List of Policies and Procedures for JCC Review 11-10-25

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revised	LHHPP	20-14	Leave of Absence and Bed Hold	**M. Antoc**	1. Deleted "Bed Reservation" definition 2. Deleted bed reservation information "According to Medi-Cal riles"
Revised	LHHPP	24-17	Comfort Care	**A. Lam**	1. Updated the definitions for “Palliative care”, “Terminally ill” and “Hospice care” 2. Added section for "Inotropic Cardiovascular Intravenous Infusion at Fixed (non-titratable) Drip."
Revised	LHHPP	45-05	Molly’s Fund – Assistive Technology Program	**L. Conover**	1. Changed "Committee" to "work group" throughout the document 2. Deleted "The Assistive Technology Committee is convened by the Accounting Partner and meets at least four times annually and/or when a Molly’s Fund application/request has been received" 3. Deleted "Every effort will be made to acquire a device, for trial purposes, from a community-based leading library to determine if it is appropriate for the resident. 4. Replaced "Rehabilitation Representative to the neighborhood" with "RCC team and/or including the Rehab staff/AT"
Revised	Activity Therapy	D2.0	Tracking of Resident Participation	**J. Carton-Wade**	Updated to reflect procedures for documenting in flowsheets. Updated to include 42CFR 483.00
Revised	A & E	04-02	After Receiving New Resident Chart		Updated to current workflow and standards. In addition, outdated language and terminology were also updated or removed
Revised	Nursing	F 5.0	Nursing Management of urinary Catheters		1. Reorganized policies 2. Rewrote Policy #1 to state: “Urinary catheters require a written physician’s order and can only be inserted by Licensed Nurses (LN). The physician order should include the indication and duration of use, size of the catheter, type of the indwelling or suprapubic catheter, balloon volume, routine indwelling catheter care, interventions when obstruction is encountered, and discontinuation of the indwelling catheter. Unless otherwise clinically indicated, the smallest bore catheter possible, consistent with good drainage is usually ordered to minimize bladder neck and urethral trauma. If indication is not included in the order, contact physician.” 3. Added that licensed nurses may insert a coude catheter (refer to Elsevier) 4. Updated precautions 5. Updated equipment based on what our current supply is 6. Clarified procedures for open vs closed system references and intermittent catheterization 7. Refer to HWPP 28-03 Aquatic Services re: use of catheters and aquatics 7a. Catheter must be removed prior to entering pool 7b. Participants must be continent of bowel and bladder, or must be successful and consistent on a bowel/bladder program for at least 2 weeks. 8. Added details to assessment and documentation for residents with catheters 9. Updated references
Revised	Nursing	G .0	Neurological Status Assessment		1. Change title to “Neurological Status Check” 2. Updated assessment frequency to current practice 3. Removed Glascow Coma Scale (this is not used at LHH) 4. Updated the characteristics of neurological status checks according to what is currently on EPIC (see following) 4a. Level of Consciousness 4b. Pupil Assessment 4c. Hand Grasp/Motor
Revised	Nursing	M 12.0	Adaptive/Assistive Devices Management Policy		1. Removed details to make it a concise and succinct policy. 2. NEC Addition: Changed “mobility bar” to “mobility loop”
Revised	Vocational Rehab	VR2.0	Scope of Services		1. Added "are at Laguna Honda" 2. Removed "General Store" and "Guest Escort" 3. Removed "VR assists with career exporation" information 4. Removed "VR assits with job search" information 5. Deleted "SFGatcareLCR" 6. Added "Individualized experiences 7. Deleted "Vounteer opportunities in community for qualified residents" 8. Added "the electronic health record" 9. Deleted "General Store" information 10. Deleted "Guest Escort/Guide": Guides visitors to destination" 11. Added "Individualized experiences: integrating persons skills, abilities and interested into an explorational opportunity. "
Revised	Vocational Rehab	VR3.0	Referral and Assessment		1. Added "Vocational Rehabilitation " 2. Cleaned up the list of areas of participation for residents. 3.Deleted " On Rehabilitation units, physicians put a Request for Consultation form in the resident's chart" 4. Replaced "Staff" with "VR" for various responsiblities i sections 2 through 9

Revised	Vocational Rehab	VR4.0	Documentation of Vocational Rehabilitation Services		1. Replaced "in the resident charts via the Vocational Rehabilitation Assessment Form and monthly LCR note" "with "for assessments and progress notes in the electronic medical record." 2. Delted "and enters the information on the assessment form" 3. Added "in the Vocational Rehabilitation Assessment section of the resident's electronic record." 4. Deleted " A copy of the assessment form is placed in the Assessment section of the medical record. 5. Added "Vocational Rehabilitation Departmental policy VR 2.0." reference
Deletion	Vocational Rehab	V05	General Store	**J. Carton-Wade**	No longer needed.
Deletion	Vocational Rehab	V06	Note Card	**J. Carton-Wade**	No longer needed.
Deletion	Vocational Rehab	V08	Newsletter Project	**J. Carton-Wade**	No longer needed.
Deletion	Vocational Rehab	V09	DVD Library	**J. Carton-Wade**	No longer needed.

Revised Hospital-wide Policies and Procedures

LEAVE OF ABSENCE AND BED HOLD

POLICY:

The facility may hold a resident's vacant bed during leave of absence and bed hold.

PURPOSE:

1. To accurately track and monitor residents discharged to acute facilities.
2. To accurately track and monitor residents Out on Pass (OOP).
3. To maintain bed availability for a specific resident.
4. To provide for return of the resident to his/her prior neighborhood wherever possible.
5. To comply with state and federal regulations

DEFINITIONS:

1. Bed Hold: When resident is transferred from a skilled nursing facility (SNF) to a general acute care hospital, which may be either Laguna Honda Hospital and Rehabilitation Center (LHH) or an outside hospital, the SNF shall afford the resident a bed hold of up to seven (7) days.
2. Out on Pass: A planned absence of a resident from LHH authorized by a physician's order, which may extend past midnight.
3. Leaving Hospital Against Medical Advice (AMA): A resident is discharged AMA when he/she leaves LHH against the advice of the physician.
4. Absent Without Leave (AWOL): A resident who leaves LHH without notification or without an approved LOA.
5. ~~Bed Reservation: A bed reservation is a bed designated for a resident's anticipated admission, transfer, or for a missing resident for whom LHH receives no remuneration. A bed reservation may be cancelled if, due to a bed shortage, that bed is needed for a new admission to LHH.~~

BACKGROUND:

1. 42 CFR §483.15 – When a skilled nursing facility transfers to an acute care facility, including LHH acute unit, the facility must provide a written notification of the facility's bed hold policy and Notice of Proposed Transfer or Discharge to the resident and

resident's representative. When the resident goes on a therapeutic leave, the facility must provide a notification of the facility's bed hold policy.

2. A resident who is receiving Medicare Part A Skilled Nursing Facility (SNF) benefits is permitted to a Leave of Absence (LOA) as necessary; however, Medicare will not provide reimbursement to the facility for that day of leave if the resident does not return to the facility by midnight.

3. If the LOA is an overnight visit (or longer) to the home of relatives or friends, LOA reimbursement by Medi-Cal is restricted as follows:

    a. Maximum time period of 18 days per calendar year for non-developmentally disabled recipients; Up to 12 additional days of leave per year may be approved in increments of no more than two (2) consecutive days when the following conditions are met:

        i. The request for additional days of leave shall be in accordance with the individual resident care plan and appropriate to the physical and mental well-being of the patient.

        ii. At least five days of SNF inpatient care must be provided between each approved overnight LOA.

        iii. Maximum of 73 days per calendar year of developmentally disabled recipients.

        iv. At the time of admission, if resident has not been an inpatient of any SNF facility for the previous 2 months or longer, the resident is eligible for the full complement of leave days (18 days per calendar year).

        v. A resident's return from overnight LOA may not be followed by a discharge within 24 hours.

4. For LOA due to acute care hospitalization:

    a. The LHH Patient Flow Coordinator shall coordinate both the LOA and bed reservation procedures in conjunction with Admissions and Eligibility (A&E) department and the neighborhood physician representing the neighborhood RCT.

        ~~i. According to Medi-Cal rules, a bed reservation is a bed designated for a resident's anticipated admission, transfer, or for a missing resident for whom LHH receives no remuneration. A bed reservation may be cancelled if, due to a bed shortage, that bed is needed for a new admission to LHH.~~

    b. Medi-Cal and some insurances pay for up to seven days of LOA due to acute hospitalization. LOAs greater than seven days requires the resident to be discharged from the SNF. The physician will write a discharge order on the

Electronica Health Record (EHR) to discharge the resident to an acute facility. Further clarification regarding insurance coverage shall be routed to Utilization Management.

Every effort is made for a resident whose hospitalization exceeds the LOA period to be re-admitted to their previous room. If the room is not available, the first semi-private room will be offered as long as the skilled nursing services required by the resident meets the eligibility for Medi-Cal and Medicare.

c. The facility shall submit claims for resident LOA days based on allowable reimbursement.

PROCEDURE:

1. Notification of LOA Policy

a. Upon admission, A&E provides the resident, family member, or legal representative with the California Standard Admission Agreement which includes written information regarding LOA-acute hospitalization.

b. Nursing shall provide the bed hold information and Notice of Proposed Transfer at the time of transfer, or within 24 hours of transfer in cases of emergency transfer. Should the written information change, LHH shall reissue the new information to the resident, their family member, or legal representative.

c. The Medical Social Worker (MSW) shall provide the bed hold information to the resident, their family member, or legal representative prior to the scheduled LOA (day/overnight/weekend).

2. Process for LOA/Bed Hold

a. An order from the Physician for a LOA for day/overnight/weekend and for sending out to another facility (ED/PES/Acute Care) shall be written in the electronic health record (EHR) for each occurrence. The LOA order will have a specific date and duration. The Physician and the Licensed Nurse shall follow the process as specified in the EHR.

b. For LOAs to an acute level of care, the Notice of Bed Hold Policy and form shall be provided to the resident and/or representative. For an LOA to a clinic/medical appointment, the Notice of Bed Hold and form is not required.

c. LOA-admitted to Acute Care Hospital from ED/PES

i. The Physician shall write a discharge summary note and enter a discharge order with the appropriate disposition code.

d. The Licensed Nurse shall provide the Bed Hold form and policy, and the Notice of Proposed Transfer form to the resident, family member or legal representative prior to transferring the resident. If the family member or legal representative is not physically present in the facility, a telephone call will be made to review the bed hold policy and Notice of Proposed Transfer/Discharge. The Licensed Nurse will indicate the telephone call to the representative on the forms. The original form will be provided to the representative, copy with the resident, and copy to Health Information Management (HIM). Nursing Operations Manager will ensure that the notices are provided to the resident, family member or legal representative.

3. Census Management

a. Nursing Department is responsible for census management which is done in the electronic health record (EHR).

4. Bed Hold

a. Requirements for bed hold for acute hospitalization:

i. A physician's order to transfer the resident to an acute care hospital.

ii. The day of departure from SNF is counted as day 1 of bed hold; the day of return is not counted.

iii. LHH shall hold the bed up to seven (7) days during hospitalization.

iv. Bed hold must terminate on the resident's date of death.

v. LHH claims must identify the inclusive date of the bed hold.

b. LHH residents discharged to an acute care at another hospital (other than Zuckerberg San Francisco General (ZSFG), LHH Acute Medical):

i. The licensed nurse on the neighborhood shall call the acute care hospital after the seventh day of LOA to ensure that resident was not discharged from acute care hospital before the seventh day to reflect accurate bed hold days.

c. The resident who is returning from LOA due to an acute hospitalization within the 7 days or after 7 days of holding the bed shall be readmitted.

5. Requirements for LOA (Out on Pass – Therapeutic Leave)

a. A bed shall be held during a resident's authorized LOA/OOP for day, weekend, or overnight.

b. A current physician's order for LOA/OOP is required.

6. Status of Residents Without an Approved LOA

a. Against Medical Advice (AMA)

i. A resident who leaves LHH against medical advice is considered AMA and shall be discharged.
ii. If possible, resident shall be asked to sign the AMA form where indicated.

iii. Physician writes AMA discharge order.

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

b. AWOL Elopements

i. A resident who leaves without notification or without an approved order is considered AWOL.

ii. A resident who goes AWOL past midnight shall result in a discharge from the facility. LHH is not permitted to place a bed hold for a resident who is not on an approved leave of absence or out on pass order.

iii. Physician writes discharge order: Discharged – AWOL.

iv. The nurse shall complete an Incident Report.

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-06 Out on Pass
LHHPP 20-07 Against Medical Advice
Medi-Cal Provider Manual Part 2 Billing and Policy for Long Term Care related to LOA and Bed Hold
State Operations Manual related to Notice of bed-hold and return and Permitting residents to return to facility.

Revised: 09/07/17, 09/10/27; 14/01/28, 14/03/25, 17/11/14, 19/05/14, 23/09/12, 25/02/03 (Year/Month/Day)

Original adoption: 01/07/12

Previously numbered LHHPP 20-02.

COMFORT CARE

POLICY:

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

DEFINITIONS:

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

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

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

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

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

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

PROCEDURE:

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

1. Recognition:

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

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

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

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

2. Assessment:

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

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

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

i. Spiritual needs

ii. Environmental preferences

iii. Nutrition and hydration concerns

iv. Oral health status

v. Bowel and bladder concerns

vi. Symptom management

vii. Level of activities desired and psychosocial needs

viii. Functional/ADL status

ix. Medications

x. Skin integrity/ Wound Care Management

3. Treatment:

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

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

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

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

e. Factors influencing the choice of treatments may include:

i. The resident's underlying diagnoses and conditions

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

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

iv. Possible adverse effects

v. Pain management

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

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

viii. Spiritual needs

ix. LHH rules and regulations

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

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

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

i. Adjusting room temperature and lighting
ii. Smoothing linens

iii. Turning and repositioning to a comfortable position

iv. Loosening any constrictive bandage or device

v. Splinting where appropriate

vi. Physical modalities

vii. Exercises to address stiffness

viii. Cognitive/behavioral interventions such as music or diversions

ix. Visits with loved ones

x. Spiritual Services

4. Monitoring:

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

b. The primary care physician will assume responsibility for the overall care and treatment of the resident's medical conditions. LHH will provide opportunities for

the primary care physician to consult with a palliative care specialist as needed.

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

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

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

ATTACHMENT:
None.

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

Revised: 10/21/25

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

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

MOLLY'S FUND - ASSISTIVE TECHNOLOGY PROGRAM

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) utilizes Molly's Fund to provide assistive technology services and devices to residents to maximize their level of functioning, decrease environmental barriers, improve quality of life, and to increase participation in daily activities, leisure pursuits, and socialization.

PURPOSE:

To provide appropriate and effective distribution of assistive technology services and equipment resulting from donations made to the LHH Gift Fund specifically related to Molly's Fund.

CHARACTERISTICS:

1. The funding source for assistive technology devices and services is Molly's Fund, a sub-fund within the LHH Gift Fund. A project code has been established within the Gift Fund to accept contributions from donors who wish to support assistive technology programs at the hospital.

2. The distribution of assistive technology equipment and services is the responsibility of~~to~~ the Assistive Technology ~~Committee~~ work group, which includes members of Activity Therapy (AT), Rehabilitation Services, Nursing, Accounting, and Administration.

3. Assistive Technology services are made available to residents and are~~is~~ in accordance with~~to~~ a standard procedure when all other funding options have been explored.

4. Devices acquired through Molly's Fund and provided to residents shall be the property of LHH and shall only become the property of the resident upon a planned discharge. A device may be repossessed by LHH and reallocated to another resident if a resident expires~~,~~ or if the device is misused or not utilized for its intended purpose.

5. The definition of Assistive Technology includes:

   "Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain or improve functional capabilities of a person with a disability." (IDEA2004, Disability Rights California), (The Role of the Occupational Therapy in Providing Assistive Technology Devices and Services, AOTA Fact Sheet, 2015)

PROCEDURE:

1. The Resident Care Team shall discuss assistive technology needs of the resident and designate a staff member to assist with completion of the Assistive Technology Fund application.

2. The completed form is submitted to the Assistive Technology ~~Committee~~ work group for consideration.

~~3. The Assistive Technology Committee is convened by the Accounting Partner and meets at least four times annually and/or when a Molly's Fund application/request has been received.~~

~~4.~~3. If the application is approved, the committee shall request an Occupational Therapy (OT) or Speech/Language Pathology (SLP) referral from the assigned physician as needed. OT/SLP shall conduct an assessment of the resident and develop a treatment plan, including the identification of an assistive technology device.

~~5. Every effort will be made to acquire a device, for trial purposes, from a community-based lending library to determine if it is appropriate for the resident.~~

~~6.~~4. When an assistive technology device or service has been determined to be appropriate for the resident, attempts will be made to acquire funding from all sources, including insurance and the resident/family.

~~7.~~5. If funding from Molly's Fund is determined to be the best option, OT/SLP will send Assistive Technology recommendations to the committee, including~~to include~~ goals and required devices or services. Information on attempts to secure funding from traditional sources shall also be provided to the committee.

~~8.~~6. The work group ~~committee~~ will approve or deny funding of devices or services.

~~9.~~7. If approved, the OT/SLP will review the Assistive Technology Contract with the resident and/or resident representative and get the necessary signatures. The signed contract will be kept on file in the Rehabilitation Services Department.

~~10.~~8. OT/SLP shall facilitate the purchasing process ~~though~~through Information Technology (IT) procurement processes.

a. Chatfield Codes ~~includes~~include:

i. Fund: 22150

ii. Department (Gift Fund): 207690

iii. Project Code: 10000328

~~11.~~9. OT/SLP shall train the resident and neighborhood staff on the use of the assistive device.

~~12.~~10. The ~~Rehabilitation Representative to the neighborhood~~ RCC team and/or including the Rehab staff/AT will monitor the appropriate use technology equipment provided to the resident~~.~~

a. If the determination is made that the resident is not meeting the terms of the Assistive Technology Contract, the Rehabilitation Representative will consult with the RCT to determine if additional support is needed.

b. If the RCT determines that the appropriate course of action is to reallocate the equipment, the OT/SLP responsible for completion of the contract will be responsible forto ~~to~~ retrivingevnge ~~e~~ the equipment from the resident.

ATTACHMENT:
Attachment 1: Assistive Technology Application Form
Attachment 2: Assistive Technology Contract
Attachment 3: The Role of the Occupational Therapy in Providing Assistive Technology Devices and Services, AOTA Fact Sheet, 2015

REFERENCE:
LHHPP 45-01 Gift Fund Management
IT Procurement Guidelines
IDEA2004, Disability Rights California

Revision: ~~23/~~03/14/23, 11/18/2025 (~~Year/~~Month/Day/Year)
Original Adoption: ~~18/~~07/10/18 (~~Year/~~Month/Day/Year)

Revised Active Therapy Policies and Procedures

TRACKING OF RESIDENT PARTICIPATION

POLICY:

The Activity Therapy Department maintains records of resident participation in activities in accordance ~~to~~with Code of Federal Regulations: 42CFR 483.00, Department of Health and Human Services Centers for Medicare & Medicaid Services ~~F679~~F248 and F680, and California Code of Regulations, Title 22.

PURPOSE:

To ~~comply with California state regulations and~~ ensure that resident participation is documented to assist with resident care planning~~.~~ and comply with federal, state, and SF Department of Public Health regulations.

PROCEDURE:

1. Neighborhood based activities

   a. Activity staff assigned to the neighborhoods utilize the "~~"~~Activity ~~Therapy Group Attendance Record" to document resident(s) daily participation~~Flowsheet in ~~activities.~~the Electronic Health Record (EHR).

      i. Activity staff ~~maintain the form with~~complete the flowsheet within each resident's electronic medical record after they participate in group or individualized activities ~~along the top vertical section.~~. The group activities shall coincide with the neighborhood calendar for each day. ~~Slots are left blank to allow the recording of additional groups as needed.~~

      ii. If a group provided differs from the neighborhood calendar~~, "Scheduled programs were changed due to:"~~ it shall be ~~marked with reason for change noted.~~documented in the residents' flow sheet.

      iii. Resident participation is recorded ~~at the intersecting square between the residents name and the activity~~as: "A" is used for "Active", "P" "Passive", "D" "Declined", and "N" "Not Available~~" is the preferred notation."~~.

      iv. The notes section is utilized for the recording of individualized activities including 1:1 ~~interventions, non-~~intervention, hospital wide neighborhood program attendance, and resident independent leisure activities. 1:1 ~~interventions~~intervention must be recorded ~~here to be tracked.~~in the Notes section of the EHR.

   ~~a. One form is used for each day of the week.~~

   ~~b. Completed forms are maintained on the neighborhood binder for 3 months. Records older than 90 days are transferred and stored in the specific neighborhood attendance record binder in the activity therapy department.~~

   ~~c. Neighborhood participation records are maintained for one year, after which they are discarded using confidential shedder bins.~~

Hospital-wide activities

~~a.~~ Activity staff record and maintain hospital wide activity participation ~~electronically.~~

a. ~~Records are saved~~ in the ~~departmental L drive.~~electronic medical record either in notes or the flowsheet.

b. Records include:
   i. Residents full name
   ii. Neighborhood in which they reside
   iii. Date of the activity
   iv. Title of the activity
   v. Mark ~~residents~~residents' participation

~~b. Completed records are maintained for 1 year.~~

REFERENCE:
Code of Federal Regulations ~~F679~~: 42CFR 483.00
California Code of Regulations, Title 22, Division 5 Chapter 3 – Skilled Nursing Facilities Section
Activity Therapy Group Attendance Record Guidelines

ATTACHMENT:

Most recent review: 7/17/23
Revised: 10/18/2010, 8/15/2012, 9/2013, 8/29/2014, 6/18/2015, 6/26/23, 7/17/23
Adopted: 8/21/2008

Revised Admissions and Eligibility Policies and Procedures

PROCEDURE FOR ~~FINANCIAL COUNSELOR~~SR. ELIGIBILITY WORKERS AFTER RECEIVING NEW RESIDENT CHART

POLICY: Laguna Honda Hospital ~~Financial Counselor~~Sr. Eligibility Worker~~s~~ should follow the steps below when they receive a new resident (patient) chart.

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PROCEDURE:

- ~~Face sheet generated by an admission prints out in the A&E office~~
- Supervisor or Admission~~Referral~~ Coordinator ~~-~~reviews admission packet and presents ~~-~~it to ~~Financial Counselor~~Sr. Eligibility Worker (~~FC~~Sr. EW)
- ~~FC~~Sr. EW assembles chart in standard ~~format~~format.
- ~~FC~~Sr. EW checks EPIC to make sure information from admission packet has been inputted correctly.
  1. ~~FC inputs County ID into EPIC for crossover to the ADL system used by Utilization Management~~
  2. ~~FC inputs BIC # (if missing) by performing an RTE so it automatically populates appropriate field~~
  3. ~~3.~~1. If resident is coming from ZSFGH, ~~FC~~Sr. EW reviews referral and ZSFGH face sheet for ~~accuracy~~accuracy.
  4. ~~4.~~2. If resident is coming from some place other than ZSFGH, review Information supplied in the admission ~~packet~~packet.
  ~~Complete Financial Agreement if missing form the admission packet~~
  5. ~~5.~~3. ~~FC~~Sr. EW- activates (RTA) Resident trust account with NEW ~~residents~~resident's consent.
- ~~FC~~Sr. EW reviews MEDS and ~~CalSAWS~~Cal SAWS: (~~FC~~Sr. EW responsible for printing ~~all of~~all the following MED screens)
  1. Medi-Cal coverage (INQM)
  Make sure correct Medi-Cal insurance plan matches what is in ~~EPIC~~EPIC.
  ~~EPIC~~
  2. Other Health Coverage (OHC) (INQM)
  If OHC, interview family/resident for accuracy. Investigate implications of OHC.
  3. Medicare HIC # matches Medicare number on face sheet (INQM)
  Make sure Medicare number from admission packet, MEDS and RTE match. ~~and RTE match.~~

Verify Social Security income of patient (INQX / INQT) INQX show SSI income, INQT shows Social Security income.

4. Check for HCP1 coverage / HCP1 Status (INQM)
   If there is Managed Care Medi-Cal is there an authorization.
5. Does patient have Medicare D coverage (MOPI)
   If Medicare D Plan is not contracted with hospital, Pharmacy may contact ~~FC~~Sr. EW to enroll resident in contracted plan.
6. If County Medi-Cal, who is the DHS worker (INQM) ~~FC~~Sr. EW uses to contact DHS of admissions and discharges.
7. Does AID Code require clearing SOC (INQM)
   If the second digit of the ~~two digit~~two-digit aid code is ~~the number~~number 7, ~~FC~~Sr. EW must clear SOC at the Medi-Cal website so billing can occur.
8. If case is pending Medi-Cal who is the worker (INQP) This screen may show who the Medi-Cal worker will be.
9. Is there Medicare coverage (INQB) (MOPI)
   Screen (INQB) shows Medicare start dates. Use as a tool but always do an RTE (see below). (MOPI) should have the same results as RTE.

- ~~FC~~Sr. EW review ~~RTE~~ EPIC RTE (Real Time Eligibility):
  1. Check to see if RTE was already verified for month. If it has, review both Medi-Cal and ~~(260),~~ Medicare ~~(161), HSF (801) and SFHP (340)~~
  2. When the RTE is performed with Medi-Cal, and if the patient has a Manage Care Medi-Cal, RTE will verify as mismatched and will prompt user to use updated plan with correct plan.~~If RTE~~ RTE ~~was only performed on Medi-Cal, complete a new RTE~~ RTE ~~including above health plans.~~
  3. If there is coverage, accept the coverage (accepting Medicare coverage will populate the start dates in the insurance field).
  4. Check for HMO/Hospice coverage. If commercial HMO there should be a denial or Letter of agreement (LOA) ~~payment agreement~~ included in the admission packet. If there is hospice coverage, resident must revoke it back to admit date.
  5. If the Medicare is an HMO, resident must disenroll.

- ~~Bill Summary~~
  1. ~~Complete Bill Summary with all known pay resources. Any insurance should have billing address, policy number, group number, ID number and phone number. Make sure the summary is complete with all information needed by the Billing Department. Attach denial letter/authorization to Bill Summary if it is available. Attach Cal-Meds printout (INQM) and copy of face sheet..~~

- Notify Social Security and DHS of Admission
  Complete a MC-171 for Long-~~-~~term residents only- and fax it to Social Security ~~Administartion~~Administration. A fax receipt must be placed in chart.~~. put it in Social Security mailbox. Social Security representative will collect them weekly.~~
  1.
  1. ~~There are a couple of acceptable ways to notify DHS if the resident has a Medi-Cal worker. A form is in the "L" drive named "DHS Notification", or if FC prefers to use the MC-171 for both SSA and DHS, a fax receipt from either must be in chart.~~

- Medi-Cal Application
    1. If a resident is admitted pending Medi-Cal, the Admission referral staff ~~FC~~ will try to find out if an application was taken prior to ~~admission,during~~admission, during the new application process. ~~If unsuccessful using electronics and other sources available to determine DHS worker, the FC must call the FC/social worker from the referring facility and ask if an application was taken.~~ If an application was not facilitated ~~taken~~, the ~~FC~~Sr. EW is responsible for completing the application ASAP. The completed application is given to the supervisor for review the ~~FC~~Sr. EW maintains a log on outstanding applications under their assigned ALPHA for priority follow-up and certification. ~~so a log can be maintained on outstanding applications.~~
    2. ~~FC~~Sr. EW must ~~follow-up~~follow up with case regularly for status.
    3. When ~~resident receives~~residents receive Medi-Cal coverage the ~~FC~~Sr. EW must update EPIC with the appropriate pay sources, ~~complete Bill Summary, and Half Sheet (Manual Financial Information) which is emailed to the Hudsman Coordinator..~~
    4. An updated MEDS (INQM) and ~~RTE~~ RTE must be put in the ~~residents~~resident's chart to show Medi-Cal coverage.

~~• Direct Deposit/Change Location Form~~

~~1. If the resident is going to be a Laguna Honda Hospital (LHH) more than a month, the resident should be asked if they would like their source of income to come to LHH. If they complete a Direct Deposit form their Social Security benefits can be wired to their LHH Trust Account (residents automatically have a Trust Account established upon admission). If their pay source is mailed to LHH a Change Location Form needs to be completed. The top portion giving LHH permission to deposit any checks without a signature. The bottom portion is a statement from the resident that they don't want their check deposited and it should be delivered to the resident unopened. Note in chart if resident refuses to sign either form.~~

- Update QS1 (Pharmacy)
    1. The Pharmacy will contact the EW with the best plan for the resident for which LHH has a contract. EW will speak with the resident and get permission to enroll in suggested plan. If the resident is not competent to make the decision the family/conservator should be contacted.
    2. If resident already has a plan connected to their pension and it is equal to or better than the plans LHH contracts with, they may want to continue with their current plan. If this is the case, arrangement will have to be made to pay any co-payment associated with their plan.
    3. ~~Create a new blue card and face sheet with Medicare D plan showing for distribution for ward only. If resident does not have Medicare, but has Medi-Cal only, enter MC on face sheet for ward. (if Medi-Cal only on admission it should already be completed)~~

- SSI Check Reduction
    1. If resident receives both SSA retirement and SSI, the SSI will be reduced to zero while in LTC and ~~all of~~all the retirement minus $35 will go toward SOC.
    2. If only SSI check will be reduced to ~~$50.00~~ $56.00.

- Social Security Share of Cost (SOC)

1. All but $35.00 of Social Security check goes to SOC.

- Pension Check
  1. All of pension check goes toward SOC unless resident does not have other income. In this case the $35.00 applies.

- Social Worker Assessment
  ~~1. Assessment should be received from social worker within two weeks. If not received contact Social Services Department secretary for a follow up.~~ Assessments ~~should be received from social worker within two weeks~~ can be found in EPIC. If ~~not, received contact~~not, MSW is contacted for ~~assessment .~~assessment.

- ~~FC~~Sr. EW - NEW Patient Screening
  1. Complete source of income /work history /payee, check list
  2. Follow up or complete required consent ~~forms~~forms.
  3. Update applicable ~~Guarantor~~Guarantor.
  4. Obtain copy of DPOA if not already in EPIC, New Patient admission packet
  5. If the patient receives SSA/pension -advise patient or Legal representative of implementation of a SOC (share of Cost)
  ~~1.~~6. Depending upon the patients projected length of stay - Provide the patient or Legal representative the option to use (RTA) Resident Trust Account – have them complete~~/~~ and~~sign the~~ sign the Resident Trust Fund notification and Authorization to DOCUMENT whether resident or Legal guardian wishes to use RTA or not.~~)~~

Most recent review: 12/11/2023~~05/21/2010~~
Revised: 10/6/25~~05/21/2010~~
~~Original adoption: 01/15/2009~~

Revised Nursing Policies and Procedures

NURSING MANAGEMENT OF URINARY CATHETERS

POLICY:

~~Urinary catheters require a written physician's order and can only be inserted by Licensed Nurses. Unless otherwise clinically indicated, the smallest bore catheter possible, consistent with good drainage, is usually ordered to minimize bladder neck and urethral trauma. If indication is not included in the order, contact physician.~~

1. Urinary catheters, including Coude catheters, require a written physician's order and can only be inserted by Licensed Nurses (LN). The physician order should include the indication and duration of use, size of the catheter, type of the indwelling or suprapubic catheter (Refer to Nursing Policy & Procedure F 7.0 Replacement and Care/Maintenance of an Existing Suprapubic Catheter), balloon volume, routine indwelling catheter care, interventions when obstruction is encountered, and discontinuation of the indwelling catheter. Unless otherwise clinically indicated, the smallest bore catheter possible, consistent with good drainage, is usually ordered to minimize bladder neck and urethral trauma. If indication is not included in the order, contact physician.

~~1.~~

2. Licensed Nurse will consult with physician regarding alternatives to an indwelling urinary catheter (e.g., condom catheter, intermittent catheterization, bladder emptying dysfunction, neurogenic bladder). Urinary catheters should not be used in residents solely for the management of incontinence.

3. Urinary catheters will only be utilized for appropriate indications and left in place only as long as needed.
   (
   Examples of appropriate indications include; Acute urinary retention or bladder outlet obstruction, need for accurate measurements of urinary output, to assist in healing of open sacral or perineal wounds in incontinent patients, patients requiring prolonged immobilization, to improve comfort for end of life care if needed.)

~~4. In the non-acute setting, clean (i.e., non-sterile) technique for intermittent catheterization is an acceptable and more practical alternative to sterile technique for residents requiring chronic intermittent catheterization.~~

~~5. Urinary catheters require a written physician's order and can only be inserted by Licensed Nurses.~~

~~6.~~4. Licensed Nurses assess indwelling urinary catheters and monitor residents for any signs and symptoms of catheter-associated urinary infections (CAUTI) every shift. Licensed Nurses assess indwelling urinary catheters for any blockage, obstruction, or leakage, and monitor residents for any signs and symptoms of catheter-associated urinary infections (CAUTI). Assessment findings, appropriate interventions, and evaluation must be documented.

~~7.~~5. Routine catheter irrigation is contraindicated unless there is a written order from the physician.

~~8. Aseptic technique is observed. Sterile equipments shall be used at all times when inserting or replacing an indwelling or intermittent catheter to prevent infection. Clean technique is observed on routine indwelling catheter care.~~

~~9.~~6. Licensed ~~N~~nurse or nursing assistants observe clean technique when ~~-~~performing daily urinary catheter care.

~~10.~~7. Indwelling catheter and drainage bags will be changed based on clinical indication such as infection, obstruction, or when the closed system is compromised.

8. Any nursing staff member (CNA, PCA, LVN, or RN) may apply a condom catheter when indicated.

9. Condom catheters are checked at least every shift and changed at least once a day and as needed, and a new catheter and new drainage bag reapplied after skin care using standard precautions.

~~11.~~10. Any nursing staff member may apply or remove a leg bag using standard precautions.

~~12.~~ Intake and output will be measured every shift for residents with a urinary catheter. {Refer to Nursing Policy & Procedure (NPP) G 3.0 Intake and Output}

~~13.~~11.

PURPOSE:

To minimize the risk of CAUTI.

PROCEDURE:

A. Equipment

- Non-sterile gloves and additional personal protective equipment if needed per standard precautions, transmission-based precautions, or enhanced barrier precautions
- Drape or blanket
- Indwelling Catheter Supplies ~~:~~
  - Closed System: (16 French or 18 French):
    - Total One Layer Tray Select Silicone Closed System Foley Catheter with Drainage bag
  - Open System: {Other Sizes (i.e., 20 French)}
    - Coude Tip Foley Catheter (if ordered)
    - Individually Packed ~~Cathter~~Catheter ~~(size based on MD order)~~
    - Catheter Insertion Tray
    - Drainage Bag
- Straight Catheter Supplies:
  - Pre-connected Vinyl Intermittent Catheter Trays
- Flashlight (as needed)

~~Urinary Catheter (Indwelling or Straight)~~
~~Urinary Catheter Insertion Tray~~
~~Closed System Urinary Drainage Bag~~
~~Flash light (as needed)~~

B. Preparations for Urinary Catheter ~~(Inserting~~ Straight Insertion,~~Intermittent and~~ Indwelling Insertion or Coude Insertion)~~Urinary Catheter~~

1. Check for physician order and indication.

~~If indication is not included in the order contact physician.~~

~~1.~~2. Review the manufacturer's instructions for the type of urinary catheter to be used, and how much balloon volume is needed.

~~2. Unless otherwise clinically indicated, consider using the smallest bore catheter possible, consistent with good drainage, to minimize bladder neck and urethral trauma.~~

3. Perform hand hygiene immediately before and after insertion or any manipulation of the catheter device or site.

4. Explain the procedure to the resident.

5. For indwelling catheterization ~~See Appendix 1 for procedure for indwelling and straight catheter insertion for both female and male resident.~~ refer to:
   - Closed System: Medline One Layer Tray Insertion Kit Video: https://vimeo.com/740873181
   - Open System: Skills: (elsevierperformancemanager.com) for procedures on Urinary Catheter: Indwelling Insertion or procedures on Urinary Catheter: Indwelling or Coude Insertion.

~~5.~~6. For straight catheterization, refer to Skills: (elsevierperformancemanager.com) for procedures on Urinary Catheter: Straight Insertion (Note: Facility kits are a preconnected closed system)

C. Proper Techniques for Urinary Catheter Maintenance

1. Following aseptic insertion of the urinary catheter, maintain a closed draining system. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment.

2. Maintain unobstructed urine flow.

   a. Keep the catheter and collection tube free from kinking.

   ~~b.~~ Keep the collecting bag below the level of the bladder, and avoiding dependent loops, at all times.

   b.

   ~~c.~~

   c. Do not rest the ~~collecting bag~~tubing or drainage bag directly on the floor. ~~I~~If a resident with a catheter uses a low bed, place the bag and any extra tubing into a new, clean basin on the floor next to the bed. Clean and disinfect basin every shift using the facility-approved disinfectant

   d. Use aseptic technique ~~when~~if changing the drainage bag to reduce risk of infection.

   e. Properly secure catheters to the resident's thigh using facility-approved catheter tube stabilization device (i.e., stat-lock).

   ~~d. Utilize clean technique by washing hands and wearing non-sterile gloves when emptying the drainage bag.~~

   ~~e.~~f. Empty the collecting bag regularly, using a ~~separate, clean collecting container for~~disposable graduated container for each resident.

3. Monitor resident for adequate urinary output every 8 hours or as indicated.

4. Provide on-going assessment of urine drainage, noting any residue, sediment, foul odor, cloudiness, or blood.

5. Perform daily routine urinary catheter care:

    a. Female resident: Clean the urinary meatus with routine hygiene products from the base of the catheter, moving up and away from the insertion site. If necessary, continue to wash the rest of the perineal and anal area from front to back. Dry skin with towel.

    b. Male resident: Retract foreskin, if present, away from the catheter. Clean around the urinary meatus with routine hygiene products. Dry skin with towel. Gently pull foreskin, if present, back around the catheter. Continue to clean between the scrotum and anus with a separate washcloth and dry the area.

6. Empty the drainage bag, utilizing clean technique by washing hands and wearing non-sterile gloves, ~~at least when bag~~when it is less than or equal to ~~i s~~ two-thirds full. ~~-~~Then clean the drainage bag outlet with routine hygiene products after emptying the drainage bag.

7. May use cloth bag to cover drainage bag when resident is out of ~~his/her~~ bed. Do not attach the drainage bag to ~~the~~ bedrails to prevent potential pulling of the catheter or bag ~~when bedrails are adjusted~~.

~~8. Verify that the catheter and tubing are secured to the resident's inner thigh using the facility-approved catheter tube stabilization device. Ensure the draining tube is not kinked, or too loose or tight to allow resident to move freely.~~

~~9.~~8. Unless obstruction is anticipated, bladder irrigation is not recommended.

~~If using a u~~Urinary leg bag~~:, refer to Appendix 2 (Application of Urinary Leg Bag). T~~ The leg bag for urinary collection is discarded after a single use or when visibly soiled. ~~To prevent backflow and possible microbial contamination, leg bag is placed below the level of the bladder and tubing draped above bag and leg bags are not used when the resident is in bed.~~

a. Application of Leg Bag
    - If using a condom catheter: Make sure the condom is not twisted where it attaches to the catheter.
    - Position the leg bag to prevent pulling on the catheter tubing and ensuring resident is comfortable. ~~.and position resident preference and comfort.~~
    - Maintain the leg bag at a position that promotes urine flowing downward.
    - To prevent backflow and possible microbial contamination, leg bag is placed below the level of the bladder and tubing draped above bag and leg bags are not used when the resident is in bed.

~~i.~~

D. Proper Techniques for Urinary Catheter Removal (For indwelling catheter removal, refer to Skills: (elsevierperformancemanager.com) for procedures on Urinary Catheter: Indwelling Removal)

~~D.~~E. Urinary Catheter Care Maintenance for Aquatic Services {Refer to Hospitalwide Policy and Procedure (HWPP) 28-03 Aquatic Services}

~~1. Perform hand hygiene and apply clean gloves.~~

2. Empty the drainage bag completely.

3. Obtain a catheter plug with cap from Central Supply, disconnect drainage bag from the urinary catheter and discard and cap the end of urinary catheter to prevent urine backflow and to stop drainage.

4. Conceal catheter tubing inside resident's swimsuit/swim trunk.

1. After aquatics therapy and return to the unit, reconnect to a new drainage bag using aseptic technique.Catheter must be removed prior to entering the pool.

5.2. Participants must be continent of bowel and bladder, or must be successful and consistent on a bowel/bladder program for at least two weeks.

E.F. Documentation

1. The physician order should include the indication and duration of use, specifies size of the catheter, type of the indwelling or suprapubic catheter, balloon volume, routine indwelling catheter care, interventions when obstruction is encountered, and discontinuation of the indwelling catheter.

1. Documentation
2.
3. Document Upon initial insertion/reinsertion of an indwelling urinary catheter (Done completed by LN):

Add an Avatar for urinary catheter and create nursing assistant worklist tasks for catheter care and intake/output.

1. Complete a nursing note: Date and time of indwelling catheter inserted, indication of use based on physician's order, including the size of the catheter, amount of fluid used to inflate the balloon and volume of balloon inflated on the electronic health record.
    a. Indication for catheter insertion/reinsertion
    b. Volume and any untoward events encountered during the procedure and urine characteristics (i.e. color, clarity, odor, presence of sediment or clots)
    c. Resident's tolerance of the procedure.
    c.d. Any untoward events encountered during the procedure and related interventions
    e. If urine specimen was sent to the laboratory. Specimen collection, if performed

2. Site Assessment and Output
    a. At least once a shift, document the following:
        - Indication
        - Urine Color
        - Urine Appearance
        - Site Assessment (LN only)
        - Collection Container
        - Catheter Bag (yes or no)- Catheter bags are only changed when indicated, see policy statement. Changed (LN document every shift; per current policy: Any nursing staff member may apply or remove a leg bag using standard precautions)
        - Securement Method
        - Volume of Urine Output
    b. Only on catheter insertion/re-insertion
        - LHH/4A Reason for continuing urinary catheter (LN Only)

3. Catheter Care
    a. Catheter Care is documented by the LN or CNA/PCA in the EHR ~~Daily Cares/Safety~~Flowsheet once a shift

.

4. Documentation for daily charting and/or~~,~~ weekly~~, or /~~monthly summary:
    a. Any unexpected events encountered during the specific period such as obstruction or leakage, bladder distention, change in urine output from baseline, clinical signs and symptoms that may indicate infection or other complications. (Refer to NPP C 4.0 Notification and Documentation of Change in Resident Status)
    b. Any interventions performed and evaluation and outcome of intervention.
    c. For straight catheterization:
        - Is the order for self-catheterization?
        - Catheter size
        - Urine return
        - Amount (mL) and characteristics of urine
        - resident/patient tolerance

    ~~b. Record any problems to the licensed nurse if resident is having problems with leg bag e.g. leakage, skin irritation etc.~~

~~5. 3. Electronic Health Record~~
~~6.~~
~~7. Document when changing close system drainage bag.~~
~~8.~~
~~9.~~5. ~~Document intake and output every shift.~~Care Plan (Done by LN): (Refer to HWPP #23-01 Resident Care Plan, Resident Care Team, and Resident Care Conference)

~~4. Plan of Care~~

a. Genitourinary diagnosis requiring catheterization
b. Indwelling catheter: Document the initial date of insertion, type and size of the indwelling catheter used, any unique management or approaches to resident when inserting catheter.
c. Intermittent catheterization:~~-~~ size of the indwelling catheter used, any unique management or approaches to resident when inserting catheter, frequency of intermittent catheterization
~~a.~~
d.
~~b.~~
~~c.~~ Address possible risk for complications and infections related to use of ~~indwelling~~ urinary catheter, measurable goals and date, and interventions. ~~On-going~~Ongoing problems should be addressed and documented in notes as indicated. Plan of care goals are reviewed and updated accordingly.~~-~~ (Refer to NPP C 4.0 Notification and Documentation of Change in Resident Status))
e.
~~d.~~
~~e.~~f. For residents whom intake may not always be able to be accurately measured and/or reported (e.g., residents on outings, consuming beverages outside neighborhood), individual needs will be documented in the plan of care.

~~**APPENDICES:**~~

~~Appendix 1 - Procedures in Inserting Urinary Catheter for Male and Female Resident~~
~~Appendix 2 – Application of Urinary Leg Bag~~

REFERENCES:

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Elsevier (2025) Urinary Catheter: Indwelling Removal https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on August 26, 2025

Elsevier (2024) Urinary Catheter: Indwelling Insertion (Female) https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on August 18, 2025

Elsevier (2024) Urinary Catheter: Straight Insertion (Male) https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on August 18, 2025

Elsevier (2024) Urinary Catheter: Straight Insertion (Female) https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on August 18, 2025

Elsevier (2024) Urinary Catheter: Straight Insertion (Male) https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on August 18, 2025

Healthcare Infection Control Practices Advisory Committee (2009). Guideline for prevention of catheter-associated urinary tract infections. Accessed at http://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf

Medline One Layer Tray Insertion Kit Video: https://vimeo.com/740873181 - accessed August 15, 2025

CROSS REFERENCE:

Hospitalwide Policy and Procedure
#23-01 Resident Care Plan, Resident Care Team, and Resident Care Conference ~~Nurising~~
#28-03 Aquatic Services

Nursing Policy and Procedure
C 4.0 Notification and Documentation of Change in Resident Status
F 7.0 Replacement and Care/Maintenance of an Existing Suprapubic Catheter
G 3.0 Intake and Output

Revised: 2006/04; 2014/05/27; 2015/03/10; 2016/11/09; 2019/07/09; 2025/08/26

Reviewed: 2019/07/09

Approved: 2019/07/09

~~APPENDIX 1 - Procedures in Inserting Urinary Catheter for Male and Female Resident~~

~~Gathers and brings the equipment needed for the procedure to the resident's bedside:~~

~~Indwelling Catheter~~
~~Catheter insertion tray~~
~~Foley Catheter (size based on MD order)~~
~~Drainage Bag~~

~~Straight Catheter~~

~~Urethral catheter tray~~

~~Flash light~~

~~Explains procedure to the resident.~~

~~Positions the resident as follows:~~

~~Female: Dorsal recumbent position (on back with knees flexed), have resident relax the thighs. Alternate position: Sims' position: side-lying with upper leg flexed at knee and hip.~~

~~Male: Supine position with legs extended and thighs slightly abducted~~

~~Covers or drapes the resident with blanket so that only perineum or genitals are exposed.~~

~~Positions light to illuminate perineum or have someone assists in holding the flashlight to visualize urinary meatus.~~

~~Performs hand hygiene.~~

~~Preparation of equipment needed:~~

~~Places unopened catheter insertion tray, foley catheter, and drainage bag on a clean surface close to the resident.~~
~~Opens the outer wrapper of the catheter tray using sterile technique.~~
~~Opens the package of the drainage bag, checks to see if drainage bag clamp is closed, and sets bag aside.~~
~~Opens the outer wrapper of the foley catheter while maintaining sterility of the inner wrapper and places catheter together with the opened, sterile catheter insertion tray.~~
~~Puts on sterile gloves.~~
~~Places absorbent pad (shiny side down) under the buttocks while keeping gloves sterile. Drapes resident's perineum. For females, expose labia. For males, expose penis.~~
~~Arranges the supplies on the sterile field.~~
~~Tests integrity of the catheter's balloon based on the manufacturer's recommendations. Using the pre-filled syringe, inflate the balloon to its maximum balloon capacity; withdraw solution if no leakage. Keep the pre-filled syringe attached to the catheter.~~
~~Lubricates catheter with sterile lubricating jelly 1 to 2 inches for female residents and 5 to 7 inches for male residents.~~
~~Pours the aseptic solution (Povidone-Iodine) over the cotton balls.~~

~~Cleanses urinary meatus with antiseptic solution~~

~~Female:~~

~~Using the non-dominant hand (non-sterile hand) separate the labia with fingers to fully expose the urinary meatus. This hand should maintain this position for the remainder of the procedure.~~
~~Using the sterile hand, use forceps to hold the pre-moistened cotton balls.~~
~~1st pre-moistened cotton ball: clean along side farthest from the nurse along the meatus in a single stroke, discard the 1st cotton ball.~~
~~2nd pre-moistened cotton ball: clean labia and meatus nearest the nurse using a single stroke, discard the 2nd cotton ball.~~
~~3rd pre-moistened cotton ball: clean the midline, directly over the meatus; then discard the 3rd cotton ball.~~
~~Using the sterile gloved hand, holds the catheter 3-4 inches from the tip. Holds the end of the catheter loosely and coils in the palm of the dominant hand.~~

~~Male:~~

~~Using the dominant hand (non-sterile hand) retract foreskin (if uncircumcised) and grasp the penis at shaft just below the glans. This hand should maintain this position for the remainder of the procedure.~~
~~Hold shaft of the penis at right angle to the body.~~
~~Using the sterile hand, use forceps to hold the pre-moistened cotton balls.~~
~~Cleanse the meatus in circular strokes, beginning at the meatus and working outwards in a spiral motion.~~
~~Repeat with three cotton balls (one at a time); discard each cotton ball after each use.~~
~~Using the sterile gloved hand, holds the catheter 3-4 inches from the tip. Holds the end of the catheter loosely and coils in the palm of the dominant hand.~~

~~Catheter insertion~~

~~Female:~~

~~Instructs resident to bear down gently and insert catheter.~~
~~Advances catheter slowly a total of 2 to 3 inches or until urine flows out catheter's end.~~
~~Once urine appears, advances the catheter another 1 – 2 inches. Do not force if resistance is encountered.~~
~~Releases labia and holds catheter securely using the non-dominant hand~~

~~Male:~~

~~Applies gently upward traction to the penis using the non-dominant hand~~
~~Instructs resident to bear down gently and insert catheter through the meatus.~~
~~Advances catheter about 7 – 9 inches or until urine flows out at the end of the catheter.~~
~~When urine appears, advances catheter to bifurcation of drainage and balloon inflation port. Do not force catheter insertion.~~
~~Lowers penis and holds catheter securely using the non-dominant hand.~~

~~Inflating the balloon catheter~~

~~Allows bladder to empty fully unless contraindicated.~~
~~Collects urine as needed.~~
~~Keeps the non-dominant hand securely holding the catheter.~~
~~Using the dominant hand,~~

~~Attaches the pre-filled syringe in the injection port at the end of the catheter.~~
~~Slowly injects the designated amount of fluid to inflate the balloon. If resident complains of sudden pain, stop injection and gently withdraw fluid from balloon, advance the catheter further and re-inflate the balloon.~~
~~After inflating the catheter balloon, releases catheter from the non-dominant hand.~~

~~Gently pulls the catheter until resistance is felt, then advance slightly.~~
~~Attaches the catheter to drainage bag.~~

~~Securing indwelling catheter with tape~~

~~Female: Secures catheter to inner thigh with tape or catheter strap, allowing slack to prevent tension.~~
~~Male: Secures to lower abdomen with tape or catheter strap. If retracted, replace foreskin over the penis glans.~~
~~Positions drainage bag lower that the bladder by attaching the bag to the bed frame. Do not attach to the side rails of the bed.~~

~~APPENDIX 2 – Application of Urinary Leg Bag~~

~~Application of Leg Bag~~

~~Make sure the condom is not twisted where it attaches to the catheter.~~

~~Position the leg bag to prevent pulling on the catheter tubing and position resident preference and comfort.~~

~~Maintain the leg bag at a position that promotes urine flowing downward.~~

~~To prevent backflow and possible microbial contamination, leg bag is placed below the level of the bladder and tubing draped above bag and leg bags are not used when the resident is in bed.~~

NEUROLOGICAL STATUS ~~ASSESSMENT~~ CHECK

POLICY:

1. ~~Assessments~~ Neurological status checks are to be performed by the ~~Registered~~ Licensed Nurse (LN) and recorded in the Electronic Health Record (EHR).

2. Frequency of assessments following head injury or other related conditions is to be based upon the resident's condition, but no less often than the schedule below for the first 72-hours unless ordered otherwise by the physician.

   - After initial status check, checks will continue at the following times: Q 30 minutes x 2, Q 1 hour x 3, Q 4 hours x 5, and then Q shift x 6.

   ~~First – 24-hour: every 2-hours for the first 12 hours, then every 4-hours for the second 12 hours;~~

   ~~Second - 24 hour: every 8 hours;~~

   ~~Third – 24 hour: every 12 hours, then daily until stable.~~

   After the initial 72 hours, if neurological assessments indicate status has stabilized, resume the pre-injury vital sign monitoring intervals or if not stabilized, continue to monitor every day as often as needed unless ordered otherwise by the physician.

3. The physician is to be notified immediately if ~~there is a decrease of one or more points in the total score of the Glascow Coma Scale or when~~ there are sudden or subtle changes in level of consciousness, vital signs or pupil reactions.

PURPOSE:

To assess neurological status following head injury or other related conditions (e.g., unwitnessed falls).

CHARACTERISTICS:

A. Neurological ~~assessment~~ status check includes:

   - Level of Consciousness
   - Pupil Assessment
   - Hand Grasp/Motor Function/Sensation Assessment
   - Neuro Symptoms

   ~~1. Level of consciousness (eye opening, verbal and motor response).~~

   ~~2. Vital signs (respiration, blood pressure, apical pulse counted for one minute, and temperature).~~

   ~~3. Pupil size and reaction to light.~~

~~B. Know the resident's baseline vital signs. In the aging resident, minor changes in level of consciousness or vital signs may indicate major problems.~~

~~C. Decrease in level of consciousness is the earliest, most sensitive indicator of deterioration. Be alert to detect increasing drowsiness, lethargy and slower verbal or motor response.~~

~~D. Symptoms of head injury may occur rapidly or over a longer time. Keep an ongoing alert for changes in neurological status which may be related to even minor head injury. For example, symptoms may be manifested in acute subdural hematomas, usually within 24 to 48 hours; subacute hematomas, anywhere from 48 hours to 2 weeks; and chronic subdural hematomas, the most common in the 60 to 70 year age group, weeks, months, and possibly years after injury.~~

PROCEDURE:

A. Preparation of Resident (Refer to Skills: Elsevier Nursing Resource for Procedures on Assessment: Neurologic)

1. Wake the resident to the extent possible.
2. Explain the procedure to the resident.
3. If able to communicate, instruct resident to notify the nurse~~, if able to communicate,~~ if headache, change in speech, ~~sensorium~~ or breathing difficulty develops.

B. Signs & Symptoms of Increased Intracranial Pressure (Report and notify physician STAT)

1. Level of consciousness decreases.
2. Changes in vital signs.

   (Classic changes are increased systolic blood pressure with widening pulse pressure, bradycardia and slow respiration. However, be alert for any changes, such as irregular respiratory patterns,
   tachycardia or other arrhythmia.~~-~~)
3. Pupil changes.
4. Headache.
5. Vomiting.
6. Changes in sensation or ability to move.

~~**C. Neurological Assessment Procedure**~~

~~**Glascow Coma Scale**~~

~~A standardized system to assess level of consciousness after head injuries. Eye opening and verbal and motor responses are evaluated, numerically ranked and totaled after each assessment~~

~~1. Level of Consciousness~~

~~a. Eye Opening~~

~~To perform this test, first observe for spontaneous eye opening without stimulus. If resident does not open eyes, approach closely and command clearly to open eyes. If still no response, apply painful stimulus (sternal rub or pressure to skin) to stimulate eye opening. If still no response, record none~~

Score	Response
4	Spontaneous
3	To voice command
2	To pain
1	None

b. Best Verbal Response

Ask the resident to tell you their full name and where they are to establish orientation. If unable to respond, ask resident to name a common object (bed, light, pillow) to determine ability to use appropriate words. If unable to identify objects, ask to make any verbal response even if only incomprehensible sounds. If no verbalization at all, mark none.

Score	Response
5	Conserves, oriented
4	Converses, disoriented
3	Inappropriate words
2	Incomprehensible sounds
1	None

c. Best Motor Response

Evaluate voluntary or involuntary movement of extremities.

Score	Response
6	Obeys commands. Ask resident to perform some activity (raise arms, extend tongue, etc).
5	Localizes pain. Apply painful stimuli, (sternal rub). Observe response. (Hand attempts to move stimulus away).
4	Withdrawal. Apply pressure to extremity. (Observe for attempt to pull away).
3	Abnormal flexion. (Posturing of upper extremity in decorticate posture with arms adducted and flexed with wrists and fingers flexed on chest).
2	Abnormal extension. (Posturing of upper extremity in decerebrate posture with arms adducted and extended with wrists and fingers flexed).
1	None (No movement or abnormal posture).

d. **Glascow Coma Scale**: Total the scores for eye opening, best verbal and motor responses after each assessment.

For example:
Eye opening 3
Verbal response 4
Motor response 4
Total Score 10

Score totals range from 3 (no response) to 15 (best possible response). A total of seven (7) or less is defined as coma.

Total scores reflect stability of resident's condition. Changes in total score indicate improvement (score increases) or deterioration (score decreases).

~~Note: Evaluations that cannot be made because resident unable to open eyes, speak or follow commands before the immediate trauma due to pre-existing condition.~~

~~2. Vital Signs~~

~~a. Blood pressure: Widening pulse pressure with increase in systolic reading and diastolic reading remaining the same is a sign of increased intracranial pressure.~~
~~b. Pulse rate: monitor and watch for changes in apical rate, rhythm and volume.~~
~~c. Respiratory rate: monitor for quality, rate and rhythm to detect abnormal breathing patterns.~~
~~d. Temperature: an increase in intracranial pressure may not cause a change in body temperature. However, an elevated temperature of one (1) degree may cause a further increase in intracranial pressure. It is important to know the resident's baseline temperature and prevent hypothermia or hyperthermia with nursing measures.~~

~~3. Pupils~~

~~a. Pupil size is measured in millimeters. For accuracy use the sample sizes on the neurological assessment record.~~
~~b. Inspect pupils with a flashlight to evaluate size and reaction to light. Compare both eyes for similarities or differences.~~
~~c. Reaction to light is measured as to how quickly pupils decrease in size when light is directed into them. For consistency use the coded responses on the neurological assessment record.~~

~~**D. What to do if neurological status declines 1 number or more**~~

~~1. Notify physician stat and report the decline.~~

~~2. Keep resident on bedrest.~~

~~a. Elevate head of bed 30 degrees.~~
~~b. Position resident supine without turning head to either side.~~

~~E.~~C. Documentation

1. Document neurological assessment and vital signs in the EHR.

2. ~~Electronic Health Record: r~~Record observations and ~~comment~~ document on the resident's level of consciousness every shift, or as the resident's condition warrants.

~~3.~~ Physician notification:
~~4.~~
~~5.~~3. Record the time notified, name of the physician, information reported to the physician and response~~.~~, time resident seen by the physician
~~a. Record time of physician's visit.~~
~~b. Record nursing action to carry out physician's orders.~~

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Revised: ~~2000/~~08/2000, ~~2005/~~01/2005, ~~2010/~~03/2010, ~~2019/~~03/12/2019; 04/16/2024; 2025/09/09

Reviewed: ~~2019/~~03/12/2019

Approved: ~~2019/~~03/12/2019

ADAPTIVE/ASSISTIVE DEVICES MANAGEMENT POLICY

POLICY:
To ensure that residents are provided with adaptive/assistive devices that facilitates their engagement in activities of daily living (ADLs) or Instrumental Activities of Daily Living (IADLs) and maintain overall quality of life (QOL).

DEFINITION:
Adaptive/Assistive Device: aids, controls, supplies, or appliances which enable an individual to increase the ability to perform ADLs/IADLs, increase independence in their environment and/or to improve the ability to communicate.

Examples include as follows but not limited to:

a. Transfer devices, e.g., sliding board
b. Mobility devices, e.g., cane, walker
c. Prosthetic devices
d. Locomotion devices, e.g., power wheelchair, manual wheelchair, high back recliner wheelchair, custom wheelchair
e. Speech Language Pathology (SLP) recommended communication devices and software
f. Adapted writing utensils
g. Dressing aids (button hooks, zipper pulls, elastic shoelaces, sock aids, dressing sticks, reach extenders/reachers etc.)
h. Eating aids (adaptive utensils, non-skid bowls, long straws, straw holders, plate guards, etc.)

Mobility loop ~~bar~~ or quarter rail for bed setup

i.
~~a.~~ Positioning devices (chair/bed)~~Transfer devices, e.g., sliding board~~

j.
~~Mobility devices, e.g., cane, walker~~

~~Prosthetic devices~~

~~Locomotion devices, e.g., power wheelchair, manual wheelchair, high back recliner wheelchair, custom wheelchair~~

- ~~Speech Language Pathology (SLP) recommended communication devices and software~~
- ~~Adapted writing utensils~~
- ~~Dressing aids (button hooks, zipper pulls, elastic shoelaces, sock aids, dressing sticks, reach extenders/reachers etc.)~~
- ~~Eating aids (adaptive utensils, non-skid bowls, long straws, straw holders, plate guards, etc.)~~
  ~~Mobility bar or quarter rail for bed setup~~
- ~~Positioning devices (chair/bed)~~

k. Adaptive Call ~~l~~Light devices (see Appendix A for details)

~~P~~**PROCEDURE:**

~~1.~~ Registered Nurse (RN) will assess and communicate with other ~~disciplines~~ resident care team members regarding the resident's needs for adaptive/assistive devices ~~that include, but are not limited to: call light, wheelchairs, mobility device, adaptive eating device, mobility loop and other related equipment to complete ADL/IADL with increased independence~~ at the following intervals and update care plan accordingly:~~:~~

1.

~~a.~~ Upon admission/readmission~~, RN will assess whether resident may benefit from an adaptive/assistive device and notify physician for further evaluation, if needed.~~

a.

~~b.~~ b. Daily ~~rounding~~ IDT leadership meeting ~~to include confirmation of the appropriate placement of adaptive/assistive device as per care plan, and verification that device is working correctly.~~

~~c.~~

b. ~~c.~~ ~~During~~

~~d.~~ R~~r~~esident ~~reviews (quarterly or as needed), in collaboration with the Resident Care Team (RCT), Resident~~ Care Conference (RCC) ~~), and/or interdisciplinary team~~. ~~The resident's individualized care plan, and the effectiveness of the adaptive/assistive device should be discussed to ensure resident's goals are met. If a functional change is noted in resident's ability to engage in ADLs, it should be considered whether an alternative adaptive/assistive device is indicated, and an assessment should be conducted by appropriate disciplines to ensure the appropriate device is ordered to meet the resident's needs.~~

~~As per resident and/or resident's family request. The RCT should collaborate with resident and family to discuss the goals of adaptive/assistive device use to meet resident's functional needs. An assessment should be conducted by appropriate disciplines to ensure the appropriate device is ordered to meet the resident's needs.~~

~~e.~~c.

~~f. If a new device, replacement of device, or repair of device is required, follow standard of work to meet resident's needs (see Appendix B).~~

~~RN will ensure the resident's care plan is updated by end of shift for appropriate interventions when it applies to meeting resident's needs for adaptive/assistive devices, and when the resident has received a physician order for use of an adaptive/assistive device. The care plan and physician order should include details regarding use (e.g., frequency, duration, positioning) as appropriate.~~

~~g. For Custom wheelchair repairs RN will .perform the following but not limited to:~~

~~h. Resident/Surrogate consent.~~

~~i. Vendor identified and appointment setup for pick up, replacement/repair/new equipment.~~

~~j. Provide resident with alternative setup (e.g., facility wheelchair until custom wheelchair repaired and returned to resident).~~

~~k. Keep record of resident's custom wheelchair, accessories, repaired portions, vendor receipts, etc.~~

~~l. Coordinate with occupational therapy department if skilled rehabilitation services required to determine the appropriateness of the equipment (current/alternative).~~

~~m. Coordinate with Materials Management if assistance required for replacement of equipment/parts, repair of equipment, and new equipment.~~

2. Physician will address resident's needs for adaptive/assistive devices through:
   ~~a.~~ Collaboration and requests submitted via ~~with~~ nursing and/or other RCT~~/IDT~~ members~~. at team meetings, and/or~~

   a.

   ~~b. Individualized~~ Physician resident assessment. ~~If the use of adaptive/assistive device is appropriate, the physician will refer the resident to the appropriate disciplines for evaluation and treatment to meet resident's needs.~~

   b.

~~3.~~

4. Rehabilitation Services will address the resident's needs for adaptive/assistive devices via responding to as follows, but not limited to:

5. Responding to physician orders as per Rehabilitation P & P 27-02.

6. Performing quarterly reviews via screen completion.

7.

8. Requesting physician order for resident evaluation if indicated as per IDT/RCT team meetings.

9. Communicate new order or replacement of parts order with Materials Management for adaptive/assistive device including but not limited to providing specificity of the item, expedited need for the item, unit/department the requisition must be submitted to, vendor details, part details, quote, etc.

10.3.

11. Facilities department will respond to work orders submitted for the resident's adaptive/assistive (facility device only), for the followingin a timely fashion. These work order requests may include, but are not limited to:

12. Adaptive Call light installation

4.

a. Facility wheelchair replacement/repair (e.g., manual wheelchair, high back recliner chair, broda chair, geri chair, bariatric wheelchair, etc.)

a.

b. Providing transport wheelchair for resident's appointments

c. Adaptive shower chairs/bathing setup

d.c. Custom wheelchair basic repairs (i.e., tightening of screw or inflating the tire) if it does not impact the integrity of the custom wheelchair

13. Biomed department will respond to work orders for the following:after physician orders, rehabilitation services evaluation and treatment (only for applicable items), and bed committee approval has been received for the release of adaptive/assistive devices to appropriate unit/department as follows, but are not limited to:

14.5. Adaptive beds

~~a.~~ Adaptive bed devices/assistive devices (e.g., mobility loop ~~bar~~, quarter rail, trapeze for bed/chair setup as applicable)

~~b. Interdisciplinary Team (IDT): Any resident care team member may submit work order to appropriate discipline to address resident's needs for adaptive/assistive devices that must be met in a timely fashion. Refer to Appendix B.~~

~~15. Adaptive/Assistive devices that may be considered a restraint must be reviewed and approved by the bed committee team before the device is assigned to the resident and resident's care plan is updated.~~

a.

CROSS-REFERENCES:

Nursing Policy and Procedure
D1 2.1 Nurse and Resident Call System
D6 5.0 Ambulation

Rehabilitation Center Policies and Procedure
70-09 Occupational Therapy Service Equipment and Supplies

REFERENCES:

Curbell Electronics, Inc. www.curbellelectronics.com

Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS) Manual System. 100-07 State Operations Provider Certification.

DHS. The ODDS Guide to Assistive Devices and Assistive Technology. Retrieved on August 11, 2023 from http://www.dhs.state.or.us/spd/tools/dd/cm/Assistive%20Devices%20and%20Technology%20Worker%20Guide.pdf

https://udservices.org/adaptive-devices-people-disabilities/

ATTACHMENTS/APPENDICES:

Appendix A: Adaptive Call Lights

Original Adoption: 07/26/2011

Adopted: 2024/03/12 (previously "Adaptive Devices Operating Guidelines")
Revised: 2014/07/22; 2024/03/12, 2025/25/07
Reviewed: 2024/03/12
Approved: 2024/03/12

~~ADAPTIVE/ASSISTIVE DEVICES~~

1. ~~Examples of adaptive/assistive devices that may be recommended to enhance a resident's ability to participate in ADLs/IADLs in their environment include but are not limited to:~~

    a. ~~Transfer devices, e.g., sliding board~~

    b. ~~Mobility devices, e.g., cane, walker~~

    c. ~~Prosthetic devices~~

    d. ~~Locomotion devices, e.g., power wheelchair, manual wheelchair, high back recliner wheelchair, custom wheelchair~~

    e. ~~Speech Language Pathology (SLP) recommended communication devices and software~~

    f. ~~Adapted writing utensils~~

    g. ~~Dressing aids (button hooks, zipper pulls, elastic shoelaces, sock aids, dressing sticks, reach extenders/reachers etc.)~~

    h. ~~Eating aids (adaptive utensils, non-skid bowls, long straws, straw holders, plate guards, etc.)~~
    ~~Mobility bar or quarter rail for bed setup~~

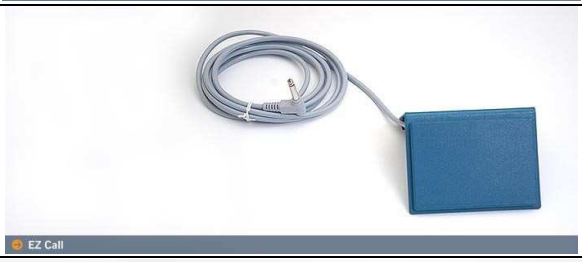
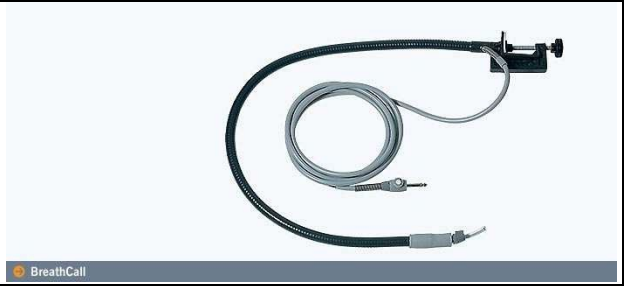
    i. ~~Positioning devices (chair/bed)~~

    j. ~~Adaptive Call light devices (see Appendix A for details)~~

APPENDIX A: ADAPTIVE CALL LIGHT DEVICES

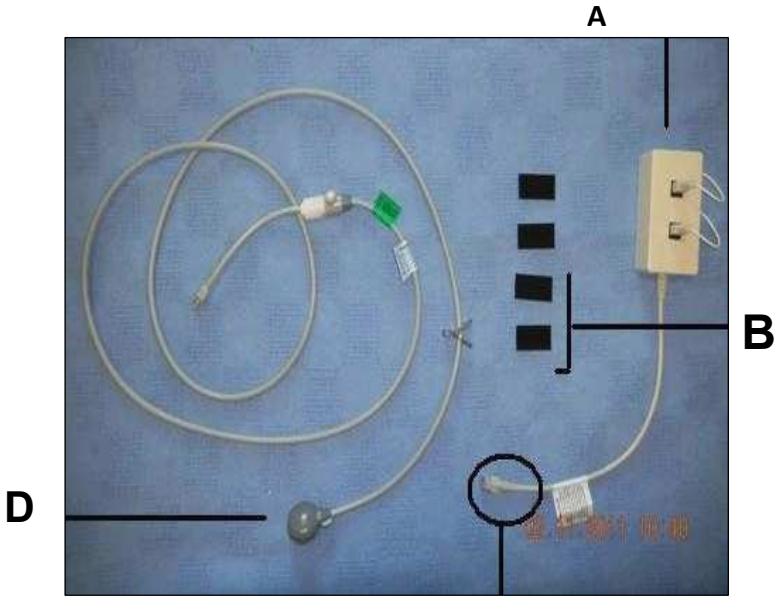
For residents who have limited or loss of hand function, please see the chart below and follow the instructions to match the resident with the appropriate device. For complex resident issues, please contact physician and request a physician order to be sent to rehabilitation services to address resident's needs for adaptive/assistive devices (See examples below: "Type of Adaptive Call Light Devices").

1. **TYPES OF ADAPTIVE CALL LIGHT DEVICES**

Indications	Name	Adaptive Device
Raise and lower their hand to/from their chest or other hard surface	Mechanical Pad	
Slightly moves fingers	EZ Call	
Has a weak pinch or grasp	Press Call	
No ability to move arms/completely plegic	Breath Call	

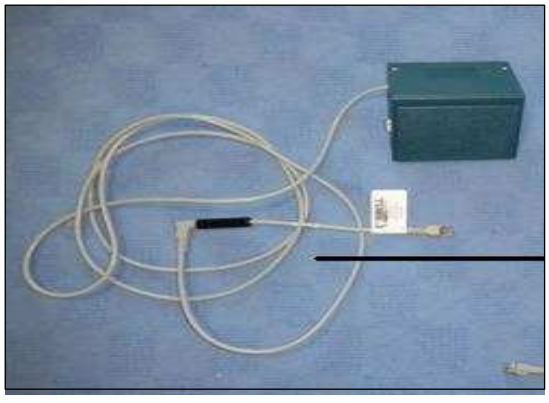
1. **NURSE CALL ADAPTOR INSTALLATION AND SET UP:**

a. <u>The following should be present in the kit received.</u>



<u>Legend</u>:

- **A** Nurse Call Adaptor
- **B** Velcro Straps
- **C** Receptacle of the Call Adaptor
  Note: Pillow speakers and assistive call light devices have also receptacle used to attached to the corresponding sockets
- **D** Assistive Call Light Device - A



Assistive Call Light Device

b. <u>Insert the receptacle of the adaptor to the socket of the nurse call panel.</u>

ARROW POINTING TO THE RECEPTACLE

CIRCLED AREA SHOWS THE SOCKET FROM CONNECTING CORD ATTACHED TO THE NURSE CALL PANEL.

c. <u>Use the black Velcro straps provided to secure the adaptor in the wall.</u>

d. <u>Insert the pillow speaker and the assistive call light device into the socket of the adaptor.</u>

ASSISTIVE CALL LIGHT DEVICE PILLOW SPEAKER

e. <u>Choose any of the two options for placement of the adaptor</u>

APPENDIX B: STANDARD OF WORK

	Major Steps	Details (if applicable)	Owner
1.	New/Replacement: Nursing/IDT identifies resident's need for equipment (new or replacement of a part). Engineering Equipment Repair: Nursing/IDT identifies resident's need for equipment repair and submits facilities' work order for a facility equipment repair. Personal Equipment Repair: Nursing/IDT identifies resident's need for personal equipment repair, and contacts vendor and submits order for resident's personal equipment repair (ensures resident/surrogate provide consent). Follow custom wheelchair policy 70-06.	Rehab and/or IDT ensures all documentation needs are met including collaborating with nursing so care plan and Kardex are updated, and physician order in place for devices (frequency, duration, start/end time), as indicated in electronic health record.	• Nursing/IDT • Engineering • Rehab
2.	Physician order sent to rehab to address resident's equipment needs; rehab responds within 24-48 hours as per policy P&P 27-02	Rehab ensures resident's functional needs are met and/or maintained, while the resident is awaiting the arrival of the item.	• Physician • Rehab
3.	Engineering addresses work order for repair in a timely fashion. This applies to LHH owned equipment only.	Engineering reaches out to nursing/IDT immediately if unable to repair.	• Engineering
4.	Rehab evaluates the resident and provides recommendation for equipment specificity to Materials Management and Restraint committee/Bed committee. **	**If the equipment is considered a restraint (e.g., broda chair, mobility bar, quarter rail, leg strap, geri chair), this must be approved by Restraint committee/Bed committee prior to Materials	• Rehab • Material Management • Biomed & Bed committee**

Major Steps		Details (if applicable)	Owner
		Management and/or Biomed contacting the vendor to initiate the ordering process as per item list (see below). Biomed items list: Mobility bar, quarter rail, bed, mattress, trapeze. Materials Management: All other items	
5.	Materials Management reaches out to the vendor, receives a quote.		• Material Management
6.	Materials Management sends quote to Rehab for final approval of specifications and ensure accuracy of item being ordered. . Once quote is approved Rehab will inform MM of the appropriate business owner (department). MM will advise the department to enter a requisition in Peoplesoft.	Rehab to advise MM if the item is to remain in Rehab, going to a specific unit/neighborhood for the resident, or if it is "facility" equipment that is maintained by Facilities. This information will determine the department entering a requisition.	• Material Management • Rehab
7.	Materials Management issues the Purchase Order and submits a CC copy to Rehab, as well as Engineering, the department responsible for inventorying, tagging, storage, and maintaining/repairing the item		• Material Management • Rehab • Engineering
8.	Material Management contacts Engineering once the items arrives for it to be tagged and inventoried, with a CC to rehab, once item arrives.	MM places Facilities work order to inventory the LHH owned equipment.	• Material Management

	~~**Major Steps**~~	~~**Details**~~ ~~(if applicable)~~	~~**Owner**~~
~~**9.**~~	~~Item is delivered to Rehab and/or appropriate unit/department, after it is inventoried, or Rehab retrieves the item from Materials Management, based on the most efficient delivery method MM places Facilities work order to inventory the LHH owned equipment.~~		~~• Nursing~~ ~~• Rehab~~ ~~• Engineering~~ ~~• Biomed~~ ~~• Material Management~~
~~**10**~~	~~Rehab applies the item to the resident and ensures it meets resident needs.~~ ~~Nursing applies the item to the resident, as applicable.~~ ~~Engineering stores a LHH facility item.~~ ~~Biomed stores items (assigned to biomed department)~~		~~• Rehab~~ ~~• Nursing~~ ~~• Engineering~~ ~~• Biomed~~

CROSS-REFERENCES:

Nursing Policy and Procedure
D1 2.1 Nurse and Resident Call System
D6 5.0 Ambulation

Rehabilitation Center Policies and Procedures
70-09 Occupational Therapy Service Equipment and Supplies

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https://udservices.org/adaptive-devices-people-disabilities/

ATTACHMENTS/APPENDICES:

Appendix A: Adaptive Call Lights
Appendix B: Standard of Work

Original Adoption: 07/26/2011
Adopted: 2024/03/12 (previously "Adaptive Devices Operating Guidelines")
Revised: 2014/07/22; 2024/03/12, 2025/25/07
Reviewed: 2024/03/12
Approved: 2024/03/12

Revised Vocational Rehabilitation Policies and Procedures

SCOPE OF SERVICES

The Vocational Rehabilitation Program is designed to meet the needs of both residents who are approaching discharge and those ~~who plan to be~~are at Laguna Honda ~~here~~ long-term.

I. Consultations for residents pending discharge

a. RCT requests consultation by completing request form and invites staff to the next appropriate RCT meeting.~~:~~ The Vocational Rehabilitation~~vo c. Rehab. Aa~~assessment is initiated upon notification.
b. Vocational Rehabilitation staff (VR) has formal and informal meetings with resident
c. VR offers the following options to resident, depending on their needs
    i. Resident can choose experience
        a. Gift Shop
        ~~b. General Store~~
        b.~~c. Guest Escort~~Individualized experiences

    ii. VR can provide connections to community programs
    iii. VR provides information on government benefits and work
    ~~iiii. VR assists with career exploration~~
        ~~a. Job match considerations~~
        ~~b. Overviews~~
        ~~c. Training locations~~
        ~~d. Career-specific information~~
    v. VR provides information on the Americans with Disabilities Act
        a. Overview
        b. Accommodations
    ~~vi. VR assists with job search~~
        ~~a. Community resources~~
        ~~b. Resumes, cover letters, and applications~~
        ~~c. Interviewing~~
        ~~d. Preparing for first day~~
        ~~e. Adjusting to workplace~~
d. VR communicates with RCT via ~~SFGetcare~~LCR~~,~~ email and personal contact

2. Long-term care vocational services

a.. RCT requests consultation
b.. VR has formal and informal meetings with resident
c.. VR offers options to resident
i. Resident can choose experience in one of our on-site enterprises
~~a. General store~~
a~~b~~. Gift Shop
b~~c~~. Individualized experiences ~~Guest Escort~~
~~ii. Volunteer opportunities in community for qualified residents~~
d. VR communicates with RCT via ~~LCR~~ the electronic health record~~note~~, e-mail and personal contact

3. On site Vocational Rehabilitation opportunities

The Vocational Rehabilitation Specialist oversees the operation of all of the Vocational Rehabilitation Program elements. All enterprises share two common expectations – that residents take responsibility for reliably being at their work site at their scheduled time and that residents follow directions.

~~**a. General Store**: Vocational Rehabilitation is responsible for the operation of the Ggeneral Sstore. In this retail setting participants work set shifts where, depending on their abilities and interests, they take part in customer service, money-handling, counting, stocking, packaging, sorting, promotions, and/or inventory display. They have the opportunity to add tasks as they progress. Residents are involved in decision-making regarding all aspects of the operations.~~

~~The participants work alongside a combination of other residents, volunteers, and, on occasion, transitional work assignment personnel, all of whom provide additional support and training.~~

~~.~~

ab~~h~~. Gift Shop: Vocational Rehabilitation is responsible for the operation of the Ggift Sshop. In this retail setting participants work set shifts where, depending on their abilities and interests, they take part in customer service, money-handling, counting, stocking, packaging, sorting, promotions, and/or inventory display. They have the opportunity to add tasks as they progress. Residents are involved in decision-making regarding all aspects of the operations.

The participants work alongside a combination of other residents, volunteers, and, on occasion, transitional work assignment personnel, all of whom provide additional support and training.

b.c. ~~Guest Escort/Guide:~~ ~~Guides visitors to destinations~~**Individualized experiences:** integrating persons skills, abilities and interested into an explorational opportunity.

REFERRAL AND ASSESSMENT

POLICY:

The Vocational Rehabilitation program has a procedure in place for receiving referrals and assessing resident their appropriateness for the Vocational Rehabilitation program.

PURPOSE:

To maintain a system for enrolling appropriate residents into the Vocational Rehabilitation program with the goal of preparing them for community re-integration. into the community.

PROCEDURE:

1. The Resident Care Team (RCT) identifies appropriate residents (idea can be resident/patient or staff initiated) who display a baseline competency and potential for participation and/or improvement in these the following areas:

   a. Get to and from the job on time
   b. Be ready to work as soon as the shift starts
   c. Perform the demonstrated tasks in a neat, safe manner
   d. Be dependable
   e.d. Have a good attitude and treatTreat people with respect
   f.e. Work well with supervisor, staff, residents and customers
   g. Organize time well
   h.f. Be clean and well-groomed
   i. Be able to wait his turn for the supervisor's time
   j.g. Listen carefully to instructions andDemonstrate ability to follow instructions
   k.h. Stay at the assigned work location for the entire shift
   l. Keep track of project due dates and turn in assignments on time
   m. Concentrate/stay focused for the entire shift
   n.i. Accept constructive feedback from the supervisor
Display openness to anger management techniques Not interrupt
Control anger and language
   j.
   o.k. Have goals consistent with the parameters of the programDemonstrate interested and initiative for participation in program

2. A RCT member talks to those the residents/patients to affirm their interest in Vocational Rehabilitation. .

3. On Rrehabilitation units, physicians put a Request for Consultation form in the resident's chart.

3. ~~-~~A RCT member contacts Vocational Rehabilitation (VR) to initiate the referral and invite Vocational Rehabilitation ~~PREP~~ staff to a RCT meeting to share pertinent information. Assessment of the resident is initiated upon notification.

4. As a part of the assessment, ~~After receiving a referral from the RCT, Vocational Rehabilitation~~VR may review relevant ~~sections of the chart~~documentation from the following areas: ~~and plans such~~ Medicine~~physician's notes~~, Nursing, ~~A~~Activity Therapy, ~~T~~Social Work, ~~report, social work page,~~ N~~n~~europsychology, ~~OT and PT information,~~Rehabilitation (OT, PT, ST) ~~chart notes,~~ and the resident's care plan.

5. ~~Staff~~ VR meets with resident to assess appropriateness for program based on attitude, interests, abilities, and perceived potential to meet basic behavioral and functional expectations as outlined under #1.

6. ~~Staff~~ VR and resident~~/patient~~ choose which services, if any, are appropriate.

7. ~~Staff~~ VR ~~charts and enters information~~completes a note in the electronic health record for assessments and monthly progress notes ~~the o. n "Vocational Rehabilitation Assessment and monthly progress notes in the resident's electronic medical record in SFGetCare."~~

8. VR monitors resident progress by ~~On-going assessment involves~~ observing ~~resident's~~ their performance of criteria listed under #1 above. ~~Staff works with resident on improvement where needed.~~Areas for individualized improvement are identified and addressed as needed.

9. RCT is ~~informed~~ updated about resident progress at quarterly Resident Care Conferences, or more frequently if the resident is short stay and/or participation requires closer monitoring. ~~periodically via conversations, meetings, email, phone calls and/or chart notes as resident progresses through the program.~~

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 22/04/04, 19/04/02,18/8/23, 17/09/12 (Year/Month/Day)
Original adoption: 12/07/13

DOCUMENTATION OF VOCATIONAL REHABILITATION SERVICES

POLICY:

The Vocational Rehabilitation Program provides documentation ~~in the resident charts via the Vocational Rehabilitation Assessment Form and monthly LCR note~~for assessments and progress notes in the electronic medical record.~~.~~

PURPOSE:

To document the services provided to residents by the department

PROCEDURE:

1. Member of RCC contacts Vocational Rehabilitation with referral information.

2. Vocational Rehabilitation staff complete an assessment of resident's skills and needs ~~and enters the information on the assessment form~~in the Vocational Rehabilitation Assessment section of the resident's electronic record..

~~3. A copy of the assessment form is placed in the Assessment section of the medical record.~~

~~4.~~3. Vocational Rehabilitation staff informs the person making the referral of the outcome of the interview with the resident.

~~5.~~4. ~~LCR~~ Progress notes ~~–~~are ~~made~~ completed if resident's participation changes from that indicated on the assessment form. In addition, events with particularly positive or negative implications are documented ~~in the LCR Notes~~as a progress note as they occur. This may include the addition or elimination of training components, the alteration of a long-term plan, improvement, or issues.

~~6.~~5. A new assessment form, indicating "re-assessment" is added to ~~medical~~ electronic medical record~~s~~ when a resident is re-admitted after discharge.

ATTACHMENT:
None.

REFERENCE:
~~None~~Vocational Rehabilitation Departmental policy VR 2.0.

Revised: 19/3/5, 18/8/23, 17/09/12 (Year/Month/Day)
Original adoption: 12/07/13

Deletion Vocational Rehabilitation Policies and Procedures

GENERAL STORE POLICIES AND PROCEDURES

POLICY:

It is the policy of the Vocational Rehabilitation Program to operate the hospital's General Store.

PURPOSE:

It is the purpose of the store to serve as a training site for residents in the PREP Program and to provide a low-cost source of snacks for residents, staff, and visitors.

PROCEDURES:

1. Staffing

a. The Vocational Rehabilitation Coordinator has the overall responsibility for the staffing and operation of the General Store.

b. PREP Volunteers

i. Residents from Vocational Rehabilitation's PREP Program have shifts in the store where they help with sales, display, marketing, customer service, inventory selection, and/or stocking. They are supervised by Vocational Rehabilitation staff and, when available, an intern. Available slots are limited to two a shift unless business flow patterns indicates there is a need for increased customer service.

ii. If there are any problems with attendance, behavior, or performance the Vocational Rehabilitation Coordinator or Specialist will meet with the resident and/or unit staff to develop strategies to rectify the situation.

iii. The staff person and residents track the resident's attendance on the time sheet in the store binder. Time periods and pay days are in accordance with the CCSF schedule. Residents earn a $1 credit for each hour of participation. On each pay day the credit for that time period is entered in the store's "Credits Earned" binder. Residents initial the binder each time they make a purchase.

c. TTWA Workers

It is the policy of the store to cooperate with the DPH Transitional Temporary Work Assignment (TTWA) program by being an available work site. Light duty workers from DPH are occasionally assigned by Occupational Health to assist in the store for up to 90 days. They are trained and supervised by the Vocational Rehabilitation Coordinator or Specialist who signs the time sheet.

The Vocational Rehabilitation Coordinator reports relevant problems to Occupational Health.

d. Volunteer Services Volunteers

The store welcomes the participation of hospital volunteers who have an interest, and ability, to work in the store. While in the store the supervisor will be the Vocational Rehabilitation Coordinator or Specialist. The volunteer signs in at the volunteer kiosk. The Vocational staff reports relevant problems to the Volunteer Coordinator.

2. Opening and Closing

a. Opening Procedure

i. Unlock cash register
ii. Turn on coffee machine.
iii. Unlock door for customers at opening time.
iiii. Re-stock as needed.

b. Closing Procedure

i. Straighten displays and check stock.
ii. Turn off coffee machine.
iii. Close out the cash register.
iv. Lock the cash register and cabinets.
v. Enter the sales total in the sales log in the store binder.
vi. Turn off lights.
vii. Close and lock doors.

3. Cash Handling

a. Cash Only

i. No credit, no coupons, no checks.
ii. No bills over $20.
iii. Can only accept $20 bills when enough cash is in the drawer.
iv. No rolled coins accepted.
v. At store's discretion, large quantities of coins may not be accepted as payment.

b. Cash Register

i. The cash register is used for the store's product line only. Vending machine refunds are not handled through the register.
ii. At the end of each business day, a roll of quarters, a roll of dimes, and a roll of nickels are left in the register along with $83 in bills.
iii. A reserve box holds $25 in extra change.

iv. Money is turned in to Patient Accounts on a pre-arranged basis along with documentation of sales.

c. Making Change
i. The store cannot honor non-customer requests to change bills as we need an array of bills to make change for our customers.
ii. Patients' Accounts serves as the store's source to exchange bills for smaller ones or for rolls of coins.

4. Exchanges/Refunds/Credit

a. We do not ordinarily offer exchanges, refunds, or credit. Exceptions will be made when a wrapped item is exchanged shortly after purchase, e.g. a nurse bought an item for a resident and it is the wrong flavor.

b. A refund will be offered if a product's quality/freshness is being questioned.

c. PREP participants earn credits to purchase items and may not buy anything if it would create a negative balance.

5. Tips

Tips are put in a can and periodically distributed to PREP participants in accordance with their amount of time training in the store.

6. Money Bag

a. On a pre-arranged basis, earnings – minus $100 – are put in the money bag along with the sales log and delivered to Patients' Account.

b. The denominations are stacked in order of value.

c. Coins are rolled in papers, when applicable, and "general store" is written on the side.

d. Smaller amounts of coins are mixed together in one small envelope.

7. Other

a. Deliveries
i. Deliveries are received and made by Nutrition Services.

ii. The Vocational Rehabilitation Coordinator signs the invoices turns in the original to Materials Management with a copy to Accounting and the dept. file.

b. Electricity

In the event of a power outage, melted freezer products should be inventoried for the store binder and then discarded.

c. Expired Items

The staff tracks inventory in order to sell items before the expiration date. Expired items cannot be sold but may be given away.

d. Resident Alert System

We cannot sell any snack or beverage product to residents with pink bands unless they are accompanied by a staff member who takes responsibility for the purchase. If a resident disputes their dietary limitations, we may offer to call and consult with their unit about their desired purchase. If there is no answer, or we are unable to ascertain the unit, we will suggest to the resident that they return with a staff member when they want to make a purchase.

e. Fire Drills

In case of a fire drill pretend you are going through the RACE and PASS steps as per the directions on your safety badge. Discuss what you are doing with one another.

f. Suggestions

It is the policy of the store to stock items requested by customers when those items are available from a city-approved vendor at a saleable price, there is a multiple-customer base for the item, there is room in the budget, and there is display room in the store.

g. Inventory

It is the policy of the store to work cooperatively with the Accounting Dept. to conduct an inventory of the stock at the end of June and on other dates designated by Accounting.

8. Vending Machine Refunds

a. The store is not responsible for the contents or operation of the vending machines but, as a courtesy, holds the vendor's refund account.

b. Vending machine refunds are not issued from the cash register.

c. We do not issue refunds for the change machine. People must call the company directly (the number is on the machine) if they lose money in that machine.

d. A separate fund, supplied by the vending company, is kept in the vending machine refund box.

i. Before issuing the refund, the store person records information on the refund record.

ii. The vending representative comes to the store once a week to pick up the refund record reimburses the fund.

iii. The store reserves the right to limit or question refund requests due to frequency or amount. Customers may contact the vendor's customer service department using the number on the machines.

e. Refund frequent-request pattern

If a resident develops a pattern of seeking frequent refunds the store will point out that using the machines does not seem to be working for them and that the vendor will not honor requests from repeat refund-seekers. The store may share this behavioral information with the RCT in order to re-direct the resident to other sources of goods, help them with the machines, or to have the RCT work with them on their budget rather using refunds as a source of income.

9. Problem Behaviors

a. Theft

Should a volunteer or limited duty worker (TTWA) steal from the store or from a person in the store, it is the policy of the store to sever relations with them immediately and 1) report the incident to the person's supervisor, 2) complete a UO report, and 3) may report to the Sheriff's Office or counsel the victim of their right to contact the Sheriff. Depending on the situation criminal charges may be filed.

Should a PREP participant steal from the store or from a person in the store, it is the policy of the store to suspend the person immediately and to 1) report the incident to the person's RCT, 2) complete a UO report, and 3) may report to the Sheriff's Office or counsel the victim of their right to contact the Sheriff. Depending on the situation, criminal charges may be filed and/or the Vocational Rehabilitation Coordinator or Specialist may deem it appropriate to fire, rather

than suspend, the individual. All or a portion of the resident's credits shall be revoked.

b. Inappropriate Behavior

i. Within Store: All persons in the store are expected to treat one another and customers with civility and respect. The Vocational Rehabilitation staff will discuss inappropriate behaviors with the individuals and help come up with alternative communication methods. Should such behavior be repeated, the person will be asked not to work or participate in the store. When necessary, the Vocational Rehabilitation staff will 1) report the incident to the person's supervisor, 2) complete a UO report, and 3) report to the Sheriff's Office or counsel the victim of their right to contact the Sheriff. Depending on the situation, criminal charges may be filed.

ii. The Vocational Rehabilitation Coordinator or Specialist may suspend or fire a resident for incidents that take place outside the store setting, e.g. assault, property damage, fire-setting, sexual harassment, or theft as individuals exhibiting such behaviors are considered a threat to a safe work environment.

iii. By Customers: It is our job to acknowledge all customers and serve them quickly and politely. However, there may be times when a customer is upset and yells or uses foul language. We reserve the right to refuse them service AT THAT TIME and invite them to come back when we can have a civil conversation. The area must be kept safe and comfortable for our PREP participants, other customers, staff, and all people in the vicinity of the store.

10. Grooming Issues

Residents may be unaware of odor emanating from dirty clothes, poor or delayed bathing, or incontinence. Some arrive with dirty hands or nails. We explain to such residents that good grooming is part of work-readiness and in a food-handling environment is a necessary part of each shift. We offer suggestions and meet with RCT members to facilitate change. If residents still are unable to meet the health standards for the store we will try to re-direct them to other opportunities.

NOTE CARD PROJECT

POLICY:

It is the policy of the Vocational Rehabilitation Program to produce note cards showcasing residents' artwork.

PURPOSE:

The PREP Program's note card project uses resident talent in several ways: art selection, artist recognition, production decisions, collation of cards and envelopes, counting and packaging, selling and marketing. The project provides these opportunities for residents to develop and utilize skills, to gain recognition, and to learn to promote a project. Such skills are transferable to jobs in the community for post-discharge consideration by the residents.

PROCEDURES:

1. Joint Project with AWE

a. Note cards are generally produced once a year or when appropriate funding and saleable artwork are available.
b. This is a joint project of the PREP Program and Art With Elders at Laguna Honda Hospital.
c. The vocational rehabilitation coordinator oversees the project with assistance from residents.
d. Art selection is done by staff and residents.
e. Written consents for the use of artwork are obtained.
f. Subject matter must be tasteful, artistically-appealing, and in keeping with the separation of church and state.
g. Appropriate administrative staff is consulted if legal questions arise regarding submissions.
h. Cards are sold at the general store, at a display table, and at other venues when available.
i. Publicity includes signs, e-mail, and ads in the newsletter.

2. Re-Worth Project

a. Program solicits used greeting cards.
b. PREP participants cut out portions of the cards and glue them in position in new patterns on blank card stock.
c. Residents collate cards with envelopes and sort by subject matter.
d.a. Cards are sold by residents at Promo display tables.

NEWSLETTER PROJECT

POLICY:

It is the policy of the Vocational Rehabilitation Program to produce *The Insider,* the Laguna Honda newsletter.

PURPOSE:

The PREP Program recruits resident talent to make editorial decisions and to write, interview, take photos, draw, proofread, design, fold, label, sort, and distribute the hospital newsletter, *The Insider.* The project provides these opportunities for residents to develop and utilize skills, to gain recognition, and to learn to work as a group. Such skills are transferable to jobs in the community for post-discharge consideration by the residents.

PROCEDURES:

1. The newsletter is produced a minimum of six times a year.

2. The Vocational Rehabilitation Coordinator oversees the project with assistance from residents

3. The newsletter does not take positions on political topics or candidates.

4. Residents, staff, and volunteers are encouraged to contribute items.

5. Written consents are obtained as applicable.

6. Appropriate administrative staff is consulted if legal questions arise regarding submissions.

7. No copyrighted items are published without permission.

8.1. *The Insider* is a vehicle for resident expression, motivation, and edification.

Resident DVD Library

POLICY:

It is the policy of the PREP Program to oversee the DVD library to make DVDs available to approved residents and Activity Therapists and to utilize the library as a training site for PREP participants.

PURPOSE:

To promote independence, responsibility and ability to adhere to a schedule. Encourage residents to venture out into the hospital community. Provide a training site for selected PREP participants to learn customer service, record-keeping, and inventory control.

PROCEDURES:

1. Resident Evaluation

a. The Activity Therapist responsible for a resident's care consults the resident care team regarding the resident checking out DVDs. The following considerations must be evaluated:

i. The resident must be able to come to the DVD library independently, or with an escort.

ii. The resident must be able to select the movies independently.

iii. The resident must be able to keep track to the DVDs to return them.

iv. The resident must be able make a reasonable effort to protect the DVDs from getting lost or taken.

v. Activity Therapist assumes responsibility for retrieving the DVDs if necessary.

vi. If the team agrees that the resident is appropriate, the activity therapist completes the "Check out Agreement" form with the resident.

vii. The Activity Therapist returns the completed form to the Vocational Rehabilitation Specialist in charge of monitoring the system.

viii. The Activity Therapist sets a time with the resident for training.

2. Training Process

a. The Activity Therapist accompanies the resident on their first visit to

the video check out.
b. The Activity Therapist introduces the resident to the staff in the department that may be assisting them in the future.
c. A staff member will explain the guidelines for the program.
d. The Activity Therapist will monitor the resident while selecting and checking out the DVDs.
e. After the training, the therapist will authorize the resident to begin checking out DVDs on their own.

3. Guidelines for Use

a. Residents must complete the "Check out Agreement".
b. Residents must complete the training with their Activity Therapist.
c. The video check out has set open hours and the resident must be able to visit during the open hours.
d. Resident can check out 3 DVDs at a time.
e. Residents must complete and sign for the DVDs on the form in the library. If they are not able to fill out the form, assistance can be provided as available.
f. DVDs should be returned within a week from the date they borrowed them.
g. Borrowed DVDs must be checked in before more DVDs can be checked out.
h. It is highly recommended that residents do not share their DVDs by loaning them to others.
i. If resources are lost or taken, a report should be completed by the Activity Therapist, resident and the Vocational Rehabilitation Specialist. A re-evaluation of the residents' ability to use the resource responsibly is included in the report.
j. If the resident is taken off the check out privilege list, the Vocational Rehabilitation Specialist, the Activity Therapist and the care team must explain the situation to the resident.
k. Reinstatement of privilege is acceptable if the resident care team and the Activity Therapist agree that the resident is able to manage the privilege.

4. Documentation and Follow-Up

a. Video check out privileges should be noted in the care plan.
b. When able, the visits to the video check out should be noted in the participation record as an independent, self directed activity.
c. Activity Therapist should be including information about video check out use in their assessments and progress notes.

5. DVD Library Management

a. The Vocational Rehabilitation Specialist manages the DVD library and utilizes the help of selected PREP participants.
b. During video check-out open hours, a staff member should be available to ensure the resource is used appropriately and procedures are followed.
c. The Vocational Rehabilitation Specialist should communicate with the Activity Therapists about the residents' use of the resource.
d.a. Regular inventory checks are completed to ensure the resource is being used effectively. It is recommended that a resident in PREP, vocational rehabilitation program, be identified for this task. It is also recommended that the inventory check be done monthly.