List of Policies and Procedures for JCC Review 12-8-25					
Blue (Hospital-wide); Grey (Departmental)					
Status	**Dept.**	**Policy #**	**Title**	**Owner/ Reviser**	**Notes**
Revised	LHHPP	24-17	Comfort Care	**A. Lam**	1. Updated the definitions for “Palliative care”, “Terminally ill” and “Hospice care” 2. Added section for "Inotropic Cardiovascular Intravenous Infusion at Fixed (non-titratable) Drip."
Revised	LHHPP	73-02	Asbestos and Lead Management Plan	**W. Spaul**	1. Added "To address procedures when Environmental Services staff may be exposed to lead or asbestos from settled dust during routine housecleaning." 2. Added "To address procedures to address where potential asbestos and lead exposures may be occurring to office employees in the Administration Building 3. Added "housecleaning" and "ACMAsbestos Containing Materials or lead-containing coatings" 4. Added "unless tested and shown otherwise" 5. Added section on "Procedure for Suspect Background Exposures while Working in the Administration Building" 6. Added "In the absence of a NEA for this type of activity, worker full shift breathing zone samples for lead and/or asbestos may be required to develop a NEA. " 7. Replaced "Workplace Safety & Emergency Management (WSEM)" with "Industrial Hygiene (IH) "throughout document. 8. Added "involving a visual inspection, bulk or surface wipe sampling, or " and "unexpected" 9. Added "and Environmental Services " 10. Deleted "Information about public health organizations that provide smoking cessation programs;" 11. Added parts iii, iv and v to the Environmental Services section 12. Added "Office Employees in the Administration Building Offices" section 13. Added "PACCM means Presumed Asbestos Containing Construction Materials and are building materials that have not been tested but are assumed to contain asbestos based on age and material type. PACCM may be rebutted following bulk testing of the material. " to Appendix A 14. Added "and a disposable protective covering, such as a breathable Tyvek disposable suit over their work clothes" and "N95 respirators are not approved for this work. Industrial hygiene should be contacted for training and fit testing for this type of respirator, and the Facilities Services department shall purchase the N100 respirators." to Appendix B. 15. Added "Procedures for Cleaning Surfaces where Asbestos- or Lead-containing Dusts have Settled" section to Appendix B
Revised	FNS	1.677	Manual Ware Washing	**E. Lavarreda**	1. Deleted-Established and 2. Revised Purpose- To outline to, To prevent food borne illness by ensuring 3. Replaced- by the use of , with using. 4. Added – comma after pads 5. Corrected high pressure to high-pressure 6. Deleted- bed with abrasiveness. 7. Deleted- Department approved detergent 8. Added- Ecolab product solitaire Detergent 9. Added- Concentration as recommended by the detergent manufacturer. Test the chemical sanitizer concentration before use by using an appropriate test kit. 10. Deleted- ammonium (oasis 146 multi–Quat Sanitizer) for at least one minute. Pot room personnel shall test sanitizer sink water each time is refilled, and document results on Ware washing Chemical Log. Employees must document every time sanitizer water is changed and tested, as this is a patient safety issue.
Revised	FNS	1.70	Scoops for Food and Ice	**E. Lavarreda**	1. Deleted- Established and 2/83,12/87, 1/89, 5/97, 9/06,7/092. Deleted- Reviewed :8/13, 814. 3. Added- 8/2024 4. Replaced -The with Food ; near by with nearby.

Revised	FNS	1.71	Replenishing Juice and Coffee	**E. Lavarreda**	1. Revised the title- Replenishing Juice and Coffee dispensers, and maintaining ice and water dispensers in the neighborhood great room to Replenishing Juice and Coffee in the Galley. 2. Deleted -Established and 12/10, 7/12, 8/14, 8/15, 11/17 3. Deleted- Reviewed: 8/13, 8/14, 8/15, 11/17 4. Deleted -dispensers and, when ever they get a cup of water to drink from the water and ice dispenser. 5. Added - coffee 6. Deleted -bulk, and coffee (apple and orange), quart size cranberry juice and package of coffee (regular and decaf) from the storeroom. 7. Replaced -Three Bucket with three-bucket 8. Deleted- (juice, coffee and water/ ice). Juice machine and ice water dispenser. 9. Added- dispenser. 10. Deleted- Quart size cranberry. Of cranberry juice. (72 hours). 11. Replaced date with discard any open. 12. Replaced of opened cranberry juice if there is no date with that have not been labeled and dated. 13. Added- or designee. 14. Replaced- either the coffee or juice manufacturer or facility service with the vendor of the dispensing unit or facility services. 15. Replaced- juice with beverage machine. 16. Deleted- juice 17. Deleted- On a monthly basis, the coffee vendor will complete a check an all coffee dispensers. The service will be noted on each machine.
Revised	FNS	1.72	Processing Mop Heads Daily	**E. Lavarreda**	1. Revised title -Processing of mop heads and cleaning rags on a daily basis to Processing Mop Heads Daily. 2. Deleted- Established and- 3/81,1/89, 5/97,3/00, 9/06, 7/09, 8/14. 3. Deleted- Reviewed:8/13,8/14. 4. Deleted- and rags, on a daily basis. 5. Replaced cost effective to cost-effective. 6. Deleted- and, the , linen department. 7. Replaced- cleaned with clean 8. Deleted- and/or cleaning rags, and/ or “soiled Rags Only”. 9. Replaced – in the chemical storage area to across from the computer station in the production kitchen. 10. Replaced days end with end of day. 11. Deleted- rags and ; and rags. 12. Modified- he as s/he 13. Deleted – or 14. Added- or designee 15. Deleted- 11/6/2005
Revised	FNS	1.73	Temperature Logs for Refrigerators/ Freezers	**E. Lavarreda**	1. Deleted- Established and- 3/87,1/89,1/92,5/97,9/06,7/09 2. Deleted -Reviewed: 8/13,8/14. 3. Added- supervisor. 4. Added – the. 5. Replaced- Log book to logbook. 6. Added -Manual. 7. Deleted- Outside and. 8. Added- Document and , and submit a work order. 9. Deleted- to the 10. Added- or designee 11. Added- if temperatures are out of the recommended range and. 12. Replaced- The assistant food service director before discarding to Food service management. 13. Deleted- Standards: freezers- -10F to !0F, 34 38F for storing meat and dairy products. 34-38 F for storing fresh fruit and vegetables. 14. Added- Temperature Ranges: Refrigerator Temperature: 41º F or lower. Freezer Temperature: 0º F or below (Freezer may have a temperature variance of +10º F during defrost cycle).
Revised	FNS	1.74	Safety inspection for Working environment	**E. Lavarreda**	1. Deleted- Established and: 8/24, 3/87, 1/89, 5/97, 10/03, 9/06, 7/09, 6/11, 11/22 2. Deleted- Reviewed:8/13, 8/14. 3. Added- 8/24 4. Added- Food 5. Replaced- i with e in ”insure” 6. Deleted- or Mr.Clean 7. Replaced or food service with or designee 8. Replaced Cafeteria with café. 9. Added- Food

Revised	FNS	1.75	Glove Usage	**E. Lavarreda**	1. Deleted- Established and 10/87, 3/97, 5/97, 7/03, 9/06, 7/09, 10/11 2. Deleted- Reviewed: 8/13/8/14. 3. Added- 8/24 4. Deleted- To assure proper sanitation and infection control when handling certain food items, equipment and material. 5. Added- To prevent foodborne illness due to hand to food cross contamination. All food will be served in a manner to ensure food safety. 6. Added- "s" to area. 7. Added- All 8. Replaced- Staff with or designee. 9. Replaced- for with of 10. Replaced Latex Examination with FDA approve Food Service grade (single use); Dishroom with Dish room. 11. Added- * Do not use bare hands to handle ready to eat foods • Wash hands and change gloves must never be used in place of hand washing. 12. Replaced – the with tray 13. Deleted- Please treat them as such 14. Added- Cotton gloves must be covered with a single-use food service grade glove. 15. Replaced hot with dishes. 16. Added- (gently rub together). Then rinse under running water in air dry. 17. Deleted -Please treat them as such. 18. Added- Sanitizing black gloves may be done by washing gloves while one would wash hands under hot water using soap (gently rub together). Then rinse under running water and air dry. These are not disposable type and can be reused. 19. Added- Cut resistant gloves – FDA approved glove that can provide cut and abrasion resistance when cutting food with a knife or cleaning/sharpening blades. Employees are responsible for laundering them as with their uniform. These are not disposable type and can be reused. Cut
Revised	FNS	1.76.	Use of Cutting Boards	**E. Lavarreda**	1. Deleted- Established and 2/83, 2/83, 12/87, 1/89, 5/97, 9/06, 7/09. 2. Deleted -Reviewed: 8/13,8/14. 3. Added- 8/24 4. Added- Cutting Board Color chart and their use: • Red= Raw Meats • Yellow =Raw Poultry • Green= fruit, vegetables, salads • Blue=Raw fish • White= Bakery Items, Cheese and Bread • Brown= Cooked Meats 5. Replaced Dishmachine with dish machine 6. Deleted- and. 7. Added-References https://www.fda.gov/food/buy-store-serve-safe-food/safe-food-handling 8. Deleted- 11/6/2015
Revised	FNS	1.77	Fire and Fire Drills	**E. Lavarreda**	1. Deleted – Established and 4/81, 1/89, 1/93, 5/97, 9/06, 7/09, 8/14, 8/15 2. Added- 10/25 3. Deleted- Reviewed: 8/13,8/14, 8/15 4. Deleted- In addition, fire plan is attached on a separate card on all employees-hospital identification card. 5. Added hyphen – inservices to in-services 6. Corrected numbering 7. Corrected- Alarm activation, contain 8. Deleted- Dial 911 and report the emergency, report that this is Laguna Honda Hospital, the exact location and building number. 9. Deleted- shut off all equipment in the general fire area for electrical and gas. 10. Added- extinguisher, hose at the base of the fire, handle. 11. Added- (Ansul system) 12. Replaced-of CO2 with and follow up with K-type fire extinguisher. 13. Deleted- will. 14. Added- chef throughout policy. 15. Added- exit back door onto the back loading dock area-push on glass doors if they don't open automatically. Check in with the supervisor, chef or designee and wait for further instructions. 16. Deleted throughout policy- Exit through double doors, turn left and go down the corridor and turn left after the restrooms and offices and go out through the door to the back of the loading dock area. Check in with supervisor and wait for further instructions. 17. Added- Dish room- exit the back door onto the back loading dock area- push on glass doors if they don't open automatically. Check in with supervisor, chef or designee and wait for further instructions. 18. Changes flag pole to flagpole. 19. Deleted- 11/6/2015
Revised	FNS	1.78	Nourishment Inventory	**E. Lavarreda**	1. Deleted – established and 2/87, 1/89, 5/97, 9/06, 7/09. 2. Deleted- Reviewed: 8/13, 8/14. 3. Added- 10/25 4. Replaced -enteral with internal, Twice with once throughout policy. 5. Replaced- to usage with by usage.

Revised	FNS	1.79	Storage of chemicals, brooms, mops and other cleaning supplies	**E. Lavarreda**	1. Deleted- Established and , New 8/14 2. Deleted -Reviewed :8/14 3. Added -10/25 4. Changed policy- To ensure that the chemical used for sanitizing food service work and other cleaning equipment's are stored properly to To prevent foodborne illness by chemical contamination food and nutrition services (FNS) staff will use and store chemicals safely. 5. Corrected numbering 6. Added- FNS has a designated location for Safety Data Sheets (SDS). 7. Added- All employees working with cleaning chemicals must be aware of where the Safety Data Sheets (SDS) are in facility. Never mix chemicals. 8. Replaced- dishmachine with dish machine; potmachine with Pot Machine through out policy. 9. Replaced- stored away from food at all times to always stored away from food. 10. Deleted- location. 11. Added- on the sanitation cart. 12. Removed handwash sinks, under the bain marie. 13. Added- of chemical(s) 14. Replaced it's with its. 15. Added- Common. 16. Deleted –(ie: a spray bottle) 17. Replaced dishroom with cart washroom. 18. Deleted- Follow the procedure for rags used for cleaning 19. Added hyphen to three bucket. 20. Corrected- rising to rinsing. 21. Added- Use the appropriate chemical test kit to measure the concentration of sanitizer daily. 22. Added- Do not use chemicals containers for storing food or water. 23. Deleted- 11/6/2015
Revised	FNS	1.81	Eye wash stations	**E. Lavarreda**	1. Deleted- Established and New 7/12. 2. Added-10/2025 3. Deleted- Reviewed :8/13,8/14 . 4. Added- Food service department where eye wash stations are located. 5. Deleted- Main Production kitchen for the ye wash stations. Locations: in the cold food preparation Area above hand washing sink; In the ot grill/ deep fryer area above hand washing sink and Dishroom across from the dish machine above hand washing sink. 6. Added- Chemical room P2236, located near the diet office. Tray-line, dish machine area, next to hand washing sink. Café, next to the three-compartment sink. The manufacture recommendations are to keep dusk cover on to allow protection from debris when not in use. Easily detected and maintained, emergency equipment with safety sign and maintenance record with weekly testing. 7. Deleted -Each eye wash station consists of two bottles of saline solution. 8. Added- The Food Service Supervisor, Chef, or designee will ensure that the daily tests are documented and completed, if not notify your supervisor. 9. Deleted- The senior Food Service Supervisor and/ or Production Chef will ensure that the bottles are changed before expiration date. 10. Deleted and/ or; on duty 11. Added- or designee 12. Replaced- Unusual Occurrence form with Incident Report Form. 13. Replaced Hygienist Assistant with Hygienist. 14. Deleted- Replace the used bottle of solution. Replacement bottles are located in chef's office or storeroom B.
Revised	FNS	1.82	Composting Food in the dish room- Salvajor Waste Collector	**E. Lavarreda**	1. Corrected title-Dishroom to dish room, Salvador to Salvajor. 2. Deleted- Established and New 8/12 3. Deleted- Reviewed: 8/13,8/14 4. Corrected throughout policy- stainless steel to stainless-steel. 5. Added spelling scrap to scrape. 6. Replaced- Change with empty. 7. Deleted – Use a 2nd or 3rd basket and rotate them through the unit so there is no down time in the warewashing process. 8. Corrected spelling- salvagor to Salvajor 9. Corrected- other wise to otherwise. 10. Deleted word- juice 11. Deleted word- containers 12. Replaced- coffee mug cover to beverage lid 13. Replaced throughout policy- warewashing to ware washing.
Revised	Nursing	A 4.0	Nursing Clinical Competency Program	**C. Figlietti**	1. Remove HHA 2. Changed "Preceptor" to "Trainer"
Revised	Nursing	A 6.0	Orientation of Nursing Personnel	**C. Figlietti**	1. Remove HHA 2. Changed "Preceptor" to "Trainer"
Revised	Nursing	A 9.0	Sick Leave-Intermittent FMLA Tardy Call-In	**C. Figlietti**	1. Remove HHA
Revised	Nursing	C 1.0	Resident Admission and Readmission for SNF	**C. Figlietti**	1. Remove content under "Decision to Accept the Referral" – Referenced HWPP 20-01 Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units 2. Updated Care Plan section to reflect initiating and competing the baseline care plan
Revised	Nursing	C 1.2	Relocation Between Laguna Honda SNF Neigh borhoods	**C. Figlietti**	1. Remove content under "Before the relocation" procedure – Referenced Standard Work on Relocation Referral to a Vacant SNF Bed

Revised	Nursing	D1 2.0	Resident Activities of Daily Living	**C. Figlietti**	1. Remove HHA 2. Changed specialized feeding plans to "individualized aspiration precautions" 3. Referred to Standard Work for Resident Clothing Laundering – Offsite for the resident's personal clothing section
Revised	Nursing	D3 2.0	Removal of Facial Hair	**C. Figlietti**	1. Remove HHA
Revised	Nursing	D6 3.0	Range Of Motion Exercises	**C. Figlietti**	1. Referred to Elsevier for Range of Motion Exercises 2. Referred to HWPP 25-06 Pain Recognition, Assessment, and Management for pain interventions 3. Updated references
Revised	Nursing	D6 5.0	Ambulation	**C. Figlietti**	1. Remove HHA
Revised	Nursing	D9 3.0	Bed Stripping and Bedside Cleaning	**C. Figlietti**	1. Moved Bedmaking into this policy and renaming policy "Bed Stripping, Bedmaking, and Terminal Cleaning" 2. Referred procedures to Elsevier 3. Moved cleansing of headboard/mattress/bed rails at head of bed (if with bed rails), foot board, under the bed frame, base of the bed frame and castors to Bed Stripping section 4. Removed content for Terminal Cleaning and referenced Standard Work on Room Readiness (Terminal Clean) 5. Updated references
Revised	Nursing	D9 8.0	Charging of Electric Wheelchair	**C. Figlietti**	1. Added "patient's" throughout the document. 2. Spelled out MSDS
Revised	Nursing	E 2.0	Assisting Residents During Mealtime	**C. Figlietti**	1. Change title to Resident Mealtime Support 2. Simplified policy, removed redundancy 3. Procedure broken down to the following sections - Preparation - Positioning - Assisting the Resident to Eat - After the Meal - Documentation
Revised	Nursing	F 1.0	Assistance with Elimination	**C. Figlietti**	Remove HHA
Revised	Nursing	F 6.0	Ostomy Management	**C. Figlietti**	1. Changed WOCN to Wound Care Nurses 2. Clarified that only licensed nurses can remove, replace or change the wafer/skin barrier for ostomies, and nursing assistants can only empty pouches/bags 3. Referred to Elsevier for Emptying or Changing Ostomy 4. Referred to HWPP 2803 Aquatic Services for Ostomy Maintenance for aquatic services 5. Updated documentation section - Ostomy wafer change done by licensed nurse (colostomy: change every 4-5 days & prn; ileostomy: change every 3-5 days and prn) - Ostomy pouch/bag - 2 piece changed daily and as needed - 1 piece changed every 4-5 days (previously 3-7 days) and as needed by licensed nurses - Revised and updated with current CPD Hospital Numbers
Revised	Nursing	G 1.0	Vital Signs	**C. Figlietti**	1. Remove HHA 2. Updated to reflect use of new Masimo Root vital signs machine 3. Updated to reflect using Masimo for oral temperatures only. If resident does not want temp taken orally, then staff may use facility approved temperature machine 4. Vitals signs checks for new admissions/relocations/courses of antimicrobial to once per shift instead of every 8 hours
Revised	Nursing	G 7.0	Obtaining Recording and Evaluating Residents Weight	**C. Figlietti**	1. Remove HHA 2. Clarified frequency of weighing to add readmission to the following statement "Residents shall be weighed weekly for 4 weeks after admission/readmission, then monthly, unless otherwise prescribed by physician."
Revised	Nursing	H 1.0	Collection of Urine Specimen	**C. Figlietti**	1. Nursing Assistant no longer allowed to collect urine specimens through midstream or clean void technique 2. Clarified the use of a "sterile" urine specimen collection container for urine collection
Revised	Nursing		Nursing Educational Programs Record Keeping	**C. Figlietti**	Remove HHA
Deletion	Nursing	D9 2.0	Bedmaking	**C. Figlietti**	Suggestion to delete and move this into D9 3.0 Bed Stripping and Bedside Cleaning
Revised	Rehab	30-01	Scope of LHH Rehabilitation Services Scope of Services to Be Provided	**D. Swiger**	Revised: • Executive title updated to current title of SFHN Associate Chief Operating Officer Integrated rehabilitation services and health at home (ACOO). • Direct of rehab position title removed and responsibilities moved under ACOO rehab and health at home executive as the respective position (director) no longer exists to meet efficiencies via one title/role serving all executive leadership related responsibilities for integrated rehabilitation services and health at home. • CPR via AHA noted and specified for rehab staff personnel including OT,PT,SLP and support staff

Revised Hospital-wide Policies and Procedures

COMFORT CARE

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing the needed care and services to residents towards the end of life in accordance with their preferences and goals, and the professional standards of practice to promote their highest practicable physical, mental, and psychosocial well-being.

DEFINITIONS:

1. **"Comfort care"** is defined by the National Institutes of Health as: Care given to people who are near the end of life and have stopped treatment to cure or control their disease. Comfort care includes physical, emotional, social, and spiritual support for patients and their families. The goal of comfort care is to control pain and other symptoms so the patient can be as comfortable as possible. Comfort care may include palliative care, supportive care, and hospice care. Also called end-of-life care[i].

2. **"Palliative care**" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice. (42 CFR §418.3)~~is specialized medical care for a resident who is living with a serious illness (e.g., heart failure, COPD, dementia, cancer). Care can include curative treatment but focuses on care that optimizes quality of life by anticipating, preventing, and treating suffering in patients who have serious or life-threatening disease. Physical, psychosocial, spiritual, and emotional suffering are assessed and addressed in this process.~~

3. **"Terminally ill"** means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. (42 CFR §418.3)~~also referred to as end-stage disease is a when an illness/disease cannot be cured or adequately treated and is expected to result in death of the resident. Specifically, for Medicare beneficiaries, terminally ill refers to a medical prognosis that the resident's life expectancy is 6 months or less if the illness runs its normal course (and is used when determining if a person is eligible for their hospice benefit).~~[1]

4. **"Hospice care"** means a comprehensive set of services described in Section 1861(dd)(1) of the Social Security Act, identified and coordinated by an interdisciplinary group (IDG) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care. (42 CFR §418.3) NOTE: These services are provided by

~~[1] Medicare Benefit Policy Manual, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance, (Rev. 12385, Issued: 11-30-23)~~

a Medicare-certified hospice.~~means a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient/resident and/or family member(s). Only patients with less than 6 months of expected life span may qualify for referral to hospice-level care.~~

PROCEDURE:

LHH utilizes a systematic approach for recognition, assessment, treatment, and monitoring of end-of-life care.

1. **Recognition:**

   a. Residents will be evaluated for end-of-life care concerns upon admission, during scheduled assessments, and upon change of condition or status.

   b. The physician will document the resident's prognosis of a life expectancy of less than 6 months, or a terminal illness.

   c. The Resident Care Team (RCT), in collaboration with the resident's primary care physician, will inform, ~~and~~ educate, and discuss with the resident and/~~or~~ the resident's family/surrogate decision maker~~-~~ about decisions for comfort care.

   d. Preferences for palliative care, hospice care, and advance directives will be identified and documented in the electronic health record (EHR). This includes preferences regarding treatment including pain management and symptom control, treatment of acute illness, and choices regarding hospitalization.

2. **Assessment:**

   a. The RCT will complete a comprehensive assessment to provide direction for the development of the resident's care plan to address choices and preferences of the resident.

   b. Assessment and evaluation may be documented by multiple members of the RCT (e.g., nurses, physician, social worker, dietitian, etc.).

   c. The assessment will include areas of concern, such as:

      i. Spiritual needs

      ii. Environmental preferences

      iii. Nutrition and hydration concerns

      iv. Oral health status

v. Bowel and bladder concerns

vi. Symptom management

vii. Level of activities desired and psychosocial needs

viii. Functional/ADL status

ix. Medications

x. Skin integrity/ Wound Care Management

3. Treatment:

a. End of life and palliative care preferences expressed by the resident or, if resident lacks capacity to make or express preferences, the resident's surrogate decision maker (SDM) will be honored as possible by LHH.

b. LHH will update and coordinate care plan with the resident and or surrogate decision maker within the shift. The interventions will be implemented in accordance with the comprehensive assessment, and the resident's needs, goals, and preferences.

c. The care plan will identify the care and services that each discipline will provide.

d. If the resident chooses hospice services, the procedures as outlined in LHHPP 20-02 Hospice Care Assessment and Transfer/Discharge Process will be followed.

e. Factors influencing the choice of treatments may include:

i. The resident's underlying diagnoses and conditions

ii. The causes, location, nature and severity of the diagnosis or conditions

iii. The resident's preferences expressed either directly or in an advance directive

iv. Possible adverse effects

v. Pain management

vi. Other symptoms such as shortness of breath, uncontrolled nausea, constipation, or vomiting

vii. Psychosocial and emotional needs of the resident and/or representative

viii. Spiritual needs

ix. LHH rules and regulations

f. Inotropic Cardiovascular Intravenous Infusion at Fixed (non-titratable) Drip.

i. Under the direction and supervision of the Resident Care Team and on a case-by-case basis, a resident may receive a fixed dose inotropic cardiovascular intravenous drip to relieve palliative symptoms in end-stage heart failure. Residents that are appropriate for this care will be located on South 3 (Palliative Care Neighborhood) or the acute unit and will not require telemetry/cardiac monitoring and/or vital signs that are more frequent than what are standard for the long-term care setting.

~~f.~~g. LHH will provide an environment which strives to support and enhance the resident's well-being and quality of life. Interventions to promote a comforting environment include, but are not limited to:

i. Adjusting room temperature and lighting
ii. Smoothing linens

iii. Turning and repositioning to a comfortable position

iv. Loosening any constrictive bandage or device

v. Splinting where appropriate

vi. Physical modalities

vii. Exercises to address stiffness

viii. Cognitive/behavioral interventions such as music or diversions

ix. Visits with loved ones

x. Spiritual Services

4. Monitoring:

a. Medical conditions will be monitored and managed according to resident/SDM goals of care and preferences, as possible.

b. The primary care physician will assume responsibility for the overall care and treatment of the resident's medical conditions. LHH will provide opportunities for the primary care physician to consult with a palliative care specialist as needed.

c. Care will be supervised to ensure that interventions are implemented as written.

d. The RCT will monitor and evaluate the resident's response to the established care plan.

e. Resident or, if resident lacks capacity, the SDM may revoke or modify goals of care. Assessment(s), treatment(s), and monitoring steps delineated above will be applied to any changes.

ATTACHMENT:
None.

REFERENCE:
20-02 Hospice Care Assessment
Centers for Medicare & Medicaid Services. *State Operations Manual, Appendix PP: Guidance to Surveyors for Long Term Care Facilities* (February 2023). F684: Quality of Care.

Revised: 10/21/25

Original adoption: ~~24/~~03/12/24 (~~Year/~~Month/Day/Year)

[i] https://www.cancer.gov/publications/dictionaries/cancer-terms/def/comfort-care

ASBESTOS AND LEAD MANAGEMENT PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to a policy of safe and effective management of building materials containing asbestos and/or lead to minimize exposure of LHH employees and other building occupants to airborne asbestos fibers and lead dust.

PURPOSE:

1. To establish and administer an effective operations and maintenance plan for LHH pursuant to Cal-OSHA, EPA, and Bay Area Air Quality Management District regulations.

2. To establish a process for renovation or demolition of areas of the Administration building that may contain asbestos and/or lead.

3. To implement procedures for LHH Facility Services employees to follow when performing short duration maintenance and repair tasks for which a negative exposure assessment has been completed.

4. To address procedures when Environmental Services staff may be exposed to lead or asbestos from settled ~~dusts~~dust during routine housecleaning.

5. To address procedures to address where potential asbestos and lead exposures may be occurring to office employees in the Administration Building

PROCEDURE:

1. Asbestos and Lead-Containing Materials

a. The hospital buildings (Pavilion, North Tower and South Tower) at LHH are LEED certified and were built without the use of any materials containing lead or asbestos.

b. Any construction, alterations, installations, maintenance, housecleaning, or repair work in the Administration building (which has potential ~~ACM~~Asbestos Containing Materials or lead-containing coatings) at LHH has the potential to disturb asbestos and/or lead.

i. The Administration Building was surveyed for asbestos by three different consulting companies between 1990 and 2006. A list of known asbestos-

containing construction material and presumed asbestos-containing construction material based on these surveys is included in Appendix A.

c. All painted surfaces in the Administration building are assumed to contain lead~~.~~, unless tested and shown otherwise.

2. Procedure for Suspect Background Exposures while Working in the Administration Building

a. Although asbestos and lead may be present in areas of the Administrative Building, the presence of asbestos or lead in building materials is not evidence of an environmental health risk. Asbestos and lead must be released into the air and in sufficient airborne concentrations to present an increased health risk.

b. In areas where settled dust on work surfaces are suspected of containing elevated concentrations of lead or asbestos, the LHH Senior Certified Industrial Hygienist may decide to collect occupational worker full-shift breathing zone samples if a Negative Exposure Assessment (NEA) has not been performed for a similar exposure situation to determine if an inhalation risk exists. If a NEA for similar exposures has been conducted, then the NEA data may be used to determine health risk.

c. Some housekeeping activities by LHH Environmental Services (ENV SVS) staff may expose workers to suspended or settled lead or asbestos dusts. Periodic surface lead and asbestos dust analyses may be required along with full-shift worker breathing zone sampling, if a Negative Exposure Assessment has not been performed to determine risks to ENV SVS staff. If a NEA for similar exposures has been conducted, then the NEA data may be used to determine health risk.

~~2.~~3. Procedures for Work Order Maintenance and Repair Activities

a. Work orders for maintenance and repairs that involve minimal disturbance of building materials, and for which a ~~negative exposure assessment (NEA)~~Negative Exposure Assessment has been completed, may be assigned to LHH Facility Services staff who have been trained according to paragraph 6a. In the absence of a NEA for this type of activity, worker full shift breathing zone samples for lead and/or asbestos may be required to develop a NEA. These staff may complete the work following the standard procedures in Appendix B.

b. Projects that are larger in scope or of longer duration than the tasks described above, which are assigned to contract employees, or which do not have a completed NEA, require additional hazard assessment to determine whether they can be done by on-site Facility Services staff, or whether they must be done by an accredited abatement worker.

c. Hazard assessments, including sampling of building materials and surfaces, will be completed by a Department of ~~Workplace Safety & Emergency Management (WSEM~~Industrial Hygiene (IH) employee, who is an accredited Asbestos Building Inspector and a CDPH-certified Lead Inspector/Assessor. If ~~WSEM~~IH Department is lacking in these certifications, then they may consult a third party for these assessments.

   i. If materials to be disturbed are found not to contain asbestos or lead, the project can proceed in house with LHH employees and/or contractors.

   ii. If materials to be disturbed are found to contain asbestos, procedures for renovation and large-scale maintenance shall be followed.

~~3.~~4. Procedures for Building Renovations and Large-Scale Maintenance

a. When a project involves the potential disturbance of asbestos and/or lead and is not covered by a standard procedure in Appendix B, the Facility Services Director will notify DPW that a contractor with appropriate accreditation for lead and/or asbestos work will be needed to perform the work.

b. DPW will select an environmental consultant who is a CAC and Lead Inspector/Assessor, and can obtain permits from BAAQMD, from their list of approved consultants.

c. DPW will arrange for a pre-job walk that will include representatives from the consultant, DPW, ~~WSEM~~Industrial Hygiene, and Facility Services.

d. The environmental consultant will collect and analyze samples of building materials and develop a detailed work plan based on information provided at the pre-job walk and the results of sampling. The work plan will include specifics regarding the scope of the job and methods to complete the work safely and in accordance with regulations.

e. The work plan shall be reviewed and approved by DPW, Facility Services, and ~~WSEM~~Industrial Hygiene.

f. DPW will schedule a bid walk with potential contractors, the environmental consultant, and a representative from Facility Services. A representative from ~~WSEM~~Industrial Hygiene may also choose, but is not required, to attend.

g. The work plan may be revised based on discussions during the bid walk and any changes must again be approved by DPW, Facility Services, and ~~WSEM~~Industrial Hygiene.

h. DPW will schedule the work and pre-construction meeting, if necessary.

i. The work will be performed by the contractor with the environmental consultant monitoring the contractor's work to ensure it is done according to the work plan.

The consultant shall stop work at any time if the contractor is not in compliance with the work plan such that their workers or building occupants are placed in danger.

j. ~~WSEM~~Industrial Hygiene is responsible for oversight of the environmental consultant and may stop work if they determine that the consultant is not adequately enforcing the work plan or regulatory standards.

k. Facility Services will ensure that all work is completed satisfactorily according to the scope.

~~4.~~5. Procedures for Addressing Unexpected Asbestos or Lead Encountered by Contractors

a. A thorough assessment, typically involving a visual inspection, bulk or surface wipe sampling, or air sampling, is required to determine presence of lead and asbestos, in areas where they can reasonably be expected to occur. For these areas, when a determination is made that neither asbestos nor lead is present in the vicinity of work being done, LHH will provide an Asbestos Information Notice, advising them to stop work and contact the Facilities Director if they feel at any point that they may have encountered unexpected asbestos or lead.

b. If asbestos or lead is encountered in the vicinity of the work, but disturbance is not expected, the contractor shall observe specified work procedures to minimize the possibility of disturbance of lead or asbestos-containing construction materials (ACCM). LHH will specify changes to the contractor's scope of work, if necessary, to minimize the disturbance of asbestos. LHH will verify that the contractor's modified work scope is acceptable and monitor the contractor's work to assure that the material remains undisturbed.

c. If asbestos is present in the vicinity of the work and it may be disturbed, asbestos abatement must be completed before the proposed work can be performed. LHH will arrange for the specified asbestos abatement according to paragraph 3 above.

~~5.~~6. Communication of Asbestos Hazard

a. Asbestos Warning Signs listing all materials with ACCM or Presumed Asbestos Containing Construction Materials (PACCM) will be posted in the following locations:

i. In the main entrance Lobby for LHH's Administration building.

ii. At the entrance to all mechanical rooms including steam tunnels.

iii. At entrances to locations of asbestos abatement work.

b. The sign must say the following or something similar: “Danger Asbestos May Cause Cancer. Causes Damage ~~T~~to Lungs. Area Authorized Personnel Only. Wear Respiratory Protection ~~And~~and Protective Clothing.”

c. All painted surfaces in the Administration building shall be assumed to contain lead paint, and Facility Services and Environmental Services Staff will be informed of this assumption during their initial and annual training.

~~6.~~7. Education And Training:

a. Facility Services Department

i. The Chief Engineer and Building and Grounds Maintenance Supervisor shall complete AHERA training for Contractor/Supervisors in order to oversee the maintenance work done by Facility Services employees.

ii. All Facility Services employees shall be trained annually on the following topics:

- The requirements of the Cal OSHA asbestos and lead standards and the contents of this Management Plan;
- The health effects of asbestos and lead;
- Recognizing asbestos containing building materials;
- Assumption of lead-based paint on all painted surfaces in the Administration building;
- The work tasks that might result in exposure to asbestos and/or lead;
- Procedures for performing maintenance tasks causing minimal disturbance of asbestos and/or lead and for which a negative exposure assessment has been completed. This will include hands on practice;
- Respiratory protection (provided in a separate training session).

~~• Information about public health organizations that provide smoking cessation programs;~~

~~7.~~

~~8. Respiratory protection (provided in a separate training session).~~

b. Environmental Services

~~i.~~

~~ii.~~i. EVS staff shall receive one hour of Asbestos and Lead Awareness Training on initial hire and annually thereafter.

~~iii.~~ii. EVS staff shall not disturb asbestos or lead, and will be trained to recognize and report damaged material that may contain asbestos.

~~b. Workplace Safety and Emergency Management (WSEM)~~

iii. EVS porter staff in some limited situations may have the potential to be exposed to settled lead and asbestos dusts when cleaning surfaces, and when there is a question about a possible exposure, the employee should contact their supervisor, who may then want to contact the LHH Industrial Hygienist.

iv. The lead and asbestos awareness training should cover the health effects from lead and asbestos, exposure limits, PPE, safe work practices, and the importance of medical surveillance. This awareness training shall be conducted initially at hiring and annually there after.

v. Employees who perform housekeeping in an area with ACM or PACM must receive annual asbestos awareness training, while employees potentially exposed to airborne asbestos levels at or above the Permissible Exposure Limit (PEL) or Excursion Limit (EL) must receive more comprehensive training before initial assignment and annually thereafter.

c. Industrial Hygiene

i. Industrial Hygienists in ~~WSEM~~the Department of ~~Industial~~Industrial Hygiene shall complete the following classes to maintain AHERA accreditation:

- AHERA Contractor/Supervisor
- AHERA Building Inspector
- AHERA Management/Planner
- AHERA Project Designer

ii. Industrial Hygienists ~~in WSEM~~ shall complete training and examination to maintain certification as a CDPH Lead Inspector/Assessor.

8. Office Employees in the Administration Building Offices

a. Cal/OSHA does not require universal asbestos training for all office employees; rather, the requirement depends on potential exposures to asbestos-containing materials (ACM) or presumed asbestos-containing materials (PACM) in the workplace.

b. ~~Employees who perform housekeeping in an area with ACM or PACM must receive annual asbestos awareness training, while employees potentially exposed to airborne asbestos levels at or above the Permissible Exposure Limit (PEL) or Excursion Limit (EL) must receive more comprehensive training before initial assignment and annually thereafter.~~ California OSHA regulations require lead awareness training in office workers only when the exposure is above the OSHA Action Limit for airborne lead, and this determination for lead or asbestos can be based on airborne testing by the employer or on a NEA under similar exposure situations that had been previously performed.

c. Awareness training for housekeepers or routine maintenance who are not likely to disturb lead or asbestos

   i. Health effects of asbestos and lead: Information on the dangers of asbestos or lead exposures.

   ii. The purpose of medical surveillance program and medical removal program~~.~~

   iii. Locations of ACM/PACM and lead coatings: Identification of where these materials are located within the building.

   iv. Recognizing damage: The ability to identify damaged or deteriorating ACM/PACM or lead coatings.

   v. Good housekeeping practices~~.~~

   vi. Proper response procedures: What to do if ACM lead coatings are accidentally disturbed and these materials are released.

ATTACHMENT:
Appendix A: Asbestos Containing Construction Materials (ACCM) and Presumed Asbestos Containing Construction Materials (PACCM)

Appendix B: Standard Procedures for Maintenance Tasks Resulting in Minimal Disturbance of Asbestos and/or Lead

~~REFERENCE~~REFERENCES:

CCR Title 8 Section 1529~~ –~~ Cal OSHA Asbestos in Construction Standard
CCR Title 8 Section 1532.1 Cal OSHA Lead in Construction Standard
CCR Title 8 Section 5198 Lead (not applicable to construction or agricultural operations)
CCR Title 8 Section 5208 Asbestos. General Industry
40 CFR Part 61 – National Emissions Standard for Hazardous Air Pollutants (NESHAP)
Bay Area Air Quality Management District (BAAQMD) Regulation 11 Rule 2 – Asbestos Demolition, Renovation, and Manufacturing.

Revised: ~~13/~~05/28/13, ~~18/~~09/11/18, ~~23/~~09/12/23, ~~25/09/11~~11/18/25
(~~Year/~~Month/Day/Year)

Appendix A:

ASBESTOS CONTAINING CONSTRUCTION MATERIALS (ACCM) AND PRESUMED ABESTOS CONTAINING CONSTRUCTION MATERALS (PACCM)

Materials	Locations
ACCM: Steam & domestic hot water pipe & fitting insulation, and block type insulation on tanks and heat exchangers	Found in mechanical rooms throughout hospital and throughout the buildings. Some piping insulation is concealed in walls and ceiling and in metal cladding.
ACCM: Acoustical Ceiling Plaster	Main hallways on 3rd, 4th, 5th, & 6th Floors
ACCM: Ceiling Tile (transite), screwed-in	~~Ward~~Wing G Rooms 301, 401, 501, and 601
ACCM & PACCM: 2' x 2' laid-in ceiling tiles	2nd, 3rd, 4th and 5th Floors of old patient's ~~ward~~wing C
ACCM: Vinyl floor sheeting, linoleum, vinyl floor tiles, and mastic	Throughout the hospital – consult the survey reports for actual locations
ACCM: Vinyl composite wall Coverings	Various areas of all buildings
ACCM & PACCM: Fire door core insulation	Various areas of all buildings
ACCM: Wall heater transite behind radiators	Throughout building
ACCM: Heater Insulation, behind sheet metal	H-Wing Library
ACCM: Exterior ~~Paint~~Paints	~~Ward~~Wing G exterior
ACCM: Undercoating on Sinks	Throughout building
ACCM: Tar coating, back of splined ceiling tiles	~~Ward~~Wing D, Room 314, and may be in other wings
PACCM: Wall & Ceiling Sheetrock	Throughout building
PACCM: Baseboard glue	Throughout building
PACCM: Insulators/contactors for elevator Control	Elevators & elevator mechanical rooms
PACCM: Ceramic tile grout, mastic and underlying vapor barrier	Throughout building
PACCM: Vapor barrier under concrete floor	Assumed to be present where there are floor drains in concrete floors.
PACCM: Mastic under Formica	Throughout building

PACCM: Asphalt & gravel roofing and vapor barrier under terracotta tiles	On various roofs
PACCM: Caulking & glazing putty on windows and doors	Throughout the exterior
PACCM: Asbestos cement (transite) panels	On bathroom balconies, in ~~Wards~~Wings

ACCM means any manufactured construction material, including structural, mechanical and building material, which contains more than one-tenth of 1 percent (0.1%) asbestos by weight. PACCM means Presumed Asbestos Containing Construction Materials and are building materials that have not been tested but are assumed to contain asbestos based on age and material type. PACCM may be rebutted following bulk testing of the material.

Appendix B: Standard Procedures for Maintenance Tasks Resulting in Minimal Disturbance of Asbestos and/or Lead

Procedures for Small Lead Paint Stabilization Jobs

LHH Painters in the Facility Services Department may complete small paint stabilization projects on surfaces that may contain lead paint. These projects will not involve removal of more than approximately two square feet of peeling paint and will be completed using the following safe practices.

1. Occupants shall not be permitted to enter the worksite during paint stabilization activities until after work has been completed.

2. The worksite shall be prepared to prevent the release of leaded dust and contain lead-based paint chips and other debris within the worksite until they can be safely removed. Practices that minimize the spread of leaded dust, paint chips, soil and debris shall be used during worksite preparation.

3. The worksite shall be secured against unauthorized entry, and occupants' belongings protected from contamination by dust-lead hazards and debris during paint stabilization activities. Occupants' belongings in the containment area shall be relocated to a safe and secure area outside the containment area or covered with an impermeable covering with all seams and edges taped or otherwise sealed.

4. Painters will wear disposable nitrile gloves, and a disposable protective covering, such as a breathable Tyvek disposable suit over their work clothes.

5. Use of a half mask respirator with HEPA filters is recommended during paint stabilization. N95 respirators are not approved for this work. Industrial hygiene should be contacted for training and fit testing for this type of respirator, and the Facilities Services department shall purchase the N100 respirators.

6. None of the following prohibited methods will be used for preparing surfaces for painting.

    a. Open flame burning or torching.

    b. Machine sanding or grinding without a high-efficiency particulate air (HEPA) local exhaust control.

    c. Abrasive blasting or sandblasting without HEPA local exhaust control.

    d. Heat guns operating above 1100 degrees Fahrenheit or charring the paint.

e. Dry sanding or dry scraping, except dry scraping in conjunction with heat guns or within 1.0 ft. (0.30 m.) of electrical outlets, or when treating defective paint spots totaling no more than 2 sq. ft. (0.2 sq. m.) in any one interior room or space or totaling no more than 20 sq. ft. (2.0 sq. m.) on exterior surfaces.

f. Paint stripping in a poorly ventilated space using a volatile stripper.

7. Paint stabilization will include the application of fresh, non-lead~~-~~-based paint.

8. Upon completion of work, the entire work area must be vacuumed with a HEPA-filtered vacuum cleaner.

9. Plastic sheeting/drop cloths that have been cleaned of debris and gloves may be thrown out in the regular trash. Paint chips and contents of HEPA ~~vacuum~~-filtered vacuum cleaners, including used HEPA-filters, are hazardous waste and must be sealed in plastic bags, labelled as hazardous lead waste and placed in the hazardous waste storage area.

10. Once clean-up is complete, remove gloves, disposable protective suit, and lastly, the respirator, and wash hands and face.

~~11. Work clothes should not be worn home.~~

Procedures for Carpentry Work on Asbestos-Containing or Lead-Painted Surfaces

LHH employees other than Painters will not be asked to perform work that requires sanding, scraping, burning, or any other means of intentionally removing paint from surface areas that may contain lead paint. However, in some cases, LHH employees may be required to make repairs on a window or other painted surface that is known or likely to contain lead paint. Such repair may cause inadvertent disturbance, chipping, or flaking of the paint, but is not expected to result in measurable airborne concentrations of lead. In these cases, the employee will follow the procedure below in order to minimize any possible lead exposure.

1. Don disposable, nitrile gloves.

2. Use a vacuum equipped with a HEPA filter to vacuum all painted surfaces that will be disturbed during repair or maintenance and will be used to remove all loose paint chips.

3. Wipe down surface with a wet rag.

4. Complete work making an effort to leave as much paint intact as possible.

5. ~~Vacuum~~Upon project completion, vacuum up any paint chips or dust from work surface and surrounding area using a vacuum equipped with a HEPA filter.

6. Remove and dispose of gloves.

7. Wash hands.

8. Dispose of gloves and rags immediately after use. These can go in the regular trash.

Procedures for Cutting or Drilling ~~Into~~into Asbestos-Containing or Lead-Painted Surfaces

Occasionally, LHH Facility Services employees are required to cut or drill into walls or ceilings in order to complete assigned work. The following procedures must be followed if you will be cutting into a surface that is known or suspected to contain lead-based paint.

1. Don disposable, nitrile gloves.

2. For cutting into surfaces, use a saw equipped with a shroud attached to a HEPA vacuum.

3. For drilling into surfaces, use a drill equipped with a shroud attached to a HEPA vacuum or drill through a wet sponge.

4. Use a HEPA vacuum to clean up any dust or debris generated by your work.

5. Wipe around edges of cut surface and any area that was vacuumed with a wet rag.

6. Remove and dispose of gloves.

7. Wash hands.

8. Dispose of gloves and rags immediately after use. These can go in the regular trash.

Procedures for Cleaning Surfaces where Asbestos- or Lead-containing Dusts have Settled

1. Don disposable, nitrile gloves.
2. Use only a HEPA-filtered vacuum cleaner to vacuum up dusts or debris.
3. Remove and dispose of gloves; wash hands.
4. Dispose of gloves immediately after use in regular trash
5. Dirty HEPA-filters from vacuum cleaners will be bagged, labelled as Hazardous Waste, and disposed as RCRA hazardous waste.

Revised Food and Nutrition Policies and Procedures

1.677 Manual Ware Washing

~~Established and~~ Revised: 10/2025

Section: Sanitation and Infection Control

PURPOSE: To prevent foodborne illness by ensuring ~~To outline~~ proper manual ware washing procedures.

Policy: Multiservice utensils shall be effectively washed to remove or completely loosen soils ~~by the use of~~using manual or mechanical methods necessary, such as the application of detergents, hot water, brushes, scouring pads, or ~~high pressure~~high-pressure sprays.

Procedure:

- Manual ware washing shall be accomplished by using a three-compartment sink where the utensils are first scraped, then washed, rinsed, sanitized, and air dried.
- During manual ware washing, food debris on utensils is first removed by scraping over a waste disposal unit or compost bin.
- If necessary for effective cleaning, utensils will be pre-soaked, or scrub~~bed with abrasives~~.
- The temperature of the washing solution and rinse sink shall be maintained at no less than 110°F. Department approve detergent ~~Ecolab product Solitaire Detergent~~ is utilized for wash sink. The utensils shall then be rinsed in clear water before being immersed in a sanitizing solution. Wash and rinse water must be changed every two hours or sooner if becomes heavily soiled, or if temperature drops below 110°F.
- Manual sanitization shall be accomplished in the final sanitizing rinse by contact with a solution concentration as recommended by the detergent manufacturer~~of 200-400 ppm quaternary ammonium (Oasis 146 Multi-Quat Sanitizer) for at least one minute~~. ~~–~~Test the chemical sanitizer concentration before use by using an appropriate test kit. ~~Pot room personnel shall test sanitizer sink water each time sink is re-filled, and document results on **Ware washing Chemical Log**. Employees must document every time sanitizer water is changed and tested, as this is a patient safety issue.~~
-
- Pots, pans, and utensils shall be inverted to drain and air-dry before they are put away in proper places.
- Detergent manufacturer~~Ecolab~~ provides routine preventative maintenance services ~~on a monthly basis~~monthly including inspection of dispenser condition at the three-compartment sink in pot room:

  - Checking on proper function of detergent dispenser system
  - Checking on ~~Multi-Quat~~ sanitizer readings

1.70 Scoops for Food and Ice

~~Established and~~ Revised: 8/2024 ~~2/83, 12/87, 1/89, 5/97, 9/06, 7/09~~
~~Reviewed: 8/13, 8/14~~

Policy: ~~The~~ Food Nutrition Services will keep all scoops out of bins when not in use. They will to be placed ~~near by~~nearby for easy access.

Purpose: Proper Sanitation of Nutrition Service Areas

Procedure:

1. Scoops for sugar, flour, salt, rice, grain bins and ice machine will not be kept inside at any time except for the use of scooping out the product needed.

2. After each use the scoop will be taken out of the bins and kept near-by for later use.

3. The scoops are stored in a safe and sanitary manner.

4. Scoops are sanitized through the pot machine ~~periodically;~~periodically, at least once a day.

5. Bins should be cleaned and sanitized before being refilled.

1.71 Replenishing Juice and Coffee ~~Dispensers , and Maintaining Ice and Water Dispensers~~ in the Galley ~~Neighborhood Great Room~~

~~Established and~~ Revised: 8/2024 ~~12/10, 7/12, 8/14, 8/15, 11/17~~
~~Reviewed: 8/13, 8/14, 8/15, 11/17~~

Policy: To ensure that residents and staff have access to juice, water, and coffee at all times in each Neighborhood.~~,~~ A~~a~~ Food Service Worker or designee will replenish the juice and coffee ~~dispensers, and~~and restock sufficient numbers of new cups for residents to use ~~whenever they get a cup of water to drink from the water and ice dispenser~~. In addition, the coffee dispensers will be cleaned and sanitized once a day.

Procedure:

1. Each morning, two food service workers are assigned to replenish the coffee and juice in each of the thirteen neighborhoods. One will complete the North Building and the other will complete the South Building and Pavilion Building. The Food Service Worker will fill out a check form and return the form to the Supervisor.

2. The Food Service Worker will gather the necessary containers of ~~bulk~~ juices from the refrigerator and coffee ~~(Apple and Orange), quart size cranberry juice and packages of coffee (regular and decaf) from the storeroom~~. The Food Service Worker will gather the necessary cleaning supplies using the ~~three bucket~~three-bucket method.

3. Before replenishing the dispensers, the Food Service Worker will use the ~~three bucket~~three-bucket method to wash, rinse and sanitize the outside and interior of all the dispenser~~ss (juice, coffee and water/ice)~~. They will empty the catcher on the ~~juice~~ dispenser~~machine and ice/water dispenser~~.

4. The Food Service Worker will restock the Galley Refrigerator up to the designated par of ~~quart size cranberry~~ juice~~s~~. They will look at the date of any opened container ~~of cranberry juice~~ and dispose of the product if it's been more than three days ~~(72 hours)~~. They will discard~~date~~ any open containers that have not been labeled and dated ~~of opened cranberry juice if there is no date~~.

5. The Food Service Worker will report any concerns or problems with the product or dispenser units to the Food Service Supervisor or designee. The supervisor or designee will take the necessary corrective action in reporting conditions to the vendor of the dispensing unit or Facility Services. ~~either the coffee or juice manufacturer or Facility Services.~~

6. On a monthly basis, the beverage machine~~juice~~ vendor will complete a check on all ~~juice~~ dispensers. The service will be noted on each machine.

~~On a monthly basis, the coffee vendor will complete a check on all coffee dispensers. The service will be noted on each machine.~~

1.72 Processing ~~of the~~ Mop Heads ~~and Cleaning Rags on a Daily Basis~~Daily

~~Established and~~ Revised~~:~~ 8/2024~~: 3/81, 1/89, 5/97, 3/00, 9/06, 7/09, 8/14~~
~~Reviewed: 8/13, 8/14~~

Policy: All mop heads ~~and rags~~ in the department will be changed ~~on a daily basis~~daily and the soiled mop heads ~~and rags~~ will be placed in a receptacle to be laundered.

Purpose: For sanitation and ~~cost effective~~cost-effective purposes.

Procedure:

Environmental Services will stock medium, all cotton, colored mop heads for our department's use where we will requisition new mop heads.

The majority of the mop heads ~~and~~ will be cleaned and recycled through ~~the~~ EVS ~~- Linen Department~~.

Each day, all the mops in the department will be changed to a clean ~~a cleaned~~ mop head.

The staff will properly dispose all used and soiled mop heads ~~and/or cleaning rags~~ into a plastic lined receptacle marked "*Soiled Mopheads Only.*" ~~and/or "*Soiled Rags Only*".~~ This receptacle is located across from the computer station in the production kitchen. ~~in the chemical storage area.~~

The receptacles will be cleaned daily.

At the end of the day ~~days end,~~ the plastic liner filled with soiled mop heads and rags will be counted, labeled, and placed into the designated soiled linen cart for laundry services to pick up daily except Fridays.

The EVS - Linen Department will properly have an outside laundry vendor wash and sanitize the soiled ~~rags and~~ mop heads. They will deliver cleaned mop heads ~~and rags~~ to the Department daily in the evening except Friday.

The clean mop heads will be centrally located for staff to use. If a staff member feels that a mop head is too worn-out or heavily soiled with grease to be reused, s/he needs to inform his immediate supervisor. The supervisor, ~~or~~ chef, or designee will evaluate the condition of the mop head prior to disposal.

~~11/6/2015~~

1.73 Temperature Logs for Refrigerators/Freezers

~~Established and~~ Revised: 8/24 ~~3/87, 1/89, 1/92, 5/97, 9/06, 7/09~~
~~Reviewed: 8/13, 8/14~~

Policy: To ensure proper storage temperature for perishable and frozen food~~,~~, the Chef, supervisor, ~~or~~ storeroom attendant, or designee will record refrigerator/freezer temperatures in the~~a~~ temperature ~~log book~~logbook.

Procedure:

1. Check manual thermometer installed ~~outside and~~ inside of each refrigerator and freezer. Record in temperature ~~log book~~logbook. This should be done twice daily in conjunction to Facility Services periodic checks.

2. Document and r~~R~~eport ~~to the~~ improper temperature to Facility Services and submit a worker order. The chef or designee will take the necessary corrective action if temperatures are out of the recommended range and~~in~~ reporting conditions to Facility Services.

3. Temperature ~~Log Book~~Logbook is reviewed periodically by ~~the Assistant~~ Food Service Management~~Director before discarding~~.

   Temperature Ranges:

   Refrigerator Temperature: 41º F or lower.

   Freezer Temperature: 0º F or below (Freezer may have a temperature variance of +10º F during defrost cycle).

   ~~Standards: Freezer -10 F to -10F; 34-38 F for storing meat and dairy products. 34 - 38 F for storing fresh fruit and vegetables.~~

1.74 Safety Inspection for Working Environment

~~Established and~~ Revised: 8/24~~ 3/87, 1/89, 5/97, 10/03, 9/06, 7/09, 6/11, 11/22~~
~~Reviewed: 8/13, 8/14~~

Policy: Inspections will be made on a regular basis to report substandard safety conditions in all areas of Food Nutrition Services Department.

Purpose: To e~~i~~nsure a safe working environment for all employees.

Procedure:

1. On a weekly basis, with the Standard Sanitation Check List, ~~or "Mr. Clean"~~ Food Service Supervisors ~~or Food Service Worker~~or designee will inspect ~~the areas in~~ each Galley located up on each floor of South, North, and Link building.

2. The Chef~~s~~ will inspect all food production areas, ~~pot~~pot, and pan washing area, refrigerators/storage areas, cafe~~teria~~, and dining room area.

3. Report all substandard safety conditions to the Food Service Director or Food Service Manager.

4. Follow through on substandard conditions by initiating necessary corrective ~~action;~~action,
   e.g. Prepare electronic Facility Services Work Requests.

5. Follow up with re-inspection to assure substandard conditions were corrected.

6. It is the responsibility of all Food Nutrition Services employees to report any substandard condition that may be a safety hazard to their supervisor.

1.75 Glove Usage

~~Established and~~ Revised: 8/24 ~~10/87, 3/97, 5/97, 7/03, 9/06, 7/09, 10/11~~
~~Reviewed: 8/13, 8/14~~

Policy: Gloves are to be worn ~~in regards t~~for~~e~~ certain job duties. *They are no substitution to proper hand washing practices*. Several gloves will be available for employees as to the specified job assignment. Wearing the correct gloves for the specified job assignment is essential. It is the responsibility of the employee to maintain their gloves in proper working condition, which may include keeping the reusable type gloves properly sanitized before and after each use.

Purpose: To prevent foodborne illness due to hand-to-food cross-contamination. All food will be served in a manner to ensure food safety. ~~To assure proper sanitation and infection control when handling certain food items, equipment and material.~~

Procedure:

1. The following is an outline of the different gloves and its specified area(s) of use. It is essential that all employees wear the correct gloves for their job assignments. Each employee will be responsible for using the correct gloves for their job assignment. It is essential for the supervisory or designee ~~staff~~ to monitor accordingly. **Even with glove protection, the employee must practice the policy ~~of~~for good hand washing technique before and after using gloves.**

   a. FDA Approve Food Service Grade ~~Latex Examination~~ Gloves (Single-use)~~s~~: used in the handling of certain food items in the production, tray service, ~~dishroom~~dish room and cafeteria-service area. Latex Examination Gloves may be used when loading the dish machine, scraping trays, picking up soiled trays/tableware, or handling the garbage or handling pots and pans. Gloves are to be changed after changing any work process that will cause a break in sanitation. Gloves should be properly disposed of after its use. **Gloves must be changed when task changes.**

      - Do not use bare hands to handle ready to eat foods.
      - Wash hands and change gloves: Gloves must never be used in place of hand washing.

   ~~a.~~b. Cotton Gloves: used in handling hot plates on tray ~~the~~ line for serving the main course. Employees are responsible for laundering them as with their uniform. These are not disposable type and can be reused. Cotton gloves must be covered with a single-use food service grade glove. ~~Please treat them as such.~~

~~b.~~ Yellow Gloves: used only for the clean end of the dish or pot machine for unloading clean dishes ~~hot .~~ –Used in the handling of clean dishes, trays, mugs, and silverware, hot plates or pots and pans. Sanitizing of yellow gloves may be done by washing gloves while washing as one would wash hands under hot water using soap (gently rub together). Then rinse under running water and air dry. These are not disposable type and can be reused. ~~Please treat them as such.~~

c.

~~c.~~

d. Black Gloves – elbow length: used only for washing pots and pans in the ~~three compartment~~three-compartment sink. Sanitizing of black gloves may be done by washing gloves while washing as one would wash hands under hot water using soap (gently rub together). Then rinse under running water and air dry. These are not disposable type and can be reused.

e. Cut resistant gloves – FDA approved glove that can provide cut and abrasion resistance when cutting food with a knife or cleaning/sharpening blades. Employees are responsible for laundering them as with their uniform. These are not disposable type and can be reused. Cut resistant gloves must be covered with a single-use food service grade glove.

~~d.~~ 2. Management will ensure that the correct sizes of gloves are available for staff. It is the responsibility of the staff to wear gloves that fit correctly. It should not be too tight, nor should it be loose fitting.

~~Management will ensure that the correct sizes of gloves are available for staff. It is the responsibility of the staff to wear gloves that fit correctly. It should not be too tight nor should it be loose fitting. Please see a Supervisor if the gloves does not fit properly.~~

1.76 Use of Cutting Boards

~~Established and~~ Revised: 8/24 ~~2/83, 2/83, 12/87, 1/89, 5/97, 9/06, 7/09~~
~~Reviewed: 8/13, 8/14~~

Policy: The Food Service shall use NSF Approved cutting boards for use in the production area.

Purpose: Proper Sanitation of Food Service Areas

Procedure:

1. NSF Approved Cutting Boards will be used in the cooking process.

2. Cutting Board Color Chart and their use:

   - Red = Raw Meats
   - Yellow = Raw Poultry
   - Green = Fruits, Vegetables, Salads
   - Blue = Raw Fish
   - White = Bakery Items, Cheese, and Bread
   - Brown = Cooked Meats

~~1.~~3. To prevent cross contamination, the cutting board is scrubbed with mild detergent and sent through the automatic ~~Dishmachine~~dish machine after each use.~~1~~ ~~–~~Allow to air dry.

~~2.~~4. The boards are stored separately from other food service equipment in a safe and sanitary manner.

Chefs will periodically check the condition of the cutting boards for stains, discoloration, deep ~~cuts~~cuts, ~~and~~ scratches, and will be replaced with new boards accordingly as required.

References

https://www.fda.gov/food/buy-store-serve-safe-food/safe-food-handling

1.77 Fire and Fire Drills

~~Established and~~ Revised: 10/25 ~~4/81, 1/89, 1/93, 5/97, 9/06, 7/09, 8/14, 8/15~~
~~Reviewed: 8/13, 8/14, 8/15~~

Policy: A Fire Plan will be posted in designated areas in the Department. ~~In addition, fire plan is attached on a separate card on all employees' hospital identification card.~~ This plan will include Fire Alarm Station Locations, Emergency Exit Doors, and Fire Drill Procedures. All employees will participate in Fire Drills and Emergency Preparedness ~~Inservices~~In-services which includes Fire Prevention and Safety.

Purpose: To protect employees from fire hazards.

Procedure:

When a fire occurs:

1) Upon notification of fire, department personnel immediately should take the following actions.
2) Use the acronym: **RACE**~~-~~: Rescue, Alarm Activation, ~~Confine/Contr~~Contain., Extinguish/Evacuate.
3) Personnel should move out of immediate danger of the fire while announcing **CODE RED** to nearby staff and residents.
~~4) Dial 9-911 and report the emergency, report that this is Laguna Honda Hospital, the exact location and building number.~~
~~5)~~4) Sound the alarm by pulling the level on the nearest alarm box.
~~6)~~5) Dial 42999 to alert the operator of Code Red, providing with the following information: *Location of the fire ~~-~~*State what is burning ~~—~~*Your name
~~7)~~6) Close all windows and doors, where appropriate.
~~8) Shut off all equipment in the general fire area for electrical and gas.~~
~~9)~~7) Use the acronym: PASS = Pull extinguisher pin~~,~~; Aim hose at the base of the fire, ~~;~~ Squeeze handle~~lever~~ and Sweep side to side.
   a) Control all small fire whenever possible with the appropriate fire extinguishers. For grill fires, pull lever for overhead fire extinguisher (Ansul System), standing back in the process to avoid any unnecessary intake ~~of CO2~~ and follow up with K-type fire extinguisher. ~~.~~
~~10)~~8) Initiate local evacuation if necessary. This procedure should be initiated by the fire department, institutional ~~police~~police, or safety engineer.
~~11)~~9) Escape Routes for staff working in the kitchen:
   a) Main Kitchen ~~-~~ ~~will~~ exit the back door onto the back loading dock area – push on glass doors if they don't open automatically. Check in with the Supervisor, Chef, or Designee and wait for further instructions.
   b) Tray-line Area – exit the back door onto the back loading dock area – push on glass doors if they don't open automatically. Check in with Supervisor, Chef or designee and wait for further instructions.~~exit through double doors, turn left and go down the corridor and turn left after the restrooms and offices and go out through the door to the back of the loading dock area. Check in with Supervisor and wait for further instructions.~~

c) ~~Dishroom~~Dish room Area – exit the back door onto the back loading dock area – push on glass doors if they don't open automatically. Check in with Supervisor, Chef or Designee and wait for further instructions.~~exit through double doors, turn left and go down the corridor, turn left and go past trayline doors, then turn left after the restrooms and offices and go out through the door to the back loading dock area. Check in with Supervisor and wait for further instructions.~~

d) Cafeteria – exit through the dining room towards old building; exit through double doors and wait by ~~flag pole~~flagpole. Check in with Supervisor and wait for further instructions.

1.78 Nourishment Inventory

~~Established and~~ Revised: 108/25 4~~3/87, 1/89, 5/97, 9/06, 7/09~~
~~Reviewed: 8/13, 8/14~~

Policy: The Department will take inventory on all ~~enteral~~internal nourishment products once~~twice~~ per week.

Purpose: To document the usage of all enteral nourishment products.

Procedure:

1. All enteral and nutritional products stored in their designated storeroom will be inventoried.

2. Once~~Twice~~ per week, the inventory will be taken by a Food Service Supervisor or designee.

3. All information derived from this inventory is forwarded to the Production Diet Clerk to be entered in the CBORD IMS. Orders will be placed against pre-set pars and reorder points as determined by~~to~~ usage.

4. Other items as determined by the Chief Dietitian will be order as needed.

1.79 Storage of chemicals, brooms, mops, and other cleaning supplies

~~Established and~~ Revised: 10/25 ~~8/24New 8/14~~
~~Reviewed: 8/14~~

Policy: To prevent foodborne illness by chemical contamination ~~ensure that the chemical used~~ Food and Nutrition Services (FNS) staff will use and store chemicals ~~for sanitizing food service work and other cleaning equipmen~~safely~~t are stored properly~~.

Procedure:

1. FNS has a designated location for Safety Data Sheets (SDS).

2. All employees working with cleaning chemicals must be aware of where the Safety Data Sheets (SDS) are in the facility. **Never mix chemicals.**

~~1.~~3. Chemicals used for ~~dishmachine~~dish machine, ~~potmachine~~pot machine, and cleaning of the ~~all kitchen~~all-kitchen equipment must be ~~stored away from food at all times~~always stored away from food. Chemicals are stored in the chemical storeroom until use.

~~2.~~4. The chemicals that are opened and being used to properly clean and/or sanitized ~~are located in~~are in the ~~dishroom~~dish room, ~~potroom~~pot room, ~~handwash sinks,~~ and on the sanitation cart ~~under the bain marie~~ for use to clean kitchen equipment.

~~3.~~5. The chemical vendor will monitor the correct titration of chemical(s) and file reports periodically to the Department.

~~4.~~6. If chemicals are to be stored in another container other than ~~it's~~its original container, it must be in correct concentration as specified by the manufacturer and be marked with the proper common name. ~~(ie: a spray bottle)~~

~~5.~~7. For the safety to the staff, the Safety Data Sheets (SDS) on chemicals are filed in a binder located on the ~~dishroom~~dish room wall and Chef's Office.

~~6.~~8. All brooms, dustpan, ~~mops~~mops, and buckets must be properly stored in a designated place away from the food in the ~~dishroom~~cart washroom.

~~7.~~9. Clean brooms, dustpan, ~~mops~~mops, and mop buckets after each use. Follow the procedure for changing mopheads.

~~8.~~10. Scrub pads and brushes are to be properly cleaned prior to storage in the designated place away from food. They are to be properly disposed when worn.

~~9. Follow the procedure for rags used for cleaning.~~

11. Follow the ~~three bucket~~three-bucket procedure for proper cleaning, ~~rising~~rinsing, and sanitizing of kitchen equipment.

~~10.~~12. Use the appropriate chemical test kit to measure the concentration of sanitizer daily.

~~11.~~ Do not use chemicals containers for storing food or water.

~~12.~~13. ~~11/6/2015~~

1.81 Eye wash stations

~~Established and~~ Revise~~d:3~~10/2025 ~~8/24New 7/12 Reviewed: 8/13, 8/14~~

Policy: To ensure the effect use and reporting use of the eye wash stations located in the main production kitchen.

Procedure:

~~1.~~ There are three locations in the Food Service department where eye wash stations are located.~~main production kitchen for the eye wash stations. Locations: In the Cold Food Preparation Area above hand washing sink; In the hot grill / deep fryer area above hand washing sink and Dishroom across from the dishmachine above hand washing sink.~~

1.

- Chemical room P2236, located near the diet office.
- Tray-line, dish machine area, next to hand washing sink.
- Café, next to the three-compartment sink.

~~2.~~ The manufacture recommendations are to keep dusk cover on to allow protection from debris when not in use. Easily detected and maintained, emergency equipment with safety sign and maintenance record with weekly testing.

2.

~~3. Each eye wash station consists of two bottles of saline solutions.~~

~~4.~~

3. It will be monitored and maintained by ~~the Supervisors and/or Chef dailys~~. ~~–~~The Food Service Supervisor, Chef, or designee will ensure that the daily tests are documented and completed, if not notify your supervisor.

~~The Senior Food Service Supervisor and/or Production Chef will ensure that the bottles are changed before expiration date.~~

4. When an employee or others uses the eye wash station for any reason to flush out their eye(s), the Supervisor, ~~and/or~~ Chef, or designee ~~on Duty~~ will complete the following:

a. Ensure the safety of the employee. Check if they need medical treatment or not.
b. Complete an entire workman's compensation or industrial accident report for each incident.
c. Go on-line and fill out an Incident Report Form .~~Unusual Occurrence Form.~~
d. Notify through email the Industrial ~~Hygienist;~~Hygienist, ~~Assistant~~ Director of Food Service, and the Food Service Manager.
~~e. Replace the used bottle of solution. Replacement bottles are located in Chef's office or Storeroom B.~~

1.82 Composting food in the ~~dishroom~~dish room – Salva~~jd~~or Waste Collector

~~Established and~~ Revised: 10/2025~~New 8/12~~
~~Reviewed: 8/13, 8/14~~

Policy: To compost food scraps returned from the resident meal trays at all meal service and ~~warewashing~~ware washing process.

Procedure:

1. Put together the Salvajor Waste Collection with the three main pieces: a food collector basket, a black plastic cover, and ~~stainless steel~~stainless-steel top cover.

2. Start the system by depressing the start button on the system after engaging the breaker.

3. Allow the trough to start pumping and fill the trough.

4. There are three up turned pipes that flow water out of them. Hold a plate over one facing the plate towards the flow. Scrape the plate, use of a gloved hand or scraper will help this process wiping the food into the trough.

5. Scrape the contents of the plate into the trough.

6. The Salvajor will fill up, and the basket will need to be pulled out and drained and the contents placed in the green bin. There is a "site" on the side of the Salvajor where you can see into the basket and can see when the basket is filling. Empty ~~Change~~ basket often as required. ~~Use a 2nd or 3rd basket and rotate them through the unit so the there is no down time in the warewashing process.~~

7. Turn off the device, drain the bin and place the organic compound into the green bin. Start the Salva~~j~~gor after putting it back together and resume the process of scraping the plates.

8. There are three stations with water jets for the scrapper to use. The fourth station can likely use the start area of the trough as a fourth cleaning jet, ~~other wise~~otherwise have the 4th position scrape using a glove or scraper to remove the food into the trough.

9. Other items such as milk cartons, paper plate, paper ~~juice~~ containers, napkins can be placed into a compost receptacle lined with a green compost bag. When half filled, take and deposit into a larger green compost bin and transported out into the loading dock area after each meal service.

10. Items such as plastic ~~containers,~~ straws, diet kit wrapping, beverage lid ~~coffee mug cover~~ are to be placed into a gray trash landfill receptacle. All filled trash bags will

be collected and transported out to the trash bin out on the loading dock at the end of the ~~warewashing~~ware washing process.

11. At the end of the ~~warewashing~~ware washing process, shut off the Salvajor unit; pull out the ~~stainless steel~~stainless-steel cover, black plastic cover and basket. Empty the basket of food into the green compost tote or bin. Rinse and wash the three pieces. Unplug and allow the Salvajor unit to be drained. Properly clean and allow to air dry. Keep the pieces out of the unit until~~l~~ the next meal service.

Revised Nursing Policies and Procedures

NURSING CLINICAL COMPETENCY PROGRAM

POLICIES:

1. Nursing Administration, Supervisors, and Nurse Managers are responsible for assuring competent nursing practice at Laguna Honda Hospital and Rehabilitation Center (LHH).

2. Registered Nurses (RN) are responsible and accountable for assuring their own clinical competence as elaborated in the California Nurse Practice Act and as consistent with the American Nurses Association's Code of Ethics for Nurses.

3. Licensed Vocational Nurses (LVN) are responsible and accountable for assuring their own clinical competence consistent with scope of practice set by the California Boards of Vocational Nursing and Psychiatric Technician (BVNPT).

4. Certified Nurse Assistants (CNA) ~~and Home Health Aides (HHA)~~ are responsible and accountable for assuring their own clinical competence consistent with certification set by the California Department of Public Health (CDPH) Licensing and Certification Program.

5. The Nursing Hiring Manager collaborates with Human Resources to recruit and hire qualified nursing personnel.

6. The Nursing Orientation Coordinator, Nurse Educator, Unit Nurse Manager, Unit Charge Nurse, and/or ~~Preceptor~~ Trainer provides competency-based orientation and evaluation of new nursing employees.

7. The Nursing Orientation Coordinator will collaborate with the unit Nurse Manager and/or unit Charge Nurse to assign orienting RNs and LVNs to an experienced, competent licensed nurse ~~preceptor~~ trainer for the duration of the orientation program. The unit Nurse Manager and/or unit Charge Nurse will assign experienced, competent ~~CNAs~~ nursing assistants to ~~precept~~ train the new CNAs, or PCAs~~, or HHAs~~.

8. Upon completion of orientation and throughout the employee's employment, the unit Nurse Managers and Supervisors, with the support of Department of Education and Training (DET) Nurse Educators and Clinical Nurse Specialists, provide ongoing competency evaluations.

9. DET shall conduct a biannual review and revision of the topics of its in-service training program to present to the Nursing Executive Committee (NEC) for review. After approval from NEC, the proposed in-service training program will be sent to Performance Improvement and Patient Safety (PIPS) Committee for a final review. Thereafter it will be sent to CDPH for approval. This process is to ensure that topics are relevant to the facility and its needs.

10. DET and Quality Management will collaborate on abuse in-services and trainings to ensure that gaps in knowledge of abuse prevention, reporting, and role of a mandated reporter are addressed.

11. Annual performance appraisals completed by designated Nurse Manager or Nursing Supervisor will include a job role competency including abuse prevention knowledge.

~~12.~~ On all shifts, Nursing Operations Supervisor and/or Nurse Managers can access education for problem prone knowledge gaps so they may provide just in time education and coaching for staff as needed.

PURPOSE:

To ensure that LHH nursing employees are competent to provide care and services in accordance with current standards and within their scope of practice**.**

DEFINITION:

Competency is defined as the employee's ability to perform a particular job or function or skill in a specific setting in accordance with regulatory, organizational, and professional standards. This includes ongoing acquisition of new knowledge, and demonstration of skills and behaviors.

PROCEDURES:

A. Clinical Nn~~n~~ursing ~~s~~Staff (RNs, LVNs, CNAs, and PCAs~~, and HHAs~~) competency includes:

1. Maintaining a current and active license and/or certification to practice.

2. Updating and maintaining skills and knowledge through:

    a. Classroom-based review and demonstration of procedure prior to actual practice or as a refresher
    b. Review of videos or online training programs.
    c. Review of procedures using resources such as policy and procedure manuals, current clinical practice guidelines or other written materials from trusted sources, such as textbooks and current articles.
    d. Demonstration/ return demonstration or actual practice guided by a competent and experienced clinician at the bedside.
    e. Participation in general, program-based or unit-based education.

3. Participating in formal needs assessment process to identify individual learning needs.

4. Participating in LHH mandatory annual trainings and other training programs.

5. Attending continuing education classes and professional conferences and/or seminars to remain clinically relevant, and as required for recertification (CNA, PCA~~, HHA~~) or re-licensure (RN / LVN).

6. Maintaining current Basic Life Support (BLS) or Cardiopulmonary Resuscitation (CPR) certification as required by job description

7. Participating in the performance appraisal process, including self-appraisal to evaluate clinical practice and to identify areas for professional development.

B. Nurse Manager

ROLE: Ensures clinical staff competency which includes:

1. Communicates job expectations to staff.

2. Collaborates with Nursing Orientation Coordinator to provide new staff with neighborhood or program-specific orientation.

3. Completes probationary performance evaluation with input from Nursing Orientation Coordinator and/or Nurse Educator, ~~preceptors~~trainers, and/or mentors for new nursing staff.

4. Completes ongoing performance evaluation in collaboration with Human Resources, including annual and intermittent competency evaluations, performance plan and performance evaluations

5. Encourages and supports employees' self-development and independent learning efforts.

6. Schedules nursing staff to regularly participate in annual and ongoing training.

7. Ensures resident/patient ~~-~~specific neighborhood training as needed.

8. Maintains documentation of competency assessment.

C. Clinical Nurse Specialist

ROLE: Supports competency development which includes:

1. Participates in interdisciplinary committees and performance improvement teams to:
   a. assess program needs in clinical areas,
   b. develop related program or interventions for individual residents/patients,
   c. evaluate processes that support or detract from nursing practice and performance.

2. Provides consultation to enhance competent clinical practice.

3. Participates with quality improvement and interdisciplinary committees in analyzing resident/patient outcome data in order to link competency training with desired resident/patient outcomes.

D. ~~D.~~ Nursing Orientation Coordinator and Nurse Educators

ROLE: Supports staff competency which includes:

1. Ensures nursing orientees complete nursing orientation and (CNA, PCA, ~~HHA,~~ LVN, and RN) meet standards for clinical competency consistent with their scope of practice and job description.

2. Participates in the assessment of educational needs required for the job and setting in collaboration with Nursing Leadership and Quality Assurance and Performance Improvement (QAPI) program.

3. Develops, implements and evaluates nursing orientation and training programs for nursing staff according to CDPH requirements.

4. Participates in the development of nursing practice standards.

5. Participates with quality improvement and interdisciplinary committees in analyzing resident/patient outcome data in order to link competency training with desired resident/patient outcomes.

6. Ensures Licensed Nurses will complete a Point of Care Test (POCT) Training on Accu-check (glucocheck) device initially during orientation. Under the guidance of the POCT Coordinator, licensed nurses will complete POCT training six (6) months post orientation, and then annually thereafter.

REFERENCES:

California Nurse Practice Act, Standards of Competent Performance
Excerpt from California Code of Regulations, Title 16 - Chapter 14

CROSS REFERENCES:

Hospitalwide Policy and Procedure
01-03 Hospital Organization Chart
80-03 Student, Volunteer and Consultant Orientation
80-05 Staff Education Program

Nursing Policy and Procedure
A 6.0 Orientation of Nursing Personnel

ATTACHMENT:

Adopted: 12/2007

Revised: ~~2012/~~05/22/2012; ~~2021/~~02/09/2021, ~~2022/~~12/13/2022; ~~2023/~~06/13/2023; ~~2025/~~05/08/2025; 06/03/2025; 10/07/2025

Reviewed: 2025/05/08

Approved: 2025/05/08

ORIENTATION OF NURSING PERSONNEL

POLICY:

1. All nursing staff employees are oriented to their job performance expectations and pertinent organizational and divisional policies and procedures prior to independent performance. Successful completion of orientation is required to pass the probationary period.

2. The Nursing Orientation program is developed by the Department of Education and Training (DET) in coordination with many other clinical departments, such as the Department of Public Health Occupational Safety & Health (OSH) and Laguna Honda Hospital (LHH) Human Resources.

3. The orientation program consists of:

    a. Didactic orientation to facility attributes, policies, procedures, regulations, and specific job description.

    b. Clinical experiences guided and supervised by the Nurse Managers, Nurse Educators, Clinical Nurse Specialists, ~~preceptors~~trainers, and mentors.

    c. Documentation that objectively reflects job competencies, as well as provides a method for performance appraisal or competency to assess knowledge acquisition and evaluating performance.

4. Successful completion of the Nursing Orientation Program is achieved when assessment of performance indicates that the orientee is competent to perform duties of the job description, as evidenced by the demonstration of job-related skills and completion of other learning activities. After which time, DET Nursing Orientation Coordinator communicates successful completion of nursing orientation with Nursing Operations Supervisor and/or designated Nurse Manager.

5. Successful orientees will demonstrate the following:

    a. The Certified Nursing Assistant (CNA) or~~,~~ Patient Care Assistant (PCA)~~, or Home Health Aide (HHA)~~ orientee will complete: a Skills Demonstration Competency Checklist including equipment and technologies, a Mealtime Competency Evaluation, a post test and an evaluation of the orientation, as well as other assignments made by the Nursing Orientation Coordinator and/or Nurse Educators.

    b. The licensed orientee {Registered Nurse (RN) or Licensed Vocational Nurse (LVN)} will complete the above plus a Competency Evaluation in Physical Assessment, a Medications Administration Competency Evaluation, Mealtime Competency Evaluation, and Point of Care Test (POCT) training on use of the Accu-check (glucometer) and Occult Blood testing In addition, the orientee will also complete exercises on the Management of Sharps, Using Information Resources Page and other assignments given by the Nursing Orientation Coordinator and/or designee.

~~6.~~ The orientee will be given the opportunity to complete the Orientation Program in an environment that is conducive to learning. A designated period of time for the CNA, PCA, ~~HHA~~ and for licensed staff will be allotted for the orientation to identify learning needs, obtain experiences, demonstrate knowledge and skills, and receive an evaluation of performance.

~~7.~~6.

~~8.~~7. The orientee shall receive Abuse-training on prevention of Abuse, Neglect, and Exploitation.

~~9.~~8. If the orientee has not completed all of the competencies within the time allotted, and the assessment indicates that the orientee is not yet competent to perform duties of the job description, as evidenced by the demonstration of job-related skills and completion of other learning activities, the need for an extension of orientation will be evaluated. The length of the extension of orientation will be determined by the Nursing Orientation Coordinator in consultation with the Nursing Director, Nurse Manager, Nurse Educator and/or ~~preceptor~~trainer/mentor. Notification will be provided to the DET Nursing Director and/or to the Directors of Nursing (DON).

PURPOSE:

To provide an orientation program to newly hired Laguna Honda Hospital and Rehabilitation Center (LHH) nursing staff in accordance with their job classification and job description.

PROCEDURE:

A. **Ongoing Assessment and Documentation**

1. Classroom time will be provided for didactic teaching according to job description.

2. Clinical experiences as practicable are provided so that performance assessments which address the criteria-based objectives may be observed, practiced, and demonstrated by the orientee.

3. The orientee's ability to perform specific skills will be documented on the Orientation Checklist by those who observe the orientee's performance or provide instruction, as designated by the Nursing Orientation Coordinator.

4. The Nurse Manager and/or ~~preceptor~~ trainer will discuss with the orientee specific skills required and whether criteria are met by the orientee and assess need for further training. The orientee and Nursing Orientation Coordinator will review the documentation together.

B. Unmet Competencies

If the orientee has specific learning needs that requires additional orientation time, efforts will be made to address those needs. The Nursing Orientation Coordinator will be informed by the Nurse Manager if the orientee is unable to meet criteria/skills required.

1. A collaborative team of the Nurse Manager, Nursing Orientation Coordinator and/or Nurse Educators will write a developmental plan to assist the orientee to meet required program objectives.

2. The developmental plan will be outlined in writing and attached to the documents for orientation completion for the individual orientee.

3. In a conference, the orientee will be advised by the Nurse Manager, Nursing Orientation Coordinator and /or Nurse Educator as to performance expectations, the developmental plan, and the target date for the completion of the plan.

4. The Developmental Plan will be signed by those participating in the conference.

5. If, at the end of the designated time, the orientee has not met job expectations as defined by the Initial Orientation Checklists and the Developmental Plan, termination of employment will be recommended to Human Resources.

C. Orientation Program

An orientation program will be provided for the following categories of nursing and affiliated staff:

1428 Unit Clerk
~~2583 Home Health Aide~~
2302 Certified Nursing Assistant
2303 Patient Care Assistant
2312 Licensed Vocational Nurse
2320 Registered Nurse
P103 Per Diem Registered Nurse

Orientation by Leadership in the same classification will be given to staff that are new to the role at Laguna Honda Hospital:

2320 Acting Nurse Manager
2320 Administrative Departments
2322 Nurse Manager
2323 Clinical Nurse Specialist
2324 Nursing Supervisor or Nursing Director
0941 Manager VI
0942 Manager VII
0943 Manager VIII
Or other Nursing Leadership Classifications

CROSS REFERENCES:

NONE

ATTACHMENT/APPENDIX:

NONE

Adopted: ~~2006/~~01/2006

Revised: ~~2007/~~10/2007, ~~2012/~~05/22/2012; ~~201/~~01/13/201; ~~2021/~~02/09/2021; ~~2022/~~12/13/2022; ~~2023/~~06/13/2023; ~~2025/~~05/12/2025; 10/06/2025

Reviewed: ~~2025/~~05/12/2025

Approved: ~~2025/~~05/12/2025

SICK LEAVE / INTERMITTENT FAMILY MEDICAL LEAVE OF ABSENCE, and TARDY CALL-IN

POLICY:

1. Employees are required to notify the Nursing Office a minimum of at least two and a half (2.5) hours before the start of their shift for any illness/absence.

2. Employees on orientation shall notify Nursing Office and e-mail Department of Education & Training (DET) a minimum of at least two and a half (2.5) hours before the start of their shift for any illness/absence while on orientation.

3. Employees shall notify Nursing Office if they will be late, and upon arrival, shall report to Nursing Office prior to reporting to assigned neighborhood.

PURPOSE:

To provide adequate coverage for unplanned staffing shortages to promote quality resident care.

RELEVANT DATA:

This policy applies to all employees of the Nursing Department, including: Program Nursing Directors, Operations Nurse Managers, Neighborhood Nurse Managers, Clinical Nurse Specialists, Nurse Educators, MDS Coordinators, Staff Registered Nurses (RN), Licensed Vocational Nurses (LVN), Certified Nursing Assistants (CNA), Patient Care Assistants (PCA), ~~Home Health Aides (HHA),~~ Unit Clerks, Beauticians, Barber, Bus/Van Drivers, Nursing Staffing Assistants and Nursing Office Support Staff.

PROCEDURE:

A. Sick Leave / Intermittent Family Medical Leave of Absence (FMLA) / Self-Cancellation Call-In

1. Employees must notify the Nursing Office by telephone of sickness, approved FMLA time off, self-cancellation of overtime or P103 no later than 2.5 hours before the start of their shift. The deadline is as follows:

   AM Shift: by 2030 (8:30 PM)
   DAY Shift: by 0430 (4:30 AM)
   PM Shift: by 1230 (12:30 PM)

2. Any notification received later than 2.5 hours before the beginning of the shift will be recorded as Absent Without Leave (AWOL).

   For extenuating circumstances (emergency and unusual situations) staff may request from the Nurse Manager to reverse the AWOL designation to paid sick time/benefit time. The decision will be made on a case-by-case basis considering both the circumstances and the individual staff's attendance pattern.

   a. Staff must inform the Nursing Office staff of the number of sick days that are needed (no more than five days). Staff may call in for consecutive days if necessary. However, staff will be marked AWOL if staff do not return on the expected shift. **Staff do not need to call in to**

return to work for the shift following an absence or benefit time off. If staff needs additional sick time, they must notify the Nursing Office.

b. Requests for sick leave in excess of five (5) continuous working days shall be certified (i.e. submission of a signed letter/certificate or completed City and County of San Francisco request for Leave Form) by a qualified health care provider. Family Medical Leave requests (intermittent or continuous) are processed in the same manner.

B. Tardy Call-In

1. Staff who call in prior to their starting time to inform the Nursing Office that they will be reporting late, may be allowed up to a thirty (30) minutes time extension from the regular reporting time to report to duty. Staff will not be docked, provided the time is made up.

2. Staff who have a pattern of tardiness may be denied the opportunity to stay over and make up the time but will be docked instead.

3. Regardless of whether staff are allowed to make up the time or are docked, incidents of tardiness may result in disciplinary action. Whether or not the employee is allowed to make up the time is a management decision depending upon the neighborhood's operational and/or staffing needs.

4. Staff who have not called the Nursing Office prior to their starting time will be allowed up to a thirty (30) minutes time extension from the regular reporting time to report to duty and will be docked. For all instances of tardiness, time will be computed in fifteen (15) minute increments. If staff is more than fifteen (15) minutes late and has not called in, he/she may be given a float assignment. Such episodes of tardiness are subject to disciplinary action.

5. Staff reporting late will report to the Nursing Office to sign in at the time of arrival.

6. Staff who report to work over thirty (30) minutes late and have not contacted the Nursing Office, will not be allowed to work and will be considered absent without leave. If a staff member is over thirty (30) minutes late but contacts the Nursing Office and is told to come to work, said staff may be allowed to work the balance of the shift if, in the judgment of the Nurse Manager/Administrator on Duty/Director, the tardiness is excusable and/or there is an operational need. The decision to allow the employee to work does not preclude subsequent disciplinary action

7. Staff who are chronically tardy may not be allowed to work when tardy after having been notified in writing in advance of such proposed action. Such refusal does not preclude the Department from taking subsequent disciplinary action.

8. If staff have not arrived to the neighborhood, the Charge Nurse must inform the Nursing Office. The Nursing Staffing Assistant must immediately notify the Nursing Operations Nurse Manager or Nursing Supervisor. Neighborhood staff must not depart the neighborhood until permitted to do so by the Nursing Operations Nurse Manager or Nursing Supervisor, as mandatory overtime may become necessary.

9. Time records must accurately reflect the time employee's start work and the number of hours worked in every work day. Employees who fail to report arriving to work late, may be subject to disciplinary actions for falsification of hours' time worked.

10. The Charge Nurse who fails to notify the Nursing Office that staff are missing or late will be held accountable for non-compliance with the standard.

Adopted 12/2007

Revised: ~~2005/~~03/2005, ~~2007/~~10/2007, ~~2011/~~04/26/2011, ~~2014/~~07/22/2014; ~~2024/~~07/09/2024; 10/06/2025

Reviewed: ~~2024/~~07/09/2024

Approved: ~~2024/~~07/09/2024

RESIDENT ADMISSION AND READMISSION FOR SKILLED NURSING FACILITY

POLICY:

1. The responsible physician, nurse manager (NM), charge nurse (CN), and the nursing director (ND) will be notified of any new admissions.

2. The licensed nurse is to document admission and readmission assessments and other documentation into the electronic health record. If the licensed vocational nurse (LVN) has collected data for the admission nursing assessment, the RN must co-sign to verify the accuracy of data.

3. The Minimum Data Set (MDS) RN is responsible for completing Resident Assessment Instrument (RAI)/MDS Tracking Assessment related to an admission or readmission {Cross Reference LHHPP File: 23-02 Completion of Resident Assessment Instrument (RAI/MDS)}.

PURPOSE:

To ensure that resident is welcomed at Laguna Honda Hospital and to develop a comprehensive plan of care for the resident and the family and/or significant others.

PROCEDURE:

A. Decision to Accept the Referral

~~The physician and/or the NM must contact the Patient Flow Coordinator (PFC) before the end of the day with a decision to accept or deny the resident to the neighborhood.~~

~~The Director of Social Services must be kept informed of pending admissions.~~Refer to Hospitalwide Policy and Procedure (HWPP) 20-01 Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units.

B. Admissions and Re-admissions Procedures:

1. Upon new admission, resident will stop by A&E to have admission photo taken and uploaded onto EPIC.

2. The resident will receive a copy of the Resident's Rights Form from the admitting clerk or A&E staff with a receipt of acknowledgement by the signature of the receiving party. (Refer to HWPP 22-03 Resident/Patient Rights)

3. The resident will receive the LHH Resident Handbook from Social Services.

4. The nurse manager/charge nurse is to notify the resident and/or surrogate decision maker that the Resident Care Team (RCT) will be assessing resident's level of nursing care upon admission

and throughout the stay. The resident will be advised on their ongoing evaluation of level of care needs and possible discharge/relocation.

5. Medication brought with resident from outside will be sent home with the resident's family or guardian. Otherwise, medications are taken to pharmacy or placed in the pharmacy pick-up tray. in a paper bag labeled with the resident's name, unit and date. Record disposition on the electronic health record. Pharmacy may dispose of medications as necessary.

6. Resident Identification

   a. Apply identification band to wrist. If resident is allergic or refuses, note on the electronic health record and use alternate method of identification (Cross reference to HWPP 25-15: Medication Administration).
   b. A current resident photograph is to be placed in the resident's electronic health record.
   c. Place resident's first name, initial of the last name (e.g. John S.) and appropriate color coded stickers on the bed card (above bed), hallway card, and mobility devices.
   d. Precautions identified by colored sticker (Refer to NPP B 5.0: Resident Identification and Color Codes).

7. Resident's Property

   a. Refer to LHHPP File: 22-05 "Handling Resident's Property and Prevention of Theft and Loss" before itemizing clothing, property and valuables on the Inventory of Property Sheet. Ask resident to sign both sides, including the "Acknowledgement and Waiver".

C. Nursing Admission Assessment

1. Upon admission, all residents are offered a shower/bath and nail trim, unless condition does not warrant, or the resident prefers bathing at a later time.

2. Upon admission the skin and hair of all residents is to be carefully inspected for possible infestation of head or body lice and scabies. The NM, Infection Control Nurse (ICN), and the physician are to be notified immediately if symptoms such as itching scratch marks, rashes, small white granules (nits) on hair shafts or living lice are present. (Refer to HWPP 72-01 Infection Control Manual – C16 Scabies Management)

3. Obtain and document vital signs (Refer to NPP G 1.0: Vital Signs)

4. Measure height and weight, and record on the electronic health record. (Refer to NPP G 4.0: Measuring Resident's Height and NPP G 7.0 Obtaining, Recording and Evaluating Residents Weight).

5. Complete the Braden Scale and a skin assessment in the EHR (Refer to NPP K1.0: Assessment, Prevention and Management of Pressure Injury, and NPP K 2.0: Wound Assessment and Management).

D. Admission Documentation:

Electronic Health Record (EHR):

1. Allergies
   a. If resident has any known allergies, document allergies and include any known reactions.

2. Admission Assessment
   i. Complete nursing admissions assessment
   ii. Licensed nurse to add applicable standard work list tasks for both LN and nursing assistants.

3. Notes
   a. Licensed Nurses will document a nurses note once each shift for at least the first 72 hours after admission assessment, or longer if condition warrants.
   b. Comprehensive weekly summaries will be documented for all residents (Refer to NPP C 3.0: Documentation of Resident Care/Status by the Licensed Nurse).

4. Care Plan Refer to HWPP 23-01 Resident Care Plan, Resident Care Tea, & Resident Care Conference
   a. Initiate baseline care plan within 8 hours on the day of admission
   ~~a.~~b. Complete and implement baseline care plan within 48 hours of a resident's admission

~~4.~~5. Medicare Coverage:
For the duration of Medicare coverage, document a daily nurses' note at minimum. Focus documentation on skilled nursing care, in addition to routine physical assessment. When no longer covered by Medicare, select charting frequency per policy as indicated by resident's condition.
   a. Initiate MDS Assessment process.
   b. Initiate the care planning process **within 8 hours** (Refer to LHHPP File: 23-01 Resident Care Plan, Resident Care Team & Resident Care Conference).

E. Re-admission Chart:

1. Submit Help Desk Request to request closed chart from Health Information Services if discharged more than 7 days ago.

2. Initiate a new Care Plan upon re-admission. IDT should review and revise the new care plan on the first IDT meeting.

REFERENCES

None

CROSS REFERENCE

Laguna Honda Hospital Policy & Procedures
- 20-01 Admission to Laguna Honda Acute & SNF Services & Relocation Between Laguna Honda SNF Units
- 22-03 Resident/Patient Rights
- 22-05 Handling Residents Property & Prevention of Theft and Loss
- 23-01 Resident Care Plan, Resident Care Team & Resident Care Conference
- 3-02 Completion of Resident Assessment Instrument (RAI/MDS)
- 25-15 Medication Administration
- 72-01 Infection Control Manual – C16 Scabies Management

Nursing Policy & Procedure
- B 5.0 Resident Identification & Color Codes
- C 3.0 Documentation of Resident Care/Status by the Licensed Nurse - SNF
- F 2.0 Assessment and Management of Urinary Incontinence

G 4.0 Measuring the Resident's Height
G 7.0 Obtaining, Recording and Evaluating Residents Weight

ATTACHMENT/APPENDIX

NONE

Revised: ~~2002/~~08/2002, ~~2008/~~04/2008, ~~2009/~~01/2009, ~~2009/~~09/2009, ~~2016/~~09/13/2016; ~~2019/~~07/09/2019; ~~2024/~~06/11/2024; 10/06/2025

Reviewed: ~~2024/~~06/11/2024

Approved: ~~2024/~~06/11/2024

Nursing Guidelines for Relocation Between Laguna Honda Skilled Nursing Facility (SNF) Neighborhoods

POLICY:

1. The resident will be processed as "Relocation" when the resident is moved from one SNF unit to another SNF unit.

2. The decision to relocate a resident is made by the Resident Care Team (RCT) based on the resident's clinical needs.

PURPOSE:

To outline Nursing Policies and Procedures for resident relocation and to provide a smooth resident transition within Laguna Honda.

PROCEDURE:

A. Sending Neighborhood

1. Before the relocation

~~a. Licensed Nurse (LN) obtains Relocation Order from the physician.~~
~~b. LN or Nurse Manager (NM) or designee enters the relocation referral in EPIC.~~
~~c. LN or Social Worker (SW) or designee Informs the resident/family/SDM of the relocation.~~
~~d. LN or SW or designee offers tour of receiving neighborhood to the resident and/or responsible party.~~
~~e. LN completes a Transfer of Room Notification form.~~
~~f.~~a. ~~Accepting Resident Care Team (RCT) to review the resident's record in order to make sure that resident's needs will be met in the new unit and notify the referring unit of acceptance.~~ Refer to Standard Work on *Relocation Referral to a Vacant SNF Bed*

2. On the day of relocation, the Licensed Nurse (LN) or designee will:

   a. Gather all resident's medications, personal belongings, and other special equipment to be sent to the receiving neighborhood.
   b. Check all personal belongings that are listed in the property inventory sheet to ensure all resident's belonging are accounted for prior to relocation.
   c. Complete a new inventory / property sheet by reviewing current personal belongings.
   d. Complete LHH Relocation Checklist – Sending Unit section.
   e. Inform the receiving neighborhood for any future clinic appointments, if indicated.
   f. Notify Food Services to cancel meals.
   g. Notify the dialysis transportation if applicable.
   h. Licensed ~~N~~nurse will document a brief summary of resident's physical and mental condition including vital signs, time of relocation, mode of transportation.
   i. The LN from both the sending and receiving units will review resident's skin condition together and update on EHR if needed.
   j. Notify ~~EVS~~ Environmental Services (EVS) to clean the room.

3. The Minimum Data Se (MDS0 Coordinator will inform the receiving neighborhood MDS Coordinator the status of any MDS assessment.

B. Receiving Neighborhood

1. Upon arrival, the receiving staff will welcome the resident to the neighborhood. Staff will introduce resident to the Nurse Manager, other nursing staff and Resident Care Team (RCT), roommates and other residents in the neighborhood.

2. The LN or designee must orient the resident to his room, review mealtime, activities offered, and pass policies.

3. The NM or designee will tour the resident and/or Surrogate Decision Maker (SDM) in the neighborhood per request.

4. The LN or designee will:

    a. Notify the physician and update electronic health record.
    b. Verify the identification wristband is in place and legible, change ID wrist when appropriate.
    c. Notify Food Services as soon as the relocation has occurred to ensure resident will receive meal tray on time.
    d. Place name card over the resident's bed and outside the room.
    e. Inform the SDM of the new room of the resident.

5. Documentation:

    a. LN will document in the electronic health record the notification of physician and SDM of relocation, orientation to the neighborhood, resident's status and response to neighborhood relocation, and complete the LHH Body Diagram.
    b. LN or designee will update the Property Inventory Sheet.
    c. For the next 72 hours, LN will document assessment of general condition and adjustment to the new environment at least once per shift.
    d. LN or designee document vital signs and pain score for the next 72 hours if stable in the electronic health record.
    e. If applicable, LN will complete a Behavior Risk Assessment, initiate a care plan if needed.

6. Inform resident and/or SDM about the Resident Care Conference schedule and encourage for the resident and/or SDM to attend and participate with plan of care.

REFERENCES:

None

CROSS REFERENCES:

Hospitalwide Policy and Procedure
20-01 Admission to LHH Acute SNF and Relocation between SNF Units
22-05 Handling Residents Property & Prevention of Theft and Loss
50-02 Resident Trust Account

Nursing Policy and Procedure
D9 3.0 Bed Stripping and Terminal Cleaning

ATTACHMENT:

NONE

Revised: ~~Revised:~~ 08/2002~~/08~~, 01/2009~~/01~~, 10/30/2015~~/10/30~~, 09/12/2017~~/09/12~~, 03/12/2019~~/03/12~~; 03/01/2024~~/03/01~~; 09/30/2025

Reviewed: ~~2024/~~06/11/2024

Approved: ~~2024/~~06/11/2024

RESIDENT/PATIENT ACTIVITIES OF DAILY LIVING

POLICY:

1. Registered Nurse assesses the functional ability of each resident/patient to perform the activities of daily living (ADL) upon admission, quarterly, annually and when a significant change in condition occurs.

2. The Licensed Nurse in collaboration with the resident care team (RCT)/interdisciplinary team meeting (IDT) develops a plan of care to meet the resident's/patient's ADL needs, while promoting as much functional independence as possible.

3. All nursing staff~~, except Home Health Aides,~~ may be assigned to provide assistance with ADL care.

4. Under the supervision of the Licensed Nurse, the Home Health Aide may assist with feeding.

5. Non-medicated personal hygiene items may be stored at the bedside in a bag and placed in a closed drawer. Non- medicated personal oral hygiene items must be kept in another bag separate from topical personal hygiene items. (Refer to B 6.0 Items Allowed at The Bedside)

6. When an unanticipated significant decline in ADL function is noted, the RCT will meet to review the plan of care.

7. Residents on a low air loss mattress require 2 person assist for all bed mobility activities (e.g., perineal care, transfers).

PURPOSE:

1. To promote resident/patient comfort and hygiene.

2. A program of ADLs is provided to residents/patients to maintain or prevent decrease in functional status and/or return resident/patient to their highest level of independence.

PROCEDURE:

A. Preparation of Resident/Patient – The resident's/patient's care is individualized to include personal, cultural and religious preferences and is to be provided in a manner that is respectful of the resident's/patient's dignity, privacy, safety and confidentiality.

1. Gather all anticipated hygiene and grooming supplies before approaching the resident/patient.
2. Knock before entering the room and introduce yourself to the resident/patient.
3. Explain care activities to the resident/patient and engage their participation.
4. Maintain privacy during care and keep the resident/patient warm and covered as much as possible during care.
5. Engage the resident/patient in a manner that is appropriate to their cognitive and communication abilities using appropriate language, and communication aides as needed.
6. The individualized resident/patient care plan is followed by all nursing staff and updated as needed.

B. Activities of Daily Living – Activities of daily living are tasks related to personal care: bed mobility, ambulation, locomotion, dressing, eating, toileting, eating, transferring, personal hygiene, and bathing. Basic nursing care procedures are to be followed utilizing Mosby's Textbook for Nursing Assistants and related nursing and hospital-wide procedures as a guide.

1. **Personal Hygiene**

    a. Individualized restorative nursing programs, for Skilled Nursing residents, for dressing / grooming are implemented as indicated on the care plan to maintain or improve resident's abilities.
    b. Resident/patient is positioned at the sink or bedside with all necessary equipment within reach.
    c. Equipment and instruction provided to maintain personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excluding baths and showers).
    d. Skin care routinely includes teaching and assisting the resident/patient to gently cleanse under breasts, chest, back, buttocks and genitals, thoroughly patting dry and application of lotion to back and buttocks.

2. **Dressing**

    a. Residents/patients are encouraged to participate in putting on, fastening, and removing all items of clothing (includes donning/removing prosthesis or TED hose).
    b. Residents/patients are encouraged to choose their clothing.
    c. Adaptive equipment is provided and used as needed.
    d. Alternative methods of dressing are taught as needed.
    e. Occupational therapy consultation is requested as needed through the primary physician.

3. **Eating**

    a. Food preferences are to be respected to the extent possible and are brought to the attention of dietary staff as needed.
    b. Residents/patients are encouraged to eat preferably in the dining room.
    c. Residents/patients are to be in an upright 90-degree position for eating unless contraindicated or refused and so documented on the care plan.
    d. ~~Specialized~~ Individualized aspiration precautions~~feeding plans~~, standard precautions, and restorative eating programs are to be followed. Refer to related procedures as needed.
    e. Dentures and adaptive devices are provided and utilized as needed.
    f. Oral care after each meal is strongly encouraged. When residents/patients do not want oral care the reasons are explored and the team is consulted to negotiate the best possible oral care under the specific circumstances. The dental hygienist and dentist are consulted as needed. Mouthwash and lemon glycerin swabs are not to be used in place of good oral care with a toothbrush and toothpaste.

4. **Toilet Use**

    a. Cognizant residents/patients are instructed on the purpose and use of diet, exercise, and medications in the elimination process by licensed nurses. Nursing caregiver may reinforce this information within their scope of practice and related policies.
    b. Privacy and comfort during elimination must be maintained during toileting whether in resident/patient~~s~~ room~~s~~ or while in tub, shower and toilet rooms.
    c. When placing resident/patient on the toilet or commode, the employee is to ensure resident/patient safety until resident/patient is ready to leave, then assist resident/patient to stand and walk or transfer as needed.
    d. Incontinent residents/patients are cleaned promptly with soap and water, rinsed thoroughly and patted dry. Sensitivity to related discomfort and embarrassment is to be provided.
    e. Use of incontinence products such as pads, briefs, and barrier creams is based on individual resident/patient need. Factors such as skin condition and ability to retrain are to be considered and related policies followed.
    f. Residents/patients with indwelling urinary catheters receive perineal care each shift and as needed.
    g. Bedpans, urinals, and bedside commodes are emptied and cleaned in toilets when soiled and replaced when needed,

5. **Transfer, Ambulation**

    a. Follow related procedures, including transfers, ambulation, range of motion and Restorative Nursing. (Refer to NPP D6 5.0 Ambulation)
    b. Follow basic safety principles for transfer and ambulation such as coaching the resident /patient to rise slowly to gain balance, providing non-skid footwear, obtaining adequate assistance and providing adaptive devices as prescribed.
    c. The minimum frequency of range of motion requiring staff coaching or physical assistance is noted on the care plan and is to be followed.

6. **Bed Mobility**

    a. Nursing standards for every two-hour turning/ repositioning of dependent residents/patients are to be followed.
    b. Exceptions to the above-noted standard related to resident/patient preferences not to be disturbed during hours of sleep are to be discussed with the Resident Care Team (RCT)/Interdisciplinary Team (IDT) members in relation to individual skin condition and other factors with care decisions noted on the care plan.
    c. Resident/patient may be taught and assisted to shift their weight, particularly when seated and when turning is limited by existing pressure areas, unless the resident/patient has limited weight bearing status.

C. Organization of Resident/Patient Care Assignments

1. **Call lights** are to be kept within reach and periodic rounds are to be done to facilitate prompt identification of needs, including incontinence or toileting needs.

2. **Initial Rounds** are done by the nursing caregivers at the start of each shift on all assigned residents/patients on the neighborhood to let each resident/patient know who is caring for them and to identify priorities for care based on immediate safety and comfort needs.

    a. Rounds are to include the resident's/patient's rooms, bathrooms, and other areas on the neighborhood where residents/patients are residing.
    b. Immediate interventions during rounds frequently include repositioning for comfort, toileting/incontinent care, and providing water and call lights within reach.
    c. To ensure safety, reassure dependent residents/patients to request for assistance to move or get up.
    d. Before beginning a lengthy procedure with a resident/patient, it is usually appropriate to check on the staff's other residents/patients first to promote regular monitoring of residents/patients.

3. **Time preferences:** Check in with residents/patients for preference of bathing time. Refusals of care or resident/patient requests that place an undue burden on the staff are negotiated to achieve a reasonable compromise with RCT/IDT members' support as needed.

D. Environment of Care

1. **Personal supplies**- (Refer to B 6.0 Items Allowed ~~A~~at ~~T~~the Bedside~~.~~)~~-~~ Personal supplies or items may include~~,~~ non-medicated personal hygiene items, oral hygiene equipment, washbasins, adaptive eating utensils, brush, combs, bedpans and urinals. Electric shavers and personal razors are not allowed to be kept at the bedside. These items shall be stored in a locked drawer in the unit after each resident's/patient's use for safety.

    a. Items such as oral hygiene equipment, washbasins, and adaptive eating utensils are labeled with the resident's/patient's initials, rinsed after each use, allowed to air dry and returned to resident's/patient's bedside.
    b. Clean urinal, bedpan, and bedside commode with facility-approved disinfectant.
    c. Clean bedpans or urinals may be kept in the lower drawer of bedside cabinet. If resident/patient prefers, clean urinals may be kept within reach of resident/patient.
    d. Oral hygiene equipment, bedpans or urinals are changed as needed.

2. **Combs and brushes** are to have hair removed and are to be cleaned as needed and replaced when broken or worn.

3. **Resident's/Patient's area** is to be kept orderly and clean including:

    a. Overbed tables are wiped off with facility-approved disinfectant after use during bathing or incontinence care and as needed, and weekly as part of bed stripping and room cleaning.
    b. Spills or unclean floors are brought to the attention of EVS staff. Nursing shall clean the spill, then EVS shall mop and disinfect spill area.
    c. Resident/patient preference to keep their private area cluttered with belongings is to be negotiated with sensitivity to the resident's/patient's feelings about the loss of their usual environment with RCT assistance as needed. Allowing for personal preferences in a way that does not impede safety and infection control is preferable to restricting residents/patients unnecessarily, for example:

        i. Provide containers for non-perishable food.
        ii. Offer regular snacks and provide a realistic means for able residents/patients to obtain nutritious snacks independently.
        iii. Offer assistance in tidying up with the resident/patient/family/responsible party.
        iv. Offer assistance in prioritizing items if resident/patient feels strongly about having items at the bedside versus those that can be stored in the wardrobe or sent home.
        v. Communicate regularly with residents/patients regarding which items they value so that items are not inadvertently discarded as trash.
        vi. Unsafe or prohibited items such as spoiled food, drug paraphernalia, or weapons are **not** permitted and related policies are to be followed, (i.e. Infection Control, STAT notification of Institutional Police, and Prohibition of Illicit Drugs or Paraphernalia Possession / Use by Residents or Patients / Visitors.)

4. Resident's/patient's **personal clothing** is laundered ~~per~~ per standard work. (Refer to standard work for Resident Clothing Laundering – Offsite). ~~facility . See Cross References to Nurse Guidelines and Facility Services Equipment Management Program.~~

5. **Linen** and other **personal care items** are not to be brought to another resident's/patient's area once such items are brought into a resident's/patient's room.

    a. The linen is to be handled with appropriate infection control precautions including keeping the clean linen room door closed, hand washing before handling clean linen and discarding contaminated linen in the hamper.
    b. The soiled linen hamper is to be covered at all times and ~~is to be~~ emptied before it is more than ¾ full or when it is malodorous.
    ~~c. Linens carts are distributed to each neighborhood by laundry staff once a day.~~
    ~~d.~~c. Gather supplies needed for each resident/patient prior to beginning care.

E. Instrumental Activities of Daily Living (IADLs)

1. IADLs include activities that occur in addition to basic hygiene and grooming procedures and include activities of choice, use of the telephone, and other functions that are usually done at home and the community, such as housework, shopping, and meal preparation.

2. Nursing collaborates with other disciplines, such as Activity Therapy, Occupational Therapy, and Social Services, to support IADLs and to specifically plan and provide activities that are interesting and satisfying to individual residents/patients.

3. IADL programming that specifically supports resident/patient comfort and hygiene and may be provided in whole or in part by nursing may include:

    a. Manicures
    b. Make-up application
    c. Walking, including walk to dine programs
    d. Exercise programs
    e. Practice folding garments or linen
    f. Grooming activities
    g. Off neighborhood visits, strolls, and activities

F. Reporting and/or Documentation

1. **Electronic Health Record (EHR):)**
CNA or PCA: Record level of function for each ADL. Report any physical or behavioral changes to the charge nurse and document.

2. Licensed nurse: Record and report any changes in condition to physician, supervisor, family and charge nurse of oncoming shift. Review resident/patient ADLs and additional entries and document resident/patient status on the weekly summary, as directed by the documentation policy.

REFERENCES:

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

CROSS REFERENCES:

Standard Work: Resident Laundering - Offsite

Hospitalwide Policy and Procedure
22-03 Resident Rights

Nursing Policy and Procedure
B 5.0 Color Codes –Resident Identification
B 6.0 Items Allowed at the Bedside
C 3.0 Documentation of Resident Care/Status by the Licensed Nurse
C 3.2 Documentation of Resident Care Nursing Assistant
D6 5.0 Ambulation
E 1.0 Oral Management of Nutritional Needs
Section F: Elimination Procedures

Facility Services Policy and Procedure
EM-6 Laundry Equipment Repairs and Clean Up

ATTACHMENTS/APPENDICES:

None

Revised: ~~2005/~~12/2005, ~~2006/~~01/2006, ~~2009/~~09/2009, ~~2010/~~04/2010, ~~2016/~~07/2016, ~~2019/~~03/12/2019; ~~2022/~~11/08/2022; ~~2023/~~04/11/2023; ~~2023/~~09/12/2023; ~~2024/~~06/11/2024; 10/06/2025;

Reviewed: 2024/06/11

Approved: 2024/06/11

REMOVAL OF FACIAL HAIR

POLICY:

1. The decision to remove facial hair is based on resident preference or by the decision maker.
2. Any nursing staff ~~, except for Home Health Aide,~~ can perform and/or assist resident with removal of facial hair.
3. Disposable razors are discarded in the sharps container after use. Electric razors are stored in the resident's bedside.
4. An electric razor is preferred for residents who are on anticoagulant therapy or have bleeding tendencies.

PURPOSE:

To promote dignity and comfort, and provide safe removal of facial hair.

PROCEDURE: (Refer to Skills (elsevierperformancemanager.com) for procedures on Hair Care: Facial Shaving)

1. Review care plan for resident's preference.
2. Inform resident of the procedure. Instruct resident to notify if shaving becomes uncomfortable, if able to verbalize.
3. Encourage resident to participate with self-grooming if able.
4. Inspect condition of facial hair.
5. Discard disposable razors in a sharps container, remove personal protective equipment (PPE) and perform hand hygiene.
6. Document in the electronic health record for any unexpected outcomes and related interventions (e.g., skin nicked, excessive or prolonged bleeding, reactions). Report to licensed nurse any unexpected outcomes.
7. Document procedure, or refusal, in resident's electronic health record:

REFERENCES

Adapted from Perry, A.G. and others (Eds.). (2025). *Clinical nursing skills & techniques* (11th ed.). St. Louis: Elsevier.

Elsevier (2024) *Hair Care: Facial Shaving* https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025

CROSS-REFERENCES:

None

ATTACHMENTS/APPENDICES:

None

Revised: ~~2001/~~03/2001; ~~2010/~~02/2010; ~~2014/~~07/22/2014; ~~2019/~~03/12/2019; ~~2022/~~11/08/2022; ~~2025/~~03/26/2025; 10/06/2025

Reviewed: ~~2025/~~06/06/2025

Approved: ~~2025/~~06/09/2025

RANGE OF MOTION EXERCISE

POLICY:

1. Registered Nurse (RN) will assess need for Range of Motion (ROM) and any contraindications consistent with the resident's goal of care.

2. Licensed Nurse (LN), Certified Nurse Assistant (CNA), or Patient Care Assistant (PCA) can perform range of motion exercises.

3. Nursing Assistants receive initial training during orientation. Other trained staff or volunteers may lead residents through Active ROM (AROM).

PURPOSE:

Range of motion exercises are used to maintain or restore range and maximal function, prevent deformities, stimulate circulation, and enhance a sense of well-being.

PROCEDURE:

A. Assessment

1. The RN begins the functional assessment for range of motion needs during the admission assessment.
2. Skilled Nursing Facility (SNF): Functional assessments are completed as required by MDS (Section G and/or GG as appropriate) at least annually and when a significant change of condition occurs. Refer to Hospitalwide ~~p~~Policy & Procedure (HWPP) 23-02 Completion of Resident Assessment Instrument/Minimum Data Set (RAI/MDS).
3. Assess whether limitations in Range of Motion (ROM) are related to unrelieved joint pain based on resident's report of pain or observation of pain related behaviors, such as moaning, striking out, or grimacing.
4. A physician may order a physical or occupational therapy consultation on admission or anytime there is an assessed need, such as an unanticipated functional decline or contracture.
5. Consider if resident is high risk for fracture before implementing ROM.

B. Planning

1. If appropriate, initiate ROM interventions based on assessment or as ordered.~~.~~
2. SNF:
   a. Range of motion programs that occur daily for 15 min/day generally qualify as restorative and should be care planned as such with maintenance or improvement-oriented goals.
   b. Range of motion that is incidental to Activities of Daily Living (ADL) only does not qualify as a restorative AROM and/or Passive ROM (PROM) program and does not necessitate a full care plan.
   c. Refer to Nursing ~~p~~Policy & Procedure (NPP) D 1.0 Restorative Nursing Program.
3. Acute:
   a. Acute rehabilitation: provide ROM based on assessment, as ordered, or as part of rehabilitation program in conjunction with rehabilitation therapists as part of the Acute Rehab plan of care.
   b. Acute medical: provide ROM as appropriate based on assessment or as ordered and as permitted by acute condition.

4. Plan pain management interventions for residents with contractures and/or chronic joint pain to enable resident's or patient's maximal participation in ROM exercises and to prevent further functional limitation. Gentle ROM is considered an intervention for degenerative joint disease related pain and high risk for fracture.

C. Interventions

1. SNF: Range of motion may be accomplished during bathing, dressing, grooming, or at scheduled times according to resident need or preference, however, range of motion that is incidental to ADLs cannot be considered a restorative nursing program.
2. Provide pain interventions as planned and appropriate. (Refer to HWPP 25-06 Pain Recognition, Assessment, and Management).
3. Loosen or remove restrictive clothing or devices.
4. ROM Procedure: (
5.
6. Refer to Skills: (elsevierperformancemanager.com) for procedures on Range of Motion Exercises)Refer to "Range of Motion Exercises" on Elsevier Clinical Skills for detailed information: https://epm601.elsevierperformancemanager.com/Personalization/Home?virtualname=sanfrangeneralhospital-casanfrancisco
7.4.
8.5. Active Range of Motion (AROM)
    a. AROM is performed by the resident/patient with cueing as needed and supervision from LN or nursing assistant. When the resident does most of the exercise, but needs some assistance with the final stretch, it is still considered active range of motion.
    b. SNF: AROM may be provided in a group with a 1:4 ratio of staff/ or trained volunteer as part of a Restorative AROM program. Videos, music, and small weights are often used to enhance the program.

D. Evaluation / Documentation and Reporting

1. SNF: document minutes of ROM provided.
2. Care Plan
    a. Document a measurable goal with individualized ROM interventions.
    b. SNF: ROM that is not part of a restorative program should be care planned, but not included in a restorative care plan.
3. SNF weekly summaries: document ROM progress toward care planned goals or any changes from baseline is addressed with each nursing summary to evaluate the resident's response to the program.
4. Acute care plan note: document progress toward care planned goals every shift.

REFERENCES:

Elsevier (2025) Range of Motion Exercises https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on September 30, 2025

MDS 3.0 RAI Manual v1.1720.1v4R Errata October 1, 2021. Retrieved on 9/230/2-2025 from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

~~Elsevier Clinical Skills:~~
~~https://epm601.elsevierperformancemanager.com/Personalization/Home?virtualname=sanfrangeneralhospital-casanfrancisco~~

CROSS REFERENCES:

Hospitalwide Policy and Procedure
23-02 Completion of Resident Assessment Instrument/Minimum Data Set (RAI/MDS)
25-06 Pain Recognition, Assessment, and Management

Nursing Policy and Procedure
Acute-02.0 Documentation of Care – Acute Unit
C 3.0 Documentation of Resident Care/Status by Licensed Nurse
C 3.2 Document of Resident Care by the Nursing Assistant
D 1.0 Restorative Nursing Program
~~XX.XX Documentation of Care – Acute Unit~~

~~23-02 Completion of Resident Assessment Instrument/Minimum Data Set (RAI/MDS)~~

Revised: ~~-~~12/2004~~/12;~~; 01/~~-~~2008~~/01~~; 03/25/2014~~/03/25~~; 12/13/2022~~/12/13~~; 09/30/2025

Reviewed: 2022/12/13

Approved: 2022/12/13

AMBULATION

POLICY:

1. The Registered Nurse (RN) assesses the resident's/patient's ability to ambulate and need for adaptive devices in collaboration with resident care team upon admission and any change of condition.

2. Any member of the nursing staff ~~except Home Health Aides (HHA)~~ may ambulate resident as indicated on the resident's/patient's plan of care.

PURPOSE:

To prevent complications of immobility & deconditioning.

PROCEDURE:

A. Assessment

1. Assess resident's/patient's cognition and ability to retain weight-bearing status before completing any ambulation.
2. Ensure equipment used is safe to be used.
3. Upon completion of the initial & on-going assessment the RN will communicate to the care team members regarding the resident's/patient's ambulation needs and assistive/adaptive devices required.

4. See ~~Restorative~~ Nursing Policy and Procedure (NPP) D1.0 Restorative Nursing Program~~)~~

B. Documentation

1. Resident Care Plan

   a. Include ambulation needs, devices, and preferences on the Resident Care Plan. {Refer to Hospitalwide Policy & Procedure (HWPP) 23-01 Resident Care Plan, Resident Care Team, & Resident Care Conerence}~~.~~

2. Electronic Health Record

   a. At minimum, include documentation addressing declines from baseline when ambulation is not part of a restorative program.

REFERENCES:

CMS Long -Term Care Resident Assessment User's Manual (2007)

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

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

CROSS REFERENCES:

Hospitalwide Policy and Procedure
23-01 Resident Care Plan (RCP), Resident Care Team (RCT), & Resident Care Conference (RCC)

Nursing Policy and Procedure
~~C1.0 Resident Admission and Readmission Procedures for Skilled Nursing Facility~~
~~C1.2 Relocation between Laguna Honda SNF Neighborhoods~~
~~C1.3 Discharge Procedure to Acute~~
~~C3.0 Documentation of Resident Care/Status by the Licensed Nurse~~
~~C3.2 Documentation of Resident Care by the Nursing Assistant~~
D1.0 Restorative Nursing Care
D1 2.0 Resident Activities of Daily Living
~~D5 2.0 Limb Care Following Amputation~~
~~D5 5.0 Application and Management of Braces~~

ATTACHMENTS/APPENDICES:

None

Revised: ~~2004/~~12/2004; ~~2008/~~01/2008; ~~2014/~~03/25/2014; ~~2019/~~03/12/2019; ~~2023/~~09/12/2023; ~~2025/~~04/09/2025; 10/06/2025

Reviewed: ~~2025/~~06/09/2025

Approved: ~~2025/~~06/09/2025

BED STRIPPING, BEDMAKING, AND TERMINAL CLEANING

POLICY:

1. The charge nurse schedules and assigns the nursing staff to perform weekly bedside cleaningng.

2. The entire bed is to be routinely cleaned stripped, wiped with facility-approved disinfectant, anddisinfectant and allowed to air dry, and all linens changed at least once a week as scheduled by the neighborhood.

2.3. Linen change is performed daily, and as needed, for residents/patients who are total bed rest and incontinent. Any nursing staff may make a resident's/patient's bed.

3.4. Any part of the bed or bedside area that becomes soiled between the scheduled cleaning is to be cleaned at that time.

5. 4. Terminal cleaning of the bedside is to be performed when residentthe resident/patient is discharged, transferred or has expired.

4.6. Don additional PPE based on resident's/patient's need for isolation precautions or the risk of exposure to body fluids. Perform hand hygiene before application and after removal of Personal Protective Equipment (PPE).

PURPOSE:

To maintain a clean environment and provide a clean bed for the resident/patient.

PROCEDURE:

1. Raise the bed to a safe and comfortable working level, keeping bed flat.

2. Reposition bed as needed to maintain proper body mechanics.

3.2. Maintain proper body mechanics at all times.

4.3. Immediately report defective equipment to the nurse manager/charge nurse, who will order a replacement or submit a work order to Facility Services.

A.

B.

C.A. **Bed Stripping:**

1. Stripping the bedsheets - Refer to HWPP 72-01 F4 Management of Hospital-Provided Linen
    a. For residents/patients on isolation precautions, refer to HWPP 72-01 F2: Isolation Room Disinfection
    b. Strips dirty linen from the bed being careful to not shake linens and roll linen away from your body.
    c. Holds dirty linens away from your body and places directly in dirty linen hamper (for chemo precautions, put dirty linen in yellow laundry bag, then place bag in dirty linen hamper - refer to HWPP 25-05 Hazardous Drugs Management).

d. Discards/throws away pillows.
e. Removes and discards dirty gloves then cleanses/sanitizes hands.
f. Applies clean gloves.
g. With facility approved disinfectant wipes or solution, cleans and disinfects the bed:
    i. Start from top to bottom, wiping in a clockwise direction.
    ii. Start and finish one side at a time to avoid any straining/injury.
        - Headboard:
            - Wipe headboard from top to bottom in a clockwise direction.
            - Remove headboard and wipe surface underneath.
            - Replace headboard after surface is dry.

        - Mattress:
            - Starting from top to bottom, wipe ~~mattress~~the mattress in a clockwise direction including the sides of the mattress
            - Place mattress on the side and clean bottom/underside of the mattress
            - Clean bed frame underneath the mattress
            - ~~Inspects~~Inspect the mattress for any cracks and ~~notifies~~notify CN if the mattress needs to be replaced by Facility Services

        - Bed Rails at the Head of the Bed (if with bed rails)
            - Wipe bed rails at head of the bed, starting on the inside then outside surfaces

        - Foot Board:
            - Unplugs bed
            - Clean the top, inside, outside and sides of the foot board
            - Removes the foot board, lays it on the bed, and cleans the bottom surface of the foot board
            - With a cotton swab, cleans electronic crevices underneath footboard
            - After the foot board and surfaces dry, ~~replaces~~replace the foot board and re-~~plugs~~plug the bed

        - Under the Bed Frame:
            - Elevate HOB to 90 degrees and clean the frame's underside
            - Lower the HOB back into a flat position
            - Manually lift the foot of the bed and clean the frame's underside
            - Replace the foot of the back into a flat position
            - Wipe bottom bed rails if present
            - Avoid directly cleaning any wires or circuits and only clean around them

        - Base of the Bed Frame and Castors
            - Wipe all surfaces on the base of the bed frame, including castors around the wheels and foot pedals

~~g.~~h. Remove PPE, perform hand hygiene
    ~~i. Start from top to bottom, wiping in a clockwise direction.~~
    ~~ii. Start and finish one side at a time to avoid any straining/injury.~~
        ~~Headboard:~~
            ~~Wipe headboard from top to bottom in a clockwise direction.~~
            ~~Remove headboard and wipe surface underneath.~~
            ~~Replace headboard after surface is dry.~~

- ~~Mattress:~~
  - ~~Starting from top to bottom, wipe mattress in a clockwise direction including the sides of the mattress~~
  - ~~Place mattress on the side and clean bottom/underside of the mattress~~
  - ~~Clean bed frame underneath the mattress~~
  - ~~Inspects the mattress for any cracks and notifies CN if the mattress needs to be replaced by Facility Services~~

- ~~Bed Rails at the Head of the Bed (if with bed rails)~~
  - ~~Wipe bed rails at head of the bed, starting on the inside then outside surfaces~~

- ~~Foot Board:~~
  - ~~Unplugs bed~~
  - ~~Clean the top, inside, outside and sides of the foot board~~
  - ~~Removes the foot board, lays it on the bed, and cleans the bottom surface of the foot board~~
  - ~~With a cotton swab, cleans electronic crevices underneath footboard~~
  - ~~After the foot board and surfaces dry, replaces the foot board and re-plugs the bed~~

- ~~Under the Bed Frame:~~
  - ~~Elevate HOB to 90 degrees and clean the frame's underside~~
  - ~~Lower the HOB back into a flat position~~
  - ~~Manually lift the foot of the bed and clean the frame's underside~~
  - ~~Replace the foot of the back into a flat position~~
  - ~~Wipe bottom bed rails if present~~
  - ~~Avoid directly cleaning any wires or circuits and only clean around them~~

- ~~Base of the Bed Frame and Castors~~
  - ~~Wipe all surfaces on the base of the bed frame, including castors around the wheels and foot pedals~~

B. Bedmaking

Equipment

Standard Bed:

- 2 large sheets (1 fitted, 1 flat)
- 1 linen draw sheet
- 1 bed pad
- 1-2 pillowcases
- 1 bed spread
- Facility-approved disinfectant wipes

Low Air Loss Mattress:

- Use 1 draw sheet or 1 ultrasorb only
- NO fitted sheet

1. Perform hand hygiene and don clean gloves

2. For residents/patients on isolation precautions, refer to HWPP 72-01 F2: Isolation Room Disinfection

3. Refer to Skills (elsevierperformancemanager.com) for procedures on Bed Making: Unoccupied or Bed Making: Occupied

4. Return bed to lowest position for resident/patient transfer

5. Remove PPE and perform hand hygiene

C. Terminal ~~Cleaning:~~Cleaning

Refer to Standard Work on Room Readiness (Terminal Clean)

~~1. Follow steps for bed stripping above.~~

~~2. Remove all personal items.~~
~~a. Inventory, box and label property of previous resident.~~

~~3. Remove respiratory/medical equipment from the bedside and place work order with Central Supply to retrieve.~~

~~4.1.Headboard:~~
~~a. Wipe headboard from top to bottom in a clockwise direction.~~
~~b.a.Remove headboard and wipe surface underneath.~~
~~c.a.Replace headboard after surface is dry.~~

~~5.1.Mattress:~~
~~a. Starting from top to bottom, wipe mattress in a clockwise direction including the sides of the mattress~~
~~b.a.Place mattress on the side and clean bottom/underside of the mattress~~
~~c.a.Clean bed frame underneath the mattress~~
~~d.a.Inspects the mattress for any cracks and notifies CN if the mattress needs to be replaced by Facility Services~~

6.1. Bed Rails at the Head of the Bed (if with bed rails)
- a. Wipe bed rails at head of the bed, starting on the inside then outside surfaces

7.1. Foot Board:
- a. Unplugs bed
- b.a. Clean the top, inside, outside and sides of the foot board
- c.a. Removes the foot board, lays it on the bed, and cleans the bottom surface of the foot board
- d.a. With a cotton swab, cleans electronic crevices underneath footboard
- e.a. After the foot board and surfaces dry, replaces the foot board and re-plugs the bed

8.1. Under the Bed Frame:
- a. Elevate HOB to 90 degrees and clean the frame's underside
- b.a. Lower the HOB back into a flat position
- c.a. Manually lift the foot of the bed and clean the frame's underside
- d.a. Replace the foot of the back into a flat position
- e.a. Wipe bottom bed rails if present
- f.a. Avoid directly cleaning any wires or circuits and only clean around them

9.1. Base of the Bed Frame and Castors
- a. Wipe all surfaces on the base of the bed frame, including castors around the wheels and foot pedals

10. Bedside Table and Bedside Call System
- a. Wipe down tabletop surface
- b. Wipe down the pillar of the bedside table
- c. Wipe down foot of the beside table
- d. Wipe down call light and call light panel

11. Nightstand
- a. Unplug and wipe down lamp, re-plugs lamp after it has dried
- b. Wipe down outside of night stand
- c. Remove drawer lines
- d. Wipe down both interiors of drawers and plastic liners
- e. Replace liners back into drawers once they have dried

12. Dresser
- a. Remove drawer liners
- b. Wipe down both interiors of drawers and plastic liners
- c. Wait to dry before replacing liners back into drawers

13. Miscellaneous
- a. Wipe down any other equipment or furniture in the resident's bedside

14. Bedside Closet
- a. Wipe down interior of closet, including mirror
- b. Removes bottom drawer, wipes down inside surface and drawer itself
- c. Wait for drawer to dry before replacing it back into closet

15. Final Steps
- a. Notify CN that room is ready for EVS cleaning

~~b. With the CN, visually inspects the bed and the bedside area (i.e., table, nightstands, etc.) for a cleanliness quality check~~
~~c. When EVS confirms to the charge nurse that the room s cleaned, returns to the room to:~~
~~iii. Make the bed with fresh linens and new pillows~~
~~iv. Zero the bed scale~~
~~v. Check the bed and all light are working~~
~~vi. Notify charge nurse that the room is now ready for a new resident~~

REFERENCE:

Centers for Disease Control and Prevention (CDC). (2024). Healthcare-associated infections (HAIs): Appendix D – Linen and laundry management from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/appendix-d.html?CDC_AAref_Val=https://www.cdc.gov/hai/prevent/resource-limited/laundry.html

Elsevier (2024) Bed Making: Occupied https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on October 7, 2025

Elsevier (2024) Bed Making: Unoccupied https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on October 7, 2025

~~NONE~~Standard Work: Room Readiness (Terminal Clean)

CROSS-REFERENCE:

Hospitalwide Policy and Procedure
File #20-12 Discharge Cleaning
File #25-05 Hazardous Drugs Management
~~File #72-01 F2 Isolation Room Disinfection~~
File #72-01 F4 Management of Hospital-Provided Linen
~~File #72-01 F2 Isolation Room Disinfection~~

Nursing Policy and Procedure
D9 2.0 Bed Making

ATTACHMENT/APPENDIX

NONE

Adopted: D9 2.0 Bedmaking 10/07/2025

Revised: ~~2000/~~08/2000; ~~2009/~~08/2009; ~~2014/~~09/09/2014; ~~2019/~~03/12/2019; ~~2024/~~04/15/2024; 10/07/2025

Reviewed: 2024/07/09

Approved: 2024/07/09

~~ASSISTING~~ RESIDENT MEALTIME SUPPORTS ~~DURING MEALTIME~~

POLICY:

Nursing staff will assist residents during meals to ensure a safe, sanitary, and dignified dining experience. ~~This includes:~~

1. This includes:
   - Supporting hand hygiene before and after meals
   - Using clothing protectors as needed
   - Providing adaptive devices, dentures, eyeglasses, and hearing aids during meals
   - Verifying meal trays match menu ticket orders (name, preferences, content, consistency)

   Residents will be offered:
   - Table service at clinically appropriate, height-adjusted tables
   - Neighborhood dining options and meal preferences
   - Three nutritious, appetizing meals daily plus snacks, aligned with national food standards

2. If a resident declines any food item, nursing staff will offer suitable substitutions based on available options and therapeutic diet orders. Requests beyond galley availability will be communicated to the diet office ~~{{see~~Refer to Food and Nutrition Services (FNS) Policy & Procedure 1.83 Resident Meal Services~~}}~~.

3. During respiratory infectious outbreaks, nursing will implement social distancing and infection prevention measures in communal dining areas or provide in-room dining as needed.

~~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 respectful, attentive, and dignified assistance to residents during mealtimes, ensuring their nutritional needs are met in a safe, comfortable, and socially engaging environment. This support promotes independence where possible, fosters a sense of community, and enhances the overall well-being and quality of life for each resident. ~~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.~~ Pre-Meal Preparation
- Wash residents' hands and face.
- Offer clothing protectors and assist with hand hygiene.
- Orient residents to mealtime and escort them to their preferred dining area.
- Adjust tables and lighting for safety and comfort.

~~2.~~ Table & Tray Setup
- Disinfect tabletops and let air dry.
- Ensure hot liquids are safely placed and inform residents of their location.
- Keep meal cart door closed between tray deliveries.

~~3.~~ Serving & Assistance
- Follow diet orders and aspiration precautions for at-risk residents.
- Position food and utensils for visibility and ease of use.
- Respect preferences—ask before opening or cutting food.
- Set up adaptive equipment and encourage independence.

~~4.~~ Support for Visually Impaired Residents
- Describe food placement using clock-face orientation.
  - Example: "Chicken at 12:00, potatoes at 3:00."
- Inform residents of hot and cold liquid locations.

~~5.~~ Group Dining & Feeding
- Arrange group meals to promote social interaction.
- Feed residents in rotation, allowing time to chew.
- Perform hand hygiene between assisting each resident.

~~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.~~

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

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

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

~~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.~~

~~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.~~

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

~~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.~~

~~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.~~

~~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.~~

~~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.~~

- ~~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

Chair Positioning for Communal Dining

- Seat residents upright with good body alignment to reduce aspiration risk.
- Use stable chairs with armrests to prevent sliding or falling.
- Residents unable to sit upright should use assistive chairs— - consult therapy as needed.
- Staff assisting with feeding should sit directly across from the resident at eye level.

Bed Positioning for In-Room Dining

- Elevate the head of the bed to at least 45°, or to the highest comfortable level, to aid swallowing and reduce aspiration.
- Support the head with a pillow to maintain alignment - —slightly forward, not tilted back or resting on the chest.
- Use pillows to support arms and maintain alignment, especially on weaker sides.
- For residents with aspiration precautions or enteral feeding, keep the bed elevated 45° or more for at least 1 hour after meals.

~~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.~~

~~A.~~C. Assisting the Resident to Eat

Food Preparation & Comfort
- Prepare food from the tray and check if the temperature is comfortable for the resident.
- Only mix foods if the resident requests it.

Promoting Independence & Dignity
- Encourage self-feeding when possible (e.g., holding bread or crackers).
- Avoid overfilling drink containers; use sipping lids only if needed.
- Open containers if the resident cannot; wear gloves when handling bare food.

Food Modification
- Cut food into bite-size pieces only if requested or required.
- Use ordered thickeners strictly as directed for residents at risk of aspiration.

Feeding Technique
- Offer a sip of liquid first to moisten the mouth and aid swallowing.
- Feed small amounts at a time, placing food where muscle control and taste are best.
- Allow time for chewing; do not rush.
- Ensure each bite or sip is swallowed before offering more.
- Alternate between food and fluids based on resident preference.

Monitoring & Safety
- Watch for "pocketing" (food not swallowed); slow down and encourage chewing.
- Notify nursing staff if swallowing issues arise for speech therapy referral.

Cleanliness & Substitutes

- Gently clean the face and any nasal secretions; perform hand hygiene.
-
- If less than 50% of the meal is consumed or refused, offer appropriate s

~~If less than 50% of the meal is consumed or refused, offer appropriate substitutes per dietary orders.~~

~~Prepare the food from the tray for eating:~~

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

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

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

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

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

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

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

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

~~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.~~

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

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

~~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.~~

~~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.~~

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

~~B.~~ After the Meal

D.

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

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

~~Clean and label any adaptive equipment used, and keep it at the bedside.~~

- ~~Place the water pitcher within reach (unless restricted) and encourage fluids between meals.~~Clean and label any adaptive equipment used and keep it at the bedside.
- Place the water pitcher within reach (unless restricted) and encourage fluids between meals.

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

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

E. Documentation

~~Mealtime Documentation~~
Record in the resident's electronic health record:

- If the meal was attempted or refused
-
- How much help was needed
-
- How much food was eaten

~~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: 01/09/2018

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

Reviewed: 08/19/2025

Approved: 08/19/2025

ASSISTANCE WITH ELIMINATION

POLICY:

1. All nursing staff, including Registered Nurse (RN), Licensed Vocational Nurse (LVN), Certified Nursing Assistant (CNA), or Patient Care Assistant (PCA), ~~except Home Health Aide (HHA),~~ may assist residents with elimination needs.

2. Residents who require assistance with toileting will be supervised when using the bathroom and/or commode.

3. Perineal care is provided to all residents who are incontinent and unable to perform toileting self care.

4. Each bedpan or urinal will be labeled with the resident's last name and first name initial.

5. Invasive elimination procedures that require insertion/removal of a finger or device into the resident's body (i.e., rectal tubes, urinary catheter insertion) may only be performed by a licensed nurse.

PURPOSE:

1. The resident will be clean, dry, comfortable and odor-free.

2. Assistance with elimination will be provided in a manner that conveys respect, promotes dignity, functional independence, and safety.

PROCEDURE:

A. Assistance with Toileting
   1. Refer to current reference text for Nursing Assistants for procedural information about use of bedpan, commode and urinal.

   2. Privacy shall be maintained during toileting whether in resident patient rooms, or while in tub, shower and toilet rooms.

   3. Bedpans, urinals, and bedside commodes are emptied into toilet and ~~cleaned when~~cleaned when soiled and replaced when needed. A urinal may be kept within the resident's reach.

   4. See Cross-References below for nursing-related procedures with management of incontinence and restorative programs.

B. Documentation
   1. The CNA or PCA documents elimination in the electronic health record (EHR).

   2. The licensed nurse (LN) documents any unusual physical or behavioral observations related to elimination. Interventions implemented to address these will be included in the EHR progress notes.

   3. The LN records resident specific elimination interventions for the CNA or PCA to implement on the health record.

4. The LN documents the effectiveness of the resident care plan in meeting elimination needs in the Resident Care Plan.

REFERENCES:

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

CROSS REFERENCES:

Nursing Policy and Procedure
D1.0 Restorative Nursing Program
F2.0 Assessment and Management of Urinary Incontinence
F3.0 Assessment and Management of Bowel Function

ATTACHMENT/APPENDICES

None

Revised: ~~2000/~~08/2000; ~~2005/~~03/2005; ~~2008/~~09/2008; ~~2010/~~10/2010; ~~2014/~~07/22/2014; ~~2019/~~03/12/2019; ~~2023/~~09/12/2023; ~~2024/~~06/11/2024; 10/06/2025

Reviewed: ~~2024/~~06/11/2024

Approved: ~~2024/~~06/11/2024

OSTOMY MANAGEMENT

POLICY:

1. The licensed nurse is responsible for the management of ostomy.

2. Licensed nurse is to consult the ~~Wound, Ostomy, and Continence Registered Nurse(s) (WOCNs)~~Wound Care Nurses~~-~~ for peri-stomal skin irritation that is not improving with routine care.

3. Only licensed nurses can remove, replace or change the wafer/skin barrier for ostomies. Patient Care Assistants/Certified Nursing Assistants may only empty pouches/bags.~~The certified nursing assistant (CNA) or patient care assistant (PCA) can only change or empty the bag for a **two-piece** colostomy or ileostomy every shift and as needed. CNAs/PCAs cannot remove or change the wafers, also known as skin barriers.~~

4. Residents who have demonstrated ability to manage their own ostomy may change or empty their own ostomy pouch/bag.

PURPOSE:

To provide appropriate ostomy management.

BACKGROUND:

Ostomy care includes containment of excrement, urinary drainage, skin protection, patient education, and patient support.

PROCEDURE:

A. Emptying or Changing Ostomy (refer to Skills: (elsevierperformancemanager.com) for procedures on Ostomy Pouching: Colostomy or Ileostomy)

1. An ostomy pouch/bag should be checked for leakage at least every shift~~ and pouches changed as needed (PRN)~~. The pouch/bag should be emptied when 1/3 full to prevent dislodgement of the appliance**.**

2. Resident with a urostomy may wear a urinary leg bag during daytime. During night time, connect the urostomy pouch to a ~~Foley~~ urinary drainage bag.

B. Ostomy Maintenance for Aquatic Services (Refer to Hospitalwide Policy & Procedure 28-03 Aquatic Services)

~~1. Bodily fluids must be reliably contained, and the tube entry site must be clean and dry~~
~~2. Residents with well-established ostomies may use pools as long as excretions are reliably contained. A clean ostomy bag shall be applied at least 1 hour prior to entering pool.~~
~~3. Prior to swimming, make sure pouch seal is secure~~
~~4. Empty pouch before getting into pool~~

C. Documentation

1. Electronic Health Record (EHR)

   a. Licensed Nurse documentation every shift document:
      - ~~CNA/PCA records o~~Output ~~in the intake/output (I/O) section.~~
      - Type of stomal appliance
      - Condition of stomal appliance
      - Site assessment
      - Peristomal site assessment
      - Treatment provided
      - Stool amount
      - Stool ~~apperance~~appearance

   b. ~~Licensed nurse documents~~Document ~~date of change~~change of:
      - Ostomy Wafer (done by licensed nurse):
        - Colostomy ~~of the ostomy~~ wafer: ~~(~~ C~~c~~hange ~~at least~~ every 4 to 5 days, and as needed
        - ~~o~~ Ileostomy wafer: Change every 3 to 5 days, ~~7 days or~~and as needed~~) and check condition of peri-stomal skin.~~
        -
      - Ostomy Pouch/Bag
        - 2-piece ~~pouch~~ system ~~-~~ – ~~use new pouch once/day~~change daily, and as needed
        - 1-piece ~~pouch~~ system – change system every~~up to Q~~ ~~3~~4-~~7~~5 days, and as needed (done by licensed nurse)

   ~~b. Document type of ostomy product(s) and indications for use~~

~~1.~~2. ~~Progress~~ Nurses' Notes (Licensed Nurse)

   a. Document and notify physician for any concerns such as:~~Any change in appearance, discharge, bloody drainage or discoloration of stoma and peri-stomal skin~~
      - Irritated, blistered, rash or bleeding skin around the stoma
      - Blood when the pouch is emptied
      - Unusual changes in stoma appearance, color, or size which may indicate stoma ischemia, prolapse, retraction, stenosis
      - Chills or fever
      - For colostomy or ileostomy: Bowel obstruction such as no liquid or soft stool in the pouch, cramping, vomiting; or high output from ileostomy
      - For urostomy: No urine output for several hours or output of less than 30 ml/hr, foul odor of urine, flank or back pain
        -

   b. Document ~~R~~resident/patient and family education when provided.

REFERENCES:

Carmel, J.E., Colwell, J., Goldberg, M.T. (Eds.). (2022). *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed.). Philadelphia: Wound, Ostomy, and Continence Nurses Society.~~Basic Ostomy Skin Care. A Guide for Patients and Healthcare Providers~~
~~2007. Wound, Ostomy and Continence Nurses Society~~

Elsevier (2024) Ostomy Pouching: Colostomy or Ileostomy https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on September 24, 2025

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

CROSS-REFERENCES

NONE

ATTACHMENTS:

One-piece Ostomy (SenSura® - 1 Piece Pouch Colostomy)
Two-Piece Ostomy (SenSura® Flex – 2 Piece Pouch)
Coloplast Types of Colostomies and Accessories

Original Document: September 30, 2008

Revised: ~~2015/~~03/10/2015, ~~2017/~~03/14/2017, ~~2019/~~03/12/2019; ~~2024/~~07/09/2024; 09/24/2025

Reviewed: 07/09/2024~~2024/07/09~~

Approved: 07/09/2024~~2024/07/09~~

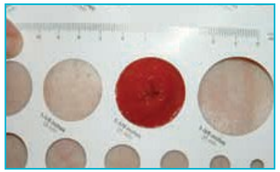
SenSura®

Coloplast

SenSura® 1-piece Pouch

Pictorial Instructions for Use

Preparation - 1



Measure the stoma.

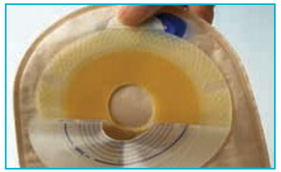
Preparation - 2

Trace measurement onto back of the barrier.

Preparation - 3

Cut opening in the barrier.

Preparation - 4



Remove protective backing by pulling the blue release tab away from the barrier.

Application - 1

Apply pouch by centering barrier around stoma.

Application - 2

Secure to skin by applying gentle pressure.

Emptying the Pouch - Urostomy - 1

Empty the urostomy pouch by holding end of the outlet upwards. Remove plug from spout. Pinch spout to control drainage, direct spout and release to drain. Replace plug.

Emptying the Pouch - Urostomy - 2

Urostomy night bag can be attached for bedside drainage.

Emptying the Pouch - 1

Open the outlet by lifting both tabs off the Velcro® plate. Unfold outlet.

Emptying the Pouch - 2

Fold back lower plate to avoid soiling when emptying. Attach Velcro® dots to hold plate in place.

Emptying the Pouch - 3

Empty pouch by pinching outer edges of the outlet open.

Emptying the Pouch - 4

Clean the outlet.

Closing the pouch - 1

Release the Velcro® dots. Using the guide, fold the lower plate over the upper plate.

Closing the pouch - 2

Fold upwards. Seal the outlet by attaching the Velcro® hook tabs onto the Velcro® plate.

Closing the pouch - 3

Hide-away: Tuck sealed outlet up and under the protective pocket.

Removal - 1

To remove, use the white tab on the barrier to gently pull the pouch away from the skin.

For product support, call the Coloplast Consumer Care Team at 1-888-726-7872.

Coloplast

Reviewed 10/7/2025

M1331N 07.13

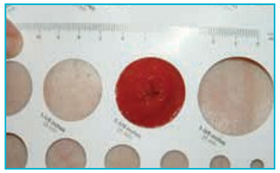
SenSura®

Coloplast

Bolsas colectoras SenSura® de 1 pieza

Instrucciones ilustradas para su uso

Preparación - 1



Mida el estoma.

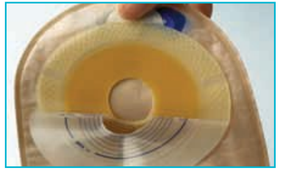
Preparación - 2

Trace la medida del estoma sobre la parte trasera de la placa adhesiva.

Preparación - 3

Corte la parte trazada en la placa adhesiva.

Preparación - 4



Remueva el plástico protector tirando de la lengüeta azul.

Colocación - 1

Colocación - 2

Para vaciar la bolsa de Urostomía - 1

Para drenar la bolsa, retire el tapón del tubo de descarga, apriete el tubo para controlar el drenaje, dirija el tubo y libere para drenar. Para cerrar el tubo de descarga coloque de nuevo el tapón.

Para vaciar la bolsa de Urostomía - 2

Un drenaje práctico para enfermos en cama se puede acoplar para el drenaje nocturno.

Para vaciar la bolsa - 1

Abre el orificio de la salida. Desprenda las dos lengüetas de la placa de Velcro. Desdoble el orificio de salida y póngalo en posición para vaciar el contenido.

Para vaciar la bolsa - 2

Doble hacia atrás la placa inferior para evitar que se manche mientras se vacía la bolsa. Los dos puntos de Velcro sostendrán la placa en su lugar.

Para vaciar la bolsa - 3

Para vaciar la bolsa - 4

Para cerrar la bolsa - 1

Desenganche los puntos de Velcro que sostienen la placa inferior doblada hacia atrás. Use la guía y doble la placa inferior sobre la placa superior más grande, como si estuviera sellando un sobre.

Para cerrar la bolsa - 2

Doble una vez más hacia arriba. Selle la abertura uniendo las lengüetas sobre la placa de Velcro®.

Para cerrar la bolsa - 3

Doble la salida cerrada hacia arriba para esconderla dentro del bolsillo protector.

Para retirar la bolsa - 1

Para retirar la bolsa, use la lengüeta blanca que está en el adhesivo para ir desprendiendo suavemente la bolsa de la piel.

Para pedir asistencia sobre el producto, llame a nuestro Grupo de Especialistas para el Consumidor al teléfono 1-888-726-7872.

Coloplast

C o l o q u e

Reviewed 10/7/2025

bolsa centrando la placa adhesiva alrededor del estoma.

Adhiérala a la piel ejerciendo una presión suave y aplicando calor.

Vacíe la bolsa apretando los bordes de la salida para abrirla.

Limpie por dentro y por la orilla de la abertura usando un pedazo de papel hygiénico.

Coloplast desarrolla productos y servicios que facilitan la vida de aquellas personas con afecciones muy personales y privadas. Trabajar cerca de las personas que utilizan nuestros productos nos permite crear soluciones que se adaptan a sus necesidades especiales. Nosotros lo denominamos asistencia médica de confianza. Nuestra empresa abarca atención en caso de ostomía, urología y continencia, y cuidados para la piel y las heridas. Operamos a nivel mundial y empleamos a más de 7000 personas.

M1331N 07.13

SenSura® Flex 2-piece pouch

Pictorial Instructions for Use

Reviewed 10/7/2025

Abbreviated instructions for use. Please refer to product label for complete product instructions for use, contraindications, warnings, precautions and adverse events.

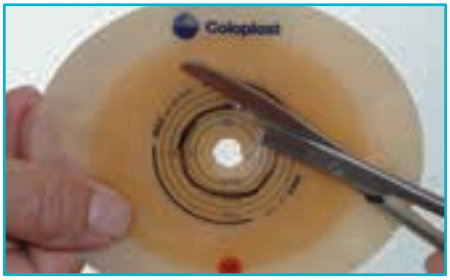
Prepare - 1

Measure the stoma.

Prepare - 2

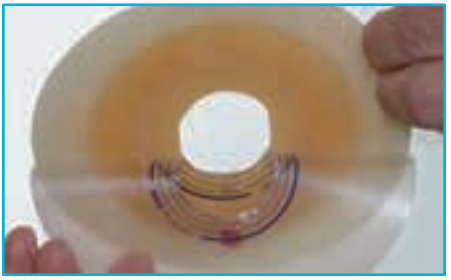
Trace measurement onto the back of the barrier.

Prepare - 3



Cut opening in the barrier.

Prepare - 4



Remove protective backing by pulling the blue release tab away from the barrier.

Apply - 1

Center barrier around stoma. Secure to skin by applying gentle pressure.

Apply - 2

Remove the protective paper from the adhesive ring on the pouch.

Apply - 3

Place pouch by aligning the bottom edge of the adhesive ring with the blue line at the bottom of the floating baseplate.

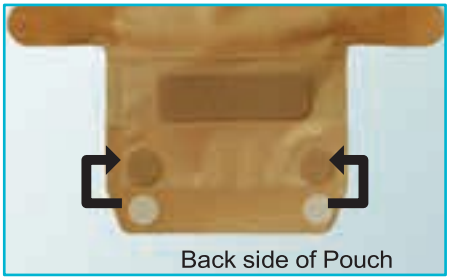
Apply - 4

Secure pouch by applying gentle pressure around the baseplate.

Empty - 1

Open the outlet by pulling both tabs off the Velcro® plate. Unfold outlet.

Empty - 2



Fold back lower plate to avoid soiling when emptying. Seal Velcro® dots together to hold plate in place.

Empty - 3

Empty pouch by pinching the outer edges of the outlet open.

Empty - 4

Clean inside the outlet and wipe the plates with fresh tissue.

Close - 1

Release the lower plate from the Velcro® dots. Fold the lower plate back over the upper plate to block the outlet, using the shiny indented outline as a guide.

Close - 2

Fold upwards two more times. Seal the outlet by attaching the Velcro® hook tabs onto the Velcro® plate.

Remove - 1

Remove pouch by using the blue tab located on the adhesive ring and gently pull down and away.

Remove - 2

Use the white tab to gently pull the barrier away from the skin using the “push-pull” technique.

For product support, call a Coloplast Consumer Care Specialist at 1-877-858-2656.

Coloplast develops products and services that make life easier for people with very personal and private medical conditions. Working closely with the people who use our products, we create solutions that are sensitive to their special needs. We call this intimate healthcare. Our business includes ostomy care, urology and continence care and wound and skin care. We operate globally and employ more than 8,500 people.

Reviewed 10/7/2025

Coloplast Corp.
Minneapolis, MN 55411
1.800.533.0464

www.coloplast.us

M1355N 06.14

Reviewed 10/7/2025

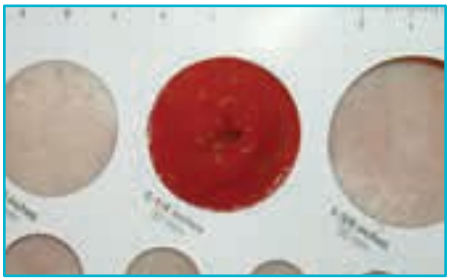
SenSura® Flex balsa de 2 piezas

Instrucciones ilustradas para su uso

Reviewed 10/7/2025

Instrucciones abreviadas para el uso. Por favor, consulte la etiqueta del producto para obtener instrucciones completas de productos para su uso, contraindicaciones, advertencias, precauciones y efectos adversos.

Preparación - 1

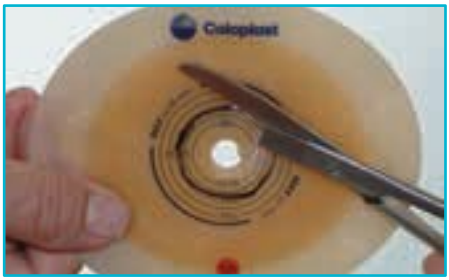


Mida el estoma.

Preparación - 2

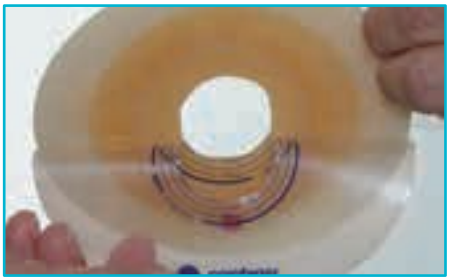
Traza la medida al reverso de la placa adhesiva.

Preparación - 3



Corte la parte trazada en la placa adhesiva.

Preparación - 4



Remueva el plástico protector tirando de la lengüeta azul.

Aplicación - 1

Centre la barrera alrededor del estoma. Asegúrela a la piel

Aplicación - 2

presionando levemente.

Reviewed 10/7/2025

Quite el papel protector del anillo adhesivo de la bolsa.

Aplicación - 3

Coloque la bolsa alineando el borde inferior del anillo adhesivo con la línea azul de la parte inferior de la placa base.

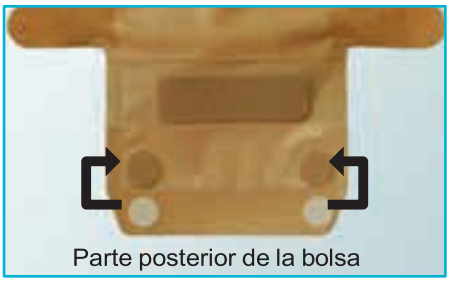
Aplicación - 4

Asegure la bolsa presionando levemente alrededor de la placa base.

Para vaciar la bolsa - 1

Abra la salida laventando ambas lengüetas de la placa de Velcro®. Desdoble la salida.

Para vaciar la bolsa - 2



Doble hacia atrás la placa inferior para evitar ensuciarla al vaciar la bolsa. Junte los puntos de Velcro® para sujetar la placa en su sitio.

Para vaciar la bolsa - 3

Vacíe la bolsa apretando los bordes de la salida para abrirla.

Para cerrar la bolsa - 4

Limpie el interior de la salida y con un nuevo pañuelo de papel limpio seque

la placa.

Para cerrar la bolsa - 1

Separe la placa inferior de los puntos de Velcro®. Usando la guía, doble la placa inferior sobre la placa superior.

Para cerrar la bolsa - 2

Doble hacia arriba. Selle la salida uniendo las lengüetas de enganche de Velcro® a la placa de Velcro®.

Para retirar la bolsa - 1

Quite la bolsa tomando la lengüeta azul ubicada sobre el anillo adhesivo y con cuidado tire de ella hacia abajo y sepárela.

Para retirar la bolsa - 2

Retire la placa adhesiva jalando suavemente la lengüeta blanca para quitarla completamente de la piel.

Para pedir asistencia sobre el producto, llame a nuestro Grupo de Especialistas para el Consumidor al teléfono 1-877-858-2656.

Coloplast

Coloplast desarrolla productos y servicios que facilitan la vida de aquellas personas con afecciones muy personales y privadas. Trabajar cerca de las personas que utilizan nuestros productos nos permite crear soluciones que se adaptan a sus necesidades especiales. Nosotros lo denominamos asistencia médica de confianza. Nuestra empresa abarca atención en caso de ostomía, urología y continencia, y cuidados para la piel y las heridas. Operamos a nivel mundial y empleamos

Reviewed 10/7/2025

a más de 8,500 personas.

Coloplast Corp.
Minneapolis, MN 55411
1.800.533.0464

www.coloplast.us

M1355N 06.14

Laguna Honda Hospital & Rehab Center

One-Piece

	Description	Code	Size	Units	PMM#
	SenSura® One-Piece EasiClose™ WIDE Outlet Non-Convex, Standard Wear, Cut-to-fit. Large size, drainable pouch with filter, soft cloth back. Transparent 11½" (29 ½ cm) / 655 mL NOT MADE WITH NATURAL RUBBER LATEX	15521	⅜-3" (10-76 mm)	20	1001223
	SenSura® One-Piece EasiClose™ WIDE Outlet Convex Light, Standard Wear, Cut-to-fit. Large size, drainable pouch with filter, soft cloth back. Transparent 11½" (29 ½ cm) / 655 mL NOT MADE WITH NATURAL RUBBER LATEX	~~15606~~H 4473	⅝-1 1⁄16" (15-43 mm)	10	1046710
	SenSura® One-Piece Multi-Chamber Urostomy Pouch Flat, Standard Wear, Cut-to-fit. 1-piece urostomy pouch with soft, plug-type outlet. Transparent 10⅜" (26 cm) / 400 mL NOT MADE WITH NATURAL RUBBER LATEX	11804	⅜-3" (10-76 mm)	10	1001198
	SenSura® One-Piece Multi-Chamber Urostomy Pouch Convex Light, Standard Wear, Cut-to-fit. 1-piece urostomy pouch with soft, plug-type outlet. Transparent 10⅜" (26 cm) / 400 mL NOT MADE WITH NATURAL RUBBER LATEX	11814	⅜-1 5⁄16" (10-33 mm)	10	1021457

Two-Piece Barrier and Pouch

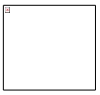
	SenSura® Flex Barrier Flat, Standard Wear, Cut-to-fit. Unique double-layer adhesive. Cut-to-fit NOT MADE WITH NATURAL RUBBER LATEX	10103	⅜-2¾" (10-68 mm) Yellow	10	1046708
	SenSura® Flex Barrier Convex Light, Standard Wear, Cut-to-fit. Unique double-layer adhesive. Cut-to-fit NOT MADE WITH NATURAL RUBBER LATEX	~~113074~~ 471	⅝-2" (15-53 mm) Yellow	5	1046707
	SenSura® Flex EasiClose™ WIDE Outlet, Drainable Maxi Pouch Drainable pouch with filter, soft cloth on back. Transparent 11½" (29 cm) / 410 mL NOT MADE WITH NATURAL RUBBER LATEX	~~11517~~H 4472	Match with Yellow SenSura Barriers	20	1046709

Post-op

	SenSura® Post-Op Pouch with Window Flat, Standard Wear, Cut-to-fit. 1-piece drainable pouch with soft outlet and access window. Transparent 13" (33 cm) / 830 mL NOT MADE WITH NATURAL RUBBER LATEX	19021	⅜-4½" (10-115 mm)	5	1001221

Last Revised 10/07/2025

Accessories

	**Brava® Ostomy Belt (Adjustable)** Elastic belt made from 90% cotton / 10% rayon with flexible clasps of polypropylene. NOT MADE WITH NATURAL RUBBER LATEX	~~4215~~4480	43⅓" length	15	7020316
	**Brava® Moldable Ring** Convenient ring-shaped product used to fill in uneven skin surfaces and protect the skin. Alcohol- and sting-free. NOT MADE WITH NATURAL RUBBER LATEX	~~120307~~4502	2.0 mm thick	10	1046711
	**Brava® Protective Sheet** Hydrocolloid skin barrier that protects the skin from stoma output. NOT MADE WITH NATURAL RUBBER LATEX	32105	4 x 4" (10 x 10 cm)	10	7046808
	**Brava® Elastic Barrier Strips** Skin-friendly strips provide extra security and support longer wear time. NOT MADE WITH NATURAL RUBBER LATEX	120700	5½" strips	20	1046712
	**Brava® Lubricating Deodorant Sachet** A pouch lubricant + deodorizer in one. Powder-fresh liquid neutralizes odor and allows output to slide to the bottom of the pouch for easier emptying.	12060	.25 fl. oz. (7.5 mL) sachet	20	1047225

Coloplast Care Specialist: 1-888-726-7872

VITAL SIGNS

POLICY:

1. Any nursing staff member ~~except Home Health Aide~~ may perform vital signs (V/S) measurements.

2. Vital signs include blood pressure (BP), pulse rate (PR), respiratory rate (RR), temperature (T), and oxygen saturation (O2 sat).

~~2.~~3. Only oral temperature readings can be taken when using the Masimo Root automated vital signs machine. If unable to obtain temperature via oral route, staff may use facility approved tympanic temperature machine.

~~3.~~4. Staff who find a resident/patient, unresponsive, pulseless or apneic shall initiate a Code Blue ~~call immediately or 911~~ per Code Blue Policy {Refer to Hospital-wide Policy & Procedure (HWPP) #24-16 Code Blue}.

   a. For staff required to have Basic Life Support (BLS), staff shall assess for resident's/patient's responsiveness, breathing and pulse per BLS guidelines. C~~P~~ardiopulmonary ~~R~~Resuscitation (CPR) shall be initiated immediately when needed.

~~4.~~5. Orthostatic V/S, are measured as per policies and procedures, as per physician's order, and whenever clinically indicated based on the assessment of the licensed nurse.

~~5.~~6. For residents/patients whose reimbursement for s~~S~~killed ~~N~~nursing ~~F~~ care is Medicare, V/S should be taken and recorded at least daily. In long-term care neighborhoods, V/S are checked monthly at a minimum, unless otherwise ordered.

~~6.~~7. Residents/patients receiving certain cardiovascular or antihypertensive medications are monitored as per Medication Administration procedure. (Refer to HWPP #25-15 Medication Administration)

~~7.~~8. Residents/patients in isolation rooms will have designated automated V/S machine and tympanic thermometer available. When available, individual BP cuffs are kept at the resident's/patient's bedside.

~~8.~~9. The use of individualized BP cuffs is encouraged. When an individualized BP cuff is not available, use the multi-use BP cuffs, and clean the cuff in between resident/patient use with facility approved disinfectant.

PURPOSE:

To outline frequency of vital sign measurement and nursing responsibilities.

PROCEDURES:

A. Frequency of Monitoring V/S

1. Admission for all SNF Neighborhoods:~~-~~ V/S are taken upon admission to any neighborhood in Laguna Honda Hospital (LHH) ~~with~~ at a minimum of once per~~every 8 hours~~ shift for the first three

(3) days, unless otherwise ordered. Orthostatic BP/PR is done once as part of the admission nursing assessment to evaluate for hypotension and whenever clinically indicated.

2. Acute Units:
   - ❑ Pavilion Mezzanine Acute (Medical): upon admission and every four (4) hours, or more frequently as clinically indicated.
   - ❑ Pavilion Mezzanine Acute (Rehab): upon admission and then daily or as clinically indicated.

3. Discharge~~: before~~: before discharge from Pavilion Mezzanine Acute or to outside acute facility or hospital.

4. Relocation from one neighborhood to another within LHH: every ~~8~~shift ~~hours~~ for the first 3 days of relocation or as clinically indicated.

5. Receiving course of antimicrobial: ~~every 8 hours at a minimum~~once per shift for the entire course of the antimicrobials
   a. For antimicrobials prescribed for prophylaxis – refer to NPP C 3.0 Documentation of Resident Care by LN for frequency.

6. Unanticipated change in resident/patient condition or potential/actual decline: check V/S once per shift at a minimum for 3 days as often as clinically indicated depending on the nature of the change.

7. Fall incident (Refer to HWPP #24-13 Falls).

8. New wounds or worsening of skin ulcers/wounds - check V/S once per shift at a minimum for 3 days and as clinically indicated.

B. Reporting

1. CNA or PCA should report immediately to the licensed nurse in charge of the resident/patient if:

   - BP is less than 90/50 or greater than 160/90
   - PR less than 50 or greater than 100
   - RR less than 14 or greater than 25
   - T over 100 degrees F
   - O2 sat of less than 90
   - Orthostatic V/S changes

2. Licensed Nurse (LN) is to assess resident/patient immediately and notify physician as needed for further medical evaluation if vital signs are outside of normal parameters (FYI: Critical values identified for vital signs in EHR are for guideline purposes).

C. Documentation:

1. Record V/S (BP, PR, RR, T, & O2 sat) in the electronic health record (EHR).

2. A LN reviews the V/S. If further assessment is required, LN shall notify physician and will document notification in the EHR.

REFERENCES:

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

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

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

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

CROSS REFERENCES:

Hospital-wide Policies & Procedures
- ~~File #~~24-16 Code Blue
- ~~File #~~25-06 Pain Assessment and Management
- ~~File #~~25-15 Medication Administration

Nursing Policies & Procedures
- C 1.0 Resident Admission and Readmission for Skilled Nursing Facility~~Procedures~~
- C 1.2 Relocation Between Laguna Honda SNF Neighborhoods
- C 1.3 Discharge Procedure to Acute
- C 3.0 Documentation of Resident Care by Licensed Nurse - SNF
- C 3.2 Documentation of Resident Care by Nursing Assistant
- G 2.0 Neurological Status Assessment

ATTACHMENTS:

None

Revised: ~~2006/~~01/2006, ~~2010/~~10/2010, ~~2012/~~07/31/2012; ~~2015/~~11/10/2015, ~~2018/~~03/06/2018; ~~2022/~~05/10/2022; ~~2024/~~04/15/2024; 10/06/2025

Reviewed: ~~2024/~~12/10/2024

Approved: ~~2024/~~12/10/2024

OBTAINING, RECORDING AND EVALUATING RESIDENTS WEIGHTS

POLICY:

1. Any nursing staff~~, except for Home Health Aide,~~ may obtain residents' weights.

2. Resident weight is obtained on the day of admission/readmission, monthly, upon relocation by the receiving neighborhood, as clinically indicated, and during the observation period of the Minimum Data Set (MDS) unless otherwise indicated by a physician order.

3. Reweighs are performed each time the weight varies from the previous weight by five or more pounds (2.27 kilograms or more) that is not otherwise explained in the plan of care (e.g., planned weight loss).

4. Licensed staff will inform the dietitian and physician regarding unintended weight loss or gain.

5. Monthly weights shall be obtained by the 7th of each month.

PURPOSE:

To obtain accurate weight measurements and identify unintended weight changes to facilitate effective care planning.

PROCEDURE:

A. Obtaining Weights

1. Check previous weight prior to weighing resident to immediately identify any potential discrepancy.

2. To obtain accurate weight, weigh resident in the day shift at a consistent time and have resident wear consistent clothing and/or devices.

3. Resident will be weighed using the same scale, clothing, and/or linen with each reweigh.

   a. Use the scale's manufacturer's instructions for steps to balance and measure the resident. Instructions are attached to the scale or available in the Central Supply Room (CSR)
   b. If the manufacturer's instructions are not readily available, contact Facility Services.
   c. Improperly functioning scales are reported to Facility Services through a work order.

4. Immediately prior to weighing resident, staff shall zero the scale.

B. Reweighing

1. If there is a weight change greater than 5 pounds (+/-), immediately reweigh resident.

2. Continue to reweigh resident daily for the next 2 consecutive days.

C. Frequency of Weights

1. On admission/readmission, nursing will obtain resident weights on the day of admission/readmission.

2. Residents shall be weighed weekly for 4 weeks after admission/readmission, then monthly, unless otherwise prescribed by physician.

3. Nursing will weigh resident for a significant change in condition, change in food intake, and other evidence of altered nutritional status or fluid and electrolyte imbalance.

D. Reporting

1. Weights must be reported to the licensed nurse during the shift it was obtained.

2. If the weight variation is greater than five pounds (2.27 kilograms) and is unanticipated weight change, the licensed nurse notifies the physician and dietitian.

3. The nurse reports unintended weight loss or gain to the dietitian and physician:
   a. 5% or greater over 30 days
   b. 7.5% or greater over 90 days
   c. 10% or greater over 180 days

4. The licensed nurse will notify the MDS Coordinator or Nurse Manager to include resident with significant weight change on the list of residents for discussion at the next Resident Care Team meeting.

E. Documentation

1. The type of scale (e.g. wheelchair or floor scale, EZ-Lift scale, or electronic bed scale) to be used is noted on Care Plan

2. Nursing Staff documents all weights on the resident's electronic health record.

3. Licensed nurse will document on the electronic health record the assessment and actions taken for unintended weight changes.

REFERENCES

NONE

CROSS REFERENCES:

NONE

ATTACHMENT/APPENDIX:

NONE

Revised: ~~2018/~~01/09/2018, ~~2019/~~03/12/2019, ~~2019/~~09/10/2019; ~~2023/~~08/08/2023; ~~2024/~~04/08/2024; 10/07/2025

Reviewed: ~~2024/~~06/11/2024

Approved: ~~2024/~~06/11/2024

COLLECTION OF URINE SPECIMEN

POLICY:

1. The licensed nurse may obtain urine specimen through midstream catch (clean-catch) technique, intermittent (straight catheterization), or indwelling urinary catheter as ordered by the physician.

~~2. The Certified Nursing Assistant (CNA) or Patient Care Assistant (PCA) is allowed to collect urine specimen through midstream or clean-void technique.~~

~~3.~~2. The licensed nurse will notify the physician if the specimen cannot be obtained.

PURPOSE:

To describe guidelines for urine specimen collection.

PROCEDURE:

A. Laboratory Requirements

1. Licensed Nurse completes two different laboratory requisitions for urinalysis and for urine culture and sensitivity.

2. All sterile urine specimen collection containers must be securely tightened to avoid leakage. Depending on the type of test, some urine specimens may require transport on ice.

B. Methods of Collecting Urine Specimen: Refer to Skills (elsevierperformancemanager.com) for Procedures on ~~Collecting~~ Urine Specimen Collection: Midstream (Clean-Voided); Straight Catheterization (Female); Straight Catheterization (Male); and Indwelling Catheter

D. Disposition of Urine Specimens

1. For STAT order, on weekends, holidays, or after hours, the specimen is delivered to Clinical Laboratory specimen ~~refrigerator~~refrigerator, and the Licensed Nurse will call Nursing Operations~~/~~ Nurse Manager to arrange Lab courier transportation to pick-up specimen.

2. For regular working hours, send urine specimens directly to the Clinical Laboratory by any nursing staff for regular lab courier pick-up. For STAT-order, inform Lab Technician to include urine specimen in the earliest lab courier pick-up time.

3. For non-STAT order, on weekends, holidays, or after hours, urine specimens are delivered to and stored in the laboratory refrigerator.

E. Documentation

Licensed Nurse will document ~~on~~ in electronic health record once specimen is obtained.

REFERENCES:

Elsevier (2024) Urine Specimen Collection: Midstream (Clean-Voided) https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on October 8, 2025

Elsevier (2024) Urine Specimen Collection: Straight Catheterization (Female) https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on October 8, 2025

Elsevier (2024) Urine Specimen Collection: Straight Catheterization (Male) https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on October 8, 2025

Elsevier (2024) Urine Specimen Collection: Indwelling Catheter https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on October 8, 2025

~~Skills (elsevierperformancemanager.com) https://point-of-care.elsevierperformancemanager.com/skills?virtualname=sanfrangeneralhospital-casanfrancisco~~

CROSS REFERENCES:

Nursing Policy and Procedure
F 5.0 Nursing Management of Urinary Catheter

ATTACHMENTS:

None

Revised: ~~2001/~~08/2001; ~~2008/~~11/2008, ~~2010/~~10/2010; ~~2015/~~07/14/2015, ~~2019/~~03/12/2019; ~~2024/~~04/18/2024; 10/08/2025

Reviewed: ~~2024/~~07/09/2024

Approved: ~~2024/~~07/09/2024

NURSING EDUCATIONAL PROGRAMS

BACKGROUND:

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

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

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

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

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

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

PROGRAM ELEMENTS:

A. Orientation

Refer to Nursing Policy and Procedure (NPP) A 6.0 Orientation of Nursing Personnel.

B. In-service and Continuing Education {Refer to Hospitalwide Policy and Procedure (HWPP) 80-05 Staff Education Program

1. Nursing Education is accomplished in various milieus including classroom setting, scheduled in-services, unit-based education, train-the-trainer, and/or electronic educational modules delivered via the learning management system.
2. Crisis Prevention Institute's Responding and Intervening During a Non-Violent Crisis training for Laguna Honda Hospital staff is provided annually as an electronic educational module.
3. Department of Education and Training (DET) responds to requests for individualized education from Nurse Manager or Nursing Supervisors.
4. A monthly calendar of scheduled educational in-services shall be sent electronically to LHH staff with DPH email accounts and posted on the intranet.

C. Nursing Affiliations

Refer to NPP A 5.0 Nursing Educational Affiliations (Student Placements)

D. Record Keeping

The Department of Education and Training maintains:

1. Current CNA and Board of Registered Nursing (BRN) continuing education provider numbers.
2. Current Director of Staff Development certification as appropriate for each nursing educator.
3. Program approvals from California Department of Public Health (CDPH) for CNA, and PCA~~, and HHA~~ orientation and in-services.
4. Records of all courses provided will include lesson plans, outlines, sign-in sheets, sample evaluations and posttests as documentation that learning has occurred. (Kept for a period of four years).
5. Orientation records (Kept for a period of 10 years). Orientation records are then submitted to Human Resources for record keeping in the employee's file.
6. Annual education calendar of all classes and in-services are provided by Department of Education and Training.
7. In-service records and orientation records (hard copy and digital) will be stored at LHH DET, Room A300, Administration Building, 375 Laguna Honda Blvd, San Francisco, CA 94116.
8. LHH DET Nurse Director, DET Nurse Manager, and/or designee will be responsible for record keeping.

REFERENCES

NONE

CROSS REFERENCES:

Hospitalwide Policies & Procedures
80-05 Staff Development

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

APPENDIX/APPENDICES:

NONE

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

Revised: ~~2002/~~08/2002, ~~2007/~~10/2007, ~~2012/~~05/22/2012; ~~2014/~~07/27/2014; ~~2021/~~02/09/2021; ~~2022/~~05/10/2022; ~~2023/~~05/26/2023; ~~2023/~~06/13/2023; ~~2023/~~08/08/2023; ~~2025/~~07/12/2025; 10/06/2025

Reviewed: ~~2025/~~07/12/2025
Approved: ~~2025/~~07/12 /2025

Deletion Nursing
Policies and Procedures

BED MAKING

POLICY:

1. Any nursing staff including Home Health Aides (HHA) may make the resident's bed.

2. Beds will be routinely stripped and wiped and all linens changed once a week as scheduled by the neighborhood.

3. Linen change is performed daily and as needed for residents who are total bed rest and incontinent.

4. Gloves will be worn to remove linen soiled with body secretions.

PURPOSE:

To provide the resident with a clean bed.

EQUIPMENT:

2 large sheets (1 fitted, 1 flat)
1 linen draw sheet
1 bed pad
1-2 pillowcases
1 bed spread
Facility-approved disinfectant wipes
Dirty linen hamper

PROCEDURE:

A. Standard Bed:

1. Change wet, damp and soiled linens right away (Refer to Bed Stripping Policy).

2. Bring only the linens needed.

3. Raise bed to a comfortable working height and keep bed flat.

4. Reposition bed as needed to ensure proper body mechanics.

5. Maintain proper body mechanics at all times.

6. Follow Standard Precautions.

7. Place clean linens on a clean surface

8. Place fitted sheet on mattress, applying one side of the bed first, then folding over to the other side to cover mattress pad.

9. Apply open draw sheet on top of fitted sheet using same procedure as fitted sheet. Tuck both sides of draw sheet under mattress.

10. Apply flat sheet on top of fitted sheet and draw sheet using same procedure as fitted sheet.

11. Place blanket on the bed. Tuck in top linens together at foot of bed and make a mitered corner.

12. Straighten all top linen.

13. Apply pillowcase to pillow(s) and place pillow(s) on bed.

14. Straighten loose sheets, blankets and bedspreads.

15. Keep bed at low position, return bed to desired position and lock all wheels when done.

16. Immediately report defective equipment to the nurse manager/charge nurse who will order a replacement or submit a work order to Facility Services by telephone or online.

B. Low Air Loss Mattress

1. Use 1 draw sheet or 1 ultrasorb only

2. No fitted sheet

REFERENCES:

Bedmaking, Unoccupied. 2014. Beddoe, A. and Caple, C. authors. CINHAL Information System, a division of EBSCO Information Services, 2014 –electronic access on June 6, 2014.

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

CROSS-REFERENCES:

Nursing Policy and Procedure
D9 3.0 Bed Stripping and Bedside Cleaning

ATTACHMENTS/APPENDICES:

None

Revised: 2000/08/2000; 2010/04/2010; 2014/09/09/2014; 2019/03/12/2019; 2023/09/12/2023; 10/06/2025

Reviewed: 2023/09/12/2023; 2025/04/05/2025

Approved: 2023/09/12/2023

Revised Rehabilitation Policies and Procedures

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) ~~Executive Administrator Integrated Rehabilitation Services and Health at Home~~Associate Chief Operating Officer Integrated Rehabilitation Services and Health at Home
- ~~SFHN Director of Integrated Rehabilitation Services~~
- Senior Occupational Therapist
- Senior~~n~~ 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 (Occupational Therapy team, Physical Therapy team, Speech language Pathology team including rehab support 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, active Basic Life Safety (BLS) CPR certification and in accordance with the 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 San Francisco Health Network (SFHN) Associate Chief Operating Officer for Integrated Rehabilitation Services and Health at Home

~~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~~Associate Chief Operating Officer for 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~~ Associate Chief Operating Officer 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 ~~Executive Administrator Integrated Rehabilitation Services and Health at Home~~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~~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.
- 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 Deputy Director Chief Operating Officer and Chief Strategy Officer, and Chief of Rehabilitation (Medical Director).
- 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 the San

Francisco Health Network Deputy Director Chief Operating Officer and Chief Strategy Officer, and Chief of Rehabilitation (Medical Director).

- Supervising Senior Therapists and other staff
- Complying with all regulatory department, hospital, state, and federal regulations Senior Occupational Therapist

~~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.

ATTACHMENT: -None

REFERENCE~~S~~:

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: 25/10/27, 25/06/20, 18/08/24, 06/09/22, 10/12/07, 13/08/22, 14/08/21, 04/02/24

Original Adoption: