less than 90%, apply oxymask at 10L and contact anesthesia provider. If not resolved, call Respiratory.
- Vital signs are taken on admission, then every five (5) minutes X3,then, if stable, every 10-15 minutes for the first hour, then every thirty (30) X4. Notify the anesthesia provider if vital signs have not stabilized fifteen minutes after admission or immediately if there is a sudden change during the PACU stay. The temperature will be taken within the first 30 minutes, then every hour, and at discharge.
- Pain medication will only be given as ordered by the anesthesia provider/surgeon.
- The IV solution from surgery will be followed with the IV solution specified in the post-operative orders.
- If there are no post-operative orders for an IV, the present IV may be discontinued prior to transfer unless contraindicated by the patient's condition. If this situation occurs, the surgeon or anesthesia provider must be contacted for orders.
- Cardiac monitoring will be initiated on admission and a printed rhythm strip documentation of the cardiac rhythm will be obtained and placed on the PACU record.
- The Aldrete Scoring System for discharge will be used:

Post Procedure Monitoring and Discharge Criteria:

Documentation of the Aldrete Score will be completed prior to patient discharge. The score must return within 2 points of the patient's baseline before the patient may be released from the procedure area. The range is 10 for complete recovery to 0 in comatose patients. Evidence that the patient has met discharge criteria must be clearly documented in the medical record.

1. Motor Activity:

   Muscle activity is assessed by observing the ability of the patient to move his/her extremities spontaneously or on command.

   a. Score:

      2 – Moves 4 extremities voluntary/command

1 – Moves 2 extremities voluntary/command

0 – moves 0 extremities voluntary/command

2. Respiration:

Respiratory efficiency is evaluated in a form that permits accurate and objective assessment without complicated physical tests.

a. Score:

2 – Able to deep breathe and cough freely

1 – Dyspnea or limited breathing

0- Apneic

3. Circulation:

Use changes of arterial blood pressure from pre-anesthetic level.

a. Score:

2 – B/P + or – 20mmHg of pre-procedure level

1 – B/P + or – 20-50 mmHg of pre-procedure level

0 – B/P + 50 mmHg of pre-procedure level

4. Neurologic Status

Determination of the patient's Level of Consciousness.

a. Score:

2 – Fully awake and oriented

1- Arousable on calling-drifts to sleep

0- Not responding or responds to pain

5. Oxygen Saturation Aldrete

   a. Score:

   2- 02 sat > or = to 92% on room air

   1 – Needs 02 for 02 sat > or =90%

   0- 02 sat < 90% even with 02

All outpatients who receive sedation for any procedure must be observed and monitored for a minimum of 30 minutes after the last medication given prior to being discharged home. Vital signs (heart rate, respiratory rate, blood pressure, ETCO2, and temperature) are recorded at 10 minute intervals.

RESPONSIBILITY:

- PACU personnel are responsible for the initiation of all routine patient care in the PACU. Any patient who does not meet the criteria established for a "normal" recovery period (approximately 1 hour) must be reported to the anesthesia provider for evaluation.
- The anesthesia provider has responsibility for all patient care ordered in the PACU in collaboration with the surgeon. Post-anesthesia evaluation to be done prior to discharge by an anesthesia provider.
- Discharge Aldrete score must be within 2 points of the patient's pre-op baseline..

REFERENCES:

- Aldrete Score 2018-2019, Meditech 6.1 PP3, Copyrights Protected and SVMC has contract on file
- Perianesthesia Nursing Standards Practice Recommendations and Interpretive Statements, The American Society of Post Anesthesia Nurses,. 2023-2024.

SUBJECT: **SCHEDULING SURGICAL PROCEDURES**	SECTION:

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

PURPOSE:

To provide an organized process for scheduling surgical procedures.

DEFINITIONS:

Block Time: A period of time (block) assigned to a surgeon or service.

Block Time Utilization: The percentage of block time used by the surgeon or service to which it was assigned.

Start Time: The time the patient is in the room. The incision will be made as soon thereafter as possible.

Volume of Cases: The total number of scheduled and unscheduled procedures, in and out of block time, within a designated time frame.

POLICY:

1. Surgery Scheduler will schedule surgical procedures following the ongoing guidelines to maximize the use of all available resources providing for efficient service to surgeons and their patients.

2. The Surgery Scheduler will check the surgeon's privileges at the time a case is scheduled, using the "E-Priv" intranet program.

3. The Director of Health Information Management (HIM) for medical record deficiencies (e.g., unsigned charts) will enter physician suspensions into Meditech. The scheduling system will not allow a case to be scheduled until the deficiency is resolved, however, previously scheduled cases or emergency cases will be permitted. The Medical Staff Service Department will coordinate with HIM regarding suspensions.

4. At the time of scheduling a case, the surgeon will request the need for a Registered Nurse First Assistant or an Operating Room Technician, in addition to the Scrub Technician. The Scheduler will check the staff availability at that time.

5. All cases including laterality must be scheduled as either right or left. All procedures involving multiple structures, such as toes or fingers, must be identified. To assure patient safety, the scheduling office will not accept any surgical scheduling without the information.

6. Prior to coming to the Operating Room (OR), the patient and/or designated family/caregiver will be seen by the surgeon and will have received an explanation of the planned procedure along with explanation of risks, benefits and alternatives. Exceptions may be made for life or limb-threatening emergencies.

7. Surgery scheduler will use physician pre-registration form to schedule procedures; form to be sent in by physician's office.

AFFECTED AREAS/ PERSONNEL: *MAIN OPERATING ROOM (OR); MATERNAL CHILD HEALTH OPERATING ROOM (MCH OR); ENDOSCOPY; RADIOLOGY/SCHEDULER; DIRECTOR OF SURGICAL SERVICES – MCH- RADIOLOGY; RN HOUSE SUPERVISOR; CARDIAC CATH LAB/IR*

PROCEDURE:

1. SCHEDULING BASICS

   a. Elective surgical cases may be scheduled with surgical scheduling secretaries between 8 a.m. and 5 p.m., Monday through Friday by sending in the physician pre-registration form and following up with a phone call.

   b. When applicable, procedures scheduled after 1500 for the next day may be considered as "Add-on" procedures to be fit into the schedule as staffing and anesthesia providers are available.

   c. After 1700, all cases to be added on to the next day's schedule will be arranged through the House Supervisor. The "Add-On" forms for next day cases scheduled will be attached to the next day's printed schedule, which is given to the House Supervisor for the night.

   d. The next morning, the House Supervisor will inform the OR Scheduler of requested Add-ons along with requested times.

   e. These additional procedures will be fit into the schedule as staffing and Anesthesia coverage permits.

   f. Surgeons will be notified by the Charge Nurse and/or Manager of the scheduled time available for their Add-On procedures.

   g. Information required for scheduling:

      - Patient name, date of birth, telephone number, and social security number, if available
      - Procedure with requested date and time
      - Requests for assistant (registered nurse first assistant (RNFA), extra scrub), pathology, special equipment, and blood needs
      - Site specification if right, left, or digits

h. Scheduling of elective surgical cases will be through a BLOCK system.

i. The OR Charge Nurse, Clinical Manager or the Surgical Services Director will add add-on cases to the first available room.

j. After hours add-on cases for the following day will be arranged through the Nursing House Supervisor. He/she will obtain the required information. The Nursing House Supervisor will inform the early A.M. OR Scheduler of any scheduling additions. The Director of Surgical Services and/or Clinical Manager can also be called at home to intervene for first case of the day changes.

2. BLOCK SCHEDULING

a. Block scheduling is a process that allows surgeons to request a specific block of time on a designated day to be held for scheduling their routine elective cases:

- Monday through Friday, four (4) rooms from 0700 AM – 1500 PM, and one (1) room until 1700 PM offering anesthesia coverage may be assigned to a specific surgeon; thus providing optimum use of resources to each surgeon.

- SVMC will allow a specific percentage of surgery hours, Monday through Friday, 0730 to 1500, to be allocated as block time. This percentage will be based on block time utilization and surgical volume.

b. Block Scheduling Basics:

- Surgeon requests a Block on the OR schedule, selecting an available time that will best meet his/her needs. The computer is set to hold the time for the designated surgeon. All routine, elective cases for this surgeon are placed in this BLOCK.

- Block time will be allocated to surgeons based on utilization. Sierra View Medical Center (SVMC) Director of Surgical Services will collect the block utilization data and submit to OR Committee for evaluation on a quarterly basis.

- Depending on the results, physicians with less than 40% utilization of their block time may have their allotted time reduced. If block average is above 85%, the surgeon will be contacted to see if more time is desired. Zero % utilization for 2 consecutive months will result in the cancellation of block time. Surgeons will be given notice prior to any modifications of their block time.

- Block time requests, including additions, deletions and other changes, will be requested in writing to the SVMC Director of Surgical Services.

- Unused BLOCK time is held until 7 days prior to the date and is then released for first-come-first-serve scheduling. Requests for extension of the block release time will be denied.

- The OR scheduling office needs to be notified as soon as possible when BLOCK time can be released for planned absences; i.e., vacations. This released time will not be counted towards block utilization.

3. FIRST-COME-FIRST-SERVED SCHEDULE BASICS

   a. Is available when a block is open or when a block lifts

   b. Surgeons who prefer not to have a designated block to schedule their routine, elective surgical procedures after 1230 each day may do on a first-come-first-served basis.

   c. Once a designated surgeon releases a BLOCK, it will become available for first-come-first-served scheduling.

4. SCHEDULING EMERGENCY CASES

   a. Monday through Friday between 6:00 AM and 5:00 PM, all emergency cases are to be scheduled directly with OR.

   b. After hours, weekends and holidays, emergency cases must be scheduled through the Nursing House Supervisor.

   c. The call crew will be called in at the surgeon's discretion.

   d. weekend cases scheduled for inpatients will begin no earlier than 0900 unless prior arrangements are made with all concerned parties.

5. BUMPING CASES

   a. If a surgeon needs to "bump" a case, it is his/her responsibility to inform the surgeon whose case is being "bumped". The surgeon that is "bumped" then notifies the Director of Surgical Services and/or Clinical Manager and OR Charge Nurse or House Supervisor if after hours.

   b. Life-threatening emergencies go into the first available room with adjustments to the schedule made as soon as practical for the bumped cases(s) to follow.

   c. If the bumping surgeon has block time allocated at the time of the bump, he will bump himself.

d. If a sincere effort is made to contact the surgeon being bumped and the bumping surgeon is not able to reach him/her, inform the Director of Surgical Services and/or Clinical Manager and OR Charge Nurse or the Nursing Supervisor if after hours. The information will be documented.

e. Failure to inform the surgeon being bumped means that surgeon may elect to proceed with his/her case as originally scheduled.

f. If conflict occurs, the Anesthesiologist will render an opinion that takes precedence. If satisfactory resolution of the issue does not occur, the Chief of Surgery or the Chief of the Medical Staff will be contacted to arbitrate.

6. CANCELLATION OF CASES

Before any surgical cases are cancelled (rescheduled) due to bed unavailability, the following will be considered:

- Bed status throughout the hospital;
- Number of and requested placement for Emergency Room (ER) patients being held in admission;
- OR schedule for possible overnight or long-term admission;
- Elective cases with special circumstances (e.g., bowel preps, special equipment needs and supplies).

CROSS REFERENCE:

- Scope of Services for Surgical Service Policy

SUBJECT:	SECTION:
SCOPE OF OCCUPATIONAL THERAPY	***[Enter manual section here]***

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

PURPOSE:

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

POLICY:

DEFINITIONS:

1. Scope of Practice:

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

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

2. Types of Patients:

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

3. Age of Patients:

Middle Adult: 21 - 65 years

Late Adult: Over 65

4. Services:

Occupational Therapy services include, but are not limited to:

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

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

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

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

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

5. Hours of operation:

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

6. Department Goals:

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

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

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

7. Staffing Plan:

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

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

8. Qualification of staff

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

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

AFFECTED PERSONNEL/AREAS: *ALL OCCUPATIONAL STAFF*

REFERENCES:

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

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

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

PURPOSE:

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

POLICY:

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

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

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

D. LVNs are directly supervised by a registered nurse.

REFERENCE:

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

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

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

PURPOSE:

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

POLICY:

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

AFFECTED AREAS/PERSONNEL: *DP/SNF RESIDENTS*

PROCEDURE:

1. Residents with a known history of positive PPD reaction will be screened for TB with an annual chest x-ray.

2. Residents with no known history of positive PPD reaction will be screened for TB on admission with a questionnaire /chest x-ray and the two-step Mantoux test as follows:

   a. Intracutaneous administration of 5 units of purified protein derivative tuberculin (PPD).

   b. Read skin test within 48-72 hours of administration.

   c. If the skin test induration is = or > 10mm, the reaction is considered positive. Anything less than 10mm induration is considered negative unless clinical/historical information is significant. Record the results.

   d. Residents with a negative PPD skin test initially shall have a repeat skin test the following week to identify the booster phenomenon. The method of administration and reading is the same as the initial skin test.

3. PPD skin test results will be recorded on the resident's chart. Staff caring for residents with a positive PPD test result shall consider active TB as a differential diagnosis should the resident develop the signs/symptoms of active TB (persistent cough, night sweats, fever, weight loss, etc.)

4. All residents will be screened annually for TB. Residents with positive PPDs will have a chest X-ray completed annually.

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

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

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

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

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

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

REFERENCES:

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

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

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

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

SUBJECT: **SEASONAL INFLUENZA PLAN**	SECTION: **Page 1 of 5**

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

PURPOSE:

The purpose of the SVMC Seasonal Influenza Plan is twofold:

1. To implement prevention control measures to address seasonal influenza. The expected results are a reduction of cases with reduced severity of seasonal influenza cases.
2. To describe the processes that will ensure the safety of patients, visitors, volunteers and healthcare personnel in the event of severe seasonal influenza.

INTRODUCTION:

- Influenza (the 'flu') is a contagious viral respiratory illness. Influenza virus strains perennially circulate throughout the world. In this area, the influenza season can begin as early as October and continue through late May.
- The influenza virus can cause mild to severe illness, which may sometimes lead to death. The elderly, young children and individuals with specific health conditions such as metabolic diseases or a weakened immune system, etc., are at higher risk for serious complications from influenza. Research shows that the best way to prevent influenza is through yearly vaccination.
- Influenza is a disease that is transmitted by droplets expelled when an infected person coughs, sneezes or speaks. Less often, a person may contract influenza via fomite (surfaces that harbor viral particles) followed by touching their own face, especially the mouth, eyes or nose.
- Most individuals are able to transmit the influenza virus to others one day before symptoms appear and up to and through the 7th day after the appearance of symptoms.

POLICY:

- Sierra View Medical Center (SVMC) will monitor guidance and recommendations from the Centers for Disease Control (CDC), as well as state and local health officials, and may revise this flu season policy as more information becomes available.
- SVMC seeks to minimize the risk of influenza infection in patients, staff, students and visitors.
- The seasonal influenza plan and respiratory isolation precautions shall be implemented in the event of signs/symptoms of influenza.

AFFECTED AREAS/PERSONNEL: *ALL PATIENTS/VISITORS/STAFF*

PROCEDURE:

1. Visual alerts in Spanish and English will be posted in all appropriate entrances to the facility instructing all persons with signs/symptoms of infectious disease, especially respiratory, to:
   a. Inform reception and healthcare personnel when they first register for care that they may be infectious.

b. Practice respiratory hygiene/cough etiquette: covering mouth and nose when coughing or sneezing, using tissues and disposing of them correctly.

2. The waiting area will be set up to enable patients with respiratory symptoms to sit at least 3 feet away from other patients and visitors; if feasible.

3. Signs promoting respiratory hygiene/cough etiquette will be placed in areas such as patient rooms to serve as reminders to all persons in the facility. The signs will instruct persons to:

a. Cover the nose/mouth when coughing or sneezing.

b. Use tissues to contain respiratory secretions.

c. Dispose of tissues in the nearest waste receptacle after use.

d. Patients with respiratory signs/symptoms will be given masks upon entry to the facility with instructions to wear them until evaluated and admitted or discharged.

e. Perform hand hygiene after contact with respiratory secretions.

4. Personal protective measures:

a. Early self-isolation of those feeling ill, feverish and having other symptoms of influenza (e.g., coughing, sneezing)

b. Avoid close contact with sick people

c. Avoid touching one's eyes, nose or mouth

5. SVMC will provide appropriate materials in waiting areas for patients and visitors:

a. Surgical Masks
b. Tissues and waste receptacles for used tissue disposals.

c. Conveniently located dispensers of hospital-approved alcohol-based hand sanitizers.

d. Soap and disposable towels for hand washing where sinks are available.

e. If the condition is respiratory in nature and infectious, family members accompanying the patient will be asked to wear masks.

f. Visitors will be limited to those necessary for patient's emotional well-being and care.

g. Visitors will be required to wear surgical mask while visiting an infected patient.

h. Visitors will be instructed on hand hygiene practices (washing hands with soap and water or using alcohol-based hand sanitizer for at least 20 seconds).

6. SVMC staff, volunteers, healthcare personnel and students are required NOT to report to work if they have a fever greater than 100.4° Fahrenheit (38° Celsius), combined with one or more of the following symptoms:

- Cough
- Sore throat
- Runny or stuffy nose
- Body aches
- Headache
- Chills
- Fatigue
- Diarrhea
- Vomiting

7. Influenza-related complications may affect people over age 65 years and older, people with chronic medical conditions, pregnant women and young children and include:

- Bacterial pneumonia
- Otitis media
- Bronchitis and more

8. Prevention of illness:

a. SVMC endorses and encourages all healthcare personnel, staff, volunteer, and students to adhere to the guidance of the CDC to minimize the risk of becoming sick with seasonal flu. For instance:

- Get the influenza vaccination
- Practice good hand hygiene by washing hands often with soap and water or by using alcohol-based hand sanitizer, especially after coughing or sneezing.
- Practice good respiratory etiquette by covering the mouth and nose with tissue when coughing or sneezing. If a tissue is not available, the cough or sneeze should be directed into a sleeve, elbow, or shoulder, but **not into hands**. Avoid touching eyes, nose or mouth.
- Individuals who are sick with influenza-like illnesses (ILI) should stay home.

Health Care System and Provider Actions

- Vaccinate health care workers.

- Review plans and prevention strategies for seasonal influenza in the health care setting, including implementation of respiratory hygiene, appropriate management of ill staff, and infection control precautions.
- Coordinate with the CDC to identify likely influenza strains that could affect California during the next influenza season:
    1. CDC guidance can be found at: http://www.cdc.gov/flu/professionals/index.htm.
- Monitor any disease outbreaks with patients exhibiting upper-respiratory infections or symptoms of ILI.
- Monitor ILI-activity in hospital emergency departments for statistically significant warnings and threats.
- Conduct laboratory testing to identify and confirm any influenza cases prior to the beginning of influenza season or early influenza activity phase.
- Monitor and report adverse reactions to vaccine.

REFERENCES:

- Influenza (Flu), Centers for Disease Control and Prevention. https://www.cdc.gov/flu/index.htm Accessed August 28, 2023. Last reviewed August 24, 2023.
- Influenza (Flu), California Department of Public Health. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Influenza.aspx Accessed August 28, 2023. Last reviewed May 25, 2023.
- Influenza (Flu) Vaccine (Inactivated or Recombinant): What You Need to Know. https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html Accessed August 28, 2023. Last reviewed August 6, 2021.
- Grohskopf LA, Blanton LH, Ferdinands, et al. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2022–23 Influenza Season. MMWR Recomm Rep 2022; 71(No. RR-1): 1-28. ISSN: 1057-5987 (Print). Accessed Aug. 27, 2022. https://www.cdc.gov/mmwr/volumes/71/rr/rr7101a1.htm?s_cid=rr7101a1_w
- Influenza (Seasonal) 2018. Accessed August 29, 2022, from World Health Organization: https://www.who.int/en/news-room/fact-sheets/detail/influenza.
- Centers for Disease Control and Prevention. Chapter 12: Influenza, in Epidemiology and Prevention of Vaccine-Preventable Diseases (The Pink Book). Hall E., Wodi A.P., Hamborsky J., et al., eds. 14th ed. Washington, D.C. Public Health Foundation, 2021. Accessed August 27, 2022 at https://www.cdc.gov/vaccines/pubs/pinkbook/

SUBJECT: **SKIN CARE TIPS FOR NURSING ASSISTANTS**	SECTION:

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

PURPOSE:

The purpose is to assure skin integrity is maintained.

POLICY:

Sierra View Medical Center (SVMC) will utilize protocols for skin care to promote resident comfort and to provide preventive skin care measures.

AFFECTED PERSONNEL/AREAS: *CNAs*

PROCEDURE:

A. INCONTINENT:

1. Check residents at least every 2 hours for wetness. Change as needed. Make a point to check incontinent residents between other duties.
2. Wash perineal area and dry at each change.
3. Use diaper or padding under resident in bed or up in chair; not up between legs. Do not layer incontinent pads between resident and pressure relief devices.
4. Check for redness and report it to the licensed nurse.
5. Toilet residents that are up in chairs at least every 2 hours or according to individualized toileting schedule.

B. CONTACTURES:

1. Practice gentle handling of area; move slowly so you do not hurt the resident.
2. Wash skin gently with wash cloth, dry well and pat with a soft cloth.
3. Check resident's fingernails, and trim if needed so they do not cut into the palms of hands. Check for redness, and report it to the nurse.

C. PRESSURE INJURIES:

1. Turn resident every 2 hours or more often as needed.
2. Do not leave resident on reddened area longer than to bathe or feed.
3. If incontinent, change as soon as wet, wash and dry.
4. Do not rub reddened area.

5. Any change in skin condition should be reported to the nurse.

D. SKIN:

1. Never rub. Only pat to wash and to dry.
2. Dress slowly, so cloth does not pull skin.
3. Be careful during transfers.
4. Use lotion to keep skin lubricated.

E. SKIN FOLDS:

1. Wash and dry under every skin fold.
2. If a patient is obese, padding may be needed under breast or stomach.
3. If redness is found, report it to the licensed nurse.

F. GENERAL:

1. Tuck linen loosely over residents and pressure relief devices.

REFERENCES:

- California Code of Regulations (2021). Title 22. §72315 (5) (6). Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **SKIN PREPARATION FOR SURGICAL PATIENTS**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 5**

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

PURPOSE:

To establish guidelines for reducing resident microbial counts on the skin to as low as possible in the shortest period of time and with the least amount of tissue irritation and to inhibit rapid rebound growth of microbes.

POLICY:

The surgical team members shall be responsible for the guidelines set forth for achieving skin preparation of the operative site to reduce the risk of post-operative wound infection.

AFFECTED AREAS/PERSONNEL: *MAIN OR, AMBULATORY SURGERY DEPARTMENRT (ASD), MATERNAL CHILD HEALTH (MCH), OR-FLEX CARE/REGISTERED NURSE (RN)-OPERATING ROOM TECHNICIAN (ORT), MED/SURG, ICU/TELE*

EQUIPMENT:

Cordless Clipper, ClipVac, Prep Tray, Prepping Solutions

GUIDELINES:

1. Surgeon orders may indicate cleansing with an antiseptic agent the night before or morning of surgery.

2. The preoperative patient interview should include asking the patient questions regarding allergies and history to best determine the appropriate surgical prep and gloves used.

3. Per physician order, removal of hair shall be performed as near to the time of the operation as possible, preferably not in the operating room. (Please refer to "Hair Removal at Surgical Site" policy.)

    - Clip Vac and Cordless Clippers with disposable heads will be used for hair removal.
    - The prepared area needs to be large enough to accommodate extension of the incision, additional incisions, and all potential drain sites.

4. Specific criteria in the selection of an anti-microbial agent include, but are not limited to:

    a. Speed of action

    b. Spectrum of activity

    c. Skin irritation and/or sensitivity

d. Flammability characteristics

e. Documented incompatibilities

5. The operative site shall be prepared with an FDA-approved anti-microbial agent per physician preference, listed on the preference cards.

6. All agents are to be used following manufacturer's recommendations.

7. Exercise aseptic technique when performing skin prep prior to incision.

8. Always prep from clean to dirty area.

9. Do not allow prep solution to run into skin folds or pool under the patient.

10. Remove wet material from prep area. If using 4x4 gauzes to prep, discard them promptly to minimize confusion with counted sponges.

11. If antiseptic solution contacts the electrosurgical unit (ESU) dispersive electrode, replace the pad with a new one to dry skin surface.

12. When a stoma or other contaminated area is involved in the prep procedure -

a. A prep sponge soaked in the antiseptic agent is placed over the stoma when the prep is initiated

b. Prep the area around the stoma first

c. At the completion of the prep, discard the sponge

13. POVODINE-IODINE PREP:

a. Open a single-use sterile prep set

b. Put on sterile gloves

c. Scrub for a minimum of 5 minutes using a circular motion with the povidine-iodine scrub. Scrub begins at the incision site in a circular motion and proceeds toward the periphery. After the periphery is reached, the sponge is discarded into the kick bucket. (Note: A soiled sponge is never brought back over a scrubbed area.)

d. Blot the lather from the prep with a sterile towel.

e. Upon completion of the scrub procedure, paint the area with povodine-iodine solution.

f. Allow the area to dry for at least 3 minutes before draping the patient.

14. CHLORAPREP (Chlorhexidine gluconate 2% & Isopropyl alcohol 70%):

a. Do not use on:

- Children less than 2 months of age because of potential for excessive skin irritation and increased drug absorption
- Lumbar punctures or contact with meninges
- Mucous membranes; i.e., vaginal prep. Keep out of eyes, ears and mouth.
- Open skin wounds or as a general skin cleanser
- Do not use 26ml Applicator on Face or Neck

b. Pinch the wings on the applicator to break the ampule and release the antiseptic. Do not touch the sponge.

c. Dry surgical sites (such as abdomen or arm): Use repeated back-and-forth strokes of the applicator for approximately 30 seconds. Completely wet the treatment area with antiseptic. Allow the area to completely dry for 3 minutes (up to 1 hour if hair is prepped). Do not blot or wipe away.

d. Moist surgical sites (such as the inguinal fold): Use repeated back-and-forth strokes of the applicator for approximately 2 minutes. Completely wet the area with antiseptic. Allow the area to dry completely. Do not blot or wipe away.

e. It is recommended that ChloraPrep with tint remain on the skin – especially at the incision site – post-procedure, to provide maximum antimicrobial activity. If cleanup is preferred, the antiseptic can be removed with alcohol or soap and water.

15. SINGLE-FIELD STERILE-SCRUB, PREPARATION AND DWELL FOR LAPAROSCOPIC HYSTERECTOMY

- The standard abdominal perineal prep is performed starting with cleaning the debris from the apex of the umbilicus using cotton tipped applicators.
- A vigorous betadine scrub is performed, in sequence, on the abdomen, perineum, top third of the thighs, and vulva, and then the vaginal interior up to the cervix. The sponges are

discarded after swabbing the anus. The circulator is careful to swab the apical vagina and cervix. This scrub is repeated 5 more times.

- The standard abdominal perineal prep is then continued using betadine solution to paint, in sequence, the abdomen, perineum, top third of the thighs, vulva, vaginal interior up to the cervix, and posteriorly to the anus.

- Last, with the patient in a slight Trendelenburg position, 60ml of betadine solution is injected into the vaginal cavity. This leaves the iodine indwelling in the vaginal canal and on the cervix.

16. Burned, denuded or traumatized skin may be prepared with normal saline irrigation.

17. Open wounds and body orifices are potentially contaminated areas and are prepared after the surrounding unbroken skin is cleansed.

18. DOCUMENTATION: The pre-operative skin preparation of the patient shall be documented in the patient's record:

    a. The method of hair removal

    b. Time of removal and by whom

    c. The area prepared

    d. The development of any sensitivity

    e. Accidental nicks, cuts, or abrasions

    f. The anti-microbial agent(s) used.

REFERENCES:

- Association of Perioperative Registered Nurses (AORN) Standards and Recommended Practices, ~~2020~~ May 13, 2021.

- Chloraprep Applicator (2023.). Retrieved from ~~https://www.bd.com/en-us/offerings/capabilities/infection-prevention/skin-preparation/chloraprep-patient-preoperative-skin-preparation-products/chloraprep-applicators.~~

  https://www.bd.com/en-us/products-and-solutions/products/product-brands/chloraprep#inserviceresources

- ClipVac (2023). Retrieved from ~~https://www.bd.com/en-us/offerings/capabilities/infection-prevention/preprocedure-hair-removal/clipvac-presurgical-hair-removal-system.~~

  https://www.bd.com/en-us/products-and-solutions/products/product-families/clipvac-presurgical-hair-removal-system#inserviceresources

CROSS REFERENCES:

- Infection Control Surveillance in the Operating Room Policy
- Hair Removal at Procedural Site Policy

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

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

PURPOSE:

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

POLICY:

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

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

PROCEDURE:

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

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72319 (k) (1) (5) (2A & B), San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **STANDARDS OF CARE: INTERDISCIPLINARY TEAM ASSESSMENT**	SECTION: **Page 1 of 9**

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

PURPOSE:

To provide Standard of Care medically and psychologically, as a treatment guideline that specifies appropriate treatments and collaboration between medical professionals involved in the care and treatment of each resident.

To define 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.

To develop a plan of care to meet the needs of each resident. To establish a plan of care for any existing medical conditions or change in the residents' condition.

POLICY:

1. All residents admitted to the Distinct Part Skilled Nursing Facility (DP/SNF) Unit will be assessed weekly for 4 weeks and then monthly by the Interdisciplinary Team (IDT). These meetings will take into account the residents 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. Assessments are performed by each discipline within its scope of practice, state licensure laws, applicable regulations, or certification.

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

4. Care decisions will be based upon data and information gathered in assessments and reassessments. This data will be utilized in prioritizing resident care needs and selecting appropriate interventions during their stay but not limited to the IDT Meetings.

5. Prioritizing resident care will be as follows:

    a. Emergent needs

    b. Actual needs

    c. Potential needs

    d. Educational/ Spiritual needs

6. On admission, the resident and/or family/responsible party will be provided initial/baseline summary plan of care consisting of medications, goals, treatments and diet.

SUBJECT: **STANDARDS OF CARE: INTERDISCIPLINARY TEAM ASSESSMENT**	SECTION: **Page 2 of 9**

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

AFFECTED PERSONNEL/AREAS: *DIRECTOR, CLINICAL MANAGER, MEDICAL DIRECTOR, NURSING, RESPIRATORY THERAPY, NUTRITIONAL SERVICES, SPEECH THERAPY, SOCIAL SERVICES/ DESIGNEE, ACTIVITIES, CHAPLAIN, RESTORATIVE NURSES*

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

   o. Create a plan of care to meet the residents' needs and monitor medical conditions or changes

p. 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:

- The anticipated length of stay
- The complexity of nursing care needs
- The dynamics of the resident's condition(s)

q. Family involvement in the IDT Meetings will be encouraged/facilitated by the Social Service Designee (SSD). SSD will call, email and send an invitational letter to the resident and/or family in a timely manner prior to each meeting.

2. Reassessment by IDT Members

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
- To update existing care plans or develop a plan of care for any changes in the resident's condition
- Minimally every month and as deemed necessary related to a change in condition and change in the course of treatment

b. Documentation of the reassessment will be located on the unit-specific IDT form.

2. Reassessment by Care Plan Committee

a. The Care Plan Committee will meet at least on a weekly basis to review all care plans in place for each resident scheduled for that week.

b. The Care Plan Committee will update all existing and establish new care plans as needed to meet the needs of the individual resident on a monthly basis.

c. The Registered Nurse will also review, create, and update the care plans of the resident after each IDT Meeting in which changes were brought forth from the meeting and each week as she/he completes the resident's Weekly Summary.

RESPIRATORY CARE

1. Assessment

a. An assessment will be completed on a weekly basis for 4 weeks after admission and then monthly by a Respiratory Care Practitioner (RCP).

b. The resident is evaluated by:

- Diagnosis
- History
- Physical Assessment
- Clinical Data – ABG's, Pulse Oximetry, Breath Sounds, Chest X-ray
- Resident's ability to perform ordered procedures
- Necessary respiratory care changes

c. The assessment is made as to effectiveness of the residents' therapy and its appropriateness to the resident's condition and abilities. Treatments and resident's response are documented on the IDT form and care plans are updated if any changes occur.

NUTRITIONAL SERVICES

1. Assessment

a. Will be done on a weekly basis for four (4) weeks after admission and then monthly at the IDT Meetings. 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 and completed by a Registered Dietitian.

2. Reassessment

a. Residents will be reassessed and information will be documented on the IDT form by the Registered Dietitian.

- Assessment will be completed in collaboration with lab data ordered
- As deemed appropriate since last evaluation

- To monitor any weight variance which occurs
- When ordered by a physician
- Or more often as deemed necessary by the Registered Dietitian

SPEECH THERAPY

1. Assessment

a. Will be done within 5 days of admission and then as needed at IDT Meetings. All residents are screened for the need of further assessment. Residents needing assessments will be performed by a Speech Therapist (SLP) upon receipt of physician order (within 48 hours) and may include information from resident interview.

- Evaluation may include: Dysphasia, Cognition, and Communication

2. Reassessment

a. Reassessment of the functional status and needs are ongoing with each session given, to determine the resident's response to interventions. Information for reassessment will be gathered from residents and other healthcare professionals and physician input. Reassessment documentation will be located on the IDT form.

DISCHARGE PLANNING

1. Assessment

a. Will be done on a weekly basis for 4 weeks after admission and then monthly at the IDT Meeting. A Social Service Designee will assess residents when given notification by nursing, or upon review of the resident's medical record that indicate risk factors which warrant further discharge planning activities.

b. The resident is evaluated for:

- Diagnosis
- Physical ability
- 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 and documents discharge planning progress notes on the IDT form.

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 residents, families, other healthcare professionals, and physician input. Reassessment documentation will be located in the IDT form.

SOCIAL SERVICES

1. Assessment

a. Will be done on a weekly basis for 4 weeks after admission and then monthly at the IDT Meetings.

2. Reassessment

a. Information for reassessment will be gathered from residents, families, other healthcare professionals, and physician input. Reassessment documentation will be located on the IDT form.

ACTIVITIES

1. Assessment

a. Will be done weekly for four (4) weeks after admission and then monthly for IDT Meetings.

b. Will be assessed by the Activity Director or designee for:

- Changes in communication and ability to participate in activities
- Alertness
- Encouragement to engage in activities
- Decline in condition or refusal to participate

- Increase in activity and participation
- Room visits

2. Reassessment

a. Information for reassessment will be gathered from residents, families, other healthcare professionals, and physician input. Reassessment documentation will be located on the IDT form.

RESTORATIVE NURSING

1. Assessment

a. Will be done weekly for 4 weeks after admission and then monthly for IDT Meetings. The following will be monitored for any changes or needs:

- Contractures/ Tone
- Splints or orthotics of any kind
- Residents' responses to ROM/ Splinting
- Pain assessment with care

2. Reassessment

a. Information for reassessment will be gathered from residents, families, other healthcare professionals and physician input. Reassessment documentation will be located on the IDT form.

DECISION MAKING FOR UNREPRESENTED RESIDENTS (H & S CODE 1418.8)

a. If the attending physician /surgeon of a resident in a skilled nursing facility or intermediate care facility prescribes or orders a medical intervention that requires that informed consent be obtained prior to administration of the medical intervention, but is unable to obtain informed consent because the physician/surgeon determines, as per (b), that the resident lacks capacity to make decisions concerning his or her health care and that there is no person with legal authority to make those decisions on behalf of the resident, the physician/surgeon shall inform the skilled nursing facility or intermediate care facility.

b. To make the determination regarding capacity, the physician shall interview the patient, review the patient's medical records, and consult with skilled nursing or intermediate

care facility staff, as appropriate and family members and friends of the resident, if any have been identified.

c. For purposes of subdivision (a), a person with legal authority to make medical treatment decisions on behalf of a patient is a person designated under a valid Durable Power of Attorney for Health Care, a guardian, a conservator, or next of kin. To determine the existence of a person with legal authority, the physician shall interview the patient, review the medical records of the patient, and consult with skilled nursing or intermediate care facility staff, as appropriate, and with family members and friends of the resident, if any have been identified.

d. The attending physician and the skilled nursing facility or intermediate care facility may initiate a medical intervention that requires informed consent pursuant to subdivision (e) in accordance with acceptable standards of practice.

e. Where a resident of a skilled nursing facility or intermediate care facility has been prescribed a medical intervention by a physician / surgeon that requires informed consent and the physician has determined that the resident lacks capacity to make health care decisions and there is no person with legal authority to make those decisions on behalf of the resident, the facility shall, conduct an interdisciplinary team review of the prescribed medical intervention prior to the administration of the medical intervention. The interdisciplinary team shall oversee the care of the resident utilizing a team approach to assessment and care planning, and shall include the resident's attending physician, a registered professional nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, and, where practicable, a patient representative, in accordance with applicable federal and state requirements.

2. (a) A patient representative may include a family member or friend of the resident who is unable to take full responsibility for the health care decisions of the resident, but who has agreed to serve on the interdisciplinary team, or other person authorized by state or federal law.

(b) The interdisciplinary team shall periodically evaluate the use of the prescribed medical intervention at least quarterly or upon a significant change in the resident's medical condition.

(c) In case of an emergency, after obtaining a physician/surgeon's order as necessary, a skilled nursing or intermediate care facility may administer a medical intervention that requires informed consent prior to the facility convening an interdisciplinary team review. If the emergency results in the application of physical or chemical restraints, the interdisciplinary team shall meet within one week of the emergency for an evaluation of the medical intervention.

(d) Physicians/surgeons and skilled nursing facilities and intermediate care facilities shall not be required to obtain a court order pursuant to Section 3201 of the Probate Code prior to administering a medical intervention which requires informed consent if the requirements of this section are met.

(e) Nothing in this section shall in any way affect the right of a resident of a skilled nursing facility or intermediate care facility for whom medical intervention has been prescribed, ordered, or administered pursuant to this section, to seek appropriate judicial relief to review the decision to provide the medical intervention.

(f) No physician or other health care provider, whose action under this section is in accordance with reasonable medical standards, is subject to administrative sanction if the physician or health care provider believes in good faith that the action is consistent with this section and the desires of the resident, or if unknown, the best interests of the resident.

DEPARTMENT PROTOCOL

If unable to contact a resident's family or responsible decision maker by documented phone call attempts/ e-mails for 30 days, the facility will send three (3) Certified, Return Signature letters, one (1) week apart, to the current address on file. In the event of no return of the confirmation of receipt and no attempts to contact the facility have been made, the Ombudsman will be notified, an Adult Protective Services report for family search will be done , then referred to the Public Guiardian. The Interdisciplinary Team will then assume the responsibility for making decisions for the care, safety and best interests of the resident.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, §73523, San Francisco, California, Title 22. https://govt.westlaw.com/calregs/Document/IE5EFA840A39811E08822C131FF5E2170?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)#:~:text=CCR%20%C2%A7%2073523-.%C2%A7.Patients'%20Rights.&text=Patients%20shall%20have%20the%20right,and%20regulations%20governing%20patient%20conduct.

- Med Pass, Inc., (updated February 6, 2015) Facility Guide to OBRA Regulations, F272, #483.20, #483.20(b) United States of America, Med Pass Inc.

- Annals of Long Term Care and Aging, 2016; 24(4): 17-20, Richard G Stepanacci, DO, MGH, MBA, AGSF, CMD.,The Access Group, Berkeley Heights, NJ. California Department of Public Health (CDPH) All Facilities Letter (AFL) : 20-83

- IMPACT Act of 2014. (2014). https://www.govtrack.us/congress/bills/113/hr4994.

CROSS REFERENCE:

- SVMC DP/SNF Policy, Interdisciplinary Assessment and Reassessment

SUBJECT: **SURGICAL SERVICES ON-CALL SYSTEM**	SECTION: ***Leadership (LD)*** **Page 1 of 3**

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

PURPOSE:

To identify the surgical teams and scheduled availability for emergency cases.

POLICY:

The Surgical Services Department will provide on-call personnel to ensure that the needed services are available for the people of the community.

AFFECTED AREAS/ PERSONNEL: *ALL SURGICAL SERVICES STAFF/ANESTHESIA PROVIDERS*

PROCEDURE:

ANESTHESIA CALL COVERAGE

- Main OR-Anesthesiologist and/or Certified Registered Nurse Anesthetist
- Maternal Child Services OR-Certified Registered Nurse Anesthetist and/or Anesthesiologist

NURSING STAFF CALL COVERAGE

- The call schedule for each group (RNFA, RN, ORT, PACU RN, ENDOSCOPY RN, ENDOSCOPY TECH, Cardiac Cath Lab RN, and Interventional Radiology RN) is created through a collaborative effort of all involved parties. All staff are expected to cover for absent personnel and may be asked to accept additional call if patient needs arise. Personnel are not to take call the evening of a scheduled shift if they were absent due to illness, unless approved by the Manager or Director.

The schedule is typed by the Scheduling Secretaries. A handwritten copy of the daily on-call roster will be delivered and emailed to the Nursing Supervisor's office each day.

WEEKDAY CALL COVERAGE

- The Operating Room RN, RNFA, ORT starts at 1515 through 0645 the following day.
- The PACU RN starts at 1630 through 0700 the next day. When nurses other than PACU nurses (i.e. Maternal Child Services) perform recovery, the nurses recovering those patients will have met PACU competencies.
- Endoscopy RN and Endoscopy Tech starts at 1530 through 0000.
- Cardiac Cath Lab starts 1530 (or end of shift) through 2000, or when last patient is discharged.

WEEKEND/HOLIDAY CALL

- The Operating Room weekend call begins at 0700 Saturday morning and ends at 0645 on Monday morning. The weekends can be split as long as it is mutually agreed by all involved parties and approved by management. Holiday call begins at 0700 and ends at 0700 if a weekend day or 0645 on a weekday. Holiday call days are covered in an equitable manner.
- PACU weekend call begins at 0700 on Saturday morning and ends at 0700 Monday morning. Holidays are covered on a rotating basis and start at 0700 and end at 0700 the following morning. Endoscopy weekend/Holiday call begins at 0700 and ends at 0000 (midnight).

CENTRAL SERVICES CALL COVERAGE

- Central Processing department will have staff On Call and available from 2015-0545 Monday through Thursday and 2015-0830 on Friday. On Saturday the On Call CPD staff will be available from 0830-1750 and On Call from 1750-0830 on Sunday. On Sunday the CPD ON Call staff will be available from 0830-1750 and ON Call from 1750-0545 Monday. Central Processing's ON Call response time is 30 minutes.

CASE COORDINATION

- Regarding cases scheduled prior to 1700 on Monday through Friday for surgeries after hours, the Surgical Services Scheduling Secretaries will notify the on-call staff. The information will be communicated to the Nursing Supervisor before leaving for the day. All other after hour cases will be coordinated through the Nursing Supervisor with notification of on-call staff occurring through him/her.

TEAM AVAILABILITY

- A document is sent daily from Surgical Services (Friday's form includes information for Saturday and Sunday) to the House Supervisor with a list of who is on call, telephone and pager numbers. It is the employee's responsibility to notify the Supervisor of any number changes.

- The on-call team is available by telephone or pager (if pager is used, it is expected that the call is returned to the Surgery Scheduler/Nursing Supervisor, depending on the situation). It is also expected that the employee return to the hospital within 30 minutes of notification, with the exception of PACU and Endoscopy Call Teams, who will coordinate arrival time based on case start time. More immediate responses are indicated if the patient's condition is severely compromised.
- The type of case determines the team members required for a case. Extra personnel may be needed for complex cases (i.e., trauma, abdominal aneurysm).

- If surgery is scheduled for a specific time, the surgical team is expected to have the surgical suite prepared and the patient ready to enter the OR at least 15 minutes before the scheduled time, patient safety being the utmost concern.

- Check to ascertain that all additional services (i.e. Radiology, Blood Bank) are available for the case. Radiology requires as much notice as possible (45-60 min), as extra technicians are not on site. Lab does not deliver blood, so the Nursing Supervisor will need to facilitate the task.

COMMUNICATE WITH THE NURSING SUPERVISOR FOR THE FOLLOWING:

- Emergency Situations-He/she can provide assistance and/or secure resources. Inform him/her of necessity for ICU bed, changes in status, etc.

- Add on cases/cancelled cases-He/she needs the information to facilitate coordination of cases. The PACU nurse will be contacted at the same time as the call team by the house supervisor. This will ensure that all team members are aware of the case or cases to take place after hours. The PACU nurse will then coordinate an arrival time with the circulating nurse on call. This will ensure that the call team has a sufficient amount of staff members to care for the patient in the operating room.

REFERENCES:

- American College of Surgeons. facs.org. Quality Programs. Page 17. 1996-2021 https://www.facs.org/~/media/files/quality%20programs/trauma/vrc%20resources/1_chapter_23%20new%20criteria%20reference%20guide%20v1.ashx11.

CROSS REFERENCES:

- ~~PACU/FLEX Staffing Policy?~~
- —
- ~~Central Services Staffing Policy?~~

SUBJECT: **THERAPEUTIC DRUG SUBSTITUTION PROTOCOL**	SECTION: ***Clinical Pharmacy Drug Protocols*** **Page 1 of 11**

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

PURPOSE:

To promote cost effective, rational drug therapy by controlling the number of similar medications within a given therapeutic class that will be available on formulary.

POLICY:

A therapeutically equivalent drug may be dispensed following the development of objective interchange guidelines by the medical and pharmacy staff through the Pharmacy and Therapeutic Committee.

AFFECTED AREAS/PERSONNEL: *MEDICAL STAFF, PHARMACY, NURSING*

PROCEDURE:

The Pharmacy and Therapeutics Committee will identify potential therapeutic classes of medications, which may provide an opportunity for therapeutic interchange. Upon identification, experts in the area of therapeutic classification will be changed with selecting an appropriate therapeutic class representative drug. In making this selection, the following factors should be considered: mechanism of action, adverse effect profile, dosing schedule, monitoring parameters, potential drug interactions, and cost. Following the agent selection, objective interchange guidelines will be established and will be reviewed with other members of the medical staff.

The P&T Committee will review these guidelines. Following approval by P&T, the Medical Executive Committee of the institution will review and approve. Once approved the medications within "Non-Form" section will become non-formulary.

Medications with a DAW or dispense as written designation will be reviewed through the non-formulary process.

If patient has documented allergy to therapeutic substitute, the substitute will not take place.

DEFINITIONS:

1. Therapeutic Substitutions- Is the replacement of the originally prescribed drug with an alternative molecule with assumed equivalent therapeutic effect. The alternative drug may be within the same class or from another class with assumed therapeutic equivalence.

2. Biosimilar- FDA approved medication that is highly similar to the reference product. For approval, the structure and function of an approved biosimilar were compared to reference product and shown to have no clinically meaningful differences in safety, purity, or potency (safety and effectiveness) compared to the reference product.

Appendix A: Proton Pump Inhibitor

Pantoprazole (Protonix®) will be the preferred (medication substituted to) proton pump inhibitor at Sierra View Medical Center. Lansoprazole (Prevacid®) 30mg Solutabs may be used if PPI needed to be delivered via G-tube. Orders written for oral dexlansoprazole (Dexilant®), esomeprazole (Nexium®), lansoprazole (Prevacid®), omeprazole (Prilosec®) or rabeprazole (Aciphex®) are autosubstituetd by Pharmacy per the table below.

Preferred Agent					
Pantoprazole (Protonix®)	**Omeprazole (Prilosec®)**	**Esomeprazole (Nexium®**	**Rabeprazole (Aciphex®)**	**Lansoprazole (Prevacid®**	**Dexlansoprazole (Dexilant®)**
20mg daily	10mg daily	20mg daily	20mg daily	15mg daily	30mg daily
40mg daily	20mg daily	20mg daily	20mg daily	30mg daily	60mg daily
40mg BID	20mg bid or 40mg daily	40mg daily	20mg BID	30mg BID	30mg BID
80mg BID	40mg bid	80mg daily	40mg BID	60mg BID	60mg BID

Note: In the event of a drug shortage for Pantoprazole; Esomeprazole will be the substitute agent.

Appendix B: Nasal Corticosteroid Products

Substitutive Agent-Therapeutic Interchange	Non-Form
Fluticasone Nasal 1 spray each nostril daily	Beclomethasone Nasal, 1-2 spray each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Budesonide Nasal, 1-2 spray each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Flunisolide Nasal, 2 sprays each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Mometasone Nasal, 2 sprays each nostril daily
Fluticasone Nasal 2 spray each nostril daily	Triamcinolone Nasal, 2 sprays each nostril daily

Note: In the event of a drug shortage for Fluticasone nasal, Triamcinolone Nasal will be the substitute agent.

Appendix C: Inhaled Combination Medication Therapeutic Interchange

Substitutive Agent- Therapeutic Interchange	Non-Form
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Budesonide/Formoterol (Symbicort) 80/4.5 mcg 2 puffs BID 160/4.5 mcg 2 puffs BID
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID 500/50 mcg 1 puff BID	Fluticasone/Salmeterol(Advair HFA) 45/21 mcg 2 puffs BID 115/21 mcg 2 puffs BID 230/21 mcg 2 puffs BID
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Fluticasone/Vilanterol (Breo) 100/25 mcg daily 200/25 mcg daily
Albuterol MDI same dose and frequency plus Tiotropium (Spiriva Respimat) 2 INH daily	Ipratropium/Albuterol (Combivent)
Fluticasone/Salmeterol (Advair) 250/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Mometasone/Formoterol (Dulera) 100/5 mcg 2 puffs BID 200/5 mcg 2 puffs BID
Tiotropium (Spiriva Respimat) 2 inhalations (2.5mcg) daily	Tiotropoium (Spiriva Handihaler) Inhale contents of one capsule daily

Appendix D: Insulin Therapeutic Interchange

Substitutive Agent- Therapeutic Interchange	Non-Form
Insulin Lispro (Humalog) 1:1 conversion	Insulin Aspart (Novolog)
Insulin glargine 1:1 conversion	Insulin degludec (Tresiba)
Insulin glargine 1:1 conversion	Insulin detemir (Levemir)

Note biosimilar's for substitutive therapeutic interchange may be used.

Appendix E: Antihistamine agents

Substitutive Agent- Therapeutic Interchange	Non-Form
Loratadine (Claritin) 10mg daily	Cetirizine (Zyrtec) Oral 5mg or 10mg daily
Loratadine (Claritin) 10mg daily plus Equivalent Pseudoephedrine up to 60mg po QID	Cetirizine/Pseudoephedrine (Zyrtec-D) All doses
Loratadine (Claritin) 10mg daily	Desloratidine (Clarinex) Oral 5mg daily
Loratadine (Claritin) 10mg daily	Fexofenadine (Allegra) Oral all doses
Loratadine (Claritin) 10mg daily Equivalent Pseudoephedrine up to 60mg po QID	Fexofenadine/Pseudoephedrine (Allegra-D) All doses
Loratadine (Claritin) 10mg daily	Levocetirizine (Xyxal) Oral 2.5 to 5mg daily
Loratadine (Claritin) 10mg daily Equivalent Pseudoephedrine up to 60mg po QID	Loratidine/Pseduoephedrine (Claritin D)

Appendix F: HMG CoA Reductase Inhibitors

Substitutive Agent- Therapeutic Interchange	Non-Form
Atorvastatin (Lipitor) 5mg daily 10mg daily	Fluvastatin (Lescol) 40mg daily 80mg daily
Atorvastatin (Lipitor) 5mg daily 10mg daily 20mg daily	Lovastatin (Mevacor) 20mg daily 40mg daily 80mg daily
Atorvastatin (Lipitor) 20mg daily 40mg daily 80mg daily 80mg daily	Rosuvastatin (Crestor) 5mg daily 10mg daily 20mg daily 40mg daily
Atorvastatin (Lipitor) 5mg daily 10mg daily 20mg daily	Simvastatin (Zocor) 10mg daily 20mg daily 40mg daily
Atorvastatin (Lipitor) 5mg daily 10mg daily 20mg daily	Pitavastatin 1mg daily 2mg daily 4 mg daily

Note: In the event of a drug shortage for Atorvastatin, Simvastatin will be the substitute agent.

Appendix G: Angiotensin II Receptor Blocker

Substitutive Agent- Therapeutic Interchange	Non-Form
Losartan 25mg 50mg 100mg 150mg	Telmisartan (Micardis) 20mg 40mg 80mg >80mg
Losartan 25mg 50mg 100mg 150mg	Olmesartan (Benicar) 5-10mg ----- 20mg 40mg
Losartan 25mg 50mg 100mg 150mg	Irbesartan (Avapro) 75mg 150mg 300mg ---
Losartan 25mg 50mg 100mg 150mg	Candesartan (Atacand) 4-8mg --- 16mg 32mg
Losartan 25mg 50mg 100mg 150mg	Azilsartan (Edarbi) 40mg 80mg --- ---
Losartan 25mg 50mg 100mg 150mg	Eprosartan (tevetan) 400mg 600mg 800mg ---

Appendix H: Angiotensin Converting Enzyme (ACE)

Substitutive Agent- Therapeutic Interchange Equivalent Daily Dosage	Non-Form
Lisinopril 10mg (Max 40mg)	Benazepril 10mg
Lisinopril 10mg (Max 40mg)	Enalapril 5mg
Lisinopril 10mg (Max 40mg)	Fosinopril 10mg
Lisinopril 10mg (Max 40mg)	Moexipril 7.5mg
Lisinopril 10mg (Max 40mg)	Perindopril 4mg
Lisinopril 10mg (Max 40mg)	Quinapril 10mg
Lisinopril 10mg (Max 40mg)	Ramipril 2.5mg
Lisinopril 10mg (Max 40mg)	Trandolapril 2mg

Appendix I: Biosimilar Medications

Note- Preferred agents should be utilized for inpatient and outpatient use. If a patient's payer requires use of a non-preferred agent, the non-preferred biosimilar may be used.

Therapeutic Interchange (Preferred agent)	Reference Product	Comments
Alymsys (Bevacizumab- maly) Mvasi (Bevacizumab- awwb)	Avastin (Bevacizumab)	As required by payor
Ogivri (trastuzumab-dkst) Kanjinti (Trastuzumab-anns)	Herceptin (Trastuzumab)	As required by payor
Ziextenzo (pegfilgrastim-bmez)	Pegfilgrastim (Neulasta)	As insurance allows Pegfilgrastim biosimilar and products is NON-FORMULARY for inpatients. Filgrastim should be used for inpatients
Releuko (Filgrastim-ayow)- preferred Zarxio (Filgrastim-sndz)	Neupogen (Filgrastim)	As required by payor
Renflexis (infliximab-abda)- preferred Inflectra (infliximab-dyyb)	Remicade (Infliximab)	As required by payor
Retacrit- epoetin alpa-epbx	Procrit/Epogen- epoetin alpha	
Truxima (rituximab-abbs)- preferred Riabni (rituximan-arrx)	Rituxan-rituximab	As required by payor

Cancer Treatment Center Procedure:

If it is discovered that a patient's insurance rejects said biosimilar as part of the patient's treatment, the patient's care plan will be adjusted by the CTC pharmacist to reflect the approved agent. Example: Mvasi is rejected but insurance will cover Avastin→Pharmacist will be allowed by physician to make the adjustment in the patient's care plan.

1. Upon receipt of new care plan, CTC pharmacist will confirm with said list and if necessary, adjust the medication within the care plan to reflect the current approved medication from Addendum A if necessary to conform to insurance authorized and physician requested care plan.

2. After pharmacist adjustment in care plan, they will forward to insurance authorizer for approval. Once approved, Pharmacy will order as needed.

Dose Rounding for Continuous Infusion of Oncology Medications

1. Upon receipt of new orders for chemotherapy or biotherapy, the pharmacist will verify all calculations for dosage of agents ordered by the MD.
2. The pharmacist will evaluate the availability of the medications ordered. If the medication is available as a single use vial, the pharmacist shall calculate the difference in the dose ordered and the dose rounded to vial size.
3. For all single use vials of chemotherapy the pharmacist shall round the dose to a vial size within a 10% range of the dose ordered.
4. For all single use vials of monoclonal agents, the pharmacist shall round the dose to vial size within a 10% range of the dose ordered.
5. The provider will not be notified for dose changes of up to 5% for either chemotherapy or monoclonal agents.
6. The provider will be notified for dose changes greater than 5% and up to 10% for either chemotherapy or monoclonal agents.
7. Patients enrolled in clinical trials are excluded from the policy (unless dose rounding is specifically allowed in the investigational protocol)
8. If the physician does not wish to have the rounding policy applied, they will document on the order "no dose rounding" within the treatment plan within the administration instructions section.

Duplicate Orders

- Pharmacists may delete duplicate orders of the same medication, dose, and route with varying schedules. It will be assumed the new order with updated schedule is intended to replace the previous order (update frequency, dose, etc). E.g. Acetaminophen 650mg PO Q4HRS prn pain and Acetaminophen 650mg po Q6hrs prn pain. Pharmacist can authorize to delete the old order, and verify the new order while adding additional comments not to exceed 4gm/day as they see necessary.

Interchange between liquid and solid dosage forms

Pharmacists may automatically interchange between liquid and solid forms and route. EG patient is receiving medication and/or feedings via NG,OG,PEG; Pharmacist after discussion with patient's nurse will switch from oral to liquid form if available. Exception-Phenytoin with consult to patient practioner.

Therapeutic Duplications

Duplicate orders for the same indication are only appropriate if clear instructions around the circumstances each order applies to are indicated by the ordering practitioner. Any duplicative order without clear distinction will be assessed and addressed by the reviewing pharmacist.

Any parenteral (IV, IM, SQ) or rectal (PR) medication ordered as needed (PRN), will have direction added by pharmacist to "use when unable to tolerate oral" if another order for an oral alternative is ordered for the same as needed indication.

> Example: Order written for Ondansetron 4mg IV q8h prn Nausea/vomiting with an existing Ondansetron 4mg PO q8h prn Nausea/vomiting. Pharmacist to clarify in the comment field of the IV order: Ondansetron 4mg IV q8h prn Nausea/vomiting, use when unable to tolerate oral

> Example: Order written for Oxycodone 5mg PO q4h prn pain scale 4-7 with an existing Hydromorphone 0.4mg IV q4h prn pain scale 4-7. Pharmacist to clarify in the comment field: Hydromorphone 0.4mg IV q4h prn pain scale 4-7, use when unable to tolerate oral

Any order for a parenteral (IV, IM, SQ) as needed (i.e., PRN) opioid will be discontinued when a subsequent order for a parenteral PRN opioid is placed unless there is clear criteria included on the order for when to administer one opioid over the other (e.g. breakthrough pain).

> Example: Order written for HYDROmorphone (Dilaudid®) 0.5 mg IV q4h PRN pain 8-10 ordered on a patient with an existing order for Morphine 2 mg IV q4h PRN pain 8-10. Pharmacist will discontinue the existing Morphine order and validated the new HYDROmorphone (Dilaudid®) order.

Any order for a short-acting PRN oral opioid will be discontinued when a subsequent order for a short-acting oral PRN opioid is placed unless there is clear criteria included on the order for when to administer one opioid over the other (e.g. Breakthrough pain).

> Example: Order written for Oxycodone Immediate Release (IR) 5 mg PO q4h prn pain 8-10 ordered on a patient with an existing order for Tramadol (Ultram) 50 mg PO q4h prn pain 8-10. Pharmacist will discontinue the existing Tramadol order and validate the new Oxycodone order.

Any orders for parenteral or oral as needed (i.e. PRN) opioids will discontinued when a subsequent order for a PCA or epidural is placed unless a clear indication that both can be administered concurrently via an order clarified with the provider.

Any orders for parenteral or oral as needed (i.e. PRN) opioids will be left unvalidated if ordered at the same time as a PCA or epidural unless a clear indication that both can be administered concurrently via an order clarified with the provider. Upon PCA or epidural discontinuation, parenteral or oral as needed opioids will be validated.

Any orders with overlapping pain scales ordered at the same time will be clarified that the higher dose of medication is clarified to the higher pain scale as long as no medication is indicated for that pain scale.

> Example: Orders written for Oxycodone Immediate Release 2.5mg PO q4h prn pain 4-7 and Oxycodone Immediate Release 5mg PO q4h prn pain 4-7. Pharmacist will adjust the Oxycodone Immediate Release 5mg PO q4hr prn pain 4-7 to a pain scale of 8-10 upon validation.

Any orders with pain scales of 1-3 or 4-7 and no order or information that include the higher pain scales will be clarified to include the higher pain scale as long as no medication is indicated for that pain scale.

> Example: Order written for Tramadol 50mg PO q4hr prn pain 4-7. Pharmacist will adjust the Tramadol 50mg PO q4hr prn pain 4-7 to a pain scale of 4-10 upon validation.

Appendix: IV to PO Subsection

PURPOSE: To provide a process for changing parenteral medications to the oral/enteral route when medically appropriate. The advantages of this program are to provide an oral/enteral dosage form with comparable bioavailability to the intravenous form, which has been shown to decrease length of hospitalization.

To reduce the added risks associated with continued intravenous therapy.
To lower overall medication and associated costs to the patient and the hospital.

Additional benefits include greater patient comfort, decreased nursing needs, & easier ambulation. Orders for approved intravenous (IV) medications are automatically changed to PO (by mouth) administration form when medical staff approved conditions and guidelines are met, and the switch is appropriate.

PROCEDURE: Patients must meet the following criteria in order to be considered for automatic IV to PO conversion of the selected medications. If the patient does not meet all criteria listed below, they will not be considered for automatic IV to PO conversion.

Inclusion Criteria

- The patient must be on IV therapy for at least 24 hours before IV to PO conversion consideration.
- The patient is tolerating scheduled medications and diet (orally, or via NG or G tube).
- The patient is not on a pre-operative or -procedure or post-operative or -procedure fast.
- The patient has not experienced any recurrent nausea, vomiting or diarrhea for at least 24 hours.
- The patient does not have documented esophophageal sphincter incompetence.
- The patient does not have an active gastrointestinal bleed.

- The patient does not have documented problems with oral absorption (i.e., ileus, short bowel syndrome, celiac sprue, and inflammatory bowel disease or malabsorption syndrome).
- The patient is not at risk for aspiration (e.g., decreased consciousness, seizures, etc.).

Additional criteria for antibiotic/antifungal agents

- The patient is afebrile for at least 24 hours (temp < 100.4° F).
- The patient is clinically improving (white blood cell count decreasing, bands decreasing, improved signs and symptoms as documented in prescriber progress notes).
- The infection is at a site where an oral agent will achieve an adequate level (not endocarditis, meningitis, brain abscess, orbital cellulitis, other CNS infections, osteomyelitis, and endophthalmitis).
- The patient is not septic, and is hemodynamically stable (heart rate ≤ 100 beats/minute, respiratory rate ≤ 24 breaths/minute, and systolic blood pressure > 90 mm Hg without vasopressor support).
- For documented fungemia, fluconazole will continue IV for 7 days before PO switch.

The pharmacist may automatically switch the following medications to the oral dosage form, if the conditions under section 1 of this policy are met:

Antimicrobials

Medication	Intravenous Dose	Oral Equivalent
Azithromycin	250 mg IV daily 500 mg IV daily	250 mg PO daily 500 mg PO daily
Ciprofloxacin	200 mg IV every 12 hours 400 mg IV every 12 hours 400 mg IV every 8 hours	250 mg PO every 12 hours 500 mg PO every 12 hour 750 mg PO every 12 hours
Clindamycin	600mg-900mg IV every 8 hours	300mg-450 mg PO every 8 hours
Doxycycline	100 mg IV every 12 hours	100 mg PO every 12 hours
Levofloxacin	250 mg IV daily 500 mg IV daily 750 mg IV daily	250 mg PO daily 500 mg PO daily 750 mg PO daily
Fluconazole	100 mg IV daily 200 mg IV daily 400 mg IV daily	100 mg PO daily 200 mg PO daily 400 mg PO daily
Linezolid	600 mg IV every 12 hour	600 mg PO every 12 hours
Metronidazole	500 mg IV every 8 hours	500 mg PO every 8 hours
Rifampin	600 mg IV daily	600 mg PO daily
Trimethoprim / Sulfamethoxazole (TMP/SMX)	5-20 mg TMP/kg/day in 3-4 divided doses IV	As close to 1:1 conversion of TMP as possible: 1 double strength = 160 mg TMP 1 single strength = 80 mg TMP
Voriconazole	3-4 mg/kg IV every 12 hours (maintenance dose)	<40 kg: 100 mg PO every 12 hours ≥40 kg: 200 mg PO every 12 hours

Others

Medication	Intravenous Dose	Oral Equivalent
Acetaminophen IV (Ofirmev) (restricted only for those with strict NPO)	IV to PO is equivalent	Same dose regimen and frequency. May need to adjust in multiples of 325mg. IV acetaminophen doses limited to 2 doses for PRN orders and 4 doses for scheduled orders.
Famotidine **Ranitidine**	20 mg IV every 12 hrs. 50 mg IV every 6 or 8 hrs.	20 mg PO every 12 hours 150 mg PO every 12 hours

Pantoprazole	40 mg IV daily	40 mg PO daily (lansoprazole 30mg NG daily)
Folic Acid	1mg IV daily	1mg PO daily
Levetiracetam	500 mg IV every 12 hours	500 mg PO every 12 hours
Metoclopramide	10 mg IV every 6 hours PRN	10 mg PO Q6H every 6 hours PRN
Thiamine	100 mg IV daily	100 mg PO daily
Multivitamin	10 ml IV daily	1 tablet PO daily

The pharmacist will review the criteria and effect the change when appropriate. He/She will enter an order in the patient's chart under "Physician Orders" as "Change I.V. (*insert drug name*) to P.O. per protocol". The notation "Per SVMC Policy" will be entered or written adjacent to the pharmacist's signature.

REFERENCES:

- CMS Standards for Conditions of Participation guidelines on Antibiotic Stewardship beginning on July 1, 2015. (**HSC §1288.8 (a)(3)**)
- Johnston A, Asmar R, Dahlöf B, Hill K, Jones DA, Jordan J, Livingston M, Macgregor G, Sobanja M, Stafylas P, Rosei EA, Zamorano J. Generic and therapeutic substitution: a viewpoint on achieving best practice in Europe. Br J Clin Pharmacol. 2011 Nov;72(5):727-30. doi: 10.1111/j.1365-2125.2011.03987.x. PMID: 21486316; PMCID: PMC3243005. Accessed December 12, 2022.
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- Medicare Prescription Drug Improvement and Modernization Act (MMA), December 2003 creation of Medicare Part D and Medication Therapy Management Services.
- Nesbit TW, Shermock KM, Bobek MB, et. al. Implementation and pharmacoeconomic analysis of a clinical staff pharmacist practice model. Am J Health-Syst Pharm 2001 May 1; 58(9):784-90
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SUBJECT: **TREATMENTS RELATED TO MEDICATION-CNA**	SECTION: **Page 1 of 1**

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POLICY:

It is the policy of this facility that a Certified Nurse Assistant may administer medicated shampoos (OTC only) and non-prescription, topical ointments, creams, lotions, and solutions to areas of unbroken skin.

AFFECTED PERSONNEL/AREAS:

DIRECTOR OF STAFF DEVELOPMENT, CERTIFIED NURSE ASSISTANTS (CNAs)

PROCEDURE:

1. CNA will follow the procedure in the Nursing Policy and Procedure Manual (Medication Administration).

2. CNA will be in-serviced by the Director of Staff Development (DSD) on the procedure.

3. CNA will give a satisfactory return demonstration to the Director of Staff Development or another licensed nurse.

4. Documentation of a satisfactory level of performance will be kept in an Education Binder with the DSD.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72313, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT:	SECTION:
VERBAL & TELEPHONE ORDERS –PERSONS PERMITTED TO ACCEPT, READBACK, and AUTHENTICATION OF	***Record of Care, Treatment and Services*** **Page 1 of 4**

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

PURPOSE:

To define the organization's implementation of CMS 482.23 regarding the receipt of telephone or verbal orders from licensed independent practitioners (LIP) to include the following:

- Limitations and/or prohibitions on use of verbal orders
- Mechanisms to ensure the authenticity of the practitioner issuing a verbal or telephone order
- Elements required for inclusion in the verbal order process
- Situations in which a verbal or telephone orders may be used
- Organizational personnel authorized to receive and write a verbal or telephone order
- Requirements of organizational staff to read back verbal orders and confirm their read back using approved format

POLICY:

It is the position of the organization's leadership and the Medical Staff that verbal and telephone orders are allowed. However, in an effort to reduce errors, the use of these types of orders are discouraged except in situations when delay in treatment could compromise patient safety as listed below.

AFFECTED PERSONNEL/AREAS: *ALL REGISTERED/LICENSED STAFF; ALL PATIENT CARE AREAS*

PROCEDURE:

Limitations and/or prohibitions on the use of verbal orders

Prescribers are encouraged to enter all orders for medications, treatments and procedures 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, such as in surgery or the emergency department.

Mechanism to ensure the authenticity of practitioner

If the person receiving the order is unfamiliar with the voice of the practitioner issuing the order, the person authorized by the organization to receive orders should:

- Go to hospital intranet and verify practitioner on staff.
- Ask the practitioner if you may put them on speaker for others to offer authenticity verification.

- If unable to verify through above methods, provide a fax number for physician to send a written, timed, dated, and signed order.

Elements required for inclusion in the verbal order process

Electronic

1. Enter/Select appropriate provider giving the verbal/telephone order.
2. Enter the Order Source of Telephone Order Read Back or Verbal Order Read Back from the list, as appropriate.
3. Begin typing the name of the order/medication in the search field and select the appropriate option provided. Edit order details, as necessary.

Paper

All orders are entered directly into the electronic order management system. However, if the system is unavailable, such as during a system downtime event, staff are to utilize paper orders and, when writing the telephone or verbal order, must ensure the following is documented:

1. The date and time the order is prescribed verbally or via telephone
2. The name of the individual prescribing the drug, treatment, dietary order, or laboratory test, followed by the first initial, last name and licensure of the individual taking the verbal or telephone order.
3. Medication orders shall include the following information:
    a. Date and time the order is prescribed verbally or via telephone
    b. The name of the individual prescribing the drug
    c. The name of the drug
    d. Drug dosage (strength or concentration)
    e. Quantity and/or duration
    f. Route drug is to be administered
    g. Frequency of administration
    h. Specific indications for use, as appropriate (e.g. all PRN orders)

i. Name and level of licensure of the individual receiving and documenting the order

Situations in which verbal and telephone orders may be used

- The prescribing practitioner has determined that the patient is in need of medication within a specific time period and he/she is unable to physically enter the order in the patient's medical record due to his/her physical location.
- To delay the medication, treatment, dietary order, or laboratory test would not be in the best interest of the patient's plan of care and treatment and therefore expedient ordering is necessary.
- The prescribing practitioner has determined that the patient is in need of medication, treatment, dietary or laboratory order in an urgent or emergent situation where verbal or telephone communication presents the swiftest method of accomplishing the order.

Persons authorized to accept and write a verbal or telephone order

- Registered Nurse
- Licensed Vocational Nurse
- Registered Pharmacist as per protocols established by the Medical Staff, as well as for clarification of medication orders received by licensed practitioner
- *Registered Dietitian if approval obtained from Interdisciplinary Practice Committee*
- Registered Respiratory Therapist (within the sphere of competence)
- Physical Therapist (within the sphere of competence)
- Clinical Laboratory Scientist, phlebotomist, lab clerical (within the sphere of competence)
- Registered Radiological/Imaging Technician, Nuclear Medicine Technician (within the sphere of competence)

Requirements for telephone order/verbal order read back

To prevent errors related to verbal/telephone orders, all individuals licensed and approved by this hospital to receive and record these types of orders must strictly observe the following practices when performing this function:

- Obtain all appropriate criteria information for verbal/telephone orders as listed above.

Repeat back to the provider the information given to confirm accuracy. During the read back, the person receiving the order should not use any abbreviations. If the order is received for "BID" frequency, the receiver will read the order back "to be administered or drawn twice daily or two times per day".

- Enter the order directly into the electronic order management system, following the process outlined above.

  During a system downtime, use paper orders and write down the complete order on the physician's order sheet of the specific patient's medical record and read back to the physician for confirmation. The written order must indicate "TORB" for telephone order read back and "VORB" for verbal order read back with the name of the licensed independent practitioner (LIP) giving the order and the signature and title of the person who received the order. At no time is the receiver to record the order using unapproved abbreviations, range orders or metric symbols.

- The telephone or verbal order must be countersigned by the LIP within 48 hours as defined in the Medical Staff Health Information Management Rules and Regulations.

- If the order requires correction, the person questioning the original order must contact the LIP for clarification, then discontinue the original order within the order management system, indicate the reason for cancellation and enter the new clarified order. If using paper orders, the person who received the clarification order must utilize the next space below the original order and write "Order Clarification" followed by the new order reflecting the correction.

REFERENCES:

- California Department of Public Health, Title XXII §70263 (g)

- The CMS Interpretive Guidelines for the Hospital Conditions of Participation. (2014) HCPro, Marblehead, MA.

- Cohen, Michael R. (2005 2010). Medication Errors. American Pharmaceutical Association, Washington DC.

- The Joint Commission (2023). TJC Laboratory & Point-of-Care Testing Standards. Joint Commission Resources. Oak Brook, IL. DC.01.02.01. EP 7, DC.01.02.01. EP 9

CROSS REFERENCES:

- *Abbreviations in the Medical Record*– House-Wide Policy & Procedure Manual

- *Requisitions, Collecting, Analysis & Reporting* – Laboratory Standard Operating Procedure Manual

SUBJECT:	SECTION:
WAIVED & POINT OF CARE TESTING: BINAXNOW INFLUENZA A & B WITH DIGIVAL	*Waived Testing*

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INTENDED USE

The BinaxNOW Influenza A & B Card 2 is an *in vitro* immunochromatographic assay for the qualitative detection of influenza A and B nucleoprotein antigens in nasopharyngeal (NP) swab and nasal swab specimens. It is intended to aid in the rapid differential diagnosis of influenza A and B viral infections. Negative test results are presumptive and should be confirmed by cell culture an FDA-cleared influenza A and B molecular assay. Negative test results do not preclude influenza viral infection and should not be used as the sole basis for treatment or other patient management decisions. BinaxNOW Influenza A & B Card 2 must be read by the DIGIVAL.

SUMMARY AND EXPLANATION OF THE TEST

The BinaxNOW Influenza A & B Card 2 provides a simple, rapid method for the diagnosis of influenza a dn B using NP swab and nasal swab specimens. The easy-to-use format and rapid results allow for its use in "STAT" testing where it can provide information to assist with treatment and hospitalization decisions.

POLICY

A. The BinaxNOW Influenza A & B Card 2 will be utilized in the Emergency Department only, for the rapid detection of Influenza A & B.

B. Nursing personnel performing influenza A & B testing will be trained utilizing this policy and procedure and complete a competency prior to performance. Training will include reading Waived and Point of Care Testing – BinaxNOW Influenza A & B with Digival policy.

C. Nursing personnel will have competency validated initially and annually.

D. Emergency Department will maintain records of all individuals who have completed training and competency validation.

E. Quality Control procedures will be completed with each new shipment received and once for each untrained operator. Emergency Department is responsible for completing the Quality Control on each new shipment and keeping a log. Emergency Department is responsible for ensuring a quality control is completed with each newly trained operator during their training and competency validation upon hire.

F. DIGIVAL meter will be calibrated every 30 days. Emergency department will complete calibration and keep a log.

AFFECTED PERSONNEL/AREAS: *EMERGENCY DEPARTMENT REGISTERED NURSES, LICENSED VOCATIONAL NURSES, AND EMERGENCY DEPARTMENT TECHNICIANS*

EQUIPMENT:

- Test card
- Transfer pipette

- Nasal swab
- DIGIVAL meter

PRECAUTIONS:

A. For *in vitro* diagnostic use.

B. Leave test card sealed in its foil pouch until just before use.

C. When using the DIGIVAL, to prevent tearing through the barcode, do not open the foil pouch prior to scanning or entering manually the Test Device ID.

D. Do not use kit past its expiration date.

E. Do not mix components from different kit lots.

F. Any labels or writing placed on the front of the card should be contained within the 2 lines provided on the right side of cared face, to reduce interference with the DIGIVAL. Do not write on or cover the barcode on the front of the test card prior to inserting into the DIGIVAL.

G. The **WHITE** sample pad at the top of the test strip contains reagents that extract the target antigen from the virus. To ensure optimum performance, add the sample to the **TOP HALF** of this pad such that all of the sample volume absorbs into the pad.

H. Solutions used to make the control swabs are inactivated using standard methods. However, patient samples, controls and test cards should be handled as though they could transmit disease. Follow standard precautions when handling patient samples and reagents.

I. INVALID RESULTS can occur when an insufficient volume of specimen is added to the test cards. To ensure delivery of an adequate volume, make certain that the lower shaft of the transfer pipette is full and does not contain air spaces before dispensing contents of the pipette onto the Sample Pad of the card. If air spaces are present, expel the specimen back into the container by squeezing the top bulb and redraw the specimen into the pipette. Use a new pipette if necessary.

J. All transfer pipettes and elution solution vials are single use items – do not use with multiple specimens.

K. Elution solution contains Triton X-100 and Proclin 300. Warning: may cause an allergic skin reaction, causes serious eye irritation. Safety data sheets for this product are available on the hospital intranet site.

L. For result interpretation, DO NOT read results visually; results must be read by the DIGIVAL.

STORAGE AND HANDLING:

A. Kits must be stored at 2-30° C.

B. The BinaxNOW Influenza A & B Card 2 kit and reagents are stable until the expiration dates marked on their outer packaging and containers.

SPECIMEN COLLECTION AND HANDLING:

A. Use freshly collected specimens for optimal test performance. Inadequate specimen collection or improper sample handling/transport may yield a false-negative result.

B. Samples should be tested as soon as possible after collection. If swab specimens cannot be immediately eluted after collection, the swab is to be returned to its respective sheath and may be store up to four (4) hours at room temperature. If the swab sample will be held longer than 4 hours, specimens may be refrigerated at 2-8° C and tested within 24 hours from the time of sample collection.

TEST PROCEDURE:

Part 1 – DIGIVAL meter Set up

A. Turn on the DIGIVAL by pressing power button. Wait for approximately 10 seconds for the instrument start up sequence.

B. Enter Operator ID by placing Operator ID barcode under scanner or entering manually with the keyboard. Enter Operator Password and confirm by pressing "OK".

C. Tap "Read Test" on the DIGIVAL menu, this starts the reading process.

D. Enter Test Device ID by placing the barcode on the fo9il pouch under scanner or entering manually with the keyboard.

E. Enter Patient ID by scanning barcode on Patient ID band or entering manually with the keyboard.

F. Confirm the data entry of Operator ID, Patient ID and Test Device ID on the screen then tap "OK" to confirm.

Part 2 Test Procedure

G. BinaxNOW Elution Solution vials are pre-filled. Twist off the vial cap.

H. Put the swab to be tested in the vial. **Rotate the swab three (3) times in the liquid** while pushing vigorously against the bottom of the vial. Minimize bubbles.

I. **Push the swab against the side of the vial** and turn as you remove it from the vial. This removes sample from the swab. Discard the swab into a biohazard waste container.

J. Test the liquid sample (from the test vial) in the BinaxNOW Influenza A & B Card 2 as soon as possible.

K. Remove card from the foil pouch **just prior to testing** and lay flat on the work bench.

L. Fill pipette by firmly squeezing the top bulb and then placing pipette tip into sample. Slowly release bulb while tip is still in the sample. This will pull liquid into the pipette. Make sure there are no air spaces in the lower part of the pipette.

M. See arrow on test card to find the **WHITE** sample pad at the top of the test strip. Add entire contents of pipette in a continuous flow to the **TOP HALF** of this pad by squeezing the top bulb such that all of the sample volume absorbs into this pad. **DO NOT** add sample to the pink/red colored pad. If the sample is added to the incorrect location on the test strip, the test should be discarded. Repeat the test using a new test device and ensure the sample is added to the correct location on the test strip.

N. Peel off adhesive liner from the right edge of the test card. Close and securely seal the card by pressing the right edge of the test card.

Part 3 – Reading the Results

O. Read Now Mode: Once card is securely closed, wait 15 minutes. At the 15 minute read time open the DIGIVAL drawer, insert the Binax NOW Influenza A & B Card 2 test into the drawer with the barcode and result window facing up and close the drawer.

P. WAIT until the result is displayed on the screen. DO NOT OPEN THE DRAWER until Test Results appear on the screen.
NOTE: Do not read test results before or after 15 minutes as they may not be correct.

Q. If using a Printer, tap "Print" to print test results.

R. Open the drawer, remove and discard the used BinaxNOW Influenza A & B Card 2 Test and clse the drawer. The Home screen will automatically appear. DO NOT REINSERT TEST DEVICE ONCE A RESULT HAS BEEN OBTAINED.

RESULT INTERPRETATION:

A. Influenza A Positive/Negative
Influenza B Positive/Negative
Results will be automatically displayed on the DIGIVAL screen. Results will be interpreted as positive or negative for Influenza A and Influenza B in addition to the procedural control line status.

B. Invalid Test. If the test is invalid, another specimen should be collected and tested.

C. Co-infection Result: Co-infection with influenza A and B is very rare. A clinical specimen that generates positive results for both influenza A and B on the BinaxNOW Influenza A & B Card 2 Test should be considered an invalid result and another specimen should be collected and tested. If the test result is again positive for influenza A and B, the specimen should be re-tested by another method prior to reporting the results.

COMPETENCY ASSESSMENT

A. All Operators must read the "Waived & Point of Care Testing: BinaxNOW Influenza A & B with Digival" policy and complete training and competency validation during initial training.

B. Competency validation is completed at orientation and annually using at least two of the following methods:
   1. Observation of test performance
   2. Written test
   3. Each user's quality control performance is monitored
   4. Performing a test on a blind specimen

C. Only approved operators are allowed to perform the test and report results.

D. Competency validation is tracked electronically in the learning management system and in employee e-files.

QUALITY CONTROL:

A. The BinaxNOW Influenza A & B Card 2 has built-in procedural controls.

   1. An untested card has a blue line at the "Control" position. If the test flows and the reagents work, this blue line will always turn pink in a tested card.

   2. If the blue control line is not present on the test strip before use DO NOT use the test. Discard the test and use another test card from the test kit.

B. External Positive and Negative Controls

   1. External Positive and Negative Quality Control procedures will be completed with each new shipment received and once for each untrained operator. BinaxNOW Influenza A & B Card 2 kits contain Influenza A & B Positive and Viral Negative Control swabs. The influenza A and B Positive Control swab should generate a positive result for both Influenza A and B. When read by the DIGIVAL, the positive result will be displayed as "Passed".

   2. Emergency Department is responsible for completing the Quality Control on each new shipment and keeping a log.

3. Emergency Department is responsible for ensuring a quality control is completed with each newly trained operator during their training and competency validation upon hire.

4. Quality Control procedure

    a. Turn on the DIGIVAL meter. Wait for approximately 10 seconds for the instrument start up sequence.

    b. Enter Operator ID by scanning employee ID barcode or manually entering with the keyboard.

    c. Tap "Read QC Test" on the DIGIVAL menu. This starts the reading process.

    d. Enter Test Device ID by placing the barcode on the foil pouch under scanner or entering manually with the keyboard.

    e. Select the Positive or Negative control to be tested and tap "OK" to continue.

    f. Confirm the data entry of Operator ID, Test Type, Control Type and Test Device ID on the screen then tap "OK" to confirm.

    g. Follow the "Part 2 Test Procedure" above.

    h. Confirm Control test Passed. Repeat quality control procedure for the positive or negative control swab. Both Positive and Negative controls should be tested.

    i. Log Quality Control performance on Quality Control Log.

5. If the correct control results are not obtained, do not report patient results. Contact Technical Service 1-888-735-5317 during normal business hours.

LIMITATIONS OF THE PROCEDURE:

A. A negative test result does not exclude infection with influenza a and/or B. Therefore the results obtained with the BinaxNOW Influenza A & B Card 2 should be used in conjunction with clinical findings to make an accurate diagnosis.

B. The BinaxNOW Influenza A & B Card 2 detects both viable and non-viable influenza A and B. Test performance depends on antigen load in the specimen and may not correlate with cell culture performed on the same specimen.

C. False negative results may occur if a specimen is improperly collected, transported or handled. False negative results may occur if low levels of viruses are present in the specimen.

D. Performance of the BinaxNOW Influenza A & B Card 2 has not been established for monitoring antitiviral treatment of influenza.

E. Individuals who have received nasally administered influenza A vaccine may test positive in commercially available influenza rapid diagnostic tests for up to three days after vaccination.

F. Positive and negative predictive values may vary depending on the prevalence and population tested.

G. The test has not been evaluated for patients without signs and symptoms of influenza infection.

REFERENCES:

Abbot (2019). BinaxNOW Influenza A & B Card 2 with Digival Manufacturer's instructions.

CROSS REFERENCES:

Waived and Point of Care Testing: Competency and Quality policy

SUBJECT: **WAIVED & POINT OF CARE TESTING: COVID-19 AG**	SECTION: ***Waived Testing*** **Page 1 of 5**

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

INTENDED USE

The BinaxNOW™ COVID-19 Ag Card is a lateral flow immunoassay intended for the qualitative detection of nucleocapsid protein antigen from SARS-CoV-2 in direct anterior nasal (nares) swabs from individuals suspected of COVID-19 by their healthcare provider within the first seven days of symptom onset. Positive results indicate the presence of viral antigens, but clinical correlation with patient history and other diagnostic information is necessary to determine infection status. Negative result should be treated as presumptive and confirmation with a molecular assay, if necessary, for patient management, may be performed.

SUMMARY AND EXPLANATION OF THE TEST

BinaxNOW COVID-19 Ag Card is a rapid lateral flow immunoassay for the qualitative detection and diagnosis of SARS-CoV-2 directly from nasal swabs, without viral transport media. The BinaxNOW COVID-19 Ag Card kit contains all components required to carry out an assay for SARS-CoV-2.

POLICY

A. The BinaxNOW COVID-19 Ag Card will be utilized in the Emergency Department only, for the rapid detection of COVID-19.

B. Nursing personnel performing COVID testing will be trained utilizing this policy and procedure and complete competency prior to performance. Training will include reading Waived and Point of Care Testing: BinaxNOW COVID-19 Ag Card policy.

C. Nursing personnel will have competency validated initially and annually.

D. Emergency Department will maintain records of all individuals who have completed training and competency validation.

E. Quality Control procedures will be completed with each new shipment received and once for each untrained operator. Emergency Department is responsible for completing the Quality Control on each new shipment and keeping a log. Emergency Department is responsible for ensuring a quality control is completed with each newly trained operator during their training and competency validation upon hire.

AFFECTED PERSONNEL/AREAS: *EMERGENCY DEPARTMENT REGISTERED NURSES, LICENSDED VOATIONAL NURSES, AND EMERGENCY ROOM TECHNICIANS*

EQUIPMENT:

- Test card
- Nasal swab
- Extraction reagent

PRECAUTIONS

A. For *in vitro* diagnostic use.

B. Leave test card sealed in its foil pouch until just before use. Do not use if pouch is damaged or open.

C. Do not use kit past its expiration date.

D. Do not mix components from different kit lots.

E. Do not reuse the used test card.

F. Solution used to make the positive control swab are non-infectious. However, patient samples, controls, and test cards should be handled as though they could transit disease. Observe established precautions against microbial hazards during use and disposal.

G. INVALID RESULTS can occur when an insufficient volume of extraction reagent is added to the test card. To ensure delivery of adequate volume, hold vial vertically, 1/2 inch above the swab well, and add drops slowly.

H. False Negative results can occur if the sample swab is not rotated (twirled) prior to closing the card.

I. Swabs in the kit are approved for use with BinaxNOW COVID-19 Ag Card. **Do not use other swabs.**

J. The extraction reagent packaged in this kit contains sale, detergents and preservatives that will inactivate cells and virus particles. Samples eluted in this solution are not suitable for culture.

STORAGE AND STABILITY

A. Store kit at 2-30°C.

B. Ensure all test components are at room temperature before use.

SPECIMEN COLLECTION AND HANDLING

Test specimens immediately after collection for optimal test performance. Inadequate specimen collection or improper sample handling/storage/transport may yield erroneous results.

TEST PROCEDURE

A. Open the test card just prior to use, lay it flat, and perform assay as follows:

1. Hold Extraction Reagent bottle vertically. Hovering 1/2 inch above the **TOP HOLE**, slowly add **6 drops** to the **TOP HOLE** of the swab well. **DO NOT** touch the card with the dropper tip while dispensing.

2. Insert sample into **BOTTOM HOLE** and firmly push upwards so that the swab tip is visible in the **TOP HOLE**.

3. Rotate (twirl) swab shaft 3 times **CLOCKWISE** (to the right). Do not remove swab.

4. Peel off adhesive liner from the right edge of the test card. Close and securely seal the card. Read result in the window 15 minutes after closing the card. In order to ensure proper test performance, it is important to read the result promptly at 15 minutes, and not before. Results should not be read after 30 minutes.

RESULT INTERPRETATION

A. Negative: a **negative specimen** will give a single pink/purple colored Control Line in the top half of the window, indicating a negative results. This Control Line means that the detection part of the test was done correct but no COVID-19 antigen was detected.

B. Positive: a **positive specimen** will give two pink/purple colored lines. This means that COVID-19 antigen was detected. Specimens with low levels of antigen may give a faint Sample Line. Any visible pink/purple colored line is positive.

C. Invalid: If no lines are seen, if just the Sample Line is seen, or the Blue Control Line remains blue, the assay is invalid. Invalid tests should be repeated.

COMPETENCY ASSESSMENT

A. All operators must read the "Waived & Point of Care Testing: Binax NOW COVID-19 Ag Card and complete training and competency validation during initial training.

B. Competency validation is completed at orientation and annually using at least two of the following methods:

1. Observation of test performance
2. Written test
3. Each user's quality control performance is monitored
4. Performing a test on a blind specimen

C. Only approved operators are allowed to perform the test and report results.

D. Competency validation is tracked electronically in the learning management system and in employee e-files.

QUALITY CONTROL

A. The BinaxNOW COVID-19 Ag Card has built-in procedural controls:

1. The pink-to-purple line at the "Control" position is an internal procedural control. If the test flows and the reagents work, this line will always appear.

2. The clearing of background color from the results window is a negative background control. The background color in the window should be light pink to white within 15 minutes. Background color should not hinder reading of the test.

B. External Positive and Negative Controls:

1. BinaxNOW COVID-19 Card kits contain a Positive Control Swab and Sterile Swabs that can be used as a Negative Control Swab. These swabs will monitor the entire assay. Test these swabs once with each new shipment received and once for each untrained operator.

2. Emergency Departments is responsible for completing the Quality Control on each new shipment and keeping a log.

3. Emergency Department is responsible for ensuring a quality control is completed with each newly trained operator during their training and competency validation upon hire.

4. If the correct control results are not obtained, do not perform patient tests or report patient results. Contact Technical Support 1-800-257-9525 during normal business hours before testing patient specimens.

LIMITATIONS OF THE PROCEDURE

1. This test detects both viable (live) and no-viable, SARS-CoV and sARS-CoV-2. Test performed depends on the amount of virus (antigen) in the sample and may or may not correlate with viral culture results performed on the same sample.

2. A negative test result may occur if the level of antigen in a sample is below the detection limit of the test.

3. False negative results may occur if a specimen is improperly collected, transported, or handled.

4. False results may occur if specimens are tested past 1 hour of collection. Specimens should be tested as quickly as possible after specimen collection.

5. False negative results may occur if inadequate extraction buffer is used (e.g., <6 drops).

6. False negative results may occur if swabs are stored in their paper sheath after specimen collection.

7. False negative results may occur if specimen swabs are not twirled within the test card.

8. Positive test results do not rule out co-infections with other pathogens.

9. False negative results are more likely after eight days or more of symptoms.

10. Positive test results do not differentiate between SARS-CoV and SARS-CoV-2.

11. Negative test results are not intended to rule in other non-SARS viral or bacterial infections.

12. The presence of mupirocin may interfere with the BinaxNOW COVID-19 Ag test and may cause false negative results.

13. Negative results should be treated as presumptive and confirmation with a molecular assay, if necessary, for patient management, may be performed.

REFERENCES

Abbot (2021). BinaxNOW COVID-19 Ag Card Manufacturer's instructions.

CROSS REFERENCES:

Waived and Point of Care Testing: Competency and Quality policy

SUBJECT: **WATER PASS**	SECTION:

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

PURPOSE:

To provide fresh cold water to residents daily and as needed to maintain hydration.

POLICY:

It is the policy of this facility to provide residents with a clean water pitcher and cover, glass and fresh cold water on a daily basis and as needed, unless the resident is NPO, or on restricted fluids.

AFFECTED PERSONNEL/AREAS:

LICENSED NURSES, CNAs

PROCEDURE:

1. Establish a schedule to provide nursing with clean, disposable pitchers, covers and plastic cups.

2. Nursing will ensure that the clean pitcher liners are changed and filled with fresh water according to the schedule established.

3. Each resident (unless they are NPO) will be provided with a covered pitcher of fresh water and a clean cup daily. Pitchers and cups will be made available on resident's bedside stands or over bed tables.

4. All Nursing Assistants will offer water or fluids every 2 hours and assist those residents capable of PO intake to drink as needed (unless NPO). Then, the CNA will document in the appropriate area on PCS.

5. Nursing Assistants will replenish water throughout their shift as needed.

REFERENCES:

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

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

SUBJECT: **WEIGHT VARIANCE - DP/SNF**	SECTION: **Page 1 of 3**

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

PURPOSE:

To establish guidelines for treatment of residents with unusual or significant weight variance.

POLICY:

Monitoring and treatment for unusual or significant weight variances will be based on best practice. The weekly disciplinary team will discuss treatment options. Treatment will proceed once a physician's order and consent is secured and on record.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, DP/SNF*

PROCEDURE:

1. Each resident will have their weight and length measured on admission. The facility will establish a schedule to obtain each resident's weight. A new resident will be weighed weekly for four (4) weeks and then monthly, unless ordered otherwise. Weights will be recorded in pounds. Increased frequency of weight monitoring will be determined by the resident need at the discretion of the physician, clinical director, dietitian, or registered nurse.

2. The facility will adhere to the guidelines for obtaining accurate weights to ensure accuracy.

3. Staff members obtaining residents' weight will be in-serviced on procedures for obtaining accurate weights and for reporting unusual or significant weight variances to the licensed nurse.

4. Scales will be re-balanced by staff prior to obtaining each resident's weight.

5. Unusual or significant weight variance includes the following:

    a. Gain or loss of five (5) pounds or more or 5% of weight (whichever is greater) in one month when the resident weighs over 100 pounds.

    b. Gain or loss of three (3) pounds in one month when the resident weighs 100 pounds or less.

    c. Gain or loss of three (3) pounds or more in one week if the resident is on weekly weights.

    d. Consistent weight gain or loss of 7.5% in 3 months or 10% of weight in 6 months.

6. Significant weight losses/gains, (both planned and unplanned) will be reported to the physician and the dietitian.

7. When a weight loss or gain trend has been identified as undesirable, an entry will be included on the resident care plan and reported to the dietitian.

8. Residents requiring a weight loss/gain regimen will be presented at the weekly interdisciplinary meeting. If the team agrees with the recommendation, the Registered Dietitian will secure consent for weight loss/gain from the resident or patient family member. A physician order will be placed in the medical record.

9. All obtained weights will be recorded in the resident's permanent record.

10. All physician notifications will be documented in the nurse's notes.

11. If a patient refuses to be weighed, reattempt in three (3) days. After two refusals, the physician and dietitian will be notified and refusals documented in the medical record.

GUIDELINES FOR OBTAINING ACCURATE WEIGHTS:

1. Locate the scale in a convenient place and avoid moving it if at all possible.

2. Try to weigh residents within time frames as consistent as possible.

3. Try to maintain consistency in staff performing weights. This increases accuracy.

4. Validate weight discrepancies by re-weighing prior to notification of the physician.

5. The contracted bio-med company will calibrate scales routinely (according to policy) and document the calibration.

"Consent for Weight Gain / Loss Regimen" Form Attached

REFERENCES:

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

- Med Pass, Inc. (Updated February 6, 2015), Facility Guide to OBRA Regulations,483.35 (1),483.25 (i).

SIERRA VIEW MEDICAL CENTER
DISTINCT PART SKILLED NURSING FACILITY
CONSENT FOR WEIGHT GAIN/LOSS REGIMEN

INFORMED CONSENT FOR DIET REGIMEN

CIRCLE ONE : **WEIGHT LOSS** **WEIGHT GAIN**

NAME OF RESIDENT_____

ADVANTAGE: To allow the dietitian and physician to adjust calories in the diet as needed to maintain a healthy weight.

SIDE EFFECTS: If a resident chooses not to follow dietary regimen recommended by the dietitian and physician, subsequent clinical manifestations may arise over time (i.e. obesity, cardiovascular disease, skin and respiratory issues).

The above information has been explained to me. I consent and agree with the treatment recommended by the physician and dietitian to change the diet when needed for a healthy nutrition status.

CHECK A BOX : Telephone conversation ☐ In person ☐

_____ _____
(Resident Name or Representative) Date
If signed by other than resident, indicate relationship.

_____ _____
Registered Dietitian Date

_____ _____
Physician Date

_____ _____
Registered Nurse (Witness) Date

rev 01/2019 cj

SUBJECT: **WITHOLDING OR WITHDRAWING LIFE-SUSTAINING TREATMENT DPSNF**	SECTION: **Page 1 of 6**

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

PURPOSE:

To define the guidelines for decision-makers to determine that life-sustaining treatment may be withheld or withdrawn.

AFFECTED PERSONNEL/AREAS: *ALL STAFF*

PROCEDURE:

Rights of the Resident

Sierra View Medical Center recognizes that an adult person who has capacity has the right to make his/her own health care decisions after having been fully informed about the benefits, risks and consequences of treatment alternatives, even when such decisions might result in shortening the individual's life.

For adult residents who lack capacity, the patient may have his/her wishes followed, if they are known, or decisions made on their behalf by a decision-maker, as described below.

For the purposes of this policy:

1. "**Capacity**" means a resident's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives. Capacity shall be determined by the resident. A resident is presumed to have the capacity to make a healthcare decision, to give or revoke an advance health care directive, and to designate or disqualify a surrogate. The physician is required by law to document any finding regarding a resident's capacity in the resident's medical record.

2. **"Health care decision"** – means a decision made by a resident or the resident's primary health care decision maker, power of attorney for health care, conservator, or surrogate, regarding the resident's health care, including the following:

    a. Selection and discharge of health care providers and institutions.

    b. Approval or disapproval of diagnostic tests, surgical procedures, and programs of medication.

    c. Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

3. **"Individual health care instruction"** means a resident's written or oral direction concerning a health care decision for the resident.

4. "**Life-sustaining treatment**" -- includes, but is not limited to, medically administered hydration and nutrition, blood products, antibiotics, chemotherapy and radiation therapy, pressor agents,

renal dialysis, surgery, endotracheal intubation, and mechanical ventilation. Cardiopulmonary resuscitation is the subject of a separate Do Not Resuscitate (DNR) policy.

Decision-Makers for Adult Residents Who Lack Capacity

1. The decision-maker for an adult resident who lacks capacity is, in the following descending order of legal priority:

   a. The resident's designated agent under a valid power of attorney for health care (PAHC);

   b. A court appointed conservator; or

   c. A surrogate decision-maker designated by the resident or otherwise selected by the physician as provided in Section 2 below.

   Unless otherwise stated in the PAHC, the agent in the PAHC has priority over all other decision-makers including court-appointed conservators. When no agent under a valid PAHC, court appointed conservator, or designated surrogate decision-maker is reasonably available and willing to make the decision, the physician may identify an appropriate surrogate decision-maker.

2. In seeking to identify the appropriate surrogate decision-maker for a resident who has no PAHC agent, conservator or designated surrogate decision-maker reasonably available and willing to make the decisions, the physician may consider family members who:

   a. Know the resident's feelings and wishes regarding treatment,

   b. Have expressed concern for the resident's comfort and welfare, and

   c. Have expressed an interest in the resident by visits or inquiries to the resident's physician or hospital staff.

   California law provides no guidance on the order of family members for physicians to select to make a resident's health care decisions. In addition to family members, the physician may select as a surrogate decision-maker a non-family member who satisfies the above criteria and is willing to make decisions.

3. The PAHC agent, conservator or surrogate decision-maker must make the decision in accordance with the resident's individual health care instructions, if any, and other wishes to the extent known to the PAHC agent, conservator or surrogate decision-maker.

4. If the resident did not write or otherwise express individual healthcare instructions, or the PAHC agent, conservator or surrogate decision maker does not know the resident's wishes, the decision is to be made in accordance with the PAHC agent's, conservator's or surrogate decision-maker's determination of the resident's best interest. That determination is to be made by analyzing the resident's personal values to the extent known to the PAHC agent, conservator or surrogate decision-maker, the comparative benefits and burdens of continued treatment and such factors as

relief of suffering, the preservation or restoration of function, and the quality and the extent of life sustained.

Communication with Resident and Surrogate Decision-Maker

1. If the resident is an adult and has capacity, proposed treatment should be discussed with the resident. The physician should provide the resident with information on diagnosis, prognosis and recommended treatments, including their risks and benefits and alternative treatments, as well as the resident's prognosis without such treatments. Precedence must be given to the resident's right to self-determination. If the resident's physician determines that the resident has capacity to make health care decisions, the resident's wishes for treatment should be determined through discussion with the physician. This discussion should be held with the surrogate decision-maker if the resident lacks capacity. For the resident who lacks capacity, his/her wishes may be expressed in an Advance Directive, or may have been expressed orally.

2. If the resident is an adult who lacks capacity, the decision to withdraw or withhold life-sustaining treatment should nevertheless be discussed with the resident as well as the resident's PAHC agent, conservator or surrogate decision-maker.

3. If the resident lacks capacity and has no Advance Directive and no PAHC agent, conservator or surrogate decision-maker, the case may be presented for discussion by the Biomedical Ethics Committee upon request of the attending physician. In rare circumstances, the opinion of legal counsel may be sought.

Conflict Resolution

1. In the event a resident or decision-maker for a patient requests that certain treatments be withheld or withdrawn, but the attending physician does not concur, resolution may be obtained by:

   a. Consulting with another physician or the Chief of Service

   b. Transferring care to another physician; and/or

   c. Consultation with the Biomedical Ethics Committee.

2. If the resident or decision-maker for a patient disagrees with the attending physician's recommendations for withholding or withdrawal of life-sustaining treatments, the resident or the resident's decision-maker may initiate a consultation with the Biomedical Ethics Committee.

   NOTE: The Bio Ethics Committee functions only in an advisory capacity, NOT as a decision-maker. It can be very helpful and assist in dealing with decisions to withhold or withdraw life support.

   The committee may be helpful in discussing and exploring alternative approaches to the issues, clarifying legal or ethical issues, facilitating communications, resolving any disputes or questions

among members of the healthcare team, or identifying perspectives on the issues not previously considered by the physician or by a decision-maker.

3. In all cases, pain relief and palliative care must be continued.

Role of the Courts

1. The California Legislature has found that in the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment.

2. There are some cases, however, when it may be advisable to seek judicial intervention. For example, when there are disputes about a decision among the resident's family members or significant others and the person has not specifically named a PAHC agent or orally designated a surrogate decision-maker. In the event of disagreement and several equally vocal family members or others, the following should occur:

   a. Consultation with the Biomedical Ethics Committee

   b. Consultation with legal counsel

   c. Resident care conference with all members of the health care team and the resident or surrogate decision maker.

3. Death that results from withholding or withdrawing life-sustaining treatment at the direction of a resident or appropriate decision-maker, in good faith and in accordance with generally accepted health care standards does not constitute a suicide or homicide.

4. Compliance with the direction of a resident or appropriate decision-maker, in good faith and in accordance with generally accepted health care standards, does not subject the physician or to the hospital or its staff to civil or criminal liability or to discipline for unprofessional conduct.

PAHC and Documentation of Resident Treatment Preferences

1. Physicians should be familiar with the PAHC and should encourage its use because it identifies and appoints a person (and alternates) to act as agent to make health care decisions for the resident and allows the patient to specify particular wishes. In addition, the PAHC agent has priority as a decision-maker. It offers the opportunity for discussion and reflection concerning treatment issues and helps to assure that the resident's wishes will be followed. The PAHC is generally the most powerful and flexible method available by which a person may attempt to assure future medical treatment in accordance with his/her preferences. It is best if the patient provides his/her physician with a copy of any Advance Directive, including a PAHC, although that is not legally required.

2. Any communication by a resident concerning treatment preference(s), whether written or oral, may provide helpful guidance in determining an appropriate course of treatment. Residents with

clear treatment preferences should be encouraged to state them in writing. If a copy is provided to the physician, it shall be included in the medical record. Residents should be cautioned, however, that any specific written instruction, unless later revoked, controls the decision-maker, who may not act to the contrary. Any oral statements of treatment preferences must be documented in the medical record and are also legally binding.

Written Orders

1. All orders to withhold or withdraw treatment from a patient must be written, dated, timed and **signed by the physician** ON THE PHYSICIAN ORDER SHEET IN THE RESIDENT'S MEDICAL RECORD and must be specific. Such orders should be given only after discussion with the resident or the surrogate decision-maker and documentation thereof.
NOTE: required supporting documentation listed in Item 3(a-d) below.

   Options:

   a. The primary care physician may send a facsimile (FAX) copy of a written, signed order regarding withhold/withdrawal of life-sustaining treatment to the nursing unit – **Attention to the specific resident's nurse.** All FAX orders must be verified by initial or signature as soon as possible but in no case longer than 24 hours.

   b. As a general rule, orders to withhold/withdraw life-sustaining treatment should not be given by telephone. In extremely extenuating circumstances only, the primary care physician may communicate telephone orders regarding withholding/withdrawal of life-sustaining treatment to a registered nurse utilizing a conference call allowing another licensed nurse to witness and co-sign the telephone orders. **The nurses must identify themselves to the physician at the time the order is taken. Both nursing signatures will appear on the written physician order.** All telephone orders must be verified by initial or signature as soon as possible but in no case longer than 24 hours.

   c. The primary care physician may communicate directly with the Emergency Room physician regarding decision-making and orders to withhold/withdraw life-sustaining treatment.

2. The physician shall verbally inform the nursing staff that such an order has been given to ensure that the order is known, understood at the time it is written, and carried out in a timely fashion.

3. The orders or decision to withhold or withdraw life-sustaining treatment must be supported by the following being present in the resident's medical record:

   a. Complete written documentation in the progress notes. Such dictated or written documentation may include, but is not limited to, a summary of the medical situation that specifically addresses that resident's situation. This summary must include reference to the resident's capacity, mental status, diagnoses, and prognosis at the time the order is written or the decision is made and test results or an explanation if no tests were performed.

b. The outcome of any consultations, if any, with other physicians. Physicians who provide consultations must document their findings and recommendation.

c. A statement indicating the basis upon which particular person(s) have been identified as appropriate decision-maker(s) for the resident.

d. A statement summarizing the outcome of consultations with the resident, or, if the resident lacks capacity, the resident's parent, agent under a valid PAHC, court appointed conservator, guardian, or surrogate decision-maker.

4. The resident's physician is responsible for the decision regarding disconnecting medical devices such as ventilators, pacemakers, etc.

a. A physician may delegate the function of discontinuing life-sustaining treatment to a registered nurse.

b. If the registered nurse wishes to decline, the nursing manager must be notified immediately and an alternate, qualified healthcare provider be assigned who is willing to comply.

5. Brain Death: When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be an independent confirmation by another physician.

REFERENCES:

- CANHR Long term Care Justice and Advocacy. Feb 4, 2016. Retrieved from https:/canhr.org/newsroom/releases/2016/PDFs/CANHRv.Chapman.pdf.
- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.25 United States of America, Med Pass Inc.

CROSS REFERENCES:

- Nursing Administration Manual: *PRONOUNCING CESSATION OF LIFE SIGNS*
- House-Wide Manual: *DIAGNOSIS OF DEATH BY NEUROLOGIC CRITERIA*