List of Hospital-wide/Departmental Policies and Procedures Submitted to JCC for Approval on May 12, 2025

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revised	LHHPP	20-04	Discharge and Transfer Process	**N. Zahir**	1. Added "and document who made the determination that discharge is not feasible and why" 2. Added "Laguna Honda allows residents to return to the facility following hospitalization or therapeutic leave. A resident whose hospitalization or therapeutic leave exceeds the bed hold period under the state plan returns to the facility to their previous room if available or immediately upon the first availability of the bed in a semi-private room if the resident requires the services provided by the facility and is eligible for Medicare or Medi-Cal skilled nursing facility services." 3. Added "This orientation must be provided in a form and manner that the resident can understand" 4. Added "The resident's goals of care and treatment preferences will be incorporated." 5. Deleted definition for "Facility initiated Transfer or Discharge", "Resident initiated Transfer or Discharge", "Discharge", "Transfer" 6. Adde definition for "Transfer and Discharge", "Bed-hold" 7. Added "A discharge that is planned and not due to the resident's death or an emergency (e.g., hospitalization for an acute condition or emergency evacuation)." 8. Deleted "discharge that is planned and not due to unforeseen circumstances, t=including, for example, the resident's death or an emergency." 9. Added "“Reserve Bed Payment”: Payments made by a State to the facility to hold a bed during a resident's temporary absence from a nursing facility. " 10. Added "“Therapeutic Leave”: Absences for purposes other than required hospitalization." 11. Added "Quarterly assesses residents' interests in transition to community living under Section Q of the MDS. More information on this requirement is available in the Resident Assessment Instrument (RAI) manual." 12. Added "Evaluate caregivers availability, capacity, and/or capability to perform needed care to the resident following discharge." 13. Added " The resident's assigned MSW will contact A&E Financial Counselor (FC) to inform of the planned discharge to coordinate, arrange and/or settle resident's financial affairs by the time discharge." 14. Added "Psychiatry providers and addiction medicine specialist, in collaboration with medical social worker, provide support for residents with mental health and/or substance treatment service needs to connect with outpatient treatment services after discharge, as indicated." 15. Added "A&E Financial Counselors (FC) will work with RCT and resident and/or resident's financial decision maker to make sure all financial affairs are coordinated, arranged, and/or settled by the time of discharge" 16. Added "The transfer or discharge is necessary as resident needs cannot be met in the facility. Documented attempts to meet the resident's specific needs and an assessment at the time of discharge indicating what needs cannot be met." 17. Added "Documentation to show the resident's health has improved." 18. Added "Documented instances of examples of behaviors that have the potential to endanger the safety or health of individuals in the facility." 19. Added "Resident has failed after reasonable and appropriate notice to pay for a stay at the facility. Documented that the facility offered the resident to pay privately or apply for medical assistance, or documentation that the resident refused to pay or have their stay paid for by Medicare or Medi-Cal. Medi-Cal eligible residents will be provided oral and written information on how to apply for Medicaid." 20. Added "The facility is ceasing to operate" 21. Deleted "Otherwise, the 30-day period may be waived only in cases of resident-initiated transfer or discharge." 22. Deleted "resident initiated"
					1. Replaced "All residents" with "Each residen" 2. Added"Sling tags are to be labeled, using permanent marker, with resident's full name and the month/year first opened. Manufacturer recommends slings are to be replaced every 6 months, or if damaged. Damaged slings must be discarded and replaced with a new sling." 3. Deleted "Each sling must have resident's name and room number." 4. Deleted " Any member of" 5. Added "Nursing", " {licensed nurse(LN), nursing assistant (CNA/PCA)}" and "transfer technique and" 6. Added "Residents on a low air loss mattress shall require two person assist for all transfers." 7. Added "Two nursing staff members are always required for operation of battery-operated lifts." 8. Replaced "Mechanical" with "Battery Operated" 9. Deleted "Transfer and NPP D6 1.4 Battery Operated Ceiling Lift" 10. Replaced "resident's" with "any" 11. Added "Nursing will document any unexpected outcomes and related interventions '

Revised	LHHPP	27-10	Transfer Techniques	**D. Swiger**	11. Added "Nursing will document any unexpected outcomes and related interventions." 12. Deleted "be documented on the Care Plan indicating what type of lift is used, type and size of sling used, and number of persons required to assist in transfer" 13. Added "have documented on their care plan/Kardex the type of lift, type and size of sling used, and color of straps to apply for the resident." 14. Added "APPENDIX: Appendix A: Gait Belt FAQs" 15. Added "REFERENCES: " 16. Added "Elsevier (2024) Transfer Technique: Pivot Transfer https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025 " 17. Added "Elsevier (2024) Transfer Technique: Bed to Wheelchair using Slide Board https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025 " 18. Added "Elsevier (2024) Transfer Technique: Assisting Patients to Sitting Position https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025" 19. Added "Perry, A.G. and others (Eds.). (2022). Clinical nursing skills and techniques (10th ed.). St. Louis: Elsevier." 20. Added "CROSS-REFERENCES: Nursing Policy & Procedures D6 1.1 Battery Operated Lift" 21. Merged Nursing policy D6 2.0 into this policy.
Revised	LHHPP	31-03	Clinical Product Andand Device Evaluation	**S. Hoffman**	1. Added "/Equipment" to the policy name and throughout the document. 2. Added "LHH" throughout the document. 3. Added "product or device/equipment must first be evaluated. Clinical product evaluations will be conducted through the LHH Value Analysis Committee (VAC). Devices/Equipment will first be evaluated by Biomedical Engineering. Devices/Equipment will then be presented at VAC for additional evaluation and review." 4. Deleted "Product Evaluation must evaluate" 5. Replaced "Product Evaluation" with "Value Analysis" throughout the document. 6. Added "Zuckerberg" 7. Replaced "a pharmacist" with "Pharmacy, Respiratory Therapy, Lab Services, Wound Care, Rehabilitation Therapy, Infection Prevention, Health at Home, Biomedical Engineering, Department of Education and Training" 8. Replaced "the Committee" with "VAC" 9. Replaced "in person" with "invited to attend VAC meetings" 10. Replaced "pilot" and "piloted" with "trial" and "trialed" 11. Added "meets monthly to review new and pending product or device/equipment evaluations. VAC can also meet ad-hoc for critical or time-sensitive evaluations." 12. Deleted "will review new products on an as-needed basis."
Revised	LHHPP	60-01	Quality Assurance Performance Improvement	**N. Zahir**	1. Added "“Health equity” refers to the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes." 2. Added "Data collection and monitoring will be related to outcomes of sub-populations to address any health equity concerns. Data analysis shall include an evaluation of factors known to affect health equity, such as race, sexual orientation, socioeconomic status, and or preferred language." 3. Added "including concerns related to health equity" 4. Added reference "CMS Framework for Health Equity https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework"
Revised	LHHPP	65-02	Monitoring of Third Party Agreements	**J. Carton-Wade**	1. Added "Hospital and Rehabilitation Center" 2. Added "Department of Public Health" 3. Replaced "Laguna Honda Executive Administrator" with "LHH Chief Executive Officer/Nursing Home Administrator (CEO/NHA)" 4. Replaced "Executive Administrator" with "CEO/NHA" throughout the document. 5. Added "provided safely and effectively and" 6. Added "In the event of an adverse outcome, inappropriate conduct, or failure to meet the standard of care, the Contract Manager shall immediately notify the contractor and develop a plan for correction and performance improvement." 7. Replaced "Laguna Honda" with "LHH" throughout the document 8. Added section "The Performance Improvement and Patient Safety (PIPS) Committee is responsible for: 9. Added "Each patient care contract performance measures shall be reviewed by the LHH Performance Improvement and Patient Safety PIPS Committee annually. The purpose of this review is to provide administrative, clinical and medical staff leaders with an opportunity to evaluate the performance of the sources of clinical services provided through contractual agreements. This evaluation shall include a review of the annually established performance measures. The evaluation of the contracted services shall be conducted in relation to LHH’s expectations." 10. Added "The Performance Improvement and Patient Safety PIPS Committee shall ensure that steps are taken to improve contracted services that do not meet expectations. Examples of improvement efforts that may be considered include the following:" 11. Added "Increased monitoring of the contracted services," 12. Added "Providing consultation or training to the contractor," 13. Added "Renegotiating the contract terms," 14. Added "Applying defined penalties, and" 15 Added "Terminating the contract." 16. Added "Deleted "The Executive Committee is responsible for:" 17. Added "Reviewing aggregate performance ratings of all third party agreements on an annual basis. Reviewing PIPs more frequently as needed." 18. Added "Providing guidance on how to handle low performing third party vendors."

Revised	FNS	1.100	Labelling and Dating of Food	**M. Adusumalli**	1. Added- and Dating of 2. Removed- Established 3/81, 1/89, 5/97, 9/06, 7/09, 8/14 3. Removed – Reviewed 8/13, 8/14 4. Added -7/2024 5. Added – To provide guiding principles in food safety, reduce the risk of foodborne illness and reduce waste. 6. Replaced- its with It has 7. Removed – ed. 8. Added – To monitor Time/ temperature Control Safety (TCS) Foods. 9. Added- To Reduce Waste. 10. Added- Food Shall be handled in accordance with applicable food sanitation guidelines. 11. Replaced – N with n; P with p; and the D with d ; it with the items; opened with opened and use by date (discard date). 12. Added- Food item will be discarded after 3 days or not to exceed a manufacturer's use- by date. 13. Replaced- insure with ensure; this with labeling and dating. 14. Added- or designee 15. Removed- on a daily basis that this is occuring 16. Added -daily to ensure product is covered, labeled and added 17. Added- cover, label, and 18. Removed -label and cover 19. Added -s 20. Added - References: 21. Added- Food Product Dating https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-product-dating#:~:text=Does%20Federal%20Law%20Require%20Food%20Product%20Dating%3F&text=For%20meat%2C%20poultry%2C%20and%20egg,in%20compliance%20with%20FSIS%20regulations. •State Food Safety Resources https://www.statefoodsafety.com/Resources/Resources/time-temperature-control-for-safety-tcs-foods-poster •2022 FDA Food Code – U.S. Food and Drug Administration chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.fda.gov/media/164194/download?attachment
Revised	FNS	1.143	Food Supply & Storage	**M. Adusumalli**	1. Deleted – Established and 8/81, 1/89, 1/92, 9/94, 5/97, 9/06, 7/09, 1/10. 2. Deleted- Reviewed: 8/13,8/14 3. Deleted - Metal 4. Replaced- a with A ; 36- 38^{o}F with 40^{o}F or below 5. Replaced- b with B ; 36- 38^{o}F with 40^{o}F or below 6. Replaced- c with C ; 30- 38^{o}F with 40^{o}F or below 7. Replaced- d with D ; 10- 20^{o}F with 0^{o}F or below 8. Replaced and/or assistant Food Service Director with supervisor or designee. 9. Deleted- of time 10. Added- a in cryovac 11. Added- or per manufacturer recommendation. 12. Deleted – Operations 13. Deleted -Production 14. Updated 11/6/2015 to 7/2024
Revised	NSPP	B 5.0	Resident Identification, Color Codes, and Safety Alerts	**C. Figlietti**	1. Updated to reflect current practices including clarification of the PINK dot for individualized aspiration precaution risk and alert signage 2. Added "Patient" since policy also refers to PMA/PMR 3. Clarified A&E Department to "Patient Access – LHH A&E" 4. Added "Resident who decline or are unable to tolerate a wristband, may be offered and identification card (ID) that has same information and can be used as the same purposes as the wristband (i.e., barcode on ID can be scanned for medication administration) if they meet the following criteria below:" to reflect residents who do not wear a wrist id band
Revised	NSPP	D6 1.1	Appendix 1, 2 and 3	**J. Selerio**	o Appendix 1: • Updating to new sizing guideline with guide provided for new slings o Appendix 2: • Current Appendix 2 moved to Appendix 3 (see below). Replace with NEW appendix for Sling Application o Appendix 3: • NEW appendix for Lift Operation for both Ceiling and EZ Lift
Revised	LHHPP	20-07	Against Medical Advice	**A. Lam**	1. Deleted "a copy of the LHH AMA Policy" 2. Added "the facility "House Rules" which discusses elements of this policy"
Revised	LHHPP	20-13	Notification of Proposed Transfer/Discharge Due to Nonpayment for the Stay at the Facility	**G. Villavicencio**	1. Deleted "The Laguna Honda Patient Accounting Department and A & E will follow A&E's Policy on Residents with Unresolved Account Balances and Referrals to the BDR. Documentation related to the accounts will be kept with resident's records." 2. Added "The Laguna Honda Patient Financial Services Department will follow the Policy on Residents with Unresolved Account Balances and Referrals to the BDR. Documentation related to the accounts will be kept with resident's records." 3. Replaced "Accounting" with "Financial Services"

Revised	LHHPP	23-01	Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)	**A. Lam**	1. Added "Preadmission Screening and Resident Review" 2. Added "Minimum Data Set" 3. Added "Laguna Honda Hospital and Rehabilitation Center" 4. Added "Registered Dietician, Activity Director" 5. Added "Within seven days after completing Comprehensive MDS with CAA including Admission MDS, Annual, Significant Change in Status Assessment MDS" 6. Deleted "Comprehensive MDS with CAA" 7. Deleted "Within seven days of new admission" 8. Deleted "Annually" 9. Added "such as new pressure ulcer, new behavior, fall"
Revised	LHHPP	23-02	Completion of Resident Assessment Instrument/Minimum Data Set (RAI/MDS)	**N. Zahir**	1. Added "Resident Assessment Instrument /Minimum Data Set (RAI/MDS)" 2. Added "Laguna Honda Hospital (LHH)" 3. Added "major " 4. Added "Omnibus Budget Reconciliation Act (OBRA) " 5. Added "14" 6. Added "(5 Day assessment, Interim Payment Assessment (IPA), Part A PPS Discharge Assessment) - " 7. Added "Skilled Nursing Facility (SNF) " 8. Deleted "High-Risk/Unstageable" 9. Added "Percent of Resident with Pressure Ulcers" 10. Deleted "Low-Risk Residents Who Lose Bowel/Bladder Control" 11. Added " New or Worsened Bowel or Bladder Incontinence (L*)" 12. Replaced "Need for Help with ADLs Has Increased" with "Increased ADL help" 13. Replaced "Percent of Residents Whose Ability to Move Independently Worsened" with "Ability to Walk Independently Worsened" 14. Deleted "Percent of Residents Who Made Improvements in Function (S)*" 15. Added "Discharge Function Score (SNF QRP)"
Revised	LHHPP	25-15	Medication Administration	**E. Ocampo**	1. Added "Laguna Honda Hospital and Rehabilitation Center " 2. Added "Laguna Honda Hospital IV Push Guidelines" 3. Removed "Appendix III"
Revised	LHHPP	27-09	Splint/Brace Care Management Policy	**D. Swiger**	1. Added "Splint or brace is labeled with resident's name." 2. Added "the following (Any deviations from the following must be reported and documented by nursing staff to charge nurse and/or nurse manager immediately)" 3. Deleted "Any deviations from the following must be reported and documented by nursing staff to charge nurse and/or nurse manager immediately. " 4. Deleted "Monitor for swelling, bruising, and skin irritation Inspect skin for redness, edema, open areas before applying, and after removal." 5. Added "Inspect skin for signs of skin irritation, redness, pain, abrasions, breakdown, cyanosis, temperature changes or other problems. If present, notify charge nurse and or nurse manager immediately." 6. Deleted "If present, notify charge nurse immediately." 7. Deleted "the" 8. Replaced "resident for" with "the following" 9. Deleted "Ensure " 10. Deleted "Inspect skin for redness, edema, open areas before applying, and after removal. If present, notify charge nurse immediately." 11. Deleted "Splint of brace does not have or develop rough edges, cracks, or tears. Apply skin protector or padding, and notify charge nurse, and/or nurse manager immediately." 12. Added "Once splint or brace is removed" 13. Added "Inspect for signs of skin irritation, redness, pain, abrasions, breakdown, cyanosis, temperature changes or other problems in the area of the splint or brace. If present, notify charge nurse and/or nurse manager immediately." 14. Deleted "Once splint or brace is removed, ensure the following occurs:" 15. Deleted "Check resident skin, and note resident's complaint of pain, observe signs of pressure, red or open areas, blisters, edema, cyanosis, irritation, temperature changes, or other problems in the area of the splint or brace. Notify charge nurse and/or nurse manager immediately." 16. Added "Nursing staff will ensure daily compliance and documentation of splint or brace care management recommendations and instructions, and wearing schedule (frequency, duration, location, shift)." and "Documentation:" 17 Added "The use of splint or brace is documented in the ADL care plan." 18. Deleted "Nursing staff will ensure daily compliance and documentation (including but not limited to worklist and care plan updated for splint use) of splint or brace care management recommendations and instructions, and wearing schedule (frequency, duration, location, shift)." 19. Added "Documentation in the electronic health record (EHR) includes, but is not limited to:" 20. Added "Resident level of skill and progress toward self-care and use of brace." 21. Added "Teaching in care of appliance and safety of use" 22. Added "Brace application and removal" 23. Added "Skin checks every shift" 24. Deleted " Any deviations noted, will be immediately informed, and documented to the charge nurse and/or nursing manager." 25. Replaced "this notification" with "any deviations" 26. Merged Nursing policy D5 5.0 into this policy.

Revised	FNS	1.165	General Cleaning and Sanitizing work Surfaces and Kitchen or Galley Equipment	**M. Adusumalli**	1. Deleted - 8/13, 8/14. 2. Added -7/2024 3. Added – "s" to begin 4. Replaced - are with 'is" 5. Replaced- Rags with "cloths". 6. Replaced- Tuff Suds Detergent with "department approved detergent" 7. Replaced – MikroKlene with "department approved sanitizer" 8. Updated footer date to 7/2024 in place of11/6/2015
Revised	FNS	1.59	Authorized Personnel Only	**M. Adusumalli**	1. Deleted- Established and 3/81, 1/89, 5/97, 9/06, 7/09. Reviewed, 8/13,8/14 2. Added- 7/2024. 3. Deleted-space in non food 4. Added- when 5. Added- Authorized personal or visitors must adhere to safe food safety practices and safety precautions to prevent injury. 6. Deleted -space in non food 7. Deleted- to do so. 8. Added- Shoes must cover the entire foot (no open toe, high heel, and/ or slippery shoes or sandals). 9. Added- contractors 10. Replaced- going to with entering. 11. Added- wash their hands and 12. Added- personal protective equipment(PPE) , prior entering the department. 13. Removed- hair covering 14. Deleted footer date 11/6/2015.
Revised	FNS	1.60	Equipment Repair	**M. Adusumalli**	1. Deleted- Established and 7/80, 1/89, 5/97, 9/06, 7/09 2. Deleted – Reviewed: 8/13 ,8/14 3. Added- 8/2024. 4. Deleted – A work Order will be written and submitted to facility services for equipment repair. 5. Added- Designees 6. Capitalized p to P, Deleted- Please 7. Replaced- Manual with Log. 8. Replaced- past with passed. 9. Replaced Supervisor with supervisor or designee. 10. Added- Food and nutrition services management team will meet with Facilities Services Management to review all. 11. Deleted – A print out of all work orders will be generated by facility services for our. As a follow up, the senior food service supervisor and production chef will meet with a facility services supervisor on a monthly basis to review outstanding work orders. 12. Removed space- can not. 13. Replaced Material Management with Facility Service. 14. Deleted footer -11/6/2015
Revised	FNS	1.61	Sanitation Inspections	**M. Adusumalli**	1. Deleted- Established and 1/92, 5/97, 9/06,7/09. 2. Deleted – Reviewed: 8/13 ,8/14 3 Added- 8/2024. 4. Deleted – Once a week. 5. Capitalized- s to S. 6. Added- or designee 7. Replaced - in the production and storage area to of the department. 8. Deleted- The Supervisor may conduct the safety and sanitation inspection in the tray service and warewashing area. A Mr. Clean report may be completed and signed by the Supervisor. 9. Deleted- Assistant Director or Food Service manager 10. Added- Management team 11. Added thrice- or designee 12. Deleted – and signature. 13. Replaced- He may with S/he may 14. Deleted footer -11/6/2015
Revised	FNS	1.93	Food Preparation Standards	**M. Adusumalli**	1. Removed- Established and revised: 5/98, 9/06, 7/09, 11/10, 11/22, 8/13, 8/14 2. Deleted – always 3. Added - at all times. 4. Replaced 140 with 135^{o}F 5. Added - ^{o}F 6. Updated Footer- 11/29/2022 with 7/2024

Revised	NSPP	A 4.0	Nursing Clinical Competency Program	**J. Selerio**	Updates roles (e.g., from Advanced Practice Nurses to Clinical Nurse Specialists) • Including collaboration with unit Nurse Manager to assign orienting nursing staff to an experienced/competent preceptor • Clarified that annual performance appraisals to be completed by Nurse Manager or Supervisor. • Added: "Nursing Operations Supervisor and/or Nurse Managers can access education for problem prone knowledge aps so they may provide just in time education and coaching for staff as needed." • Clarified developing, implementing and evaluating nursing orientation and training programs according to CDPH • Included guidance of the POC
Revised	NSPP	A 6.0	Orientation of Nursing Personnel	**J. Selerio**	Added to policy #4: "After which time, DET Nursing Orientation Coordinator communicates successful completion of nursing orientation with Nursing Operations Supervisor and/or designated Nurse Manager" • Removed "Chief Nursing Officer" and changed to "Directors of Nursing"
Revised	NSPP	J 1.1	Obtaining, Handling, and Storage of Medications	**C. Figlietti**	1. Additional revisions after 4.11.2025 NEC 2. Removing "put empty drug container or tubes in pharmacy pick up tray" These are thrown in trash 3. Referenced the disposal of unlabeled and expired medications to HWPP 25-05 Hazardous Drugs Management. 4. Generalized this to be discarded in the "appropriate medication waste bin."
Revised	NSPP	K 9.0	Management of Residents on Hemodialysis	**C. Figlietti**	1. Updated policy to "All residents on hemodialysis are weighed at least weekly (or per provider order) and PRN." (Current policy states "daily or per provider order.") 2. Vital signs/weight documented "as ordered" 3. Added to Dialysis Communication Note: "Dialysis care and outcome to treatment can be reviewed in the EHR for residents who receive dialysis at ZSFG."
Deletion	NSPP	D5 5.0	Application and Management of Braces	**C. Figlietti**	Recommendation to delete this policy to consolidate it all to HWPP 27-09 Splint/Brace Care Management.
Deletion	NSPP	D6 2.0	Transfer Techniques	**C. Figlietti**	Recommendation to delete this policy to consolidate it all to HWPP 27-10 Transfer Techniques

JCC Follow-up

DISCHARGE AND TRANSFER PROCESS

PHILOSOPHY:

Laguna Honda Hospital and Rehabilitation Center (LHH) has a responsibility to provide timely access to skilled nursing services to San Franciscans who are in need of such services. In order to fulfill this responsibility, LHH continually facilitates timely and safe resident discharges or transfers to the appropriate level of care.

POLICY:

~~1.~~ LHH strives to assist every client/resident (hereafter "resident") to achieve their optimal health, functioning, and well-being and achieve discharge to the lowest level of care possible. When discharge from a skilled nursing unit or rehabilitation unit is not achievable, the Resident Care Team (RCT) shall continue to support maximal social integration and document who made the determination that discharge is not feasible and why.~~.~~ In addition, LHH may also transfer patients to another skilled nursing facility to continue the current level of care of skilled nursing needs if appropriate based on hospital operation. Laguna Honda allows ~~residents to return~~ readmission into the facility following hospitalization or therapeutic leave. When a ~~A~~ resident whose hospitalization or therapeutic leave exceeds the bed hold period under the state plan returns to the facility to their previous room, if available, or immediately upon the first availability of the bed in a semi-private room if the resident requires the services provided by the facility and is eligible for Medicare, ~~or~~ Medi-Cal, ~~skilled~~ or other commercial insurance with prior authorization for skilled nursing facility services.

~~2.~~1. LHH provides inter-disciplinary discharge planning services that meet the resident's health and safety needs with appropriate and available resources in the community, taking into account the resident's preferences. This orientation must be provided in a form and manner that the resident or surrogate decisionmaker can understand.

~~3.~~2. Residents who no longer meet skilled nursing facility (SNF) level of care and/or whose SNF needs can be met a lower level of care shall be prepared for discharge into the community with supportive services.

~~4.~~3. Intensive discharge planning support and skills training shall be provided to the resident to assist them to transition from an institutional setting to community living. The resident's goals of care and treatment preferences will be incorporated.

~~5.~~4. The RCT shall recognize that residents with decision-making capacity and/or their surrogate decision-maker (SDM), have the right to decline recommended discharge/transfer options aimed at achieving their optimal health outcome, and that they have the right to appeal their discharge/transfer plan.

~~6.~~5. Residents with decision making capacity who repeatedly decline discharge/transfer options, or refuse to participate in discharge/transfer planning shall be provided with sufficient notice and issued a written Notice of Proposed Transfer/Discharge when a viable, safe and orderly post-discharge plan of care has been formulated by the RCT. The notice requires that a discharge/transfer address and discharge/transfer date be obtained prior to issuance.

~~7.~~6. This policy does not apply to residents who are being relocated to another SNF as a "Facility Closure Transfer," only when LHH is subject to a facility closure plan, as described in LHHPP 01-16 Facility Closure Plan. Facility Closure Transfers are subject to the requirements and procedures described in LHHPP 01-16 Facility Closure Plan. Residents who are discharged to the community, including their home or a lower level of care facility, when LHH is subject to a facility closure plan will be discharged according to the procedures outlined in this policy, LHHPP 20-04 Discharge and Transfer Process

~~8.~~7. For residents who qualify for Medicare hospice care services, LHH will either arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices or, if such an agreement(s) has not been arranged, then LHH will assist the qualifying resident to transfer or discharge to a facility that will arrange for the provision of hospice care services when the resident requests a transfer or discharge.

PURPOSE:

To implement a safe and orderly discharge process for residents who desire discharge to the community, no longer need SNF services, and/or are able to be cared for at a lower level of care. To implement a safe and orderly transfer process for residents who require transfer to an emergency department or for residents who desire to be transferred to another SNF, but in this specific instance, only when LHH is not subject to a facility closure plan.

DEFINITION:

~~"**Facility-initiated Transfer or Discharge**": A Transfer or Discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.~~

~~"**Resident-initiated Transfer or Discharge**": Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).~~

~~**"Discharge"**: Includes movement of a resident outside of the certified LHH skilled nursing facility in either of the following instances: (1) to a bed in an acute care facility, including~~

~~but not limited to the licensed general acute care portion of LHH; or (2) to the community, which may include the resident's home or a facility that provides a lower level of care.~~

~~**"Transfer"**: Includes movement of a resident outside of the certified LHH skilled nursing facility in either of the following instances: (1) to a bed in an emergency department; or (2) to another certified skilled nursing facility. Transfer does not refer to movement of a resident to a bed within LHH's skilled nursing facility.~~

"Transfer and Discharge": Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same facility. (See §483.5) Specifically, transfer refers to the movement of a resident from a bed in one facility to a bed in another facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another facility or other location in the community, when return to the original facility is not expected.

"Anticipated Discharge": A discharge that is planned and not due to the resident's death or an emergency (e.g., hospitalization for an acute condition or emergency evacuation).~~discharge that is planned and not due to unforeseen circumstances, including, for example, the resident's death or an emergency.~~

"Bed-hold": Holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization.

"Continuing Care Provider": the entity or person who will assume responsibility for the resident's care after discharge. This includes licensed facilities, agencies, physicians, practitioners, and/or other licensed caregivers.

"Recapitulation of Stay": a concise summary of the resident's stay and course of treatment in the facility.

"Reconciliation of Medications": a process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care.

"Reserve Bed Payment": Payments made by a State to the facility to hold a bed during a resident's temporary absence from a nursing facility.

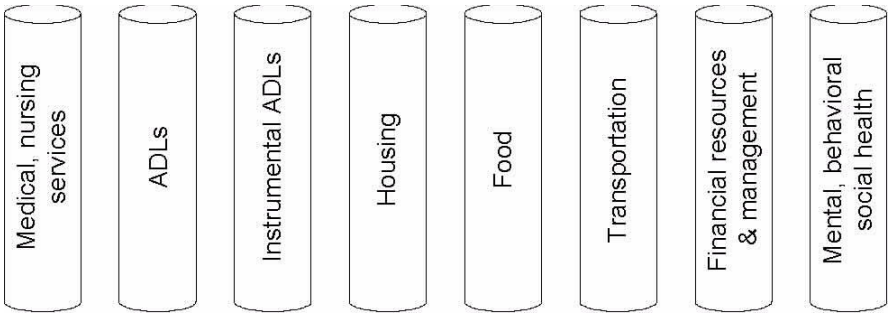
"Therapeutic Leave": Absences for purposes other than required hospitalization.

Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs): Activities of daily living (ADLs) are the basic activities necessary for self-care or care by others. Instrumental activities of daily living (IADLs) are higher-level activities necessary for living in the community. ADLs and IADLs are sometimes remembered by the

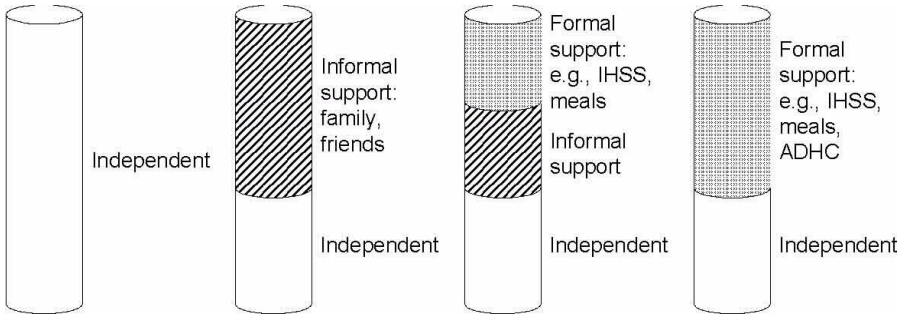
mnemonics DEATH and SHAFT:

ADLs	IADLs
Dressing	Shopping
Eating	Housework
Ambulating	Accounting/finances
Toileting	Food preparation
Hygiene	Transportation

Assessment domains: Discharge planning begins with assessment of needs and resources in multiple domains that often overlap and interact. These domains include medical and nursing services, ADLs, IADLs, housing, food, transportation, finances, emotions, behavior, personal relationships, and work. Safety issues often arise in many of these domains.



Informal and formal support: Informal support refers to unpaid services such as family, friends, and neighbors. Formal support refers to services received through an agency that is reimbursed. Four examples are shown below. The assessment process could reveal that a person is independent in ADLs. Another might be only partially independent but get adequate informal care giving support from family and friends. Another, also partially independent, could get ADL needs met with a combination of informal support and formal support services such as In-Home Supportive Services (IHSS) and Meals on Wheels. Another may have no informal caregivers but could live independently with formal supports such as IHSS, meals, and adult day health care (ADHC).



PROCESS GUIDELINE:

1. **Discharge assessment process considers:**

    a. The resident's characteristics, needs, and resources (including informal and formal supports) in functional, medical, and psychosocial domains (see definitions appendix).

    b. The resident's values and preferences.

        i. These values and preferences remain central to the assessment process even when they are contradictory, inconsistent over time, or in need of interpretation across cognitive deficits.

        ii. The resident's self-assessment of needs and priorities may legitimately differ from that of the RCT[1].

2. **Discharge planning:**

    a. Begins during the resident's admission assessment.

    b. Is an ongoing process that adapts to changes in the resident's needs, resources, and preferences.

        i. A resident may need to progress through several stages of increasing independence prior to discharge.

    c. Requires negotiation of the goals of care, the interventions needed to overcome barriers to discharge, and the overall discharge plan.

        i. Informed choice is a fundamental principle of service delivery.

        ii. Independence and autonomy are often in conflict with safety, protection, and beneficence. The resident (or SDM), caregivers and RCT members may have different risk tolerances and may differ in how to weigh independence versus safety.

        iii. Residents, SDMs, caregivers, and RCT members may enlist the Clinical Leadership Committee, ombudsman program, and/or administrative leadership for help in resolving conflicts.

3. **Utilization Resources:**

[1] Consumer-centered care means also that providers cede some decision-making to consumers and that consumers be permitted to make tradeoffs that they consider important in choosing a care setting and provider and the details of a care plan. The idea that a single 'appropriate' setting exists for each consumer based on disability level must give way to an understanding that more than one choice can work for many consumers." (Institute of Medicine: Improving the Quality of Long-Term Care, 2001, p. 291).

a. Resident independence and resource stewardship are LHH values that inform discharge planning.

   i. Residents shall be discharged to the lowest possible levels of care, consistent with the notions of least restrictive setting and most integrated setting. This includes residents who meet SNF Medicare and or Medi-Cal criteria but whose care needs can be safely provided in the community, as well as residents whose medical conditions have improved and no longer require daily SNF level of care.

   ii. If there are barriers to discharge, the resident and RCT shall set reasonable care plan goals to maintain living skills, self-care readiness, and a sense of hope for future possibilities.

4. Conservatorship and decisional capacity:

a. Some conserved residents retain the legal right to make decisions regarding discharge, whereas others do not.

b. Unless otherwise specified in a written advance health care directive or absent legal adjudication, the primary physician bears responsibility for determining if a resident lacks or has recovered capacity to make health care decisions, including informed choices about interventions and discharge planning.

c. A resident with capacity retains the right to make decisions that RCT members consider unwise.

   i. RCT members shall educate the resident (or conservator or other SDM), about the risks associated with their decision(s) and document their concerns, but a resident with capacity has the final say in defining his/her well-being and self-interest.

d. For a resident who is conserved or lacking capacity, the RCT shall nevertheless elicit, document, and consider the resident's current and/or past values and preferences relevant to discharge.

e. A resident (for example with multiple hospital stays or history of homelessness) may not be able to formulate an informed preference about where to live and may have ill-informed fears about living in the community. RCT members should attempt a strategy that gradually exposes these residents to appropriate community settings, events, shops, and religious and recreational centers.

5. Collaboration:

a. LHH is committed to developing collaborative relationships with other organizations in order to meet the residents' needs.

b. The RCT members shall be familiar with community-based services appropriate to their disciplines.

c. The RCT members shall seek positive collaborations with members of the resident's informal and formal support systems, encouraging face-to-face meetings prior to and after discharge.

PROCEDURE:

Discharge to the Community

1. Discharge assessment and planning is initiated on admission and re-assessed, at a minimum, quarterly, or sooner; or when the resident's condition improves, and they no longer require SNF services. The RCT assessment and discharge planning process is collaborative and includes the resident, their designated family member(s), or SDM.

2. Upon admission and periodically during admission, designated members of the RCT shall educate the resident and/or their SDM that when their health condition sufficiently improves, or outcomes have been achieved, and a lower level of care is deemed appropriate, discharge plans shall be prepared and finalized to transition the resident back to the community.

3. If there is internal disagreement amongst members of the RCT on the adequacy of the discharge plan, the Director of Social Services or designee, the Utilization Management Nurse Manager or designee, the Chief Medical Officer or designee, and Chief Nursing Officer or designee, shall promptly meet and to resolve the issues and make recommendations for implementing a safe and orderly discharge plan for the resident.

4. RCT Roles and Responsibilities
   The following roles and responsibilities exist unless specific alternate arrangements are made. All responsibilities assume appropriate consultation from others. Communication with outside caregivers assumes appropriate permission from resident or surrogate.

   a. RCT Responsibilities[2]

[2] The RCT is flexibly defined for discharge planning purposes. The resident and the surrogate and informal caregivers, if present, can be considered central members of the RCT. Others called into the process as needed may include the vocational rehabilitation coordinator, psychologist, psychiatrist, physiatrist, other specialty physicians, substance abuse specialist, physical, occupational, and speech therapists, respiratory therapist, community case manager, and other community-based staff.

~~The physician, social worker, nurse, activity therapist, dietitian, rehabilitation specialist, occupational therapist, physical therapist, or speech therapist with others as needed:~~

~~i. Perform the discharge assessment process as described and negotiate the discharge plan.~~

~~ii. Review the discharge plan at least quarterly and document progress toward measurable discharge-related goals.~~

~~iii. Encourage the resident to sustain healthy relationships and interests in the community.~~

~~iv. Strive to find effective graduated strategies for residents who lack motivation for discharge, who are chronically non-adherent with the care plan, who are unable to formulate an informed preference regarding discharge, or who have ill-informed fears about discharge.~~

~~v. Identify education needs for discharge, provide or arrange for education to resident and caregivers, and document the education provided.~~

~~vi. Identify need for evaluation of resident's baseline function in regard to ADLs, IADL, or mobility that require rehabilitative services to assess readiness for discharge.~~

~~vii. Document the resident's (and/or SDM's) understanding of the discharge plan.~~

~~viii. Complete the appropriate sections of the AVS (After Visit Summary) and related discharge sections on the Social Work Activity Tab in Epic.~~

~~b. Physician~~

~~i. Addresses the resident's preliminary rehabilitation and discharge potential in the admission History & Physical.~~

~~ii. Communicates with the resident (or SDM), caregivers, and with other RCT members regarding the resident's conditions and expected course so that the goals of care can be adjusted as needed.~~

~~iii. Documents rehabilitation and discharge potential in quarterly reassessments and as needed.~~

~~iv. Attempts to simplify the resident's medication regimen, preferably months or weeks prior to discharge.~~

~~v. Ensures that appropriate post-discharge medical follow-up is arranged.~~

~~vi. Writes discharge order.~~

~~c. Social Worker~~

~~i. Coordinates the discharge assessment process and plan. Quarterly assesses residents' interests in transition to community living under Section Q of the MDS. More information on this requirement is available in the Resident Assessment Instrument (RAI) manual.~~

~~ii. Contacts the resident's caregivers and community-based support services to inform them of the admission, to invite them to care conferences, and to seek their collaboration.~~

~~iii. Attempts to secure the resident's housing if discharge is appropriate.~~

~~iv. Identifies Medicaid waivers available to the resident and encourages and facilitates the application process.~~

~~v. Enters into the electronic health record (EHR) any resident who expresses desire for discharge, has a supportive person interested in discharge, or is expected to improve and transition to a lower level of care.~~

~~vi. Updates the EHR discharge section as needed due to pertinent changes or upon readmission to LHH.~~

~~vii. If discharge is not currently a viable option and is not included in the formal care plan, documents the reason(s).~~

~~viii. Identifies differences of opinion among RCT members in regard to the resident's discharge and encourages open discussions based upon professional assessments.~~

~~ix. Provides counseling and psychosocial support to help the resident (or surrogate) and caregivers manage current and expected transitions. Evaluate caregivers availability, capacity, and/or capability to perform needed care to the resident following discharge.~~

~~x. Makes referrals for community placement (housing and other services) consistent with the discharge assessment and plan.~~

~~xi. Makes additional referrals as needed prior to discharge.~~

~~xii. Discusses the discharge plan with the resident (or surrogate) and caregivers, preferably months or weeks prior to discharge.~~

xiii. ~~Prepares and provides the resident and Ombudsman with a preliminary copy of a Notice of Proposed Transfer/Discharge. If the date changes, a revised Notice of Proposed Transfer/Discharge will be given to resident and the Ombudsman.~~

xiv. ~~After nursing signs and prints the AVS, reviews the AVS with resident.~~

~~Documents discharge planning efforts and resident preparation and orientation to the discharge plan to ensure a safe and orderly discharge from the facility.~~

xv. ~~The resident's assigned MSW will contact A&E Financial Counselor (FC) to inform of the planned discharge to coordinate, arrange and/or settle resident's financial affairs by the time discharge.~~

~~d. Nurse~~

~~i. Collaborates with the resident and family to provide assessment and interventions to maintain or improve self-care functioning.~~

~~ii. Provides resident and family education to support self-care and independence, based on the care plan. Identifies and advocates for referrals to rehabilitative services to improve self-care and independence.~~

~~iii. Arranges for discharge supplies as needed.~~

~~iv. Arranges pre-discharge pharmacy consultation for medication education.~~

~~v. Completes and prints out the AVS on day of discharge for resident.~~

~~e. Activity Therapist~~

~~i. Assesses and documents the resident's pre-admission interests.~~

~~ii. Promotes maintenance/enhancement of IADLs through activities.~~

~~iii. Involves the resident in campus-based and community-based programs to provide living skills learning, socialization, and self-confidence.~~

~~iv. Provides information and education to the resident and family regarding community resources to support living in the planned discharge setting.~~

~~f. Rehabilitation Specialist (occupational, physical, speech therapy) upon receipt of referral from physician: Performs evaluation of resident's overall functioning including basic activities of daily living, instrumental activities of daily living, community re-integration, recommendations and training for use of Durable~~

~~Medical Equipment, recommendations for continued therapy and support services at the appropriate level of care post-discharge.~~

~~g. Other Disciplines/Services~~

~~In addition to the RCT responsibilities noted above:~~

~~i. Pharmacist provides medication education to the resident and caregiver and completes the appropriate section of the EHR Post-Discharge Plan of Medication Instruction.~~

~~ii. Dietitian provides nutrition education to residents on therapeutic diets prior to discharge and collaborates with the social worker on enteral feeding supplies.~~

~~iii. Utilization management staff provides focused studies of the quality of discharge/transfer planning and documentation based on level of care.~~

~~iv. Vocational Rehabilitation, the People Realizing Employment Potential (PREP) Coordinator meets with interested residents about pre-vocational options, training, and community resources.~~

~~Peer Mentors provide education and practical support about In-Home Support Services (IHSS) to residents transitioning into the community.~~

~~Psychiatry providers and addiction medicine specialist, in collaboration with medical social worker, provide support for residents with mental health and/or substance treatment service needs to connect with outpatient treatment services after discharge, as indicated."~~

~~A&E Financial Counselors (FC) will work with RCT and resident and/or resident's financial decision maker to make sure all financial affairs are coordinated, arranged, and/or settled by the time of discharge.~~

Each discipline involved in the Resident Care Team(RCT)-including physicians, nurses, social workers, activity therapists, rehabilitation specialists, and others-has clearly defined roles and responsiilities in the discharge planning process. See Standard Work.

5. Notification of Resident Regarding Discharge/Transfer from Facility

a. The social worker, nurse, or physician shall notify the resident and, if known, a family member or legal representative of the resident, of the discharge/transfer and the reasons for the move in writing and in a language and manner they understand and record the reasons for discharge in the resident's medical record. A resident or SDM is entitled to written 30-day notification except under the following conditions:

i. The transfer or discharge is necessary as resident needs cannot be met in the facility. Documented attempts to meet the resident's specific needs and an assessment at the time of discharge indicating what needs cannot be met.

~~i.~~ii. Improvement in medical condition requiring a lower level of care. Documentation to show the resident's health has improved.

~~ii.~~iii. The health or safety of individuals in the facility is endangered. Documented instances of examples of behaviors that have the potential to endanger the safety or health of individuals in the facility.

iv. Resident has resided in the facility less than 30 days.

v. Resident has failed after reasonable and appropriate notice to pay for a stay at the facility. Documented that the facility offered the resident to pay privately or apply for medical assistance, or documentation that the resident refused to pay or have their stay paid for by Medicare or Medi-Cal. Medi-Cal eligible residents will be provided oral and written information on how to apply for Medicaid.

~~iii.~~vi. The facility is ceasing to operate.

b. The nurse, or physician shall notify the resident and, if known, a family member or legal representative of the resident, of a transfer and the reasons for the move in writing and in a language and manner they understand and record the reasons for discharge in the resident's medical record. A resident or SDM is entitled to written notification on the day of transfer based on the conditions below:

i. Medical emergency.

ii. Deterioration in medical condition requiring a higher level of care.

c. The social worker will forward a copy of the Notice of Transfer/Discharge provided to the resident or legal representative and Ombudsman.

d. Written notice (MR 707) to the resident or SDM shall include:

i. Name of resident

ii. Date resident notified

iii. Reasons for discharge/transfer.

iv. Date the discharge/transfer will occur.

v. Discharge/transfer destination.

vi. Name, address, and phone number of the State ombudsman.

vii. For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals.

viii. For residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act

ix. Resident's right to appeal to the California State Department of Health Services.

x. Witness signature, and explanation if resident or resident's representative did not sign the written notice.

e. Residents may choose to waive their notice period if they wish to be discharged/transferred prior to the conclusion of the notice period.

f. If the resident or SDM is opposed to discharge/transfer, they will be encouraged to discuss it with the RCT and ombudsman.

i. Utilization Management leadership (UM) will alert the Medical Director, Chief Nursing Officer or designee, Chief Quality Officer, and Executive Administrator (or their designee) prior to issuance of the written notification of discharge/transfer.

ii. One or more of these executive leaders will meet with the resident or surrogate if so desired.

iii. When the Resident Care Team (RCT) identifies that a resident's health has improved sufficiently to allow discharge/transfer to the community, and the resident verbalizes that they disagree with the plan to be discharged/transferred to the community and refuses reasonable placement options, the Social Worker shall request for a level of care review by UM.

iv. The UM Nurse shall conduct a review of the resident's medical record and determine if the facility has met the conditions for discharging/transferring the resident to the community. A Discharge Plan Review form is available for use to assure that a comprehensive review is carried out.

v. The UM Nurse shall notify the RCT with a recommendation to proceed with the Notice of Proposed Transfer/Discharge or continue to address identified discharge planning issues prior to issuing the Discharge/Transfer Notice within 3 – 5 working days.

vi. The resident shall be presented with the Notice of Proposed Transfer/Discharge at least 30 days before the resident is scheduled for discharge. If the resident falls into the five categories listed above in section 5a and 5b, the notice may be less than 30 days. ~~Otherwise, the 30-day period may be waived only in cases of resident-initiated transfer or discharge.~~

~~vi.~~vii. When a resident chooses to appeal his or her discharge from the facility, the facility may not discharge the resident while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals.

- The RCT shall document the danger(s) that failure to transfer or discharge would pose.

~~vii.~~viii. The Social Worker shall notify the UM Department as soon as s/he is aware that the resident has filed a complaint to contest the discharge/transfer.

~~viii.~~ix. The UM leadership or designee shall gather pertinent resident information and be prepared to respond to resident issues that may be investigated by the assigned Licensing and Certification Health Facilities Evaluator Nurse.

~~ix.~~x. When the facility is notified of a scheduled discharge hearing date, the UM leadership or designee shall coordinate with the RCT, UM Nurse and if necessary, the Deputy City Attorney to prepare oral and written testimony for the discharge hearing to demonstrate compliance with resident discharge planning requirements.

~~x.~~xi. The RCT shall present oral testimony, clarify concerns and submit written documentation to the assigned Hearing Officer at the scheduled discharge hearing.

~~xi.~~xii. The resident may not be involuntarily discharged from the facility prior to the discharge hearing or issuance of the Decision and Order, but may choose to be voluntarily discharged and s/he can request for assistance with discharge planning arrangements from the RCT.

~~xii.~~xiii. While the appeal is pending, the facility can proceed to discharging the resident when failure to transfer or discharge endangers the health or safety of the resident or other individuals in the facility. The facility must document the danger the resident poses to self and/or others that the failure to transfer or discharge would pose.

- The UM leadership shall coordinate a meeting to discuss the safety risk with the LHH Executive team and, if necessary, the City Attorney's Office.

- The facility's Administrator or designee is required to provide DHCS Office of Administrative Hearings and Appeals written notification as soon as possible if the resident is transferred or discharged prior to the hearing under this exception.

~~xiii.~~xiv. The RCT shall clearly document that such discharge planning arrangements were made based on the resident's request.

~~xiv.~~xv. If the resident is voluntarily discharged from the facility while the hearing is pending, the QM designee is responsible for notifying the California Department of Public Health Office of Regulations and Hearings and the local Licensing and Certification Office.

~~xv.~~xvi. Following the discharge hearing, the State of California will issue a Decision and Order and the facility shall proceed with the issued directions contained in the document.

6. After Visit Summary (AVS) and Discharge Summary

   a. For Anticipated Discharges, the physician shall develop a discharge summary for the resident and shall include:

      i. An overview of the resident's stay including, but not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results;

      ii. A final summary of the resident's status including items from the resident's most recent comprehensive assessment (Refer to LHHPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC), Procedure 1(c)(ii).) that may be available to authorized persons and agencies upon consent of the resident or resident's representative;

      iii. A reconciliation of the resident's pre-discharge medications with his/her/their post-discharge medication, both prescribed and over the counter; and,

      iv. A post-discharge plan of care that is developed with consideration to the resident's and/or the resident's representative preferences, which shall include where the resident shall live, information on the resident's follow-up care, any necessary medical and non-medical services, and information on how and when to contact the continuing care provider(s).

   b. The discharge summary shall be complete and conveyed, with the resident's permission, to the receiving provider at the time the resident leaves the facility.

7. Transfer to an Emergency Department (ED)

a. Physician

i. The physician will assess the need for higher level of care. If appropriate, the physician will order the LOA order for transfer to the ED.

ii. The physician will conduct a hand-off with the receiving ED.

iii. Document in the EHR of the medical assessment and need for higher level of care.

iv. Complete the Interfacility Transfer Record.

b. Nursing

i. Document that Change of Condition in the EHR.

ii. Place the resident on LOA in the EHR.

iii. Print out necessary transfer documents from the EHR to send with the resident.

8. Discharge to an Acute Care Facility

a. Bed Hold (refer to LHHPP 20-14 Leave of Absence and Bed Hold Policy)

b. Nursing

i. Contacts the acute facility to determine if the resident was admitted.

c. Physician

i. Writes a discharge summary in the EHR.

9. Involuntary Discharges

i. Involuntary discharges, whether arising from level of care or behavioral issues, require careful assessment, planning, and documentation. Legal counsel shall be consulted in circumstances when the resident and or SDM refuses to participate in discharge planning efforts (e.g., refuses to sign release of information forms or complete housing applications, etc.).

ii. A Notice of Proposed Transfer/Discharge may be issued after a resident and or the SDM has been presented with two housing options that the RCT considers to be the best viable discharge option available in the community.

10. Transfer to Another Skilled Nursing Facility

a. The physician, social worker, nurse, activity therapist, dietitian, rehabilitation specialist, occupational therapist, physical therapist, and/or speech therapist with others as needed will work in collaboration to complete the transfer assessment process according to the transfer plan.

b. Physician

   i. Addresses the resident's continued skilled nursing needs as transfer potential in the progress note.

   ii. Communicates with the resident (or SDM), caregivers, and with other RCT members regarding the resident's conditions and expected course so that the goals of care can be adjusted as needed.

   iii. Attempts to simplify the resident's medication regimen, preferably months or weeks prior to transfer, if appropriate.

   iv. Ensures that appropriate post-transfer medical follow-up needs are communicated through physician -to- physician report prior to resident transfer.

   v. Writes transfer order.

c. Social Worker

   i. Coordinates the transfer assessment process and plan. Documents the assessment and plan in the EHR.

   ii. Contacts the resident's caregivers and community-based support services to inform them of the transfer, to invite them to care conferences, and to seek their collaboration.

   iii. Updates the EHR discharge section as needed due to pertinent changes or upon readmission to LHH.

   iv. If transfer is not currently a viable option and is not included in the formal care plan, documents the reason(s).

   v. Identifies differences of opinion among RCT members in regard to the resident's transfer and encourages open discussions based upon professional assessments.

   vi. Provides counseling and psychosocial support to help the resident (or surrogate) and caregivers manage current and expected transitions.

   vii. Makes referrals to other skilled nursing facilities.

viii. Discusses the transfer plan with the resident (or surrogate) and caregivers, preferably months or weeks prior to discharge.

ix. Prepares and provides the resident and Ombudsman with a preliminary copy of a Notice of Proposed Transfer/Discharge. If the date changes, a revised Notice of Proposed Transfer/Discharge will be given to resident and the Ombudsman.

x. Documents transfer planning efforts and resident preparation and orientation to the transfer plan to ensure a safe and orderly discharge from the facility.

d. Nurse

i. Collaborates with the resident and family to provide assessment and interventions to maintain or improve self-care functioning.

ii. Provides resident and family education to support self-care and independence, based on the care plan.

iii. Prepares resident's personal belongings prior to the transfer. Conduct inventories to ensure that all belongings are transferred to the receiving facility.

iv. Completes and prints out the AVS on day of transfer for resident. Include additional medical records requested by a receiving facility.

11. Residents Leaving Against Medical Advice (AMA)

a. When a resident indicates that he or she intends to leave without a discharge order, the nurse will inform the physician of the need for an urgent visit to assess the resident and situation.

b. If the resident is conserved or does not understand the nature and consequences of a decision to leave LHH without permission, the physician will immediately attempt to contact the SDM.

c. If leaving LHH would have life-threatening consequences for the resident, the physician will obtain emergency psychological or psychiatric consultation.

d. If the consultant deems the resident a danger to self or others due to mental illness, the consultant will initiate a psychiatric hold and transfer the resident to acute care.

e. The nurse or physician will present the form MR 804, "Request to Leave the Hospital Against Medical Advice," to the resident (or surrogate) in the presence of a witness.

i. If the resident or surrogate refuses to sign, the nurse or physician will write on the form, “Resident refuses to sign.” Nurse/physician and witness will sign.

f. The nurse or physician will complete an Unusual Occurrence form.

g. When RCT members have adequate advance warning regarding a resident leaving AMA, they should consider providing appropriate medication referrals, in addition to providing a list of emergency shelters and food sources.

12. Residents Qualifying for Hospice Care Services

a. If a resident qualifies for hospice care services and chooses a hospice provider that does not have an agreement with LHH, then LHH shall assist the resident in discharging to a facility or transferring to a SNF that uses the hospice chosen by the resident.

b. If a resident requests to discharge or transfer to a facility that provides hospice care, LHH will follow the procedures detailed in this policy for ~~resident-initiated~~ transfers or discharges and is not required to provide a notice of discharge or transfer.

ATTACHMENT:
Attachment A: Residential Substance Use Treatment and Dual Diagnosis Treatment Placement for LHH Residents
Attachment B: LHH Referral Protocol for Opiate Replacement Treatment

REFERENCE:
LHHPP 20-06 Out on Pass
LHHPP 20-07 Against Medical Leave (AMA)
LHHPP 20-14 Leave of Absence and Bed Hold
LHHPP 20-10 Transfer and Discharge Notification
LHHPP 22-10 Management of Resident Aggression
LHHPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)
NSPP C1.0 Resident Admission and Readmission for SNF

Revised: 08/04/29, 09/10/27, 13/05/28, 13/09/24, 13/11/21, 15/05/12, 17/09/12, 19/03/12, 19/07/09, 20/10/13, 22/07/12, 23/06/13, 24/10/08, 25/05/12 (Year/Month/Day)
Original adoption: 03/07/15

TRANSFER TECHNIQUES

POLICY

1. The Licensed Nurse and/or Rehab staff assesses the resident's ability to transfer with or without staff assistance or adaptive devices upon admission and as needed.

2. The proper level of assistance will be utilized in transferring resident based on their functional status.

3. ~~All residents~~Each resident who requires a battery-operated lift transfer must have their own assigned sling for transfer and bathing. Sling tags are to be labeled, using permanent marker, with resident's full name and the month/year first opened. Manufacturer recommends slings are to be replaced every 6 months, or if damaged. Damaged slings must be discarded and replaced with a new sling.~~Each sling must have resident's name and room number.~~

4. The principles of good body mechanics are to be adhered to at all times to avoid injuries to either the resident or the staff members.

5. ~~Any member of nursing~~Nursing staff {licensed nurse(LN), nursing assistant (CNA~~, or~~/PCA)} may perform transfer procedure. Check care plan for transfer technique and required number of staff assistance during transfer, level of assistance, use of assistive or adaptive device including gait belt (refer to Appendix A: Gait Belts FAQs)

6. Residents on a low air loss mattress shall require two person assist for all transfers.

~~5.~~7. Two nursing staff members are always required for operation of battery-operated lifts.

~~6.~~8. Criteria for assessing use of gait belt with transfers, as follows, but not limited to:

   a. Inclusion Criteria:

      i. Level of assist requires hands on or physical assist

      ii. Due to resident related factors, resident requires supervision and/or stand by assist for safety

   b. Exclusion:

      i. Resident is independent or modified independent and does not require a gait belt for safety, as per resident's care plan.

      ii. Mechanical lift used for transfers that does not require use of gait belt for safety, as per resident's care plan.

PURPOSE

To ensure resident's and staff's safety when moving the resident from one surface to another.

PROCEDURE

1. Prior to Transfer

a. Review Resident Care Plan prior to transfer of resident.

2. Transfer Techniques

a. **Slide Transfer Technique** (Gurney to Bed and Vice Versa)

i. Place the gurney parallel to the bed.

ii. Position the bed and the gurney at the same height with head of the bed and gurney in a flat position.

iii. If any motor weakness or sensory deficit or neglect is present on one side, place the gurney next to the strongest side.

iv. Set all brakes on all equipment in a "locked" position after the equipment is positioned.

v. Use a draw sheet or slider sheet to assist with transfer.

vi. Always have drainage bags lower than the area being drained.

b. **Pivot ~~t~~Transfer Technique**

i. Stand in front of resident or along resident's weak side

ii. Position resident's feet flat on the floor

iii. Grasp gait belt at each side from underneath

iv. Brace knees against resident's weak lower extremities

v. Use knee and foot to block the resident's weak leg or foot, and place your other foot slightly behind you for balance or straddle your legs around the resident's weak leg

vi. Ask resident to push down on the mattress and on the count of “3” have the resident bend and lean forward (like a see-sawing motion)

vii. *Do NOT carry resident*

viii. Assist resident to a standing position as you straighten your knees.

ix. Encourage resident to take small steps towards the chair or wheelchair if resident is able.

x. Turn resident so they can grasp the far arm of the chair or wheelchair. Legs will touch the edge of the seat.

xi. Continue turning resident until the other armrest is grasped.

xii. Lower resident into the chair or wheelchair as you bend your hips and knees. To assist, the resident leans forward and bends the elbows and knees.

xiii. Make sure resident’s hips are to the back of the seat. Position resident in good alignment.

xiv. Position the resident’s feet on the wheelchair footrests.

xv. Remove gait belt.

xvi. Position the chair as resident prefers and keep belongings and call light within reach.

xvii. After completing transfer, check in with the resident for any adverse effects: dizziness, pale complexion, pain, and/or decreased consciousness. Report any change in condition to the license nurse.

c. **Sliding Board Transfer Technique**

i. Use sliding board or transfer board as a bridge between the bed and chair or wheelchair.

ii. Lower the bed to the same height as the seat of the chair or wheelchair.

iii. Lock all bed and wheelchair brakes.

iv. Move armrest and fold wheelchair footrests back.

v. Assist the resident in a seated position to prepare for bed to chair transfer. Place gait belt on the resident.

vi. Place one end of the board beneath the resident and the other end on the seat of the chair or wheelchair.

vii. Slide the resident along the board to reach the chair.

viii. Remove the gait belt and the sliding board.

i. Secure armrest and footrest back in position.

d. **Transfer Techniques using ~~Mechanical~~ Battery Operated Lift** (Refer to NPP D6 1.1 Battery Operated Lift ~~Transfer and NPP D6 1.4 Battery Operated Ceiling Lift~~)

3. Reporting and/or Documentation

a. All care teams will report and communicate to the physician and rehab staff when additional transfer training is warranted.

4. Documentation

a. Electronic Health Record (EHR)

i. The CNA/PCA documents the highest level of assistance needed and number of staff required during transfer with/without use of assistive device or adaptive equipment and gait belt respectively.

ii. The Licensed Nurse documents weekly, monthly, and as needed ~~resident's~~ any change in functional level and reports this during the 24-hour report, handoff for all nursing shifts, and RCT team meetings.

~~ii.~~iii. Nursing will document any unexpected outcomes and related interventions.

5. Care Plan

a. The Licensed Nurse documents in the Care Plan the type and level of assistance needed for transfer with or without use of assistive device or adaptive equipment, and with or without use of gait belt, and the position of the device (i.e., wheelchair place on strong side).

b. All residents who require battery-operated lift transfer must ~~be documented on the Care Plan indicating what type of lift is used, type and size of slings used, and number of persons required to assist in transfer.~~have documented on their care plan/Kardex the type of lift, type and size of sling used, and color of straps to apply for the resident.

c. For residents in active rehabilitation, collaborate with Rehab Services and with the RCT to write an individualized care plan entry on functional transfer (bed <> chair; toilet transfers; may include shower transfer).

APPENDIX:

Appendix A: Gait Belt FAQs

REFERENCES:

Elsevier (2024) Transfer Technique: Pivot Transfer https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025

Elsevier (2024) Transfer Technique: Bed to Wheelchair using Slide Board https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025

Elsevier (2024) Transfer Technique: Assisting Patients to Sitting Position https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025

Perry, A.G. and others (Eds.). (2022). *Clinical nursing skills and techniques* (10th ed.). St. Louis: Elsevier.

CROSS-REFERENCES:

~~Nursing Policy & Procedures~~NSPP D6 1.1 Battery Operated Lift

Revised: 23/10/10, 25/05/12 (Year/Month/Day)

Adopted from Nursing D6. 2.0 on 23/10/10

Original: 2000/08

Appendix A: Gait Belt FAQs

1. What is a gait belt?
    a. Gait belts are thick fabric or vinyl belts that give staff a place to hold onto the resident to assist with balance and support of the resident. Contact your supervisor for location of gait belts on your unit.
2. Why should you use a gait belt?
    a. Gait belts should be worn to ensure safe mobility for resident and staff.
3. Who should use a gait belt?
    a. Every staff member that assists resident with mobility, including transfers and ambulation, provided resident meets inclusion criteria for gait belt use. Criteria for assessing use of gait belts with transfers, as follows, but not limited to:
        i. Inclusion Criteria:
            - Level of assist requires hands on or physical assist
            - Due to resident related factors, resident require supervision and/or stand by assist for safety
        ii. Exclusion:
            - Resident is independent or modified independent and does not require a gait belt for safety, as per resident's care plan.
            - Mechanical lift used for transfers that does not require use of gait belt for safety, as per resident's care plan.
4. Where should you place a gait belt?
    a. Most gait belts are placed at the waist level. Some residents have injuries, surgery, drainage, and tubes that require the belt to be placed higher or lower than waist level.
5. When should you use a gait belt?
    a. Gait belts should be worn every time you assist a resident with mobility!!! Exceptions to this are the following:
    b. Exclusion Criteria:

i. Resident is independent or modified independent and does not require a gait belt for safety, as per resident's care plan.

ii. Mechanical lift used for transfers that does not require use of gait belt for safety, as per resident's care plan.

c. Gait belts should be worn in resident's room, in the halls if ambulating, or any place resident will need to transfer from one surface to another.

6. How do you use a gait belt?

a. Refer to Gait Belt Competency.

Reference:

Institute for Healthcare Improvement. How to Guide: Reducing Patient Injuries from Falls. (December 2012).

CLINICAL PRODUCT AND DEVICE/EQUIPMENT EVALUATION

POLICY:

Clinical products and devices/equipment that are used to render direct patient/resident care require review and approval before being put into routine use at Laguna Honda Hospital ~~and Rehabilitation Center (Laguna Honda)~~(LHH).

PURPOSE:

To utilize safe, efficacious and cost-effective clinical products and devices in the care of the residents/patients at Laguna Honda Hospital.

PROCEDURE:

1. Before a new clinical product or device/equipment may be purchased or introduced at ~~Laguna Honda~~LHH, the ~~Laguna~~ LHH ~~Honda~~ product or device/equipment must first be evaluated. Clinical product evaluations will be conducted through the LHH Value Analysis Committee (VAC). Devices/Equipment will first be evaluated by Biomedical Engineering. Devices/Equipment will then be presented ~~at~~ to the VAC for additional evaluation and review. ~~Product Evaluation must evaluate it.~~ Items that have already been evaluated and selected by Zuckerberg San Francisco General Hospital's ~~Product Evaluation Committee~~Value Analysis Committee may be approved by the ~~Laguna Honda~~LHH ~~Product Evaluation Committee~~VAC based on that recommendation or may be subject to additional evaluation.

2. Members of the ~~Product Evaluation~~ Value Analysis Committee include the Director of Materials Management, a physician, designees from Nursing Administration, ~~a pharmacist~~Pharmacy, Respiratory Therapy, Lab Services, Wound Care, Rehabilitation Therapy, Infection Prevention, Health at Home, Biomedical Engineering, Department of Education and Training, a designee from the Quality Management department, and others by invitation, depending on the product under review. ~~A representative from~~ Facility Services shall participate in equipment decisions when Facility Services may be providing maintenance either upon procurement or in the future.~~will be providing maintenance~~.

3. Presentations to ~~the Committee~~VAC may be made by a representative of the subcommittee or the clinician requesting evaluation of a new product. A sales representative may be requested to provide product information in writing or ~~in person~~ invited to attend VAC meetings at the discretion of the Committee.

4. The Committee may determine that an investigative trial is warranted and will select criteria by which the product will be evaluated. These criteria may be areas such as clinical response, comparative cost to like products, ease of use, and availability. The related product literature, observations made by staff and reported past experience of

individuals familiar with the product will be given consideration in ~~making a decision~~decision making.

5. When a ~~pilot~~trial is instituted, a member of the Committee will be identified to coordinate selection of participants, obtain approval of the neighborhood physician and nurse manager as needed, initiate the ~~pilot~~trial, collect the data during a defined time period and make a formal summary report. To promote the most reliable feedback, the Committee will involve in ~~pilot~~ the trial those individuals who have the highest degree of expertise in the area being evaluated.

6. New products should not be ~~piloted~~trialed on residents/patients whose prognosis is poor to avoid interference with the evaluation process in the event of a negative outcome. An exception may be made to allow the evaluation of palliative care products on terminally ill residents.

~~7.~~ The ~~Product Evaluation~~Value Analysis Committee meets monthly to review new and pending product or device/equipment evaluations. VAC can also meet ad-hoc for critical or time-sensitive evaluations. ~~will review new products on an as-needed basis.~~

ATTACHMENT:
None

REFERENCE:
None

Revised: 94/12/01, 11/09/27, 15/01/13, 15/11/09, 25/05/12 (Year/Month/Day)
Original adoption: 94/11/30
Approved for renumbering from 78-01 to 31-03: 15/01/13

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PROGRAM (QAPI)

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to quality and patient safety and recognizes that patients, staff, and visitors have the right to a safe environment. It is the policy of LHH to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on outcomes indicators of care and quality of life, and addresses all care and services the facility provides. Identifying, analyzing, and resolving systems and human behavior risks sets a foundation grounded in patient safety. The QAPI Program provides the framework to achieve and maintain a safe environment by promoting a culture that encourages error identification, reporting and prevention through education, system redesign and human behavior management.

The Medical Staff, through the Medical Executive Committee, is responsible for the establishment, maintenance, and support of an on-going, organization-wide QAPI Program in accordance with Federal and State requirements, professional regulations, and the LHH Medical Staff Bylaws.

Hospital leadership works collaboratively with the medical staff and the governing body to set expectations for performance improvement and manages processes to ensure that the QAPI Program is meeting the hospital's goals as well as meeting all regulatory requirements.

PURPOSE:

The intent of the QAPI Program is to promote a culture of safety and provide a systematic, coordinated and continuous approach to optimizing clinical outcomes and patient safety.

This is achieved by:

1. Collaboration of the Governing Body, Joint Conference Committee, and Hospital Leadership to establish annual performance goals directly linked to the LHH True North Metrics.

2. Creating a culture of safety to anticipate, identify and acknowledge risks and errors and promote error reporting as part of the provision of care and safety of the patient.

3. Assessing the perceptions of patient safety by administering a Culture of Safety Survey at least every 24 months.

4. Establishing a "just-culture" framework that addresses both systems issues and human behaviors that can undermine performance and patient safety.

5. Aggregating data to identify trends and high-risk activities while defining measures to address identified safety issues.

6. Review and follow-up on Patient/Resident Safety Events – includes adverse events or potential adverse events that are determined to be preventable; and healthcare-associated infections.

7. Ensuring that proactive risk assessments and process improvements are communicated to managers and those directly involved when appropriate.

8. Developing solutions to systemic patterns and practices that place patients at risk and to stimulate, initiate and support interventions designed to reduce risk of errors and to protect patients from harm.

9. Promoting a uniform monitoring and evaluation process for performance improvement and patient safety activities.

10. Promoting the involvement of care providers in defining quality, establishing standards, and developing mechanisms to monitor, evaluate, and improve processes and patient outcomes.

11. Promoting a culture geared toward proactive risk assessment by increasing the reporting of medical errors and adverse events and expanding opportunities to reduce errors and adverse outcomes.

12. Guiding LHH in meeting legal, professional, accreditation, and regulatory requirements.

DEFINITION:

1. **"Adverse Event"** is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.

2. **"Health equity"** refers to the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

3. **"High Risk Areas"** refers to care or service areas associated with significant risk to the health or safety of residents. Errors in these care areas have the potential to cause adverse events resulting in pain, suffering, and/or death. Examples include tracheostomy care; pressure injury prevention; administration of high-risk medications such as anticoagulants, insulin, and opioids.

4. **"High Volume Areas"** refers to care or service areas performed frequently or affecting a large population, thus increasing the scope of the problem (e.g.,

transcription of orders; medication administration; laboratory testing).

5. **"Indicator"** is a measurement of performance related to a particular care area or service delivered. It is used to evaluate the success of a particular activity in achieving goals or thresholds.

6. **"Performance Improvement (PI)"** is the continuous study and improvement of processes with the intent to improve services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement.

7. **"Problem-Prone Areas"** refers to care or service areas that have historically had repeated problems (e.g., call bell response times; staff turnover; lost laundry).

8. **"Quality Assurance (QA)"** is the specification of standards for quality of service and outcomes, and systems throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards. QA is on-going, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards.

9. **"Quality Assurance and Performance Improvement (QAPI)"** is the coordinated application of two mutually reinforcing aspects of a quality management system: (QA) and Performance Improvement (PI). QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes, while involving residents and families in practical and creative problem solving.

10. **"Serious Adverse Event (SAE)"** This is defined as an error or event that causes the Death or Serious Disability of a resident, staff or visitor, includes events necessitating the transfer to a higher level of care.

11. **"Unusual Occurrence (UO)"** An unusual occurrence is determined as an event or condition, which has had or may have an adverse effect on the health or safety of a resident, visitor, volunteer, staff or student. These occurrences are reported through the electronic reporting system as described in policy: LHHPP 60-04 Unusual Occurrences.

12. **"Sentinel Event (SE)"** A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

    a. Death

    b. Permanent harm

c. Severe temporary harm* (critical, potentially life-threatening harm lasting for a limited time with no permanent residual but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

PROCEDURE:

1. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) COMMITTEE

a. The Performance Improvement and Patient Safety Committee is an interdisciplinary executive and medical staff committee promoting:

i. Communication – Cross-functional learning from departmental reflection on problem solving drivers.

ii. Alignment – Identify common goals, challenges, opportunities, partners.

iii. Accountability – Ensure all levels of organization are driving true north.

iv. The PIPS Committee is responsible for implementing the objectives of the organization wide QAPI program. The PIPS Committee takes an interdisciplinary and proactive approach in the prevention of adverse events, medical errors and near misses, and promotes patient outcomes/safety as a core value in providing quality patient care. The PIPS Committee uses data to drive improvement efforts, guide day to day operations and prioritize performance improvement projects that includes input and experience from healthcare workers, residents, families, and other stakeholders.

v. The PIPS Committee is a Joint Hospital Leadership and Medical Staff Committee. The Committee shall consist of the following members: Chief of Medicine or designee, Chief of Physical Medicine and Rehabilitation Services or designee, Chief of Outpatient Clinics or designee, Chief of Psychiatry or designee, Chair of the Medical Quality Improvement Committee or designee, Chief Dietician or designee, Chief Health Informatics or designee, Director of Social Services or designee, Director of Pharmacy or designee, Director of Activity Therapy or designee, Infection Prevention and Control Officer or designee, Director of Rehabilitative Services or designee Privacy/Compliance Officer or designee, Director of Regulatory Affairs, Director of Risk Management, Director of Performance Improvement, Quality Improvement Coordinators and a Deputy City Attorney. Executive Leadership Team members, including the Chief Executive Officer (CEO)/Nursing Home Administrator (NHA), Assistant Nursing Home Administrators (ANHA), Directors of Nursing and Chief of Staff are committee members. The Chief Medical Officer/Medical Director (CMO) and the Chief Quality Officer (CQO) serve as the Co-Chairs of the PIPS Committee.

b. **Functions of PIPS Committee Include:**

i. On an annual basis, reviews the effectiveness of the LHH QAPI Program in meeting the organization-wide purpose, goals and objectives and revises the program as necessary.

ii. Identifies organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data obtained from: Serious Adverse Events (SAE) in the SNF and Sentinel Events (SE) in Acute; patient/resident safety events; patient case reviews; risk management reports; infection prevention and control reports, hospital claims; patient and staff surveys; patient/visitor concerns; clinical service and ancillary/diagnostic department performance improvement reports; ongoing medical record review, and other sources as appropriate.

iii. Formulates and recommends actions for improving patient care and safety to clinical services, ancillary/diagnostic departments, and PI committees as appropriate.

iv. Makes recommendations based on an evaluation of the care provided (e.g., efficacy, appropriateness) and how well it is done (e.g., availability, timeliness, effectiveness, continuity with other services/practitioners, safety, efficiency, and respect and caring).

v. Reports and forwards recommendations monthly to the Medical Executive Committee, Joint Conference Committee, and the Health Commission (Governing Body) through the CMO and CQO.

vi. Facilitates a multidisciplinary, interdepartmental collaborative approach to improving the quality of patient care and safety, and appropriate utilization of resources.

vii. Reviews and approves the clinical and departmental performance improvement measures and patient safety initiatives of LHH.

viii. Annually reviews and approves hospital-wide performance measures, including the evaluation of performance by patient care services provided through contractual agreements.

ix. Reviews and approves the QAPI plan.

x. Develops recommendations for performance improvement activities according to potential impact upon patient outcomes and safety and in accordance with the hospital's mission, vision, care and services provided, and the population served.

xi. Ensures that safety issues have priority status and are taken into account when designing and redesigning processes.

xii. Ensures appropriate review, analysis and follow-up of performance improvement opportunities, including analyses of staffing adequacy related to undesirable patterns, trends, or variations pertaining to safety or quality.

2. THE GOVERNING BODY

The San Francisco Health Commission is ultimately responsible for maintaining the quality of patient care and safety. Through the LHH Joint Conference Committee of the Health Commission:

a. Approves the LHH QAPI Plans for SNF and Acute units.

b. Through the Director of Public Health and the LHH CEO and Nursing Home Administrator, supports performance improvement and patient safety initiatives and mechanisms by employing specific staff to provide technical and consultative support to the various departments and programs.

c. Ensures quality planning is incorporated into the strategic planning process.

d. Through the Joint Conference Committee and the PIPS Committee, regularly reviews reports on performance improvement and patient safety activities and acts upon them when appropriate.

e. Annually reviews and approves hospital-wide performance measures, including the evaluation of performance by patient care services provided through contractual agreement.

3. INDIVIDUAL ROLES AND RESPONSIBILITIES

a. Director of Public Health: Provides support and facilitates communication throughout the Department of Public Health in regard to activities and mechanisms for monitoring and evaluating the quality of patient care/safety, identifying and resolving problems, and identifying opportunities for improvement. Serves as the Chief Executive Officer of the Health Commission.

b. LHH Chief Executive Officer/ Nursing Home Administrator

i. Assumes overall administrative accountability and responsibility for the LHH QAPI Program; and

ii. Assists in identifying opportunities for improvement of the quality of patient care/safety and resolution of problems.

c. Assistant Nursing Home Administrators

i. Assists in identifying opportunities for improvement of the quality of patient care/safety and resolution of problems.

ii. Participates in and leads performance improvement and patient safety initiatives; and

iii. Reviews departmental and committee performance improvement and patient safety reports/ plans to identify interdepartmental and/or interdisciplinary quality issues.

d. Chief Medical Officer

i. Works with the CQO to develop and implement the QAPI Program;

ii. Participates in and leads performance improvement and patient safety initiatives;

iii. Reviews departmental and committee performance improvement and patient safety reports/ plans to identify interdepartmental and/or interdisciplinary quality issues;

iv. Ensures medical staff and infection prevention and control review of all patient deaths and identification of deaths that may be preventable or related to hospital-acquired infections.

v. Serves as Co-Chair of the PIPS Committee;

vi. Ensures that the LHH Medical Staff Bylaws reflect the function and role of the PIPS Committee;

vii. Oversees and participates in the education of Medical Staff, nursing staff, and others regarding performance improvement and patient safety

viii. Presents performance improvement reports to the Medical Executive Committee and to the Joint Conference Committee.

e. Chief Quality Officer

i. Develops, implements, and monitors the QAPI Program under the direction of the LHH CEO;

ii. In collaboration with the CMO, coordinates projects of the PIPS Committee;

iii. Administers the Incident Report System;

iv. Analyzes data for trends and makes recommendations to reduce or prevent incidents that may adversely affect patient care or the safety of patients/residents, visitors, employees and visitors;

v. Offers technical assistance with regards to QAPI activities to the Medical Staff, LHH staff, Committees, performance improvement and patient safety teams**,** and LHH leadership;

vi. Reviews departmental and committee performance improvement reports to identify interdepartmental and/or interdisciplinary quality or patient safety issues;

vii. Participates in resolving patient care/safety issues as identified from incident report data and regulatory agency reports;

viii. Develops pertinent reports for the CEO, Medical Staff, committees and external agencies;

ix. Provides education to the Medical Staff, LHH leadership, and others regarding performance improvement and patient safety;

x. Consults with Department of Education and Training on LHH performance improvement and patient safety education curriculum; and

xi. Serves as Co-Chair of the PIPS Committee.

f. The Director(s) of Nursing: Ensures that Nursing quality improvement activities are clearly delineated and implemented in alignment with the QAPI Plan and True North.

g. The Chief of Service, LHH Leadership, and Department Managers
It is recognized that all leaders have a major role in promoting Quality and Patient Safety at LHH. Chiefs of Service, LHH Leadership, and Department Managers are responsible for the continuous, effective operation and improvement of their respective departments. The Chiefs of Service, LHH Leadership, and Department Managers:

i. Define the scope of services provided and identify key functions and indicators to monitor practice. Communicate monitoring, evaluation, and improvement results to other disciplines and departments as appropriate. Incorporate strategic planning goals into PI activities, as appropriate;

ii. Develop and implement performance improvement activities in accordance with the QAPI Program;

iii. Develop, implement and monitor performance measures within each department and report status of measure to PIPS;

iv. Assign representatives to participate in the PIPS Committee and to present performance improvement and patient safety activities as scheduled; and

v. Participate in Morbidity and Mortality and Peer Review to ensure safe physician practice.

h. Medical Director for Risk Management

i. As a role covered by the Chief Medical Officer or Assistant Chief Medical Officer, the Medical Director of Risk Management provides medical oversight of the management of SAE, SE, the Incident Report system and the process for around-the-clock reporting of patient safety events;

i. Director of Regulatory Affairs and Director of Risk Management

i. Provides administrative oversight of the management of SAE, SE, the Incident Report system, and the process for around-the-clock reporting of patient safety events;

j. Patient/Resident Safety Officer

i. The Patient/Resident Safety Officer collaborates with the CQO, Director of Regulatory Affairs, Director Risk Management, CMO, Nurse Director of Education and Training in developing and planning the Patient/Resident Safety Plan;

ii. Presents Patient/Resident Safety Plan to PIPS for approval and coordinates its implementation;

ii. Works collaboratively with the Chiefs of Service, Associate Administrators, Infection Prevention and Control, and Department Managers in the evaluation of processes and activities implemented or noted in the Patient/Resident Safety Plan; and

iii. Facilitates communication of proactive risk assessments and the results of Patient/Resident Safety Plan to managers and staff.

k. Nurse Director of Education and Training

i. Determines education and training needs by assessing a variety of data sources which include the Performance Improvement and Patient Safety Committee;

ii. In collaboration with Performance Improvement and Patient Safety Committee, develops and implements an annual mandatory training program that addresses identified needs; and

iii. Provides assistance and consultation to managers and supervisors hospital-wide to determine educational needs and to enhance the competency and performance level of all employees.

l. Infection Prevention and Control Nurse

i. Performs the annual Infection Control Risk Assessment for the Facility in collaboration with Infection Control Committee Chairs and members.

ii. Develops and organizes the Infection Prevention and Control Annual Plan using results of the risk assessment. The Annual Plan will identify educational activities, plan for investigating unusual infectious events, and develop other routine program activities.

iii. Assumes responsibility for surveillance and investigation of infectious exposure incidents or outbreaks and prepares and utilizes statistical analysis as appropriate to judge significance of data.

m. LHH Staff and Providers

The responsibility for providing quality services is shared by all staff. The staff:

i. assist in identifying opportunities for improvement of the quality of patient care/safety;

ii. participate in performance improvement and patient safety activities;

iii. incorporate performance improvement and patient safety findings into patient care, treatment and services; and

iv. report medical/health care errors and near misses through the Incident Report system.

n. Clinical and Support Departments: The clinical and support departments are responsible for developing and maintaining performance improvement and patient safety activities based on the LHH's prioritized initiatives.

o. **Patient/Client/Resident:** LHH recognizes that the Patient/Resident is an integral part of the healthcare team. Upon admission and throughout their hospitalization, the Patient/Resident is informed of his/her rights, responsibilities and role in patient safety. This includes providing accurate information about their current health, allergies, current medications and their past medical history.

4. COMMUNICATION PATHWAYS AND REPORTING

a. Communication pathways are established to provide feedback to all committees, task forces, departments, and services responsible for performance improvement and patient safety activities.

b. Hospital, Departmental, and Medical Staff Committees have functions related to the improvement of patient/resident outcomes and safety, development of standards of care and/or improvement of organizational systems and functions, and report to the Performance Improvement and Patient Safety Committee at least annually.

c. The CMO and/or the CQO report performance improvement activities and issues to the LHH Medical Executive Committee and the LHH Joint Conference Committee.

5. IDENTIFICATION OF POTENTIAL PATIENT SAFETY ISSUES

LHH annually reviews the scope and breadth of its services. During this review, attention is paid to systems and processes that may have a significant negative impact on the health and well-being of patients if an error or “near miss” occurs. Sources used to identify potential patient safety issues are:

a. Performance improvement data, including performance measures.

b. Unusual occurrence, sentinel event, staff patient safety suggestion tool, patient complaint and medical device failure reports.

c. Regulatory and/or accrediting agencies survey reports and changes in their regulations and/or standards.

d. Input is solicited from patients and families for improving patient safety by:

i. Conversations with patients and families during routine care and patient safety rounds,

ii. Comments from Patient Satisfaction surveys, and/or

iii. The grievance process.

6. USE OF DATA

a. Performance monitoring and improvement activities are data driven. Data collection is prioritized by the LHH PIPS Committee based on the organization's mission, care, treatment and services provided, and the population served. Data collection for performance improvement activities focuses on processes that have a major impact upon patient outcomes (e.g., high risk, high volume, problem prone). The data is drawn from multiple sources, including input from all staff, residents, families, and others as appropriate. This data is reported to the QAA (PIPS) committee.

i. The QAA (PIPS) committee analyzes the data in order to identify or better understand a problem.

ii. Data collected will represent the care areas considered to be associated with high-risk, high-volume, and/or problem-prone issues.

iii. Data collection methodology is to be consistent, reproducible and accurate to produce valid and reliable data, and support all departments and the facility assessment.

b. Data collection and monitoring will be related to outcomes of sub-populations to address any health equity concerns. Data analysis shall include an evaluation of factors known to affect health equity, such as race, sexual orientation, socioeconomic status, and or preferred language.

~~b.~~c. LHH collects data from multiple sources, including input from all staff, residents, families, and others as appropriate. This data is reported to the PIPS committee. Once a potential problem is identified, the committee utilizes a systematic approach (e.g., Five Whys, flowcharting, fishbone diagram, etc.) to help identify the root cause of the problem.

~~c.~~d. As corrective actions are taken, the committee continues to collect and analyze data to determine the effectiveness of any changes.

~~d.~~e. The PIPS Program encompasses data and information collected from the following established processes:

i. The facility assessment

ii. Grievance logs

iii. Minimum Data Set

iv. Quality measures

v. Survey outcomes

vi. Medication errors, including near misses

vii. Adverse Drug Events

viii. Environment of Care data;

ix. Patient, family and staff satisfaction surveys;

x. Incident Reports, including but not limited to:

- Medication errors
- Death and complications
- Violence
- Patient/Resident abuse
- Patient/Resident falls
- Absent Without Leave (AWOL)
- Performance measures data
- Restraint and seclusion use
- Core Measures required by CMS and selected by the Hospital's leadership
- Outcomes related to resuscitation
- Mortality and autopsy results
- Infection Prevention and Control Surveillance
- Claims
- Clinical Service and ancillary/diagnostic department performance improvement reports
- SAE and SE Review findings
- Patient/Resident grievances

- Ongoing medical record review
- Other sources as appropriate

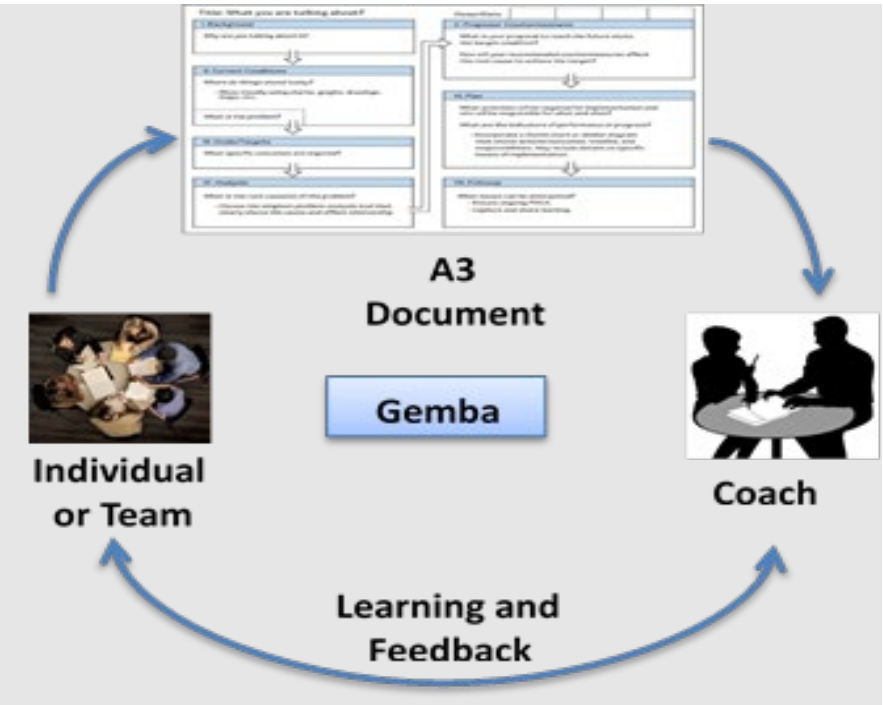
7. PERFORMANCE IMPROVEMENT METHODOLOGY

a. Performance indicators will be established based on data and will be monitored/evaluated in the QAA Committee meetings.

i. A combination of process, outcome, and use measures will be utilized to monitor progress towards goals. The type of measure used will be appropriate to the type of data being collected.

ii. Goals will be modified as necessary.

b. Once actions are implemented, the facility continues to track performance to ensure that improvements are realized and sustained. A combination of process and outcome measures are used to measure success following the implementation of change. Performance improvement efforts are conducted and documented by using a Lean improvement strategy A3 Thinking. A3s are a standard language and template for problem solving and improvement plans. A3 thinking includes defining a problem, understanding root causes, considering countermeasures and studying and adjusting for results (PDSA: Plan-Do-Study-Act).



Using A3 thinking, LHH selects measurable gaps and targets to improve that will

impact system-wide goals (True North metrics). We learn by sharing our problem solving and inviting questions. We improve continuously by focusing on performance gaps aligned with True North. In addition to A3 thinking, LHH also utilizes the following tools to improve performance:

i. **Value Stream Map** – A full visual representation of a specified process from start to finish, typically from the patient's perspective. This process map is developed through direct observation of patients and staff.

ii. **Kaizen** – a word used to describe the process of taking something apart and making it better, also referred to as a process of continuous improvement.

iii. **Daily Management System** – A system comprised of a set of tools designed to empower frontline staff to become problem solvers and use data to drive improvements**.**

iv. **Leader Standard Work** – A standardized approach that allows a leader to create a stable organized plan for their day, week and month. Leader standard work also creates focus on the important work of improving and sustaining.

c. Corrective Action: Once the root cause of a problem is identified, the PIPS Committee shall oversee the development of an appropriate corrective action plan. An appropriate corrective action plan is one that addresses the underlying cause of the issue comprehensively, at the systems level.

i. Corrective action plans include:

- A definition of the problem – which includes determining contributing causes of the problem;
- Measurable goals;
- Step-by-step interventions to correct the problem and achieve established goals; and
- A description of how the QAA committee will monitor to ensure changes yield the expected results.

ii. The PIPS Committee uses the “Plan, Do, Study, Act” (PDSA) cycle of improvement for testing any changes within a Performance Improvement Plan (PIP). Multiple PDSA cycles may be implemented until the desired performance goals have been met.

- Plan: developing a plan related to the change that will be tested
- Do: carrying out the plan

- Study: observing and analyzing data collected, learning from any consequences

- Act: making a decision regarding the change, such as to adopt, modify, or abandon the change and start over

8. MONITORING

a. The PIPS Committee identifies and ensures appropriate follow-up of organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data.

b. The PIPS Committee selects at least one process annually for proactive risk assessment.

c. Performance indicators are established based on data analysis and monitored/evaluated in the PIPS Committee meetings, which take place on a monthly basis and as needed.

   i. A combination of process, outcome, and use measures will be utilized to monitor progress towards goals. The type of measure used will be appropriate to the type of data being collected.

   ii. Goals will be modified as necessary.

d. Medical errors and adverse events will be tracked.

   i. Residents will be monitored for medical errors and adverse events in accordance with established procedures for the type of adverse event.

   ii. An investigation will be conducted on each identified medical error or adverse event to analyze causes.

   iii. Preventive actions and mechanisms will be implemented to prevent medical errors and adverse events, including feedback and education.

   iv. Monitoring will be conducted to ensure desired outcomes are achieved and sustained.

9. FEEDBACK

a. Feedback from staff, residents, resident representatives, and other sources will be used to identify problems that are high-risk, high-volume, and/or problem prone, as well as opportunities for improvement.

b. Feedback is actively sought from staff members, including concerns related to health equity.- Sources of staff feedback may include, but are not limited to:

   i. Staff satisfaction surveys

   ii. Staff meetings

   iii. One on one discussion with management

   iv. Suggestion or comment boxes

c. Feedback is actively sought from both residents and their family members/representatives. Sources of resident and family feedback may include, but are not limited to:

   i. Resident and family satisfaction surveys

   ii. Resident Council meetings

   iii. Care plan meetings

   iv. Grievance Log

   v. Suggestion or comment boxes

10. CONFIDENTIALITY

a. All monitoring results, abstracted data, related records, correspondence, and all reports developed for quality improvement purposes are confidential to the fullest extent permitted by law.

b. Discussions, deliberations, records and proceedings of all medical staff committees having responsibilities for evaluation and improvement of quality of care rendered in this Hospital are confidential to the fullest extent permitted by law.

ATTACHMENT:
Appendix A: LHH QAPI Plan

REFERENCE:
LHHPP 01-03 Hospital Organizational Chart
LHHPP 60-04 Unusual Occurrences
LHHPP 60-05 Review of Serious Adverse Events
LHHPP 60-13 Patient Safety Committees and Plans
CMS Framework for Health Equity https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework

Revised: 1998/04/01, 2008/01/08, 2016/07/12, 2018/11/13, 2020/09/08, 2022/03/08, 2022/12/14, 2023/03/14, 24/05/14, 25/01/13, 25/05/12 (Year/Month/Day)
Original adoption: 1995/05/01

MONITORING OF THIRD PARTY AGREEMENTS

POLICY:

1. Third party agreements are defined as agreements that Laguna Honda Hospital and Rehabilitation Center (LHH) ~~Laguna Honda~~ works with the Department of Public Health (DPH) Central Contract office to execute. This includes, but is not limited to contracts, Memorandums of Understanding, and intern and school agreements.

2. The Contract Manager (~~Laguna Honda~~LHH Managers who oversee third party agreements) is responsible for establishing written agreements that define clear expectations and standards of quality. Written agreements must be developed in accordance with City and DPH contract policies and be approved by DPH contract office and City Attorney. The ~~Laguna Honda Executive Administrator~~LHH Chief Executive Officer/Nursing Home Administrator (CEO/NHA) signs the agreement prior to the start date of goods and services.

3. All third party agreements shall have a formal evaluation annually to assure accountability and compliance with contractual standards, identify problem areas and provide information for future planning. Any contractual service which has not been monitored will not be considered for contract renewal unless good cause can be shown.

4. ~~Laguna Honda~~LHH Administration Office is responsible for centralizing all agreements and Monitoring Reports. The ~~Executive Administrator~~CEO/NHA or designee will delegate this task to support staff.

5. All Request for Proposals must comply with S. F. Adm. C. Chapter 21: Acquisition of Commodities and Services and Chapter 21A: Health Related Commodities and Services.

PURPOSE:

To ensure that third party agreements between ~~Department of Public Health/Laguna Honda~~DPH/LHH and the party providing the good or service meet clear objectives, standards of quality, City regulations ~~and~~, are provided safely and effectively and formally monitored annually.

PROCEDURE:

1. Respective ~~Laguna Honda~~LHH Contract Managers are responsible for:

    a. Establishing agreements with third party vendors through DPH Central Contracts and City Attorney's Office. The LHH CEO/NHA~~Laguna Honda Executive Administrator~~ signs the agreement.

b. Submitting on a timely basis a copy of signed written agreements to ~~Laguna Honda~~ LHH Administration, including extensions, modifications and/or new agreements.

c. Reading and clearly understanding the expectations and quality of services rendered by the third party vendor.

d. Verifying and approving invoices (if any) submitted for payment from the third party.

e. Completing the annual *Third Party Agreement: Monitoring Report* (refer to Appendix A). The Monitoring Report is due to ~~Laguna Honda~~LHH Administration by July 30th every year. The review period is the previous fiscal year. If multiple departments work with the third party under the same contract, it is the responsibility of the designated Contract Manager to gather performance input from all individuals involved.

f. Provide ongoing review of the third party work as needed. Throughout the year if performance concerns arise, the Contract Manager must document these issues and speak with the appropriate person at the time. If needed, the Monitoring Report may be used at this point to document concerns and to develop Performance Improvement Plans (PIP).

g. In the event of an adverse outcome, inappropriate conduct, or failure to meet the standard of care, the Contract Manager shall immediately notify the contractor and develop a plan for correction and performance improvement.

2. Instructions for completing the *Third Party Agreement: Monitoring Report*

a. Part A: The Contract Manager rates the third party's performance on a scale from 1 (unacceptable) to 4 (exceeds standards) for four overall measures.

b. If the average performance rating is less than a three (< 3) then the Contract Manager and the third party shall develop a Performance Improvement Plan.

i. The plan describes what will be done to improve performance and compliance. It also includes a timeline and no later than quarterly progress reports.

ii. For the PIP, the Contract Manager documents regular progress assessments and provides status updates to their Direct Supervisor. If program performance does not improve, this will be handled on a case by case basis

c. Part B: The Contract Manager communicates the findings from the monitoring report in Part A with the appropriate representative from the third party. The third party documents the response to the performance rating by either responding in an email to questions specified or acknowledging and signing a paper version.

d. Part C: The direct supervisor of the ~~Laguna Honda~~LHH Contract Manager reviews Part A, including the PIP, and Part B. The direct supervisor responds to the

questions in Part C.~~-~~ When sufficient work has been completed, the direct supervisor and Contract Manager will provide their final signatures to complete the monitoring process.

3. ~~Laguna Honda~~LHH Administration Office support staff is responsible for:

   a. Maintaining paper and electronic copies of all third party agreements for ~~Laguna Honda~~LHH, as submitted by the Contract Manager.

   b. Tracking agreements in an electronic spreadsheet, including the annual overall performance rating.

   ~~b.~~c. Providing reports to Contract Managers, direct supervisors and Executive Committee as requested.

4. Direct Supervisor is responsible for:

   a. Communicating as needed with the Contract Manager about the performance of third party agreements.

   b. Providing supervisory support as needed during the Monitoring Report process. Completing Part C of the Monitoring Report after ensuring the Part A and B are completed.

   c. Working with the Contract Manager to address performance measures rated less than a three (< 3). Providing oversight during the PIP development, implementation and review process.

5. The Performance Improvement and Patient Safety (PIPS) Committee is responsible for:

   a. Each patient care contract performance measures shall be reviewed by the LHH ~~Performance Improvement and Patient Safety~~PIPS Committee annually. The purpose of this review is to provide administrative, clinical and medical staff leaders with an opportunity to evaluate the performance of the sources of clinical services provided through contractual agreements. This evaluation shall include a review of the annually established performance measures. The evaluation of the contracted services shall be conducted in relation to LHH's expectations.

   b. The ~~Performance Improvement and Patient Safety~~PIPS Committee shall ensure that steps are taken to improve contracted services that do not meet expectations. Examples of improvement efforts that may be considered include the following:

      i. Increased monitoring of the contracted services,
      ii. Providing consultation or training to the contractor,
      iii. Renegotiating the contract terms,

iv. Applying defined penalties, and
v. Terminating the contract.

~~5. The Executive Committee is responsible for:~~

~~a. Reviewing aggregate performance ratings of all third party agreements on an annual basis. Reviewing PIPs more frequently as needed.~~

~~b. Providing guidance on how to handle low performing third party vendors.~~

ATTACHMENT:
Appendix A: Monitoring Report Summary

REFERENCE:
Health Commission Contract Policies

Revised: 24/04/09, 25/05/12 (Year/Month/Day)
Original adoption: 14/11/25

1.100 Labeling and Dating of Food

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

Policy: Food and Nutrition Services is dedicated in providing an environment that models the health, safety, and well-being of residents, staff, and visitors. To achieve this goal, a~~A~~ll opened prepared or raw food items will be covered, labeled, and dated ~~, and covered before being stored~~to meet Hazard Analysis Critical Control Points (HACCP) guidelines. ~~.~~

Purpose:

To provide guiding principles in food safety, reduce the risk of foodborne illness, and reduce waste.

- To identify what the product is and how long ~~its~~it has been open~~.ed.~~
- To use up perishable food products in a timely manner.
- To comply with health regulations.
- For safety and sanitation purposes.
- To monitor Time/Temperature Control Safety (TCS) Foods
- To reduce waste.
-

Procedure:

1. Food shall be handled in accordance with applicable food sanitation guidelines.

2. Before storing opened prepared or raw food products, place a label on each item. Label should include the n~~N~~ame of p~~P~~roduct, ~~and the d~~~~D~~ate of which the items ~~it~~ was prepared ~~or~~ ~~opened~~opened and use by date (discard date).

3. Food item will be discarded after 3 days after the package has been opened or not to exceed a manufacturer's use-by date.

4. Cover all products with appropriate food ~~covering;~~covering, ~~e.g.~~e.g., plastic wrap, aluminum foil, butcher's wrap paper, stainless steel cover, or plastic cover.

5. It is the responsibility of each employee to ~~insure~~ensure that labeling and dating~~this~~ occurs.

6. The Chef~~s~~, ~~or~~ Supervisors, or designee will check ~~on a daily basis~~daily to ensure product is covered, labeled, and dated. ~~that this is occurring.~~

7. In the Galleys, Nursing Staff will cover, label, and date ~~, label and cover~~ food items

that are opened for residents' consumption~~.~~ ~~ie~~i.e.: peanut butter, jelly, cookies, bread, soy sauce, catsup, mayonnaise, mustard, thicken juices, prune juice~~s~~, milk, etc.

References:

- Food Product Dating

  https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-product-dating#:~:text=Does%20Federal%20Law%20Require%20Food%20Product%20Dating%3F&text=For%20meat%2C%20poultry%2C%20and%20egg,in%20compliance%20with%20FSIS%20regulations.

- State Food Safety Resources

  https://www.statefoodsafety.com/Resources/Resources/time-temperature-control-for-safety-tcs-foods-poster

- 2022 FDA Food Code – U.S. Food and Drug Administration

  chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.fda.gov/media/164194/download?attachment

1.143 Food Supply/Food Storage

~~Established and~~ Revised: 7/2024~~3/81, 1/89, 1/92, 9/94, 5/97, 9/06, 7/09, 1/10~~
~~Reviewed: 8/13, 8/14~~

Policy: All foods and supplies will be stored properly under HACCP guidelines.

Purpose: To ensure safety of the food supply while in storage. To comply to Federal, State, and Local regulations.

Procedure:

1. Upon delivery, perishable foods are placed in a freezer or refrigerator which is maintained at appropriate temperature.
2. All staple supplies are stored on ~~n metal~~ shelves in a ventilated storeroom. The temperature for dry storage will be between 40*F to 70*F. Temperatures will be checked daily to assure that recommended temperatures are maintained.
3. All food and supplies are rotated into storage with the older units in front or on top, as appropriate. (First in/First out)
4. Food is stored away from potentially hazardous substances such as cleaning supplies.
5. Temperatures of refrigerators/freezers are checked daily to ~~a~~assure that recommended temperatures are maintained. A~~a~~. Dairy: 40º~~36 – 38*~~ F or below~~.~~ B~~b~~. Produce: 40º F or below ~~36 – 38* F.~~ C~~c~~. Meat: 40º F or below ~~30 – 38* F.~~ D~~d~~. Freezer: 0º~~10 – 20*~~ F or below.
6. Food that is outdated, spoiled, or contaminated will be properly identified with a sign and removed from the general stores area. The storeroom clerk will promptly notify the Chef, supervisor or designee ~~and/or Assistant Food Service Director~~. If the product needs to be returned to the vendor for credit, the food item will be stored in a designated area for returned items and a sign will be placed on the items.
    i. The maximum time products will be retained on hand in the designated storage locations e.g. storeroom and freezers will be one (1) year~~s~~ or per manufacturer's recommendation.
    ii. The maximum of period ~~of time non~~ nonperishable products will be retained after being put into use e.g. spices etc. will be six (6) months.
    iii. The maximums period ~~of time~~ perishable products will be retained under refrigeration will be seventy~~-~~-two (72) hours. Unless in cr~~a~~yovac packaging left unopened, one month, or per manufacturer recommendation.~~-~~
7. HACCP (Hazard Analysis Critical Control Point) methods will be used and maintained during the food storage process.
8. The Chef ~~Operations~~ is accountable for designated storage locations e.g. storeroom and freezers.

~~9.~~ The ~~Production~~ Chef is accountable for designated locations in the kitchen and adjacent areas associated with Production.

~~10.~~9.

PATIENT/RESIDENT IDENTIFICATION, COLOR CODES, AND SAFETY ALERTS

POLICY:

1. Each patient/resident ~~is to~~ wears a legible ~~wrist~~ identification wristband with patient/resident name, hospital number and have a photograph on their individual electronic health record (EHR). Any member of nursing staff may change wrist-bands as needed. A patient/resident may have an identification card generated in lieu of the patient/resident wristband if patient/resident meets criteria.

2. ~~Residents~~ Patient/Residents requiring designated ongoing precautions and safety monitoring are assessed by the Patient//Resident Care Team (RCT) and identified using a consistent system of stickers placed on:
   - Bed card (above bed)
   - Hallway
   - Mobility devices (wheelchairs, geri-chairs, canes, front wheel walkers, etc.)~~requiring designated ongoing precautions and safety monitoring are assessed by the Resident Care Team (RCT) and identified using a consistent system of wristbands with associated snap precautions and safety alerts~~.

3. The nurse manager, charge nurse or nursing team leader will designate the use of color coding and safety alert interventions based on a thorough assessment of individual patient/resident conditions, needs and risks.

~~1.~~

~~2. Each resident is to wear a legible wrist identification band with resident name, hospital number and have a photograph on their individual electronic health record. Any member of nursing staff may change wrist bands as needed.~~

~~3. Residents requiring designated ongoing precautions and safety monitoring are assessed by the Resident Care Team (RCT) and identified using a consistent system of wristbands with associated snap precautions and safety alerts.~~

PURPOSE:

To promote patient/resident safety by ensuring quick and accurate identification of high-risk diagnoses and problems, and special needs approaches.

PROCEDURE:

A. Patient/**Resident Identification and designation of precautions and safety monitoring**

1. New patient/resident is photographed upon admission by Patient Access Laguna Honda Hospital (LHH) ~~Upon admission, the resident will get their photograph taken and uploaded from the Admissions and Eligibility Department (A&E) for visual identification of the resident~~ Admissions and Eligibility (A&E) department ~~in the resident's electronic health recor~~for the Electronic Health

Record (EHR)~~d~~. Notify ~~Admissions and Eligibility (~~LHH A&E~~)~~ if the patient/resident's photograph in EPIC needs to be updated as needed.

2. The ~~Nursing staff will print out t~~patient/resident's nameplate card with the resident's first name and initial of last name is placed at the patient/resident's bedside and hallway by nursing which can be printed or written from LHH A&E or unit staff.

Nursing prints and applies the patient/resident's wristband ~~from the electronic health record~~and ~~and apply on the resident. Wristbands will be~~ change~~d~~ as needed when identification information is ~~resident name, hospital number, barcode or QR code are not~~ not legible.

3.

4.

~~A&E will send the resident's nameplate card with the resident's first name and initial of last name to be placed by nursing staff at the bedside and hallway when the resident arrives on the unit. A&E can reprint as needed or unit staff can write or print on paper as needed.~~

Patient/Residents who decline or are unable to tolerate a wristband, may be offered an identification card (ID) that has same information and can be used as the same purposes as the~~the~~ wristband (i.e., barcode on ID card can be scanned for medication administration) if they meet the following criteria below:

a. Patient/Resident is alert and oriented (they do not need to be own decision-maker, but can reliably provide name, date of birth and correct DOB and the correct time medications are administered),
b. Patient/Resident must safely store ID card,
c. Patient/Resident must be able to present (or state location of ID card if physically unable to present) when asked by staff,
d. Storage of the card would be the responsibility of the patient/resident for safekeeping in a wallet/pouch, on their person, or in bedside drawer.
e. Patient/Residents who meet all requirements above for an ID card, must be reviewed and documented in a Patient/Resident Care Conference note regarding the appropriateness and planned usage for the ID card, then referred to the Nursing Clinical Liaison Team.

~~5.~~ 5. Safety precautions and Alert Color Codes are identified by the Patient/Resident Care Team (RCT) and other consulting departments (e.g. Speech Therapy) ~~will identify safety precautions and monitoring~~ based on the patient/resident's ~~resident~~ condition~~s~~, needs and risks which is reviewed and updated on readmission, relocation, quarterly and as needed. Nursing ensures that they are applied in the designated areas. ~~Nursing leader (e.g., nurse manager, charge nurse, team leader) will ensure that precautionary and alert dot color coding, signage, wristband snaps are applied in the appropriate designated areas. Nursing staff and RCT will review this process ongoing on readmission, relocation, quarterly and as needed to ensure coding, signage and wristbands are updated.~~

~~2.~~

A. Safety Precautions or Alert Color Codes

1. Color coded stickers will be applied as below:

COLOR OR SYMBOL	COLOR OR SYMBOL	HALLWAY, MOBILITY DEVICES, & BED CARD
	FALLING STAR	FALL RISK
	RED	ALLERGIES
	YELLOW	DIABETES
	BLUE	SEIZURE RISK
	PINK	INDIVIDUALIZED ASPIRATION PRECAUTIONS
	PURPLE	SPECIAL APPROACH

COLOR OR SYMBOL	COLOR OR SYMBOL	HALLWAY, MOBILITY DEVICES, & BED CARD
	FALLING STAR	FALL RISK
	RED	ALLERGIES
	YELLOW	DIABETES
	BLUE	SEIZURE RISK
	PINK	INDIVIDUALIZED ASPIRATION RISK
	PURPLE	SPECIAL APPROACH

COLOR OR SYMBOL	COLOR OR SYMBOL	HALLWAY, MOBILITY DEVICES, & BED CARD
	FALLING STAR	FALL RISK
	RED	ALLERGIES
	YELLOW	DIABETES
	BLUE	SEIZURE RISK
	PINK	ASPIRATION RISK
	PURPLE	SPECIAL APPROACH

B. Safety Precautions or Alert Signage

1. Patient/Resident~~'~~s with individualized precautions, alerts, preferences or individualized plan of care can be posted at the bedside to alert staff by writing on the alert paper indicated below and keeping protected health information (PHI) covered.

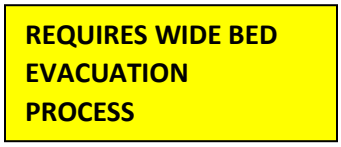
   a. Care Alert (Confidential Patient/Resident Information)

   b. Dialysis Care Alert (e.g., NO BP/IV on Right Arm)

   c. If patient/resident has a wide bed in a non-bariatric room, signage will be applied on the resident's hallway nameplate:

~~Dialysis Care Alert (e.g., NO BP/IV on Right Arm)~~

~~If resident has a wide bed in a non-bariatric room, signage will be applied on the resident's hallway nameplate:~~

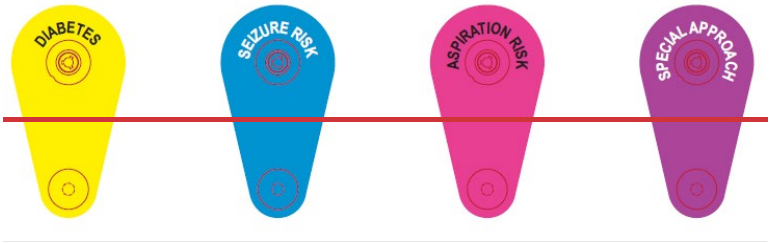


~~a.~~d. Patients/Residents with same or similar name as another patient/resident on neighborhood may have "Name Alert" ~~signage~~ stickers or alert on ~~hallway~~ nameplates.

~~**Safety Precautions or Alert Wristbands**~~

~~Obtain wristbands from central supply and colored precaution snaps.~~

~~Snap on the associated precaution or alerts onto the wristband~~



B. Documentation

1. Document precautions in Electronic Health Record (EHR):
   a. Physician can list precautions through an order
   b. Care plan precautions and individualized interventions into appropriate care plan and update as needed when there are changes.
   c. Can be discussed and noted during the Patient/Resident Care Team meeting.

2. ~~-~~Review~~-~~ patient/resident identification, precautions and alert signage during Readmission, Quarterly, Relocation, Change of Condition and as needed. Update identifications, alerts and signages if there are changes and update the EHR ~~-~~as needed.~~and document in Resident Care Team Conference and Progress Notes as needed.~~

~~2.~~3. Document in the Care Plan if patients/residents refuse identifications (i.e., wristband, photo), precautions and alerts.

CROSS REFERENCE:

LHHPP 26-02 Management of Dysphagia and Aspiration Risk

Revised: 2011/11, 2005/0, 2010/01; 2011/04/26, 2019/03/12, 2022/12/13; 2023/11/14; 2025/04/17

Reviewed: 2023/11/14

Approved: 2023/11/14

Operating the Battery-Operated Ceiling Lift

BATTERY-OPERATED CEILING LIFT (C 625)

POLICY:

1. Two nursing staff members are always required for operation of the Battery-Operated Ceiling Lift.

2. The Licensed Nurse assesses each resident to determine safe transfer techniques, type and size of sling according to resident's height and weight.

3. Each resident should have their own slings labelled with their own names.

4. Ceiling lift is to be charged when not in use to prolong battery life and assure readiness for use at any time.

5. Each staff using the sling must inspect sling's seams, loops, straps, and fabric for any loose threads, fraying, and holes prior to use and after laundry. Do not use damaged slings and order a replacement. Slings are to be thrown away if resident expires or is permanently discharged.

6. Never use damaged or broken ceiling lifts (i.e., lift straps are frayed, emergency raising or lowering feature is not working, carry bar has no cuts/dents/sharp edges). Broken/damaged ceiling lifts must be tagged and reported to Facility Services as soon as identified. The ceiling lift must not be used until repair and inspection is completed.

7. Weight restriction for C-625 ceiling lift model is less than or equal to 625 pounds.

8. Ceiling lift slings should only be used for ceiling lifts. EZ-lift slings should never be used with ceiling lifts.

PURPOSE:

To provide dependent residents with safe transfers, privacy, and dignity.

BACKGROUND:

The C-625 is a battery-operated ceiling lift which lifts, positions and transfers residents. The C625 is a fixed lift and can carry up to 625 lbs. Lift tracks are securely mounted to the ceiling of the resident's rooms, in the bathroom, in the tub rooms, and in the therapy areas of the ground floor Pavilion. The ceiling lift can move a resident from bed to chair, bed to toilet, chair to tub, and vice versa; or from floor to bed. In some rooms, a ceiling turn table changes track lift directions.

Components of the Ceiling Lift System:

1. Tracks
2. Lifting straps
3. Emergency stop/Lowering feature
4. Carry bar
5. Pneumatic hand control

PROCEDURES:

Follow manufacturer's instruction.

A. Turning the Lift On and Charging the Lift Battery

1. To turn on the lift on, press any button on the hand control. The indicator light on the underside of the lift will turn **GREEN** and the display screen will turn on. If the lift fails to turn on, ensure that the Emergency Stop/Lowering Cord has not been pulled and that the plastic clip at the end of the cord has not come out.

2. The battery has to be charged or returned to charger at the end of the track to sustain the longest life for the batteries. The lift can remain on the charger until the next time it is needed.

3. In the event of power outage, fully charged batteries will last between 80-100 lifts.

4. If the batteries are low, the indicator light will turn **ORANGE** on the underside panel. The display screen will indicate a low battery and a slow beeping audible alarm will sound. If the battery is low and in the middle of transfer, complete the lift in progress, and then move the lift to the end of the track where the charger is located.

5. If the batteries are completely discharged/fully drained, the indicator light will turn **red** on the underside panel and a fast beeping audible alarm will sound. The lift will not raise or lower and the display will indicate 0% battery. **EMERGENCY LOWERING** will still function. The lift requires four (4) hours of charging when batteries are depleted.

6. The indicator light on the charge turns **GREEN** when the batteries are fully charged and will indicate 100% on the screen on the underside panel.

7. **Emergency stopping** - This allows the staff to shut off the power completely. To activate this feature, the red cord is pulled once. The lift immediately stops and its functions will be disabled. To restore the power back to the lift, the white plastic tab that popped out when the cord was pulled, needs to be reinserted into the lift and pushed back in to turn the lift on.

8. **Emergency lowering –** In the event that the DOWN button on the hand control does not function or in the event of power failure, the carry bar can be lowered by pulling down and holding the RED emergency cord. Continue to pull down the cord until the carry bar (or resident) is safely lowered to the desired position. The unit will continue to beep as long as the cord is pulled down and it will not stop until the cord is released. The EMERGENCY lowering button does not provide a raising function.

9. **Emergency manual raising and lowering –** When the above emergency procedures do not work, contact Facility Services to perform the manual emergency interventions.

~~B. Prior to Resident's Transfer~~

~~1. Check resident's care plan.~~

~~2. Explain the transfer and how the ceilings lift works to the resident.~~

~~3. The staff needs to ensure that resident's weight does not exceed 625 pounds.~~

~~4. Each resident will have his/her own sling (bathing or regular transfer sling).~~

~~5. Provide privacy. All residents are to be completely draped before using the ceiling lift.~~

C.B. Resident's Transfer Using Ceiling Lift

1. Prepare the chair/bed/gurney to which the resident is to be transferred. Position the chair against a solid surface. Ensure that all bed and chair brakes are locked.

2. Move the lift away from the charging station close to the resident who is being transferred. Move the lift along the tracks using the bar.

3. Prepare the resident being transferred with the appropriate sling. *Make sure the sling is correctly fitted and adjusted on each side of the individual so that maximum comfort and safety are achieved prior to transferring.*

4. Once the resident is fitted with the sling, move the lift so that it is positioned directly over the resident. Lower the carry bar to a height so that the straps of the sling can be easily attached to the carry bar. Check to ensure that the lift is correctly positioned directly above the resident to be lifted.

5. Attach the straps of the sling to the hooks of the carry bar. The straps on each side of the sling are generally attached to the corresponding side of the carry bar. Double check to ensure that the straps are properly attached to the carry bar and that the resident being lifted is properly positioned in the sling prior to lifting. (Refer to Appendix 2: Sling Application)

6. Raise the resident by pressing the UP button of the hand control.Ensure that the resident's arms are in the sling. Raise the resident by pressing the UP button of the hand control. When there is tension and resident is ~2 inches off the mattress, confirm that loops are secure in hooks, and sling is smooth and not pinching residents skin, before lifting further. Observe for verbalizations and/or signs of discomfort.

6.7. Always use caution when lowering/raising a resident who is on the sling of the lift and when moving the lift along the tracks. Watch out for and avoid any obstructions that may cause injury to the resident, or damage to the lift.

7.8. Once at the correct height the resident can be moved along the track to the desired location. Move the lift alonglift along the track by gently pushing the carry bar or individual in the sling. Never pull the lift along the track.

8.9. Once at the desired location the resident in the sling can be lowered / raised to the correct height in order to complete the transfer. ***Prior to removing the straps of the sling from the carry bar, be sure to check that the resident being lifted is securely supported in the final desired position.***

9.10. Lower the carry bar sufficiently to allow the straps of the sling to be easily removed from the carry bar. Ensure that the carry bar does not come in contact with the resident in the sling. Remove the straps from the carry bar. Raise the carry bar and move it away so it does not interfere with the removal of the sling from the resident.

10.11. The sling can now be gently removed from the resident and stored.

11.12. The lift can now be moved to a safe location or its original location. It is recommended that the lift be left on charge when not in operation.

Types of Sling and Application

1. Sling Selection and Sizing Guidelines

   a. Selection of sling model is based on the resident's condition (their ability, need for support and comfort, and type of transfer needed). After sling model is chosen, sling size is based on the resident's height and weight. The process of selection of sling does not stop once appropriate model and size is selected. Assessment continues during the lifting process, evaluating the resident's safety, comfort and position. When a resident's condition or size changes, a re-assessment of appropriate sling may be needed.

   b. Sizing Guide

Size	Height	Weight
(Grey)	Junior <3-4 feet	70-110 lbs
(Red)	Small 4'-5'6"	95 lbs-150 lbs
(Yellow)	Medium 5'-6'	125 lbs-250 lbs
(Green)	Large 6'-7'	250 lbs-400 lbs
(Blue)	X-Large 6'-7'	400 lbs-480 lbs
(Black)	XX-Large >6.5'	>480 lbs

Operating the Battery-Operated EZ Lift

A. Turning the Lift On and Charging the Battery

1. To turn the unit on, push the ON/OFF button. The EZ Way Smart Lift will display a greeting message.

2. Make sure the battery charge level is showing on the screen.

3. Red emergency stop button must be in the UP position. Unit will not operate if button is in the DOWN position, and display will indicate EMERGENCY STOP.

B. Resident's Transfer Using the Lift

1. Prepares environment and clears path for the lift to be used safely; ensures lift can fit under or around receiving surface and through doorways.

2. Prepare the chair/bed/gurney to which the resident is to be transferred. Position the chair against a solid surface. Ensure that all bed and chair brakes are locked.

3. Once the resident is fitted with the sling, move the lift so that the green nose cone is about 2 inches in front of the resident's head. Lower the carry bar to a height so that the straps of the sling can be easily attached to the carry bar. If needed, raise the head of the bed to ease application of top loops Check to ensure that the lift is correctly positioned directly above the resident to be lifted.

4. Attach the straps of the sling to the hooks of the carry bar. The straps on each side of the sling are generally attached to the corresponding side of the carry bar. Double check to ensure that the straps are properly attached to the carry bar and that the resident being lifted is properly positioned in the sling prior to lifting. (Refer to Appendix 2: Sling Application)

5. Ensure that the resident's arms are in the sling. Raise the resident by pressing the UP button of the hand control. When there is tension and resident is ~2 inches off the mattress, confirm that loops are secure in hooks, and sling is smooth and not pinching resident's skin, before lifting further. Observe for verbalizations and/or signs of discomfort.

6. Always use caution when lowering/raising a resident who is on the sling of the lift and when moving the lift along the tracks. Watch out for and avoid any obstructions that may cause injury to the resident, or damage to the lift.

7. Maneuver the lift away from bed. Maneuver the lift by using the lift handles.

8. Adjust the legs of the lift to go around wheelchair/toilet/chair by using the spreader bar

9. Position the wheelchair under the resident. If transferring the resident to a chair or toilet, position the resident so he/she is properly aligned to be lowered onto the chair, toilet or wheelchair.

10. Push the DOWN button on the hand control

11. Stand behind the resident and hold onto the center handle located on the back of the sling. When resident is nearly seated, gently pull up on the center handle of the sling to ensure the resident will be seated in an upright position

~~Different Types of Slings and Application~~

a. ~~**Hammock Sling** - Provides support around the hips and sacral area and under the thighs up to the shoulders (optional head support is also available). It is well suited for a double leg amputee. The slings have a small to medium commode opening.~~

   ~~How to apply:~~
   i. ~~The resident should be rolled onto the sling with his/her spine aligned with the stripe facing the bed.~~
   ii. ~~The top of the sling should start in the area between the top of the resident's head and top of his/her ear and ends at the resident's tailbone. If the sling has a head support the neck and head shall rest on the head support.~~
   iii. ~~Cross the long leg strap through the short strap.~~
   iv. ~~The straps on the sling should be attached to the carry bar starting from the middle straps, then the outside straps.~~
   v. ~~Always use the long loops for the legs/thighs and the short loops for the shoulders.~~
   vi. ~~For a bilateral lower extremity amputee, the short leg straps can be crossed in between the resident's thighs. The long leg straps are then crossed through the shorter leg straps and hooked to the carry bar.~~
   vii. ~~Hold the carry bar away from the resident's face until it is higher than his/her head.~~
   viii. ~~Ask the resident to hold onto the legs straps while being lifted.~~

b. ~~**Universal Sling** - Multi-purpose seated transfer sling that provides toileting access as well as support around the hips and sacral area and under the thighs up to the shoulders (optional head support is also available). The sling comes with leg, hip, and shoulder straps and features loops to accommodate various seated positions.~~

Types of Universal Slings:

i. Universal mesh sling – use for bathing.
ii. Universal quilted – use for transfer.
iii. Universal padded with a head support - use for transfer.

How to apply:

i. The resident should be rolled onto the sling with his/her spine aligned with the stripe facing the bed.
ii. The sling can also be applied while the resident is sitting up in chair or head of the bed is raised up. The sling needs to be placed behind the resident with the stripe of the sling aligned with the center of the resident's back – label facing outside.
iii. The top of the sling should start at the shoulders and it should end at the resident's coccyx. If the sling has a head support the neck and head shall rest on the head support.
iv. Gently pull the inside leg loops until the sling's bottom is underneath the resident's thighs. Then cross the inner leg loops between the resident's thighs. The right leg strap should connect to the left hook and vice versa.
v. When attaching the sling to the carry bar, first hook the leg, then the thigh loops, and finally the shoulder loops. By using this order, it prevents the carry bar from hitting the resident in the face.
vi. Always use the longest loop for the legs and thighs.
vii. Use the short loop for the shoulders (for a 90 degree position).
viii. Before lifting, ask the resident to hold on to the cross straps that come up through the legs.
ix. Lift the resident straight up before moving.
x. Position the resident to the desired location/bed.
xi. Raise the head of the bed before lowering the resident into the bed or chair.
xii. Remove the sling from the carry bar and pull the sling up from the back of the resident.

c. **Positioning Sling –** It is intended to be permanently in place on the bed (either under a sheet or incontinent pads) for repositioning and turning a resident from side to side or for lateral supine transfers.

Use for Lifting/Transfers:

i. The white stitching down the middle of the sling should be aligned with the resident's spine.
ii. Two pillows must be always be used with this sling. The first pillow should be placed lengthwise under the resident's head to support head and neck. The second pillow should be placed under the knees for support.
iii. Depending on resident's width, the carry bar can be aligned widthwise or lengthwise, parallel to the resident.
iv. Attach the sling to the carry bar starting with the middle straps and then out to the head and feet.

Use for Positioning:

i. With the sling already under the resident in the bed, attach the loops from only one side of the sling to the carry bar.
ii. Raise the side rail on the opposite side of the attached sling.
iii. Raise the sling, allowing the resident to turn towards the raised side rail.
iv. When turning a resident the nurse can either support the position with pillows or leave the sling attached to the ceiling lift.

d. **Band Slings** – Designed to assist caregivers in lifting and supporting a resident's limbs for various situations such as wound care, foot care, pericare/hygiene care, etc.. This sling will aid in tilting the pelvis and spreading the legs. Band Slings can be used with the EZ lift.

Use for Foot Care:

i. Place band sling under the calf and lift to desired height. Do not lift too high or the sling will slip under the knees.

Use for Pericare:

i. Lower the head of the bed.
ii. Place one band sling under each thigh and lift.
iii. The pads also support and hold the thighs away from the perineum.

e. **Ambulation Slings** – Specialized slings used by resident in the Therapy Gym. This walking sling is designed to ambulate resident during therapy.

f. **Pool Slings** – Sling designed to lower and raise residents in and out of the pool during Fitness and Aquatic Therapy.

i. Residents being lowered into the pool require one person operating the sling mechanism and a second person placed in the pool to guide the resident.

D. Documentation

1. Licensed Nurse to document in the Care Plan that ceiling lift is used for transfers and the type and size of sling.
2. **Under Mobility, CNA/PCA/LN documents ceiling lift as assistive device used.**

E. Care and Maintenance of Ceiling Lift and Sling

1. The carry bar must only be cleaned and disinfected by facility-approved disinfectant after each resident use. Wipe the carry bar lift and hooks after each use.

a. Visually Check the Equipment for the following:

i. Lifting strap shows no signs of fraying or breaking along its entire length including where it connects to the carry bar shows NO signs of fraying or breaking.
ii. Slings show no signs wear and tear. The straps of the sling that connect to the carry bar of the lift shows NO signs of fraying and breaking.
iii. The airline tube that connects the hand control to the lift is not kinked, twisted or knotted, cut or damaged.
iv. All the functions of the hand control correctly (UP and DOWN buttons).
v. The brackets that hold the track in place on the ceiling are secure and do not move or appear loose.
vi. There are no cuts, dents or sharp edges on the carry bar that may damage the straps of the sling.
vii. The lift has no unusual sounds when the lift is moved UP/DOWN or the lift is moved Left/Right.
viii. The end stops are installed and secured at each end of the track.

b. Sling Care

i. Hang to air dry.
ii. After laundering:

- Check all seams, loops, straps and fabric for any damage from laundering.
- Check the loops if damaged, torn or frayed.
- Check for loose stitching.

- Check for heat damage (puckering or crumpling).
- Check for significant staining.
- Check for tears in the fabric.

iii. Replace sling as necessary.

REFERENCE:

Waverley Glen. (2010). C450/C605 User Guide.
Handicare -Slings_NA_Brochure.pdf

CROSS REFERENCES:

Nursing Policy and Procedure
D6 2.0 Transfer Techniques
D6 4.0 Positioning and Alignment in Bed and Chair

ATTACHMENTS/APPENDICES:

Attachment 1: Competency Check List for Ceiling Lift for Nursing Staff

New: 2010/11/16
Revised: 2011/01, 2016/09/13, 2019/03/12, 2022/01/11
Reviewed: 2022/01/11
Approved: 2022/01/11

Revised Hospital-wide Policies and Procedures

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.

   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. Against Medical Advice (AMA): A 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 (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 ~~a copy of the LHH AMA Policy~~the facility "House Rules" which discusses elements of this policy.

2. The resident or SDM acknowledges receipt of the policies and agrees to abide by its requirements by 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 medical record to have the capacity to make their own decisions. 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.

4. 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.

    a. 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.)

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

        i. Documentation in the 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:

    a. Physician completes AMA form (MR 804) and documents the reason resident wants to leave and the discussion of the risk of leaving AMA.

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

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

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

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

    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. If that occurs:

    a. Physician shall place an order for discharge as AMA in the electronic health record (EHR) and complete the AMA form based on prior resident care conference

counseling about risk of AMA if 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 then 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
LHPP 24-22 Code Green Protocol
MR 804

Revised: 15/05/12, 19/07/09, 20/10/13, 23/07/11, 23/11/14, 25/05/12 (Year/Month/Day)
Original adoption: 09/03/02

NOTIFICATION OF PROPOSED TRANSFER/DISCHARGE DUE TO NONPAYMENT FOR THE STAY AT THE FACILITY

POLICY:

The resident who has failed, after reasonable and appropriate notice, to respond to notices of nonpayment for the stay at the facility will be issued a Notice of Proposed Transfer/Discharge

Nonpayment applies if the resident does not submit the necessary paperwork for third party payment (e.g. Medicare or Medicaid) or after the third party denies the claim and the resident refuses to pay for his or her stay.

Nonpayment applies if the resident's account has been sent to Bureau of Delinquent Revenue (BDR).

PURPOSE:

1. To identify residents who do not submit the necessary paperwork for third party payment or, after the third party denies the claim, refuses to pay for the stay at the facility.

2. To identify residents whose accounts have been sent to BDR.

3. To inform residents that, after reasonable and appropriate notice, ongoing failure to respond to notices of nonpayment may result in transfer/discharge from the facility.

PROCEDURE:

1. Unresolved account balances and Referrals to the BDR.

~~a. The Laguna Honda Patient Accounting Department and A & E will follow A&E's Policy on Residents with Unresolved Account Balances and Referrals to the BDR. Documentation related to the accounts will be kept with resident's records.~~ The Laguna Honda Patient Financial Services Department will follow the Policy on Residents with Unresolved Account Balances and Referrals to the BDR. Documentation related to the accounts will be kept with resident's records.

2. Follow-up on Delinquent Accounts.

a. The A&E Manager or designee shall notify the resident's medical social worker (MSW) regarding the resident's delinquent accounts.

b. The MSW shall inform the RCT of the resident's financial status. The MSW and/or RCT will inform the ombudsman and the resident of his/her nonpayment status as it relates to potential discharge. If possible, the RCT shall work to facilitate

resolution of nonpayment status. If no resolution is forthcoming, the resident will be subject to Notice of Proposed Transfer/Discharge based on nonpayment and a plan for discharge will be pursued.

c. The A&E Manager or designee, Patient ~~Accounting~~Financial Services Manager or designee, MSW Director or designee, UM Nurse Manager or designee will meet monthly to identify residents who would be subject to Notice of Proposed of Transfer/Discharge due to nonpayment of accounts. The resident list will be brought for discussion at the monthly UM Committee for appropriate action.

ATTACHMENT:
None.

REFERENCE:
A ~~&~~ E Department P&P on Residents with Unresolved Account Balances and Referrals to the Bureau of Delinquent Revenue (BDR)

Revised: 25/05/12 (Year/Month/Day)
Original adoption: 19/09/10 ~~(Year/Month/Day)~~

RESIDENT CARE PLAN (RCP), RESIDENT CARE TEAM (RCT) & RESIDENT CARE CONFERENCE (RCC)

POLICY:

1. An interdisciplinary Resident Care Team (RCT), in conjunction with the resident, resident's family, or surrogate decision-maker shall develop a Baseline Plan of Care within 48 hours of the resident's admission. It shall include instructions needed to provide effective and person-centered care of the resident and shall at a minimum include initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and if applicable, Preadmission Screening and Resident Review (PASRR) recommendation(s).

2. The RCT, in conjunction with the resident or representative, shall develop a comprehensive care plan, based on the care team disciplines' assessments, that includes measurable objectives and a timeframe to meet the resident's medical, nursing, and psychosocial needs, if appropriate.

3. The Resident Care Plan (RCP) shall be person-centered, evaluated during weekly or monthly summaries, when indicated for short term problems, every quarter during quarterly assessments, and revised as needed during change of condition to serve as an essential resource for improved resident outcomes. Nursing will document these summaries on the Electronic Health Record (EHR).

4. The resident, family and/or representative shall be part of the development and implementation of his or her person-centered plan of care.

5. Care problems require various professional disciplines working together in planning, implementing and evaluating goals and interventions.

6. A Resident Care Conference (RCC) shall be conducted with the scheduled completion of an admission, quarterly, annually and/or with a significant change in condition.

7. Special Review (SR) RCC's shall be held when the review of specific care issues is clinically indicated.

8. Stable, ongoing resident needs, and resident preferences are addressed on the Baseline Care Plan in the electronic health record (EHR). Unstable, alterable problems that require a more goal directed approach are addressed on the RCP in the EHR. Together they comprise the resident's care plan.

9. Care Area Assessment (CAA) that are triggered during completion of the comprehensive Minimum Data Set (MDS) requires evaluation and discussion from the resident and/or representative, and RCT to develop a comprehensive care plan for the triggered care areas.

PURPOSE:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessments. To promote the resident's highest possible physical, mental and psychosocial well-being.

DEFINITION:

Resident's goal: The resident's desired outcomes and preferences for admission, which guides decision making during care planning.

Interventions: Actions, treatments, procedures, or activities designed to meet an objective.

Measurable: The ability to be evaluated or quantified.

Objective: A statement describing the results to be achieved to meet the resident's goals.

Person-centered care: To focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

"Culture" is the conceptual system that structures the way people view the world – it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

"Cultural Competency" is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

"Trauma-informed care" is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.

PROCEDURE:

1. The Resident Care Team

a. The RCT is an essential component of the care planning process. The RCT shall include members from those disciplines essential to the planning and delivery of care for the resident. RCT members include:

   i. Nurse Managers (or designee)

   ii. Licensed Nurse

   iii. Nursing Assistant

   iv. Attending Physician

   v. Medical Social Worker

   vi. MDS Coordinator

   vii. Activity Therapist

   viii. Registered Dietitian

b. The resident, family and/or representative shall be part of the development and implementation of his or her person-centered plan of care, including but not limited to:

   i. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

   ii. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

   iii. The right to be informed, in advance, of changes to the plan of care.

   iv. The right to receive the services and/or items included in the plan of care.

   v. The right to see the care plan.

c. In the event a special review meeting is necessary, the following disciplines must be present: nurse, physician, MDS coordinator, Registered Dietician, Activity Director and social worker. The remaining RCT members shall be notified of any care plan changes, including the resident and/or representative.

d. Consultative Members may be part of the RCT if actively involved in the care of the resident and may include as appropriate:

   i. Chaplaincy

   ii. Clinical Nurse Specialist

   iii. LHH Psychiatry providers (Psychiatrist/Psychologist/Behavioral Health Clinician/mental health or substance treatment counselor)

   iv. Occupational Therapist

   v. Quality Management

   vi. Pharmacy

   vii. Rehabilitation Services

   viii. Dietary Technicians

   ix. Peer Mentors

   x. Ombudsmen

   xi. Any other consultants as needed

e. The RCT shall address resident care needs and preferences through assessment of the resident and the development and implementation of the RCP.

f. The RCT shall incorporate the resident's personal and cultural preferences in developing goals of care, and address the resident's care needs through assessments such as:

   i. Minimum Data Set (See LHHPP 23-02 Completion of Resident Assessment Instrument/Minimum Data Set)

   ii. Admission assessments including but not limited to:

      - Physician History and Physical

- Resident Social History Assessment
- Nutrition Screening and Assessment
- Admission Nursing Assessment
- Comprehensive Pain Assessment
- Behavioral Risk Assessment
- Discharge Assessment
- Pressure Ulcer Risk Assessment
- Activity Therapy Assessment
- RCT Pre and Post Elopement Event (Cross Reference LHHPP 24-22 Code Green Protocol)
- Bed Rail Order (if appropriate)
- Smoking Assessment and Plan of Care
- Social Services Psychosocial Assessment

2. Resident Care Conferences

a. The RCC shall serve as the forum for interdisciplinary development and review of the care plan. Care plan review shall be done:

i. On a quarterly schedule with the MDS

ii. With discharge planning

iii. Within 14 – 21 days of a permanent relocation to another unit in LHH

iv. Special Review(s)

- Within seven days after completing Comprehensive MDS with CAA including Admission MDS, Annual, Significant Change in Status Assessment MDS
  ~~Comprehensive MDS with CAA~~
- ~~Within seven days of new admission~~
- ~~Annually~~

- Significant change in resident condition such as new pressure ulcer, new behavior, fall
- Temporary relocations, I.e., Covid unit

b. RCT members shall conduct their assessments and prepare f~~or~~ prior to the RCC. This will allow for efficient reporting from each discipline and provide a forum for major care problems to be discussed by the team with the resident.

c. The RCT shall facilitate the inclusion of the resident and/or representative. The resident and/or representative shall be informed of the meeting, date and time. The resident shall be invited and encouraged to attend the RCC, unless contraindicated by the resident's condition. If the resident is unable to attend, a representative is required to attend on behalf of the resident.

   i. The social worker shall contact the representative about the meeting date and time in advance to ensure attendance. The RCC will be rescheduled based on the representative's availability. If the representative is unable to attend in person, attendance can occur via telephone or video call.

   ii. The resident or representative shall have the opportunity to express concerns and preferences during the RCC.

   iii. The social worker has an option to request for a public patient representative through the California Patient Representative Information System (CAPRIS) when there is no representative.

d. The nursing assistant and assigned licensed nurse shall be present, or provide information if unable to attend, at the RCC and consultants shall be invited as appropriate.

e. The Team Conference Note in the EHR shall be completed for each RCC.

3. Baseline Care Plan

a. Shall be initiated by nursing within eight hours on the day of admission.

b. Shall be completed and implemented within 48 hours of a resident's admission.

c. The baseline care plan shall address the resident's immediate needs for safety, management of risks, and medical attention, including but not limited to the minimum healthcare information necessary to properly care for the resident as outlined in policy statement #1.

d. The baseline care plan shall reflect the resident's stated goals and objectives and include interventions that address his or her current needs.

   i. It shall be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable.
   ii. The baseline care plan documents the interim approaches for meeting the resident's immediate needs, professional standards of quality care shall dictate that it shall also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs~~,~~ occurring prior to development of the comprehensive care plan.

   iii. LHH staff shall implement the interventions to assist the resident to achieve care plan goals and objectives.

e. Is reviewed with the resident and/or representative, in their preferred language, no later than seven days after admission.

f. LHH shall provide the resident and/or resident representative with a written summary of the baseline care plan by completion of the comprehensive care plan. The summary shall include:

   i. Initial goals for the resident;

   ii. A list of current medication and dietary instructions; and

   iii. Services and treatments that shall be administered by LHH.

g. Problems identified by the Resident Assessment Instrument (RAI), shall be care planned within seven days of the completion of the comprehensive assessment.

4. Comprehensive Care Plan

a. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed.

b. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale to proceed with care planning will be evidenced in the clinical record. For clinical

problems, care planning will be initiated with individualized interventions based on short-term or long-term goals.

c. The comprehensive care plan shall include measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment, specifically in the CAA.
   i. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

   ii. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment.

   iii. Identify concerns in the CAA that may warrant interventions.

   iv. Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-~~-~~being in the context of the resident's condition, choices, and preferences for interventions.

   v. Address other important considerations, such as advance care planning and palliative care.

   vi. Describe any specialized services or specialized rehabilitative services t LHH shall provide as a result of the PASRR recommendations.

   vii. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate.

   viii. Individualized interventions for trauma survivors that ~~recognizes~~recognize the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.

   ix. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.

d. In consultation with the resident and/or representative, the comprehensive care plan shall describe:

   i. The resident's goals for admission and desired outcomes.

ii. The resident's preference and potential for future discharge. LHH shall document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

iii. Discharge plans in the comprehensive care plan, as appropriate.

e. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to:

i. The attending physician or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan.

ii. A registered nurse with responsibility for the resident.

iii. A nurse aide with responsibility for the resident.

iv. A member of the food and nutrition services staff.

v. The resident and the resident's representative, to the extent practicable.

vi. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to:

- The RAI Coordinator.
- Activities Director/Staff.
- Social Services Director/Social Worker.
- Licensed therapists.
- Family members, surrogate, or others desired by the resident.
- Administration.
- Discharge Coordinator.
- Mental health professional.
- Chaplain.

f. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

g. The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative.

h. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

5. Identifying and Writing the Problem Statement

a. Problems, needs, strengths, and preferences are identified by members of the RCT and the resident as a result of careful, comprehensive, and ongoing assessments.

b. Problem statements are resident focused and not staff focused.

c. The statement may, but does not require the reason for the problem, (i.e., what the problem is related to “R/T”).

d. The statement may include some, but not all, of the common observable signs and be described as “As Evidenced by (AEB)”.

6. Determining the Goal Statement

a. The goal statement indicates the outcome desired by the resident or representative and aims at promoting or maintaining the resident’s highest practicable physical, mental, and psycho-social well-being.

b. Goals must be realistic, specific, reflect the problem, measurable, and have a target date.

7. Developing Interventions

a. Interventions can address how to minimize the risk of problem(s), address resident’s preferences, and meet the resident’s goals.

b. Interventions are specific, individualized and describes the team member(s) responsible for carrying it out and the frequency for conducting the interventions.

c. Interventions reflect standards of current professional practice.

8. Evaluating Effectiveness of the Care Plan

a. Evaluation of the care plan requires accurate knowledge and analysis of the resident's present status and is documented in the summary notes.

b. The progress of the goal is based on the following:

i. If there is evidence or progress towards the outcome desired by the resident or representative.

ii. If the evaluation indicates that the goal is not being met, the RCT shall determine the cause for the lack of progress and make the necessary changes.

c. Consideration by the RCT should include:

i. Identification of the problem. Is it an accurate reflection of resident's present status?

ii. Measurable and realistic goals.

iii. Appropriate interventions for each goal.

iv. Additional information as appropriate.

d. The evaluation of the effectiveness of the care plan is documented in the EHR under:

i. The Team Conference note

ii. The Nursing Weekly Summary

iii. Discipline specific progress notes~~\~~

9. Behavioral Plans are a part of the Resident's Plan of Care and documented in the EHR.

a. These plans are developed by the interdisciplinary RCT members. Plan development may require specialized behavioral planning meetings. Planning discussion is documented by a summary special review meeting note.

b. These plans are drafted by team members, most often the Nursing, in consultation with a LHH Psychiatry provider, and/or consultation with other key team members on different shifts.

c. The RCT is to discuss behavioral plans with the resident and/or the resident's surrogate decision-maker when appropriate.

d. Behavioral Plans are revised as needed and discontinued when the target behavior no longer poses a problem.

e. Behaviors identified for modification shall be clearly described, noted and tracked in the Behavior Monitoring Record (BMR).

10. Communication

a. The MDS Coordinator shall identify the scheduled RCC meeting based on the MDS assessments.

b. Nursing (i.e., MDS Coordinator, Nurse Manager or Charge Nurse) shall coordinate all Special Review RCC meeting dates and times.

c. The RCT shall communicate with one another in a timely manner using the EHR, email, and text paging, as needed.

d. The BMR shall be used by nursing to document resident behaviors and reviewed by the RCT to evaluate the resident's response to the behavioral plan.

e. Changes that affect the resident's care or daily routine shall be communicated to the resident or representative as soon as possible in the method that is most practical for the resident or representative and shall be repeated as needed or provided in writing.

ATTACHMENT:
None.

REFERENCE:
LHHPP 23-02 Completion of Resident Assessment Instrument/Minimum Data Set (RAI/MDS)
LHHPP 24-22 Code Green Protocol
MSPP D08-10 Behavioral Management Services by LHH Psychiatry
Long Term Care Survey, June 2006 Edition
42 Code of Federal Regulation (CFR) 483.21(a)(1)-(3) Comprehensive Person-Centered Care Planning, Baseline Care Plans

42 Code of Federal Regulation (CFR) 483.10(c)(2)-(3) Resident Rights – Planning and Implementing Care
Comprehensive User Manual Version 3.0 Resident Assessment Instrument. Chapter 4. CAA Process and Care Planning.

Revised: 01/10/20, 09/10/27, 10/05/25, 16/11/08, 19/03/12, 19/05/14, 19/07/09, 23/09/12, 25/05/12 (Year/Month/Day)

Original adoption: 92/05/20

COMPLETION OF RESIDENT ASSESSMENT /MINIMUM DATA SET (MDS)

POLICY:

1. The assessments of the Resident Care Team (RCT) members are the primary data sources used by the MDS coordinator to complete the MDS assessments.

2. Respective members of the RCT are responsible for the timely completion of MDS assessments i.e., Admission, Quarterly, Annual, Significant Changes, Medicare and other required assessments.

3. The RCT shall utilize the MDS assessments to develop, review and revise each resident's comprehensive plan of care.

PURPOSE:

1. To successfully use the Resident Assessment Instrument /Minimum Data Set (RAI/MDS) process to enhance resident care, increase resident's active participation in care, and to promote the quality of life of the resident(s).

2. To utilize the RAI/MDS during care planning process.

3. To ensure accurate and timely completion of the Resident Assessment / Minimum Data Set.

BACKGROUND:

The MDS is a tool used to identify resident problems, strengths, weaknesses, and preferences and provides information for the development of an individualized plan of care.

PROCEDURE:

1. MDS Accuracy and Completion

a. The MDS Coordinator notifies Resident Care Team members by the 15th of each month identifying those residents who are scheduled for assessments the following month. The MDS Coordinators may send an updated list after the initial notification to reflect schedule revisions and additions.

b. The MDS Coordinator shall approve changes to the individual resident's schedule of MDS completion.

c. The Resident Care Team and the Department of Admissions and Eligibility are responsible for completing respective MDS sections as specified in Attachment C.

d. The team member whose area of assessment is triggered shall complete the Care Area Assessments (CAA). CAA that are triggered during completion of the comprehensive MDS shall be evaluated and discussed during RCC whether or not a comprehensive care plan needs to be developed for the triggered care areas (See LHHPP 23- 01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC).

e. The MDS Coordinator shall access the MDS in the electronic health record (EHR) during the scheduled Resident Care Conference for final review.

f. The MDS Coordinator shall facilitate discussion of the MDS, care areas (CAA) triggered and prompt the care planning process during the RCC and/or individual RCT members prior to the scheduled RCC.

g. All staff who complete any portion of the MDS shall enter their signatures, titles, sections, or portion(s) of section(s) they completed, and the completion date in the EHR.

2. The MDS Assessments

A MDS assessment (CAA process and utilization guidelines) shall be completed for all residents at Laguna Honda Hospital (LHH).

a. Assessment Types:

i. Tracking Records

- Entry- completion of an Entry tracking Record during admission and reentry.
- Death in facility- refers to when a resident dies in the facility or dies while on leave of absence (LOA).

ii. OBRA Assessments

- Admission- comprehensive assessment for a new resident or a returning resident if leave of absence is more than 30 days.
- Annual- comprehensive assessment completed on an annual basis (at least every 366 days).
- Significant Change in Status Assessment- comprehensive assessment is completed if RCT determined that a resident meets the significant change guidelines for either major improvement or decline (see Standard Work for Significant Change in Status Assessment)

- Quarterly- an Omnibus Budget Reconciliation Act (OBRA) non-comprehensive assessment completed ~~within 92~~within 92 days following the previous OBRA and is used to track resident's status between comprehensive assessments.

- Significant Correction to Prior Comprehensive Assessment- completed when the RCT determines that a resident's prior Comprehensive assessment contains a significant error.

- Significant Correction to Prior Quarterly Assessment- completed when the RCT determines that a resident's prior Quarterly assessment contains a significant error.

- Discharge return not anticipated or return anticipated)- must be completed within 14 days when resident is discharged from the facility either return anticipated or return not anticipated.

- Medicare Assessment (5 Day assessment, Interim Payment Assessment (IPA), Part A PPS Discharge Assessment) - assessment of clinical condition of the resident receiving Part A Skilled Nursing Facility (SNF) - level care.

3. Submission of required data to Centers for Medicare and Medicaid Services (CMS)

a. The facility must report data to meet the SNF Quality Reporting Program (QRP). The MDS 3.0 is transmitted to CMS through the Internet Quality Improvement Evaluation System (iQIES).

IQIES will update the quality measures report that are generated by submitted MDS assessments.

i. List of Quality Measures

- ~~High Risk/Unstageable~~ Percent of Resident with Pressure Ulcers (L*)
- Physical Restraints (L*)
- Falls (L*)
- Falls with Major Injury (L*)
- Residents Who Newly Received an Antipsychotic Medication (S*)

- Residents Who Received an Antipsychotic Medication (L*)
- Prevalence of Antianxiety/Hypnotic Medication Use (L*)
- Antianxiety/Hypnotic Medication Use % (L*)
- Behavior Symptoms Affecting Others (L*)
- Depressive Symptoms (L*)
- Urinary Tract Infection (L*)
- Catheter Inserted and Left in Bladder (L*)
- ~~Low-Risk Residents Who Lose Bowel/Bladder Control~~ New or Worsened Bowel or Bladder Incontinence (L*)
- Excessive Weight Loss (L)
- ~~Need for Help with ADLs Has Increased~~ Increased ADL help (L)
- ~~Percent of Residents Whose Ability to Move Independently Worsened~~ Ability to Walk Independently Worsened (L)*
- ~~Percent of Residents Who Made Improvements in Function (S)*~~
- Changes in Skin Integrity Post-Acute Care Pressure Ulcer/Injury* (SNF Only)
- Discharge Function Score (SNF QRP)

b. The facility is required to submit staffing information through the Payroll Based Journal (PBJ) on a quarterly basis.

ATTACHMENT:
Attachment A: Required OBRA Assessment Schedule for the MDS
Attachment B: Medicare MDS Assessment Schedule
Attachment C: MDS 3.0 Section by Section

REFERENCE:
LHHPP 23-01 Resident Care Plan, Resident Care Team & Resident Care Conference
MDS 3.0 User's Manual, MED-Pass
Standard Work for Timely Submission and Accuracy of MDS
Standard Work for Significant Change in Status Assessment RCC

Revised: 10/01/20, 12/05/22, 19/05/14, 19/07/09, 22/12/13, 23/03/14, 24/02/13, 25/05/12 (Year/Month/Day)

Original adoption: 10/01/20

*L-Long Stay
*S-Short Stay

Attachment A: Required OBRA Assessment Schedule for the MDS

ADMISSION	Refer to RAI Manual Chapter 2 page 2 – 8, 2-17, 2-22 to 2-23
ANNUAL	Refer to RAI Manual Chapter 2 page 2 – 17 & 2-23 to 2-24
SIGNIFICANT CHANGE IN STATUS	Refer to RAI Manual Chapter 2 page 2-17 & 2 - 24 to 2- 30
SIGNIFICANT CORRECTION OF A PRIOR FULL ASSESSMENT	Refer to RAI Manual Chapter 2 page 2-18 & 2-32
QUARTERLY	Refer to RAI Manual Chapter 2 page 2-18 & 2-32
SIGNIFICANT CORRECTION OF A PRIOR QUARTERLY ASSESSMENT	Refer to RAI Manual Chapter 2 page 2-18 & 2-35
ENTRY	Refer to RAI Manual Chapter 2 page 2-20 & – 2-37
DEATH IN FACILITY	Refer to RAI Manual Chapter 2 page 2-20 & 2-38
DISCHARGE (Return not anticipated and return anticipated)	Refer to RAI Manual Chapter 2 page 2-19 & 2-38 to 40

Attachment B: MEDICARE MDS Assessment Schedule

5 Day NPE (Medicare Last Covered Day) IPA (Interim Payment Assessment) Interrupted Stay	Refer to RAI Manual

Attachment C: MDS 3.0 Section by Section

SECTION	RESPONSIBLE DISCIPLINE(S)
A	
A0050	MDS
A0100 - A0200	A&E- autoflow
A0200	MDS
A0300 – A0410	MDS
A0500 – A0900	A&E - autoflow
~~A1000~~ A1005-A1010	MDS - SS autoflow
A1100 - A1300	SOCIAL SERVICES and MDS
~~A1200 – A1550~~ A1500	MDS ~~& A&E AUTOFLOW~~
~~A1600 – A1700~~ A1600-A2105	~~MDS~~ A&E Autoflow
~~A1800~~ A2121– ~~A2400~~ A2400	MDS & A&E autoflow
B	
B0100 – ~~B1200~~ B1300	MDS
C	
C0100 – C0500	SOCIAL SERVICES
C0600 – C1000	SOCIAL SERVICES
C1310	SOCIAL SERVICES
D	
D0100 – ~~D0350~~ D0160	SOCIAL SERVICES – system calculation
D0500A1 – ~~D0600~~ D0700	SOCIAL SERVICES
E	
E0100 – E600	MDS
E800 – E1100	MDS
F	
F0300 – F0400	ACTIVITIES
F0500 – F0700	ACTIVITIES
F0800	ACTIVITIES
GG GG0100-GG0170	MDS
H	
H0100 – H0600	MDS
I	
~~I 0100~~ I0020– I 8000	MDS
J	
~~J0120~~ J0100– ~~J2000~~ J1900	MDS
~~J2100~~ J2000 – ~~J500~~ J5000	MDS
K	

K0100 – K0710	Diet Technician, Registered
L	
L0200	MDS
M	
M0100 – M1200	MDS/Charge Nurse
N	
N0300 – N2005 ~~0450~~	MDS
O	
O0110- O ~~0300~~ O0350	MDS
O 0400 - O0430	MDS (in collaboration with Rehab)
O 0400 D & E	MDS
O 0400 F	MDS
O 0500 ~~– O 0700~~	MDS
P	
P0100- P0200	MDS
S	
S9040A- S9040H	MDS
Q	
~~Q0100~~ Q0110	MDS
~~Q0300~~ Q0310 – Q0600	SOCIAL SERVICES
V	
V0100	MDS
V0200	RCT
V0200 B&C	MDS
X	
~~X0100~~ X0150 – X1100	~~RAI~~ MDS
Z0100	SOFTWARE CALCULATION
Z0400	RCT
Z0500 A&B	MDS COORDINATOR

MEDICATION ADMINISTRATION

POLICY:

1. Registered Nurses (RN) and Licensed Vocational Nurses (LVN) must demonstrate safe medication administration competency and are responsible for administering, monitoring, and documenting medications consistent with their scope of practice.

    a. Only an RN may administer intravenous (IV) medications, whether by IV piggyback or IV push.

    b. The LVN may administer medications per LVN scope of practice, except for IV medications.

    c. The Certified Nursing Assistant/Patient Care Assistant (CNA/PCA) may, under the supervision of Licensed Nurses (LN), administer the following: medicinal shampoos and baths, non-prescription topical ointments, creams, lotions, and solutions when applied to intact skin surfaces.

    d. Exception: Moisture barrier cream to macerated areas is acceptable for the CNA/PCA to apply.

2. All medications and herbal supplements, require a physician's order which includes:

    a. Medication name/agent

    b. Dose

    c. Frequency

    d. Route of administration

    e. Indication for use.

        i. If indication for use is not on order, consult with ordering physician.

3. Personal medications will not be obtained, stored or used by residents unless they have been ordered by a Laguna Honda Hospital and Rehabilitation Center (LHH) physician, and shall not be kept at bedside.

4. LN will follow the "6 Rights" of medication administration:

    a. Right resident

    b. Right drug

c. Right dose

d. Right time

e. Right route

f. Right documentation

5. Bar Code Medication Administration (BCMA) is not a substitute for the LN performing an independent check of the 6 Rights of medication administration.

6. Resident arm bands should only be scanned if the arm band is secured on the resident. Arm bands should be replaced if worn, torn, or do not scan.

7. Select residents can use identification (ID) cards in lieu of ID wristbands. The ID cards will be used by staff to correctly identify residents for the purpose of BCMA and point of care testing (POCT). (See appendix II)

8. The LN will prepare medications at the resident's side (i.e., If resident is in bed, preparation will be at bedside, if resident is in great room, they may receive at chair side).

9. The LN will prepare medication(s) at the time just prior to administration. Do not prepare medications prior to administration or store out of the package.

10. LHH does not allow medication to be separated from the original package and stored for administration at later time, this is considered pre-pouring.

11. IV medications are only prepared by RN for emergency situations and must be labeled with resident name, date and time of preparation, medication name, strength, amount, and name of the person preparing.

12. Medication delivered via transdermal route must have date, time, and LN's initials. Before application of new patch, old transdermal patch must be removed.

13. Medication times are standardized in the Electronic Health Record (EHR). Medication administration times may be modified to accommodate clinical need or resident's preferences. The LN will notify pharmacy via the EHR with medication administration time change request.

14. The safe administration of psychotropic, hazardous, high risk/high alert medications, and reporting of Adverse Drug Reactions (ADR) will be followed as outlined in other LHH policies and procedures.

15. Medications may not be added to any food or liquid for the purpose of disguising the medication, except in the following limited circumstances:

    a. a resident who has capacity to make their own health care decisions and provides written consent; or

    b. a resident who is LPS-conserved and has a current, valid court order that determines the resident does not have the right to refuse the type of medication in question (i.e., “Affidavit B” for psychiatric medications); or

    c. a resident who is conserved under the Probate Code and has a current, valid court order that explicitly grants the conservator authority to consent to health care, whether or not the conservatee objects, and the conservator consents in writing; or

    d. a resident who has been found by a court or their physician to lack capacity to make their own health care decisions and has in place a current, valid, signed durable power of attorney or advanced directive form which explicitly authorizes the legal decisionmaker to consent to all medications or the type of medication in question and the decisionmaker consents in writing.

16. Any medications that are opened but not administered shall be disposed of in the appropriate pharmaceutical waste container, including crushed, dissolved, or disguised medications. Controlled substances shall be disposed of in the Rx Destroyer located in the medication rooms. All other medication is disposed of in the yellow and white pharmaceutical waste bin.

17. Partial doses of controlled substances being pulled from Omnicell must be pulled at time of administration with witness and immediately wasted with co-signer/other LN at the time of retrieval from Omnicell.

    a. 2nd LN shall witness when the medication is still in the sealed packaging, and the actual wasting of the partial dose.

    b. Partial doses should not be placed in medication cart for administration at later time.

18. Each powdered medication administered via enteral tube should be diluted with at least 30 mL of water. Highly viscous suspensions should be diluted in a volume of at least 1:1 with water.

19. Each medication needing to be crushed for administration via enteral tube must be administered individually (do not mix medications together).

20. Oral medications that are safe to be crushed can be crushed at the discretion of the LN.

21. Each crushed medication must be given individually unless approved by the physician via an order to crush and combine medications for oral administration (medications may not be combined for enteral tube administration as noted above), and after pharmacy review for compatibility of mixed medications which is documented in the EHR.

22. A provider order must be obtained for medications to be mixed with pudding.

23. Medications mixed with food mediums (e.g., apple sauce, pudding) must have the food medium dated, timed and discarded at the end of each medication pass.

24. It is the legal and ethical responsibility of the LN to prevent and report medication errors.

25. Topical creams and ointments that are ordered “until healed” can be discontinued by the LN via an order in the EHR, and ordered “per protocol, co-sign required”.

26. Nursing students may administer medication under the direct supervision of their clinical LN instructor or the LHH LN. The supervising LN or clinical instructor must co-sign in the eMAR.

27. Medications and ordered herbal supplements are not to be stored at the bedside, with the exception of nasal naloxone if ordered.

28. Residents who request to self-administer medications and/or herbal supplements must be assessed by Resident Care Team (RCT) and determined to be able to safely self-administer medications.

29. Herbal supplements are not medications. The contents and purity of herbal supplements are not regulated and may contain undeclared contaminants. A limited number of herbal supplements are on the hospital formulary. Non-formulary herbal supplements are limited to USP verified supplements.

30. All medications and herbal supplements for self-administration will be stored securely by nursing, including rescue medications, except nasal naloxone. Rescue medications, such as inhalers will be given to resident when they go out on pass with physician order and will return medication for safe storage on their return, with the exception of nasal naloxone that resident can safely store on person or at bedside.

DEFINITIONS:

1. BCMA: Bar Code Medication Administration

2. eMAR: Electronic Medication Administration Record

~~2. /~~MAR: Medication Administration Record
3.

4. EHR: Electronic Health Record

5. WOW: Workstation on Wheels

PURPOSE:

Medications will be competently and safely administered.

1. Critical Points

Six Rights of Medication Administration

a. Right Resident

i. Two forms of identification are mandatory.

ii. Verify identity of resident using any of the following two methods:

iii. Successful scan of identification band, only if arm band is on the resident, or successful scan of identification card for the resident who meets criteria (See appendix II)

iv. Resident is able to state his/her first and last name (Ask for first and last name without prompting)

v. Resident Medication Profile Photograph matches the resident image in the EHR.

vi. Resident is able to state date of birth (Ask without prompting.)

vii. In situations where the LN can positively identify the resident, visual identification is acceptable as a second form of identification.

viii. Family member or fellow caregiver identifies resident by standing next to or touching the resident (caregiver should not point from a distance).

b. Right Drug

i. Review eMAR for drug/medication ordered

ii. Review resident allergies to medications or any other contraindication

iii. Check medication label and verify with the eMAR for accuracy. Check with physician when there is a question.

- Checks or verifies information about medication using one or more of the following references, when needed:

- Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline

- Black Box Warnings via Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline

c. Right Dose

i. Review eMAR for dose of drug/medication ordered

ii. Check medication label and confirm accuracy of dose with eMAR

d. Right Time

i. Review eMAR for medication administration time.

- Medications will be administered one hour before or one hour after the scheduled time with the exception of short acting insulin, and any medication ordered more often than every 4 hours will be administered within 30 minutes before or after schedule time.

- All medications scheduled for administration at midnight (0000) will be given by A.M. (night) shift.

- See Appendix I for routine medication times and abbreviations.

- Medications requiring special timing to maximize bioavailability or to prevent adverse effects are included in Appendix A.

e. Right Route

~~i.~~ Review routes of administration

- Enteral Tube Drug Administration: Refer to NPP E 5.0

~~ii.~~i. IV Push and IV Piggyback - Medications that an RN may give as I.V. push, without a physician at the bedside, are specified in the following link: Laguna Honda Hospital IV Push Guidelines

f. Right Documentation

i. Document the administration of medication in eMAR at the time medication is given utilizing bar code scanning.

ii. If resident is not wearing an armband, or refuses to allow scanning of their arm band, document reason in override section.

iii. If product/medication is not scanned, document the reason in override section.

2. Override of medication administration

a. If a resident requires urgent attention, use clinical judgment when deciding to override BCMA in order to provide care.

b. Document override reason.

3. **Two LN independent check of medications**

a. Two LN independent check of medication is the process by which 2 LNs perform an independent review of the medication to be administered, without prompting or cueing for other LN prior to medication being administered:

b. Each LN reviews the Right resident, Right medication, Right dose, Right route and Right time.

c. Each LN will complete their own documentation in EHR.

4. **Crushing medications for oral administration**

a. Crushing medications is based on nursing judgement and resident care plan.

i. Do not crush hazardous, enteric, sustained release or medications with “do not crush” in the admin instructions of the eMAR.

ii. Each resident shall have their own pill cutter, which is cleaned with alcohol wipes between uses.

iii. Pill crushers will be cleaned with alcohol wipe at the end of the medication pass prior to returning to medication room for charging, and PRN.

iv. Staff may choose to wear mask when crushing or cutting pills.

v. Medications which are to be crushed for administration, must be given individually and should not be combined with other crushed, uncrushed or liquid medications (e.g. in pudding or other similar food), unless pharmacy has reviewed the medications for safety and efficacy, and pharmacy has documented that it is safe to mix crushed medications together and the physician has placed an order for crushing and combining the medications.

~~b.~~a. When using a food medium (e.g., apple sauce or pudding) to administer medications, the LN will:

i. Date and time the food medium container at time of opening. Food medium container should remain on the medication cart if the food medium will be used for multiple residents. Use hand hygiene per protocol between each resident.

ii. For each individual resident, use a new, clean spoon to remove a portion of the food medium and place it in a different container (e.g., medicine cup or pill crusher cups.)

iii. If using pudding as the food medium to administer medications, a physician order is required for the pudding.

iv. The opened food medium must be kept covered throughout the duration of the medication pass and discarded at the end of medication pass. Food medium cannot be stored in or on the medication cart beyond your medication pass time.

5. HAZARDOUS MEDICATIONS

a. Special precautions need to be applied when preparing and handling and disposing of hazardous medication. (Refer to LHHPP 25-05 Hazardous Drugs Management ~~LHHPP 25-05~~).

b. Instructions for administering the medication can be found in administration instructions on the MAR.

6. PHYSICIAN ORDER

a. LNs may accept telephone orders from an authorized prescriber (Refer to LHHPP 25-03) and will confirm resident's medication allergies with prescriber and read back the order entered into the EHR for accuracy with the physician. Verbal orders should only be taken during emergent situations when provider is unable to enter the order due to care being provided to resident.

b. STAT medication orders are processed immediately and administered no later than four hours after the order was written.

c. All other medication orders are administered as soon as the medication is available, unless clinical needs warrant more immediate action.

PROCEDURE:

1. Once determined medications are due, and eMAR has been reviewed, minimize distractions or interruptions from preparation to documentation.

2. Determine which resident(s) need medication(s) pulled from Omnicell for this medication pass time only. Do not pull for future med pass times.

   a. Pull those resident's cassettes from the medication cart and place them on top of the WOW~~,~~ or bring the medication cart inside med room if space permits.

      i. Ensure each cassette is labeled with the correct resident name.

      ii. Do not overcrowd the WOW with too many cassettes.

   b. Bring WOW with the resident(s) medication cassette(s) into the medication room.

      i. If using medication cart with computer screen attached, bring the entire cart into the medication room.

   c. Use resident's order in EHR to retrieve medication from Omnicell for 1 resident at a time.

   d. Physically count the medication found in the Omnicell bin and confirm it matches the Omnicell screen count prior to removing the medication.

      i. If the count is off, immediately notify your charge nurse and/or nursing supervisor.

   e. Once confirmed medication is correct, immediately put the medication(s) into the appropriate resident cassette.

   f. Repeat this for each resident that need medication(s) removed if needed.

   g. Return to medication cart with WOW and cassettes and put cassettes in medication cart.

i. Do not place any medication(s) in pockets, cups or other containers. Medications must be placed in appropriate resident cassette~~,~~ and immediately followed by placing cassettes in the medication cart.

3. Log into the EHR and review the medications which will be administered. Remove those medications from resident's cassette and place on top of WOW. Bring the WOW with only the medications to be administered and needed supplies to the resident's side.

4. Confirm with the resident that they are ready to receive their medications in the location they are located if they are not in their room, such as the great room.

a. Support patient privacy/dignity by pulling the curtain in the room or closing the room door prior to administering medications~~,~~ or confirm with the resident that they prefer ~~to not~~not to have the curtain pulled and/or the door closed and has a care plan specifying this preference.

~~a.~~b. If administering medication(s) in community or common area, such as the great room, confirm with resident they would like to receive medications in that area and resident has care plan specifying preference/acceptance of receiving medications in the common area.

~~4.~~5. Scan the arm band of resident to correctly identify resident and open their MAR.

a. If the resident is wearing their arm band, this will serve as is one form of identification. Then, use a second form of identification to confirm you are administering to the Right Resident.

b. If the resident is not wearing arm band, navigate to the MAR of the resident who will receive the medications.

c. Use two forms of identification to confirm the Right Resident. Document an override, and then select the reason why bar code scanning of the resident is not used.

~~5.~~6. Scan medication(s) barcode(s) at bedside/chairside.

~~6.~~7. Compare each medication package to the medication prescribed in the MAR according to first 5 Rights.

~~7.~~8. Immediately prepare medication(s), if appropriate. (e.g., crush), and administer medication(s).

a. If this is the first dose being given, document that the "1st dose" resident education has been performed as appropriate.

~~8.~~9. Remain with the resident until all medications have been taken.

a. Never leave medications at the bedside/chairside.

~~9.~~10. Document in real time in the EHR medication(s) given, not given, etc.

~~10.~~11. Log out of the EHR. If medication cassette was brought to bedside, disinfect it and return the cassette to the medication cart.

ADMINISTRATION OF MEDICATION(S) THROUGH ENTERAL TUBE

1. Request medications be in liquid form whenever possible. If liquid form is not available from the Pharmacy, and a tablet form must be used, crush the tablets (except for enteric coated, hazardous or sustained release medications).

2. Do not add medication directly to an enteral feeding formula.

3. Prior to administering the medication, stop the feeding and flush the tube with at least 15 mL of water.

4. Dissolve the tablets or dilute the medication in at least 30 mL of water, to sufficiently allow for medication to pass through the tube.

5. Each medication should be administered separately. After each medication flush the tube with 15 mL of water.

6. Administer diluted medications or fluids through enteral tubes by gravity or gentle flush using a 60 mL catheter-tip syringe.

7. Give medication at the appropriate time in relation to feeding.

   a. Some medications should be given with food, while some should be given on an empty stomach with tube feeding stopped for a prescribed interval before and after medication is given (e.g., Dilantin suspension).

   b. For proper action, some medications must be delivered into the stomach rather than into the duodenum or jejunum.

   c. Consult with pharmacist about administration and drug-drug or drug-nutrient compatibility.

8. Elevate the resident's head of the bed to a minimum of 30 degrees unless otherwise ordered by the physician before administering medication, and for 30 minutes after administration of medication to decrease risk of gastroesophageal reflux and/or aspiration.

9. Confirm correct placement of enteral tube (refer to NPP E 5.0 Enteral Tube Management).

10. Nutritional formula may be given before medications. To flush formula from the tube prior to instilling medication, flush the tube with approximately 15 mL of water using gravity or gentle flush with the syringe.

11. After all medication(s) is administered, instill approximately 15 mL of water to flush medication.

12. If a resident is on fluid regulation, and requires a different flushing schedule, a physician must place order which includes the amount of water to be used for the flushing between each crushed medication.

13. Document the amount of the flush used for medication administration in the flowsheet.

ADMINISTRATION OF NARCOTIC (OPIATE) MEDICATIONS

1. As needed, and for newly admitted residents, the LN will explain to resident that due to hospital safety reasons, confirmation of swallowing is required after administering medication:

    a. After performing the six rights of medication administration and administering the narcotic medication, LNs will confirm resident has swallowed the medication by:

        i. Visually inspecting the mouth by requesting the resident opens their mouth and lifts their tongue to view entire mouth.

        ii. Request the resident to repeat a sentence such as “no, ifs, ands, or buts,” to ensure the oral medication have been swallowed.

    b. If resident declines to allow confirmation, notify the resident the narcotic medication will be held and notify provider for further guidance.

        i. Notify the physician of refusal to follow protocol and request for follow-up such as change of order to liquid opioids or crushed medications.

        ii. If resident initially agrees to new procedure but then refuses to open mouth for inspection, stay with resident and ask 2nd LN to notify charge nurse to call physician.

        iii. Notify resident care team of refusal for discussion of alternatives and interventions.

        iv. Document occurrence in a nursing note and update care plan.

2. Administration of buprenorphine-naloxone.

    a. Buprenorphine-naloxone should not be swallowed and must be allowed to dissolve in the mouth; therefore, verification of swallow per standard narcotic administration should not be performed.

    b. Buprenorphine administration is as follows:

        i. Place the sublingual tablet or film under the tongue and keep in place until fully dissolved.
            - 5-10 minutes for sublingual tablet
            - 3-8 minutes for film

        ii. Resident should not eat, drink, smoke or talk until the film/tablet is completely dissolved.

iii. If other medications are needed at the same time, give these medications prior to buprenorphine-naloxone administration.

c. For buprenorphine induction, physician may order clinical opiate withdrawal scale (COWS).

i. If ordered, document COWS in EHR COWS nursing flowsheet.

ADMINISTRATION OF AEROSOL/NEBULIZER MEDICATIONS

1. Monitor resident

a. Before administering the initial treatment, monitor the resident's ability to participate in the medication administration process, and to ascertain the most appropriate gas delivery device (e.g., mouthpiece, mask, etc.).

b. Whenever the resident's condition warrants, and/or per physician's order, monitor heart rate and auscultate lung sounds before and after treatment administration, especially when giving a new medication or when there has been a change in the treatment.

c. Residents who are unable to self-manage the delivery system safely and effectively

2. Administration

a. Refer to Medication Administration: Nebulized -CE Elsevier Clinical Skills, follow Manufacturer's Instructions, and/or consult with Pharmacy or Nursing Education for clarification for appropriate use of inhaled medication devices.

b. When using multiple puffs of the same medication, allow at least 1 minute to elapse between each puff.

c. When using multiple inhaled medications, wait 5 to 10 minutes between drugs to get maximum benefit. NOTE: If both bronchodilator and a steroid inhaler are prescribed, use the bronchodilator first.

d. When using a steroid inhaler, rinse the mouth afterwards to help reduce dry mouth, hoarseness, and to prevent fungal growth.

e. Compressor/ Nebulizer (brand name Misty-Fast)

i. Use with nebulizer face mask, which has medication cup and lid.

ii. Pour medication into the cup. Connect the blue end of the tubing to the cup, and the green end of the tubing to the air source.

iii. Air source

- Nebulizer machine: Do not place machine on soft surfaces. Turn on the machine until mist is no longer produced.
- Compressed wall air: Turn on the flow rate at 8 liters per minute for 3-4 minutes or until mist is no longer produced.
- For residents with a physician's order for oxygen and the resident is not a known carbon dioxide (CO2) retainer: Oxygen may be used as a delivery method. If using oxygen, set the liter flow at 8 liters per minute for 3-4 minutes, or until mist is no longer produced. Thereafter, set the oxygen at the flow rate prescribed by the physician.

f. For residents able to follow instructions, encourage resident to breathe as calmly, deeply, and evenly as tolerated until the nebulizer stops producing mist.

3. Assessing Resident during treatment and for the effectiveness of treatment.

a. Briefly stop the treatment if rest is needed. Provide assisted coughing and expectoration as needed and suction as clinically indicated.

b. Assess the resident's response to treatment.

ADMINISTRATION OF EYE MEDICATIONS

1. Eye Drops

    a. Using your finger, pull lower lid down gently to form a small pocket (cul-de-sac).

    b. Instruct the resident to tilt head back and look upward.

    c. Gently squeeze a drop into the center of the lower lid (cul-de-sac). If more than one drop is prescribed wait at least one minute between drops of the same medication.

    d. Do not touch the dropper tip to eye, or any surface, in order to avoid contamination of the solution.

    e. Apply pressure to the nasolacrimal duct (inner canthus) after each prescription eye medication for 30 seconds to prevent possible systemic effects.

    f. Do not wipe the dropper or rinse under water

    g. Instruct the resident to close both his eyes and to keep them closed for a full minute without squeezing.

    h. To blot excess eye drops from the eyes, use a clean, separate tissue or gauze for each eye.

    i. If a resident has an order for more than one eye medication, wait about five minutes between drugs to prevent one medication from washing the previous medication away

2. Eye Ointments

    a. To administer eye ointments, apply a small strip of ointment into the cul-de-sac pocket. Avoid contacting the tube tip with the eye.

3. Administration of Medications in ear

    a. Have resident lie on side or sit with his/her head tilted and hand supporting the head on the unaffected side.

    b. Use medication at room temperature.

    c. Clean external orifice gently with cotton swab.

    d. Gently pull the pinna upward and outward to straighten the auditory canal

e. Drop the prescribed amount of medication against the side of the ear canal and hold the ear in position for a moment to enable the drop to spread down the canal.

f. Have the resident maintain his position for a few moments.

g. Place a tissue or gauze loosely at canal opening to protect the canal and catch any outflow.

4. Administration of Medications in the Nose

a. Nose Drops

i. Have resident lie flat with his head slightly lower than the shoulders.

ii. Steady resident's head. Holding the dropper in a vertical position near the nasal opening, instill the number of drops ordered.

iii. Keep the resident in position for at least two minutes. During this time, instruct the resident to sniff three or four times and not to blow his nose.

b. Nasal Spray

i. Resident may be in a sitting position during this procedure.

ii. Place the tip of the bottle in resident's nostril.

iii. Instruct resident to sniff up as you simultaneously squeeze the lower portion of the bottle.

~~i.~~iv. Instruct the resident to continue sniffing 3-4 times~~,~~ and ask that ~~he~~ they do not blow ~~his~~ their nose for at least two minutes.

Special Considerations:

1. If the resident does not wish to take medication(s) at the prescribed time, you may attempt to return and administer later if medication is still unopened and in the original packaging.

2. If medication(s) is not given within the time schedule, review “Appendix B: Specific Medication Administration Times and Abbreviations” to avoid giving time sensitive medications outside acceptable timeframe and according to special considerations.

3. Other medications should be reviewed for modification of times (see Policy Statement #9.

4. If non-time-sensitive medications are given outside of the time schedule, document the rationale in the override section of eMAR.

5. If medications have been prepared/removed from packaging, and resident does not take the medication(s), the medication must be wasted and documented in eMAR.

6. Request from pharmacy any missing doses and/or need for replacement.

PREPARATION FOR INJECTABLE AND PARENTERAL MEDICATIONS AND IV FLUID

1. IV medication prepared by pharmacy and IV fluid bags will have a medication label which includes a bar code for administration.

2. In urgent situations, if RN needs to prepare IV drip, it must be labeled with resident name, date and time of preparation, medication name, strength and amount, and name of person preparing.

3. Prepare parenteral medication and fluids in a clean workspace away from distractions.

4. Prepare the IV as close as possible to administration time and administer no more than 1 hour after reconstitution, such as spiking IV fluid bag, spiking prepared IV antibiotic bag, or reconstituting antibiotic.

5. Exception: Insulin and IM injections should be drawn into syringe at time of administration.

SHAKING MEDICATIONS OR MIXING A SUSPENSION

1. Medications labeled “shake well” must be shaken vigorously to evenly distribute the dose, immediately before administration.

2. Medications which require mixing, but are not to be shaken, should instead be “rolled.”

3. Any rolling motion used is acceptable as long as the suspension appears milky, and the rolling action has not created bubbles.

CARDIOVASCULAR DRUG PARAMETERS NURSING PROTOCOL

1. Scan the arm band of resident to correctly identify resident and open their eMAR.

2. Every cardiovascular drug requires vital sign monitoring as outlined below:

    a. Frequency of monitoring:

i. Monitor and document in flowsheet the heart rate for antiarrhythmic medications or combined antiarrhythmic/antihypertensive medications before each dose, for 7 days, then weekly.

ii. Monitor and document in flowsheet the blood pressure for antihypertensive and combined antiarrhythmic/antihypertensive medications before each dose for 7 days, then weekly.

b. Default parameters:

i. Hold medication for SBP < 105 and/or hold for HR < 55.

ii. If the systolic BP or heart rate is below the specified parameter, hold medication and notify physician. The nurse will document medication held in the eMAR and notify physician.

c. If the physician desires more frequent monitoring, they will specify parameters which will be in the EHR.

d. Whenever the nurse believes per his/her judgement that more frequent monitoring is warranted, they may check vital signs per their scope of practice.

e. If a resident is on weekly cardiovascular monitoring schedule, and a medication is held, the LN will monitor and record cardiovascular monitoring before each dose, for a minimum of 3 additional days, to assist in the evaluation of therapy. The medication will continue to be administered as scheduled unless outside of specified parameters. Weekly monitoring may be resumed without written physician orders only after physician has been notified of outcome of monitoring, and the resident's vital signs have been outside of the hold parameters for 3 consecutive days.

3. PRN Cardiovascular Medication Orders

a. When a PRN cardiac medication is ordered to be administered for blood pressure above a specified parameter, the blood pressure is to be re-checked within 30-60 minutes of the time the medication was administered. If the blood pressure continues to remain above the parameter, the physician is to be called for further orders.

SPECIAL MONITORING REQUIREMENTS

1. Antibiotics

a. Document VS and response to therapy once every shift for duration of therapy.

2. Pain

    a. Document pain scores per pain management policy. (Refer to HWPP 25-06**)**

3. Psychoactive Drugs (Refer to HWPP 25-10 and NPP J2.5)

4. High Alert Drugs (Refer to HWPP 25-01)

5. Hazardous Medications (Refer to HWPP 25-05)

6. Controlled Substance Medications (Refer to Pharmacy P&P 09.01.00)

SHIFT-TO SHIFT LN REPORTING

1. During change of shift, hand-off and when reporting to team lead or charge nurse, report:

    a. Any new medications started, indication and monitoring required.

    b. Any suspected Adverse Drug Reactions (ADRs).

    c. If receiving medication that requires monitoring, report clinically relevant data including abnormal VS or laboratory results.

    d. Time or food sensitive medications to be given on incoming shift.

    e. PRNs given at end of shift requiring evaluation of effect.

    f. Refusal of medication.

2. Document application and location of patch in the eMAR.

3. Verification of patch placement and monitoring

    a. Inspect site of application every shift to verify that the patch remains in place.

    b. Document verification in the eMAR.

    c. If the patch has come off, attempt to locate the patch and dispose of it. If the patch is not recovered, complete an Incident Report. Reapply a new patch and document per application procedure above.

    d. Do not apply heat source to the patch as it may enhance absorption and result in bolus administration. Note: high fever can result in bolus effect as well.

e. If resident is diaphoretic, the patch may come off. In some instances, applying a transparent dressing covering the patch may help to keep it in place.

f. The resident may shower, wash and bathe with the patch in place, as long as not scrubbing over the patch area which will disturb the adhesive.

4. Disposal

a. Fentanyl patch disposal requires a two LN independent check of medication disposal and will be documented in Omnicell.

b. After removing the patch, fold the old patch in half so that the adhesive sides are in contact, request 2nd license nurse to witness the disposal in medication room disposal container and both LN's will complete documentation of the waste in Omnicell.

SELF-ADMINISTRATION

The resident must be assessed by the Resident Care Team (RCT) and determined to be able to safely self-administer medications and re-assessed quarterly and as needed thereafter. The assessment of the residents' ability to self-administer medications and/or herbal supplements will be documented in the RCT note and include input from the resident during this process.

1. Self-Administration

a. The RCT and other disciplines as indicated, will collaborate to assess the residents' ability to participate in medication and/or herbal supplement self-administration. This assessment must include:

i. The medications appropriate and safe for self-administration.

ii. The resident's physical capacity to swallow without difficulty and to open medication bottles;

iii. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for;

iv. The resident's capability to follow directions and tell time to know when medications need to be taken;

v. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.

vi. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.

vii. The resident's ability to ensure that medication is stored safely and securely. Appropriate notation of these determinations must be documented in the resident's medical record and care plan.

b. If the resident assessment or re-assessment has determined that a resident cannot safely self-administer medication this will be communicated to the physician and to the resident.

c. A resident may only self-administer medications and/or herbal supplements after the appropriate orders have been placed and the assessment is complete.

d. Orders will be entered in the EHR for medications and herbal supplements.

e. The LN will observe the resident self-administer prescribed medications and herbal supplements and will follow the 6 Rights of medication administration including scanning of resident and the medications and/or herbal supplements the resident is self-administering.

f. The resident will prepare and take their own prescribed medications and/or prescribed herbal supplements, which are kept in the medication cart, under the supervision of the LN. The LN will observe self-administration preparation at each medication time and answer the resident's questions, or reinforce the teaching as indicated.

g. If the nurse notices the resident is about to make an error, the nurse will intervene to stop the preparation. The nurse will also discuss and clarify with the resident the accurate manner of self-administration. The RCT will be kept informed of any change in the residents' ability to safely self-administer, or the need to re-evaluate the resident for self-administration of medications and/or herbal supplements.

h. The LN observing the resident taking the appropriate prescribed medications and/or herbal supplements via self-administration will document in MAR as 'given' and "self-administered"

i. For self-administration of a rescue medication stored at bedside that was not observed, the resident will report to the LN who will document in the MAR as given and "self-administered" and include a comment of 'patient reported' in the MAR.

   i. If a resident fails to report self-administration of a medication despite on-going education, the RCT will re-assess if self-administration is appropriate

j. Education and training skills will be documented, and care planned in the EHR.

k. The storage of all medications and/or supplements for self-administration will follow Pharmacy Policy 02.01.03: Bedside Storage of Medications

2. Bedside Medication (Refer to Pharmacy Policy 02.01.03: Bedside Storage of Medications)

WASTING MEDICATION

1. Medications that are not administered must be disposed of in the appropriate medical waste container (See LHHPP 73-11 Medical Waste Management Program & LHHPP 25-05 Hazardous Drugs management).

   a. Any opened unused medications, and containers that may contain residual medications, shall be disposed of in the appropriate pharmaceutical waste container (including crushed, dissolved or disguised medications). Nonhazardous medications shall be disposed of in either the blue and white pharmaceutical waste bin or the yellow and white pharmaceutical waste bin. Hazardous drugs shall be disposed of in the yellow and white pharmaceutical waste bin.

      i. Whole pills out of the package, such as those refused by resident, dropped on floor, or opened in error, should go in medication waste bin.

      ii. Empty medication cups go in the garbage.

      iii. Crushed, whole pills or liquid medications that are mixed with liquid or food that is not entirely consumed go in the med waste.

      iv. The empty spoon can go in the garbage.

      v. If resident consumes the entire amount of apple sauce or pudding or liquid the medication was in, the empty container it was in can be crushed and put the garbage.

      vi. For residents who are at risk for digging through the garbage, care plan your intervention to attempt to minimize and avoid this behavior.

      vii. Cups which had medication it, and the contents were consumed can also be crushed and go in the garbage.

      viii. Empty packets of powered medications can be thrown in the garbage.

2. The LN must secure narcotics/controlled substances from time of receipt/removal from Omnicell to administration by having in physical possession or securely locked in medication cart.

3. Narcotics/controlled substances that are removed and not administered and/or are only partially administered, shall be immediately wasted in pharmaceutical waste

container with witness of a 2nd LN.

a. The need for partial wasting shall be identified prior to leaving the medication room.

b. A 2nd LN shall be present to initiate controlled substance waste.

c. The 2nd LN shall witness both when the medication is still in the sealed packaging and the wasting of the partial does.

d. Both LNs shall document the waste in Omnicell.

4. If resident refuses medication, the LN shall return the medication to original package.

a. 2nd LN will also witness the waste of the controlled substance in the Omnicell.

b. 2nd LN can validate and ID medication for partial doses, as packaging has been opened.

i. This may be done via looking up the IC medication tag through Lexicomp.

~~b.~~c. 2nd LN shall witness actual wasting of controlled substance medication that was refused by the resident.

~~c.~~d. Both LNs shall document waste in Omnicell.

EMERGENCY MEDICATIONS – CODE BLUE AND EMERGENCY BOX

Emergency Box and Crash Cart store medications that are used for emergency situations and during CODE BLUE. Locks are checked and documented on the Emergency Equipment / Refrigeration Monitoring Sheet.

THERAPEUTIC LEAVE/OUT ON PASS MEDICATIONS

1. For planned trips away from the hospital, the attending physician will place an order in the ~~the~~ EHR for each out on pass medication, including controlled substance medications. The order shall include the name of the medication, strength, directions for use, and the number of days needed.

a. The nurse will have the order filled at the hospital Pharmacy.

b. The pharmacist will dispense the medications in properly labeled child-proof containers.

c. The nurse will review the directions and check the number and appearance of the drug with the resident or responsible person.

2. When the Pharmacy is closed the physician may dispense only the amount of medications for the duration of the pass from the resident's own medication supply~~,~~ and will record the drugs and quantity dispensed on the Physicians Order Sheet in the Medication Record.

    a. Controlled substances may not be dispensed by the physician from the neighborhood's supply. When the Pharmacy is closed, the Nursing Supervisor will contact a pharmacist at home.

    b. Blank prescription labels and empty child-proof containers will be available in the Supplemental Drug Supply Room for the physician to properly label the pass medications taken from the resident's own supply.

    c. The physician will counsel the resident on proper use of his/her medications.

3. When Resident is on therapeutic leave/out on pass, the MAR will be on hold status.

PERSONAL MEDICATION

1. Medications brought into LHH with the resident at admission:

    a. Will be given to family or guardian to take home.

    b. If medications are not returned to family or guardian, they are to be taken to Pharmacy or placed in the pharmacy pick-up tray.

    c. Pharmacy manages the medications and may dispose of as necessary.

    ~~d.~~ Personal medications are permitted only to assure continuous therapy ~~e.~~d. while awaiting replacement by LHH Pharmacy. Such medications are not to be used unless the physician enters an order to use them.

    ~~f.~~e. If the physician orders use of the medication, the medications are verified, relabeled, and reissued according to Pharmacy department policies. The nurse is not to administer the medication unless it has been relabeled by the LHH Pharmacy.

2. Personal medications will not be obtained, stored or used by residents.

3. If a resident or family member requests that medication(s) be filled by other than the Laguna Honda Hospital Pharmacy, refer the request to the Pharmacy Director.

MISSING MEDICATIONS

1. After confirming a medication that is due is missing, document on the MAR the med is not available, and actions taken to secure a supply.

2. Notify pharmacy via MAR message of need for dose

3. Administer when dose is available

4. If dose is grossly overdue, confer with physician and/or pharmacy on administering vs waiting till next dose is due

5. If not administered on shift it is due, a brief note should be entered in EHR indicating plan and follow up

EXCESS MEDICATIONS

If resident is refusing medications and there is an excess of medications, return excess medications to the Pharmacy.

ATTACHMENT:

Appendix I Specific Medication Administration Times
Appendix II Use of Identification Cards for Resident Identification for Bar Code Medication Administration
~~Appendix III – LN Wasting Controlled Substance (Partial Dose and Resident Refuse Meds)~~

REFERENCE:

Lexicomp Online website:
Institute for Safe Medication Practices Link. Oral dosage forms that should not be crushed. Institute for Safe Medication Practices. Retrieved from: http://www.ismp.org/tools/donotcrush.pdf or https://onlinelibrary.wiley.com/doi/epdf/10.1177/0148607116673053

AeroChamber Plus® Flow-Vu® Cleaning Instructions
DeWit, Susan, Fundamental Concepts and Skills for Nursing, 3rd edition, 2009

Mosby's Skills – ~~Elsivier~~Elsevier: Medication ~~Administration:Nebulized~~Administration: Nebulized – CE: https://point-of-care.elsevierperformancemanager.com/skills/372/quick-sheet?skillId=GN_20_9&virtualname=sanfrangeneralhospital-casanfrancisco

Mosby's Skills - ~~Elsivier~~Elsevier: Medication Administration: Nasal ~~Instaillation~~Instillation – CE: https://point-of-care.elsevierperformancemanager.com/skills/370/quick-sheet?skillId=GN_20_7&virtualname=sanfrangeneralhospital-casanfrancisco

Mosby's Skills – ~~Elsivier~~Elsevier: Medication Administration: Eye – CE: https://point-of-care.elsevierperformancemanager.com/skills/367/quick-sheet?skillId=GN_20_4&virtualname=sanfrangeneralhospital-casanfrancisco

~~CROSS REFERENCES:~~

LHHPP File: 25-01 High Risk – High Alert Medications
LHHPP File: 25-02 Safe Medication Orders
LHHPP File: 25-03 Verbal/Telephone Orders
LHHPP File: 25-04 Adverse Drug Reaction Reporting Program
LHHPP File: 25-05 Hazardous Drugs Management
LHHPP File: 25-06 Pain Assessment and Management
LHHPP File: 25-08 Management of Parental Nutrition
LHHPP File: 25-10 Use of Psychoactive Medications
LHHPP File: 25-11 Medication Errors and Incompatibility
LHHPP File: 25-13 Herbal Supplements
LHHPP File: 73-11 Medical Waste Management Program
LHH Pharmacy P&P: 01.02.02 Automatic Stop Orders
LHH Pharmacy P&P: 02.01.02 Disposition of Medications
LHH Pharmacy P&P: 02.01.03: Bedside Storage of Medications
LHH Pharmacy P&P: 02.02.02 Fentanyl Transdermal Patches
LHH Pharmacy P&P: 02.02.00 Controlled Substances
LHH Pharmacy P&P: 02.02.00b Distribution of Medications and Medication Order Processing
LHH Pharmacy P&P: 09.01.00 Automated Medication Dispensing Cabinets
Nursing P&P: C 9.0 Transcription and Processing Orders
Nursing P&P: E 5.0 Enteral Tube Feeding Management System
Nursing P&P: I 5.0 Oxygen Administration
Nursing P&P: J 2.5 Monitoring Behaviors and Effects of Psychoactive Meds
Nursing P&P: J 7.0 Central Venous Access Device Management
Standard Work - LN Wasting Controlled Substance (Partial Dose and Resident Refuse Meds)

Revised: 23/11/14, 25/05/12 (Year/Month/Day)
~~Original adoption (as NPP J 1.0): 23/06/13~~

Hospital Wide Adoption: ~~20~~23/~~13~~06/~~06~~ 13 as 25-15 Medication Administration
~~Revised: 23/11/14 (Year/Month/Day)~~
Original adoption (as NPP J 1.0): 23/06/13

SPLINT/BRACE CARE MANAGEMENT POLICY

POLICY

To ensure compliance with Centers for Medicare and Medicaid Services (CMS) Regulations when providing individualized care to meet residents' needs with physician orders for splints and braces.

GOAL

To ensure all residents' needs are met through a multidisciplinary evidence-based resident-centered care approach and compliance with the resident's individualized plan of care respectively, in order to attain, maintain, enhance, and achieve overall residents' quality of life (QOL).

DEFINITION

1. Splints: A splint or a brace can immobilize and protect joints, reduce pain, decrease swelling, and facilitate healing of acute injuries. It is a type of orthotic device that supports or corrects musculoskeletal deformities or abnormal, treat contractures, as well as to alleviate other joint problems. Splints or Braces are used to do as follows, but not limited to:

    a. Improve alignment

    b. Prevent skin breakdown

    c. Prevent deformities and contractures of the joints

    d. Protect the joints during activities

    e. Promote healing

    f. Position joints in good alignment during rest

    g. Relieve muscle strain around weak joints

    h. Relieve pain

    i. Maintain and improve mobility and ROM

    ~~a.~~ Increase ability to use arms and legs functionally

PROCEDURE

1. Splint or brace is labeled with resident's name. Splint or b~~B~~race management care recommendations and instructions may include, but not limited to the following (*Any deviations from the following must be reported and documented by nursing staff to charge nurse and/or nurse manager immediately*): ~~*Any deviations from the following must be reported and documented by nursing staff to charge nurse and/or nurse manager immediately.*~~

   a. Prior to applying the Splint or Brace:

      ~~i. Monitor for swelling, bruising, and skin irritation~~ Inspect skin for redness, ~~edema, open areas before applying, and after removal.~~ Inspect skin for signs of skin irritation, redness, pain, abrasions, breakdown, cyanosis, temperature changes or other problems. If present, notify charge nurse and or nurse manager immediately.~~If present, notify charge nurse immediately.~~

      i.

      ~~ii.~~ Be sure ~~the~~ skin is clean and dry~~.~~
      ii.

      ~~iii.~~ Perform range of motion or stretching exercises, if prescribed as per rehabilitation services, prior to splint or brace application

      iii.

      ~~iv.~~ Ensure splint or brace is clean prior to application

      iv.

      v. Be gentle and ensure awareness of care plan instructions for splint or brace application, position, wearing schedule (frequency, duration)

   b. When applying the splint or brace, ensure:

      ~~i.~~ Splint or brace fits appropriately

      i.

      ~~ii.~~ Does not dig into or rub into the skin

      ii.

~~iii.~~ Maintains appropriate joint alignment

iii.

~~iv.~~ Allow to fit one to two fingers between the splint or brace liner and the resident's skin, and between the strap and the skin

iv.

v. Fastened correctly

c. Once splint or brace is applied, monitor ~~resident for~~the following:

~~i.~~ Skin is clean and dry under the device

i.

~~ii. Ensure b~~Bony prominences are protected and padded

ii.

~~iii. Inspect skin for redness, edema, open areas before applying, and after removal. If present, notify charge nurse immediately.~~

~~iv.~~ Inspect for signs of skin irritation, redness, pain, abrasions, or breakdown. If present, notify charge nurse and or nurse manager immediately.

iii.

~~v.~~ Monitor for signs of impaired circulation, such as numbness, tingling, cyanosis, color or temperature changes, or edema. If present, notify charge nurse and/or nurse manager immediately.

iv.

~~vi. Splint or brace does not have or develop rough edges, cracks, or tears. Apply skin protector or padding, and notify charge nurse, and/or nurse manager immediately.~~

v. Check splint or brace for breakage, loose, or missing parts, deterioration, wear and tear. If this is identified, check with charge nurse and/or nurse manager for removal of device or discontinue of order. Nurse will alert physician to send a new order for rehabilitation services (occupational therapy/physical therapy) to address splint or brace replacement needs.

d. Once splint or brace is removed:

~~d.~~ Inspect for signs of skin irritation, redness, pain, abrasions, breakdown, cyanosis, temperature changes or other problems in the area of the splint or brace. If present, notify charge nurse and/or nurse manager immediately. ~~Once splint or brace is removed, ensure the following occurs:~~

~~i. Check resident skin, and note resident's complaint of pain, observe signs of pressure, red or open areas, blisters, edema, cyanosis, irritation, temperature changes, or other problems in the area of the splint or brace. Notify charge nurse and/or nurse manager immediately.~~

~~ii.~~i.

2. **Nursing staff** will ensure daily compliance and documentation of splint or brace care management recommendations and instructions, and wearing schedule (frequency, duration, location, shift).

a. Documentation:

i. The use of splint or brace is documented in the ADL care plan.

ii. ~~Nursing staff will ensure daily compliance and documentation (including but not limited to worklist and care plan updated for splint use) of splint or brace care management recommendations and instructions, and wearing schedule (frequency, duration, location, shift).~~Documentation in the electronic health record (EHR) includes, but is not limited to:

- Resident level of skill and progress toward self-care and use of brace.
- Teaching in care of appliance and safety of use
- Brace application and removal
- Skin checks every shift

~~1. Any deviations noted, will be immediately informed, and documented to the charge nurse and/or nursing manager.~~

~~a.~~b. Nursing management will ensure immediate notification and documentation of ~~this notification~~any deviations, to the following, but not limited to:

~~i.~~ Physician

i.

~~ii.~~ Rehabilitation Services

ii.

~~iii.~~ Orthotics & Prosthetics

iii.

iv. Interdisciplinary and Multidisciplinary meetings including but not limited to: immediate notification and discussion during unit huddles or 24 hour shift report per shift discussions for all units.

~~b.~~c. Interdisciplinary and multidisciplinary meetings will include, but are not limited to:

~~i.~~ Resident care team meetings/Resident care conferences will discuss current physician order for splints and/or braces and current resident outcomes and responses to the respective devices.

i.

ii. Quality Assurance and Performance Improvement (QAPI) meetings will also discuss residents' related outcomes and compliance with use of splints and braces as per physician orders; interventions or strategies utilized to increase compliance, and ongoing concerns to address quality of resident care.

3. **Physicians** will address residents' needs in relation to any deviations reported for splints or braces care recommendations and instructions, and additional resident's needs, as indicated per resident's health care team report, and/or resident's or resident's family self-report; and document as follows, but not limited to:

~~i.~~ Discontinue current physician orders, if indicated for the resident as per physician expertise

i.

~~ii.~~ Send physician orders to Rehabilitation Services and/or Orthotics & Prosthetics to address ongoing residents' needs that may impact deviation from resident's splint or brace care recommendations or instructions. Resident needs in relation to splint or brace may include but not limited to: onset of contracture or worsening contracture, skin integrity compromised, worsening pain or new onset of pain, new positioning needs or worsening positioning, resident's tolerance changes or need for modification of frequency/location/duration, and resident's need for a new splint or brace or alternative rehabilitation skilled approaches, etc.

ii.

iii. Send physician orders and/or additional communication to nursing and or other departments, as it relates to the residents' needs in relation to the resident's splint or brace care management recommendations and instructions.

4. **Rehabilitation Services** will address physician orders in relation to resident's splints as follows but not limited to:

i. As per clinical judgment, rehab staff will perform a comprehensive assessment (evaluation and/or treatment) that may include but not limited to, as follows, an analysis of resident factors, resident's functional needs and overall QOL and possible risk:

~~i.~~ Resident factors: primary active diagnosis, comorbidities especially in relation to peripheral vascular or neuropathy, cognition, resident behaviors and history of response or compliance to previous devices and splints and associated non-compliance or concerns.

i.

ii. Possible risk/contraindications: Anatomical positioning (e.g., contractures, range of motion limitations), risk of pressure injury or skin ulcers especially with prominent bony prominences, violation of skin integrity, open wounds, risk for soft tissue injury, etc.

b. Documentation: Rehab staff will ensure all documents for evaluation, treatment daily notes, progress notes, re-evaluation, and discharge notes include the following but not limited to:

~~i.~~ Provide indicator for the splint or brace and no contraindications indicated~~.~~

i.

~~ii.~~ Clinical reasoning for recommendation for splint or brace to meet resident's functional needs and overall QOL

ii.

~~iii.~~ Document recommendation for the splint or brace versus a trial of the splint or brace; also document who will be monitoring the resident during the trial of the splint or brace and list of items in addition to the splint or brace recommendations or instructions for monitoring during the trial period.~~.~~

iii.

~~iv.~~ Document training and education provided to nursing staff and/or nursing management for the resident's splint or brace care management

recommendations and instructions. Ensure nursing demonstrates compliance via teach back and visual demonstration methods for resident's splint or brace – application, monitoring during wearing, removal, documentation, awareness of risk factors.

iv.

v. At discharge and/or when the splint or brace is recommended while resident may be on therapy caseload, whichever occurs first for the resident, and requires the resident's individualized plan of care to be updated, include the following but not limited to: wearing schedule (frequency, positioning, location, nursing shift), training completed and documented with competency checked off, if applicable, resident's consent, and response, and overall benefit and consequences of compliance to the splint or brace for the resident. In addition, ensure resident's

c. Interdisciplinary/Multidisciplinary Report: Rehab staff will discuss splint or brace care management recommendations and instructions during the following, but not limited to: Rehab department resident-care meetings, unit huddles or resident care team meetings or resident care plan meetings, and QAPI meetings, to ensure compliance with CMS, and overall quality standards established by the organization to meet all residents' needs and overall QOL.

REFERENCES:

Agency for Healthcare Research and Quality (AHRQ): Safety Program for Long Term Care.
Althoff.A.D., and Reeves, R.A. *Splinting.* National Center for Biotechnology Information. (February 5, 2023).
Centers for Medicare and Medicaid Services (CMS). Activities of Daily Living (ADL) Critical Element Pathway.
CMS. Positioning, Mobility & Range of Motion (ROM) Critical Element Pathway. (2018).
CMS. Activities of Daily Living (ADL) Critical Element Pathway. (2017).
CMS. Range of Motion (ROM) Critical Element Pathway. (2017).
CMS. Specialized Rehabilitative or Restorative Services Critical Element Pathway. (2017).
CMS. Pain Recognition and Management Critical Element Pathway. (2017).
CMS. Resident Assessment Critical Element Pathway. (2017).
CMS. 3.0 RAI Manual (2019).
CMS. 3.0 RAI Manual (2023).
CMS. Quality Assurance & Performance Improvement (QAPI) and Quality Assessment & Assurance (QAA) Review. (2022).
CMS. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (2023).
Sprouse.R.A., McLaughlin.A.M., and Harris.G.D. *Braces and Splints for Common Musculoskeletal Conditions.* American Academy of Family Physicians. (2018: 98(10): 570-576).
Trivers.A., and Rebernik.D. *Contractures and Splinting.* CNA Training Advisor. (August 2014).

Revised: 2025/04/16, 25/05/12

Original adoption: 2023/10/10

Revised Food and Nutrition Policies and Procedures

1.165 General Cleaning and Sanitizing work Surfaces and Kitchen or Galley Equipment

Reviewed: 07/2024 ~~8/13, 8/14~~

Cleaning is the process in which a food service worker is removing food and other types of soil from a surface such as countertop or plate. Sanitizing is the process in which a food service worker uses a sanitizer on the same surface that was previously cleaned to reduce the number of micro-organisms to a safe level. To be effective, the food service worker must conduct a two-step process, cleaning and sanitizing. Surfaces must be first cleaned and rinsed before being sanitized.

All food-contact services must be washed, rinsed and sanitized:

- After each use
- Any time the food service worker begins working with another type of food
- Any time the food service worker is~~are~~ interrupted during a task and the tools or items that the food service worker has been working ~~with,~~with may been contaminated
- At four- hour intervals, if the items are in

~~constant~~constant use ~~use~~ Equipment needed for Cleaning and

Sanitizing:

- Three Clean ~~Rags~~cloths
- Three color coded 3 qt size buckets – green for cleaning solution; blue for clean rinse water; and red for sanitizing solution.
- Gloves
- Apron
- May need the use of Goggles and Mask
- Warm Water
- Spray ~~bottle~~bottles of sanitizing solution if applicable for a particular equipment such as a large kettle or inside wells of the steam table.
- Cart for transporting the three buckets for cleaning and sanitizing

General Cleaning and Sanitizing Procedure:

1. On a cart, place the three-~~-~~color coded 3 qt size buckets – green for cleaning solution; blue for clean rinse water; and red for sanitizing solution.
2. At the designated sink, fill the green bucket with an ounce ~~of department~~of department approved detergent ~~Tuff Suds Detergent~~ (one pump) and fill with 3 quarts of warm water.
3. Fill the Blue bucket with clean warm water.
4. Fill the red bucket with department approved sanitizer~~Mikrolene~~ using the auto-dispenser. To properly dispense of the premix solution of department approved sanitizer~~MikroKlene~~, press the blue button and allow it to run through the clear

tube for a couple of seconds then proceed to filling up the red bucket. If the dispenser does not work properly, you may mix using the vile and pump, 2 ml with 3 qt. water (75-100 degrees water)

5. Using the cleaning solution detergent~~tuff suds~~, use a clean cloth and clean the surface such as countertop or food service equipment.
6. Rinse the surface with a clean rag of warm to hot water ~~water~~.
7. Sanitize the surface by using a clean cloth with sanitizer~~Mikroklene~~. Then allow surface~~ervice~~ to air dry.
8. If the equipment has been approved to use a spray bottle filled with sanitizer~~MikroKlene~~, spray evenly onto the surface and allow to air dry. (Do not wipe down).
9. Change solution and water after each equipment has been cleaned and sanitized or within (2) two hours of usage.
10. After you have cleaned and sanitized all the countertops and food service equipment, dispose of the water into the designated sink. Rinse out each bucket~~s~~ and run them through the dish machine. Allow to air dry. Put into their proper storage location.
11. If using a spray bottle, refill with product and place back in correct storage location.
12. Take the soiled rags and dispose them into the correct container. ~~for laundry.~~
13. Keep all chemical products away from food.
14. Be familiar with the Chemical Safety Data Sheets~~'s Material Safety Data Sheets~~ on proper handling and safe use of the chemicals.
15. Never mix chemicals together.
16. It is important to follow the policy and procedure on testing the concentration of Sanitizer~~MikroKlene~~. This will be done twice daily to ensure that the chemical is being effective. It is important to follow Ecolab's recommendation on the concentration for effectiveness and consistency. ~~For our general purpose, we will be at 25 ppm.~~

Note; Using the Dish machine for cleaning and sanitizing may be appropriate to use such as a slicer that has detachable parts that can be run through the dish machine.

Spray bottles must be clearly labeled with the product sanitizer~~MikroKlene~~ and to be used for this ~~particular~~ chemical. Please do not use the spray bottle if it is not clearly labeled as such and report it to your supervisor.

Testing of correct concentration for MikroKlene

To ensure that the chemical used for sanitizing food service work equipment and surfaces are at the correct concentration for most effective use of the product sanitizer~~MikroKlene~~.

Procedure:

1. Twice a day (AM and PM) a senior food service worker or designee for Galley Service and Chef~~s~~ in the main Production Kitchen will test with an iodine litmus paper strip the concentration of the chemical sanitizer~~MikroKlene~~ to ensure that it is at the appropriate ~~25~~ppm for sanitizing the work services and food service equipment.

2. Fill 3~~-~~-quart container with sanitizer~~MikroKlene~~ using the auto-dispenser. To properly dispense of the premix solution of sanitizer~~MikroKlene~~, press the blue

button and allow it to run through the clear tube for a couple of seconds then proceed to fill the bucket~~cup~~. Take

~~an iodine litmus~~ paper test strip and dip half of it into the bucket~~cup~~ and concentration per manufacturer recommendation~~hold for one minute~~. Take the test~~litmus~~ paper out of the solution and match it to the color chart to read ~~25ppm~~.

3. If the dispenser does not work properly, you may mix one half ounce of product to 2 ½ gallons of warm water (75-100~~F~~)F).
4. If solution is acceptable document the results ~~it reads 25 ppm, document the results~~ on the daily equipment checklist managed by the Supervisors and/or Chefs.
5. Report any concerns immediately to Ecolab for corrective action when product does not meet standard~~. of 25 ppm.~~ Ecolab's contact number: (800)-352-5326.
6. If it is not dispensing correctly, tag the dispenser do not use until repaired.
7. Instruct the food service worker to mix concentrated solution per manufacture recommendation.~~with warm water. (half ounce per 2 ½ gallons of warm water (75-100 degrees) or 2ml with 3 quarts of water.)~~

Note: Quarterly, the Ecolab Representative will test the titration of each sanitizer~~MikroKlene~~ dispensing units in Galleys and Production Kitchen. They will take correction action when product does not meet standard ~~or 25ppm~~.

1.59 Authorized Personnel Only

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

Policy: All ~~non food~~nonfood service personnel or visitors will not be allowed in the production area except when authorized by Management. Authorized personnel or visitors must adhere to safe food safety practices and safety precautions to prevent injury.

Purpose: For safety and sanitation purposes and to comply with health regulations.

Procedure:

- All ~~non food~~nonfood service personnel and visitors will not be allowed in the production area except those that are authorized by Management ~~to do so~~.
- Shoes must cover the entire foot (no open toe, high heel and/or slippery shoes or sandals).
- Hospital Staff members, contractors, and visitors should check with Management prior to entering~~going to~~ the production area. They may be required to wash their hands and wear the proper personal protective equipment (PPE), prior entering the department ~~hair covering~~.

There are those that are authorized to be in the area on a usual business basis such as service technicians and food business vendors.

~~11/6/2015~~

1.60 Equipment Repair

~~Established and~~ Revised: 8/2024 ~~7/80, 1/89, 5/97, 9/06, 7/09~~
~~Reviewed: 8/13, 8/14~~

Policy: Facilities Services is responsible for managing repairs and Preventative Maintenance (PM) of kitchen equipment to maximize its lifespan and downtime.~~A work order will be written and submitted to Facility Services for equipment repair.~~

Purpose: To effectively repair equipment and maintain all capital equipment in proper working order.

Procedure:

- When repairs are required, supervisors, ~~or~~ chef, or designee~~s~~ will submit an electronic Facility Services Work Order Request Form and complete all sections. P~~Please p~~rovide the necessary information that may ~~include:~~include identification of equipment and its location. Give a brief description of the nature of the problem or what is being requested. Copies are to be recorded in the Maintenance and Repair Log ~~Manual~~ in the Chef's Office.

- Facility Services will respond to the work request in the order of urgency/priority and safety. If ~~a~~reasonable time has ~~past~~passed and there are no corrective actions taken from Facility Services, follow up will be made by a ~~Supervisor~~supervisor, ~~and/or~~ Chef, or designee.

- On a monthly basis, Food and Nutrition Servies Management team will meet with Facilities Services Management team to~~a print out of all work orders will be generated by Facility Services for our~~ review all~~for~~ outstanding work orders. ~~As a follow up, the senior food service supervisor and production chef will meet with a Facility Services Supervisor on a monthly basis to review outstanding work orders.~~

- If Facility Services ~~can not~~cannot effectively repair equipment, an outside source may be called for service. A Purchase Order may be generated through Facility Service ~~Material Management~~ along with a price estimate of the repair required. All purchase orders are approved through the Director of Facilities Services~~Nutrition Services~~.

~~11/6/2015~~

1.61 Sanitation Inspections

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

Policy: To ensure the safety and sanitation of the department, an inspection will be conducted on a ~~weekly~~regular basis.

Procedure:

1. S~~Once a week a s~~afety and sanitation inspection (Kitchen & Café Inspections) will be taken in the production kitchen ~~two general areas~~ as listed:

    i. The Chefs or designee will conduct the safety and sanitation inspection of the department ~~in the production and storage area~~. The ~~A "Mr. Clean"~~ report will be completed and signed by the Chef or designees~~.~~ ~~The Supervisor may conduct the safety and sanitation inspection in the tray service and warewashing area. A "Ms Clean" report may be completed and signed by the Supervisor.~~ It will be forwarded to the ~~Assistant~~ Food Service Management ~~Director~~ team ~~or Food Service Manager~~ for review and signature.

    ii. The Supervisors or designee will conduct the safety and sanitation inspection in each of the Galleys. A Sanitation Report will be completed and signed by the Food Service Supervisor or designee. It will be forwarded to the Food Service Manager for review and signature.

2. The safety and sanitation reports are used to ensure that the food production and food service areas are safe, clean, and sanitized. Any deviation from standards will be addressed by the Chef, ~~or~~ Food Service Supervisor, or designee. The necessary corrective action will be initiated to assure compliance to food service standards. Upon completion of the assigned cleaning or maintenance and repair, a follow up will be completed to ensure that the problem has been corrected.

3. All Safety and Sanitation Reports are forwarded to the Director of Nutrition Services for review ~~and signature~~. ~~He may~~S/he may ~~follow up with the necessary corrective action to assure its compliance.~~

4. All reports may be kept on file for up to one year before being discarded.

~~11/6/2015~~

1.93 Food Preparation Standards

~~Established and revised: 5/98, 9/06, 7/09, 11/10, 11/22~~

Reviewed: ~~8/13,8/14,~~ 7/24

Policy: All food items will be prepared in a manner that will ensure the best quality food product. Cooking methods will be used to conserve good nutrient value, to maintain food temperatures outside of the danger zone, and to maintain good color, texture, and flavor of the food item. Food will be cooked progressively and held for service under heated conditions for no more than 45 minutes.

Procedure:

1. All food items will be received, stored, issued and processed under the HACCP guidelines. Thawing of food products will be completed under the HACCP guidelines. Chefs will monitor this process.

2. All cold food items will be stored covered under proper refrigeration. Employees will handle the food ~~item~~items in batches to ensure that standards are ~~always~~ maintained at all times. Cold Food Preparation (Advance Prep) will be monitored by the Production Chef and be assigned for completion by trained staff 24-48 hours in advance of service date.

3. All hot food items, if not being heated for service, will be stored covered in the refrigerator.

4. All hot food items will be cooked in batches and will not be left in a holding cabinet for more than 45 minutes.

5. Vegetables will be stored under refrigeration until the cooking process begins. All vegetables will be batch cooked for meal service.

6. The cooks will make temperature and quality checks on all food items prior to leaving the production area for cafeteria and tray service.

7. Cooling Down Log Policy

    a. Each day the on-duty Chef or designee will check and monitor the cool down temperature of a lunch and dinner meal selection (entrée, mechanical soft = ground and puree) in addition to one other menu selection.
    b. Temperatures will be measured when the selected foods reach 140°F.
    c. All foods will be cooled in two (2") inch uncovered inserts in the blast chiller.
    d. Large cuts of meat will be cut into five (5#) pound pieces and cooled in the blast chiller.
    e. All foods must be cooled from ~~140~~ 135°F to 70°F or below within two hours (2) hours; then from 70°F – 40 F or below within four (4) hours or the food will be discarded. Chef shall take immediate corrective action if cooling is not progressing in a timely manner.
    f. All food products will be labeled, covered and stored in a refrigerator after the food reaches 40°F or lower. Food will be stored in 4" or 6" deep inserts, only after the food is at 40°F or lower.

8. When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards.

a. Thawing – approved methods for thawing frozen foods include thawing in the refrigerator, submerging under cold water, thawing in a microwave oven, or as part of a continuous cooking process. Thawing at room temperature is not acceptable.

b. Cooking – foods shall be prepared as directed until recommended temperatures for the specific foods are reached. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed.

c. Cooling – various strategies (e.g., placing foods in shallow pans, cutting roasts into smaller portions, utilizing ice water baths, and stirring periodically) shall be implemented to cool foods so that the total time for cooling does not exceed 6 hours.

d. Holding – staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed.

e. Reheating – food that is cooked and cooled must be reheated so that all parts of the food reach an internal temperature of 165°F. Ready-to-eat foods that require heating before consumptions must be heated to at least 165°F.

9. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Strategies include, but are not limited to:

a. Covering all foods when traveling a distance (i.e., down a hallway, to a different unit or floor).

b. Using tray lines, mobile food carts or portable steam tables transported to dining areas.

c. Washing hands properly before distributing trays.

d. Washing hands between contact with residents and after collecting soiled plates and food waste.

e. Use of gloves when touching and assisting with ready-to-eat foods.

f. Timely distribution of all meals/snacks.

10. All equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination.

a. Staff shall follow facility procedures for dishwashing and cleaning fixed cooking equipment.

b. Clean dishes shall be kept separate from dirty dishes.

c. Staff shall wash hands prior to handling clean dishes and shall handle them by outside surfaces or touch only the handles of utensils.

11. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects.

a. Staff shall wash hands according to facility procedures.

b. Staff shall not touch food with bare hands, exhibiting appropriate use of gloves, tongs, deli paper, and spatulas.

c. Staff who exhibit a communicable or infectious disease shall be restricted from working in accordance with the facility's work restrictions/infectious diseases policy.

d. Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food.

e. Hairnets should be worn when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad. However, staff do not need to wear hairnets when distributing foods to residents at the dining table(s) or when assisting residents to dine.

f. Staff should maintain nails that are clean and neat, and wearing intact disposable gloves in good condition that are changed appropriately to reduce the spread of infection.

g. Staff shall keep jewelry to a minimum and cover hand or wrist jewelry with gloves when handling food.

h. Gloves will be worn when directly touching ready-to-eat foods and when serving residents who are on transmission-based precautions. However, staff do not need to wear gloves when distributing foods to residents at the dining table(s) or when assisting residents to dine unless touching ready-to-eat food.

12. Additional strategies to prevent foodborne illness include, but are not limited to:

a. Preventing cross-contamination of foods.

b. Washing fresh fruits and vegetables prior to use.

c. Keeping cut and raw fruits and vegetables refrigerated.

d. Proper refrigeration of meat, poultry, and pasteurized dairy products.
e. Cleaning and sanitizing the internal components of the ice machine according to manufacturer's guidelines.

Revised Nursing Policies and Procedures

NURSING CLINICAL COMPETENCY PROGRAM

POLICIES:

1. Nursing Aadministration, Ssupervisors, and Nnurse Mmanagers are responsible for assuring competent nursing practice at Laguna Honda Hospital and Rehabilitation Center (LHH).

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

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

4. Certified Nnurse Aassistants (CNA) and d Hhome Hhealth Aaides (HHA) are responsible and accountable for assuring their own clinical competence consistent with certification set by the California Department of Public Health (CDPH) Licensing and Certification Program.

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

6. The Nursing Orientation Coordinator, Nurse Educator, Unit Nurse Manager, Unit Charge Nnurse, and/or Ppreceptor provide competency-based orientation and evaluation of new nursing employees.

75. The Nursing Orientation Coordinator will collaborate with the unit Nurse Manager and/or unit Ccharge Nnurse to will assign orienting RNs and LVNs to an experienced, competent licensed nurse preceptor for the duration of the orientation program. The unit Nurse Manager and/or unit Ccharge Nurse will assign experienced, competent CNAs to precept the new CNAs, PCAs, or HHAs.

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

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

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

7. 11. Annual performance appraisals completed by designated Nurse Manager or Nursing Supervisor will include a job role competency including abuse prevention knowledge. to assess knowledge of employee's abuse prevention.

8. 12. On all shifts, immediate needs for clinical training to assure safe practice are routed through the nurse manager, if present, nursing operations or the clinical resource nurse, who have access to educational materials and can assist in coordinating 1:1 coaching. An experienced, competent clinician may also be asked to assist with the instruction.Nursing Operations Supervisor and/or Nurse

Managers can access education for problem prone knowledge gaps so they may provide just in time education and coaching for staff as needed.

PURPOSE:

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

DEFINITION:

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

PROCEDURES:

A. Clinical nursing staff (RNs, LVNs, CNAs, PCAs, and HHAs) competency includes:

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

2. Updating and maintaining skills and knowledge through:

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

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

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

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

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

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

B. Nurse Manager

ROLE: Ensures clinical staff competency which includes:

1. Communicates job expectations to staff.

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

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

~~4.~~ 4.Completes ongoing performance evaluation in collaboration with Hh~~u~~man Rr~~e~~sources, including annual and intermittent competency evaluations, performance plan and performance evaluations~~, training and progressive discipline. up to and including separation of employees unable to meet job expectations. An action plan will be developed for employees who are not meeting standards and/or competency(ies).~~

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

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

7. Ensures resident -specific neighborhood training as needed.

8. Maintains documentation of competency assessment.

C. Clinical Nurse Specialist

ROLE: Supports competency development which includes:

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

2. Provides consultation to enhance competent clinical practice.

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

~~D.~~ D. Nursing Orientation Coordinator ~~-~~and Nurse E~~e~~ducators

ROLE: Supports staff competency which includes:

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

~~2.~~ 2.Participates in the assessment of educational needs required for the job and setting in collaboration with Nursing Leadership and Quality Assurance and Performance Improvement (QAPI) program. ~~LHH Performance Improvement Teams (PITs), Nursing QI Program, committees and department managers.~~

~~E.~~ 3.Develops, implements and evaluates nursing orientation and training programs for nursing staff according to CDPH requirements.~~, as outlined in the Nursing Educational Programs Policy. Programs~~

~~are based on CDPH approved orientation program, assessed needs, core competencies, quality improvement findings, and evaluation of learner and/or resident outcomes.~~

~~1.~~2. 4.Participates in the development of nursing practice standards.

~~2.~~3. 5.Participates with quality improvement and interdisciplinary committees in analyzing resident outcome data in order to link competency training with desired resident outcomes.

~~3.~~4. 6.Ensures Licensed Nurses will complete a Point of Care Test (POCT) Training on Accu-check (glucocheck) device initially during orientation.~~,~~ Under the guidance of the POCT Coordinator, licensed nurses will complete POCT training six (6) months post orientation, and then annually thereafter~~, under the guidance of the POCT Coordinator~~.

REFERENCES:

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

CROSS REFERENCES:

Hospitalwide Policy and Procedure
01-03 Hospital Organization
80-03 Employee and Volunteer Orientation
80-05 Staff Development
~~80-12 Staff Competency~~

Nursing Policy and Procedure
A 6.0 Orientation of Nursing Personnel

~~Human Resources Policy for the Developmental Plan/Disciplinary Action.~~

ATTACHMENT:

California Code of Regulations Standards of Competent Performance for RNs.

Adopted: 12/2007

Revised: 2012/05/22; 2021/02/09, 2022/12/13; 2023/06/13

Reviewed: 2023/06/13

Approved: 2023/06/13

ORIENTATION OF NURSING PERSONNEL

POLICY:

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

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

3. The orientation program consists of:

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

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

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

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

5. Successful orientees will demonstrate the following:

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

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

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

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

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

PURPOSE:

To provide an orientation program to newly hired Laguna Honda Hospital and Rehabilitation Center (LHH) nursing staff ~~who provide or supervise direct patient care, and to staff who function in roles of consultation.~~in accordance with their job classification and job description.

PROCEDURE:

A. **Ongoing Assessment and Documentation**

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

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

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

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

B. Unmet Competencies

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

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

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

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

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

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

C. Orientation Program

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

1428 Unit Clerk

2583 Home Health Aide

2302 Certified Nursing Assistant

2303 Patient Care Assistant

2312 Licensed Vocational Nurse

2320 Registered Nurse

P103 Per-Diem Registered Nurse

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

2320 Acting Nurse Manager
2320 Administrative Departments~~, Nurse Educator~~
2322 Nurse Manager
2323 Clinical Nurse Specialist
2324 Nursing Supervisor or Nursing Director
0941 ~~Chief Nursing Officer, Hospital Associate Administrator~~Manager VI
0942 Manager VII
0943 Manager VIII
Or other Nursing Leadership Classifications

CROSS REFERENCES:

NONE

ATTACHMENT/APPENDIX:

NONE

Adopted: 2006/01

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

Reviewed: 2023/06/13

Approved: 2023/06/13

Revised: 2023/06/13

OBTAINING, HANDLING, AND STORAGE OF MEDICATIONS AND TREATMENTS

POLICY:

1. The charge nurse or team leader is responsible to have a continuous supply of prescribed medications available 24 hours a day, seven days a week through Department of Pharmacy Services or automated medication dispensing cabinets.

2. The medication room, medication cart, treatment cart, and medication refrigerator are to be locked when not in use or attended.

3. Complete an Incident Report if there is an error in the medication dispensed, or labeling error. Return any drug dispensed in error to the Pharmacy immediately and obtain a replacement. If Pharmacy is closed, notify the nursing supervisor who can return the medication to the pharmacy.

4. Licensed nurse adheres to relevant policies and procedures outlined by the Department of Pharmacy Services.

5. Unless otherwise stated in this policy, the licensed nurse does not need to date products with opened date.

PURPOSE:

Correct medications will be available and stored properly.

PROCEDURES:

A. Pharmacy Accessibility (Refer to Pharmacy Policy 01.01.01)

B. Obtaining medication from Pharmacy

1. New medication orders will be transmitted to pharmacy as an electronic prescription via the electronic health record. Medications will be available via automated dispensing cabinet or patient specific supply delivered by pharmacy. Medications needed prior to the next pharmacy delivery may be picked up at the pharmacy window by a licensed nurse or licensed psychiatric technician.

2. Maintenance Medications:

    a. Pharmacy will deliver a resident specific supply of maintenance medications to the neighborhood with scheduled oral medications.
    b. For new ordered medication, pharmacy will dispense the amount of medication up to the next cart fill exchange.

3. Short-term Medications:

    a. Pharmacy will dispense only the amount of medication that was specified in the order.
    PRN or “As Needed” Medications (Refer to Pharmacy Policy 09.01.00).
    b.

4. Medication Refills:

   If refill is needed before routine date of replacement ~~put empty drug container or tubes in pharmacy pick up tra~~y. Request the refill via the EHR.

5. Stock Items (Refer to Pharmacy Policy 09.01.00).

6. Controlled Substance Medications (Refer to Pharmacy Policies 09.01.00 and 02.02.00).

C. Labeling Medications

1. The licensed nurse inspects the condition and legibility of labels. All prescription drugs that do not have a clearly legible label are to be returned to Pharmacy for replacement. If having difficulty scanning barcode of medication label, notify pharmacy of issue.

2. Label Changes:

   a. If label becomes soiled, illegible, or if change is made in dosage or frequency of an existing medication, the drug container is to be placed in a relabel zip lock bag and placed in the pharmacy pick up tray.
   b. In the event that the correct dose for the resident involves more than one strength of the medication to achieve the dose, multiple strengths of medication will be sent to achieve dose. It is the responsibility of the LN to confirm dose prescribed with amount to be administered.

D. Storage of Medications

1. Condition of Container and Contents

   a. Medications are to be kept in the containers received from Pharmacy. If containers become cracked, soiled, or do not have secure closures, return to Pharmacy for replacement.
   b. If drug contents become outdated, contaminated or show deterioration, return to Pharmacy for replacement.

2. Orderliness of Medication and Treatment Carts

   a. Medication Cart:

      Medication cart stores the resident's supply of internal medication including injectables, ophthalmic preparations, otic preparations and inhalation preparations (nebulizer / aerosol).

      Licensed nurse checks expiration dates of medications before administering medication and on a weekly basis. All unlabeled and expired medications are to be discarded in ~~the~~appropriate medication waste bin~~.~~ (Refer to HWPP 25-05 Hazardous Drugs Management).

   b. Treatment cart:
      i. Ointments and creams are labeled with resident's name and are legible. All medication tubes and bottles are to have covers.

ii. Irrigating solutions are checked for expiration date labeling. Normal saline, sterile water and isopropyl alcohol are ordered from Central Supply and are single use only, and after single use, remainder of solution is ~~discarded.~~discarded.
iii. Other irrigation solutions are ordered from Pharmacy and are labeled with expiration dates. Unlabeled or expired solutions are to be returned.
    i. When bottles of irrigation solution supplied by pharmacy are first opened, write the date, time and nurse's initials on the label. Refer to Pharmacy Policy 02.01.06 Appendix 1 for expiration policies and practice.
    ii. Irrigation solutions supplied by pharmacy are not to be used 24 hours after ~~opening .~~opening.

c. Medication Room

~~Licensed nurse checks expiration dates of medications before administering medication and on a weekly basis. All unlabeled and expired medications are to be discarded in the medication waste bin.~~

The following items are stored in locked medication room, locked carts or the automatic dispensing cabinet(s). Internal, external, and injectable items must be stored separately.
i. Approved ward stock supplies or medications.
ii. Emergency drug box, Emergency I.V. bag, I.V. solutions and tubing.
iii. Test reagents, Chemstrips, or hemoccult tests.

3. Medication refrigerator - is used only for drugs needing refrigeration.

a. Refrigerator temperature is monitored continuously via wireless refrigerator monitoring system. The temperature log is checked ~~twice daily~~ by nursing staff (Refer to LHHPP 31-01: Wireless Refrigerator and Freezer Temperature Monitoring System).
b. Store oral medications together in one area, refrigerated injectables together in a different area, and rectal suppositories together in another area inside the refrigerator.
c. No food or specimens are to be placed in the biological refrigerator.

~~4. Emergency Drug Box / Crash Cart~~

~~Emergency Box and Crash Cart stores medications that are used for emergency situations and during CODE BLUE. Locks are checked and documented in the Emergency Equipment / Refrigeration Monitoring Sheet.~~

~~a.DAY Shift licensed nurse checks lock of Crash Cart daily.~~
~~b."Red lock" of the Emergency Drug Box is checked by licensed nurse every shift.~~

~~* For Wellness Center ONLY - Emergency Equipment such as AED & Crash Cart must be checked daily when Wellness Center is open, by Day Shift Licensed Nurses assigned to Pavilion – Mezzanine SNF.~~

E. Handling Medications

1. Oral Liquid Syringe Dispenser is used to accurately measure liquid medications such as Dilantin suspension. Shake the suspension medication well and be sure the syringe plunger is fully depressed before inverting the bottle to fill the syringe. Use the inside edge of the black measurement ring to read volume. The syringe may be attached to an enteric tube or put into the mouth between the teeth and cheek to administer medication. Discard dispenser after each individual dose.

2. Hazardous Medications (formerly known as antineoplastic / cytotoxic medications)

   Special precaution needs to be applied when preparing and handling hazardous medication administration (Refer to LHHPP 25-05).

3. Controlled Substance Medications (Refer to Pharmacy Policy 02.02.00).

4. Multidose Injectables:

   a. Multiple ~~dose injectables~~dose injectables shall be visually inspected prior to use and discarded if any of the following occur:
      i. There is a change in appearance of the solution.
      ii. There is damage or loss of integrity of the closure.
      iii. The drug has been improperly stored.
      iv. The vial is known or suspected to be contaminated
      v. The vial has met the expiration date

   b. Expiration Dating (Refer to Pharmacy Policy 02.01.06 Appendix 1).

   c. Injectables that do not contain preservative shall be used immediately and any remaining contents shall be discarded.

   d. Insulin vials shall be:
      i. Dated upon initial entry~~.~~
      ii. Open vials may be kept in individual resident cassettes or in the refrigerator.
      iii. Open, in-use vials shall be discarded after 28 days. Pharmacy assigns expiration date.
      iv. Intact vials are to be kept in the refrigerator until the manufacturer's expiration date on the vial.

   e. Injectables that contain preservatives shall be:
      i. Refrigerated for stability, if recommended by the manufacturer.
      ii. Discarded when empty or upon expiration (refer to Pharmacy 02.01.06 Appendix 1).

~~5. Resident Transfers:~~

~~a. When a resident is relocated within LHH, (SNF unit to SNF unit) the nurse will send the resident's medication to the receiving neighborhood.~~
~~b. When a resident is transferred to or from an Pavilion Medical acute (PMA) unit, the resident's medicines are *not* sent with the resident if the pharmacy is open. New orders must be placed. If the pharmacy is closed at the time of transfer to or from the acute care householdPMA, the nurse will send the medications to the receiving unit. The medications will be sent to the pharmacy for relabeling when the pharmacy opens.~~

~~6. Discontinued Medications:~~

~~a. Immediately after the medication is discontinued, print "DC" on the prescription label and place the medication in the pharmacy pickup box. This also applies to the medications of residents who expire.~~

~~b. Resident Discharges:~~

~~i. When a resident is discharged to any an outside acute setting, all medications must be returned to pharmacy.~~
~~ii. When a resident is discharged to the community. All in-house medications must be returned to pharmacy after resident is discharged.~~

F. Monthly Pharmacy Ward Survey

1. The pharmacist or pharmacy extern student may observe the nurse while doses of medication are being prepared and administered to the resident to ascertain that medications are given accurately and with acceptable infection control measures employed.

2. The pharmacist reviews the resident's drug regimen to monitor the suitability of drugs ordered for the resident.

CROSS REFERENCES:

Hospitalwide Policies & Procedures
25-01 High Risk - High Alert Medications
25-02 Safe Medication Orders
25-05 Hazardous Drugs Management
31-01 Wireless Refrigerator and Freezer Temperature Monitoring System

Pharmacy Policies & Procedures
01.01.01 Accessibility to Medications
01.02.02 Stop Orders
01.08.00 Extern Students
02.02.00 Controlled Substance
02.01.06 Expiration Dating of Pharmaceuticals
09.01.00 Automated Medication Dispensing Cabinets
02.01.00a Acute Care Order Processing and Med Distribution

Nursing Policies & Procedures
B 6.0 Items Allowed at the Bedside

Emergency Equipment/Refrigeration Monitoring Sheet
Emergency Equipment Monitoring Sheet for Wellness Center Only

Adopted from NPP J 1.0 12/2006

New: 2010/04

Revised: 2011/03/17; 2015/07/14; 2017/01/10; 2019/05/14; 2020/05/19; 2023/11/14; 2024/11/08; 2025/04/18

Reviewed: 2023/11/14

Approved: 2023/11/14

MANAGEMENT OF RESIDENTS ON HEMODIALYSIS

POLICY:

1. A physician's order by a LHH physician or a nephrologist is required for hemodialysis and related lab work, diet orders, and medications.

2. All residents on hemodialysis are weighed ~~daily~~at least weekly ~~-~~(or per provider order) and PRN ~~at the same time each day, on the same scale with the same amount of clothing.~~

3. Coordination of nursing care for the resident undergoing hemodialysis is the joint responsibility of the LHH licensed nurse (LN) and the hemodialysis nurse.

4. Nursing interventions for pre and post hemodialysis care are care planned. The dialysis center phone numbers for routine and emergency consultation are listed in the care plan.

5. The licensed nurse will communicate to the dialysis nurse any clinically relevant change in the resident's condition via dialysis communication progress note in EPIC.

6. Dialysis catheters are NEVER used for blood draws or IV hydration, unless ordered by physician during life threatening situations.

7. The licensed nurse will monitor the AV shunt and fistula for audible bruit and palpable thrill every shift and report absence of bruit and/or thrill to the LHH physician.

8. Dialysis schedule may be adjusted based on clinic visits or planned surgical procedures. Consult with physician and team.

PURPOSE:

To coordinate care of residents receiving hemodialysis treatment at an outside agency location through collaboration with the dialysis agency, its nephrologists, the Laguna Honda Hospital ward physician and nursing staff.

PROCEDURE:

A. Care Before Dialysis

1. LHH staff prepare resident for transport to dialysis treatment.
    a. Notify physician and dialysis nurse prior to transporting if resident has symptoms of acute illness.
        i. The team may decide that transporting to the clinic is still necessary, but precaution such as a patient mask, may be indicated. For cases of contagious illness – such as the flu or COVID, notification/consultation with the infection control nurse may also be appropriate to contain the spread of infection.
    b. Vital signs prior to sending resident to dialysis.

2. Consult with the pharmacist and/or physician regarding timing of anti-diabetic medications and water soluble medications as needed.

3. Report any change in the resident's physical and emotional status or any new physician's orders to the dialysis nurse or technician. Send the primary physician's phone number and pager

4. If the resident is unable to eat during dialysis and missed a meal, arrange for a tray to be served on return from dialysis facility. Send a bag meal with the resident when indicated.

5. Securely fax or route via EHR the Dialysis Communication Note to the dialysis center for any pertinent information that the dialysis center needs regarding current condition of the resident.

B. Care Immediately After Dialysis

1. The LN reviews the Dialysis Communication Note received from dialysis center for any changes in condition of the resident post-dialysis. For residents who receive dialysis at ZSFG, information can be found in the EHR.

2. The LN documents in the EHR any clinically relevant communication that is sent/faxed/obtained between LHH and the dialysis center.

3. The LN notifies the LHH physician immediately of changes in dialysis venous access device patency and laboratory values outside acceptable ranges for the resident. Consultation with the dialysis clinic nurse or physician is done as needed.

4. The LN receives a resident status report from the dialysis nurse to include:
   a. dry weight from dialysis
   b. fluid status/balance
   c. vital signs/tolerance of procedure
   d. lab tests and results
   e. medications given or with held
   f. blood transfusion if given
   g. unusual events
   h. type of temporary hemodialysis access

5. The LN observes for any bleeding at the access site upon return from dialysis.

6. The LN observes fistula for thrill and bruit. If thrill or bruit is absent, notify the physician immediately.

7. Perform vital signs upon return from dialysis and prn unless ordered otherwise. Report any significant changes to the physician.

8. Fluid Monitoring (refer to NPP G 3.0 Intake & Output).

C. Vascular Access Precautions

1. Constrictive clothing or jewelry cannot be worn on the extremity with dialysis access.

2. Venipuncture for laboratory tests, I.V. fluids, or taking blood pressure may not be performed on the extremity with dialysis access.
   a. A sign may be posted in the room to **alert** health team members not to use extremity with shunt or fistula.

D. Tunneled Dialysis Catheter Care

1. The dialysis nurse performs the dressing change of the shunt or dialysis catheter during each treatment at the dialysis center.

2. Neighborhood RN may perform dressing reinforcement if dressing is soiled or loosened.

E. Resident Education

1. Explain precautions for the extremity with the vascular access.

2. Educate resident to report any changes or problems to vascular access.

3. Educate importance of following fluid intake limitations and appropriate diet.

F. Documentation in EHR to include:

1. Resident Care Plan – Ensure hemodialysis is care planned in EHR
2. LDA to identify type of access
3. Presence or absence of AV shunt/fistula audible bruit and palpable thrill
4. Condition of dialysis access site.
5. Vital signs/Weight as ordered
6. Progress Notes
7. Resident response to dialysis treatments in weekly summary.
8. Assessment of ability to comprehend and follow precautions needed for venous access, dietary and fluid requirements.
9. Documentation of any health education or teachings given to resident.
10. Dialysis Communication Note: Communication via secured fax between dialysis nurse and unit nurse resident's information or changes in condition such as lab, weights, vital signs or any unusual drainage, bleeding from the dialysis site. Describe any need to reinforce site dressing. (See Appendices)
    a. If paper copy received, submit to HIM for scanning.
    ~~a.~~b. Dialysis care and outcome to treatment can be reviewed in the EHR for residents who ~~recieve~~receive dialysis at ZSFG.

REFERENCES:

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

CROSS REFERENCES:

Nursing P&P G 3.0 Intake and Output
Nursing P&P J 7.0 Central Venous Access Device (CVAD) Management

APPENDICES:

Attachment 1: Coordination of Care for LHH Residents Requiring Outpatient Hemodialysis

Adopted: 2000/08

Revised: 2006/03, 2008/04, 2010/10, 2015/07/14, 2016/09/13, 2017/01/10; 2019/05/14, 2023/09/12; 2025/04/17

Reviewed: 2023/09/12

Approved: 2023/09/12

Deletion Nursing
Policies and Procedures

APPLICATION AND MANAGEMENT OF BRACES

POLICY:

1. The Licensed Nurse, in collaboration with Rehabilitation Services, is responsible for monitoring the correct application of braces by Certified Nursing Assistant (CNA) or Patient Care Assistant (PCA) and resident.

2. Braces require a physician's order.

3. Obtain Physical Therapy or Occupational Therapy consultation for residents who used a brace prior to admission.

PURPOSE:

To support proper application and management of braces.

PROCEDURE:

A. EQUIPMENT

Brace with label for resident's name
Other devices as necessary (i.e., socks or stockings, shoehorn, etc.)

B. CARE OF RESIDENT WITH BRACE

1. Review brace application with Rehabilitation if unfamiliar with device.

2. Nursing staff will check braces for any missing or loose screws or loose or worn-out straps or buckles prior to putting leg brace to resident.

3. CNA or PCA will check skin at least every shift, and before and after applying brace, for any redness, irritation, or breakdown.

4. Refer to Physical Therapist if brace is worn-out or ill-fitting. Have the brace checked periodically by the orthotist in conjunction with the Physical Therapist.Check brace for breakage, loose or missing parts, deterioration

5. Consult with Wound Care Specialist for complex skin conditions.

6. Consult with Rehabilitation Services, ZSFG or LHH Clinic to obtain a replacement brace if necessary.

D. REPORTING /DOCUMENTATION

1. Electronic Health Record:
   a. Record resident level of skill and progress toward self-care and use of brace.
   b. Record teaching in care of appliance and safety of use.
   c. Document brace application and removal.
   Document skin checks every shiftt
   d. Monitor and document any redness, irritation, or breakdown and report skin changes to licensed nurse.

e. Monitor and document any redness, irritation, or breakdown and report skin changes to Licensed Nurse.

2. Resident Care Plan:
   a. Initiate a Resident Care Plan
   b. Document use of the Brace.

ATTACHMENTS/APPENDICES:

None

REFERENCES:

Hospital-wide Policy & Procedure
File #27-09: Spring/Brace Care Management Policy

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

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

Revised: 2000/08, 2010/02, 2016/07, 2019/03/12, 2025/04/09

Reviewed: 2023/07/14

Approved: 2019/03/12

TRANSFER TECHNIQUES

POLICY:

1. The Licensed Nurse and/or Rehab staff assesses the resident's ability to transfer with or without staff assistance or adaptive devices upon admission and as needed.

2. The proper level of assistance will be utilized in transferring resident based on their functional status.

3. All residents Each resident who requires a battery-operated lift transfer must have their own assigned sling(s) for transfer and bathing. Sling tags are to be labeled, using permanent marker, with resident's full name and the month/year first opened. Manufacturer recommends slings are to be replaced every 6 months, or if damaged. Damaged slings must be discarded and replaced with a new sling. Each sling must have resident's name and room number.

4. The principles of good body mechanics are to be adhered to at all times to avoid injuries to either the resident or the staff members.

5. Nursing staff {licensed nurse (LN), nursing assistant (CNA/PCA)} may perform transfer procedure. Check care plan for transfer technique and required number of staff assistance during transfer.

Residents on a low air loss mattress shall require 2 person assist for all transfers

6. Two nursing staff members are always required for operation of battery-operated lifts.

PURPOSE:

To ensure resident's and staff's safety when moving the resident from one surface to another.

PROCEDURE:

A. Prior to Transfer - Review care plan prior to transfer of resident.

B. Transfer Techniques

1. **Slide Transfer Technique** (Gurney to Bed and Vice Versa)

   a. Place the gurney parallel to the bed.
   b. Position the bed and the gurney at the same height with head of the bed and gurney in a flat position.
   c. If any motor weakness or sensory deficit or neglect is present on one side, place the gurney next to the strongest side.
   d. Set all brakes on all equipment in a "locked" position after the equipment is positioned. Lock all bed brakes.
   e. Use a draw sheet or slider sheet to assist with transfer.
   f. Always have drainage bags lower than the area being drained.

2. **Pivot Transfer Technique**

   a. At the time of transfer, resident should have shoes and socks on.
   b. Position wheelchair or chair at head of bed, parallel to the bed. If the resident has one non-functioning upper or lower extremity, place the chair on the resident's unaffected side.
   c. Lock all bed and wheelchair brakes and fold wheelchair footrests back.
   d. Adjust height of the bed to what is appropriate for the resident.
   e. Help the resident sit on the side of the bed with feet touching the floor.
   f. Use a gait belt as needed.

g. If transferring resident without the gait belt, support the resident by placing your hands under the arms and around the shoulder blades of the resident.
h. During transfer, block resident's feet and knees with your feet and knees to prevent falling.

3. Sliding Board Transfer Technique

a. Use sliding board or transfer board as a bridge between the bed and chair or wheelchair.
b. Lower the bed to the same height as the seat of the chair or wheelchair.
c. Assist the resident in a seated position.
d. Place one end of the board beneath the resident and the other end on the seat of the chair or wheelchair.
e. Slide the resident along the board to reach the chair.
f. Lock all bed and wheelchair brakes and fold wheelchair footrests back.

4. **Transfer Techniques using Mechanical Battery Operated Lift** (Refer to NPP D6 1.1 Battery Operated Lift Transfer and NPP D6 1.4 Battery Operated Ceiling Lift)

C. Reporting and/or Documentation

1. Reporting
All care team will communicate to the physician and rehab staff when further transferring training is warranted.

2. Documentation
a. Electronic Health Record (EHR)
i. The CNA/PCA documents the highest level of assistance needed and number of staff required during transfer.
The Licensed Nurse documents on weekly summary any change in functional level.
ii. Nursing will document any unexpected outcomes and related interventions
b. Care Plan
i. The Licensed Nurse documents in the Care Plan the type and level of assistance needed for transfer.
ii. All residents who require battery-operated lift transfer must have documented on their care plan/Kardex the type of lift, type and size of sling used, and color of straps to apply for the resident.be documented on the Care Plan indicating what type of lift is used, type and size of slings used, and number of persons required to assist in transfer.
iii. For residents in active rehabilitation, collaborate with Rehab Services and with the RCT to write an individualized care plan entry.

REFERENCES:

Elsevier (2024) Transfer Technique: Pivot Transfer https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025

Elsevier (2024) Transfer Technique: Bed to Wheelchair using Slide Board https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025

Elsevier (2024) Transfer Technique: Assisting Patients to Sitting Position https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025

Perry, A.G. and others (Eds.). (2022). *Clinical nursing skills and techniques* (10th ed.). St. Louis: Elsevier.

Transfer of Patient, Manual: Bed to Chair/Commode or Gurney. 2013. Smith, N. and Caple, C.

authors. CINHAL Information System, a division of EBSCO Information Services, 2014 – electronic access on February 14, 2014

Transfer of Patient: Use of Assistive Devices. 2013. Smith, N. and Caple, C. authors. CINHAL Information System, a division of EBSCO Information Services, 2014 – electronic access on February 14, 2014

CROSS REFERENCES:

Hospitalwide Policy and Procedure

24-19 The C-625 Battery Operated Ceiling Lift and

Nursing Policy and Procedure D1 1.0 Restorative

Nursing Program
D6 1.1 Battery Operated Lift Transfer
D6 4.0 Positioning and Alignment in Bed and Chair

D1 1.0 Restorative Nursing Program
D6 1.1 Battery Operated Lift Transfer Nursing
D6 1.4 Battery Operated Ceiling Lift
D6 4.0 Positioning and Alignment in Bed and Chair

ATTACHMENTS/APPENDICES:

None

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