List of Policies and Procedures for JCC Review 8-11-25					
Blue (Hospital-wide); Grey (Departmental)					
Status	**Dept.**	**Policy #**	**Title**	**Owner/ Reviser**	**Notes**
Revised	LHHPP	01-08	Media Relations	**J. Carton-Wade**	1. Changed "Assistant Hospital Administrator" to "Assistant Nursing Home Administrator" 2. Replaced "Assistant Hospital Administrator" with "Public Information Officer" or "LHH PIO" throughout the document. 3. Changed "554-2507" with "699-9815" 4. Updated Appendix C
Revised	LHHPP	24-13	Falls	**K. MacKerrow**	1. Policy name change from "Falls" to "FALLS PREVENTION & FALL RESPONSE " 2. Added "the total falls as well as " 3. Added "RN and can be updated by a RN or LVN" 4. Added "b. Device examples that can be consideration for the fall individualized care plans:" 5. Added "Floor Mat – place on floor on the side(s) of the bed" 6. Deleted "furniture (i.e., bed, chair) that the resident may exit from/patient Guidelines" 7. Added "Mechanical Lift – ensure the appropriate sling is provided for the resident and a minimum of 2-person assist is provided during transfers." 8. Added "Specialized Air Mattresses – ensure that a minimum of 2-person assist is provided during positioning" 9. Added "Seat belts, mobility bars, specialized chairs (e.g., gerichair, Broda chair), specialized beds (e.g. wide bed, low bed) – evaluate by team, and refer to rehabilitation therapy, restraint committee, restraint policy as needed." 10. Added "A yellow falling star sticker will be placed on the resident's/patient's name plate at bedside, hallway and mobility devices." 11. Deleted "the entrance of the room as well as the head of the bed." 12. Added "and staff" 13. Deleted "Notify the Fall Responder (Appendix F: Fall Responder)." 14. Deleted "Flowsheet in the EHR" 15. Moved "Nursing documentation of the fall incident and resident monitoring and evaluation will also be documented in a Nursing Progress Note every shift for 72 hours, and as often as clinically indicated depending on the nature of the change in condition of the resident." 16. Added "review the care plan interventions in the" 17. Deleted "include the outcome of the fall in subsequent" 18. Deleted "in the EHR until injuries or consequences are resolved." 19. Added "Purposeful Rounding to define 5Ps" to Appendix A 20. Removed Occupational and Physical Therapists examples from Appendix B 21. Deleted Appendix C 22. SW is pending LHH KPO Approval Process.
Revised	Rehab	20-01	Responsibility and Accountability of Rehabilitation Services	**D. Swiger**	Revised the title for executive leader to current DPH title: Associate Chief Operating Officer Integrated Rehabilitation Services and Health at Home.
Revised	Rehab	30-01	Scope of Services to be provided	**D. Swiger**	Updated to current DPH executive leadership title for Associate Chief Operating Officer Integrated Rehabilitation Services and Health at Home. Added American Heart Association Basic Life Safety. Reworded to "has the following responsibilities" for the title of Associate Chief Operating Officer Integrated Rehabilitation Services and Health at Home. Remove Appendix B – Org chart (as this is located on the intranet for 10-03)
Revised	Rehab	70-02	OT Staff	**C. Beier**	Added that the BLS/CPR certification is in accordance with the American Heart Association
Revised	Rehab	80-02	Physical Therapy Staff	**D. Swiger**	Revised – updated #4 of procedure, "Basic Life Safety CPR certification in accordance with American Heart Association (AHA)"
Revised	Rehab	90-02	Speech Language Pathology Staff	**D. Swiger**	Reviewed, minor grammatical and formatting updates, added "Basic Life Safety CPR certification in accordance with American Heart Association (AHA)"
Deletion	Rehab	30-05	Behavioral Health Services	**Y. Qian**	Covered with LHHPP 24-28
Deletion	Rehab	30-06	Social Work Services	**J. Gillen**	Social work have their own policy
Deletion	Rehab	30-07	Activity Therapy Services	**J. Carton-Wade**	Activity Therapy has their own policies
Revised	NSPP	A 2.0	Nursing Services: Organization, Authority/Responsibility and Operations	**C. Figlietti**	• Changed "CNO" to "DON's (1) South Tower and (2) North Tower" • Removing Appendix on Nursing Organizational Chart -> Referring to HWPP #01-01 Appendix A: Hospital Organizational Chart • Updated Nursing Services Administration personnel list to current job titles • Removed "Temporary Agency Nurses are required to show their license to the Nursing Supervisor/NAOD or designee on her/his initial shift…" – they are not told to do this. Agencies provide this information • Removed Respiratory Care Practitioners in section re: demonstration of competence. Nursing does not dictate what RT's do • Removed sections that are addressed by HR (e.g., prospective hires showing proof of current CPR, documentation of physical disability) • Referred to HWPP 80-05 Staff Education Programs • Removing Attachment and updating reference list
Revised	NSPP	E 2.0	Assisting Residents During Mealtime	**C. Figlietti**	Added "Close the door to the meal cart in between passing out meal trays to residents. "
Revised	NSPP	I 3.0	Tracheostomy Care	**C. Figlietti**	• Added "patients" throughout policy to reflect Acute Unit • Updated "tracheostomy tie" to "tracheostomy tube holder" • Updated "shower bibs" to "tracheostomy protectors"

Revised	NSPP	I 6.0	Non-Invasive Ventilation Support (CPAP/BiPAP)	**C. Figlietti**	• Updated policy #2 to refer to HWPP #20-01 Admission to LHH Acute and SNF Services and Relocation Between LHH SNF Units about screening for appropriateness of residents • Updated what physician's order needs to specify for CPAP/BiPAP • Updated references
Revised	NSPP	J 9.0	Insulin Subcutaneous Infusion Therapy for Patient Managed Insulin Pump	**C. Figlietti**	Added "LHH provider" for authorization of starting or continuing the use of pump

Revised Hospital-wide Policies and Procedures

MEDIA RELATIONS

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to protect every resident's (resident) right to privacy. Protected health information may be released only for approved purposes, with proper authorization from the resident, conservator or guardian when required, and in accordance with state and federal laws as discussed in LHH's policies and procedures.

2. LHH staff are directed to refer media inquiries to the ~~Assistant Hospital Administrator~~Assistant Nursing Home Administrator (ANHA). In the event that the A~~ssistant Hospital Administrator~~ NHA is not available, LHH staff are directed to refer media inquiries to the Department of Public Health (DPH) Public Information Officer (PIO).

3. The LHH ~~Assistant Hospital Administrator~~PIO or designee has the primary responsibility for managing the media, including all inquiries, news releases initiated by or involving persons associated with LHH, public comments on behalf of the hospital, and internet or social media presence operated by LHH. The ~~Assistant Hospital Administrator~~LHH PIO or designee is responsible for determining the communication value of a story and may consult with DPH and LHH executive colleagues, as well as the form, method, time and sources of the dissemination of relevant information.

4. The ~~Assistant Hospital Administrator~~ LHH PIO shall inform the LHH Chief Executive Officer, Administrator on Duty, and the Hospital Executive Committee of any high-profile media issues.

5. LHH may deny media access to any area of the campus including, but not limited to, the resident neighborhoods and households, patient/resident care areas, acute care units, and rehabilitation center. If media is granted access to LHH, the ~~Assistant Hospital Administrator~~PIO or designee shall accompany the media at all times.

PURPOSE:

The purpose of this policy is to provide guidelines for:

1. Protecting residents' rights to privacy regarding media inquiries

2. General media inquiries

3. Information that may be publicly released

4. Authorization and consent to interview, photograph or film

5. Equipment maintenance and inventory review

PROCEDURE:

1. Residents' Rights.

   a. Information is to be released only with specific authorization from a resident, legally authorized surrogate decision-maker, guardian or conservator.

   b. Residents have the right to request cessation of interviewing, photographing, filming and or other applicable recordings.

   c. Residents have the right to rescind consent for use up until a reasonable time before all applicable recordings mentioned above are used.

2. Media Inquiries and Release of Information

   a. Staff with knowledge of media interest shall work through Administration so the release of information can be coordinated and handled according to applicable policies and procedures. When appropriate, the Assistant Hospital Administrator shall work with the DPH Public Information Officer in the management of media relations.

   b. All media inquiries are coordinated by the ~~Assistant Hospital Administrator~~LHH PIO, (415) ~~759-3576~~699-9815 or designee.

   c. In the absence of the ~~Assistant Hospital Administrator~~ PIO, ANHA, or an on-campus designee, media calls shall be referred to the Public Information Officer at DPH (415) ~~415-~~699-9815~~554-2507~~.

   d. Off-hours (Mon. - Fri., 5:30 pm through 8:30 am), weekends, and on holidays: All media calls through the switchboard or Nursing Office are directed to the Administrator on Duty (AOD). The AOD may provide basic information and should consult with the information officer on call. An information officer from the hospital or the Department of Public Health shall be on call 24 hours / day, seven days / week**.**

3. Authorization and Consent to Interview, Photograph or Film for Media Purposes

   a. Residents who have no decision-making authority and no surrogates may not be photographed or interviewed by the media.

   b. Permission to interview, photograph or film may be given if the resident has signed a written consent. The signed consent shall be uploaded to the resident's medical record in the electronic health record.

   c. If media representatives request to interview, photograph or film a resident, request information about a resident, or request access to family members, the request shall be directed to Administration for approval prior to access. The Assistant Hospital

Administrator or designee shall request consent from the resident, legally authorized surrogate decision-maker, guardian or conservator with assistance of the charge nurse and physician assigned to the neighborhood where the resident lives. Management of these types of requests is done during regular Administration business hours, 8:30 a.m. to 5:30 p.m. Monday through Friday. High profile residents or situations may require Administration staff, AOD, or nursing staff on all shifts to communicate status and updates to the next shift.

4. Equipment Maintenance and Inventory Review

   a. The ~~Assistant Hospital Administrator~~LHH PIO or designee shall conduct quarterly maintenance checks on all media related equipment purchased and used by Administration to interview, photograph or videotape. Any media related equipment deemed to be inoperable shall be recycled and new equipment shall be requested.

   b. Any media related equipment purchased through Administration shall receive an identification tag and or label with original purchase date. An inventory list shall be updated annually and or when new equipment is purchased and given a new identification tag and or label.

   c. All media related equipment purchased through Administration shall be stored in a locked cabinet in the Administration suite. Department staff or managers wishing to borrow equipment may make request through the ~~Assistant Hospital Administrator~~LHH PIO or designee. A sign in and sign out list shall be maintained.

5. Department of Public Health (DPH)

   a. All inquiries regarding DPH administration, programs, or policies shall be referred to the DPH Public Information Officer at (415) 415-699-9815~~554-2507~~.

ATTACHMENT:
Appendix A: Information Officer Contact Info
Appendix B: Photo Release Form
Appendix C: January 2011 Memo Re: Media Policy from Barbara A. Garcia, MPA, and Director of Health

REFERENCE:
LHHPP 01-06 Administrator on Duty
LHHPP 20-01 Admission to ~~Laguna Honda~~LHH Acute and SNF and Relocation ~~b~~Between ~~Laguna Honda~~ SNF Units
LHHPP 21-01 Medical Records Information: Confidentiality and Release
LHHPP 22-03 Resident Rights
LHHPP 50-09 Capital Asset Administrative Policy
LHHPP DPH 16.06 Patients, Visitors, and Staff Photo/Audio/Video Recording

Revised: 07/12/04, 09/10/27, 11/03/24, 14/11/25, 15/11/09, 16/09/13, 19/07/09, 22/06/30 (Year/Month/Day)
Adoption date: 88/01/22

Appendix A

Information Officer Contact Information

Title	Name	Office Number	Cell Phone No.	Email
LHH Chief Executive Officer	~~Roland Pickens~~Diltar Sidhu	~~759-4510~~628-754-4510	Refer to AOD Schedule	Diltar.Sidhu@sfdph.org ~~Roland.pickens@sfdph.org~~
LHH Public Relations Officer	Zoe Harris	N/A	415-699-9815	Zoe.Harris@sfdph.org
LHH ~~Assistant Hospital Administrator~~Assistant Nursing Home Administrator	~~Diltar Sidhu~~ Jennifer Carton-Wade	~~759-3015~~ ~~682-5622~~628-754-5622	N/A	~~Diltar.Sidhu@sfdph.org~~ Jennifer.Carton-Wade@sfdph.org
LHH Administration Services	Main Number	~~759-2363~~628-754-2363	N/A	LHH.Administration@sfdph.org
DPH Public Information Officer	~~Zoe Harris~~~~Rachael Kagan~~Deirdre Hussey	~~N/A~~554-~~2507~~274-0426	N/A~~415-699-9815~~~~N/A~~	deirdre.hussey@sfdph.org~~Zoe.Harris@sfdph.org~~ ~~Rachael.Kagan@sfdph.org~~
LHH Administrator on Duty	Schedule rotates - refer to the Intranet or call the Nursing Office	682-1502	N/A	N/A

Appendix B

Photo Release Form

City and County of San Francisco
London N. Breed
Mayor

San Francisco Department of Public Health
Grant Colfax, M.D.
Director of Health

CONSENT TO INTERVIEW OR PHOTOGRAPH

DATE _____

I hereby agree that I may be interviewed and/or photographed/filmed and that the interview and/or photos/films are obtained with my full knowledge for the purposes stated below.

I further agree that the interview and/or photograph/film may be printed or publicized for public distribution.

_____Interview _____Photo/video _____Public Distribution

_____Other

Additional info or statement:

_____
_____
_____
_____

By signing this consent form I release the City and County of San Francisco-Department of Public Health from any and all liability or claims from the use and re-use of these films, photographs, or audio recordings of me and/or my child/children.

_____
Signature of resident or surrogate decision maker

(415) 554-2600 101 Grove Street San Francisco, CA 94102

Appendix C

~~January 2011~~February 2017 Memo Re: Media Policy from Barbara A. Garcia, MPA, and Director of Health

City and County of San Francisco

Edwin M. Lee, Mayor

San Francisco Department of Public Health
Barbara A. Garcia, MPA
Director of Health

San Francisco Department of Public Health
Policy & Procedure Detail*

Policy & Procedure Title: DPH Media Policy (EXF2)		
Category: External Affairs		
Effective Date: January 1, 2011	**Last Revision Date:** February 3, 2017	
DPH Unit of Origin: Communications Office		
Policy Owner: Rachael Kagan	**Phone:** 415-554-2507	**Email:** rachael.kagan@sfdph.org
Distribution: DPH-wide ☒	**Other:**	

All sections in table required.

1. Purpose of Policy

This policy and procedure is necessary in order to ensure a consistent, unified message to the media regarding the policies and activities of the San Francisco Department of Public Health (SFDPH). It also allows SFDPH to track the issues that are making news and to allow the Communications Office to remain informed about which public health topics are of interest to the media. In many cases, reporters are at the front line of significant public health breaking news stories.

It is the policy of SFDPH to cooperate with the media, by providing accurate and timely information to the public. That goal must be balanced in every instance against the imperative to protect patient privacy and limit disruption to administrative and clinical operations.

It is the policy of SFDPH to maintain the privacy of Protected Health Information (PHI) pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Protected health information may be released only for approved purposes, with proper authorization from the patient when required, and in accordance with state and federal laws. Refer to the Administrative Policy *HIPAA Compliance: Privacy and the Conduct of Research*.

2. Policy

SFDPH's Media Policy requires that all staff receive approval the Communications Office before:

- Making a statement or granting an interview with a reporter or member of the media; and/or
- Permitting professional or independent photography or videography in any workplace location where patients/clients receive services and/or
- If you believe you have information or a story relating to or about SFDPH

The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans.
We shall ~ Assess and research the health of the community ~ Develop and enforce health policy ~ Prevent disease and injury ~
~ Educate the public and train health care providers ~ Provide quality, comprehensive, culturally-proficient health services ~ Ensure equal access to all ~

@

3. Procedures

a. Press/Media Inquires

If contacted by a reporter or news agency, employees should refer the reporter to the Director of Communications or to the Communications Office designee assigned to the appropriate program or facility. Alternatively, the employee can call or e-mail the Communications Office directly for advice. There are four individuals to contact:

- Rachael Kagan: (415) 554-2507, rachael.kagan@sfdph.org
  Overall DPH Communications, Population Health Division and San Francisco Health Network

- Brent Andrew: (415) 206-3170, brent.andrew@sfdph.org
  Zuckerberg San Francisco General Hospital (ZSFG)

- Quoc Nguyen: (415) 759-3576, quoc.nguyen@sfdph.org
  Laguna Honda Hospital

An employee must contact their Communications officer regardless of the situation. It does not matter where the employee is or what is happening. If it is related to the individual's work at SFDPH, the Communications Office is the first point of contact before making a statement or arranging an interview. There is no exception to this policy during an emergency. In fact, it is even more important during an emergency to involve the Communications Office.

b. Authorization and Consent to Photograph, Videotape and Audio Record

After obtaining prior approval from the SFDPH Communications Office for public media, Authorization and Consent to Photograph / Interview/ Videotape forms will be provided by the Communications Office. These forms must be signed by the patient/client involved before continuing.

The original signed consent form must be filed in the patient's medical record. A copy of the signed consent form will be kept by the Communication's Office. If a third party is involved (e.g. a clinic), they will also keep a copy of the consent form.

While written approval should be obtained before permitting media photography or videography in a location where patients/clients may be present, written approval does not need to be obtained from SFDPH staff or contracted staff. As an employee of a public agency, SFDPH staff have given implicit consent to any photography or videography that may take place during regular business hours for public media purposes that have been authorized through the SFDPH Communications Office.

c. Interviewing Patients

Members of the media may request to interview/photograph patients/clients as part of covering a core health issue. This is reasonable and makes the story better understood by the public. Any patient/client interviewed must first agree and sign a SFDPH consent form.

The patient's provider, care-taker or medical director of the particular clinic or program will be consulted to determine if there are any clinical reasons to deny the interview such as whether it would jeopardize the patient's condition or if the patient does not have decision-making capacity.

d. Escorting Media during interview and/or photography, videography

Any member of the media wanting to conduct business at an SFDPH facility or with SFDPH staff as a part of a ride-along or on or off-site engagement must be escorted by a member of the SFDPH Communications Office or designee. This will ensure that the privacy of SFDPH patients, clients, residents, and staff is protected and will minimize interference with a SFDPH's operations.

e. Interacting with media during non-work time

SFDPH employees, while acting as individuals on their non-work time, are permitted to speak to a reporter without checking with anyone and/or obtaining permission through the SFDPH Communications Office. However, the employee is required to make it clear to the reporter that he/she is not speaking in any official capacity as an SFDPH employee. The Communications Office is available to provide any guidance that you may need on this matter.

FALL PREVENTION & FALL RESPONSE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall employ fall prevention strategies designed to identify fall risk factors, minimize fall risk by ameliorating or eliminating risk factors when appropriate, while at the same time maintaining or improving the resident's mobility and quality of life in accordance with their advance care planning wishes.

2. The goal of the LHH Falls Program will be to reduce the total falls as well as fall-related-injuries while honoring our residents' autonomy and wishes to retain as much independence for as long as possible, and in accordance with their advanced health care planning choices.

3. LHH will collect and analyze fall-related metrics to plan and implement performance improvement (PI)/quality improvement (QI) activities aimed at reducing total falls and falls with major injury. These PI/QI improvement activities will occur on a hospital-wide basis via the Falls Committee and on a unit-based level via the Quality Assurance and Performance Improvement (QAPI) structure (e.g., Falls/Restraints QAPI).

PURPOSE:

1. To describe the process for identifying residents at risk for falling, utilizing evidence-based and multidisciplinary individualized fall prevention strategies.

2. Describe the response process post fall.

DEFINITION:

Fall: A fall is any event whereby a resident unintentionally comes to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force, whether resulting in injury or no injury.

Major Injury: Injury that results in bone fractures, joint dislocations, closed head injuries with altered consciousness, and/or subdural hematoma (intracranial hemorrhage).

PROCEDURE:

1. **Fall-Risk Screening:** See Post Fall Standard Work

    a. The Licensed Nurse (LN) completes the 'Schmid Fall Risk Assessment' screening tool in the electronic health record (EHR) at the following intervals: See Standard Work (Appendix A)

i. Admission/Re-Admission,

ii. Transfer to a new unit (the receiving unit will complete the assessment),

iii. With a change in resident condition,

iv. Post fall (after a fall),

v. Quarterly with MDS assessment completion,

vi. Anytime the LN deems it appropriate based on resident condition.

2. **Individualized Care Planning Based on Fall-Risk:** Appendix A (Common Fall Risk Factors and Interventions)

   a. Residents/Patients determined to be at high risk for falls shall have a multidisciplinary individualized Safety/Fall Care Plan initiated by the RN and can be updated by a RN or LVN.

   b. Device examples that can be considered for the fall individualized care plans:

      i. Floor Mat – place on floor on the side(s) of the bed

      ii. Mechanical Lift – ensure the appropriate sling is provided for the resident and a minimum of 2-person assist is provided during transfers.

      iii. Specialized Air Mattresses – ensure that a minimum of 2-person assist is provided during positioning

iv. Seat belts, mobility bars, specialized chairs (e.g., gerichair, Broda chair), specialized beds (e.g. wide bed, low bed) – evaluate by team, and refer to rehabilitation therapy, restraint committee, restraint policy as needed.

3. **Visual Management Aids to Communicate Residents at High-Risk for Falls:** See Post Fall Standard Work

   a. Staff will utilize visual management tools to communicate about residents who are a high-fall risk and re-revaluate and regular intervals based on any change in resident's functional status.

   b. A yellow falling star sticker will be placed on the resident's/patient's name plate at bedside, hallway and mobility devices.

4. **On-going Assessment/Reassessment** of Fall Risk and Fall Prevention Interventions:

a. An ongoing assessment and reassessment of fall prevention interventions shall be documented to ensure their proper implementation and effectiveness and modified or replaced as necessary within the resident's plan of care. This will be completed at the following frequency:

   i. Annually

   ii. Quarterly with MDS/RCC Reviews

   iii. Upon a change in condition

   iv. Post-fall

5. **Immediate Post Fall Response:** See Post Fall Standard Work

   a. When a resident experiences a fall, the initial resident and staff interventions post-fall will include:

      i. Refer to Standard Work for the Resident Care Team (RCT) role in post-fall response, resident assessment, and nursing huddle.

      ii. If a serious injury is suspected, do not attempt to move the resident. Notify the physician whether an injury is suspected or not. The physician will evaluate the resident and determine interventions based on the resident's wishes as expressed in their advanced care plan and/or as determined via discussion with their Surrogate Decision Maker (SDM) or Public Guardian.

6. **Post Fall Notification:**
   See Post Fall Standard Work

   a. The physician will be notified as referenced in the Immediate Post Fall Response in the above section (5, a, ii),

   b. Notify the Supervisor/Nurse Manager,

   c. Notify the Medical Social Worker,

   d. Notify the resident's family or legal representative,

7. **Post Fall RCT Huddle:** See Post Fall Standard Work

   a. The post fall huddle will be a brief review of what occurred and will be led by the Charge RN along with those who were present at the time of the fall (witnessed fall), or those who discovered the resident after the fall (unwitnessed fall).

8. **Documentation:** See Post Fall Standard Work
   a. **Post-Fall Assessment:** The RN will document the initial Post Fall Assessment in the EHR within the 'Post Fall Assessment Flowsheet.'

   b. **Nursing Note:** See Standard Work for content/instructions.
      i. Nursing documentation of the fall incident and resident monitoring and evaluation will also be documented in a Nursing Progress Note every shift for 72 hours, and as often as clinically indicated depending on the nature of the change in condition of the resident.

   c. **Post Fall Monitoring (Reassessment)Flowsheet in EHR:** See Standard Work

   d. **Weekly Summaries:** Nursing will review the care plan interventions in the weekly summaries.

   e. **Resident Care Plan Review, Care Plan Update, and Review:** See Appendix A (Common Fall Risk Factors and Interventions)

9. **Incident Report:**

   a. The Licensed Nurse who witnessed the fall, or staff who discovered the resident had experienced an unwitnessed fall, will complete an Incident Report. Refer to LHHPP 60-04 Unusual Occurrences. This will be completed for each fall occurrence.

10. The Nurse Manager (NM) or designee will consult with Risk Management (RM) to determine when a root cause analysis (RCA) should be completed (e.g., Departmental RCA versus Organizational RCA).

ATTACHMENT:

Appendix A: Common Fall Risk Factors and Interventions
Appendix B: Physical Rehabilitation Guidelines

REFERENCE:
LHHPP 27-02 Referrals for Rehabilitation Services
LHHPP 60-03 Incidents Reportable to the State of California
LHHPP 60-04 Unusual Occurrences
LHHPP 22-07_A01 Restraint Free Environment
LHHPP 22-07 A02 Physical Restraints – Acute Units
LHHPP 22-07_Attachment A.pdf
NPP B 5.0 Resident Identification and Color Codes

Centers for Disease Control and Prevention (CDC). STEADI – Older Adult Fall Prevention. Retrieved on July 23, 2023, from: Institute for Healthcare Improvement (IHI). *How to Guide: Reducing Patient Injuries from Falls.* (December 2012).

Centers for Medicare and Medicaid Services (October 2018). *Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.16 Baltimore, MD*
Joint Commission (JC). Sentinel Alert Event. Retrieved on July 23, 2023, from: Veteran Health Affairs (VHA). National Center for Patient Safety: Falls Notebook.

Agency for Healthcare Research and Quality (AHRQ) (2020). Health Literacy Universal Precautions Toolkit, 2nd Edition. Plan-Do-Study-Act (PDSA) Directions and Examples. Accessed at: https://www.ahrq.gov/health-literacy/improve/precautions/tool2b.html

Daniels, J.F. (2016). Purposeful and timely nursing rounds: A best practice implementation project. *Joanna Briggs Institute Database of Systematic Reviews & Implementation Reports, 14(1), 248-267*

McLeod, J. & Tetzlaff, S. (2015). The value of purposeful rounding. American Nurse. Accessed at: http://www.myamericannurse.com/value-purposeful-rounding/

Revised: 08/01/08, 11/03/14, 17/01/10, 19/07/09, 24/2/23, 24/04/09, 25/02/03 (Year/Month/Day)
Original Adoption: 00/01/27

Appendix A: Common Fall Risk Factors and Common Interventions That May be Used.

1. **Common risk factor and interventions table:**

Risk Factor	Common Issues/Problems	Interventions
Recent Medical History • Review of medical record • Nursing interview • MD interview	• Infection • Dehydration or electrolyte imbalance • Anemia • Hypo/Hyperglycemia • Vestibular dysfunction • Acute hypoxia • Cardiac arrhythmia • Pain	• Monitor for signs and symptoms of infection • Assess for dehydration • Obtain lab values for possible electrolyte imbalances or anemia (monitor for signs and symptoms) • Check blood sugars • Check pulse oximetry • Assure adequate pain control
Polypharmacy • Adverse Effects of Medication • Review of medical record • Nursing interview • MD interview • PharmD review	• Resident is on medication that may contribute to falling (Antipsychotic, antidepressant, antihypertensive, antianxiolytic, antihistamine, sedative/ hypnotic, anticonvulsant) • Resident is on more than four medications • Possible toxic or supratherapeutic drug levels • Recent change in medications • ETOH or substance abuse	• Check orthostatic blood pressure and pulse • Notify physician of oversedation or change of condition • Instruct cognitively intact residents of appropriate ways to minimize drug side effects (e.g., rising slowly, flexing lower extremities before rising from sitting position, etc.) • Consult for focused review of medications to identify alternative pharmacologic agents with less sedation and/or orthostatic hypotension. • Obtain baseline levels of anticonvulsants to establish resident is not in supratherapeutic range
Social/Behavioral History • Review of medical record • Nursing interview • Activity Therapy review	• Unit or bed change • Care giver or staff change (other than shift change) • New admission • Difficulty coping with changes • History or signs of depression • History of increased agitation • History of wandering	• Provide increased company and conversation • Move high risk resident close to nursing station • Charting near resident • Periodically reassess residents, especially following new episodes of illness or change in medication • Increase nurse-to-resident ratio • Change of scene • Try to eliminate the cause of restlessness, agitation, and/or discomfort that may result in resident attempting to get up unattended • Visual barriers to unsafe areas • Calm music or relaxation tapes • Focused review of prior areas of interest, personal coping strategies, etc. Identify specific activities that reduce restlessness or agitation • Psychology/Psychiatry consult

Care Planning: Use the Risk Factors and Common Issues/Problems columns to develop the care plan problem statement. The intervention column will help you with the Care Plan interventions. A common care plan goal is "minimize risk of falls and injury from falls while maximizing mobility and quality life".

[4] Scott V., Donaldson, M., Gallagher, E., Gallagher, E., Donaldson, M. (2003, September, 1-29). "A Review of the Literature on Best Practices in Falls Prevention for Residents of Long-term Care Facilities," *Long Term Care Falls Review*.

[5] Rubenstein, L., Josephson, K., Robbins, A. (1994, September) "Falls in the Nursing Home," *Annals of Internal Medicine*, 121: 6, 442-451.

Appendix A: Common Fall Risk Factors and Interventions (continued)

Risk Factor	Common Issues/Problems	Interventions
Postural Hypotension • Positional BP's • HR rest and activity • Review of medical record	• Drop in systolic BP >20 mm Hg between lying and after standing 1 minute • Complaint of dizziness when first standing	• Raise head of bed to minimize sudden drop in blood pressure on rising • Consider elastic stockings to minimize venous pooling in the legs • Rise slowly or sit on the side of the bed for several minutes before standing up • Assess for dehydration • Focused medication review to identify possible ADR of medications (antipsychotics, antihypertensives, antidepressants, gabapentin)
Mobility Impairments • Review of medical record • Nursing interview • Resident observation	• Lower-extremity weakness • Poor balance or sliding in chair • Balance problem while standing or walking • Unilateral weakness • Contractures • Use of assistive device • Use of prosthesis • Foot problems (especially painful feet) • No shoes or poorly-fitting shoes • Incontinence	• Provide fall prevention education for residents, families, visitors and staff • Restorative walking program • Provide assistance with transfers and ambulation • Focused review of medications potentially contributing to unsteady gait • PT consult for: – Gait training – Strength training – Balance Assessment – Assistive Devices • OT consult for wheelchair positioning assessment • Provide well-fitting shoes • Toileting program
Environmental Factors • Nursing interview • Resident observation	• Loose wheelchair brakes • Loose bed brakes • Poor lighting • Cluttered space • Need for grab bars • Bed too high • Wet floors • Unstable wheelchair	• Keep smooth floors dry and clean • Minimize obstacles • Furniture should be arranged to provide support for patient when walking • Conveniently placed grab bars • Call button within easy reach • Provide low bed • Calm environment • Lock bed wheels • Wheelchair shop consult: – Adjust brakes – Install anti-tip bars – Install weights
Sensory Deficits • Review of medical record • Nursing interview • Resident observation	• Decreased hearing • Hearing aid not working or ill-fitted • Decreased vision • Glasses dirty or ill-fitted • Peripheral neuropathy	• Audiology consult • Optometry consult • Check glasses and/or hearing aids for proper fit and operation • Check for impacted cerumen • Occupational Therapy Low Vision Consult

2. Purposeful Rounding

Identifying individualized “Purposeful Rounding” interventions can help meet resident care needs, safety and decrease falls. Purposeful Rounding considerations are below:

“5 Ps”:

- Pain
- Positioning (e.g., is it time to shift positions)
- Personal items within reach (e.g. call light, assistive devices
- Personal Needs (e.g. toileting, hydration)
- Peaceful Environment (e.g. acceptable noise level, minimize distractions)

Appendix B: Falls – Physical Rehabilitation Guidelines

Goal

To ensure a multifactorial approach is taken to prevent and/or reduce residents' risk of falls, and/or reduce risk or severity of injuries related to falls.

Purpose

To streamline rehabilitation services process and procedure for addressing residents' needs as follows, but not limited to: status post fall, history of falls, prevent falls, and prevent or reduce risk of injury from falls.

Procedure

1. Physical and Occupational Therapists will respond to physician orders received for any falls occurring within 24-48 hours, as follows, but not limited to:

    a. Conduct resident assessments of rehabilitation needs and falls risks (Refer to Policy 27-02)

    b. Evaluate resident mobility and safety in the resident's environment to ensure safe transfers, mobility, and activities of daily living.

    c. Develop, implement, and evaluate an intervention program for residents to reduce their fall-risk and injury risk. Update resident falls care plan accordingly.

    d. Contribute to interdisciplinary care planning and participate in resident care team (RCT)/resident care conference (RCC) meetings for residents on rehabilitation services caseload.

    e. Participate in clinical education of staff and program evaluation at the unit-service level, as indicated.

    f. Consult with multidisciplinary team including the following but not limited to: speech language pathologist to collaborate on cognitive strategies for falls prevention; neuropsychologist for special approaches to behavioral management and falls prevention, biomedical services to trial environmental modification strategies and approaches for falls prevention, etc.

    g. Conduct clinical cross-training with nursing staff for mobility and training.

    h. Examine and enhance tools and products at the unit for fall and injury prevention (rolling seated walkers, w/c brake extenders, non-skid seating, etc.)

i. Rehab representative will perform as follows but not limited:

i. fully engage in all aspects of fall prevention,

ii. care planning

iii. treatment decisions as residents are discussed in, special review falls RCC meetings for residents, who've had a fall related to mobility and/or ADLs,

Revised Rehab

Policies and Procedures

RESPONSIBILITY AND ACCOUNTABILITY OF THE REHABILITATION SERVICES

POLICY:

The responsibility and accountability of the Rehabilitation Services to the medical staff and administration is outlined below.

PROCEDURE:

1. Under the direction of the Medical Director of the Hospital, the overall responsibility for Physical Medicine Services at the Rehabilitation Services lies with the Chief of Rehabilitation Services.

    a. The Chief of Rehabilitation Services provides medical oversight of Rehabilitation Services and supervision of physiatrists or physicians practicing in the field of rehabilitation medicine. The Chief of Rehabilitation Services facilitates integration of the service with other services within the hospital, including but not limited to.

    b. The Department of Public Health (DPH)/San Francisco Health Network (SFHN) Director of Integrated Rehabilitation Services, in consultation with the Chief of Rehabilitation Services and under the direction of the SFHN Associate Chief Operating Officer Integrated Rehabilitation Services, and/or SFHN Chief Operating Officer, provides administrative management of the Rehabilitation Services, including monitoring the budget; chairing monthly department meetings; oversight of the continuing education program; assuring adherence to federal, state and local regulations; and identification and planning for future program needs, including but not limited to.

2. The delivery of medical rehabilitation services is provided by qualified physicians on the Medical Staff who have training and experience in the field of rehabilitation medicine (e.g. physiatrists).

    a. On the Rehabilitation Unit(s), the physiatrist, in consultation with other members of the Rehabilitation Unit's Patient Care Team (PCT)/ Resident Care Team (RCT), determines rehabilitation goals and prescribes a comprehensive interdisciplinary rehabilitation treatment plan for each patient/resident, which includes a detailed diagnosis and a projected length of treatment time.

    b. On the Acute Rehabilitation Unit, physiatrists will provide patients with close medical supervision and ongoing assessment of their changing medical and rehabilitation needs. Face to face visits will be made by physiatrists at least three times/week and documented in the electronic medical record.

    b. On general skilled nursing facility units, the Unit Physician is responsible for the general medical care of the patient/resident and ancillary services, as needed.

When consulted, Rehabilitation Services and physiatrists interact closely with the Unit's PCT/RCT, patient/resident and the patient's/resident's family/caregivers towards achieving realistic rehabilitation goals.

3. Under the direction of the SFHN Associate Chief Operating Officer Integrated Rehabilitation Services, the Senior Physical Therapist, Supervising Speech/Language Pathologist, and Senior Occupational Therapist arrange scheduling of patients, supervise all staff activities, bear responsibility for carrying out prescribed treatment programs, and assure proper documentation in patient's/resident's charts, including but not limited to.

ATTACHMENT: None

REFERENCE:

1. Medical Staff P&P: A05-01 Rehabilitation Services
2. Barclays California Code of Regulations, Title 22 § 70597 (a)

Most Recent Review: 18/08/24, 16/08/05, 20/04/22, 21/07/13, 22/04/29, 23/05/16
Revised: 25/06/20, 18/08/24, 06/09/22, 14/08/21, 17/07/31, 20/07/17, 24/04/24 Original Adoption: 99/08/23

SCOPE OF LAGUNA HONDA HOSPITAL (LHH) REHABILITATION SERVICES TO BE PROVIDED

POLICY:

Rehabilitation Services provides Occupational Therapy (OT), Physical Therapy (PT), and Speech Language Pathology (SLP) to enhance and facilitate the rehabilitation process and patients' and/or residents' quality of life (QOL).

BACKGROUND:

The Rehabilitation Department provides Rehabilitation Services at Laguna Honda Hospital and Rehabilitation Center for the: Inpatient Rehabilitation Facility, Skilled Nursing Facility, and Outpatient Clinics.

PROCEDURE:

Rehabilitation Department consists of skilled health care professionals who provide skilled rehabilitation services to meet patients' and/or residents' needs, that include, but are not limited to:

- Physical Therapy, Speech/Language Pathology, and Occupational Therapy departments are employed to meet the needs of patients and/or residents within the scope of rehabilitation services.
- Rehabilitation services and consultation are available during regular working hours.
- The delivery of evidence based clinical practice, as outlined within their scope of practice and in keeping with state laws and regulations, license board rules and regulations
- The development and implementation of patient/resident treatment regimens based on clinical evaluations
- Patient/resident, family, caregiver education
- Effective communication, orally and/or in writing, and collaboration with other interdisciplinary departments to provide optimal care for all patients/residents

The Rehabilitation Department staff is comprised of different classifications, see detailed job descriptions – Appendix A. All Rehabilitation Department staff titles include the following, but not limited to:

- Chief of Rehabilitation Services
- San Francisco Health Network (SFHN) Associate Chief Operating Officer Integrated Rehabilitation Services and Health at Home
- SFHN Director of Integrated Rehabilitation Services
- Senior Occupational Therapist
- Senior Physical Therapist
- Speech Language Pathologist Supervisor
- Occupational Therapist
- Physical Therapist
- Speech Language Pathologist
- Physical Therapist Assistants
- Therapy Aides
- Office Clerks
  Occupational Therapist Assistants
  Health care worker

The Rehabilitation Department staff must remain in good standing and in compliance with required licensure, certification or education that includes, but is not limited to:

- Active professional licenses, American Heart Association basic life safety (BLS) certification including CPR applicable components, and any related specialized certifications or licenses

- Mandatory core courses educational requirements through department of education and training

- Annual health completion and compliance

Staffing:

- The Rehab Department will ensure that patients' needs are met with appropriate levels of staffing. In the event, the staffing levels are unable to meet patients' caseload, the Rehabilitation Department prioritization guideline will be followed to provide care in all areas (inpatient and outpatient).

- Registry staffing services may be utilized after completion of departmental orientation and training, to ensure all patient care needs are met. The registry will be held responsible for ensuring that registry staff maintain competency, licensure, certification, verification and job duties that are consistent with San Francisco Health Network policies and procedures.

- Minimum Staffing Plan for Disaster and/or Work Stoppage: Disaster and/or work stoppage staffing is dependent upon the needs of the hospital. Staff can be recalled 24 hours/day as indicated.

Authority, Responsibility, Accountability:

The organizational plan is designed for the effective and efficient implementation of rehabilitation services. Delegation of responsibility and authority within the Rehabilitation Department can be seen directly in the organizational chart (See Appendix B).

Appendix A:

Chief of Rehabilitation Services

The Medical Director is a UCSF physician who is certified by the American Board of Medical Specialties in their appropriate specialty with specialty training in rehabilitation. They possess medical staff privileges at ZSFG and a California medical license. The Medical Director's responsibilities include, but are not limited to:

- Providing medical care to patients and patient care programs
- Developing policies governing the use and availability of rehabilitation services with the Director of Rehabilitation
- Coordinating rehabilitation services with referring services
- Reviewing the quality and appropriateness of rehabilitation services and assures the appropriate actions based on findings
- Developing new and expanding programs in conjunction with the San Francisco Health Network (SFHN) Director of Integrated Rehabilitation Services and the Executive Administrator, Integrated Rehabilitation and Health at Home
- Acting as a consultant to other physicians, other departments at ZSFG and across the continuum of care
- Acting as liaison between Rehabilitation Services, hospital personnel and administration
- Coordinating, planning, and implementing programs and establishing annual departmental goals, objectives, programs and services in concert with the the San Francisco Health Network (SFHN) Director of Integrated Rehabilitation Services and the Executive Administrator, Integrated Rehabilitation and Health at Home
- Complying with all regulatory, departmental, hospital, state, and federal regulations

SFHN Associate Chief Operating Officer Integrated Rehabilitation Services and Health at Home must possess a valid, unrestricted clinical license issued by the State of California as a Registered Nurse (RN), Registered Physical Therapist (RPT), Registered Occupational
Therapist (OTR), Licensed Speech Pathologist (LSP), Registered Respiratory Therapist (RRT), or similar/closely related health care license. SFHN Executive Administrator Integrated Rehabilitation Services and Health at Home has the following responsibilities that include but are not limited to:

- Responsible for all day-to-day operations
- Adherence to Materials and Supplies and Contract budgets
- Developing and executing staffing plans
- Assists the SFHN leadership team in ensuring Rehabilitation Services aligns procedures and workflows to meet the rehabilitation services needs of patients across the SFHN.

SFHN Director of Integrated Rehabilitation Services responsibilities include as follows:

The Director of Integrated Rehabilitation Services is a Physical Therapist, Occupational Therapist or Speech Language Pathologist. As an Occupational Therapist they must be licensed by the Occupational Therapy Board of the State of California. As a Physical Therapist they must be licensed by the Physical Therapy Board of the State of California. As a Speech Pathologist they must be licensed as a Speech Pathologist by the Speech Language Pathology and Audiology Board of California and the American Speech and Hearing Association. The Director of Integrated Rehabilitation Servcies responsibilities include but are not limited to:

- Developing and executing operational policies, ensure that the entire department complies with all regulatory, departmental, hospital, state, and federal regulations.
- Supervising department leadership personnel and other staff as needed to ensure that the department's operational needs are met, maintaining an equitable "just culture" environment for both patients and staff
- Manage departmental fiscal stewardship program, including direct oversight of charge capture, salary variance reports, materials and supply procurement and distribution systems.
- Ensure proper care and maintenance of equipment, implementation of infection control measures, and departmental compliance with national and local safety standards.
- Promote development of programs for the continuing education iof personnel related to rehabilitative care.
- Collaborate to coordinate, plan, and implement programs and establish annual departmental goals, objectives, programs, and services with the San Francisco Health Network Rehabilitation Director and Chief of Rehabilitation.
- Promoting development of programs for the continuing education of personnel related to rehabilitative care
- Maintaining administrative records and reports
- Complying with human resources policies and procedures
- Providing oversight of rehabilitation quality of services
- Coordinating, planning, and implementing programs, and establishing annual departmental goals, objectives, programs and services along with SFHN Rehabilitation Director and Chief of Rehabilitation
- Supervising Senior Therapists and other staff
- Complying with all regulatory department, hospital, state, and federal regulations

Senior Occupational Therapist

The Senior Occupational Therapist is licensed by the Occupational Therapy Board of the State of California and possesses a knowledge of current evidence based occupational therapy practice, clinical skills, client training and education.

The Senior Occupational Therapist responsibilities include but are not limited to:

Establishing and implementing policies, standards, and procedures governing the operation of the occupational therapy department

- Supervising and evaluating staff performance including support personnel as allowed by discipline specific state practice acts
- Staff scheduling for inpatient, ambulatory, and skilled nursing services, and outpatient services
- Staffing
- Participation in the hiring process for direct reports
- Participating in the treatment and rehabilitation of patients or clients in a physical disability, psychiatric, or pediatric setting of a hospital or other institution
- Using and applying various modalities including splinting
- Performing tests and measures as part of evaluations of ADL and/or functional mobility
- Participate in quality improvement opportunities using LEAN methodologies
- Maintains accurate records per regulatory guidelines and enforces safety procedures
- Develops departmental learning opportunities for staff including monthly inservices and discipline specific competencies
- Serves as a mentor to staff and supports clinical education

- Conducting patient evaluations including assessment, treatment program planning and implementation
- Providing therapeutic interventions that may involve: activities of daily living and related functional activities, coordination activities, therapeutic exercises, therapeutic agents, activity and task analyses, work evaluation and home assessments, and the application, and/or training in the use of assistive devices
- Fabricating orthotic and prosthetic devices and educating patients in their use
- Providing patient/caregiver training and education , including instruction regarding community re-entry
- Completing documentation required by hospital and department policies and federal and state regulations
- Complying with all regulatory department, hospital, state, and federal regulations
- Directing and participating in student and staff development, performance improvement, coordination of in-services and clinical mentoring for therapists

Performs other duties as required

Senior Physical Therapist

The Senior Physical Therapist is licensed by the Physical Therapy Board of California and possesses knowledge of current evidence based physical therapy practice, clinical skills, client training and education. The Senior Physical Therapist responsibilities include but are not limited to:

- Direct supervision of PTs, PTA's, and supportive staff.
- Regular participation and oversight of performance improvement projects and direct patient care within an acute care hospital and skilled nursing facility, and/or outpatient that serves a diverse patient population with complex rehabilitation needs.
- Participates collaboratively with the executive administration, department leadership team, staff, and patients, assisting, as necessary, in ensuring the entire department's operational needs are met.
- Staffing
- Participation in the hiring process for direct reports
- Patient care
- Supervising and coaching professional and non-professional personnel in the delivery of therapy services at the acute and skilled nursing levels, and/or outpatient services
- Using and applying various modalities and procedures
- Keeping accurate records for compliance, regulatory, and quality improvement projects
- Reviewing, developing, and implementing appropriate safety procedures
- Assisting in developing budgets and supply requests
- Participate in quality improvement opportunities using LEAN methodologies
- Maintains accurate records per regulatory guidelines and enforces safety procedures
- Develops departmental learning opportunities for staff including monthly inservices and discipline specific competencies
- Serves as a mentor to staff and supports clinical education

- Conducting patient evaluations including assessment, treatment program planning and implementation. Provides therapeutic intervention including the use of therapeutic exercise, functional mobility training and physical agents such as heat, ice, hydrotherapy, electricity, and manual techniques
- Training patients in the use of orthotic and prosthetic devices
- Providing patient/caregiver training and education, including instruction regarding community re-entry
- Completing required documentation required following hospital and department policies, federal and state regulations
- Complying with all regulatory department, hospital, state, and federal regulations
- Directing and participating in student and staff development, performance improvement, coordination of in-services and clinical mentoring for therapists

- Other related duties as assigned/required

Speech Language Pathology Supervisor

Speech Language Pathologists are licensed by the Speech Language Pathology and Audiology Board of California and American Speech and Hearing Association and possess a certification of clinical competence in Speech and Language Pathology. The Speech Language Pathologists Supervisor responsibilities include but are not limited to:

- Establishing and implementing policies, standards, and procedures governing the operation of the occupational therapy department
- Supervising and evaluating staff performance including support personnel as allowed by discipline specific state practice acts
- Staff scheduling for inpatient, ambulatory, and skilled nursing services, and outpatient services
- Keeping accurate records for compliance, regulatory, and quality improvement projects
- Reviewing, developing, and implementing appropriate safety procedures
- Assisting in developing budgets and supply requests
- Participate in quality improvement opportunities using LEAN methodologies
- Maintains accurate records per regulatory guidelines and enforces safety procedures
- Develops departmental learning opportunities for staff including monthly in-services and discipline specific competencies
- Serves as a mentor to staff and supports clinical education
- Directing, planning, prioritizing and coordinating daily operations of the Speech Language Pathology service
- Supervising Speech Language Pathologists
- Performing diagnostic evaluations and treatments for patients utilizing oral sensory stimulation and integration, auditory reception, verbal expression, speech intelligibility, oral motor ROM/strength coordination/control, socialization skills, dysphagia and cognitive training, gestural language, augmented communication, reading, and writing
- Providing patient/caregiver training and education, including instruction regarding community re-entry
- Completing required documentation required following hospital and department policies, federal and state regulations
- Complying with all regulatory department, hospital, state, and federal regulations
- Directing and participating in student and staff development, performance improvement, coordination of in-services and clinical mentoring for therapists.

Occupational Therapists

Occupational Therapists are licensed by the Occupational Therapy Board of the State of California. The Staff Occupational Therapists responsibilities include but are not limited to:

- Conducting patient evaluations including assessment, treatment program planning and implementation. Providing therapeutic intervention including ADLS's and related functional activities, coordination activities, therapeutic exercises, therapeutic agents, activity and task analyses, work evaluation and home assessments, and instruction on the application, and/or training in the use of assistive devices.
- Fabricating orthotics and prosthetic devices and educating patients in their use
- Providing patient/caregiver training and education, and community re-entry
- Completing required documentation required following hospital and department policies, federal and state regulations
- Complying with all regulatory department, hospital, state, and federal regulations.

Physical Therapists

Physical Therapists are licensed by the Physical Therapy Board of California. The staff physical therapists' responsibilities include but are not limited to:

- Conducting patient evaluations including assessment, treatment program planning and implementation. Providing therapeutic intervention including the use of therapeutic exercise, functional mobility training and physical agents such as heat, ice, hydrotherapy, electricity, and manual techniques
- Training patients in the use of orthotic and prosthetic devices
- Providing patient/caregiver training and education, including instruction regarding community re-entry
- Completing required documentation required following hospital and department policies, federal and state regulations
- Complying with all regulatory department, hospital, state, and federal regulations

Speech Language Pathologists

Speech Language Pathologists are licensed by the Speech Language Pathology and Audiology Board of California and American Speech and Hearing Association and possess a certification of clinical competence in Speech and Language Pathology. The Speech Language Pathologists responsibilities include but are not limited to:

- Conducting diagnostic evaluations and treatments for patients utilizing oral sensory stimulation and integration, auditory reception, verbal expression, speech intelligibility, oral motor ROM/strength coordination/control, socialization skills, dysphagia and cognitive training, gestural language, augmented communication, reading, and writing
- Providing patient/caregiver training and education, including instruction regarding community re-entry
- Completing required documentation required following hospital and department policies, federal and state regulations
- Complying with all regulatory department, hospital, state, and federal regulations

Physical Therapist Assistants

Physical Therapist Assistants are licensed by the Physical Therapy Board of California. Physical Therapist Assistants responsibilities include but are not limited to:

- Providing physical therapy services to patients under the supervision of a Physical Therapist. With regular consultation with the patient's primary physical therapist, physical therapy assistants facilitate program implementation and modification. Activities include the use of therapeutic exercise, ROM, functional mobility training, massage, manual techniques, durable medical equipment training, physical agents such as heat, ice, hydrotherapy, electric stimulation
- Providing patient/caregiver training and education, including instruction regarding community re-entry
- Completing required documentation required following hospital and department policies, federal and state regulations
- Complying with all regulatory department, hospital, state, and federal regulations

Rehabilitation Aides

Therapy Aides are unlicensed health care workers who receive on the job training. The therapy aides' responsibilities include but are not limited to:

- Conducting patient related activities under direct supervision of the licensed occupational, physical and speech therapists
- Performing non-patient related tasks
- Complying with all regulatory department, hospital, state, and federal regulations

Office Clerks

Office clerks provide clerical functions. Responsibilities include but are not limited to:

- Scheduling patient appointments
- Preparing and maintaining a wide variety of operating, financial, purchasing, and accounting records Receptionist's duties
- Complying with all regulatory department, hospital, state, and federal regulations.

SUPPORT SERVICES

1. Orthotics and Prosthetic Services by contract.
2. Vocational Rehabilitation Services by referral.

OTHER DEPARTMENT SERVICESThe following services are additional departmental services provided at the Rehabilitation Center by licensed health care professions:

1. Physiatry care, provided by a specialist in the field of Physical Medicine and Rehabilitation
2. Medical care, provided by an internist or family practitioner
3. Rehabilitation Nursing care

4. Audiology
5. Social Services
6. Nutrition Services
7. Activity Therapy
8. Pharmacy Services
9. Psychiatric care
10. Psychologic support
11. Neuropsychology testing
12. Substance treatment and recovery services
13. Outpatient Rehabilitation services
14. Basic cardiopulmonary resuscitation is available at all times when in the Rehabilitation Services department. Advanced cardiopulmonary support is provided by the Code Blue Team if needed.

CONSULTATIONS

Rehabilitation Services are referred by physicians and the physician orders may be received from the following medical and surgical subspecialties, but not limited to, as indicated for patients and/or residents' care:

1. Cardiology
2. Neurology
3. Urology
4. Rheumatology
5. Dermatology
6. Neuropsychology
7. Gastrointestinal Medicine
8. Electrodiagnostic Study
9. Psychiatry
10. Hematology/Oncology
11. Endocrinology
12. Ophthalmology
13. Orthopedic Surgery
14. Vascular Surgery
15. Plastic Surgery/Hand Surgery
16. General Surgery
17. Ear, Nose, and Throat
18. Podiatry
19. Dentistry
20. Gynecology
21. Optometry
22. Nephrology
23. Pain

SUPPORT SERVICES

3. Orthotics and Prosthetic Services by contract.
4. Vocational Rehabilitation Services by referral.

(Remove org chart)

ATTACHMENT: None

REFERENCE:

1. HWP&P: 23-01 Interdisciplinary Care Planning
2. Barclays California Code of Regulations, Title 22 § 70597(a)(4), § 72403 Physical Therapy Service Unit–Services, § 72413 Occupational Therapy Service Unit–Services, § 72423 Speech Pathology and/or Audiology–Services

Most Recent Review: 22/04/19, 18/08/24, 17/08/14, 16/08/14, 20/04/22, 20/07/21, 21/07/13
Revised: 25/06/20, 18/08/24, 06/09/22, 10/12/07, 13/08/22, 14/08/21, 04/02/24

Original Adoption:

OCCUPATIONAL THERAPY STAFF

POLICY:

1. Under the direction of the Director of Rehabilitation Services, the Senior Occupational Therapist ensures that the occupational therapy service complies with all regulatory hospital, state, and federal regulations.

2. The Occupational Therapy Department Senior is responsible for the coordination of a therapeutic program in the Rehabilitation Program (Pavilion Building, Mezzanine Floor), and consultative/SNF services on the long-term, short-term care units, and out-patient services.

3. There is sufficient staff to meet the needs of the patients/residents and scope of the services offered. The staff consists of Occupational Therapists, and additionally may consist of therapy aides, health workers, and other supportive personnel.

4. An Occupational Therapist must supervise occupational therapy treatments rendered by therapy aides. When therapy aides are providing treatment, an occupational therapist must provide direct line of sight supervision of treatment rendered.

5. An Occupational Therapist will provide supervision to a health worker II, as described below:

   "Non-patient-related task" means a task related to observation of the patient, transport of the patient, physical support only during functional mobility, ADL care, or transfer training, housekeeping duties, clerical duties, and similar functions.

PROCEDURE:

1. The Occupational Therapy Department is under the direct supervision of the Occupational Therapy Department Senior (or designee), who is under the immediate supervision of the Rehabilitation Manager and/or Rehabilitation Director (or designee).

2. The Occupational Therapy Department Head is responsible for the coordination of therapies on all Units, which includes the Rehabilitation Services (Pavilion Building, Mezzanine Floor), and consultative services and treatment on all longterm, short-term care units, and out-patient services.

3. Sufficient occupational therapy staff are employed to meet the needs of the patients/residents and provide all occupational therapy services. Staff members work under the direct supervision of the Occupational Therapy Department Senior.

4. Occupational therapy students work under the direct supervision of assigned supervising Occupational Therapists. There is an assigned Fieldwork Educator.

5. Occupational therapy aides or therapy aides work directly under occupational therapist supervision.

6. Restorative therapy aides work directly under the Nursing department but may receive practice area guidance from treating therapists.

7. Occupational Therapy Department staff work the hours necessary to accomplish those tasks listed above.

8. The Occupational Therapists employed at LH have evidence of possessing the proper qualifications. Must have current licensure from the California Board of Occupational Therapy. Preferred but not mandated to be registered by the National Board for Certification in Occupational Therapy, Inc.

9. The Occupational Therapists should provide evidence of possessing an active Basic Life Safety CPR certification, and in accordance with the American Heart Association.

ATTACHMENT:
None

REFERENCE:

Barclays California Code of Regulations, Title 22 § 72417

Most recent review: 16/08/05, 17/07/28, 20/04/27, 21/07/22, 23/05/16, 24/04/02
Revised: 00/06/12, 09/11/12, 10/10/21, 16/08/05, 18/08/14, 22/04/21, 25/06/23

Original Adoption: 99/08/23

PHYSICAL THERAPY STAFF

POLICY:

1. Under the direction of the SFHN Executive Rehab Leadership of Integrated Rehabilitation Services, the Senior Physical Therapist ensures that the physical therapy service complies with all regulatory hospital, state, and federal regulations, including but not limited to.

2. There are sufficient staff to meet the needs of the patients/residents and scope of the services offered. The staff consists of physical therapists, and may additionally consist of physical therapy assistants,~~,~~ therapy aides, health worker II, and other supportive personnel, including but not limited to.

3. A physical therapist supervises treatment rendered by assistants and aides.

PROCEDURE:

1. Sufficient physical therapy staff will be employed to meet the needs of the patients/residents and the scope of the services offered.

2. The Physical Therapy Department is under the direct supervision of the Physical Therapy Department Senior (or designee), who is under the immediate supervision of the SFHN Executive Rehab Leadership of Integrated Rehabilitation Services.

3. The physical therapists and physical therapy assistants employed at LHH must be licensed by the State of California.

4. The Physical Therapists and physical therapy assistants should provide evidence of possessing an active Basic Life Safety CPR certification in accordance with American Heart Association (AHA).

5. A physical therapist will provide supervision to health worker II, as described below:

   "Non-patient/resident-related task" means a task related to observation of the patient/resident, transport of the patient/resident, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions.

6. A physical therapist will provide direct supervision and line of sight as per California Board of Physical Therapy regulations, as described below, when physical therapy aides are providing treatment:

   a. A physical therapist may utilize the services of one aide engaged in patient/resident-related tasks to assist the physical therapist in the practice of physical therapy. “Patient/Resident-related task” means a physical therapy service rendered directly to the patient/resident by an aide, excluding nonpatient/resident-related tasks. “Non-patient/resident-related task” means a task related to observation of the patient/resident, transport of the patient/resident, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions, including but not limited to. The aide will at all times be under the orders, direction, and immediate supervision and line of sight of the physical therapist. Nothing in this section will authorize an aide to independently perform physical therapy or any physical therapy procedure. The physical therapist shall assign only those patient/resident related tasks that can be safely and effectively performed by the aide. The physical therapist will provide continuous and immediate supervision and line of sight for the aide. The physical therapist will be in the same facility as, and in proximity to within line of sight, the location where the aide is performing patient/resident-related tasks, and will be readily available at all times to provide advice or instruction to the aide. When patient/resident-related tasks are provided to a patient/resident by an aide, the supervising physical therapist will, at some point during the treatment day, provide direct service to the patient/resident as treatment for the patient's/resident’s condition, or to further evaluate and monitor the patient's/resident’s progress, and will correspondingly document the patient’s/resident’s record.

   b. The administration of massage, external baths, or normal exercise not a part of a physical therapy treatment will not be prohibited by this section.

7. A physical therapist provides supervision for physical therapy assistants, as described below, including but not limited to:

   a. A licensed physical therapist is at all times responsible for all physical therapy services provided by the physical therapist assistant. The supervising physical therapist has continuing responsibility to follow the progress of each patient/resident, provide direct care to the patient/resident, and to assure that the physical therapist assistant does not function autonomously. The supervising physical therapist will be readily available in person or by telecommunication to the physical therapist assistant at all times while the physical therapist assistant is treating patients/residents. The supervising physical therapist provides periodic on-site supervision and observation of the assigned patient/resident care rendered by the physical therapist assistant.

b. Evaluations

- Following an initial evaluation, the supervising physical therapist will indicate when the patient/resident is to be re-evaluated and determine which elements of the treatment plan may be assigned to the physical therapy assistant. This information will be communicated, either verbally or in writing, to the physical therapy assistant.

- The supervising physical therapist will reevaluate the patient/resident as previously determined, or more often if necessary, and modify the treatment, goals, and plan as needed. The reevaluation will include treatment to the patient/resident by the supervising physical therapist. The reevaluation will be documented and signed by the supervising physical therapist in the patient's/resident's record and will reflect the patient's/resident's progress toward the treatment goals and when the next reevaluation will be performed.

8. Documentation

- The physical therapist assistant will document each treatment in the patient/resident record, along with the physical therapist's signature. The physical therapist assistant will document in the patient/resident record and notify the supervising physical therapist of any change in the patient's/resident's condition not consistent with planned progress or treatment goals. The change in condition necessitates a reevaluation by a supervising physical therapist before further treatment by the physical therapist assistant.

- The physical therapist assistant will document weekly notes. The supervising physical therapist will discuss the weekly notes in a care conference with the physical therapist assistant and co-sign the weekly note.

ATTACHMENT: None

REFERENCE:

1. California Code of Regulations, Title 16, Division 13.2, Physical Therapy Regulations
2. Barclays California Code of Regulations, Title 22 § 70559(a-c);§ 70597(c); 70599(d); § 72407 (a-d);
3. § 70597(g)

Most recent review: 16/08/16, 17/07/27, 18/08/14, 20/04/27, 21/07/14, 22/04/20,
Revised: 00/06/14, 07/08/24, 10/10/21, 11/08/30, 16/08/16, 23/05/16, 24/04/24, 25/17/06
Original Adoption: 99/08/23

SPEECH LANGUAGE PATHOLOGY STAFF

POLICY:

A licensed Speech Language Pathologist (SLP) has overall responsibility for the services rendered in the Department. Staffing is sufficient to meet the needs of the patients/residents and the scope of the services provided.

PROCEDURE:

1. The SLP working at Laguna Honda Hospital must show evidence of being fully qualified and licensed by the California State Board of Quality Assurance, as well as certified by the American Speech, Language, and Hearing Association and should provide evidence of possessing an active Basic Life Safety CPR certification in accordance with American Heart Association (AHA).

ATTACHMENT:

None

REFERENCE:

Barclays California Code of Regulations, Title 22 § 70597(b)

Most recent review:	16/08/05, 17/08/01, 20/04/29, 21/07/22, 22/04/21, 23/05/17, 25/06/23
Revised:	04/08/18, 23/05/19, 24/04/24
Original Adoption:	99/08/2

Deletion Rehab

Policies and Procedures

BEHAVIORAL HEALTH SERVICES

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to ensure all residents receive necessary behavioral health care and services to assist them in reaching and maintaining their highest level of physical, mental and psychosocial functioning (HWPP 24-28). Specialty behavioral health services, including neuropsychological services, shall be available for consultation for patients undergoing a comprehensive rehabilitation program.

PROCEDURE:

1. Request for specialty behavioral health services may be submitted via the electronic health record.

2. Based on the service needs, the request will be triaged to appropriate LHH Psychiatry provider(s), including psychiatrist, neuropsychologist, clinical psychologist, behavioral health clinician, and counselor.

3. Services include (MSPP D08-02):

    a. Neuropsychological and Psychological Testing services (MSPP D08-08), which include neuropsychological assessment of patients with cognitive dysfunction after central nervous system injury.

    b. Behavioral Management services (MSPP-D08-10), which include

        i. Assistance in the development of behavior management programs appropriate to patients in need of cognitive, psychosocial, or behavior therapy.

        ii. Coordination of the implementation of such behavior management programs with all Medical, Nursing, Rehabilitation Services, psychiatry and psychology, and other therapy staff responsible for the care of the patient.

        iii. Ongoing reassessment of the patient's status and function, and revision of the behavioral plan, as indicated.

    c. Mental Health Services (MSPP D08-09), which include psychotherapy.

    d. Psychotropic Medication Management services (MSPP D01-05)

    e. Substance Treatment and Recovery Services (MSPP-D08-07)

5. LHH Psychiatry providers may participate in *Rehabilitation Patient Care Case Conferences* and discharge planning as needed.

6. The Chief of Psychiatry/designee shall assist the Chief of Rehabilitation Services in long-term program planning for the optimal therapeutic milieu for identified patients with psychological needs, with input from LHH Psychiatry providers.

ATTACHMENT: None

REFERENCE:

Barclays California Code of Regulations, Title 22 § 70599(d)(4)(g)
HWPP 24-28 Behavioral Health Care and Services
MSPP D08-02 LHH Psychiatry Scope of Service and Organization
MSPP D08-03 Access to LHH Psychiatry Services
MSPP D01-05 Psychotropic Medication Management
MSPP D08-07 Substance Treatment and Recovery Services
MSPP D08-08 Neuropsychological and Psychological Testing Services
MSPP D08-09 Mental Health Services
MSPP D08-10 Behavioral Management Services

Most Recent Review: 14/08/21, 23/06/03
Revised: 06/09/22, 17/08/14, 22/04/20, 03/04/24
Original Adoption: 99/08/23

SOCIAL WORK SERVICES

POLICY:

In the rehabilitation setting, social work services shall provide assessments and interventions relative to psychosocial factors and the social context in which the physically disabled patient/resident lives.

PROCEDURE:

1. The scope of rehabilitation social work services includes, but need not be limited to, the following:

    a. Assessment of the patient/resident 's personal coping history and current psychosocial adaptation to their disability.

    b. Assessment of immediate and extended family members, caregivers and other support persons relative to support networks.

    c. Assessment of housing, living arrangements, and stability and source of income relative to facilitating discharge plans.

2. Intervention strategies designed to increase the effectiveness of coping, strengthen informal support systems, and facilitate continuity of care include, but need not be limited to, the following:

    a. Discharge planning activities

    b. Casework counseling and therapy, including but not limited to Trauma Informed Care screening.

    c. Group work focused on education and therapy

    d. Community service linkage/referrals

3. Social Work Services staff monitor the achievement of goals relative to discharge planning activities designed to meet the basic sustenance, shelter, transportation, and quality-of-life needs of patient/resident and their families.

ATTACHMENT:
None.

REFERENCE:

Social Work Services P&P

Most Recent Review: 22/04/20, 17/08/11, 18/08/23, 20/04/27, 21/07/16
Revised: 06/09/22, 23/05/23, 12/04/24
Original Adoption: 99/08/23

ACTIVITY THERAPY SERVICES

POLICY:

In the rehabilitation setting, recreational and other leisure time activity therapy services provide for development, maintenance, and expression of an appropriate leisure/social lifestyle for individuals with physical or cognitive impairments.

PROCEDURE:

1. Activity Therapy staff monitor the patient/resident's participation in their chosen activities, and the extent to which goals are explored relative to the use of leisure time and the acquisition of socialization skills.

2. Activity therapy services provide, but need not be limited to, the following:

    a. Assessment of the patient/resident's preferred leisure, social, and recreational abilities, as well as identifies deficiencies, interests, barriers, life experiences, needs, and potential.

    b. Activities are designed and offered to improve social, emotional, and cognitive well-being to prepare for future, leisure/social involvement.

    c. Leisure education designed to help the patient/resident acquire the knowledge, skills, and attitudes needed for independent leisure/social involvement, adjustment in the community, decision-making ability, and appropriate use of free time.

ATTACHMENT: None

REFERENCES:

Activity Therapy Services P&P

Most Recent Review: 23/05/16, 17/08/11, 20/04/27, 21/07/16, 22/04/20
Revised: 06/09/22, 14/08/21, 16/08/11, 18/08/23, 21/07/16, 12/04/24
Original Adoption: 99/08/23

Revised Nursing Policies and Procedures

NURSING SERVICES: ORGANIZATION, AUTHORITY/RESPONSIBILITY AND OPERATIONS

POLICY:

The operational units of Nursing Services include skilled nursing, medical acute, and rehabilitation acute care. Laguna Honda Hospital and Rehabilitation Center (LHH) Nursing Services shall be organized, staffed, equipped, and supplied to meet the needs of the residents/patients of LHH.

PURPOSE:

To describe and communicate LHH Nursing Services structure, authority, responsibility, and operations.

~~RELEVANT DATA:~~

1. The ~~Chief Nursing Officer (CNO)~~Directors of Nursing (DON's) {(1) South Tower and (1) North Tower}, or designee:

   a. Holds an active Registered Nurse license and is employed by SFDPH as ~~the~~ a ~~CNO~~ DON on a full-time basis, defined as 40 or more hours per week,

   b. ~~-~~Actively participates in the organization's leadership functions with the Governing Body, Medical Staff, Hospital Management, and Clinical Leaders in the Hospital's decision-making structures and processes;

   c. Ensures the continuous and timely availability of nursing services to residents/patients;

   d. Ensures that Nursing Practice Guidelines and Nursing Policies and Procedures are consistent with current evidence-based practice and nationally recognized professional standards;

   e. Implements the findings of current research from nursing and other literature into policies and procedures that govern the provision of nursing care;

   f. Ensures that Nursing Services staff carry out applicable processes in resident/patient care and organization wide functions;

   g. Assigns responsibility for individuals or groups of nursing staff members to act on improving the performance of Nursing Services through the implementation of an effective, ongoing program to measure, assess, and improve the quality of nursing care delivered to residents/patients;

   h. Participates with leadership from the Governing Body, Medical Staff, Hospital Management, and other Clinical Leaders in planning, promoting, and conducting organization wide performance improvement activities;

   i. Collaborates with other hospital leaders in designing and providing resident/patient care programs, services, policies, and procedures that describe how residents'/patients' nursing care needs are assessed, evaluated, and met;

   j. Develops and implements the organization plan for providing nursing care to those residents/patients requiring nursing care;

   k. Participates with hospital leaders in providing for a sufficient number of appropriately qualified nursing staff to care for residents/patients'; and

l. Manages the Nursing Services' portion of the hospital budget.

m. May serve as a Cc~~c~~harge Nn~~n~~urse only when the facility has average daily occupancy of 60 or fewer residents/patients.

ORGANIZATION

LHH Nursing Services are provided within a decentralized organizational structure~~. (See Appendix A "Nursing Organizational Chart")~~. {Refer to Hospitalwide Policy and Procedure (HWPP) #01-01 Appendix A: Hospital Organizational Chart}

The Nursing Services Administration includes the following personnel:

- Laguna Honda Hospital (LHH) ~~Chief Nursing Officer~~Chief Executive Officer (CEO)/Nursing Home Administrator (NHA)
- Directors of Nursing Services (DON)
- Nursing Directors
- Nursing Operations ~~Supervisors~~Nurse Managers
- ~~Shift Supervisors~~
- Nurse Managers
- Nursing Leadership which supports nursing management and/or resident/patient care functions (e.g., ~~Advanced Practice Nurses,~~ Clinical Nurse Specialists, Minimum Data Set/Resident Assessment Instrument (MDS/RAI) Program Coordinators, MDS Coordinators, Informatics Nurses, EPIC Super-Users, ~~Nurse Recruiter,~~ Nursing Recruitment and Hiring Manager, Nursing Orientation Coordinator, and ~~Nurse~~ Educators)

All areas providing Nursing Care/Service are represented at the Nursing Executive Committee (NEC) that is chaired by the ~~CNO~~ DONs/designee.

AUTHORITY/RESPONSIBILITY

All areas providing Nursing Services are accountable to the ~~Chief Nursing Officer~~Directors of Nursing Services ~~-~~ for Nursing Practice Guidelines, Nursing Policies & Procedures, and Quality Assurance and ~~-~~ ~~Nursing~~ Performance Improvement Programs.

2. Authority for Nursing Services is specified in the job descriptions of the nursing leadership staff.

3. The DONs assume the duties of the NHA in their absence.

~~3.~~4. The ~~CNO~~ DONs ~~is~~are usually present in the hospital during business hours Monday through Friday. When ~~the~~ both DONs ~~CNO is~~are not present, ~~she/he~~they will designate a ~~Nursing Administrator Director~~Director of Nursing to assume overall responsibility for the operation of Nursing Services. The Nursing Operations Supervisor assumes all responsibility on evening and night shifts, weekends, and holidays.

~~4.~~5. ~~The Nursing Directors are usually present in the hospital during business hours Monday through Friday.~~ Each DON is responsible for making ~~-~~ arrangements for administrative coverage

for their divisional/unit operations in the event of their absence.

~~5.~~6. Individuals in nursing administrative/nursing leadership positions are knowledgeable about hospital/nursing services goals and objectives, hospital/nursing organizational structure, hospital/nursing policies and procedures, nursing staff job descriptions, staffing methodologies, scope of services provided by each nursing unit, and mechanisms for monitoring/evaluating the quality and appropriateness of resident/patient care.

OPERATIONS

A. INTEGRATION

1. The ~~Nursing~~ Directors of Nursing Services, Nursing Operations Supervisors, Clinical Nurse Specialists, ~~Advanced Practice Nurses,~~ MDS/RAI Program Coordinators, Chair of the Nurse Managers Council, and Director of Quality Management are members of the Nursing Executive Committee.
2. Nursing Services administrative staff (listed as above) participate with other hospital leaders in the decision-making of structures and processes.
3. Nursing Services are represented and participate ~~o~~in hospital, medical staff, and nursing committees.
4. The NEC may appoint Task Forces and Ad Hoc Committees when needed to accomplish specific projects or goals.

B. MANAGEMENT FUNCTIONS

1. Structure:

The Nursing Services organizational structure, delineating lines of authority and accountability, is displayed graphically in the ~~Nursing~~ LHH Leadership Organizational Chart ~~(See Appendix A)~~. Other documents describing authority, accountability, and communication within the department are located in job descriptions and in policy/procedure statements.

2. Personnel Policies and Procedures:

Nursing Services works within the framework of personnel policies/procedures set forth by the Human Resource Services Department that have been developed and reviewed with input and involvement of the Hospital Executive Committee.

The ~~CNO~~ DONs and members of the NEC are responsible for the identification of qualifications required for each classification of nursing positions. The ~~CNO~~DONs, in collaboration with the ~~Director of Nursing Operations, Nurse Recruiter~~Nursing Recruitment and Hiring Manager, and a representative from Human Resources, has the authority to make decisions with regard to employment, deployment, and assignment of nursing staff.
Employment activities and placement of nursing personnel are coordinated with the Human Resource Services Department through the Nursing Recruitment and Hiring Manager~~Nurse Recruiter~~ or designee.

The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ) system.

3. Nursing Policies & Procedures, Criteria/Indicators:

Nursing Services Policies and Procedures are reviewed and approved by the NEC.

Performance criteria are derived from job descriptions and policies/procedures. Individual nursing performance criteria are evaluated through criteria-based performance appraisals annually. Quality improvement indicators are used to measure, assess, evaluate, and improve the quality of Nursing Services. Quality improvement activities are reported to the Nursing ~~Quality~~Quality Assurance and Performance ~~–~~Improvement ~~Coordinating~~ Committee. (Refer to HWPP 01-01 Approval and Format of Hospital-wide and Departmental Policies and Procedures)~~.~~

4. Nursing Executive Committee (NEC):

a. The Nursing Executive Committee is the decision-making body relating to Nursing Services at LHH. The goals of the NEC are:

i. to set policy for Nursing Services;

ii. to define the mission, philosophy, and goals for nursing at LHH;

iii. to approve Hospital Policies and Procedures that affect nursing services and care delivery;

iv. to promote communication throughout all levels of Nursing Management across the organization;

v. to oversee nursing practice throughout the organization;

vi. to discuss innovations in nursing care delivery and management systems;

vii. to discuss and promote interdepartmental and institutional relation.

b. Members of the Nursing Executive Committee are:

i. ~~Chief Nursing Officer~~Directors of Nursing (Chair)

ii. Nursing Directors

iii. Chair of Nurse Manager Council

iv. Operations Supervisors

v. Clinical Nurse Specialists

vi. ~~Bed Control~~Patient Flow Coordinator

c. The ~~Chief Nursing Officer~~Directors of Nursing and a Nurse Manager co-chair the Nursing Executive Committee. The NEC meets once a month. An agenda is prepared and a permanent record of proceedings is maintained.

5. Licensing and Certification:

Nursing Services participates in the Licensing and Certification Survey with the Department of Health Services (DHS). Nursing administrative staff has knowledge of the Title 22 Regulations and other regulatory standards.

6. Licensure:

a. Nursing Services complies with Title 22 and other regulatory requirements regarding

staff licensure and certification requirements.

b. Nursing Services hires Registered Nurses, Licensed Vocational Nurses~~/Licensed Psychiatric Technicians~~, and Certified Nurse Assistants who are licensed or certified to practice in the State of California. ~~The process for verifying and monitoring current licensure or certification status is written and available for review.~~ Human Resource Services (HRS) Department has the responsibility of verifying and ongoing maintenance and monitoring of all personnel licenses. HRS collaborates with the Nursing Department through the Director of Nursing Operations or designee to ensure that the system of ongoing license monitoring is achieved.

c. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week.

~~d. Temporary Agency Nurses (e.g. Nurse Registries) are required to show their license to the Nursing Supervisor/NAOD or designee on her/his initial shift. The responsibility for verifying licensure and ongoing maintenance rests with the employing agency per the Temporary Services Contract language.~~

7. Competency Assessment Program:

a. The competency of all Registered Nurses, Licensed Vocational Nurses, Certified Nursing Assistants, and other nursing personnel is evaluated at the time of hire, at the end of the probationary period, and annually thereafter. Evaluations for nursing personnel involved in direct patient care activities are criteria-based and related to performance criteria specified in the individual's job description.

b. Employees from temporary help agencies (e.g. Nurse Registries) are evaluated by the unit Nurse Manager or designee, with input from nursing staff, following their initial shift and annually thereafter if the assignment is for an extended period of time.

8. Job Descriptions:

a. The job description for each nursing classification delineates functions, responsibilities, and qualifications of the position. Job descriptions are reviewed and revised when necessary to reflect changing job requirements. They are maintained in the nursing office and by Human Resource Services Department.

b. Job descriptions are available to nursing personnel at the time they are hired and when requested.

c. Appropriate staff will demonstrate competence in cardiopulmonary resuscitation (CPR) basic life support (BLS) issued by the American Heart Association (AHA) in compliance with the California Code of Regulations: Title 22, and according to established standards of the AHA.

i. Competence must be demonstrated by direct care providers such as LHH Registered Nurses (includes staff nurses, nurse managers, nursing directors, clinical nurse specialists, educators, supervisors, and nursing directors), Licensed Vocational Nurses (LVNs), Certified Nursing Assistants (CNAs), and Patient Care Assistants (PCAs)~~, and Respiratory Care Practitioners~~.

~~ii. Cardiopulmonary Resuscitation training is provided at Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) monthly, while taking into consideration the availability of on-campus BLS instructors. American Health Association~~

~~Standards are used to evaluate levels of competency.~~

~~iii. Prospective employees are expected to show proof of current CPR certification from the AHA prior to being considered for employment in any class requiring CPR/BLS as a minimum qualification. Current BLS cards will be submitted as part of the hiring packet/process. Copies of AHA eCards are also acceptable, as long as they are able to be verified using the AHA eCard verification system.~~

~~iv. Staff with no evidence of valid CPR certification and no valid documentation of physical disability are unable to work until proof of current certification is presented to their manager/supervisor.~~

9. Staffing:

a. Nursing Services plans for and implements staffing requirements according to staffing guidelines, policies, legislative requirements, and budgetary considerations.

b. Each nursing area specifically plans for staffing assignments based on staff competencies, resident/~~client~~ patient care needs, the care delivery system, and volume indicators.

c. Skilled nursing areas are budgeted according to Hours Per Patient Day (HPPD).

10. Nursing Process, Plan of Care, and Documentation:

Nursing contributes to the inpatient interdisciplinary plan of care and documents resident/patient assessment, planning, intervention, and evaluation as defined in policies/procedures.

11. Education/Training Programs (Refer to HWPP 80-05 Staff Education Programs):

a. Education/training programs for nursing services staff are ongoing and designed to augment knowledge of pertinent developments in resident/patient care and to maintain current competence.

b. The scope and complexity of the program is based on the educational needs of nursing staff. Educational needs are identified through monitoring and evaluation activities, annual competency evaluation, and needs assessment surveys.

c. Nursing collaborates with the Department of Education and Training in development and coordination of nursing hospital orientation activities and required training.

~~12.~~ **Quality ~~Assessment~~ Assurance and Performance Improvement:** ~~this is NEC Quality and Safety (there is only one NEC and it is the quality and admin meeting so we should put the NEC quality charter language in this section~~

~~13.~~12.

~~Nursing Services has a planned and systematic process for monitoring and evaluating the quality and appropriateness of resident care and for resolving identified problems~~Nurse Executive Committee's (NEC) Quality and Safety Committee provides guidance and oversight to ensure the existence of, and adherence and improvement of nursing standards; promote a culture of continuous improvement: and identify, monitor and address emerging quality issues.~~ Nursing services follows the process outlined in LHHPP 60-01 Quality Assurance Performance Improvement (QAPI).~~

~~14.~~13. **Interdepartmental Relationship:**

Nursing Services work collaboratively with other hospital departments and disciplines to promote quality resident/patient care. Policies and procedures are developed collaboratively with other disciplines for the provision of an interdisciplinary approach to resident/patient care.

ATTACHMENTS:

NONE

REFERENCE:

Hospitalwide Policies and Procedures

File #01-01 Approval and Format of Hospital-wide and Departmental Policies and Procedures
File #80-05 Staff Education Programs

California Code of Regulations: Title 22

https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I6F56A7E1D4B611DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)

Date Adopted: 2007/10

Revised: 2022/07/12, 2022/12/13; 2023/06/13; 2025/05/23

Reviewed: 2023/06/13

Approved: 2023/06/13

ASSISTING RESIDENTS DURING MEALTIME

POLICY:

1. Nursing staff will assist the resident for meals including hand hygiene prior to and after meals and utilize appropriate clothing protectors as needed for a safe, sanitary, and dignified dining experience.

2. The facility will provide table service to all residents who desire it, served at tables of appropriate height when clinically appropriate to do so.

3. Nursing will provide residents with adaptive devices, dentures, eyeglasses, and hearing aids, if needed, during mealtime.

4. Nursing staff will verify that resident's meal tray matches menu ticket order for name, meal preference, content, and consistency.

5. Nursing staff will offer residents options for neighborhood dining preference, ensure meal preferences are offered and provide a nutritionally-based, appetizing meal three times per day plus snacks following nationally recognized food standards.

6. If an individual is not eating a food (or foods) served on the meal tray, the nursing staff will offer resident suitable food replacement. The individual will be encouraged to verbalize a choice of substitution from available selections and as appropriate for the individual's therapeutic diet order. Nursing staff will communicate request to the diet office if a suitable substitution is not available in the galley. {Refer to Food and Nutrition Services (FNS) Policy 1.83 Resident Meal Service}

7. During periods of respiratory infectious outbreaks, nursing will plan for social distancing between residents and other necessary infection prevention practices when meals are served in communal dining areas, and/or provide for in-room dining when situations warrant the need to reduce the high risk for transmission.

PURPOSE:

To provide staff guidance for a safe, sanitary and dignified meal service for residents and to provide appropriate assistance with meal service as needed, including the use of assistive devices to promote independence in eating.

PROCEDURE:

A. Preparation

1. Prepare for meals by making sure the resident's hands and face are washed. Offer clothing protector to all residents each time. Provide opportunities for hand hygiene prior to meal service.

2. Orient the resident, as needed, that it is mealtime and provide appropriate clothing protectors. Assist resident to dining area of choice, if applicable.

3. Adjust bedside table to proper height for in-room dining and ensure proper lighting and safety.

4. Nursing staff will disinfect tabletop using facility-approved disinfectant and allow to air dry, prior to meal service.

5. Nursing staff will provide for safety measures when serving hot liquids including coffee, tea or hot soups. Notify the resident of the location of the hot beverage/liquid on the tray.

6. Staff who are feeding or supervising residents designated at-risk for aspiration are responsible for reviewing and complying with the resident's diet order, standard aspiration precautions, and any individualized precautions assigned to the resident.

7. Close the door to the meal cart in between passing out meal trays to residents.

8. Remove plates from the tray and position the food according to resident's ability to see the contents, use utensils, and swallow (e.g., food in the line of vision, and place utensils on the functional side). If resident prefers to have plates on the tray, indicate in the care plan and/or preferences.

9. Assist the resident to open cartons, remove coverings and to cut up food as necessary. Maintain resident dignity by not automatically cutting residents food up or opening food items without requesting permission from the resident first to do so first.

10. Set up adaptive equipment for residents such as scoop bowls, braces, looped spoon handles etc. Allow and encourage the resident to be as independent as possible during mealtime.

11. Inform visually impaired residents of menu content and placement of food on their plate or tray. Review plate contents using a clock face for orientation, even if the resident is being fed by staff. For example, "Your chicken is located at 12:00, mashed potatoes at 3:00 and broccoli is at 7:00". Informed resident of location of liquids, both hot and cold.

12. When residents are out of bed during mealtime, if possible, arrange a group to allow residents the opportunity for socialization. Grouping will allow the staff to give close attention to several residents while assisting them with their food. By feeding one resident a spoonful, and successively rotating turns among the residents performing hand hygiene between residents, each resident is allowed time to chew the food without hurrying.

B. Positioning

1. Positioning in chair for communal dining:

    a. Resident should sit upright in a comfortable position utilizing good body alignment to minimize aspiration.

    b. Chairs should be stable and have arm rests to prevent sliding or falling. Residents who cannot hold themselves upright should not be placed in a regular chair. Consult with therapy for appropriate assistive chairs.

    c. Staff who are providing feeding assistance will position themselves directly across from the resident in a seated position at eye-level.

2. Positioning in bed for in-room dining:

    a. Elevate the head of the bed to the highest comfortable position for the resident but minimally 45 degrees, to position the resident upright to aid in swallowing and reduce aspiration.

i. If needed, support resident's head with a pillow to keep the head in good alignment, positioned just slightly forward, chin not resting on the chest and head not tilted backward.

ii. Pillows may be used to support the resident's arms as needed.

iii. Use support pillows to maintain good alignment, with particular attention to weaker sides from strokes or other disabilities and for stability.

iv. For residents with aspiration precautions and/or enteral feeding, leave head of the bed elevated 45 degrees or more for at least one hour (1 hour) after meals.

C. Assisting the Resident to Eat

1. Prepare the food from the tray for eating:

   a. Check with resident if food temperature is comfortable as their preference.

   b. Do not mix foods together unless the resident requests such as mixing peas and mashed potatoes for example, or eggs and hot cereal.

   c. Provide opportunities for independence and dignity for self-care while eating, as appropriate such as holding their own bread or cracker, for example.

   d. Do not overfill drinking containers; provide sipping lids as appropriate but do not assume every resident needs a drinking lid.

   e. Open all containers if the resident cannot, even if resident may not eat the contents. If handling bare food, wear gloves.

   f. Cut up food into bite-size pieces if the resident requires or requests. Residents may prefer to not have food cut up by others.

   g. Ordered thickeners are to be used only as directed for those at high risk for aspiration.

2. Offer a sip or two of liquid first to moisten resident's mouth before feeding to stimulate secretions and swallowing.

3. Put a small amount of food in the mouth at one time in the area of the mouth where resident has the best muscle control and taste perception to promote safe swallowing. Allow enough time for chewing. Do not rush the resident.

4. Watch to see that food or fluids are swallowed before offering more.

5. Alternate food and fluids, offering food in the order the resident prefers.

6. Feeding assistants should be aware of residents who may not swallow each bite ("pocketing"). If this is occurring, slow down the process and encourage resident to chew and swallow. Staff should seek assistance from nursing staff to alert speech therapist for individualized guidance.

7. Clean away food or liquid from the face as needed to promote a dignified experience. Clean nasal secretions away immediately using a tissue and preform hand hygiene.

8. If the resident consumes less than 50% of the meal or does not want the provided meal, offer diet-order compliant substitutes.

D. After the Meal

1. Offer opportunities to clean the resident's hands and face, remove clothing protectors, and provide oral hygiene.

2. Keep resident sitting upright for at least 20 minutes after the meal. If resident must lie down, position on their side.

3. Clean any adaptive equipment that the resident used. Keep adaptive equipment at the bedside and labeled with their name.

4. Place water pitcher within resident's reach unless resident is on fluid restriction, or otherwise ordered, and encourage fluid intake between meals.

E. Documentation

Document mealtime events in the resident's electronic health record (i.e., was activity attempted or refused, level of assistance required, amount consumed).

REFERENCES:

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

CAHAN (California Advocates for Nursing Home Reform (2016). Nursing Home Care Standards. Food and Nutrition. http://www.canhr.org/factsheets/nh_fs/html/fs_CareStandards.html

CROSS REFERENCES:

Hospitalwide Policies & Procedures
- 26-02 Management of Dysphagia and Aspiration Risk
- 26-04 Resident Dining Services

Food and Nutrition Services Policies & Procedures
- 1.83 Resident Meal Service

Nursing Policies & Procedures
- E 1.0: Oral Management of Nutritional Needs

Original: 2018/01/09

Reviewed: 2018/01/09; 2021/02/09; 2023/04/11; 2024/10/31; 2025/06/12

Approved: 2025/01/13

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/patient 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/patients 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, unless ordered otherwise, and PRN. Site assessment/observation 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/patients requiring specialized tracheostomy tubes, trained registered nurses (RN) or licensed vocational nurses (LVN) will change the cuffless tracheostomy ~~tube of~~outer cannula for residents/patients 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/patient~~t~~ has a non-standard tracheostomy tube, the resident/patient 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/patient 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/patient with a fresh tracheostomy to an emergency room for acute surgical consultation.

B. Emergency Care Using the Resuscitation Bag:

1. Hyperextend the resident's/patient's neck, UNLESS the resident/patient 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/patient 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/patient by mouth while covering the stoma.

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

4. **Nursing Alert:**

   a. New tracheostomy
      i. Manipulation of ~~neck ties~~tracheostomy tube holder and face plate should be minimized.
      ii. Residents/patients who are likely to remove or manipulate the tracheostomy tube may need assessed by~~have a~~ the physician and Resident Care Team ~~'s order for~~ to determine if mitten(s) or restraints ~~if assessed as~~ are 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 than~~t~~ the tube the resident/patient 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/patient's physician immediately. Consider referral to speech therapy for urgent swallowing evaluation

C. Resident/Patient Considerations:

1. Assess resident/patient: 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/patient and significant others that speaking with a tracheostomy is difficult.

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

4. The resident/patient 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/patient may be provided with ~~shower bib~~tracheostomy protector during bathing to protect his/her airway. ~~Shower bibs~~Tracheostomy protectors are obtained in LHH Central Supply Room.

D. Equipment:

Disposable sterile tracheostomy care kit for suctioning, cleaning, additional sterile gloves.
Tracheostomy tube holder
~~-~~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 Site Care: Changing Inner Cannula of Cuffed or Cuffless Tracheostomy - Done BID and PRN):

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/patient has copious secretions.
d. Stand at the resident's/patient'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.
g.

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.~~a. 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.~~b. 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.~~c. 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~~ ~~D~~iscard. ~~into bedside bag.~~
~~e.~~d. 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.~~e. Replace the ~~Velcro fastening~~ tracheostomy ~~tie~~ tube holder if soiled.
~~g.~~f. 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/patient 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/patient goes into a laryngeal spasm, or the resident/patient 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.~~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.

~~e.~~f. Velcro/fasten the tracheostomy ~~tie~~tube holder.
~~f.~~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/patient 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/patients 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/patients~~s~~ 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/patient 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-

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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; 2025/06/12

Reviewed: ~~-~~2023/10/10

Approved: 2023/10/10

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/patient 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/patients 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, unless ordered otherwise, and PRN. Site assessment/observation 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/patients requiring specialized tracheostomy tubes, trained registered nurses (RN) or licensed vocational nurses (LVN) will change the cuffless tracheostomy outer cannula for residents/patients 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/patient has a non-standard tracheostomy tube, the resident/patient 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/patient 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/patient with a fresh tracheostomy to an emergency room for acute surgical consultation.

B. Emergency Care Using the Resuscitation Bag:

1. Hyperextend the resident's/patient's neck, UNLESS the resident/patient 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/patient 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/patient by mouth while covering the stoma.

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

4. **Nursing Alert:**

   a. New tracheostomy
      i. Manipulation of tracheostomy tube holder and face plate should be minimized.
      ii. Residents/patients who are likely to remove or manipulate the tracheostomy tube may need assessed by the physician and Resident Care Team to determine if mitten(s) or restraints are appropriate.
      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 than the tube the resident/patient 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/patient's physician immediately. Consider referral to speech therapy for urgent swallowing evaluation

C. Resident/Patient Considerations:

1. Assess resident/patient: 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/patient and significant others that speaking with a tracheostomy is difficult.

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

4. The resident/patient 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/patient may be provided with tracheostomy protector during bathing to protect his/her airway. Tracheostomy protectors are obtained in LHH Central Supply Room.

D. Equipment:

Disposable sterile tracheostomy care kit for suctioning, cleaning, additional sterile gloves.
Tracheostomy tube holder
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 Site Care: Changing <u>Inner Cannula</u> of Cuffed or Cuffless Tracheostomy - Done BID and PRN):

1. Preparations:

   a. Perform suctioning of the trachea and pharynx as necessary before changing inner cannula. (Refer to 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/patient has copious secretions.
   d. Stand at the resident's/patient'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. Cleanse the skin around the stoma site. If crusts are present, soften them with sterile 4" x 4" gauze slightly moistened with sterile saline.
b. 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.
c. Cleanse external areas of tracheostomy tube with sterile cotton-tipped applicators moistened in the saline. Rinse areas with sterile saline-dipped applicators and d iscard.
d. Place a dry drain sponge under and around the tracheostomy tube. Reserve the extra tracheostomy dressings as needed for changes in between tracheostomy care.
e. Replace the tracheostomy tube holder if soiled.
f. 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/patient 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/patient goes into a laryngeal spasm, or the resident/patient 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.

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 tube holder.
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/patient 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/patients 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/patients 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/patient 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)

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(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 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; 2025/06/12

Reviewed:2023/10/10

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INSULIN SUBCUTANEOUS INFUSION THERAPY FOR PATIENT MANAGED INSULIN PUMP

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) will allow residents with diabetes who have an insulin infusion pump to self-manage their insulin needs under the supervision of LHH clinical staff.

2. Residents who have an insulin infusion pump and wish to continue to self-manage their diabetes will sign written consent by completing the "Contract for the use of continuous subcutaneous infusion (Insulin Pump) in the hospital" consent form.

3. Residents on a subcutaneous insulin infusion pump are responsible for their own subcutaneous puncture and the supplies needed.

4. Residents with an insulin infusion pump who are not able to demonstrate safe use of pump will be disconnected from the device by clinical staff. Staff will immediately notify provider for standard insulin orders and treatment guidance.

5. Insulin used in insulin pump will be provided by LHH pharmacy per physician order and will be stored in the medication cart, labeled, and maintained per hospital policy.

6. Any resident with insulin pump will have endocrinology service involved in their care and pump settings will be determined by endocrinologist.

7. Licensed nurses (LN) who care for residents with an insulin infusion pump will not manipulate the device and will only be responsible for monitoring and observing the residents' use of device.

8. LN will perform Point of Care Testing (POCT) per orders.

PURPOSE:

1. To provide safe care for residents with an insulin infusion pump that is used for self-management of diabetes.
2. Establish guidelines to staff for monitoring and documenting of resident's use of insulin infusion pump.

CONTRAINDICATIONS:

1. Subcutaneous Insulin Pump therapy should not continue if any of these reasons exist:
    a. Resident Care team deems the resident is not competent to manage their pump/insulin therapy safely.
    b. Resident develops altered cognition or level of consciousness.
    c. Pump is out of insulin and pharmacy cannot supply specific insulin type.
    d. Pump is malfunctioning.
    e. Infusion set is malfunctioning, and the patient has no replacement infusion sets to replace it.
    f. Patient does not want to wear the pump during hospitalization.

DEFINITIONS:

Insulin Infusion Pump – Small, computerized device that delivers doses of short or rapid acting insulin via subcutaneous infusion. Device can deliver insulin at a basal rate and/or as bolus infusions. Pump has a reservoir which stores the insulin to be delivered to resident. Reservoir is filled and replaced every 48-72 hours or per provider instructions.

Infusion Set – Infusion device which combines an infusion set (catheter) with an aid for infusion (inserter). It is used for inserting subcutaneous needle and is for single use only. Once inserted, the catheter is held in place by a transdermal patch. This site is connected to the insulin infusion pump with pump tubing. Infusion set is changed every 48-27 hours per provider instructions.

PROCEDURE:

1. Residents identified with insulin infusion pump, who wish to start or continue its' use, will need authorization from endocrinology and LHH provider who will provide instructions for pump setting orders which resident is to use.
2. Confirm the resident has signed consent and it is scanned to EHR.
3. LHH provider will enter orders in EHR.
4. Confirm with the resident the insulin infusion pump supplies are setup to be delivered to LHH or there is a plan for family/surrogate to bring supplies to LHH.
5. Responsibilities of LN caring for resident:
    a. Check infusion site for redness or dislodgement of infusion catheter each shift. If the appearance of the infusion site indicates inflammation or there is pain/tenderness at infusion site, notify provider as insertion set may need to be replaced.
    b. Review with resident the pump's basal rate and the remaining insulin reservoir amount every shift with site assessment.
    c. Report repeated high blood glucose readings to provider based on provider parameter order.
        i. New onset hyperglycemia despite insulin infusion may indicate the infusion set is not functioning properly and infusion set should be changed.
    d. Treat hypoglycemia per hypoglycemia protocol.
    e. Document observation of resident programming pump for all insulin boluses given by the patient through the insulin infusion pump in the MAR.
    f. Report to the physician if the patient is unable to operate the pump for any reason.
    g. Disconnect pump at catheter infusion site for the following reasons. Do not remove the subcutaneous application patch.
        i. If the pump malfunctions, infusion set dislodges, catheter kinks, or if reservoir becomes empty and the patient is not able to correct these problems by changing the infusion set and/or reservoir. This may be performed by resident.
        ii. If resident becomes unconscious due to suspected hypoglycemia.
        iii. If the resident care team determines that the resident is unable to operate the pump safely for any reason.
        iv. When resident is showering. This may be performed by resident.
        v. Per provider order to discontinue.
    h. Resident will be educated on the following:
        i. He/she should not change the pump profile settings without medical team's direction.
        ii. It is against hospital policy and state regulation to keep insulin vials at the bedside and to use insulin from home.
        iii. Insulin will be supplied by the hospital pharmacy.

iv. If resident cannot provide supplies for the pump, including extra infusion sets, reservoirs, and batteries, the infusion will be discontinued.
v. Resident will change the infusion set every 3 days if system remains uncompromised or if they experience unexplained hyperglycemia or if there are signs of infection at the insertion site.
vi. He/she shall show the LN or physician the pump settings whenever he/she requests.
vii. The pump should be disconnected for mammogram, bone density measurement, radiation treatment, CT scan, MRI, X-rays. The infusion set can stay in place unless it is made of metal.
viii. He/she should not change the pump settings without the medical team's direction.
ix. He/she will not inject insulin boluses without the LN's supervision and will show the LN the bolus amount before delivering via pump.

DOCUMENTATION:

1. LN will add an LDA in the EHR Avatar to reflect the insulin infusion pump titled "Pump Device".
    a. Complete assessment Q Shift
    b. Update LDA documentation with insertion site changes.
    c. When resident fills/refills reservoir with insulin provided by pharmacy, document in the MAR.

2. Document in MAR when resident self-administers bolus and/or correction insulin doses.

3. Care plan for self-administration.

CROSS REFERENCES:

Nursing Policies & Procedures:
G 5.0 Blood Glucose Monitoring

ZSFG & LHH Contract for the Use of Continuous Subcutaneous Insulin Infusion (Insulin Pump) In the Hospital

New: 2022/05/10

Approved: 2022/05/10