List of Hospital-wide/Depsrtmental Policies and Procedures submitted for Approval on July 9, 2024

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Notes
Revised	LHHPP	22-01	Abuse and Neglect Prevention, Identification, Investigation Protection, Reporting and Response	1. Added "Prevention " through out the document 2. Added "the Nursing Home Administrator who serves as the Abuse Prevention Coordinator" 3. Added "Chief Quality Officer (CQO)" 4. Added "QM Regulatory Affairs team, after conferring with the LHH Executive Team." 5. Added "SOC 341 Form"
Revised	LHHPP	24-16 Appendix 5	Code Blue Appendix 5 Code Blue Record	1. Deleted "(print EKG strip)" 2. Deleted "Family Notified:", "Yes", "No" and "Name of Family Contact" 3. Replaced "Bring Copy to Nursing Office - Code Blue Committee Mailbox" with "Email a copy to: DPH-LHHCodeBlueCommittee@sfdph.org"
Revised	LHHPP	24-16 Appendix 6	Code Blue Appendix 6 Code Blue Drill Record	1. Replaced "Open the airway (head tilt, chin lift)" with "Look, listen and feel for breathing/chest rise." 2. Deleted "Look for breathing," 3. Added "(if applicable)"
Revised	LHHPP	24-16 Appendix 7	Code Blue Appendix 7 Post Code Blue Checklist	1. Replaced "Susan Sabai, MD, Emily Kinebuchi, MD, Code Blue Chair, Kathleen MacKerrow, RN, CNS " with "Email copy to DPH-LHHCodeBlueCommittee@sfdph.org"
Revised	LHHPP	25-11	Medication Errors and Incompatibility	1. Replaced "Prevention" with "Reduction" 2. Added "(MERC)"
Revised	LHHPP	75-01	Security Management Plan 2022-2023	1. Added "Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC.02.01.01" 2. Added "California Code of Regulations, Title 22, Sections 22 CCR 70738" 3. Deleted "Hospital and Rehabilitation Center operations and processes" 4. Deleted section on the "Successful implementation of the Security Management Plan involves the incorporation of the principles of the plan into the culture and operations of the organization. Implementation of the security program is the responsibility of the Director of Security, and SFSO Unit Commander. The performance is monitored quarterly by the Campus Safety and Security Committee and the Executive Committee. They include:" and items 1-5 5. Updated various dates from 2021 and 2022 to 2023 and 2024 6. Replaced "SFPD, BART, and MUNI" with "the following: San Francisco Police Department's Missing Persons Unit,Central Warrants Bureau, Department of Justice, Zuckerberg San Francisco General Hospital, Medical Examiner's Office andCounty Jail #1" 7. Replaced "Disruptive Resident" and "Contacting Security "with "De-escalation Principles" and "Contraband and Prohibited Policy" 8. Added "Response-rate Threshold – 80%"; "Response-rate Target – 90%" and "Response-rate Stretch – 100%"
Revised	LHHPP	75-15	Security Records Retention and Disclosure Policy	1. Added "Request for" 2. Added "be made through either" 3. Deleted "for security records, including video surveillance footage is made through" 4. Added "or City Attorney's Office" 5. Added "Description of persons involved in the incident" 6. Added "surveillance " throughout the document 7. Added "for operational purposes only and should be"
Revised	EVS	90-01	Environmental Services	1. Added "and disinfecting" 2. Replaced "removing" with "transporting" 3. Added "(except e-waste and construction wastes)" 4. Made minor changes to Hours of Operation throughout the document. 5. Removed "Routine laundering and processing of linen" 6. Replaced "Laundering and processing" with "Collecting and transporting soiled or clean" 7. Added "for processing by laundry vendor" 8. Replaced "Saturday" with "Friday" 9. Replaced "SFGHMC" with "Zuckerberg San Francisco General Hospital and Trauma Center" 10. Replaced "the respective nurse's station" with "Social Services Department" 11. Added "by EVS staff or the city certified vendor" 12. Changed format of dates after reference section.
Revised	EVS	II	Environmental Services	1. Added "Replace curtains" 2. Deleted "schedule resident medical appointment transportation" 3. Added "Provide Pest Control services to the facility."

Revised	EVS	III	Environmental Services Organizational Chart	1. Replaced "Chief" with "ANHA" 2. Renumbers some positions 3. Added "*ANHA – Assistant Nursing Home Administrator of Supportive Services" 4. Added revision dates
Revised	EVS	V	EVS Staff General Information	1. Added details to Break Time and Lunch Time section. 2. Removed "Pay telephones are available in various areas."
Revised	EVS	VI	Performance Guidelines	1. Format changes
Revised	EVS	VII	Work Rules	1. Added "The requests are approved on First Come First Served." 2. Deleted "calls from a child, baby-sitter, or calls identified as" 3. Replaced "You are not to leave your workstation to answer the pay phone" with "Employees are required to step out the assigned area for emergency call after notifying the immediate supervisor." 4. Deleted "and on the pay phone only." 5. Added "resident areas" 6. Added "LHH is a Smoke Free Campus. " 7. Deleted "building" and "on designated smoking areas " 8. Deleted "Be careful to process all linen in a clean and safe way. Do not pick up off floor (re-wash), do not allow to touch floor, etc." 9. Update "Break/Lunch Times" chart 10. Added reference section
Revised	EVS	XIII	PATIENT, RESIDENCE CARE AREAS	1. Change name from "PATIENT, RESIDENCE CARE AREAS" to "SPA ROOM" 2. Simplified instructions.
Revised	EVS	XVIII	Microfiber damp mopping cleaning	1. Added "Neutral Cleaner1. Change name from "PATIENT, RESIDENCE CARE AREAS" to "SPA ROOM" 2. Simplified instructions. 3. Replaced "Hand Gloves or personal protective equipment" with "Personal Protective Equipment" 4. Replaced "separate" with "Sting loop" 5. Added reference section
Revised	EVS	XX	Privacy Curtain Replacemet	1. Deleted "Place the dirty curtain in a plastic bag and give to the Laundry for cleaning." 2. Added "Keep all hardware are locked in the drawers to prevent safety hazards." 3. Added "Place the dirty curtains in a soiled linen plastic bag and give to the outside laundry services for cleaning."
Revised	EVS	XXII	EVS TEMPORARY SERVICES	1. Replaced "may be" with "are only performed when it is"
Revised	EVS	XXIII	ENVIRONMENTAL SERVICES – Management of Electronic Equipment	1. Deleted "Environmental Services Policies and Procedures Revised:(Year/Month/Day) Original adoption:"
Revised	MSPP	001-03 and PMA Admissions Project Flowchart	Laguna Honda Acute Medical Unit Admission Guidelines	1. Addition of consideration of GOC in the decision to transfer to Acute care 2. Revision/Addition of inclusion/exclusion criteria for use of the Acute Medical Unit 3. Removal of transfusion/infusion services which are not available on the AMU at this time 4. Updated workflow for current EHR
Revised	NPP	A 9.0	Sick Leave Intermittent FMLA Tardy Call – In	1. Current policy states calling in sick must be done at a minimum at least 2 hours prior to the start of the shift. However LHH Nursing Department Handbook states a minimum of at least 2.5 hours, instead of 2 hours, for calling in sick. 2.5 hours is also taught during nursing orientation. 2. Added 2 additional policies to address orientee sick calls and tardy calls 3. Updated times for when to report sick call by based on the 2.5 hours
Revised	NPP	B 6.0	Items at Bedside	1. Added oral hygiene items and non-medicated oils for items allowed for bedside storage. 2. Clarified that O2 tubing in use shall be labeled with date and changed every 7 days and PRN 3. Added verbiage on water pitchers
Revised	NPP	B 7.0	Nursing Care of Resident with Seizure	1. Removed reference to medication administration/enteral nutrition policies (these policies do not reference anticonvulsant medication) 2. Added to loosen clothing 3. Revised Ictal Phase procedures to reflect what is taught during Code Blue and orientation
Revised	NPP	D 4.0	Care of a Prosthetic Eye (Artificial Eye)	1. Removed procedural steps and referenced Elsevier for skills
Revised	NPP	D9 3.0	Bed Stripping and Terminal Cleaning	1. Delineated between bed stripping and terminal cleaning 2. Referred to HWPP 25-05 Hazardous Drugs Management and HWPP 72-01 F4 Management of Hospital-Provided Linen, and 72-01 F2 Isolation Room Disinfection
Revised	NPP	D9 8.0	Charging of Electric Wheelchair	Reformatted. No major changes
Revised	NPP	E 5.0	Enteral Nutrition Support	1. Policy: Updated references 2. Appendix with following change: Added “All free water bags must have a label indicating resident name, volume of water, frequency, date/time and staff initials.”
Revised	NPP	F 5.0	Nursing Management of Urinary Catheters	1. Refer to Elsevier for skills 2. Included language on condom catheters
Revised	NPP	F 6.0	Ostomy Management	Updated section on use during Aquatics

Revised	NPP	G 1.0	Vital Signs	1. Delete appendices 2. Added verbiage on documentation of antimicrobials for prophylaxis 3. Removed section on Pain
Revised	NPP	H 1.0	Collection of Urine Specimen	1. Consider deleting procedures and reference Elsevier instead 2. Keep sections that are specific to LHH
Revised	NPP	H 6.0	After Hours STAT Blood Draw	Revised to reflect current practice
Revised	NPP	J 6.0	IV Maintenance	Revise to reflect current practice and any updates (e.g., matching ZSFG policy on changing every 72 hours for certain PIV infusions)
Deletion	NPP	D5 2.0	Limb Care following Amputation	Refer to Elsevier for amputation management and prosthetic care
Deletion	NPP	D5 6.0	Elastic & Anti-Embolism Stockings	Refer to Elsevier for compression stockings
Deletion	NPP	D9 6.0	Water Pitchers	Move key content into E 1.0 Oral Management of Nutritional Needs and B 6.0 Items Allowed at the Bedside
Deletion	NPP	F 4.0	Application of Condom Catheter	Suggest to delete and include condom catheters in urinary catheters
Deletion	NPP	M 2.0	Guideline for Prevention, Assessment and Management of Residents at Risk for Dehydration	Refer to Elsevier and HWPP 70-01 Emergency Preparedness and Response Manul C9 Heat Emergency Plan
Deletion	NPP	M 3.0	Medi-Therm II Hyper/Hypothermia Machine	Device has not been used here since 2016. Staff can reference Manufacturer Recommendations in the event that a resident has a prescribed use for this.
Deletion	NPP	M 4.0	Protocol for Personal Laundry and Use of Washer and Dryer Machine	Reference72-01 F3 Management of Resident's Personal Clothing
Deletion	NPP	M 6.0	Transport Gurney Protocol	Check off for use of transport gurney during orientation
Deletion	NPP	M 7.0	Electric Medical/Surgical Bed Protocol	1. Refers to beds we are phasing out. 2. Competency is checked upon orientation for how to use Stryker bed and should be checked annually 3. Refers to alarms, which are no longer on the units
Deletion	NPP	M 8.0	Electronic Wheelchair Scale Protocol	Competency is checked upon orientation for how to use floor scale with wheelchair
Deletion	NPP	M 16.0	Protocol for Resident Escort Off Hospital Grounds	Refer to Standard Work
New	OC	TBD	Outpatient Clinic Vacation Request & Approval	New policy
New	OC	TBD	Outpatient Clinic Sick Call	New policy
Revised	OC	A2	Outpatient Clinic Appointment System	Removed "Community Client" content since OPC no longer accept community referrals. Tightened language.
Revised	OC	A3	Outpatient Clinic Flow and Activities	Removed "Community Client" content since OPC no longer accept community referrals. Tightened language.
Revised	OC	A5	Nurse and Resident Call System	Changed Policy title to reflect OPC setting. Replaced all "resident" with "patient." Tightened language. Removed listed references.
Revised	OC	A6	Clinic Staff Licensure & Certification	Removed "community client"
Revised	OC	B1	Simple Surgical Procedures in Outpatient Clinic	Tightened general language
Revised	OC	B2	Protocol for Flame Use for Denture Molding in Patients Who are on Chronic Oxygen in Dental Suites	Replaced all "resident" with "patient." Clean-up formatting.

Revised Hospitalwide Policies and Procedures

ABUSE AND NEGLECT PREVENTION, IDENTIFICATION, INVESTIGATION, PROTECTION, REPORTING AND RESPONSE

PHILOSOPHY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall promote an environment that enhances resident well-being and protects residents from abuse, neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

POLICY:

1. LHH employees, contractors, and volunteers shall provide a safe environment and protect residents from abuse, neglect, misappropriation of property, exploitation, and use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's condition.

2. All LHH employees, contractors, and volunteers are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse.

3. LHH employees, contractors, and volunteers shall immediately respond to observed or suspected incidents of abuse.

4. LHH employees, contractors, and volunteers shall report alleged violations to the California Department of Public Health (CDPH), the Ombudsman, and Nursing Operations within specified timeframes:

    a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or

    b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

5. The LHH Department of Education and Training (DET) shall be responsible for developing curricula for and training all employees, volunteers, and contractors on abuse prevention and timely reporting.

6. LHH Department Managers are responsible for monitoring staff compliance with this policy and LHH Quality Management (QM) and Human Resources (HR) departments shall be responsible for the process oversight.

7. LHH shall not employ or otherwise engage individuals who:

    a. have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

b. have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; and/or

c. have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

8. LHH will promote a culture of safety and open communication where retaliation against any persons who lawfully reports a reasonable suspicion of resident abuse, causes a lawful report to be made, or takes steps in furtherance of making a lawful report is strictly prohibited.

9. Pursuant to Section 1150B of the Social Security Act, LHH employees, contractors, and volunteers shall report any reasonable suspicion of a crime committed against a resident of this facility.

10. LHH shall complete their internal investigation within 5 working days of the reported incident.

PURPOSE:

1. To protect the resident from abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

2. To report incidents or alleged violations of abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms without fear of retaliation and in a timely manner.

3. To promptly investigate allegations of abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

4. To provide clinical interventions to prevent and minimize abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

5. To meet reporting requirements as mandated by federal and state laws and regulations.

6. To establish coordination with the QAPI program.

DEFINITION:

1. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.

    a. "Verbal Abuse" means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.

    b. "Sexual Abuse" is non-consensual sexual contact of any type with a resident.

    c. "Physical Abuse" includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment.

    d. "Mental Abuse" includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s).

    e. Financial abuse includes, but is not limited to, wrongful, temporary, or permanent use of a resident's money without the resident's consent.

2. "Willful," means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

3. "Neglect" means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

4. "Exploitation" means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.

5. "Misappropriation of Resident Property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.

6. "Involuntary Seclusion" refers to the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will

of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs as long as the least restrictive approach is used for the minimum amount of time.

7. "Injuries of unknown source" should be classified as an "injury of unknown source" when all of the following criteria are met:

   a. The source of the injury was not observed by any person; and

   b. The source of the injury could not be explained by the resident; and

   c. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

8. "Crime" is defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township or village, or any local unit of government created by or pursuant to State law.

9. "Serious Bodily Injury" means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse.

10. "Criminal sexual abuse" is serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under State law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act.

PROCEDURE:

1. Screening of Potential Employees

a. Criminal Background Checks

   i. Applicants for employment at LHH must submit to fingerprinting by federal authorities and must have a clear background check prior to processing of any appointments for hire at LHH. This is required in addition to the existing bi-

annual fingerprinting and background check process in the State of California for initial certification and continued CNA certification as a condition of employment.

ii. LHH will screen employees for a history of abuse, neglect or mistreating residents by attempting to obtain information from previous employers and/or current employers and checking with the appropriate licensing boards and registries.

iii. Registry agencies will provide documentation of screening of staff to LHH.

iv. LHH will maintain document of proof that screening occurred.

b. Experience and References

i. Applicants for employment shall provide a photocopy of certification and verification (including references) of qualifying experience. The facility will make reasonable efforts to verify previous employment and to obtain information from previous and/or current employers.

2. Education

a. Employee and Volunteer Education

i. New employees, registry staff, and volunteers, including transfers or inter-facility reassignments to LHH, shall, as a condition of employment, review and sign a statement acknowledging the prohibition against the abuse of elder and dependent adults and the obligation to report such abuse. A copy of the signed statement “Dependent Adult/Elder Abuse Prohibition and Reporting Requirement” shall be kept in the employee’s/volunteer’s personnel file.

ii. New employees, registry staff, and volunteers, including transfers or inter-facility reassignments to LHH, shall, as a condition of employment, participate in “The Abuse Prohibition/Prevention Program”, which includes the following:

- Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation;

- Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property;

- Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators;

- Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources;

- Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as:
    - Aggressive and/or catastrophic reactions of residents;
    - Wandering or elopement-type behaviors;
    - Resistance to care;
    - Outbursts or yelling out; and
    - Difficulty in adjusting to new routines or staff.
- Facility orientation program on residents' rights, including confidentiality, preservation of dignity, identifying what constitutes abuse, and recognizing and reporting abuse without fear of retaliation;
- Nonviolent safety management and prevention of challenging behaviors**;**
- Annual in-service education provided by the Department of Education and Training (DET) to all employees, which includes a review of residents' rights, abuse and neglect prohibition/prevention, mandated reporting, and resident and employee freedom from retaliation when reporting abuse allegations.
- DET shall provide additional abuse and neglect prevention training to nursing and other staff annually, including recognition of psychological, behavioral, or psychosocial indicators of abuse, recognition of environmental factors that could potentially lead to abuse, and other pertinent abuse and neglect prevention and response educational topics.
- Annual performance appraisals will include a competency to assess knowledge of employee's abuse prevention.

b. Employees shall be informed of their rights during New Employee Orientation (NEO) and through posted information in the Human Resources Department. This shall include the right to file a complaint with the State Survey Agency if anyone at LHH retaliates against an employee who files a report of a reasonable suspicion of a crime committed against a resident to a law enforcement agency (such as the San Francisco Sheriff's Office (SFSO) at 4-2319).

    i. Information on employee rights related to reporting a crime or retaliation shall be posted in HR.

ii. Retaliation includes but not limited to demotion, suspension, threats, harassment, denial of promotion or other employment-related benefit, or discrimination in the terms and conditions of employment.

iii. LHH shall not file a complaint or a report against a nurse or other employee with the appropriate state professional disciplinary agency because of lawful acts done by the nurse or employee.

c. Resident Education

i. Residents are presented on admission with a Residents' Handbook that contains information on residents' rights and responsibilities, contacting advocates, and the abuse reporting process. Residents are informed to whom they may report concerns, incidents and complaints.

ii. A listing of Residents' Rrights shall be posted on each unit.

iii. Resident education topics such as reporting abuse, neglect, exploitation and/or mistreatment shall be reviewed at the neighborhood/unit community meetings at least twice a year or more frequently as determined by the Resident Care Team (RCT).

3. Prevention

a. LHH shall identify, correct, and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.

b. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.

c. LHH shall ensure the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions.

d. Staff (including registry staff) shall be trained in nonviolent safety management and prevention of challenging behaviors, which includes assessment, response techniques, and tools to prevent and identify potential crisis and/or de-escalate challenging behaviors. Training includes:

i. Nonverbal communication

ii. Para verbal communication

iii. Verbal communication

iv. Precipitating factors, rational detachment and the integrated experience

v. Staff fear and anxiety

vi. Decision making

vii. Physical interventions (disengagement skills) as a last resort

viii. Debriefing

e. Staff and families shall be provided with information on how and whom they may report concerns, incidents and grievances, as well as feedback regarding their expressed concerns (see procedure 2.a. Employee and Volunteer Education).

f. RCT members and clinical staff shall conduct ongoing resident assessments, revise care plans as needed, and monitor resident's needs and behaviors that may lead to conflict or neglect (see procedure 9 Resident Assessment and Care Planning).

4. Identification: Signs of Possible Abuse, Neglect, Misappropriation of Resident Property, or Exploitation

a. Abuse may result in psychological, behavioral, or psychosocial outcomes. The following signs may alert LHH staff to possible resident abuse and indicate the need for immediate reporting, response, and investigation:

i. Statements from a resident alleging abuse, neglect, misappropriation of resident property, or exploitation (including involuntary seclusion and unreasonable confinement) by staff, another resident, or visitor;

ii. Sounds and/or utterances that suggest physical or verbal abuse, neglect, misappropriation of resident property, or exploitation, chemical or physical restraints;

iii. Injuries, abrasions, falls, or bruises of unknown or suspicious origin and/or location;

iv. Illogical accounts given by resident or staff member of how an injury occurred;

v. Sudden or unexplained changes in resident's personality or behavior(s) such as aggressive or disruptive behavior, running away, fear of being around a certain person or being in a particular context, withdrawal, isolating oneself, expressions of guilt and/or shame, depression, crying, talk of suicide and/or attempts, disturbed sleep;

vi. Resident asks to be separated from caregiver or accuses caregiver of mistreatment;

vii. Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning & positioning

viii. Resident-to-resident altercations;

ix. Visitor-to-resident altercations;

x. Unexplained contraction of sexually transmitted diseases, vaginal or anal bleeding, or torn and/or bloodied underclothing.

xi. Evidence of photographs or videos of a resident that are demeaning or humiliating in nature, regardless of whether the resident provided consent and regardless of the resident's cognitive status.

xii. Sudden or unexplained changes in behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame.

b. These signs may indicate that mental and/or verbal, sexual, or physical abuse, and/or the deprivation of goods and services has occurred; in the event that an indicator becomes apparent, LHH staff should immediately respond to and report the potential abuse.

5. Protection: Staff/Volunteer Intervention

a. In the event that an employee/volunteer/contractor:

i. Observes abuse,

ii. Suspects that abuse has occurred,

iii. Observes resident–to-resident or visitor-to-resident altercation,

iv. Identifies an injury of unknown source/ origin,

v. Learns about an allegation of abuse, neglect or exploitation of any LHH resident, and/or is the first person to learn of a resident-to-resident or visitor-to-resident altercation, that employee/contractor/volunteer shall immediately attempt to identify the involved resident(s) and notify the responsible manager and the nurse manager or nursing supervisor.

b. The employee and/or responsible managers shall take immediate measures to assure resident safety as follows:

i. In the event of alleged employee to resident abuse, neglect or exploitation, the responsible manager shall remove the alleged employee from the resident care area and inform Human Resources to place the employee on administrative leave. These measures shall be in place until the investigation is completed.

ii. In the event of alleged resident-to-resident abuse or resident-to-resident altercation, the employee shall immediately separate the residents and move each resident to a safe area apart from one another until the incident is addressed by the responsible manager/supervisor.

c. The responsible nursing manager shall document the incident in each respective involved resident's medical record and develop or revise care plan as necessary.

d. Upon receiving a report of alleged abuse, neglect or exploitation, the licensed nurse shall assess the resident for any injury, pain, mental anguish, or potential change in condition. The attending or on-call physician shall be promptly notified of any allegation of abuse, neglect, or exploitation and shall complete a physician assessment of the resident.

i. The physician shall document the history of abuse as relayed, any findings of the assessment and psychological evaluation, and any treatment initiated. The physician shall, in the event of a resident-to-resident altercation, perform a physical exam on both residents and record in the progress notes of both residents' medical records the history, examination findings, psychological evaluation and any treatment initiated.

e. The Medical Social Services Worker shall follow-up with the resident within 72 hours to assess and to provide psychosocial support.

6. Reporting Protocol

a. All LHH employees, volunteers, and contractors are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse.

i. The mandated reporter shall immediately respond to the observed or suspected incident(s).

ii. Reporting shall be completed within the specified timeframes:

- Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or

- Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

iii. Reporting shall be to the following agencies in the above specified timeframes:

- CDPH (415) 330-6353
- Ombudsman (415) 751-9788
- Nursing Operations (415) 327-1902

iv. QM will assist the staff, contractor, or volunteer with reporting requirements and ensure specified timelines are followed accordingly for both the initial and follow-up investigation reports, and any other State level required reporting.

v. The mandated reporter may report anonymously to each internal and/or external agency.

b. LHH mandates suspected abuse to be reported to the local Ombudsman office as required by State law.

c. LHH shall report to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service.

d. LHH also requires any reasonable suspicion of a crime committed against a resident of LHH be reported to SFSO.

i. LHH will work with SFSO annually to determine which crimes are reportable.

ii. Examples of crimes that are reportable include but are not limited to the following:

- Murder;
- Manslaughter;
- Rape;
- Assault and battery;
- Sexual abuse;
- Theft/Robbery
- Drug diversion for personal use or gain;
- Identity theft; and

- Fraud and forgery.
- Certain cases of abuse, neglect, and exploitation

e. Notification requirements:

i. Within 2 hours: Events involving crimes or suspicion of crimes that result in bodily injuries; and alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.

ii. Within 24 hours: Events involving crimes or suspicion of crimes that do not result in serious bodily injury; and allegations of abuse that are not substantiated and do not result in serious bodily injury.

iii. The mandated reporter shall report the incident to CDPH, the Ombudsman and Nursing Operations.

iv. Nursing Operations shall immediately notify the Nursing Home Administrator (NHA)/Chief Executive Officer (CEO),~~,~~ SFSO, and QM.

f. The Abuse Prevention Coordinator, nurse manager, charge nurse, and nursing supervisor shall communicate to inform one another of the alleged abuse. The nurse manager, charge nurse, and nursing supervisor shall:

i. Immediately notify the attending or on-call physician of the alleged abuse;

ii. Immediately inform the resident and/or surrogate decision-maker that the abuse allegation is being taken seriously; identify for the resident and/or the surrogate decision-maker the steps being taken to provide for the resident's safety; and assure the resident and/or the surrogate decision-maker that an investigation is being conducted, the outcome of which will be reported to the resident and/or surrogate decision-maker.

g. If given permission by a resident with decision-making capacity, the physician or nurse manager shall contact the resident's family or representative regarding the alleged abuse. If the resident does not have decision-making capacity, the physician shall notify the resident's surrogate decision-maker.

h. If an abuse allegation involves a LHH staff person, the nursing supervisor shall notify the staff person's immediate supervisor. The staff's direct supervisor will be notified within 24 hours. The direct supervisor or nursing supervisor shall remove the staff from the unit and inform HR to issue a Paid Administrative Leave Memo for the duration of the investigation.

i. The nurse manager or nursing supervisor shall also assess and determine if the incident warrants contacting other resources, such as the psychiatric on-call physician.

j. The nurse manager or nursing supervisor shall assess on a case-specific basis allegations of resident to resident altercations, including altercations that occur between two residents with dementia that do not result in bodily injury, or rise to a reasonable suspicion of a crime, and determine, if an incident is reportable to SFSO. The Deputy Sheriff may be consulted as necessary if the allegation warrants official notification to the Sheriff's Department.

k. In cases of alleged or factual rape the following steps must be taken:

   i. LHH staff must immediately notify SFSO (Ext. 4-2319).

   ii. The attending physician shall make a direct referral to the San Francisco Rape Treatment Center located at 2801A – 25th Street, San Francisco (Ph: 415-821-3222) and shall direct the staff to preserve physical evidence to include the resident's physical condition and related personal effects.

   iii. At the San Francisco Rape Treatment Center, the resident shall be interviewed, specimens shall be taken, and treatment for possible sexually transmitted diseases as well as HIV prophylaxis shall be prescribed as deemed appropriate.

   iv. In all cases of rape, the attending physician shall request a psychiatric consultation for the resident.

   v. If a non-employee is identified as a suspect of rape, the nursing supervisor or nurse manager shall contact the Sheriff's Department.

l. The results of the investigation shall be reported to CDPH within five working days of the incident by QM. If the alleged violation is verified, appropriate corrective actions shall be taken.

m. The respective department head, in consultation with HR, shall report cases of substantiated abuse investigations to the appropriate employee's Licensing and Certification Boards.

Federal Regulation (F-Tags)	**Suspicion of a Crime 42 CFR 483.12(b)(5) and Section 1150B of the Social Security Act**	**Alleged Violations 42 CFR 483.12(c)**
	F-609 Report of Alleged Violations	

What to Report	Any reasonable suspicion of a crime against a resident or an individual receiving care from the facility	1) All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property 2) The results of all investigations of alleged violations
Who is Required to Report	Every Employee (Mandated Reporter) shall report to: CDPH, the Ombudsman, and Nursing Operations.	
Who Will Report to CDPH and the Ombudsman	Employee (Mandated Reporter)	
Who Will Report to SFSO, QM, CEO	Nursing Operations	
When to Report to CDPH, Ombudsman and SFSO	Serious bodily injury- Immediately but not later than 2 hours* after forming the suspicion No serious bodily injury – not later than 24 hours*	All alleged violations- 1) Immediately but not later than 2 hours*- if the alleged violation involves abuse or results in serious bodily injury 2) Not later than 24 hours*- if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; and does not result in serious bodily injury Results of all investigations of alleged violations- within 5 working days of the incident

7. Investigation

a. Any nurse or RCT member involved in the investigation of a resident-to-resident altercation, or allegation of abuse, neglect or exploitation shall document in the progress notes the details surrounding the incident (e.g., the times of physician notification and visits, the time of notification of the nursing supervisor, pertinent orders and actions, relevant resident remarks and assessment of resident condition related to the situation).

b. If an abuse, neglect or exploitation allegation involves a LHH employee, the supervisor/manager shall immediately work with HR to place the employee on administrative leave, pending completion of the investigation. The administrative leave will be in place until the investigations are complete. The employee shall be formally notified of the outcome of the investigation and future employee assignment.

c. If an abuse allegation, neglect or exploitation involves a LHH employee and the conclusion to the investigation does support the allegation, the manager shall continue the administrative leave measure pending completion of the full investigation by HR. The investigating supervisor/manager may consider the following factors in determining whether the alleged employee shall be placed on leave or reassigned to non-patient care duties:

i. Severity of the allegation,

ii. Circumstances of the case per the investigation, and

iii. Prior disciplinary and employment history.

d. QM staff shall forward investigation documents related to the abuse, neglect or exploitation allegation involving LHH staff to HR. The HR department shall conduct an independent investigation of any abuse allegation involving LHH staff whenever the investigating party determines that the alleged abuse is substantiated.

e. Once a suspected crime has been committed, caution will be exercised when handling materials that may be used for evidence or for a criminal investigation. LHH will reference applicable State and local laws regarding preserving evidence.

f. HR shall confer with the involved staff's immediate supervisor about the findings of the investigation to determine the appropriate administrative course of action.

g. If an employee or non-employee is identified as a suspect of a crime, the nursing supervisor or nurse manager shall contact SFSO. The nursing supervisor or manager shall initiate action to protect the resident and the SFSO and or San Francisco Police Department shall carry out the investigation.

h. The nurse manager or nursing supervisor shall inform the resident and responsible party of the findings of the investigation and provide feedback to the employee who reported the criminal incident or abuse allegation.

8. Forms Completion and Submission

a. The Charge Nurse or designee shall complete the Unusual Occurrence report related to the suspected criminal incident or allegation of abuse and submit to QM electronically.

b. The "Report of Suspected Dependent Adult/Elder Abuse" form (SOC 341), shall be completed by the designation of Nursing Operations. The staff person may be the Nurse Manager, Charge Nurse, Medical Social Worker or Nursing Operations Nurse Manager. The completed SOC 341 shall be faxed to CDPH and Ombudsman within 2 hours from the time the incident occurred and shall be submitted to QM including the fax receipts from CDPH and Ombudsman. (Refer to LHH SharePoint Forms page for an electronic form).

c. The "Written Notification to SFSO" form shall be completed by the Nurse Manager or designee after a telephone call is made to SFSO. The completed Written

Notification to SFSO form shall be faxed to SFSO and shall be submitted to QM including the fax receipts from SFSO.

d. The supervisor/manager shall verify that the Unusual Occurrence, the SOC 341, Written Notification to SFSO forms have been completed.

e. The QM Regulatory Affairs team shall complete the Investigation of Alleged Abuse form in cases of:

   i. Resident-to-resident

   ii. Visitor-to-resident

   iii. Staff-to-resident

   iv. Injury of unknow origin

   v. Neglect

   vi. Misappropriate of resident's property

f. In cases of alleged resident abuse, neglect or exploitation by staff or visitor, the final conclusion shall be determined by the Nursing Home Administrator who serves as the Abuse Prevention Coordinator or executive designee and partnership with ~~CQO~~Chief Quality Officer (CQO).~~QM Regulatory Affairs team, after conferring with the LHH Executive Team.~~

g. QM staff shall submit the SOC 341 form to the Ombudsman Office via fax (415-751-9789) if the fax verification was not received by Nursing Operations or designee.

h. QM staff shall provide a copy of the SOC 341 form to SFSO.

9. Resident Assessment and Care Planning

a. In cases of allegations of abuse, neglect or exploitation or resident-to-resident or visitor-to-resident altercation, the nurse manager or charge nurse, with input from the RCT and the resident(s) themselves (if possible) shall take the lead in assessing and updating the residents care plan(s). Considerations for care planning may include the following:

   i. Short-term and long-term ~~measures~~interventions to provide the resident with a safe and secure environment.

   ii. ~~Measures~~Interventions to mitigate the psychological impact of the incident.

iii. Characteristics, behaviors or habits that make the resident vulnerable at risk for aggression or altercations.

iv. Physiologic factor(s) involved in this incident. This should consider:

- Was the resident hungry, thirsty, constipated, in need of going to the bathroom, sleep deprived?
- Was the resident in pain?
- Did the resident have signs of an infection or delirium?

v. Treatment that may have contributed to or induced the resident's behavior.

vi. Need for psychiatric evaluation.

vii. Environmental stimulus/factor(s) contributing to this incident (excessive noise, crowded room).

viii. Staff action and/or inaction that may have contributed to the resident's behavior

ix. Ability to modify environment.

x. Likelihood of a repeat incident.

xi. Interventions to minimize the risk of recurrence.

xii. Need for frequent check-ins

xiii. Need for relocation or transfer to another level of care.

10. Coordination with QAPI

a. LHH will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program.

i. Cases of physical or sexual abuse, for example by facility staff or other residents, will be reviewed for and receive corrective action and tracking by the QAA Committee. This coordinated effort results in the QAA Committee determining:

- If a thorough investigation is conducted;
- Whether the resident is protected;
- Whether an analysis was conducted as to why the situation occurred;

- Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors); and
- Whether there is further need for systemic action such as:
    - Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation/exploitation,
    - Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about,
    - Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions,
    - Measures to verify the implementation of corrective actions and timeframes, and
    - Tracking patterns of similar occurrences.

11. **The Role of the Abuse Prevention Coordinator**

The Abuse Prevention Coordinator is responsible for the oversight for ~~overseeing abuse screening,~~ training, prevention, identification, investigation protection, reporting and response for all allegations of abuse, neglect, misappropriation and exploitation. The Abuse Prevention Coordinator serves as a central point of contact, promoting communication and collaboration among departments involved in resident care. This role should include implementing regular meetings, conducting case reviews, or convening multidisciplinary teams to share information, discuss potential abuse cases, and coordinate actions. The primary goal of coordination is to ensure abuse allegations are addressed urgently and timely.

The Abuse Prevention Coordinator ~~Coordination~~:

a. Collaborates with the Resident Care Team to ensure interventions are immediately implemented and documented to ensure resident safety during the investigative process.

b. Oversees and participates in Abuse and Neglect policy updates, mandatory training and investigation training for the facility.

c. Collaborates with Quality Management to ensure that a thorough investigation process occurs.

d. Reviews all investigations prior to be submitted to regulatory agencies.

ATTACHMENT:
Appendix A: Investigation of Alleged Abuse Form

REFERENCE:
LHHPP 22-03 Resident Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 22-07 Physical Restraints Including Bed Rails
LHHPP 22-08 Threats of Violence to Residents by an External Party
LHHPP 22-10 Management of Resident Aggression
LHHPP 24-06 Resident Complaints/Grievances
LHHPP 73-05 Workplace Violence Prevention Program
SOC 341 Form

Revised: 07/15/96, 12/27/99, 05/18/00, 01/03/01, 04/18/05, 04/28/05, 06/28/05, 07/29/05, 04/05/06, 01/08/08, 12/03/27, 16/01/12, 17/09/12, 18/05/08, 18/09/11, 19/05/14, 19/07/09, 19/09/10, 20/01/14, 21/02/09, 23/03/14, 23/07/11, 23/11/14 (Year/Month/Day)

Original adoption: 05/20/92

Appendix A: Investigation of Alleged Abuse Form

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Investigation of Alleged Abuse

PART I: INCIDENT INFO

TODAY'S DATE _____

Type of Alleged Abuse

☐ Injury of Unknown Origin ☐ Misappropriation of Resident's Property ☐ Neglect ☐ Other to Resident
☐ Resident to Resident ☐ Staff to Resident ☐ Other _____

Occurrence of Incident

Date of Incident: _____ Time of Incident: Location of Incident:

Brief Description of Incident
PLEASE INCLUDE WHO, WHEN, WHERE, WHAT AND WHY.

List of Witnesses

☐ No witnesses were identified.

Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached
Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached

PART II: REPORTER INFO

Date of Report: _____ Name of Reporter: Job Class/Title: _____

Reporter is: ☐ LHH Staff ☐ Other (specify): Contact Number: _____

Reported to: _____ Job Class/Title:

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Investigation of Alleged Abuse

PART III: PERSONS INVOLVED

Resident A (Alleged Victim)

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

☐ Own Decision Maker (ODM) ☐ Cognitively Impaired (CI) ☐ Surrogate Decision Maker _____

Resident B (Suspected Abuser) ☐ N/A

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

☐ Own Decision Maker (ODM) ☐ Cognitively Impaired (CI) ☐ Surrogate Decision Maker _____

Staff/Other ☐ N/A

First Name _____ Last Name _____ Contact Number _____

Job Class/Title _____ Relationship to Resident _____

PART IV: PROTECTIONS TAKEN

Staff to Resident ☐ N/A

☐ Reassignment of alleged staff to a non-patient area.

☐ Staff sent home or on administrative leave.

Resident to Resident / Other to Resident ☐ N/A

☐ Involved parties were separated and counseled. If not, please explain why:

☐ One of more residents moved or relocated.

☐ Other. Please explain:

Other Types of Alleged Abuse ☐ N/A

☐ Please describe action taken:

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Investigation of Alleged Abuse

PART V: NOTIFICATION TO BE COMPLETED

***Notification Requirements** to CDPH, CEO/AOD, Ombudsman, QM Staff and SFSD based on criteria below:*

***Within 2 hours:** Events involving crimes or suspicion of crimes that result in bodily injuries; and alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.*

***Within 24 hours:** Events involving crimes or suspicion of crimes that do not result in serious bodily injury; and allegations of abuse that are not substantiated and do not result in serious bodily injury.*

Notification of Resident's Responsible Party ☐ N/A

Resident A: Name _____ Date _____ Time _____

Resident B: Name _____ Date _____ Time _____

LHH Staff Notification Checklist *(Check appropriate boxes)*

- ☐ Charge Nurse, Nurse Manager, and Nursing Director
- ☐ Physician
- ☐ Director of Social Work or Designee
- ☐ Urgent Psych for Evaluation (415-327-5130)
- ☐ Administrator/AOD
- ☐ Quality Management Department
- ☐ UO Documentation Complete
- ☐ Other _____

External Notification Checklist *(Check appropriate boxes)*

- ☐ Sheriff's Department (415-759-2319)
- ☐ SFSD Notification Form Faxed (415-759-3019)
- ☐ SOC-341 Completed and Faxed (415-751-9789)
- ☐ Rape Treatment Center (415-821-3222)
- ☐ Other _____
- ☐ CDPH Office (415-330-6353)
  - Name _____ ☐ Answering Machine
  - Date _____ Time _____
- ☐ Local Ombudsman Office (415-751-9788)
  - Name _____ ☐ Answering Machine
  - Date _____ Time _____

Sample call to CDPH:

This is ___ (your name and title) at Laguna Honda Hospital. This call is to notify you that on___ (date and time), a report of alleged resident abuse involving ____ (name of resident) was received.

Please spell the resident's name(s) and give the resident's date of birth when reporting the incident. Specify if there was any resident injury that occurred. State that an investigation of the incident has been initiated.

If there are any questions, please contact Quality Management at ext. 4-3055, ext. 4-3057, ext. 4-3575, or ext. 4-3530.

Investigation of Alleged Abuse

PART VI: ASSESSMENT

Medical Assessment of Resident A ☐ N/A

Name of Physician _____ Date _____ Time _____

Brief Statement of Findings:

Medical Assessment of Resident B ☐ N/A

Name of Physician _____ Date _____ Time _____

Brief Statement of Findings:

Resident to Resident Incident Assessment(s) ☐ N/A

Please complete ONLY if incident is Resident to Resident.

	Resident A	Resident B
Behavior Risk Assessment current and complete.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Care plan discusses problem behavior or risk of being a target of aggression.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Order for any scheduled psychotropic medications.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Order for any PRN psychotropic medications.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Received PRN psychotropic medications within 6 hours prior to incident.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
History of problem behaviors within the last 3 months.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Prior psych consult completed within the last 12 months.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A
Additional psych consult necessary.	☐Yes ☐No ☐N/A	☐Yes ☐No ☐N/A

Resident Interview

Resident MUST be interviewed unless comatose, discharged, or expired.

Resident A: Date _____ Time _____ ☐ Statement Attached ☐ Unable to Interview

Resident B: Date _____ Time _____ ☐ Statement Attached ☐ Unable to Interview

Analysis

Was this a deliberate act? ☐ Yes ☐ No If no, please explain: _____

If yes, did the deliberate act result in:

Physical Harm ☐ Yes ☐ No Pain ☐ Yes ☐ No Mental Anguish ☐ Yes ☐ No

Describe any physical injury, pain, and/or mental anguish:

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Investigation of Alleged Abuse

PART VII: CONCLUSION

Based on the interviews and other information available at this time, and in the exercise of my clinical judgment:

☐ I conclude that the abuse is substantiated.
☐ I conclude that the abuse is NOT substantiated.
☐ I conclude that the theft occurred.
☐ I conclude that the theft did NOT occur.

Please explain the reason for your conclusion below.

Reason(s) for my conclusion:

PART VIII: SUPPORTING DOCUMENTS

Additional Required Notifications

(Check appropriate boxes)

Resident/responsible party has been notified of the outcome of this investigation.	☐ Yes	☐ No	☐ N/A
Resident/responsible party was satisfied with the outcome of the investigation.	☐ Yes	☐ No	☐ N/A
Employee(s) has been notified of the outcome of this investigation.	☐ Yes	☐ No	☐ N/A
Reporter of alleged abuse has been notified of the outcome of this investigation.	☐ Yes	☐ No	☐ N/A
Human Resources has been notified when staff to resident alleged abuse is substantiated.	☐ Yes	☐ No	☐ N/A

Additional Required Documents

(Check appropriate boxes)

I have attached a copy of the staff reassignment/ send home letter.	☐ Yes	☐ No	☐ N/A
I have attached a copy of the resident's current and revised care plan.	☐ Yes	☐ No	☐ N/A
I have attached a copy of the staff assignments.	☐ Yes	☐ No	☐ N/A
I have attached a copy of the RCT special review and revised/reviewed the resident's care plan.	☐ Yes	☐ No	☐ N/A

Name / Title: _____ Date Completed: _____

Signature: _____

Name / Title: _____ Date Completed: _____

Signature: _____

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Investigation of Alleged Abuse

ADDITIONAL SPACE

Please use space as needed. Indicate the section additional detail is being provided for.

Page 6 of 6

Code Blue Record (Date: _ _ / _ _ / _ _ _ _)

Type of Code Blue Event (Please circle event)	Cardiac Arrest/ Respiratory Arrest/ Seizure/ Loss of Consciousness Other: _____
Code Status: DNR/DNI Full Code	
CPR Initiated (Yes or No) by Name:	Time CPR initiated:
Pt last seen responsive by Name: Time:	Pt Found by: Time:
1st MD Arrival Time: Name:	2nd MD Arrival Time: Name:

Time	Rhythm ~~(print EKG strip)~~	RR	Pulse	B/P	O2 Sat	Defibrillate (Joules)	Medications (i.e. Epinephrine, Atropine, Amiodarone)	Other interventions (i.e. Blood Sugar, Ventilation, Intubation, O_2)
						120/150/200 J		
						120/150/200 J		
						120/150/200 J		
						120/150/200 J		
						120/150/200 J		
						120/150/200 J		
						120/150/200 J		
						120/150/200 J		
						120/150/200 J		
						120/150/200 J		

IV Fluid Summary					
Time	Inserted by	Type of Access (PIV, CVD, IO)	Site	Size	Solution

Please Fill Out Back Page

Time Code Stopped: _____ Disposition: ☐ Survived ☐ Expired

Transferred to: _____ (~~Hospital)~~ @Hospital) @ _____ time

~~**Family Notified: ☐ Yes ☐ No Name of Family Contact: _____**~~

Code Blue Participants (Print Name & Sign):

- **Physician/Code Team Leader: _____**
- **Other Physicians Present: _____**
- **Compressions: _____**
- ~~**Airway :**~~**Airway: _____**
- **IV Med Nurse (s): _____**
- **AED Operator: _____**
- **Recorder: _____**
- **Other: _____**

*** **Original Copy = Resident Medical Record**

~~**Bring Copy to Nursing Office - Code Blue Committee Mailbox**~~ **Email a copy to: DPH-LHHCodeBlueCommittee@sfdph.org**

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

LAGUNA HONDA
HOSPITAL AND REHABILITATION CENTER | A COMMUNITY OF CARE
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

CODE BLUE DRILL RECORD

North/South Neighborhood: ____

Start Time		**End Time**		**Date:**	
Shift		**Code Blue Drill Neighborhood:**		**Evaluator:**	

Instructions: **1) All neighborhood staff must actively participate.**
2) List names of ward staff who participated
3) FAX completed form to Nursing Education: at 759-4655

YES	NO	DESCRIBE CORRECTIVE ACTION FOR ANY "NO" RESPONSE ~~ON LINE~~ONLINE PROVIDED
		1. Check for unresponsiveness (tap and talk: "Are you O.K.?")
		2. If no response and if resident is in bed, pull outward one of the CPR release handles (head of the bed) until the bed is completely lowered to a flat position then release the handle.

		3. ~~Open the airway (head tilt, chin lift)~~ Look, listen and feel for breathing/chest rise.
		4. ~~Look for breathing, c~~Check pulse (carotid 5-10 sec).
		5. Abnormal/no breathing and/or no pulse, activate the code blue/nurse call if you are in the resident's ~~room and~~room and call 42999
		a. State "Code Blue Drill ~~Pavillion~~Pavilion/North/South/ Neighborhood _____."
		b. ~~Simulates calling~~Simulates ~~9~~calling 9-9-1-1 and communicates to 9-1-1 operator per script
		c. P.A. announcement audible within 15 seconds (~~Time:~~ Time: _____)
		6. If you are in great ~~room ,~~room, living room, dining room, call 42999 using your spectralink phone
		7. Staff brings chart (√ **code status**) and equipment to the emergency site, e.g. crash cart, emergency drug ~~box,~~ box,~~-~~ glucometer (DOES NOT DELAY Compressions-Airway-Breathing) while awaiting Code Status).
		8. Remove headboard (if applicable) and insert backboard from the crash ~~cart under~~cart under ~~the resident~~the resident
		9. Obtain ambu bag, insert oral airway, and give 2 breaths.
		11. Begin CPR (2 persons - **30:2** ratio).
		12. Assisting staff bring other emergency equipment quickly.
		a. Oxygen - turn on and connect to ambu bag
		b. Emergency I.V. bag and pole
		c. Emergency drug box
		13. Start I.V. and locate EZ-IO supplies (needle kit, pressure bag)
		14. Provide adequate space by moving adjacent beds away
		15. Close curtains of nearby residents.
		a. Stay with any residents who need help.
		b. Take family member to lounge and give assistance
		16. Assign C.N.A./PCA by the elevator to direct code blue members to the site
		17. Assign a C.N.A./PCA to meet EMS at the Pavilion lobby
		18. LN stay with the victim until transported out by EMS
		19. Recording RN accurately completes Code Blue Record
		20. Staff performs drill per the nursing and responsibilities (Appendix 3 of Code Blue P&P)

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

LAGUNA HONDA
HOSPITAL AND REHABILITATION CENTER | A COMMUNITY OF CARE
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

CODE BLUE DRILL RECORD

Participants (PRINT) Name and Classification

Name (Print First/Last)	Class	Name (Print First/Last)	Class
1,		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

IDENTIFIED AREAS for FOLLOW-UP EDUCATION/TRAINING/PRACTICE:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Reviewed by (Department of Education/CNS):

Print Name	Signature	Title	Date
Print Name	Signature	Title	Date
Print Name	Signature	Title	Date
Print Name	Signature	Title	Date

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER | A COMMUNITY OF CARE
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

POST CODE BLUE CHECKLIST - ADDRESSOGRAPH

Medical Quality Assurance & Nursing Performance Improvement

Criteria	Yes	No	Comments
Was the Code Blue announcement on PA system audible?			
Appropriate pagers received Code Blue Call?			
• Physicians (acute/SNF)			
• Nursing (supervisor, neighborhood code blue pager)			
• Respiratory			
Response time adequate (<5 minutes)?			
• Physician arrival			
• Crash cart arrival			
• Other personnel or equipment arrival			
Was the CPR instituted in a timely manner? By whom?			
• Neighborhood Staff			
• Code Team Member			
• If not, why?			
Was the airway/respiratory support instituted in a timely manner?			
• Comments:			
Was the equipment accessible, set up, and functioning in a timely manner? If no, explain:			
• Board under the patient			
• Cart plugged in?			
• O2 started?			
• EKG/Defib. machine ready?			
• Suction machine ready?			
• O2 connected to ambu bag?			
Was there equipment or medication needed that is not present on the code carts? Explain:			
Was the emergency drug box brought to the Code?			
Did one physician clearly assume responsibility for the code? If no, how did this impact on the Code efficiency?			
Did the patient have a DNR order? If yes, why was the Code called?			
Did the Code Team operate efficiently? Any suggestions for improving the Code Blue process? (Please respond on the back of this page if necessary.)			
• Effective CPR			
• Meds/I.V.			
• VS/Zoll Defibrillator			
• Suction/Respiratory			
• Nursing supervisor directs nursing personnel appropriately			
• Clear communication			
Code Blue Record (part of the medical chart) is complete and accurate? If no, why not?			
Code Blue performance and checklist reviewed with team. If no, why not?			

_____ _____

MD signature ***R.N. Supervisor Signature***

This is NOT part of medical chart. Information is a confidential part of the medical quality assurance process.

Original: Nursing Education

Copies: **Email copy to DPH-LHHCodeBlueCommittee@sfdph.org** ~~Susan Sabai, MD, Emily Kinebuchi, MD, Code Blue Chair, Kathleen MacKerrow, RN, CNS~~

Print names of participants in the back.

MEDICATION ERRORS AND INCOMPATIBILITIES

POLICY:

1. Medication errors and incompatibilities that cause or have the potential to cause resident harm will be reported immediately to the attending (or covering physician). If a covering physician is notified the attending physician will also be notified as soon as they are available.

2. Medication errors and incompatibilities that do not cause harm or minimal harm may be reported to the attending physician as soon as they are available.

3. Medication errors and near misses are reported, investigated and evaluated by the Medication Error ~~Prevention~~ Reduction Subcommittee (MERC) of the Pharmacy and Therapeutics Committee.

4. Medication errors and incompatibilities will be documented in the medical record.

PURPOSE:

1. Medication errors and incompatibilities are identified and reported to maintain resident safety.

2. Medication errors are investigated to identify and change systems issues that contribute to errors.

DEFINITION:

1. Medication Error Classification

    a. MEDICATION ERROR: Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. Such events may be related to professional practice, or health care products, procedures, and systems, including prescribing, order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.[1]

    b. ACTUAL MEDICATION ERROR: A mistake in prescribing, dispensing or administering of drugs that is not detected before the drug reaches the resident. All actual medication errors should be reported on an Unusual Occurrence Report form and immediately forwarded to the Quality Improvement Coordinator.

c. POTENTIAL MEDICATION ERROR: A mistake in prescribing, dispensing or planned administration of drugs that is detected and corrected through intervention before actual medication administration. Examples of potential errors that should be reported on the Unusual Occurrence Report form include transcription errors, pharmacy dispensing errors, and physician order writing errors.

2. Types of Medication Errors[2]

a. PRESCRIBING ERROR: Incorrect drug selection, dose, dosage form, quantity, route, concentration, rate of administration, or instructions for use of a drug product ordered or authorized by the physician; illegible prescriptions or medication orders that lead to errors that reach the resident.

b. OMISSION ERROR: Failure to administer an ordered dose to a resident before the next scheduled dose, if any.

c. TIME ERROR: Administration of medication outside a predefined time interval from its scheduled administration time.

d. UNAUTHORIZED DRUG ERROR: Administration to the resident of medication not authorized by a legitimate prescriber, or not authorized pursuant to Pharmacy and Therapeutics Committee approved protocols for therapeutic or generic substitution of drugs.

e. DOSE ERROR: Administration of a dose that is greater than or less than the amount ordered by the prescriber or administration of duplicate doses.

f. DOSAGE-FORM ERROR: Administration of a drug product in a different dosage form than ordered by the prescriber.

g. DRUG-PREPARATION ERROR: Drug product incorrectly formulated or manipulated before administration.

h. ADMINISTRATION TECHNIQUE ERROR: Inappropriate procedure or improper technique in the administration of a drug.

i. DETERIORATED DRUG ERROR: Administration of a drug that has expired or for which the physical or chemical dosage-form integrity has been compromised.

j. MONITORING ERROR: Failure to review a prescribed regimen for appropriateness and detection of problems, or failure to use appropriate clinical or laboratory data for adequate assessment of patient response to prescribed therapy.

k. OTHER MEDICATION ERROR: Any medication error that does not fall into one of the above medication error types.

3. Medication Error Severity Index[3]

a. CATEGORY A: –No error occurred, but circumstances or events that have the capacity to cause error are identified.

b. CATEGORY B: An error occurred but the medication did not reach the resident.

c. CATEGORY C: –An error occurred that reached the resident but did not cause the resident harm.

d. CATEGORY D: –An error occurred that resulted in the need for increased resident monitoring but no resident harm.

e. CATEGORY E:– An error occurred that resulted in the need for treatment or intervention and caused temporary resident harm.

f. CATEGORY F:– An error occurred that resulted in initial or prolonged acute hospitalization and caused temporary resident harm.

g. CATEGORY G: An error occurred that resulted in permanent resident harm.

h. CATEGORY H:– An error occurred that resulted in a near-death event (e.g., anaphylaxis, cardiac arrest.)

i. CATEGORY I: An error occurred that resulted in resident death.

4. Significant Medication Error and Sentinel Events

a. SIGNIFICANT MEDICATION ERROR: An error that causes the resident discomfort or jeopardizes his/her health and safety[4]. Errors classified as severity categories D through I, are significant medication errors.

b. SENTINEL EVENTS: Medication errors classified as severity categories F through I, may be sentinel events and should be investigated as outlined by the Hospital-Wide Policy and Procedure on Sentinel Events.

5. Medication Incompatibility

a. A drug incompatibility occurs when drugs interfere with one another chemically or physiologically. Drugs known to be incompatible must not be mixed, administered together, or administered within a timeframe where they will interfere with each other.

PROCEDURE:

1. Errors and incompatibilities that result in or have the potential to result in an adverse effect to the resident shall be immediately reported by the individual who makes or discovers the medication error or incompatibility to the appropriate physician and supervisor.

2. Errors and incompatibilities that result in no or insignificant harm to the resident shall be reported by the individual who makes or discovers the medication error or incompatibility to the appropriate physician and supervisor as soon as they are available.

3. All medication errors and incompatibilities will be recorded in the medical record.

4. The individual who makes or discovers the actual or potential medication error or medication incompatibility shall complete the On-Line Unusual Occurrence Report (UOR).

5. The RISK MANAGEMENT NURSE will review the UOR and assign to the appropriate department manager for investigation, follow-up and recommended further action.

6. All reported medication errors and incompatibilities are reviewed each month by the Medication Error Reduction Subcommittee.

7. The Medication Error Reduction Subcommittee will:

    a. note the type and severity of the medication error and forward this information to the RISK MANAGEMENT NURSE. If not already initiated, medication errors that may be sentinel events will be immediately referred to the RISK MANAGEMENT NURSE for further investigation and action as outlined in the Hospital-Wide Policy and Procedure on Sentinel Events.

    b. review the manager's investigation and follow-up actions for completeness.

    c. identify trends and/or systems issues that may have contributed to the medication error and recommend a plan of correction to the appropriate department managers, committees, or Executive Staff.

    d. provide at least annually to the Pharmacy and Therapeutics Committee, the estimated medication error rate at the hospital, as calculated by the following formula:

$$\text{Medication Error Rate}^{4} = \frac{\text{Number of errors reported on UOR form}}{} \times 100$$

Estimated opportunities for errors
[Approximate # doses administered]

ATTACHMENT:

None.

REFERENCE:

[1] National Coordinating Council for Medication Error Reporting and Prevention. What is a Medication Error?. May 2008. www.nccmerp.org

[2]ASHP guidelines on preventing medication errors in hospitals. *Am J Hosp Pharm*. 1993; 50:305-14

[3]Dunn ED, Wolfe JJ. Medication error classification and avoidance. *Hospital Pharmacy.* 1997; 32:860-865.

[4]Guidance to surveyors - Long Term Care Facilities; State Operations Manual.

Reviewed: 19/09/10 (Year/Month/Day)
Original adoption: 11/11/29

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Laguna Honda Hospital and Rehabilitation Center

Security Management Plan 20223-20234

REFERENCES

Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC.02.01.01
California Code of Regulations, Title 8, Sections 8 CCR 3203 *et seq.*
California Code of Regulations, Title 22, Sections 22 CCR 70738
Health & Safety Code, Section 1257.1, 1257.8, 1257.7

I. PROGRAM OBJECTIVES, INTENT and CORE VALUES

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing a safe, secure, accessible, and effective environment of care, consistent with its mission, scope of services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes the risk of harm to residents/patients, staff, and visitors.

It is the overall intent of this plan is to establish the framework, organization, and processes for the development, implementation, maintenance, and continuous improvement of a comprehensive Security Management Program. This program is designed to provide protection through appropriate staffing, security technology, and environmental controls.

The objectives of the Security Management program include:

- Continuous review, survey, and auditing of the physical conditions, processes, operations, and applicable statistical data to anticipate, discern, assess, and control security risks, and vulnerabilities.
- Ensure timely and effective response to security emergencies.
- Ensure effective responses to service requests.
- Report and investigate security related incidents.
- Promote security awareness and education.
- Enforce various hospital rules and policies.
- Establish and implement critical program elements that safeguard people, equipment, supplies, medications, and control traffic in and around the hospital campus.
- Establish policy and procedures for addressing illicit drugs on the hospital campus.

II. SCOPE and APPLICATION

The Security Management Plan comprises standards applicable to addressing and facilitating the protection, welfare, safety, and security of the environment. Included is a full range of protective

services for persons, property, and assets at the hospital. The Security Management plan requires compliance with all policies and procedures. The management plan calls for best in class customer service for resident/patients, visitors, volunteers, contractors, and staff as well as the protection of property and assets.

The scope of the plan addresses all program elements required to provide a safe and secure environment. Key aspects include:

- Program planning, design, and implementation
- The measurement of outcomes and performance improvement
- Risk identification, analysis, and control
- Reporting and investigating of incidents, accidents, and failures
- Security Awareness, education, and training
- Emergency response
- Addressing legal and criminal matters
- Use and maintenance of equipment, locks, physical barriers, security surveillance systems, alarms, etc.
- Security of medications
- Traffic control
- Security of sensitive areas
- Visitors Screening and Property Searches

III. AUTHORITY

The SF Health Network provides the program's vision, leadership, and support. The Director of Health appoints a Director of Security who is responsible for the oversight of security program development, and implementation. The Director of Security reports directly to the Department of Public Health, Chief Operating Officer and will collaborate with and maintain communication with the LHH Chief Executive Officer to ensure that the healthcare security program reflects an alignment with the LHH mission, vision, and strategic objectives.

IV. RISK ASSESSMENT

Security risks, vulnerabilities, and sensitive areas are identified and assessed through ongoing campus-wide processes that are coordinated by Facility Services, San Francisco Sheriff's Office, and the DPH Director of Security. These processes are designed to proactively evaluate facility grounds, periphery, behaviors, statistics, and physical systems. Considerations include:

- Routine Environmental of Care Rounds
- Root Cause Analysis of significant events
- Failure Mode and Effects Analysis (FMEA)
- Sentinel Event Alerts
- Security Patrols
- Unusual Occurrence Reports- Review of pertinent data/information, incident reports, evaluations, and risk assessments
- Community crime statistical data or CAPRISK Reports
- Facility crime, incident and property loss statistics, workplace violence, and crime statistics
- Customer and benchmarking surveys
- "At Risk" residents/patients (such as clinically indicated restraints, medical holds, and stand-by services)
- Hours of operation
- Employee, Resident/Patient and Visitor Identification
- Hospital operations and processes
- ~~Employee, resident and visitor identification~~
- ~~Hospital and Rehabilitation Center operations and processes~~

The profile of potential risks results in an integrated approach to risk control and management. Identified "Sensitive Areas" include the ~~all areas with protected health information (~~PHI Areas,~~),~~ Administrative Offices, Human Resources, ~~Pharmacy,~~ Nutritional Services, Pharmacy,~~and~~ Psychiatry, Information Technology, and Central Plant areas.

V. PROGRAM ORGANIZATION AND RESPONSIBILITIES

The Director of Security is responsible for the quality oversight of the security program. The Director of Security in partnership with the San Francisco Sheriff's Office is responsible for the overall management of the security program. This includes the program design, implementation, identification, control of risks, staff education, training, and consultation.

The Director of Security manages the work order with the San Francisco Sheriff's Office (SFSO) by participating in the development and approval of standard operating procedures, ensuring the appropriate resources are available to accomplish the objectives and goals of the Security Management Plan.

The SFSO Unit Commander manages the public safety and law enforcement services, including providing law enforcement personnel, management of SFSO operations, and compiling data from incident reports to form the Environment of Care Security Report.

The Unit Commander assures that SFSO assigned staff receive hospital related training, including racial humility and trauma informed care training; participate in safety and security, and threat management committees, and assures that all SFSO staff follow LHH security operating procedures.

The Director of Security and the SFSO Unit Commander will collaboratively establish and maintain communication and mutual ownership for outcomes by identifying and troubleshooting emergent safety and security concerns.

The Director of Security reports to the Environment of Care Committee about the implementation of new procedures and operations, as well as installation of new electronic security systems.

The Environment of Care Committee (EOC) comprised of clinical, administrative, operations support services, and labor representatives to ensure that the security management program is aligned with the core values and goals of the organization by providing direction, setting strategic goals, determining priority, and assessing the need for change.

The EOC is the central hub of the information collection and evaluation system and acts as a clearinghouse for action items, recommendations, and ensuring that risks are controlled in a timely fashion. The committee also ensures coordination, communication and integration of performance improvement, strategic planning, and injury prevention activities in committee activities.

In the context of security management, the Environment of Care Committee is designed to:

- Develop strategic goals and annual performance targets, relative to Security and the Environment of Care (EOC) programs.
- Carry out analysis and seek timely, effective, and sustainable resolution to security related issues.
- Prioritize goals and resources.

Department managers are responsible for the provision of a safe and secure work environment for staff through full implementation of established Environment of Care programs. This includes the identification of security risks, staff education, developing and implementing department specific security policies and procedures, incident reporting, and the protection of residents/patients and their belongings.

Employees are responsible for following security policies and practices about personal protection and reporting of security incidents, risks, and threats. Employees include contract employees, volunteers, students, registry personnel, physicians and anyone working under the facility's auspices.

VI. PROGRAM IMPLEMENTATION AND PROCESSES

Successful implementation of the Security Management Plan involves the incorporating the principles of the plan into the culture and operations of LHH. Implementation of the security program is the responsibility of the Director of Security and SFSO Unit Commander. The performance is monitored

quarterly by the Environment of Care Committee, Campus Safety and Security Committee, and the Performance Improvement & ~~Resident/~~Patient Safety Committee. They include:

1. The designation of a person to be responsible for program development and oversight. The Director of Security as the person responsible for the quality oversight of the security program's development, implementation, and monitoring.

2. The Security Services Department and the San Francisco Sheriff's Office conduct investigations and complete written reports about security incidents involving residents, staff, visitors, domestic related incidents that impact LHH, and property. Investigations are documented and reviewed by the SFSO Unit Commander and the DPH Director of Security. Corrective actions are developed and implemented to mitigate risks. The Director of Security in collaboration with the SFSO Unit Commander ensures that incident reports are distributed to the appropriate departments (i.e., Quality, Risk Management, etc.) Significant events are reported to the Administrator-on-Duty, Nursing Ops, Executive Leaders, and the Environment of Care Committee.

3. Security in collaboration with Facility Services will ensure that employees, vendors, and contractors wear personnel identification badges to facilitate the creation of a safe and secure environment. Badges are issued to all employees, physicians, volunteers, and vendors.

4. Access to the hospital's perimeter and buildings are maintained by appropriate security safeguards, including security surveillance cameras, routine checks on all perimeter doors, and the securing of individual departments after normal business hours. All employees are responsible for ensures that access to the facility is restricted to residents, employees, visitors by providing an appropriate greeting and wayfinding. Unauthorized individuals, suspicious persons and activity are reported to the SFSO/contract security supplier—**race, gender, and religious affiliation are NOT considered suspicious**.

5. Security controls access to and egress from security sensitive areas by means of direct observation, locks and other physical barriers, signage, alarm systems and access control systems.

~~Successful implementation of the Security Management Plan involves the incorporation of the principles of the plan into the culture and operations of the organization. Implementation of the security program is the responsibility of the Director of Security, and SFSO Unit Commander. The performance is monitored quarterly by the Campus Safety and Security Committee and the Executive Committee. They include:~~

~~1. The designation of a person to be responsible for program development and oversight. The Health Director has designated the Director of Security as the person responsible for the quality oversight of the security program's development, implementation and monitoring.~~

~~2. The Security Services Department and the San Francisco Sheriff's Office conduct investigations and completes written reports about security incidents involving residents/patients, staff, visitors, volunteers, and property. Investigations are documented and reviewed by the SFSO Unit Commander and the DPH Director of Security. Corrective actions are developed and implemented to mitigate risks. The Director of Security in collaboration with the SFSO Unit Commander ensures that incident reports are distributed to the appropriate departments (Quality, Risk Management, etc.) Significant events are reported to~~

~~the Chief Executive Officer, LHH Chief Operating Officer and to the Director of Workplace Safety and Emergency Management.~~

~~3. Security will ensure that employees, vendors, and contractors wear personnel identification badges to facilitate the creation of a safe and secure environment. Badges are issued to all employees, consultant physicians, volunteers, and vendors.~~

~~4. Access to the hospital's perimeter and buildings is maintained by a lock down of unoccupied areas, routine checks on all perimeter doors, and the securing of individual departments after normal business hours. The contract security provider ensures that access to the facility is restricted by confirming unauthorized personnel and escorting them off the premises.~~

~~5. Security controls access to and egress from security sensitive areas by means of direct observation, locks and other physical barriers, signage, alarm systems and access control systems.~~

6. SFSO and the contract security provider conduct regular foot and vehicular patrols to identify potential security risks and assess the status of physical conditions within the buildings and on the hospital campus. Regular patrols, security checks of the campus interior and exterior, and parking areas, and maintaining fixed positions are conducted to deter theft, vandalism, and other criminal activity, including use or possession of contraband, and prohibited items.

7. The Director of Security and the SFSO Unit Commander are actively involved in the Campus Safety and Security Committee and Threat Management Workplace Violence Prevention Committee, providing investigative and protective services for LHH Hospital Administration, Human Resources, and Resident.

8. The Security Operations Center provides call-taking and dispatch services, monitors alarms and surveillance cameras to augment patrol staff and ensure an appropriate and timely response to security-related incidents and service request.

9. The Security Services Department, and SFSO maintains records of all incident reports, service calls and crime statistics. Incident reports that involve safety, residents and environmental issues will be forwarded to the Executive Committee, Risk Manager, and Facilities Director.

10. The collaborative efforts of Security Services and Facilities Services maintains and coordinates the badge access program. The Access Card Request Form is reviewed by the Facilities Department to determine the need for the requestor to have card access. Approved Card Request are processed by the Facilities Department. Records of all issued access cards are maintained with Human Resources and Facilities.

11. The SFSO and the contract security provider will respond to hospital emergencies, including:

- **Code Red** – Respond to the alarm point of origin to assist in implementing initial fire plan, aid local fire department and Facilities.

- **Internal / External disasters** - Control access, crowd management, and activate mutual-aid responses as required.

- **Code Green** - Deploy security personnel to designated locations to establish a perimeter and begin the search for missing residents.

- **Media and VIP Response** - Managing situations involving media or VIPs by aiding the Information Office and safeguarding info of any VIP on premises.

- **Lockdown Procedure** - Heightening existing security measures as needed during civil unrest, disturbances, demonstrations, or acts of terrorism.

- **Resident Assist** – SFSO will provide emergency assistance to address resident-initiated attacks on medical staff, including resident stand-by services. The contract security provider's assistance will be provided at the direction of a physician, affiliated professional, or nurse, to assess, control, moderate, or prevent the inappropriate behavior of a resident.

- **Resident Standby** – the contract security provider's assistance will be provided at the direction of a physician, affiliated professional, or nurse, to assess, control, moderate, or prevent the inappropriate behavior of a ~~resident/~~patient, including following the ~~resident/~~patient that is attempting to leave and radioing the exterior security units the elopement attempt.

- **Patient Abuse Reporting** – Investigation and document all incidents of ~~resident/~~patient abuse as required by SOC-341.

12. All new employees, at the time of hire, will complete the~~attend a~~ New Employee Orientation Program. All employees will receive basic information related to the Security Services Department and the~~its~~ Security Management Plan. During the security portion of the orientation, employees will receive information about the following:

- Security Department Services

- Prudent security practices

- ID Policy

- Threat Management and Workplace Violence Prevention

- Reporting a security incidents or suspicious activity

- Security location~~locations~~ and phone numbers, etc.

13. Additional training will be provided to all Clinical and Ancillary Departments in Non-Violent Crisis Intervention (CPI), Management of Aggressive Behavior, and Threat Management and Workplace Violence Prevention, and Active Shooter.

14. The SFSO Unit Commander and the contract security provider's Account Manager will verify that LHH assigned SFSO and contract security employees, complete all required trainings. Training records will be retained by the Department of Education and Training for Security Services and SFSO assigned staff.

15. Security refresher in-services will be based on the assessment of the department's need, change in roles or regulatory requirements, and EOC findings.

VII. PROGRAM EFFECTIVENESS

Through the Environment of Care Committee, the effectiveness of the security program is monitored and assessed on an ongoing basis. Identified risks are used to develop performance metrics to create a safe and secure environment for staff, residents, and visitors to the hospital. A quarterly report is submitted to the Environment of Care Committee. Recommendations are made, as needed, to facilitate improvements in performance. Action plans are developed and implemented to improve performance.

VIII. PERFORMANCE

The hospital has developed and implemented a systematic, campus-wide approach for performance improvement. It is intended to assist the hospital in developing and maintaining improvement programs that are meaningful, realistic, and adjustable based upon relevant data and customer feedback. The standards and metrics by which the performance of this plan will be measured are based on hospital and department experiences, ~~2021-~~2022-2023 Security Risk Assessment/Survey and~~, 2021-2022~~ Annual EOC Security Report, exercise evaluation results, observed work practices, customer expectations/satisfaction, and Environment of Care Committee recommendations.

During ~~2022-~~2023-2024, the measures that will be collected, tracked, and analyzed by the Environment of Care Committee on a quarterly basis include:

Performance Metric #1 – Code Green, SFSO Resident Elopement Response Incidents and Drills:

During actual Code Green incidents/drills, the effectiveness of the contract security provider will be measured to determine their response in the following areas:

- Initial Perimeter and Search
- Notification of the following: ~~SFPD, BART, and MUNI~~
  1. San Francisco Police Department's Missing Persons Unit
  2. Central Warrants Bureau
  3. Department of Justice
  4. Zuckerberg San Francisco General Hospital
  5. Medical Examiner's Office
  6. County Jail #1
- Documentation of Search Activity

- Locate/Not Located Procedure

1. The contract security provider will be measured on their ability to effectively respond i.e., initial perimeter search, and notification of SFPD, BART, and MUNI as applicable, and document the search activity:

   Response-rate Threshold – 80%

   Response-rate Target – 90%

   Response-rate Stretch – 100%

2. The contract security provider, in collaboration with the hospital will be measured on its ability to make contact i.e., determine the location, and deem safe, an "At Risk" resident/patient, and when they are not located, follow the Not Located Procedure.

   Locate/Return-rate Threshold –90%

   Locate/Return-rate Target – 98%

   Locate/Return-rate Stretch – 100

Performance Metric#2 – Employee Security Awareness:

During EOC rounds, hospital staff will be tested on 5 questions regarding their full knowledge of~~:~~

- Code Green Response
- Unauthorized Person
- Workplace Violence
- De-escalation Principles~~.~~
- Contraband and Prohibited Policy
  - ~~Disruptive Resident~~
  - ~~Contacting Security~~

Threshold - 80% Partial Knowledge~~Somewhat Satisfied~~

Target - 90% Full Knowledge~~Satisfied~~

Stretch – 98% Exceeded Target~~Very Satisfied~~

Performance Metric#3 – Electronic Security System Performance:

To ensure that~~On a monthly basis the Security Operations Center will inspect the~~ electronic security devices are functional, systems will be inspected monthly.~~system for functionality.~~ The Facilities Department will monitor all service call/work-orders to ensure timely response. Facility Services,~~The~~ Security Director, and SFSO~~SFSD~~ Unit Commander will develop a plan to mitigate risk, resulting from system malfunctions. The action plan will be documented in EOC~~Campus Safety and~~ Security Report.

The monthly target is for 100% of the system to be inspected and will be 98% functional.

Performance Metric#4 – Contraband and Prohibited Item Reductions:

The security program will be measure on its performance to reduce contraband and prohibited items from the established 1199 item baseline through:

- Patrol rounds at resident gathering places where illicit drug activity is suspected.
- Conducting property screening and searches at the Pavilion Lobby entrance.

Response-rate Threshold – 80%

Response-rate Target – 90%

Response-rate Stretch – 100%

Significant Reporting Performance – The security management plan will demonstrate effectiveness through significant performance results, including:

- DPH and SFSO, MOU Performance and Compliance
- Threats and Workplace Violence Incident Reductions
- Crimes Against Property and Person Reduction
- Use of Force Reduction
- Security/Law Enforcement Service Call Response Time
- Property Screening Audits

IX. ANNUAL PROGRAM EVALUATION ANNUAL PROGRAM EVALUATION

On an annual basis, the security management program is evaluated relative to its objectives, scope, effectiveness, and performance. This evaluation process is coordinated through the Director of Security, in conjunction with the contract security provider, San Francisco Sheriff's Office, Environment of Care, and the Campus Safety and Security Committee.

The continued appropriateness and relevance of program objectives are assessed, as well as whether these objectives were met. The scope is evaluated to determine continued applicability. The year is reviewed retrospectively to determine the extent to which the program was effective in meeting the needs of the hospital, the residents, and staff. The performance results are assessed as an

indicator of ongoing performance improvement. Results of this evaluation process will form the basis for strategic goal setting, planning, and verifying the continued applicability of program objectives.

SECURITY RECORDS RETENTION AND DISCLOSURE POLICY

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to provide a safe, accessible, and effective environment of care. The overall intent of the video surveillance plan is to ensure that staff can access appropriate, and necessary information to fulfill this policy.

PURPOSE:

The purpose of this policy is to establish LHH guidelines for retaining security records, including video surveillance footage, and to describe the process for responding to security record requests.

SCOPE:

This policy applies to all approved video surveillance recording, conducted within the LHH campus.

PROCEDURE:

1. Retention of Records

    a. Video surveillance continuously records activity at the LHH campus.

    b. The camera images are stored on a computer hard drive.

    c. The image data can be retrieved from the host server for up to one year.

    d. After a 60-day period, analog camera images transition from high resolution to low resolution.

2. Disclosure of Records

    a. Request for ~~S~~security surveillance ~~-~~records ~~request~~ made by ~~from~~ parties outside of DPH require that a written public records request or ~~,~~ third party request/subpoena be made through either ~~for security records, including video surveillance footage is made through~~ the DPH Information Office or City Attorney's Office. ~~.~~

        i. To process a public records request for ~~video~~ surveillance records ~~footage~~, the following information shall be provided:

            - Date of the Incident

- Approximate time of the Incident
- Location of the Incident
- Description of the Incident
- Description of persons involved in the incident.

b. The request shall be handled accordingly, taking into consideration the privacy rights of patients'/residents, and other parties, and the business operations of the facility, among other factors.

c. Upon being notified by the DPH Information Office or City Attorney's Office, the Director of Security shall submit the surveillance records directly to the DPH Information Office/City Attorney.

d. Surveillance ecurity record requests that are made from within DPH shall be for operational purposes only and should be made through the DPH Director of Security.

ATTACHMENT:
None.

REFERENCE:
LHHPP 75-10 Security Services Standard Operating Procedures

Original adoption: 16/07/12 (Year, Month, Day)

Revised EVS
Policies and Procedures

ENVIRONMENTAL SERVICES

POLICY:

Environmental Services Department (EVS) is responsible for providing cleaning and disinfection, laundry and linen, mail and messenger, and shuttle services.

PURPOSE:

1. To provide a clean and sanitary environment.

2. To ensure an adequate supply of clean linen is available at all times to residents and Laguna Honda Hospital (Laguna Honda) departments.

3. To provide Laguna Honda and residents' mail services.

4. To provide shuttle services between the Laguna Honda and the Forest Hill Muni station.

PROCEDURE:

1. Housekeeping Services

a. Hours of Operation:

i. Environmental Services operates seven days per week 24 hours a ~~day~~ ~~.~~day. Day shift hours are 7:00 a.m. - 3:30 p.m. P.M. shift hours are 3:30 p.m. - 12:00 midnight. A.M. Shift is 11:00 p.m. – 7:30 a.m.

b. Scope of Services:

i. Routine cleaning and disinfecting of environmental surfaces in Laguna Honda resident neighborhoods, clinics, pharmacy, restrooms, offices, corridors, lobbies, entrances, walkways, etc. Window washing and floor care including mopping, floor stripping and refinishing.

ii. Collecting soiled linen for processing by laundry vendor.

iii. Storing and distributing furniture and equipment as scheduled or requested.

iv. Exchanging privacy curtains as scheduled or requested.

v. Coordinating the pest control and animal/pigeon abatement program.

vi. Collecting and transporting~~removing i~~ waste~~s~~ (except e-waste and construction waste~~s~~) from all areas of the Laguna Honda. Coordinating the recycling program.

viii. Transporting equipment and supplies between buildings.

ix. Providing routine and special event general labor support.

x. Environmental Services maintains and periodically reviews and revises its EVS PP Manual, which contains detailed procedures.

c. Requests

i. Call 4-4624 for routine requests

ii. Submit project requests by work order, found on Laguna Honda Intranet

2. Laundry and Linen Services

a. Hours of Operation:

i. Seven days per week on two shifts. Day shift hours are 7:00 a.m. - 3:30 p.m. and ~~Evening~~ P.M. shift hours are 3:~~03~~0 p.m. ~~–~~ 12:00 midnight~~1:30 p.m~~. Delivery service is provided on the PM shift, as needed request on the day shift.

b. Scope of Services:

~~i. Routine laundering and processing of linen.~~

~~ii.~~i. Delivery of clean linen to units and various departments to maintain established par.

~~iii.~~ii. Transporting soiled linen to and from collection by laundry vendor.

~~iv.~~iii. ~~Laundering and processing~~Collecting and transporting soiled or clean specialty items such as table linens, shower curtains and privacy curtains for processing by laundry vendor.

~~v.~~iv. Maintaining sufficient in-use inventory of Laguna Honda linen.

~~vi.~~v. Environmental Services maintains and periodically reviews and revises its Laundry/Linen P&P Manual, which contains detailed procedures.

c. Requests

i. Call 4-4624 for linen services in the Main building.

3. Mail and Messenger Services

a. Incoming mail: Monday - ~~Friday~~Friday, excluding City holidays, U. S. and City Inter-office mail is sorted to mailroom boxes and delivered to resident mailbox.

b. Outgoing mail: Outgoing mail is delivered twice a day to DPH Central Office for posting to the U.S. and City systems. Information: call 4-4624.

c. Messenger/courier service: Monday - FridaySaturday, 8:00 a.m. - 4:30 p.m., excluding City holidays, service to 101 Grove Street Central Office, City Hall, SFGHMCZuckerberg San Francisco General Hospital and Trauma Center, and some local agencies is available to selected Laguna Honda departments; call 759-4624.

d. Resident parcels and packages received from the United States Parcel Service (USPS) delivered to the Laguna Honda mailroom will be sorted and sent to the respective nurse's stationSocial Services Department for distribution.

5. Shuttle Services

a. Hours of operation:

i. Five days per week from 96 a.m. to 5:30 p.m., Monday to Friday.

b. Scope of services:

i. Provides shuttle services between the Laguna Honda and the Forest Hill Muni station by EVS staff or the city certified vendor.

c. In the event that shuttle service is unavailable:

i. A sign stating that the shuttle service is unavailable will be posted by EVS in the lobby of the Pavilion and the Administration Buildings.

ATTACHMENT:
None.

REFERENCE:
Environmental Services Policies and Procedures

Revised: May 1, 1995; April 22, 2003; September 25, 2012; January 12, 2016; September 14, 2021; May 15, 2024
95/05/01; 03/04/22, 12/09/25, 16/01/12, 21/09/14 (Year/Month/Day) Original adoption: 92/05/20May 20, 1992

II. ENVIRONMENTAL SERVICES

A. Hours of Operations

Environmental Services operates seven days per week 24 hours per day.

1. Day Shift: 7:00 AM – 3:30 PM
2. PM Shift: 3:30 PM – 12:00 AM
3. AM Shift: 11:00 PM – 7:30 AM

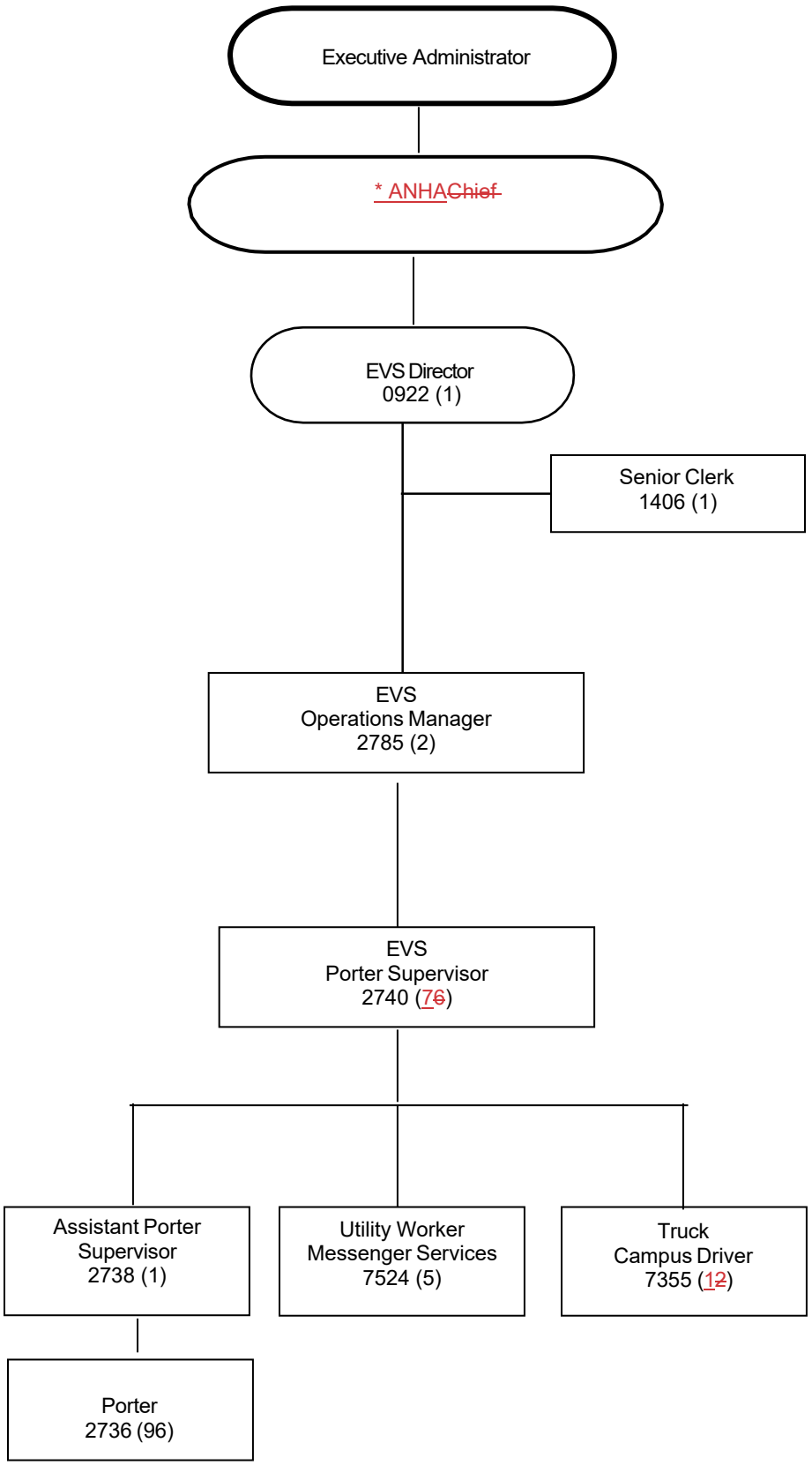
B. Scope of services:

1. Daily cleaning and disinfecting of high and frequently touched surfaces in the facility.
2. Performs floor care throughout the facility including mopping, buffing, scrubbing, waxing, floor stripping, and carpet cleaning.
3. Transport clean linen to throughout hospital.
4. Replace curtains
5. Furniture removal and room set up
6. Exchanging curtains as scheduled or requested.
7. Collecting and removing trash, recycle and compost from all areas of the facility.
8. Transportation: provides shuttle service for residents and staff, ~~schedule resident medical appointment transportation,~~ coordinate maintenance of facility fleet.

~~8.~~9. Provide Pest Control services to the facility.

Revised: May 97,Jan 07,Aug 21

III. ENVIRONMENTAL SERVICES ORGANIZATION CHART



A. Organizational Chart Breakdown

1. EVS Director – Reports to Chief Operations Officer. This position is responsible for overall management of the department.

2. EVS Operations Manager – Reports to Environmental Services Director and acts as his/her representative in/her absence. Assists Environmental Services Director in management of the department.

3. Porter Supervisor – Reports to Operations Manager. Responsible for shift operations or a large segment of shift operation of the Environmental Services Department.

4. Assistant Porter Supervisor – Reports to Porter Supervisor. Responsible for a small segment of shift operations or a particular area. May assume duties of a Porter Supervisor in his/her absence. May also assume the duties of a Porter.

5. Porter – Reports to Assistant Porter Supervisor and/or Porter Supervisor. Responsible for maintaining an assigned area of the Hospital utilizing basic housekeeping techniques.

6. Truck Driver & Institutional Utility Worker – Reports to Porter Supervisor or his/her designee. Responsible for driving of vehicles and performing other utility functions in the Hospital.

*ANHA – Assistant Nursing Home Administrator of Supportive Services

Revised: May97, Jan07, Aug08, Aug09, Aug15

V. EVS STAFF GENERAL INFORMATION

A. Hours of Work
Eight (8) hours per day, forty (40) hours per week, duty hours as assigned by the General Services Manager. Employee will generally work five (5) consecutive days with two (2) consecutive days off each week. However, at times, a change of schedule may be necessary, and employees may be requested to work more or less than five (5) consecutive days between days off, or more than eight (8) hours per day. Employees authorized to work more than eight (8) hours per day, or forty (40) hours per week, shall be paid overtime for those hours worked.

B. Pay Days
All employees will be paid bi-weekly, every other Tuesday, If an error or discrepancy appears on your check, consult the Payroll Officer as soon as possible. Be courteous when discussing payroll errors.

C. Correct Address
Be sure your correct address and telephone number are on file in the Housekeeping Office. It is imperative that you report any change of address or telephone number. Per Civil Service Commission rules.

D. Work Area
All employees are required to stay in their assigned area except for required duties elsewhere, breaks and lunch. Porters' closets in your assigned area are to be kept locked at all times. Equipment and Porters' closets must be kept clean. Pick up supplies at the start of your shift before going to your assigned are. If you need additional supplies, contact your supervisor and he/she will either get them or give you permission to get them.

E. Break Time and Lunch Time
Break time consists of two fifteen (15) minutes ~~in the morning and in the afternoon~~and a 30-minute lunch break.
AM shift: 11:00pm-7:30 am
2am-2:15am, Lunch 4am-4:30am, 6am-6:15am
~~The~~Dayshift:7am-3:30pm
~~morning break is from~~ 10:00 – 10:15am, ~~and the afternoon is from~~lunch 12:00 -12:30pm, 2:00 – 2:15pm.
PM shift: 3:30pm – 12:00am
5:30- 5:45pm, lunch 7:30pm – 8:00pm, 9:30pm – 9:45pm

~~Lunch time is form 12:00 – 12:30~~

As needs of the Department dictate, an employee may request, or elect, to take his/her break or lunch at another time. If this occurs, let your supervisor know. Break and lunch time consists of the time your stop work to the time you resume work.

F. Leaving Hospital Premises
All employees must obtain permission to leave the Hospital other than when on break or lunch time from a supervisor.

G. Paging
Answer all pages as quickly as possible.

H. Personal Telephone Calls
Personal phone calls on Hospital telephones or personal cell phones while on duty is not permitted. ~~Pay telephones are available in various areas.~~ Unless it is an emergency, restrict phone usage to break and lunch times. Employees may not receive phone calls in their assigned work area. If an individual needs to contact an employee, calls will be routed through the Office and a message will be taken and given to the employee as quickly as possible.

I. Absence due to Illness

In the event of absence from duty due to illness, or for reasons that fall under the category of illness, Office must be contacted before starting time and the reason communicated to the individual in charge.

Should an employee be absent due to illness for more than five (5) working days, the employee will be required to submit a "Request for Leave" form available from Human Resources. The employee must have his/her physician complete Section 12-19. After completion, return the form to the Office for processing.

Excessive absenteeism, or more than one (1) non-consecutive days for illness per month within six (6) months, is caused for disciplinary action.

As a courtesy when returning to duty after illness, contact the Office by 4:00 pm on the day preceding return.

J. Absence for Personal Leave

Unpaid absence from duty for valid reason, approved by the Environmental Services Director or his designated representative is personal leave. Excessive requests for personal leave will not be granted. Employees falling into the category of excessive absenteeism will not be granted personal leave except for emergencies.

As in case of illness of more than five (5) working days, employees will be required to submit a "Request for Leave" form available from Human Resources.

K. Absence without Leave

Employees absent from duty without a valid reason or without approval are considered A.W.O.L. An employee will be subject to disciplinary action if designated A.W.O.L.

L. Tardiness

Employees who call in prior to their starting time to inform their supervisor they will be late, will be allowed up to a thirty (30) minutes extension to report to work.

Employees who have not called will be allowed up to thirty (30) minutes to ~~report, and~~report and may be docked up to half (1/2) an hours per fifteen (15) minutes they are late. An employee who has not called may be replaced in his/her assigned area and given a float assignment after (15) minutes tardy. After (30) minutes an employee who has not called will not be allowed to work and will be carried A.W.O.L. for that day. Chronic tardiness will result in disciplinary action.

A tardy employee who requests personal leave must have the request granted by the Environmental Services Director or his designated representative.

M. Loitering

All employees must remain off Hospital property when not scheduled, or at work. An employee who remains on the Hospital property after work or during off hours will be considered loitering and the employee could face disciplinary action.

Three (3) exceptions to the above are: (1) Time spent for meals; (2) Request to remain with supervisor's permission; (3) Official Hospital business.

N. Holidays

All employees are required to work on holidays that fall on their regularly scheduled day to work unless granted permission from the Environmental Services Director or his representative. A work list of those scheduled is posted in the Office prior to the holiday. If a holiday falls on an employee's regularly scheduled day off, a compensating day off will be given at a mutually convenient time.

O. Vacation

After one (1) year of continuous service, an employee is entitled to two (2) weeks paid vacation. After five (5) years of continuous service, three (3) weeks; and after fifteen (15) years of continuous service, four (4) weeks. The cumulative balances for the three (3) categories above

are 320, 360 and 400 hours respectively. One week of vacation consists of five (5) consecutive days. The Environmental Services Director rewards the~~schedules~~ annual vacations with consideration given to seniority.

P. Accident or Injury

Report all accidents or injuries, no matter how small, received while on duty, to a supervisor. All

Injuries incurred while on duty are covered under Workers' Compensation. Either the supervisor or the employee will file a report as required. If treatment is necessary, report to San Francisco General Hospital Emergency Department. Transportation may be provided by Hospital Security.

Q. Money and Valuables

Employees are not to accept money from resident~~patients~~, have checks cashed for them, or run errands. Refer the request to the head nurse. Do not receive or deliver any notes, messages, or packages to, or from, resident~~patients~~. Refer the request to the head nurse. Employees are not permitted to accept tips, gifts, or gratuities from resident~~patients~~ or visitors. Remember, we are paid to perform a service.

Money or other valuables brought to the Hospital will be at the employee's risk. The Hospital and the Department of Public Health assume no responsibility in the event of loss or if theft occurs.

It is requested and advisable that an employee neither lends nor borrows money from another employee. If repayment does not occur, hard feelings or an altercation could develop. Management will not assist in the recovery of a loss.

R. Information Concerning Residents~~Patients~~

Employees are prohibited from disclosing ~~not to give out~~ any information regarding patients or their care. This includes discussing a particular resident ~~patient~~ with fellow employees unless work related. Employees are not to read resident~~patient~~ charts. Questions concerning residents ~~patients~~ from any individual should be referred to the nursing team~~head nurse~~.

S. Smoking, Gambling and Alcohol

Smoking is permitted in all areas of the Hospital except resident~~patient~~ wards and areas designated as no smoking.

Gambling is not permitted on Hospital property. Alcohol and drugs are not permitted on Hospital property. Gambling, or the use of alcohol or drugs on Hospital property calls for immediate disciplinary action.

T. Sexual Harassment

The San Francisco Administrative Code prohibits sexual harassment, verbal, physical or visual. Also, the request for sexual favors or unwanted sexual advances is considered sexual harassment and is prohibited.

U. Safety

Report any unsafe condition to your supervisor immediately. Always work in a safe manner and with the proper equipment to prevent accidents. This means using wet floor signs, etc. Horseplay and using equipment improperly will not be tolerated. An employee who knowingly causes or contributes to an accident could face disciplinary action.

V. Locker Room

The l~~A l~~ocker rooms are~~is~~ located at the H2 area Administration Building~~provided in the rear of the Housekeeping/Environmental Services Office~~. Each staff member is allotted with a locker and is responsible for providing own padlock. ~~Tape your name to the locker for identification.~~

W. Parking

Employees may park in the designated areas of the Hospital with the displayed monthly tag permit. Don't be a litterbug in parking areas. Tampering with another person's vehicle will bring Police action.

X. Grooming
Employees should report for work ~~well groomed~~well-groomed and wearing suitable clean work clothes. An employee could be sent home if lacking in personal hygiene or poorly groomed.

Y. Stealing
Stealing from another employee or the Hospital is prohibited by the San Francisco Administrative Code and involves with Police. Removal, borrowing without authorizations, or the use of Hospital property without authorization is prohibited.

Z. Employee Relations
Employees are requested to be courteous, ~~friendly~~friendly, and helpful to fellow employees, visitors and residents. Rude behavior is uncalled for in any situation. ~~Work quietly, and avoid creating or becoming involved in alterations.~~All employees are responsible to create an Equitable, Fair, and Respectful Working Environment.

AA. Completion of Shift
Employees must sign out and return keys to the EVS Key Watcher outside ~~in~~ the ~~Housekeeping/~~Environmental Services Office. If an employee is unable to complete an assignment, he/she must let a supervisor know with a satisfactory reason. Failure to complete an assignment without a valid reason is unacceptable. An employee can return keys and sign out no sooner than ten (10) minutes prior to the end of their shift.

Reference
Environmental Services P&P VII Work Rules
Environmental Services P&P Safety VIII
P&P 01-15 Staff Use of Personal Recording Device Cell Phones
P&P 21-18 Breach Policy
P&P 76-02 Smoke and Tobacco Free Environment
P&P 90-04 Parking on The Laguna Honda Campus

VI. PERFORMANCE GUIDELINES

PURPOSE:
To ensure satisfactory job performance and appropriate, professional behavior is maintained by all departmental staff.

A. PROCEDURE:

1. It is expected that all department staff maintain satisfactory attendance in accordance with departmental guidelines and follow established call - in procedures for absences/tardiness.

2. It is assumed that all assigned tasks are completed at the end of each shift. If any work was not completed it must be reported to a supervisor prior to signing out for the day along with any Maintenance repairs that are required.

3. All Porters are responsible for the overall cleanliness and appearance of their assigned areas. This is accomplished through compliance to completion of assigned daily and periodic tasks. This also requires that Porters exercise good judgment in *independently* performing the necessary job-related tasks to meet this goal. The past practice of utilizing work orders to initiate performance of periodic tasks will no longer be in effect.

4. Established proper procedure is to be followed at all times during the performance of all assigned tasks and duties. This includes proper use of all supplies, chemicals and equipment.

5. To ensure customer needs are met as quickly as possible, all pagers are to be answered promptly. It is the responsibility of the assigned HOUSEKEEPING Worker to ensure their pagers are turned on and in proper working condition. Any problem is to be reported to the supervisor immediately.

6. All service requests are to be completed immediately unless current duty is deemed as priority by the assigned supervisor. In this case, the supervisor will clearly communicate whether they will have the request completed by another means or have the assigned Porter complete it following completion of the current task(s).

7. All break schedules are to be followed as outlined. If this is not possible due to customer needs or an emergency situation the Porter shall notify their supervisor of the situation. It is encouraged that designated break areas be utilized.

8. Professional and appropriate behavior is to be exhibited at all times while on the grounds of Laguna Honda Hospital and/or during the course of performing duties for Laguna Honda Hospital. Loud, argumentative, threatening and/or profane language will not be
9. tolerated and will result in the initiation of the appropriate disciplinary action, up to and including termination. In the event that a Porter is the victim of such behavior, they are to IMMEDIATELY notify their Supervisor or the Institutional Police rather than participate in that type of behavior.

10. To ensure that the maximum amount of work is produced during working hours, all staff are expected to use their work time wisely. This includes but is not limited to:

    a. Obtaining all supplies and equipment needed at the start of the shift.

    b. Refrain from non-work related conversations during the course of performing duties.

    c. Paging the Supervisor vs. coming down to the office for supplies, questions, etc.

d. When assigned work is completed, check with customer and or supervisor to determine how remainder of work time should be spent.

e. Clean up of Porter's cart shall not start more than 15 minutes prior to the end of the shift. It is expected that all Porters continue work in their area until that time.

11. To promote good communications and relations with our customers, Porters are requested to check in with their customers at the beginning of their shift. This time is to be used to establish who is the assigned Porter and any special needs that the Unit may have. It is further requested that Porters notify their customers if they need to leave their assigned areas for any reasons other than normal breaks for example, Departmental Meetings, additional assignments elsewhere, etc.

12. Presentation of a professional image is important to promote a good image of the Porters and the department. It is expected that all Porters comply with the department dress code, maintaining good hygiene, wearing the provided uniforms and proper ID badge. Failure to do so will result in appropriate corrective action.

13. All Porters are subject to have their assignment changed or have additional duties assigned due to operational needs. It is expected that the Porter complete all work at the time it is assigned providing it does not present a safety hazard and they possess the qualifications necessary for the task. Should an employee believe the request is unfair, a grievance may be filed in accordance with established procedures in the Memorandum of Understanding.

14. Actual times are to be recorded on time sheets when reporting on and off duty. Incidents of timesheet falsification will result in the initiation of the appropriate discipline action, up to and including termination.

15. Scheduled shift hours are to be observed at all time unless previous arrangements have been made due to operational needs. Making time up due to tardiness or leaving early is not permitted.

16. To ensure individual safety as well as the safety and well being of others, all Safety procedures and Infection Control guidelines are to be followed at all times during the course of performing all assigned duties. This includes following label instructions for product use and using the recommended Personal Protective Equipment. All On-the-Job accidents are to be reported to the Shift Supervisor immediately.
17. Assigned Porters are responsible to maintain their work areas in a clean and organized fashion. Eating and drinking is prohibited while on duty. Food and beverages are prohibited should not be located on the Porters carts.
18. Porters are encouraged to meet the daily needs of their customers and have the ability and authority to alter their normal work routine to meet those needs when necessary. Any variations to normal work routines and schedules need to be communicated to the Supervisor.

The above general guidelines are to be used in accordance with department policies and procedures as well as Laguna Honda Hospital policies and procedures.

VII. WORK RULES

A. Time and Attendance:

1. Employees are required to sign in and out on the time sheet at their actual time of arrival and departure. One employee cannot sign in or out for another employee. NOTE: Employees are required to finish the work shift and are not allowed to leave until the official end of their shift, unless approved by the Assistant General Services Manager or designee.
2. Employees are to report to their workstation immediately after signing in.
3. Employees may not work before or after their assigned work hours unless approved by the Assistant General Services Manager or designee.
4. Employees are to call their supervisor at least one-half hour before the start of their scheduled shift each day if requesting sick leave. Sick Leave cannot be used to conduct personal business. In some cases, verification of illness may be required. Employees required to bring in verification will be notified in writing five days in advance of the effective date. Employees required to bring in verification of illness because of excessive absenteeism or a pattern of absence will be counseled regarding their absenteeism.

B. Time Off:

1. Requests for Lieu Days, Comp Days or Hours, Floating Holidays, Personal Leave must be submitted in writing to your supervisor 72 hours in advance of the requested time off. Requests are to be submitted by the supervisor to the Assistant General Services Manager or designee for final approval. The requests are approved on First Come First Served.
2. Vacation time must be submitted in writing at least two weeks in advance.
3. Consideration for any requests for vacation taken after December 31 will be in accordance with the following procedure:

   Prior to January 1 of any year, any employee may submit up to three (3) choices of a preferred vacation period. The Department shall approve such choices ~~on the basis of~~based on employee seniority within his or her classification and shift at the facility and shall post a list of scheduled vacations within thirty (30) days.

   Any employee who fails to submit a choice or any new employee who misses the sign-up period shall schedule vacation by mutual agreement with the Department, provided that such scheduling shall not supersede a vacation scheduled by prior submission.

   The Department has the right to limit the number of employees on vacation at any one time consistent with the needs of the service. Consideration of all requests will be in accordance with schedules, workload, MOU, and Civil Service regulations.

NOTE: ANY TIME OFF (Lieu Days, Comp Days or Hours, Floating Holidays, Personal Leave or Vacation) WITHOUT APPROVAL FROM EVS OPERATIONS MANAGER or DESIGNEE SHALL BE MARKED AWOL.

C. Lunch and Break:

1. Lunch and breaks are to be taken in the allotted and scheduled time only.
   a) 15 minutes break for each ~~4 hour~~4-hour work period.
   b) 30 minutes lunch

D. Clean Up Change Time:

1. For those employees in protective clothes, no more than five minutes change time will be allowed for coming and going, to and from lunch and break ~~time~~time.
2. All employees are allowed no more than ten minutes at the end of their shift to clean up.

E. Telephones / Cellular Phones:

1. Only ~~calls from a child, baby-sitter, or calls identified as~~ emergencies calls shall be connected to an employee during work time.
2. ~~You are not to leave your work station to answer the pay phone~~Employees are required to step out the assigned area for emergency call after notifying the immediate supervisor.
3. Department phones are to be used for Hospital or other Departments business only.
4. Personal phone calls are to be made or accepted on lunch and break time~~ and on the pay phone only~~.
5. Cellular phones cannot be used while on duty to ensure work safety and to minimize the disruption of workflow. The standard of conduct is as follow:
   a. Cellular phones must not be in use during work hours except break or lunch hour at designated areas (i.e. Locker Room)
   b. Never use or answer cellular phones while on the unit resident areas, in the hallway or corridor at all times.

F. Work Assignment:

1. Employee will be assigned work at the beginning of each shift. Assignments may be rotated at any time depending on production need and staffing requirements. The intent is to eventually have weekly work assignments.
2. When an employee has completed his/her immediate work assignment, he/she will assist to complete the nearest task in the work area assigned (Soiled or Clean Area), unless given other direction by the supervisor.
3. Employees will stay in assigned work area, working at all times, unless notifying their supervisor.

G. Uniform:

1. All employees who have issued uniforms will be in uniform while on duty. New employees waiting for uniforms to be issued must wear shirt/blouse and pants/skirt.
2. All employees must wear low-heeled protective shoes.
3. Clothing, jewelry and hair that could be a safety problem should not be worn; e.g., bracelets, necklaces, earrings, long fingernails, long hair not tied back.
4. Employees are required to wear a Hospital ID badge at all times, except when wearing protective clothes.
5. Employees should come to work neat, clean, refreshed, alert and ready for duty.

H. Safety:

Safety is everybody's ~~job,~~job; therefore all employees are required to:

1. Take care and follow proper methods of processing work.
2. Keep everything up off the floor in working area.
3. Report any unsafe condition to supervisory staff immediately.
4. Report any on-the-job injury to supervisory staff immediately.

~~5.~~ Keep food, cigarettes, cigars, and personal reading materials out

~~6.~~5. of the work area.

Cross contamination: In accordance with Title 22, employees working in the soil sort area must wear protective barrier clothing, hair covers, eye goggles, cloves, gowns, pants, shoe covers, i.e.,

rubber boots. Before employees can come to the clean linen area, protective clothing must be removed to prevent contamination of clean linen. (Laundry/Linen)

I. Smoking:

1. LHH is a Smoke Free Campus. Smoking is allowed only during lunch and breaks – outside the ~~building~~ campus ~~on designated smoking areas~~ only.

J. Other Important Rules:

1. Employees must treat each other with respect and courtesy; verbal and/or physical abuse OR the threat of physical abuse is unacceptable.
2. Sexual, racial, ethnic, or religious slurs are NOT acceptable. The use of slurs against any person on the basis of color, national origin, ancestry, age, sexual orientation or disability is also NOT acceptable.
3. No drugs, alcohol, illegal substances, firearms, or weapons of any kind are allowed on the premises.
4. All employees are responsible for keeping work areas of the Department as clean as possible at all times.

~~a. Be careful to process all linen in a clean and safe way. Do not pick up off floor (re-wash), do not allow to touch floor, etc.~~

~~b.~~a. Keep all equipment and all areas clean at all times. Keep trash in barrels, etc. If trash containers are full, employees are responsible to remove the plastic bag and place in the designated area.

~~c.~~b. Clean up after yourself in all areas; this includes locker room, bathroom, etc.

K. Questions:

If an employee has any question concerning these guidelines and ~~rules~~rules, contact a supervisor for explanation. Please do not hesitate to ask questions when in doubt about an assignment, policy or procedure, other phase of your job.

L. Break/Lunch ~~Meal~~ Times:

~~**1 - AM #1**~~	~~**SHIFT STARTS: 6:00AM**~~	~~**SHIFT ENDS: 2:30PM**~~
~~**Break**~~	~~**Break Starts**~~	~~**Break Length**~~
~~**First Break**~~	~~9:00am~~	~~15 Minutes~~
~~**Second Break**~~	~~11:30am~~	~~30 Minutes~~
~~**Third Break**~~	~~1:30pm~~	~~15 Minutes~~
12 – Day shift~~AM #2~~	**SHIFT STARTS 7:00AM**	**SHIFT ENDS: 3:30PM**
Break	**Break Starts**	**Break Length**
First Break	10:00am	15 Minutes
Second Break	12:00pm	30 Minutes
Third Break	2:00pm	15 Minutes
2 – PM Shift	**SHIFT STARTS 3:30PM**	**SHIFT ENDS 12:00AM**
Break	**Break Starts**	**Break Length**
First Break	6:00pm	15 Minutes
Second Break	7:45pm	30 Minutes
Third Break	9:45pm	15 Minutes
3 – AM shift	**SHIFT STARTS 11:00PM**	**SHIFT ENDS 7:30AM**

Break	Break Starts	Break Length
First Break	1:00am	15 Minutes
Second Break	3:00am	15 Minutes
Third Break	5:00am	15 Minutes
~~**3 – PM #1**~~	~~**SHIFT STARTS: 3:00PM**~~	~~**SHIFT ENDS 11:30PM**~~
~~**Break**~~	~~Break Starts~~	~~Break Length~~
~~**First Break**~~	~~5:30pm~~	~~15 Minutes~~
~~**Second Break**~~	~~7:30pm~~	~~30 Minutes~~
~~**Third Break**~~	~~9:30pm~~	~~15 Minutes~~

~~**4 – PM #2**~~	~~**SHIFT STARTS 3:00PM**~~	~~**SHIFT ENDS 11:30PM**~~
~~**Break**~~	~~**Break Starts**~~	~~**Break Length**~~
~~**First Break**~~	~~6:00pm~~	~~15 Minutes~~
~~**Second Break**~~	~~7:45pm~~	~~30 Minutes~~
~~**Third Break**~~	~~9:45pm~~	~~15 Minutes~~
~~**5 – NIGHT**~~	~~SHIFT STARTS **11:00PM**~~	~~**SHIFT ENDS 7:30AM**~~
~~**Break**~~	~~**Break Starts**~~	~~**Break Length**~~
~~**First Break**~~	~~12:45am~~	~~15 Minutes~~
~~**Second Break**~~	~~3:00am~~	~~15 Minutes~~
~~**Third Break**~~	~~5:00am~~	~~15 Minutes~~

~~(Rev. 10/29/96)~~

M. Employee Uniforms / Dress Code Standard:

1. Policy
   It is the policy of the Environmental Services Department to establish guidelines concerning the issuance and wearing of uniforms provided by Laguna Honda Hospital. The policy affects 2736 & 2738 classifications.

2. Purpose
   Presentation of a professional image is important to promote a good image of the Porters, Laundry, Linen, and the department. It is expected that staff members comply with the department dress code, maintaining good hygiene, wearing the provided uniforms and proper ID badge.

3. Policy Statement
   a. Each employee will receive five sets of uniforms upon hire.
   b. Each employee is entitled to two sets of uniforms each year. The Department will issue voucher for two sets of uniforms to each employee every twelve (12) months upon request from employee.
   c. Uniforms determined by the Department to be damaged in the line of duty will be replaced by the Department with reasonable prove.
   d. The employee will pay for replacements for uniforms damaged by employees outside their line of duty.
   e. Employees who terminate their employment with the Department will be required to return the uniforms to the Department.
   f. It shall be the responsibility of each employee to launder his or her own uniforms.
   g. Employees shall not use their uniforms during off duty hours as street clothes other than for travel to and from work.
   h. Employees shall report for duty in complete uniform ready for work. This will include ID badge, clean uniform with inscribed logo on shirts, comfortable and supportive shoes.
   i. Employees who report for duty either out of uniform or in partial uniform shall not be permitted to work. An employee will be sent home if lacking in personal hygiene or poorly groomed. The Department will use progressive corrective action for policy enforcement.

Reference
P&P 01-15 Staff Use of Personal Recording Device Cell Phones
P&P 21-18 Breach Policy
P&P 76-02 Smoke and Tobacco Free Environment

P&P 90-04 Parking on The Laguna Honda Campus
Memoranda of Understanding (MOU), Service Employees International Union, Local 1021

XIII. ~~PATIENT, RESIDENCE CARE AREAS~~SPA ROOM

A. ~~PATIENT BATHROOMS~~Clean and disinfect the room by performing the Hospital Cleaning Steps with proper chemicals.

B. Check shower curtains. Report to the supervisor for the replacement if needed.

~~A.~~C. Arjo Bathtub

~~**Material Recommended** – For Germicidal Detergent: Use Virex 256~~

~~Bath Tub and Shower Rooms~~

~~Always knock on door of bathroom before entering. Patients in some hospitals are requested to have occupied signs on outer door knob when bathroom is occupied. Sometimes the patient forgets to hang the occupied sign out. If you always knock before entering you will at all times avoid the possibility of embarrassing a patient.~~

~~Check cubicle curtains. In the event these cubicle curtains are stained or soiled, they should be removed and replaced immediately.~~Clean and disinfect the Arjo bathtub following the manufacture guidelines.

~~Empty wastebasket and wipe the interior and exterior with cloth dipped in germicidal disinfectant solution and reline wastebasket.~~

~~Mix germicidal disinfectant solution in bucket. Using Virex 256 disinfectant, two sided scrubbing sponge, scrub all porcelain surfaces, shower walls sink and toilet. Wipe all porcelain surfaces dry, if necessary, with a clean cloth to avoid water spotting.~~

~~Wipe clean all metal surfaces, pipes, faucets and fixtures, stainless steel, shower curtains, rods and handles along with any mirrors. Damp dust with germicidal disinfectant solution. Wipe the mirrors dry.~~

~~In shower areas where you have tile walls, wash down tile walls using germicidal disinfectant solution. Be sure to wipe down all tile surfaces dry, if necessary, to eliminate water spotting.~~

~~Use fresh germicidal disinfectant solution in mop bucket. Wet mop the floor with germicidal disinfectant solution using heel of mop to scrub stubborn stains or spots from the floor. Allow the solution to remain for at least two or three minutes, the longer you leave the solution on the floor, the more benefit you gain from the germicidal action of the germicidal disinfectant. Damp dry floor. Never leave the shower, bath floor soaking wet.~~

~~Damp dust front and back of door, door knobs, kick plates, tops of door and door closer with cleaning cloth dipped in germicidal disinfectant solution. Push cubicle curtain against walls so the area does not appear occupied. Turn out light and close door.~~

Reference:

Environmental Service P&P, XI Hospital Cleaning steps

Arjo Parker Quick reference guide – Cleaning and Disinfecting

~~Patient Toilets~~

~~**Material Recommended:**~~
~~For Germicidal Disinfectant: Use Virex 256~~
~~For Bowl Cleaner: Use Porcelain and Tile Cleaner: Crew Non-Acid Bowl Cleaner~~

~~Empty wastebasket by tying off bag liner inside with tie and removing bag. Wipe off interior and exterior of wastebasket with damp cloth dipped in germicidal detergent solution. Reline empty wastebasket with plastic bag liner.~~
~~Refill paper towel dispenser and toilet tissue dispenser.~~
~~Clean any mirrors and glass surfaces in the toilet area with germicidal disinfectant solution and wipe dry with paper towels, if necessary, to prevent spotting.~~
~~Wash all metal surfaces with germicidal disinfectant solution. This includes pipes, plumbing, faucets, fixtures, handles, towels racks, paper towel dispensers and soap dispensers.~~
~~From top to bottom, were all porcelain surfaces with germicidal disinfectant solution, top of the sink, outside of the toilet bowl, any shelves and counter tops. Wipe toilet seat dry.~~
~~Clean patient equipment shelf with damp cloth and germicidal disinfectant solution. Lift each item off shelf and wipe underneath item and replace it exactly in the same place.~~

~~PATIENT ROOM CLEANING~~
~~**Material Recommended** – For Germicidal Disinfectant: Virex 256~~

~~**Daily Duties**~~
~~Empty wastebasket by patient bed and in patient bathrooms.~~
~~Close, twist and tie plastic bag while still in the wastebasket. Remove plastic bag from wastebasket and deposit in large bag on porter's cart, or in designated area.~~
~~Check wastebasket interior for cleanliness. Wipe interior with a damp cleaning cloth dipped in germicidal disinfectant solution, if needed.~~
~~Reline wastebasket with fresh plastic bag liner. Be sure to fold the bag edges back over the sides of the wastebasket.~~

~~Furniture in patient room should be damp dusted with two-sided scrubbing sponge or clean cloth, using germicidal disinfectant solution.~~
~~Damp dust back, seat arms, sides and legs of visitors chairs.~~
~~Damp dust back, seat, arms, sides and legs of patient's easy chair.~~

~~Dust mop floors with treated dust mop. Starting in far corner, dust left to right and work to door. Dust mop under bed, bedside cabinet and chairs. Roll bedside table to one side, lift wastebaskets and dust mop underneath. Dust mop center section using butterfly stroke until you reach the door.~~

~~Damp mop patient room floor starting in same far corner. Damp mop left to right side of room, working towards door. Damp mop underneath the bed, bedsides cabinet and chairs. Roll bedsides table to one side damp mop underneath. Damp mop center section using butterfly stroke until you reach the door.~~

~~Check all metal surfaces in patient room – light switches, thermostat, signal plates, door knobs, light cords and overhead lights.~~
~~Damp dust with germicidal disinfectant~~
~~Wipe dry, if needed, to avoid water spotting.~~

~~Remove all finger marks from door, door knobs and handles. Wipe down kick plates, top of door, knobs, closet hinges, with damp cloth or sponge soaked in germicidal disinfectant solution.~~

XVIII Microfiber damp mopping cleaning

POLICY: The Housekeeping Department will clean and maintain all area of the hospital as require of the hospital standards.

PURPOSE: The usage of Microfibers mop program is to prevent the spread of cross contamination in all areaareas of the hospital and to remove dust and light litter or soil from the floors as part of daily cleaning process and the preparation for the wet damp mopping cleaning.

Materials:

- Microfiber flat and Microfiber loop mops
- Mop Handle, Poles and dispensing containercontainer.
- Virex 256/Neutral Cleaner
- Personal Protective EquipmentHand Gloves or personal protective equipment
- Wet signage / Porter bucket and wringer

PROCEDURE:

Daily:

A. Put on hand gloves and other protective equipment.Perform Hand Hygiene and put on proper Personal Protective Equipment
B. Set up the Wet Floor Signs and move all obstacles and furniture
C. Dust mop floor
D. Apply damped microfiber mop
E. Use one microfiber mop per room
F. Use a separate Sting loop mop for the bathroom
G. Remove the wet floor signs when floor is completely dry

Note: Outbreak of infection: Use Infection Control guidelines such as bleach solutions to wipe clean all surfaces.

REFERENCE:

LHHPP 72-01 b1 Standard Precaution.
LHHPP 72-01 B2 Hand Hygiene
LHH EVS P&P XI Hospital Cleaning Steps

Revise December 2010

XX. ~~Privacy~~PRIVACY ~~-~~CURTAIN ~~-~~REPLACEMENT

POLICY: It is the policy of the Environmental Services Department to replace privacy curtains as needed.

PURPOSE: To ensure all privacy curtains are clean.

EQUIPMENT:

1. Caution Sign
2. Clean Cloths
3. Clean Curtains
4. Equipment required for changing a specific type of curtain
5. Step Ladder

PROCEDURE:

A. Replace the curtains and anytime they become soiled or after ~~isolationto~~isolation to prevent cross contamination. ~~Place the dirty curtain in a plastic bagand give to the Laundry for cleaning.~~

B. Post the caution sign and set up the ladder. Ensure that the ladder is on a level surface and that it is locked open before climbing on it.

~~B.~~C. Keep all hardware are locked in the drawers to prevent safety hazards.

~~C.~~D. Remove all hardware and hooks and replace them on the track or set aside for use with the new curtain.

~~D.~~E. Insert new hooks in the clean curtain, being careful to keep the new curtain off the floor.

~~E.~~F. Wipe the track ledges with a clean damp cloth prior to hanging the new curtain.

G. Hang the new curtain and ensure it is working properly.

H. Place the dirty curtains in a soiled linen plastic bag and give to the outside laundry services for cleaning.

XXII. EVS TEMPORARY SERVICES

POLICY: The Housekeeping Department will clean and maintain all areas of the hospital as required of the hospital standards.

PURPOSE: Temporary services ~~may be~~are only performed when it is required in emergency situations above the EVS scope of Work.

TEMPORARY PROTOCOL FOR GALLEY SERVICE CLEANING

MATERIALS:

- Mop Bucket
- Mop Handle/Wringer
- Virex 256
- Wet floor sign/caution floor sign
- Broom
- Dustpan
- String Mop
- Appropriate PPE (gloves)

PROCEDURE:

A. Check soap and paper towel dispensers and refill as needed.

B. Empty out trash, recycle, and compost bins by tying off bag and removing bag. Wipe off interior and exterior of wastebasket with damp cloth dipped in germicidal disinfectant solution as needed. Reline empty wastebasket with plastic bag liner

C. Transport bags by using mobile trash bin every 30 minutes from start of sanitation process. Mobile trash bin is provided and is used to transport trash, compost, and recycle.

D. Assemble equipment – one clean string mop, mop bucket and wringer, broom, mop handle, dustpan.

E. Fill mop bucket with germicidal disinfectant solution (Virex 256).

F. Take equipment to Galley.

G. Move movable items (trash bins, etc.) to center of room.

H. Sweep floor with broom. Sweep floor from back to front including under the cabinets.

I. Sweep debris to door and deposit into garbage bag using dustpan.

J. Place caution wet floor sign by the door.

K. Damp mop floor with germicidal disinfectant solution (Virex 256) from back to front using string mop.

L. Allow floor time to dry before removing caution wet floor sign.

M. Return movable items (trash bins, etc.) in its proper place.

N. Use new string mop for every galley. Use new germicidal disinfectant solution before cleaning of next ~~galley~~galley.

O. Return to Porter's closet and clean equipment. Put dirty string mops inside dirty mop bin inside the dirty utility room.

P. Return mop bucket/wringer, mop handle, broom, and dustpan to EVS storage closet.

GALLEY SEQUENCE
North 6, South 6, North 4, South 4, North 2, South 2

CLEANING TIMES
- After Breakfast: 10:00am
- After Lunch: 3:00pm
- After Dinner: 9:00pm

XXIII ENVIRONMENTAL SERVICES – Management of Electronic Equipment

POLICY:
The Environmental Services Department shall maintain an iPad Air2 management plan for the purposes of conducting quality assurance inspections, and monitor cleanliness of resident care areas.

PURPOSE:
To establish guidelines for the use and safe keeping of the device.

PROCEDURE:

I. Three iPads has been assigned to the Department, one each for the South, North and Pavilion/Administrative Buildings.

II. The device will be stored in the EVS Operation manager's office for safe keeping.

III. Each supervisor assigned to each of the buildings is responsible to sign in and sign out of the device.

IV. The device use shall be in accordance with LHH, DPH and City and County of San Francisco use of equipment. Device is not for personal use and shall not be removed from the Hospital.

V. Upon completion of inspection and performing associated tasks, return the device to the Operation manager's office for safe keeping.

VI. Records shall be maintained of inspection results and follow up as needed.

VII. Each supervisor assigned the iPad is responsible for the loss and replacement of device.

VIII. The EVS Operations Manager shall develop quality assurance schedules, follow up on results and deficient areas corrected within 48 hours if not sooner.

IX. The iPad Air 2 with City Seal number LHHB2975, LHHB2976, and LHHB2977 shall be documented on the "minor non-capital equipment inventory" list and be certified by the Department Head at the end of every fiscal year.

X. In the event of lost, damaged, or outdated equipment, the Department Head will report the device to be disposed on the annual inventory list and notify the Accounting Department.

I tagged the iPad Air 2 with our City Seal. They are as follow LHHB2975, LHHB2976, and LHHB2977.

~~Environmental Services Policies and Procedures~~

~~Revised: (Year/Month/Day) Original adoption:~~

Revised Medical Services Policies and Procedures

Laguna Honda Acute Medical Unit Admission Guidelines

POLICY:

For optimal clinical care, LHH residents who meet criteria for intensity of care and severity of illness shall be transferred to the Acute Medical Unit.

PURPOSE:

To provide guidelines to be used when evaluating residents for admission to the Acute Medical Unit.

PROCEDURES:

See also LHH HPP 20-01 (Admission to Laguna Honda Acute and SNF Services and Relocation between Laguna Honda SNF Units)

1. ~~Medical~~ Acute Medical Unit admissions are done at the discretion of the ~~Medical~~ Acute Medical Unit admitting physician. Any disagreement between the SNF and Acute physicians regarding admission to the acute unit or discharge back to the SNF unit shall be referred to the Chief of Medicine for resolution.

2. When a resident is ready for discharge back to their SNF unit after an ~~Medical~~ Acute Medical Unit admission, the SNF physician shall write the SNF readmission orders.

3. Appropriate admissions shall be consistent with ~~Interqual~~InterQual Acute Admission Criteria and may include, but are not limited to:

    a. Acute infections (pneumonia, urosepsis, skin infections) with hypoxia, abnormal electrolytes or WBC, or abnormal vital signs.

    b. Dehydration or acute renal insufficiency requiring continuous IV hydration.

    c. Significant electrolyte abnormalities requiring continuous IV hydration and electrolyte correction.

    d. Altered mental status.

    e. Acute exacerbation of chronic conditions such as COPD, CHF or ESLD.

4. Consider acute admission to outside facility for:

   a. Residents requiring ICU/CCU level care, telemetry, ~~or~~ surgical intervention or specialty consultation and such intensity is within goals of care.

   ~~a.~~b. Residents with suspected ACS or new CVA and transfer to intensive level of treatment is within goals of care.

   ~~b.~~c. Residents with abdominal pain or tenderness who require evaluation for possible surgical intervention and whose advance~~d~~ directives are consistent with receiving this level of care.

   ~~c.~~d. Residents who have a known infection requiring a prolonged course of antibiotics (i.e. osteomyelitis) may initiate their treatment on the Medical Acute Unit if they are acutely ill, but once stabilized should be readmitted to their SNF unit to complete their course of therapy.

~~SNF residents who require blood transfusion, but are not otherwise candidates for Medical Acute Unit admission, should transfer to Medical Acute Unit on a "come and go" basis in order to received close monitoring during the transfusion. This is not an admission to the Acute Unit. Informed consent is required prior to starting transfusion, and should be obtained by the primary physician.~~

~~SNF residents who are not acutely ill but require close monitoring while receiving a subcutaneous or intravenous medication, and for the post treatment period, shall be provided for in the Acute Medical Unit as a "come and go" case, after approval by the CMO.~~

REFERENCE:
LHHPP 20-01 Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units

ATTACHMENT:
Appendix A: PMA Admissions Flowchart

REVISIONS: 19/12/05, 24/05/02 (Year/Month/Day)

PMA ADMISSIONS FLOWCHART

LHH Residents and Patients

Evaluate for medical concern

Does case meet considerations for acute care off-site?

- Yes → **Resident sent off-site to Emergency**
  - **Does case meet considerations for 911 transport?**
    - No → **Scheduled Transport (non-emergent)**
    - Yes → **Resident transported to nearest ED via 911**

Considerations for off-site ED:

- Urgent imaging (acute abdomen, r/o stroke, etc.)
- Urgent specialty consultation or procedure (surgical consult, etc.)
- Dialysis patients
- Suspicion for ACS or stroke.
- COVID positive

Exclusion:

- GOC- no transfer out of LHH

Considerations for 911 transport:

1. Chest Pain
2. Stroke
3. Hemodynamic instability
4. Anxiety level of the resident/patient

- No → **Resident to be considered for PMA Admission**
  - **GOC in line with PMA Admission?**
    - No → **Treat/ manage at SNF LOC** (no transfer to PMA)
      - Yes → **Does case meet considerations for discharge?**
        - Yes → **Case admitted to PMA**

Considerations for PMA discharge:

1. Patient is stable for SNF. (e.g. stable, improvement towards baseline)
2. Acute medical condition resolved

    - Yes → **Does case meet PMA Admission**
      - No → **Case admitted to PMA**

Considerations for PMA admission:

- Temperature 38.0+
  OR
- Change in baseline status

PLUS ONE OF THE BELOW

a. Abnormal:

- HR
- RR
- SBP
- O2 saturation

(from baseline oxygen level)

a. Abnormal WBC
b. Lactic Acid 2.2+

OR

- IV treatment needed
  - may or may not be for failed orals including pain, nausea, diuretics, antibiotics, fluids, etc.

OR

- MD discretion for severe/worsening conditions or labs

Please note:

- This guideline is intended to assist and not replace physician judgment for appropriate care and management of patients and residents. **As a rule of thumb, if the ER would admit to med/surg, then we should admit to PMA.**
- Simple treatments including one time IV fluid bolus, completion of IV abx for a stable patient, etc. may be performed on SNF.
- If questions remain, SNF / PMA doctors may escalate to chief of medicine.

San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center
Version16_05022024

Revised Nursing Policies and Procedures

ITEMS ALLOWED AT THE BEDSIDE

POLICY:

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

2. Non-medicated personal hygiene items may be stored at the bedside in a bag and placed in a closed ~~drawer~~drawer.
   • Non-medicated personal oral hygiene items must be kept in another bag separate from topical personal hygiene items.

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

Purpose:

To ensure resident safety as well as promote resident independence.

Procedures:

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

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

Emergency respiratory equipment for residents with tracheostomies: • Airway suction supplies including complete suction equipment set-up, unopened suction kit, and unopened sterile water/~~saline~~saline. • Tracheostomy of the same type, size (including inner cannula)- for emergency replacement   • Ambu bag if ordered by physician
O_2 tubing in use (labeled with date and changed every 7 days and PRN) ~~24 hrs~~)
Water pitchers with liners: • Water pitchers labeled with date and resident's initials • Pitcher and liner changed every 7 days, and PRN • Water pitchers are replenished every shift and as often as necessary. Consider resident's preference when refilling water.

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

New: 2022/11/08

Reviewed: 2022/11/08

Approved: 2022/11/08

NURSING CARE OF THE RESIDENT WITH SEIZURES (Owner: Kathleen)

POLICY:

1. Code blue shall be called in the event of seizure, unless an anticipated emergency plan has been put in place to address seizure.

2. The Registered Nurse (RN) and Licensed Vocational Nurse (LVN) are responsible for observing, reporting, monitoring, and documenting seizure activity.

PURPOSE:

To provide safe and effective nursing care to the resident experiencing a seizure, and to minimize the risk for harm to the resident.

PROCEDURE:

A. Preventive Safety and Anticipatory Measures

1. Assess the newly admitted or relocated resident within eight hours to determine seizure risk. Risk factors include but are not limited to medical diagnosis of seizure disorder, known history of seizure activity, and anticonvulsant therapy (excluding when administered for behavioral management or neuropathic pain management).

2. When a resident is assessed at risk for seizure activity:
   a. Note seizure risk in the Electronic Health Record (EHR).
   b. Coordinate development of an interdisciplinary care plan entry.

3. Administer anticonvulsants as prescribed and monitor side effects, lab results and effectiveness of medications. ~~(If resident is concurrently on enteral feedings, see NPP J 1.0 Medication Administration policy for special considerations).~~

4. Care plan and initiate individualized seizure precautions as appropriate to the resident's seizure type and pattern, which may include consideration of the following:

   a. Applying side rail pads to the side rails, if ordered, that resident utilizes.
   b. Use of a ~~Joerns bed (~~low bed~~)~~.
   c. Use of a floor pad placed next to the resident's bed.
   d. Keeping bedside clutter free.
   e. Suction set-up at bedside.
   f. Padding edges of furniture at resident's bedside.
   g. Helmet (e.g., history of TBI, craniectomy)
   h. Hip ~~protectors~~protectors.

B. Acute Seizure Management

1. Pre-Ictal Phase (period immediately before the seizure)

a. Monitor the resident for signs and symptoms of impending seizure (aura).
b. If possible, when signs of impending seizure are reported or observed, and before seizure activity has begun, take the resident to a quiet and safe environment, as indicated by historical seizure type, ~~severity~~severity, and characteristics.
c. Provide calm reassurance to the resident.

2. Ictal Phase (period of seizure activity): Administer medications to stop the seizure as ordered by the physician; check prn list to verify if resident has pre-ordered benzodiazepines for seizure activity.

a. Call a Code Blue and do NOT leave the resident alone. Time how long the seizure goes on if ~~possible~~possible.
b. Keep the resident safe and move or guide them away from harm
c. If the resident is not awake and aware
    a. Position the resident on their side (left side is preferred)
    b. Keep airway clear and do NOT put objects in their mouth
    c. Loosen tight clothes around the neck
    d. Do NOT restrain or try to stop them from shaking.
    e. If possible, put something soft under their head
d. Prepare for suctioning
        i. Suction Tubing~~– Located~~ - Located in two places: in the hanging bags; in the intubation kit inside the Respiratory Drawer
        ii. Yankauer- Located in the in the hanging bags; in the intubation kit inside the Respiratory Drawer
        iii. Suction catheter kit- In the respiratory drawer
e. Provide oxygen and assist with ventilation as needed based on assessment
f. Give the physician and/or Respiratory Therapist the oropharyngeal airway (OPA) or nasopharyngeal airway (NPA) as requested
g. Administer medications to stop the seizure as ordered by the physician
h. Consider requesting toxicology screen post seizure activity
~~a. Initiate Code Blue (call 42999).~~
~~b. Stay with the resident and provide reassurance.~~
~~c. When possible, keep the resident in a lateral side-lying position.~~
~~d. As the seizure progresses, provide supportive care including the standard C-A-Bs of basic life support (i.e., circulation, airway patency and protection, breathing), and protect against skeletal and soft tissue injury. Consider the following:~~
    ~~i) Oximetry and oxygen as needed~~
    ~~ii) Vital sign monitoring~~
    ~~iii) Check blood glucose~~
    ~~iv) Oral or nasal suctioning~~
    ~~v) Neurological monitoring~~
    ~~vi) Prepare for intravenous or intraosseous access per MD order~~
    ~~vii) Cardiac monitoring (i.e., especially when administering intravenous antiepileptic medications such as Dilantin)~~
~~e. n~~Do not attempt to force anything into the resident's mouth. Do not try to hold the resident down.
~~f. Due to the possibility of urinary and/or bowel incontinence during a seizure, cover the resident's lower abdomen and groin to provide privacy.~~
~~g. Observe and document the following:~~
    ~~i) how the seizure started,~~
    ~~ii) location and duration of motor activity,~~
    ~~iii) resident's report of sensory changes,~~
    ~~iv) pattern, duration and intensity of seizure development,~~

~~v) any other pertinent details~~

3. Post-Ictal Phase (after the acute seizure)

   a. Maintain resident is a lateral side-lying position until resident is able to maintain airway and secretions.
   a. Do not offer anything to eat or drink until fully awake and able to swallow safely.
   b. Assess the resident's post seizure status, carefully noting vital signs, neurological findings and changes, presence of injury, and resident's emotional response to the event.
   c. Report seizure activity and resident status to the physician.
   d. Provide incontinence care as appropriate.
   e. As appropriate to the resident's cognitive status, explain to the resident the circumstances of the seizure and provide reassurance.
   f. Encourage periods of rest after the seizure.
   g. Offer support to the resident, family and friends, addressing issues of embarrassment, anxiety, depression, and helplessness as they arise.
   h. During regularly scheduled or special Resident Care Team conferences, present information regarding seizure control, frequency, pattern and effectiveness of interventions.

C. Documentation

1. Electronic Health Record: Identify seizure type and characteristics associated with the resident's seizures, related safety problems, and individualized interventions for monitoring, ensuring safety, managing seizure activity, and providing support and education ~~(see Appendix 1~~).

~~2. Interdisciplinary Progress Notes:~~

   a. Document the following: presence, pattern and duration of prodromal symptoms, duration of seizure, pattern of progression, vital signs, loss of consciousness, associated behaviors, incontinence, skin pallor, injuries sustained, and neurological findings during the ictal and post-ictal phase.
   b. Evaluate resident response to specific interventions.
   c. Document physician notification and subsequent interventions.

REFERENCES:

American Association of Neuroscience Nursing (2007). Clinical practice guideline: Care of the patient with seizures, 2nd edition.
Hickey, J.V. (2014). The clinical practice of neurological and neurosurgical nursing, 7th edition, 641-684.
Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), ~~Philadephia~~Philadelphia, PA: Lippincott
Williams & Wilkins

CROSS REFERENCES:

Hospital-wide Policy and Procedure
24-16 Code Blue

Nursing Policy and Procedure
B5.0 Color Codes – Resident Identification
C4.0 Notification & Documentation of Change in Resident Status
G2.0 Neurological Status Assessment
~~J1.0 Medication Administration~~

ATTACHMENT/APPENDIX:

~~Appendix 1: Nursing Seizure Clinical Practice Guideline~~
~~Appendix 2: Classifying Seizures: A Quick Reference Guide~~
NONE

Revised: 2005/01, 2010/01, 2014/08, 2017/03/07, 2019/03/12; 2024/04/15

Reviewed: 2019/03/12

CARE OF AN PROSTHETIC EYE (ARTIFICIAL EYE) (Owner: Kathleen)

POLICY:

1. On admission, the licensed nurse (LN) will request a physician referral to the Eye Clinic to Ophthalmology for consultation of resident's who have a prosthetic eye. The Ophthalmology clinic will refer the resident to Ocularist clinic, then schedule at least yearly, and as needed, to assist in proper care, maintenance, and function.

2. The Medical Clinic nurse is responsible for scheduling and notifying the neighborhood of the Eye Clinic appointments.

3. Any nursing staff can provide routine care of a prosthetic eye.

4. The Registered Nurse is responsible for assessment of resident's routine in the care of the prosthetic eye, and ongoing condition of the eye socket.

PURPOSE:

To ensure that residents receive proper care of the prosthetic eye.

BACKGROUND

GENERAL INFORMATION ABOUT THE PROSTHETIC EYE:

1. Some prostheses are permanent implants.

2. Removing the prosthesis may irritate the mucosa, increase the tendency for the socket to get smaller and make it harder for the prosthesis to fit, so it's encouraged that residents wear the prosthesis and remove it only if necessary for cleaning or procedures. Wearing the prosthetic eye may also enhance the resident's appearance and promote dignity.

3. Care of the prosthesis is a clean procedure.

4. Cleaning helps ensure that the prosthetic eye remains comfortable.

PROCEDURE: (Refer to Skills (elsevierperformancemanager.com) for Procedures on Removing, Cleaning, Irrigating, Inserting Prosthetic Eye)

A. General Prosthetic Eye Care

1. The LN will check the affected eye daily, and as needed, for any abnormalities (e.g. discomfort, redness, discharge) and report any abnormal findings to the attending physician.

2. The prosthetic eye will be cleaned as determined by physician order and resident preference.

3. The resident may perform his/her own prosthetic eye care if determined by the LN as being functionally able to perform. For residents requiring assistance, the nursing staff will assist the resident with, or perform, the prosthetic eye care.

4. The nursing staff will consult with the eye clinic regarding the necessary prosthetic eye care

equipment.

~~B. Equipment~~

~~Gauze sponges~~
~~Bulb syringe~~
~~Normal saline/ warm water with or without mild soap~~
~~Curved basin~~
~~Soft cloth or tissue~~
~~Gloves~~
~~Rubber suction device (Medical Clinic can obtain a prescription for a new rubber suction tip one and submit it to an outside vendor)~~

~~C. Removal, Cleaning and Irrigation~~

~~1. Removing and Cleaning Prosthesis and Irrigation of Eye Socket~~
~~a. Perform hand hygiene and have the resident perform hand hygiene if they are assisting with the procedure.~~
~~b. Apply clean gloves~~
~~c. Inspect the tissues around the affected eye for signs of inflammation and/or infection and report any abnormal findings to the physician.~~
~~d. Pull the lower lid down to expose the lower rim of the prosthetic eye. Push slightly below the lower eyelid to break the suction and tip the lower rim of the prosthetic out of the orbit of the eye. Insert fingertip under the lower rim and slide prosthesis out. If prosthetic eye does not slide out, use the bulb suction device to apply direct suction to the prosthesis (see Attachment 1).~~
~~e. Place prosthetic eye in the palm of your hand and wash with mild soap and water or saline, gently wiping the prosthesis with a soft cloth.~~
~~f. Rinse prosthesis well.~~
~~g. Place prosthetic eye on a clean tissue~~
~~h. If there is a physician order to irrigate the eye socket then hold a curved basin below the affected eye, and irrigate the eye socket with warm water or saline using a bulb syringe until secretions have been cleared. Dry around eyes with gauze.~~
~~i. Insert prosthetic eye back into affected orbit as needed (see Attachment 1-Inserting Prosthesis).~~
~~j. If resident is temporarily unable to wear prosthesis, store it in a labeled (resident name and bed number) closed container filled with water or saline solution, and place container by the resident's bedside stand. Notify the physician immediately for any changes in tolerance to wearing the prosthesis.~~

~~2. Daily Eye Care without Removing Prosthesis~~
~~a. Perform hand hygiene~~
~~b. Use a soft cloth, tissue, or gauze dampened with saline solution or water to gently wipe the eye toward the nose (to avoid the prosthesis from dislodging).~~
~~c. Do not stretch the eyelids.~~

~~D. Inserting the Prosthetic Eye~~ ~~(See Attachment 1)~~

~~1. Assist/ask resident to sit up and prepare the affected eye for prosthetic insertion by washing the eyelids with mild soap and water from inner to outer canthus.~~

~~2. Moisten the prosthetic eye with water or saline.~~

~~3. With non-dominant hand, lift resident's upper eye lid with thumb and forefinger.~~

~~4. With dominant hand, hold the prosthetic eye so that the notched or pointed edge is positioned towards the nose or inner canthus.~~

~~5. Slide the prosthetic eye under the upper lid as far as possible without forcing it, then push down the lower lid allowing eye to slip into place.~~

~~6. Gently wipe away any excess fluid with clean gauze from outer to inner canthus to prevent dislodgment of artificial eye.~~

~~E.~~B. Resident Teaching

1. Encourage the resident to participate in their care of the prosthetic eye, and care of the eye socket, as much as functionally possible, including;
   a. Teaching how to remove and insert the prosthesis,
   b. Teaching how to clean and store the prosthesis,
   c. Teaching how to clean the eye socket,
   d. Signs and symptoms to report to the LN.

~~F.~~C. Recording and/or Documentation

1. Nursing staff will document the presence of the prosthetic eye when inventorying the resident's belongings on admission and document in the Electronic Health Record (EHR).
2. Document the presence of the prosthetic eye in the EHR.
3. The Registered Nurse (RN) will initiate a resident care plan on the use of the prosthetic eye ~~and the resident's routine for prosthetic eye care~~.
4. Nursing staff will document the daily care of the prosthetic eye in the EHR.
5. The LN will document changes or unusual findings in the EHR Progress Notes.

REFERENCES:

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

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

~~Ebsco, Artificial Eye: Insertion and Removal, 2014~~

Revised: 2000/08, 2010/02, 2019/03/12; 2024/04/12

Reviewed: 2019/03/12

Approved: 2019/03/12

BED STRIPPING AND TERMINAL CLEANING **(Owner: DET)**

POLICY:

1. The charge nurse schedules and assigns the nursing staff to perform weekly bedside cleaning.
2. The entire bed is to be routinely cleaned with facility-approved disinfectant, and allowed to air dry.
3. Any part of the bed or bedside area that becomes soiled between the scheduled cleaning is to be cleaned at that time.
4. Terminal cleaning of the bedside ~~unit~~ is to be performed when resident is discharged, transferred or has expired.

PURPOSE:

To maintain a clean environment for the resident.

PROCEDURE:

1. Raise the bed to a safe and comfortable working ~~height~~ level, ~~and~~ keeping bed flat.
2. Reposition bed as needed.
3. Maintain proper body mechanics at all times.

Bed Stripping:

~~Clean bed frame, headboard and bed rails, mattress platform, if needed, mattress castors, over bed trapeze, footboard, bedside call system, bedside lamp, over bed table, bedside table, bedside chair, and any other equipment or furniture in the resident's bedside.~~

~~1.~~

1. Stripping the bedsheets - Refer to HWPP 72-01 F4 Management of Hospital-Provided Linen
    - ~~a. Strip linen from beds to be washed and place in dirty linen hamper (For residents on hazardous drugs, refer to HWPP 25-05 Hazardous Drugs Management for linen care).~~ For residents on isolation precautions, refer to HWPP 72-01 F2: Isolation Room Disinfection
    - a.
    - ~~b.~~
    - ~~c. Follow Standard Precautions, unless additional precautions are necessary (e.g., chemotherapeutic precautions, contact precautions).~~
    - ~~d.~~
    - ~~e. Do not shake linens. When removing linen, roll linen away from you.~~
    - ~~f.~~
    - ~~g. Hold dirty linens away from your uniform and do not put linens on the floor or on clean linens.~~
    - ~~h.~~
    - ~~i. Discard dirty linens into the dirty linen hamper.~~
    - ~~j.~~
    - ~~k. Remove and discard dirty gloves, perform hand hygiene.~~

b. Strip dirty linen from the bed being careful to not shake ~~linens, and~~linens and roll linen away from your ~~body~~body.
c. Hold dirty linens away from your body and places directly in dirty linen hamper (for chemo precautions, put dirty linen in yellow laundry bag, then place bag in dirty linen hamper - refer to HWPP 25-05 Hazardous Drugs Management).
d. Discards/throws away ~~pillows~~pillows.
e. Removes and discards dirty gloves then cleanses/sanitizes ~~hands~~hands.
f. Applies clean ~~gloves~~gloves.
g. With facility approved disinfectant wipes or solution, clean and disinfect the bed:
    i. Start from top to bottom, wiping in a clockwise ~~direction~~direction.
    ii. Start and finish one side at a time to avoid any straining/~~injury~~injury.

Terminal Cleaning:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~1.~~ Final Steps
~~2. Clean bed frame, headboard and bed rails, mattress platform, if needed, mattress castors, over bed trapeze, footboard, bedside call system, bedside lamp, over bed table, bedside table, bedside chair, and any other equipment or furniture in the resident's bedside.~~
15.
    a. Notify CN that room is ready for EVS cleaning
    b. With the CN, visually inspects the bed and the bedside area (i.e., table, nightstands, etc.) for a cleanliness quality check
    c. When EVS confirms to the charge nurse that the room s cleaned, returns to the room to:
        iii. Make the bed with fresh linens and new pillows
        iv. Zero the bed scale
        v. Check the bed and all light are working
        ~~i.~~vi. Notify charge nurse that the room is now ready for a new resident

~~Terminal cleaning (follow bed stripping procedures and remove all personal items).~~

~~Inventory, box and label property of previous resident.~~

~~Wipe headboard from top to bottom and clockwise.~~
~~Remove headboard and wipe underneath. Replace headboard when dry.~~

~~Clean mattress top, bottom and sides.~~

~~Clean under mattress.~~

~~Clean inside and outside bed rails.~~

~~Make sure bed is unplugged. Remove footboard and carefully wipe between electrical connections. Replace footboard when dry.~~

~~Wipe bottom of the bed.~~

~~Once the bed has airdried, clean linens are applied. Refer to Bed Making P&P.~~

~~HHA/PCA/CNA notifies Charge Nurse that the room is ready for EVS cleaning~~

~~HHA/PCA/CNA initials Room Readiness Checklist located in the White Board in the Resident's room once work has been done.~~

~~Licensed Nurse signs off on the HHA/PCA/CNA work.~~

~~Check bed and call light functions.~~

~~3.~~
~~4.~~
~~5.~~
~~6. Reporting~~

~~a. Report broken or defective bed or equipment and cracks in the mattress cover to the licensed nurse and ensure a work requisition is completed and followed up.~~

CROSS-REFERENCE:

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

Nursing Policy and Procedure
D9 2.0 Bed Making

Revised: 2000/08; 2009/08; 2014/09/09; 2019/03/12; 2024/04/15

Reviewed: 2019/03/12

Approved: 2019/03/12

CHARGING OF ELECTRIC WHEELCHAIR **(Owner: DET)**

POLICY:

1. Electric wheelchairs are charged inside the resident's room and the living rooms. Electric wheelchairs must not be charged in the great rooms, hallways, and resident's or neighborhood bath or tub rooms.

2. The P.M. shift staff is responsible for charging electric wheelchairs after 2300 (11:00 P.M.). Do not charge electric wheelchair for more than 8 consecutive hours.

3. The A.M. shift staff is responsible for disconnecting the electric wheelchairs when fully charged.

4. The charge nurse, or designee, notifies Facility Services for electric wheelchairs needing repair (e.g., poorly function electric wheelchair, exposed wiring, loose hardware, cracked battery cap, etc.)

PURPOSE:

To maintain electric wheelchair equipment in operable condition and ensure resident's and staff safety.

PROCEDURE:

A. Battery Charging

1. Charging Precautions

   Avoid over or under charging wheelchair battery as this may impact battery performance.
   a. Overcharging the battery increases the battery's risk of explosion, overheating, and battery failure.
   b. Undercharging the battery decreases the electric wheelchair power.
   ~~Overcharging the battery increases the battery's risk of explosion, overheating, and battery failure.~~

~~Undercharging the battery decreases the electric wheelchair power.~~

2. Keep battery cap securely in place to avoid chemical exposure. Do not ~~to~~ open or remove battery caps or add water at any time.

3. Equipment in need of mechanical repair will to be tagged and removed from the neighborhood for repair.

B. Chemical Exposure Management

1. If the acid does splash onto the skin:

   a. Wash immediately with large amounts of running water.
   b. Contact supervisor and Industrial Hygienist immediately.
   c. Refer to MSDS.
   d. Complete work injury report

CROSS REFERENCES:

LHHPP 71-03 Electrical Equipment Safety Program
Facility Services P&P EM-10 Wheelchair Maintenance and Repair
MSDS

Revised: 8/2000, 07/31/2012; _____

Reviewed: _____

Approved: _____

ENTERAL TUBE FEEDING MANAGEMENT

POLICY:

1. Enteral nutrition is instituted after careful resident assessment and if clinically indicated for:
   a. Short-term intervention for acute management of nutritional support.
   b. Last resort treatment for insufficient oral nutrition if consistent with the resident's goal of care.

2. Position is confirmed by gastrografin for any tube placement or replacement prior to initial use.

3. Routine enteral tube placement is checked by measuring external tube length and inspecting the mouth for Nasogastric Tubes:
   - upon admission and relocation
   - after placement or replacement
   - each shift and as needed
   - prior to accessing

4. The Licensed Nurse (LN) checks the feeding pump at the beginning of the shift to verify that the pump is functional and programmed per the order.

5. For simple balloon gastrostomy tubes (no PEG or internal bumper) that are older than 6 weeks, a trained Registered Nurse (RN) replaces the tube at least every 3 months due to the balloon failure risk and as needed (i.e., worn, dislodged or clogged), unless ordered otherwise. A foley or gastrostomy tube may be placed in the stoma to keep tract open until tube can be replaced.

6. Gastrostomy tubes less than 6 weeks old are re-inserted by Interventional Radiology (IR) or Gastroenterologist. No attempts should be made by LHH staff to replace tubes less than 6 weeks old (Refer to LHHPP File # 26-03).

7. J-tubes are replaced by IR, although a foley or gastrostomy tube may be placed in the stoma to keep tract open until the resident is seen by surgery or IR.

8. A trained RN or LVN may place and remove a nasogastric tube (NGT) as ordered. Nasointestinal tubes (weighted tubes) are not inserted at LHH.

9. Tap water is used for medication dilution and access device flushes.

10. Reverse Luer lock (ENfit) devices or temporary transition adapters will be used for all enteral nutrition tubes.

PURPOSE:

To ensure safe practice associated with enteral feeding tube use, including the insertion, initial placement verification, ongoing placement verification, ~~maintenance~~maintenance, and discontinuation.

DEFINITIONS:

- **Enteral feeding** ("enteral nutrition" or "tube feeding") is the system of providing nutrition or medication directly into the gastrointestinal tract (stomach, duodenum, or jejunum).
- **Nasogastric Tube** ("NGT" or "NG tube") is a tube that is passed through the nose and down through the nasopharynx and esophagus into the stomach. NGTs are placed in residents who require enteral nutrition for up to approximately 4-6 weeks.

- **Gastrostomy Tube** ("G-tube" or "GT") is a tube that is initially placed by surgeons, interventional radiologists (IR), or gastroenterologists through the skin of the abdomen and secured in the stomach. G-tubes include balloon-type G tubes, percutaneous endoscopic gastrostomy (PEG) tubes, pigtails, mushroom tubes, and MIC tubes.
- **Jejunostomy Tube** ("J-tube") is a specialized feeding tube inserted into the jejunum of the small intestine by surgeons or interventional radiologists (IR), or gastroenterologists.
- **Transgastric jejunal feeding tube** ("G-J tube" or "GJT") is a feeding tube that is placed through the stomach into the jejunum by surgeons or IR, and that has dual ports to access both the stomach and the small intestine.
- **External bolster** ("bumper" or "disks") ~~prevent~~prevents inward migration of percutaneous enteral access device.

PROCEDURES:

A. Insertion of NGT

A licensed nurse replaces dislodged NGTs unless ordered otherwise.

Procedure for Insertion and Removal of NGT:

Refer to "Feeding Tube: Small-bore Insertion, Care and Removal" on Elsevier for detailed information (see references for link).

B. Replacement of GT, JT and GJT

1. Insertion tract < 7-10 days old: immediately notify the physician of dislodgement. This may be a medical emergency if stomach contents leak into the peritoneum. Do not attempt tube replacement because it may be accidently positioned into the peritoneum.

2. Insertion tract < 6 weeks old: tubes shall be re-inserted by Interventional Radiology or the gastroenterologist. No attempts shall be made to replace these newly placed tubes by Laguna Honda staff.

3. Insertion tract > 6 weeks old: only simple balloon GT may be replaced at the bedside. For GTs with internal bumper, inform the physician to request for removal alternative (e.g., removal at Gastroenterology Clinic).
    a. The RN replaces simple balloon GTs that are dislodged or cannot be unclogged unless ordered otherwise.
    b. For expulsion, the RN will immediately insert a balloon-type gastrostomy tube of the same size or smaller to prevent stoma closure and inform the physician.
    c. All gastrostomy tubes reinserted or replaced at LHH will have radiologic confirmation of tube placement (~~e.g~~e.g., gastrografin) prior to use.
    d. The LHH physician will check the radiology reading prior to use of a reinserted tube and inform nurses when GT may be used. If there is a question about tube placement, or the licensed nurse is unable to reinsert/replace the GT, the tube will be reinserted in the emergency department (ED) or interventional radiology (IR). Refer to 26-03 Enteral Tube Nutrition.
    e. If the resident can tolerate NGT placement, and NGT may be placed temporarily per physician order until an IR appointment is available. If an NGT cannot be placed and there is a delay in resuming enteral nutrition and medications, intravenous fluids and medications may be required.

f. Keep a replacement gastrostomy tube of the same size as resident's existing tube available in the neighborhood for emergency replacement. Gastrostomy tubes are available from Central Supply.
g. Consider tube replacement sooner than routine every 3 months, if any of the following are identified:
    i. Deterioration and dysfunction of the G-tube
    ii. A ruptured internal balloon
    iii. Stomal tract disruption
    iv. Peristomal infection that persists despite appropriate antimicrobial treatment
    v. Skin excoriation
    vi. Non-healing ulcer formation that will not heal despite good wound care technique
h. Complete an Unusual Occurrence (UO) report if the tube replacement was not scheduled (Refer to LHHPPP File 26-03 Enteral Tube Nutrition).

Procedure for Replacement of the Gastrostomy Tube

Refer to "Long Shaft Gastrostomy Tube Replacement or Removal" on Elsevier for detailed information (see references for link).

1. Measure the initial external tube length from insertion site at the stoma to the distal end of tube port(s). Do not include a Lopez Valve, if present, in the measurement. Reusable rulers are ~~single-patient~~single patient/resident use and should be disinfected before and after use.
2. Slide the GT external bumper approximately 0.5 cm from the stoma to prevent tube migration. If GT does not have an external bumper, use tape or stabilization device to position the balloon against the internal abdominal wall, and prevent migration, dislodgement or excessive traction.

C. Administration of Formula Feeding

1. Types of Enteral Nutritional Support:

a. **Closed System:** formula comes in pre-filled closed containers. Closed systems are preferred due to reduced opportunity for contamination.
    i. Label the container with the resident name, rate, date and time container is hung. The label on the container also applies to the tubing since both are one closed system.
    ii. Only spike containers once with a new tubing set. Tubing sets are never re-used and are discarded with the used container.
    iii. Shake enteral containers well prior to spiking and occasionally during hanging if settling is noticed.
    iv. Containers and tubing are discarded when the container is empty, OR within 24 hours after closed enteral container is hung.

b. **Open System**: nutritional products are transferred from a can or bottle to a feeding bag. Open enteral nutritional bags come with attached tubing.
    i. Labeled the enteral bag with the resident's name, formula, rate, date and time the bag is hung. The label on the bag also apply to the tubing as both are one system.
    ii. Open enteral bags used for formula must be discarded after each use.
    iii. Open enteral bags used solely for water must be discarded within 24 hours after they are initially hung.

Refer to Appendix 1 for Preparation for Enteral Nutritional Support – Closed and Open System.

2. Enteral tube care protocol: Refer to Appendix 2

a. Daily stoma care and as needed.
   i. Observe if GT external bumper approximately 0.5 cm from the stoma to prevent external pressure (i.e., buried bumper) or inward tube migration, which can cause leaking of gastric contents through the stoma.
   ii. Fit of the simple balloon GT should allow for easy rotation of the tube and permit cleaning under the bumper. **JT and GJT should not be rotated**.
   iii. For insertion tract < 7-10 days old, stabilize tube with one hand while cleaning skin for the first 7-10 days after initial insertion.
   iv. If GT without a bumper, use a stabilization device (i.e., Statlock or M Fixx) to secure/anchor the tube and prevent excessive tension to the exterior portion of the tube.

b. Dressing changes
   i. A 4x4 split drain sponge may be over the external bumper as needed (e.g., drainage present) and changed daily.
   ii. If the skin is irritated, a moisture barrier cream or a hydrocolloid dressing may be applied under the external bumper to protect the skin and changed as ordered.
   iii. Refer to "Feeding Tubes: PEG, Gastrostomy, and Jejunostomy Care" on Elsevier for detailed information (see references for link).

c. Skin assessments every shift skin for redness, tenderness, swelling, irritation, or presence of purulent drainage or gastric leakage. If obscured by dressing, observe if dressing is secure every shift and assess skin with dressing change (ex: daily for split drain sponge dressing, weekly for hydrocolloid dressing or securement device, such as M Fixx). Notify physician for any signs of skin breakdown.

d. Enteral tube length measurements every shift, prior to accessing, after admission or relocation, and as needed. For NGT, inspect the back of the mouth for coiling of tube.

e. Check gastric residual volume (GRV) every shift unless specified by order. Schedule the GRV checks prior to initiating intermittent formula or evenly spaced for continuous formula.

f. Flush enteral tube with a minimum of 30 mL of water using a 60 mL syringe at a minimum of once per shift, before and after intermittent feedings, before a paused feeding is resumed, after GRV measurements, and as needed. Obtain a flush order for patients/residents with fluid restrictions. For medication administration flush protocol, refer to ~~NPP J 1.0 Medication Administration~~HWPP 25-15 Medication Administration.

g. Notify the physician for compromised feeding tube integrity or patency issues.

h. Change the storage container and enteral syringes daily on AM shift. Label syringe (name and date), rinse with water after use, and store syringe at the bedside in clean, labeled (name and date), dry container or storage bag.

i. Change all closed system tube feeding containers and bags/tubing daily on AM shift using clean technique, even if bottle is not empty or expired. Change open system bags used solely for water on AM shift. Discard open system formula bags after each use.

j. Change Lopez valve weekly if used

k. Simple balloon GT replacements every 3 months, as needed for dysfunction, as ordered

l. NGT replacement every 6 weeks, as needed for dysfunction, or as ordered

m. Relocate NGT position within same nostril weekly to prevent pressure on the same site in the nostril and skin breakdown

n. Trace tubes back to their origins to prevent misconnections and ensure lines are secure prior to connections.

o. Notify the Nutrition Services diet office for any new enteral diet orders or changes in formula or calories.

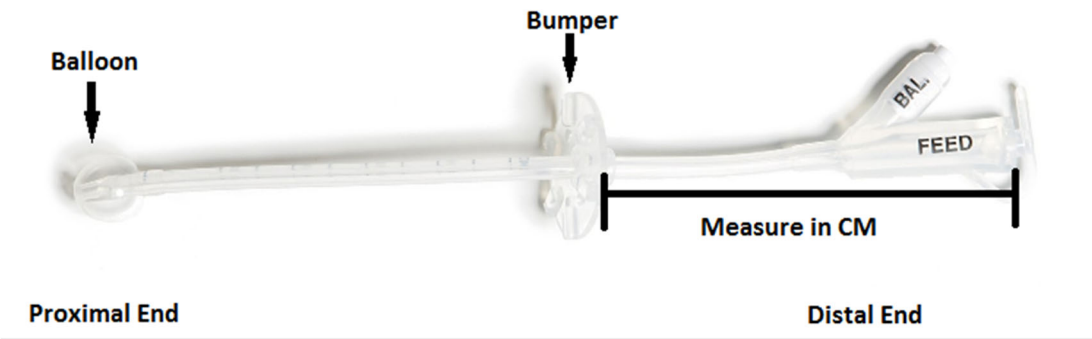
3. Positioning

a. Assess aspiration risk and implement appropriate interventions.
b. Elevate the resident's head of the bed (HOB) to a minimum of 30 degrees prior to, during, and for 30 minutes after feeding unless otherwise ordered. If the HOB needs to be lowered for a procedure (i.e., linen changes or incontinence care), feedings should only be stopped for the duration of the procedure and restarted with HOB re-elevated as soon as procedure is completed.
    i. If the resident has difficulty clearing secretions, it may be necessary to clear secretions (e.g., oral suctioning with order) regularly or prior to lowering of the HOB.
    ii. If on bedrest, may limit HOB elevation to 30 degrees and avoid positioning directly on a pressure ulcer/injury.

4. Checking Enteral Tube for Correct Placement

Enteral tube placement is checked at the bedside via external tube length. Auscultation should not be used to verify tube placement. When verifying tube placement, the nurse should use clinical judgement if concerned about migration to ensure safe patient care.

a. Measure the external tube length from insertion site at the stoma/nostril to the distal end of tube port(s). Do not include a Lopez Valve, if present, in the measurement.



b. If NGT is in place, examine the oropharynx. External tube length does not guarantee proper position, as tubes can become coiled and or/ the tube tip can become displaced into the esophagus. If there is coiled tubing, gently remove the tubing immediately to prevent airway obstruction. Inform the physician immediately if there are questions about placement.
c. If there is a question about the enteral tube placement, do not proceed with administration of medication or feeding until correct placement has been verified.
d. If a change in external tube length is observed, assess the resident for symptoms of possible dislodgement and use visualization of tube aspirate to help determine if tube has become dislocated. Do not attempt to reinsert tube if partially migrated. If in doubt of placement, notify the physician and obtain a radiograph to determine tube location. Refer to section Procedure 5 Procedure for Gastric Residual Visualization.
e. Respiratory compromise (i.e., increased respiratory rate, difficulty breathing, decreased O2 saturation, or coughing) may indicate tube feeding dislodgement or intolerance.
f. Document the procedure. Refer to section Procedure J Documentation.

5. Procedure for Gastric Residual Visualization and Measurement:

Refer to “Feeding Tube: Verification of Placement” on the Elsevier (Mosby’s) Clinical Skills for detailed information (see references for link).

a. Checking gastric residual volume (GRV) may be appropriate when initiating tube feedings, if dislodgement suspected, or if the resident/patient reports or displays any signs of intolerance, such as bloating, nausea, vomiting, and complaints of fullness, abdominal distension or abdominal pain.
b. The technique of aspirating gastric juices for GRV checks can increase clogging.
c. Stop continuous feedings for several minutes before aspirating, measuring, and returning gastric residuals.
d. Measure the amount of gastric aspirate and observe for changes in the volume and appearance of the aspirate.
    i. If the gastric residual volume is > 250 ml or the GRV order parameters, hold the tube feeding and notify physician. Aspirate, measure, and return gastric residual every 2-4 hours until resident has exhibited the ability to empty his/her stomach, at which time tube feeding may be continued or re-started with an order.
e. Notify the physician if gastric secretion volume or appearance is concerning.
f. Document the procedure. Refer to section Procedure J Documentation.

6. If Tube Occlusion Occurs

Do not use any non-facility approved devices (i.e., tube brush), cranberry juice, soda or hot water to unclog feeding tubes at the bedside.

Use a gentle back-and-forth motion with 30- or 60-mL syringe filled with water to dislodge clog or a pancreatic enzyme solution per order to dissolve clog.

Refer to “Feeding Tube: Small-bore Insertion, Care and Removal” on Elsevier for detailed information (see references for link).

D. NGT use as Intermittent Gastric Suction

Refer to “Nasogastric or Orogastric Tube: Insertion, Flushing, and Removal” Elsevier Clinical Skills for detailed information (see references for link).

1. Large bore, double lumen NGTs, such as the sump tube, are the preferred tubes for gastric suction. The large lumen allows of suction of gastric contents and medication delivery. The smaller vent lumen allows for atmospheric air to be drawn into the tube and equalizes the vacuum pressure in the stomach once the contents have been emptied. This prevents the suction eyelets from adhering to and damaging the stomach lining.
2. If using a sump tube, do not clamp the air vent, connect the tube to suction or use it for irrigation. Keep the air vent of the sump tube above the patient’s stomach level.
3. After instilling medication and/or formula and flushing with 30 ml of water, plug the NG tube for 1-1/2 hours or as ordered, before attaching to the suction machine.
4. Only use low suction unless otherwise ordered.
5. Monitor for any signs of respiratory distress and stop suction and notify physician immediately if present.
6. Document any volume of fluid instilled (intake) and suctioned (output).

E. Administration of Medication(s) Through Enteral Tube (Refer to ~~J 1.0 Medication Administration~~HWPP 25-15 Medication Administration)

F. Reassessment of Enteral Feeding

1. Enteral Feeding may be held, and physician notified for possible indications listed below:
   a. Aspiration, such as vomiting, choking, coughing, frothy sputum, tachycardia, respiratory distress, or fever.
   b. Fluid and electrolyte imbalance
   c. Intolerance of feedings, using measures such as slow gastric emptying (GI motility status), assessment for abdominal distension, firmness, diarrhea and large GRV, feeling of fullness, or nausea that might lead to gastric reflux.
   d. Peritonitis, such as abdominal pain and/or bloating, constipation, fever, nausea, vomiting, diarrhea, weakness, dizziness, dyspnea, tachycardia, tachypnea, and inability to pass gas or feces, and dehydration. Feeding tubes can perforate the stomach or small intestine, and result in peritonitis.
   e. Esophageal complications, including esophagitis, ulcerations, strictures, and tracheoesophageal fistulas.
   f. Leaking around the insertion site, abdominal wall abscess, or erosion at the insertion site, including nasal areas.
   g. Clogged tube due to plugging by formula, pill fragments, or precipitation of medications incompatible with the formula.
2. Enteral feeds will be resumed by physician order, which may include radiologic evaluation or reassessment of the goals of enteral feeding
3. Notify physician and registered dietitian:
   a. If resident has unplanned significant weight gain or loss or if a reassessment of goals of nutritional support is indicated. Refer to NPP G 7.0 Obtaining, Recording and Evaluating Residents Weights.
   b. If the Intake and Output monitoring indicate the resident is consistently receiving less than the enteral nutrition goal volume.

G. Documentation

Goals of Medical Enteral Feeding

1. Nutritional and Quality of Life goals are documented in the Resident Care Conference (RCC) note.
2. Goals of enteral feeding may be documented in Advance Care Planning by the physician.

EHR Documentation by the Licensed Nurse

1. Flowsheet or Lines, Drain and Airways (LDA) and Flowsheets
   a. Admission and Tube Insertions:
      i. If the tube was inserted at a DPH facility, continue the LDA.
      ii. Document the tube properties and assessment under LDA.
      iii. Document the resident's tolerance of the procedures and any difficulty or complications encountered
   b. Removal and Replacement:
      i. Document the removal of the original tube (permanent removal or planned replacement) under the LDA, including the remove date, removal time, removal reason.
      ii. Document the replacement by initiating a new LDA.
      iii. Document the resident's tolerance of the procedures and any difficulty or complications encountered.
   c. Documentation:
      i. Every shift and as needed: document the tube assessment under LDA.
      ii. Intake and Flush volume: Prior to the end of EACH shift, the Licensed Nurse:
         i. Checks the feeding pump and documents the volumes for "FED" and "FLUSH" at the end of the shift.

ii. ~~iii~~ Clears the pump of the volumes for "FED" and "FLUSH".
iii. ~~iv~~ Documents the volume of fluid used for flushes and medications during the shift.

iii. As needed:
i. ~~i~~ Any other problems with enteral tube management (e.g., frequent obstruction, etc.)
ii. ~~ii~~ Resident's tolerance or intolerance of feeding.

2. Education: Document any resident or family teaching provided and evaluation of learning
3. Care Plan:
   a. Care plan the clinical indication, as noted by the physician, which necessitates enteral tube placement and enteral nutrition.
   b. Include any related or potential problems, or resident needs.
   Examples of some possible adverse effects of using a feeding tube may include: diminishing socialization, and not having the opportunity to experience the taste, texture, and chewing of foods.

Non-EHR Documentation by the Licensed Nurse

Document daily enteral feeding supplies used on the Enteral Nutrition Charge Form. Refer to LHHPP 50-04 (Enteral Nutrition Charge Procedure).

ATTACHMENTS/APPENDICES:

Appendix 1: Preparation for Enteral Nutritional Support – Closed and Open System
Appendix 2: Enteral Pump Hang Tag provided by the manufacturer
Appendix 3: Enteral Nutrition Chart

REFERENCES:

Joseph Boullata, Amy Carrera, Lillian Harvey, Lauren Hudson, Carol McGinnis, Jacqueline Wessel, Sarita Bajpai, Tamara Kinn, Mark Klang, Karen Martin, Cecelia Pompeii-Wolf, Abby Wood, Peggi Guenter and ASPEN Safe Practices for Enteral Nutrition Therapy Task Force, American Society for Parenteral and Enteral Nutrition, **ASPEN Safe Practices for Enteral Nutrition Therapy**; *JPEN Journal of Parenteral and Enteral Nutrition* 2017; 41; 1 https://aspenjournals.onlinelibrary.wiley.com/doi/epdf/10.1177/0148607116673053

Library Databases: http://insidechnsf.in.sfdph.net/library_databases.htm

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https://epm601.elsevierperformancemanager.com/Personalization/Home?virtualname=sanfrangeneralhospital-casanfrancisco

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https://search.ebscohost.com/Community.aspx?community=y&authtype=ip&ugt=723761666C76658727E665D662156E9261E327E33313340331633623&stsug=AkyMCIkUzWydYOr9Kbs9Ci4vDyFarVDzc-pSjff7036IJGrWUTAikjQNEKGxiffp4Wkyb7hXQ6n_9WmS7sWXAa7ddcYwaq7u9Arm-V8u7bvrm5NOT3ySErcrAwB66-l7v6sesl2KlSczixDXa6WBwK9EpYKGuVCWUjzzeHo4Yw&IsAdminMobile=N&encid=22D731163C56352737763546328 53C973113376373C374C371C376C372C376C370C331

Bryant, R. A., & Nix, D. P. (2012). *Acute & chronic wounds: Current management concepts*. Elsevier/Mosby.

CROSS REFERENCES:

Hospital-wide Policy and Procedure
25-15 Medication Administration
26-03 Enteral Tube Nutrition
50-04 Enteral Nutrition Charge Procedure
Nursing Policy and Procedure
G 3.0 Intake and Output
G 4.0 Measuring the Resident's Height and Weight
~~J 1.0 Medication Administration and Appendices~~

Adopted: 2002/08

NEW: 2013/05/28

Revised: 2009/08; 2011/03/10, 2011/07/12; 2015/01/13; 2016/07; 2017/11/04; 2019/05/14; 2022/07/12; 2022/11/08; 2023/04/11; 2023/08/08

Reviewed: 2023/08/08; 2024/05/09

Approved: 2023/08/08

APPENDIX 1 - Enteral Nutritional Support - Closed and Open Systems

A. Administration of Formula Feeding

1. CLOSED SYSTEM

a. Equipment

Gather all equipment needed from neighborhood supply room or Central Supply Room:

i. infusion pump with tubing set
ii. 60 ml catheter tip feeding syringe

Obtain the prescribed enteral formula from the Galley or Dietary Department.

b. Preparation of Nutritional Products

i. Wash hands with soap and water or use hand sanitizing product.
ii. Follow physician orders and nutritional product instructions on container.
iii. Check expiration date of enteral formula.
iv. Enteral formula should be at room temperature.
v. Shake container for 5-10 seconds prior to spiking to mix formula evenly.
vi. Remove container lid. Do not remove the cap from the container.
vii. Label container with resident name, rate, staff initials, date and time container is hung.
viii. Spike enteral nutrition container using the open port in the cap, not the air vent; and fill water bag with room temperature tap water prior to setting the pump.
ix. Program the pump per manufacturer instructions. Refer to Appendix 2. Use **"continuous mode"** for both continuous and intermittent feeding.
x. Confirm proper positioning of the resident and correct placement of enteral feeding tube per nursing and hospital policy (Refer to NPP E 5.0 and LHH File 26-03).

2. OPEN SYSTEM

a. Equipment

Gather all equipment needed from neighborhood supply room or Central Supply Room:

i. infusion pump with open system tubing set or gravity feeding bag for bolus feeding
ii. 60 ml catheter tip feeding syringe

Obtain the prescribed enteral formula from the Galley or Dietary Department.

b. Preparation of Nutritional Products

i. Wash hands with soap and water or use hand sanitizing product.
ii. Follow physician orders and nutritional product instructions on container.
iii. Wipe top of unopened container with alcohol wipe before opening. Avoid touching any part of the formula container or the administration set that will come in contact with the formula.
iv. Make sure formula is at room temperature by any of these means:
    1. Store unopened formula at room temperature.
    2. Place refrigerated formula cans in a pan of warm water.
    3. Add warm water, as ordered, to the formula.

v. Partial cans of formula:

1. Cover, date and initial container.
2. Place in household refrigerator to use for next formula preparation.
3. Discard unused formula after 48 hours.

vi. Enteral bags are labeled with resident's name, formula, rate, staff initials, date and time bag is hung.
vii. If using enteral pump, fill the bag with formula and water flush bag with room temperature tap water.
viii. Program the pump per manufacturer instructions. Refer to Appendix 2. Use **"continuous mode"** for both continuous and intermittent feeding
ix. If using gravity feeding bag, fill bag with formula. Prime tube prior to connecting to resident.

c. Administration of high protein powder supplement with water using open enteral system:
i. Put 60-120 ml of water in the enteral feeding bag.
ii. Add the amount of protein powder ordered.
iii. If using enteral pump, fill the bag with formula and water flush bag with room temperature tap water.
iv. Program the pump per manufacturer instructions. Refer to Appendix 2. Use **"continuous mode"** for both continuous and intermittent feeding.
v. If using gravity feeding bag, fill bag with formula. Prime tube prior to connecting to resident.

B. Administration of Free Water

1. All **free water** bags must have a label indicating resident name, volume of water, frequency, date/time and staff initials.

2. Using Syringe
   a. Use 60 ml syringe.
   b. Attach the syringe to the tube port.
   c. Pour water from the resident's water pitcher into the feeding syringe.
   d. Administer water by gravity through enteral tubes unless the gastrostomy is short, such as the Bower REG. These tubes do not have adequate length for fluids to flow by gravity from a syringe. In this case, use a 60 ml catheter-tip syringe and, with the plunger, slowly and gently push fluids through the tube into the stomach.

3. Using an Enteral Bag
   a. See above procedures for open & closed systems.

4. In open systems, free water may be added to directly to the feeding bag, unless contraindicated.

C. Charging Slips for Enteral Formula

1. Refer to LHHPP File 50-04 Enteral Feeding Charges.

Changed to Appendix: 2013/05/28

Revised: 2004/06; 2011/03/10, 201305/28; 2023/04/11; 2023/08/08; 2024/05/09

Reviewed: 2023/08/08

Approved: 2023/08/08

NURSING MANAGEMENT OF URINARY CATHETERS **(Owner: Kathleen)**

POLICY:

1. 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.

2. Urinary catheters will only be utilized for appropriate indications and left in place only as long as needed.

    a. 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.

~~3. 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.~~

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

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

5. 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.

~~4.~~

~~5.~~6. 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) every shift. ~~Assessment findings, appropriate interventions, and evaluation must be documented.~~

~~6.~~7. Routine catheter irrigation is contraindicated unless there is a written order from the physician.

~~7. 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.~~

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

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

10. Any nursing staff member, except home health aides (HHA), may apply or remove a leg bag using standard precautions.

~~11. Intake and output will be measured every shift for residents with a urinary catheter.~~

PURPOSE:

To minimize the risk of CAUTI.

PROCEDURE: (Refer to Skills (elsevierperformancemanager.com) for procedures on removing, inserting and maintaining urinary catheters)

~~**A. Equipment**~~

~~Non-sterile gloves and additional personal protective equipment if needed~~
~~Drape or blanket~~
~~Urinary Catheter (Indwelling or Straight)~~
~~Urinary Catheter Insertion Tray~~
~~Closed-System Urinary Drainage Bag~~
~~Flash light (as needed)~~

~~**B. Preparations for Inserting Intermittent and Indwelling Urinary Catheter**~~

~~1. Check for physician order and indication. If indication is not included in the order contact physician.~~

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

~~3. Unless otherwise clinically indicated, consider using the smallest bore catheter possible, consistent with good drainage, to minimize bladder neck and urethral trauma.~~

~~4. Perform hand hygiene immediately before and after insertion or any manipulation of the catheter device or site.~~

~~5. Explain the procedure to the resident.~~

~~6. See Appendix 1 for procedure for indwelling and straight catheter insertion for both female and male resident.~~

~~**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 at all times.~~

~~c. Do not rest the collecting bag on the floor.~~

~~d. Use aseptic technique when changing the drainage bag to reduce risk of infection. Utilize clean technique by washing hands and wearing non-sterile gloves when emptying the drainage bag.~~

~~e. Empty the collecting bag regularly, using a separate, clean collecting 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 at least when bag is 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. Unless obstruction is anticipated, bladder irrigation is not recommended.~~

~~10. If using a urinary leg bag, refer to Appendix 2 (Application of Urinary Leg Bag). 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.~~

~~D.~~A. Urinary Catheter Care Maintenance for 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.

5. After aquatics therapy and return to the unit, reconnect to a new drainage bag using aseptic technique.

~~E.~~B. 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.~~

~~2.~~1. Documentation

a. Document on initial insertion:
   i. Date and time of indwelling catheter inserted, including the size of the catheter and volume of balloon inflated on the electronic health record.
   ii. Volume and any untoward events encountered during the procedure and urine characteristics (i.e. color, clarity, odor, presence of sediment or clots)
   iii. Resident's tolerance of the procedure.
   iv. If urine specimen was sent to the laboratory.

.

b. Documentation for daily, weekly, or monthly summary:
   i. 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.
   ii. Any interventions performed and evaluation and outcome of intervention.
   iii. Record any problems to the licensed nurse if resident is having problems with leg bag e.g. leakage, skin irritation etc.

~~c. 3. Electronic Health Record~~
~~d.~~
~~e.~~ Document when changing close-system drainage bag.
c.

d. Document intake and output every ~~shift~~shift.
~~f.~~

~~g.~~ Initiate care plan~~Document intake and output every shift.~~
~~h.~~e.

~~4. Plan of Care~~

~~a. Document the initial date of insertion, type and size of the indwelling catheter used, any unique management or approaches to resident when inserting catheter.~~

~~b. Address possible risk for complications and infections related to use of indwelling catheter, measurable goals and date, and interventions. On-going problems should be addressed and documented in notes as indicated. Plan of care goals are reviewed and updated accordingly.~~

~~c. 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~~
NONE

REFERENCES:

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

CROSS REFERENCE:

~~Nurising~~ Nursing Policy and Procedure
G 3.0 Intake and Output

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

Reviewed: 2019/07/09

Approved: 2019/07/09

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

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

    a. Indwelling Catheter
        i. Catheter insertion tray
        ii. Foley Catheter (size based on MD order)
        iii. Drainage Bag

    b. Straight Catheter

        i. Urethral catheter tray

    c. Flash light

2. Explains procedure to the resident.

3. Positions the resident as follows:

    a. 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.

    b. Male: Supine position with legs extended and thighs slightly abducted

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

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

6. Performs hand hygiene.

7. Preparation of equipment needed:

    a. Places unopened catheter insertion tray, foley catheter, and drainage bag on a clean surface close to the resident.
    b. Opens the outer wrapper of the catheter tray using sterile technique.
    c. Opens the package of the drainage bag, checks to see if drainage bag clamp is closed, and sets bag aside.
    d. 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.
    e. Puts on sterile gloves.
    f. 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.
    g. Arranges the supplies on the sterile field.
    h. 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.
    i. Lubricates catheter with sterile lubricating jelly 1 to 2 inches for female residents and 5 to 7 inches for male residents.
    j. Pours the aseptic solution (Povidone-Iodine) over the cotton balls.

8. Cleanses urinary meatus with antiseptic solution

    a. Female:

        i. 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.
        ii. Using the sterile hand, use forceps to hold the pre-moistened cotton balls.
        iii. 1st pre-moistened cotton ball: clean ~~along side~~alongside farthest from the nurse along the meatus in a single stroke, discard the 1st cotton ball.
        iv. 2nd pre-moistened cotton ball: clean labia and meatus nearest the nurse using a single stroke, discard the 2nd cotton ball.
        v. 3rd pre-moistened cotton ball: clean the midline, directly over the meatus; then discard the 3rd cotton ball.
        vi. 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.

    b. Male:

        i. 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.
        ii. Hold shaft of the penis at right angle to the body.
        iii. Using the sterile hand, use forceps to hold the pre-moistened cotton balls.
        iv. 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.
        v. 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.

9. Catheter insertion

    a. Female:

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

    b. Male:

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

10. Inflating the balloon catheter

    a. Allows bladder to empty fully unless contraindicated.

b. Collects urine as needed.
c. Keeps the non-dominant hand securely holding the catheter.
d. Using the dominant hand,

    i. Attaches the pre-filled syringe in the injection port at the end of the catheter.
    ii. 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.
    iii. After inflating the catheter balloon, releases catheter from the non-dominant hand.

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

11. Securing indwelling catheter with tape

    a. Female: Secures catheter to inner thigh with tape or catheter strap, allowing slack to prevent tension.
    b. Male: Secures to lower abdomen with tape or catheter strap. If retracted, replace foreskin over the penis glans.
    c. 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

1. Application of Leg Bag

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

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

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

    d. 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.

OSTOMY MANAGEMENT (Owner: DET)

POLICY:

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

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

3. The certified nursing assistant (CNA) or patient care assistant (PCA) can only change the bag for a two-piece colostomy or ileostomy every shift and as needed.

~~3. is responsible for emptying or changing the pouch/bag every shift and as needed.~~

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

PURPOSE:

To provide appropriate ostomy management.

BACKGROUND:

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

PROCEDURE:

~~**A. Equipment**~~

~~Select appropriate ostomy product {Attached as Appendix Formulary (Coloplast)}~~

~~B.~~A. Emptying or Changing Ostomy

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

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

~~C.~~B. Ostomy Maintenance for Aquatic Services

~~1. Ensure that ostomy site is cleaned.~~

~~2. Empty/dispose of ostomy pouch.~~

~~3. Securely place a new/empty ostomy pouch.~~

~~4. Check for leakage and patency.~~

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

~~D.~~C. Documentation

1. Electronic Health Record (EHR)
   a. CNA/PCA records output every shift in the intake/output (I/O) section.
   b. Licensed nurse documents date of change of the ostomy wafer (change at least every 7 days or as needed) and check condition of peri-stomal skin.
      i. 2-piece pouch - use new pouch once/day
      ii. 1-piece pouch – change up to Q 3-7 days and as needed
   c. ~~Document type~~Document type of ostomy product(s) and indications for use

2. Progress Notes (Licensed Nurse)

   a. Any change in appearance, discharge, bloody drainage or discoloration of stoma and peri-stomal skin
   b. Resident and family education when ~~provided~~provided.

ATTACHMENTS:

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

REFERENCES:

Basic Ostomy Skin Care. A Guide for Patients and Healthcare Providers
2007. Wound, Ostomy and Continence Nurses Society

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

Original Document: September 30, 2008

Revised: 2015/03/10, 2017/03/14, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

VITAL SIGNS **(Owner: DET)**

POLICY:

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

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

3. Staff who find a resident, unresponsive, pulseless or apneic shall initiate a Code Blue call immediately or 911 per Code Blue Policy ~~({rR~~efer to Hospital-wide Policy & Procedure (HWPP) #24-16 Code Blue~~})~~.
    a. For staff required to have BLS, staff shall assess for resident's responsiveness, breathing and pulse per BLS guidelines. CPR shall be initiated immediately when needed.

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

5. For residents whose reimbursement for SNF care is Medicare, V/S should be taken and recorded at least daily. In long-term care neighborhoods, V/S are checked monthly at a minimum, unless otherwise ordered.

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

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

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

PURPOSE:

To outline frequency of vital sign measurement and nursing responsibilities.

PROCEDURES:

~~**A. Equipment**~~

~~Automated V/S Machine~~
~~Individual BP cuffs or Multi-Use Cuffs~~
~~Manual Sphygmomanometer~~
~~Tympanic thermometer~~

~~**B.**~~**A. Frequency of Monitoring V/S**

a. Admission for all SNF Neighborhoods: V/S are taken upon admission to any neighborhood in LHH with at a minimum of every 8 hours for the first three (3) days, unless otherwise ordered. Orthostatic BP/PR is done once as part of the admission nursing assessment to evaluate for hypotension and whenever clinically indicated.

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

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

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

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

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

~~f.~~g. Fall incident~~: check V/S once per shift at a minimum for 3 days or as clinically indicated.~~ (Refer to HWPP #24-13 Falls).

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

~~C.~~B. Reporting

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

   a. BP is less than 90/50 or greater than 160/90
   b. PR less than 50 or greater than 100
   c. RR less than 14 or greater than 25
   d. T over 100 degrees F
   e. O2 sat of less than 90
   f. Orthostatic V/S changes

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

~~D.~~C. Documentation:

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

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

~~3. The CNA or PCA may record pain score as verbalized by the resident or as observed using the Pain Assessment in Advanced Dementia Scale (PAINAD) on the electronic documentation system. The CNA or PCA informs the licensed nurse for further pain assessment.~~

ATTACHMENTS:

~~Attachment 1: Automated Vital Signs Machine Operating Guidelines~~
~~Attachment 2: Quick Reference Guide for Electronic Documentation~~None

REFERENCES:

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

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

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

CROSS REFERENCES:

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

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

~~Nursing P&P J 1.0 Medication Administration~~

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

Reviewed: 2022/05/10

Approved: 2022/05/10

COLLECTION OF URINE SPECIMEN **(Owner: DET)**

POLICY:

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

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

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

PURPOSE:

To describe guidelines for the nurse collectingfor urine specimen collection.

PROCEDURE:

A. A. Equipment for Urine Collection
B.
C. Obtain the following from Neighborhood Supply if not prepackaged kit:
D.
E. Sterile screw-cap specimen container
F. Clean plastic bag
G. Antiseptic Towelette
H. 20 ml syringe with Luer- Lok tip (for catheter drain bag with needleless sampling port)
I. (As needed) Urethral catheterization tray
J. Requisition forms:
K. Urine/Fluids: Requisition for Urinalysis or other physician's order urine tests
L. Microbiology: Requisition for Cultures
M. Label
N.
O.
P.A. Laboratory Requirements

1. All specimen containers must be labeled with stamped addressograph including neighborhood and bed number prior to collection of the specimen.

2. Licensed Nurse completes the laboratory requisitions with stamped addressograph and writes the method of specimen collection, date and time. Verify the physician's ID number, applicable pager number, ICD -10 codes, collector's name and indicate if STAT was ordered.

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

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

B. Methods of Collecting Urine Specimen: Refer to Skills (elsevierperformancemanager.com) for Procedures on Collecting Urine Specimen

~~1. Midstream (Clean-Voided) Technique – refer to Attachment 1.~~

~~Intermittent Urinary Catheter – refer to Attachment 2.~~

~~Indwelling Urinary Catheter~~

~~a. Using aseptic technique, collect the specimen from the specimen collection port in the tubing of the urinary catheter (e.g., transurethral or suprapubic), not in the urine collection bag or from the catheter tubing directly.~~

~~b. Clean the needleless sampling port with a facility-approved antiseptic solution and allow to air dry.~~

~~c. Clamp or fold the urinary catheter tubing distal to the collection port.~~

~~d. Insert a luer-lock tip syringe into the port at a 90 degree angle to the tubing and slowly aspirate the urine, withdraw about 10 ml of urine.~~

~~e. Transfer the urine sample to the sterile specimen container and attach the lid securely.~~

~~f. Wipe the sampling port with a facility-approved antiseptic swab; allows to air dry. Then unclamp or unfold the urinary catheter tubing to permit urine to drain into the collection bag.~~

~~g. Secure and label the specimen container and place inside a specimen plastic bag. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.~~

D. Disposition of Urine Specimens

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

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

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

~~4.~~

~~5.~~3. ~~Refer to Clinical Lab P&P for laboratory hours and courier pick-up hours.~~

E. Documentation

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

ATTACHMENTS:

~~Attachment 1 – Urine Collection using Midstream (Clean-Voided) Technique~~
~~Attachment 2 – Urine Collection using Intermittent Catheterization~~ None

CROSS REFERENCES:

~~A1 Clinical Laboratory Policies and Procedures~~

Nursing Policy and Procedure
F 5.0 Nursing Management of Urinary Catheter

REFERENCES:

Skills (elsevierperformancemanager.com)
https://point-of-care.elsevierperformancemanager.com/skills?virtualname=sanfrangeneralhospital-casanfrancisco~~Urine Specimen: Obtaining for Laboratory Testing – Indwelling Urinary Catheter. Mennella H, Balderrama D, Pravikoff D, CINAHL Nursing Guide, April 28, 2017 – electronic access on October 25, 2018.~~

~~Urine Specimen: Obtaining for Laboratory Testing – Intermittent Urinary Catheter. Walsh, K., Schub, E, Pravikoff D, . CINAHL Nursing Guide; May 25, 2018 – electronic access on October 25, 2018.~~

~~Urine Specimen: Obtaining Midstream (Clean-Voided). Caple, C., Schub E, Pravikoff D, CINAHL Nursing Guide, April 28, 2017. – electronic access on October 25, 2018~~

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

Reviewed: 2019/03/12

Approved: 2019/03/12

AFTER HOURS STAT BLOOD DRAW ~~-~~**(Owner: DET)**

POLICY:

1. A Registered Nurse (RN) may perform venipuncture for STAT blood draw ordered by the physician.

2. The licensed nurse must notify the physician immediately if the specimen cannot be obtained.

PURPOSE:

To describe the guideline to nurses when obtaining ~~and reporting~~ after hours STAT blood draw.

PROCEDURE:

Arranging Pick-Up

1. For STAT blood draw orders, when laboratory technician is unavailable or after hours, the licensed nurse will call Nursing Operations / Nurse Manager ~~/ Nursing Supervisor~~ upon collection of specimen to arrange Lab courier transportation arrangements to pick-up specimen.

2. For STAT~~-~~ order~~, on~~ during regular working hours, inform Lab Technician to include lab specimen to the earliest lab courier pick-up time.

3. Refer to Nursing Policy & Procedure (NPP) C 9.0 Transcription and Processing of Orders.

1. Print Label from Epic assuring printer is on “Unit Collect”. The order Label will also give color of tube to be used for specific tests.

2.

~~1. Licensed Nurse completes laboratory requisitions. Verify the physician's ID number, applicable pager number, ICD codes, pertinent medical diagnosis and medications. Indicate if STAT was ordered.~~

~~4. The RN must check and verify the identification of the resident.~~

~~5. Label specimens labeled with resident’s name, room number, date and time collected~~

~~6. Place each specimen in a separate specimen plastic bag with its own lab requisition.~~

~~2.~~

3. Secure the specimen container and place inside a specimen plastic bag. Place the laboratory requisitions in the outside pocket of the specimen plastic bag. Each specimen is placed in a separate plastic bag with its own lab requisition.

4. Lab specimens are dropped off to the Clinical Laboratory Specimen ~~Refridgerator~~Refrigerator~~idgerator~~ for courier pick up. If Blood Cultures are ordered and obtained, they are to be kept at Room Temperature.~~-~~

~~3.~~

~~Licensed Nurse to initial TAR once specimen is obtained.~~

~~4. “Ward or Clinic Copy" to remain on requesting neighborhood.~~

~~5.~~

~~6.~~5. STAT blood results are viewed on the electronic health records (EHR). Critical results are usually reported by phone to the unit licensed nurse or physician.

~~7.~~6. The Nurse documents the date, time, name of physician notified of ~~the~~ STAT test~~s~~ result(s).

~~8.~~7. The charge nurse or team leader is responsible for communicating the status of all STAT orders to the oncoming shift to ensure follow up.

APPENDIX:

~~Appendix 1: Special Handling Instructions of Laboratory Specimen~~

CROSS REFERENCES:

Clinical Laboratory Policy and Procedure
- A1 Clinical Laboratory ~~Procedures~~
- A2 Phlebotomy Procedure
- A3 Identification of Resident and Collection of Blood Specimen
- A4 Blood Culture Procedure

Nursing Policy and Procedure
- J7.0 Central Venous Access Device (CVAD) Management
- J7.1 Peripherally Inserted Central Catheters (PICC) Management
- ~~J8.0 Blood Transfusion~~

Revised: 2001/03; 2009/01; 2010/10; 2015/07/14; 2019/03/12; 2024/04/18

Reviewed: 2019/03/12

Approved: 2019/03/12

INTRAVENOUS (~~I.V.~~IV) THERAPY MAINTENANCE **(Owner: Kathleen)**

POLICY:

1. The Registered Nurse (RN) is responsible for the administration, monitoring, maintenance of intravenous (~~I.V.~~IV) therapy.~~.~~

2. If the purpose of the ~~I.V.~~IV infusion is ~~is designated as~~ to maintain ~~IV line~~IV-line patency ~~of an I.V.IV line~~, the order must specify the desired infusion rate. An ~~I.V.~~IV designated only as "to keep vein open (TKO)" or "keep vein open (KVO)" should be infused at 30 mL~~cc~~ per hour ~~not~~ unless otherwise ordered. Use an ~~I.V.~~IV pump for all ~~I.V.~~IV infusions.

3. Peripheral ~~I.V.~~IV (PIV) site is to be changed or rotated every ~~ninety-six~~seventy-two (~~96~~72) hours or earlier if necessary. An RN may restart peripheral ~~I.V.~~IV site as needed without a physician's order if the ~~I.V.~~IV site is infiltrated, ~~inflamed~~inflamed, or has dislodged ~~as needed~~. All ~~I.V.~~IV bags ~~containers~~ are changed every 24 hours and PRN according to physician's orders.

4. Aseptic technique is used throughout the procedure. ~~Body substance~~Standard precautions must be observed. Gloves are worn to perform venipuncture and other vascular access procedures. Used ~~I.V.~~IV equipment will be disposed of accordingly.

~~5. An I.V.IV certified by State of California Licensed Vocational Nurse (LVN) who demonstrated competency with I.V.IV therapy may perform these following procedures under the supervision of an RN:~~

~~a. Perform venipuncture; may start, monitor, and discontinue I.V.IV – report complications to RN~~
~~b. Superimpose peripheral I.V.IV containersHang/change IV fluid containersbags~~
~~c. Change PI.V.IV tubing of intravenous peripheral intravenous lines~~

~~* LVNs **cannot** perform the following procedures:~~

~~Administer I.V.IV medications~~
~~a. Manage central line maintenance or infusions administered via central access~~
~~b. Superimpose central line I.V.IV fluid containers~~
~~c. Change central line I.V.IV tubing~~
~~d. Discontinue central line or sutured I.V.IV lines~~
~~e. Change central line I.V.IV dressings~~
~~f. Administer fluids at an unspecified rate (i.e., " bolus wide open")~~

5. Intake and output ~~is~~are monitored and documented every shift for a resident who is on ~~continuous~~ ~~I.V.~~IV therapy.

6. Extended dwell or midline PIV catheters are not inserted at LHH.

7. The maximum recommended dwell time for an extended dwell or midline PIV is <30 days. The RN is responsible for monitoring dwell time.

8. Extended dwell or midline PIVs are not central venous access devices and should only be used for the infusion of fluids or medications that are appropriate for peripheral infusion.

9. The RN will assess for continued necessity of the extended dwell or midline PIV, which should be removed when no longer necessary.

~~6.~~10. No blood pressures will be obtained on the arm with an extended dwell or midline PIV.

PURPOSE:

To provide guidelines for licensed nurses with management of ~~I.V.~~IV therapy.

RELEVANT DATA:

1. Peripheral venous catheter is usually inserted in veins of forearm or hand using a small flexible cannula. The end catheter of a peripheral ~~I.V.~~IV line does not end in a great vessel.

2. Internal Jugular (I~~.~~J), External Jugular (E~~.~~J~~.~~), Peripherally Inserted Central Catheter (PICC) lines are to be managed as central lines. Refer to NPP J 7.0 Central Venous Access Device (CVAD) Management and J 7.1 Peripherally Inserted Central Catheters (PICC) Management.~~; aseptic technique dressing changes are only done by RNs.~~

3. Extended dwell or Midline PIVs are inserted into the peripheral vascular system in the arm for short-term use. These catheters are longer (8cm-18cm) enabling the deeper veins in the arm to be safely accessed. They may be used for the administration of IV fluids, medications and blood products, and blood sampling (but may not always be possible depending on where the tip of the catheter resides).

    a. Extended dwell or midline PIVs may be indicated for patients requiring repeated replacement of PIVs, with poor or limited peripheral access, requiring larger vessel access to decrease the risk of phlebitis and infiltration, or for administration of prolonged antibiotic therapy.~~.~~
    b. Extended dwell or midline PIVs are not central venous access devices and should only be used for the infusion of fluids or medications that are appropriate for peripheral infusion.
    c. The maximum recommended dwell time for an extended dwell or midline PIV is <30 days.
    ~~a.~~d. Do not use extended dwell or midline PIVs to obtain blood cultures.

PROCEDURE:

A. ~~PIV Equipment:~~

~~**Items**~~
~~**I.V.IV administration set**~~
~~**I.V.IV secondary set (piggy back)**~~
~~**Venipuncture IV catheter, appropriate sizes (22g, 20g, 18g18-24 gauge) depends on vein size and prescribed therapy**~~
~~**Clear link luer lock intermittent injection site tubing Extension tubing**~~
~~**I.V.IV pressure hub**~~
~~**I.V.IV starter kit (contains tourniquet, tape, 2x2 gauze, alcohol pad, antiseptic applicator, transparent dressing)**~~
~~**Stabilization device (optional)**~~
~~**e and transparent dressing)**~~
~~**Catheter stabilization device**~~
~~**Pre-filled normal saline syringe 10 mL**~~
~~**I.V.IV solutions**~~
~~**I.V.IV minibag bag (NS or D5W) in 25, 50 or 100ml**~~
~~**Antiseptic pads**~~
~~**Gloves**~~
~~**Prescribed I.V.IV medications**~~

~~I.V.~~IV and medication labels
~~I.V.~~IV Flow sheet

~~B.~~ Preparation for peripheral ~~I.V.~~IV insertion

1. Check physician~~'s~~ orders prior to initiation of ~~I.V.~~IV therapy. The ~~physician's~~ order must include the type of ~~I.V.~~IV solution, rate of administration and/or duration of administration ~~and also~~and must specify medication additives (~~i.e.~~i.e., name of drug, ~~dosage~~dosage, and specific fluid amount).

~~2. Ensure that I.V.IV fluids and additives are compatible by referring to compatibility chart, Lexicomp (online formulary) or verifying with the Pharmacy.~~

~~Pharmacy:~~ **Error! Hyperlink reference not valid.**

~~online drug formulary:~~ **Error! Hyperlink reference not valid.**

3. ~~Wash hands~~Perform hand hygiene prior to palpation, inserting, replacing, or dressing any ~~I.V.~~IV. Wear clean gloves.

4. Prepare ~~I.V.~~IV fluids and medications in designated medication room; cleanse preparation site with antiseptic pads prior to each preparation.

5. Label ~~I.V.~~IV tubing and fluid bag with the date time, type of additives, and the initial of the RN preparing the admixture.

6. Select an appropriate site for insertion. PIV insertion should be avoided on a limb with an AV fistula/graft or on the limb on the same side as a mastectomy/partial mastectomy, on an arm with edema or known blood clot, on an arm affected by stroke or on the same arm with a PICC in place.

~~6.~~7. Obtain physician approval prior to insertions in the lower extremities.

~~7.~~ **Peripheral ~~I.V.~~IV insertion** (Saline-lock without extension tubing) (Refer to Skills (elsevierperformancemanager.com) for IV insertion)

~~8.~~

~~Perform hand hygiene and don gloves.~~
~~Prime extension set with needleless connector with normal saline (NS). Leave the syringe attached.~~
~~Perform hand hygiene and don gloves.~~
~~Identify an accessible vein.~~
~~Apply a flat tourniquet around the limb above the proposed insertion site.~~
~~Cleanse the insertion site with a chlorhexidine swab or alcohol pad.~~
~~Perform venipuncture. Anchor the vein below the insertion site by placing the thumb over the vein and gently stretching the skin against the direction of insertion distal to the site. Insert the catheter with the bevel up at a shallow angle.~~
~~Observe for the flashback chamber for blood return and then advance the catheter off the needle slowly into the vein.~~
~~Apply gentle pressure above the insertion site and stabilize the catheter with one hand and release the tourniquet with the other.~~
~~Remove the needle and activate the safety device. Dispose of the needle in the sharps container.~~
~~Connect the extension set to the catheter.~~

~~Confirm patency by aspirating for blood return and flushing the IV with a 10 mL pre-filled NS syringe.~~
~~Observe the site for swelling.~~
~~Remove the syringe.~~
~~Secure the catheter with a catheter stabilization device or tape.~~
~~Apply a sterile transparent dressing. Label the dressing with the date and time of application and initials~~
~~Curl a loop of tubing and secure with tape to reduce the risk of dislodging the catheter if the IV tubing is pulled.~~
~~Wash hands. DPut on gloves and perform venipuncture.~~
~~Quickly connect the intermittent infusion site into the safety I.V.IV catheter port and release tourniquet.~~
~~Secure I.V.IV needle in place with transparent dressing or tape.~~
~~Clean injection port with antiseptic pads and instill pre-filled normal saline solution. Remove gloves.~~
~~Wash hands.~~

~~Initiate the ordered infusion via infusion pump~~Set and monitor the I.V.IV flow rate on the infusion pump.

~~If peripheral I.V.~~IV ~~is an intermittent lock, flush with at least 5 mL pre-filled normal saline~~NS ~~every 8 hours, and before and after each administration of medication;~~medication, ~~unless otherwise indicated~~ordered.
~~Clamp the tubing.~~

~~Discard supplies, remove personal protective equipment (PPE) and perform hand hygiene.~~
~~9.~~8.

B~~C~~. Administering Medications

1. Refer to ~~NPP~~ HWPP ~~J 1.0~~25-15 Medication Administration.

2. Ensure that IV fluids and additives are compatible by referring to compatibility chart, Lexicomp (online formulary) or verifying with the Pharmacy.

   - ~~——~~Pharmacy: https://in-dphsp01.in.sfdph.net/lagunanet/pharmacy/SitePages/Home.aspx

   - ~~——~~O~~o~~nline drug formulary: https://online.lexi.com/lco/action/home

~~For I.V.~~IV ~~fluids and additives are compatible by referring to compatibility chart, , Lexicomp (online formulary) or verifying with the Pharmacy~~

2. Extended dwell or midline PIVs are not central venous access devices and should only be used for the infusion of fluids or medications that are appropriate for peripheral infusion.

D~~C~~. Maintenance of ~~I.V.~~IV Site

1. ~~1.~~ ~~——~~Peripheral ~~I.V.~~IV site may be in place up to 967~~2~~96 hours. If the ~~I.V.~~IV line is not changed in 967~~2~~96 hours, notify MD and document reason (~~i.e.~~i.e., poor vein access, resident refused ~~I.V.~~IV site change), and notify the physician. If venous access is limited, request physician order to extend use of the current site.

2. The maximum recommended dwell time for an extended dwell or midline PIV is <30 days.

3. All catheters used as intermittent devices are flushed:

   a. Pre and post each administration of medication
   b. After the administration of blood products
   c. When converting a continuous infusion to an intermittent device
   ~~a.~~d. Every 8 hours when catheter is not in use (locked)

~~2. I.V.~~IV ~~primary and secondary tubing is changed every 72~~96 ~~hours (unless there is contamination or drug incompatibility, may change as needed).~~

~~3. I.V.~~IV ~~solution is changed every 24 hours.~~

~~4. I.V.~~IV ~~transparent dressing is changed with each site change and as needed.~~

~~5. For resident with fragile skin, consider use of the skin barrier prep prior to applying transparent dressing. May apply elastic net dressing to secure I.V.~~IV ~~site when needed.~~

~~6.~~4. Evaluation of ~~Peripheral I.V.~~IV Site

~~a. Inspect and gently palpate the area around the infusion site each shift and as needed.~~
a. ~~Assess for inflammation, blanching, discharge, hardness, swelling, pain, or temperature change (warmer or cooler).~~ If complications are evident, ~~change the infusion site~~notify the physician, and if a PIV, change the site. Refer to Visual Infusion Phlebitis Scale (VIPS) under Section F Discontinuing IV site.~~.~~

SUMMARY OF IV CHANGES ***New tubing is required for new PIV site**		
TUBING TYPE	**DEFINED AS**	**WHEN CHANGED**
IV bag		Q24 hours
Maintenance tubing	Continuous infusion, not disconnected	~~Q3 day~~72 hours and with every site change
Primary IV administration set	Connected intermittently to infuse medications (e.g., antibiotics & electrolytes)	Daily and with every site change
Secondary tubing (attached to maintenance tubing)	If connected to primary tubing that is not disconnected from patient	Q~~3 days~~ 72 hours and with every site change
Secondary tubing (attached to intermittently attached tubing or using multiple secondary tubing)	If disconnected from primary tubing or if primary tubing is only attached intermittently	~~Daily~~Q24 hours and if site is changed
Continuous medication drips	If not disconnected	Q72 ~~3 day~~hours and if site is changed
TPN tubing		Daily – along with positive pressure valve (PPV) change when new bag is hung
Blood and blood products		Change with every unit

~~E~~D. Extended dwell or midline PIV maintenance and dressing change: (
Refer to Skills (elsevierperformancemanager.com) for dressing change)
~~Use 10 ml 0.9% Normal Saline (NS) syringes for flushing.~~
~~The positive pressure valve (PPV) should be changeds with each dressing change, every time the administration tubing is changed and after every blood draw.~~
~~Dressing changes~~
~~Dressing changes are every 7 days and PRN (such as, if moist or not intact)~~
~~Supplies:~~

- ~~Central line dressing kit~~
- ~~Peripheral line insertion kit~~
- ~~Alcohol swabs~~
- ~~New PPV~~
- ~~Pre-filled 10 mL 0.9% NS syringes~~
- ~~PIV or PICC stabilization device (such as Statlock) depending on type of catheter~~
- ~~Face masks for nurse and patient (if wants to talk in the direction of the line)~~
- ~~Perform hand hygiene and don clean gloves~~
- ~~Prepare sterile supplies and opening packages making sure not to contaminate contents.~~
- ~~DonPlace face mask on face and put sterile gloves to the side for access later.~~
- ~~With clean gloves, remove old dressing and securement device, being careful to prevent catheter dislodgement.~~
- ~~Prior to donning sterile gloves, another RN may be asked to help hold the device in place (after performing hand hygiene and donning clean gloves) for a few minutes while donning sterile gloves and preparing supplies.~~
- ~~With sterile gloves, crack the CHP stick and allow the liquid to soak the sponge.~~
- ~~From this point, the non-dominant hand will no longer be sterile, but will be used to support the catheter and prevent dislogementdislodgement.~~
- ~~Using sterile dominant hand, cleanse the site and surrounding area with the CHG swab for 30 seconds and allow to air dry completely (approximately 2 minutes).~~
- ~~Use the skin prep in the central line dressing kit to prep around the outer edges of the dressing, surrounding area, and where the securement device will adhere to the skin. Do not put any skin prep near the insertion site. Allow the skin prep to dry completely.~~
- ~~Apply PIV/PICC securement device to secure the line.~~
- ~~Apply the CHG impregnated sponge (blue side up) to the insertion site.~~
- ~~Apply clear occlusive dressing to the site, covering the securement device and insertion site in the center of the dressing.~~
- ~~Use tape to anchor the extension tubing to prevent pulling and accident dislodgement.~~
- ~~Initial and date the dressing.~~
- ~~Change the PPV by:~~
- ~~Prime the new valve with 10 mL NS syringe. Leave in tip protector until applied to the extension set.~~
- ~~Prepare alcohol swab and remove the old valve after clamping the extension tubing to prevent leakage of air embolus.~~
- ~~Scrub the extension set end for 15 seconds.~~
- ~~Apply new valve securely and flush in the 10 mL of the attached syringe use to prime the valve.~~
- ~~Remove and discard syringe.~~

~~Blood sampling~~

~~Blood sampling from an extended dwell catheter may or may not be possible depending on where the tip of the catheter resides and how long the catheter has been in.~~

~~Do not attach vacutainers directly to the extended dwell or midline PIV. Use the syringe method of drawing blood.~~

~~If the tip of the catheter is in an adequately sized vein, perform blood sampling by:~~

~~Perform patient identification using 2 patient identifiers.~~

~~Gather supplies:~~

~~Tourniquet~~

~~Clean gloves~~

~~Lab vials for the tests ordered – do not draw blood cultures~~

~~Sterile syringes (with enough volume to fill vacutainer specimen containers~~

~~Alcohol swabs~~

~~Female Luer lock adapter to deliver syringe blood samples to the vacutainers~~

~~New PPV~~

~~10 mL NS flushes x3~~

~~Labels and lab requisitions~~

~~Assist the patient into a comfortable position with arm abducted to the side~~
~~Prepare supplies at bedside on a clean surface~~
~~Perform hand hygiene and don gloves~~
~~Turn off any infusions running to the catheter~~
~~Partially open sterile packaging so that the tips are still sterile but easy to access~~
~~Scrub the end of the catheter hub/PPV for 15 seconds with alcohol~~
~~Attach and flush the catheter with a 10 mL NS syringe using the push-pause technique and leave the empty syringe attached~~
~~Wait approximately 30 seconds. The arm may be briefly raised to encourage venous drainage and then returned to the normal position.~~
~~Apply tourniquet high in the axilla to ensure that the tourniquet is above the tip of the catheter within the vein.~~
~~Gently and slowly withdraw 2 mL of (waste) blood into the syringe.~~
~~Holding the catheter end to prevent contamination, remove the waste syringe and lay carefully to the side on a protected surface.~~
~~Attach the first sterile 10 mL syringe and fill to desired level for sampling.~~
~~Remove syringe (fill another syringe if more volume is required) and attach to the needle safe female Luer lock adaptor to use to fill the vacutainers.~~
~~Scrub the end cap on the extension set for 15 seconds with alcohol swab~~
~~Attach and flush the catheter with a 10 mL NS syringe using the push-pause technique.~~
~~Change the PPV by:~~
~~Prime the new valve with 10 mL NS syringe. Leave in tip protector until applied to the extension set.~~
~~Prepare alcohol swab and remove the old valve after clamping the extension tubing to prevent leakage of air embolus.~~
~~Scrub the extension set end for 15 seconds.~~
~~Apply new valve securely and flush in the 10 mL of the attached syringe use to prime the valve.~~
~~Remove and discard syringe.~~
~~Dispose of all sharps in the appropriate sharps container and clean up environment by disposing of any waste in the appropriate receptable.~~

E~~F~~F~~E~~. Discontinuing ~~Peripheral I.V.~~IV site: (Refer to Skills (elsevierperformancemanager.com) for discontinuing IV site)

~~1.~~
- ~~After~~
~~1. After hand washing hygiene and applying donning clean gloves, gently remove any tape or dressing and stabilization device. Place a folded gauze over the site and afterWwithdraw the catheter using a slow, steady motion.~~
~~a. For a PIV, Aapply pressure with a sterile 2 x 2 sterile dressing for 1-2 minutes or longer to prevent hematoma formation at the I.V.IV site.~~
~~b.~~
~~c. 2. Place dry dressing or Band-aid over the insertion site.~~
~~For extended dwell or midline PIV, place tape over the gauze to create a pressure dressing and hold pressure for approximately 30 seconds or until bleeding stops. Leave gauze in place until exit site is granulated.~~
~~For extended dwell or midline PIV, assess that the catheter tip is intact. If the catheter tip is not intact, notify the physician immediately.~~
- ~~Dispose of any IV related products with visible blood in the sharps container. Dispose of larger items without sharps in the red biohazard waste bin.~~

- ~~Dispose of~~ 3. ~~A~~any I.V.IV ~~related products with visible blood are dispose in the sharps container. Dispose of lLarger items without sharpss can be disposed of in the red biohazard waste bin.~~

- When phlebitis is noted, use the Visual Infusion Phlebitis Scale (VIPS) to determine ~~seveirty~~severity and notify the physician. Perform nursing interventions listed below to treat the phlebitis. Reassess site routinely for changes during and after nursing interventions.

VISUAL INFUSION PHLEBITIS SCALE (VIPS)		
For any signs and symptoms of phlebitis and infiltration/extravasation: • Stop infusion immediately and disconnect from PIV • Attempt aspiration of the residual drug from the IV device prior to removal		
SITE OBSERVATION	**SCORE**	**STAGE/ACTION**
IV site appears healthy	0	**No sign of phlebitis**
ONE of the following signs are evident: • Slight pain near IV site • OR • Slight redness near IV site	1	**Possible first signs of phlebitis** **Action:** continue to use PIV and routinely assess
Both of the following are evident or one is significant: • Pain at IV site • Redness	2	**Mild phlebitis** **Action:** Remove and if necessary, replace PIV
ALL of the following are evident: • Pain along path of cannula • Redness around site • Swelling	3	**Moderate phlebitis** **Action:** Remove and if necessary, replace PIV **Consider treatment**: See interventions below
ALL of the following are evident and extensive: • Pain along path of cannula • Redness around site • Swelling • Palpable venous cord	4	**Advanced phlebitis OR early thrombophlebitis** **Action:** Remove and if necessary, replace PIV **Initiate treatment:** See interventions below
ALL of the following are evident and extensive: • Pain along path of cannula • Redness around site • Swelling • Palpable venous cord • Pyrexia (fever)	5	**Advanced thrombophlebitis** **Action:** Remove and if necessary, replace PIV **Initiate treatment:** See interventions below
Administer the following nursing interventions and document the response: • Elevate the extremity for 24-48 hours to aid in reabsorption • Thermal application: ○ Warm compress: aids in vasodilation, enhancing dispersion of the vesicant agent and decreasing drug accumulation in the local tissue; used for non-DNA binding vesicants such as vancomycin, nafcillin, and penicillin ○ Cold compress: aids in vasoconstriction, limiting drug dispersion in the extended tissue; used for contrast media, hyperosmolar ~~fluids~~fluids, and most DNA-binding		

vesicants. Consult pharmacy for treatment recommendations for chemotherapy extravasation.

- Thermal applications should be applied for 15-20 minutes every 4 hours for 24-48 hours until symptoms resolve
- Notify provider

~~GF. Reporting and/or Documentation~~
~~GF~~. Reporting and/or Documentation

1. Electronic Health Record (EHR):

a. PIV Insertion procedure:
   i. Document the Peripheral IV properties under Lines, Drains and Airways (LDA)
   ii. Document the Peripheral IV assessment under LDA
   iii. Document the resident's tolerance of the procedure and any difficulty or complications encountered, interventions implemented and physician notification.

b. Extended dwell or midline insertion:
   i. Continue the Midline/Extended Dwell Peripheral IV properties
   ii. If receiving the patient without the insertion documented in LDA, initiate the Midline/Extended Dwell Peripheral IV properties with information received in report and/or transfer documents

~~PIV and extended dwell or midline PIV Peripheral IV properties: placement date and time, placed by external staff, hand hygiene completed, IV change due, size (gauge), orientation, location, inserted by (if not inserted by documenter), patient tolerance~~

~~Midline/Extended Dwell Peripheral IV:~~

~~If catheter was inserted at a DPH facility, continue the LDA~~

~~Placement date and time, placed by external staff, hand hygiene completed, IV change due, size, catheter length (inches), orientation, location, and vein depth (CM)~~

c. Removal procedure:
   i. Document the removal in the Peripheral IV properties under LDA, including the removal date, time, VIPS and reason.
   ii. Document any difficulty or complications encountered, interventions implemented and physician notification.

~~PIV and extended dwell or midline PIV Peripheral IV and Midline/Extended Dwell Peripheral IV properties: removal date and time, removal reason, catheter tip intact, visual infusion phlebitis scale, phlebitis intervention~~

d. Site assessments every shift:
   i. Document the Peripheral IV assessment under LDA
   ii. Document the resident's tolerance of the procedure and any difficulty or complications encountered, interventions implemented and physician notification.

~~Peripheral IV assessment: date and time taken, reason for line, site assessment/surrounding skin, visual infusion phlebitis scale, dressing time, line status, line care, dressing status, dressing intervention, reason not rotated, # of 10 mL NS Flushes used, IVF tubing~~

~~Midline/Extended Dwell Peripheral IV: date and time taken, site assessment/surrounding skin, dressing type, line status, dressing status,~~

~~dressing intervention, dressing change due, reason not rotated, # of 10 mL flushes used IVF tubing~~

e. Intake and Output every shift, including all IV fluids, medications and flushes

~~Medication, fluids, and flushes~~

~~a. Document procedure, date, time, new bags for continuous I.V.IV fluids; volume hung, type of solution, flow rate, type of line, site location and needle gauge and signature.~~

~~b. Document I.V.IV site assessments, dressing or tubing changes, amount infused and amount left in bottle~~

~~c. Document~~

~~i. Unusual findings on I.V.IV site~~

~~ii. Difficulties encountered and how the resident tolerated the treatment~~

~~d. Record intake and output every shift~~

~~e. Document dosage and time of I.V.IV piggyback or I.V.IV push medications administered~~

~~f. Saline flush maintenance instillations documented every shift, unless resident receives an intravenous medication at least every eight hours~~

~~Complications immediately reported to physician~~

~~g. Report type and amount of remaining solution, rate of flow and any special considerations to relief nurse.~~

REFERENCE:

CDC Guidelines for Prevention of ~~Intravenous Therapy~~Intravascular Catheter-Related Infections

Mosby's Clinical Skills:
https://epm601.elsevierperformancemanager.com/Personalization/Home?virtualname=sanfrangeneralhospital-casanfrancisco

- Midline Catheter: Removal
- Midline Catheter: Maintenance and Dressing Change
- Intravenous Therapy: Short Peripheral Catheter Insertion
- Intravenous Therapy: Maintenance and Dressing Change
- Intravenous Therapy: Discontinuation

Perry, A.G. and others (Eds.). (2022). *Clinical nursing skills & techniques* (10th ed.). St. Louis: Elsevier. Clinical Review: Martha Beck, MA, BSB, RN, CNOR, June 2021

CROSS REFERENCE:

Hospital-wide Policy and Procedure
25-05 Hazardous Drugs Management
25-15 Medication Administration

Nursing Policy and Procedure
~~J 1.0 Administration of Medications~~
J 7.0 Central Venous Access Device (CVAD) Management
J 7.1 Peripherally Inserted Central Catheters (PICC) Management

Revised: 2000/08, 2010/06; 2015/03/10; 2019/03/12; 2024/05/01

Reviewed: 2019/03/12

Approved: 2019/03/12

Deleted Nursing Policies and Procedures

LIMB CARE FOLLOWING AMPUTATION **(Owner: Kathleen)**

POLICY:

1. The Licensed Nurse (LN), Certified Nursing Assistant (CNA), or Patient Care assistant (PCA) may perform and/or assist residents with limb care.

2. Registered nurses are responsible for assessments of residents with recent amputations.

3. The LN is responsible for resident education when indicated.

PURPOSE:

To prevent complications after an extremity amputation and to optimize prosthetic fit in the residual limb when indicated.

PROCEDURE:

A. Care of the Residual Limb following a recent amputation

1. Lower Extremity Amputations

   a. Positioning
      i. For transtibial (BKA: below the knee) amputations, when seated, have resident/patient avoid dangling or hanging limb. If ordered, use an "amputee board" or "stump protector" to position the residual limb in extension at the knee. These devices are not necessary for amputations at or proximal to the knee.
      ii. Encourage the resident/patient to move the residual limb to prevent stiffness, spasms, contractures, skin breakdown, and thromboembolism.
      iii. If resident/patient is unable to reposition self, turn and reposition the resident/patient regularly to prevent spasms.
      iv. Turn the resident/patient to a prone position to help prevent contractures in lower extremity amputations per physicians order and as tolerated.
      v. For transtibial amputations, keep the knee straight.
      vi. If a residual limb present, keep the limb flat and extended.

   b. Residual limb shrinker sock use
      i. Don the shrinker sock (see Appendix A).
      ii. The patient is to wear the shrinker sock at all times except for twice daily skin checks and bathing.
      iii. Keep the shrinker sock clean.
      Wash the shrinker sock by hand and let air dry
      iv. Ensure that each patient has 2 socks (one to wear and one to wash)

2. Upper Extremity Amputations

   a. Muscle stretching and strengthening
      i. Follow exercises as ordered or recommended by a rehabilitation specialist.
      ii. Educate and encourage the resident/patient to perform these exercises independently if appropriate.

b. Touch and Desensitization
   i. Follow the physician's orders and rehabilitation therapists' recommendations regarding gentle massage, tapping and rubbing to the residual limb in preparing the limb for prosthesis.

c. Residual limb shaping
   i. To manage swelling and prepare the residual for prosthetic fit, a residual limb stocking ("stump" shrinker or compression stocking) may be obtained from orthotics clinic.
   ii. The stocking is washed regularly and when soiled with soap and water and must be thoroughly dried before being applied to the limb.
   iii. Stockings should be used daily unless otherwise specified.
   iv. If a wound is present, skin should be checked q shift.

3. DO NOT elevate or prop up knee or hip after 48 hours post-op.

B. Daily care of the residual limb

1. Examine the limb daily after the prosthesis is removed for redness, swelling and impaired skin integrity.

2. Assist the resident/patient with washing the residual limb with warm water and mild soap.

3. Rinse and dry thoroughly.

4. While limb is in the process of shrinking for prosthesis fit, do not apply moisturizers and do not shave the limb.

5. Unless otherwise ordered, stump shrinker stockings should be worn daily for comfort and skin protection.

C. Care of Prosthesis

1. Clean the interior socket daily with mild soap and water using a soft cloth. Leave to dry overnight.

D. Reporting and/or Documentation:

1. In the electronic health record (EHR), the licensed nurse will document any redness, abrasions, blisters, boils or edema.
2. LN will document assessment in the EHR and report any changes to physician.

ATTACHMENTS/APPENDICES

Attachment I: Donning the Shrinker Sock

REFERENCES:

Jacelon, C.S., (2011). *The specialty practice of rehabilitation nursing: a core curriculum*, (6th ed), Chicago, IL: Rehabilitation Nursing Foundation of the Association of Rehabilitation Nurses

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

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

CROSS REFERENCES

Nursing Policies & Procedures
D 1.0 Restorative Nursing Program

Revised: 2000/08, 2010/02, 2011/04/25, 2014/04, 2016/07/12, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

ELASTIC OR ANTI-EMBOLIC STOCKINGS **(Owner: DET)**

POLICY:

1. A physician's order is required for elastic compression or anti-embolic stockings.

2. Any nursing staff member may measure and/or apply these stockings.

3. A licensed nurse is responsible for assessing pedal pulses and for evaluating for potential complications.

PURPOSE:

To correctly apply and remove elastic stockings, to promote optimal therapeutic effect and to avoid potential complications.

PROCEDURE:

A. Equipment

Tape measure (follow manufacturer's measuring & sizing instructions)
Order 2 pairs anti-embolism stockings, size and type as prescribed by MD

B. Assessment by Licensed Nurse

1. Licensed nurse will assess for the presence or absence, and quality of pedal pulses and document the findings in the integrated progress note before initial application of elastic stockings. Re-measure or resize stockings for worsening edema or weight loss.

2. Inspect the toes regularly during the time elastic stockings are worn.

3. Note skin irritation, temperature, sensation, swelling, circulation, and change.

4. If complications occur, i.e., skin lesions, remove the stocking and notify the physician.

5. Remove stockings daily and wash when necessary.

6. Educate resident who are alert & verbal to report any complications.

C. Documentation

1. Care Plan
   a. Document type, size and length of stockings.
   b. Date and time stockings are applied.

Revised: 2006/09; 2014/03/25, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

WATER PITCHERS **(Owner: DET)**

POLICY:

1. Water pitchers with liners are provided to all residents unless contraindicated.

2. Water pitchers are to be labeled with the resident's initials and date changed.

3. Water pitchers and water pitcher liners are changed weekly and as needed.

PURPOSE:

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

PROCEDURE:

1. Equipment:

   Water pitcher with lid
   Water pitcher liner
   Straws
   Disposable drinking cups

2. Wash hands before beginning to replace new liners and pitchers.

3. Replenish water pitcher every shift and as often as necessary. Consider resident's preference when refilling water.

4. Change disposable drinking cups or straws as needed.

5. Discard and replace broken water pitchers and liners.

Revised: 2001/03; 2006/03; 2006/09; 2009/09; 2014/09/14; 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

APPLICATION AND MANAGEMENT OF CONDOM CATHETER (Owner: Kathleen)

POLICY:

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

2. 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.

PURPOSE:

To keep the skin dry and prevent skin breakdown in males who have urinary incontinence.

BACKGROUND:

Evidence suggests a benefit of using external catheters over indwelling urethral catheters in male patients who require a urinary collection device, but do not have an indication for an indwelling catheter such as urinary retention or bladder outlet obstruction (HIPAC, 2009).

PROCEDURE:

A. Equipment

- External condom catheter package
- Connecting tube and extension tubing, if needed
- Bedside drainage bag or leg bag
- Catheter securing device (avoid tape)

B. Consult with manufacturer's instructions for information about condom catheter sizing and application.

C. Application of External Condom Catheter

1. Perform hand hygiene.

2. Place the absorbent pad or bath towel under the resident.

3. Wash the penis rinse, and dry the penis carefully. Inspect the penis to make sure it does not have any broken or reddened skin.

4. You may want to clip the hair or shave the area near the base of the penis.

5. Hold the penis at a 90 degree angle from the body. Gently roll the condom over the penis. Leave 1 to 2 inches of the condom catheter at the end of the penis.

6. Wrap the sheath holder around the condom at the base of the penis. Do not wrap the sheath holder too tightly because this may stop blood from going to the penis.

7. Attach the condom catheter to the appropriate drainage bag.

D. Management of the Condom Catheter

1. Keep the drainage bag below the level of the bladder to prevent backflow of urine.

2. Change the condom catheter once per day and PRN.

E. Documentation

1. Electronic Health Record (EHR): Record date and time of catheter application and removal; note any changes in skin condition such as redness, skin breakdown, or pain.

2. Document presence of condom catheter in the resident's care plan

3. Progress Notes: Note alterations in skin condition, problems with condom management, or any symptoms of UTI.

REFERENCES:

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

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

HIPAC (2009). Guideline for prevention of catheter associated urinary tract infections.

CROSS REFERENCES:

Nursing Policy and Procedure
F 1.0 Assistance with Elimination
F 2.0 Assessment and Management of Urinary Incontinence
F 5.0 Management of Urinary Catheters

Revisions: 2006/07; 2013/09/24; 2014/07/22; 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

Protocol for the Prevention, Assessment and Management of Dehydration (Owner: DET)

A. Definition:

- An abnormal depletion of body fluids, due to inadequate water intake to meet a body's metabolic requirements (adapted from Merriam Webster Medical Dictionary, https://medlineplus.gov/mplusdictionary.html)
- According to the CDC, there is no recommendation for the amount of water adults should drink daily.
- **Note:** when a person is at the end of life and in the process of dying, decreased fluid and food intake is expected and aggressive intervention is contraindicated, food and fluids are offered for pleasure and as desired.

B. Risk Factors for Dehydration

- Heat wave conditions
- Air conditioning malfunction
- Medications/Supplements: diuretics, anti-hypertensive agents, antihistamines, chemotherapy agents, osmotic laxatives, protein-dense nutritional supplements/formula
- Medical problems: uncontrolled DM, fever/infection, GI infections, other causes of diarrhea, vomiting, salt wasting syndrome, hyponatremia.
- Age related changes: decreased thirst sensation, inability to independently drink fluids, intentional decrease in fluids due to toileting concerns.
- Inadequate intake
- Dysphagia
- Others: alcohol intoxication

C. Interventions to Prevent, Assess or Manage Dehydration :

Prevention

- Resident-specific fluid needs are determined by the Dietitian and documented on the Nutrition Screening and Assessment form, along with the amount of fluids served with meals daily.
- Nursing staff as clinically indicated, and as ordered by physician will:
  - offer fluids between meals and at bedtime, smaller amounts provided frequently may be preferred
  - encourage full glass/cup of fluid with oral medication administration
  - administer free water flushes, per MD order, for residents receiving enteral nutrition
  - assisting the resident to drink
  - offer foods with high water content (fruits, vegetables, soups, cream cereals, Jell-O, ice cream, popsicles).
  - keep (preferred) fluids within easy reach.
  - monitor fluid intake on trays and between meals
  - implement bladder training/toileting plan for residents restricting their fluid intake to minimize urinary urgency/incontinence

Assessment

- Monitor for early warning signs of inadequate fluid intake: change of condition, increased confusion, decreased appetite, tiredness, complaints of thirst or requests for water/ice chips, weight loss, drinking less than ~ 800 cc per day, urinating less than the usual amount.
- Recognize late signs impending dehydration: dry mouth or cracked lips, concentrated or scanty urine, elevated serum sodium, hemoconcentration and other abnormal laboratory findings.
- Monitor intake and/or output and weight as nursing orders.

Management

- Report findings to physician for orders to correct dehydration
- Anticipate need to establish IV access for IV fluids and/or oral rehydration
- Initiate safety measures given increased fall and confusion risks
- Initiate/update care plan for dehydration risk/management
    - The care plan goals state - fluid intake recommended by the RD, and urinary output maintained at resident's baseline.
    - Resident's fluid intake and output is recorded each shift by the nursing assistant.
    - Fluid balance will be analyzed by LN until no longer at risk for dehydration, or plan of care has changed.
    - Consult with RD for additional fluid replacement on meal tray and provide alternative oral replacement as per MDS.
    - Discuss with MD need for additional hydration, i.e., IV fluids or, if appropriate, enteral tube free water supplementation.
    - Measure weight weekly until condition has improved or plan of care has been reviewed / revised.
    - Consider underlying causes of dehydration and need for nursing or possible medical intervention, e.g. uncontrolled BG, hot weather, nausea / vomiting.

Reference:

CDC. Get the Facts: Drinking Water and Intake (accessed 12/27/17; https://www.cdc.gov/nutrition/data-statistics/plain-water-the-healthier-choice.html)

National Institute on Aging. Getting Enough Fluids. (accessed 12/27/17; https://www.nia.nih.gov/health/getting enough fluids)

Cross Reference:

LHHPP File: 24-17 Heat Wave

Origination: 2008/03

Revised: 2013/01/29; 2018/03/06

Reviewed: 2018/03/06

Approved: 2018/03/06

~~MEDI-THERM II HYPER/HYPOTHERMIA MACHINE® (Owner: DET)~~

~~POLICY:~~

1. ~~The Medi-Therm II Hyper/Hypothermia Machine® is provided to a resident based upon a clinical assessment of a resident whose core temperature is above or below his/her normal temperature. It is not indicated solely for comfort.~~

2. ~~The manual mode of operation, including the prescribed blanket, use of a patient/resident rectal probe to monitor resident's temperature, and duration of use require a physician's order.~~

3. ~~Resident's temperature, condition of the skin in contact with the blanket, and the blanket water display are checked every 20 minutes, and as clinically indicated, and discontinued once the core temperature is normal.~~

4. ~~Residents who have impaired skin sensation or are unable to report skin sensory perception, or refuse a rectal probe temperature check, are contraindicated.~~

5. ~~After adjusting the room temperature and exploring other options (i.e., providing additional clothing/blankets, warm liquids, relocation, etc.), use of the Medi-Therm II Hyper/Hypothermia Machine may be needed to help regulate the patient/resident's temperature.~~

6. ~~Resident and/or responsible parties will be educated on the risks of the Medi-Therm II Hyper/Hypothermia Machine®.~~

~~PURPOSE:~~

~~To safely provide hyper/hypothermia therapy to a patient/resident.~~

~~DEFINITIONS:~~

~~The Medi-Therm II Hyper/Hypothermia Machine is a device that may be used to help regulate a patient/resident's temperature via temperature-controlled water that flows through a hyper/hypothermia blanket.~~

~~This treatment is generally considered aggressive therapy for pathophysiologic hyper/hypothermic dysregulation.~~

~~PROCEDURE:~~

~~A. Equipment:~~

~~Refer to the user's manual and instructions on the machine for complete details of the following procedures:~~

- ~~Medi-Therm II Hyper/Hypothermia Machine® Distilled Water~~
- ~~Hypo/hyperthermia blanket~~
- ~~Patient/resident Rectal Probe~~

B. Start-Up Procedure

1. Filling the Water Supply
   a. Raise the water fill opening and fill with distilled water ONLY until the green band on the float is visible. Do NOT use alcohol, operate without water, or overfill machine
   b. Recheck water level indicator 5 minutes after starting and before attaching a second blanket and refill if needed.

2. Attaching/Replacing Blanket
   a. Close the pinch clamps on the connector hose and blanket and attach the connector hose to the Medi-Therm II® machine and the blanket. Verify that the attachments are secure by snapping the locking ring into place.
   b. Open the pinch clamps, check/re-check the water level, and plug machine to a power receptacle. Check that the water blankets are not leaking to prevent electrocution and to decrease the risk for infection.

3. Press the *ON/OFF* switch to *ON* position and perform the indicator light test by pressing and holding the *TEST LIGHTS* button and verifying that all lights function properly and alarm sounds. Do NOT use if lights or alarms are not functioning.

4. Place the patient/resident probe if ordered and wait five minutes before choosing the Mode of Operation.

5. Discontinue treatment IMMEDIATEY when resident is normothermic, there is evidence of skin impairment, or hypo/hypertensive and notify the physician.

C. Resident/Patient Rectal Probe

1. Insert and secure the sensing end of the rectal probe into the patient/resident.

2. Insert the plug end of the patient/resident probe into the PATIENT PROBE jack.

3. The patient/resident's temperature will show on the PATIENT temperature display.

4. If the patient/resident probe senses an abnormal patient/resident temperature (below 32^0C/89.6^0F or above 45^0C/113^0F), therapy will stop and CHECK PATIENT Probe alert will light and sound. Verify the placement of the probe, perform PROBE CHECK (see manual), and replace probe or machine if needed.

D. Manual Mode (machine heats/cools blanket water temperature to the selected SET POINT temperature)

1. Press the MANUAL mode button.

2. The BLANKET display will show the current blanket temperature

3. The SET POINT display will initially show the default temperature of 32^0C/89.6^0F. Change the temperature scale to Celsius or Fahrenheit by pressing the C^0/F^0 button

4. Refer to the physician's orders and adjust the SET POINT display to the prescribed blanket temperature by pressing the up or down arrows.

5. The STATUS display will show HEAT or COOL as the machine heats or cools the blanket water. When the blanket temperature stabilizes to the SET POINT temperature, the IN-TEMP indicator will light indicating the desired blanket water temperature is being maintained.

6. Do NOT place additional heat sources between the resident and the blanket. Keep the resident's skin dry.

E. Documentation

1. On the Treatment Administration Record, the licensed nurse will monitor:
   i. Start and End of treatment
   ii. Vital signs at start of treatment
   iii. Vital signs every 20 minutes x 1 hour, then hourly
   iv. Rectal temperature and skin checks every 20 minutes
   v. Blanket SET POINT temperature

2. Integrated Progress Notes (done every shift while on therapy)
   i. Resident response to treatment
   ii. Adverse effects

REFERENCES:

Elkin, Perry & Potter, Nursing Interventions & Clinical Skills, 4th edition, 2007

Medi-Therm™ Hyper/Hypothermia Machine MTA 5900 Series. 1st ed. Orchard Park: Gaymar, 1998. Web. 5 Jan. 2017.

Adopted 2016/11/08

Reviewed 2016/11/08

Approved 2016/11/08

PROTOCOL FOR PERSONAL LAUNDRY AND USE OF WASHER AND DRYER MACHINE (Owner: Maria Antoc)

1. Nursing staff will be able to operate neighborhood laundry equipment to assure resident's laundry is clean, and fire safety and equipment functioning is maintained.

2. Nursing staff will report any damage, malfunctioning of laundry equipment to Facility Services for repair.

3. Before placing laundry in washer, check pockets to remove any items and return toresident.

4. Follow for manufacturer's operating instructions for both the Washer and Dryers in the Neighborhood Laundries.

   a. Avoid overloading washer and dryer machine with clothes.
   b. **Use a single powdered detergent packet for each washing load** or as recommended.
   c. **Remove the lint from the lint trap before starting the dryer**.

APPENDIX:

Quick Reference for Operating the Washing Machine and Dryer

REFERENCES:

ASKO W6022 Manual of Operating Instructions: Washing Machine MAWA300 1/36
ASKO T702C Manual of Operating Instructions: Tumble dryer, DRVE 300 1/32

CROSS REFERENCES:

NPP D1 2.0 Resident Activities of Daily Living (Basic Care)
NPP D5 4.0 Arm Slings
NPP D4 6.0 Elastic or Anti-Embolic Stockings
NPP D6 1.1 Battery Operated Lift Transfer
LHHPP 24-19 The C-625 Battery Operated Ceiling Lift
LHHPP 72-01 Infection Control Manual F3: Handling Resident's Personal Clothing

New: 10/2010

Revised: 05/27/2014

Reviewed: 05/27/2014

Approved: 05/27/2014

~~APPENDIX 1: Quick Reference~~

~~Operating Washing Machine and Dryer~~

~~A. For Operating the Washing Machine~~

1. ~~Read the item's laundry label. Sort and launder by color.~~
2. ~~Loading the laundry: Press the main power switch. If the door is closed, press the Door Opening Button (key symbol). The red field lights up and the door opens after a few seconds. Load the laundry and close the door.~~
3. ~~Detergent compartment: Use the detergent compartment to put the powdered detergent packet.~~
4. ~~Selecting the washing cycle program: Select the program by turning the program selector. And choose the appropriate cycle and water temperature. Then press the Start/Stop button.~~
5. ~~Program finished: Once the washing cycle is finished, the washer door automatically opens. Remove the laundry. Turn off the main power switch.~~

~~B. For Operating the Dryer~~

1. ~~Fabrics: Dry fabrics of the same type together to ensure they dry as evenly as possible.~~
2. ~~Choose items for dryer that do not have large metal hooks, etc. to prevent damage to dryer.~~
3. ~~Turn on the main power switch.~~
4. ~~Load the laundry, close the door.~~
5. ~~Selecting a program and options: Turn the program selector to the desired program. Select any options desired.~~
6. ~~Press the Start/Stop button.~~
7. ~~Drying program finished.~~ ~~**Clean the lint filter after each load.**~~
8. ~~Once tumble drying has finished, turn off the main power switch and close the door.~~

~~TRANSPORT GURNEY PROTOCOL (Owner: DET)~~

~~1. As part of orientation, the competency of all bedside nursing staff to use transport gurney are validated; and annually thereafter as part of their performance appraisal.~~

~~2. Select appropriate gurney based on resident weight:~~
~~a. 250 pounds or less~~
~~b. more than 250 pounds but less than 750 pounds.~~

~~3. Follow the manufacturer's instructions for operating the transport gurney.~~

~~4. The gurney must be cleaned after every use with the facility approved disinfectant and covered with sheet when stored.~~

~~5. All nursing staff shall inform the licensed nurse if the stretcher is broken or not functioning. Licensed Nurse will call or submit work order to Plant Services for any repair or services as needed.~~

~~**REFERENCE:**~~

~~Pedigo Stretcher Manual~~

~~**APPENDIX:**~~

~~Appendix 1 - Quick Reference for Operating Transport Gurney~~

~~New Document: 2010/10/19~~

~~Revised: 2014/05/27, 2016/09/13~~

~~Reviewed: 2016/09/13~~

~~Approved: 2016/09/13~~

APPENDIX 1 – QUICK REFERENCE

Operating Transport Gurney

1. Transporting a resident using the gurney

    a. When transporting a resident with the gurney, keep the bed in a horizontal position (if not contraindicated) and in the lowest position with the side rails locked in the upright position for safety.
    b. Resident must be properly clothed or covered when transporting the resident for privacy and dignity issues.
    c. The gurney is equipped with brake/steer pedals on each corner. Stand at an angle to the brake/steer pedals when depressing the pedals.
    d. Brake: The brakes are marked in red with the letter P. Depressing the brake pedal will prevent the gurney from moving. For resident and staff safety, always apply all brakes when the resident enters or exits the gurney, or when the gurney is not in transport, or when the gurney is not in use.
    e. Steer: The steer position is marked in green with a picture of a steering wheel. The steer position will allow for straight movement (e.g., down a hallway), and left and right turns.
    f. Neutral: The neutral position is activated when the brake/steer foot pedal is horizontal. The neutral position allows for lateral/parallel movement (e.g., against a wall or against a bed for transfer).

2. Operating the Pneumatic Lift

    a. To change the height of the gurney, use the pneumatic lift pedal using the up or down arrow as marked on the pedal until the gurney reaches the desired height. The lift pedal is located on either side of the gurney.

3. Operating the side rails

    a. Pull out one of the one-hand latches located on all four corners of the side rails to lower down the side rails. The rails are tucked completely on the side of the gurney.
    b. Grab the rail and lift the rail from the stowed position to rails the side rails. Once you hear a click sound, the side rails are locked.
    c. For safety: Before putting the rails down, ensure that the resident's extremities are neither hanging out nor any other tubes that may be displaced by the rails.

4. Operating the oxygen tank holder

    a. Pull the quick-release "O_2 Pull" handle located underneath the litter. The green pneumatic oxygen tank holder will descend.
    b. After placing a portable oxygen tank on the oxygen tank holder, push the holder back into place.
    c. Do not operate the gurney with the oxygen tank holder hanging out.

5. Operating the Pneumatic Assist Fowler

    a. Squeeze the red Pneumatic Assist Fowler's handle bar located underneath the head to raise the head of the gurney. Release the red handle when the head of the gurney reaches the desired

~~height. The head of the gurney can be identified by the picture of a head located on the rail at the head of the gurney.~~

~~b. Squeeze the red handle bar while applying a downward pressure on the head of the gurney to lower down the head of the gurney. Release the red handle bar when the head of the gurney reaches the desired height.~~

~~6. Operating the Hand Control for Trendelenburg or Reverse Trendelenburg Position~~

~~a. The gurney should not be in its highest or lowest position. In order for the gurney to tilt into the Trendelenburg or reverse Trendelenburg position, the gurney's height must be somewhere in the middle range.~~

~~b. Always use two (2) nursing staff when changing the position of the gurney into Trendelenburg or reverse Trendelenburg position. One person will operate the hand control located underneath the litter at the foot of the gurney. The second person will stand at the head of the gurney to ensure that the resident does not slide off the gurney.~~

~~c. Never leave the resident unattended if the resident is placed on a Trendelenburg or reverse Trendelenburg position.~~

~~Electric Medical/Surgical Bed Protocol (Owner: DET)~~

~~1. As part of orientation, the competency of all bedside nursing staff to use electric medical/surgical bed are validated; and annually thereafter as part of their performance appraisal.~~

~~2. The power cord located at the head of the bed must be unplugged prior to cleaning the bed with facility-approved liquid disinfectant.~~

~~3. Nursing staff will inform licensed nurse if power cord is frayed, broken connections, cracks in headboard, side rails, footboard, or mattress, or bed features are not functioning. Licensed Nurse will call or submit a work order request to the Facility Services for any repair or services as needed.~~

~~4. The bed has a built in scale to weigh resident between 50 lbs. to 500 lbs.~~

~~a. In order for the scale to weigh the resident correctly, do not tilt the bed past (+) 12 or ( ) 12 degrees.~~

~~5. Operating the bed exit alarm system:~~

~~a. Select the desired zone by pressing the ZONE button repeatedly until the desired zone LED light comes on. There are three zones to choose from.~~
~~i. Zone 1 (picture of a whole person inside a box) - resident can move in bed but not fully exit the bed without setting off the alarm.~~
~~ii. Zone 2 (picture of a smaller box enclosing the person's upper half of the body) - resident may sit up in bed but attempts to scoot down the bed will set off alarm.~~
~~iii. Zone 3 (picture of a box within a person's upper torso) - an alarm will sound with slight movements such as the resident raising his/her arm.~~
~~iv. The bed alarm will be connected to the nurse call system for better monitoring~~

~~b. After turning off alarm by pressing ARM/DISARM button and checking in on resident, make sure to reactivate bed alarm again by repressing ARM/DISARM button and checking that the light is on.~~

~~6. CPR emergency release- located at the head of the bed:~~

~~a. To access CPR mode, clear the area of people and equipment.~~

~~b. Pull outward on one of the CPR emergency releases until head of the bed is in the flat position.~~

~~c. The head board cannot be used as a back board during CPR.~~

~~d. Head of the bed must be completely flat in order for the bed to reset itself.~~

~~REFERENCES:~~

~~Stryker Electric Med/Surg Bed Manual~~

~~CROSS REFERENCES:~~

~~Nursing P&P D1 2.1 Nurse and Resident Call System~~

~~**ATTACHMENTS/APPENDICES:**~~

~~Appendix 1 - Quick Reference for Operating Electric Medical/Surgical Bed~~

~~New Document: 2010/10~~

~~Revised: 2014/05/27, 2016/09/13~~

~~Reviewed: 2016/09/13~~

~~Approved: 2016/09/13~~

~~APPENDIX 1 – QUICK REFERENCE~~

~~Operating Medical/Surgical Bed~~

~~1. Operating the Side rails~~

~~a. To lower the head side rails, lift the yellow lever and rotate the side rails downward towards the head of the bed until it is completely lowered. Tuck the side rail away by pushing it against the mattress.~~

~~b. To lift the head side rails, grasp the rail handle, pull outward and rotate the rail upward toward the head of the bed until it locks into position.~~

~~2. Operating Fowler position, knee gatch, and raising and lowering the bed~~

~~a. The controls for Fowler (head of the bed) position, knee gatch (foot of the bed), and raising and lowering the bed can be found on the inner and outer control panels of the side rails and at the foot of the bed.~~

~~b. For resident safety, the side rails' inner control panel lacks the controls to raise or lower bed height.~~

~~c. Press the button according to the denotation of the UP and DOWN arrows on the pictures of the resident in bed in order to position the bed in the desired state.~~

~~d. Underneath the middle of the bed are degree markings that indicate how many degrees the head of the bed are elevated.~~

~~3. Operating the lockout controls~~

~~a. The lockout controls located on the foot of the bed are safety features that may be used to prevent a resident from changing the bed's position.~~

~~b. To lockout the side rails' Fowler positioning controls, press the button above the padlock icon associated with head of the bed. The icon will light up indicating Fowler lockout is activated.~~

~~c. To lockout the side rails' knee gatch positioning controls, press the button above the padlock icon associated with the foot of the bed. The icon will light up indicating knee gatch lockout is activated.~~

~~d. To lockout all the controls related to bed positioning and bed height located on the side rails and the foot board, press the button above the padlock icon associated with total lockout.~~

~~4. Transporting the resident using the electric, med/surg bed~~

~~a. The bed is equipped with brakes/steer pedals on either side of the bed for ease in resident transportation.~~

~~i. Brake - Fully depress the side of the pedal identified with a RED label to park the bed.~~
~~ii. Steer wheel – Fully depress the side of the pedal identified with a GREEN label to move the bed in a straight line and pivot around corners.~~
~~iii. Neutral – Depress the pedal in horizontal position to move the bed laterally.~~

b. When transporting a resident with the electric, med/surg bed, keep the bed in a horizontal position (if not contraindicated) and in the lowest position with the siderails fully raised and locked.

c. Move the bed using the push/pull handles integrated into the head and foot boards.

d. Always apply all brakes when a resident enters and exits the bed. Apply all brakes when bed is not in transport.

5. Operating the bed scale

a. Position the resident away from the bed such that their weight is not on the bed.

b. Prepare the bed for resident placement using linens, pillows, etc.

c. Press the ENTER button at the foot of the bed to turn on the scale display panel.

d. Zero the bed by pressing and holding down ZERO button until the display reads "release ZERO".

e. Follow the next instructions which state "DO NOT TOUCH THE BED".

f. The scale mode will return and show the weight reading as zero. After the bed has been zeroed, do not place or hang any other objects on the bed, side rails, or footboard. The resident may now be placed in a normal lying position (not sitting) on the bed and the resident's weight will automatically be displayed on the scale display panel.

g. To change the weight from lbs. to kg or vice versa, press the MENU up or down buttons repeatedly until the display panel reads "UNITS" and then press ENTER, The display will read either "lb and press enter" or "kg and press enter." Select the weight unit desired using the MENU up or down buttons and then presses ENTER. The scale display panel will return with desired weight unit on the screen.

h. For future weights of the same resident, use the same bed set-up (i.e. number of linens, pillows, etc.) when the bed was first zeroed.

i. The bed will function properly with different mattresses as long as the bed is zeroed after the new mattress has been applied.

6. Operating the bed exit alarm system

c. Assure that the scale has been zeroed (see operating the bed scale).

d. Place and ensure that the resident lies in the bed in its usual position.

e. Activate the Bed Exit alarm system by pressing ARM/DISARM button which will light up if activated.

f. After turning off alarm by pressing ARM/DISARM button and checking in on resident, make sure to reactivate bed alarm again by repressing ARM/DISARM button and checking that the light is on.

7. Other bed features

~~a. Foley hooks- located underneath the bed, two on either side near the middle of the bed and the foot of the bed. Caution: The hooks underneath the head section moves as head of the bed is raised or lowered. Lock the Fowler motion when using these foley hooks near the head of the bed.~~

~~b. Trendelenburg / Reverse Trendelenburg~~

~~i. The controls for Trendelenburg/Reverse Trendelenburg are located at the foot of the bed.~~
~~ii. The scale display panel, when turned on, will show how many Trendelenburg (+) / Reverse Trendelenburg (-) degrees the bed is tilted at.~~

~~c. Auxiliary power outlet usage - located on the left side at the foot end of the bed. May be used to plug in hospital equipment consuming 5A or less.~~

~~d.~~a. ~~Nightlight located underneath the bed which turns on as the room lights dim.~~

ELECTRONIC WHEELCHAIR SCALE PROTOCOL (Owner: DET)

1. As part of orientation, the competency of all bedside nursing staff to use electronic wheelchair scale are validated; and annually thereafter as part of their performance appraisal.

2. The electronic wheelchair scale is considered a floor scale and can be used either on standing position or in a wheelchair. The scale has a maximum weight capacity of 800 pounds.

3. When setting up the scale, for staff safety, use two nursing staff to set the scale platform down. Remove the storage pin. Avoid dropping the scale to prevent from breaking the weight sensors in the scale legs.

4. Nursing staff must always set the weighing scale to “0.0” before weighing the resident to get the accurate weight of the resident.

5. The scale does not have a memory. If a resident's weight cannot be recorded immediately, once the resident's weight has stabilized while the resident is on the scale, press the "Lock/Release" button to lock the weight on the display for up to three minutes.

6. Storing of the weighing scale:

    a. Weight scale must be turned off.
    b. Insert the storage pin to lock the scale platform.
    c. For staff safety, use two nursing staff when lifting the scale platform.
    d. Transport and store the scale in the upright position inside the storage room.

7. Maintenance of weighing scale:

    a. The scale uses six (6) C-batteries. The scale will automatically turn off after three minutes of inactivity.
    b. If "Battery Low" appears in the display, this indicates batteries are low and need to be replaced.
    c. If “ERR” appears on the display, this indicates that the scale is not working.
    d. Nursing staff will inform the Licensed Nurse to call or submit a request work order to Facility Services if batteries need to be replaced or for repair or other services.

APPENDIX:

Appendix 1 - Quick Reference – Operating Wheelchair Scale

REFERENCES:

Detecto Electronic Wheelchair Scale Manual

New: 11/16/2010

Revised: 05/27/2014

~~Reviewed: 05/27/2014~~

~~Approved: 05/27/2014~~

APPENDIX 1 – QUICK REFERENCE

Operating Electronic Wheelchair Scale

1. Transporting the Electronic Wheelchair Scale

    a. Tilt the scale onto the large back wheels and pull the scale backwards while walking.

    b. Tilt the scale upright (90 degrees) and walk sideways with the scale to move through a doorway.

2. Setting-up the Electronic Wheelchair Scale

    a. For staff safety, use two people to set the scale down gently while exercising proper body mechanics. Avoid dropping the scale to prevent breaking the weight sensors in the scale legs.

    b. Remove the storage pin.

    c. Slide the release lever up while lifting the column to the full, upright position. A click will be heard when the column locks into the upright position.

3. Measuring a Standing Weight

    a. Press the "On/Off" button to activate the scale.

    b. Wait for “0.0” to appear on the screen. If it does not, press the "Zero" button to zero the scale. This will adjust the scale so that the starting weight value is “0.0 lbs”.

    c. Help the resident walk onto the scale. Wait until the weight value stabilizes and then record the weight.

        i. If the resident is wearing a gown, ensure that the back is closed to preserve dignity.
        ii. The resident does not have to stand in the center of the scale to obtain an accurate weight. The scale will weigh the resident accurately as long as the resident is standing on the scale's platform.
        iii. For resident safety, encourage unsteady residents to hold the grab bars to prevent falls. Holding the grab bars will not result in an inaccurate weight.
        iv. Press the "Units" button while the resident is on the scale to change the units from pounds to kilograms and vice-versa.

    d. Assist the resident off the scale.

4. Measuring a Wheelchair Weight

    a. Prepare the wheelchair with the same set-up the resident uses when on the wheelchair (e.g., cushions, footrests, blankets, etc).

    b. Press the "On/Off "button to activate the scale.

    c. Wait for “0.0” to appear on the screen. If it does not, press the "Zero" button to zero the scale. This will adjust the scale so that the starting weight value is “0.0 lbs”.

    d. Back the wheelchair without the resident in it onto the scale and wait until the weight stabilizes.

~~The wheelchair must be pulled backwards onto the scale to prevent the mat from peeling off or the wheelchair footrests from catching the scale surface.~~

~~e. Record the wheelchair weight.~~

~~f. Back the wheelchair off the scale and assist the resident into the wheelchair. Zero the scale once more and then back the wheelchair with the resident in it now onto the scale.~~

~~g. Record the weight when the weight value stabilizes.~~

~~i. Press the units button while the resident is on the scale to change the units from pounds to kilograms and vice-versa.~~

~~h. Back the wheelchair off the scale.~~

~~i. Subtract the wheelchair weight from the total weight (resident + wheelchair) to obtain the resident's weight.~~

~~5. Locking a weight~~

~~a. The scale does not have a memory. If a resident's weight cannot be recorded immediately, once the resident's weight has stabilized while the resident is on the scale, press the "Lock/Release" button to lock the weight on the display for up to three minutes.~~

~~b. Assist the resident off the scale to a safe place, then come back to the scale and record the locked weight.~~

~~c. Erase the locked weight by pressing the "Lock/Release" button again.~~

~~6. Storing the Electronic Wheelchair Scale~~

~~a. Press the on/off button to turn off the scale.~~

~~b. Slide the release lever up and lower the column down. The column will click when locked into the storage position.~~

~~c. Insert the storage pin back into place.~~

~~d. For staff safety, use two people to life the scale into an upright position while exercising proper body mechanics.~~

~~Transport and store the scale in the upright position inside the storage room.~~

PROTOCOL FOR RESIDENT ESCORT OFF HOSPITAL GROUNDS

(Owner: Ed)

PURPOSE:

1. To maintain resident safety while escorting the resident and provide guidance to nursing staff in obtaining and communicating relevant information regarding clinic appointments off LH grounds.

2. To maintain thorough and confidential documentation that preserves the resident's privacy.

A. General Guidelines

1. Nursing staff shall be assigned to escort the resident to and from off campus clinic appointments as necessary.

2. The resident is not to be left unattended without clinical personnel.

   ***Note:** In the event of an urgent situation when escort has to leave temporarily, it is the escort's responsibility to endorse and receive verbal agreement with clinic staff for supervision of resident until escort return (e.g. need for restroom, food, water, etc.).

3. The escorts are expected to take care of their personal needs first prior to leaving Laguna Honda Hospital grounds (i.e., need for restroom, food, water, etc.).

4. In the event of that the resident and escort missed the scheduled transportation pick-up or the resident is admitted to the acute hospital, the escort must call the unit as well as the Nursing Office for further instructions. Refer to LHHPP 24-08 Off Campus Appointments or Activities.

B. Responsibilities of the Escort

1. The escort's sole responsibility is the resident's safety and well-being.

2. Comply with confidentiality rules. The escort is not to handle any medical records except for "Instructions to Escort Form" which is not to be stamped with addressograph information.

3. The escorts sign-in at the Nursing Office and receive their assignment.

4. Report to the neighborhood to receive pertinent information regarding the resident's appointment.

5. Escorts are responsible for obtaining all the necessary information from the charge nurse or unit clerk, including the unit telephone number. Escorts shall be instructed to first call the unit in the event of a problem.

6. Escorts must introduce themselves to the resident and give a brief explanation to the resident about what to expect in effort to reduce possible anxiety and build rapport.

C. Preparing for the Appointment

1. The unit clerk or charge nurse shall provide the escort with the resident's gold card and any pertinent information which must be written on the Instructions to Escort Form (Refer to Attachment 1) including:

a. Any Risks such as behavioral challenges, elopement, etc.
b. Neighborhood Phone Number
c. Destination (including phone numbers)
d. Time of Appointment
e. Reason for Appointment
f. Van Service Name (including phone numbers)

***Note:** If resident has never been to SFGH and no gold card was given, the escort must first accompany the resident to SFGH Admission Department to register and obtain a gold card.

2. Escorts shall be instructed by the Charge Nurse or designee where and when the resident's appointment is to take place (i.e. specifically what radiology test, not just report to radiology).

D. During the Appointment

1. The escort should assert their responsibility for safety of the resident and never leave the resident for any reason, even at the resident's request.

2. The escort is responsible for accompanying the resident into the exam room even in the presence of family member or loved ones, unless the resident is their own decision maker and requests escort not be in the exam room.

3. The escort shall call the neighborhood team for further instructions in the event of any problems (i.e. resident elopement, or appointment runs late, etc.).

E. After the Appointment

1. The resident and escort will meet the transport service at an agreed upon designated location and return to LHH.

2. The escort is responsible for accompanying the resident to their neighborhood and reporting off to nursing staff upon return.

3. The escort will provide the neighborhood charge nurse with the follow-up contact number for further instructions and follow up.

4. The Escort shall report to Nursing Office to report the time of their return.

ATTACHMENT:

Attachment 1: Instruction to Escort Form

CROSS-REFERENCES:

LHHPP File: 24-08 Escorting Residents To Off Campus Appointments or Activity

New: 11/10/2015

Reviewed: 11/10/2015

Approved: 11/10/2015

New Outpatient Clinic Policies and Procedures

OUTPATIENT CLINIC VACATION REQUEST & APPROVAL

POLICY:

Only one registered nurse (RN) may take scheduled time-off so that at least one RN stays at Outpatient Clinic (OPC).

No more than 3 OPC Nursing Staff may take scheduled time-off during the same period to maintain minimum staffing of 1 RN, 2 additional staff (RN, LVN, MEA) for each clinic section.

Exceptions to the minimal staffing as described above must be approved by OPC Management Team as well as Nursing Director for OPC.

PURPOSE:

To ensure the care and safety of patients, staff, and others while planning for adequate staffing level to support clinic operations and to provide consistent patient care and employee health services.

PROCEDURES:

1. Employees shall request vacation dates for a 12-month period for each calendar year.

2. The department prefers that vacation requests are no longer than three (3) weeks at a time. Approvals and denials are subject to operational needs and consideration for seniority.

3. Vacation leave is granted and available for personal use at the discretion of management based upon operational need of the department. Approval must be sought and received in advance. Plans and intentions for being off from work shall not be made unless request form has been signed and direct supervisor or department manager has approved the time off.

4. Employees may only submit requests for time which they have already accrued, or expect to accrue under the following: Vacation, Floating Holiday, Furlough Floating Holiday, and Comp time.

5. Personal leave for which no pay is received will be approved subject to operational needs of the department.

6. Employees shall submit vacation requests by December 1st of each year for the subsequent calendar year.

7. At the end of December, requests shall be reviewed and approved based on seniority.

8. Employee numbered prioritization of requests: The supervisor shall review the vacation requests in a cyclical process only approving up to three (3) requests per employee at a time. Each cycle will begin with the most senior employee and end with the least senior employee.

9. Employees who elect not to submit requests in December may submit them at any time during the year. Requests shall be approved based upon seniority and department operational needs.

10. Floating Holiday time off may be used at any time and is subject to vacation policy.

11. No retro-requests for vacation shall be approved.

12. Seniority: Vacation approvals in accordance with the Local MOU are based on seniority, and department operational needs.

13. Employees shall be supplied a vacation priority request form each fall to request time off for the following calendar year.

14. Vacation approvals shall be clearly indicated on a shared electronic calendar.

15. During peak vacation periods (i.e. Christmas, New Year's, Easter, school breaks), a rotation shall be maintained by the Nurse Manager and Medical Director.

16. If changes are desired amongst staff, mutual consent must be confirmed between the involved staff, and the changes must be approved by the Nurse Manager and Medical Director.

17. Subsequent vacation requests will be approved as staffing allows on a first come first served basis as outlined below.

    a. The written request for time-off must indicate the inclusive date(s) of the requested time-off and the accrued time against which the time-off will be charged (e.g. vacation, compensatory time, etc.).
    b. The request must be received at least 2 weeks in advance.
    c. The Nurse Manager or Medical Director shall respond to the request in writing within 10 working days following receipt.

OUTPATIENT CLINIC SICK CALL

POLICY:

Outpatient Clinic (OPC) employees, contractors, consultants, and learners are required to call in sick when they are ill with an infectious disease or when they anticipate arriving after scheduled work start time.

Combining sick leave with vacation time off is not permissible and shall not be approved.

The department will record all individuals calling in for sick leave or late arrival.

PURPOSE:

To ensure the safety of patients, staff, and others while planning for adequate staffing level to support clinic operations.

PROCEDURES:

Sick Leave Notification

1. Outpatient Clinic employees, contractors, consultants, and learners (Individuals) must call at least 2 hours before the starting of their shift or assigned clinical schedule. Anyone not meeting this requirement will be marked: Absence Without Leave (A.W.O.L). The Department reserves the right to request a physician note to return to duty.

2. Individuals shall notify direct supervisor or designee, and OPC Charge Nurse or Charge Nurse on Duty by phone. Clinic nurse practitioners, physicians, and dentists shall notify OPC Service Chief and OPC Charge Nurse or Charge Nurse on Duty by phone.

3. Individuals suffering from symptoms of nausea, vomiting, diarrhea, skin lesions, heavy coughing/sneezing, or other respiratory and gastrointestinal symptoms shall not come to work. Individuals must notify direct supervisor, who will record in Sick Call Log at LHH Intranet; and individuals shall be referred to Covid Investigation Team for interview.

4. Use of Sick Leave more than one day per month over a period of six consecutive months is considered excessive. The department will monitor employees' attendance periodically. Excessive absenteeism may result in an employee disciplinary action. After the initial formal counsel, the attendance records will be monitored within the next three months for any improvements. Further disciplinary action may follow if excessive absenteeism persists.

5. If individuals need to be out for more 1 day, individuals shall call daily to report the illness. For any illness that exceeds 5 days or more, a physician note will be required.

6. If individuals become ill while on duty, individuals may be sent home. The supervisor will file all necessary documentation.

7. Sick leave request before or after approved non-sick leave shall not be approved. This includes vacation, in-lieu days, floating holidays, or compensation days off. In the event employees call in sick before or after their requested time off, formal medical verification may be required upon their return to duty.

Late Arrival (Tardiness) Notification

1. Individuals calling direct supervisor and charge nurse to report late arrival, prior to their work start time may ask for accommodation to make up the time. Approval is case by case. Individuals with a pattern of tardiness may be denied the opportunity to stay over and make up the time.

2. Regardless of whether individuals are allowed to make up the time or are docked, incidents of tardiness may result in disciplinary action.

3. Individuals who have not called the direct supervisor and charge nurse prior to their starting time shall be allowed up to a thirty (30) minutes time extension from the regular reporting time to report to duty and will be docked. For all instances of tardiness, time will be computed in fifteen (15) minute increments. If individuals are more than fifteen (15) minutes late and have not called in, such episodes of tardiness are subject to disciplinary action.

4. Individuals reporting late shall report to the Main Nursing Station and report to charge nurse at the time of arrival.

5. Individuals who report to work over thirty (30) minutes late and who have not contacted direct supervisor and charge nurse, shall not be allowed to work, and shall be considered absent without leave. If individuals are over thirty (30) minutes late but have contacted direct supervisor and charge nurse, individuals may be allowed to work the balance of the shift if, in the judgment of the OPC management team, tardiness is excusable and/or there is an operational need. The decision to allow the employee to work does not preclude subsequent disciplinary action.

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

7. Time records must accurately reflect the time employee's start work and the number of hours worked in every workday (self-reporting at Employee Portal with manager validation/approval). Individuals who fail to report work time accurately including, but not limited to, late start time may be subject to disciplinary actions for falsification of time worked.

REFERENCE:

Revised Outpatient Clinic Policies and Procedures

OUTPATIENT CLINIC APPOINTMENT SYSTEM

POLICY:

It is the policy of the Laguna Honda Hospital (LHH) Outpatient Clinic~~s~~ (OPC) to provide access to health care in a timely and cost-effective manner. All ~~clinics~~OPC services require a scheduled appointment. Drop-ins are accepted according to the ~~resident's~~ patient's ~~or clients~~ clinical needs as directed by ~~their~~ patient's Attending or Consulting Physicians.

~~LHH provides equal access to services to Limited English Proficient (LEP), and the hearing impaired/deaf through the interpreter and designated bilingual Hospital employees, and video medical interpretation (VMI).~~

PURPOSE:

The purpose of this policy is to:

1. ~~to d~~Define ~~the~~ standard procedure for the scheduling of ~~resident~~ patient ~~or Community Client (client)~~ appointments based on urgency and health care concerns ~~and~~
2. ~~to facilitate the effectiveness and efficiency of the Laguna Honda Hospital (LHH) Outpatient Clinics regarding resident/client appointments~~

PROCEDURE:

1. Request for Clinic Services:
    a. The Attending or other authorized physician completes an E-Referral request for consultation. (refer to E-Referral Consultation for Outpatient Clinics Policy MSPP-A00)

2. Scheduling:
    a. Clinic Staff or the Consultant reviews the E-Referral request for consultation.
    b. Clinic Staff schedules an appointment through the EHR system for the ~~resident/client~~patient based on the availability of the Consultant Staff and LHH contractual arrangement. Medical Services updates and posts the Consultant schedules on the LHH intranet.
    c. If a Clinic is cancelled or rescheduled, the Clinic Staff reschedules the ~~resident/client~~patient for the next available Clinic ~~in the EHR system~~. ~~The Community Client is notified by phone of the rescheduled appointment.~~
    d. If a patient ~~resident/client~~ misses an appointment, the Clinic Staff reschedules the ~~resident/client~~patient for the next available Clinic ~~in the EHR system . The Community Client is notified by phone of the rescheduled appointment.~~
    e. Follow up appointments are scheduled per the request of the Consultant or Attending physician.

REFERENCES:
Medical Services Department Policy MSPP-A00 "E-Referral Consultation for Outpatient Clinics"
~~Outpatient Clinics Policy A4 "Clinic Appointment Scheduling for Community Clients"~~

Most recent review: 10/01/2010, 09/24/2013, 05/21/2019~~10/10, 13/09/24. 19/05/21~~

OUTPATIENT CLINIC FLOW AND ACTIVITIES

POLICY:

Outpatient Clinic (OPC) activities will shall be organized in an orderly flow to assist Laguna Honda Hospital (LHH) residentspatients/residents , Community Clients and Medical clinical staff Staff and to promote resident/client safety and efficient use of Clinic resources.

PURPOSE:

The purpose is to provide a safe, efficient and orderly process for operating ensuring LHH patients/residents are transported between assigned neighborhood and OPC. the Outpatient Clinics.

PROCEDURE:

1. Resident Patient/Resident Check-in

   a. Residents Patient/Resident is are brought to the clinicsOPC by the Neighborhood Staff.
   b. Patient/Residents may come independently to the Clinic.
   c. The Clinic Staff checks the identification and condition of the residentpatient/resident.
   d. Patient/Residents who are is coming from a Locked Unit, restless or aggressive and who are is at risk for falls should shall be escorted at all times by the Neighborhood Staff for safety purposes.
   e. Patient/Residents who are is a high elopement risk should be escorted at all times by the Neighborhood Staff for safety purposes.
   f.e. For Community Clients please see Clinic Appointment Scheduling for Community Clients Policy A4.

2. Priority Order

   The Clinic Nurse determines the order in which residents patients/residents are seen. In general, residents patients/residents are seen in the order of their scheduled of their appointments. A change in the order in which the resident patient/resident is seen may occur due to the nature of the urgent consult, and for residents patients/residents who are ill, restless or have overlapping appointments.

3. Returning Residents Patient/Resident to Neighborhoods

   After the ClinicOPC visit, the patient/residentresident will be brought to the waiting area to wait for the neighborhood staff or clinic volunteer to transport the patient/resident back to their assigned neighborhood, or the patient/resident may independently return to his/herassigned neighborhood, if safe and able to do so.

Most recent review: 08/01/2012, 09/24/2013, 05/21/2019 12/08, 13/09/24. 19/05/21

~~NURSE~~ CLINIC PATIENT ~~AND RESIDENT~~ CALL SYSTEM

POLICIES:

1. All resident/~~-~~patient calls for assistance must be answered promptly to identify and to address the resident's~~-~~/patient's needs. Calls made from any emergency pull cord station (i.e., bathroom/toilet and exam room ~~and shower/tub room~~) or staff emergency calls must be answered immediately.
2. All Registered Nurses, Licensed Vocational Nurses, Medical Evaluation Assistants ~~(MEAs)~~, and Dental ~~a~~Assistant personnel are trained to respond to the nurse call system whether routine or emergency from whatever location the call is activated in the clinic.
3. All Licensed Nurses and MEAs in the clinic will be assigned a SpectraLink® phone.

PURPOSE:

To meet the resident's~~-~~/patient's needs in a timely and prompt manner.

PROCEDURE:

The Master Call Station - comes with a computer, ~~touch-screen~~touchscreen monitor with mouse, ~~key-board~~keyboard and is connected to a designated phone to answer a resident's/~~-~~patient's call. The interactive touch screen interface uses a floor map displaying all exam rooms. **"HELP"** buttons located throughout the program allow the user to obtain answers to operational questions on demand.

The Master Call Station will allow staff to respond to resident's~~-~~/patient's call, make a call directly to the exam room, and monitor requests that have been dispatched to staff members. A toolbar on the screen provides ~~"~~"~~-~~shortcut~~"~~" buttons to answer resident~~'~~'s ~~call, and~~call and place a call to the exam room.

1. Resident/~~-~~Patient Call System

The R~~r~~esident~~-~~/Patient call system is located in every exam room. All calls activated will show in the Master station screen and will be routed directly to the clinic staff SpectraLink® phone. There is an Emergency pull cord located in every resident bathroom.

2. Hallway Dome Light Patterns

For each type of call, the dome lights outside of each exam room will present visual cues to the staff for the location where a call has been made.

- Code Blue Call - Flashing strobe lights (all colors)
- Bathroom Call - Flashing white light
- Routine Call - Solid white light
- Cord-out call – Solid white light

a. Code Blue Call – is the highest priority call. Code Blue button is intended only for life-threatening medical emergencies. This call will supersede any routine call or bathroom call.
b. Bathroom Call – is considered an emergency call. This type of emergency call is activated from the emergency pull cord station located in every bathroom.
c. Routine Call – is considered regular call made by resident from resident's station.
d. Cord-out call – is considered a routine call. This call will be activated every time the call cord is accidentally pulled out or disengaged from the ~~connector~~connector.

3. Receiving and Responding to Calls

a. When a call is made by a resident/~~-~~patient, the call will appear in the Master Call Station and display the call number, call type, exam room and elapsed time of the active call. If multiple calls exist in the system, the call will be listed in order of highest priority. In addition, only one alarm (corresponding to the highest priority call) will be heard at a time.

b. By selecting the call, the resident/~~-~~patient recall window will appear with the pending request and present the following options:
   - ~~cancel~~ Cancel all requests and speak with the patient, or
   - ~~keep~~ Keep all requests and speak to the patient, or
   - ~~keep~~ Keep all requests and continue to wait

c. A Routine call is displays as *green-colored bar* in the Master Call Station's monitor screen.

   - Clicking an item in the Calls column will open the *Answer* screen.
   - Lift the phone handset and speak with the resident/patient.
   - If resident/~~-~~patient is calling for a simple request ~~(such as extra blanket, pain medication, water, bed pan, urinal, bathroom assist, and etc.)~~, click the "*request"* button. Select the pre-programmed request or one of the multiple requests that can be selected in the Master's Call Station.
   - If the resident's/~~-~~patient's request is not listed, the request can be typed manually in the *Manual Task Entry* field and the appropriate clinic staff selected (currently the Master Call Station only lists Licensed Nurse as an option in clinic).
   - Once a request is selected, click the "OK" button to initiate the request in the system and the request will be sent to the clinic staff SpectraLink® phone.
   - The request will now appear in the *Requests* column and must be cleared by pressing the *cancel* button on the patient station. If the request is not cleared by the staff by a predetermined time, the request will re-appear on the screen in the *calls* column.
   - A Cord-out call or machine malfunction call, will initiate automatic request to the staff member's SpectraLink® phone. This call will display "cord-out" in the Master Call Station's monitor screen. This call must be cancelled by directly in the resident's room/bed.

d. A Bathroom call will display as a *flashing red-colored bar* in the Master Call Station's monitor screen. Once activated, this call will automatically send a request to the assigned staff member's phone. Any available clinic staff should respond and check resident's status or condition for immediate assistance. This type of call must be cancelled directly from the bathroom where call was made.

e. A Code Blue call will display as "*blue-colored bar*" in the Master Call Station's monitor screen.
   - Refer to LHHPP 24-16 Code Blue
   - Code Blue call must be responded immediately by any Licensed Nurse by going directly to the resident's location where the call was activated.
   - Code Blue call will be automatically routed to the PBX-phone operator to inform the Operator of Code Blue and its location.
   - Any clinic staff member must place a call to 4 2999 directly to the nursing office.
   - A Code Blue Team is assigned to respond to the Code Blue call.
   - A Code Blue Call cannot be initiated at any Master call Station. Code Blue Call is only made at the patient's station where medical emergency assistance is needed.
   - A Code Blue call can only be cancelled directly from the patient's station where the call was activated after Code Blue has been cleared by the Code Blue Team.

REFERENCES:

~~Attachment 1: Nurse Call System User Guidelines~~
~~Attachment 2: Wireless Phone Operating Guidelines~~
~~West-Com Nurse Call Systems, Inc., West-Call® FocusCare® Software User's Guide Version 1.1.8, December, 2009~~
~~Avaya 3645 Wireless IP Telephone Reference Guide~~

CROSS REFERENCES:

LHHPP 24-16 Code Blue

~~Most recent review: 13/09/24~~
~~New: 13/09/24~~
Revised: 09/24/2013, 04/01/2024

CLINIC STAFF LICENSURE & CERTIFICATION

POLICY:

Outpatient Clinic (OPC) Staff will be qualified by training, experience experience, and certification for the services they perform in providing care to the LHH residents/ patients. and Community clients.

PURPOSE:

To ensure that Clinic OPC staff maintain current licenses and certifications to perform their job duties.

PROCEDURE:

The following employee classes are required to maintain certificates and licenses:

1. Registered Nurses (RN) are required to have a current license issued by the State of California, Board of Nursing and a current BLS certification.
2. Licensed Vocational Nurses (LVN) are required to have a current license issued by the State of California, Board of Nursing and a current BLS certification.
3. Medical Evaluation Assistants (MEA) are required to have a current license issued by the State of California, Department of Public Health, CPT1 and a current BLS certification.

Most recent review: 10/10, 13/08/02
Revised: 10/01/2010, 08/02/2013, 11/21/2013 13/11/21

SIMPLE SURGICAL PROCEDURES IN OUTPATIENT CLINIC

POLICY:

It is the policy of LHH that patients be given adequate information about the risks, benefits and alternatives for any operationsimple surgical procedure, and special diagnostic or therapeutic procedure which involves significant risk of bodily harm.

The physician performing the procedure in the outpatient clinic settingOutpatient Clinic (OPC) is responsible for ensuring that adequate disclosure is made, and informed consent is obtained prior to instituting such a treatment. (please see LHH Medical Staff P&P "Patient's Consent for Treatment and Operation")

DEFINITION:

Surgery is a procedure that structurally alters the human body. Any procedure considered invasive as defined in the State Operations Manual requires consent and a pre-operative History and Physical.

Simple surgical procedures are those procedures that require only an informed consent and not a pre-operative assessment prior to performing the procedure which includes, but not limited to, injection into a joint, bursae, tendon sheath or soft tissue; and injection of a local anesthesticanesthetic. The procedures requiring a local anesthesia injection shall include, but are not limited to, tissue biopsy, fine needle aspirations, suturing of tissue, and incision and drainage of wounds,, nail avulsion, root canal, teeth extraction, and fillings. Any procedure that does not require injection of a local anesthetic does not need an informed consent or a pre-operative history and physical.

PURPOSE:

The purpose is to provide on-site simple surgical procedures to assist the Medical Staff of LHH in the care of patients/residents.

PROCEDURE

The physician performing the procedure will obtain the informed consent as outlined in LHH Medical Staff P&P Patient's Consent for Treatment and Operation.

Follow up of patients will be provided per physician recommendations until deemed to have healed or received adequate treatment and follow-up by the consultant MDphysician.

Surgeries or procedures that require the patient to receive services outside of LHH will follow the policies and procedures of the facility.

REFERENCES:
LHH Medical Staff P&P Patient's Consent for Treatment and Operation

Most recent review: 13/05/28, 13/09/26
Revised: 05/28/2013, 09/26/2013, 11/21/920113/11/21

PROTOCOL FOR FLAME USE FOR DENTURE MOLDING IN PATIENTS WHO ARE ON CHRONIC OXYGENATION IN DENTAL SUITES

PURPOSE:

To prevent resident patient injury in dental suites from flame use for denture molding for a resident patient who requires constant use of oxygen.

BACKGROUND:

The dentist is responsible for the correct use of flames in denture molding at an appropriate distance from the patient who requires constant use of oxygen. The use of an open flame represents a potential hazard to the patient for burns because oxygen is highly flammable. The sources of oxygen can include nasal cannula, tubingtubing, and oxygen cylinders. Paper and cloth drapes are the most implicated reasons for fire.
Other causes include antiseptic alcohol basedalcohol-based skin agents, endotracheal tubes and breathing equipment and others.

PROCEDURES:

1. Dental staff training in fire prevention and extinguishing which includes location of fire extinguishers, fire alarms and exits for evacuation.

2. Smoke detector and fire extinguisher in dental suite.

3. All electrical equipment in the area is grounded.

4. Dentist and dental staff will consult with the Medical Staff if resident will be able to tolerate being without oxygen for at least 10-15 minutes.

    a. If resident patient will be able to tolerate being off ofoff oxygen, the dentist will turn off the oxygen and remove nasal cannula and wait at least one minute (for oxygen to dissipate) before using an open flame.
    b. If resident patient is not recommended to have his/her oxygen discontinued for any reason,
        - the The dentist will use an open flame at least six feet away in accordance towith community standard.
        - avoid Avoid tenting of surgical drapes in a fashion that allows accumulation of oxygen, oroxygen or remove surgical drape and allow oxygen to dissipate for one minute.
        - oxygen Oxygen tubing will be kept away from open flame.
        - consider Consider the use of water solublewater-soluble based substances for nostrils to ease dryness from the nasal cannula, should it be required or requested by the residentpatient.

REFERENCES:

American College of Surgeons on perioperative care: Fires in the Operating Room
AORN guidance statement fire prevention in the operating room
Cincinnati Children's Hospital Medical Center: Oxygen Use Precautions

Most recent review: 14/03/05
Revised: 03/25/2014, 04/01/202414/03/25