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

**AGENDA**
**July 23, 2024**

**OPEN SESSION (5:00 PM)**

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

**Call to Order**

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

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

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

**CLOSED SESSION (5:01 PM)**

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

**III. Closed Session Business**

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

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

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

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54957(b); Health and Safety Code Section 32106(b): Discussion Regarding Confidential Personnel Matter; Pursuant to Gov. Code Section 54957(b) and Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Confidential Personnel Matter as it pertains to Trade Secrets and Services. Estimated Date of Disclosure, for non-confidential personnel records – August, 2027

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Professional Services (2 Items). Estimated Date of Disclosure for Item One October, 2024. Estimated date of Disclosure for Item 2, August 2026.

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning Estimated Date of Disclosure August, 2027

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

To the extent items on the Closed Session Agenda are not completed prior to the scheduled time for the Open Session to begin, the items will be deferred to the conclusion of the Open Session Agenda, or until a time the Board deems necessary during the meeting to re-enter Closed Session to best address each Agenda Item.

## IV. Adjourn Closed Session and go into Open Session

**OPEN SESSION (5:30 PM)**

## V. Closed Session Action Taken

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

A. Chief of Staff Report

*Recommended Action*: Information only; no action taken

B. Quality Review

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

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

C. Discussion Regarding Trade Secrets and Confidential Personnel Matter – 2 Items
*Recommended Action: Information Only: No Action Taken*

*D. Discussion Regarding Trade Secrets Pertaining to Professional Services – 2 Items*
*Recommended Action: Information Only: No Action Taken*

E. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
*Recommended Action: Information Only: No Action Taken*

F. Conference with Legal Counsel
*Recommended Action*: Information Only; No Action Taken

## VI. Public Comments

Pursuant to Gov. Code Section 54954.3 - NOTICE TO THE PUBLIC - At this time, members of the public may comment on any item not appearing on the agenda. Under state law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public may make comments at this time or present such comments when the item is called. This is the time for the public to make a request to move any item on the consent agenda to the regular agenda. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all interested parties have an opportunity to speak with a total of thirty (30) minutes allotted for the Public Comment period. Please state your name and address for the record prior to making your comment. Written comments submitted to the Board prior to the Meeting will distributed to the Board at this time, but will not be read by the Board secretary during the public comment period.

## VII. Consent Agenda

Recommended Action: Approve Consent Agenda as presented

***SIERRA VIEW LOCAL HEALTH CARE DISTRICT***
***BOARD OF DIRECTORS AGENDA***
***July 23, 2024***

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

**VIII. Approval of Minutes**

A. **June 25, 2024 Minutes of the Regular Meeting of the Board of Directors**
*Recommended Action*: Approve/Disapprove June 25, 2024 Minutes of the Regular Meeting of the Board of Directors

**IX. Business Items**

A. **June 2024 Financials**
*Recommended Action:* Approve/Disapprove *June* 2024 Financials

**X. CEO Report**

**XI. Announcements:**

A. Regular Board of Directors Meeting – August 27, 2024 at 5:00 p.m.
B. Special Board of Directors Meeting - August 10, 2024 at 7:00 a.m.
C. November 5th General Election Nomination Period is Open from July 15 – August 9th

**XII. Adjournment**

**PUBLIC NOTICE**

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

**PUBLIC NOTICE ABOUT COPIES**

SIERRA VIEW MEDICAL CENTER

***SIERRA VIEW LOCAL HEALTH CARE DISTRICT***
***BOARD OF DIRECTORS AGENDA***
***July 23, 2024***

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

| MEDICAL EXECUTIVE COMMITTEE | 07/03/2024 |
|---|---|
| **BOARD OF DIRECTORS APPROVAL** | |
| | 07/23/2024 |
| BINDUSAGAR REDDY, MD, CHAIRMAN | DATE |

# SIERRA VIEW MEDICAL CENTER
# CONSENT AGENDA REPORT FOR
# July 23, 2024 BOARD APPROVAL

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

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| **I. Policies:** | | **APPROVE** |
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| • Antibiotic Stewardship Program for DP/SNF | 3-7 | |
| • Assessment-Joint Mobility | 8-9 | |
| • Assistive Devices | 10 | |
| • Bedholds, Discharges, and Transfers | 11-15 | |
| • Blood and Blood Components-Administration DPSNF | 16-21 | |
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| • Care Planning | 24-26 | |
| • Change in Condition-Significant | 27-28 | |
| • Changing a Trach Tube on Subacute | 29-32 | |
| • Changing a Tracheostomy Tube | 33-35 | |
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| • Consumer Information | 37-38 | |
| • DP/SNF Activity Program | 39-40 | |
| • Deaths Reportable to Coroner | 41-42 | |
| • Dental Services | 43-45 | |
| • Documentation and Record Keeping-DP/SNF | 46-47 | |
| • Documentation Nursing DPSNF | 48-51 | |
| • End of Life Issues | 52-53 | |
| • Enteral Nutrition Orders | 54-55 | |
| • Food at Bedside-Storage | 56 | |
| • Functions of Social Service Department | 57-58 | |
| • Hair and Scalp, Care of | 59-63 | |
| • Hand Rolls | 64 | |
| • Incidental Medical Services | 65 | |
| • Infection Prevention and Control – DP/SNF | 66-68 | |
| • Maintaining Patency of Feeding Tube | 69-70 | |
| • Mattress-Air | 71 | |
| • Mattress-Alternating Air | 72-73 | |
| • Medication Administration Through a Feeding Tube | 74-75 | |
| • Nursing Care, Restorative and Supportive | 76-77 | |
| • Nursing Weekly Summary | 78-79 | |
| • Oral Care | 80-83 | |
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| • Pain: Assessment and Management | 89-93 | **APPROVE** |
| • Patient Access to the Outdoors | 94 | ↓ |
| • Prioritizing Social Service Referrals | 95 | |
| • Quality Assurance/Performance Improvement-DP/SNF | 96-99 | |
| • Razor Cleaning-Electric | 100-101 | |
| • Referrals to Social Service Department | 102 | |
| • Residents' Personal Clothing | 103 | |
| • Residents' Personal Refrigerator | 104 | |
| • Scope of Services-Social Services at DP/SNF | 105-106 | |
| • Shared Bathrooms | 107 | |
| • Skin Integrity Team Guidelines | 108-109 | |
| • Social Service Role in the Admission of Residents | 110-112 | |
| • Swallowing Assessment and Residents' Rights-DP/SNF | 113-114 | |
| • Theft and Loss | 115-118 | |
| • Tracheostomy Care-DP/SNF | 119-121 | |
| • Transfer, Interfacility Resident | 122-123 | |
| • Transfer of Resident To-From Bed | 124-126 | |
| • Trapeze-Overbed | 127 | |
| • Trust Account-Social Service Policy | 128-129 | |

| SUBJECT: **ADMISSION PROCESS** | SECTION:  |
|---|---|



**PURPOSE:**

The purpose of this policy is to ensure equal access to care and facilitate the admission process according to state and federal guidelines.

**POLICY:**

The Unit Director, Support Staff (IP, SSD), or Support Registered Nurse (RN) will assess referrals for admission possibility, using criteria set forth by state and federal guidelines for Distinct Part Skilled Nursing Facility (DP/SNF). Assessed referrals are to be submitted to the Medical Director for approval. Upon selection by the medical director, coordination of disciplines and between facilities is maintained by the Director of the DP/SNF or Admissions Case Manager (if applicable) with the aim of expediting a safe and timely admission into the DP/SNF.

**AFFECTED PERSONNEL/AREAS:**

*MEDICAL DIRECTOR, ANCILLARY STAFF, UNIT DIRECTOR, SUPPORT RN*

EQUIPMENT:

- Fax machine
- Computer
- Telephone

**PROCEDURE:**

1. Receive, assess and catalog prospective referrals. Obtain information as needed from submitting facility. Assess prospective resident in person if possible.

2. Utilize Minimum Adult Eligibility Criteria:

   a. Stable with no acute care needs

   b. 24/hour RN nursing care required

   c. Any one of the following four items:

      - A tracheostomy with continuous ventilation >50% of the day
      - Tracheostomy care and at least one of the six treatment procedures of section "D"
      - SNF residents: any one of the six in Section D

d. **Treatment Procedures:**

- Inpatient Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) for a minimum of 2 hours/day, 5 days/week
- Total Parenteral Nutrition
- Nasogastric tube/gastric tube (NGT/GT)
- Respiratory Therapy (RT) minimum 4 times a day
- Intravenous (IV) therapy
- Wound debridement

3. Eliminate referrals that do not fall within criteria and/or facility capability, i.e. dialysis needs, under age of 21, or severe psychiatric diagnosis in an alert resident. Notify submitting facility of inability to provide care.

4. Submit referrals to the Medical Director, taking into consideration the type of available accommodation such as male or female, shared bath and/or isolation needs.

5. Notify sending facility of acceptance and arrange for admit with the time, date and specific resident needs.

6. Notify disciplines of acceptance and impending admit to include the Unit Director, Medical Director, Nursing, Respiratory Services, Social Services, Infection Control Officer, Registration and the Billing Department.

7. Maintain contact with sending facility as needed until the admit process is complete. Maintain referral pack for future reference.

**REFERENCES:**

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 72315 (a, b, c) San Francisco, California, Title 22.
- Med Pass, Inc.,( updated February 6, 2015) Facility Guide to OBRA Regulations, 483.12 (D) United States of America, Med Pass Inc.

| SUBJECT: **ANTIBIOTIC STEWARDSHIP PROGRAM FOR DP/SNF** | SECTION: **Page 1 of 5** |
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**PURPOSE:**

Sierra View Medical Center (SVMC) is committed to optimizing antimicrobial therapy while minimizing unintended outcomes, including medication toxicity, increased antimicrobial resistance, and unwarranted costs.

**DEFINITIONS:**

**Antimicrobial Stewardship:** A program with the intentions to comply with mandated California Senate Bill 739, and program requirements for Long Term Care facilities by California Department of Public Health (CDPH) and Centers for Disease Control and Prevention (CDC). The Antimicrobial Program is an organizational priority to improve the process of appropriate selection, dosing, route of administration and duration of antimicrobial therapy. A multidisciplinary approach is utilized to collect and analyze data in an effort to slow the emergence of antimicrobial resistance and transmission of resistant pathogens.

**ANTIMICROBIAL STEWARDSHIP COMMITTEE:**

The DP/SNF has an Antibiotic Stewardship Committee that meets & reports quarterly during the Infection Control Committee meeting. Antibiotic Use is being reported on a weekly basis by the DP/SNF Infection Control Officer to the Interdisciplinary Team (IDT) during the IDT meeting. This Committee is a subcommittee of the Pharmacy &Therapeutics (P&T)/Infection Control Committee of the Hospital with the intention to develop and implement a Centralized Antimicrobial Stewardship Program. The program will strive to foster collaboration between the DP/SNF and SVMC Pharmacy and Medical Staff in the appropriate utilization of antibiotics.

Members of the DP/SNF Antimicrobial Stewardship Team may include but are not limited to:

- Infection Control Officer (Designated Team Leader)
- Medical Director/Physician
- Director of DP/SNF
- Clinical Manager
- DP/SNF Pharmacist (Model Drug Pharmacy)
- Nurses

The P&T/Infection Control Committee is chaired by an infectious disease physician who will work closely with other committee members including clinical pharmacists, pharmacy administration, the Infection Prevention Department and the Department of Microbiology to provide guidance and education on the appropriate use of antimicrobials.

Members of the Housewide Antimicrobial Stewardship Team may include but are not limited to:

- Infectious Disease Physician
- Clinical Pharmacist (SVMC)
- Infection Prevention
- Clinical Microbiologist
- Clinical Information System Analyst
- Primary Nurse
- Dietitian

Antibiotic Stewardship Meetings by P&T/Infection Control Committee will be held at a minimum of annually to review analyzed data and discuss agenda items that will assist in meeting the following Antimicrobial Stewardship goals.

SUMMARY OF CORE ELEMENTS OF HOSPITAL ANTIBIOTIC STEWARDSHIP PROGRAMS

- Leadership Commitment: Dedicating necessary human, financial and information technology resources
- Accountability: Appointing a single leader responsible for program outcomes. Experience with successful programs show that a physician leader is effective.
- Drug Expertise: Appointing a single pharmacist leader responsible for working to improve antibiotic use.
- Action: Implementing at least one recommended action, such as systemic evaluation of ongoing treatment need after a set period of initial treatment (i.e. "antibiotic time out" after 48 hours)
- Tracking: Monitoring antibiotic prescribing and resistance patterns
- Reporting: Regular reporting information on antibiotic use and resistance to doctors, nurses and relevant staff
- Education: Educating clinicians about resistance and optimal prescribing

**Goals**

- Promotion of appropriate use of antimicrobials
- Minimization of antimicrobial resistance

- Prevention of antimicrobial toxicity
- Improvement of patient outcomes
- Utilization of education to expand Antibiotic Stewardship practices to all healthcare employees, patients and their families.

**POLICY COMPLIANCE / KEY ELEMENTS:**

The Clinical Pharmacists will work with the interprofessional team to optimize the utilization of antimicrobials and to avoid the potential consequences of inappropriate antimicrobial therapy. This includes, but is not limited to:

- The selection of appropriate antimicrobials including empiric regimens based on evidence-based national guidelines site.
- The timely initiation, escalation, de-escalation and duration of antimicrobial therapy.
- The proper dosing, frequency, route and administration time of antimicrobial agents.
- The monitoring and tracking of related labs, cultures, drug-bug mismatch, and sensitivity in assessing optimization of antimicrobial therapy.
- The avoidance of toxicity.
- The avoidance of emergence of antimicrobial resistance or the development of hospital acquired infections (HAI).
- The prevention of increased morbidity and mortality.
- Identification of redundant therapy.
- The annual education of staff involved in antimicrobial ordering , dispensing, administration, and monitoring about antimicrobial stewardship practices through hospital-wide competency program.
- The education of patients and their families regarding the appropriate use of antimicrobial medications.

**AFFECTED PERSONNEL/AREAS:** *ALL CLINICAL DEPARTMENTS*

**PROCEDURE:**

The Clinical Pharmacist will employ antimicrobial stewardship practices that include the appropriate selection, dosing, route of administration and duration of antimicrobial therapy. Examples of strategies to be employed include, but are not limited to, the following:

- Vancomycin and aminoglycoside dose adjustments as allowed per policy.
- IV to PO conversion when appropriate, as allowed per policy.
- Renal dosage adjustments/recommendations, as allowed per policy.
- A seven days auto-stop implementation for duration of antimicrobial therapy, which may be extended if therapeutically warranted after a renewal re-assessment by the prescriber and pharmacist's verification.
- Avoid delays in initiation of appropriate antimicrobial therapy when ordered by the prescriber.
- Collaborate with the Infection Preventionist on monitoring drug-bug mismatches in cultures and susceptibilities and notifying the prescriber if a change in antimicrobial therapy is indicated.
- Direct interaction and feedback with the prescribers, nursing, lab and infection prevention.
- Documentation of monitoring, adjustments and interventions performed by pharmacy.

**TRACKING AND REPORTING:**

**Pharmacists:**

- Over the following year, pharmacy will track interventions/recommendations made to prescribing physicians and percent accepted will be calculated.
- The results will be analyzed and reported at Antibiotic Stewardship Committee and P&T Committee quarterly.

**Infection Prevention:**

- Infection Preventionist (IP) will conduct monitoring and prevention of hospital-associated infection and will analyze and report outcomes. Specifically, MDROs will be tracked to identify trends and report results to P&T and IP.
- IP will educate staff on strategies to optimize the use of antibiotics.

**REFERENCES:**


- ASHP Midyear 2016 , Emerging Issues in Antimicrobial Resistance, , American Society of Health-System Pharmacists, Inc.
- California Department of Public Health. The California Antimicrobial Stewardship Initiative. Retrieved on June 30, 2015 from Last update August 12, 2019_ http://www.cdph.ca.gov/programs/hai/pages/AntimicrobialStewardshipProgramInitiative.aspx

- CDC. Core Elements of Hospital Antibiotic Stewardship Programs. Atlanta, GA: US Department of Health and Human Services. CDC; 2015 . Retrieved on June 30, 2015 from_ http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html.

- Infectious Diseases Society of America. Infection prevention and control of healthcare associated infection. Retrieved on July 18, 2018 from http://www.idsociety.or/Infection_Control_Policy/.

- The Joint Commission. 2022 National Patient Safety Goals. Retrieved on June 30, 2015 from http://www.jointcommission.org/standards_information/npsgs.aspx.

- Infectious Diseases Society of America, 2016, Implementing an Antibiotic Stewardship Program: Guidelines by the Infectious Disease Society of America and the Society for Healthcare Epidemiology of America. Retrieved from: www.idsociety.org/Antimicrobial_Agents/#ImplementinganAntibioticStewardshipProgram.

- McGregor, PhD,Jessina, Fitzpatrick,MD,MS, Margaret, American Medical Services, February 2021, Expanding Antimicrobial Stewardship Through Quality Improvement,

- Silvers J, Martinez C., Antimicrobial Stewardship Program Development. March 26, 2015.

- World Health Organization (WHO) Antimicrobial Resistance. Fact Sheet. Retrieved on July 31, 2020 from http://www.who.int/mediacentre/factsheets/fs194/en.


**CROSS REFERENCES:**

- Sierra View Medical Center – Pharmaceutical Services Policy and Procedure Manual. IV to PO Dosage Form Conversion Protocol

- Sierra View Medical Center – Pharmaceutical Services Policy and Procedure Manual. Renal Dosage Adjustment Protocol

- Sierra View Medical Center – Pharmaceutical Services Policy and Procedure Manual. Aminoglycoside Protocol Per Clinical Pharmacist

- Sierra View Medical Center – Pharmaceutical Services Policy and Procedure Manual. Vancomycin Protocol Per Clinical Pharmacist

| SUBJECT: **ASSESSMENT- JOINT MOBILITY** | SECTION:  |
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**PURPOSE:**

To determine a resident's range of motion for all major joints and to implement plans of care to increase, maintain, or prevent deterioration of joint mobility.

**POLICY:**

It is the policy of this facility to assess all residents for joint mobility limitations upon admission and at a minimum of every three months thereafter.

**AFFECTED PERSONNEL/AREAS:** *PHYSICAL THERAPIST, REGISTERED NURSE (RN)*

**PROCEDURE:**

1. Upon admission, each resident will be assessed for limitations in joint mobility by a licensed nurse.

2. Limitations in joint mobility will be defined in the following terms:

   a. FRM – full range of motion/no limitation

   b. Minimal – represents a decrease in joint mobility of approximately 1 to 40% of the normal range of motion

   c. Moderate – represents a decrease in joint mobility greater than 50% to approximately 75% of the normal range of motion

   d. Severe – represents a decrease in joint mobility greater than 75% to approximately 100% of the normal range of motion

3. The Physical Therapist will assess each joint for range of motion and document findings on the Joint Mobility section in PCS. For each joint, indicate the degree of mobility. Date and then update reassessment and changes. This will show progress or lack of progress.

4. The information is used to assist in developing or modifying a plan of care, especially in the areas of physical functioning such as positioning, locomotion, and activities of daily living (dressing, grooming, and eating).

5. The RN will assess the effectiveness of the plan of care and the resident's response to treatment on a weekly basis in the licensed weekly summary.

6. The mobility assessment is then used to reassess the overall joint mobility of each resident on an as needed and/or quarterly basis.

7. Resident care plans are updated as necessary.

8. Assessments or evaluations may be requested if interventions prove ineffective or complications occur requiring therapy expertise.

**REFERENCES:**


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

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 22 CCR § 72403, 22 CA ADC § 72403, San Francisco, California, Title 22.

| SUBJECT: **ASSISTIVE DEVICES** | SECTION: **Page 1 of 1** |
|---|---|

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

**PURPOSE:**

To compensate for patients inability to handle standard utensils, cups or plates; adaptive equipment is provided.

**POLICY:**

The hospital will provide assistive eating devices for residents who require them.

**AFFECTED PERSONNEL/AREAS:**

*OCCUPATIONAL THERAPIST, SPEECH THERAPIST, DIETICIAN, NURSING*

**PROCEDURE:**

1. Upon the recommendation of the Interdisciplinary Team, an Occupational Therapist, Speech Therapist, or Dietician will evaluate, recommend and order adaptive equipment.
2. Food and Nutrition Services will wash and track adaptive equipment.
3. Plan of care will be developed specific to each resident's needs and will be reviewed on an ongoing basis by the Interdisciplinary Team.

**REFERENCES:**

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 22 CCR § 72419, § 87608 § 72419, San Francisco, California, Title 22

| SUBJECT: **BEDHOLDS, DISCHARGES, AND TRANSFERS** | SECTION: **Page 1 of 5** |
|---|---|

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

**PURPOSE:**

To facilitate the request to hold open the resident's bed during temporary stays away from the facility. To maintain the resident's record in compliance for billing and separation of facility admissions, stays, therapeutic leaves and discharges.

**POLICY:**

Residents will be informed upon admission of their right to have a bed hold in the event the resident must be transferred to an acute facility or during therapeutic leave. The resident or representative will be given notice of the rights to a bed hold at the time of transfer or leave. Residents will be informed that Medi-Cal will pay for up to seven (7) bed hold days for an acute care hospitalization.

**AFFECTED PERSONNEL/AREAS:** *BILLING, PATIENT ACCOUNTING, CHARGE NURSE, SOCIAL SERVICES AND ADMITTING*

**Transfer and Discharge Requirements**

All Skilled Nursing Facilities (SNFs) must adhere to specified notice, transfer, discharge, and right to return requirements.

Each facility must permit residents to remain in the facility, and not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

3. The safety of individuals in the facility is endangered;

4. The health of individuals in the facility would otherwise be endangered;

5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;

6. The facility ceases to operate; or

7. The resident has made a material or fraudulent representation of his or her finances.

8. A facility may involuntarily discharge a resident for failure to pay his or her share of the cost. However, a resident cannot be transferred for non-payment if he or she has submitted all the paperwork necessary for the bill to be paid by a third-party payor. Non-payment occurs if a third-

party payor, including Medicare or Medi-Cal, denies the claim and the resident refuses to pay for his or her stay. Additionally, a dual-eligible resident residing in a Medi-Cal certified facility has a right to transition to Medi-Cal from Medicare if the resident needs continuing care in the facility. If a facility participates in Medi-Cal or Medicare, the facility may not transfer or discharge a resident, nor transfer a resident within the facility solely because of a change from private pay or Medicare to Medi-Cal payment. However, a facility may transfer a resident from a private room to a semiprivate room if the resident changes to Medi-Cal payment status.

**Notice Provided to Resident Prior to Transfer or Discharge**

Before any transfer or discharge occurs, the facility must notify, in writing, the resident and, if known, the family member or legal representative of the transfer or discharge and the reasons for the move. The reasons for the move must be recorded in the resident's clinical record. This notice must be made by the facility at least 30 days before the resident is transferred or discharged unless the transfer is made for medical, health and safety reasons, or in cases of facility closure.
Except in an emergency, a facility may not transfer a resident to another room within the facility against his or her wishes, unless given prior reasonable written notice.

**Notice to the LTC Ombudsman**

The Local LTC Ombudsman will be provided notice, the same time as the resident or the resident's representatives, when a facility-initiated transfer or discharge occurs. The facility will send a notice to the local LTC Ombudsman for any transfer or discharge that is initiated by the facility, whether or not the resident agrees with the facility's decision. The facility does not need to notify the LTC Ombudsman of transfers initiated by the resident. The facility will provide a copy of the notice to the LTC Ombudsman, as soon as practicable, if a resident is subject to a facility-initiated transfer to a general acute care hospital on an emergency basis.

**BEDHOLDS**

1. The facility shall not be required to offer a bedhold if the resident requires a level of care greater than that provided by the facility upon the resident's return. If the facility fails to follow this procedure, then the resident will be offered the next available bed.

2. The resident may terminate the bedhold option during the seven (7) day period by notifying the facility in writing. The facility will bill only for bedhold days prior to the written request to end the bedhold.

3. If the resident's attending physician notifies the facility in writing that the resident's treatment at the acute care facility will exceed seven (7) days from the date of admission, the facility will not be required to maintain a bedhold for the resident.

4. If the MediCal eligible resident is transferred from the facility and does not request a bedhold, the facility shall extend the resident readmission rights to the next available bed. If a resident's hospitalization or therapeutic leave exceeds the bedhold period, then the resident shall be

admitted to the next available bed if he/she requires the services of the facility and is eligible for MediCal nursing facility services.

5. The Medicare program does not make payments for bedholds, thus any Medicare resident exercising his/her right to maintain a bedhold shall pay the facility's private daily rate during the period of the bedhold.

6. Any privately funded resident exercising his/her right to maintain a bedhold shall pay the facility's daily rate for the period of the bedhold. The resident's insurance may or may not cover cost for a bedhold. MediCal will reimburse for up to seven (7) bedhold days. If MediCal coverage for a bedhold does not exist, the bedhold will be considered to be a non-covered service and the resident shall be obligated to pay the facility's daily private rate for each day of the bedhold.

7. A bedhold option shall be extended to MediCal eligible residents even if he/she has outstanding MediCal balances and if hospitalized beyond the State's bedhold policy, he/she must be readmitted to the first available bed. Once readmitted, however, the resident may be transferred if the facility can demonstrate that non-payment of charges exists and documentation and notice requirements are followed. The facility is not required to hold the same bed or room previously occupied by the resident.

8. If the resident or responsible party desires in advance that a bedhold is to be provided to the resident, the resident shall acknowledge it in writing with parties upon completion of admission agreement, and it will become a part of the resident record. However, the resident will still receive notification at the time of transfer. In cases of emergency transfer, notice "at the time of transfer" means that the responsible party shall be provided with written notification within 24 hours of the transfer. The notice of bedhold is also considered to be served if the resident's copy of the notice accompanies the resident and transfer records to the acute care facility.

9. If the resident does not return to the facility by midnight (11:59 p.m.) of the eighth day, the facility may discharge the resident. (Bedhold starts on the day of transfer; however, the discharge day will not be counted.)

It is not necessary to initiate a bedhold if the resident goes to an acute facility for an outpatient procedure or on a therapeutic leave, and returns the same day.

**RESIDENTS RIGHTS TO RETURN TO THE FACILITY, SPECIFIC TO ALL SNF AND ICF REQUIREMENTS:**

1. All SNFs shall afford any resident transferred to a general acute care hospital a bed hold of at least seven days and inform each current resident or resident's representative in writing of the resident's right to exercise this bed hold provision.

2. Whenever a resident is transferred to a hospital, the facility must provide written notice to a resident of the bed hold policy. The resident or the resident's representative shall inform the facility within 24 hours if the resident desires the facility to hold a bed for him or her. Residents must be permitted to return to the facility if they exercised their right to a bed hold. Moreover, a nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility.

**Nursing Unit Procedures:**

1. Obtain a physician's order for transfer to the acute facility for treatment or for a therapeutic leave and for bedhold.

2. Complete an Interfacility Transfer Form for acute transfers. Send the original with the requested copies of the resident's record and place a copy of the transfer form on the DP/SNF record.

3. Copy all reports, physician's progress notes, and other parts of the record as requested by the receiving facility. Clearly mark these as copies, and send with the resident. (Do not send the DP/SNF chart.)

4. Document on the resident's record that he/she was transferred to acute facility, and was placed on bedhold status. (Do not discharge the resident from the DP/SNF Facility.)

5. Notify the resident and/or the resident's responsible party of the transfer and the right to initiate a bedhold. Document their decision in the resident record. (Nursing and/or Social Service). Notify the Admitting Office of the resident's transfer to acute or therapeutic leave, and his/her placement on bedhold status (Nursing or Program Secretary). The Bedhold Notification Form shall be used to document notice to the resident/family of the bedhold.

6. Maintain the resident's record open on the unit.

7. If the resident returns to the facility within the seven (7) day bedhold period, document this in the nursing notes section of the resident's record.

8. Verify that the physician has written an order to resume care and treatment, and note if there are additional orders based on the resident's change of condition.

9. Initiate and complete a new MDS only if the resident has experienced a permanent change in his/her condition that affects functional level.

10. If the resident does not return to the facility by midnight (11:59 p.m.) of the eighth ($8^{th}$) day, then discharge the resident, and break down and organize the resident's record according to the facility's policy and send to Medical Records. (Bedhold starts on the day of transfer, however, the discharge day will not be counted.)

11. Open a new resident record if the resident returns to the facility after bedhold has expired. (Readmit the resident and follow MDS instructions for admission.)

12. Remember that the acute facility should open an acute or outpatient chart with a new account number when the resident is received.

13. Medicare and private insurance do not routinely pay for bedholds, and these residents should be discharged when transferred to acute, if the resident or insurer declines to pay privately for the bedhold option. It is not necessary to discharge these residents for outpatient procedures.

14. The bedhold is recorded on the "CENSUS REPORT," in the Unit Resident Transfer Log, and in the individual resident record.

**REFERENCES:**

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72520, §72527, §73504, §73523, San Francisco, California, Title 22.

- Med Pass, Inc.,(Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.12 (B) CCR , 483.13 (a) United States of America, Med Pass Inc.

- California Department of Public Health, AFL 17-27 Assembly Bill (AB) 940, Health and Safety Code section 1439.6. Retrieved from cdph.ca.gov.

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

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

**PURPOSE:**

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

**POLICY:**

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

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

**EQUIPMENT:**

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

**PROCEDURE:**

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

1. Ordering and Obtaining Blood Products

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Preparing the resident

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

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

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

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

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

5. At the bedside

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

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

- Donor blood group and Rh type

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

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

6. Preparation for Transfusion

a. Wash hands thoroughly. Put on gloves.

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

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

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

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

7. Administration

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

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

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

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

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

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

8. Completion of Transfusion

a. Clamp blood component bag

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

c. Remove blood products and tubing

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

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

PLATELETS

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

FRESH FROZEN PLASMA

- Use same procedure as when ordering and verifying PRBCs.

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

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

SPECIAL CONSIDERATIONS

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

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

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

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

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

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

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

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

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

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

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

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

DOCUMENTATION

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

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

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

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

**REFERENCES:**

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

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

**CROSS REFERENCES:**

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

| SUBJECT: **BOWEL AND BLADDER TRAINING** | SECTION: **Page 1 of 2** |
|---|---|

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

**PURPOSE:**

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

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

**POLICY:**

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

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

EQUIPMENT:

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

**PROCEDURE:**

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

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

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

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

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

DOCUMENTATION:

1. Maintain accurate I & O records.

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

**REFERENCES:**

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

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

| SUBJECT: CARE PLANNING | SECTION:  |
|---|---|

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

**PURPOSE:**

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

**POLICY:**

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

**AFFECTED PERSONNEL/AREAS:** *INTERDISCIPLINARY TEAM*

**PROCEDURE:**

1. Resident Care Plan forms will be maintained as part of the resident health record.

2. Each diagnosis will be listed and updated as necessary.

3. The long term goal is stated in relation to the expected outcome of the resident's condition and is determined collectively by the health care team as part of the review of the care plan. Reviews will be recorded by date in number sequence.

4. Identify the problems or needs. After information has been gathered, the data is analyzed to determine what problems and needs exist.

5. The following guidelines should be employed when identifying, selecting, and recording problems:

    a. The date recorded should reflect when the problem was identified.

    b. A problem is a difficulty or concern experienced by the resident.

    c. The problems include currently existing difficulties, as well as potential problems, as identified by the minimum data set:

        - The date recorded should reflect when the problem was identified.
        - Medical status measurements: labs, diagnostic reports, vital signs, etc.
        - Functional status
        - Sensory and physical impairments

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

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

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

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

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

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

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

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

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

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

    b. Are the actions/approaches appropriate and effective?

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

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

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

**REFERENCES:**


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

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72311 (a), (1A-C), San Francisco, California, Title 22.

| SUBJECT: **CHANGE IN CONDITION- SIGNIFICANT** | SECTION:  |
|---|---|

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

**PURPOSE:**

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

**POLICY:**

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

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

**PROCEDURE:**

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

*A significant change in condition is identified as:*

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

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

**REFERENCES:**

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

| SUBJECT: **CHANGING A TRACH TUBE ON SUBACUTE** | SECTION:  |
|---|---|



**PURPOSE:**

To define a consistent method for changing a tracheostomy tube while ensuring resident safety and welfare.

**POLICY:**

The Respiratory Care Practitioner and/or Registered Nurse will be responsible for changing the tracheostomy tube once per month and prn. A Portex D.I.C. non-fenestrated cuffed tracheostomy tube will be used unless another is indicated by the MD. Any resident not utilizing this brand of tracheostomy tube on the DP/SNF Unit must be changed within 48 hours, unless the tracheostomy is less than 30 days old or the MD may have ordered a specialized type of tracheostomy tube for certain residents. Then, the Respiratory Care Practitioner and/or the Registered Nurse will wait 30 days prior to changing the tracheostomy tube. All residents will have the same size or one size smaller tracheostomy tube at his/her bedside.

**AFFECTED PERSONNEL/AREAS:** *RESPIRATORY CARE PRACTITIONER, REGISTERED NURSE*

**PROCEDURE:**

1. Wash hands thoroughly and wear gloves.

2. Place all necessary pieces of equipment at the resident's bedside.

3. Remove the replacement tracheostomy tube from its packaging. Take care not to cause any damage to the cuff, the tubing used to inflate the cuffs, or to the control balloon.

4. Remove the inner cannula (if supplied).

5. If a cuffed tracheostomy tube is being inserted, use a clean dry syringe to inflate the cuff up to the right volume for the leak test. You will find this volume listed in the package leaflet enclosed with the tube. The air volume can be read off the markings on the syringe.

6. Using the syringe, release all the air again. While doing so, push the cuff carefully off the end of the tube in the direction of the neck flange. Make sure that you remove all air. (This makes it easier to insert the tube.)

7. Thread the tube holder through one of the openings on the neck flange. If appropriate, insert the obturator in the tube (carry out this step before you insert the tube); have a new tracheal compress ready at hand.

8. Coat the trach with a thin layer of water-soluble lubricant.

9. Hyperextend the residents' neck by placing a folded towel under the neck or remove pillow from behind the head.

10. Suction the tracheostomy tube until clear.

11. Using the syringe, release all air from the cuff on the old tube that is still in the trachea. Now remove the tube. If you are not able to remove the old tube, consult your doctor. *Never apply force.*

12. Manually ventilate the resident (if on Continuous Mechanical Ventilation ). At the end of their inhalation, remove the tube carefully; insert the new tube into the stoma.

13. Carefully insert the new tube while the patient is inhaling. Advance the tube with an arching motion first towards the back and then downwards. While doing this, insert the tube at an angle and push it with a slight turning movement into a central position. Positioning the patient with the neck extended to bring trachea forward should be done on all patients unless contraindicated (ie cervical spine injury).

14. Remove the obturator immediately while holding the tube in place with your fingers.

15. Tie the trach tube with trach collar around the resident's neck, leaving room for the insertion of two fingers between the resident's neck and trach collar. This is a safety check procedure to assure that the tie is not too tight.

16. Inflate the cuff to the correct pressure using a cuff pressure monitor (cpm). You may also use the minimal leak technique (MLT) or minimal occlusion volume (MOV). Recommended value: 25 mmHg, do not exceed 30 mmHg.

17. Carry out stoma care as usual; perform suctioning once more as required.

18. Document the trach change in the EMR.

EQUIPMENT:

- Tracheostomy tube (similar size or one size smaller)
- Tracheostomy tube ties/trach collar
- Water soluble jelly
- Sterile gloves
- Suction catheter
- Resuscitation bag with trach tube connection and mask on standby
- 5cc syringe

SPECIAL CONSIDERATION:

The resident has a right to refuse monthly tracheostomy changes. When this occurs, document the patient's refusal in the Electronic Medical Record (EMR).

CONTRAINDICATIONS:

- The tracheostomy tube should not be changed when the resident's condition is too unstable to warrant this procedure.
- The tracheostomy tube should not be changed when there is existence of neck and facial edema sufficient to make the reinsertion of the new tracheostomy tube very difficult.

ASSESSMENT OF THERAPY:

- Breath sounds should be assessed immediately after replacing the tube to determine proper tracheostomy tube placement.
- Heart rate, respiratory rate, and SpO2 will be monitored before and after the procedure.
- Make sure there is another tracheostomy tube (same size or one size smaller) at resident's bedside.

HAZARDS:

- Bleeding
- Tracheostomy tube may not be easily reinserted
- Hypoxia
- Paroxysmal coughing
- Pneumothorax
- Cardiopulmonary arrest
- Infection

**REFERENCES:**

- Johnson, William A., MD. (2020, February 14) *Clinical Procedures, Tracheostomy Tube Change.* Medscape WebMD. Retrieved from https://emedicine.medscape.com.
- American Association for Respiratory Care (2010). *Endotracheal Suctioning of Mechanically Ventilated Patients With Artificial Airways 2010.* AARC Clinical Practice Guidelines. Retrieved from http://rc.rcjournal.com/content/respcare/55/6/758.full.pdf.

- Tracheostomy education: Tracheostomy tube changes. (2019, June 5). Retrieved from https://www.tracheostomyeducation.com/tracheostomy-tube-changes/

| SUBJECT: **CHANGING A TRACHEOSTOMY TUBE** | SECTION: **Page 1 of 3** |
|---|---|

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

**PURPOSE:**

To define a consistent method for changing a Tracheostomy Tube while ensuring patient safety and welfare.

**POLICY:**

The RCP and RN will be responsible for changing the Tracheostomy tube once per month and prn. Every patient that has a tracheostomy tube will have a replacement tracheostomy tube hanging on the wall at the head of the bed. This tube will be the same size the patient has inserted or one size smaller if the same size is not available at the time.

**AFFECTED PERSONNEL/AREAS:** *RESPIRATORY CARE PRACTITIONER, REGISTERED NURSE*

**PROCEDURE:**

1. Wash hands thoroughly and wear gloves.
2. Place all necessary pieces of equipment at the resident's bedside.
3. Remove the replacement tracheostomy tube from its packaging. Take care not to cause any damage to the cuff, the tubing used to inflate the cuffs, or to the control balloon.
4. Remove the inner cannula (if supplied).
5. If a cuffed tracheostomy tube is being inserted, use a clean dry syringe to inflate the cuff up to the right volume for the leak test. You will find this volume listed in the package leaflet enclosed with the tube. The air volume can be read off the markings on the syringe.
6. Using the syringe, release all the air again. While doing so, push the cuff carefully off the end of the tube in the direction of the neck flange. Make sure that you remove all air. (This makes it easier to insert the tube.)
7. Thread the tube holder through one of the openings on the neck flange. If appropriate, insert the obturator in the tube (carry out this step before you insert the tube); have a new tracheal compress ready at hand.
8. Coat the trach with a thin layer of water-soluble lubricant.
9. Hyperextend the patients' neck by placing a folded towel under the neck or remove pillow from behind the head.
10. Suction the tracheostomy tube until clear.

11. Using the syringe, release all air from the cuff on the old tube that is still in the trachea. Now remove the tube. If you are not able to remove the old tube, consult your doctor. Never apply force.

12. Manually ventilate the resident (if on Continuous Mechanical Ventilation). At the end of their inhalation, remove the tube carefully; insert the new tube into the stoma.

13. Carefully insert the new tube while the patient is inhaling. Advance the tube with an arching motion first towards the back and then downwards. While doing this, insert the tube at an angle and push it with a slight turning movement into a central position. Positioning the patient with the neck extended to bring trachea forward should be done on all patients unless contraindicated (ie cervical spine injury).

14. Remove the obturator immediately while holding the tube in place with your fingers.

15. Tie the trach tube with trach collar around the resident's neck, leaving room for the insertion of two fingers between the resident's neck and trach collar. This is a safety check procedure to assure that the tie is not too tight.

16. Inflate the cuff to the correct pressure using a cuff pressure monitor (cpm). You may also use the minimal leak technique (MLT) or minimal occlusion volume (MOV). Recommended value: 25 mmHg, do not exceed 30 mmHg.

17. Carry out stoma care as usual; perform suctioning once more as required.

18. Document the trach change in the EMR.

EQUIPMENT:

- Tracheostomy tube (similar size and one size smaller than patient)
- Tracheostomy tube ties
- Water soluble jelly
- Sterile gloves
- Suction catheter
- Resuscitation bag with mask on standby
- 5cc syringe

CONTRAINDICATIONS:

- The patient's condition is too unstable to warrant this procedure.

- The existence of neck and facial edema sufficient to make the reinsertion of the new Tracheostomy tube very difficult.

ASSESSMENT OF THERAPY:

- Breath sounds should be assessed immediately after replacing the tube to determine proper Tracheostomy tube placement.
- Heart rate, respiratory rate, and SpO2 will be monitored before and after the procedure.
- Make sure there is another Tracheostomy tube (same size or one size smaller) at patient's bedside.

HAZARDS:

- Bleeding
- Tracheostomy tube may not be easily reinserted
- Hypoxia
- Paroxysmal coughing
- Pneumothorax
- Cardiopulmonary arrest
- Infection

**INFECTION CONTROL:**

Universal precautions

**REFERENCES:**

- American Association for Respiratory Care (2010). Endotracheal Suctioning of Mechanically Ventilated Patients With Artificial Airways 2010. AARC Clinical Practice Guidelines. Retrieved from http://rc.rcjournal.com/content/respcare/55/6/758.full.pdf.
- Johnson, William A., MD. (2020, February 14) Clinical Procedures, Tracheostomy Tube Change. Medscape WebMD. Retrieved from https://emedicine.medscape.com.
- Tracheostomy education: Tracheostomy tube changes. (2019, June 5). Retrieved from https://www.tracheostomyeducation.com/tracheostomy-tube-changes/

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

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

**PURPOSE:**

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

**POLICY:**

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

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

**PROCEDURE:**

Cleansing and Decontamination:

1. It is Nursing's responsibility to empty contents of commode and bedpans.

2. The commode/bedpan is removed from the patient care area and taken to the dirty utility room or bathroom.

    a. Bedpan or commode receptacle contents are rinsed into toilet.

    b. Receptacle or bedpan is wiped thoroughly with a clean, damp cloth or hospital-approved disinfectant only and allowed to air dry.

    c. The bedpan should be marked with the resident's name, room number and dated. Keep in bathroom away from other personal equipment.

    d. Bedpans are to be changed weekly every Sunday on day shift and as needed.

**REFERENCES:**

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

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

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

**PURPOSE:**

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

**POLICY:**

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

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

**PROCEDURE:**

1. The Social Services Designee posts required information as it is received by the facility.

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

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

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

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

    a. Existing facility license

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

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

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

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

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

    g. Activity calendar

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

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

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

k. Resident trust banking hours

l. DHS complaint filing statement

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

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

**REFERENCES:**

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

| SUBJECT: | SECTION: |
|---|---|
| **DP/SNF ACTIVITY PROGRAM** | ***Activity Program***  |



**PURPOSE:**

It is the purpose of the Activity Program to provide each resident the opportunity to participate in activities planned to meet their individual needs and interests. This includes, and is not limited to, ventilated and non-ventilated residents who require continuous oxygenation.

**POLICY:**

It is the policy of the Distinct Part Skilled Nursing Facility (DP/SNF) to provide an activity leader qualified by training or experience, to assign and implement activities that are planned to address the individual needs and ability to participate of our residents, thus promoting emotional and social support. Individual plans will be integrated with interdisciplinary care plans.

A designated activity area/room will be identified on the DP/SNF which meets independent and group activity needs and is accessible to ambulatory and non-ambulatory residents. This activity area/room will be sufficient in size to accommodate necessary equipment and allow for unobstructed movement of the residents.

The activity program shall consist of individual, small and large group activities which are designed to meet the needs and interests of each resident. Every effort shall be made to keep residents active and out of bed for reasonable periods of time, except when contraindicated by physician order. The activity program shall include, but are not limited to, the following:

A. Social activities

B. Indoor and out-of-doors activities, which may include supervised daily walks

C. Religious programs

D. Opportunity for patient involvement for planning and implementation of the activity program

E. Creative activities

F. Educational activities

G. Exercise activities

H. Activities shall be available on a daily basis.

**AFFECTED PERSONNEL/AREAS:** *ACTIVITIES LEADER, ACTIVITIES SUPPORT STAFF, NURSING, RESPIRATORY CARE SERVICES*

**PROCEDURE:**

1. Activity personnel will provide a daily visit to the resident in their assigned room.

2. Orientation to date and time and invitation to the daily activity will be offered.

3. A written, planned schedule of social and other purposeful independent or group activities will be followed.

4. Documentation of each resident's participation or refusal in the Patient Care System (PCS).

5. Mechanically ventilated and non-ventilated residents requiring oxygenation will be cared for in the following manner:

   A. The $O_2$ source will be transitioned from the wall source to a cylinder oxygen tank to allow maintenance of $O_2$ provision during resident transport from their room to the activity room.

   B. Once the resident has arrived in the activity room, the $O_2$ source will then be transitioned from the cylinder tank to the drop down $O_2$ connection.

   C. The same procedure will be followed in reverse when the resident is to be transferred back from the activity room to their respective rooms, ensuring the $O_2$ source from the cylinder tank is transferred to the O2 source on the wall.

   D. Stated transport of the mechanically ventilated and non-ventilated residents requiring oxygenation will be the responsibility of a licensed staff (RN/LVN) with due assistance by another (staff) to ensure coverage, respectively, for immediate clinical intervention as needed and to facilitate safe transport.

**REFERENCES:**

- Thomson Reuters (Revised edition April 1, 1990). Barclay's California Code of Regulations, §72381, 72383, 72385, 72005, 70709, 72383 (A1), 72315 (E), 72389, San Francisco, California, Title 22.

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.15(f)(1), (f)(2) United States of America, Med Pass Inc.

| SUBJECT: **DEATHS REPORTABLE TO CORONER** | SECTION: **Page 1 of 2** |
|---|---|

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

**PURPOSE:**

To establish a procedure for notifying the Coroner's office of a reportable death in the Distinct Part Skilled Nursing Facility (DP/SNF).

**POLICY:**

It is the policy of this facility that the Coroner's office will be notified of a death as required by State law.

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

**PROCEDURE:**

1. A resident death that fits any category of Section 27491 of California State Law will be reported to the Coroner's office.

2. The Coroner's office telephone number is available at the nurse's station of DP/SNF.

3. The officer will ask for certain information regarding the deceased and will give a case referral number.

4. The officer will give information regarding the disposition of the deceased (i.e., can be released to mortuary or hold for coroner visit).

5. Document on the licensed progress notes when the Coroner's office was notified, the name of the officer, the deceased assigned case number and the disposition of the case.

6. NOTE: Government Code, State of California, Section 27491, directs the Coroner to inquire into and determine the circumstances, manner, and cause of the following deaths, which are immediately reportable:

    a. No physician in attendance

    b. Medical attendance less than 24 hours

    c. Wherein the deceased has not been attended by a physician in the 20 days prior to death

    d. Physician unable to state the cause of death

    e. Known or suspected homicide

    f. Known or suspected suicide

    g. Involving any criminal action or suspicion of a criminal act

h. Following an accident or injury (primary or contributory, occurring immediately or at some remote time)

i. Fire, hanging, gunshot, stabbing, cutting, exposure, alcoholism, drug addiction, strangulation, or aspiration

j. Accidental poisoning (food, chemical, drug, therapeutic agents)

k. Occupational diseases or occupational hazards

l. Known or suspected contagious disease, constituting a public hazard

m. All deaths where a resident has not fully recovered from an anesthetic, whether in surgery, recovery room or elsewhere

n. All solitary deaths (unattended by physician or other person in the period preceding death)

o. Recent admission with hip fracture

**REFERENCES:**


- California Legislative Information (January 1, 2016). California Governmental Code Section 27491. Retrieved from http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=27491.
- Centers for Disease Control and Prevention (2019). Investigations and Autopsies. Retrieved from https://www.cdc.gov/phlp/publications/coroner/investigations.html.

| SUBJECT: DENTAL SERVICES | SECTION:  |
|---|---|

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

**PURPOSE:**

To ensure residents' dental service needs are assessed and provided as needed.

**POLICY:**

It is the policy that each resident admitted to this facility shall be encouraged and assisted by all those responsible for his care to obtain and maintain an adequate level of oral health through periodic examination and other required dental treatments by the contracted dentist. The attending physician may elect to do the oral exam and will document in the History and Physical or in the Dental form provided. An oral/dental assessment will be completed after the resident's admission at the next scheduled dentist visit and annually thereafter.

The facility shall maintain an agreement with an Advisory Dentist to advise and assist the facility in providing proper dental care to all residents residing in the facility. All nursing personnel shall be properly trained in the correct procedures for resident oral hygiene, denture care, and for supervision and carrying out orders of the attending physician and/or dentist concerning medication, treatment and oral hygiene as written on the resident's chart. In addition, all nursing personnel shall be given in-service training so that they might recognize symptoms or oral pathology and report the same to attending physician and/or dentist annually.

All residents' dentures shall be properly cleaned and maintained as prescribed by correct hygiene procedures. All dentures shall be readily identifiable.

Contracted dentist will be available for dental emergencies. Dental emergencies are defined as broken teeth, abscessed tooth, and severe dental caries, which cause intense pain.

All dental complaints and/or appointments will be kept in a dental log maintained by the Social Services designee.

**AFFECTED PERSONNEL/AREAS:** *REGISTERED NURSE; DENTIST; SOCIAL SERVICE DESIGNEE, ATTENDING PHYSICIAN*

**PROCEDURE:**

The Administrator is responsible for the following procedures:

1. Initiates and maintains a written agreement with an Advisory Dentist for the facility.

2. Consults with the Advisory Dentist in matters affecting the dental health and dental care of the residents in the facility.

3. Evaluates, at least annually, the performance and effectiveness of the Advisory Dentist to determine if the facility's agreement should be renewed.

4. Ascertains that the Director of Nursing is maintaining proper dental care and oral hygiene procedures in the practices of all nursing services personnel.

The Advisory Dentist is responsible for the following procedures:

1. Provides dental consultation to the Administrator, licensed nursing personnel, and when necessary, the attending physicians.

2. Conduct, at least annually, in-service training in dental care, oral hygiene and dental pathology for the nursing staff at the facility.

3. Reviews the facility's Dental Service policy upon update, minimum annually, and recommends revisions when required.

4. When necessary, serves as a liaison between the resident's physician and resident's dentist.

5. When circumstances warrant, provides emergency dental services.

6. Advisory Dentist is allowed to bring his own equipment and supplies for use on the unit.

7. When necessary, the Advisory Dentist will do more extensive dental procedures in the Operating Room.

The Director of Nursing or designee is responsible for the following procedures:

1. Ascertains that all licensed personnel are checking their assigned residents to make sure they are receiving correct oral hygiene care and, that in weekly summaries, they are including information on the condition of the residents' mouth, teeth, dentures and gums as well as their general ability to chew and eat.

2. Ascertains that dental problems are addressed, when present, in the resident's Plan of Care.

3. Ascertains that all residents' dentures are identifiable.

4. If residents' dentures are lost or damaged, assures the dentist is contacted immediately and an appointment made to repair or replace the dentures. A theft and loss report will be made, an investigation of the loss will be conducted if necessary, and a dental consult will be made to replace the dentures.

5. Maintains a dental log of all complaints and/or appointments for residents.

Licensed Nurses are responsible for the following procedures:

1. Registered Nurse assesses the resident's dental/oral condition.

2. The Director of Staff Development/Speech Therapist gives instruction to nurse assistants at least annually in correct procedures for the resident's oral hygiene and dental care.

3. Checking the performance of residents and the conditions of residents to ascertain that they are receiving correct oral hygiene.

4. Making recommendations to the resident regarding "self-care" dental hygiene practices.

5. Checks residents' rooms to make sure that dentures and denture cups are being properly cared for by the nurse assistants.

6. Licensed Nurses will chart, in the weekly summaries and nurses' progress notes in the Electronic Medical Record, the condition of the resident's mouth, teeth, gums, tongue and dentures, as well as chewing ability and overall oral condition.

7. Contacting the physician (or Director of Nursing) when a dental problem/mouth problem is present.

8. Carrying out prescribed orders by the attending physician and/or dentist for treatment and medication for oral health problems.

9. Assisting the dentist when he/she visits a resident.

Nurse Assistants are responsible for the following procedures:

1. Giving oral hygiene and denture care – The mouth is one of the least clean areas of the body in terms of bacteria present. Therefore, extra care should be taken to maintain oral hygiene.

2. If at all possible, resident should brush after every meal. The mouth should also be rinsed at that time. In some cases, the resident can brush his/her own teeth.

**REFERENCES:**

- California Code of Regulations (2021). Title 22. §72031
  Retrieved from
  https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.55. United States of America, Med Pass Inc.

**CROSS REFERENCE:**

- SVMC Policy and Procedure: THEFT AND LOSS

| SUBJECT: **DOCUMENTATION AND RECORD KEEPING - DP/SNF** | SECTION: *Social Services* **Page 1 of 2** |
|---|---|

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

**PURPOSE:**

To assure the timely and appropriate completion of all Social Service documentation requirements necessary for regulatory compliance and to meet the psychosocial needs of residents/families residing in the DP/SNF.

**POLICY:**

Social Service designee will assure that all pertinent data related to the emotional and social needs and the overall well-being of the resident and family shall be recorded in the electronic medical record. Information entered into the resident's electronic medical record will be kept confidential and shall be utilized by team members in executing the resident's comprehensive plan of care.

**AFFECTED PERSONNEL/AREAS:** *SOCIAL SERVICES DESIGNEE*

**PROCEDURE:**

1. Psychosocial assessment is documented in medical records within 48 hours of resident's weekday admission to the unit, reviewed within 30 days, and re-evaluated annually or at changes in resident's status.

2. Initial discharge planning assessment is to be documented in records within 48 hours of admission, with the plan reviewed during weekly Interdisciplinary Team conference for short-term or transitional residents and monthly for long-term or DP/SNF residents. The assessment is updated quarterly, annually and upon change in resident or responsible party status. The discharge planning goal is entered in the residents' plan of care within 7 days of admission. The discharge/transfer notification and designated portion of the Post Discharge Plan of Care Form is completed as appropriate for eminent discharge.

3. Weekly Social Service progress notes. These may be written more often as needed, inclusive of concerns related to physical, psychological, financial, spiritual, emotional and concrete needs of resident.

4. Goals and treatment for resident's plan of care are to be included in the psychosocial assessment and the resident care plan. Updating of plan of care goals is done on monthly, quarterly and annual basis.

5. Monthly Interdisciplinary Team conference reports, quarterly reviews, documentation of resident/family invitation, and attendance at meetings, and minutes of meeting.

6. Completion of designated portions of the Minimum Data Set (MDS)
consents and acknowledgements obtained from facility admission agreement within 24 to 48 hours of admission

7. Quarterly summary of progress updates and report of the resident's status, needs, and support interventions provided.

8. Completion of the entire admission process within 48 hours of admission, including psychosocial and discharge planning assessments within above timelines, and the admission agreement.

**REFERENCE:**

- National Association of Social Workers (2019). Retrieved from https://www.socialworkers.org.
- 42 CFR 483.15-483.65 (2017). Admission, transfer, and discharge rights. Retrieved from https://www.law.cornell.edu/cfr/text/42/483.15.

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

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

**PURPOSE:**

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

**POLICY:**

Documentation will provide an accurate description of a patient's condition, clear and concise communication between healthcare disciplines and meet legal requirements through proper use of nursing and interdisciplinary forms in the Electronic Medical Records Interventions.

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

**PROCEDURE:**

INITIAL ASSESSMENT FORMS:

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

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

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

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

INTERDISCIPLINARY PLAN OF CARE:

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

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

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

Once a problem is resolved the Care Plan will be discontinued in the EMR with a stop date.

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

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

NURSING EVENT NOTES IN MEDITECH SYSTEM

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

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

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

4. Pain is an event that will be documented in the EMR. If pain medication is administered and will be monitored in the nurses Pain Assessment Intervention in the EMR three times a shift.

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

   a. Initials

   b. Location

   c. Time/Date

   d. Description

   e. Pain Scale Number (0-10)

   f. Intervention

   g. Time of Reassessment (after intervention)

   h. Response after intervention (0-10)

RN ASSESSMENT AND DOCUMENTATION

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

LVN NOTES/ASSESSMENT IN PCS

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

CNA DOCUMENTATION IN MEDITECH

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

MEDITECH DOWNTIME

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

**REFERENCES:**

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

**CROSS REFERENCES:**

- MEDITECH DOWNTIME - CLINICAL DOCUMENTATION

| SUBJECT: | SECTION: |
|---|---|
| **END OF LIFE ISSUES** | **Page 1 of 2** |

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

## POLICY:

It is the policy of the DP/SNF unit to assist those residents who are facing end of life conditions to proceed through the death process with comfort, dignity and respect. As death is viewed as the final act of living, generated from within the person, all efforts will be set forth by the organization to identify, address and positively respond to the resident's needs, related to all primary and secondary diagnoses and symptoms, and those of their families as they relate to psychological, social, emotional and spiritual issues.

## AFFECTED PERSONNEL/AREAS:

*SOCIAL SERVICES; PHYSICIANS, ALL DPSNF STAFF, PASTORAL CARE STAFF*

## PROCEDURE:

1. Every effort is made by the members of the healthcare team to identify and respond to the resident's belief and value systems, including those that are cultural and spiritual. This effort is made for all residents throughout the facility to ensure the appropriate level of care.

2. For those residents who require specialized interaction due to belief and value systems, the direct resident care provider will contact the Social Services Department and/or the Pastoral Care Department for direction and participation in the resident's care.

3. For those residents who are facing end of life issues, emphasis on therapeutic communication will be in place to allow for identification of end of life issues as they relate to belief and value systems, psychosocial, emotional and spiritual issues. Identification of these issues will be made with the assistance of the Social Services Department and the Pastoral Care Department.

    a. The Social Services and Pastoral Care Departments will be notified via the computer system by the direct resident care provider of those residents admitted with a terminal illness.

    b. The Social Services and Pastoral Care Departments will be notified by the direct resident care provider via the computer system of those residents for whom a diagnosis of terminal illness, either short term or long term, has been identified and documented as a definitive primary or secondary diagnosis.

4. Direct resident care providers will defer to the Social Services and/or Pastoral Care Departments in their psychosocial interventions based on those departmental members' specialized interactions with the resident and family. Direction will be taken from the Social Services and/or Pastoral Care Department members as to management of the resident/family end of life issues as they relate to belief and value systems, cultural, spiritual, emotional and psychosocial issues.

5. Resident care staff will be educated and trained regarding the unique needs of the resident facing end of life issues. Staff will be educated how to best assist the resident and their family members through the end of life process while maintaining the resident's comfort, dignity and respect.

**REFERENCES:**


- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.25 United States of America, Med Pass Inc.
- National Institute on Aging, January 2022, Different Care Settings at the End of Life, US Department of Health and Human Services, retrieved from: caringinfo@nhpco.org

| SUBJECT: **ENTERAL NUTRITION ORDERS** | SECTION:  |
|---|---|



**PURPOSE:**

The purpose of this policy is to write a clear, concise, compliant order for enteral administration of formula and water.

**POLICY:**

Enteral orders must include the following:

1. Type of formula, amount, total calories, protein.
2. How often/rate it is to be given.
3. Method of administration (intermittent gravity, bolus or pump).
4. Amount of water flush to be given and how often.
5. Amount of water to be used for flushing before and after medications.
6. The type of feeding tube (NG, G, or J tube)
7. How often feeding tube is to be changed.
    a. Feeding tubes will be changed with every formula bottle change/every 24 hours and PRN by licensed nursing staff
8. Specific orders for elevation of HOB, tube care, residual checks, and site care.

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

**PROCEDURE:**

1. Determine the specific orders from the physician – have the physician write them, or the RN may write them as a verbal/telephone order.
2. ENTERAL NUTRITION ORDER FORMAT FOR LONG TERM CARE

    TUBE FEEDING: _____

    TOTAL: _____Vol /24 hours

    TO PROVIDE: _____Kcals

    _____Protein

Method of administration: _____ (bolus, intermittent, continuous gravity or pump).

Administer via pump:

Run at _____cc/hour over_____ hours

FREE WATER in addition to formula: _____CC/24 hours minimum or maximum, whichever the doctor writes.

- Elevate HOB 35-45 degrees at all times while feeding is administered; and for one hour after feeding if bolus or intermittent.
- Flush feeding tube with water a minimum of once per shift, and after administering medications as per flush order by MD.
- Flush GT with 30ml $H_2O$ prior to medication administration. Flush with 15ml in between each medication given and complete medication pass with a flush of 30 ml $H_2O$.
- Check residual every shift, and prior to administration of feeding, water, or medications.
- Check residual every shift, and PRN gastric distress; hold tube feeding for 1 hour if residual is greater than 250ml.
- If residuals remain over 250ml after 1 hour, hold tube feeding and recheck residuals hourly. If tube feeding held greater than 24 hours, notify MD and obtain a dietary consult. If residuals are less than 250ml, resume tube feeding at previous rate.
- Tube site care with soap and water as needed for excessive drainage. Leave site open to air if the skin is intact. (Please indicate specific orders for skin care if needed.)

**REFERENCES:**


- ASPEN Safe Practices for Enteral Nutrition Therapy, Joseph I. Boullata PharmD, RPh, BCNSP, FASPEN, FACN, November 4, 2016. https://aspenjournals.onlinelibrary.wiley.com.
- Enteral feeding: Indications, complications, and nursing care. Jan 11, 2017. www.myamericannurse.com.
- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.40 (a) United States of America, Med Pass Inc.

| SUBJECT: **FOOD AT BEDSIDE- STORAGE** | SECTION:  |
|---|---|

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

**PURPOSE:**

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

**POLICY:**

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

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

**PROCEDURE:**

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

**REFERENCES:**

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

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

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

**PURPOSE:**

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

**POLICY:**

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

**AFFECTED PERSONNEL/AREAS:** *SOCIAL SERVICE/DPSNF*

**PROCEDURE:**

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

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

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

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

**REFERENCES**:

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

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

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

**PURPOSE:**

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

**POLICY:**

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

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

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

**PROCEDURE:**

A. DAILY GROOMING

EQUIPMENT:

1. Comb and brush
2. Towel

B. PROCEDURE:

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

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

C. ROUTINE SHAMPOO

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

D. THERAPEUTIC SHAMPOO

PURPOSE:

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

EQUIPMENT:

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

PROCEDURE:

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

SHAMPOO IN BED:

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

EQUIPMENT:

1. Large pitcher

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

PROCEDURE:

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

**REFERENCES:**

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

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

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

**PURPOSE:**

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

**POLICY:**

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

**AFFECTED PERSONNEL/AREAS:** *RNA, CNA*

**EQUIPMENT:**

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

**PROCEDURE:**

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

**REFERENCES:**

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

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

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

**PURPOSE:**

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

**POLICY:**

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

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

**PROCEDURE:**

1. Social Services will maintain a system to monitor the dental, optometry and podiatry (others, e.g. speech therapist, as needed) evaluations.

2. Evaluations will be scheduled on an annual basis and/or as needed.

3. Evaluation dates will be documented in the Electronic Medical Record and on logs maintained separately as agreed upon with nursing.

4. Social Services will notify resident or authorized representative of any recommendation for medical services/ evaluations made by a consultant. prior to scheduling the appointment.

**REFERENCES:**

- Thomson Reuters (Revised edition April 1, 1990). Barclay's California Code of Regulations, 72423, 72031, 72089, 72401 San Francisco, California, Title 22.

- Long Term Care State Operations Manual, F636 Comprehensive Assessment Timing, Intent 483.20(b) (1) (2) (i) & (iii), November 28, 2017.

| SUBJECT: **INFECTION PREVENTION AND CONTROL - 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 provide an overview of the prevention and control program whose intention is to reduce the risks of transmission of infection in the DP/SNF of Sierra View Medical Center (SVMC). The program is in accordance with epidemiological principles and local/state and federal regulations. The program shall include, but is not limited to: surveillance activities, infection control, resident care, employee health, and in-service education in infection prevention.

**POLICY:**

- The DP/SNF staff will follow the hospital-wide employee health and infection control guidelines.
- All staff will receive an initial orientation to infection control principles and exposure prevention as well as annual updates/in-services.
- All staff will utilize standard precautions in resident care as described in the acute care section of this manual.
- Hand hygiene with alcohol rub will be a primary means of reducing the risk of transmission within the DP/SNF and the staff will follow the protocol described in the acute care section of this manual.
- There will be on-going surveillance of resident infections.

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

**PROCEDURE:**

A. Surveillance:

1. There shall be one person (Infection Preventionist) assigned to do ongoing surveillance of all resident infections (method of house-wide surveillance).
2. The Infection Preventionist will coordinate data collection with the Directorr of Infection Control.
3. Surveillance data will be entered in a log and will be analyzed for the following elements to detect clusters or trends:
    a. Date of onset
    b. Site of infection
    c. Room
    d. Culture information

4. Infection rates will be calculated monthly and quarterly, then presented to the Infection Control Committee (ICC) and shared with staff members/ family or significant others in the Interdisciplinary Team Meetings, as appropriate.

5. The Infection Preventionist will monitor lab cultures for trends, including antibiotic-resistant bacteria in the Sub Acute Unit, intervene as necessary, and assist in the reporting to the Pharmacy and Therapeutics Committee (P&T)/ICC.

B. Outbreak Control:

1. Surveillance data will be used to detect outbreaks in the DP/SNF.

2. The ICC Chairperson and/or his designee (the Infection Preventionist) shall take corrective action as necessary to protect staff and residents during an outbreak of an infectious disease.

3. Outbreaks shall be reported to the local health officer in accordance with T17.

C. Reportable Conditions:

1. The Infection Preventionist will report all conditions required by local and state law to the Tulare County Health Department.

D. Isolation Precautions:

1. Standard precautions shall be used for all resident care activities.

2. When transmission-based precautions are indicated, a private room is preferred, but not always available. The Manager of Infection Control shall make recommendations on transmission-based precautions issues. Modifications will be made based on the type of precautions indicated in accordance with epidemiological principles.

E. Resident Vaccination Program:

1. All residents will be offered the flu vaccine annually in the fall, unless medically contraindicated.

2. All residents will be offered a pneumococcal vaccine upon admission if indicated.

F. Housekeeping, Laundry, Clean Linen, Soiled Linen, and Waste Handling shall be handled in the same fashion as the acute care facility and in accordance with local, state, and federal regulations.

**REFERENCES:**

- Centers for Disease Control and Prevention (March 2019). Infection Control. Retrieved from https://www.cdc.gov/infectioncontrol/index.html.

- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.65, 483.65(a) United States of America, Med Pass Inc.
- Smith, P.W. and Rusnak, P. G. (1991). APIC Guideline for Infection Prevention and Control in the Long-Term Care Facility. AJIC 1991: 19 (4): 198-215.
- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, Chapter 3, Section 72523, 72535, 72537, 72621, 72625, 72627, 72647, San Francisco, California, Title 22.

| SUBJECT: **MAINTAINING PATENCY OF FEEDING TUBE** | SECTION: **Page 1 of 2** |
|---|---|

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

**PURPOSE:**

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

**POLICY:**

Occluded percutaneous endoscopic gastrostomy tube (PEG) feeding tubes will be reported to the physician, and an order obtained for a surgical consult for removal.

*Note:* Foley feeding tubes will be changed as needed by licensed nursing staff. Nursing staff are not to remove a PEG tube.

*Agents:*

- Warm Water

**AFFECTED PERSONNEL/AREAS:**

*RN, LVN*

**EQUIPMENT:**

- 60cc Syringe
- Warm Water
- Container

**PROCEDURE:**

1. Wash hands thoroughly.
2. Explain procedure to resident.
3. Draw up 20-50cc of warm water.
4. Attach syringe to tube, alternately push in and pull back on the plunger to avoid continued excessive pressure.
5. If unsuccessful, instill 10-20cc of H2O; clamp tube for about 20 minutes.
6. Check tube as per #4.
7. If unsuccessful, repeat 5 and 6.

8. If unable to unclog tube – replace per physicians orders. If the resident has a permanent tube which cannot be removed (PEG), notify the physician.

RECORDING:

1. Record procedure and results in resident's electronic medical record.

**REFERENCES:**


- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.30 United States of America, Med Pass Inc.
- American Society for Parenteral and Enteral Nutrition (ASPEN). (Mar 22, 2019). *Combat the Clog: Tips for Keeping Feeding Tubes Clear*. Tubefed.com by AVANOS. Retrieved from https://tubefed.com/newsletter/combat-the-clog-tips-for-keeping-feeding-tubes-clear/.

| SUBJECT: **MATTRESS- AIR** | SECTION: **Page 1 of 1** |
|---|---|

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

**PURPOSE:**

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

**POLICY:**

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

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

EQUIPMENT:

- Air mattress

**PROCEDURE:**

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

**REFERENCES:**

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

| SUBJECT: **MATTRESS- ALTERNATING AIR** | SECTION: **Page 1 of 2** |
|---|---|

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

**PURPOSE:**

The purpose is to provide stimulation and pressure relief to resident's at risk for skin breakdown and to distribute body weight relieving areas of pressure.

**POLICY:**

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

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

**PROCEDURE:**

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

**REFERENCES:**


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

- Wound Reference, Inc. (2019). Wound Reference. Retrieved from https://woundreference.com/.

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

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

**PURPOSE:**

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

**POLICY:**

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

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

EQUIPMENT:

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

**PROCEDURE:**

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

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

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

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

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

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

13. Resume feeding as ordered.

RECORDING:

Chart medications given on MAR in the EMR. Chart fluids administered with medication on EMR.

SPECIAL CONSIDERATIONS:

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

**REFERENCES:**


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

| SUBJECT: **NURSING CARE, RESTORATIVE AND SUPPORTIVE** | SECTION: **Page 1 of 2** |
|---|---|

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

**PURPOSE:**

To provide residents with restorative and supportive nursing care to enhance the resident's physical, mental and social well-being and independence.

**POLICY:**

It is the policy of this facility that each resident will be provided with an individualized restorative and supportive plan of care to allow the resident the highest degree of independence possible within their physical and mental capabilities and to provide early detection and intervention when independence declines in order to prevent complications and maintain the resident at their highest level of functioning.

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

**PROCEDURE:**

1. Each resident shall be assessed upon admission for levels of functional abilities utilizing the Nursing Assessment and the interdisciplinary Minimum Data Set.

2. An interdisciplinary plan of care will be established identifying short-term and long-term resident goals.

3. The resident and family will be involved in establishing the plan of care whenever possible.

4. Restorative and supportive care shall include:

    a. Maintaining good body alignment and proper positioning of bedfast and dependent residents.

    b. Encouraging and assisting residents at least every two hours.

    c. Making every effort to keep residents active and out of bed for reasonable periods of time, except when contraindicated by physician order.

    d. Encouraging resident to achieve the highest degree of independence in activities of daily living by teaching self-care, transfer and ambulation techniques and providing assisting devices.

    e. Assessing bowel and bladder function, providing toileting assistance and retraining programs based on the individual resident need and abilities.

f. Providing range of motion to maintain joint mobility, prevent contractures or prevent further deterioration and complications of limited range of motion.

g. Assessing self-feeding skills and providing adaptive devices and retraining programs based on resident needs and capabilities, including weaning from feeding tubes.

h. Assessing skin integrity and nutritional status to ensure prevention or early detection of pressure ulcers.

i. Assessing social activity preferences/needs and implementing social service and activity plans of care to enhance the residents' emotional and social well-being.

j. Referring therapy programs (PT, OT, and ST) as indicated by resident assessment and need.

5. Restorative and Supportive Nursing Care Services when provided to the resident will be documented on the CNA / RNA in the EMR as indicated.

**REFERENCE:**


- California Code of Regulations (2019). Title 22. §70557. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

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

| SUBJECT: **NURSING WEEKLY SUMMARY** | SECTION:  |
|---|---|

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

**PURPOSE:**

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

**POLICY:**

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

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

**PROCEDURE:**

1. Review the resident personalized care plans, nurses' notes, ancillary progress notes, intake and output record, physician's orders, MAR, TAR, lab and radiology reports for the last seven days.
2. Assess the resident.
3. Complete the weekly summary, addressing all personalized care plan problems.
4. Be sure to include resident status and progress in the following basic areas of focus:

    a. Skin Integrity

    b. Intake and Output

    c. Elimination

    d. Mobility

    e. Skin Risk

    f. Neurological Evaluation

    g. Psych/Social Evaluation

    h. HEENT Evaluation

i. Cardiovascular Evaluation

j. Gastrointestinal Evaluation

k. Genitourinary Evaluation

l. Integumentary Evaluation

m. Musculoskeletal Evaluation

n. Male/Female Reproductive Evaluation

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

p. Restraints, if present

q. Infection, if present

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

**REFERENCE:**

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

| SUBJECT: **ORAL CARE** | SECTION: **Page 1 of 4** |
|---|---|

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

**PURPOSE:**

To maintain a healthy mouth and teeth.

**POLICY:**

It is the policy of this facility to provide oral care before breakfast, before bed in the evening, upon request and as needed.

Special mouth care is provided for the resident who is unable to assist, those with indwelling nasal or oral tubes and those receiving oxygen.

**AFFECTED PERSONNEL/AREAS:**

*RN, LVN, CNA*

EQUIPMENT:

- Curved basin
- Towel
- Mouthwash or water in a cup
- Package of glycerin and lemon swabs (optional)
- Resident's personal dentifrice and toothbrush and/or toothettes

**PROCEDURE:**

A. ROUTINE ORAL CARE

1. Wash hands thoroughly/wear gloves. Assist resident to sitting position. Provide privacy.
2. Place over bed table in front of resident and arrange necessary articles within reach.
3. Assist and instruct resident to brush teeth and rinse mouth as necessary.
4. Apply non-petroleum based lubricant, if mouth or lips are cracked and dry.

B. CARE OF DENTURES

1. Many residents with dentures are sensitive about them. Guard against offending resident in any way.

2. Most residents wear their dentures continuously and may need to clean dentures after each meal.

3. If resident is on bed rest, the nurse should clean their dentures for them.

4. While dentures are being cleaned, the resident can clean their mouth with a soft brush or rinse well with mouthwash.

5. Wash hands/wear gloves prior to handling dentures.

6. Remove dentures from the resident's mouth, pushing up gently on the upper denture to break suction.

7. Brush dentures with the resident's preferred cleansing agent and a brush, more vigorously than when using a regular toothbrush.

8. Rinse dentures under cool, running water.

9. Dentures should be wet when returned to mouth.

10. When not in the resident's mouth, dentures should be stored in a clean, labeled, covered denture cup filled with water.

11. Store denture cup in the bedside stand when not in use.

12. Wash hands thoroughly.

C. SPECIAL ORAL CARE

GENERAL CONSIDERATIONS

1. If a resident is unable to assist, the nurse will do complete care of the resident's mouth and teeth every 12 hours and as needed.

2. If a resident needs to be encouraged to take food, cleansing the mouth before eating helps to make food more palatable.

EQUIPMENT:

- Lemon glycerin swabs or toothettes
- Gauze wrapped around a tongue blade
- Container of water, mouthwash or salt water
- Tongue blade

- Emesis basin
- Towel
- Resident's personal dentifrice and toothbrush

D. PROCEDURE:

1. Wash hands thoroughly/ hand rub / wear gloves.
2. Explain procedure to resident.
3. Elevate head of bed or turn resident's head or body to side.
4. Spread towel across chest.
5. Place emesis basin under resident's chin.
6. Use tongue blade to hold mouth open while cleansing tongue and teeth.
7. Use toothettes or lemon glycerin swab as cleansing tool or gauze wrapped tongue blade.
8. Cleanse gently and as frequently as is necessary.
9. Moisten cleansing tools as needed until care completed.
10. Using moistened brush held at a 45 degree angle to the gum, perform ½ minute gum massage.
11. Apply small amount of toothpaste to brush, and brush teeth, using circular motion.
12. Brush tongue.
13. Have resident rinse mouth, if able, or swab with toothettes or lemon glycerin swab.
14. Remove towel.
15. Wipe resident's mouth.
16. Wash equipment and return it to its proper place.
17. Wash hands thoroughly.

E. AFTER-CARE OF RESIDENT AND EQUIPMENT:

1. After care of mouth, wash and dry articles. Place toothbrush, toothpaste, cup, and curved basin in designated storage area.

2. After special mouth care, replenish articles used in preparation for next treatment.

3. Discard waste, and return equipment taken from bedside stand.

4. Leave resident comfortable.

F. DOCUMENTATION:

***Nurse's Notes***: Record unusual conditions of resident's mouth and special solutions used. Report unusual conditions to resident's physician.

**REFERENCE:**

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

| SUBJECT: **ORAL NUTRITION SUPPLEMENT** | SECTION:  |
|---|---|

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

**PURPOSE:**

To establish protocol for oral nutrition supplement (ONS).

**DEFINITIONS:**

ONS includes high calorie protein drinks and protein powders/liquids that are considered by the manufacturer to be medical foods.

**POLICY:**

ONS and oral modular supplements are available to patients as ordered by the physician and/or registered dietitian (RD).

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

**PROCEDURE:**

A. The RD may order or discontinue any ONS for patients on a modified diet using the ONS and Diet Type chart. The RD may modify the frequency, delivery time, and flavor of the existing ONS orders entered by the physician. RDs may only discontinue ONS ordered by other RDs. *See attached addendum.*

B. The RD may add protein modular (amino acid powders/protein powders/liquids).

C. The RD may adjust the diet downwards for calories, protein and textures.

**REFERENCES:**


- California Code, Business and Professions Code - BPC § 2585. (n.d.). Retrieved from https://codes.findlaw.com/ca/business-and-professions-code/bpc-sect-2585.html.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2024). 482.2 8(b) Tag-0629 482.28(b)(1). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- The Joint Commission (2024). Hospital accreditation standards. PC.02.02.03, EP 7

**ADDENDUM**

Food and Nutrition Services Dept. Diet Manual
Diet Types & Oral Nutrition Supplements (ONS)

**Oral Nutrition Supplements by Diet**

A crosswalk illustrating the ONS that fits the macronutrient composition and pattern of the diets listed. These may be selected by the Clinical Dietitian or Nurse, to be offered to patients based on assessed need. Only a physician may order alternate supplements.

| Diet in Electronic Medical Record | Allowed Oral Nutrition Supplements |
|---|---|
| • **High Iron**<br>• **Regular**<br>• **Vegetarian**<br>• **Kosher**<br>• **High Calorie/High Protein Pregnancy/Lactation**<br>• **Low Microbial/Neutropenic**<br>• **Full Liquid**<br>• **Low Fiber, Low Residue**<br>• **Dysphagia I,II, III**<br>• **Blenderized Puree**<br>• **Cardiac**<br>• **Low Sodium2 gm**<br>• **No Added Salt (4 gm)**<br>• **Low Fat**<br>• **Gluten Free**<br>• **PUD/GERD**<br>• **6 Small Meals**<br>• **Hyperemesis Gravidarum** | • Boost Plus<br>• Ensure Clear<br>• Ensure Plus High Protein<br>• Ensure Plant Based Protein<br>• Ensure Max Protein<br>• Glucerna Therapeutic Nutrition Shake<br>• TwoCal HN<br>• Nepro<br>• SF Mighty Shake, Regular Mighty Shake<br>• Suplena<br>• Pediasure<br>• Propass Powder<br>• SF Prostat<br>• Banatrol Plus<br>• Juven |
| • **Thickened Liquids** | All ONS thickened to appropriate consistency |
| • **Clear Liquid w/Supplement**<br>• **Clear Liquid**<br>• **Diabetic Full Liquid**<br>• **Diabetic Clear Liquid** | • Ensure Clear (Not on Diabetic Clear/Diabetic Full Liquid)<br>• Juven<br>• SF ProStat<br>• Diabetic FL: Glucerna, SF Mighty Shake, Ensure Max Protein, Banatrol Plus, Ensure Plant Based |
| • **Consistent Carbohydrate**<br>• **Consistent Carbohydrate Low**<br>• **Gestational DM** | • Glucerna Therapeutic Nutrition Shake<br>• Ensure Plant Based<br>• Ensure Max Protein |

| SUBJECT: **ORAL NUTRITION SUPPLEMENT** | SECTION: **Page 3 of 3** |
|---|---|

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

| | |
|---|---|
| | • Banatrol Plus<br>• Nepro<br>• Suplena<br>• Propass powder<br>• SF Prostat<br>• SF Mighty Shake |
| • **Renal**<br>• **Renal – High Protein** | • Nepro, Glucerna (dialysis)<br>• Suplena (Low Protein Diet, no dialysis)<br>• Ensure Clear<br>• Propass Powder, SF ProStat<br>• Juven |
| • **Calorie Restriction: 1200, 1500, 1800, 2000, 2400** | • All ONS<br>• Propass<br>• SF Prostat<br>• Consult RD if needed |
| • **Hepatic 2gm Na+, 50gm protein**<br>• **Low protein (50gm)**<br>• **Renal Low Protein (60g)** | • Suplena, consult RD if needed |
| **Combination Diets**<br>• **Consistent Carb/Renal**<br>• **Consistent Carb Cardiac**<br>• **Cardiac Low Potassium** | • Glucerna, no chocolate<br>• Nepro<br>• Suplena<br>• Propass Powder<br>• SF Prostat |
| • **Toddler 1-2**<br>• **Pediatric 2-12** | • Pediasure<br>• Ensure Enlive |
| • **Gastro Pediatric**<br>• **BRAT** | No supplement |
| • **NPO Except Supplements** | Any liquid oral supplement (No Meal Tray) |

| SUBJECT: **ORDERS- PHYSICIAN NOTING** | SECTION:  |
|---|---|

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

**PURPOSE:**

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

**POLICY:**

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

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

**PROCEDURE:**

1. The nurse shall verify each order for completeness, clarity, and appropriateness of dose and allergies.
2. Monitoring criteria for the medications (vital signs, behavior, laboratory tests, etc.) are part of the Medication Administration Record (MAR) in the EMR.
3. Orders are entered into Meditech in the residents EMR by the RN.
4. Appropriate doses and administration times are established for each medication. (See MEDICATION ADMINISTRATION TIMES )
5. All new orders are phoned or faxed to the contracted drug company.
6. If applicable, signal labels are affixed to current containers of medication (Order Change, Discontinued, and Hold).
7. The order is "noted" when the above steps, and any other appropriate actions, are taken. To note an order the nurse shall acknowledge the order in the EMR.

**REFERENCES:**


- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.20 (a) United States of America, Med Pass Inc. Thomson Reuters: (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, San Francisco, California.
- American Health Information Management Association, 2019, Documentation in the Long–Term Care Record-AHIMA Body of Knowledge, Physicians Orders (F271).


**CROSS REFERENCES:**

- MEDICATION ADMINISTRATION TIMES

| SUBJECT: **ORDERS- PHYSICIAN RECAPPING** | SECTION:  |
|---|---|

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

**PURPOSE:**

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

**POLICY:**

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

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

**PROCEDURE:**

1. The Registered Nurse will review the physician orders that turn red in the EMR each shift at 1500 and 0300. Accuracy is essential and all orders will then go to the Medical Director for signature.

2. All new orders will be added during each shift when received by the MD, and discontinued orders will be removed after discontinued date. The Charge Nurse and licensed nurse needs to make sure all medications have an administration time.

**REFERENCES:**

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

| SUBJECT: **PAIN: ASSESSMENT AND MANAGEMENT** | SECTION: **Page 1 of 5** |
|---|---|

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

**PURPOSE:**

To define the process of assessment and management of pain.

**POLICY:**

Adequate pain management is crucial to quality patient care. We recognize that pain is a unique and individual experience for each patient, and as such will involve the patients in all aspects of their care including pain assessment and management. We are committed to assessing pain scores at the following times:

- On admission
- At least each time vital signs are measured (This is not necessary if vital signs are being measured more frequently than 30 minutes, unless the resident is undergoing a painful procedure)
- Whenever a resident complains of pain
- Reassessment within 30 – 60 minutes of administration of medication to treat pain depending on the route given and expected onset of relief of the drug, and resident's condition.

Routine Pain Assessment schedule for each shift as follows: NOC Shift– 2200, 0200, 0600; AM Shift-1000, 1400, 1800; PRN Pain Assessment implemented in between.

All residents will be questioned regarding the presence of pain and what form of pain management is most effective.

Management of the resident's pain is an interdisciplinary process based on current standards of practice with medical director assistance and is to be included in the Interdisciplinary Plan of Care. It is the responsibility of all clinical staff to assess and reassess the resident for pain and responses to treatment.

The resident's care providers will provide information to the resident and the resident's family/significant others regarding pain management. Optimal management of pain is a primary goal of the resident's care and is consistent with the organization's mission and value statements.

Placebos will NOT be prescribed and/or administered for:

- Pain assessment
- When traditional therapy is failing, has failed or has an adverse effect upon the resident even to the point of worsening symptoms
- Diagnosing psychogenic symptoms thought to be exaggerated, imagined or fake symptoms
- Psychotic, manipulative or demanding behaviors

**AFFECTED PERSONNEL/AREAS:**

*ALL PATIENT CARE AREAS*

EQUIPMENT:

Healthcare professionals will assess pain using one of the developmentally appropriate tools used at Sierra View Medical Center:

- 0-10 scale (numeric scale) for adults who can understand abstract numbers (10 point scale)
- Wong-Baker Faces Scale for those residents who can communicate intensity and location of pain, but who do not understand abstract numbers (10 point scale)
- FLACC (Face, Legs, Activity, Cry, Consolability) for the cognitively impaired
- Mild pain is defined as a value of 1-3 on the numeric and FLACC scales. Moderate pain is defined as 4-6 and severe pain is defined as 7-10.

STAFF EDUCATION, ORIENTATION AND TRAINING

1. During the initial orientation period, all levels of staff that have direct resident care responsibilities, including contract/agency staff, are oriented to this policy and procedure and to appropriate pain management.

2. Competency validation related to pain management is documented in employee files.

**PROCEDURE:**

INITIAL ASSESSMENT

1. Upon admission, all residents will be assessed for the presence of pain. The most appropriate pain rating scale will be used to evaluate the resident's pain (i.e. Numeric pain scale for adults).

2. Pain assessment will include, but not be limited to, the following information based on a mnemonic of: **P – A – I – N – E – D.**

   **Place:** Location or site of pain (use a body chart for patients to locate)

   **Amount of pain:** Use a pain intensity rating scale appropriate for the resident population.

   **Intensifiers:** What makes the pain worse, i.e. position, movement, time of day?

   **Nullifiers:** What makes the pain better, i.e. position, heat or cold, medication?

**Effects:** What are the effects of medication (relief, side effects), effects on activities of daily living, quality of life?

**Description:** Quality of the pain (dull, sharp, aching, stabbing, cramping, etc?) in the resident's own words.

3. The resident's cultural, spiritual, ethical, family and personal beliefs and values will be included in the assessment as appropriate.

4. The resident /significant other's learning needs, abilities, preferences and readiness to learn will be assessed to include but not be limited to:

   a. Emotional barriers and motivations;

   b. Financial implications of core choices;

   c. Physical and cognitive limitations;

   d. Educational level and language and literacy;

   e. Beliefs and values.

REASSESSMENT

1. The resident will undergo reassessment of pain during each designated vital sign assessment, when a resident complains of pain, during a painful procedure and after every pain control mechanism used by the resident. Data collected will be documented in the Nursing pain assessment in the electronic medical record and the medication administration record (MAR). Pain control mechanisms include, but are not limited to:

   a. Medications administered for the control or relief of pain

   b. Medications administered for the control or relief of anxiety

   c. Repositioning of the resident

   d. Ambulating of the resident

   e. Mild resident exercise, PROM (Passive Range Of Motion), AAROM(Active Assisted Range of Motion)

   f. Therapeutic massage (i.e. back rub)

   g. Bathing

   h. Diversion techniques (i.e. television or videotape viewing, reading)

i. Therapeutic communication

j. Spiritual counseling

k. Visitation from family/significant others

2. Any resident's care provider that has implemented a pain control mechanism will reassess the resident within 30 – 60 minutes of administration of medication to treat pain depending on the route given and expected onset of relief of the drug, and patient condition.

PATIENT EDUCATION

1. All residents' care providers will provide information to the resident and the resident's family/significant other about pain management. Optimal management of pain is a primary goal of resident care and is consistent with the organizations' mission and value statements. Education will be documented in the Interdisciplinary Patient/Family Education Record.

2. Residents will be taught that pain management is part of their treatment.

3. Residents will be instructed to keep his/her nurse informed about their pain so that they may be medicated as ordered.

4. The resident and his/her family/significant other(s) will receive education provided by the staff regarding management of the resident's pain. Education includes, but is not limited to:

a. Types of pain the resident actually or potentially experienced;

b. Pain control mechanisms available and/or that have been employed;

c. Potential limitation of pain management and treatment;

d. Potential and/or actual side effects of pain management and treatment;

e. Determination of the resident's acceptable level of pain, i.e. the terminally ill resident may wish complete relief from pain, knowing this may render his/her in a semi-somnolent state; or this resident may request relief from pain to the degree where pain may still be experienced, however his/her ability to remain mentally alert and relate to family/significant others remains intact;

f. Discharge planning process with emphasis on symptom management, i.e. pain, nausea, or dyspnea.

**REFERENCES:**


- The Joint Commission (2021). Hospital accreditation standards. PC.01.02.03; PC.01.02.07. Joint Commission Resources. Oak Brook, IL.

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 72082, 72319, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I4CBE8CB0D4BC11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default).

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

| SUBJECT: **PATIENT ACCESS TO THE OUTDOORS** | SECTION: ***Ethics, Rights & Responsibilities (RI)*** **Page 1 of 1** |
|---|---|

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

**PURPOSE:**

To provide direction to staff when patients/residents have been granted therapeutic access to the outdoors.

**POLICY:**

The patient/ resident will have safe access to the outdoors when they have a length of stay thirty days or longer.

**AFFECTED PERSONNEL/AREAS:** *ALL PATIENT CARE AREAS*

**PROCEDURE:**

1. The physician will assess the patient's/resident's status to determine if their condition allows for them to be taken outdoors and provide a written order.

2. The patient/resident will be either wheeled out in a wheelchair, geri chair or taken out in their bed by nursing staff. Appropriate clothing will be provided to protect the patient's dignity and provide protection from the elements.

3. The patient/resident will be accompanied at all times by personnel competent in monitoring and maintaining patient equipment (i.e., $O_2$, intravenous fluids or tracheostomies and/or ventilators).

4. The patient/resident will be taken to the patio area next to the cafeteria. The patio area has grass, trees and flowing shrubbery.

5. The patient/resident will be provided with a shade covering and their sunglasses, if needed.

6. Patients/residents will not be taken outdoors if it is raining, too hot or poor air quality (i.e., smoke from fires).

7. If the patient/resident condition allows and the patient /resident is ordered full ambulation privileges, he/she may go outside with supervision.

8. If a family member is competent and accepts responsibility for the patient/resident, that family member may accompany the patient/resident outside and must stay with the patient/resident until he/she returns to the patient care unit. This is only if the patient/resident does not have a trach and is not on a ventilator.

**REFERENCE:**

- The Joint Commission (2019). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- Thomson Reuters: (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, §87219 Planned Activities, San Francisco, California.

| SUBJECT: **PRIORITIZING SOCIAL SERVICE REFERRALS** | SECTION: *Social Services* **Page 1 of 1** |
|---|---|

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

**PURPOSE:**

To provide guidelines for the prioritizing of social service referrals in order to facilitate timely response based on resident needs and risk factors.

**POLICY:**

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

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

**PROCEDURE:**

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

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

**REFERENCES:**

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

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

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

**PURPOSE:**

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

**POLICY:**

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

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

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

OBJECTIVES

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

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

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

MODEL

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

P – Plan — The planning stage evaluates and researches the identified problem.

D –Do — This stage is implementing the change that will improve a process.

S – Study — This stage studies the results of the change by viewing data for process variation and evidence of process improvement.

A – Act — This stage is taking action needed to maintain improvements or to determine the next steps for further improvement or to maintain the gain.

## REPORTING OF QUALITY DATA

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

## QUALITY IMPROVEMENT COMMITTEE

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

## QA/PI ASSESSMENT AND ASSURANCE

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

b) Track, investigate and prevent recurrence of adverse events

c) Receive and investigate complaints

d) Seek feedback from residents and caregivers

e) Set targets for quality

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

g) Commit to balancing a safe environment with resident choices

h) Strive for deficiency-free surveys

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

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

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

FIVE ELEMENTS OF QA/PI

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

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

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

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

5. SYSTEMIC ANALYSIS AND SYSTEMIC ACTION: Use a systemic approach to determine analysis that is needed to understand the problem, its causes and implications for change. These problems may be caused by the deliverance of the care or services. This will also serve to address the following: a) the need to develop Policies and Procedures and demonstrate proficiency in the

use of Root Cause Analysis, b) the need to focus primarily on systems and processes, and c) develop and review Systemic Actions that will focus on continual learning and continuous improvement.

COMMUNICATION:

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

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

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

**REFERENCES:**


- Thomson Reuters (2019) Barclay's California Code of Regulations, 72082, 72319, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

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

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

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

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

**PURPOSE:**

To clean and maintain electric razors.

**POLICY:**

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

**AFFECTED PERSONNEL/AREAS:**

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

**PROCEDURE:**

AFTER RESIDENT HAS SHAVED:

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

*NOTE:*

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

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

**REFERENCES:**

- How to Clean an Electric Shaver to Ensure It Has a Long Life. Retrieved September 2019 from https://groomandstyle.com/clean-electric-shaver/.

- Manufacturer's guide for each razor

| SUBJECT: **REFERRALS TO SOCIAL SERVICE DEPARTMENT** | 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 process by which social services are requested in the Distinct Part Skilled Nursing Facility (DPSNF).

**POLICY:**

Requests for social services may be made at any time by any staff member, physician, resident, or family member. Social Services Designee will respond to such requests within 24 hours on weekdays or for emergencies only on weekends.

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

**PROCEDURE:**

1. During business hours, referrals may be called directly to the Social Service office or made verbally to the Social Service Designee.

2. After hours, or on weekends or holidays, a written request may be placed in the mailbox on the door of the Social Service Designee.

3. At any time, a voice mail message may be left on the office phone of the Social Services Designee.

4. If the matter is extremely urgent, the Unit Director or Manager may be contacted by the Charge Nurse.

**REFERENCES**:

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

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

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

**PURPOSE:**

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

**POLICY:**

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

**AFFECTED PERSONNEL/AREAS:**

*NURSING STAFF; SOCIAL SERVICES; UNIT DIRECTOR*

**PROCEDURE:**

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

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

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

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

**REFERENCES:**

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

| SUBJECT: **RESIDENTS' PERSONAL REFRIGERATOR** | SECTION: **Page 1 of 1** |
|---|---|

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

**PURPOSE:**

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

**POLICY:**

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

**AFFECTED PERSONNEL/AREAS:**

*NURSING STAFF, SOCIAL SERVICES, UNIT DIRECTOR*

**PROCEDURE:**

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

**REFERENCES:**

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

| SUBJECT: | SECTION: |
|---|---|
| **SCOPE OF SERVICE- SOCIAL SERVICES AT DP/SNF** | ***Social Services***  |

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

**PURPOSE:**

To describe the purpose and scope of the social services program provided to residents of the DPSNF.

**POLICY:**

It is the policy of the DPSNF that all residents are provided the medically-related social services that will enable them to achieve and maintain their highest attainable level of physical, mental, and psychosocial wellbeing.

**AFFECTED PERSONNEL/AREAS:** *SOCIAL SERVICE*

**PROCEDURE:**

Social Service Designee is responsible for the following:

1. Consultation with allied health professionals regarding provisions for the social and emotional needs of the resident and family.
2. Comprehensive documentation of social service assessment and intervention for each resident.
3. Obtaining pertinent information regarding personal and family problems related to the Resident's illness and care needs.
4. Maintaining regular progress and follow-up notes indicating the resident's response to the Care Plan and interventions.
5. A In collaboration with the patient account specialist, assist residents/families with financial, insurance, and benefit programs, and maintaining required logs and records.
6. Maintaining current information regarding community health and service agencies.
7. Maintaining contact with the Resident's family members, significant others or responsible party, and involving them in the Resident's plan of care.
8. Providing or arranging supportive counseling to Residents and/or families.
9. Informing the Resident or responsible party of the Resident's personal property rights to assure that complaints and/or grievances are promptly resolved.
10. Participation in interdisciplinary staff meetings, providing social service information to ensure appropriate intervention and/or treatment of the social and emotional needs of the Resident as a part of the total Care Plan.

11. As a member of the interdisciplinary team, discuss with residents, family or authorized representative alternative therapeutic strategies for residents with behavior problems and/or who are prescribed psychotropic medications for discharge.

12. Coordinating the discharge planning process with resident, responsible party, and facility staff.

13. Providing financial and legal assistance through referral to appropriate resources.

14. Developing and participating in in-service training programs and classes.

15. Making arrangements for obtaining adaptive equipment needed for discharge, such as wheelchairs, walkers, clothing, and personal items.

**REFERENCES:**

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 72433, San Francisco, California, Title 22.

- CANTANA Health (September 17, 2019) *Is Your IDT Ready for PDPM?* PDPM Resource Center, Lindsey Rose, Author.

| SUBJECT: **SHARED BATHROOMS** | SECTION: **Page 1 of 1** |
|---|---|

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

**PURPOSE:**

To outline the process for maintain each resident's right to privacy with regards to shared bathroom assignments.

**POLICY:**

It is the policy of this facility to ensure access to bathroom facilities for all ambulatory residents while respecting their right to privacy.

**AFFECTED PERSONNEL/AREAS:**

*NURSING STAFF; DIRECTOR; CLINICAL MANAGER; SOCIAL SERVICE DESIGNEE*

**PROCEDURE:**

1. Ambulatory residents are to share bathroom facilities with residents of the same sex only.

2. Residents of the opposite sex who have no possibility for personal use of the bathroom facilities may be given room assignments with a designated shared bathroom.

**REFERENCES:**

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

| SUBJECT: **SKIN INTEGRITY TEAM GUIDELINES** | 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 provide a systematic interdisciplinary approach to wound care.

The primary purpose(s) of developing a specialized team is to evaluate each pressure area and skin problem and assist the physician to provide the most effective coordination of treatment as well as a baseline of information for the nursing staff and other team management members.

**POLICY:**

- The wound care team will consist of facility personnel.
- The team will improve overall skin/wound care management and continuity of treatment throughout the facility.
- A comprehensive and ongoing education program will be provided for nursing personnel and all other team members.

**AFFECTED PERSONNEL/AREAS:**

*REGISTERED NURSE (RN); PHYSICIAN; RESPIRATORY THERAPIST (RT); REGISTERED DIETITIAN (RD); CERTIFIED NURSING ASSISTANT (CNA); RN WOUND NURSE*

**PROCEDURE:**

A. SKIN INTEGRITY TEAM RESPONSIBILITIES

1. The Clinical Director/Designee will coordinate skin integrity team activities.
2. The team may include the following: Treatment Nurse, Charge Nurse, Clinical Director, RT, RD or Food Service Supervisor, Nursing Assistant, M.D., and RN Wound Nurse.
3. Pressure and dermal ulcers, skin tears and excoriations will be reviewed every week.
4. The RN Wound Nurse and nursing will assess and document the status of skin problems in the electronic medical record (EMR).
5. Nursing will assess for skin risk status on admission and as needed thereafter. This interdisciplinary assessment will include information on nutritional state, incontinency and mental status, mobility and activity.

B. SKIN INTEGRITY TEAM MEMBERS RESPONSIBILITIES

1. Clinical Director/ Designee
   a. Will see that there is a functioning Skin Integrity Team in the facility.

b. Will monitor new admission skin integrity assessments.

c. Will monitor ongoing skin integrity assessments and effectiveness of prevention and treatment procedures.

d. Will play a key role in staff education by the Director of Staff Development (DSD) / Education Department of the hospital on an ongoing basis.

e. Will coordinate and periodically review all aspects of skin integrity management in the facility.

f. Review ongoing skin issues weekly during Interdisciplinary Team Meetings.

2. Treatment Nurse/Charge Nurse, RN Wound Nurse

a. Will make recommendations to physicians consistent with current policies and procedures and carry out treatments as indicated.

b. Will provide documentation as indicated.

c. Will supervise nursing assistants to insure an ongoing high quality of direct resident care.

3. Nursing Assistants

a. Will carry out direct resident care with special emphasis on prevention and skin integrity management.

b. Will attend in-service programs related to skin integrity by the DSD.

c. Will communicate to charge nurse any change in skin integrity, verbally notifying licensed nurse.

**REFERENCES:**

- Thomson Reuters (2021) Barclay's California Code of Regulations, §72315 (7) , 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: **SOCIAL SERVICE ROLE IN THE ADMISSION OF RESIDENTS** | SECTION: Social Services **Page 1 of 3** |
|---|---|

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

**PURPOSE:**

To assure that residents are informed of their rights and the responsibilities governing resident conduct during their stay in the facility.

**POLICY:**

The facility's skilled nursing admission agreement will be used to communicate rights and services information to the resident or his representative prior to or upon admission, during resident's stay as changes may occur, and when the facility's rules change. This information will be given both orally and in writing according to applicable regulations.

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

**PROCEDURE:**

1. Upon receipt of notice of the resident's admission, the Social Service Designee (SSD)/Admitting Representative will schedule a meeting with resident and/or responsible party within 24 hours of admission. Within 24-48 hours of the initial appointment, the SSD will complete the admission agreement and initial consents, unless they are mailed out of the area.

2. The admission agreement will be reviewed with the resident unless she/he lacks decisional capacity, has been adjudicate incompetent, or wishes to delegate decision making to a responsible party. (Should any of these circumstances change, the Social Service Designee/Admitting Representative will review the information with the resident to complete a new admission agreement.)

3. The Social Services Designee will document, in Meditech and on the admission agreement, the resident's decision to delegate responsibility, and any portions of the agreement that were reviewed with the resident. (i.e., resident informed of rights but preferred to have information reviewed and signed by responsible party)

4. In the absence of a responsible party, the Social Services Designee/Admitting Representative will document in Meditech and on the admit checklist the reasons for an unsigned admission agreement, and will include in Notes all efforts made to seek a surrogate on the resident's behalf.

    a) Under the judgment of the Epple Bill, facilities serving current residents who lack capacity and have no surrogate decision will need to take immediate steps to do the following:

        a. First, facilities must provide verbal and written notice to those residents of: (1) the determination made by their physician that they lack capacity to make medical decisions; (2) the determination that they have no surrogate decision maker; (3) the current treatment ordered by their physician is that the treatment will continue without interruption.

b) The notice also needs to inform the resident that they have the right to a representative and that the resident can seek judicial review of the determinations made by their physician as well as the intervention being provided by the facility.

c) A copy of the written notice also needs to be sent to the resident's representative if there is one. If there is no representative, a copy of the written notice needs to be sent to the local office of the long-term care ombudsman's office for the county or counties served by that office.

d) Second, if facilities are serving new residents who are determined by their physician to lack capacity and have no surrogate decision makers, facilities will need to likewise provide verbal and written notice to the resident as to those determinations as well as the fact that medical decisions of the physician, that the resident has the right to have a representative present at the IDT where the proposed treatment and the right to seek judicial review.

5. When the resident lacks capacity and the responsible party is out of area and/or unable to come in to review admission agreement, it should be mailed (by certified mail, to verify receipt of the information). The Social Services Designee shall review the information orally with them by phone if possible to assure understanding prior to their signing and returning the packet. The Social Services Designee shall document ongoing efforts to complete this task in the electronic medical record.

6. When the resident is physically unable or refuses to review admission agreement, the following steps should be taken:

   a. Document reasons, and ongoing efforts to obtain cooperation and compliance.

   b. Assure that at least the following documents are completed with the resident within the first 24-48 hours: Resident Rights, Advance Directive Acknowledgement, Physician Orders for Life Sustaining Treatment, facility's conditions of admission or the consent for treatment portion of the admission agreement.

   c. Give resident the admission agreement and request signature on the admission page to acknowledge receipt. Social Services Designee shall document all efforts to complete process.

   d. Provide information to surrogate/responsible party on resident's behalf, and document efforts.

7. When a resident is unable to comprehend English, a translator/interpreter will be utilized. For foreign languages commonly used in the facility (i.e., Spanish), written translations of the Resident Rights, Resident Responsibilities, and other forms will be utilized as available, along with an interpreter. For less commonly encountered languages, a representative of the resident may serve as interpreter, and sign that s/he has explained the statement of rights to the resident prior to acknowledgement of receipt.

8. When a resident is admitted, the Social Services Designee/Admitting Representative will make all efforts to review the admission agreement in its entirety with the resident or responsible party. If unable to complete due to resident's condition, refusal to cooperate, etc., the Social Services Designee will follow steps outlined in #6, above.

9. As an interim measure to expedite the admission consents for treatment, Social Services Designee or charge nurse should obtain consents by phone with a witness present, and should document this on the forms as in #6(b), above. Alternatively, documents can be faxed to the responsible party to be reviewed and immediately returned by fax. These measures should only be undertaken when the resident lacks capacity and the responsible party is unable to be present at the time of admission.

**REFERENCES:**

- CAHF, California Association of Health Facilities, California Court of Appeals (July 23, 2019) EPPLE Bill, Health and Safety Code 1418.8.

| SUBJECT: **SWALLOWING ASSESSMENT AND RESIDENTS' RIGHTS – DP/SNF** | SECTION: **Page 1 of 2** |
|---|---|

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

**PURPOSE:**

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

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

**POLICY:**

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

**AFFECTED PERSONNEL/AREAS:**

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

**PROCEDURE:**

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

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

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

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

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

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

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

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

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

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

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

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

**REFERENCES:**


- California Department of Public Health, updated Oct 6, 2017, Nursing Home Residents Rights, retrieved from: https:www.cdph.ca.gov

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

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


**CROSS REFERENCES:**

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

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

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

**PURPOSE:**

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

**POLICY:**

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

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

**AFFECTED PERSONNEL/AREAS:**

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

**PROCEDURE:**

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

2. Staff shall receive this information during annual orientation, and updated annually during in-services/staff meetings.

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

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

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

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

   a. A description of the article;

   b. The article's estimated value;

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

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

   e. The action taken.

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

   a. Determine whether items were removed from the facility;

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

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

   d. Submit report of theft and loss to the Director.

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

   Upon Admission:

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

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

   During the resident's stay:

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

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

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

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

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

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

Upon Discharge:

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

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

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

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

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

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

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

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

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

**REFERENCES:**

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

- Thomson Reuters (2019) Barclay's California Code of Regulations, 72529, 73557, San Francisco, California. Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

**CROSS REFERENCES:**

- RESIDENTS' FUND POLICY

| SUBJECT: **TRACHEOSTOMY CARE- 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 define the procedure for maintaining the patent airway during tracheostomy care, decreasing the opportunity for infection, and securing resident comfort.

**POLICY:**

All residents with tracheostomies will receive tracheostomy (trach) care twice a day and PRN. This will be performed to ensure that the dressing is clean and dry and to prevent infection and breakdown of the skin.

**AFFECTED PERSONNEL/AREAS:** *REGISTERED NURSE (RN), RESPIRATORY CARE PRACTITIONER (RCP), LICENSED VOCATIONAL NURSE (LVN)*

**EQUIPMENT:**

- Suction catheter
- Cleaning solutions: 0.9% NaCl and H202
- 4 x 4 gauze sponge
- Sterile split 4 x 4 gauze
- One pair of sterile gloves (for tracheostomy < 30 days old)
- One pair of clean gloves (for tracheostomy ≥ 30 days old)
- Tracheostomy ties
- Tracheostomy collar
- Sterile cotton swabs (optional)
- Sterile disposable inner cannula (if inner cannulas are used)

**PROCEDURE:**

1. Prepare a clean work area.
2. Gather supplies and wash hands.
3. Explain the procedure to the resident.
4. Position resident in a semi-fowler position, if possible.
5. Put on clean gloves and suction oropharyngeal airway and tracheostomy.

6. Remove soiled tracheostomy dressing and discard dressing and gloves.

7. Wash hands, put on sterile gloves, and prepare a sterile field for tracheostomies < 30 days old and/or clean gloves and a clean field for tracheostomies ≥ 30 days old.

8. Place 4 x 4 gauze sponge, tracheostomy tie, and sterile split 4 x 4 on sterile or clean field.

9. If the tracheostomy tube has an inner cannula, remove it and discard. Replace with a new disposable inner cannula.

10. Clean the tracheostomy incision, if needed. Remember to use sterile technique for tracheostomies < 30 days and clean technique for tracheostomies ≥ 30 days old.

11. Apply sterile split 4 x 4 next to skin around tracheostomy tube.

12. Replace the tracheostomy collar. Always hold the tracheostomy in place while the tracheostomy collar is being changed. Ask for assistance if needed.

13. Attach tracheostomy to tubing of suction catheter at T-piece using tracheostomy ties.

14. Discard all contaminated items in the trash.

15. Be sure the resident is clean and comfortable before leaving.

16. The tracheostomy stoma requires daily care. Assessments of the stoma include observations for signs of infection and breakdown of the skin.

**INFECTION CONTROL:**

1. Change tracheal suction tubing each Tuesday and Saturday night and as needed.

2. Change suction canister liners every three (3) days, odd rooms on night shift and even rooms on day shift. Change suction canister liners as needed when three (3) quarters full. Date when changed.

3. Change Yaunkers every Tuesday and Saturday, if opened, and as needed.

4. Change tracheostomy tube each month (by RCP), and as needed for dislodgment and cuff failure.

**DOCUMENTATION:**

Each time the tracheostomy dressing is changed, the procedure will be documented in the resident record in the electronic medical record (EMR). This includes assessment of the site pertaining to skin integrity, drainage, and how the patient tolerated the procedure.

**REFERENCES:**


- American Cancer Society (October 16, 2019). Caring for a tracheostomy. https://www.cancer.org/search.html?q=cleaning+the+tracheostomy

- AACN Publishing. *Critical Care Guidance for Tracheostomy Care during Covid-19 Pandemic: A Global, Multidisciplinary Approach,* Am J Crit Care (2020) 29 (6): e116-e127, Vinciya Pandian, Phd, MBA, APN, RN, ACNP-BC.

- Arakawa-Sugueno, L. (2017). *What Is the Best Way to Take Care of a Patient with a Tracheostomy Tube?* Tracheostomy, 377-390. doi:10.1007/978-3-319-67867-2_22.

    - American Cancer Society, Oct 2019, *Caring for a Tracheostomy,* retrieved from: https://www.cancer.org

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



**PURPOSE:**

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

**POLICY:**

It is the policy of this facility that:

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

**AFFECTED PERSONNEL/AREAS:**

*ALL*

**PROCEDURE:**

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

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

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

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

DOCUMENTATION:

Nursing notes must include the following discharge information:

1. Date and time of resident transfer or discharge.

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

3. Condition of resident when transferred.

4. How resident was transferred and by whom.

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

**REFERENCE:**

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72519, San Francisco, California, Title 22. Retrieved from : https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

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

| SUBJECT: **TRANSFER OF RESIDENT TO-FROM BED** | SECTION: **Page 1 of 3** |
|---|---|

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

**PURPOSE:**

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

**POLICY:**

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

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

**EQUIPMENT:**

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

**PROCEDURE:**

**ASSISTING TO CHAIR:**

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

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

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

c. Place appropriate pressure reducing devices into chair.

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

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

f. Assist resident into daily attire.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TRANSFER TO BED:

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

   a) Physical therapist assist
   b) Mechanical Devices

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

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

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

**REFERENCES:**


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

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

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

**PURPOSE:**

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

**POLICY:**

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

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

**PROCEDURE:**

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

**REFERENCES:**

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

| SUBJECT: **TRUST ACCOUNT-SOCIAL SERVICE POLICY** | SECTION: **Page 1 of 2** |
|---|---|

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

**PURPOSE:**

To assure a system for the facility to hold, safeguard, manage and account for the personal funds of the resident when deposited with the facility. To assure a system which allows the resident access to their monies and provides a means for the reimbursement of their personal debts.

**POLICY:**

The resident or responsible party will have the right to manage his/her own financial affairs. The resident my delegate this responsibility to the facility in writing. The facility will accept the resident's funds and merge them in an interest bearing trust account, in accordance with the requirements of Federal and State law. The facility may not require residents to deposit their personal funds with the facility.

**AFFECTED PERSONNEL/AREAS:** *SOCIAL SERVICES, PATIENT ACCOUNTING*

**PROCEDURE:**

1. The Social Service Designee will advise the resident or responsible party at the time of admission, and/or when changes occur in financial status, of the availability of trust account services.

2. When trust account services are needed, the resident or surrogate will sign the authorization for the facility to establish and manage the trust account. The social service designee will ensure that the authorization is obtained and forwarded to the trust account manager.

3. When a resident is incapable of managing his/her personal funds and has no one to assume this responsibility, the Social Service Designee will notify the Ombudsman and request authorization for the facility to establish a trust account for the resident. When the Ombudsman does not provide this service, the facility will establish an account and the circumstances documented in the medical record by the Social Service Designee. The Designee will also refer residents to the Public Guardian's office when their funds are in excess of routine m monthly benefits and/or financial resources.

4. When requested, or in the absence of a responsible party, the patient account specialist coordinates the funds being directly deposited into the Resident Trust Account and monitors the balance to ensure continuance of benefits when applicable.

5. The Patient Accounting Specialist will establish and maintain a system to assure notification of the resident/responsible party and/or Social Service Designee when the amount in the account of a Medi-Cal beneficiary reaches $200 less than the SSI resource limit. The Social Service Designee will assist the resident with spending down funds in the trust account in accordance with guidelines established by SSI/Medi-Cal for the purpose of maintaining eligibility.

6. The Patient Accounting Specialist will establish and maintain a system for the timely withdrawal and reconciliation of the funds from the trust account to meet resident's monthly share of cost payments and non-covered charges.

7. The Social Service Designee (SSD) will assist the resident or responsible party with making withdrawals from the trust account to purchase personal items, to pay debts, and other person expenditures. The SSD will assure that receipts are obtained and provided to the Trust Account Manager, in order to maintain accurate accounting and monitoring of the residents' funds.

8. The Social Service Designee and Patient Account Specialist will each maintain records of resident authorizations, financial notices, and relevant financial interactions made on behalf of the resident; SSD records will be maintained in the social service files.

9. The SSD will monitor trust account activity and assure the resident or responsible party receives statement at least quarterly of his/her financial records/trust account balance including accrued interest and expenditures made, in accordance with the facility's trust account policy and regulatory requirements.

10. The Patient Account Specialist will monitor to assure that trust account balance and property held by the facility are forwarded to appropriate parties in a timely manner, upon request and at the resident's discharge or death.

11. The Social Service Designee will monitor to assure that the facility Patient Account Specialist maintains a surety bond for the protection of all residents' trust account funds and financial security, in accordance with affidavits filed with regulatory agencies that establish the amount of funds the facility anticipates handling.

**REFERENCES**


- California Code of Regulations (2020). Title 22. §72445 Special Treatment Program Service. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Botek, Anne-Marie (2020). *7 Things to Know About Nursing Home Resident Trust Funds.* Aging Care 2020 Newsletter. Retrieved from https://www.agingcare.com/articles/things-to-know-about-nursing-home-trust-funds-162627.htm.

- CMS Compliance Group, Inc, F567, Protection/ Management of Personal Funds, Resident's Rights, Dec 7, 2018, Brandie Elizaitias MS, CDP, CDS, Director of Operations.

| SUBJECT: **DIET MANUAL & THERAPEUTIC DIET MENUS** | SECTION: **Page 1 of 2** |
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**Printed copies are for reference only. Please refer to the electronic copy for the latest version.**

**PURPOSE:**

To establish a standard for therapeutic diets and non-therapeutic diets.

**POLICY:**

A therapeutic diet manual is used for standardization of the diet orders, defining diets, and planning diets. The therapeutic diet manual shall be approved by the dietitian and the medical staff. The publication or revision date of the approved therapeutic diet manual must not exceed five (5) years. The therapeutic diet manual is available to all medical, nursing and food service personnel.

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

**DEFINITIONS:**

Therapeutic diet: A diet ordered as part of the patient's treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

**PROCEDURE:**

1. The Clinical Nutrition Manager (CNM) will review the therapeutic diet manual annually.
2. The therapeutic diet manual will be updated a minimum of every five (5) years.
3. The CNM, Pharmacy & Therapeutics Committee, Medical Executive Committee (MEC) and the CEO/Board of Directors will approve the manual.
4. A diet manual is available for viewing on Sierra View Medical Center (SVMC) Employee Portal. The SVMC Interpretation of Diet Servicesserves as a reference for medical and nursing personnel when ordering hospital-specific diets.
5. A hard copy of the therapeutic diet manual is available in the Food & Nutrition Service diet office and in the dietitian office. This serves as a guide for food service staff for special diet food preparation.
6. Nutritional adequacy is based the on weekly average of each nutrient. Menus are designed to meet nutritional requirements specified in accordance with the Dietary Reference Intake (DRI) from the Food and Nutrition Board, Institute of Medicine, and National Academies of Science's guidelines. Nutritional adequacy is referenced to a male of 51-70 years of age, unless otherwise specified.
7. Any modified diet not outlined in the diet manual will be transcribed by the dietitian(s), using reputable nutrition references.
8. Due to limitations within the nutrient database, not all micronutrient values are available. Every effort shall be made for adequate provision of these micronutrients.

**REFERENCES:**


- The Joint Commission (2024). Hospital accreditation standards. PC.02.02.03, EP 22

- Centers for Medicare & Medicaid Services. Title 42 Regulations:
  - A-0629 §482.28(b) (1)
  - A-0631§482.28(b) (3)

| SUBJECT: **EMPLOYEE REIMBURSEMENT REQUEST** | SECTION: **Page 1 of 2** |
|---|---|

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

**PURPOSE:**

To define the procedural guidelines for requesting an employee expense reimbursement check from Accounts Payable.

**POLICY:**

An Employee Reimbursement Request Form is to be utilized for requesting payment from Accounts Payable for the reimbursement of Sierra View Medical Center business related expenses. Supporting documentation and receipts for these expenses are required to be submitted.

**AFFECTED PERSONNEL/AREAS:** *ALL DEPARTMENTS*

**PROCEDURE:**

**Frequency:** As needed

**Responsibility:** Accounts Payable Staff

1. The employee requesting reimbursement must complete the Employee Reimbursement Request Form. The employee is responsible for submitting the form electronically to their leader for approval along with supporting documentation and receipts within 60 days of incurring the expense.

2. Employee expense reimbursement requests that exceed $5,000 require administrative approval and must be signed by the appropriate Administrative Director, Vice President or Chief Executive Officer.

3. Completed forms must be received electronically by Accounts Payable no later than 12:00 PM on the Thursday preceding each check-run date in order to be processed in the check-run on the following Monday.

**Internal Revenue Service (IRS) Regulations:**

Sierra View Medical Center follows the Accountable Plan for employee business expenses under the Internal Revenue Service (IRS) Publication 535 Business Expenses. The Accountable Plan requires employees to meet all of the following requirements. Employees must:

1. Have paid or incurred deductible expenses while performing services as an employee.

2. Adequately account for their expenses within 60 days after the expenses were paid or incurred.

3. Return any excess reimbursement within 120 days after the expense was paid or incurred.

Reimbursements not meeting these requirements would be considered taxable wages to the employee and Sierra View Medical Center would be required to report it as wages on the employee's Form W-2.

| SUBJECT: | SECTION: |
|---|---|
| **NON-DISCRIMINATION PATIENT CARE** | ***House Wide Policy*** |
| | **Page 1 of 3** |

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

**PURPOSE:**
To demonstrate compliance with applicable Federal and State requirements pertaining to non-discriminatory practices.

**POLICY:**
Sierra View Medical Center (SVMC) complies with applicable Federal and State civil rights laws and does not discriminate, on the basis of a person's race, religion, color, sex, national origin, sexual orientation, ancestry, age, marital status, registered domestic partner status, medical condition or genetic information, pregnancy, veteran status, culture, primary language, citizenship, socioeconomic status, immigration status (unless required by federal law), gender identity or expression or physical or mental disability or handicap, be knowingly excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in the provision of any care or service, whether carried out by SVMC directly or through a contractor or any other entity with which SVMC arranges to carry out its program or activities.

This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges.

SVMC also prohibits unlawful discrimination based on the perception that anyone has any of those characteristics, or is associated with a person who has or is perceived as having any of those characteristics.

Nondiscriminatory policies that prohibit discrimination based on gender identity and gender expression are a first and necessary step toward ensuring that transgender patients have equal access to respectful, knowledgeable treatment and care. Section 1557 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) prohibits sex discrimination in any hospital or health program that receives federal funds, and in May 2016, the U.S. Department of health & Human Services (HHS), Office for Civil Rights (OCR), issued regulations explaining that this prohibition extends to claims of discrimination based on gender identity and sex stereotyping.

1. The Joint Commission (TJC) standard RI.01.01.01, EP 29 requires nondiscrimination policies.

The patient has the right to competent, considerate and respectful care in a safe setting that fosters the patient's comfort and dignity and is free from all forms of abuse and harassment, including abuse or harassment based on gender identity or gender expression. Please refer to the Patient Rights Policy.

SVMC makes reasonable modifications in policies, practices, or procedures when such modifications are necessary to afford equal access to its services, programs, and activities.

Specifically, the above includes (but is not limited to) the following:

1. Inpatient, outpatient and emergency care will be provided in a non-discriminatory basis;

2. All patients will be assigned and/or transferred to rooms, floors, and sections in accordance with their medical need on a non-discriminatory basis.

3. Employee assignments will be made on a non-discriminatory basis, where neither the employee nor the patient suffers discriminatory conditions.

4. Medical staff privileges will be granted on a non-discriminatory basis.

5. Training programs sponsored or carried on by SVMC shall be without discrimination.

6. Human Resource practices will be carried out in a non-discriminatory manner. Refer to Human Resource Policy & Procedure, Equal Employment Opportunity.

**AFFECTED PERSONNEL/AREAS:** *ALL HOSPITAL PERSONNEL*

**REFERENCES:**


- California Code of Regulations (2019). Title 22, §70715. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- The Americans with Disabilities Amendments Act of 2008 (2008). Retrieved from https://www.ada.gov/pubs/adastatue08.htm.
- The Americans with Disabilities Act of 1990as Amended. Retrieved from http://xn--https-ix3b//www.ada.gov/law-and-regs/ada/%20California%20Civil%20Code,%20Section%2051%20(2016).%20Retrieved%20from%20https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV&sectionNum=51.
- The Immigration and Nationality Act (1952). Retrieved from https://www.uscis.gov/legal-resources/immigration-and-nationality-act.
- The Joint Commission (2019). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Section 504 of the Rehabilitation Act of 1973 (1973). Retrieved from
- https://www.dol.gov/agencies/oasam/civil-rights-center/statutes/section-504-rehabilitation-act-of-1973.
- Title VII Civil Rights Act of 1964 (1964). Retrieved from https://www.eeoc.gov/laws/statutes/titlevii.cfm.
- Affordable Care Act, 42 U.S.C. § 1811(a) (2010)
- Lambda Legal (2016) Transgender rights toolkit: Transition-related health care. Retrieved at http://www.lambdalegal.org/publications/trt-transition-related-health-care

**CROSS REFERENCE:**

- Anti-Discrimination, Harassment & Non-Retaliation Policy
- Equal Employment Opportunity Policy
- Gender Identity & Gender Expression Non-Discrimination Policy
- Interpretive Services: Language Assistance Program Policy
- Non-Discrimination on the DP/SNF Policy
- Reasonable Accommodations Policy
- The Joint Commission. (2017). *Hospital accreditation standards*. Joint Commission Resources. Oak Brook, IL.

## I. EXECUTIVE SUMMARY

Each environment of care poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Environment of Care Safety (EC) Program is designed to identify and manage the risks of the environments of care operated and owned by Sierra View Medical Center (SVMC). The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. An environmental safety program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for Environmental Safety describes the risk, safety, and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other individuals coming to the organization's facilities. The management plan and the environmental management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Wound Healing Center, Urology Clinic, Clinical Lab, Community Health Center, and Medical Office Building of Sierra View Medical Center. The Management Plan for Environmental Safety and associated polices extends to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates including contracted services of Sierra View Medical Center.

## II. PRINCIPLES

A. The identification of specific risks faced by patients, employees, and others is essential for designing safe work areas and work practices.

B. The identified risks and proven risk management practices are used to design procedures and controls to reduce the threats of adverse outcomes. In addition, the identified risks and the procedures and controls are used to educate staff to effectively use work environments and safe work practices to minimize the potential for adverse impact on them, patients, and other individuals coming into the environment.

C. Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and regular environmental rounds are essential management tools for improving the safety of the environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and increase staff knowledge.

## III. OBJECTIVES

A. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of Sierra View Medical Center.

B. Perform additional risk assessments when changes involving these issues occur.

C. Analyze accidents, incidents, and occurrences to identify root cause elements of those incidents.

D. Make changes in the procedures and controls to address identified root causes of incidents.

E. Conduct environmental rounds in all areas of the hospital and affiliated medical practices. Staff making rounds will evaluate the physical environment, equipment, and work practices. Rounds are conducted in all support areas at least annually and all patient care areas at least semi-annually.

F. Present quarterly reports of EC management activities to the Safety Committee. The reports from each EC area manager will identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified EC issues. The Safety Officer coordinates the documentation and presentation of this information.

G. Assure that all departments have current organization wide and department specific procedures and controls designed to manage identified risks.

H. Review the risks and related procedures and controls at least once every three years to assure that the EC programs are current.

I. Assign qualified individuals to manage the EC programs and to respond to immediate threats to life and health.

J. Perform an annual evaluation of the management plan and the scope, objectives performance and effectiveness of the environmental safety program.

K. Design and present environmental safety education and training to all new and current employees, volunteers, members of the medical staff and others as appropriate.

## IV. PROGRAM MANAGEMENT STRUCTURE

A. The Safety Officer, Vice President of Quality and Regulatory Affairs , and Manager of Infection Control work as the Environmental Safety Leadership Team (ESLT) to develop the environmental safety program. They collaborate with leaders throughout the organization to conduct appropriate risk assessments, develop risk-related procedures and controls, develop staff education and training materials, and manage day-to-day activities of the environmental safety program. They also collaborate with the Performance Improvement/Patient Safety Committee to integrate environment of care safety concerns into the Patient Safety program.

B. The Environmental Safety Leadership Team coordinates the development of reports to the Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other environmental safety issues.

C. The Safety Committee monitors and evaluates the processes used to manage the environment of care. Members of the Safety Committee are appointed by the Committee Chair. The Safety Committee meets a minimum of four (4) times per year. During each meeting, one or more EC performance management and improvement reports is presented. In addition, reports of the findings of environmental rounds, incident analysis, regulatory changes, and other issues are presented as appropriate. The Committee acts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes related to changes in regulations.

The Committee assigns individual's or group's responsibility for developing solutions to identified issues. Finally, the Committee maintains a tracking log to assure identified issues are acted on and that analysis of activities after implementation of changes demonstrates that the changes are effective.

Membership of the Committee includes representation from Nursing Administration, Facilities Management, Risk Management, Quality and Patient Safety, Human Resources, Senior Administration, Education, Medical Staff, Physician representation, Infection Control, and others as deemed appropriate.

D. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the environmental safety program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer. The Board of Directors collaborates with the Chief Executive Officer and Senior Leadership to assure budget and staffing resources are available to support the environmental safety program.

E. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Environmental Safety Program. The Chief Executive Officer collaborates with the ESLT and other appropriate staff to address environmental safety

issues and concerns. The Chief Executive Officer also collaborates with the Safety Officer to develop a budget and operational objectives for the Environment of Care Safety Program.

F. The Emergency Management Program contains provisions for management staff on duty to take immediate, appropriate action in the event of a situation that poses an immediate threat to life, health, or property.

G. The Human Resources Department, with the assistance from the Education Department and other leadership staff, are responsible for the development and presentation of appropriate materials for orienting new staff members to the organization, the department to which they are assigned, and task specific safety and infection control procedures. The orientation and ongoing education and training emphasize patient safety.

H. Department Directors are responsible for assuring that all staff actively participates in the environmental safety program by observing established procedures and conducting work-related activities in a manner consistent with their training. Department Directors also participate in the reporting and investigation of incidents occurring in their departments and in the monitoring, evaluation, and improvement of the effectiveness of the environmental safety program in their areas of responsibility.

I. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

## V. ELEMENTS OF THE ENVIRONMENTAL SAFETY MANAGEMENT PROGRAM

### EC.01.01.01 EP1 – Appointment of Environmental Safety Leadership

The Chief Executive Officer appoints a team of qualified individuals to assume responsibility for the development, implementation and monitoring of the environmental safety management program. The Environmental Safety Leadership Team (ESLT) includes the Safety Officer, Vice President of Quality and Regulatory Affairs and the Manager of Infection Control.

The ESLT coordinates the development and implementation of the environmental safety program and assures it is integrated with patient safety, infection control, risk management, and other programs as appropriate.

The ESLT maintains a current knowledge of environmental safety laws, regulations, and standards of safety, and assesses the need to make changes to procedures, controls, training, and other activities to assure that the environmental safety management program reflects the current risks present in the environment of Sierra View Medical Center.

The Emergency Management program includes specific response plans for Sierra View Medical Center that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate event incident commander is appointed at the time any emergency response is implemented.

The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations pose an immediate threat to patients, staff, physicians, or visitors or the threat of major damage to buildings or property. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

The Chief Executive Officer has appointed the Safety Officer, the Nursing House Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

**EC.01.01.01 EP4 – Environmental Safety Management Plan**

The Environmental Safety Management Program is described in this management plan. The Environmental Safety Management Plan describes the procedures and controls in place to minimize the potential adverse impact of the environment on patients, staff, and other people coming to the facilities of Sierra View Medical Center.

**EC.02.01.01 EP1 – The hospital identifies safety risks associated with the environment of care**

The ESLT of Sierra View Medical Center performs proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others. The risk assessments use information from sources such as environmental rounds, the results of root cause analysis (RCA), incident reports, and external reports such as The Joint Commission Sentinel Event Alerts and FDA product recall notices.

The ESLT coordinates the risk assessment process with the Facilities Manager and Department Directors and others as appropriate.

**EC.02.01.01 EP3 – The hospital takes action to minimize or eliminate identified safety risks in the physical environment**

The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of

equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of environmental safety in a planned and systematic manner.

**EC.02.01.01 EP14 & EP16 – The hospital manages safety risks in the MRI environment**

The Radiation Safety Officer (RSO) follows the MRI Safety Policy to ensure the safety of all patients, visitors, and staff who enter the MRI Suite. Staff is trained to eliminate or reduce identified risks. MRI staff are familiar with proper screening procedures for all patients and staff (*i.e. ferrous objects, metallic implants and devices)* and trained to recognize when patients display signs of claustrophobia, anxiety, or emotional distress.

**LD.04.01.07 EP1 – Development and Management of Policies and Procedures**

The Safety Officer follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Safety Officer assists department heads with the development of department or job-specific environmental safety procedures and controls.

The organization-wide policies and procedures and controls are available to all departments and services on the organizational intranet. Departmental procedures and controls are maintained by department directors. The department directors are accountable for ensuring that all staff are familiar with organizational, departmental, and appropriate job-related procedures and controls. Department Directors are also accountable for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is accountable for implementing the policies, procedures and controls related to her/his work processes.

The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years.

The Safety Officer coordinates the reviews of policies and procedures with department heads and other appropriate staff.

**EC.02.01.01 EP5 – The hospital maintains all grounds and equipment**

The Facilities Manager is responsible for managing the appearance and safety of the hospital grounds. In addition, the Facilities Manager is responsible for assuring that the equipment used to maintain the grounds is in proper operating condition and that grounds staff is trained to operate and maintain the equipment.

The grounds include but are not limited to lawns, shrubs and trees, sidewalks, roadways, parking lots, lighting, signage and fences. External equipment includes but is not limited to mobile docking facilities, the oxygen storage facility, electrical service entrances and transformers,

sewage and storm lift stations and equipment yards. Sierra View Medical Center does not provide any patient care, treatment, or services outside of hospital buildings. There are no patient activity areas outside of hospital buildings that require supervision by hospital staff.

The Facilities Manager is responsible for scheduling the work required to maintain the appearance and safety of hospital grounds. The Engineering staff and Security Officers make regular rounds of the grounds to identify unsafe conditions. The Security Supervisor and Engineering staff reports all deficiencies to the Facilities Manager for appropriate action.

**EC.02.01.01 EP11 – The hospital responds to product notices and recalls**

The Manager of the Environment of Care and the Director of Materials Management coordinates a product safety recall system. The system is designed to quickly assess safety recall notices; to respond to those that affect Sierra View Medical Center; and to assure all active safety recalls are completed in a timely manner.

A quarterly report of safety recall notices that required action to eliminate defective equipment or supplies from Sierra View Medical Center is presented to the Environmental Safety Committee by the Manager of the Environment of Care and the Director of Materials Management.

**EC.02.01.03 EP1 – The hospital prohibits smoking except in specific circumstances**

Sierra View Medical Center has developed a Tobacco Free Environment policy. The policy prohibits the usage of any tobacco product (i.e.: cigarettes, cigars, pipe, chewing tobacco, e-cigarettes) in any hospital building or grounds by all, including staff, visitors and patients.

Sierra View Medical Center has identified alternatives to tobacco products that are offered to all. Sierra View Medical Center has developed tobacco replacement product resources to assist staff and patients with smoking cessation as desired.

The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.

**EC.02.01.03 EP6 – The hospital takes action to maintain compliance with its smoking policy**

The procedures for managing the use of smoking materials are followed and enforced by all leadership and staff.

**EC.04.01.01 EP1 - EP11 – The hospital monitors conditions in the environment**

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the Chief Executive Officer, Board of Directors and Senior Leadership as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies, including identification of opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and the Facilities Manager, who represents each of the seven management of the environment of care functions, use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement/Patient Safety Committee prepare quarterly reports to the leadership of Sierra View Medical Center. The quarterly reports summarize key issues reported to the Committees, with their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure Hospital leaders that management responsibilities have been carried out.

**EC.04.01.01 EP15 – Every twelve months, the hospital evaluates each environment of care management plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.**

The Safety Officer coordinates the annual evaluation of the management plans associated with the Environment of Care functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the

operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review (PPR). Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement.

Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes.

The annual evaluation is distributed to the Chief Executive Officer, Board of Directors, Senior Leadership, the Performance Improvement/Patient Safety Committee and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

**EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues**

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement.

Each time a need for improvement is identified, the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

**EC.04.01.05 EP1 Improving the Environment**

When the Senior Leadership or the Vice President of Quality and Regulatory Affairs concurs with the Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital administration, performance improvement, and patient safety leadership.

**GOAL:**

- Work to lower the OSHA Lost Workday Injury/Illness Quarterly Rate to the 50th percentile in the Osborne Engineering Benchmarking Database. The current rate is the 92nd percentile

**HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 Orientation and Ongoing Education and Training**

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate.

The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with participation from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment.

The Human Resources Department, with participation from the Education Department, maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job-related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Vice President of Quality and regulatory Affairs, Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job-related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each EC program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job-related physical risks are to be managed or eliminated as part of daily work. In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

**AFFECTED PERSONNEL / AREAS:** *BOARD OF DIRECTORS, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS, CONTRACTED SERVICES AND STAFF*

**REFERENCES:**


- The Joint Commission (2024). Hospital accreditation standards. EC. 01.01.01 EP4 Joint Commission Resources. Oak Brook, IL.
- The Joint Commission (2023). Laboratory & Point-of-Care standards. EC.04.01.01, EP1 Joint Commission Resources. Oak Brook, IL.


**CROSS REFERENCES:**

- WORKPLACE VIOLENCE PREVENTION PLAN

## I. EXECUTIVE SUMMARY

Each environment of care poses unique security risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Security Management Program is designed to identify and manage the security risks of the environments of care operated and owned by Sierra View Medical Center (SVMC). The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. A security management program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for a Secure Environment describes the security risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the security of patients, staff, and other individuals coming to the organization's facilities. The management plan and the Security Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Wound Healing Center, Urology Clinic, Clinical Lab, Sierra View Community Health Clinic and Medical Office Building of Sierra View Medical Center. The Security Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted services of Sierra View Medical Center.

## II. PRINCIPLES

A. Security is a system made up of human assets and technology.

B. Visible and clandestine components of the system are used to reduce the potential for criminal activity, the threat of workplace violence, and to increase feelings of security among patients, staff, and others coming to Sierra View Medical Center.

C. Initial and ongoing assessment of security threats is essential for timely identification of changes in the types of security threats facing Sierra View Medical Center.

D. Collection and analysis of information about adverse security events provides information to help predict and prevent personal violence, crime, and other incidents.

E. Staff awareness of security is an essential part of an effective program. Sierra View Medical Center orients and trains all staff to the security program and to techniques for managing security risks related to work areas or daily activities.

## III. OBJECTIVES

A. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of Sierra View Medical Center.

B. Perform additional risk assessments when changes in the campus design or patterns of security events indicate a change in the security threat level.

C. Analyze security incidents and occurrences to identify root cause elements of them.

D. Conduct ongoing random security patrols in all areas of the hospital, affiliated medical practices, and outpatient facilities. Staff making rounds evaluates the physical environment, equipment, and work practices. Rounds are conducted in all support areas and all patient care areas at least once per day.

E. Present reports of Environment of Care management activities to the Environmental Safety Committee quarterly. The reports identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified security issues. The Safety/Security Officer coordinates the documentation and presentation of this information.

F. Assure that all departments have current organization-wide and department-specific procedures and controls designed to manage identified security risks.

G. Review the risks and related procedures and controls at least once every three years to assure that the security program is current.

H. Assign qualified individuals to manage the program and to respond to immediate security threats.

I. Perform an annual evaluation of the management plan and of the scope, objectives performance and effectiveness of the security program.

J. Design and present security education and training to all new and current employees, volunteers, members of the medical staff, contract staff and others as appropriate.

K. Provide timely response to emergencies and requests for assistance.

L. Communicate with law enforcement and other civil authorities as needed.

M. Manage access to the grounds, buildings, and sensitive areas of Sierra View Medical Center.

## IV. PROGRAM MANAGEMENT STRUCTURE

A. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Security Program from the Environmental Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety/Security Officer.

B. The Board of Directors collaborates with the Chief Executive Officer and other Senior Leadership to assure budget and staffing resources are available to support the Security Program.

C. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Security program. The Chief Executive Officer collaborates with the Safety Officer and other appropriate staff to address security issues and concerns. The Chief Executive Officer also collaborates with the Safety/Security Officer to develop a budget and operational objectives for the Security Program.

D. The Safety/Security Officer works under the general direction of the Chief Executive Officer or designee. The Safety Officer, in collaboration with the Environment of Care/Safety and Security Manager, is responsible for managing the Security Program. The Safety/Security Officer reports program findings to the Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other security issues.

E. Department Directors are responsible for orienting new staff members to the department and job and to task specific security procedures. The orientation and ongoing education and training emphasize patient safety. Department Directors are also responsible for participating in the reporting and investigation of incidents occurring in their departments.

F. Individual staff members are responsible for learning and following job and task specific procedures for secure operations.

## V. ELEMENTS OF THE SECURITY PLAN

### EC.01.01.01 EP1 – Appointment of Security Leadership

The Chief Executive Officer of Sierra View Medical Center appoints the Safety Officer, and selects a qualified individual capable of overseeing the development, implementation and monitoring of the security program.

The Safety Officer coordinates the development and implementation of the security program and assures it is integrated with the patient safety, information management, and other programs as appropriate. The Safety Officer job is defined by a job description. The Chief Executive Officer or designee evaluates the competence of the Safety/Security Officer annually.

The Safety Officer maintains a current knowledge of laws, regulations, and standards of security. The Safety Officer also continually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of Sierra View Medical Center.

The Emergency Management program includes specific response plans for Sierra View Medical Center that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate Incident Commander is appointed at the time that any emergency response is implemented.

The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations pose an immediate threat to patients, staff, physicians, or visitors, or the threat of major damage to buildings or property. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

The Chief Executive Officer has appointed the Safety Officer, the Nursing House Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

**EC.01.01.01 EP5 – Management Plan for a Secure Environment**

The Security Management Program is described in this management plan. The Security Management Plan describes the policies, procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse security event.

**EC.02.01.01 EP1 – Proactive Risk Assessment**

The Safety Officer of Sierra View Medical Center performs proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others.

The Safety Officer works with Department Directors and Managers, the Patient Safety Officer, Risk Coordinator, the Vice President of Quality and Regulatory Affairs and others as appropriate.

**EC.02.01.01 EP3 – The hospital takes action to minimize or eliminate identified security risks in the physical environment**

The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner.

**LD.04.01.07 EP1 – Development and Management of Policies and Procedures**

The Safety Officer follows the administrative policy for the development of organization-wide and department-specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Safety Officer assists department heads with the development of department or job specific environmental safety procedures and controls.

The organization wide policies, procedures and controls are available to all departments and services on the organizational intranet. Departmental policies, procedures and controls are maintained by Department Directors. The Department Directors are responsible for ensuring that all staff is familiar with organizational, departmental, and appropriate job-related policies, procedures and controls. Department Directors are also responsible for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is responsible for implementing the policies, procedures and controls related to her/his work processes.

The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years. The Safety Officer coordinates the reviews of procedures with department heads and other appropriate staff.

**EC.02.01.01 EP7 – Identification of Patients, Staff, and Others Entering the Facility**

The identification of staff is an interdisciplinary function. Several Directors share responsibility for designing identification systems and establishing procedures and controls to maintain the effectiveness of the systems.

The current systems in place at Sierra View Medical Center include photographic ID badges for all staff, volunteers, students, contracted staff and members of the medical staff, password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing/badges to facilitate rapid visual recognition of critical groups of staff.

The identification of patients is also an interdisciplinary function. The current system includes personal identification of patients in medical records and by use of various arm band systems. It also includes functional identification of patients who are fall risks, have allergies to medications or nutritional products, have DNR orders or Advance Directives, who are undergoing surgery, who are receiving blood or blood products, and who are security risks.

The identification of others entering Sierra View Medical Center is managed by the Security and Materials Management Departments. The Safety Officer, in collaboration with the Chief Executive Officer and other appropriate staff, manages the procedures for identification of contractors and visitors. The Director of Materials Management manages the procedures for identification of vendors. The Safety Officer takes appropriate action to remove unauthorized persons from areas and to prevent unwanted individuals from gaining access to Sierra View Medical Center.

Sierra View Medical Center requires all guests/visitors on Sierra View Medical Center premises to wear authorized colored identification wristbands indicating the date and the area or department they are visiting or rendering services from:

- White – Radiology/Lab
- Orange – Distinct Part Skilled Nursing Facility (DPSNF)
- Purple – Cath Lab
- Yellow – Emergency Department
- Blue – Post Anesthesia Care Unit (PACU)/Surgery
- Red – Intensive Care Unit (ICU)/Telemetry
- Green – Medical Surgical Unit
- Pink – Women's Services

**EC.02.01.01 EP8 – Identification and Management of Security Sensitive Areas**

The Safety Officer is responsible for identifying security sensitive areas, and controls access to and from the security sensitive areas.

The following areas have been designated as sensitive areas:

- Cashiers Window
- Emergency Department
- Human Resources
- Labor & Delivery
- Women's Services

- Pharmacy
- Information Services
- Health Information Management (HIM)
- Medication Rooms
- OTHERS as deemed necessary

Staff in each sensitive area participates in intensive training addressing the unique risks of the area and the procedures and controls in place to manage them. The Safety Officer assesses the need for reinforcement of department level education on an annual basis.

**EC.02.01.01 EP9 – Management of Security Incidents Including an Infant or Pediatric Abduction**

The Safety Officer has developed procedures for rapid response to breaches of security. The on-duty Security Officers and local police have the manpower and technological resources to respond to a wide variety of incidents. The Safety Officer or a designee is responsible for assessing breaches of security and determining what resources are required to respond effectively.

The responding officers use appropriate written procedures and techniques, including use of force, to bring security incidents under control and to restore order.

The Safety Officer and the Vice President of Patient Care Services are responsible for the design and management of systems to reduce the threat of abduction of infants or children and to respond to any threats of or actual abductions.

The Safety Officer and the Clinical Directors of Neonatal and Pediatric Services are required to conduct at least one abduction drill annually. In addition, activations of the abduction alert system and all attempted or actual abductions of infants or children are treated as security incidents and reported and analyzed appropriately.

**EC.04.01.01 EP1 – EP11 – The hospital monitors conditions in the environment**

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works

with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Environment of Care Safety Committee Chairperson provides summary information related to incidents to the Chief Executive Officer and other leaders, including the Board of Directors, as appropriate.

The Safety Officer works with the Security Supervisor and the Safety Committee to collect information about Security deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven environments of care use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.

The Safety Officer and the Performance Improvement/Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

**EC.04.01.01 EP15 – Every twelve months the hospital evaluates each environment of care management plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.**

The Safety Officer coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources.

The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of the Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of the Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Performance Improvement/Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

**EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues**

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule.

The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified, the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

**EC.04.01.05 EP1 – Improving the Environment**

When the Board of Directors, Senior Leadership or Quality and Patient Safety concurs with the Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to the Board of Directors, Senior Leadership and Quality and Patient Safety leadership.

**GOAL:**

Work to reduce the number of Incidents of Property damage & Vandalism/100,000 Total Square Feet to the 5oth percentile in the Osborne Engineering Benchmarking Database. The current rate is the 66th percentile.

**HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 – Orientation and Ongoing Education and Training**

Orientation and training addressing all subjects of the environment of care is provided to each employee, contract staff, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as contract staff, volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses the changes to the policies, procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department and the Education Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job-related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Vice President of Quality and Regulatory Affairs, Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate

how job-related physical risks are to be managed or eliminated as part of daily work. In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

**AFFECTED PERSONNEL / AREAS:** *BOARD OF DIRECTORS, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS, CONTRACTED SERVICES AND STAFF*

**REFERENCES:**

- The Joint Commission (2024). Hospital accreditation standards. EC.01.01.01 EP5 Joint Commission Resources. Oak Brook, IL.

**CROSS REFERENCES:**

- WORKPLACE VIOLENCE PREVENTION PLAN

| SUBJECT: **SERIOUS CLINICAL ADVERSE EVENT** | SECTION: *Leadership (LD)* **Page 1 of 16** |
|---|---|

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

**PURPOSE:**

To describe the mechanism for identifying, responding to, and reporting of serious clinical adverse events that occur in the organization.

**AFFECTED AREAS/AUTHORIZED PERSONNEL:** *ALL HOSPITAL PERSONNEL/DEPARTMENTS*

**POLICY:**

Sierra View Medical Center (SVMC) staff is expected to identify and to respond appropriately to all adverse events occurring within the organization. Appropriate response may include the following: a formalized team response that stabilizes the patient, discloses the event to the patient and provides support for the family and staff involved in the event, notification of hospital leadership, immediate investigation, completion of a comprehensive systematic analysis for identifying the casual and contributory factors, corrective actions, timeline for implementation of corrective actions, and systemic improvement.

1. Sierra View Medical Center observes two (2) categories of events:

    a. California Department of Public Health's (CDPH) 28 adverse events (as mandated by SECTION 1. Section 1279.1 of the California Health and Safety Code) – Reportable to CDPH

    b. The Joint Commission's (TJC) sentinel events – Internal response and investigation

**DEFINITIONS:**

**TJC Sentinel Event**: A sentinel event, as defined by the Joint Commission, is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, severe harm or permanent harm.

a. Permanent Harm: An event or condition that reaches the individual, resulting in any level of harm that permanently alters and/or affects and individual's baseline.
b. Severe harm: An event or condition that reaches the individual, resulting in life-threatening bodily injury that interferes with or results in loss of functional ability or quality of life that requires continuous physiological monitoring or a surgery, invasive procedure, or treatment to resolve the condition.

**CDPH Reportable Events:** Reportable Adverse Events specified by the CDPH include the following:

A. Surgical Events:

    1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt

action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.

2. Surgery performed on the wrong patient.

3. The wrong surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.

4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and present prior to surgery that are intentionally retained.

5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation to be performed are localized and do not entail a systemic disturbance.

**B. Product/Device Events:**

1. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

2. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

3. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

**C. Patient Protection Events:**

1. An infant discharged to the wrong person.

2. Patient death or serious disability associated with patient disappearance for more than 4 hours, excluding events involving adults who have competency or decision-making capacity.

3. A patient suicide or attempted suicide resulting in serious disability due to patient actions after admission, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.

**D. Patient Care Management Events:**

1. A patient death or serious disability associated with medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

2. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

3. Maternal death or serious disability associated with labor or delivery in low-risk pregnancy, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

4. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.

5. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

6. An unstageable pressure ulcer acquired after admission.

7. A Stage 3 or 4 ulcer, acquired after admission, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

8. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.

**E. Environmental Events:**

1. A patient death or serious disability associated with electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric counter shock.

2. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.

3. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.

4. A patient death associated with a fall.

5. A patient death or serious disability associated with use of restraints or bedrails.

**F. Criminal Events:**

1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

2. The abduction of a patient of any age.

3. The sexual assault on a patient within or on the grounds of the facility.

4. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the hospital grounds.

**G. Other:**

1. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

For purposes of this policy, "serious disability" means "a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss last more than seven days or is still present at the time of discharge from an inpatient health facility, or the loss of a body part."

For purposes of this policy, "Unusual Occurrence" is defined through Title 22, California Code of Regulations, Section 70737.

**Root Cause Analysis (RCA):** a process for identifying the basic or contributing causal factors that underlie variations in performance associated with Adverse Events or Near Miss events. An RCA is a specific type of focused review that may be used for Adverse Events or Near Miss as requiring analysis.

1. RCA Characteristics

a. The review is interdisciplinary in nature with involvement of those knowledgeable about

the processes involved in the event.

b. The analysis focuses primarily on systems and processes rather than individual performance.

c. The analysis identifies changes that could be made in systems and processes through either redesign or development of new processes or systems that would improve performance and reduce the risk of the Adverse Event or Near Miss occurrence.

d. When an event requires an RCA to be performed, the Patient Safety Officer or designee will assign a lead reviewer to the case. The lead reviewer's responsibilities are as follows (time frames reflected may vary based on individual and situational barriers to obtaining all necessary data):

i. Day 1-3: Review the case and investigate/conduct interviews as needed. A timeline will then be constructed and a summary of the investigation will be prepared for the Confer and Consensus Meeting.

ii. Day 4: Schedule the Confer and Consensus meeting.

iii. Day 5-10: Develop thoughts around process improvement using systems theory and Just Culture.

iv. Day 11-14: Schedule the Solutions meeting.

v. Monitor the plan implemented for compliance and effectiveness.

**A.** **Confer and Consensus Meeting:** Where the timeline and incident write up is presented to the group. This may also include causal diagrams, photos, and a list of contributing factors. This meeting should include:

Lead reviewer, Patient Safety Officer, Vice President of Quality, Vice President over affected area, Chief Nursing Officer, Relevant Stakeholders

**B.** Solutions Meeting: To discuss the best targeted solution and develop implementation plan. This session should include development of timelines and delineation of responsibilities around implementation.

Those to be included:

- Lead reviewer(s)
- Front line staff
- Subject matter experts
- Patient Safety Officer

**PROCEDURES**:

**A. Response**

1. The caregiver assesses and stabilizes the patient.

2. Immediately report the event within the medical center. The notification shall be verbal and the person notifying the next level in the chain of command shall receive an acknowledgment from the person receiving the notification. See Appendix A for "Serious Clinical Adverse Event Response."

   The following people shall be notified:

   a. Charge Nurse, Lead Technician/Technologist, or Supervisor

   b. All Attending, Consulting Physicians and Licensed Independent Practitioners caring for the patient

   c. House Supervisor

   d. Manager

   e. Director

   f. Division Vice President

   g. Patient Safety Officer

   h. VP of Quality and Regulatory Affairs

   i. The VP for Patient Care Services/ Chief Nurse Executive for all patient care related sentinel events.

3. Preserve evidence.

   a. All physical and medical information related to the error is to be retained.

   Examples:

   - Supplies
   - Medications including labels, syringes, vials, and any packaging
   - Blood bag and tubing
   - Cardiorespiratory monitor data

- IV bag and tubing
- Equipment
  - When equipment is involved in an error:
    - Tag and remove from service (refer to Disposition of Asset Property and Equipment for Obsolescence, Donation, and/or Sale)
    - Keep all associated pieces and settings intact

4. Document the event

   a. In order to facilitate prompt review of any event, documentation shall be completed by involved parties as soon as possible following the event. A patient safety event report shall be submitted. Staff should not leave the facility prior to the completion of the required documentation.

Patient Safety Officer will:

a. Conduct an initial overview of the event

b. Assign Lead Reviewer(s)

c. Determine if the event will trigger a BETA Heart response

d. Implement Heart response, including sequestering evidence, speaking with family and patient, apologizing, and supporting team members.

e. Oversee the RCA process

f. Determine if the event needs to be reported to state and federal regulatory agencies

g. Determine if suspension of a service is appropriate

h. Determine if the charges and expenses directly related to the event will not be billed.

i. Review event with VP of Quality and Regulatory Affairs to determine if the event is reportable to CDPH based on noted definitions within this policy.

B. **Resolution**

The following are high-level steps to consider when resolving a HEART event. Additional details can be found within the BETA HEART tool-kit guides. All steps are to be documented.

1. Cognitive Interviewing with those involved
2. Meeting with the Early Resolution Team
3. Determine if the care was appropriate
4. Determine if bills need to be held or reimbursed
5. Notify Insurance Carrier/Legal counsel as appropriate
6. Hold the Stakeholder Consensus meeting to determine appropriate response to family/patient to determine damages and financial resolution recommendations with the input of insurance carrier/legal.
    a. This can be financial or non-financial
7. Communicate outcomes with the family/patient

**C. Confidentiality**

All proceedings, records, and materials developed in conjunction with the performance improvement/peer review efforts are protected as confidential and privileged pursuant to Evidence Code 1157 and the Patient Safety and Quality Improvement Act of 2005 (Public Law 109-41). This includes all verbal and written communications and electronic mail. At the direction of Risk Management and/or the medical staff, any investigations and analysis shall remain confidential and protected under Evidence Code 1157 and attorney client privileged and work product doctrine.

**D. Disclosure/Communication with patient and family**

When a serious clinical adverse event occurs, the patient, and when appropriate, the family (or legal representative) is entitled to an explanation that an event occurred, as well as an apology. See Communication with the Patient/Family After a Harm Event policy.

**E. CDPH Reportable Events**

Specified adverse events shall be reported to the California Department of Public Health (CDPH) in accordance with Health & Safety code 1279.1 et seq. Certain privacy violations (SB 541; AB 211) shall also be reported to CDPH.

Adverse Events that meet the definition as set forth in Health & Safety Code § 1279 shall be reported to the CDPH within 5 days after they are detected or, if an ongoing urgent or emergent threat is present, no later than 24 hours by the VP of Quality and Regulatory Affairs or designee.

**F. CDPH Penalties:**

CDPH may impose fines of $100 per day for late reporting. If a penalty is imposed and a decision is made to contest the penalty, the Senior Quality Leader or designee shall contact CDPH and request an adjudicative hearing within 10 days of the notice of the penalty pursuant to Health & Safety Code §11400 and 11500.

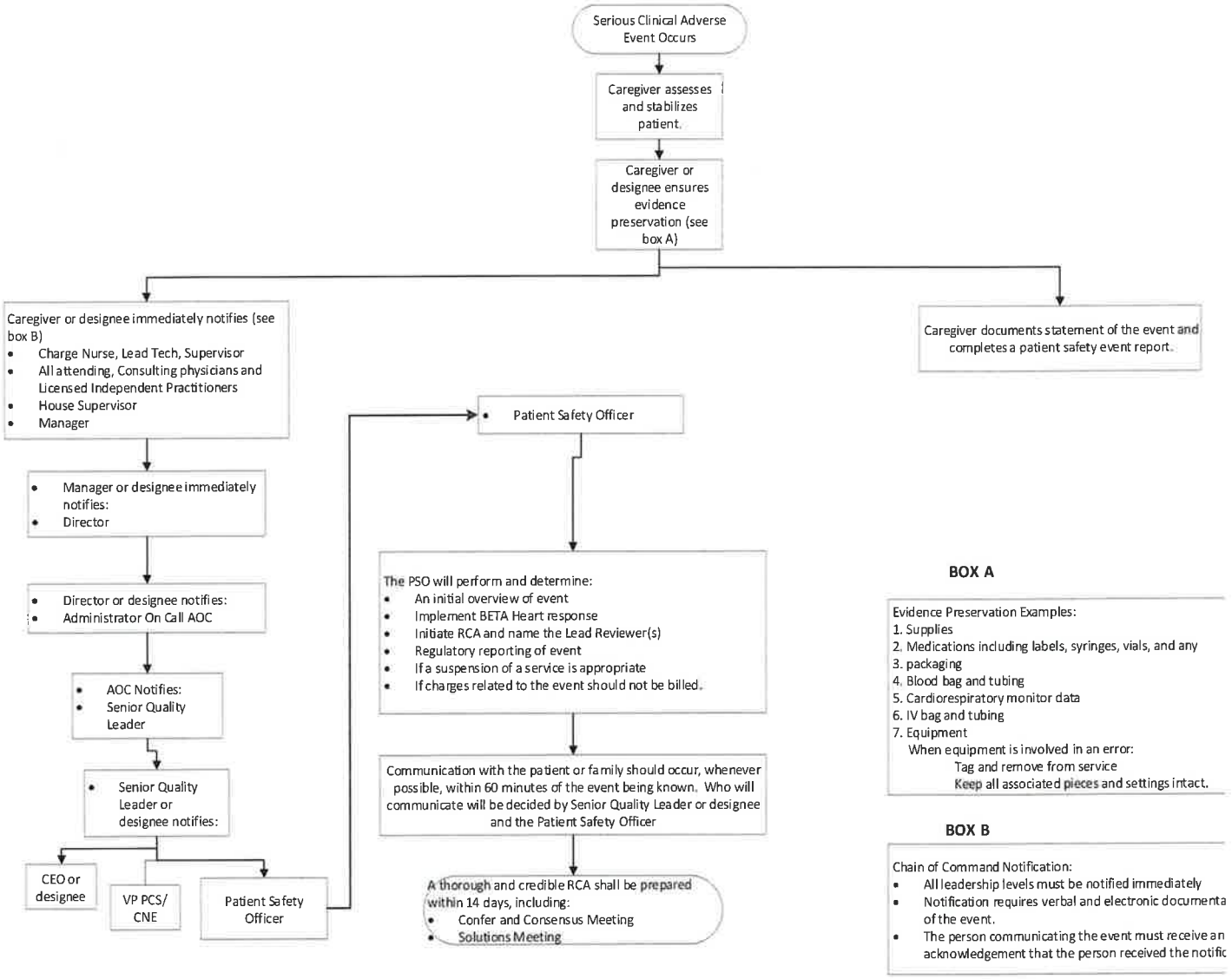
**G. Retaliation**

Sierra View Medical Center will not retaliate against anyone who identifies or reports an adverse event.

**H. Unusual Occurrences**

Definition: An unusual event such as an epidemic outbreak, poisoning, fire, major accident, disaster or other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors. (Title 22; Ca Code of Regulations, Section 70737). Unusual occurrences shall be reported to CDPH as soon as reasonable and practical by the Senior Quality Leader or designee. Notice to the patient is not required under Title 22 and shall be determined on a case by case basis by the VP of Quality and Regulatory Affairs, in consultation with the VP of Patient Care Services.

**Appendix A**
**Serious Clinical Adverse Event Response**




## Appendix B

## Respectful Management/Resolution Process of Serious Clinical Adverse Events Checklist for Consideration

| Element | Dimension | Started (x) | Completed (x) | N/A (x) |
|---|---|---|---|---|
| **Internal Notification** | Has the CEO, Executive Leaders, Risk Management, QI and Patient Safety, PR, and other relevant leaders been notified of the event? | | | |
| | Has the board of trustees been notified? | | | |
| **Priority 1: The Patient and Family** | Who is the organizational 24/7 contact person for the patient and family? | | | |
| | Has the organization acknowledged the pain, expressed empathy and regret? | | | |
| | Are the immediate needs of the patient and family met? | | | |
| | Has the patient had a full clinical assessment? | | | |
| | Has the organization assessed the personal safety of the patient and family? | | | |
| | Has the patient's primary care physician and extended care team been notified? | | | |
| | What is being heard from the patient and family? | | | |
| | Has the organization apologized, as appropriate? | | | |
| | Does the organization understand what the patient and family want said to others about the event? | | | |
| | Is the organization providing ongoing support to the patient and family, including reimbursement of out-of-pocket expenses? | | | |
| | Is the organization prepared to have open discussions about compensation, if deemed | | | |

| | | | | |
|---|---|---|---|---|
| | appropriate? | | | |
| | Has the family been engaged in the immediate investigation and then invited to participate in the root cause analysis (RCA) of the event? | | | |
| | Has the organization suppressed all normal PR and other communications to the patient or family that could inflict further pain? | | | |
| **Priority 2: The Frontline Staff** | Who is the organizational 24/7 contact person for staff involved in the event? | | | |
| | Has the personal safety of frontline staff been assessed? | | | |
| | What is being heard from the frontline staff? | | | |
| | Has the organization expressed empathy and been visible (offering up R.I.S.E)? | | | |
| | Has front line staff been invited to participate in any investigation and the RCA? | | | |
| **Priority 3: The Organization** | **The Event** | | | |
| | Has an overall organizational point person been established? | | | |
| | What is known about what happened?<br><br>What is the system for updates? | | | |
| | Is there clear and present danger to other patients, given what we know? | | | |
| | Has the root cause analysis been initiated?<br><br>Is there an executive sponsor? | | | |
| | What about the event is known internally and externally? | | | |
| | What is being heard internally and externally | | | |

| | | | | |
|---|---|---|---|---|
| | in response? | | | |
| | What are the priorities to be addressed and who is the point person? | | | |
| | Are there materials that need to be sequestered? | | | |
| | Has consideration of the bill taken place? | | | |
| | Was the documentation received (patient safety event report and statement)? | | | |
| | **Internal and External Communications** | | | |
| | What is the organization prepared to say internally and externally? | | | |
| | Who is (are) on point for communications? | | | |
| | Is there clarity on what the patient and family want said to others?<br><br>Have they had input into all communications materials? | | | |
| | Has a press release been prepared in case it is needed? | | | |
| | Have there been communications to trustees, patients, families, staff, and internal/external members of the patient's extended care team? | | | |
| | Have there been external communications to the media, the community? | | | |
| | Should outside media help be obtained? | | | |
| | **External Notifications and Unannounced Visits** | | | |
| | Are there required notifications to state public health, Centers for Medicare & Medicaid Services? | | | |

| | | | | |
|---|---|---|---|---|
| | Is this event being reported to the Joint Commission, others? | | | |
| | Have risk insurers/outside legal counsel been notified? | | | |
| | Are there federal agencies to be notified (e.g., Health and Human Services, National Institutes of Health)? Does the Food and Drug Administration need to be contacted? | | | |
| | Do law enforcement agencies need to be notified? | | | |
| | Are there others that would benefit from learning from this event (e.g., Institute for Safe Medication Practices)? | | | |

**REFERENCES:**


- BETA Heart presentation materials and toolkit. (2024). Retrieved from https://www.betahg.com/services/rm_beta_heart_resources.asp.
- California Evidence Code Section 1156. Retrieved February 28, 2019, from http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1156.&lawCode=EVID.
- California Evidence Code Section 1157. Retrieved February 28, 2019, from http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1157.&lawCode=EVID.
- California Health & Safety Code, §1279.1(b): 1279.2, 1279.3, 1279.4, &100171. Retrieved February 28, 2019, from http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=HSC&tocTitle=+Health+and+Safety+Code+-+HSC.
- A Consensus Statement of Harvard Hospitals (2006). When Things go Wrong: Responding to Adverse Events. Massachusetts: Coalition for the Prevention of Medical Errors.

- Conway J, Federico F, Stewart K, Campbell M. Respectful Management of Serious Clinical Adverse Events (Second Edition). IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org).

- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- National Quality Forum (NQF), *Serious Reportable Events in Health-care-2011 Update: A Consensus Report,* Washington, DC: NQF; 2011.

**CROSS REFERENCES:**

- House-Wide Policy & Procedure Manual: Communication with the Patient/Family After a Harm Event

- House-Wide Policy & Procedure Manual: Patient Safety Event

- House-Wide Policy & Procedure Manual: Disposition of Asset Property and Equipment for Obsolescence, Donation, and/or Sale

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**MINUTES OF A REGULAR MEETING OF THE**
**BOARD OF DIRECTORS OF**
**SIERRA VIEW LOCAL HEALTH CARE DISTRICT**

The monthly meeting of the Board of Directors of Sierra View Local Health Care District was held **June 25, 2024 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 5:02 p.m.

**Directors Present**: **REDDY, LOMELI, MARTINEZ, KASHYAP, PANDYA**

**Others Present**: Donna Hefner, President/Chief Executive Officer, Jeffery Hudson, VPPCS/CNO/DIO, Tracy Canales, VP of Human Resources, Craig McDonald, Chief Financial Officer, Melissa Mitchell, VP Quality and Regulatory Affairs, Ron Wheaton, VP of Professional Services/Physician Recruitment, Doug Dickson, Strategic Financial Advisor, Julie Franer, Director of Revenue Cycle, Dan Blazer, Patient Experience Officer, Kim Pryor-DeShazo Director of Marketing/Community Services, Cindy Gomez, Compliance Privacy Officer, Silvia Roberts, Manager of Care Integration, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff

I. Approval of Agenda:

Chairman REDDY motioned to approve the Agenda. The motion was moved by Director PANDYA, seconded by, Director MARTINEZ and carried to approve the agenda. The vote of the Board is as follows:

| | |
|---|---|
| REDDY | Yes |
| LOMELI | Absent |
| MARTINEZ | Yes |
| PANDYA | Yes |
| KASHYAP | Yes |

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:03 p.m. to discuss the following items:

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update – Quality Report

*Vice Chairman Lomeli arrived at 5:15pm.*

C. Pursuant to Gov. Code Section 54956.9; Existing Litigation to subdivision (d) (1): Conference with Legal Counsel. Beazley Claim No. BEAZL100005275260

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

*Closed Session Items D, E and F were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session*.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:29 p.m., reconvening in Open Session at 5:30 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report provided by Chief of Staff Sandhu.
Information only; no action taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review

Following review and discussion, it was moved by Director MARTINEZ, seconded by Director PANDYA, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

| | |
|---|---|
| REDDY | Yes |
| LOMELI | Abstain |
| MARTINEZ | Yes |
| PANDYA | Yes |
| KASHYAP | Yes |

2. Quality Division Report – Quality Repot

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ, and carried to approve the Quality Report as presented. The vote of the Board is as follows:

| | |
|---|---|
| REDDY | Yes |
| LOMELI | Abstain |
| MARTINEZ | Yes |
| PANDYA | Yes |
| KASHYAP | Yes |

IV. Public Comments

No Public Comments

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). It was moved by Director MARTINEZ, seconded by, Vice Chairman LOMELI and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

| | |
|---|---|
| REDDY | Yes |
| LOMELI | Yes |
| MARTINEZ | Yes |
| PANDYA | Yes |
| KASHYAP | Yes |

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Vice Chairman LOMELI and seconded by Director PANDYA to approve the May 28, 2024 Regular Board Meeting Minutes as presented. The motion carried and the vote of the Board is as follows:

| | |
|---|---|
| REDDY | Yes |
| LOMELI | Yes |
| MARTINEZ | Yes |
| PANDYA | Yes |
| KASHYAP | Yes |

B. Following review and discussion, it was moved by Vice Chairman LOMELI and seconded by Director MARTINEZ to approve the June 3, 2024 Special Board Meeting Minutes as presented. The motion carried and the vote of the Board is as follows:

| | |
|---|---|
| REDDY | Yes |
| LOMELI | Yes |
| MARTINEZ | Yes |
| PANDYA | Yes |
| KASHYAP | Yes |

VII. Business Items

A. May 2024 Financials

Craig McDonald, CFO presented the Financials for May 2024. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $15,228,708. Supplemental Funds were $2,472,672. Total Operating Expenses were $14,477,493. Gain from operations of $751,215.

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve the May 2024 Financials as presented. The vote of the Board is as follows:

| | |
|---|---|
| REDDY | Yes |
| LOMELI | Yes |
| MARTINEZ | Yes |
| PANDYA | Yes |
| KASHYAP | Yes |

*Business items B, C and D deferred until remaining closed session items were presented.*

VIII. CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View.

IX. Closed Session: Board adjourned Open Session at 5:56 p.m., reconvening in Closed Session at 5:56 p.m. to discuss the following items.

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

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

F. Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter. Estimated Date of Disclosure, for non-confidential personnel records – August, 2024

X. Open Session: Chairman REDDY adjourned Closed Session at 6:53 p.m., reconvening in Open Session at 6:53 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning

Information Only: No Action Taken

E. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning

Information Only: No Action Taken

F. Discussion Regarding Confidential Personnel Matter

Information Only: No Action Taken

XI. Business Items (Continued)

B. SVLHCD Fiscal Year 2025 Operating Budget

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA and carried to approve the 2025 Operating Budget as presented. The vote of the Board is as follows:

| | |
|---|---|
| REDDY | Yes |
| LOMELI | Yes |
| MARTINEZ | Yes |
| PANDYA | Yes |
| KASHYAP | Yes |

C. SVLHCD Fiscal Year 2025 Capital Budget

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA and carried to approve the 2025 Capital Budget as presented. The vote of the Board is as follows:

| | |
|---|---|
| REDDY | Yes |
| LOMELI | Yes |
| MARTINEZ | Yes |
| PANDYA | Yes |
| KASHYAP | Yes |

D. Salary Equity Adjustment

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA and carried to approve the Salary Equity Adjustment as presented. The vote of the Board is as follows:

| | |
|---|---|
| REDDY | Yes |

| | |
|---|---|
| LOMELI | Yes |
| MARTINEZ | Yes |
| PANDYA | Yes |
| KASHYAP | Yes |

XI. Announcements:

A. Regular Board of Directors Meeting – July 23, 2024 at 5:00 p.m.

XII. Adjournment

The meeting was adjourned at 6:57 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: tv

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FINANCIAL PACKAGE
June 2024

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

**Sierra View Medical Center**
**Financial Statistics Summary Report**
**June 2024**

| Statistic | Jun-24 Actual | Budget | Over/ (Under) | % Var. | YTD Actual | Budget | Over/ (Under) | % Var. | Fiscal 23 YTD | Increase/ (Decrease) Jun-23 | % Change |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Utilization** | | | | | | | | | | | |
| SNF Patient Days | | | | | | | | | | | |
| Total | 27 | 108 | (81) | -75.0% | 477 | 1,296 | (819) | -63.2% | 1,513 | (1,036) | -68.5% |
| Medi-Cal | 27 | 28 | (1) | -4.2% | 477 | 724 | (247) | -34.1% | 1,110 | (633) | -57.0% |
| Sub-Acute Patient Days | | | | | | | | | | | |
| Total | 1,004 | 868 | 136 | 15.7% | 11,723 | 10,449 | 1,274 | 12.2% | 10,239 | 1,484 | 14.5% |
| Medi-Cal | 914 | 575 | 339 | 58.9% | 10,260 | 6,983 | 3,277 | 46.9% | 6,844 | 3,416 | 49.9% |
| Acute Patient Days | 1,588 | 1,871 | (283) | -15.1% | 19,849 | 22,202 | (2,353) | -10.6% | 21,128 | (1,279) | -6.1% |
| Acute Discharges | 445 | 486 | (41) | -8.4% | 5,213 | 5,766 | (553) | -9.6% | 5,377 | (164) | -3.1% |
| Medicare | 177 | 166 | 11 | 6.6% | 2,041 | 2,199 | (158) | -7.2% | 2,054 | (13) | -0.6% |
| Medi-Cal | 195 | 258 | (63) | -24.4% | 2,504 | 2,790 | (286) | -10.3% | 2,601 | (97) | -3.7% |
| Contract | 66 | 58 | 8 | 13.9% | 627 | 746 | (119) | -16.0% | 694 | (67) | -9.7% |
| Other | 7 | - | 7 | - | 41 | 30 | 11 | 36.6% | 28 | 13 | 46.4% |
| Average Length of Stay | 3.57 | 3.85 | (0.28) | -7.3% | 3.81 | 3.85 | (0.04) | -1.1% | 3.93 | (0.12) | -3.1% |
| Newborn Patient Days | | | | | | | | | | | |
| Medi-Cal | 141 | 173 | (32) | -18.7% | 1,923 | 2,055 | (132) | -6.4% | 2,040 | (117) | -5.7% |
| Other | 32 | 34 | (2) | -4.5% | 373 | 407 | (34) | -8.4% | 379 | (6) | -1.6% |
| Total | 173 | 207 | (34) | -16.4% | 2,296 | 2,462 | (166) | -6.7% | 2,419 | (123) | -5.1% |
| Total Deliveries | 94 | 113 | (19) | -16.8% | 1,186 | 1,389 | (203) | -14.6% | 1,318 | (132) | -10.0% |
| Medi-Cal % | 78.72% | 82.81% | -4.09% | -4.9% | 83.43% | 82.81% | 0.62% | 0.8% | 82.81% | 0.62% | 0.7% |
| **Case Mix Index** | | | | | | | | | | | |
| Medicare | 1.5988 | 1.6395 | (0.0407) | -2.5% | 1.6368 | 1.6395 | (0.0027) | -0.2% | 1.6395 | (0.0027) | -0.2% |
| Medi-Cal | 1.1763 | 1.1881 | (0.0118) | -1.0% | 1.1975 | 1.1881 | 0.0094 | 0.8% | 1.1881 | 0.0094 | 0.8% |
| Overall | 1.3480 | 1.3732 | (0.0252) | -1.8% | 1.3724 | 1.3732 | (0.0008) | -0.1% | 1.3732 | (0.0008) | -0.1% |
| **Ancillary Services** | | | | | | | | | | | |
| **Inpatient** | | | | | | | | | | | |
| Surgery Minutes | 6,675 | 9,044 | (2,369) | -26.2% | 98,031 | 108,495 | (10,464) | -9.6% | 103,701 | (5,670) | -5.5% |
| Surgery Cases | 84 | 109 | (25) | -22.9% | 1,106 | 1,253 | (147) | -11.7% | 1,227 | (121) | -9.9% |
| Imaging Procedures | 1,418 | 1,483 | (65) | -4.4% | 17,060 | 17,755 | (695) | -3.9% | 17,468 | (408) | -2.3% |
| **Outpatient** | | | | | | | | | | | |
| Surgery Minutes | 13,423 | 12,448 | 975 | 7.8% | 153,438 | 149,376 | 4,062 | 2.7% | 154,720 | (1,282) | -0.8% |
| Surgery Cases | 178 | 187 | (9) | -4.8% | 2,415 | 2,277 | 138 | 6.1% | 2,309 | 106 | 4.6% |
| Endoscopy Procedures | 192 | 142 | 50 | 35.2% | 2,206 | 1,700 | 506 | 29.8% | 2,251 | (45) | -2.0% |
| Imaging Procedures | 4,060 | 3,706 | 354 | 9.6% | 48,297 | 44,573 | 3,724 | 8.4% | 47,026 | 1,271 | 2.7% |
| MRI Procedures | 270 | 290 | (20) | -6.9% | 3,605 | 3,535 | 70 | 2.0% | 3,505 | 100 | 2.9% |
| CT Procedures | 1,311 | 1,183 | 128 | 10.8% | 15,030 | 14,141 | 889 | 6.3% | 14,330 | 700 | 4.9% |
| Ultrasound Procedures | 1,393 | 1,103 | 290 | 26.3% | 15,681 | 13,225 | 2,456 | 18.6% | 12,846 | 2,835 | 22.1% |
| Lab Tests | 31,903 | 33,241 | (1,338) | -4.0% | 385,089 | 398,958 | (13,869) | -3.5% | 405,430 | (20,341) | -5.0% |
| Dialysis | 1 | - | 1 | - | 43 | 33 | 10 | 30.3% | 69 | (26) | -37.7% |

## Sierra View Medical Center
### Financial Statistics Summary Report
### June 2024

| Statistic | Jun-24 Actual | Budget | Over/ (Under) | % Var. | YTD Actual | Budget | Over/ (Under) | % Var. | Fiscal 23 YTD | Increase/ (Decrease) Jun-23 | % Change |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cancer Treatment Center** | | | | | | | | | | | |
| Chemo Treatments | 2,233 | 1,713 | 520 | 30.4% | 21,573 | 20,556 | 1,017 | 4.9% | 19,207 | 2,366 | 12.3% |
| Radiation Treatments | 1,876 | 1,647 | 229 | 13.9% | 22,490 | 19,830 | 2,660 | 13.4% | 20,225 | 2,265 | 11.2% |
| **Cardiac Cath Lab** | | | | | | | | | | | |
| Cath Lab IP Procedures | 14 | 13 | 1 | 7.7% | 164 | 123 | 41 | 33.3% | 113 | 51 | 45.1% |
| Cath Lab OP Procedures | 31 | 22 | 9 | 40.9% | 364 | 330 | 34 | 10.3% | 350 | 14 | 4.0% |
| Total Cardiac Cath Lab | 45 | 35 | 10 | 28.6% | 528 | 453 | 75 | 16.6% | 463 | 65 | 14.0% |
| **Outpatient Visits** | | | | | | | | | | | |
| Emergency | 3,439 | 3,415 | 24 | 0.7% | 41,525 | 40,936 | 589 | 1.4% | 40,335 | 1,190 | 3.0% |
| Total Outpatient | 13,780 | 12,810 | 970 | 7.6% | 164,960 | 153,731 | 11,229 | 7.3% | 156,885 | 8,075 | 5.1% |
| **Staffing** | | | | | | | | | | | |
| Paid FTE's | 881.85 | 841.56 | 40.29 | 4.8% | 862.92 | 841.56 | 21.36 | 2.5% | 889.93 | (27.01) | -3.0% |
| Productive FTE's | 748.19 | 735.98 | 12.21 | 1.7% | 740.60 | 735.98 | 4.62 | 0.6% | 761 | (20.66) | -2.7% |
| Paid FTE's/AOB | 4.93 | 4.88 | 0.04 | 0.9% | 5.01 | 4.97 | 0.04 | 0.8% | 5.25 | (0.24) | -4.6% |
| **Revenue/Costs (w/o Case Mix)** | | | | | | | | | | | |
| Revenue/Adj.Patient Day | 10,874 | 10,981 | (107) | -1.0% | 10,760 | 11,028 | (268) | -2.4% | 10,783 | (23) | -0.2% |
| Cost/Adj.Patient Day | 2,842 | 2,572 | 270 | 10.5% | 2,694 | 2,614 | 80 | 3.1% | 2,755 | (61) | -2.2% |
| Revenue/Adj. Discharge | 51,179 | 52,700 | (1,521) | -2.9% | 53,223 | 53,073 | 150 | 0.3% | 53,336 | (113) | -0.2% |
| Cost/Adj. Discharge | 13,374 | 12,343 | 1,031 | 8.4% | 13,327 | 12,583 | 744 | 5.9% | 13,629 | (302) | -2.2% |
| Adj. Discharge | 1,141 | 1,078 | 64 | 5.9% | 12,715 | 12,852 | (137) | -1.1% | 12,516 | 199 | 1.6% |
| Net Op. Gain/(Loss) % | 5.60% | -1.19% | 6.79% | -568.6% | -3.60% | -1.19% | -2.40% | 201.3% | -10.83% | 7.23% | -66.8% |
| Net Op. Gain/(Loss) $ | 904,658 | (156,960) | 1,061,618 | -676.4% | (5,885,428) | (3,317,692) | (2,567,736) | 77.4% | (16,665,987) | 10,780,559 | -64.7% |
| Gross Days in Accts Rec. | 94.00 | 88.87 | 5.13 | 5.8% | 94.00 | 88.87 | 5.13 | 5.8% | 92.76 | 1.24 | 1.3% |
| Net Days in Accts. Rec. | 49.85 | 72.82 | (22.97) | -31.5% | 49.85 | 72.82 | (22.97) | -31.5% | 64.64 | (14.79) | -22.9% |

**COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR**
**SIERRA VIEW LOCAL HEALTH CARE DISTRICT**

| | JUN 2024 | MAY 2024 |
|---|---|---|
| ASSETS | | |
| CURRENT ASSETS: | | |
| CASH & CASH EQUIVALENTS | $ 23,036,803 | $ 16,134,432 |
| SHORT-TERM INVESTMENTS | 9,835 | 20,830 |
| ASSETS LIMITED AS TO USE | 68,541 | 64,019 |
| PATIENT ACCOUNTS RECEIVABLE | 184,617,734 | 178,337,176 |
| LESS UNCOLLECTIBLES | (20,390,166) | (21,777,352) |
| CONTRACTUAL ALLOWANCES | (140,412,574) | (134,809,105) |
| OTHER RECEIVABLES | 16,580,402 | 20,877,648 |
| INVENTORIES | 4,290,652 | 4,097,600 |
| PREPAID EXPENSES AND DEPOSITS | 2,301,439 | 3,519,579 |
| LEASE RECEIVABLE - CURRENT | 299,577 | 299,577 |
| TOTAL CURRENT ASSETS | 70,402,243 | 66,764,406 |
| ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS | 36,365,602 | 35,772,664 |
| LONG-TERM INVESTMENTS | 128,735,361 | 127,984,655 |
| PROPERTY, PLANT AND EQUIPMENT, NET | 77,801,521 | 78,173,086 |
| INTANGIBLE RIGHT OF USE ASSETS | 423,316 | 435,299 |
| SBITA RIGHT OF USE ASSETS | 2,472,522 | 2,578,120 |
| LEASE RECEIVABLE - LT | 993,321 | 1,018,804 |
| OTHER INVESTMENTS | 250,000 | 250,000 |
| PREPAID LOSS ON BONDS | 1,510,532 | 1,531,512 |
| TOTAL ASSETS | $ 318,954,418 | $ 314,508,545 |

**COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR**
**SIERRA VIEW LOCAL HEALTH CARE DISTRICT**

| | JUN 2024 | MAY 2024 |
|---|---|---|
| LIABILITIES AND FUND BALANCE | | |
| CURRENT LIABILITIES: | | |
| BOND INTEREST PAYABLE | $ 783,700 | $ 653,083 |
| CURRENT MATURITIES OF BONDS PAYABLE | 4,055,000 | 4,055,000 |
| CURRENT MATURITIES OF LONG TERM DEBT | 1,201,171 | 1,201,171 |
| ACCOUNTS PAYABLE AND ACCRUED EXPENSES | 5,809,943 | 3,908,924 |
| ACCRUED PAYROLL AND RELATED COSTS | 8,418,736 | 7,572,123 |
| ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS | 3,656,945 | 3,731,945 |
| LEASE LIABILITY - CURRENT | 133,974 | 133,974 |
| SBITA LIABILITY - CURRENT | 1,272,203 | 1,272,203 |
| TOTAL CURRENT LIABILITIES | 25,331,672 | 22,528,424 |
| SELF-INSURANCE RESERVES | 1,159,085 | 1,202,433 |
| CAPITAL LEASE LIAB LT | 939,976 | 1,023,852 |
| BONDS PAYABLE, LESS CURR REQT | 37,510,000 | 37,510,000 |
| BOND PREMIUM LIABILITY - LT | 2,702,061 | 2,760,631 |
| LEASE LIABILITY - LT | 310,387 | 321,845 |
| SBITA LIABILITY - LT | 1,388,709 | 1,497,293 |
| DEFERRED INFLOW - LEASES | 1,223,945 | 1,250,246 |
| TOTAL LIABILITIES | 70,565,834 | 68,094,723 |
| UNRESTRICTED FUND | 245,134,891 | 245,134,891 |
| PROFIT OR (LOSS) | 3,253,694 | 1,278,932 |
| TOTAL LIABILITIES AND FUND BALANCE | $ 318,954,418 | $ 314,508,545 |

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

| JUN 2024 ACTUAL | JUN 2024 BUDGET | DOLLAR VARIANCE | PERCENT VARIANCE | | Y-T-D ACTUAL | Y-T-D BUDGET | DOLLAR VARIANCE | PERCENT VARIANCE |
|---|---|---|---|---|---|---|---|---|
| | | | | ***** OPERATING REVENUE ***** | | | | |
| 5,041,769 | 5,710,005 | 668,236 | (12)% | INPATIENT - NURSING | 63,624,847 | 68,747,430 | 5,122,583 | (8)% |
| 17,758,493 | 19,902,283 | 2,143,790 | (11)% | INPATIENT - ANCILLARY | 214,304,522 | 237,272,895 | 22,968,373 | (10)% |
| 22,800,262 | 25,612,288 | 2,812,026 | (11)% | TOTAL INPATIENT REVENUE | 277,929,369 | 306,020,325 | 28,090,956 | (9)% |
| 35,595,637 | 31,172,500 | (4,423,137) | 14% | OUTPATIENT - ANCILLARY | 398,800,755 | 376,080,736 | (22,720,019) | 6% |
| 58,395,898 | 56,784,788 | (1,611,110) | 3% | TOTAL PATIENT REVENUE | 676,730,124 | 682,101,061 | 5,370,937 | (1)% |
| | | | | DEDUCTIONS FROM REVENUE | | | | |
| (4,296,458) | (17,105,655) | (12,809,197) | (75)% | MEDICARE | (206,976,284) | (205,267,904) | 1,708,380 | 1% |
| (16,038,387) | (20,103,940) | (4,065,554) | (20)% | MEDI-CAL | (210,710,782) | (241,247,280) | (30,536,498) | (13)% |
| (22,686,132) | (6,634,411) | 16,051,721 | 242% | OTHER/CHARITY | (97,177,125) | (79,612,932) | 17,564,193 | 22% |
| 78,032 | (13,160) | (91,192) | (693)% | DISCOUNTS & ALLOWANCES | (125,700) | (157,898) | (32,198) | (20)% |
| 93,528 | (439,236) | (532,764) | (121)% | BAD DEBTS | (4,883,855) | (5,270,832) | (386,977) | (7)% |
| (42,849,416) | (44,296,402) | (1,446,986) | (3)% | TOTAL DEDUCTIONS | (519,873,746) | (531,556,846) | (11,683,100) | (2)% |
| 15,546,482 | 12,488,386 | (3,058,096) | 25% | NET SERVICE REVENUE | 156,856,379 | 150,544,215 | (6,312,164) | 4% |
| 617,813 | 654,369 | 36,556 | (6)% | OTHER OPERATING REVENUE | 6,710,721 | 7,852,428 | 1,141,708 | (15)% |
| 16,164,295 | 13,142,755 | (3,021,540) | 23% | TOTAL OPERATING REVENUE | 163,567,099 | 158,396,643 | (5,170,456) | 3% |
| | | | | ***** OPERATING EXPENSE ***** | | | | |
| 5,475,986 | 5,274,445 | 201,541 | 4% | SALARIES | 67,294,803 | 63,500,758 | 3,794,045 | 6% |
| 919,424 | 564,149 | 355,275 | 63% | S&W PTO | 8,518,002 | 6,784,283 | 1,733,719 | 26% |
| 1,615,310 | 1,437,304 | 178,006 | 12% | EMPLOYEE BENEFITS | 16,979,288 | 17,874,476 | (895,189) | (5)% |
| 1,693,464 | 1,397,764 | 295,700 | 21% | PROFESSIONAL FEES | 17,336,615 | 16,755,202 | 581,413 | 4% |
| 1,024,817 | 833,025 | 191,792 | 23% | PURCHASED SERVICES | 10,545,774 | 10,108,801 | 436,973 | 4% |
| 1,897,869 | 1,957,446 | (59,578) | (3)% | SUPPLIES & EXPENSES | 24,883,742 | 23,677,537 | 1,206,205 | 5% |
| 261,040 | 247,412 | 13,628 | 6% | MAINTENANCE & REPAIRS | 2,917,056 | 2,924,597 | (7,541) | 0% |
| 275,587 | 263,897 | 11,690 | 4% | UTILITIES | 2,961,680 | 3,166,764 | (205,084) | (7)% |
| 41,808 | 11,255 | 30,553 | 272% | RENT/LEASE | 403,022 | 158,248 | 244,774 | 155% |
| 125,287 | 118,267 | 7,020 | 6% | INSURANCE | 1,455,611 | 1,419,204 | 36,407 | 3% |
| 1,064,229 | 889,938 | 174,291 | 20% | DEPRECIATION/AMORTIZATION | 11,881,910 | 11,538,150 | 343,760 | 3% |
| 864,817 | 304,813 | 560,004 | 184% | OTHER EXPENSE | 4,275,024 | 3,806,315 | 468,709 | 12% |
| 0 | 0 | 0 | 0% | IMPAIRED COSTS | 0 | 0 | 0 | 0% |
| 15,259,637 | 13,299,715 | 1,959,922 | 15% | TOTAL OPERATING EXPENSE | 169,452,526 | 161,714,335 | 7,738,191 | 5% |
| 904,658 | (156,960) | (1,061,618) | (676)% | NET GAIN/(LOSS) FROM OPERATIONS | (5,885,427) | (3,317,692) | 2,567,735 | 77% |
| 226,495 | 116,558 | (109,937) | 94% | DISTRICT TAXES | 1,618,570 | 1,398,696 | (219,874) | 16% |
| 360,670 | 277,386 | (83,284) | 30% | INVESTMENTS INCOME | 4,042,642 | 3,328,632 | (714,010) | 22% |
| 50,259 | 43,282 | (6,977) | 16% | OTHER NON OPERATING INCOME | 653,025 | 519,384 | (133,641) | 26% |
| (87,175) | (105,515) | (18,340) | (17)% | INTEREST EXPENSE | (1,071,434) | (1,187,258) | (115,824) | (10)% |
| 76,006 | (36,775) | (112,781) | (307)% | NON-OPERATING EXPENSE | (417,275) | (441,300) | (24,025) | (5)% |
| 626,255 | 294,936 | (331,319) | 112% | TOTAL NON-OPERATING INCOME | 4,825,529 | 3,618,154 | (1,207,375) | 33% |
| 1,530,913 | 137,976 | (1,392,937) | 1,010% | GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT | (1,059,899) | 300,462 | 1,360,361 | (453)% |
| 443,849 | 0 | (443,849) | | NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT | 4,313,592 | 0 | (4,313,592) | |
| 1,974,762 | 137,976 | (1,836,786) | 1,331% | NET GAIN/(LOSS) | 3,253,694 | 300,462 | (2,953,232) | 983% |

**SIERRA VIEW MEDICAL CENTER**
**Statement of Cash Flows**
**06/30/24**

| | CURRENT MONTH | YEAR TO DATE |
|---|---|---|
| **Cash flows from operating activities:** | | |
| Operating Income/(Loss) | 904,658 | (5,885,427) |
| Adjustments to reconcile operating income/(loss) to net cash from operating activities | | |
| Depreciation and amortization | 1,064,229 | 11,881,910 |
| Provision for bad debts | (1,387,186) | (7,351,636) |
| Change in assets and liabilities: | | |
| Patient accounts receivable, net | (677,088) | 9,524,376 |
| Other receivables | 4,297,246 | (903,728) |
| Inventories | (193,052) | (272,693) |
| Prepaid expenses and deposits | 1,218,140 | 81,540 |
| Advance refunding of bonds payable, net | 20,980 | 251,756 |
| Accounts payable and accrued expenses | 1,901,018 | 39,013 |
| Deferred inflows - leases | (26,301) | (468,038) |
| Accrued payroll and related costs | 846,613 | 1,061,775 |
| Estimated third-party payor settlements | (75,000) | 501,675 |
| Self-insurance reserves | (43,348) | (506,871) |
| Total adjustments | 6,946,251 | 13,839,079 |
| Net cash provided by (used in) operating activities | 7,850,909 | 7,953,652 |
| **Cash flows from noncapital financing activities:** | | |
| District tax revenues | 226,495 | 1,618,570 |
| Noncapital grants and contributions, net of other expenses | 113,223 | 59,727 |
| Net cash provided by (used in) noncapital financing activities | 339,718 | 1,678,297 |
| **Cash flows from capital and related financing activities:** | | |
| Purchase of capital assets | (680,681) | (4,389,777) |
| Proceeds from lease receivable, net | 25,483 | 457,258 |
| Principal payments on debt borrowings | - | (3,880,000) |
| Interest payments | (2,086) | (1,684,500) |
| Net change in notes payable and lease liability | (98,320) | (1,338,117) |
| Net changes in assets limited as to use | (597,460) | (1,488,817) |
| Net cash provided by (used in) capital and related financing activities | (1,353,064) | (12,323,953) |
| **Cash flows from investing activities:** | | |
| Net (purchase) or sale of investments | (306,857) | 7,337,517 |
| Investment income | 360,670 | 4,042,642 |
| Net cash provided by (used in) investing activities | 53,813 | 11,380,159 |
| **Net increase (decrease) in cash and cash equivalents:** | 6,891,376 | 8,688,155 |
| Cash and cash equivalents at beginning of month/year | 16,155,262 | 14,358,483 |
| Cash and cash equivalents at end of month | 23,046,638 | 23,046,638 |

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
June 2024

| | PATIENT ACCOUNTS RECEIVABLE | OTHER ACTIVITY | TOTAL DEPOSITED |
|---|---|---|---|
| Jul-23 | 9,542,222 | 1,209,276 | 10,751,498 |
| Aug-23 | 11,411,456 | 2,278,509 | 13,689,964 |
| Sep-23 | 11,153,141 | 297,374 | 11,450,515 |
| Oct-23 | 10,806,912 | 1,614,798 | 12,421,710 |
| Nov-23 | 11,048,937 | 5,395,178 | 16,444,115 |
| Dec-23 | 9,261,593 | 1,749,227 | 11,010,820 |
| Jan-24 | 12,040,509 | 3,417,973 | 15,458,481 |
| Feb-24 | 10,531,309 | 1,474,392 | 12,005,701 |
| Mar-24 | 11,275,398 | 3,178,205 | 14,453,603 |
| Apr-24 | 13,314,378 | 6,920,700 | 20,235,078 |
| May-24 | 11,564,879 | 10,488,610 | 22,053,489 |
| **Jun-24** | **10,598,225** | **7,664,994** | **18,263,219** |

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - Receipts for Café, rebates, refunds, and miscellaneous funding sources

- Non-Operating Revenues - rental income, property tax revenues

- Medi-Cal OP Supplemental and DSH Funds
- Medi-Cal and Medi-Care Tentative Cost Settlements
- Grants, IGT, HQAF, & QIP Supplemental Funds
- Medicare interim payments

June 2024 Summary of Other Activity:

| | |
|---|---|
| 39,802 | Tulare County First 5 01/24 - 03/24 Qtr |
| 2,482,967 | M-Cal AB113 IGT FY23 Final |
| 846,043 | State of CA HQAF8 Direct Grant CY23 |
| 3,106,471 | M-Cal AB113 IGT FY24 |
| 825,759 | M-Cal IP DSH 04/24 - 05/24 |
| 363,952 | Miscellaneous |
| 7,664,994 | 06/24 Total Other Activity |