List of Policies and Procedures for JCC Review 5-11-26

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revised	LHHPP	20-07	Against Medical Advice	**A. Lam**	1. Replaced "resident is discharged AMA" with "type of resident self-discharge when" 2. Added "LHHPP" 3. Replaced "policies" with "House Rules" 4. Replaced "medical record" with "electronic health record (EHR)" 5. Added "A resident who does not have documentation to lack capacity is assumed to retain the capacity to make their own decisions. 5. Added "The physician should review the following with the resident who expresses the desire to leave AMA: a. What the resident wishes to do after they leave b. Why it's important to them c. How the resident plans to leave d. Safety gaps in resident plan and resident response in discussion of these gaps: i. Obtaining and Preparing Food preparing food ii. Shelter iii. Clothing iv. Access to ongoing/urgent medical care" 6. Deleted "The physician will then assess the resident's current cognitive capacity and ability to understand the risks of leaving LHH and discontinuing medical treatment. Based on this assessment, the physician will determine whether the patient has the capacity to decide to leave AMA." 7. Deleted "Residents with a history of substance use disorder may be at increased risk for leaving the facility without notification and/or for illegal or prescription drug overdose if the resident continues using substances while residing in the facility. Residents with a history of substance use disorder should be assessed for these risks and care plan interventions should be implemented to ensure the safety of all residents." 8. Deleted "(see 5.d.)" and "medical record" 9. Added "or Nursing" and " in the EHR" 10. Replaced "House Rules" with "Resident Rules and Responsibilities" 11. Replaced "acknowledges receipt of the policies" to "receives the" 12. Replaced "and agrees to" with "and is required to" 13. Deleted "its requirements with their signature on all required documents in the Admissions packet provided by A&E" 14. Added "counseling provided at the resident care conference regarding the risk of AMA" 15. Replaced "then the member of the RCT will also complete the corresponding documentation" with "document this attempt"
Revised	LHHPP	24-10	Coach Use for Close Observation	**A. Michaud**	1. Added "may provide" 2. Added "an individual who provides" 3. Deleted " It is synonymous with the term "alternate assignment"" 4. Added "and/or" 5. Deleted "(See Policy #3)" 6. Replaced "Nursing Director/Nursing Operations" with "the Directors of Nursing" 7. Replaced Nurser Manager /Licensed Nurse" with "Nurse Manager" 8. Replaced "Designee" with "the Coach Utilization Committee" 9. Replaced "nursing operations" with "the Nursing Operations Supervisor" 10. Added "Coaches are expected to" 11. Deleted "provide all resident needs within their scope of practice and not deviate from their roles allowable by law (home health aide, certified nursing assistant or licensed nurse)." 12. Added "not deviate from their roles as a coach or leave the resident for any reason" 13. Added "assigned as coaches" 14. Deleted "for resident who is provided with a coach" 15. Added "shall include the reason " 16. Deleted "and a progress note must be entered in electronic health record (EHR) either as a nursing note or on the flowsheet." 17. Deleted "Possible close observation measures may include, but are not limited to" 18. Deleted "Executive review team will provide on-going guidance as needed based on the plan as needed." 19. Added "resident's baseline behaviors and are aware of interventions" 20. Replaced "charge nurse/team leader" with "CN" 21. Added "from the assigned coach" 22. Replaced "charge nurse" with "CN" throughout the document. 23. Replaced "Contributing to the RCT discussions and/or plan of care" with "Communicating their observations to the RCT discussions and contributing to the plan of care" 24. Added "and/or facility provided phone" 25. Replaced "summon" with "request" 26. Replaced "help/breaks/etc" with "assistance, a break, or any other need while assigned" 27. Deleted "the EHR flowsheet or in a nursing note in " 28. Added "The following EHR documentation shall be completed regularly by the LN to include observations from the assigned coach staff" 29. Added "to monitor any behavioral target symptom identified in the provider's behavior order" 30. Deleted "via EHR to include any changes reported by coaches"
Delete	LHHPP	20-08	Use of Isolation Rooms	**M. Barajas**	No longer needed

Revised	Nursing	A-05.0	Nursing Clinical Affiliations	**C. Figlietti**	1. Removed Home Health Aides and Paramedic Students from policy #1 on whom LHH supports clinical training and education of 2. Changed communication by clinical instructor of "all planned treatments and medications" to "communicate resident care". Students may not administer medications 3. Procedure outlines steps clinical instructors need to take 6 weeks prior to start of clinical rotation (current timeline states 1-2 months) 4. Clarified roles of "LHH Student Affiliation Coordinator" (currently Affiliation Coordinator) 5. Removed outdated (e.g., as written agreements specifying responsibility of faculty for supervising students' administering meds and treatments) 6. Clinical Instructors will attend an initial tour of the facility, coordinated with the LHH Student Affiliation Coordinator 7.0Updated compliance documents and orientation education requirements 8. Added orientation to be provided via SF Learning ELM to cover regulatory compliance topics 9. Added "The clinical instructor will be present and available for students during their clinical assignment in any of the care areas at LHH" 10. Added "Student must maintain confidentiality of resident information and must not take any printed resident information off the care units." 11. Clarified to label water pitchers with date they are changed
Revised	Nursing	B 6.0	Items Allowed at the Bedside	**C. Figlietti**	1. Removed "if ordered by the physician" for Ambu Bag. New policy for tracheostomies states that an Ambu Bag shall be at the bedside 2. Clarified to include resident's initials for o2 tube administration devices labeling 3. Clarified to label water pitchers with date they are changed
Revised	Nursing	D2 3.0	Tub Baths and Showers	**C. Figlietti**	1. Revised definition of bathing to clarify bathing as "washing, rinsing, and cleansing the skin and hair. On bath days, personal hygiene such as nail care and shaving, if appropriate, are also provided." 2. Added "Personal Hygiene" to grooming section 3. Added reference to Standard Work for Arjo Bathtub Cleaning and Disinfecting, and Standard Work for Shower Gurney and Shower Chair Cleaning
Revised	Nursing	D9 6.0	Water Pitchers	**C. Figlietti**	1. Removed redundant policies re: changing of pitchers/liners (these are already addressed in table of Policy #2) 2. Added "Unless contraindicated" for the replenishment of water pitchers every shift.
Revised	Nursing	K 1.0	Assessment, Prevention, Mgmt or PI	**C. Figlietti**	1. Removed WOCN and changed th Wound care RNs
Revised	Nursing	K 1.0 Appendix 1	Pressure Injury Intervention	**C. Figlietti**	1. Added Wound Care Team for whom to communicate to re pressure injuries. Added repositioning #every 2 hours, or per order"
Revised	Nursing	K 1.0 Appendix 2	Wound Care Supply List	**C. Figlietti**	1. Major update to Wound Care Supply List to reflect current products for wounds and current beds used.

JCC Follow-up

AGAINST MEDICAL ADVICE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) supports the rights of residents to:

    a. make decisions regarding their medical care,~~.~~

    b. request or refuse treatment, to the extent permitted by law~~.~~, and

    c. leave the facility against the advice of physicians, to the extent permitted by law.

PURPOSE:

To comply with State and Federal regulations pertaining to Resident's Rights and the medical necessity criteria for continued stays of residents in Skilled Nursing Facilities.

DEFINITIONS:

1. Discharge Against Medical Advice (AMA): ~~-~~A type of resident self-discharge ~~when resident is discharged AMA when~~ the resident chooses to leave LHH against the advice of the physician or if the resident is outside of the approved parameters of a therapeutic Leave of Absence (LOA).

2. Elopement: A resident who leaves LHH without notification or without an approved leave of absence, as defined in the Code Green Protocol (LHHPP 24-22).

3. Leave of Absence Bed Hold: A planned absence of a resident from LHH authorized by a physician's order, which extends past midnight.

PROCEDURES:

1. LHH Admissions and Eligibility (A&E) shall provide each newly admitted resident/surrogate decision maker (SDM) with the facility "~~House Rules~~Resident Rules and Responsibilities" which discusses elements of this policy.

2. The resident or SDM receives the ~~acknowledges receipt of the policies~~ "~~House Rules~~Resident Rules and Responsibilities" ~~and agrees to~~ and is required to abide by these rules~~its requirements by with their signature on all required documents in the Admissions packet provided by A&E~~.

3. When a resident expresses the desire to leave AMA, the physician will assess whether the resident is currently documented in the electronic ~~medical~~ health record (EHR) to have the capacity to make their own decisions. A resident who does not have documentation ~~of incapacity~~to lack capacity is assumed to retain~~s~~ the capacity to

make their own decisions. However, if capacity is in question, the team will reevaluate as needed.

~~4.~~ The physician should collaborate with the resident to optimize the discharge plan and with the intent to minimize risk to the resident. ~~a resident who expresses the desire to leave AMA~~

~~a. wW~~

~~b. preparing food~~

~~i. Access to ongoing/urgent medical care~~

~~The physician will then assess the resident's current cognitive capacity and ability to understand the risks of leaving LHH and discontinuing medical treatment. Based on this assessment, the physician will determine whether the patient has the capacity to decide to leave AMA.~~

~~5. Residents with a history of substance use disorder may be at increased risk for leaving the facility without notification and/or for illegal or prescription drug overdose if the resident continues using substances while residing in the facility. Residents with a history of substance use disorder should be assessed~~ educated ~~for~~ on ~~these risks and care plan interventions should be implemented to ensure the safety of all residents.~~

4. LHH shall advise ~~at risk~~ residents that leaving the facility without a physician order may result in an unplanned discharge. Appropriate referrals and discharge instructions will be provided whenever possible. ~~(see 5.d.)~~

   a. Residents with decision-making capacity who choose to leave LHH without a physician order, despite counseling by staff of the risks related ~~of~~to leaving and the potential for unplanned discharge, will be considered leaving AMA.

      i. Documentation in the EHR~~medical record~~ should include counseling, other options that might have been offered, risks of leaving AMA and time the resident left the facility.

5. For residents leaving ~~Against Medical Advice~~AMA:

   a. Physician or Nurs~~e~~ing completes the AMA form (MR 804) in the ~~H~~EHR and documents the reason the resident wants to leave and the discussion of the risk of leaving AMA.

   ~~a.~~b. The resident will be asked to sign the AMA form. For residents who refuse to sign the form, mark the form accordingly.

   ~~b.~~c. Physician shall place an order for AMA discharge in the ~~electronic health record (~~EHR~~)~~.

c.d. A member of the Resident Care Team (RCT) gives the resident a list of emergency shelters, food sources, medical referrals and medication referrals prescriptions if there was sufficient advance notice of the resident's intentions and completes the corresponding documentation.

d.e. Once these procedures are completed, the resident is considered discharged AMA and will be discharged.

e.f. LHH will not hold the resident's bed.

6. If the resident leaves or remains out of the facility in a manner outside of the duration or conditions of the Leave of Absence (LOA) physician order, they may be discharged AMA (LHHPP 20-14). If that occurs:

   a. Physician shall place an order for discharge as AMA in the electronic health record (EHR) EHR. and The Nnurse or physician will complete the AMA form based on including prior resident care conference counselincounseling provided at the resident care conferenceRCC regarding the risk of AMA.g about the risk of AMA If theif resident leaves or remains out of the facility outside of the duration or conditions of LOA.

   b. A member of the Resident Care Team (RCT) will attempt to provide the resident a list of emergency shelters, food sources, medical and medication referrals if the resident returns to the facility or can be reached by phone, and document this attemptthen the member of the RCT will also complete the corresponding documentation.

   c. Once these procedures are completed, the resident is considered AMA and will be discharged.

   d. LHH will not hold the resident's bed.

ATTACHMENT:
None.

REFERENCES:
LHHPP 20-04 Discharge Planning
LHHPP 20-14 Leave of Absence and Bed Hold
LHHPP 24-22 Code Green Protocol
MR 804

Revised: 15/05/12/15, 19/07/09/19, 20/10/13/20, 23/07/11/23, 23/11/14/23, 25/05/12/25, 04/20/26 (Year/Month/Day/Year)

Original adoption: 09/03/02/09 (Year/Month/Day/Year)

COACH USE FOR CLOSE OBSERVATION

POLICY:

1. Nursing Services at Laguna Honda Hospital and Rehabilitation Center (LHH) ~~is responsible for providing~~ may provide close observation (coaching) of residents when needed.

2. The term “coach” is used to describe an individual who provides ~~1:1~~ close observation forto any resident who requires additional support and/or supervision. ~~It is synonymous with the term “alternate assignment”~~

~~1.~~3. The nurse manager (NM)~~/~~ and/or charge nurse (CN), in collaboration with Nursing Operations,~~ staff~~ are responsible for allocating staff for coach assignment(s) to provide the appropriate level of supervision.

~~2.~~4. Resident behaviors that may require ~~1:1~~ close observation include but are not limited to the following:

   a. High risk for falls.

   b. Impulsive behavior.

   c. Risk for aggression.

   d. Elopement risk.

   e. Intrusive behavior.

   f. Harm to self or others ~~(See Policy #3)~~.

   g. Other extenuating needs as determined by Resident Care Team (RCT) and with the approval of ~~Nursing Director/Nursing Operations~~the Directors of Nursing.

~~3.~~5. Long-term close observation measures are not intended for residents who are having suicidal ideation (defined as someone who is verbalizing an intent to harm self and has a plan and means to do so) or in imminent danger of harm to themselves or others, except while awaiting urgent evaluation and/or transfer to a higher level of care setting.

   a. For residents who are having active suicidal ideation and have scored at medium risk or higher on the Columbia Suicide Severity Rating Scale (CSSRS~~C-SSRS~~) a temporary coach shall be provided while waiting for further

psychiatric evaluation. Coaches are provided informed of education regardingon their duties and expectations at the time of assignment.

4.6. The need foreof a coach is will be a nursing decision and is intended as a short-term intervention while developing a long-term plan for resident safety.

5.7. The RCT is responsible for documentation of the initial assessment and ongoing evaluation/need for close observation measures.

6.8. The Nurse Manager (NM)NM or designee/Licensed Nurse (LM) or designee will use the online portal to request a coach after agreement from the Resident Care TeamRCT.

a. During business hours, a request for coach must be submitted via the online portal and approved by Directors of Nursing or Designee.the Coach Utilization Committee.

b. Initial coach assignment for short-term need during weekends and off hours can be approved by nursing operationsthe Nursing Operations Supervisor. and for For ongoing need of a coach, nurse manager the NM must bring this upforward the ask at the morning Stand Up Interdisciplinary Care Team (IDT) Stand Up meeting for further discussion and approval by Directors of Nursing or Ddesignee.

7.9. Coaches shall provide continuous close observation andor engage the resident as appropriate for the need documented in their individual care plan. Coaches and are expected to provide all care needs within the scope of their licensure or certification while refraining from the following:

a. Speaking in a non-business language or a language the resident does not understand,

b. Engaging in activities that distract the coach from coach duties, such as (but not limited to) using personal cell phone, reading, sleeping.Using personal cell phone,

c. Reading, and/or

d.b. Sleeping.

8. Nursing staff assigned to a resident requiring close supervision shall provide all resident needs within their scope of practice and not deviate from their roles allowable by law (home health aide, certified nursing assistant or licensed nurse). not deviate from their roles as a coach or leave the resident unattendedfor any

reason.

10.
9.11. LHH Patient Care Assistant (PCA)/ Certified Nursing Assistant (CNA) assigned as coaches are expected to documendocument in the electronic health record (EHR)tdocument hourly. for resident who is provided with a coach. This documentation on whyshall include the reason the resident was assigned a coach which is specific to each resident according to their individualized care plan. This documentation must be reviewed by the licensed nurse at the end of their shift and a progress note must be entered in electronic health record (EHR) either as a nursing note or on the flowsheet. Refer to section 3 Documentation below for additional guidance.

10.12. The team leader/charge nurse is responsible for checking the resident's condition frequently and as needed.

PURPOSE:

To provide a therapeutic and physically safe environment with appropriate level of supervision for residents who have been determined to have safety needs that exceed routine care and intervention measures.

PROCEDURE:

1. **Role of the RCT**

   a. If the RCT determines that a resident's behaviors and condition require close observation, the RCT shall do the following:

      i. Assess needs.

         - The RCT (at a minimum, the physician and RN) shall review the resident's condition, the specific behaviors that need intervention, and the close observation measures needed to ensure resident safety.

      i.ii. RCT must develop an observation and intervention plan, which may include, but are not limited to, as follows:

      The RCT (at a minimum, the physician and RN) shall review the resident's condition, the specific behaviors that need intervention, and the close observation measures needed to ensure resident safety. ii. RCT must develop an observation and intervention plan as follows:
      RCT must develop an observation and intervention plan as follows:
      Possible close observation measures may include, but are not limited to:

         - Increasing/decreasing the frequency of observation time periods

- Assignment of staff to provide close observation of residents needing such observation.

- Develop measurable ~~goal/s~~goals related to the use of close observation.

- Document the intervention plan and prior alternative(s) that have been unsuccessful.
  ~~Executive review team will provide on-going guidance as needed based on the plan as needed.~~

- The ~~nurse manager/charge nurse~~NM and or CN shall assign staff as permitted, preferably unit staff who have received coach training and know the resident's baseline behaviors and are aware of interventions~~,~~ to promote resident safety while providing direct care needs. The ~~charge nurse/team leader~~CN shall round frequently to check on the resident's condition and for updates from the assigned coach.

- Any request for additional staff used as coach shall be made through the Nursing Office.

- When a resident's family member or significant other assists with the resident's care and observation, the care plan shall reflect their participation and education. Nursing staff shall maintain overall responsibility for the care provided to the resident, including appropriate education on safety measures to be given to the resident, family and/or staff providing close observation of the resident.

iii. Evaluate the plan.

- While close observation is implemented, the RCT shall meet regularly, every two weeks and quarterly to: ~~:~~
  - Review any changes in the resident's condition.
  - Assess effectiveness of current interventions.
  - Evaluate resident goals and the need for ongoing close observation.
  - The RCT shall summarize each meeting ~~via~~ in the EHR.

- If the resident is not progressing with support of a ~~one-to-one~~ coach, the ~~Resident Care Team~~RCT will evaluate and may refer to the

Department of Care Coordination for potential transfer or discharge to another appropriate facility.

2. **Role/Expectations of the Coach Providing Close Observation**

   a. A coach should be made aware of three important aspects of their assignment:

      i. Why ~~they are~~are they assigned to the resident.

      ii. What goals are identified for this resident.

      iii. What interventions can be employed with the resident.

   b. All staff that are assigned to be coaches are expected to perform the duties within their scope of practice specific to LHH for their assigned resident unless specified otherwise. The coach's responsibilities include but are not limited to the following:

      i. Reporting to the ~~charge nurse~~CN at the start/end of their shift for endorsements and obtaining shift endorsement from outgoing coach.

      ii. Close monitoring of assigned resident(s) to prevent resident(s) from injury to self or injury to others.

      iii. Engaging the resident with goal-focused resident-centered interventions and ongoing activities.

      iv. Observing, reporting, and documenting resident behavior on an hourly basis, including observation of antecedents that may agitate or improve resident behavior.

      v. Providing nursing care as within their scope, which may include feeding, bathing, transferring, toileting (including incontinence care), repositioning, dressing, skin care and pivot transfers as ordered.

      vi. Ensuring environment is clean and free of clutter, which includes, but is not limited to bed making, replenishing of the water pitcher, and bedside cleaning.

      vii. Co~~ntributing~~mmunicating -their observations to~~to~~ the RCT discussions and contributing ~~to~~ ~~the~~to the~~and/or~~ plan of care.

      viii. Transporting/escorting residents to internal/external scheduled appointments.

ix. Other duties as assigned~~,~~ including specific responses to certain needs of the resident.

c. Coaches shall not leave residents unattended under any circumstances and are to use the call light and/or facility provided phone to ~~summon~~ request for ~~help/breaks/etc~~assistance, a break, or any other need while assigned.

d. Registry coaches shall perform all the duties as outlined above. Registry coaches may assist the LHH nursing assistant or licensed nurse but may not perform the following tasks independently:

i. Feeding residents on a Specialized Feeding Plan

~~i.~~ii. ~~ii.~~ Showering/bathing

iii. Use of any equipment or assistive devices for which they have not been trained.

3. ~~3.~~ **Documentation** (See Attachment A for table reference)

a. The coach providing the close observation shall identify and report physical changes to the Licensed Nurse (LN) such as alterations in gait that may increase risk of falls, changes in urination and bowel patterns, changes in skin, level of weakness, and vital signs. They shall also report any observable nonphysical~~non-physical~~ changes in demeanor, appetite, sleep patterns, increased confusion or agitation, and reports of pain and document their observations, as well as any potential antecedents and interventions.

b. ~~LHH~~ The PCA/CNA ~~who are~~ assigned as coaches are expected to complete documentation hourly. The LN will verify coach presence and documentation through LN documentation in ~~the EHR flowsheet or in a nursing note in~~ the EHR.

c. The following EHR documentation shall be completed regularly by the LN to include observations from the assigned coach staff:

i. The behavior monitoring flowsheet shall be completed regularly by nursing and other clinical staff as appropriate to monitor any behavioral target symptom identified in the provider's behavior order~~.~~

LHH Nursing Weekly Summary shall be completed by the LN ~~via EHR to include any changes reported by coaches.~~

The care plan shall be updated by LN on an ongoing basis and include any new interventions for addressing the safety needs of the resident, including the ongoing need for close observation as an intervention.

i.ii. Each RCT meeting shall be documented via EHR and include the reason for the resident's close observation, attempts to wean the resident from close observation by exploring alternative interventions to address resident behaviors, and progress towards meeting goals.

- Education provided to the resident, resident's family or significant other as related to safety measures shall be documented.

ATTACHMENT:
Attachment A: Coach Use for Close Observation Roles and Responsibilities

REFERENCE:
None.

Revised: 21/07/29, 00/03/28, 00/11/22, 01/05/10, 01/05/18, 09/06/09, 13/01/29, 16/11/08, 17/11/14, 19/07/09, 19/09/10, 21/10/12, 22/12/13, 23/06/13, 23/10/10, 24/05/14, 24/10/08, 26/05/18 (Year/Month/Day)

Original adoption: 98/11/16

Attachment A: Coach Use for Close Observation Roles and Responsibilities

Role	Responsibility
LHH PCA/CNA	• Responsible for all duties within their scope of practice for assigned resident. • Documents and communicates resident behaviors to regular CNA and or team. • Communicates any behaviors to the Licensed Nurse to be documented in EHR behavior monitoring flowsheet.
Registry Coach	• May assist LHH nursing assistant or licensed nurse but not use any equipment or assistive devices for which they have not been trained.
Charge Nurse/ Licensed Nurses	• Assigns coach based upon available nursing staff. • Gives report to oncoming coach. Completes rounds frequently for updates • Completes rounds frequently for updates. • Documents any behaviors in EHR behavior monitoring flowsheet. • LN will review EHR coach documentation for their shift and determine was the coach status initiated, continued or discontinued.
Resident Care Team	• Assesses need for Close Observation. • Conducts RCT review to evaluate continued coach need. • May provide focused review with consultants. Nurse Manager to present the review to morning Stand Up IDT • Nurse Manager to present the review to morning Stand Up IDT • May refer to Clinical Leadership for placement

USE OF ISOLATION ROOMS

POLICY:

1. High level respiratory isolation rooms are used primarily to care for residents suspected or known to be infected with a highly contagious airborne pathogen. Isolation rooms may also be utilized for purposes of preventing the transmission of other highly contagious pathogens via the contact route.

   [Note: Rooms S428A, S448A, S528A, S548A, S628A, S648A and PM56A are high-level respiratory isolation rooms. Room PM56A is licensed as a general acute care bed. All other isolation rooms are licensed as a skilled nursing facility (SNF) bed.]

2. Isolation rooms S528A and S548A shall be reserved and used only by residents who require high-level respiratory isolation.

3. An additional isolation room shall be reserved for use by residents with suspected or lab-confirmed influenza during the influenza season. For special cases, exceptions may be made with approval from the Chief Medical Officer (CMO), Chief Nursing Officer (CNO), or their respective designees.

4. Exceptions may be made to Policy Statement #1, 2, and 3 under the following circumstances and/or temporary conditions for skilled nursing facility residents:

   a. When no other bed is available;

   b. During a public health emergency such as a pandemic;

   c. For the safety of a resident;

   d. As a bed hold for a resident who is currently receiving acute care services; and/or

   e. Approved by both the Chief Executive Officer (CEO) and CMO, or their respective designees.

5. When the reserved isolation rooms on South 5 are occupied, an additional isolation room in South 6 (Room S648A) shall be made available and reserved for isolation use until the need for isolation rooms, or an outbreak is declared over by the Chair of the Infection Control Committee or the Infection Control Nurse. Legends shall be placed on these isolation rooms in the electronic health record to identify them as high level respiratory isolation rooms.

6. A physician's order shall be written when placing a resident or patient for high level respiratory isolation.

7. Residents who are placed in any of the seven isolation rooms and do not require high-level respiratory isolation shall:

   a. be assessed for appropriate level of care and safety before being placed or relocated to a skilled nursing facility isolation room, and

   b. meet at least one of the exceptions criteria listed under Policy #4.

8. Residents who are placed in a SNF isolation room and are not needing the high level respiratory isolation, shall be informed that their room placement is only temporary, and that they shall be relocated to another room when a non-isolation room becomes available, or they no longer need to be isolated or in a private room.

PURPOSE:

To maximize use of all available beds at Laguna Honda Hospital and Rehabilitation Center for residents in need of skilled nursing facility or acute care services while maintaining a safe and prudent capacity to isolate residents with potentially serious communicable diseases.

PROCEDURE:

1. Communication and Documentation

   a. The Patient Flow Coordinator shall notify staff on South 4, 5 and 6, Facility and Environmental Services staff, when the isolation room(s) is scheduled for use by a resident not requiring isolation.

   b. The Infection Control Nurse or Operations Nurse Manager shall notify Facility and Environmental Services (EVS) staff when the room is used for high level respiratory isolation or other types of isolation.

   c. Nursing staff shall monitor and document the resident's response to the temporary room placement.

   d. Nursing staff shall notify EVS staff when the isolation room is vacated (as the resident is relocated to another room or neighborhood).

2. Use of isolation rooms by residents not requiring high-level respiratory isolation

   a. Nursing staff shall remove the red door sign ("STOP. Check With The Nurse Before Entering") from the outer door.

   b. Nursing staff shall remove supplies for high-level respiratory isolation from the anteroom.

3. Converting the room for high-level respiratory isolation

   a. Facility Services staff shall verify the integrity of the special air handling and ventilation system

   b. Nursing staff shall re-stock the anteroom with supplies for high level respiratory

isolation.

c. Refer to LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement.

ATTACHMENT:
None.

REFERENCE:
Environmental Services Policy and Procedure, Section XII Non-daily Cleaning
LHHPP 20-01 Admission to Laguna Honda and Relocation between Laguna Honda SNF Units
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement

Revised: 17/05/09, 17/09/12, 19/07/09, 20/10/13 (Year/Month/Day)
Original adoption: 12/07/31

NURSING CLINICAL AFFILIATIONS (Student Placements)

POLICY:

1. Laguna Honda Hospital (LHH) supports the clinical training and education of nursing professions, including Nursing Assistants, Unit Clerks, ~~Home Health Aides, Paramedic Students,~~ Licensed Vocational Nurses, Registered Nurses, Advanced Practice Nurses and those enrolled in doctoral programs.

2. Each ~~c~~Clinical ~~i~~Instructor will not exceed eight (8) students per clinical shift. The Clinical ~~I~~Instructor will provide supervision on-site to all their students.

3. All nursing students or ~~preceptees~~trainees, whether pre-certification, pre-licensure, or in a post-licensure course of education must:

    - Be enrolled in an educational institution approved by the California Department of Public Health, Board of Registered Nurses, and/or Board of Vocational Nursing and Psychiatric Technicians.~~,~~
    - Be enrolled in an educational program that has a current contract with the San Francisco Department of Public Health. The contract stipulates responsibilities of faculty and of LHH staff consistent with legal and ethical standards of practice.~~,~~
    - ~~Adhere to the following procedures.~~

4. The ~~c~~Clinical ~~i~~Instructor must ~~communicate all planned treatments and medications~~ communicate resident care prior to implementation for approval to the Charge Nurse.

5. The ~~c~~Clinical instructor will ~~complete~~sign in and out on the *Clinical Instructor's Sign-in Sheet* in the Nursing Office each day that they are on-site with the students. The Clinical Instructor will provide a copy of students' daily sign-in sheets to Department of Education and Training (DET).

6. Department of Education and Training (DET) is responsible for ~~monitoring current affiliations' agreements and~~ following up on clinical or educational concerns that occur as a result of student placements and will provide a regular update to the Director of DET and/or ~~Chief Nursing Officer~~Directors of Nursing (DONs).

7. To avoid conflicts of interests:

    - LHH nursing staff are not permitted to be paid or unpaid ~~c~~Clinical ~~i~~Instructors of educational programs and supervise students at their place of employment.
    - LHH nursing staff are not permitted to be placed into a student placement at LHH.
    - LHH nursing staff are not permitted to serve as a nursing student ~~preceptor~~ trainer for other LHH nursing staff.

PURPOSE:

1. To outline guidelines to ensure a safe and educationally sound clinical experience.

2. To clarify the roles and responsibilities of the school and the nursing staff of LHH.

PROCEDURE:

A. ~~One Two~~~~One months~~ Six (6) W~~w~~eeks ~~p~~Prior to the ~~practicums~~Start of the ~~c~~Clinical ~~r~~Rotation.

1. The ~~c~~Clinical ~~i~~Instructor ~~-~~will send a request ~~via email~~ for student placement to the LHH Student Affiliation Coordinator in the Department of Education and Training ~~Department~~.

~~2.~~ The C~~c~~linical ~~i~~Instructor~~r~~ ~~-~~will electronically send ~~a clinical syllabus~~all required documents to the LHH Student Affiliation Coordinator prior to the start of the clinical rotation.~~.~~
2.
~~3.~~

~~3.~~ All schools who utilize LHH as a clinical site must have an approved school affiliation contract with the City and County of San Francisco.~~.~~
~~4.~~3.
~~5. If the school has not had a recent affiliation with LHH (i.e. within the past school year), the Affiliation Coordinator will verify with the Contracts Office at (415) 554-2839 to determine if a current contract exists between the school and DPH.~~

~~6.~~4. ~~4.~~ The C~~c~~linical ~~i~~Instructor and the LHH Student Affiliation Coordinator, in collaboration with the Nurse Manager, when applicable, shall determine the practicum dates, days, hours and the resident care units where students will be placed.

~~1. A written agreement is reached describing the clinical experience among the faculty, Affiliation Coordinator, and Nurse Manager. This agreement will specify the days and hours the student will be on the neighborhood, the skills the student will be practicing, services the students will be providing and programs the students will be developing. The written agreement will specify in writing the faculty's responsibility related to supervising pre-licensure students' administration of medication or treatments.~~

~~7. Students will receive orientation prior to the first day of their clinical rotation via SF Learning ELM and EHR (Epic) training as appropriate.~~
~~8.~~
~~9.~~5. ~~5.~~ The Clinical I~~i~~nstructor ~~r~~ will send the list of students with complete demographics for pre-boarding and onboarding, ~~and~~ to obtain POI numbers for each student. LHH Student Affiliation Coordinator will conduct~~i~~ pre-boarding and communicates with the Clinical Instructor~~s~~ all instructions to disseminate instructions to the students.

~~10.~~6. 6. ~~For 6.~~ All ~~c~~Clinical ~~i~~Instructors will need to inform the LHH Student Affiliation~~s~~ Coordinator and provide complete demographics in order to start the pre-boarding and onboarding process. Orientation of ~~c~~Clinical I~~i~~nstructors will be conducted via SF Learning ELM, complete required EHR (Epic) training, and attend ~~in-person nursing orientation~~initial tour of the facility. Scheduling of ~~orientation~~tour can be arranged with the LHH Student Affiliation Coordinator and/or ~~the New Employee Orientation Coordinator~~designee via email or phone call.

7. ~~7.~~ Once request for clinical rotation is confirmed, the LHH Student Affiliation Coordinator will electronically send the Clinical Instructor all required compliance documents and orientation education requirements~~Student/Instructor Health Screening Verification Form, and Student/Instructor Roster/Clinical Schedule~~, preboarding, ~~and~~ onboarding, and orientation instructions.

8. ~~8.~~ Students will receive orientation prior to the first day of their clinical rotation via SF Learning ELM and EHR (Epic) training as appropriate.

B. Orientation f~~t~~or Clinical Instructor

1. Clinical Instructor orientation will be coordinated by the LHH Student Affiliation Coordinator or designee.~~, New Employee Orientation Coordinator, and/or Nursing Orientation Coordinator~~

~~1.~~2. Clinical Instructor orientation education will be provided via SF Learning ELM to cover regulatory and compliance topics.

~~2. The following orientation content will be covered during the clinical instructor orientation via SF Learning ELM:~~

~~a. Welcome and Overview~~
~~b. Hospital and Nursing Organization~~
~~c. Resident Rights and Civil Rights~~
~~d. Abuse Video: Film on "Iit's Your Legal Duty" and Mandated Reporting Law~~
~~e. Abuse Post Test, Attestation,~~
~~f. Code of Conduct~~
~~g. Confidentiality Agreement~~
~~h. Privacy and Compliance~~
~~i. Infection Control~~
~~j. Fire Safety,~~
~~k. Disaster Preparedness~~
~~l. Cardiopulmonary Emergencies~~
~~m. Prevention of Workplace Violence~~
~~n. Injury Illness Prevention Program~~
~~o. Quality Assurance Performance Improvement (QAPI)~~
~~p. Cultural Humility~~
~~q. Dementia and Behavior~~
~~r. Trauma Informed Care~~
~~s. Resident Color Codes, Code Green~~
~~t. Individualized Precautions to Prevent Aspiration~~
~~u. Therapeutic Communication~~
~~v. Facility tour by the Clinical Instructor~~

C. Clinical Instructor Responsibilities

1. The cClinical Iinstructor shall collaborate with the Charge Nurse and/or Nurse Manager to determine students' resident assignments.

2. The cClinical iInstructor will ensure that students receive hand-off report from the Charge Nurse or designee before providing care.

~~2.~~3. The Clinical Instructor will be present and available for students during their clinical assignment in any of the care areas at LHH.

~~3. The cClinical iInstructor will provide direct/line of sight supervision for each student during medication administration, and each student will be supervised during treatments by either the clinical instructor or the LHH licensed nurse. Students will **not** administer controlled substances. The clinical instructor will co-sign the student in the EHR for each medication administered, and tThe cClinical iInstructor or LHH licensed nurse will co-sign in the EHR for the treatment administered.~~

~~The cClinical iInstructor will co-sign all EHR documentation completed by student.~~

D. Student Responsibilities

1. Each student must wear a visible school identification (ID) badge so that it can be easily identified.

2. Each student must obtain a hand-off report from the Charge Nurse or designee before providing care. When leaving the neighborhood, students will provide appropriate hand-off report to the Charge Nurse or designee, and C~~c~~linical I~~i~~nstructor.

~~3. Students needing to review medical records prior to clinical rotation must check in with the Charge Nurse and adhere to LHH policy on confidentiality (LHH 21-01 Medical Record Information: Confidentiality and Release).~~

3. Students may s~~S~~eek guidance from their Clinical Instructor ~~faculty member~~ or LHH Student Affiliation~~s~~ Coordinator regarding activities and student role.

4. Students must maintain confidentiality of resident information and must not take any printed resident information off the resident care units.

E. LHH Student Affiliation Coordinator ~~Responsibilities~~ or Designee

1. Ensure students completion of required forms and required information for pre- and onboarding prior to orientation.

2. Request for POI access and coordinate SF Learning ELM orientation and EHR (Epic) training for C~~c~~linical I~~i~~nstructor and student orientation prior to start of clinical rotation.

3. Keep records of clinical instructors and students' orientation and training documents.

4. Maintain communication with the school affiliation.

5. Maintain communication with the school affiliation and report any problems related to the student(s).

6. Keep records of student roster and neighborhood assignments including assigned C~~c~~linical I~~i~~nstructors.

REFERENCE: ~~ATTACHMENT:~~

NONE

CROSS REFERENCE:

Hospitalwide Policy and Procedure
~~Laguna Honda HHPP~~ 84-01 Student Affiliation
~~LHH 2~~21-01 Medical Record Information: Confidentiality and Release

ATTACHMENT:

NONE

Adopted: 1/2005

Revised: ~~2007/~~10/2007; ~~2011/~~09/27/2011; ~~2015/~~09/08/2015; ~~2019/~~07/09/2019; ~~2022/~~12/13/2022; 10/21/2025

Reviewed: ~~2022/~~12/13/2022

Approved: ~~2022/~~12/13/2022

Revised Nursing
Policies and Procedures

ITEMS ALLOWED AT THE BEDSIDE

POLICY:

1. All medicated ointments, creams, lubricants lotions, shampoo, soaps (i.e., hydrocortisone cream, Selenium Sulfide products such as Selsun Blue and Nizoral, lidocaine cream such as Aspercreme) shall continue to be stored in the treatment cart or the treatment compartment of the medication cart.

2. 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.

3. All wound care and treatment supplies including cleaning/irrigation solutions, dressings, and scissors shall be stored in the treatment cart or treatment compartment of the medication cart.

Purpose:

To ensure resident safety as well as promote resident independence.

Procedures:

1. Nursing will ensure that ~~the only~~only the following items (see table below) are stored at the bedside.

Items Allowed for Bedside Storage
Non-medicated ointments, creams, lubricants, lotions, shampoo, soaps Examples include: • A & D Ointment • Aquaphor • Lubriderm • Protective barrier creams (i.e., Dimethicone, Zinc Oxide) • Aloe Vesta Body Wash and Shampoo • Remedy No-Rinse Cleanser • Deodorants • Shaving Cream • Resident's personally supplied hygiene items such as shampoo, soap, deodorant, lotions, make-up as long as items are non-medicated
Oral hygiene items such as toothbrushes, toothpaste, and mouthwash, with or without fluoride
Non-medicated oils that are to be used for topical application only. Examples include but not limited to: • Rosemary, hemp seed, coconut, avocado and lavender oils.
Enteral syringe (labeled with date and changed every 24 hrs.)

Emergency respiratory equipment for residents with tracheostomies:

- Airway suction supplies including complete suction equipment set-up, unopened suction kit, and unopened sterile water/saline.
- Tracheostomy of the same type, size (including inner cannula)- for emergency replacement
- Ambu bag ~~if ordered by physician~~

O_2 tubing administration devices in use
(labeled with date and resident's initials~~)~~)

- Daily and PRN:
  - Change ~~P~~pre-filled nebulizer, sterile water for humidifier, tracheostomy collar, tracheostomy tubing and tracheostomy mask.
- Weekly and PRN:
  - Change ~~N~~nasal cannula oxygen tubing, suction tubing, suction cannister, Yankauer, nebulizer set (mask and tubing) and reusable humidifier bottles.

Water pitchers with liners for resident (kept at bedside unless contraindicated e.g., fluid restrictions, nothing by mouth):

- Water pitchers are replenished every shift and as often as necessary. Consider resident's preference when refilling water.
- Water pitchers
  - ~~L~~Labeled with date they are changed and resident's initials
  - Pitcher changed every 7 days, and PRN
  - Liner changed every shift, every time water is refilled, and PRN

~~Liner changed q shift, every time water is refilled, and PRN~~
~~Water pitchers are replenished every shift and as often as necessary. Consider resident's preference when refilling water.~~

2. Remove all non-approved items if found at the bedside and store in the appropriate place.

REFERENCES:

NONE

CROSS-REFERENCES:

Nursing Policies & Procedures
D9 6.0 Water Pitchers
I 5.0 Oxygen Administration

ATTACHMENT/APPENDIX:

NONE

New: ~~2022/~~11/08/2022

Revised: ~~2022/~~11/08/2022; ~~2024/~~07/09/2024; ~~2024/~~09/16/2024; 02/12/2026

Reviewed: ~~2024/~~11/02/2024

Approved: ~~2024/~~11/02/2024

TUB BATHS AND SHOWERS

POLICY:

1. It is the policy for Laguna Honda Hospital for patients and residents to bathe or shower as medically appropriate to meet hygiene needs.

PURPOSE:

To promote health and wellbeing of patients and residents by meeting bathing needs.

PROCEDURE:

A. Definitions

Bathing -is defined adds washing, rinsing, and cleaning the skin and hair. On bath days, personal hygiene such as nail care and shaving, if appropriate, are also provided.i ncludes nail care, hair care, shaving, and cleansing of skin surfaces.

B. Roles and Responsibilities

1. Licensed Nurse in collaboration with the Nursing Assistant, and if appropriate, Rehabilitation Staff, and/or Resident Care Team (RCT) are responsible for assessing, planning, meeting bathing needs, and accommodating preferences of residents.

2. A resident who requires assistance shall not be left unattended for safety reasons.

3. Bathing alternatives will be offered if resident finds a tub bath or shower distressing or unacceptable.

4. Any refusal of care shall be escalated as appropriate per resident's plan of care for any further interventions as needed.

5. Nursing staff are responsible for cleaning and disinfecting the shower chair and tub. All care equipment used for bathing are cleaned and disinfected after each resident's use.

C. Preparation

1. Gather all equipment prior to bathing the resident.

2. Check with the Licensed Nurse for any preparation needs.

3. **Preparation of Resident/Patient –** The resident'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 dignity, privacy, safety and confidentiality.

D. Bathing the Resident using the Tub

1. Bath can be provided using the spa tub or portable tub based on resident preference and physical function.

2. Use appropriate transfer technique per resident care plan.

3. Slings used for bathing are labeled per individual resident. {(Refer to NPP D 6 1.1 Battery Operated Lift Transfer (C-625 Ceiling Lift & EZ Way Smart Lift) and LHHPP 24-19 The C-625 Battery-Operated Ceiling Lift)}

4. Follow recommendations for bathing in the resident care plan.

5. If the resident has a bowel movement in the tub, transfer resident out of the tub. Transfer the resident to a wheelchair or commode chair while cleaning the tub due to the bowel movement and cover the resident to keep warm.

   a. Remove feces and deposit in the toilet if possible.
   b. Disinfect the tub with facility approved cleaning agent.
   c. Refill the tub with water and check the temperature.
   d. Return the resident to the tub and continue with the bath.

D. Bathing Resident using the Shower

1. Shower can be provided to a resident using an appropriate shower chair based on function and resident preference.

2. Use appropriate transfer technique per resident care plan.

3. Resident who is independent in showering:

   a. Teach resident about safety precautions such as having all necessary materials within reach, applying all brakes to shower chair if used, and to test water temperature prior to showering.
   b. Instruct resident to call for assistance using nurse call system when needed.
   c. Periodically check resident for any assistance needed.

E. Grooming or Personal Hygiene

1. Gently apply lotion or mositurizer on resident's back, legs, and feet.

2. Dress resident or assist with dressing as needed.

3. Clip toenails straight across and shape fingernails. (Refer to NPP D5 1.0 Foot Care)

4. Comb hair. Handle hair gently when combing, brushing, or styling to avoid damage.

5. Assist the resident to shave facial hair if appropriate.

6. Apply makeup with resident's consent according to their preference.

E. Reporting / Documentation

1. Any abnormal skin changes, discomfort or refusals for nail care, hair care, or cleansing skin shall be reported to the Licensed Nurses and documented in the medical record and indicated in the Care Plan of the electronic health record.

F. Environmental Infection Control

1. Refer to Infection Control Manual

2. The nursing staff are responsible for cleaning and disinfecting the shower chair and tub. For additional details, refer to Standard Work: Arjo Bathtub Cleaning and Disinfecting, and Standard Work: Shower Gurney and Shower Chair Cleaning.

REFERENCES:

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

CROSS REFERENCES:

Hospitalwide Policy and Procedure
24-19 The C-625 Battery Operated Ceiling Lift

Nursing Policy and Procedure
D5 1.0 Foot Care
D6 1.1 Battery Operated Lift Transfer (C-625 Ceiling Lift & EZ Way Smart Lift)

ATTACHMENTS/APPENDICES:

None

Revised: ~~-~~8/2002, 2/2010; 05/12/2015; ~~2016/~~09/13/2016; ~~2019/~~03/12/2019; ~~2023/~~09/12/2023; ~~2024/~~10/31/2024; 01/27/2026

Reviewed: 2025/01/13

Approved: 2025/01/13

WATER PITCHERS

POLICY:

1. Water pitchers with liners are provided to all residents unless contraindicated {e.g., fluid restrictions, nothing by mouth (NPO)}.

2. Water pitchers and liners are changed on a scheduled basis. See table below:

	Water Pitcher	**Water Pitcher Liner**
Resident	• Weekly • As-needed	• Every shift • Every time water is refilled • As needed
Medication Cart	• Daily at the end of PM shift • As-needed	• Every shift • Every time water is refilled • As needed

3. Water pitcher and liners are labeled with the date they are changed. Water pitchers for residents are also labeled with the resident's initials.

~~4. Water pitchers for residents are changed weekly and as needed.~~

~~5. Water pitcher liners for residents and the medication carts are changed every shift, every time water is refilled and as needed.~~

~~6. Watcher pitchers for the medication cart are changed every day at the end of PM shift.~~

PURPOSE:

To provide fresh water and clean drinking supplies for the resident and medication cart.

PROCEDURE:

1. Equipment:

   Water pitcher with lid
   Water pitcher liner
   Straws
   Disposable drinking cups

2. Perform hand hygiene before replacing new liners and pitchers.

3. Unless contraindicated, ~~R~~replenish water pitcher every shift and as often as necessary. Consider resident's preference when refilling water.

4. Change disposable drinking cups or straws as needed.

Revised: ~~2001/~~03/2001; ~~2006/~~03/2006; ~~2006/~~09/2006; ~~2009/~~09/2009; ~~2014/~~09/14/2014; ~~2019/~~03/12/2019; DELETED ~~2024/~~07/09/2024; ~~2024/~~11/08/2024, ~~2024/11~~

Reviewed: ~~2025/~~01/13/2025; 01/27/2026

Approved: Deleted ~~2024/~~07/09/2024, Resurrected ~~2025/~~01/13/2025

ASSESSMENT, PREVENTION, AND MANAGEMENT OF PRESSURE INJURY

POLICY:

1. The Registered Nurse (RN) is responsible for assessing each resident for presence and risk of pressure injury (PI) on admission navigator and/or flowsheet section in EHR and/or following any significant/clinical change in condition that may increase the resident's risk of developing a pressure injury.

2. Upon resident's intra-facility (within Laguna Honda) relocation, including Pavilion Acute, and/or vice-versa, the sending licensed nurse is responsible for conducting skin checks and completing skin section in the electronic health record (EHR) for any presence of pressure injury/complex wound.

3. The sending RN from SNF and/or Pavilion Acute and the receiving RN from SNF and/or Pavilion Acute will perform skin assessment of the resident.

4. Upon resident's discharge to acute hospital, the licensed nurse is responsible for conducting skin checks and complete skin section of the EHR.

5. Wound~~, Ostomy, and Continence RNs (WOCNs)~~ care RNs, trained wound care champion RNs, or physicians can identify and stage pressure injuries.

6. The RNs, Licensed Vocational Nurses (LVN), Certified Nursing Assistants (CNA), within his/her scope of practice, for observing and reporting changes in the resident's skin status.

PURPOSE:

To provide guidelines to nursing in prevention and management of pressure injury.

PROCEDURE:

1. **Prevention of Pressure Injury for Resident at Risk**

   a. Skin care: nursing assistants should keep the resident clean and dry and minimize exposure to moisture and associated irritants from incontinence, perspiration, or wound. Handle skin gently and minimize friction (refer to Appendix B for LHH Skin Care products).

   b. Skin check: nursing assistants are to thoroughly check the resident's skin at least once daily, paying particular attention to bony prominences and report changes to the primary nurse (team leader) and charge nurse This may be incorporated into the resident's daily hygiene care.

   c. Repositioning: reposition residents who are immobile, at least every 2 hours or per care plan. Draw sheets should be used for repositioning. Avoid positioning directly on trochanter or existing ulcer.

   d. Use caution when moving a resident. Avoid shearing/friction by using lifting devices or bed linen to position residents who cannot assist during transfers and position changes.

   e. Positioning devices: use wedges, and/or pillows to keep bony prominences from direct contact with one another.

f. Support surfaces: nursing staff will apply a pressure-relieving support surface (bed/wheelchair) and/or specialized mattress when needed after evaluation from the physician and RCT. If re-evaluation is needed notify the physician for evaluation and/or consult with the wound specialist or to the Plastics clinic (Refer to LHPP 24-03 Support Surfaces).

g. Protective devices:

   i. Protectors for ankle and elbow to minimize friction.
   ii. Heel protectors/devices or pillows under the length of the lower legs to suspend the heels. Do not put the pillow directly under the knees.
   iii. Footboards or bed cradles can be used to keep the pressure of bed linens off the feet.
   iv. Foam arm rest covers (available from central supply under "arm desk stabilizer lateral") for wheelchair arms can be used.

h. Careful placement in chairs: position chair-bound resident with good postural alignment, and distribution of weight, balance and pressure relief.

   i. Refer to occupational therapy for evaluation of appropriate seating device.
   ii. Avoid sitting directly on the pressure injury.
   iii. Keep top of thighs horizontal and ankles in a comfortable, neutral position on floor or footrest.
   iv. Rest elbows, forearms and wrists on arm supports. Use foam armrest supports on wheelchair.
   v. Instruct or assist residents to relieve pressure by redistributing weight off buttocks at least hourly. Have residents shift their weight every 15 minutes if they are able.
   vi. Document the use of positioning devices and repositioning schedule (as tolerated) in the resident care plan.

2. Assessment of Pressure Injury

The licensed nurse shall complete the Braden scale to identify residents at risk of developing PI. The Braden scale shall be completed on admission, weekly thereafter for 3 consecutive weeks; then quarterly and annually following the Minimum Data Set (MDS) schedule; and when there is a significant decline or change of condition.

a. The charge nurse or licensed nurse will inform the Resident Care Team (RCT) of any resident identified at risk utilizing the Braden score for pressure injuries and develop an initial care plan. The RCT will review and contribute to the care plan as needed.

b. The charge nurse or licensed nurse will ensure that the plan of care is reviewed with nursing staff and ensure through direct supervision that the plan of care is being implemented.

c. The Wound, Ostomy, and Continence RNs (WOCNs) trained wound care champion RNs, or physicians will assess pressure injuries when present. The LVN may assist in data collection under supervision of RN:

   i. location
   ii. size (length, width, depth in cm)
   iii. stage of injury
   iv. wound bed, color and type of tissue, including evidence of healing (granulation tissue)
   v. whether the wound edge around the ulcer is hard, thick, rolled or white-gray tissue, macerated edge, or open edge (healthy edge)
   vi. presence of pain, nature, frequency

vii. exudate, slough, eschar, necrotic tissue and odor
viii. sinus tracts, tunneling, undermining
ix. peri wound for erythema, warmth, maceration, or induration
x. signs of wound infection, such as tenderness of surrounding tissue, edema or swelling, purulent drainage or foul odor

Indicators of a deteriorating pressure injury include increase in injury size, increase in exudate, loss of granulation tissue, purulent drainage and development of slough, necrosis, eschar or odor.

d. The RN will reassess pressure injuries, at least weekly, to determine whether the prescribed treatment is working and document on the electronic health record (EHR) until healed. A clean pressure injury should show evidence of some healing within two weeks.

e. The RN will reevaluate the treatment plan weekly, or as soon as there is any evidence of deterioration in the condition of the resident or the wound. If the injury fails to respond to treatment, notify the physician to evaluate and/or refer the resident to the Plastics clinic.

3. Management of /Pressure Injury

a. Following detection of a pressure injury, the charge nurse or designee will:

i. notify the neighborhood provider (or if immediate treatment is needed, on-call physician) and a treatment plan shall be implemented within eight (8) hours;
ii. notify the dietitian within 24 hours (call Dietary office)
iii. notify the resident and / or Surrogate Decision Maker (SDM) within twenty-four hours
iv. complete a wound assessment and progress note in the electronic health record (EHR)
v. develop a plan of care for prevention and treatment for the injury(ies) with interdisciplinary team input
vi. submit an Incident Report
vii. Schedule a Resident Care Conference (RCC) within a week. The RCT shall conduct a meeting to review the plan of care of resident with newly identified PI.

b. ~~The Wound, Ostomy and Continence (WOCN) RNs~~Wound care RNs, trained wound care champion RNs, and/or physicians will assess pressure injury(ies) weekly. The LVN may assist in gathering data under the supervision of the RN.

c. The RCT will reevaluate the treatment plan if the injury(ies) fails to show evidence of healing within two weeks, or when the injury(ies) shows signs of deterioration.

d. The Attending Physician in conjunction with the RCT will evaluate non-healing and worsening pressure injuries. The Physician will refer to the Plastics Clinic when it is needed.

4. Documentation of Pressure Injury

a. Admission: Complete the Braden Scale and a skin assessment in the EHR.

b. Document condition of skin as part of Minimum Data Set (MDS quarterly, annually including significant change of condition assessments and complete the Braden scale.

c. Intra-facility relocation: the sending licensed nurse is responsible for conducting skin checks and completing the skin assessment in the EHR for any presence of pressure injury/complex wound.

d. Discharge to acute:

   i. Upon resident's discharge to acute hospital, the licensed nurse is responsible for conducting skin checks and completing the skin assessment in the EHR.
   ii. LHH Acute: The sending RN from SNF and the receiving RN from Pavilion Acute will perform skin assessments of the resident.

e. Complete the Braden scale on admission, every weekly thereafter for 3 consecutive weeks, then quarterly and annually following the Minimum Data Set (MDS), and for any decline or signification change in condition.

f. Resident Assessment Instrument (RAI): When a pressure ulcer/pressure injury is triggered as a Care Area Assessments (CAA) Problem Area, the MDS Coordinator will:

   i. Utilize the CAA guidelines to identify additional areas needing assessment.
   ii. Document the assessment in the CAA notes, including the decision to care plan or not.
   iii. Review the RAI policy and consult with the physician and RCT to determine if a significant change in condition MDS assessment must be completed when a resident develops a stage 2 or higher pressure ulcer/pressure injury.

g. Resident Care Plan: If the resident is identified as being at risk for pressure injuries as determined through the Braden scale or has a pressure injury, a comprehensive, interdisciplinary care plan is developed that:

   i. identifies problems (i.e., PI risk factors and/or presence of injury),
   ii. develops individualized goal(s),
   iii. develops interventions to address prevention or treatment
   iv. develops interventions for wound and wound treatment pain if assessed as problem

h. SNF and Acute care units: Wound assessment is done weekly and/or when there is a decline in the condition of the wound. These assessments are documented in the EHR.

i. Nursing Assistants are to document any changes in skin condition they observed in the EHR, including the name of the licensed nurse notified.

j. Daily documentation: Evaluation of status of dressing if present (whether intact or with presence of drainage; the status of area surrounding PI (that can be observed without removing the dressing); the presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection; whether pain, if present, is being adequately controlled.

k. Weekly nursing summaries: Summaries include assessment of any new risk factors for developing a pressure injury as well as an evaluation of the effectiveness of implemented treatment/interventions and revision of care plan as needed.

l. Notification: Document all notifications to the physician, dietitian and family or SDM when a pressure injury is detected and when the ulcer shows no evidence of healing.

m. Resident education/counseling: Resident teaching or counseling related to prevention/management of pressure injuries is to be documented in the EHR and/or resident care plan.

APPENDICES:

Appendix 1: Definition of Pressure Ulcer and Intervention
Appendix 2: LHH Wound Care Formulary
Appendix 3: Waffle Overlay

REFERENCES:

Acute & Chronic Wounds: Current Management Concepts, Elsevier, 4th edition, 2012

Evidence-Based Pressure Ulcer Prevention: A Study Guide for Nurses, HC Pro, 2008 Sizewise

European Pressure Ulcer Advisory Panel (EPUAP), National Pressure Injury Advisory Panel (NPIAP), Pan Pacific Pressure Injury Alliance (PIPPIA). (2019). In *Prevention and treatment of pressure ulcers/injuries: Clinical practice guidelines. The international guideline* (3rd ed.).

Wound, Ostomy and Continence Nurses Society-Wound Guidelines Task Force WOCN 2016 Guideline for Prevention and Management of Pressure Injuries (Ulcers), Journal of Wound, Ostomy and Continence Nursing: May/June 2017 - Volume 44 - Issue 3 - p 241-246

CROSS-REFERENCES:

Hospitalwide Policy and Procedure
- 24-15 Prevention and Management of Pressure Ulcer

Nursing Policy and Procedure
- C 1.0 Admission and Readmission Procedures
- C 1.2 Nursing Guidelines for Relocation between Laguna Honda SNF Neighborhoods
- C 3.0 Documentation of Resident Care/Status by the Licensed Nurse
- C 4.0 Notification and Documentation of Change in Resident's Status

Document originated: 2001/11

Revised: 02/2005; 03/2008; 12/04/2015; 11/04/2017; 2018/03/06; 2019/03/12; 2022/10/11; 2023/05/09; 2024/02/13

Reviewed: 2025/02/03

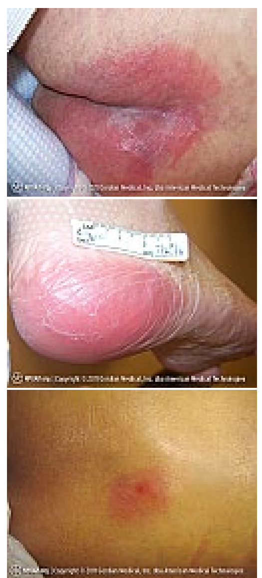
Approved: 2025/02/03

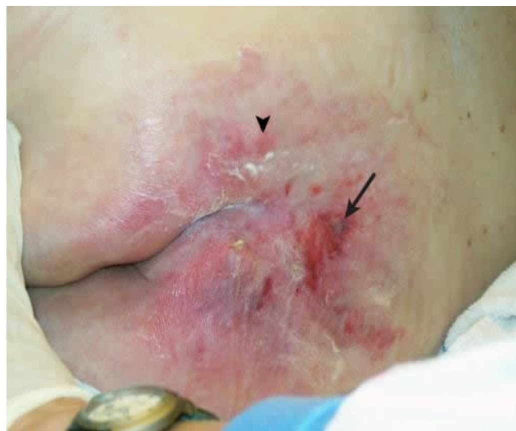
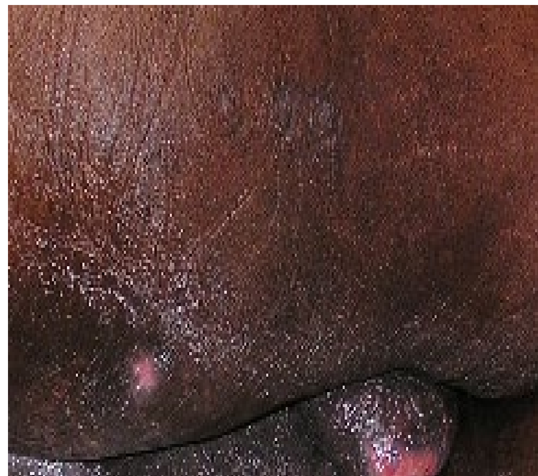
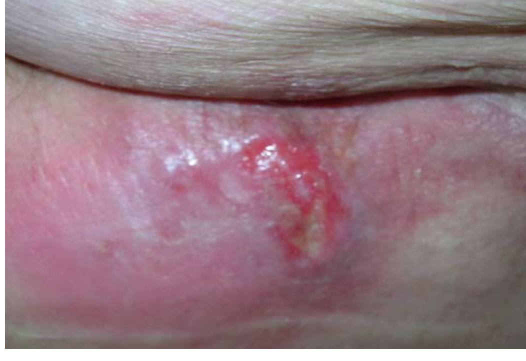
APPENDIX 1: Definition of Pressure Injury and Intervention

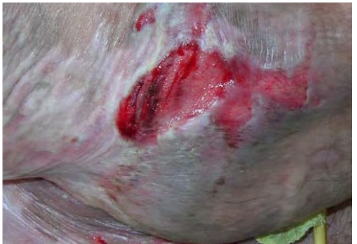
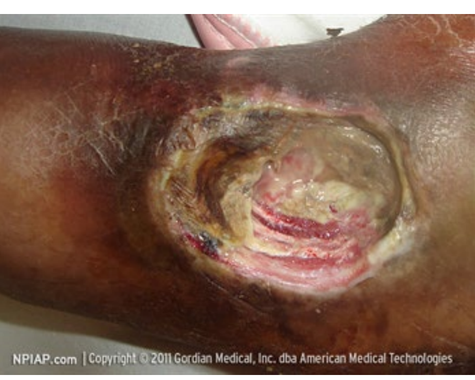
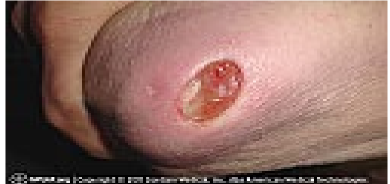
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, comorbidities and condition of the soft tissue.

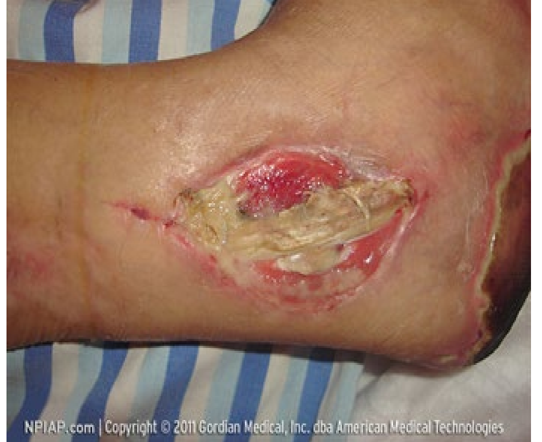
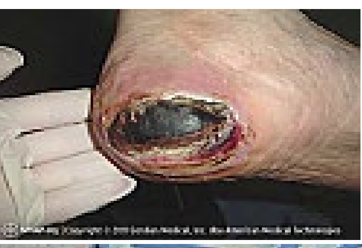
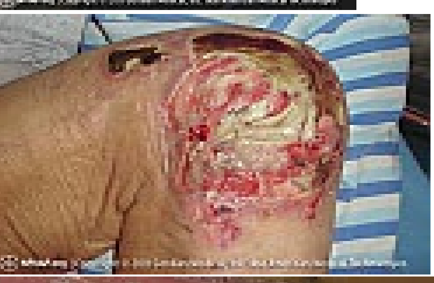
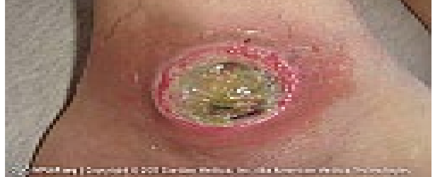
STAGE	DISCRIPTION	INTERVENTIONS
DEEP TISSUE PRESSURE INJURY-DTI	Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister, Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions	**Pressure Redistribution Devices: Obtain from CPD** 1.Waffle overlay (*i.e. Ehob)* for bed 2.Waffle seat or gel foam cushion for chair (*i.e. Ehob)* 3.Heel protectors *(i.e. RCAi, make sure to measure foot size)* *4. Apply Turning Wedges if sensory, activity and mobility are compromised* ***Consider,* Upgrade to low air loss mattress (LAL)** ** train unit clerks to order mattress & Wound Care specialist to continue tracking log

Appendix 1: Definition of Pressure Injury and Intervention

STAGE 1 	Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. ***Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.*** **Tissue** may be painful, firm, soft, warm or cool as compared to surrounding tissue.	1. Reposition patient off the affected area to relieve pressure. 2. Initiate an Optifoam dressings for all bony prominences and float heels. 3. Communicate in report at end of shift and, Wound Champions and charge nurse. 4. Enter Wound assessment data in the Avatar: Mark the correct location. 5. Document in Nursing notes new PI onset, including interventions that are implemented to promote healing. 6. Initiate turning clock and schedule. 7.Apply pressure redistribution surface (bed & chair) to area, 8. Patients with incontinence/frequent loose stool - use skin barriers, inter-dry sheet within all folds, and consult with MD. 9.Heel protectors *(i.e. RCAi, make sure to measure foot size)*

STAGE 2  	Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum filled blister. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), Denudation due to stool, intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions	1. Reposition patient off the affected area to relieve pressure. 2. Initiate an Optifoam dressings for all bony prominences and float heels. 3. Communicate in report at end of shift and, Wound Champions and charge nurse. 4. Enter Wound assessment data in the Avatar: Mark the correct location. 5. Document in Nursing notes new PI onset, including interventions that are implemented to promote healing. 6. Initiate turning clock and schedule. 7.Apply pressure redistribution surface (bed & chair) to area, 8. Patients with incontinence/frequent loose stool - use skin barriers, inter-dry sheet within all folds, and consult with MD. 9.Heel protectors *(i.e. RCAi, make sure to measure foot size* **10.COMMUNICATE WITH PRIMARY DR/PLASTIC TEAM/WOUND CARE TEAM**
STAGE 3 	Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and	1. Reposition patient off the affected area to relieve pressure. 2. Initiate an Optifoam dressings for all bony prominences and float heels. 3. Communicate in report at end of shift and, Wound Champions and charge nurse. 4. Enter Wound assessment data in the Avatar: Mark the correct location. 5. Document in Nursing notes new PI onset, including

	tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. *The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage 3injuries can*	interventions that are implemented to promote healing. 6. Initiate turning clock and schedule. 7.Apply pressure redistribution surface (bed & chair) to area, 8. Patients with incontinence/frequent loose stool - use skin barriers, inter-dry sheet within all folds, and consult with MD. 9. Heel protectors *(i.e. RCAi, make sure to measure foot size.* **10.COMMUNICATE WITH PRIMARY DR/PLASTIC TEAM/WOUND CARE TEAM**
STAGE 4  	Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. Stage 4 injuries can extend into muscle and/or supporting structures (e.g., fascia, or joint capsule) making osteomyelitis possible.	1. Reposition patient off the affected area every 2 hours, or per order, to relieve pressure. 2. Initiate an Optifoam dressings for all bony prominences and float heels. 3. Communicate in report at end of shift and, Wound Champions and charge nurse. 4. Enter Wound assessment data in the Avatar: Mark the correct location. 5. Document in Nursing notes new PI onset, including interventions that are implemented to promote healing. 6. Initiate turning clock and schedule. 7.Apply pressure redistribution surface (bed & chair) to area, 8. Patients with incontinence/frequent loose stool - use skin barriers, inter-dry sheet within all folds, and consult with MD.

		9. Heel protectors *(i.e. RCAi, make sure to measure foot size.* **10.COMMUNICATE WITH PRIMARY DR/PLASTIC TEAM/WOUND CARE TEAM**
UNSTAGEABLE  	Unstageable Pressure Injury: Obscured full thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar ***(i.e. dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or Removed.*** ***PAINT WITH BETADINE SWAB UNTIL ASSESSED BY WOUND Specialist.***	1. Reposition patient off the affected area to relieve pressure. 2. Initiate an Optifoam dressings for all bony prominences and float heels. 3. Communicate in report at end of shift and, Wound Champions and charge nurse. 4. Enter Wound assessment data in the Avatar: Mark the correct location. 5. Document in Nursing notes new PI onset, including interventions that are implemented to promote healing. 6. Initiate turning clock and schedule. 7.Apply pressure redistribution surface (bed & chair) to area, 8. Patients with incontinence/frequent loose stool - use skin barriers, inter-dry sheet within all folds, and consult with MD. 9. Heel protectors *(i.e. RCAi, make sure to measure foot size.* **10.COMMUNICATE WITH PRIMARY DR/PLASTIC TEAM/WOUND CARE TEAM**

Appendix 1: Definition of Pressure Injury and Intervention

LHH Nursing Policies and Procedures

Original adoption: 08/15/2000

Revised: 05/01/2011; 12/04/2015,7/12/2022, 2022/10/11/2022; 2023/05/09/2023, 02/11/2026

Reviewed: 2024/02/13

Approved: 2024/02/13

Laguna Honda Hospital Wound Care Supply List

PRODUCT	IMAGE	INDICATIONS FOR USE	CONTRAINDICATIONS	CPD Hospital # When ordering please add H number and item description
DRESSINGS				
~~AQUAPHOR GAUZE~~ ~~(~~**CURITY NON-ADHERENT** ~~STRIPS~~DRESSING~~)~~ ~~(3x8)~~ **Dressing**		**Recommended Use:** • ~~-~~Wounds presenting with a minimal amount of exudate. • ~~-~~Superficial wounds: burns, abrasions, graft donor sites, & radiation injuries. **Duration:** Change Daily	~~–~~Should not be used on patients with known allergies to Vaseline, Aquaphor ointment or zinc oxide.	~~(3x8)~~ **H7021546**

~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~

~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~
DRAWTEX (~~Self-adaptive wound dressing~~Nonadhesive Hydroconductiv Wound Dressing) (4X4) Dressing		**Recommended Use:** • Moderate to copious exudating wounds • Partial- and full-thickness wounds such as pressure injuries (stages 3-4). • Lower extremity injuries (venous or arterial) • Diabetic foot injuries. • Surgical or traumatic wounds. • Burns **Duration**: Change Every 3-4 Days	Not intended for heavy arterial bleeding. Should be used as the primary dressing.	**(4x4) H1050715**
UrgoTul Ag/Silver Wound Contact Layer Dressings (4x5, 6x8)		**Recommended Use:** UrgoTul™ Ag is for use on acute and chronic wounds or wounds with signs of clinical infection. **Duration:** Change Every 3-4 Days	Contraindicated for use with HBOT.	**(4x5) H1050797** **(6x8) H1050798**

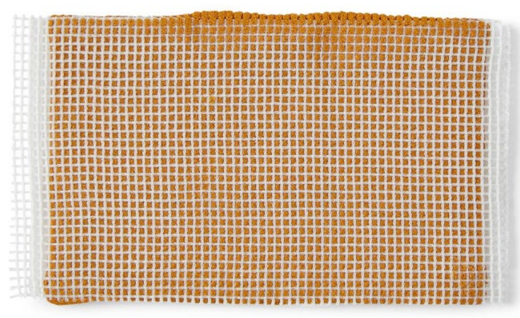
PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
Vashe: 4 oz		HOCl – hypochlorous acid. Lowering the pH into a range of 4-6 results in HOCl as the dominant species and a pH similar to intact human skin. Hypochlorous acid has many uses including chronic wound care & endoscope cleansing		(4 oz) H1050703
EXUDERM Satin Hydrocolloid Wound 4x4 Dressing		**Recommended Use:** • Used for light draining partial and shallow wounds. • Used to manage skin tears, pressure injuries (stage 2), partial-thickness wounds, minor abrasions, or wounds with slough or necrosis, etc. **Duration:** Change Every 72 Hours	Should not be used for 3rd degree burns.	H7021645

~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~
~~UrgoTul Ag green 4x5~~		~~**Recommended Use:**~~ ~~UrgoTul™ Ag is for use on acute and chronic wounds or wounds with signs of clinical infection.~~ ~~**Duration:** Change Every 3-4 Days~~	~~Contraindicated for use with HBOT.~~	~~**4x5**~~ ~~**H1050797**~~
HYDROFERA Blue Ready Antibacterial Foam Dressing		**Recommended Use:** • Use on wound sites that have moderate to copious amount of exudate. • Pressure injuries, diabetic injuries, venous stasis injuries, arterial injuries, superficial burns, donor sites, post-surgical incisions, and trauma wounds. **Duration:** Change Every 72 Hours	Should not be used for 3rd degree burns. - None to small amounts of exudate. - Wounds with dry eschar. - May cause slight blue staining of skin.	**(4x5)** **H1047560** **(8x8)** **H1047561**

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
Plurogel Burn and Wound 50 gram tub	Corius Tissue Regeneration PluroGel® Burn and Wound Dressing 1.75oz (50g)	A Concentrated surfactant works to hydrate the wound, control exudate and provide gentle debridement. Applications are daily, or every two, three days	Contraindicated for use on third- and fourth-degree burns.	**(50 gram)** H4501

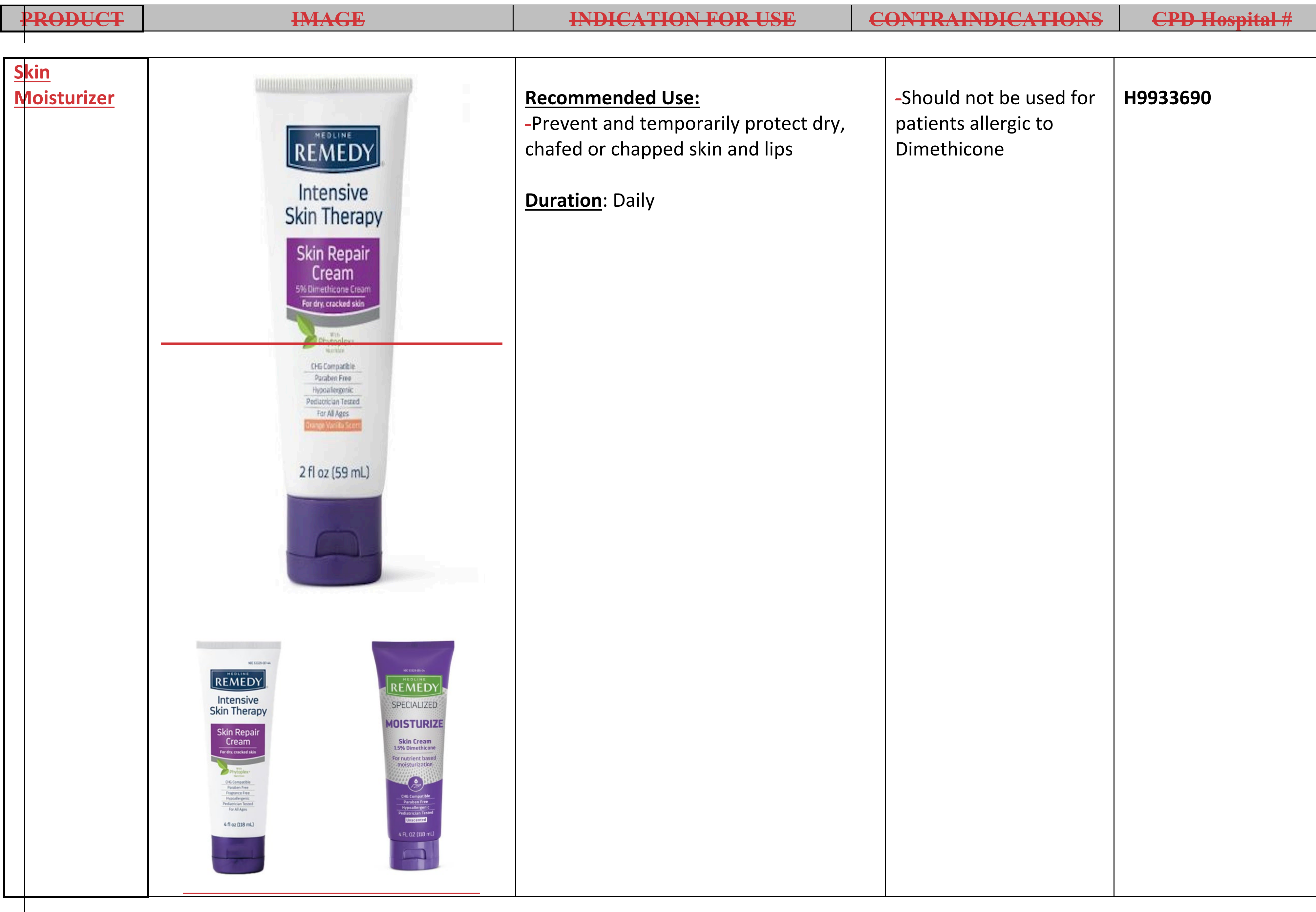
PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
Vashe: 4Oz,	highest concentration of hypochlorous acid	HOCl – hypochlorous acid. Lowering the pH into a range of 4-6 results in HOCl as the dominant species and a pH similar to intact human skin. Hypochlorous acid has many uses including chronic wound care, endoscope cleansing,		4 Oz H1050703
EXUDERM 4X4) Dressing		**Recommended Use:** • - Used for light draining partial and shallow wounds. • - Used to manage skin tears, pressure injuries (stage 2), partial-thickness wounds, minor abrasions, or wounds with slough or necrosis, etc. **Duration:** Change Every 72 Hours	Should not be used for 3rd degree burns.	(4x4) H7021645
			-	

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
HYDROFERA BLUE FOAM **Dressing**		**Recommended Use:** • - Use on wound sites that have moderate to copious amount of exudate. • - Pressure injuries, diabetic injuries, venous stasis injuries, arterial injuries, superficial burns, donor sites, post-surgical incisions, and trauma wounds. **Duration:** Change Every 72 Hours	Should not be used for 3rd degree burns. - None to small amounts of exudate. - Wounds with dry eschar. - May cause slight blue staining of skin.	**(4x5) H1047560** **(8x8) H1047561**
Plurogel **20 Gram-tube** **50 gram-TUB**		A Concentrated surfactant works to hydrate the wound, control exudate and provide gentle debridement. Applications are daily, or every two, three days	Contraindicated for use on third- and fourth- degree burns.	**50 gram** H1054501

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
IODOFLEX- **ActicoatCadexomer Iodine Pads – Non-adhesive** **Dressing**		**Recommended Use:** -Use in absorbing and cleaning wet injuries and wounds such as venous stasis injuries, pressure sores, and infected traumatic and surgical wounds **Duration:** Can Be Used For A Maximum of 1-3 Days		(4x61.5 x 2.5) **H7083211**

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
BARRIER CREAMS				
HYDRAGUARD-D CREAM 24% SILICONE BLENDHydraguard-D Silicone Barrier **Topical**		**Recommended Use:** • -Dry, cracked, or scaly skin • -For incontinence of urine and stool, should be mixed with Zguard cream **Duration:** -If Incontinent, Mix with Zguard and Apply q2h	--Should not be used for 3rd degree burns.	**H4166**

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
ZguardZ-Guard Skin Protectant Paste		**Recommended Use:** • **Protects skin and treats irritation due to incontinence.** • -Helps seal out wetness & relieves sore, irritated skin -Itchy skin -Stops skin stripping from stool incontinence • -Blocks trans-epidermal water loss, keeping the skin moist **Duration:** -If Incontinent, Mix with Hydra-guard and Apply q2h	Should not be used on: - Deep or puncture wounds - Animal bites - Serious burns	**H1423**

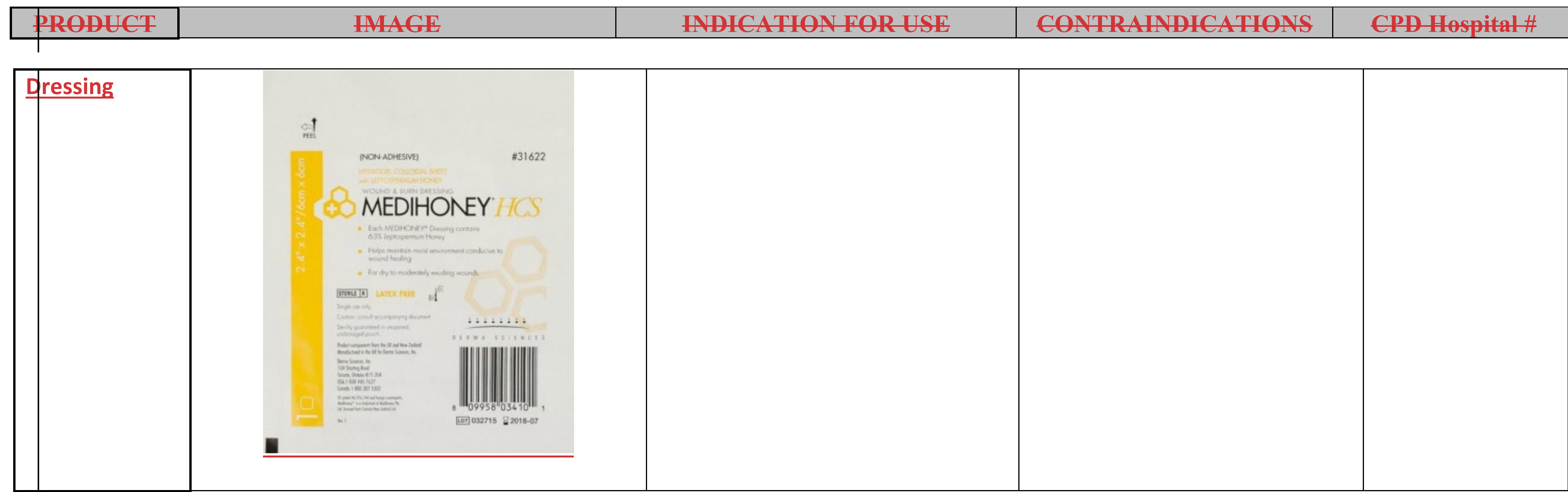
~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~
Skin Moisturizer		**Recommended Use:** -Prevent and temporarily protect dry, chafed or chapped skin and lips **Duration**: Daily	-Should not be used for patients allergic to Dimethicone	**H9933690**

~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~

BARRIER FILM				
PRODUCT	IMAGE	INDICATIONS FOR USE	CONTRAINDICATIONS	CPD Hospital #
~~non-sting barrier film~~No Sting Barrier Film Topical		**Recommend Use:** • Surgical wounds • Venous Injuries **Duration:** Change Every Day or Every 48 Hours	Should not be used as a covering in situations that require dressing protection from bacterial contamination/penetration, e.g. intravenous therapy catheter sites and full or partial thickness wounds. Should not be used on infected areas of the skin	**H1046334**

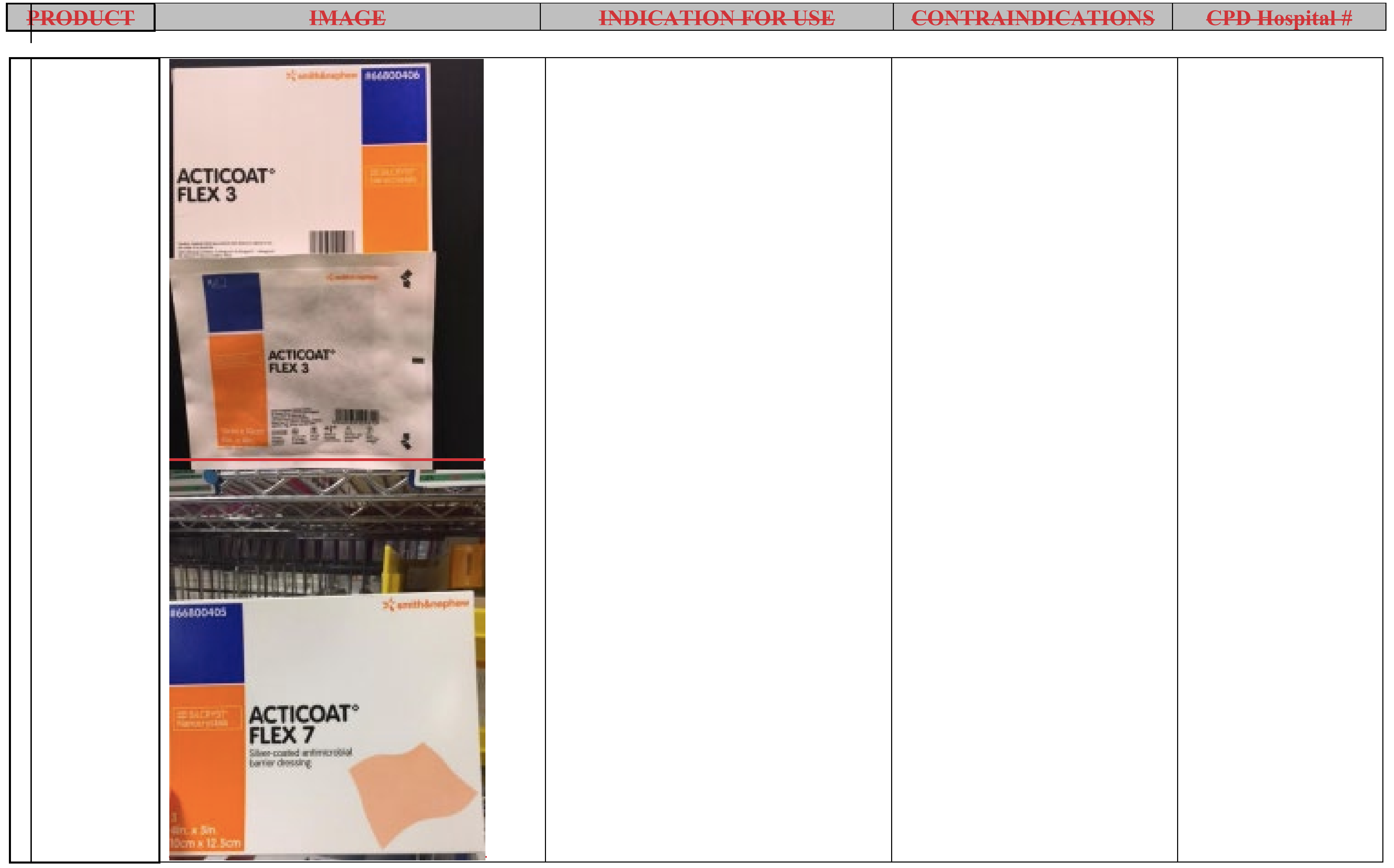
PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
	3M Cavilon No Sting Barrier Film Protects damaged or intact skin from: • Body fluids • Adhesive trauma • Friction • Incontinence 3345			

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
MEDIHONEY PRODUCTS				
MEDIHONEY/ THERAHONEY GEL (ACTIVE LEPTOSPERMUM HONEY CONTENT – 80%, NATURAL GELLING AGENTS – 20%) **Packing/Topical**		**Recommended Use:** • –Use on minimal to none exudating wounds/superficial to full-thickness wounds • –For burns, for autolytic debridement & for all phases of wound healing **Duration:** Change Every Day or Every 48 Hours	–Should not be used on patients with known allergies to honey. –May not be used in very deep wounds or where there is undermining/tracking with sinuses, which could potentially be blocked. –Patient may exhibit burning sensation, because of the low pH.	**H1046768**
MEDIHONEY/ THERAHONEY (Hydrogel Colloidal Sheet) (LEPTOSPERMUM HONEY CONTENT – 63%) **(2x2, 4x4)**		**Recommended Use:** • Used for 1st and 2nd degree burns only! • Use for dry to moderately exudating superficial wounds. **Duration:** Change Daily or Every 48 Hours	Should not be used on 3rd degree burns. Should not be used on patients with known allergies to honey, algae or seaweed. Should not be used to control bleeding. Patient may exhibit burning sensation, because of low pH.	**(2x2) H1046764/H3038** **(4x4) H1047396/H3039**

~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~
Dressing				

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
MEDIHONEY HCS (LEPTOSPERMUM HONEY CONTENT – 63%) **(2.4 x 2.4, 4.5 x 4.5)** **Dressing**		**Recommended Use:** • - Used for 1st and 2nd degree burns only! • - Use for dry to moderately exudating superficial wounds. **Duration:** Change Daily or Every 48 Hours	- Should not be used on 3rd degree burns. - Should not be used on patients with known allergies to honey, algae or seaweed. - Should not be used to control bleeding. - Patient may exhibit burning sensation, because of low pH.	**(2.4x2.4) H1046764** **(4.5x4.5) H1046765**

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
SILVER PRODUCTS				
ACTICOAT Silver Antimicrobial Barrier Dressing Dressing		**Recommended Use:** -Used for partial and full thickness wounds such as: first and second degree burns, covering of grafts, surgical sites, venous injuries, pressure injuries, and diabetic injuries. **Duration:** Can Stay On Up To 3-7 days	-Do not use on patients with a known sensitivity to silver. -Remove dressing for patients who are undergoing MRI. -Prior to administering radiation therapy. -Not to be used on 3rd degree burns. E-External use only.	H7100078H3040

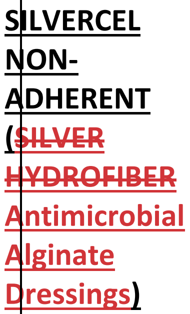
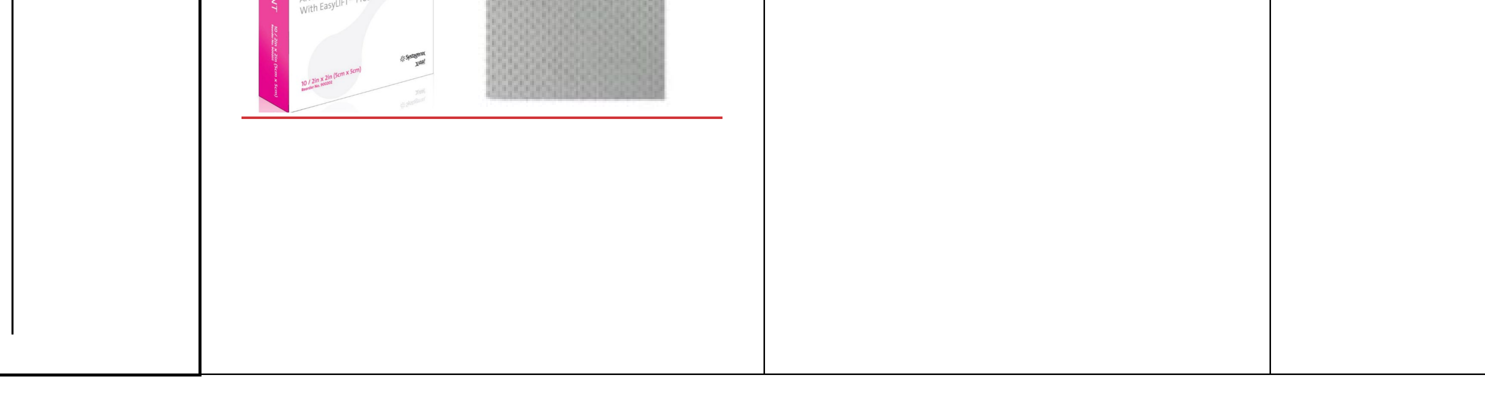
~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~
				

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
INTERDRY (Ag Textiles with Silver Complex) **Dressing**		**Recommended Use:** • Mainly used for skins folds. • Manages symptoms associated with intertriginous dermatitis (ex: erythema, erosion, itching/burning, odor & pain). • Manages complications associated with skin folds or skin-to-device contact areas. **Duration:** Change Daily. When Using Inter-dry Do NOT Use Nystatin.	Do not use on patients with allergies to silver. Do not use during radiation treatment (ex: x-ray, MRI, CT scan). Do not use on copious exudating wounds.	**H5788656**

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
INTERDRY (ANTIMICROBIAL SILVER) Dressing		**Recommended Use:** • Mainly used for skins folds. • Manages symptoms associated with intertriginous dermatitis (ex: erythema, erosion, itching/burning, odor & pain). • Manages complications associated with skin folds or skin-to-device contact areas. **Duration:** Change Daily. When Using Inter-dry Do NOT Use Nystatin.	Do not use on patients with allergies to silver. Do not use during radiation treatment (ex: x-ray, MRI, CT scan). Do not use on copious exudating wounds.	H5788656
SILVADENE CREAM (SILVER SULFADIAZINE CREAM 1%) Topical		**Recommended Use:** • Wounds that are dry or with eschar. • 2nd or 3rd degree burns • Open wounds • Provides hydration of eschar and nonviable tissue to promote debridement of wound site. **only apply thin coat and must use fluff as a primary dressing, then a silicone dressing. ** PRESCRIPTION ONLY **Duration:** Change BID Once Applied. CANNOT Be Used With Other Siler Products.	Do not used on patients with allergies to silver or sulfonamides. Do not use on patients that are pregnant or breastfeeding. Do not use on face, it might stain. Patients who will have a MRI, CT scan, X-ray, or radiation therapy. Do not use for long term (do not use longer than 2 weeks).	**To Be Ordered By MD**

~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~

~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~
SILVASORB GEL TUBE Packing/Topical		**Recommended Use:** • Use to protect burns, cuts scrapes, and other wounds from infections. It may also be used for other skin conditions such as: wounds with small amount of exudates. • Manages partial and full-thickness wounds (ex: pressure injuries, diabetic food injuries, skin tears, graft wounds, surgical wounds, etc.). **Duration:** Change Daily Or BID Depending On Wound Presentation	Do not use if: Patient is allergic to silver Has a wound with moderate to large exudate. Patient will have a MRI, CT scan, X-ray, or radiation therapy. Do not use on patients that are pregnant or breastfeeding.	**H7041411**
~~SILVASORB GEL~~ ~~Packing/Topical~~		~~**Recommended Use:**~~ ~~• Use to protect burns, cuts scrapes, and other wounds from infections. It may also be used for other skin conditions such as: wounds with small amount of exudates.~~ ~~• Manages partial and full-thickness wounds (ex: pressure injuries, diabetic food injuries, skin tears, graft wounds, surgical wounds, etc.).~~ ~~**Duration:** Change Daily Or BID Depending On Wound Presentation~~	~~Do not use if:~~ ~~-Patient is allergic to silver~~ ~~-Has a wound with moderate to large exudate.~~ ~~-Patient will have a MRI, CT scan, X-ray, or radiation therapy.~~ ~~-Do not use on patients that are pregnant or breastfeeding.~~	~~**H7041411**~~

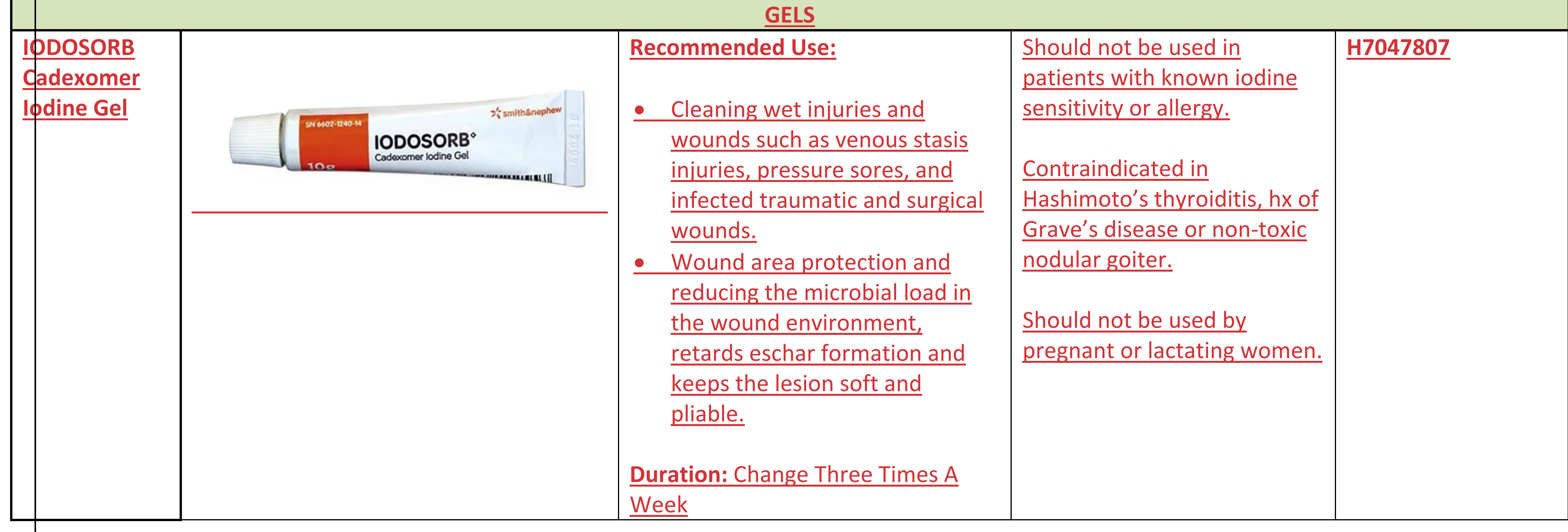
~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~
 **SILVERCEL NON-ADHERENT (~~SILVER HYDROFIBER~~ Antimicrobial Alginate Dressings)** **Packing/Topical** **(Ribbon, 2x2, ~~4x4,~~ 5x8, 11x11)**	 	**Recommended Use:** • Use for wounds that have moderate to copious exudate. • Pressure injuries, venous injuries, diabetic injuries, donor sites, and traumatic and surgical wounds, including cavities. **Duration**: Change q48-72 Hours	Should not be used on patients with known allergies to alginates, CMC (carboxymethylcellulose), EMA (ethylene methyl acrylate) or silver. Should be removed in patients undergoing MRI, CT scan, or X-ray. Do not use on patients who are pregnant or breastfeeding.	**(~~ribbon~~RIBBON)** **H1047419** **(2x2)** **H7034302** **(8x4)** **H7034303** **(11x11)** **H7034301~~(4x4) H7034301~~** **~~(5x8) H7034303~~**

~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~
Marathon No Sting Cyanoacrylate Skin Protectant **(0.5g, 1.5g)**		Marathon skin protectant bonds to the skin surface and integrates with the epidermis as the **cyanoacrylate** polymerizes at the molecular level while supporting the natural integrity of the skin. It provides higher strength and higher resistance to wash off than other thin film barriers. Marathon Liquid Skin Protectant is resistant to external moisture, yet it allows the skin to breathe. • 3 day wear time • Cyanoacrylate protectant • Flexible and long-lasting • Protects from friction • Protects from moisture (urine, exudate, sweat, & other bodily fluids) that can cause maceration	Contraindicated for second or third degree burns, infected areas and directly to the wound bed or to deep puncture wounds.	**(0.5 g)** **H1047611** **(1.5g)** **H1050911**

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
Marathon		Marathon skin protectant bonds to the skin surface and integrates with the epidermis as the **cyanoacrylate** polymerizes at the molecular level while supporting the natural integrity of the skin. It provides higher strength and higher resistance to wash off than other thin film barriers. Marathon Liquid Skin Protectant is resistant to external moisture, yet it allows the skin to breathe. • 3 day wear time • Cyanoacrylate protectant • Flexible and long-lasting • Protects from friction • Protects from moisture (urine, exudate, sweat, and other bodily fluids) that can cause maceration •	Contraindicated for second or third degree burns, infected areas and directly to the wound bed or to deep puncture wounds.	H1047611

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
OCCLUSIVE DRESSINGS				
XEROFORM (Non-Adherent Petrolatum Gauze Dressing)		**Recommended Use:** Donor sites, pin sites, chest tubes. **Duration:** Change Daily	Xeroform gauze is impregnated with petrolatum and bismuth and can cause irritation and inflammation to the wound tissue.	**H7023609**
Optifoam Gentle EX (Super Absorbent) Silicone Faced Foam & Border Dressing (3x3, 6x6)		**Recommended use for wound management by secondary intention:** Shallow granulating wounds, chronic and acute exudative wounds, full and partial thickness wounds such as pressure injuries, leg injuries, diabetic foot injuries, malignant wounds, surgical wounds, first and second degree burns, donor sites, skin tears, & fungating injuries. **Duration:** 7 days for non-sacral dressing or until exudate covers more than 50% of the absorbent pad.	Do not use for third degree burns. Do not use with oxidizing agents such as hypochlorite solutions (Dakin's) or hydrogen peroxide. If reddening or sensitization occurs, discontinue and consult health professional. Too frequent dressing changes in patients with fragile skin may result in skin stripping.	**(3x3) H1905** **(6x6) H1904**

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
Optifoam Gentle – Sacral Silicone Bordered Foam (8x7, 10x9)				**Small Sacrum (8x7) H1060953** **Large Sacrum (10x9) H1050952**
Optifoam Gentle EX (Super Absorbent) - Sacral (7x7, 9x9)		**Recommended use for wound management by secondary intention:** Recommended to all patients with a Braden Score of <14 **Duration:** 5 days for sacral dressing or until exudate covers more than 50% of absorbent pad.	Do not use for third degree burns. Do not use with oxidizing agents such as hypochlorite solutions (Dakin's) or hydrogen peroxide. If reddening or sensitization occurs, discontinue and consult health professional. Too frequent dressing changes in patients with fragile skin may result in skin stripping.	**Small Sacrum (7x7) H1050950** **Large Sacrum (9x9) H1050951**

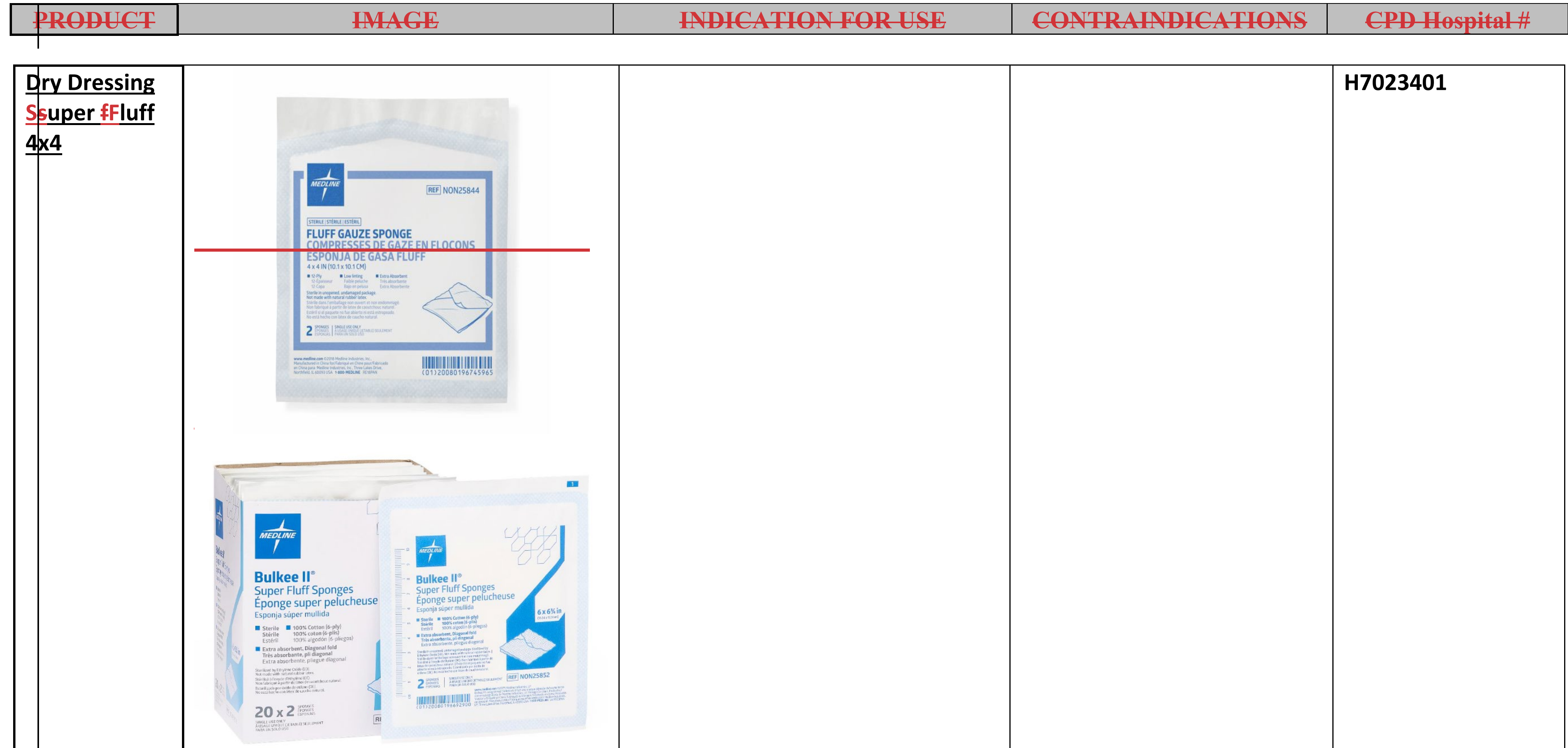
PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
Optilock LF Polymer Non-Adhesive Dressing (5.5x5, 8x12)				(5.5x5) H1046973 (8x12) H1046974
GELS				
IODOSORB Cadexomer Iodine Gel		**Recommended Use:** • Cleaning wet injuries and wounds such as venous stasis injuries, pressure sores, and infected traumatic and surgical wounds. • Wound area protection and reducing the microbial load in the wound environment, retards eschar formation and keeps the lesion soft and pliable. **Duration:** Change Three Times A Week	Should not be used in patients with known iodine sensitivity or allergy. Contraindicated in Hashimoto's thyroiditis, hx of Grave's disease or non-toxic nodular goiter. Should not be used by pregnant or lactating women.	H7047807

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
OCCLUSIVE DRESSINGS				
XEROFORM (OCCLUSIVE GAUZE STRIP) Dressing		**Recommended Use:** - Donor sites, pin sites, chest tubes. **Duration:** Change Daily	- Xeroform gauze is impregnated with petrolatum and bismuth and can cause irritation and inflammation to the wound tissue.	H7023609
Optifoam EX 3x3, 6x6		**Recommended use for wound management by secondary intention:** -Shallow granulating wounds, chronic and acute exudative wounds, full and partial thickness wounds such as pressure injuries, leg injuries, diabetic foot injuries, malignant wounds, surgical wounds, first and second degree burns, donor sites, skin tears, & fungating injuries. **Duration:** 7 days for non-sacral dressing or until exudate covers more than 50% of the absorbent pad.	-Do not use for third degree burns. -Do not use with oxidizing agents such as hypochlorite solutions (Dakin's) or hydrogen peroxide. -If reddening or sensitization occurs, discontinue and consult health professional. -Too frequent dressing changes in patients with fragile skin may result in skin stripping.	3x3 H1905 6x6 H1904

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
Optifoam **Sacral Dressing EX** **Sacrum Small** **Sacrum large**		**Recommended use for wound management by secondary intention:** -Recommended to all patients with a Braden Score of ≤14 **Duration:** 5 days for sacral dressing or until exudate covers more than 50% of absorbent pad.	-Do not use for third degree burns. -Do not use with oxidizing agents such as hypochlorite solutions (Dakin's) or hydrogen peroxide. -If reddening or sensitization occurs, discontinue and consult health professional. -Too frequent dressing changes in patients with fragile skin may result in skin stripping.	**Small Sacrum H1050950** **Large Sacrum H1050951**

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
GELS				
IODOSORB **Packing/Topical**		**Recommended Use:** • Cleaning wet injuries and wounds such as venous stasis injuries, pressure sores, and infected traumatic and surgical wounds. • Wound area protection and reducing the microbial load in the wound environment, retards eschar formation and keeps the lesion soft and pliable. **Duration:** Change Three Times A Week	-Should not be used in patients with known iodine sensitivity or allergy. -Contraindicated in Hashimoto's thyroiditis, hx of Grave's disease or non-toxic nodular goiter. -Should not be used by pregnant or lactating women.	**H7047807**

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
Dry Dressing Super Fluff 4x4				**H7023401**

~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~
ABD ~~p~~Pad ~~5x9~~ 8x10				~~5x9~~ ~~H7020704~~ ~~8x10~~ H7020803

~~PRODUCT~~	~~IMAGE~~	~~PMM#~~

WOUND VAC SUPPLIES		
~~KIT CANISTER V.A.C. W/ISOLYSER~~CANISTER WITH GEL, RESERVOIR		**H1658**

~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~

DRAPE ONLY		H7074792
VAC SIMPLACE AND SIMPLACE EX DRESSING KITS (SMALL, MEDIUM)		(SMALL) H7074785 (MEDIUM) H7074786

PRODUCT	IMAGE	PMM#
DRAPE VAC		H7074792
KIT VAC BLACK FOAM DRSG SM SIMPLACE		H7074785

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #

KIT VAC BLACK FOAM DRSG MED SIMPLACE		H2016
TRAC PAD ONLY		H7074791

Equipment Rental Order List: Order in EPIC under generic Supply		
Heel Medix Footcheck Heel Protectors		(Small) H1043725

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #

Small and Regular *(Foot to be measured before application)*		**(Regular)** **H1043709**

	PRODUCT	IMAGE	PMM#
	SOFT WHITE VAC FOAM DRSG LARGE		H1660

~~PRODUCT~~	~~IMAGE~~	~~PMM#~~
~~PAD TRAC ONLY~~		~~H7074791~~
~~**Equipment Rental Order List:**~~ ~~**Order in EPIC under generic Supply**~~		
~~**Off load boot RCAi**~~ ~~Small and Regular~~ ~~*Foot to be measured before application*~~		~~H1043709~~

~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~

Beds **(Types of Beds available at LHH – all beds by default have no rails. Exceptions noted with "*")**		
Bed Vendor Model	**Function Type and Size**	**Availability**
Stryker	Standard no-rail bed (W 35" x L 84")	Same day
Agility Horizon LTC 13.1 **CME Drive Bed**	Low bed, Wide bed, Alternative devices Up to 500 lbs	Delivery based on current need (non-urgent, urgent, emergent) 24-48 hours
Umano ook snow ALL*	Pavilion Acute hospital use only	Same day
Hillrom Envella* **** LHH Approved Rental***	Air Fluidized Therapy (AFT)	Delivery 24-48 hours

Types of Mattresses or Surfaces Available/Currently in Use at LHH		
Bed Vendor Model	**Function Type and Size**	**Availability**

~~PRODUCT~~	~~IMAGE~~	~~INDICATION FOR USE~~	~~CONTRAINDICATIONS~~	~~CPD Hospital #~~

Comfortex Foam	Pressure Reducing Foam 35” x 80”/84”	Same day
ARJO Auralis	Active wound care therapy Low air loss 35” x 84”	Standard 24-72 hours Bariatric 24-72 hours
ARJO Velaris	Active (alternating pressure system with pump)/Reactive (constant low pressure system without pump) options for wound care therapy Low air loss 35” x 84”	Standard 24-72 hours Bariatric 24-72 hours
Umano AirNest Orange Xi	Multifunction Surface with Low Air Loss option *built in adaptability: 36”, 42” ,84” x 80” ,84” ,88”	Same day
Envella **** Rental product only***	AFT Bed **** can only be used with Envella Bed***	24-72 hours
Sizewise Platinum 6000 *(Sunsetting to be replaced with ARJO advanced options)*	Alternation/Immersion with Microclimate Assist 35” x 80”	24-72 hours
Agiliti NPT4 *(Sunsetting to be replaced with ARJO advanced options)*	Advanced pressure reducing surface with microclimate pump 35” x 80”	Same day
Mattress Extenders		
Bed Vendor Model	**Function Type and Size**	**Availability**
Medline	Mattress surface extension: 36” x 6” x 4”	Same day
~~EHOB cushion for wheel chair (19x19)~~ ~~EHOD cushion for Bariatric~~		~~H1049807~~ ~~H4436~~
~~EHOB overlay BED~~		~~H4260~~
~~Bariatric Low Air loss Surface (Sizewise)~~	~~**Bariatric Pulsate OR pulsate with trapeze,**~~	~~It is indicated for the prevention and treatment of pressure injuries, including~~

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #
		Pulsate utilizes automatic pressure adjustment in zoned areas of the body for superior pressure redistribution. Static mode promotes proper envelopment and immersion to effectively manage the microclimate, while pulsation mode adds gentle stimulation that aids in the increase of capillary blood flow to the skin. The fowler feature allows for increased airflow to the mattress when the head section is elevated.	post-operative care of pressure injuries and flaps/grafts.	
ICU Bariatric Beds, (Sizewise)		**Bari Rehab platform2 with power drive and big Turn low air loss therapy** 48 inch wide and bed-86 inch long for patients taller than 76 inches.		
Bariatric equipment (Sizewise)		Trapeze, Bari lift and transfer Overhead with sling, (1000lb capacity), Bari chair, Bari walker, 750 lb capacity Bari shower commode , 750 lb capacity Bari Commode, 1000 lb capacity		
Low Air Loss Immersion Therapy (Sizewise)		**Immerse,** could ordered with Trapeze Full body therapeutic mattress system that provides active pressure redistribution when mobility, moisture, and/or inactivity are a concern. The greater the immersion and envelopment into a support surface, the more contact area between the body and the surface. This allows for lower interface pressure and creates greater pressure redistribution.	It is indicated for the prevention and treatment of pressure injuries, including post-operative care of pressure injuries and flaps/grafts.	
Envella Air Fluidized Therapy Bed HillRom		The pressure redistribution surface pushes air through millions of tiny beads, creating a fluid-like environment that feels similar to floating on water. This action boosts immersion and envelopment, minimizes shear and pressure, and helps control the skin's microclimate	Helps with stage 4, flaps and Grafts.	
Sizewise Posey bed, enclosure bed		A complete bed system that provides a safe, controlled environment for patients at risk of injury from fall or unassisted bed exit.	The Posey Enclosure Bed helps meet the CMS requirements for less restrictive devices by reducing the need for physical restraints.	

PRODUCT	IMAGE	INDICATION FOR USE	CONTRAINDICATIONS	CPD Hospital #

References:

Kestrel Health Information. (2014). *Wound source.* Retrieved from http://www.woundsource.com

Just Health Shops. (2014). *Just wound care.* Retrieved from http://justwoundcare.com

Wound Educators. (2014). *Wound care resources.* Retrieved from http://woundeducators.com/resources/wound-dressings/

HealthCom Media. (2014). *Wound care advisor.* Retrieved from http://woundcareadvisor.com

Derma sciences. (2014). *Dermasciences.* Retrieved from http://www.dermasciences.com

Wounds international. (2014). *Wounds international: the essential wound management resources for clinicians worldwide.* Retrieved from http://www.woundsinternational.com

WCR. (2014). *A caring approach to wound healing.* Retrieved from http://www.woundcareresources.net/education.html

Hess, C. T. (2012). Clinical Guide to Skin and Wound Care. 7th edition. Lippincott Williams & Wilkins