List of Hospital-wide/Departmental Policies and Procedures Submitted to JCC for Approval on 7/14/2025

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revised	FNS	1.63	Pest Control Service	**M. Adusumalli**	1. Deleted – Established and 3/87,1/89, 1/92, 5/97, 9/06, 7/09 2. Added -8/2024 3. Deleted- Revised 8/13, 8/14 4. Added- pest management is a top priority in Food and Nutrition Services (FNS), and any pests in FNS. 5. Deleted in the Nutrition Services Area. 6. Added- Food and, department 7. Deleted- area. 8. Replaced exterminate with treat as needed 9. Added completed by the pest company and, FNS and Environmental Services (EVS) 10. Deleted- General services and a copy will be left with the department. 11. Replaced- Our with the 12. Deleted- will enhance the service. 13. Added- the weekly pest report. If there are any signs of pests in-between service a work order will be generated with EVS for follow up and corrective action. 14. Deleted- a pest sighting, logbook located in the Chef's office -production area. The pest control company will review logbook at each service. Following on the corrective action will be taken. Gross infestations will be noted in the above log and will be called in to the pest control company. 15. Added- or designee 16. Replaced records to meet the requirements of regulatory agencies with FNs will maintain pest report for a minimum of 12 months.
Revised	NSPP	I 3.0	Tracheostomy Care	**C. Figlietti**	1. Updated reference for Tracheostomy Care to Elsevier 2. Added to title of Section F: Changing Tracheostomy Tube (Outer Cannula) of a Cuffless Tracheostomy - Done Monthly and PRN 3. Changed from "Call the physician immediately" to "Call a Code Blue" if difficulty occurs when changing outer cannula (e.g., laryngeal spasm, difficulty breathing, etc) 4. Updated references
Revised	NSPP	J 2.5	Monitoring Behavior and Effects of Psychotropic Medications	**C. Figlietti**	1. Added to policy "All psychotropics ordered by the provider (as well as any medications used as a substitution for a psychotropic medication shall be accompanied by an order with targeted behavior: in the order which is to be monitored by nursing using the Behavioral Monitoring Flowsheet in the electronic health record (EHR). 2. Added that the behavior monitoring record has to be reviewed on a weekly basis, in the nursing weekly summary, to assess whether the target behavior symptom goals are addressed 3. Purpose rephrased: "To ensure the resident is taking the lowest dose psychotropic medication possible for the shortest amount of time to effectively manage behaviors by documenting the effectiveness of pharmacological and non-pharmacological interventions. 4. Added details on psychotropics as a last resort (e.g., non pharmacological approaches first unless clinically indicated, RCT ruling out any underlying medical conditions, and including documentation on rationale, and evaluation, for use of psychotropics. 5. Moved the following statement (priority statement) "Nursing must ensure residents are free from chemical restraints (any drug imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms). 6. Removed sections pertaining to other departments 7. Removed "tardive dyskinesia" and added "extrapyramidal symptoms" 8. Added unit based QAPI for reviewing of side effects such as extrapyramidal symptoms for those on antipsychotics 9. Updated references

Revised	LHHPP	29-11	California End of Life Option Act: Implementation at Laguna Honda Hospital	**A. Lam**	1. Replaced "ingestion of" with "self-administer" throughout the document 2. Added "This policy describes the requirements and procedures for compliance with The California End of Life Option Act (SB380) for responding to requests from LHH residents with decisional capacity for self-administration of aid-in-dying medications due to a terminal illness." 3. Deleted "terminally ill residents with decisional capacity to self ingest aid in dying medications at LHH safely." 4. Added "Definitions a. Self-administer – per statute to self-administer means a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about their own death. b. Aid-in-dying (AID) drug – per statute an aid-in-dying drug means a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about their death due to a terminal disease. c. Attending Physician - means the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease. d. Consulting Physician - means a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's terminal disease." 5. Added "or is requesting a medication under EOLOA" 6. Changed "his/her" to "their" throughout the document 7. Added "willingness (if applicable, otherwise see section 1.e.) " 8. Changed ""providers" to "physicians" 9. Added "for the request " 10. Deleted "regarding anticipatory suffering" 11. Added "and date of the request " 12. Added "the physician's notice of their objection in the" 13. Added "request that the ", "active medical staff ", and "a physician board certified or privileged in palliative medicine. " 14. Deleted "the S3 MD" 15. Added "mental health services and " and "interventions as appropriate" 16. Deleted "", such as aggressive symptom management including palliative sedation, etc" 17. Replaced "occur in the daytime" with "be scheduled" 18. Replaced "taking" with "self-administration" throughout the document. 19. Added "or sends AID prescription via electronic order within the electronic health record." 20. Added "The cause of death for the resident should be listed as the underlying terminal condition. "
Revised	LHHPP	72-01 F15	Storage of Medical Supplies	**M. Barajas**	1. Added "This policy is in accordance with guidance provided by Association for the Advancement of Medical Instrumentation, Association for Professionals in Infection Control and Epidemiology, Inc., and Association of Perioperative Registered Nurses. " 2. Added "determining shelf lives for all items unless otherwise indicated by the manufacturer shelf-life instruction for use because of potential product deterioration. Event-related sterility assumes that a properly cleaned, packaged, and sterilized item, when handled and maintained appropriately, will remain sterile indefinitely." 3. Deleted "packaging materials dependent upon package material, storage conditions, transport, and handling." 4. Replaced "Staff" with "All personnel" 5. Deleted "a broken seal, tears or holes in packaging material, evidence of water damage, etc." 6. Added "Package integrity – no holes, tears, open ends, loose tape, water or soil marks, damage of any sort, or missing plastic wrapper." 7. Added "Sterility" 8. Added "For facility sterilized items: Steam autoclave tape, indicator cards, etc., are checked to ensure proper color change indicating parameters for sterilization were met. Items that fail to meet sterility standards will be returned to Sterile Processing and Distribution (SPD) for reprocessing."
Revised	FNS	1.66	Equipment Operation	**M. Adusumalli**	1. Deleted- Established and 3/81, 1/89, 3/91, 5/97, 9/06, 7/09 2. Deleted- Reviewed :8/13, 814. 3. Added- 8/2024 4. Added- operating procedures. Manufacturer safety warning/ hazards and guidelines must be followed when equipment is in use. 5. Added- and sanitation 6. deleted- directions, and, that. 7. replaced insure with ensure. 8. replaced run with operate. 9. Replaced Employees will be taught with the chef or designee will instruct. 10. Replaced instructions with procedure.
Revised	NSPP	C 2.0	Change of Shift Hand-Off	**C. Figlietti**	1. Removed policy statements 1 and 2. The policy and procedure itself outlines the expectations for reporting. Purpose statement also states the importance of effective communication and its relation to patient safety 2. Removed attachments. Reference to Standard Work that is placed on the LHH Intranet, as these are the documents the most up to date. Standard work also includes the hand off report forms. 3. Update the Standard Work form titles. Titles in current policy state "Hand-off" whereas the actual title is "Reporting"
Revised	NSPP	D 1.0	Restorative Nursing Program	**C. Figlietti**	1. Clarified in policy statement that the purpose for this policy is to focus on RNP services for providing maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. 2. Added that residents are referred by the Resident Care Team and evaluated by rehab for RNP services 3. Removing verbiage related to services offered via nursing assistants. 4. Staff trained in restorative nursing care interventions can implement and document restorative interventions 5. Residents are identified during initial, quarterly and/or change of condition for this program 6. Outlined roles of RNP Licensed Nurse

Revised	NSPP	G 5.0	Blood Glucose Monitoring	**C. Figlietti**	1. Added performance of quality control to be done on other shifts (aside from AM) for when QC is required. 2. Added: "Test strips can be obtained through the Central Processing Distribution (CPD). They should be stored at room temperature in the original, tightly sealed vial. After removing a test strip, promptly replace the vial cap to maintain the strips' integrity. Test strips remain stable until the expiration date printed on the vial, and any expired strips must be discarded. Make sure to use the entire vial of test strips before opening a new one, even if the barcode number is the same." 3. Generalized cleansing of glucometer machine to the use of facility-approved disinfectant. 4. Added Hypoglycemia Treatment Protocol
Revised	NSPP	G 6.0	Behavioral Risk Assessment	**C. Figlietti**	1. Removed policy statements 1 and 2: They are not necessarily a policy related to behavioral risk assessment directly and are more so a statement of keeping residents from harm. 2. Reword Purpose statement: "To maintain a safe and secure environment by assessing behavior risk for all residents." 3. Referred to HWPP 24-28 Behavioral Health Care and Services 4. Added verbiage on adding non pharmacological interventions to the care plan 5. Delete attachment – it was more of a tip sheet and could be redundant. 6. Updated references
Revised	NSPP	K 3.0	Wound Irrigation and Cleansing	**C. Figlietti**	1. New policy statement (this was moved from the Definition section to Policy): "Licensed Nurses are responsible for performing wound irrigation and shall only perform mechanical and chemical wound debridement. 2. Added 3-ml and 10-ml syringe sizes (recommended for small and hard to reach wounds) to list of syringes used for wound irrigation. 3. Updated Preparation for Wound Irrigation/Cleansing section. Included updates to storage and disposal of specific supplies, and labeling instructions (e.g., dispose of scissors after use, Vashe is single person use and must be labeled, normal saline disposed after use) 4. Update to discard of all disposable wound supplies into the hazardous waste bin after procedures. 5. Added documentation guidelines
Revised	NSPP	K 10.0	Prevention and Treatment of Skin Tears	**C. Figlietti**	1. Revised Policy #1 to state: "Licensed nurse is responsible for identifying residents/patients at risk for skin tear development and implementing intervention strategies to minimize the occurrence of avoidable skin tears. 2. Added Policy #3: "Registered Nurse is responsible for wound assessment, dressing application and notifying for presence of wound infection, wound deterioration and no-healing wound. 3. Added Policy #4: "The Licensed Vocational nurse, under the supervision of the RN, may collect wound assessment data and perform dressing application as ordered by the physician." 4. Rewrote Purpose statement to "To prevent the occurrence of avoidable skin tears and promote the healing of skin tears." 5. Added to background the following; "Skin tears do not extend through the subcutaneous layer." – This is the International Skin Tear Advisory Panel definition of skin tear. 6. Removed section on "The changes to the skin associated with aging." Not needed in policy. 7. Generalized section on prevention and treatment of skin tears 8. Removed section on equipment needed, as this is dependent upon treatment orders 9. Updated Documentation section to outline current practice for documenting on wound care. 10. Updated references
Revised	NSPP	NPP	Nursing Educational Programs	**C. Figlietti**	1. Referenced to Nursing P&P A 6.0 Orientation of Nursing Personnel for orientation program 2. Clarified CPI as being provided annually as an electronic educational module 3. Added that DET responds to requests for individualized education from Nurse Manager or nursing Supervisors 4. Added "A monthly calendar of scheduled educational in-services shall be sent electronically to LHH staff with DPH email accounts and posted on the intranet."
Revised	NSPP	G 6.0 Attachment 1	Behavioral Risk Assessment	**C. Figlietti**	Delete Attachment – it was more of a tip sheet and could be redundant.
Deletion	NSPP	I 5.0 Attachment 1	Oxygen Therapy Devices	**C. Figlietti**	Delete Attachment. Links to Elsevier within policy reflect updated information

JCC Follow-up

1.63 Pest Control Service

~~Established and~~ Revised: 8/2024 ~~3/87, 1/89, 1/92, 5/97, 9/06, 7/09~~
~~Reviewed: 8/13, 8/14~~

Policy: ~~To~~Pest Management is a top priority in Food and Nutrition Services (FNS). To ~~-~~control infestation of unwanted pests such as cockroaches, ~~rodents~~rodents, ~~and~~ ants, and any pests ~~in~~ FNS.~~, in the Nutrition Services Area,~~ T~~t~~he approved pest control company will conduct ~~a~~ weekly service.

Procedure:

- On a weekly basis, the approved Pest Control Company will inspect and treat as needed all ~~the~~ Food and Nutrition Services areas for cockroaches, rodents, ants and other unwanted pests. ~~department area. They will inspect and treat as needed for~~exterminate ~~cockroaches, rodents, ants, and other unwanted pests in the Food Service Area.~~ A service report will be completed by the pest company and filed with FNS and Environmental Services (EVS). ~~General Services and a copy will be left with the department.~~

- In conjunction to the treatment, the pest control will conduct a sanitation report of the ~~our~~ area, t~~. T~~aking the necessary correction action to address the recommendations. ~~will enhance the service.~~

- ~~If there are any~~Any sightings of pests after the routine inspection~~, it will~~ shall be documented in the weekly pest report. ~~a Pest Sighting Log Book~~~~Logbook~~ ~~located in the Chef's office~~ ~~Production Area~~. If there are any signs of pests in-between service a work order will be generated with EVS for follow-up and corrective action. ~~The Pest Control Company will review the logbook at each service. Follow up on the corrective action will be taken.~~

  ~~Gross infestations will be noted in the above log and will be called in to the Pest Control Company.~~

- ~~The~~ Pest Control Company will arrive to the department at least 30 minutes prior to starting their service ~~so they can communicate concerns with a Supervisor~~supervisor, ~~/Chef~~Chef, ~~or designee~~.so that a supervisor, Che, or designee can communicate their concerns with the vendor.

- FNS will m~~M~~aintain pest report for a minimum of 12 months. ~~records to meet the requirements of regulatory agencies~~.

~~11/6/2015~~

TRACHEOSTOMY CARE

POLICY:

1. Physician's order is required for all tracheostomy care.

2. The **first tracheostomy tube** change will be performed by Ear, Nose, & Throat (ENT) Physician.

3. Cuffed tracheostomy tubes: Cuffed tracheostomies are **only** changed by ENT.

4. Upon admission, the attending physician may refer any resident with a tracheostomy to the ENT and/or other specialists for review and evaluation. If the primary physician determines the referral is not indicated, the reason will be documented in the medical record. Referral to the ENT, Speech Language Pathologist (SLP) and/or Respiratory Therapists (RT) shall be made via e-referral.

5. Residents admitted with a speaking valve will also be referred to Speech pathology per HWPP 27-01 Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir.

6. Emergency respiratory equipment shall always be available at the bed-side:
    a. Airway suction supplies including complete suction equipment set-up, unopened suction kit, and unopened sterile water/saline
    b. Tracheostomy of the same type, size (including inner cannula)- for emergency replacement
    c. Ambu bag if ordered by physician

7. The disposable inner cannula (DIC) should never be cleaned and reused. It is intended for a one-time use only and is changed at least twice daily and as needed. Discard the used cannula and insert a new one, touching only the external portion. Lock it securely in place.

8. Tracheostomy site care should be performed daily and PRN. Site assessment should be performed and documented QShift to determine status of dressing.

9. Subsequent replacements of the outer cannula standard tracheostomy tubes will be carried out by nursing at least once per month. If an urgent appointment is needed, phone the Surgical Clinic and mark "urgent" on the ENT e-referral. (Note: if an ENT appointment cannot be obtained in a timely manner, consult with Respiratory Therapy).

10. With the exception of those residents requiring specialized tracheostomy tubes, trained registered nurses (RN) or licensed vocational nurses(LVN) will change the cuffless tracheostomy tube of residents who have had a tracheostomy for more than three weeks old and who have been seen by ENT for initial change. The type, tube size, and day of change are to be ordered by the physician.

11. Non-standard Tracheostomy Tubes for Special Needs (e.g., extra-long tracheostomy tubes): If a resident has a non-standard tracheostomy tube, the resident shall be referred to ENT for all tracheostomy tube changes. A spare non-standard tracheostomy tube will be kept at the bedside to be used only in an emergency (e.g., tracheostomy tube falls out).

PURPOSE:

To maintain a patent airway and to prevent infection.

PROCEDURE:

A. Emergency Care for Dislodged or Removed Tracheostomy Tube:

1. If the tracheostomy tube of a fresh tracheostomy becomes dislodged or pulled out, the licensed nurse is to have another staff person call code blue (Ext. 42999) while the LN stays with the resident and attempts to open the airway.

2. In a **new** tracheostomy (less than 7 days) do not attempt to reinsert another tracheostomy tube. Keep the wound open with a clamp (Mayo or Kelly) or use the stay sutures if they are present.

3. In a **fresh** tracheostomy (less than 21 days), a smaller size or a size below the existing tracheostomy tube should be at the bedside to keep the stoma open until the physician arrives.

4. In a more chronic, well-established tracheostomy, may keep tracheostomy open with a tracheostomy set, one size smaller, kept in treatment room.

5. During an emergency the physician may choose to immediately insert an endotracheal tube by mouth whether or not the tracheostomy is new or has an established tract.

6. The physician may transfer the resident with a fresh tracheostomy to an emergency room for acute surgical consultation.

B. Emergency Care Using the Resuscitation Bag:

1. Hyperextend the resident's neck, UNLESS the resident has had a recent cervical injury, has a cervical brace, or is on cervical precautions.

2. If the tracheostomy tube has been accidentally removed and the resident does not have a complete upper airway obstruction, a gaping stoma, or a laryngectomy, a Bag Valve Mask (BVM) resuscitation device may be used to ventilate the resident by mouth while covering the stoma.

3. Squeeze the bag once every 5 seconds while it is connected to oxygen set at 15L/min until the physician arrives.

4. **Nursing Alert:**

    a. New tracheostomy
        i. Manipulation of neck ties and face plate should be minimized.
        ii. Residents who are likely to remove or manipulate the tracheostomy tube may have a physician’s order for mitten restraints if assessed as appropriate by Resident Care Team.
        iii. A suction machine is to be readily available.
        iv. A sterile clamp (Kelly or Mayo) and a sterile endotracheal tube and tracheostomy tube set matching the type of tube, but one size smaller that the tube the resident has in place, are to be kept in a plastic bag in the top drawer of the bedside stand.

    b. Tracheostomy emergency replacements sets should be kept in the bedside stand, sterile replacement tube sets and clamps may be kept in the treatment room. Keep one set for each size and type tracheostomy tube in use on the unit.

c. Aspiration: If food or liquid is noted during suctioning, inform the resident's physician immediately. Consider referral to speech therapy for urgent swallowing evaluation

C. Resident Considerations:

1. Assess resident: there may be apprehension about choking, inability to communicate verbally, inability to remove secretions, and difficulty in breathing.

2. Explain the function of the equipment. Inform the resident and significant others that speaking with a tracheostomy is difficult.

3. Provide resident the best method of communication, for example: letter boards, paper and pencil, dry erase board.

4. The resident with a tracheostomy will be positioned at approximately 45 degrees or sitting upright when possible with position changes about every 2 hours to ensure ventilation to all lung segments and to prevent secretion accumulation around the tracheostomy tube.

5. The licensed nurse is to assess breath sounds as needed for evidence of crackles, rhonchi, or diminished breath sounds. Secretions are to be observed for amount, consistency, color, and odor.

6. The resident may be provided with shower bib during bathing to protect his/her airway. Shower bibs are obtained in LHH Central Supply Room.

D. Equipment:

Disposable sterile tracheostomy care kit for suctioning, cleaning, additional sterile gloves.
Suction equipment
Sterile connecting tubing and catheter plug
Mask, goggles and plastic apron
Sterile clamps (Mayo, Kelly, or Magill)
Water soluble lubricant
Sterile saline solution
Bedside waste bag
10 mL Luer syringe to inflate/deflate cuffed tubes
Bag Valve Mask
Oxygen source

E. Routine Tracheostomy Care: Changing <u>Inner Cannula</u> of Cuffed or Cuffless Tracheostomy:

1. Preparations:

a. Perform suctioning of the trachea and pharynx as necessary before changing inner cannula. (Refer to ~~NPP I 2.0 Tracheobronchial~~ Skills: (elsevierperformancemanager.com) for procedures on Tracheostomy Tube: Care and Suctioning)
b. Wash hands thoroughly before and after performing this procedure.
c. Put on a mask, goggles, and/or plastic apron if resident has copious secretions.
d. Stand at the resident's side while suctioning or cleaning the tracheostomy tube.
e. Sterile saline solution is single use only and should be discarded after procedure is completed.
f. Remove the soiled dressing from around the stoma and discard.
g. Observe the skin surrounding the tracheostomy for evidence of irritation or infection.

h. Wash hands.
i. Prepare the sterile field on the bedside table.
j. Open the tracheostomy care set on sterile field and prepare the equipment
k. Put on the sterile gloves. Keep dominant hand sterile throughout the procedure. Use the other hand as clean hand to handle unsterile items.
l. Use your sterile-gloved hand to remove the remaining contents of the set onto the sterile field and separate the basins.
m. Use your clean gloved hand to pour the solution.

2. Tracheostomy site skin care:

a. Tracheostomy site skin care should performed daily and PRN.
b. Cleanse the skin around the stoma site. If crusts are present, soften them with sterile 4" x 4" gauze slightly moistened with sterile saline.
c. Rinse with a sterile saline-soaked 4" x 4" gauze and pat dry. Avoid snagging loose threads on the tracheostomy tube because they could be inhaled.
d. Cleanse external areas of tracheostomy tube with sterile cotton-tipped applicators moistened in the saline. Rinse areas with sterile saline-dipped applicators and~~.~~ D ~~D~~iscard~~. into bedside bag.~~
e. Place a dry drain sponge under and around the tracheostomy tube. Reserve the extra tracheostomy dressings as needed for changes in between tracheostomy care.
f. Replace the Velcro fastening tracheostomy tie if soiled.
g. Discard used equipment. Remove and discard gloves and wash hands.

F. Changing Tracheostomy Tube (Outer Cannula) of a Cuffless Tracheostomy - Done Monthly and PRN

1. Prepare equipment:

a. Refer to Section E1 above to set up equipment for cleaning solutions and suctioning catheter.
b. Open the packages containing the replacement tracheostomy tube and sterile 4" x 4" gauze.
c. Squeeze a small amount of water soluble lubricant on the sterile 4" x 4" gauze
d. Suction the resident if necessary.
e. Insert obturator into the outer cannula of the new tracheostomy tube.
f. Lubricate the tracheostomy tube well.

2. If difficulty occurs:

If the resident goes into a laryngeal spasm, or the resident has difficulty breathing, or you cannot get the tracheostomy tube in place, as an emergency measure, quickly insert the mayo clamp into the stoma opening and spread the clamp. This is to be done only in case of emergency. Call a code blue IMMEDIATELY.~~the physician immediately~~

3. Changing the cuffless tracheostomy tube monthly and as needed:

a. Use clean-gloved hand to cut the tracheostomy tape attached to the tracheostomy tube that you are going to change.
b. Remove old tracheostomy tube.
c. With sterile-gloved hand, insert the new tracheostomy tube into the stoma, using a downward motion.
d. Quickly remove the obturator.
e. Using sterile-gloved hand, insert the inner cannula and lock in place according to the type of tracheostomy tube in use. That is, a Shiley tube twists into place and a Portex tube snaps in

place.

f. Velcro/fasten the tracheostomy tie.
g. Apply a sterile drain sponge around the tracheostomy tube.

G. Cuffed Tracheostomy Tubes: **Only Changed by ENT physician**

If an emergency occurs during the day shift, notify the physician. (MSPP #D06-01 Tracheostomy Management.) If an emergency occurs with a cuffed tracheostomy tube during am or pm shift, follow emergency procedures on page 1, part A.

1. The attending physician will document in the medical record if a resident is admitted with a cuffed tracheostomy tube and will write specific orders regarding cuff inflation/deflation.

2. If cuff inflation/deflation is ordered by the physician, Respiratory Therapy shall be consulted to review inflation/deflation procedure/precautions with Licensed Nurse.

H. Speech with a Tracheostomy Tube:

Consult with Speech Language Pathologist and/or Respiratory Therapists for information on the care and use of speaking devices.

I. Documentation:

1. The licensed nurse is to document pertinent information, including the type and size of the tracheostomy in the electronic health record.

2. Tracheostomy care during routine care or tube changes:

   For Acute care, residents with tracheostomies under 6 weeks in progress notes:

   a. Resident/patient tolerance of tracheostomy care procedure such as cyanosis or respiratory distress.
   b. Appearance of the tracheostomy skin site
   c. Characteristics of secretions

   For chronic care residents with stable tracheostomies, document above on weekly, monthly summaries.

3. Tracheal Cuff care:

   a. Tracheal cuff release time.
   b. Amount of air used for cuff inflation.
   c. Any changes in respiratory status during deflation/inflation.
   d. Amount, color and consistency of secretions

4. Inform physician and document if the resident develops a cough, chest pain, fever, rales, dullness of the chest on percussion, or stoma site develops signs of infection.

REFERENCES:

Elsevier Nursing Resource: Clinical Skills - Oxygen Therapy for Patients with an Artificial Airway (Respiratory Therapy)

https://point-of-care.elsevierperformancemanager.com/skills/10872/quick-

sheet?skillId=RC_023&virtualname=lhh

Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St. Louis, MO: Elsevier

Lippincott, Williams, and Wilkins Staff; (2007) *Best practices: evidence-based nursing procedures*, (2nd ed), Philadelphia, PA: Lippincott Williams & Wilkins

Mosby's Clinical Skills, Tracheostomy Tube: Care and Suctioning

Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadephia, PA: Lippincott Williams & Wilkins

CROSS REFERENCES:

LHHPP File: 27-01 Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passey-Muir.
LHHPP File: 27-05 Tracheostomy Management

~~Nursing P&P I 2.0 Tracheobronchial Suctioning~~
Nursing P&P I 5.0 Oxygen Administration

ATTACHMENTS/APPENDICES

None

Revised: 2000/09, 2008/08, 2016/09/13, 2019/03/12; 2019/05/14; 2022/07/12; 2023/10/10

Reviewed: 2023/10/10

Approved: 2023/10/10

MONITORING BEHAVIOR AND THE EFFECTS OF PSYCHOTROPIC MEDICATIONS

POLICY:

1. Resident's behavior is monitored to assist the Resident Care Team (RCT) in assessing the response to treatment, which includes the gradual reduction of psychotropic medication dosage.

2. All psychotropics ordered by the provider (as well as any medications used as a substitution for a psychotropic medication) shall be accompanied by an order to address a targeted behavior. The target behavior shall be monitored by nursing using the Behavioral Monitoring Flowsheet in the electronic health record (EHR).

3. Behaviors shall be monitored for each resident receiving psychotropic medication(s) and/or for those with challenging behaviors identified by the Resident Care Team but not requiring management by the use of psychotropic medications.

4. All Patient Care Assistants (PCAs)/Certified Nursing Assistants (CNAs) will observe for presence of target behavior (and/or side effects of psychotropic medication) and report to the licensed nurse if observed.

5. The licensed nurse will review the behavior monitoring record and compare it to the nursing care plan goals to assess whether the goals of target behavior symptoms, as identified by provider, have been adequately addressed on a weekly basis in the Laguna Honda Hospital (LHH) Weekly Nursing Summary.

6. The physician will place an order for target behaviors to monitor and nursing will initiate a care plan which will include the target behaviors to be monitored, individualized nonpharmacological interventions and any potential medication side effects.

7. The electronic health record behavioral monitoring flowsheet will be used to monitor the effectiveness of medications prescribed to induce sleep when ordered by physician. If resident is on sleeping aid, nursing shall document on LHH Nursing Weekly Summary.

PURPOSE:

To ensure the resident is taking the lowest dose psychotropic medication possible for the shortest amount of time to effectively manage behaviors by documenting the effectiveness of pharmacological and non-pharmacological interventions.

Psychotropics as a Last Resort

Non-pharmacological approaches must be documented as attempted before psychotropics are initiated, unless clinically indicated.

Resident Care Team must determine the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions.

Resident's medical record should include documentation of this rationale and evaluation.

BACKGROUND:

Psychotropic medications are medications that affect brain activities associated with mental processes and behavior. Psychotropic medications also include any other drugs used for the purpose of effecting mental status or behavior. These include medications used to treat anxiety, depression, mania, schizophrenia, psychosis or to induce sleep. (Refer to MSPP D01-05 Psychotropic Medications**)**

The goal with the use of psychotropic medications is to use the lowest dose possible for the shortest amount of time to effectively manage behaviors.

DOCUMENTATION:

Nursing must ensure residents are free from chemical restraints (any drug imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

To ensure freedom from chemical restraints, nursing monitors residents on psychotropics for the following:

- Sedation, such as sleeping during hours that he/she would not ordinarily sleep;
- Withdrawal from activities and socializing;
- Loss of autonomy and dignity;
- Confusion, cognitive decline, and depression;
- Weight loss, decline in skin integrity, or continence level; and/or
- Decline in physical functioning including an increased dependence in activities of daily living.

Medications used to substitute for psychotropics are subject to the same requirements under §483.45(e).

A. Monitoring and documenting behaviors using Behavior Monitoring flowsheet in EHR:

1 The licensed nurse collaborates with the CNA/ Patient Care Assistant (PCA) and/or other members of the Resident Care Team (RCT) regularly to identify and document the target behavior trigger(s), side effects, and the effectiveness of interventions and the prescribed medications.

2 The licensed nurse will summarize the presence or absence of target behavior(s) and side effects on the LHH NSG Weekly Summary and communicate any changes to the provider.

Monitoring and documenting presence of side effects.

1. The nurse will identify and observe the resident for known common medication side effects and document any follow up interventions in the EHR.

2. For medication side effects that the physician has determined are stable, well-managed and acceptable in view of the medication benefits, the nurse may record the side effect in the LHH NSG weekly summary.

B. Monitoring and documenting presence of extrapyramidal symptoms.

1. Nursing shall develop an individualized care plan for those with involuntary movements disorders or extrapyramidal symptoms such as tardive dyskinesia including interventions to support the resident's unique challenges related to ADLs, social and emotional well-being.

2. Unit Based QAPI for psychotropic medications will review side effects, including extrapyramidal symptoms, which include involuntary movement disorders for residents on antipsychotics.

CROSS REFERENCES:

Hospitalwide Policies & Procedures

25-10 Use of Psychotropic Medications
25-15 Medication Administration

Nursing Policies & Procedures
C 3.0 Guidelines for Documentation of Resident Status/Care by Licensed Nurses
C 3.2 Documentation of Resident Care by Nursing Assistant

Medical Staff Policies & Procedures
D01-05 Psychotropic Medications

Document originated: 6/2006

Revised: 2010/10; 2013/01/29; 2015/07/19; 2019/05/14; 2023/01/10; 2023/08/08; 2025/04/30

Reviewed: 2023/08/08

Approved: 2023/08/08

Revised Hospital-wide Policies and Procedures

CALIFORNIA END OF LIFE OPTION ACT: IMPLEMENTATION AT LAGUNA HONDA HOSPITAL

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) supports the decision of qualified Skilled Nursing Facility (SNF) residents to exercise their right ~~of~~to self-administer ~~ingestion of~~ aid-in-dying medications.

2. Staff members or volunteers for reasons of morality, cultural or religious considerations, have the right to opt out of participating in the care and support of residents exercising this option.

3. Patients without a skilled ~~N~~nursing need will not be admitted to LHH solely for the purpose of exercising this right.

4. The California End of Life Option Act (EOLOA) shall remain in effect only until January 1, 2031, unless a later enacted California statute deletes or extends that date.

5. Laguna Honda Hospital shall include on its website its policies and procedures regarding provision of aid-in-dying medications.

PURPOSE:

~~D~~This policy describes the requirements and proces~~s~~dures for compliance with The California End of Life Option Act (SB380) for responding to requests from LHH residents with decisional capacity for self-administration of aid-in-dying medications due to a terminal illness. ~~terminally ill residents with decisional capacity to self-ingest aid- in-dying medications at LHH safely.~~

DEFINITION

1. Self-administer – per statute to self-administer means a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about their own death.

2. Aid-in-dying (AID) drug – per statute an aid-in-dying drug means a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about their death due to a terminal disease.

3. Attending Physician - means the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.

4. Consulting Physician - means a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional

diagnosis and prognosis regarding an individual's terminal disease.

PROCEDURE

1. **Qualifications/Eligibility for End-of-Life Option Act (EOLOA)**

   a. LHH Attending Physician is notified that a resident requests information about ~~End of Life~~End-of-Life Option Act or is requesting a medication under EOLOA. ~~.~~

   b. LHH Attending Physician notes both the request and ~~his/her~~their willingness (if applicable, otherwise see section 1.e.) ~~-~~to provide such medications in resident's Medical Record.

   c. LHH Attending Physician determines the resident's eligibility for EOLOA. They must be:

      i. ~~A~~An adult 18 years or older.

      ~~ii.~~ A California resident.
      ii.

      iii. Diagnosed with a terminal illness, defined as an incurable and irreversible disease that, within the reasonable medical judgment of the LHH Attending Physician and ~~c~~Consulting ~~p~~Physician, will result in death within 6 months and~~s.~~

      iv. Has the capacity to make medical decisions to request an aid-in-dying (AID) drug and~~.~~

      v. Has the physical and mental capacity to self-administer the aid-in-dying drug.

   d. If there is unresolved disagreement among p~~roviders~~hysicians regarding the resident's eligibility for participation, or if there is any concern regarding coercion or whether the resident's motivation for the request ~~regarding anticipatory suffering~~ is due to economic situations, refer to LHH Ethics Committee.

   e. If the resident's current LHH A~~A~~ttending ~~P~~Physician opts out of participating in the EOLOA, ~~he/she~~they will:

      i. ~~-~~inform the resident and document both the resident's request and date of the request and ~~his/her~~

ii. Document in the resident's medical record the reason for choosing not to participate in the EOLOA process.~~the physician'sir response in notice of their objection in the resident's medical record~~. ~~He/she~~

iii. They will then ~~refers to~~ request that the Chief Medical Officer ~~to identify~~identifies a willing active medical staff physician to serve in this role, ideally ~~the S3 MD.~~a physician board certified or privileged in palliative medicine.

- In the latter case, the resident may be moved to S3 or may stay on their home unit and will be attended to by the identified physician~~S3 physician~~ who will now act as the resident's LHH A~~A~~ttending ~~P~~Physician and AID medication prescriber~~ of AID.~~.

~~e.~~f. LHH ~~A~~Attending ~~P~~Physician ~~-~~determines the resident's qualifications (as per above) and ~~,~~ counsels the resident about the availability of mental health services and palliative care interventions as appropriate. ~~, such as aggressive symptom management including palliative sedation, etc.~~ If the resident affirms the request for AID, this is regarded as Verbal Request #1.

~~f.~~g. LHH Attending Physician notifies QM after receipt of ~~#1 verbal request~~Verbal Request #1.

~~g.~~h. LHH Attending Physician refers the resident to a Consulting Physician to confirm qualifications for EOLOA.

~~h.~~i. If there is any concern regarding the capacity of a resident to make an informed decision as defined by the EOLOA, or any concern for mental illness interfering with a resident's medical decision-making capacity, then a Mental Health Specialist consultation is required (Under the EOLOA, a Mental Health Specialist is defined as a psychiatrist or a licensed psychologist). Ideally, decision-making capacity has already been determined through normal channels. If urgent assessment of decision-making capacity is needed, a Mental Health Specialist may be paged through urgent call pager (weekdays) or on-call pager (evenings and weekends).

~~i.~~j. For residents with limited English proficiency inquiring about the EOLOA, trained interpreters from Zuckerberg San Francisco General Hospital (ZSFG) will be prescheduled to come to LHH for an in-person counseling session with the resident and his/her LHH Attending Physician.

~~j.~~k. Resident makes second ~~d~~ request to LHH Attending Physician at a minimum of 48 hours after the initial verbal request (Verbal Request #2), ~~-~~and submits a

written attestation requesting EOLOA be implemented to LHH Attending Physician.

2. **Planning**

   a. S3 Palliative Care Unit is a designated unit for implementation of the EOLO~~-Act.~~A. However, the resident may choose to remain on their home unit with their LHH Attending Physician, or with the~~-~~ identified ~~S3~~ Physician acting as their Attending (see 1e above). Every effort will be made to honor the resident's desires.

   b. ~~R~~The resident will be counseled that ~~scheduling to ingest~~self-administration of AID medications must ~~occur in the daytime~~be scheduled during usual business hours on Monday through Friday for maximal resident support. Pharmacy can fill this prescription if given a minimum of 24 hours on weekdays and can provide AID medications on the following~~for~~ Monday, ~~if given the prescription on Friday.~~for medications ordered on Friday.

   c. Resident Care Team will meet with the resident and the resident's support system to elicit in detail the resident's wishes for a dignified and peaceful AID plan. Wishes will be documented in a Resident Care Conference note. Considerations include, but are not limited to:

      i. Who the resident wishes to be present (or not) at time of his/her self-administration of ~~taking~~ AID medications.

      ii. Any other environmental wishes, e.g. music, flowers, aromatherapy, if feasible.

      Iii. Any cultural/spiritual practices to be honored before or after death.

      iv. Any special meal or beverages requested before ~~taking~~ self-administering AID.

      v. Encouraging the resident to discuss their intent with family/friends.

3. **At least 48 hours after resident's ~~#1 verbal request~~Verbal Request #1,** LHH Attending Physician performs the second visit with the resident and, after confirming the resident's desire and ability to proceed, writes prescriptions for AID on security RX form and hand delivers to Pharmacy or sends AID prescription via electronic order within the electronic health record. Pharmacy shall notify Quality Management (QM) of receipt of prescription.

   a. Pharmacy does not prepare AID medications until the prearranged day ~~of ingestion.~~for self-administration~~.~~ has been confirmed.

b. Pharmacy reports dispensing on (Controlled Substance Utilization Review and Evaluation System (CURES) report.

4. **Implementation/Self ~~Ingestion~~-administration**

a. 24 to 48 hours before scheduled day ~~of ingestion,~~ for self-administration, Pharmacy is notified about need to prepare medications for the resident.

b. Arrangements for dignified and peaceful AID plan are completed.

c. Pharmacy dispenses AID medications to LHH Attending Physician or to the resident directly. ~~R~~The resident~~, with or without assistance of family and/or friends,~~ prepares medication as per written instructions provided by Pharmacy~~:~~.

i. Resident takes pre-medication one hour before AID medications.

ii. Resident independently ~~sips/swallows~~self-administers AID medications.

d. If during the process of self-administration ~~ingestion~~ the resident changes his/her mind, appropriate medical care will be provided.

5. **After care**

a. Family/friends, if present, shall be asked to notify Nursing when resident has stopped breathing.

b. Nursing assesses resident for absence of pulse and respiration, provides usual support and notifies Physician.

c. LHH Physician present at time of death pronounces death of the resident~~. (2).~~

d. Nursing documents in medical record and completes post-mortem care ~~(.3)~~.

e. LHH Attending Physician documents in medical record and completes and delivers legal paperwork to QM as per EOLOA requirements. The cause of death for the resident should be listed as the underlying terminal condition.

6. **Annual Review**

a. Documents submitted to CDPH shall be reviewed and compliance data aggregated by QM staff. The forms shall be sent to CDPH at the following address (or faxed to (916) 440-5209).

California Department of Public Health

Public Health Policy and Research
Branch Attention: End of Life Option
Act
MS
5205
P.O. Box 997377
Sacramento, CA 95899-7377

b. The Performance Improvement and Resident Safety (PIPS) Committee shall conduct a review of the data gathered on terminally ill residents who opted for the End- of- Life Option Act (EOLOA) to identify opportunities for improvement.

c. ~~—~~Based on the review by the PIPS Committee, a report shall be submitted to the Joint Conference Committee annually.

ATTACHMENT:
None.

REFERENCE:

NSPP D8.0 Post-Mortem Care

All of necessary EOLA forms, procedures, and documentation requirements are located on California's Department of Public Health EOLA Website below:

https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx
https://www.mbc.ca.gov/Download/Forms/aid-in-dying-request-interpreter-declaration.pdf
~~https://www.mbc.ca.gov/Download/Forms/aid-in-dying-request-interpreter-declaration.pdf~~ https://www.mbc.ca.gov/Download/Forms/aid-in-dying-request.pdf

~~LHH Nursing Policies and Procedures D8.0 Post-Mortem Care~~

Revised: 2017/07/11, 2022/07/12, 25/07/14 (Year/Month/Day)
Original adoption: 2017/05/09 (Year/Month/Day)

STORAGE OF STERILE MEDICAL SUPPLIES

POLICY:

1. This policy is in accordance with guidance provided by Association for the Advancement of Medical Instrumentation, Association for Professionals in Infection Control and Epidemiology, Inc., and Association of Perioperative Registered Nurses. Handling, transportation, and storage of medical supplies shall be done according to the accepted standards of practice for infection prevention and control to reduce contamination of products which compromise sterility.

2. Packages that have been compromised (damaged, wet, torn etc.) will be removed from circulation and not used.

3. A central processing location will be maintained for large bulk storage.

4. Each neighborhood will have smaller designated storage rooms for frequently used items utilizing the same storage standards that must adhere to standard storage requirements.

PURPOSE:

Laguna Honda Hospital (LHH) utilizes event-related sterility for determining shelf lives for all items unless otherwise indicated by the manufacturer shelf-life instruction for use because of potential product deterioration. Event-related sterility assumes that a properly cleaned, packaged, and sterilized item, when handled and maintained appropriately, will remain sterile indefinitely. ~~packaging materials dependent upon package material, storage conditions, transport, and handling.~~ An event must occur to compromise package content sterility which may include seal breakage or loss of package integrity (holes, tears, punctures), moisture penetration, or exposure to airborne contaminants. Event-related sterility is not dependent on dates of expiration but a “first in/first out” rotation should be utilized with older packages used first.

PROCEDURE:

1. Items that have a time-limited shelf life shall have a label attached which states, "Sterile Until (manufacturer’s recommended date shall be written in here)."

2. ~~Staff~~All personnel are responsible to visually inspect any sterile package prior to use to check for time-limited shelf-~~ life label and conditions which would constitute a presumptive break in package integrity. Items shall not be used past the labeled date if present or, if there is any evidence that sterility was not achieved, or the package integrity has been compromised. Situations that would indicate this include: ~~a broken seal, tears or holes in packaging material, evidence of water damage, etc.~~

a. Package integrity – no holes, tears, open ends, loose tape, water or soil marks, damage of any sort, or missing plastic wrapper.

b. Sterility

i. For facility sterilized items: Steam autoclave tape, indicator cards, etc., are checked to ensure proper color change indicating parameters for sterilization were met. Items that fail to meet sterility standards will be returned to Sterile Processing and Distribution (SPD) for reprocessing.

~~2.~~3. All items are to be transported to neighborhoods will be in covered tote bins, carts, or shelves.

~~3.~~4. Storage of sterilized items shall be as follows:

a. All items are to be stored in a segregated, designated storage area or room. Storage area shall not be in a high traffic area or in an area where there is a likelihood of damage or contamination.

b. Open shelving is acceptable if items are being stored in a segregated room designated only for the storage of sterile items. Closed shelving should be used any time there may be potential for contamination or, when items are stored in a non-dedicated room.

c. Shelving must have a solid bottom shelf to protect from dust / debris. Storage requirements include the bottom shelf being at least 10 inches above the floor, at least 2 inches from the walls and at least 18 inches from the ceiling.

d. Efforts to reduce contamination must include regular environmental cleaning, keeping door closed in the designed room, and avoiding direct sunlight on the supplies for temperature and humidity control.

e. Do not store items near water sources.

f. Outside shipping cartons including cardboard boxes are considered contaminated and shall not be used as dispenser boxes or shelf storage . Remove outside carton before transport to clean storage area

~~4.~~5. Inventory control

a. Inventory (shelf) counts shall be determined and utilized to avoid long shelf lives.

b. Inventory counts shall be evaluated periodically (a minimum of annually).

c. Items shall be stocked and rotated on the principle of “first in, first out.”

ATTACHMENT:
None.

REFERENCE:
APIC (2018) APIC Implementation guide: Infection Preventionist's guide to the OR Central Processing Department Policies and Procedures

Revised: 16/03/08, 20/10/13, 23/01/10, 23/09/14, 24/01/09, 25/07/14 (Year/Month/Day)

Reviewed: 24/11/21 (Year/Month/Day)

Original adoption: 05/11/01 (Year/Month/Day)

Revised Food and Nutrition Policies and Procedures

1.66 Equipment Operation

~~Established and~~ Revised: 8/2024 ~~3/81, 1/89, 5/97, 9/06, 7/09~~
~~Reviewed: 8/13, 8/14~~

Policy: All equipment is to be operated according to manufacturer's operating procedures~~directions~~. Manufacturer safety warning/hazards and guidelines must be followed when equipment is in use. ~~–~~Employees to use specific pieces of equipment will be instructed on the proper ~~and~~ safe use and sanitation of ~~that~~ equipment.

Purpose:

- To ~~insure~~ensure the safety of the employees who operate~~run~~ the equipment.
- To preserve the life of the equipment.

Procedure:

1. Follow correct manufacturer's operating instructions.

~~1.~~2. ~~Employees will be~~ The Chef or designee will instruct employees~~taught~~ to the manufacturer's operating procedures ~~instructions~~.

~~11/6/2015~~

Revised Nursing Policies and Procedures

CHANGE OF SHIFT HAND-OFF (NURSING)

POLICY:

~~1. It is the policy of Laguna Honda Hospital (LHH) to make successful resident/patient hand-offs an organizational priority and expectation hospitalwide.~~

~~2. It is the policy of LHH to provide the safest care and to recognize the importance of effective communication, especially during resident/patient hand-offs, to prevent resident/patient harm.~~

~~3.~~1. Laguna Honda Hospital (LHH) will use a standardized approach for nursing hand-off communications per the instructions specified in the Change of Shift ~~Hand-off~~Reporting Standard Work.

~~4.~~2. Standardized hand-off will be completed by Licensed Nursing (LN) staff and Certified Nursing Assistants (CNA)/Patient Care Assistants (PCA) at each change of shift hospitalwide, and in a timely way to ensure delivery of care and services (Joint Commission, 2017).

~~5.~~3. Standardized nursing hand-off reports will include face-to-face communication to promote opportunities to clarify information/ask questions and will include the use of standardized written templates, and utilization of the electronic health record (~~EHR~~her) (Joint Commission, 2017).

~~6.~~4. Situation-Background-Assessment-Recommendation(s) (SBAR) is the preferred communication technique to provide a hand-off (Zuckerberg Hospital, Administrative Policy Number: 8.03).

PURPOSE:

To improve the effectiveness of communication for LN staff and CNAs/PCAs by defining the structure on how and when to exchange information during hand-off, and to ultimately promote resident/patient safety.

DEFINITIONS/BACKGROUND INFORMATION:

Hand-off: ~~-~~ The transfer and acceptance of resident/patient care responsibility achieved through effective communication. It is a real-time process of passing resident-specific/patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the resident's/patient's care (Joint Commission, 2014).

SBAR: ~~-~~A structured communication technique ~~deigned~~designed to convey a great deal of information in a succinct and brief manner. SBAR stands for:

- **S**ituation-What is happening now, chief complaints, any acute change, etc.
- **B**ackground-What factors led up to this event/change, pertinent assessment information, vital signs, etc.
- **A**ssessment-What do you see, what do you think is going on, etc.
- **R**ecommendation(s)-What action do you propose, what do you think should be done, what is the plan of care for the resident/patient, explanation of what the resident/patient needs and when, etc.

Sender of 'Off-going' Staff~~: Provides~~**:** Provides the information about the resident/patient for the handoff (Arora & Farnan, 2023).

Receiver or In-coming Staff~~: Receives~~**:** Receives the information and then assumes care of the resident/patient (Arora & Farnan, 2023).

Shift Change/Change of Shift~~: The~~**:** The transfer of responsibility when one caregiver finishes and another one begins their shift (Arora & Farnan, 2023).

PROCEDURE:

A. **General Nursing Hand-off Process Recommendations for Success** (Joint Commission, 2017)

1. Conduct face-to-face hand-off communication between senders and receivers in a location free from interruptions.
2. Utilize the face-to-face hand-off structure as an opportunity to ask questions and clarify resident/patient information.
3. Hand-offs should be highly reliable, conducted in a high-quality manner for every resident/patient, every shift, with every transition of care.
4. Write-down, repeat-back, and/or read-back, as appropriate, to verify information received.
5. After all pertinent information is ~~communication~~communicated in the resident/patient hand-off, time must be allotted to review relevant chart information and ask/answer any questions that the receiver may have about the resident/patient.

B. Resident/Patient Assignment by Charge Nurse (CN)

1. The CN will complete the assignments prior to the start of change of shift hand-off report.

C. Change of Shift Hand-off: Charge Nurse (CN)

1. For additional details, refer to Standard ~~Work: '~~Work: Change of Shift ~~Hand-Off~~Reporting ~~for -~~ Charge Nurse (CN)~~'~~ ~~(Attachment A).~~
2. Upon arrival ~~to~~in the neighborhood for start of the shift, the CN will go to:
    a. Long-Term Care Areas~~: Report~~: Report room behind Nurses' Station 2
    b. Pavilion Mezzanine SNF~~: Meadow~~: Meadow Conference Room
    c. Pavilion Mezzanine Acute~~: Nurses~~: Nurses' Station
3. Shift hand-off to occur at the following time:
    a. 0710-0730 for AM to DAY shift
    b. 1510-1530 for Day to PM shift
    c. 2310-2330 for PM to AM shift
4. The off-going CN will ensure that all on-coming staff are present in the report room.
5. The CN will maintain an environment conducive to listening and hearing critical information (e.g., ensure no side conversations, minimize interruptions, minimize distraction).
6. The CN will utilize the 'EHR Kardex' to guide their hand-off report.
7. Using the 'Charge Nurse 24-Hour Hand-off Report', the CN will give ~~the~~a hand-off report on every resident, highlighting new interventions or changes in the residents'/patients' condition ~~(Attachment B)~~.
8. The on-coming CN will take notes using the 'Charge Nurse 24-Hour Hand-off Report Form' ~~(Attachment B)~~.
9. The CN should pay close attention to any staff who may be floating to the neighborhood to ensure that all key information about the resident(s)/patient(s) is received.
10. At the end of the CN hand-off report, the CN will provide time to clarify any questions that the in-coming staff may have.

D. Change of Shift Hand-off: Licensed Nurse (LN)

1. For additional details, refer to Standard Work: 'Change of Shift ~~Hand-Off~~Reporting ~~for -~~ Licensed Nurse (LN)' ~~(Attachment C)~~.
2. Upon arrival to the neighborhood for start of the shift, the LN will go to:~~;~~
    a. Long-Term Care Areas:~~-~~ Report room behind Nurses' Station 2
    b. Pavilion Mezzanine SNF:~~-~~ Meadow Conference Room
    c. Pavilion Mezzanine Acute: ~~-~~Nurses' Station
3. Shift hand-off to occur at the following time:
    a. 0710-0730 for AM to DAY shift

   b. 1510-1530 for Day to PM shift
   c. 2310-2330 for PM to AM shift
4. The LN will listen to the off-going CN give their hand-off report.
5. The LN should take notes on the 'LN to LN 24-Hour Change of Shift Report Form' ~~(Attachment D).~~
6. Once the off-going CN is complete with their hand-off report, the out-going LN will complete their hand-off with the in-coming LN.
7. The LNs should utilize the 'EHR Kardex' to guide their hand-off report utilizing the workstation on wheels (WOW).
8. The out-going LN will utilize the 'LN to LN 24-Hour Change of Shift Report Form' and ~~(Attachment D) and~~ provide hand-off report on every resident within the LN's assignment, highlighting new interventions/new orders, changes in resident condition, and any safety concerns.
9. The in-coming LN will utilize the 'LN to LN 24-Hour Change of Shift Report Form' ~~(Attachment D)~~ and take notes on the form capture resident/patient hand-off information.
10. At the end of the LN hand-off report, the out-going LN will provide time to clarify any questions that the in-coming LN may have.

E. Change of Shift Hand-off: ~~-~~PCA/CNA

1. For additional details, refer to Standard Work: ~~-~~'Change of Shift ~~Hand-Off~~Reporting ~~for -~~ CNA/PCA' ~~(Attachment E).~~
2. Upon arrival to the neighborhood for ~~start~~the start of the shift, the in-coming CNA/PCA will go to:
   a. Long-Term Care Areas:~~-~~ Report Room behind Nurses' Station 2
   b. Pavilion Mezzanine SNF:~~-~~ Meadow Conference Room
   c. Pavilion Mezzanine Acute: ~~-~~Nurses' Station
3. Shift hand-off to occur at the following time:
   a. 0710-0730 for AM to DAY shift
   b. 1510-1530 for DAY to PM shift
   c. 2310-2330 for PM to AM shift
4. The off-going CNA/PCA will be responsible for call light coverage and response that go off during the shift change and will remain rounding on residents while change of shift CN and LN handoff is occurring.
5. The in-coming CNA/PCA will listen to the CN hand-off report and listen to the LN hand-off report and takes notes on the 'CNA/PCA~~-~~CNA/PCA Shift-to-Shift Hand~~-~~off Form' ~~(Attachment F)~~.
6. At the completion of the CN and LN reports, the off-going and the on-coming CNAs/PCAs will huddle.
   a. The off-going CNA/PCA will provide any additional information to the in-coming CNA/PCA and discuss any unique needs of the resident's individualized Purposeful Rounding Plan (e.g., view Person-Centered Information section of Kardex).
   b. If time allows, round on residents/patients together, particularly with new or specialized needs, or those who with any recent change in condition.
7. At the completion of the off-going and in-coming CNA/PCA huddle, the off-going CNA/PCA will endorse (face-to-face discussion) to the off-going CN that they have provided a hand-off to the in-coming CNA/PCA.

REFERENCES:

Arora, V. & Farnan, J. (2023). Patient handoffs. UpToDate, accessed on 8/18/2023, at https://www.uptodate.com/contents/patient-handoffs?search=handoffs&source=search_result&selectedTitle=1~11&usage_type=default&display_rank=1

The Joint Commission (2017). Inadequate hand-off communication. *Sentinel Event Alert, Issue 58.*

The Joint Commission Center for Transforming Healthcare. Improving transitions of care: Hand-off communications. Oakbrook Terrace, Illinois: The Joint Commission, 2014.

CROSS REFERENCE:

Zuckerberg San Francisco General, Patient Hand-off and Report with Safe Communication. Administrative Policy Number: ~~-~~8.03

ATTACHMENT / APPENDICES:

~~Attachment A: Standard Work: Change of Shift Hand-Off for Charge Nurse (CN)~~
~~Attachment B: Charge Nurse 24-Hour Hand-off Report Form~~
~~Attachment C: Standard Work: 'Change of Shift Hand-Off for Licensed Nurse (LN)~~
~~Attachment D: LN 24-Hour Change of Shift Report Form~~
~~Attachment E: Standard Work: 'Change of Shift Hand-Off for CNA/PCA~~
~~Attachment F: CNA/PCA Shift-to-Shift Handoff Form~~
NONE

Revised:2023/10/10; 2025/05/06

Reviewed: 2023/10/10

Approved: 2023/10/10

RESTORATIVE NURSING PROGRAM (RNP)~~PROGRAMS~~

POLICY:

It is the policy of Laguna Honda to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. These services are provided via Restorative Nursing Program (RNP) and on the unit via Activities of Daily Living Care (ADL). For the purposes of this policy, the focus is on RNP services. For ADL services see "Resident Activities of Daily Living" policy D1 2.0.

DEFINITION:

~~**"Restorative nursing program"** refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.~~ Restorative Nursing Program (RNP) is a planned and organized program designed to maintain, and/or improve the resident's highest level of range of motion (ROM), mobility status, functional independence and ADLs, and prevent declines unless clinically unavoidable.

BACKGROUND:

This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

POLICY EXPLANATION AND COMPLIANCE GUIDELINES

A. Cognitive and physical functioning of all residents will be assessed in accordance with the facility's assessment protocols.
B. Any member of the Resident Care Team (RCT), with the support and guidance from the physician, will assure the ongoing review, evaluation, and decision making regarding the services needed to maintain or improve resident's abilities in accordance with the resident's comprehensive assessment, goals, and preferences. The Restorative Nursing Program (RNP) does not require a physician's order and can be initiated by a licensed nurse. However, for residents

with complex clinical conditions such as fractures or severe contractures, a consultation with a physician and/or licensed rehabilitation therapist may be appropriate.

C. Residents participating in RNP~~Nursing personnel, Certified Nursing Assistants (CNAs) and Patient Care Assistants (PCAs),~~ are referred by the RCT and evaluated by rehabilitation therapists.

~~C.~~D. Staff who have been trained in restorative~~on basic, or maintenance~~ nursing care interventions can implement and document restorative interventions.~~that does not require the use of a qualified therapist or licensed nurse oversight.~~ This training may include, but is not limited to:

1. Maintaining proper positioning and body alignment.
2. Encouraging and assisting residents, as needed, in turning and position changes.
3. Encouraging residents to remain active and assisting with any exercises according to the plan of care.
4. Promoting independence in Activities of Daily Living (ADLs), performing tasks for residents only as needed to ensure completion of tasks.
5. Assisting residents in adjustment to their disabilities and use of any assistive devices.
6. Assisting residents with range of motion exercises, performing passive range of motion for residents who lack active range of motion ability.
7. Promoting continence with various toileting and/or bowel and bladder training activities.

~~**A.** All residents will receive maintenance nursing services as described above, as needed, by CNAs and PCAs during daily routine care and ADLS.~~

~~**B.** The Restorative Nurse and restorative aides receive additional training on Restorative Nursing Program (RNP) activities upon hire and as needed.~~

~~D.~~E. Residents, as identified during initial, quarterly, and/or change of condition~~the comprehensive~~ assessment process, will receive services from RNP~~restorative aides~~ when they are assessed to have a need for restorative nursing services. These services may include:

1. Technique: Restorative activities provided by nursing staff and trained staff.
    i. Active Range of Motion (AROM): exercises performed by the resident, with cueing, supervision, or physical assist by staff. Includes AROM and active-assisted range of motion (AAROM).
        - AROM: performance of an exercise to move a joint without any assistance or effort of another person to move the muscles surrounding the joint.
        - AAROM: the use of the muscles surrounding the joint to perform the exercise but requires some help from the staff or equipment.

    ii. Passive Range of Motion (PROM): provision of passive movements ~~in order~~ to maintain flexibility and useful motion in the joints of the body. PROM is the movement of a joint through the range of motion with no effort from the patient.

    iii. Splint or Brace Assistance with provision of:
        - Verbal~~verbal~~ and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint.
        - A~~a~~ scheduled program of applying and removing a splint or brace.

2. Training and Skill Practice: Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.
    i. Amputation or Prosthesis Care: activities provided to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses.
    ii. Activities of Daily (ADL) Training
        - Bed Mobility: activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning self in bed.
        - Transfer: activities provided to improve or maintain the resident's self- performance in moving between surfaces or planes either with or without assistive devices.
        - Walking: activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices.
        - Dressing and/or Grooming: activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing, and washing, and performing other personal hygiene tasks with or without assistive devices.
        - Eating and/or Swallowing: activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids with or without assistive devices, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.
    iii. Communication: activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.
    iv. Bowel and Bladder Training:
        - Urinary Toileting Program: implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique voiding pattern targeted at decreasing or resolving incontinence (ex: bladder rehabilitation or retraining, prompted voiding, and habit training or scheduled voiding)
        - Bowel Toileting Program: implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique bowel pattern targeted at maintaining bowel continence.

F. A resident may participate concurrently in unit's ADLs, RNP or Skilled Rehabilitation Therapy if deemed therapeutic and beneficial in maximizing the resident's functional status.

~~C. Residents may receive Restorative Nursing Program (RNP) services upon admission when not a candidate for specialized rehabilitation services, when restorative needs arise during the course of a longer term stay, in conjunction with specialized rehabilitation therapy, or upon discharge from therapy.~~

~~E.~~G. Potential candidates for restorative nursing services may be identified through one or more of the following processes:

1. Physical assessments
2. MDS assessments
3. Specialized rehabilitation assessments
4. In-house referrals due to safety~~unusual occurrence~~incident reports/events ~~event~~

~~F.~~H. The Restorative Licensed Nurse is responsible for maintaining a current list of residents who require restorative nursing services, and for ensuring that all elements of each resident's program are implemented.

I. Restorative Licensed Nurse provide direction, oversight and follow up for restorative nursing interventions performed regularly by CNAs/PCAs and other trained staff, with or without consultation by a licensed therapist.

J. The RNP treatments or activities are individualized to the resident's needs, planned, monitored, evaluated, documented in the resident's medical record and may be provided in the wellness gym and/or on the unit:

1. Wellness gym: RNP treatment in the wellness gym utilizes specialized equipment. Under the supervision of the Licensed Nurse, initial recommendations for treatment with specialized equipment and follow up consultations provided by the licensed therapist.
2. Unit based: RNP care depending on the medical or physiological complexity of the resident, the restorative services can be done one-to-one or in a small group.

~~G.~~K. A resident's Restorative Nursing Program (RNP) plan will include:

1. The problem, need, or strength the restorative tasks are to address.
2. The type of activities to be performed.
3. Frequency of activities.
4. Duration of activities.
5. Measurable goal and target date.

~~H.~~L. The discharging therapist, Restorative Licensed Nurse, or designated licensed nurse will communicate to the appropriate RNP or unit staff~~restorative aide~~, the provisions of the resident's Restorative Nursing Program (RNP) plan, providing any necessary training to carry out the plan.

~~I.~~M. RNP or other trained staff~~Restorative aides~~ will implement the plan for a designated length of time, performing the activities, and documenting on the Restorative Care Flowsheet in EPIC.

~~J.~~N. The RNP Charge~~Restorative~~ Nurse, or designated licensed nurse, will complete periodic and/or quarterly evaluation of RNP~~restorative~~ activities is demonstrated by routine documentation ~~in summaries~~ and resident care conference (RCC) notes. The nurse evaluates the effectiveness of the restorative treatments by documenting the progress towards restorative goals and describing the resident's related clinical status or changes to the interventions or goals as needed:~~.~~

~~1. CNAs/PCAs are responsible for weekly summaries that must be reviewed and co-signed by the restorative LN. The note will include any changes in performance, participation or changes in clinical status identified during Restorative Nursing Program session.~~
~~2. CNAs/PCAs may initiate a monthly summary that must be reviewed and co-signed by the restorative LN.~~

1. The note will include progress towards goals, activities provided, the response to treatment, level of assistance and functional status.
2. Documentation should reflect how the resident responds to the program in relation to behavior (e.g., refusal, anxious, combative, etc.), along with physical response (e.g., fatigue level, attention, distractibility, etc.).
3. Restorative LN evaluates the care plan effectiveness, and initiates any changes in treatment, interventions, or goals as needed.

~~K.~~O. If resident exhibits a lack of progress, a decline, or the achievement of goals, the treatments or program may be reevaluated for discontinuation or modification to be more appropriate for the resident.

~~L.~~P. When RNP~~restorative nursing~~ services are no longer warranted, or the resident is appropriate for being transferred to the unit's ADL care, if needed, RNP Charge~~nursing assistants, the restorative aide, Restorative~~ Nurse , ~~and/~~or designed RNP staff~~designated licensed nurse~~ will train the appropriate unit staff~~nursing assistants~~ on the maintenance care or activities that need to be provided on an on ongoing basis.

~~M.~~Q. Minimum Data Set (MDS)

The MDS coordinator completes section O, "Nursing rehabilitation/ restorative care" of the MDS to indicate the number of days the restorative techniques or practices were provided for equal to or greater than 15 minutes per day in the last 7 days.

The MDS coordinator records bladder retraining and scheduled toileting in section H0200 Urinary Toileting Program.

APPENDIX:

NONE

REFERENCES:

Centers for Medicare & Medicaid Services. *Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.18.11.* (October 2023) Chapter 3, Section O, Item O0500.

CROSS REFERENCES:

Nursing Policies and Procedures
C 3.1 Guidelines for Documentation of Resident Care by the Licensed Nurse C 3.2 Documentation of Resident Care by Nursing Assistant
D1 2.0 Resident Activities of Daily Living (Basic Care)
D5 2.0 Limb Care following Amputation
D5 4.0 Arm Sling
D5 5.0 Braces - Leg
D6 2.0 Transfer Techniques
D6 3.0 Range of Motion Exercise
D6 4.0 Positioning and Alignment in Bed and Chair
D6 5.0 Ambulation
E1.0 Oral Management of Nutritional Needs
F1.0 Assistance with Elimination
F2.0 Assessment and Management of Urinary Incontinence
F3.0 Assessment and Management of Bowel Functions
F4.0 Application and Management of Condom Catheters
F 6.0 Colostomy Management
Hospital wide Policies and Procedures
LHPP 20-37 Management of Dysphagia and Aspiration Risk
LHPP 20-48 In-house Requests for Rehab Consultations and Services
LHPP 28-03 Aquatic Services

~~NONE~~

Original: 2001/12

Revised: 2008/09; 2015/03/10; 2019/09/10; 2022/10/11; 2023/06/13; 2024/03/08; 2024/12/16 ; 2025/04/29

Reviewed: 2024/05/14

Approved: 2024/05/14

Reviewed: 2025/4/29

Approved: PENDING

BLOOD GLUCOSE MONITORING

POLICY:

1. A bar code scanner is used to enter patient/resident identification (ID) and/or operator ID in the facility-approved glucometer machine.

2. Physician order shall indicate~~s~~ hypoglycemic value to treat hypoglycemia, and hyperglycemic value ~~for~~ which requires physician notification.

3. Hypoglycemia is considered <70mg/dL, and hyperglycemia is considered >400mg/dL, unless otherwise specified in Physician order. Whenever blood glucose (BG) values change from the resident's usual range, or the blood glucose value is not consistent with resident condition, the nurse is to repeat the test, assess for symptoms of hypoglycemia or hyperglycemia, treat according to order and inform the physician STAT.

4. ~~Glucometer~~The glucometer machine is cleaned after each use and in between patients/residents with facility-approved disinfectant wipes for the glucometer.

5. Daily quality control (QC) test, with low and high glucose solutions, will be performed daily by licensed nurse (LN) on AM shift and other shift when QC is requiered~~.~~

6. Licensed Nurse will perform a QC for the following:
   a. If a test strip vial has been left opened,~~.~~
   b. Anytime a LN wants to test the performance of the meter,~~.~~
   c. Each time a new vial of tests strips is opened.

7. Quality control tests that fall outside of designated parameters are reported to the Point of Care ~~Services~~Coordinator (POCC).

8. The Point of Care Coordinator, or designee, coordinates any updates or changes to the initial setup of the facility-approved glucometer machine, and manages lot number~~s management,~~ and ~~/manages~~ software upgrades~~.~~.

9. The Point of Care Coordinator, or designee, is responsible for coordinating facility-approved glucometer machine quality management tracking and reporting.

10. ~~AC (~~Before ~~M~~meal~~eal time~~ (AC) blood glucose checks should be taken no ~~more~~ earlier than 30 minutes before meal.

11. Insulin being administrated prior to meal:

    a. Regular insulin should be given no ~~more~~ earlier than 30 minutes before meal, unless otherwise specified
    b. Rapid Insulin (Lispro /Humalog and Aspart/Novolog) should be given no more than 15 minutes before ~~or immediately after a~~ meal.

12. If fasting blood glucose check is missed and taken instead after resident has already eaten, and the order was to check blood glucose ~~pre~~ before meal (AC), do not give rapid insulin (Lispro/Humalog, Aspart/Novolog), regular insulin or intermediate(NPH) acting insulin per the scale. Notify physician.

13. Long acting insulin is not held unless patient/resident is hypoglycemic. After treatment per protocol and BG ≥100, it can be given unless there is an order to hold by physician.

14. All licensed nurses assigned at LHH, {{including ~~n~~Nursing ~~o~~Operations, unit Nurse ~~m~~Managers, Minimum Data Set (MDS) coordinators, Department of Education and Training (DET) and Clinical Nurse Specialists (CNS)} will complete an annual competency review of Point of Care blood glucose testing. Newly hired LN's will complete the competency at time of hire, 6 months after, then annually.

15. The ~~M~~meter should be placed on docking station after use and when not in use.

PURPOSE:

1. To accurately monitor blood glucose levels using facility-approved glucometer machine.

2. To initiate the appropriate nursing intervention when blood glucose levels are outside ~~not within~~ normal range. ~~Refer to medication orders for treatment of hypoglycemia and hyperglycemia.~~

PROCEDURE:

A. Equipment:

Refer to the facility-approved glucometer machine user's manual for the following procedures:

1. Patient/resident ~~P~~preparation
2. Coding (Calibration)
3. Patient/resident ~~T~~testing
4. Quality Control Testing
5. Facility approved disinfectant wipes for the glucometer for infection prevention
6. Instrument Care/Maintenance
7. Linearity (performed by Point of Care Coordinator or designee)
8. Troubleshooting

B. Blood Glucose Check

1. Test strip
   a. Test strips are available through the Central Processing Distribution (CPD).
   b. Test strips must be stored at room temperature. Test strips are stored in the same tightly capped vial in which they are packaged. The vial cap is immediately replaced after removal of a test strip. Test strips are stable until the expiration date on the vial. Outdated test strips are discarded. The entire test strip vial should be used prior to opening a new vial, even if the barcode number is the same.
   ~~b.~~c. Test strips can be obtained through the Central Processing Distribution (CPD). They should be stored at room temperature in the original, tightly sealed vial. After removing a test strip, promptly replace the vial cap to maintain the strips' integrity. Test strips remain stable until the expiration date printed on the vial, and any expired strips must be

discarded. Make sure to use the entire vial of test strips before opening a new one, even if the barcode number is the same.

~~c.~~d. The test strip code displayed by the facility-approved glucometer machine must match the code of the test strips in use.

~~d.~~e. Test strip code information must be verified in the facility-approved glucometer machine by the operator whenever a patient/resident or quality control test is performed.

2. Proper infection control procedures are followed when using the facility-approved glucometer machine and testing with blood glucose monitoring equipment.
   a. Glucometer machine is cleaned after each use and in between patient/resident
   ~~a.~~b. with facility-approved disinfectant ~~wipes (such as Super Sani-Cloth Germicidal Disposable Wipes® or Clorox Germicidal Wipes®)~~ for the glucometer. Adhere to the contact time per manufacture's recommendation
      i. Use a damp wipe to clean entire machine. Never drench machine with cleaning solution.
      ii. Allow to dry for 1 minute, or according to manufacturer's recommendation, in order to disinfect machine.
      iii. Verify that the meter is dry and there is no solution left on the meter. If meter is still wet use gauze to thoroughly dry the glucometer after cleaning and disinfecting.
      iv. Disinfectant wipes are available from CPD.

3. If the meter is not functioning properly:
   a. Consult the "Trouble Shooting" section of the User's Manual.
   b. For problems that cannot be resolved, contact POC~~S~~C.
   c. Meters that are not functioning properly will be exchanged through POCC~~S~~.

4. The most recent facility-approved glucometer machine available on each neighborhood is referenced for procedural information.?

5. When preparing a resident for discharge, glucose monitoring teaching must be done using the type of device that the resident will be using when discharged.

Hypoglycemia: For blood glucose levels less than ~~below~~ 70 mg/dL or as specified by physician orders, review orders for treatment. ~~administer 8 oz of juice orally if the resident is able to take it by mouth (PO). If the resident has an enteral tube, provide the juice via the tube. Recheck blood glucose (BG) in 15 minutes. If the BG remains below 70 mg/dL, repeat the treatment and perform a fingerstick every 15 minutes until the blood glucose reaches 100 mg/dL or higher. If the patient or resident does not respond to treatment or if their condition worsens, notify the physician immediately.~~

A. ~~For blood glucose less than 70 mg/dL or for value identified by physician order, treat with 8 oz of juice orally if resident is able to take orally by mouth (PO) or if resident has G an enteral tube, via Genteral tube. Recheck BG in 15 minutes. Repeat treatment and fingerstick every 15 minutes until blood glucose is greater than or equal to 100 mg/dL.~~
   a. Notify physician if patient/resident ~~does not respond to treatment or condition worsens~~.

C. Documentation

1. Check mark date column on the emergency equipment checklist to indicate quality control tests on the glucometer were done.

2. Guidelines for Hypoglycemia Documentation:
   (1) Dock the glucometer after use to upload blood glucose values into the electronic health record (~~EHR~~her).
      (a) If resident is using personal glucometer, document BG value in "Glucose (manual)" flowsheet.

   (2) Hypoglycemia event should be documented in Hypoglycemia ~~f~~Flowsheet in the EHR.
      (a) ~~Additional actions can be documented in progress notes~~Document all actions and treatments in the EHR

   (3) Review care plan and~~/or~~ if appropriate, update care plan with individualized goals and interventions.

REFERENCES:

Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St. Louis, MO: Elsevier

Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadephia, PA: Lippincott Williams & Wilkins

http://www.accu-chekinformii.com/pdf/05234654001_ACI2_QRG_forWEB.pdf

Blood Speciman Collection: Glucose Point of Care Screen
https://point-of-care.elsevierperformancemanager.com/skills/430/quick-sheet?skillId=GN_43_12&virtualname=lhh

Reviewed: 2002/08, 2010/03, 2010/10 2014/03/25, 2016/09/13, 2017/03/14; 2019/05/14; 2020/03/17; 2023/09/12; 2025/04/30

Revised: 2023/09/12

Approved: 2023/09/12

BEHAVIORAL RISK ASSESSMENT ~~AND CARE PLANNING~~

POLICY:

~~1. Residents have the right to be safe and free from harm.~~

~~2. The existence of aggressive behavior or the likelihood of being a target of aggressive behavior that places residents and staff at risk is regularly assessed in all residents.~~

~~3.~~1. The Registered Nurse (RN) is responsible for completing a behavioral risk assessment on each resident upon admission, quarterly, whenever there is a change of condition, upon transfer to another neighborhood, and whenever clinically indicated.

PURPOSE:

To maintain a safe and secure environment by assessing behavior risk for all residentst~~s. and enhance the therapeutic milieu.~~

~~1. To identify residents whose behaviors, pose potential risks to themselves and/or to others.~~

PROCEDURE:

~~**Nursing Assessment for Behavioral Risk**~~

A. Nursing Assessment and Care Planning for Behavioral Risk (Refer to HWPP 24-28 Behavioral Health Care and Services)

1. The Nursing Assessment for Behavioral Risk is to be completed as part of the comprehensive Minimum Data Set (MDS).

   a. The *Risk for Aggression* assessment is located in the quarterly Navigator activity of the EHR. Information from the Behavioral Monitoring flowsheet populates this assessment to determine if the resident is at risk for aggressive behaviors directed at others.

      i. From the data within this section, if nursing determines the need for care planning for aggression, an online care plan template shall be accessed to address the problem. The care plan then is reviewed and further individualized adding non pharmacological interventions by the Resident Care Team (RCT).

      ii. If a nurse determines that an aggressive behavior care plan is not indicated, an explanation is documented as to the reason. For example: "The resident's increased psychomotor activity (pacing) is related to side effects of medication effects and not ~~a~~ related to aggression."

   b. The *Risk for Target of Aggression* is located in the SNF Assessment Flow Sheet section of the EHR and asks questions to assess the resident's risk ~~for~~of being a target of aggression.

      i. If any question is answered with a *yes*, the nurse is to access the online care plan template to address the problem of b~~r~~eing at risk for being a target of aggression. The

care plan then is reviewed and further individualized adding non pharmacological interventions, by the RCT.

B. Assessment and Reassessment ~~t~~Time ~~p~~Parameters~~.~~

1. The Behavioral Risk Assessment is completed as part of a comprehensive Minimum Data Set (MDS) and therefore is completed:

    a. Within two (2) weeks of admission
    b. At the time of a significant change of condition
    c. Annually
    d. Quarterly

2. In addition, the assessment is completed
    a. Within two (2) weeks of relocation to another neighborhood
    b. When otherwise clinical indicated and at the request of any RCT member

~~**C. Guidelines to Develop Behavioral Risk Care Plans**~~

~~1. Refer to Attachment 1: Guidelines to Develop Behavioral Risk Care Plans~~

ATTACHMENTS:

~~Attachment 1: Guidelines to Develop Behavioral Risk Care Plans~~

CROSS REFERENCES:

Hospitalwide Policies and Procedures

~~File #22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response~~
~~LHHPP~~File #23-01 Resident Care Plan, Resident Care Team, & Resident Care Conference
~~LHHPP 24-01 Missing Resident Procedures~~
~~LHHPP 22-01 Abuse Protection Program: Prevention, Recognition, Reporting~~

Adopted: June 2005

Revised: 2014/05/27; 2015/09/08; 2021/01/07; 2021/04/13; 2025/04/30

Reviewed: 2021/04/13

Approved: 2021/04/13

WOUND IRRIGATION AND CLEANSING

POLICY:

1. Wound irrigation requires a physician's order. Irrigation An irrigation order must include the type of wound irrigation solution to be used.
2. 1.
   The Licensed Nurse is responsible for performing wound irrigation.
3. 2. Licensed Nurses are responsible for performing wound irrigation and shall only perform mechanical and chemical wound debridement.

4. All wWound care and treatment supplies including cleaning/irrigation solutions, dressings, scissors, medicated topical ointments shall be stored in the treatment cart and/or where treatments are stored in the medication cart.
5. Over-the-counter skin creams and lubricant (i.e., protective barriers, Vitamin A & D, Aquaphor) and personal hygiene products (i.e., shampoos and soaps) are stored in a locked container.
6. 3.

PURPOSE:

To provide guidelines for appropriate and effective wound cleansing and irrigation.

DEFINITIONS:

"Cleansing" refers to the use of an appropriate device and solution to clean the surface of the wound bed and to remove the looser foreign debris or contaminants in order to decrease microbial growth.

"Irrigation" refers to a type of mechanical debridement, which uses an appropriate solution delivered under pressure to the wound bed to vigorously attempt to remove debris from the wound bed. Licensed Nurses in Laguna Honda may only perform mechanical and chemical wound debridement.

Types of Syringes used for Wound Irrigation

1. 60-ml catheter tip piston syringe delivers approximately 4 pound per square inch (psi) of pressure. This is recommended for general irrigation and cleansing.

2. 35-ml syringe with an 18-gauge angiocath delivers approximately 8 psi of pressure. This is recommended for deep undermining, sinuses and tunneling, and for loosening adherent debris.

2. 3. 3-ml and 10-ml syringes delivers approximately 7-8 psi of pressure. This is recommended for small wounds and hard to reach wounds.

Types of Irrigation Solutions

1. Normal Saline, or Vashe - most commonly used and least toxic irrigation/cleansing solution.

2. Chemical Solutions – must be use for a limited period, unless specified by the physician.

These types of solution may damage healthy wound bed tissues or granulating tissues. The Licensed Nurse must reassess use of chemical solutions at least weekly and notify physician.

~~3.~~2.

a. Povidone Iodine (Betadine)
b. Dakin's Solution (1/4 strength and 1/20 strength)
c. Hydrogen Peroxide - may be used to remove crusts from fixators and orthopedic pins. Once the crusts are removed, the site is cleansed with Vashe.

~~4.~~3. Commercial Wound Cleanser – does not contain harmful chemicals. This contains surfactants and other chemicals intended to enhance their efficacy. Wounds with adherent materials may benefit from a wound cleanser.

PROCEDURE:

A. Equipment:

~~60 ml catheter tip piston syringe or~~Appropriate syringe for wound (NOTE: ~~*~~35 ml syringe with 18-gauge angiocath ~~(*~~requires special order from CSR)
Prescribed wound solution or cleanser
Wound irrigation kit
4 x 4 gauze
Cotton tip
applicator Pad or
towel
Tape
Secondary wound dressing (if needed)
~~-~~Stockinet (if needed)
Kidney basin (if needed)
Gloves
Plastic Bag

~~A.~~B. General ~~P~~preparation for Wound Irrigation and/or Cleansing

1. Don appropriate personal protective equipment (PPE) before resident/patient contact.
2. Perform hand hygiene and change gloves between tasks/procedures (i.e., removing dressing to cleaning wound to applying treatment to applying a new dressing).
3. Verify correct resident/patient.
4. Clean the work surface with facility-approved disinfectant (do NOT use the treatment cart as a work surface).
5. Gather all necessary equipment for wound irrigation or cleansing
6. Provide privacy.
7. Explain ~~the~~ procedure to the resident/patient. Review if pain medication prior to wound care is needed and ensure it is given timely. ~~Assess resident for pain prior to wound treatment.~~
8. Assist resident/patient to a comfortable position and expose only the wound area ~~The treatment cart is never to be used as a work surface when performing the treatment.~~
9. Wound cleansing or wound irrigation uses clean technique, unless otherwise specified to use sterile technique.
10. Wound irrigation solutions and cleansers (excluding normal saline), when opened, must be labeled with date, time, and licensed nurse initials.
    a. Normal saline must be discarded immediately after use.
    b. Vashe is single resident/patient use and must be labeled with the

resident's/patient's name on the back of the bottle
a.c. Unused or other opened wound irrigation solution or cleanser is discarded before the expiration date.

2. Provide privacy.
The treatment cart is never to be used as a work surface when performing the treatment.
Wound cleansing or wound irrigation uses clean technique, unless otherwise specified to use sterile technique.
All wound irrigation solutions, normal saline, and wound cleansers when opened must be labelled with date, time, and licensed nurse initials.

3.

a. Normal Saline must be discarded 24 hours after being opened.

4.11. Other unused, opened wound irrigation solution or cleanser is discarded before the expiration date.Discard of all disposable supplies into the hazardous waste bin after procedures

B.C. Preparation of Resident forProcedure for Wound Irrigation (Refer to Skills (elsevierperformancemanager.com) for procedures on Wound Irrigation)

1. Gather all necessary equipment for wound irrigation.
2. Position the resident and expose the affected wound area.
3. Protect bedding with a pad or towel under area to be irrigated.
4.1. Create a clean working area (i.e. bedside table) to oOpen wound irrigation kit, and prepare the irrigating solution to be used, irrigating syringe, secondary dressing, tape, gloves, and plastic bag.
2. Perform hand hygiene and ut don clean gloves.
3. Examine dressing for quality and quantity of drainage.
4. Carefully Rremove wound dressing. and Place discard soiled dressing and gloves into a the plastic bag. Remove gloves.
5.
5. Perform hand hygiene and Change to another don clean gloves.
6. and proceed with wound irrigation.
7.6. Fill the syringe with irrigating solution. Attach angiocath to the syringe if needed.
8.7. Position kidney basin to catch the solution during irrigation.
9.8. Perform wound irrigation. Gently insert tip of syringe or angiocath, if applicable, into wound areas and irrigate until returns are clear. Be Ensure solution reaches all areas of the wound.
9. As needed, cleanse periwoundperi wound skin with moistened normal saline, or Vvashe, gauze and pat to dry.
10. Assess wound and peri wound area.
10.11. Perform hand hygiene and don gloves.
11.12. Apply secondary dressing, if applicable. Initial and date your dressing.
12.13. Discard the irrigation kit, disposable scissors (if used), and gloves.

C.D. Preparation of ResidentProcedure for Wound Cleansing

1. Gather all necessary equipment for wound cleaning.
2. Spray wound cleanser may be applied directly to the wound or can be sprayed onto clean 4x4 gauze then applied to the wound.
3. Put on clean gloves. Remove wound dressing. Place soiled dressing and gloves into the plastic bag.

1. Gather all necessary equipment for wound cleansing.
2. Examine dressing for quality and quantity of drainage.
3. Perform hand hygiene and don gloves.
4. Carefully remove soiled dressing and discard into a plastic bag. Remove gloves.
5. Perform hand hygiene and don gloves.

4. Perform wound cleansing. Spray wound cleanser may be applied directly to the ~~wound or~~wound or can be sprayed onto ~~clean~~a clean 4x4 gauze, then applied to ~~the~~ wound.
6.
5. When ~~Change to another clean gloves and proceed with cleaning of wound.~~
6. U~~u~~sing the wound spray cleanser directly to wound, hold ~~the~~ spray bottle approximately 1 inch from the wound bed. Aim the nozzle at the wound, spray directing the stream of cleanser along the base and sides of ~~the~~ wound.
7.
7. Blot up excess moisture with a clean gauze.
8.
8. Dry the surrounding skin area.~~.~~
9.
10. Assess wound and peri wound area.
11. Perform hand hygiene and don gloves.
9. Apply secondary dressing, if applicable. Initial and date your dressing.
12.
10. Discard plastic bag with wastes into hazardous waste bin.
11. 13.

~~D.~~E. Documentation

Licensed Nurse will document wound ~~care~~ in the electronic health record at least weekly and/or when there is a decline in the condition of the wound:

- Location
- Type of wound
- Wound bed tissue type
- Wound measurements
  - Dimensions (length, width, depth in cm)
  - Undermining
  - Tunneling
- Wound edges
- Peri wound
- Pain assessment

~~E.~~F. Storage of Supplies (See Nursing Policy and Procedure B 6.0 Items at Bedside)

Wound care and treatment supplies are normally stored in a treatment cart, which is locked when not in use, or stored in a place inaccessible to residents/patients. Chemical solutions and commercial wound cleansers must be stored in the treatment ~~The following must be stored in the treatment~~ cart when not in use.

~~a. Chemical solutions and commercial wound cleansers must be stored in a locked treatment cart~~
~~b. Syringes and scissors must be stored in a locked treatment cart~~

REFERENCES:

Elsevier (2025) Wound Irrigation https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on May 5, 2025

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CMS Manual System, Pub. 100-07 State Operations, transmittal 4, Nov. 12, 2004

CROSS REFERENCES:

Hospitalwide Policy and Procedure
24-15: Pressure Ulcer Management

Nursing Policy and Procedure
B 6.0 Items at Bedside
K 1.0 Pressure Ulcer P~~p~~revention and Treatment
K 2.0 Wound Assessment and Management

Revised: 2000/08, 2005/02, 2008/02, 2019/07/09, 2022/07/12; 2023/05/09; 2025/05/05

Reviewed: 2023/05/09

Approved: 2023/05/09

PREVENTION AND TREATMENT OF SKIN TEARS

POLICY:

~~1. The~~ Licensed Nurse is responsible for identifying residents/patients at risk for skin tear development and ~~initiating,~~implementing intervention strategies to minimize the occurrence of avoidable skin tears~~for preventing skin tears.~~.

1.

Licensed N~~n~~urse is responsible for notifying and obtaining a treatment order from the physician when a resident/patient develops and/or is admitted with minor skin tears that are not related to pressure.

2.

3. Registered Nurse (RN) is responsible for wound assessment, dressing application and notifying for presence of wound infection, wound deterioration and non-healing wound.

4. The Licensed Vocational Nurse, under the supervision of the RN, may collect wound assessment data and perform dressing application as ordered by the physician.

~~The Licensed Nurse will evaluate, document the healing or worsening of a skin tear weekly, and shall notify the physician of any complications when needed.~~

PURPOSE:

To prevent ~~skin tears from occurring~~the occurrence of avoidable skin tears~~.~~

and~~To~~ promote the healing of skin tears.

BACKGROUND:

Skin tears are traumatic wounds that may result from a variety of mechanical forces such as shearing or frictional forces including blunt trauma, fall, poor handling, equipment injury or removal of adherent dressings. Skin tears do not extend through the subcutaneous layer. In already fragile or vulnerable skin (e.g., in aged or very young skin), less force is required to cause a traumatic injury, meaning that incidence of skin tears is often increased.

Skin tears can occur on any part of the body but are often sustained on the extremities such as upper and lower limbs or the dorsal aspect of the hands.

When a resident/patient presents with a skin tear, the initial assessment should include a full, comprehensive assessment of the resident/patient as well as the wound. It is also important to establish the cause of the injury.

~~**The changes to the skin associated with ageing include**~~

~~■ Thinning of the epidermis and flattening of the epidermal junction~~
~~■ Loss of collagen, elastin and glycosaminoglycan~~
~~■ Atrophy and contraction of the dermis (causing appearance of wrinkles and folds)~~
~~■ Decreased activity of sweat glands and sebaceous glands, causing the skin to dry out~~
~~■ Thinning of blood vessel walls and a reduction of blood supply to the extremities~~

~~■ Prolonged sun exposure~~

Skin Tear Categories {International Skin Tear Advisory Panel (ISTAP)}:

Type 1 skin tear — No skin loss
Linear or flap tear where the skin flap can be repositioned to cover the wound bed.

Type 2 skin tear — Partial flap loss
The skin flap cannot be repositioned to cover the whole of the wound bed.

Type 3 skin tear — Total flap loss
Total skin flap loss that exposes the entire wound bed.

PROCEDURE:

A. Prevention of Skin Tears

~~1.~~ Review history of previous skin tears and identify risk factors for ~~Inspect skin and investigate previous history of skin tears~~
1. accidental trauma (e.g., fragile skin, dryness)
2. Consider medications that may directly affect skin (e.g. topical and systemic steroids)
3. Manage dry skin and use emollients
4.
5. to moisturize
6. Consider the use of protective clothing (e.g. shin guards, long sleeves or retention bandages)
7. Staff should not have jewelry in resident/patient contact
8. Exercise caution when repositioning and transferring resident/patient to avoid any surface that can cause skin tearing.
   a. Use transfer techniques that prevent friction or shear
   b. Pad bedrails, wheelchair arms, and leg supports
   c. Support dangling arms and legs with pillows or blankets
9. Encourage meal and fluid intake
10. Initiate/update an individualized skin care plan

~~Consider medications that may directly affect skin (e.g. topical and systemic steroids) If patient has dry, fragile, vulnerable skin, assess risk of accidental trauma~~
~~Manage dry skin and use emollient to rehydrate limbs as required~~
~~Implement an individualized skin care plan using a skin-friendly cleanser~~
~~Prevent skin trauma from adhesives, dressings and tapes, (use silicone tape and cohesive retention bandages)~~
~~Consider medications that may directly affect skin (e.g. topical and systemic steroids)~~
~~Be aware of increased risk due to extremes of age~~
~~Discuss use of protective clothing (e.g. shin guards, long sleeves or retention bandages)~~
~~Staff should not have jewelery in patient contact~~

~~11. Provide a safe environment~~
~~12. Caution with repositioning and transferring resident to avoid any surface that can cause skin tearing.~~
~~13.~~
~~14. Use transfer techniques that prevent friction or shear.~~

~~b. Pad bedrails, wheelchair arms, and leg supports.~~

~~c. Support dangling arms and legs with pillows or blankets~~

B. Management and Treatment of Skin Tears
1. Control bleeding
2. Cleanse and debride per order
3. Monitor for signs and symptoms of infection
4. Monitor wound edge/closure; skin typically follows a closure trajectory of 14-21 days.

5. Consider and address factors affecting wound healing (e.g., diabetes, poor nutrition, circulation issues)

~~C.~~

1. ~~■Control bleeding by apply pressure and elevate the limb if appropriate.~~
2. ~~■ when controlling bleeding is the main goal, dressings to assist with hemostasis may be used~~
3. ~~■ Cleanse/irrigate the wound as per local protocol and remove any residual debris or hematoma, gently pat the surrounding skin dry to avoid further injury.~~
4. ~~■ If the skin flap is present but necrotic it may need to be debrided; care should be taken during debridement to ensure that viable skin flaps are left intact and fragile skin is protected.~~
5. ~~■ If viable, re-approximate the skin flap to use as a 'dressing.' Ease the flap back into place using a gloved finger, dampened cotton tip, tweezers or a silicone strip.~~
6. ~~Manage infection/inflammation~~
7. ~~■ Wound inflammation from trauma should be distinguished from wound infection.~~
8. ~~■ Wound infection can result in pain and delayed wound healing; diagnosis of infection should be based on clinical assessment and appropriate infection control measures taken.~~
9. ~~■Check tetanus immunization status and take further steps if necessary.~~
10. ~~Consider moisture balance/exudate control~~
11. ~~■Skin tears tend to be dry wounds, but there may be some circumstances in which exudate is an issue~~
12. ~~■Moisture balance is essential to promote wound healing and to protect the peri-wound skin from maceration.~~
13. ~~■Observe the volume and viscosity of the exudate when selecting a topical wound dressing~~
14. ~~Monitor wound edge/closure~~
15. ~~■Skin tears are acute wounds that should typically proceed to closure in a timely fashion and follow an acute wound closure trajectory of 14–21 days.~~
16. ~~■Ensure that all potential factors that could delay healing (e.g. diabetes, peripheral edema, nutritional issues) have been addressed.~~
17. ~~■Compression therapy should be considered if the wound is on the lower leg. Before applying compression, a full leg assessment including vascular assessment.~~

~~A.~~

~~Equipment~~

~~UrgoTul Ag or An Aquaphor Vaseline gauze~~	~~Clean gloves~~
~~2" x 2" or 4" x 4" sterile gauze pads~~	~~Plastic waste bag~~
~~Sterile Steri-Strips~~	~~Sterile applicators~~
~~Stretchy roller gauze~~	~~Tubular Stockinet~~

~~D.~~C. Treatment of Skin Tears

1. Basic c~~C~~are for ~~S~~skin ~~T~~tears

   a. Cleanse ~~all~~ skin tears with Vashe. DO NOT USE PEROXIDE.
   b. Use non-adherent dressings, if possible.
   c. Apply skin protective barriers or a non-adherent wound dressing with gauze or secondary dressing such as silicone.
   d. Use gauze wraps, stockinettes, flexible netting to secure dressings rather than tape. If you must use tape, use paper tape.
   e. If adherent dressings are required, use caution when removing the dressing or use adhesive remover pad prior to removing the dressing to prevent skin tearing.

2. Skin ~~tear~~tears with skin flap present

a. ~~Some skin tears have a skin flap; treatment~~The treatment goal should be to avoid dislodging the flap.
b. Reposition the torn flap over the wound so that there is a chance of it reattaching to the wound bed.
c. Approximate edges together by gently sliding flap over exposed wound with sterile cotton tip applicator.
d. Cover with moist wound dressing, such as hydro gel, foam, petroleum-based protective ointment (Vaseline gauze), or Steri-strip.
e. Secure non-adherent dressings with a gauze or tubular non-adhesive wrap (tubi pad or tubular stockinet).
f. Change dressing daily
g. Monitor for signs and symptoms of ~~infection;~~infection ~~if present~~ and, if present, notify the physician for new treatmen~~t~~t.

3. Skin ~~tear~~tears without flap or with hematoma

a. Cover with non-adherent dressing and ~~a foam~~foam dressing. Change daily.
b. Monitor for signs and symptoms of infection, notify physician i~~MD~~f any
~~c.~~ Continue with skin tear prevention protocols when tear heals

~~E.~~D. Documentation

1. Changes in resident's/patient's skin condition must have a Care Plan and documentation for a minimum of once per shift for 72 hours and as often as clinically indicated depending on the nature of the change

~~1. Refer to NPP K 2.0 Wound Assessment and Management.~~

2. ~~Record on the Avatar wound location and assessment~~Add "LDA Wound" in the Avatar to monitor and document wound progression.
   a. Under **Primary Wound Type,** select "**Skin Tear"**
3. Weekly Wound Assessment
   a. Include: Site assessment; peri-wound assessment; drainage with description, shape and margins; treatment and dressing performed
   b. Create a worklist task to notify staff of weekly assessment and dressing changes as ordered
   c. Complete a full wound assessment if the wound shows significant change
4. LDA or Wound documentation EVERY shift
   a. If the dressing change is not due
      • Document **Dressing Status** such as "Clean, Dry, Intact"
      • Document **Site Assessment** as "UTA" for "unable to assess" and specify in comment section the reason
   b. If the dressing change is due (i.e., scheduled changes or soiled dressing)
      • Document **Site Assessment** and **Peri-Wound Assessment**
      • Document **Dressing Change** and **Dressing Status**
   c. If no dressing is ordered
      • Document **Site Assessment** and **Peri-Wound Assessment**

If you chart Unable to Assess (UTA), document explanatory comment (example: dressing change not due)

REFERENCE:

Nettina, S., The Lippincott Manual of Nursing Practices, 9th edition, 2010

LeBlanc K, Campbell KE, Wood E, et al. Best practice recommendations for prevention and management of skin tears in aged skin: an overview. J Wound Ostomy Continence Nurs. 2018;45:540–2.

~~Van Tiggelen H, Van Damme N, Theys S, et al. The prevalence and associated factors of skin tears in Belgian nursing homes: a cross-sectional observational study. J Tissue Viability 2019;28:100–6.~~

Hawk J, Shannon M. Prevalence of skin tears in elderly patients: a retrospective chart review of incidence reports in 6 long-term care facilities. Ostomy Wound Manage 2018;64(4):30–6.

Woo K, LeBlanc K. Prevalence of skin tears among frail older adults living in Canadian long-term care facilities. Int J Palliat Nurs 2018;24:288–94.

Parker CN, Finlayson KJ, Edwards HE, MacAndrew M. Exploring the prevalence and management of wounds for people with dementia in long-term care. Int Wound J 2020;17:650–9.

CROSS-REFERENCES:

Hospitalwide Policy and Procedure
File #23-01 Resident Care Plan, Resident Care Team, and Resident Care Conference

Nursing Policy and Procedure
~~NPP~~ K 2.0 Wound Assessments and Management
~~LHHPP File 23-01 Resident Care Plan, Resident Care Team, & Resident Care Conference~~

Revised: 2002/0; 2005/02; 2008/04; 2014/05/27; 2023/05/09; 2025/05/05

Reviewed: 2023/05/09

Approved: 2023/05/09

NURSING EDUCATIONAL PROGRAMS

BACKGROUND:

1. Educational needs assessments direct the educational planning efforts including evaluation of nursing care, feedback from Qquality Mmanagement, resident population or care trends, feedback from Nursing Leadership about performance plan and appraisal ~~appraisals~~reports, and plans of correction from regulatory bodies.

2. Department of Education and Training (DET), in collaboration with Human Resources, provides orientation for new nursing employees and collaborates with Human Resources for hospital-wide orientation.

3. Department of Education and Training (DET) provides ongoing education and staff development for all Nursing Department employees to improve nursing practice and to enhance resident care outcomes.

4. Instructors include subject matter experts and clinical educators {Registered Nurses (RN), Licensed Vocational Nurses (LVN), and Clinical Nurse Specialists (CNS)}~~(CNAs, PCAs, RNs and Advanced Practice RNs)~~ who design and implement formal education programs and unit-based training.

5. Department of Education and Training (DET) provides training in-services as required by Title 22.

6. Nursing in-service education is conducted on all shifts under the supervision of a Director of Staff Development. As required by Title 22, Certified Nursing Assistants (CNAs), Patient Care Assistants (PCAs), and Home Health Aides (HHAs) are provided with a minimum of 24 hours of live in-service education each year during work time.

~~7. Department of Education and Training (DET) maintains relationships with local colleges and universities to collaborate on various programs that meet the needs of Laguna Honda Hospital (LHH) staff and the community.~~

PROGRAM ELEMENTS:

A. Orientation

~~See~~ Refer to NPP A 6.0 Orientation of Nursing Personnel for ~~a detailed description of LHH Department of Education and Training orientation program and related policies and procedures.~~policies and procedures.

B. In-service and Continuing Education

1. Refer to HWPP 80-05 Staff Education Program

2.Nursing Education is accomplished in various milieus including ~~continuing~~ classroom setting, scheduled in-services, unit-based education, train-the-trainer, and/or electronic educational modules delivered via the learning management system.~~education courses, Skills Days, and in collaboration with local colleges, universities, and other community organizations.~~

~~1.~~ 3. Crisis Prevention Institute's Responding and Intervening During a Non-Violent Crisis training for Laguna Honda Hospital ~~all LHH~~ staff is provided annually as an electronic educational module.~~, as well as computer training for nursing staff are coordinated by and/or provided by Department of Education and Training staff.~~

2.

3. 4. Department of Education and Training (DET) responds to requests for individualized education from Nurse Manager or Nursing Supervisors. ~~provides individualized training for nursing employees, as needed, for developmental plans formulated by Nurse Managers or Nurse Supervisors to improve the employee's performance.~~

5. A monthly calendar of scheduled educational in-services shall be sent electronically to LHH staff with DPH email accounts and posted on the intranet.

~~2.~~

C. Nursing Affiliations

Refer to NPP A5.0 Nursing Educational Affiliations (Student Placements)

D. Record Keeping

The Department of Education and Training maintains:

1. Current CNA and Board of Registered Nursing (BRN) continuing education provider numbers.

2. Current Director of Staff Development certification as appropriate for each nursing educator.

3. Program approvals from California Department of Public Health (CDPH) for CNA, PCA, and HHA orientation and in-services.

4. Records of all courses provided will include lesson plans, outlines, sign-in sheets, sample evaluations and posttests as documentation that learning has occurred. (Kept for a period of four years).

5. Orientation records (Kept for a period of 10 years). Orientation ~~R~~records are then submitted to Human Resources for record keeping in the employee's file.

6. Annual education calendar of all classes and in-services are provided by Department of Education and Training.

7. In-service records and orientation records (hard copy and digital) will be stored at LHH DET, Room A300, Administration Building, 375 Laguna Honda Blvd, San Francisco, CA 94116.

8. LHH DET Nurse Director, DET Nurse Manager, and/or designee will be responsible for record keeping.

CROSS REFERENCES:

Hospitalwide Policies & Procedures
80-05 Staff Development

Nursing Policies & Procedures

A 6.0 Orientation of Nursing Personnel
A 5.0 Nursing Educational Affiliations (Student Placements)
A 4.0 Nursing Competency Program

Adopted: 2000; 5/2012 as Nursing Policy & Procedure

Revised: 2002/08, 2007/10, 2012/05/22; 2014/07/27; 2021/02/09; 2022/05/10; 2023/05/26; 2023/06/13; 2023/08/08

Approved: 2022/05/10; 2023/08/08

Deleted Nursing Policies and Procedures

Attachment 1: Guidelines to Develop Behavioral Risk Care Plans

General Principles to Consider When Care Planning Individualized Interventions for Residents - At Risk for Aggressive Behaviors:

1. Consider to what degree the resident can think consequentially. An agreement or behavioral contract can only work if the resident has the capacity to understand that there are consequences to his/her behaviors.
2. Consider the resident's ability to comprehend language.
3. Determine patterns of behavior. What time of day is most difficult? Do you see more of the behavior before meals, when visitors are present? Why?
4. Always provide a substitute behavior. Consider resident's preference likes and dislikes when developing interventions.
5. Realize an intervention may work one day and not the next, so it's best to develop more than one.

A. Care Plan for Residents At Risk For Aggressive Behaviors Directed At Others

In preparation for designing interventions for residents with good cognition, consider having a team member who has a good relationship with the resident, ask the resident when the resident is calm:

1. "What are the things that cause you to become upset?"
2. "What do you experience which can be described as a warning sign?"
3. "What can staff do to help yourself remain calm?"
4. How can staff assist you?

Discussing options with the resident before a potential crisis may help them to identify ways that others may be of assistance. The resident may be able to identify their own triggers, or the staff may be able to help the resident identify triggers. Staff may gain insight as to what is most likely to be helpful. It is always a therapeutic advantage if the resident and the team can agree upon actions that be taken when the resident is showing signs of losing control in advance of a crisis. This type of interaction helps the resident recognize that the team does not see him/her as a problem, but rather as a complete person.

B. Care Plan for Aggressive Behaviors

1. To prevent aggression, consider care planning the following interventions:

    a. For residents who can communicate their feelings/ follow directions:
        i. Encourage the resident to identify his/her triggers for aggression and instruct them to do relaxation exercises "When you feel frustrated angry or tense, take three deep slow breaths and or count to 10."
        ii. Encourage the resident to journal /write down his/her feelings/grievances.
        iii. Assist the resident to call a friend or visit with another resident.
        iv. Refer to anger management class.
        v. If the resident can think consequentially and understands the effect of his behavior (and this is documented), hold the resident to a predetermined agreement which has been discussed.

    b. For all residents
        i. Decrease environmental stimuli, decrease the noise level, turn off the radio or TV, provide a soothing environment.
        ii. Distract the resident with an activity of their choice.

iii. If the aggression is a result of fear, Provide reassurance.
iv. Offer support and not censorship "You seem upset, come walk with me". You seem angry with Mike, sit here and tell me about it".

i. Normalize feelings of anger directed at intrusive residents but help them to separate feelings from actions. State "Your feelings are understandable". "I think it is normal to be upset with her." "It is hard to live here." Let the resident know his/her feelings are okay and they need to control his/her behavior.
ii. Instruct and model appropriate responses to residents who are intrusive. "Call any of the staff if she takes your things."
iii. Reassure the resident that the intrusive behavior is not intentional. "Her climbing into your bed is very annoying, but she can't help it. She is confused and does not know what she is doing."
iv. Recognize and praise behaviors that are acceptable.
v. You may call the Sheriff Office when a uniform will help set limits. Tell the officers in advance about the situation and let them know what it is you would like them to do.

2. Interventions for Resident Who Is A Target Of Aggression:

a. Keep/move the resident to an area where he/she can be observed more easily.
b. Encourage the resident to stay in his own space. Make the space attractive and interesting by providing pictures of the family, puzzles, rummage boxes, favorite items, etc.
c. If the resident can think consequentially, consider a behavioral agreement to prevent him/her from intruding on others.
d. Redirect resident with activities based upon the individual's cognitive abilities - such as folding laundry, matching socks, collating paper, or etc.
e. Provide videos of old and familiar movies.
f. Determine if the behavior, which places resident at risk, occurs as a response of being tired and plan for rests and naps. If the behavior occurs at night, keep the resident awake during day and encourage a consistent bedtime.
g. Determine if resident is hungry and there are no dietary considerations you may provide for snacks.
h. Ensure that resident is hydrated and not constipated which may lead to increased wandering.
i. Use music, nature sounds, for relaxation.
j. If determined to be appropriate by the RCT, refer to Laguna Premier Club (LPC)

C. Care Plan for Resident at Risk for Elopement

1. In preparation for care planning:

a. Try to determine the purpose the behavior serves. Ask the resident in a concerned matter of fact way for example:
"Why do you want to leave?" or "What is it that makes up upset?"
"What do you want?" or "What is it you want to do?" Where do you want to go?"

b. Consider the degree of impairment Reality orientation is not helpful with residents living with dementia.

2. Interventions for eloping residents:

a. If the resident asks for money or bags, determine through conversation and observation the resident's agenda. "Why do you want money?"; "What do you want to buy?"; "Are you thinking of leaving?" If the request is an attempt to feel more secure while on the unit, consider the following interventions:

   i. Provide a small amount of change, fake money, a wallet, a purse or an athletic bag that the resident can carry around.
   ii. Take the resident to the bank.
   iii. Reassure her that all her meals and medications have been paid for in advance; If the resident's agenda is to get money or gather her possessions to leave, consider "Let's wash your clothes now"; "The bank is closed now, let's wait till the morning".

b. Use an affirmation, then a redirection like "That's a great idea, but It is much too cold today to go out" or That would be wonderful, but the buses are not running now."
c. Provide special attention, sitting together, one-to-one activity.
d. If the resident appears angry or frightened, consider having a friendly team member interact or consider someone less familiar and more neutral to interact.
e. If the resident has an agenda "My mother wants me home, she will be worried", reassure the resident "I will call her and tell her you are here with me."
f. Assess for over tiredness. Provide for rest periods and naps during the day.
g. Assess for tobacco craving. Provide nicotine patch, gum, sugarless candy.
h. Assess for discomfort/pain. Provide analgesia for arthritis, etc.
i. Assess for hunger. Provide a snack.
j. Ask physician for a psych/ STARS consult.
k. Assess residents who are exit seeking, engage resident in activity.
l. Relocate bed away from door or where more direct observation is possible.
m. Use Resident Locator System (RLS) and seat alarms.
n. Distract with planned group activities, 1-to-1 conversations, folding linens, helping staff carry items.
o. Help resident to develop a relationship with other residents, volunteers to decrease loneliness, to increase socialization on the unit.
p. Establish a time/routine for resident to make or receive phone calls from family and friends.
q. Display photos, letters, afghans and other personnel objects near resident's bed.
r. If resident attempts to leave, remind resident that his family knows he is here, and they would be disappointed and worried if he went somewhere else

D. Steps in De-Escalation

1. Consider the following interventions and care plan for an immediate threat:

a. Stay calm.
b. Remove any person(s) who may be in danger. Attempt to isolate the resident.
c. One staff member gets the resident's attention by calling his/her name and in a loud firm voice says "STOP JOHN".
d. One staff member using clear short sentences tells the resident what he needs to do. "John, sit down in that chair now"; "John, put that glass down on the table now"; "John, take a deep breath".
e. Do not tell the resident to feel differently. Do not tell him/her to calm down. Provide direct orders in a command such as, "Walk away from Mike now".
f. Give the resident space, do not crowd him/her, and do not overwhelm him/her. Only one staff member should speak at a time.

CROSS-REFERENCES:

- LHHPP 24-01 Missing Resident Procedures
- LHHPP 75-06 Dr. Grey Code

Adopted: 2006/09
Revised: 2007/12; 2013/01/29; 2015/07/19; 2015/09/08; 2021/04/13
Reviewed: 2021/04/13
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Oxygen Device	Fi02 Delivered (approx. values)	Comments
Nasal prongs / cannula	1 lpm=24% 4 lpm=33% 2 lpm=27% 5 lpm=35% 3 lpm=30% 6 lpm=38%	-02 flow should be < 6 1pm -Humidity not required for flows <4 lpm -02 concentration will vary with patient breathing pattern
Nasal moustache / oxymizer	Nasal Prongs O mizer 3lpm 1.51pm 4lpm 2 lpm 6lpm 3 lpm	-Never humidity -02 conservation device, allows patient to cut 02 use in ½ -Not recommended for long term high flow use (>10 1pm)
Simple mask	Delivers 35-50% 02 @ flows of 6-10 1pm	-No humidity -Short term use only -Never use @ , 6 1pm
Non-rebreathing mask	Delivers 80-100% 02@ flows of 12-15 lpm	-Never humidity -Never remove one-way valves -Reservoir bag must not collapse during inspiration, adjust flow accordingly
Aerosol mask	Delivers 28-100% 02 depending on dial setting	-Never use flows < 8 1pm -Use sterile water not normal saline in nebulization chamber -Double bottle or high flow set up must be used with 02 concentration > 50%
Tracheostomy mask / hood	Delivers 28-100% 02 depending on dial setting	-Never use flows < 8 1pm -Use only sterile water -Double bottle for 02 >50% must always be on patient because normal anatomical humidification system is bypassed
Venturi mask	Delivers 24-50% 02 depending on which connector is used. Green: 24,26,28 & 30% White: 35, 40 & 50%	-Never use bubbler humidifier -Never cover connectors -Most accurate way to deliver 02 -Ideal fro CO2 retainers or hypoxic drive patients

Taken from U of O HJ Nursing Policy and Procedure for Oxygen Therapy Devices