List of Policies and Procedures for JCC Review 3-9-26					
Blue (Hospital-wide); Grey (Departmental)					
Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
					1. Deleted "The facility recognizes the resident's or designated surrogate decision maker's right to make an informed decision where the resident's enhanced quality of life, provided by eating and drinking, may be of greater importance than reducing the risk of aspiration." 2.Added "Residents and their legally authorized decision makers are responsible for making informed choices about care. If they choose to continue oral intake despite the known risk of aspiration, the care team will respect and document the decision." 3. Updated the Individualized Aspiration Precautions list 4. Updated the description for "Close Supervision" 5. Deleted "1:1 Supervision: Resident receives direct assistance or supervision during oral intake (e.g., cognition adversely effecting swallow function increasing risk of aspiration due impulsive self-feeding, cues required to follow standard aspiration precautions, HIGH risk of aspiration) " 6. Added "Dependent for meals and/or snacks: Staff must provide direct verbal cues or direct physical support to ensure adherence to individualized aspiration precautions." 7. Deleted "Line of Sight: Resident is within view of staff while eating." 8. Deleted "Once a resident is identified as being at risk for aspiration, the physician shall order Dysphagia Evaluation." 9. Deleted "If appropriate, the physician will refer the resident to the dental clinic for evaluation. " 10. Added "When a resident is identified as at risk for aspiration, the provider will refer them for a dysphagia evaluation performed by SLP to assess swallowing and to provide recommendations for an individualized aspiration precautions plan. If needed, the provider may refer the resident to dental clinic for further evaluation." 11. Added "improved or declined " 12. Deleted "When a Dysphagia Evaluation and/or diagnostic treatment requires a tray that includes items that are not consistent with the resident's current diet order, the following tray precautions shall be taken: i. The SLP shall contact Nutrition Services and ask them to write "Hold for Speech Therapy" on the tray ticket. ii. SLP shall notify Nursing and request that the tray not be served until the SLP arrives. iii. Nursing staff shall hold the tray for SLP and shall not give it to the resident. iv. SLP is responsible for removing any food or liquid items inconsistent with the resident's current diet order before leaving an unfinished tray with the resident upon completion of the session. " 13. Deleted "If treatment involves upgraded food/liquid consistencies not currently included in the resident's diet order, tray precautions delineated in paragraph 2bi -ii, above will be followed." 14. Added "Nursing staff are responsible for updating the resident's care plan to reflect these precautions." 15. Replaced "Management of Residents Who Are at Risk for Aspiration" with "Care Management for Residents on Standard or Individualized Aspiration Precautions" 16. Replaced "Once a resident has been identified by SLP as requiring individualized aspiration precautions and being at risk for aspiration, nursing shall place a pink dot at the head of the resident's bed and place a pink indicator on the resident's wristband and/or mobility device as per NPP B5.0 Color Codes. Staff and volunteers shall be trained on this color-coding system and what it means. " with "d.Once a resident has been identified by SLP as requiring individualized aspiration precautions, nursing staff shall implement visual identifiers in accordance with

Revised	LHHPP	26-02	Management of Dysphagia and Aspiration Risk	**D. Sidhu**	requiring individualized aspiration precautions, nursing staff shall implement visual identifiers in accordance with NPP B5.0 Color Code guidelines." 17. Deleted "Residents with a pink indicator on their wristbands and/or mobility device shall be provided meals consistent with their individualized aspiration precaution needs." 18. Deleted "Certified and Licensed nursing staff shall be provided with mealtime competency training by Department of Education and Training or designated trainers upon hire and annually. Facility personnel shall be trained on standard aspiration precautions, individualized aspiration precautions and signs/symptoms of aspiration upon hire and annually. " 19. Added "Nursing staff will receive mealtime/aspiration safety training upon hire and annually from The Department of Education and Training, covering feeding safety, individualized aspiration precautions, and signs of aspiration." 20. Added "Nursing staff must ensure that family members and regular visitors who help residents with meals receive proper training. If more support is needed with feeding techniques or aspiration precautions, a referral to Speech-Language Pathology may be recommended. All training must be documented in the Electronic Health Record and the resident's care plan, including the date completed. " 21. Deleted "Signage directing visitors to check with the neighborhood nursing staff before serving food or drinks to a resident indicator shall be posted in the Pavilion Lobby and designated areas." 22. Added "a. When a resident or their surrogate decision maker declines Speech Language Pathology (SLP) recommendations, the informed decision must be documented in the Resident Care Conference meeting notes, the resident's care plan, and the advanced directive. b. If the Diet and Nutrition order is changed or discontinued for quality of life reasons without SLP involvement, the Diet Office must be notified to update the resident's meal tray ticket accordingly."
Revised	HIM	1.02	Protected Health Information DOCUMENTATION	**S. Tran**	We've added a section for: • Items that should not be included in the medical record • Regulation references
Revised	FNS	1.1	Food from Home or Outside Sources Served Directly to Residents	**E. Lavarreda**	1. Updated 72 hours to 3 days. 2. Minor grammar updates. 3. Added Resident Food by the Bedside to ensure resident safety, uphold infection control standards, and respect residents' rights regarding personal food items kept at the bedside. This policy aims to prevent foodborne illness, contamination, and pest issues while maintaining compliance with state and federal regulations. 4. Updated references

Revised Hospital-wide Policies and Procedures

MANAGEMENT OF DYSPHAGIA AND ASPIRATION RISK

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center shall implement procedures to safely manage the care of residents identified to be at risk for aspiration.

2. Residents and their legally authorized decision makers are responsible for making informed choices about care. If they choose to continue oral intake despite the known risk of aspiration, the care team will respect and document the decision.~~The facility recognizes the resident's or designated surrogate decision maker's right to make an informed decision where the resident's enhanced quality of life, provided by eating and drinking, may be of greater importance than reducing the risk of aspiration~~.

PURPOSE:

To promote resident safety and enhance resident quality of life with respect to diet and feeding interventions.

DEFINITIONS:

1. Standard Aspiration Precautions:

    a. Oral care

    b. Resident to sit upright as possible (elevate Head of Bed if cannot transfer to chair) with all meals and 20 minutes after eating, including medications.

    c. Dentures in place

    d. Minimize distractions

    e. Small bites and sips

    f. Slow rate of intake

2. Individualized Aspiration Precautions

    Individualized aspiration precautions may be recommended by Speech Language Pathology (SLP) following a Dysphagia Evaluation and/or diagnostic treatment; examples include, but are not limited to:

    a. No straw

    b. Alternating solids and liquids

c. Chin tuck

d. Head turn

e. Head tilt

~~e.~~f. Dependent for meals and/or snacks ~~Feeding~~

~~f. 1:1 Supervision~~

~~g. 1:1 Assistance~~

~~h. Cutting food into small pieces~~

~~i.~~g. Liquids by spoon only

~~j.~~h. Close supervision

~~k. Line of sight supervision~~

~~l.~~i. Passy Muir Valve in place for all PO

~~m.~~j. Frazier Free Water Protocol

~~Line of Sight: Resident is within view of staff while eating.~~

3. Close Supervision: ~~One staff member sits with a limited number of residents to provide supervision during mealtime. Staff shall ensure that recommended aspiration precautions (e.g., standard precautions or individualized precautions as recommended by SLP and ordered by the physician) are followed by actively cueing, assisting, and/or observing the resident during mealtime.~~ One staff member is assigned to supervise a small group of residents during meals or snacks, ensuring adherence to individualized aspiration precautions. Staff must actively observe, provide cues, and assist residents as needed to support safe intake.

4. Dependent for ~~Feeding~~meals and/or snacks: ~~1:1 Supervision: Resident receives direct assistance or supervision during oral intake (e.g., cognition adversely effecting swallow function increasing risk of aspiration due impulsive self-feeding, cues required to follow standard aspiration precautions, HIGH risk of aspiration)~~Resident ~~requires direct supervision or hands-on assistance during meals due to cognitive impairments that impact safe swallowing. This includes behaviors such as impulsive self-feeding, poor insight to deficits, difficulty following standard or individualized aspiration precautions.~~ Staff must provide direct verbal cues or direct physical support to ensure adherence to ~~standard or~~ individualized aspiration precautions. ~~are followed secondary to high aspiration risk without use.~~

4.5. Frazier Free Water Protocol~~: Free~~: Free water is permitted before and between meals with clean oral cavity. Free water is not permitted with meals, medications, or other oral intake.

PROCEDURE:

1. Identification of At-Risk Residents

a. Residents shall be evaluated by the Resident Care Team (RCT), at minimum this will include a ~~physician~~ provider and a nurse, to determine risk for aspiration. Clinical signs that suggest risk of aspiration include, but are not limited to the following:

i. drooling and/or poor oral management of secretions and/or bolus;

ii. ineffective chewing;

iii. food or liquid remaining in the oral cavity after the swallow (oral residue);

iv. inability to maintain lip closure, leading to food and/or liquids leaking from the oral cavity;

v. extra time needed to chew or swallow;

vi. food and/or liquids leaking from the nasal cavity;

vii. complaints of food “sticking” or complaints of a “fullness” in the neck;

viii. complaints of pain when swallowing;

ix. changes in vocal quality (e.g., wet or gurgly sounding voice) during or after eating or drinking;

x. coughing or throat clearing during or after eating or drinking;

xi. difficulty coordinating breathing and swallowing;

xii. acute or recurring aspiration pneumonia/respiratory infection and/or fever

xiii. food or liquid in tracheal secretions

b. When a resident is identified as at risk for aspiration, the provider will refer them for a dysphagia evaluation performed by SLP to assess swallowing and to

provide ~~recommedations~~recommendations for an individualized ~~apsiration~~aspiration precautions plan. If needed, the provider may refer the resident to dental clinic for further evaluation.

~~If a resident is identified as being at risk for aspiration, and there is no active SLP Plan of Care in place, nursing staff shall perform the RN Swallow Screen and initiate a referral for a Dysphagia Evaluation as clinically indicated.~~

~~b. Once a resident is identified as being at risk for aspiration, the physician~~provider ~~shall order Dysphagia Evaluation.~~

~~c. If appropriate, the physician will refer the resident to the dental clinic for evaluation.~~

~~d.~~c. Residents with individualized aspiration precautions whose swallow function appears to have improved or declined shall be referred to SLP for evaluation. (~~R~~Nursing and /Provider documentation to reflect), ~~shall be referred to SLP for re-evaluation.~~

~~e.~~ Referral to the SLP for Dysphagia Evaluation may also be indicated in cases of improved or declined unexplained weight loss, dehydration, and/or poor oral intake, to rule out dysphagia as a contributing factor. Improve or decline.

~~f.~~d.

2. Dysphagia Evaluation by SLP

~~a.~~ Dysphagia Evaluations shall be carried out as per Rehabilitation Center Policy and Procedure #90-05, Establishment of Treatment Programs and Documentation: Dysphagia.

~~b.~~a.

~~When a Dysphagia Evaluation and/or diagnostic treatment requires a tray that includes items that are not consistent with the resident's current diet order, the following tray precautions shall be taken:~~ When a Dysphagia Evaluation and/or diagnostic treatment requires the use of a meal tray containing items that do not align with the resident's current diet order, the following tray precautions must be implemented:

~~The SLP shall contact Nutrition Services and ask them to write "Hold for Speech Therapy" on the tray ticket.~~

~~SLP shall notify Nursing and request that the tray not be served until the SLP arrives.~~

~~Nursing staff shall hold the tray for SLP and shall not give it to the resident.~~

~~SLP is responsible for removing any food or liquid items inconsistent with the resident's current diet order before leaving an unfinished tray with the resident upon completion of the session.~~ SLP is responsible for ensuring that any food or liquid items not aligned with the resident's current diet order are removed prior to ~~leaving an unfinished meal tray with the resident at the conclusion of the session.~~

3. Dysphagia diagnostic Treatment

~~a.~~ Following a Dysphagia Evaluation, SLP shall proceed with diagnostic dysphagia treatment as clinically indicated.

a.

~~If treatment involves upgraded food/liquid consistencies not currently included in the resident's diet order, tray precautions delineated in paragraph 2bi -ii, above will be followed.~~

4. Diet Initiation following Dysphagia Evaluation and/or Diagnostic Treatment

a. Upon completion of evaluation and or diagnostic treatment, SLP shall document the recommended least restrictive diet including, standard and/or individualized aspiration precautions or if the resident should be NPO in the Dysphagia Evaluation and/or progress notes.

   i. SLP will pend diet orders accordingly in EHR for ~~physician~~ provider review and sign. ~~signature.~~

   ii. The Dietitian and diet tech will be notified via EPIC Secure Chat by SLP regarding individualized aspiration precautions to be printed on the resident's meal ticket.

~~b. The SLP shall review recommended individualized aspiration precautions with Nursing staff and provide training, as needed. Nursing will update care plan accordingly.~~ SLP shall review recommended individualized aspiration precautions with nursing staff and provide training as needed. Nursing staff are responsible for updating the resident's care plan to reflect these precautions.

~~c.~~b.

C~~Management of Residents on Specific Who Are at Risk for Aspiration Precaut~~ Care Management for Residents on Standard or Individualized Aspiration Precautions

~~Once a resident has been identified by SLP as requiring individualized aspiration precautions and being at risk for aspiration, nursing shall place a pink dot at the head of the resident's bed and place a pink indicator on the resident's wristband~~

~~and/or mobility device~~ ~~as per NPP B5.0 Color Codes. Staff and volunteers shall be trained on this color-coding system and what it means.~~

~~a.~~ Once a resident has been identified by SLP as requiring individualized aspiration precautions, nursing staff shall implement visual identifiers in accordance with NPP B5.0 Color Code guidelines.

a.

~~b.~~

~~c. Residents with a pink indicator on their wristbands and/or mobility device shall be provided meals consistent with their individualized aspiration precaution needs.~~

~~d.~~

~~e. Certified and Licensed nursing staff shall be provided with mealtime competency training by Department of Education and Training or designated trainers upon hire and annually. Facility personnel shall be trained on standard aspiration precautions, individualized aspiration precautions and signs/symptoms of aspiration upon hire and annually.~~

b. Nursing staff will receive mealtime/aspiration safety training upon hire and annually from The Department of Education and Training, covering feeding safety, ~~indivdualized~~individualized aspiration precautions, and signs of aspiration.

~~f.~~c. ~~Staff who are feeding or supervising residents determined to be at risk for aspiration are responsible for complying with the resident's diet order, standard aspiration precautions, and any individualized precautions assigned to the resident.~~ Staff who are feeding or supervising residents identified as at risk for aspiration are expected to follow the resident's diet order, observe standard aspiration precautions, and support any individualized aspiration precautions outlined in the care plan to promote safety and well-being.

~~Nursing is responsible for ensuring that family members and regular visitors who assist residents with their meals have been trained. If a family or volunteer needs additional training regarding feeding techniques individualized aspiration precautions, nursing may recommend referral to SLP Speech Pathology. Staff shall document family or volunteer training in the medical record Electronic Health Record and resident care plan, including the date of training.~~

~~g.~~ Nursing staff must ensure that family members and regular visitors who help residents with meals receive proper training. If more support is needed with feeding techniques or aspiration precautions, a referral to Speech-Language Pathology may be recommended. All training must be documented in the Electronic Health Record and the resident's care plan, including the date completed.

d.

~~Signage directing visitors to check with the neighborhood nursing staff before serving food or drinks to a resident indicator shall be posted in the Pavilion Lobby and designated areas.~~

~~h. For residents whose nutrition is via enteral tube, Nurses shall follow interventions to reduce aspiration risk as per Nursing policies and procedures (Refer to NPP E5.0 Enteral Tube Feeding Management).~~ For residents receiving tube feeding, nurses will follow steps to lower the risk of aspiration, as outlined in NPP E5.0 Enteral Tube Feeding Management.

e.

4. Referral to Occupational Therapy OT

a. Referral to Occupational Therapy shall be considered if positioning of the resident during feeding is difficult, or body posture increases aspiration risk.

b. If indicated, the physician shall write an order for Occupational Therapy consultation.

5. Informed Decision Making for Diet Recommendations outside of SLP Recommendations

a. When a resident or their surrogate decision maker declines Speech Language Pathology (SLP) recommendations, the informed decision must be documented in the Resident Care Conference meeting notes, the resident's care plan, and the advanced directive.

b. If the Diet and Nutrition order is changed or discontinued for quality of life reasons without SLP involvement, the Diet Office must be notified to update the resident's meal tray ticket accordingly.

~~When the resident or surrogate decision maker chooses not to accept the recommendation/benefits of a therapeutic diet and feeding interventions, documentation of discussion regarding the informed decision shall be reflected in the Resident Care Conference by the physician~~prov ~~and nursing staff in the meeting notes, advance directives, and the resident care plan.~~

~~When an order with individualized aspiration precautions is discontinued without the involvement of SLP (e.g. for quality of life reasons) the reason(s) shall be documented in the Electronic Health Record by the physician and licensed nurse. The Diet office shall also be notified to delete the information from the tray ticket.~~ and the RCC team

~~a.~~c. Diet texture modification for the purposes of reducing aspiration risk is a form of treatment and, as with enteral feeding, is subject to quality-of-life

considerations/Advance Care Planning (Refer to LHHPP 24-05, Advance Care Planning, and LHHPP 26-03, Enteral Tube Nutrition).

~~b.~~d. The ~~r~~Resident ~~care~~Care ~~plan~~ Plan shall include care plan approaches for minimizing the risk of aspiration.

~~5.~~6. Other Considerations

a. Regardless of the code status, residents shall be provided with rescue interventions in the case of choking or aspiration events.

b. The Medical Examiner shall be contacted by the physician in the event that choking, or aspiration may have been related to the cause of death.

ATTACHMENT:
None

REFERENCE:
ASHA
LHHPP 24-05 Advance Care Planning
LHHPP 24-10 Coach Use for Close Observation
LHHPP 26-03 Enteral Tube Nutrition
LHHPP 26-04 Resident Dining Services
MSPP C01-04 Death Which Must Be Reported to the Medical Examiner-Coroner
NPP A3.0 Nursing Education Programs
NPP B5.0 Color Codes- Resident Identification
NPP E1.0 Oral Management of Nutritional Needs
Rehabilitation Center P&P 90-05 Establishment of Treatment Programs and Documentation: Dysphagia

Revised: 99/01/12, 99/03/25, 99/11/09, 00/03/09, 00/08/04, 02/09/17, 04/08/18, 08/08/26, 09/01/13, 09/10/09, 10/04/20, 10/08/24, 11/09/27, 14/01/28, 16/01/12, 17/07/11, 19/03/12, 21/09/14, 22/07/14, 23/01/10, 24/02/13 (Year/Month/Day)

Original adoption: 98/04/01

Revised Food and Nutrition Policies and Procedures

1.1 Food from Home or Outside Sources Served Directly to Residents

~~Established and~~ Revised: 2/2026 ~~7/2024 10/98, 9/06, 12/06, 7/09, 8/18, 2/23~~ ~~Reviewed: 8/13, 8/14, 8/18, 3/23~~

Policy: Food intended for resident consumption from outside sources shall be held to the same high levels of food safety and sanitation, storage, handling, and consumption as properly applied in the Food and Nutrition Services Department. Volunteers and Staff shall adhere to all aspects of this policy.

Purpose: To help visitors, friends, and family members understand safe food handling practices which may include holding or transporting foods containing perishable ingredients. This shall be done by assisting in the safe and sanitary storage, handling, reheat, and discard, using safe food handling practices.

Definition: Outside sources are those sources of food from any place not produced within the portals of Laguna Honda Hospital. The resident is a resident, patient, or client receiving care or services from Laguna Honda Hospital.

Procedure: Reasonable attempt shall be made to meet the following:

1. Residents have the right to accept food from a visitor, family, or friend as long as it is identified as non-facility prepared food. It is recommended that non-facility food complies within the resident's diet plan. ~~It is recommended that non-facility food the resident's diet plan~~
2. Food shall be handled in accordance with applicable food sanitation guidelines.
3. Food brought in by family or visitors shall be stored separately or easily distinguishable from facility food. Perishable food is labeled with the resident's name, date received and expiration date, and kept in the designated resident refrigerator.
4. Food from home is discarded after 3 days~~72 hours~~ or per manufacture recommendation. Any food brought in from outside will be discarded if not properly labeled and dated.
5. Nursing staff is responsible for labeling, dating, and discarding items prior to expiration.
6. Nursing staff is responsible for assisting the resident in accessing and consuming outside ~~food, if~~food if the resident is not able to do so on his or her own.
7. Food from home cannot be accepted, stored, heated, or served by Food and Nutrition department.
8. The staff member who receives, labels, and dates the food is responsible for either alerting FNS or providing education on safe food handling (see references). This may include safe cooling/reheating processes, hot/cold holding temperatures, preventing cross- contamination and hand hygiene.
10. Any volunteer or staff member serving foods shall follow safe food handling procedures.

References:

- Safe Minimum Internal Temperatures <https://www.fda.gov/food/foodborneillnesscontaminants/buystoreservesafefood/ucm255180.htm > Accessed 3/1/2023.
- Safe Food Handling: What You Need to Know <https://www.fda.gov/food/foodborneillnesscontaminants/buystoreservesafefood/ucm255180.htm > Accessed 3/1/2023.

Resident Food by the Bedside

Purpose: To ensure resident safety, uphold infection control standards, and respect residents' rights regarding personal food items kept at the bedside. This policy aims to prevent foodborne illness, contamination, and pest issues while maintaining compliance with state and federal regulations.

Food Storage and Labeling

All food kept at the bedside must be:

- Stored in covered and sealed containers.
- Labeled with the resident's name or room number and date received.
- **Open non-perishable foods** (e.g., crackers, snacks, dry goods) may be kept at room temperature and discarded **after 30 days**.
- **Perishable foods** (meats, dairy products, cooked foods) must be discarded within **2 hours** of receipt or service.
- Non-perishable foods (e.g., crackers, sealed snacks, dry goods) may be kept at room temperature if properly sealed and discarded according to the manufacturer's recommendation.
- Any food that must be refrigerated after opening i.e. condiments should not be left at bedside and stored appropriately in the resident food refrigerator per guidelines

Monitoring

- Nursing staff will check resident rooms during regular rounds to ensure compliance with safe storage.
- Environmental Services will monitor for sanitation and pest concerns during daily cleaning.
- Any spoiled, unlabeled, or unsafe food will be discarded.

Infection Control

- Open food or drink may not be placed near medical equipment, tables used for treatments, or wound care areas.
- Leftover beverages and opened containers will be discarded after meals or snack times.

Responsibilities

- Nursing Staff: Educate residents/families, monitor bedside food items, and ensure documentation of unsafe conditions.
- Food and Clinical Nutrition Services: Provide guidance on safe food handling, review diet compliance, and advise on refrigeration needs.
- Environmental Services: Monitor for cleanliness and pests, report violations to Nursing or Infection Control.
- Infection Control: Review compliance trends and update procedures as needed.

References

- Centers for Medicare & Medicaid Services (CMS) F-Tag 812: Food Procurement, Store, Preparation, Service – 42 CFR §483.60(i)
- Centers for Disease Control and Prevention (CDC) – Guidelines for Environmental Infection Control in Health-Care Facilities

Revised Health Information Systems Policies and Procedures

Protected Health Information DOCUMENTATION

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) that:

1. Medical records are maintained in paper-based and computer-based formats;
2. A medical record is created for each resident/patient assessed or treated;
3. All medical record entries are legible;
4. The clinical staff are responsible for documentation of the clinical course of the resident/patient;
5. Medical records are legal documents which are the property of LHH and are under the custodianship of the Health Information Services Department (HIS);
6. Medical record documentation is complete and timely to ensure quality of care and continuity of treatment;
7. Medical record documentation includes pertinent facts, findings and observations about an individual's health history, past and present illnesses, exams, tests, treatment and outcomes. It chronologically documents the care provided to the resident/patient and also provides documentation of each resident/patient's medical conditions and treatment for medical, legal and financial purposes;
8. Medical record documentation supports the medical necessity of tests and services for which LHH is seeking reimbursement from government and non-government payers as required by federal and state laws, rules and regulations.

Items That Should Not Be Included in the Medical Record

- Subjective or personal opinions
- Statements of blame, self-doubt, or defensiveness
- Communication with risk management and administrative/operational discussions
- Quote or screenshots of informal conversations done via emails/chats with colleagues
- Legal information / Peer review
- Unprofessional or personal remarks about the patient
- Derogatory comments about colleagues or their care
- Unprofessional conduct in communication, including:
    - Profanity
    - Hostile, condemning, or demeaning language
    - Derisive, insulting, or belittling criticism

Regulatory References

CMS Conditions of Participation (CoPs)

- §482.12 – Governing body responsibilities for professional conduct
- §482.13 – Patient rights (respect, dignity, non-discrimination)
- §482.21 – Quality Assessment and Performance Improvement (QAPI) – peer review confidentiality
- §482.24 – Medical Record Services – accuracy, timeliness, objectivity

CMS State Operations Manual (SOM)

- Documentation guidance requiring professional, objective entries

Joint Commission Standards

- RC.01.01.01 – Records must be complete, accurate, and factual
- LD.03.01.01 – Leadership must foster professional, respectful communication
- MS.11.01.01 – Prohibition of disruptive or unprofessional provider behavior

California Title 22

- §70707 – Patient rights (hospital)
- §72527 – Patients' rights (SNFs)
- §72547 – SNF medical records – objective, clinically relevant documentation

PURPOSE:

The purpose of this policy is to establish guidelines for medical record documentation of healthcare services provided at Laguna Honda Hospital. These guidelines are in accordance with Medical Staff by laws, the Center for Medicare and Medicaid Services (CMS), Title 22 - California Code of Regulations.

SCOPE:

This policy applies to all entities providing healthcare services at LHH.

PROCEDURE:

I INITIATING A MEDICAL RECORD

A A medical record is initiated for all resident/patients assessed or treated. For those resident/patients admitted to the Hospital, this includes the following clinical information:

1) A complete history and physical examination;

2) Initial diagnostic impression;

3) Diagnostic reports (such as consultation, clinical laboratory, electrocardiogram, x-ray and others);

4) Records of medical and/or surgical treatment;

5) Records of pathologic findings;

6) Progress notes; and

7) Discharge summary which briefly recapitulates the reason for hospitalization, significant findings, procedures performed, treatment rendered, final diagnosis, resident/patient's condition on discharge, and discharge instructions as pertinent.

B Laguna Honda Hospital maintains paper-based and computer based medical record systems. The hybrid medical record system that utilizes an electronic signature application for transcribed medical reports dictated by the clinical staff. This hybrid medical record system is united by an enterprise wide resident/patient identification system that is numerical. Clinical and administrative users of these systems recognize that they may have to search paper-based and computer-based systems to find all of the data necessary to perform their duties because all findings and reports associated with resident care are purposely not duplicated in multiple component systems.

C Laguna Honda Hospital supports an electronic signature application for all medical reports dictated by the clinical staff. The acute and SNF dictated medical reports transcribed and signed electronically are: H&P's. Discharge summaries, radiology reports, operative reports, annual assessments, consultations and clinic notes.

D Entries are made in the medical record by individuals having direct primary knowledge of the healthcare services provided to the resident/patient. Such individuals include:

1) Licensed practitioners,

2) Other credentialed health professionals,

3) Physicians in post graduate residency programs, nursing staff and allied health professions students.

II MEDICAL RECORD DOCUMENTATON REQUIRED FOR SERVICES RENDERED

A The following general principles apply to the documentation of each resident/patient treatment encounter by a licensed independent practitioner in order to substantiate the need for the services provided.

1) The resident/patient's medical record clearly, accurately and legibly conveys that:

(a) the services have been provided;

(b) the services were appropriate for the resident/patient's condition, and (c) The services meet reasonable standards for medical care.

2) The presenting problem is clear. There is a complete notation of the resident/patient's complaint(s), condition and/or reason(s) for the healthcare visit.

3) Physical exam findings and prior diagnostic test results are recorded. The reasons for ordering diagnostic and other ancillary services should be easily determined, if not specifically described in the record.

4) Assessment, clinical impression or diagnosis is recorded.

5) A plan of care and/or a description of the care rendered during the encounter are documented.

6) The resident/patient's progress, response to changes in treatment, and any revision to the diagnosis is documented.

7) Health risk factors specific to the resident/patient are documented.

8) The date and time, and the legible identifier (Name, signature and title.)

9) Each entry must be able to "stand alone" and support the test, and/or service being reported.

III PHYSICIAN'S ORDERS

A The presence of an order is required to substantiate the medical necessity for laboratory, radiology and other diagnostic services. Orders may be written by a physician or affiliated staff who are working under approved standardized procedures.

B Requisitions for Laboratory tests, Radiology, and other Diagnostic or Therapeutic Services must include:

1) The diagnosis (es) or finding(s) that best define(s) the need for the service(s). This may be the same reason for the hospital admission or clinic visit.

2) The ordering/referring physician's signature, title, and CHN ID number.

IV RESPONSIBILITIES OF THE TEACHING PHYSICIAN

A It must be clearly documented that the attending physician actually provided the services and/or is physically present during the portion of the service.

B Documentation for all minor procedures, surgeries, and interpretation of diagnostic tests must follow the guidelines for documentation of evaluation and management services developed by the American Medical Association

C It is the responsibility of the attending physician to supervise the practice of medical students and physicians involved in postgraduate residency programs and to approve the diagnostic and treatment regimens developed by them for resident/patients at LHH.

V AUTHENTICATION

A All medical record entries must be timed and dated and signed. Documentation of physicians involved in a postgraduate residency program is authenticated with signature, and title. Documentation of nurses and other health professionals is authenticated with signature and credential designation. All documentation entered by students must be co-signed by the supervising attending physician, nurse, or other health professional.

VI CORRECTING AND AMENDING ENTRIES

A Corrections or amendments by clinical staff

1) Correcting an erroneous entry

(a) The paper record: Any corrections should be made by putting one line through the erroneous entry, writing "error" in the margin and initialing it. Do not erase or otherwise obliterate the erroneous entry; it should remain legible.

2) Late Entries and Addenda: All entries in the record should be written at the time of the event. If it is necessary to make a late entry or addendum to include important clinical information in the record, follow these guidelines:

(a) Label the entry as a late entry or an addendum.

(b) Date and time the entry when it was written (do not back date the entry).

(c) Sign the entry.

(d) Enter the late entry or addendum in the Progress Notes or Nurses' Notes. Do not utilize the flow sheet or graphic records for late entries.

(e) The late entry or addendum should not obliterate any earlier entry.

Signed by:

Date Adopted:
Reviewed: ~~**06/26/15**~~
Revised: September 2007, August 2008, June 2015, October 2025