List of Hospital-wide/Departmental Policies and Procedures Submitted to JCC for Approval on November 14, 2023

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
New Hospital-wide Policies and Procedures					
New	_LHHPP		Organ Donation Policy	**L. Hoo**	1. Policy has been updated with removal of one sentence on the recommendation of consultants. 2. Based on recent discussion with the California Tissue Donor Network, an alternative to verification of Asystole added and confirmation of the list of Exclusion Criteria. 3. Formatting changes.
New	_LHHPP		Safe and Homelike Environment	**J. Carton-Wade**	New policy
Revised Hospital-wide Policies and Procedures					
Revised	_LHHPP	20-07	Against Medical Advice	**N. Ratanawongsa**	2. Added "including leaves outside of the approved parameters of a therapeutic Leave of Absence (LOA)." 3. Replaced "Absent Without Leave" with "Elopement". 4. Deleted "/Out on Pass" 5. Added :(A&E), "SDM", and "provided by A&E" 6. Added "whether the resident is currently documented in the medical record to have the capacity to make their own decisions. The physician will then assess". 6. Replaced "the hospital" with "LHH". 7. Replaced "can" with "has the capacity to decide to". 8. Added "4.Residents with a history of substance use disorder may be at increased risk for leaving the facility without notification and/or for illegal or prescription drug overdose if the resident continues using substances while residing in the facility. Residents with a history of substance use disorder should be assessed for these risks and care plan interventions should be implemented to ensure the safety of all residents." 9. Added "a. LHH should advise residents of the risks of leaving the facility to seek out substances and/or early, unplanned discharge, and provide appropriate referrals and discharge instructions whenever possible." 10. Added "b. A resident who leaves LHH prior to their planned discharge, but with facility knowledge of the departure and despite efforts to explain the risks of leaving, will be considered leaving AMA." 11. Added "i. Documentation in the medical record should show that LHH staff attempted to provide other options to the resident and informed the resident of potential risks of leaving AMA. Documentation should also identify the time LHH staff became aware of the resident leaving the facility." 12. Added "electronic health record" and "Resident Care Team" 13. Added "6.If the resident leaves or remains out of the facility in a manner outside of the duration or conditions of the Leave of Absence (LOA) physician order, they may be discharged AMA. If that occurs" 14. Added "a.Physician shall place an order for discharge as AMA in the electronic health record (EHR) and complete the AMA form based on prior resident care conference

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Revised	_LHHPP	22-01	Abuse and Neglect Prevention, Identification, Investigation Protection, Reporting and Response	**N. Talai**	1. Added "New Employee Orientation " 2. Added "contractor" 3. Deleted "reassign the employee who is being investigated to non patient care duties or" and "are not available at the point the manager was notified of the allegation" 4. Added "nursing" 5. Added " immediately" and "Nursing Home Administrator (NHA)/" 6. Deleted " Administrator on Duty (AOD): 7. Added "Abuse Coordinator" 8. Deleted "give the involved employee an interim reassignment to a non patient cre area or" and "reassignment or" 9. Added "The Role of the Abuse Coordinator" 10. Added " The Abuse 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 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." 11. Added "The Abuse Coordination shall:" 12. Added "Collaborates with the Resident Care Team to ensure interventions are immediately implemented and documented to ensure resident safety during the investigative process." 13. Added "Oversees and participates in Abuse and Neglect policy updates, mandatory training and investigation training for the facility." 14. Added "Collaborates with Quality Management to ensure that a thorough investigation process occurs." and "Reviews all investigations prior to be submitted to regulatory agencies"
Revised	_LHHPP	24-06	Resident and Visitor Complaints/Grievances	**N. Talai**	1. Added "Resident Care Team" 2. Added "via unit-based grievance boxes and suggestion boxes throughout the facility" 3. Added ", including how to contact the Ombudsman" 4. Added "Assistant Nursing Home Administrator for Care Experience (ANHA- CEX)" 5 Added "attempled" 6. Added "Should the grievance be concerning property loss, the resident/patient may file a claim for loss of property, by completing a claim form entitled "Claim Against the City and County of San Francisco". The filing of a claim form does not guarantee reimbursement for the lost or stolen property. The Medical Social Worker or any member of the RCT may assist the resident/patient in completing claims form." 9. Added "a. LHH is liable for damage or loss of the personal property of a resident, but only if negligence or willful wrongdoing on the part of LHH or its employee is shown. LHH may also deny liability when reasonable efforts to safeguard the resident's personal property has been provided and the resident chooses to take other actions or the property is not listed on the resident's IRP. Liability is subject to the amounts provided by law, including Civil Code sections 1840, 1859. " 10. Replaced "complaint" with "grievence" 11. Added "to the main Laguna Honda email address laguna.honda@sfdph.org, and then " 12. Replaced " Administrative Director" with "AHNA-CEX" 13. Added "and members of the Executive Leadership team" 14. Replaced "5 business day" with "within the same day of receipt of the grievance" 15. Added "committees" 16. Replaced "monthly" with "Quaterly" 16. Added "LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss" 17. Added " LHHPP 75-07 Theft and Lost Property " Replaced "July 18, 2023" with "23/07/18"
Revised	_LHHPP	25-15	Medication Administration	**M. Healy**	Added sections on Administration of Eye Medications, Ears and Nose

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Revised	_LHHPP	26-02	Management of Dysphagia and Aspiration Risk	**L. Cecconi**	1. Added "Resident to sit upright as possible (elevate Head of Bed if cannot transfer to chair) with all meals and 20 minutes after eating, including medications" 2. Simplified language in section 1 Identification of At-Risk Residents. 3. Rearranged information in section "5.Management of Residents Who Are at Risk for Aspiration" 4. Removed secion 6c i-v in 6.Referral to Occupational Therapy OT 5. Deleted sections "7. Indications for REferral to Speach Pathology for Dysphagia Evaluation" section 6. Deleted "8. Dysphagia Evaluation" section 7. Deleted "9. Treatment" section 8. Deleted "10. Referal to Occupational Therapy" section 9. Deleted "11. Management of Residents Who Are at Risk for Aspiration" section 10. Deleted "12. Individualized Aspiration Precautions" section 11. Deleted "13. Folow-up" section
Revised	_LHHPP	27-02	Referrals for Rehabilitation Services	**D. Swiger**	1. Added "In-House" 2. Deleted "audiology, and physiatry services" throuhout the document 3. Replaced "five (5) working" with "24 – 48 hours during business" and "excluding holidays"
Revised	_LHHPP	27-06	Guidelines for Inpatient Rehabilitation Facility Documentation	**D. Swiger**	1. Replaced "Resident Care Team (RCT)" with "Interdisciplinary Team (IDT)" throughout the document. 2. Added "A minimum data set (MDS)" 3. Added "v. Medical necessity for" 4. Deleted section 10ii.
Revised	_LHHPP	50-02	Resident Trust Account	**L. Conover**	1. Replaced "the EPIC" with "The electronic health record (EHR)" 2. Simplified the language in section "2. Set-Up of Resident Trust Account" 3. Moved Section "Representative Payee Program, Legal Conservator and Public Guardian" from 8 to 3. 4. Added section "4. Financial Decision Maker – Authorized Designee:" 5. Added "resident's name, episode number, and check amount. After completing the log, the check log and checks shall be sent to the Cashiers." 6. Added details in section "10. Trust Account Quarterly Statements" 7. Added details to section "11.\Distribution Funds after Death" 8. Removed section 11d. 9. Replaced "EPIC" with "EHR" throughout the document. 10. Added section "16.Withdrawal Authorizations Requested by Resident or Designee: " 11. Removed "16. Steps for Authorization of Funds: " section 12. Removed section "17. Authorizations Requested by Resident:" 13. Removed section "20. Authorization Request by MSW" 14. Added "Assurance of Financial Security 1.The facility will purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility." 15. Added "2.The facility will not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts)." 16. Added "3.The facility may charge the resident for requested services that are more expensive than or in excess of covered services, as authorized by law." 17. Added "Resident Trust Fund Notification and Authorization"
Deletion Medical Staff Policies and Procedures					
Deletion	Medical Staff	C01-03	Organ/Tissue Transplant Donation Program	**L. Hoo**	Request to delete and move to HWPP.
Revised Nursing Policies and Procedures					
Revised	Nursing	B 5.0	Resident Identification and Color Codes	**J. Selerio**	1. Revised process to include wristbands, and snap wristband, and clarify having photograph taken by A&E for EPIC 2. Included use of identification card for residents declining or unable to tolerate wristband 3. Included signage for resident's with wide beds in a non-bariatric room 4. Included "Name Alert" signage
Revised	Nursing	J 1.1	Obtaining, Handling, and Storage of Medications and Treatments	**J. Selerio**	1. Added "Treatments" to policy title and policy 2. Added returning of "any drug dispensed in error" to pharmacy and "notify the nursing supervisor who can return the medication to the pharmacy 3. Clarified that sterile water and isopropyl alcohol are single use only, and remaining solution to be discarded after single use 4. Irrigation solutions supplied by pharmacy 5. Clarified that Wellness Center emergency equipment to be checked daily "when Wellness Center is open"

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Deletion Nursing Policies and Procedures					
Deletion	Nursing	J 1.3	Aerosol/Nebulizer and Appendix	**J. Selerio**	Deleting policy and appendix since it is now in medication administration policy
Deletion	Nursing	J 1.4	Instillations of the Eye, Ear and Nose	**J. Selerio**	Deleting policy since it is sent now added to medication administration (pending approval of changes to HWPP 25-15)
Revised Food and Nutrition Services Policies and Procedures					
Revised	FNS	1.83	Resident Meal Service	**L. Cecconi**	Added verbiage around resident's food preferences and appropriate substitution

New Hospital-wide Policies and Procedures

ORGAN/TISSUE TRANSPLANT DONATION PROGRAM

POLICY:

1. Laguna Honda Hospital (LHH), in compliance with ~~PPHS~~ 42 CFR Part 482.45- Hospital Conditions of Participation, ~~for Hospitals, California Assembly Bill 631, Section 7184, and Public Law 99509, Section 9138~~ identifies potential tissue donors and cooperates in procurement of anatomical gifts. ~~At this time, LH has been excused from organ donation due to no available intensive care services at the hospital.~~

~~A.~~

2. All acute patients who die will be screened for potential tissue donation by ~~California Transplant~~ Donor Network West(~~CTDN~~DNW) optimally within 1 hour of asystole.

~~B.~~

3. All cases under the Medical Examiner's (ME) jurisdiction must be reported to the ME office prior to request to family members for tissue donation at LH and the ~~CTDN~~ DNW staff shall contact the ME office and the family.

~~C.~~

4. ~~This~~ A referral shall be made within 1 hour of the time of asystole. The acute unit physician and/or the acute unit RN may make the initial referral call. In the event Asystole is not documented, time the patient was last seen alive before death pronouncement should be noted and reported.

~~D.~~

a. ~~Referrals to CTDN must be documented on the Tissue Donation request form, with the CTDN referral #.~~ Referrals for tissue donation are made by calling DNW (1-800-55DONOR). Have the patient's medical record available and present patient information to DNW specialist.

~~1.~~

~~a.~~ ~~CTDN~~ Medical suitability for tissue donation will be determined by means of a telephone evaluation by DNW specialist~~or designated tissue bank coordinator will evaluate the potential tissue donor to determine medical suitabilit~~y.~~.~~

b. Document notification of DNW in the electronic health record (EHR)

c. Medical and other hospital staff should refrain from discussing tissue donation with the family. All information related to donation and provided to the decision makers of a potential donor is the responsibility of DNW.

~~2.~~

5. Medical suitability of potential donors for tissue donation

~~E.~~

a. Exclusion criteria - Although DNW renders the final decision on exclusion of a donor, the following are some guidelines:

~~1.~~

i. History of serum or infectious hepatitis, extracranial malignancy, systemic sepsis, or active transmissible disease at time of death

~~a.~~

~~b.~~ii. Jacob-Creutzfeldt disease or senile dementia of unknown etiology.

iii. Suspicion of exposure to HIV or at high risk for exposure to HIV

~~c.~~

iv. Tissue irradiation or chronic steroid therapy

~~d.~~

Acute hospital residence of longer than 2 weeks may be an exclusion ~~criteria~~criterion.

v.

~~In jail or prison for greater than 72 hours.~~ Incarceration for greater than 72 hours.~~.~~

vi.

~~F.~~**6.** Medical Examiner Cases: All cases under the Medical Examiner's jurisdiction must be reported to the Medical Examiner's Office prior to any request to family members. ~~The jurisdiction of the Medical Examiner is defined in California Government Code Section 27491 and LHH Administrative Policy LHH 20-09.~~ A listing of criteria for ME cases can be found in the EHR Deceased navigator tab. The telephone number for the ME's office is 415-553-1694.

PURPOSE:

The purpose of this policy is to facilitate tissue donation and to protect privacy and interests of the donors, recipients, and family members. Laguna Honda Hospital and Rehabilitation Center (LHH) will use discretion and sensitivity appropriate to the circumstances, beliefs and desires of the family members. This policy and procedure must be followed for Acute patients who die but may optionally be followed for Skilled Nursing residents who die.

PROCEDURE:

1. Identification and Referral of Potential Donors

a. All Acute unit deaths must be reported to the ~~California Transplant Donor Network~~Donor Network West (DNW). 1 800 55 DONOR (1-800-553-6667)

~~b.~~

b. For tissue donation, the ~~CTDN network~~DNW must be notified within one hour of asystole or last seen alive.~~.~~

~~c.~~

d.c. CTDN DNW or the designate tissue bank coordinator will evaluate the potential tissue donor to determine medical suitability.

Tissue retrieval: Tissue retrieval is approved on a case-by-case basis by calling the CTDN DNW at 1 800 55 DONOR. THE CTDNDNW then refers the call to the Musculoskeletal Transplant Foundation Foundation (MTF-(tissue bank).

2.

d. The Tissue Bank Coordinator will perform a telephone evaluation of the potential tissue donor with the LHH attending physician to determine medical suitability.

a.

e. LHH attending physician will provide information including but not limited to:

b.

i. Cause of death

ii. Lab results

ii.

iii. IV fluids/blood products received

iii.

iv. Next-of-kin information

3.7. **Medical Examiner Cases:** If after consultation with the donor's physician, it is determined that the case falls under the jurisdiction of the ME, the CTDN DNW coordinator is responsible for contacting the ME's office for approval to procure tissue donation before approaching the family.

4.8. **Consent and Release –** the tissue bank coordinator will assess the family's readiness to be offered the option of tissue donation and obtain consent of the family members. A copy of the consent will be included in the patient's medical record.

5.9. **Tissue Recovery Process**

a. The Tissue Coordinator will schedule a time with the LHH Administrator on Duty (AOD) or designee to determine where tissue recovery will take place (e.g. the morgue)

a.

b. The Tissue Bank Coordinator will provide all needed staff, instrumentation and supplies used during the tissue recovery.

b.

c. The Tissue Bank staff will ensure the appropriate disposition of the body and clean the facility when tissue recovery is completed.

c.

d. The Tissue Bank Coordinator will assume responsibility for notifying all appropriate agencies regarding the donation (e.g. recovery team, funeral director, and ME if appropriate)

d.

e. The Musculoskeletal Transplant Foundation (MTF) reimburses LHH for all costs incurred for tissue recovery.

f. LH will work cooperatively with MTF and CTDN staff in educating acute care staff on donation issues and specified in the agreements.

~~g. LH Quality Management staff will collaborate with MTF and CTDN staff in performance improvement activities and monitor the effectiveness of facility protocols and policies (an example of a performance improvement activity is the review of death records of acute care patients to ensure that potential donors are identified).~~

10. LHH will work cooperatively with MTF and ~~CTDN~~ DNW staff in educating acute care staff on donation issues ~~and specified in the agreement~~.s.

~~6.~~

~~7.~~11. LHH Quality Management staff will collaborate with MTF and ~~CTDN~~ DNW staff in performance improvement activities and monitor the effectiveness of facility protocols and policies (an example of a performance improvement activity is the review of death records of acute care patients to ensure that potential donors are identified).

ATTACHMENT:

None~~Tissue Donation Referral Form~~

REFERENCE:

MSPP C01-02 PATIENT EXPIRATION

Original adoption: xx/xx/xx (Year/Month/Day)

SAFE AND HOMELIKE ENVIRONMENT

POLICY:

In accordance with residents' rights, Laguna Honda Hospital (LHH) shall provide a safe, clean, comfortable, and homelike environment, allowing residents to use their~~his or her~~ personal belongings to the extent possible. This includes ensuring that ~~the~~ residents can receive care and services safely and that the physical layout of LHH maximizes residents' independence and does not pose a safety risk.

PURPOSE:

LHH supports a homelike environment for residents that creates a living environment that is supportive of a resident's preferred style.

DEFINITIONS:

"Adequate lighting" means levels of illumination suitable to tasks the resident chooses to perform or LHH staff must perform.

"Comfortable lighting" means lighting that minimizes glare and provides maximum resident control, where feasible, over the intensity, location, and direction of lighting to meet their needs or enhance independent functioning.

"Comfortable and safe temperature levels" means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia/ hyperthermia and is comfortable for the residents.

"Comfortable sound levels" means levels that do not interfere with the resident's hearing, levels that enhance privacy when privacy is desired, and levels that encourage interaction when social participation is desired.

"Environment" refers to any environment in LHH that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas.

A "**homelike environment"** is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A determination of "homelike" should include the resident's opinion of the living environment.

"Orderly" is defined as an uncluttered physical environment that is neat and well-kept.

"Sanitary" includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care

equipment includes, but is not limited to, equipment used in the completion of the activities of daily living.

PROCEDURE:

1. LHH shall create and maintain, to the extent possible, a homelike environment that de-emphasizes the institutional character of the setting.

    a. LHH shall allow residents to use their personal belongings, including furnishings and clothing (as space permits) to assist in creating and maintaining a homelike environment. This use must not infringe upon the rights or health and safety of other residents.

    b. Members of the Resident Care Team, especially Social Services and Activity Therapy, shall encourage residents and their families to bring in personal belongings (within space constraints) to personalize residents' rooms.

    c. LHH shall honor and document a resident's choice not to personalize his/her room.

2. LHH exercises reasonable care for the protection of the resident's property from loss or theft.

3. EVS and Facilities services shall be provided as necessary to maintain a sanitary, orderly and comfortable environment.

4. LHH shall provide and maintain bed and bath linens that are clean and in good condition.

5. LHH shall provide sufficient individual closet space in each resident room.

6. LHH shall provide and maintain adequate and comfortable lighting levels in all areas that allow for procedures as required.

    a. The Facilities Director or designee shall perform periodic rounds to ensure functioning lights.

    b. Even light levels should be utilized in common areas and hallways to avoid patches of low light.

    c. Daylight should be utilized as much as possible.

7. LHH shall maintain comfortable and safe temperature levels.

    a. LHH should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit.

    b. If and when a resident prefers his or her room temperature be kept below 71 degrees Fahrenheit, or above 81 degrees Fahrenheit, LHH shall assess the safety of this practice on the resident and the resident's roommate.

    c. If and when residents who share a room do not agree on the temperature of the room, LHH shall assist in negotiating a compromise that the residents agree on or shall assist in a room change.

8. LHH shall maintain comfortable sound levels in the facility. Overhead paging shall be limited to emergency situations and as needed for providing prompt care and treatment of the residents.

9. General Considerations:

    a. Minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to EVS Department.

    b. Minimize the use of institutional signage in areas visible to residents and the public.

    c. Eliminate the use of meal trays during dining service, unless otherwise requested by the resident.

    d. Maintain minimal use of alarms, using alternative interventions, unless otherwise indicated by the care plan.

    e. Report any furniture in disrepair to Facilities by promptly placing a work order.

    f. Report any unresolved environmental concerns to the Administrator.

    g. Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two.

ATTACHMENT:
None

REFERENCE:
Centers for Medicare & Medicaid Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities (February 2023 Revision). F584 - Safe/Clean/Comfortable/Homelike Environment §483.10(i)(1)-(7).

Original adoption: 23/11/14 (Year/Month/Day)

Revised Hospital-wide Policies and Procedures

AGAINST MEDICAL ADVICE

POLICY:

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

   a. make decisions regarding their medical care.

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

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

PURPOSE:

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

DEFINITIONS:

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

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

2. Leave of Absence~~/Out on Pass~~ Bed Hold: A planned absence of a resident from LHH authorized by a physician's order, which extends past midnight.

PROCEDURES:

1. LHH Admissions and Eligibility (A&E) shall provide each newly admitted resident/surrogate decision maker (SDM) with a copy of the LHH AMA Policy.

2. The resident or ~~surrogate decision maker~~SDM acknowledges receipt of the policies and agrees to abide by its requirements by their signature on all required documents in the Admissions packet provided by A&E.

3. When a resident expresses the desire to leave AMA~~—~~, the physician will assess whether the resident is currently documented in the medical record to have the capacity to make their own decisions. The physician will then assess the resident's current cognitive capacity and ability to understand the risks of leaving ~~the hospital~~LHH and discontinuing medical treatment. Based on this assessment, the

physician will determine whether the patient ~~can~~ has the capacity to decide to leave AMA.

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

   a. ~~LHH should advise residents of the risks of leaving the facility to seek out substances and/or early, unplanned discharge, and provide appropriate referrals and discharge instructions whenever possible.~~ LHH will advise at risk residents that leaving the facility without a physician order may result in an unplanned discharge. Appropriate referrals and discharge instructions will be provided whenever possible (see 5.d.)

   b. ~~A resident who leaves LHH prior to their planned discharge, but with facility knowledge of the departure and despite efforts to explain the risks of leaving, will be considered leaving AMA.~~ Residents who choose to leave LHH without a physician order, despite counseling by staff of the risks related of leaving and the potential for unplanned discharge, will be considered leaving AMA.

      i. Documentation in the medical record ~~should show that LHH staff attempted to provide other options to the resident and informed the resident of potential risks of leaving AMA~~ should include counseling, other options that might have been offered, risks of leaving AMA and time the resident left the facility.. ~~Documentation should also identify the time LHH staff became aware of the resident leaving the facility.~~

~~4.~~5. ~~If the resident chooses to leave LHH~~For residents leaving A~~a~~against ~~m~~Medical ~~a~~Advice:~~,~~

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

   b. The resident ~~should also sign the AMA form where indicated.~~will be asked to sign the AMA form. F~~ (NB: f~~or residents who refuse to sign the form, mark the form accordingly.

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

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

e. Once these procedures are completed, ~~T~~the resident is considered AMA and will be discharged.
~~e.~~f. LHH will not hold the resident's bed.

~~f.~~g. ~~LHH will not hold the resident's bed.~~

6. ~~I~~If the resident leaves or remains out of the facility in a manner outside of the duration or conditions of of the~~a~~ Leave of Absence (LOA) physician order, they may be discharged * ~~as Against Medical Advice (AMA).~~AMA. If that occurs:

~~g.~~a. Physician shall place an order for discharge as AMA in the electronic health record (EHR) and complete the AMA form based on prior resident care conference counseling about risk of AMA if resident leaves or remains out of the facility outside of the duration or conditions of LOA.

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

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

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

ATTACHMENT:
None.

REFERENCES:
LHHPP 20-02 Bed Hold
LHHPP 20-04 Discharge Planning
LHHPP 20-06 Leave of Absence ~~(Out on Pass)~~
MR 804
LHPP 24-22 Code Green Protocol

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

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.

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' rights 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 ~~i~~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 ~~reassign the employee who is being investigated to non-patient care duties or~~ place the employee on administrative leave. ~~if non-patient care duties. are not available at the point the manager was notified of the allegation. T~~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. ~~If the resident is noted to have a change in condition, T~~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 ~~. 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), ~~Administrator on Duty (AOD)~~, SFSO, and QM.

f. The Abuse 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 ~~HR and~~ the staff person's immediate supervisor. The staff's direct supervisor will notify within 24 hours. The direct supervisor or nursing supervisor shall remove the staff from ~~resident care~~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 ~~give the involved employee an interim reassignment to a non-patient care area or~~ work with HR to place the employee on administrative leave, pending completion of the investigation. The ~~interim reassignment or~~ 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 fax 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).

~~b.~~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.

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

d.e. The SOC 341 shall be faxed to 415-751-9789 by Nursing Operations or designee and the fax verification submitted to QM.

e.f. 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.g. In cases of alleged resident abuse, neglect or exploitation by staff or visitor, the final conclusion shall be determined by QM Regulatory Affairs team, after conferring with the LHH Executive Team.

g.h. 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.i. 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 to provide the resident with a safe and secure environment.

ii. Measures 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.

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

The Abuse 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 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 Coordination shall:

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.

%

~~A~~TTACHMENT:
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 (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: _____

Page 1 of 6

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:

Page 2 of 6

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.

Page 3 of 6

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:

Page 4 of 6

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: _____

Page 5 of 6

Investigation of Alleged Abuse

ADDITIONAL SPACE

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

Page 6 of 6

RESIDENT/PATIENT AND VISITOR COMPLAINTS/GRIEVANCES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) strives to create an environment that is responsive to residents/patients/visitors complaints/grievances and addresses residents/patients/visitors' concerns.

2. LHH encourages residents to raise concerns for resolution with their Resident Care Teamcare team (RCT), at Community meetings, or at Residents' Council without discrimination or fear of reprisal.

3. LHH encourages patients on the acute medical unit to raise concerns for resolution with the care providers on the acute unit without discrimination or fear of reprisal.

4. LHH shall make prompt efforts to resolve grievances residents/patients/visitors may have by actively working toward a resolution.

5. Individual resident/patient concerns that are addressed by the RCT or acute medical care team shall be documented in the medical record. Concerns raised during Residents Council and Community meetings shall be reflected in meeting minutes and or notes of those meetings respectively.

6. When methods for resolving concerns have not been successful and residents/patients/visitors choose not to use any of the above methods, LHH has a Complaint/Grievance form that can be submitted to the Administration Department (Administration) to address unresolved complaints/grievances in equitable and inclusive manner via unit-based grievance boxes and suggestion boxes throughout the facility.

7. The neighborhood bulletin board shall display necessary information, consistent with federal requirements, on the residents/patients/visitors right to file complaints/grievances orally and in writing, including anonymously, and the process for submitting complaints/grievances, including how to contact the Ombudsman.

8. The Administrative DirectorAssistant Nursing Home Administrator for Care Experience (ANHA- CEX) shall act as the Grievance Official and is responsible for managing the grievance process; receiving and tracking grievances through to their conclusions; leading/directing any necessary investigations; maintaining confidentiality of information compiled; issuing written grievance decisions on behalf of department/unit managers; and coordinating with state and federal agencies as necessary.

PURPOSE:

1. To ensure that ~~significan~~t complaints are addressed and appropriate follow-up actions are taken to resolve the issue to the fullest extent possible.

2. To optimize the experience and satisfaction of the residents/patients/visitors with the care and services in a timely manner.

DEFINITION:

Complaint/Grievance: A verbal or written communication about a problem and/or concern signed or anonymous, presented via resident drop boxes, included in resident satisfaction surveys, or given directly to staff. Examples of complaints/grievances may include those about treatment, care, management of funds, lost clothing, or violation of rights.

PROCEDURE:

1. On admission, each resident receives the Resident Guidebook and the social worker orients him/her to the Resident Complaints/Grievance policy.

    a. If admitted to the acute medical unit at Laguna Honda, the admitting nurse will remind the patient of their right to file a grievance.

2. The Resident/Patient/Visitor Complaint/Grievance policy will be reviewed in Hospital-wide orientation for new employees and will be included in Resident's Rights annual in-services ~~when policy changes occur.~~

3. Resident/Patient/Visitor Complaint/Grievance forms shall be kept on each unit, in the Social Services Office, in the Nursing Office, and in the Administration Office to be available for residents or families as requested.

4. Grievance forms and submission boxes shall be located near the elevators of each neighborhood so that residents, families and visitors may submit grievances without the assistance of LHH staff.

5. The ~~Resident Care Team~~RCT in the Skilled Nursing Facility, and/or the care team on the medical acute unit, shall encourage a resident/patient to complete the Resident/Patient/Visitor Complaint/Grievance form when methods for resolving concerns are not successful despite attempted interventions ~~by the Team~~ and the resident's concerns continue to be unresolved.

6. Should the grievance be concerning property loss, the resident/patient may file a claim for loss of property, by completing a claim form entitled "Claim Against the City and County of San Francisco". The filing of a claim form does not guarantee reimbursement for the lost or stolen property. The Medical Social Worker or any member of the RCT may assist the resident/patient in completing claims form.

a. LHH is liable for damage or loss of the personal property of a resident/patient, but only if negligence or willful wrongdoing on the part of LHH or its employee is shown. LHH may also deny liability when reasonable efforts to safeguard the resident's personal property has been provided and the resident chooses to take other actions or the property is not listed on the resident's IRP. Liability is subject to the amounts provided by law, including Civil Code sections 1840, 1859.

~~6.~~7. If the resident/patient/visitor is unable to or does not wish to complete the grievance ~~complaint~~ form, staff may document the resident/patient's complaint/grievance on behalf of the resident/patient/visitor. The Resident/Patient Complaint/Grievance form may be submitted via the Grievances boxes near the elevators on the neighborhoods, to staff in Nursing, Social Service, or Administration. Any staff that receives a complaint/grievance form is responsible for submitting the completed form to Administration.

~~7.~~8. Residents/Patients/Visitors who wish to file their grievances anonymously may submit their Complaint/Grievance form into drop boxes labelled "Suggestion box" located at near the elevators on the neighborhoods, at the Pavilion lobby entrance (ground floor), Out-patient clinic lobby (first floor Pavilion) and the Administration lobby.

~~8.~~9. Contents from Suggestion B~~b~~oxes shall be picked up Monday through Friday, excluding holidays by the Resident/Patient Safety Advocate or designee. Complaint/Grievance forms and Suggestion forms sent via email to the main Laguna Honda email address, laguna.honda@sfdph.org, and then shall be routed to the ~~Administrative Director~~ANHA-CEX or their designee and members of the Executive Leadership team.~~.~~

~~9.~~10. The Resident/Patient Safety Advocate, with guidance from the ~~Administrative Director~~ANHA-CEX as needed, shall triage the complaint/grievance. The grievance shall be logged into the grievance log and assigned to the appropriate departments for timely follow up.

~~10.~~11. The appropriate department/unit manager shall acknowledge the complaint/grievance and or make contact the resident/patient in within the same day of receipt of the grievance.~~5 business days~~. The resident/patient's right to confidentiality and privacy will be respected at all times.

~~11.~~12. If the complaint/grievance is anonymous, follow up with the complainant is not possible. However, the appropriate department head is still responsible for acknowledging receipt of the complaint/grievance, investigate the complaint/grievance, and address the general concerns of the complaint if the matter can be confirmed to the Grievance Official.

~~12.~~13. The Grievance Official shall respond to the complaint/grievance with a final resolution in 10 business days.

~~13.~~14. Appropriate corrective action(s) shall be implemented by the facility if an alleged violation of resident's rights is confirmed.

~~14.~~15. Documentation consistent with federal requirements related to resident grievances shall be maintained for a period of 3 years from the issuance of the grievance decision.

~~15.~~16. Complaints/grievances shall be evaluated and analyzed by the Grievance Official with respect to type, timely follow-up, trends, identification of problems/process gaps and the prevention of similar future problems. Data will be reported out in the following committees and meetings:

a. Weekly at the Executive Committee meeting to ensure leadership have the opportunity to address complaints during leadership rounding. Discussion of the data shall be documented in the minutes.

~~a.~~

b. Monthly at Resident Council and during Community Meetings. Discussion of the data shall be documented in the respective groups' meeting minutes.

~~b.~~

c. ~~monthly~~ Quarterly at the Quality Assurance Performance Improvement/Performance Improvement and Patient Safety (PIPS) meeting.

ATTACHMENT:
Attachment A: Grievance Information Flyer
Attachment B: Grievance Form
Attachment C: Grievance Acknowledgment
Attachment D: Grievance Response Form

REFERENCE:
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response
LHHPP 22-03 Residents' Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 75-07 Theft and Lost Property
Appendix PP/Guidance to Surveyors for Long Term Care Facilities F585/Sections 483.10(j) (1) – (4)

Revised: 09/10/01, 10/04/27, 16/01/12, 17/09/12, 19/03/12, 20/01/14, 22/08/17, 22/08/30, 22/12/13, 23/05/09, 23/07/18~~-~~ (Year/Month/Day)
Original adoption: 92/03/01

MEDICATION ADMINISTRATION

POLICY:

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

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

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

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

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

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

    a. Medication name/agent

    b. Dose

    c. Frequency

    d. Route of administration

    e. Indication for use.

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

3. Personal medications will not be obtained, stored or used by residents unless they have been ordered by a LHH physician, and shall not be kept at bedside.

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

    a. Right resident

    b. Right drug

c. Right dose

d. Right time

e. Right route

f. Right documentation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DEFINITIONS:

- BCMA: Bar Code Medication Administration
- eMAR: Electronic Medication Administration Record/MAR: Medication Administration Record

- EHR: Electronic Health Record
- WOW: Workstation on Wheels

PURPOSE:

Medications will be competently and safely administered.

A. CRITICAL POINTS

1. Six Rights of Medication Administration

. Right Resident

i. Two forms of identification are mandatory.

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

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

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

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

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

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

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

2. Right Drug

a. Review eMAR for drug/medication ordered

b. Review resident allergies to medications or any other contraindication

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

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

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

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

3. Right Dose

a. Review eMAR for dose of drug/medication ordered

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

4. Right Time

a. Review eMAR for medication administration time.

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

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

iii. See Appendix I for routine medication times and abbreviations.

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

5. Right Route

a. Review routes of administration

~~i. Aerosol/Nebulizer: Refer to NPP J 1.3~~

~~ii.~~i. Enteral Tube Drug Administration: Refer to NPP E 5.0

~~iii. Eye/Ear/Nose Instillations: Refer to J 1.4~~

b. IV Push and IV Piggyback - Medications that an RN may give as I.V. push, without a physician at the bedside, are specified in the following link: Laguna Honda Hospital IV Push Guidelines

6. Right Documentation

a. Document the administration of medication in eMAR at the time medication is given utilizing bar code scanning.

b. If resident is not wearing an armband, or refuses to allow scanning of their arm band, document reason in override section.

c. If product/medication is not scanned, document the reason in override section.

B. OVERRIDE OF MEDICATION ADMINISTRATION

1. If a resident requires urgent attention, use clinical judgment when deciding to override BCMA in order to provide care.

2. Document override reason.

C. TWO LN INDEPENDENT CHECK OF MEDICATIONS

1. Two LN independent check of medication is the process by which 2 LNs perform an independent review of the medication to be administered, without prompting or cueing for other LN prior to medication being administered:

2. Each LN reviews the Right resident, Right medication, Right dose, Right route and Right time.

3. Each LN will complete their own documentation in EHR.

D. CRUSHING MEDICATIONS FOR ORAL ADMINISTRATION

1. Crushing medications is based on nursing judgement and resident care plan.

2. Do not crush hazardous, enteric, sustained release or medications with “do not crush” in the admin instructions of the eMAR.

3. Each resident shall have their own pill cutter, which is cleaned with alcohol wipes between uses.

4. Pill crushers will be cleaned with alcohol wipe at the end of the medication pass prior to returning to medication room for charging, and PRN.

5. Staff may choose to wear mask when crushing or cutting pills.

6. Medications which are to be crushed for administration, must be given individually and should not be combined with other crushed, uncrushed or liquid medications (e.g. in pudding or other similar food), unless pharmacy has reviewed the medications for safety and efficacy, and pharmacy has documented that it is safe to mix crushed medications together and the physician has placed an order for crushing and combining the medications.

7. When using a food medium (e.g., apple sauce or pudding) to administer medications, the LN will:

. Date and time the food medium container at time of opening. Food medium container should remain on the medication cart if the food medium will be used for multiple residents. Use hand hygiene per protocol between each resident.

a. For each individual resident, use a new, clean spoon to remove a portion of the food medium and place it in a different container (e.g., medicine cup or pill crusher cups.)

b. If using pudding as the food medium to administer medications, a physician order is required for the pudding.

c. The opened food medium must be kept covered throughout the duration of the medication pass and discarded at the end of medication pass. Food medium cannot be stored in or on the medication cart beyond your medication pass time.

E. HAZARDOUS MEDICATIONS

1. Special precautions need to be applied when preparing and handling and disposing of hazardous medication. (Refer to Hazardous Drugs Management LHHPP 25-05).

2. Instructions for administering the medication can be found in administration instructions on the MAR.

F. PHYSICIAN ORDER

1. LNs may accept telephone orders from an authorized prescriber (Refer to LHHPP 25-03) and will confirm resident's medication allergies with prescriber and read back the order entered into the EHR for accuracy with the physician. Verbal orders should only be taken during emergent situations when provider is unable to enter the order due to care being provided to resident.

2. STAT medication orders are processed immediately and administered no later than four hours after the order was written.

3. All other medication orders are administered as soon as the medication is available, unless clinical needs warrant more immediate action.

PROCEDURE:

1. Once determined medications are due, and eMAR has been reviewed, minimize distractions or interruptions from preparation to documentation.

2. Determine which resident(s) need medication(s) pulled from Omnicell for this medication pass time only. Do not pull for future med pass times.

. Pull those resident's cassettes from medication cart and place on top of WOW, or bring med cart inside med room if space permits.

i. Ensure each cassette is labeled with the correct resident name.

ii. Do not overcrowd the WOW with too many cassettes.

a. Bring WOW with the resident(s) medication cassette(s) into the medication room.

i. If using medication cart with computer screen attached, bring the entire cart into the medication room.

b. Use resident's order in EHR to retrieve medication from Omnicell for 1 resident at a time.

c. Physically count the medication found in the Omnicell bin and confirm it matches the Omnicell screen count prior to removing the medication.

i. If the count is off, immediately notify your charge nurse and/or nursing supervisor.

d. Once confirmed medication is correct, immediately put the medication(s) into the appropriate resident cassette.

e. Repeat this for each resident that need medication(s) removed if needed.

f. Return to medication cart with WOW and cassettes and put cassettes in medication cart.

   i. Do not place any medication(s) in pockets, cups or other containers. Medications must be placed in appropriate resident cassette, and immediately followed by placing cassettes in medication cart.

3. Log into the EHR and review the medications which will be administered. Remove those medications from resident's cassette and place on top of WOW. Bring the WOW with only the medications to be administered and needed supplies to the resident's side.

4. Confirm with the resident that they are ready to receive their medications in the location they are located if they are not in their room, such as the great room.

   . Support patient privacy/dignity by pulling curtain in room or closing room door prior to administering medications, or confirm with resident that they prefer to not have the curtain pulled and/or the door closed and has care plan specifying this preference

   a. If administering medication(s) in community or common area, such as the great room, confirm with resident they would like to receive medications in that area and resident has care plan specifying preference/acceptance of receiving medications in the common area.

5. Scan the arm band of resident to correctly identify resident and open their MAR.

   . If the resident is wearing their arm band, this will serve as is one form of identification. Then, use a second form of identification to confirm you are administering to the Right Resident.

   a. If the resident is not wearing arm band, navigate to the MAR of the resident who will receive the medications.

   b. Use two forms of identification to confirm the Right Resident. Document an override, and then select the reason why bar code scanning of the resident is not used.

6. Scan medication(s) barcode(s) at bedside/chairside.

7. Compare each medication package to the medication prescribed in the MAR according to first 5 Rights.

8. Immediately prepare medication(s), if appropriate. (e.g., crush), and administer medication(s).

    . If this is the first dose being given, document that the “1st dose” resident education has been performed as appropriate.

9. Remain with the resident until all medications have been taken.

    . Never leave medications at the bedside/chairside.

10. Document in real time in the EHR medication(s) given, not given, etc.

11. Log out of the EHR. If medication cassette was brought to bedside, disinfect it and return the cassette to the medication cart.

ADMINISTRATION OF MEDICATION(S) THROUGH ENTERAL TUBE

1. Request medications be in liquid form whenever possible. If liquid form is not available from the Pharmacy, and a tablet form must be used, crush the tablets (except for enteric coated, hazardous or sustained release medications).

2. Do not add medication directly to an enteral feeding formula.

3. Prior to administering the medication, stop the feeding and flush the tube with at least 15 mL of water.

4. Dissolve the tablets or dilute the medication in at least 30 mL of water, to sufficiently allow for medication to pass through the tube.

5. Each medication should be administered separately. After each medication flush the tube with 15 mL of water.

6. Administer diluted medications or fluids through enteral tubes by gravity or gentle flush using a 60 mL catheter-tip syringe.

7. Give medication at the appropriate time in relation to feeding.

. Some medications should be given with food, while some should be given on an empty stomach with tube feeding stopped for a prescribed interval before and after medication is given (e.g., Dilantin suspension).

a. For proper action, some medications must be delivered into the stomach rather than into the duodenum or jejunum.

b. Consult with pharmacist about administration and drug-drug or drug-nutrient compatibility.

8. Elevate the resident's head of the bed to a minimum of 30 degrees unless otherwise ordered by the physician before administering medication, and for 30 minutes after administration of medication to decrease risk of gastroesophageal reflux and/or aspiration.

9. Confirm correct placement of enteral tube (refer to NPP E 5.0 Enteral Tube Management).

10. Nutritional formula may be given before medications. To flush formula from the tube prior to instilling medication, flush the tube with approximately 15 mL of water using gravity or gentle flush with the syringe.

11. After all medication(s) is administered, instill approximately 15 mL of water to flush medication.

12. If a resident is on fluid regulation, and requires a different flushing schedule, a physician must place order which includes the amount of water to be used for the flushing between each crushed medication.

13. Document the amount of the flush used for medication administration in the flowsheet.

ADMINISTRATION OF NARCOTIC (OPIATE) MEDICATIONS

1. As needed, and for newly admitted residents, the LN will explain to resident that due to hospital safety reasons, confirmation of swallowing is required after administering medication:

    . After performing the six rights of medication administration and administering the narcotic medication, LNs will confirm resident has swallowed the medication by:

        i. Visually inspecting the mouth by requesting the resident opens their mouth and lifts their tongue to view entire mouth.

        ii. Request the resident to repeat a sentence such as “no, ifs, ands, or buts,” to ensure the oral medication have been swallowed.

    a. If resident declines to allow confirmation, notify the resident the narcotic medication will be held and notify provider for further guidance.

        i. Notify the physician of refusal to follow protocol and request for follow-up such as change of order to liquid opioids or crushed medications.

        ii. If resident initially agrees to new procedure but then refuses to open mouth for inspection, stay with resident and ask 2nd LN to notify charge nurse to call physician.

        iii. Notify resident care team of refusal for discussion of alternatives and interventions.

        iv. Document occurrence in a nursing note and update care plan.

2. Administration of buprenorphine-naloxone.

    . Buprenorphine-naloxone should not be swallowed and must be allowed to dissolve in the mouth; therefore, verification of swallow per standard narcotic administration should not be performed.

    a. Buprenorphine administration is as follows:

        i. Place the sublingual tablet or film under the tongue and keep in place until fully dissolved.

            - 5-10 minutes for sublingual tablet

            - 3-8 minutes for film

ii. Resident should not eat, drink, smoke or talk until the film/tablet is completely dissolved.

iii. If other medications are needed at the same time, give these medications prior to buprenorphine-naloxone administration.

b. For buprenorphine induction, physician may order clinical opiate withdrawal scale (COWS).

i. If ordered, document COWS in EHR COWS nursing flowsheet.

ADMINISTRATION OF AEROSOL/NEBULIZER MEDICATIONS

A. Monitor residentResident

1. Before administering the initial treatment, monitor the resident's ability to participate in the medication administration process, and to ascertain the most appropriate gas delivery device (e.g., mouthpiece, mask, etc.).

2. Whenever the resident's condition warrants, and/or per physician's order, monitor heart rate and auscultate lung sounds before and after treatment administration, especially when giving a new medication or when there has been a change in the treatment.

3. Residents who are unable to self-manage the delivery system safely and effectively require frequent or continuous monitoring to ensure proper medication delivery.

B. Administration

1. Refer to Medication Administration: Nebulized -CE Elsevier Clinical SkillsRefer to Appendix 4, follow Manufacturer's Instructions, and/or consult with Pharmacy or Nursing Education for clarification for appropriate use of inhaled medication devices.

2. When using multiple puffs of the same medication, allow at least 1 minute to elapse between each puff.

3. When using multiple inhaled medications, wait 5 to 10 minutes between drugs to get maximum benefit. NOTE: If both bronchodilator and a steroid inhaler are prescribed, use the bronchodilator first.

4. When using a steroid inhaler, rinse the mouth afterwards to help reduce dry mouth, hoarseness, and to prevent fungal growth.

5. Compressor/ Nebulizer (brand name Misty-Fast)

. Use with nebulizer face mask, which has medication cup and lid.

a. Pour medication into the cup. Connect the blue end of the tubing to the cup, and the green end of the tubing to the air source.

b. Air source

i. Nebulizer machine: Do not place machine on soft surfaces. Turn on the machine until mist is no longer produced.

ii. Compressed wall air: Turn on the flow rate at 8 liters per minute for 3-4 minutes or until mist is no longer produced.

iii. For residents with a physician's order for oxygen and the resident is not a known carbon dioxide (CO2) retainer: Oxygen may be used as a delivery method. If using oxygen, set the liter flow at 8 liters per minute for 3-4 minutes, or until mist is no longer produced. Thereafter, set the oxygen at the flow rate prescribed by the physician.

c. For residents able to follow instructions, encourage resident to breathe as calmly, deeply, and evenly as tolerated until the nebulizer stops producing mist.

C. Assessing Resident during treatment and for the effectiveness of treatment.

1. Briefly stop the treatment if rest is needed. Provide assisted coughing and expectoration as needed and suction as clinically indicated.

2. Assess the resident's response to treatment.

ADMINISTRATION OF EYE MEDICATIONS

A. Eye Drops

a. Using your finger, pull lower lid down gently to form a small pocket (cul-de-sac).

b. Instruct the resident to tilt head back and look upward.

c. Gently squeeze a drop into the center of the lower lid (cul-de-sac). If more than one drop is prescribed wait at least one minute between drops of the same medication.

d. Do not touch the dropper tip to eye, or any surface, in order to avoid contamination of the solution.

e. Apply pressure to the nasolacrimal duct (inner canthus) after each prescription eye medication for 30 seconds to prevent possible systemic effects.

f. Do not wipe the dropper or rinse under water

g. Instruct the resident to close both his eyes and to keep them closed for a full minute without squeezing.

h. To blot excess eye drops from the eyes, use a clean, separate tissue or gauze for each eye.

i. If a resident has an order for more than one eye medication, wait about five minutes between drugs to prevent one medication from washing the previous medication away

B. Eye Ointments

a. To administer eye ointments, apply a small strip of ointment into the cul-de-sac pocket. Avoid contacting the tube tip with the eye.

ADMINISTRATION OF MEDICATIONS IN EAR

A. Have resident lie on side or sit with his/her head tilted and hand supporting the head on the unaffected side.

B. Use medication at room temperature.

C. Clean external orifice gently with cotton swab.

D. Gently pull the pinna upward and outward to straighten the auditory canal

E. Drop the prescribed amount of medication against the side of the ear canal and hold the ear in position for a moment to enable the drop to spread down the canal.

F. Have the resident maintain his position for a few moments.

G. Place a tissue or gauze loosely at canal opening to protect the canal and catch any outflow.

ADMINISTRATION OF MEDICATIONS IN THE NOSE

A. Nose Drops

a. Have resident lie flat with his head slightly lower than the shoulders.

b. Steady resident's head. Holding the dropper in a vertical position near the nasal opening, instill the number of drops ordered.

c. Keep the resident in position for at least two minutes. During this time, instruct the resident to sniff three or four times and not to blow his nose.

B. Nasal Spray

a. Resident may be in a sitting position during this procedure.

b. Place the tip of the bottle in resident's nostril.

c. Instruct resident to sniff up as you simultaneously squeeze the lower portion of the bottle.

d. Instruct resident to continue sniffing 3-4 times, and ask that he not blow his nose for at least two minutes.

SPECIAL CONSIDERATIONS:

1. If the resident does not wish to take medication(s) at the prescribed time, you may attempt to return and administer later if medication is still unopened and in the original packaging.

2. If medication(s) is not given within the time schedule, review “Appendix B: Specific Medication Administration Times and Abbreviations” to avoid giving time sensitive medications outside acceptable timeframe and according to special considerations.

3. Other medications should be reviewed for modification of times (see Policy Statement #9.

4. If non-time-sensitive medications are given outside of the time schedule, document the rationale in the override section of eMAR.

5. If medications have been prepared/removed from packaging, and resident does not take the medication(s), the medication must be wasted and documented in eMAR.

6. Request from pharmacy any missing doses and/or need for replacement.

PREPARATION FOR INJECTABLE AND PARENTERAL MEDICATIONS AND IV FLUID

1. IV medication prepared by pharmacy and IV fluid bags will have a medication label which includes a bar code for administration.

2. In urgent situations, if RN needs to prepare IV drip, it must be labeled with resident name, date and time of preparation, medication name, strength and amount, and name of person preparing.

3. Prepare parenteral medication and fluids in a clean workspace away from distractions.

4. Prepare the IV as close as possible to administration time and administer no more than 1 hour after reconstitution, such as spiking IV fluid bag, spiking prepared IV antibiotic bag, or reconstituting antibiotic.

5. Exception: Insulin and IM injections should be drawn into syringe at time of administration.

SHAKING MEDICATIONS OR MIXING A SUSPENSION

1. Medications labeled “shake well” must be shaken vigorously to evenly distribute the dose, immediately before administration.

2. Medications which require mixing, but are not to be shaken, should instead be “rolled.”

3. Any rolling motion used is acceptable as long as the suspension appears milky, and the rolling action has not created bubbles.

CARDIOVASCULAR DRUG PARAMETERS NURSING PROTOCOL

1. Scan the arm band of resident to correctly identify resident and open their eMAR.

2. Every cardiovascular drug requires vital sign monitoring as outlined below:

    a. Frequency of monitoring:

i. Monitor and document in flowsheet the heart rate for antiarrhythmic medications or combined antiarrhythmic/antihypertensive medications before each dose, for 7 days, then weekly.

ii. Monitor and document in flowsheet the blood pressure for antihypertensive and combined antiarrhythmic/antihypertensive medications before each dose for 7 days, then weekly.

b. Default parameters:

i. Hold medication for SBP < 105 and/or hold for HR < 55.

ii. If the systolic BP or heart rate is below the specified parameter, hold medication and notify physician. The nurse will document medication held in the eMAR and notify physician.

c. If the physician desires more frequent monitoring they will specify parameters which will be in the EHR.

d. Whenever the nurse believes per his/her judgement that more frequent monitoring is warranted, they may check vital signs per their scope of practice.

e. If a resident is on weekly cardiovascular monitoring schedule, and a medication is held, the LN will monitor and record cardiovascular monitoring before each dose, for a minimum of 3 additional days, to assist in the evaluation of therapy. The medication will continue to be administered as scheduled unless outside of specified parameters. Weekly monitoring may be resumed without written physician orders only after physician has been notified of outcome of monitoring, and the resident's vital signs have been outside of the hold parameters for 3 consecutive days.

3. PRN Cardiovascular Medication Orders

a. When a PRN cardiac medication is ordered to be administered for blood pressure above a specified parameter, the blood pressure is to be re-checked within 30-60 minutes of the time the medication was administered. If the blood pressure continues to remain above the parameter, the physician is to be called for further orders.

SPECIAL MONITORING REQUIREMENTS

1. Antibiotics

a. Document VS and response to therapy once every shift for duration of therapy.

2. Pain

    a. Document pain scores per pain management policy. (Refer to HWPP 25-06**)**

3. Psychoactive Drugs (Refer to HWPP 25-10 and NPP J2.5)

4. High Alert Drugs (Refer to HWPP 25-01)

5. Hazardous Medications (Refer to HWPP 25-05)

6. Controlled Substance Medications (Refer to Pharmacy P&P 09.01.00)

SHIFT-TO SHIFT~~TOSHIFT~~ LN REPORTING

1. During change of shift, hand-off and when reporting to team lead or charge nurse, report:

    a. Any new medications started, indication and monitoring required.

    b. Any suspected Adverse Drug Reactions (ADRs).

    c. If receiving medication that requires monitoring, report clinically relevant data including abnormal VS or laboratory results.

    d. Time or food sensitive medications to be given on incoming shift.

    e. PRNs given at end of shift requiring evaluation of effect.

    f. Refusal of medication.

2. Document application and location of patch in the eMAR.

3. Verification of patch placement and monitoring

    a. Inspect site of application every shift to verify that the patch remains in place.

    b. Document verification in the eMAR.

    c. If the patch has come off, attempt to locate the patch and dispose of it. If the patch is not recovered, complete an unusual occurrence report. Reapply a new patch and document per application procedure above.

    d. Do not apply heat source to the patch as it may enhance absorption and result in bolus administration. Note: high fever can result in bolus effect as well.

e. If resident is diaphoretic, the patch may come off. In some instances, applying a transparent dressing covering the patch may help to keep it in place.

f. The resident may shower, wash and bathe with the patch in place, as long as not scrubbing over the patch area which will disturb the adhesive.

4. Disposal

a. Fentanyl patch disposal requires a two LN independent check of medication disposal and will be documented in Omnicell.

b. After removing the patch, fold the old patch in half so that the adhesive sides are in contact, request 2nd license nurse to witness the disposal in medication room disposal container and both LN's will complete documentation of the waste in Omnicell.

SELF-ADMINISTRATION

The resident must be assessed by the Resident Care Team (RCT) and determined to be able to safely self-administer medications and re-assessed quarterly and as needed thereafter. The assessment of the residents' ability to self-administer medications and/or herbal supplements will be documented in the RCT note and include input from the resident during this process.

1. Self-Administration

a. The RCT and other disciplines as indicated, will collaborate to assess the residents' ability to participate in medication and/or herbal supplement self-administration. This assessment must include:

i. The medications appropriate and safe for self-administration.

ii. The resident's physical capacity to swallow without difficulty and to open medication bottles;

iii. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for;

iv. The resident's capability to follow directions and tell time to know when medications need to be taken;

v. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.

vi. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.

vii. The resident's ability to ensure that medication is stored safely and securely. Appropriate notation of these determinations must be documented in the resident's medical record and care plan.

b. If the resident assessment or re-assessment has determined that a resident cannot safely self-administer medication this will be communicated to the physician and to the resident.

c. A resident may only self-administer medications and/or herbal supplements after the appropriate orders have been placed and the assessment is complete.

d. Orders will be entered in the EHR for medications and herbal supplements.

e. The LN will observe the resident self-administer prescribed medications and herbal supplements and will follow the 6 Rights of medication administration including scanning of resident and the medications and/or herbal supplements the resident is self-administering.

f. The resident will prepare and take their own prescribed medications and/or prescribed herbal supplements, which are kept in the medication cart, under the supervision of the LN. The LN will observe self-administration preparation at each medication time and answer the resident's questions, or reinforce the teaching as indicated.

g. If the nurse notices the resident is about to make an error, the nurse will intervene to stop the preparation. The nurse will also discuss and clarify with the resident the accurate manner of self-administration. The RCT will be kept informed of any change in the residents' ability to safely self-administer, or the need to re-evaluate the resident for self-administration of medications and/or herbal supplements.

h. The LN observing the resident taking the appropriate prescribed medications and/or herbal supplements via self-administration will document in MAR as 'given' and "self-administered"

i. For self-administration of a rescue medication stored at bedside that was not observed, the resident will report to the LN who will document in the MAR as given and "self-administered" and include a comment of 'patient reported' in the MAR.

i. If a resident fails to report self-administration of a medication despite on-going education, the RCT will re-assess if self-administration is appropriate

j. Education and training skills will be documented, and care planned in the EHR.

k. The storage of all medications and/or supplements for self-administration will follow Pharmacy Policy 02.01.03: Bedside Storage of Medications

2. Bedside Medication (Refer to Pharmacy Policy 02.01.03: Bedside Storage of Medications)

WASTING MEDICATION

1. Medications that are not administered must be disposed of in the appropriate medical waste container (See LHHPP 73-11 Medical Waste Management Program & LHHPP 25-05 Hazardous Drugs management).

    a. Any opened unused medications, and containers that may contain residual medications, shall be disposed of in the appropriate pharmaceutical waste container (including crushed, dissolved or disguised medications). Nonhazardous medications shall be disposed of in either the blue and white pharmaceutical waste bin or the yellow and white pharmaceutical waste bin. Hazardous drugs shall be disposed of in the yellow and white pharmaceutical waste bin.

        i. Whole pills out of the package, such as those refused by resident, dropped on floor, or opened in error, should go in medication waste bin.

        ii. Empty medication cups go in the garbage.

        iii. Crushed, whole pills or liquid medications that are mixed with liquid or food that is not entirely consumed go in the med waste.

        iv. The empty spoon can go in the garbage.

        v. If resident consumes the entire amount of apple sauce or pudding or liquid the medication was in, the empty container it was in can be crushed and put the garbage.

        vi. For residents who are at risk for digging through the garbage, care plan your intervention to attempt to minimize and avoid this behavior.

        vii. Cups which had medication it, and the contents were consumed can also be crushed and go in the garbage.

viii. Empty packets of powered medications can be thrown in the garbage.

2. The LN must secure narcotics/controlled substances from time of receipt/removal from Omnicell to administration by having in physical possession or securely locked in medication cart.

3. Narcotics/controlled substances that are removed and not administered and/or are only partially administered, shall be immediately wasted in pharmaceutical waste container with witness of a 2nd LN.

    a. The need for partial wasting shall be identified prior to leaving the medication room.

    b. A 2nd LN shall be present to initiate controlled substance waste.

    c. The 2nd LN shall witness both when the medication is still in the sealed packaging and the wasting of the partial does.

    d. Both LNs shall document the waste in Omnicell.

4. If resident refuses medication, the LN shall return the medication to original package.

    a. 2nd LN will also witness the waste of the controlled substance in the Omnicell.

    b. 2nd LN can validate and ID medication for partial doses, as packaging has been opened.
        i. This may be done via looking up the IC medication tag through Lexicomp.

    c. 2nd LN shall witness actual wasting of controlled substance medication that was refused by the resident.

    d. Both LNs shall document waste in Omnicell.

EMERGENCY MEDICATIONS – CODE BLUE AND EMERGENCY BOX

Emergency Box and Crash Cart store medications that are used for emergency situations and during CODE BLUE. Locks are checked and documented on the Emergency Equipment / Refrigeration Monitoring Sheet.

THERAPEUTIC LEAVE/OUT ON PASS MEDICATIONS

1. For planned trips away from the hospital, the attending physician will place an order in the the EHR for each out-on-pass medication, including controlled substance

medications. The order shall include the name of the medication, strength, directions for use, and the number of days needed.

i. The nurse will have the order filled at the hospital Pharmacy.

ii. The pharmacist will dispense the medications in properly labeled child-proof containers.

iii. The nurse will review the directions and check the number and appearance of the drug with the resident or responsible person.

2. When the Pharmacy is closed the physician may dispense only the amount of medications for the duration of the pass from the resident's own medication supply, and will record the drugs and quantity dispensed on the Physicians Order Sheet in the Medication Record.

i. Controlled substances may not be dispensed by the physician from the neighborhood's supply. When the Pharmacy is closed, the Nursing Supervisor will contact a pharmacist at home.

ii. Blank prescription labels and empty child-proof containers will be available in the Supplemental Drug Supply Room for the physician to properly label the pass medications taken from the resident's own supply.

iii. The physician will counsel the resident on proper use of his/her medications.

3. When Resident is on therapeutic leave/out on pass, the MAR will be on hold status.

PERSONAL MEDICATION

1. Medications brought into LHH with the resident at admission:

a. Will be given to family or guardian to take home.

b. If medications are not returned to family or guardian, they are to be taken to Pharmacy or placed in the pharmacy pick-up tray.

c. Pharmacy manages the medications and may dispose of as necessary.

d. Personal medications are permitted only to assure continuous therapy while awaiting replacement by LHH Pharmacy. Such medications are not to be used unless the physician enters an order to use them.

e. If the physician orders use of the medication, the medications are verified,

relabeled, and reissued according to Pharmacy department policies. The nurse is not to administer the medication unless it has been relabeled by the LHH Pharmacy.

2. Personal medications will not be obtained, stored or used by residents.

3. If a resident or family member requests that medication(s) be filled by other than the Laguna Honda Hospital Pharmacy, refer the request to the Pharmacy Director.

MISSING MEDICATIONS

1. After confirming a medication that is due is missing, document on the MAR the med is not available, and actions taken to secure a supply.

2. Notify pharmacy via MAR message of need for dose

3. Administer when dose is available

4. If dose is grossly overdue, confer with physician and/or pharmacy on administering vs waiting till next dose is due

5. If not administered on shift it is due, a brief note should be entered in EHR indicating plan and follow up

EXCESS MEDICATIONS

If resident is refusing medications and there is an excess of medications, return excess medications to~~notify~~ the Pharmacy.

ATTACHMENT:

Appendix I Specific Medication Administration Times
Appendix II Use of Identification Cards for Resident Identification for Bar Code Medication Administration
Appendix III – LN Wasting Controlled Substance (Partial Dose and Resident Refuse Meds)

REFERENCE:

Lexicomp Online website: ~~http://www.crlonline.com/crlsql/servlet/crlonline~~
Institute for Safe Medication Practices Link. Oral dosage forms that should not be crushed. Institute for Safe Medication Practices. Retrieved from :
http://www.ismp.org/tools/donotcrush.pdf or
https://onlinelibrary.wiley.com/doi/epdf/10.1177/0148607116673053
AeroChamber Plus® Flow-Vu® Cleaning Instructions
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Mosby's Skills – Elsivier: Medication Administration:Nebulized – CE: https://point-of-care.elsevierperformancemanager.com/skills/372/quick-sheet?skillId=GN_20_9&virtualname=sanfrangeneralhospital-casanfrancisco
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~~EBSCO - Nursing Reference Center - How to Use Your Metered Dose Inhaler (Adults)~~
~~Lippincott, Williams, & Wilkins, Best Practices: Evidence-Based Nursing Procedures, 2nd ed, 2007~~
~~Nettina, Sandra, Lippincott Manual of Nursing Practice, 8th edition, 2005~~

CROSS REFERENCES:

LHHPP File: 25-01 High Risk – High Alert Medications
LHHPP File: 25-02 Safe Medication Orders
LHHPP File: 25-03 Verbal/Telephone Orders
LHHPP File: 25-04 Adverse Drug Reaction Reporting Program
LHHPP File: 25-05 Hazardous Drugs Management
LHHPP File: 25-06 Pain Assessment and Management
LHHPP File: 25-08 Management of Parental Nutrition
LHHPP File: 25-10 Use of Psychoactive Medications
LHHPP File: 25-11 Medication Errors and Incompatibility
LHHPP File: 72-01 B8 Medication Handling/Dispensing Guidelines
LHHPP File: 73-11 Medical Waste Management Program
LHHPP File 25-13 Herbal Supplements
LHH Pharmacy P&P 01.02.02 Stop Orders
LHH Pharmacy P&P 02.01.02 Disposition of Medications
LHH Pharmacy P&P 02.02.02 Fentanyl Transdermal Patches
LHH Pharmacy P&P 09.01.00 Automated Medication Dispensing Cabinets
LHH Pharmacy P&P 02.01.03: Bedside Storage of Medications
LHH Pharmacy P&P 02.02.00 Controlled Substances
LHH Pharmacy P&P 02.02.00b Distribution of Medications and Medication Order Processing
Nursing P&P C 9.0 Transcription and Processing Orders
Nursing P&P E 5.0 Enteral Tube Management
Nursing P&P J 2.5 Monitoring Behaviors and Effects of Psychoactive Meds
~~Nursing P&P J 1.3 Aerosol/Nebulizer Medications.~~
Nursing P&P I 5.0 Oxygen Administration
Nursing P&P J 7.0 Central Venous Access Device Management
~~Nursing P&P *** Herbal Supplements: Formulary and Non-Formulary~~

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Revised: ~~23/10/10~~ (Year/Month/Day)

MANAGEMENT OF DYSPHAGIA AND ASPIRATION RISK

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center shall implement procedures to safely manage the care of residents identified to be at risk for aspiration.

2. The facility recognizes the resident's or designated surrogate decision maker's right to make an informed decision where the resident's enhanced quality of life, provided by eating and drinking, may be of greater importance than reducing the risk of aspiration.

PURPOSE:

To promote resident safety and enhance resident quality of life with respect to diet and feeding interventions.

DEFINITIONS:

1. Standard Aspiration Precautions:

    i. Oral care

    ii. Resident to sit upright as possible (elevate Head of Bed if cannot transfer to chair) with all meals and 20 minutes after eating, including medications

    ~~ii.~~iii. Dentures in place

    ~~iii.~~iv. Minimize distractions

    ~~iv.~~v. Small bites and sips

    ~~v.~~vi. Slow rate of intake

2. Individualized Aspiration Precautions

Individualized aspiration precautions may be recommended by Speech Language Pathology (SLP) following a Dysphagia Evaluation and/or diagnostic treatment; examples include, but are not limited to:

    i. No straw

    ii. Alternating solids and liquids

    iii. Chin tuck

~~iii.~~iv. Head turn

~~iv.~~v. Head tilt

~~v.~~vi. 1:1 Supervision

~~vi.~~vii. 1:1 Assistance

~~vii.~~viii. Cutting food into small pieces

~~viii.~~ix. Liquids by spoon only

~~ix.~~x. Close supervision

~~x.~~xi. Line of sight supervision

~~xi.~~xii. PMV in place for all PO

xiii. Frazier Free Water Protocol

3. Line of Sight: Resident ~~– resident~~ is within view of staff while eating.

4. Close Supervision: One ~~– one~~ staff member ~~sits~~sitting with no more than 4 residents to provide supervision during mealtime. Staff shall ensure that recommended aspiration precautions (e.g., standard precautions or individualized precautions as recommended by SLP~~speech therapy~~ and ordered by the physician) are followed by actively cueing, assisting, and/or observing the resident during mealtime.

5. 1:1 Supervision: Resident receives ~~– resident needs~~ direct assistance or supervision during oral intake (e.g., cognition adversely effecting swallow function increasing risk of aspiration due impulsive self-feeding, ~~eating beh~~cues required~~needed, unable~~ to follow standard~~feed self, level of risk for~~ aspiration precautions, HIGH risk of aspiration)

6. Frazier Free Water Protocol: Free water is permitted before and between meals with clean oral cavity. Free water is not permitted with meals, medications or other oral intake.

PROCEDURE:

1. Identification of At-Risk Residents

a. Residents shall be evaluated by the Resident Care Team (RCT), at minimum this will include a physician~~)~~ and a nurse, to determine ~~identified as being at~~ risk for

aspiration. Clinical ~~if they have clinical~~ signs that suggest risk of aspiration include, but are not limited to the following:

i. drooling and/or poor oral management of secretions and/or bolus;

ii. ineffective chewing;

iii. food or liquid remaining in the oral cavity after the swallow (oral residue);

iv. inability to maintain lip closure, leading to food and/or liquids leaking from the oral cavity;

v. extra time needed to chew or swallow;

vi. food and/or liquids leaking from the nasal cavity;

vii. complaints of food "sticking" or complaints of a "fullness" in the neck;

viii. complaints of pain when swallowing;

ix. changes in vocal quality (e.g., wet or gurgly sounding voice) during or after eating or drinking;

x. coughing or throat clearing during or after eating or drinking;

xi. difficulty coordinating breathing and swallowing;~~/aspiration, demonstrate unsafe eating behaviors or have other conditions that place them at risk (e.g., reduced alertness, need to be fed in a reclined position, partially or completely edentulous with no dentures). At a minimum, the RCT includes a physician and a nurse.~~

xii. acute or recurring aspiration pneumonia/respiratory infection and/or fever

xiii. food or liquid in tracheal secretions

~~a.~~ Once a

~~b. If the~~ resident is ~~partially or completely edentulous with no dentures:~~

~~c.~~

~~d. The RCT shall assess if the prescribed diet is deemed safe;~~

~~e.~~

~~f. The~~ identified as being at risk for aspiration, the physician shall order Dysphagia Evaluation.~~refer~~~~order a dysphagia evaluation if the residents' ability to safely swallow the prescribed diet is in question.~~

~~g.~~

~~h. The registered dietitian shall assess the residents' ability to tolerate the prescribed diet~~

~~i.~~

~~j.~~b. ~~The physician shall document discussion regarding aspiration risk if the resident~~ for a Dysphagia Evaluation by SLP. ~~is prescribed a diet other than pureed and;~~

If appropriate, the

i. ~~The~~ physician will~~shall~~ refer the resident to the dental clinic for evaluation. ~~unless there is documented reason by the physician that the referral is not necessary.~~

~~k. Once a resident has been identified as being at risk for aspiration, Nursing shall place a pink dot at the head of the resident's bed and give the resident a pink sticker on their wristband. Staff and volunteers shall be trained on this color coding system and what it means.~~

~~l.~~ Residents with individualized~~who are assessed to be at risk for aspiration, excluding those who are unable to eat by mouth (also known as NPO), shall be identified and have a physician's order for standard~~ aspiration precautions~~, which include the following:~~

~~i. Line of sight supervision~~ whose swallow function appears ~~when eating, unless documented otherwise in the Medical Record.~~

~~ii. Resident shall be positioned as upright as possible when eating/drinking, and the resident's head prevented from tilting back, as possible.~~

~~iii. Resident shall be fed/cued~~ to have improved or declined,~~eat slowly, taking small bites.~~

~~iv. When feeding a resident, make sure that the resident swallows each bite before continuing feeding.~~

~~v. Resident shall remain upright for 20 minutes after a meal.~~

~~2. Indications for Referral to Speech Pathology for a Dysphagia Evaluation~~

~~a.~~c. ~~Residents who fall into one or more of the following categories~~ shall be referred to SLP for re~~-, by physician's order, to the Speech Pathology Department for a dysphagia~~ evaluation.~~:~~

~~i. Those admitted with a known swallowing disorder, or history that is suspicious for dysphagia (unless NPO and not a candidate for oral feeding).~~

~~ii. As described under Procedure 1 b (ii).~~

~~iii. Those who have clinical signs of dysphagia or aspiration and are candidates for ongoing oral feeding. Indications for referral to Speech Pathology include, but are not limited to, the following: coughing, choking, holding food in mouth, significant pocketing of food, significantly delayed swallow, significant leakage of food or liquid from mouth, food or liquid coming from tracheostomy, and/or recurrent pneumonias. If in doubt about whether or not a referral is indicated, contact the Speech Pathology Department.~~

~~iv. Alert residents who are being considered for enteral feeding, unless clinically inappropriate (Refer to LHHPP 26-03, Enteral Tube Nutrition), and those on enteral feeding whose clinical condition has improved sufficiently that they may be candidates for oral feeding.~~

~~v. Residents with a known swallowing disorder or clinical signs of dysphagia and/or aspiration who are being considered for a diet upgrade. (If a decision to upgrade a resident's diet has already been made for quality of life reasons, referral is not necessary, but may be indicated in order for a Speech-Language Pathologist to provide training regarding reducing the risk of aspiration on the upgraded diet. All necessary documentation regarding a resident's or surrogate decision maker's understanding of risks vs. benefits of upgrading diet and agreement to accept risks must be in place prior to the Speech Pathologist's intervention).~~

~~b.~~d. Referral to the SLP for **Dysphagia Evaluation** ~~Speech Pathology Department~~ may also be indicated in cases of unexplained weight loss, dehydration, and/or poor oral intake, ~~in order~~ to rule out dysphagia as a contributing factor.

~~Dysphagia evaluation is by physician order only. If the evaluation is considered clinically urgent, the physician shall mark the order "urgent" and call the Speech Pathology Department.~~

~~RCT members shall alert the physician when signs of dysphagia, aspiration, or change in swallowing function are observed.~~

~~**Dysphagia Evaluation**~~

2. Dysphagia Evaluation by SLP

~~c.~~a. Dysphagia Evaluations~~evaluations~~ shall be carried out as per~~by a~~ Rehabilitation Center Policy and Procedure #90-05, Establishment of Treatment Programs and Documentation: Dysphagia.

~~d. When a Dysphagia~~ Evaluation and/~~of Residents for Upgraded Food/Liquid Consistencies~~

~~When a dysphagia evaluation involves upgraded food~~ or diagnostic treatment requires a tray that includes items that are ~~liquid consistencies~~ not consistent with~~currently included in~~ the resident's current diet order, the following tray precautions~~Tray Precautions~~ shall be taken:

i. The SLP~~Speech Pathologist~~ shall contact Nutrition Services and ask them to write "Hold for Speech Therapy" on the tray ticket.

SLP
ii. ~~The Speech Pathologist~~ shall notify Nursing and request that the tray not be served until the SLP~~Speech Pathologist~~ arrives.

iii. Nursing staff shall hold the tray for SLP~~Speech Pathology~~ and shall not give it to the resident.

SLP
iv. ~~The Speech Pathologist~~ is responsible for removing any food or liquid items inconsistent with~~not included in~~ the resident's current diet order before leaving an unfinished tray with the resident upon completion of the session.

3. Dysphagia diagnostic Treatment

a. Following a Dysphagia Evaluation, SLP~~dysphagia evaluation, the Speech Pathologist~~ shall proceed with diagnostic dysphagia treatment as clinically~~swallowing therapy, when~~ indicated.

b. If treatment involves upgraded food/liquid consistencies not currently included in the resident's diet order, tray precautions~~follow Tray Precautions~~ delineated in paragraph 2b~~3b~~i -ii~~-iv~~, above will be followed.~~.~~

4. Diet Initiation following Dysphagia Evaluation and/or Diagnostic Treatment

a. Upon completion of evaluation and or diagnostic treatment, SLP shall document the recommended least restrictive diet including, standard and/or individualized aspiration precautions or if the resident should be NPO in the Dysphagia Evaluation and/or progress notes.

a. SLP will pend diet orders accordingly in EHR for physician review and signature.~~Referral to Occupational Therapy~~

~~Occupational Therapy consultation shall be considered if positioning of the resident during feeding is difficult or body posture increases aspiration risk.~~

~~Occupational Therapy consultation requires a physician order and a referral form.~~

i. The Dietitian and diet tech will be notified via EPIC Secure Chat by SLP regarding individualized aspiration precautions to be printed on the resident's meal ticket.

b. The SLP shall review recommended individualized aspiration precautions with Nursing staff and provide training, as needed. Nursing will update care plan accordingly.

5. Management of Residents Who Are at Risk for Aspiration

a. Once a resident has been identified by SLP as requiring individualized aspiration precautions and being at risk for aspiration, nursing shall place a pink dot at the head of the resident's bed and place a pink sticker on the resident's wristband and/or mobility device as per NPP B5.0 Color Codes. Staff and volunteers shall be trained on this color-coding system and what it means.

i. Residents with a pink sticker on their wristbands and/or mobility device shall not be given or sold food/liquid by anyone who is not aware of the resident's feeding needs.

b. Certified and Licensed nursing staff shall be provided with mealtime competency training by Department of Education and Training or designated trainers upon hire and annually. Facility personnel shall be trained on standard aspiration precautions, individualized aspiration precautions and signs/symptoms of aspiration upon hire and annually.

~~a.~~c. Staff who are feeding or supervising residents determined~~designated~~ to be at risk for aspiration are responsible for ~~knowing and~~ complying with the resident's diet order, standard aspiration precautions, and any individualized precautions assigned to the resident.

~~6.~~

~~a. Certified and Licensed nursing staff shall be provided with mealtime competency training by Nursing Education or designated trainers upon hire and annually. Facility personnel shall be trained on choking prevention and intervention upon hire and annually.~~

~~7.~~

~~a. A sign directing visitors to check with the neighborhood nursing staff before serving food or drinks to a resident is located in the Pavilion Lobby and designated areas.~~

~~8.~~

~~a.~~d. Nursing is responsible for ensuring that family members and regular visitors who assist residents with their meals have been trained. If a family or volunteer needs additional training regarding feeding techniques individualized aspiration

precautions, nursing may recommend referral to SLP Speech Pathology. Staff shall document family or volunteer training in the medical record Electronic Health Record and resident care plan, including the date of training.

~~9.~~

a. ~~Residents~~ Signage directing visitors to check with the neighborhood nursing staff before serving food or drinks to a resident ~~pink sticker on their wristbands~~ shall ~~not~~ be posted in~~given or sold food/liquid by anyone who is not aware of the resident's feeding needs.~~

~~10.~~

~~a.~~e. ~~Diet texture modifications (including thickened liquid) or enteral feeding, may be ordered to reduce~~ the Pavilion~~risk of aspiration. These interventions may be suggested by the Speech Pathologist following a swallowing evaluation but shall be implemented only after careful resident assessment by the RCT and orders changed by the physician. Diet texture modification for purposes of reducing aspiration risk is a form of treatment and, as with enteral feeding, is subject to quality of life considerations/Advance Care Planning (Refer to LHHPP 24-05, Advance Care Planning, and LHHPP 26-03, Enteral Tube Nutrition).~~
Lobby and designated areas.

~~b.~~f. For residents whose nutrition is via enteral tube, Nurses shall follow interventions to reduce aspiration risk as per Nursing policies and procedures (Refer to NPP E5.0 Enteral Tube Feeding Management).

~~**Individualized Aspiration Precaution**~~

~~Individualized (vs. standard) aspiration precautions may be developed by the Speech Pathologist following a swallowing evaluation; Examples include:~~

~~Close supervision when eating and drinking~~

~~Provide cues/assist for unsafe eating behaviors~~

~~Thin down thick food~~

~~Small~~

6. Referral to Occupational Therapy OT

a. Referral to Occupational Therapy shall be considered if positioning of the resident during feeding is difficult, or body posture increases aspiration risk.

b. If indicated, the physician shall write an order for Occupational Therapy consultation.

~~a. Nutrition Services shall print the list of individualized precautions recommended by speech therapy on the meal ticket, providing an easy reference for caretakers.~~

~~11. Residents with individualized precautions, whose swallow function appears to have improved or declined, shall be referred to Speech Pathology for re-evaluation and updating of precautions, as needed. When a reevaluation is not indicated and Speech Pathology is no longer treating or routinely re-checking the resident, the Speech Pathologist may be invited to attend RCT meetings for that resident with individualized aspiration precautions.~~

~~12.~~

~~13.~~7. ~~8.~~**Follow-Up**

a. Physician's order is required.

~~14. The Speech Pathology Department is available to monitor any resident during a meal who has been seen for a dysphagia evaluation, is on the diet recommended by Speech Pathology, and has not had any change in condition. The request may be made by any member of the RCT. No physician's order is required. The Department shall be contacted directly by phone. A physician's order for a reevaluation is required for patients whose diet was either upgraded or downgraded without the involvement of the Speech Pathology Department, when there has been a change in condition, or when re-evaluation for diet upgrade is being requested.~~

~~15.~~

~~16. When an order with aspiration precautions is discontinued without the involvement of the Speech Pathology Department, the reason(s) shall be documented in the medical record by the physician and licensed nurse. The Diet office shall also be notified in order to delete the information from the tray ticket.~~

~~17.~~

~~18.~~8. ~~Documentati~~**Informed Decision** **Making for Diet Recommendations outside of SLP Recommendations**

a. When the resident or surrogate decision maker chooses not to accept ~~the risks of a diet upgrade, or not to accept~~ the recommendation/benefits of a therapeutic diet and feeding interventions, documentation of discussion regarding the informed decision shall be reflected in the Resident Care Conference by the physician and nursing staff in the meeting notes, advance directives, and the resident care plan.

b. When an order with individualized aspiration precautions is discontinued without the involvement of SLP (e.g. for quality of life reasons) the reason(s) shall be documented in the Electronic Health Record by the physician and licensed nurse. The Diet office shall also be notified to delete the information from the tray ticket.

c. Diet texture modification for the purposes of reducing aspiration risk is a form of treatment and, as with enteral feeding, is subject to quality-of-life considerations/Advance Care Planning (Refer to LHHPP 24-05, Advance Care Planning, and LHHPP 26-03, Enteral Tube Nutrition).

~~c.~~d. The resident care plan shall include care plan approaches for minimizing the risk of aspiration.

9. Other Considerations

~~10. Others~~

a. Regardless of the code status, residents shall be provided with rescue interventions in the case of choking or aspiration events.

b. The Medical Examiner shall be contacted by the physician in the event that~~case of~~ choking, or ~~an~~ aspiration may have been related~~event that leads~~ to the cause of death.

ATTACHMENT:
None

REFERENCE:
ASHA
LHHPP 24-05 Advance Care Planning
LHHPP 24-10 Close Observation
LHHPP 26-03 Enteral Tube Nutrition
LHHPP 26-04 Resident Dining Services
MSPP C01-04 Death Which Must Be Reported to the Medical Examiner-Coroner
NPP A3.0 Nursing Education Programs
NPP B5.0 Color Codes- Resident Identification
NPP E1.0 Oral Management of Nutritional Needs
Rehabilitation Center P&P 90-05 Establishment of Treatment Programs and Documentation: Dysphagia

Revised: 99/01/12, 99/03/25, 99/11/09, 00/03/09, 00/08/04, 02/09/17, 04/08/18, 08/08/26, 09/01/13, 09/10/09, 10/04/20, 10/08/24, 11/09/27, 14/01/28, 16/01/12, 17/07/11, 19/03/12, 21/09/14, 22/07/14, 23/01/10, 26/07/24 (Year/Month/Day)
Original adoption: 98/04/01

IN-HOUSE REFERRALS FOR REHABILITATION SERVICES

POLICY:

It is the responsibility of Laguna Honda Hospital and Rehabilitation Center (LHH) to provide residents with a full range of physical therapy, occupational therapy, and speech pathology~~, audiology, and physiatry services~~.

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PURPOSE:

To assure that each referral is processed and addressed in a timely and efficient manner.

PROCEDURE:

1. Requests for rehabilitation services or evaluations shall be made by the referring physician via the electronic health record (EHR).

2. The evaluation, recommendations and/or subsequent treatments shall be documented in the EHR.

3. Physical therapy, occupational therapy, and speech pathology, will~~audiology and physiatry shall~~ respond to referrals within 24 – 48 hours during business~~five (5) working~~ days, excluding holidays.

ATTACHMENT:

None.

REFERENCE:

None.
Reviewed: 22/04/21
Revised: 08/8/22, 09/01/13, 19/07/09 (Year/Month/Day)
Original adoption: 92/05/20 (MSPP); 01/01/11 (LHHPP)

GUIDELINES FOR INPATIENT REHABILITATION FACILITY DOCUMENTATION

POLICY:

1. Patients who are admitted to the Pavilion Mezzanine Acute Rehabilitation unit (PMR), which is designated as an Inpatient Rehabilitation Facility (IRF), shall have required assessment and documentation completed in a timely manner.

2. ~~Resident Care Team (RCT)~~ Interdisciplinary Team (IDT) members are responsible for the timely completion of patient assessment, evaluation and progress note documentation for their respective disciplines at admission, discharge and throughout the acute rehabilitation patient's stay.

3. The medical records of all patients admitted to the IRF must contain documentation that reflects the patient's need for admission and ongoing need for intensive rehabilitation delivered by the ~~RCT~~IDT.

4. All patients admitted to the IRF shall have an Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) completed electronically at admission and discharge.

5. The Utilization Management (UM) nurse shall notify the RCT and Patient Billing of Medicare A eligible patients who are admitted to the IRF and their respective Assessment Reference Day (ARD) dates within 24 hours of admission.

6. ~~The IRF~~A minimum data set (MDS) registered nurse (RN) is responsible for completing the IRF-PAI by reviewing the medical records and the assessment of the IDT ~~RCT.~~

PURPOSE:

1. To guide the IRF ~~RCT~~IDT in the completion of required documentation, including assessments and outcomes reflecting each patient's need for intensive rehabilitation and to promote continuity and quality care for Laguna Honda acute rehabilitation patients.

PURPOSE:

1. To guide the IRF IDT in the completion of required documentation, including assessments and outcomes reflecting each patient's need for intensive rehabilitation and to promote continuity and quality care for Laguna Honda acute rehabilitation patients.

BACKGROUND

An IRF is a hospital, or part of a hospital, that provides an intensive rehabilitation program

to inpatients who:

1. Can reasonably be expected to actively participate,

2. Will significantly benefit from an inpatient stay and the intensity is such that the patient's condition requires this level of care.

3. Has complex medical problems that requires the services of a physician, and

4. Can benefit from an interdisciplinary team approach in the delivery of rehabilitation care

5. Have a discharge disposition.

The IRF-PAI is a comprehensive tool to collect standardized patient assessment data to conform to the Centers for Medicare and Medicaid Services (CMS) Regulations which identifies and develops an individualized plan of care for Medicare A eligible patients admitted to the IRF unit.

PROCEDURE

1. Preadmission Screening (PAS)

    a. Is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment.

    b. Must be performed by a licensed or certified clinician (i.e., Physiatrist or Licensed Therapist). If not performed by the physiatrist, the physiatrist must document or co-sign s/he has reviewed and concurs with the finding and results prior to the IRF admission.

    c. Must be completed within 48 hours immediately preceding the IRF admission.

    d. Must be reassessed if the PAS is completed more than 48 hours prior to the admission. Any changes from the previous assessment must be documented.

    e. May be performed in person and/or via review of medical records.

    f. Include documentation of the following:

        i. Specific reasons that the IRF admission is reasonable and necessary.

        ii. Patient's prior level of function.

        iii. Expected length of time necessary to achieve the expected level of improvement.

iv. An evaluation of the patient's risk for clinical complications.

v. Medical necessity for ~~R~~rehabilitation treatments ~~needed~~ (Occupational Therapy (OT), Physical Therapy (PT), Speech Language Pathology (SLP) and/or Orthotics/Prosthetics (O&P).

vi. Expected frequency and duration of treatment in the IRF.

vii. Anticipated discharge destination.

viii. Anticipated post-discharge treatments.

ix. Other information relevant to the care needs of the patient.

g. The PAS must be retained in the patient's IRF medical record.

2. Overall Plan of Care (POC)

a. A physiatrist must develop an overall POC within 4 days of admission.

b. An overall POC is individualized to the unique care needs of the patient based on information found in the PAS and what is collected in therapy assessments. The overall POC must support the medical necessity of admission and detail the patient's medical prognosis and anticipated interventions, functional outcomes, and discharge destination from the IRF stay.

c. The admission evaluation may serve as documentation of this plan as long as:

i. The plan is completed within the first 4 days of the acute rehabilitation (IRF) admission

ii. Documentation:

- Supports medical necessity of admission.
- Includes details regarding the patient's medical prognosis and anticipated interventions (PT, OT, SLP, O&P) required during the IRF stay, including details regarding:
  - Expected intensity (numbers of hours/day);
  - Expected frequency (numbers of hours/week); and
  - Expected duration (number of total days during the IRF stay).
- Includes expected functional outcomes.
- Includes the anticipated destination following the IRF stay.

d. The POC must be retained in the IRF patient's medical record.

3. Physician Orders

    a. The physician must generate orders to admit the patient to the IRF.

    b. A valid physician signature on the physician orders must meet the following criteria:

        i. Services that are provided or ordered must be authenticated by the ordering practitioner;

        ii. Signatures are handwritten, electronic, or stamped (in the event of an inability to sign due to a disability);

        iii. Signatures are dated and times; and

        iv. Signatures are legible.

    c. The orders must be retained in the patient's IRF medical record.

4. Multiple Therapy Disciplines

    a. Multiple disciplines (i.e., OT, PT, SLP or O&P) must be actively involved in treating the patient.

5. Intensive Level of Rehabilitation Services

    a. The minimum intensity requirement for therapy services is 3 hours a day at least 5 days a week or 15 hours of therapy in the 7 consecutive day period, unless the documentation supports medical issues justifying a brief exception not to exceed 3 consecutive days.

    b. Non-medical "missed" therapy minutes in one day need to be made up on another day within the same 7 consecutive day period starting with the day of admission.

    c. Therapy treatments must be initiated within 36 hours from midnight the day of admission.

    d. The IRF record must demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment.

    e. Documentation must clearly indicate the clinician's name, professional credentials and the amount (in minutes) of each therapy service provided for each date.

6. Intensive Therapy Program

    a. Documentation must consistently support that the patient's condition necessitates

the intense interdisciplinary team approach, including close medical management, close physician supervision, and complexity for nursing services that are all necessary for an IRF stay. The patient's condition and functional status must be such that he/she can reasonably be expected to make measurable improvement participating in the intensive therapy program available at the IRF.

b. The standard of care for acute rehabilitation (IRF) patients is individualized therapy (not group therapy). Group and concurrent treatment minutes can be counted toward meeting the intensity requirement, but must not be the majority of the treatment provided.

7. Physician Supervision

a. The physiatrist must conduct three face-to-face visits with the patient each week throughout the IRF stay (starting with the day of admission) to assess the patient medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.
b. The patient's condition and/or status must require the level of physician supervision for the patient's receiving IRF services.

8. Interdisciplinary Team Approach

a. Evidence of an interdisciplinary, coordinated team review shall be documented at least once weekly, beginning with the date of admission, to provide evidence that the patient is benefiting from the program and that acute rehabilitation continues to be the most appropriate level of care. As such, documentation shall include all of the following:

i. Evidence of active participation in an interdisciplinary rehabilitation program.

ii. Evidence of progress towards stated goals documented by objective functional measures.

iii. Identification of the range and severity of the patient's problems, including medical status, self-care, mobility, psychological status and communication status.

iv. Consideration of special equipment needs when appropriate.

v. Projected length of stay and discharge or disposition planning.

vi. Status of training provided to the patient and family member or caregivers by various disciplines of the RCT regarding post discharge care.

vii. Identification of barriers to progress, including any medical complications likely to impede progress.

viii. Information regarding the status of the underlying medical condition(s).

b. The documentation of each conference must demonstrate that qualified required participants attended.

c. The following RCT members must attend interdisciplinary team conferences:

i. Physiatrist;
ii. Registered nurse;
iii. Social worker or case manager; and
iv. A licensed or certified therapist from each therapy discipline involved in treating the patient.

9. Discharge from the IRF is appropriate if one or more of the following is present:

a. Treatment goals necessitating the inpatient setting were achieved.

b. Absence of participation in an interdisciplinary rehabilitation program.

c. The patient's functional status has remained unchanged or additional functional improvement appears unlikely within a reasonable time frame.

d. The patient is unable to actively participate in the ~~intensive~~ inpatient rehabilitation program (as defined under Background and Procedure 6. Inpatient ~~tensive Level of~~ Rehabilitation Services).

e. The overall medical status is such that no further progress in anticipated or only minimal gains that could be expected may be achieved at a lower level of care or through regular daily activities.

10. IRF-PAI

a. An IRF-PAI must be completed and submitted online for all Medicare patients separately at admission and discharge, but shall transmitted to the CMS together only after discharge.

i. Within 24 hours after admission of a patient, UM shall notify the RCT and Patient Billing if the patient is Medicare A eligible and the ARD.

~~ii. The ARD is defined as the 3rd calendar day of the rehabilitation stay, which represents the last day of the 2-day admission assessment time period. If the stay is less than 3 calendar days, the admission ARD is the last day of the stay. If the patient has a program interruption, the discharge date is not included as one of the 3 calendar days.~~

b. The information in the IRF-PAI must correspond with the information provided in the patient's IRF medical record and must support the appropriate claim coding.

c. Members of the RCT are responsible for completing their assessments and documentation that will be used to fill out their respective IRF-PAI sections by the ARD. Each discipline is responsible for completing documentation as outlined in Appendix C.

d. Each staff member that entered or validated IRF-PAI information directly in the electronic health record (EHR) shall electronically sign that section.

e. An IRF registered nurse (RN) shall review the medical record and ~~Medicare A~~the IDT assessments ~~of the RCT~~, and complete the IRF-PAI using the electronic validation and entry system by Day 4.

f. After the patient is discharged and the discharge IRF-PAI has been completed, the nurse shall notify the Resident Assessment Instrument (RAI) Department nurse that the IRF-PAI is completed and ready for transmission.

g. After the patient is discharged, the Admission and Discharge IRF-PAI shall be transmitted to CMS by LHH's RAI Department nurse within 24 hours after the notification of IRF-PAI completion.

   i. Admission and discharge IRF-PAI items must be completed before data records are transmitted to CMS. If the patient's stay is less than 3 calendar days in length, the staff of the IRF must complete the IRF-PAI admission items, but do not have to complete all of the discharge IRF-PAI items.

   ii. Program interruption: the situation where a Medicare patient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days.

   iii. Discharge Date: the date the patient is discharged from the IRF and stops receiving Medicare-covered Part A fee-for-service inpatient rehabilitation services.

11. Provision of Medicare Rights Form

a. A financial counselor will meet with Medicare recipients upon admission to review the Medicare Rights form and secure a signature from the patient or responsible party.

b. All Medicare recipients upon final discharge must receive a copy of their original signed Medicare Rights form. If a patient is discharged before a copy can be given, a copy shall be mailed to the patient by the Eligibility department.

c. Refer to LHHPP 55-01 Payor Eligibility Certification and Coverage

ASSESSMENT TYPE	ADMISSION ASSESSMENT
Hospitalization Time Period and Observation Time Period	First 3 Calendar Days (Admission day = Day 1)
Assessment Reference Date	Day 3
Patient Assessment Instrument Must Be Completed By	Day 4
Payment Time Covered By This Assessment	Entire Medicare Stay Time Period
Patient Assessment Data Must be Encoded By	Day 10
Patient Assessment Instrument Data Must Be Transmitted By	Same day as discharge data are transmitted: 7th calendar day from the encoded by date

ASSESSMENT TYPE	DISCHARGE ASSESSMENT
Discharge Date	Discharge Date (Day 1)
Assessment Reference Date	Discharge Date
Patient Assessment Instrument Must Be Completed On	Day 4 of Discharge
Patient Assessment Instrument Data Must be Encoded By	Day 10 of Discharge
Date When Patient Assessment Instrument Data Transmission is Late	27 calendar days

ATTACHMENT:
Attachment A: IRF-PAI version 4.0 (effective October 1, 2020) Section by Section

REFERENCE:
IRF-PAI Manual 3.0 (effective October 2019)
Internet Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual
Internet Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual

CROSSREFERENCE:
LHHPP 55-01 Payor Eligibility Certification and Coverage

Revised: 21/07/14,19/05/14, 21/09/14 (Year/Month/Day)
Original adoption: 16/11/08

Attachment A: IRF-PAI Section by Section

INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT 4.0	
Section	**Responsible Discipline(s)**
1-12: Identification Information	Admission & Eligibility
13: Assessment Reference Date	Utilization Management
14-20: Identification Information	Admission & Eligibility
21-24: Medical Information	Medicine
25-26: Medical Information	Nursing
40-45: Discharge Information	Nursing & Social Services
46-47: Discharge Information	Medicine
O0401-O0402: Therapy Information	Rehabilitation
Z0400A: Signature of Persons Completing the Assessment	Nursing
INPATIENT REHABILITATION FACILITY – PATIENT ASSESSMENT INSTRUMENT QUALITY INDICATORS	
Section	**Responsible Disciplines(s)**
A: Administrative Information	Medicine
B: Hearing, Speech, and Vision	Nursing
C: Cognitive Patterns	Nursing
D: Mood	Nursing
GG: Functional Abilities and Goals	Rehabilitation
H: Bladder and Bowel	Nursing
I: Active Diagnoses	Medicine
J: Health Conditions	Medicine/Nursing
K: Swallowing/Nutritional Status	Medicine/Dietary
M: Skin Conditions	Nursing
N: Medications	Medicine/Pharmacy
O: Special Treatments, Procedures, and Programs	Medicine/Nursing

RESIDENT TRUST ACCOUNT

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to abide by CMS regulations to act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility. If the resident has a burial trust account, LHH is responsible for managing that Burial Trust Account as in accordance of the Social Security Operations Manual and Medi-Cal regulation requirements.

PURPOSE:

The purpose of the policy is to provide guidelines for setting-up, managing and safeguarding resident's funds deposited into the LHH Trust Accounts and identifying the roles and responsibilities of each department/staff involved in carrying out the procedure.

PROCEDURE:

1. **Resident Trust Account:**

   a. LHH can establish a Resident Trust Account to assist residents in managing their funds during their stay at LHH. ~~The EPIC~~The electronic health record (EHR) module system is used to record deposits and disbursements in the individual Trust Account for each resident. At the end of each month, accounting performs a reconciliation to balance ~~EPIC.~~the EHR.

   b. The Accounting department may consolidate into a single account per admission or multiple accounts over the residents stay at LHH. However, the Resident Trust Account shall not be co-mingled with facility funds or with the funds of any other person.

2. **Set-Up of Resident Trust Account:** Residents admitted to LHH shall be assigned a medical record number and given the ~~resident and/or designee will be asked if they would like~~opportunity to utilize the Resident Trust Account service~~..~~. The Admissions & Eligibility (A&E) Financial Counselor will assist ~~those residents and/or designee interested~~ in establishing a Resident Trust Account~~ at LHH. The~~. A~~&E Financial Counselor shall ask~~ written authorization to allow the ~~resident to sign the direct deposit form~~facility to ~~have his/her~~act as a fiduciary to manage their personal funds is required to set up an account. Funds may be deposited electronically to the ~~LHH~~Resident Trust ~~Account.~~account by completing a direct deposit form.

3. **Representative Payee Program, Legal Conservator and Public Guardian:** In most situations, a resident is presumed to be capable of managing their funds. Residents may have a Public Guardian or other legal conservator appointed to manage the residents' money. For residents who filed for or are receiving Social Security or Supplemental Security Income payments, the resident or legal conservator may elect to have LHH as the representative payee. The main responsibility is to ensure that money spent is to pay for the needs of the resident and properly save any money not needed to meet current needs. LHH as representative payee must also keep records of expenses. To

become the representative payee, LHH must submit forms SAA-787 (must be completed by patient's physician or medical officer) and SSA-11 (completed by A&E Financial Counselor) and follow guidelines set forth by SSA.

4. **Financial Decision Maker – Authorized Designee**: If a resident is assigned a legal representative to make financial decisions, the decision maker will be listed in resident EHR. This decision maker shall act as the Authorized Designee to access the Resident Trust Account and request transactions on their behalf. Residents and/or their Authorized Designees are the only individuals allowed to make Resident Trust Account transaction requests. The resident's care team including financial counselors, clinical staff, and social services may not request or deny patient financial requests unless the request exceeds the resident's available fund balance.

~~3.~~5. **Checks:** LHH receives check payments from ~~SSA/~~Social Security Administration (SSA)/Social Security Income (SSI~~,~~), Private Retirement Pensions, or other sources.

a. Checks received for Share of Cost (SOC) related or a combination or SOC/Personal Need (PN) shall be mailed/sent directly to the Billing Department. The Billing Department shall complete the check log listing the check number, resident's name, episode number, and check amount. After completing the log, the check log and checks shall be sent to the Cashiers.

~~resident's name, episode number, and check amount. After completing the log, the check log and checks shall be sent to the Cashiers.~~

b. Mailed checks received by ~~Admissions & Eligibility (A&E)~~A&E for PN only are sent directly to the Cashiers. A&E shall complete the PN check log listing the check number, resident's name, episode number, and check amount. After completing the log, the check log and checks shall be sent to the Cashiers.

c. The Cashiers enter checks in the Trust Account daily, generate batch entry reports, and post information into the ~~EPIC~~EHR system. The cashiers photocopy the checks and file the photocopies with the batch entry report in the department deposit files.

d. All hand delivered checks and cash go directly to the ~~Cahier's~~Cashier's Office. ~~MSWs, other hospital personnel, Residents, and/or Resident's representative~~Individuals hand delivering checks and/or cash shall be directed to drop off at the Cashier's Office for deposit or routing. A receipt process is already in place to keep timestamped record of the exchange. Checks for residents who have been discharged or expired shall be returned to the sender by A&E.

e. Checks for residents who have discharged or expired shall be returned to the sender by A&E.

f. All funds received are divided into share of cost and PN. PN allowance for residents receiving ~~Social Supplemental Income (~~SSI~~)~~ is posted in the PN account.

~~4.~~6. **Interest:** The resident allowance is the current monthly PN allowance. If the resident does not use his monthly PN allowance, it remains in the PN account. Active PN accounts (including burial account if applicable) with a balance of $50 or more will earn interest. Interest is posted to active PN after the interest distribution from the Controller's Office, City and County of San Francisco. After the patient expires or discharges with zero fund balance, Accounting shall write off any interest amount up to $10.00. Interest that is written off shall be used to compensate a portion of the bank charge in operations.

~~5.~~7. **Cash Deposits at the Cashier Window:** Cash deposits are accepted only at the cashier's window. After verifying the cash amount, the cashier prepares the daily log, cash receipt and issues the receipt to the depositor. After the transaction is completed, the cashier places a copy of the receipt and cash into the safe for the next bank deposit and input it into the ~~EPIC~~EHR System

~~6.~~8. **Wire Transfer:** SSA and Veteran Affairs (VA~~,~~), or other pension plan may send benefits by wire transfer directly to the Bank of America "Resident Trust Account" on a monthly basis. A report detailing the transfer from the CCSF Department of Treasure is emailed to the Accounting Department.

a. Accounting divides all received into share of cost and PN based on the Share of Costs (SOC) list that the Accounting Department receives from the Billing Department on the first of each month. Patients receiving SSI do not have a share of cost. Accounting posts the monthly SSI allowance in the PN account.

~~7.~~ Definition:

~~a.~~9. Medi-Cal current rate: A dollar amount per month that qualified residents may draw. Medi-Cal periodically changes this current rate, which is available from the A&E Financial Counselor ("FC"). B. SSI Current Rate: A dollar amount per month that qualified residents may draw. SSI periodically changes this current rate, which is available from the A&E Financial Counselor.

~~8. **Representative Payee Program, Legal Conservator and Public Guardian:** In most situations, a resident is presumed to be capable of managing their funds. Residents may have a Public Guardian or other legal conservator appointed to manage the residents' money. As an alternate option, the resident or legal conservator may elect to have LHH as the representative payee. The main responsibility is to ensure that money spent is to pay for the needs of the resident and properly save any money not needed to meet current needs. LHH as representative payee must also keep records of expenses. To become the representative payee, LHH must submit forms SAA-787 and SSA-11 (completed by A&E Financial Counselor) and follow guidelines set forth by SSA.~~

~~9.~~10. **Trust Account Quarterly Statements:** The Accounting Department issues a fiscal quarterly "Resident Trust Account Statement" (hereafter Statement) ending September, December, March and June. The Statements shall be delivered ~~mail to~~ by the Cashier's officeto the individual ~~Nursing Neighborhoods.~~nursing neighborhoods. The neighborhood will distribute the statements to Resident Trust Account holders and have them sign a signature log confirming they received their statement. Once all statements are delivered they will submit their signature log to the Cashier office. The signature logs will be reviewed quarterly by finance team staff to ensure statements are being delivered. When a legal representative manages the residents' funds the statement shall ~~also~~ be sent by mail to the address provided to LHH by the representing party. Statements will also be provided at the request of the resident/representative.

~~10.~~11. **Distribution Funds after Death:** Upon the death of a resident, the A&E Department shall Request that Patient Funds (only) be transferred to SSRV (Social Security Reserve) ~~and held for approximately 1 year~~ to avoid negative balances caused by SSA takebacks. It is the responsibility of the A&E Financial Counselor to withhold any overpayment from SSA, VA or retirement system. Within 30 days following the death of a patient, except in a coroner or medical examiner case, all money and valuables of that patient which have been entrusted to the licensee shall be surrendered to the person responsible for the patient or to the executor or the administrator of the estate in exchange for a signed receipt. Whenever a patient without known heirs dies, written notice within five working days, shall be given by the facility to the public administrator of the county as specified by Section 1145 of the California Probate Code and a copy of said notice shall be available in the facility for review by the Department. When disposing

of conserved SSI funds when a beneficiary dies any payment received for the month of death must be returned. Payments are payable for the month of death. However, any SSI payments received for any months before and/or after the month of death must also be returned. Furthermore, FCs will continue to provide the SSA-1724 form to family that feel they are entitled to any social security benefit balances due in the case of a deceased beneficiary. Social Security will then make the decision if any of the funds will be distributed out.

a. To avoid negative account balances:

   i. A&E shall request that overpayment amounts received electronically be transferred to SS-reserve fund for future electronic reverse payment.

   ii. All other funds not identified as overpayment shall be distributed to the family, conservator, or Public Administrator but only after A&E had contacted SSA and receives official documentation of no overpayments are found and to be returned.

b. Over payments received by check shall be returned via US postal service. Funds received after death shall be held until FC receives notice or email confirming that resident has no over payment.

c. Accounting shall provide the Social Security (SS-) reserve balance report quarterly to A&E and A&E shall review the SS-reserve balance report quarterly and cleanup annually when necessary to avoid accumulation.

~~d. A&E shall request a check from accounting to issue to SSA (up to 1yr later). Unless, sends an official letter of overpayment requesting funds sooner than 1 year.~~

~~e.~~d. All potential write-offs for negative balances due to SSA takeback are sent to the Chief Financial Officer (or designee), A&E Manager (or designee), and Controllers Office for review and approval.

~~11.~~12. **Burial Account:**

a. The preference is to purchase a burial plan ~~vs.~~rather than setting up a burial fund in ~~EPIC~~EHR. The resident may reserve $1500.00 plus interest in a prepaid Burial trust accounts (or as otherwise allowed by law~~) money that is~~). These funds are not subject to the resident's resource limit amount.

i. Burial funds must be for the purpose of either burial expenses or purchasing a burial plan.

ii. Burial Accounts shall not be offered if the resident has a Legal Representative, is an SSI AS-Needs-Based Recipient, has a Social Security Representative (Rep) Payee, or if patient is admitted for short stay, which includes patients admitted to the following services, PM SNF Rehab, PM Acute Rehab, LSS Short Stay (any unit). In order for SSI As-Needs-Based Recipient to open an LHH Burial Trust, the resident must provide LHH with Social Security clearance of no overpayment.

b. Transferring funds to and from the burial fund: The A&E Financial Counselor shall complete the Authorization form to the Accounting Office and to the Cashier's Office to request transfer of funds to and from the burial account.

13. **Disposition of Funds when Resident is Discharged:** Title 22 Section~~(~~ 8~~)~~ Upon discharge of a patient, all money and valuables of that patient which have been entrusted to the licensee and kept within the facility shall be surrendered to the patient or authorized representative in exchange for a signed receipt.

i. If LHH is the Rep Payee, burial funds shall be sent back to SSA, only if the funds are SSI income per SSA Title II Retirement Recipient process. All other funds unrelated to SSI can be sent to the new rep. payee or to the legal representative identifying funds as burial funds.

ii. A&E shall notify Social Services if LHH is the Rep Payee; and when patient is discharged, and funds are withdrawn and/or forwarded to the new Rep Payee or to Social Security Administration (SSA) if the income was SSI based.

iii. If residents withdrawresident withdraws funds from the burial fund, they shall be informed that the amount may be counted as income and may affect their monthly SSI benefits.

iv. If the resident or their decision maker withdraws funds, the A&E Financial Counselor shall inform them of the Medi-Cal/SSA requirement to deposit funds into a Burial Trust Account.

12.14. **Funds Transferred to Billing for late SOC payment:**

a. The billing department is responsible for ensuring that the current months SOC is credited to the patient's account by the 15th of the month.

b. The biller must contact the A&E Financial Counselor if the SOC payment is for previous months. The A&E Financial Counselor shall verify that funds in the Trust Account are designated as SOC funds for previous months. The A&E Financial Counselor shall inform the biller if money is for PN or SOC payment.

13.15. **Funds Credited from Billing to the Resident Trust Account:**

a. Billing shall contact A&E via email to notify them of overpayment on SOC to be credited back to the trust account.

b. A&E Financial Counselor shall respond with a date that funds shall be transferred back to the Resident Trust Account.

c. On the date of transfer, Billing shall notify the Accounting Department via email to proceed with the credit to the Resident Trust Account.

16. **Withdrawal Authorizations Requested by Resident or Designee**:

Residents and their Authorized Designees shall have access to funds 24 hours a day and seven (7) days a week, including holidays.

Fund Withdrawal Guidelines and Timing

a. Requests for less than $100 (less than $50 for Medicaid recipients) will be approved the same day.

b. Requests for $100 of more ($50 or more for Medicaid recipients) will be approved within three banking days (weekdays).

c. Residents and/or their Authorized Designees are the only individuals allowed to make Resident Trust Account transaction requests. The resident's care team may

not request or deny patient financial requests unless the request exceeds the resident's available fund balance.

d. Authorized Designee's must provide proof of identification and submit receipts for reimbursement requests.

The

14. ~~**Resident Has Financial Decision Making Capacity and Requests Withdrawal of Money from the Resident Accounts/Cashier Window:** If the resident wishes to withdraw funds from his/her Resident Trust Account, the resident will inform their MSW of the need to withdraw. Then the resident and/or MSW and/or MSW Designee completes the Authorization to Accounting Office form (ATAO). The A&E Financial Counselor must countersign authorization requests for amounts up to $100. The A&E Supervisor/Manager or Designee must countersign authorizations for amounts over $100.~~process for resident trust account withdrawals is as follows:

Weekday requests: Monday-Friday 8am-5pm:

a. MSW will assist resident/or Authorized Designee with Cash Authorization form.

b. The MSW shall notify A&E via email of the request.

c. A&E will confirm availability of funds and forward the signed Cash Authorization ~~requests are returned~~form to the MSW~~ for submission~~.

d. MSW will submit the completed authorization to the Cashier's Office.

e. Residents or Authorized Designees who are able will go to the Cashier to obtain funds, or if unable, MSW will go to the Cashier on their behalf. If outside of cashier hours but during weekday hours MSW may arrange pickup with finance team to satisfy same day requests.

f. If authorization is a final liquidation of the resident account due to discharge a copy of residents account in EHR shall be printed

Weeknight and weekend requests: Monday-Friday 5pm-8am and all day and night on Saturday and Sunday

a. Resident or Authorized Designee will notify their Charge Nurse/designee that they would like to withdraw cash.

b. Charge Nurse/designee will assist ~~their money, or if~~ resident ~~is unable, Social Worker will go to the Cashier on behalf of the resident.~~or Authorized Designee with Cash Authorization form.

c. Charge Nurse/designee will deliver form to Nursing Operations

d. Nursing Operations will confirm availability of funds and issue cash directly to Charge Nurse/designee from petty cash box.

e. Charge Nurse/designee will deliver cash to resident.

f. Next Day: A&E will confirm availability and transaction of funds and forward the signed Cash Authorization to the Cashier's Office

~~a.~~ Cashier's Office will post the transaction in ~~Cash shall be authorized if resident is being final discharged from LHH.~~

~~b. Any questions regarding an unreasonable request by a resident who may need guidance in managing his/her funds are to be resolved by the members of the resident's care team.~~

g. EHR

~~15.~~17. **Annual Authorization to Withdraw Monthly Allowance:** The resident or ~~MSW~~ their Authorized Designee may choose to receive monthly allowances (Medi-Cal current rate or SSI current rate) through Annual Authorization by completing and signing the Annual ~~ATAO~~Authorization form. The A&E Financial Counselor writes on the top of the form "Annual Authorization", and an expiration date. The A&E Financial Counselor forwards the original copy to the Cashier and a copy of the form is filed in A&E file. The Cashier shall file the ATAO original copy to use as reference to verify residents who participate in Annual Authorizations. Annual authorization covers monthly allowance not to exceed the SSI/Medi-Cal current rate. Additional requests for withdrawal require the resident or financial representative to sign an ATAO form for each request. Annual Authorizations are renewed on December 31, of each year. ~~Residents/MSWs wishing~~A new authorization must be complete each year to continue with annual authorizations ~~must complete a new authorization for the upcoming year.~~.

~~16. **Steps for Authorization of Funds:** The expense of the funds is intended for the resident's use to provide for his/her comfort and happiness. Included in the legitimate use of resident's funds, but not limited:~~

~~a. The purchase of specially prepared or alternative food that meets the resident's dietary needs instead of the food generally prepared by LHH.~~

~~b. Telephone; clothing; personal comfort items, including novelties, and confections; cosmetics and grooming items in excess of those for which payment is under Medi-Cal or Medicare.~~

~~c. Reading materials; social events and entertainment offered outside the scope of the activities program.~~

~~d. Flowers and plants; and television/radio/audio appliances for PN.~~

~~e. Discretionary (PN) funds may not be used to pay past-due SOC or other hospital bills. Other than current months SOC, transfer of funds to Billing must be approved by the A&E Financial Counselor via email.~~

The following chart displays required signatures for authorization or withdrawal from the resident's account. Exceptions are listed below:

Withdrawal Amount	Amounts up to Medi-Cal or ~~SSI~~SSA Current rate	Amount exceeds Medi-Cal or ~~SSI~~SSA Current rate	Amount exceeds $100.00
PFS staff signature requirements	A&E Financial Counselor	A&E Supervisor or Designee	A&E Supervisor or Designee
The LHH A&E Manager may approve authorization for any amount when funds are intended for: a. Resident's Burial or purchase of a burial plan, b. Resident Discharge or Pending Discharge c. Distribution of funds to family/estate after resident expires. d. Funds sent to the Department ~~d.~~e. t of Human Services, Public Guardian, Public Administrator, or a legal representative or Rep. Payee. ~~e.~~f. Payment of resident's bills g. Authorizations approved by the resident or Legal Representative. ~~f.~~ via email or letter, by signing the authorization form			

~~17. Authorizations Requested by Resident:~~

~~As a result of the COVID19 emergency declaration, LHH Patient Access A&E had modified the process for patients to request cash from their trust accounts. The purpose of this modification is to minimize non-essential face-to-face and paper transactions for the health and safety of our residents.~~

~~The process for assisting residents who would like to withdraw cash from their trust account will be as follows:~~

~~a. The resident shall have access to their funds 7 days a week (including weekends/holidays) during Cashier Office operating hours and through Nursing Operations at all other hours.~~

~~b. Normal operating hours: Resident will notify social worker that they would like to withdraw cash. (Able residents will no longer visit the A&E office in person to make this request.)~~

~~c. Social worker will assist patient to complete the form and sign it.~~

~~d. The social worker will notify A&E via email of the request.~~

e. A&E will confirm availability of funds and forward the signed Cash Authorization form to the social worker.

f. Social worker will submit the completed authorization to the Cashier's Office.

g.a. Residents who are able will go to the Cashier to obtain their money, or if resident is unable, Social Worker will go to the Cashier on behalf of the resident.

h. If authorization is a final liquidation of the resident account due to discharge a copy of residents account in EPIC shall be printed

i. For cash withdrawal requests for amounts over $300, A&E shall contact the cashier's office two business days in advance to ask if cash is currently available. If not, resident can arrange to pick up the cash when available or the cashier's office may issue a check for amounts over $300.

j. After Hours/Weekend/Holidays: Follow steps k-p.

k. Resident will notify their Charge Nurse/designee that they would like to withdraw cash.

l. Charge Nurse/designee will assist resident to complete the form and sign it.

m. Charge Nurse /designee will deliver form to Nursing Operations

n. Nursing Operations will confirm availability of funds and issue cash directly to Charge Nurse/designee

o.a. Charge Nurse/designee will deliver cash to resident.

p.a. Next Day: A&E will confirm availability and transaction of funds and forward the signed Cash Authorization to the Cashier's Office

q. Cashier's Office will post the transaction in EPIC

18. Fund Withdrawal Guidelines and Timing (After Hours/Weekend/Holidays):

- Requests for less than $100 ($50 for Medicaid recipients) will be approved the same day.

- Requests for $100 of more ($50 for Medicaid recipients) will be approved within three banking days (weekdays).

19. Reimbursement to Authorized Decision Maker when Resident Lacks Financial Decision Making Capacity

a. If a resident lacks capacity to make financial decisions, person identified by the MSW as the person having authority to access the resident's Trust Account.

b. If LHH is the Rep Payee, the Social Worker must sign ATOA form. Resident may sign the form if he/she has capacity to make decisions

c. MSW shall provide A&E with name and contact information of person authorized to access the resident's Trust Account.

i. The A&E Financial Counselor shall keep a record of the name and contact information for the financial decision maker in the A&E file.

ii. The A&E Financial Counselor shall verify that person requesting funds is the authorized decision maker. If not, the person shall be referred to contact the resident's social worker.

iii. If the person is authorized to access funds, the A&E finance counselor shall review the Trust Account ledger to verify that funds are available and ask the person to provide Government identification.

iv. The authorized decision maker must submit a written request for funds indicating amount and reason for the request.

v. Authorized decision makers must submit receipts for resident purchases for reimbursement when the resident lacks financial decision-making capacity.

vi. Refer to Steps for Authorization of Funds

20. ***Authorization Request by MSW***

a. If in the opinion of the residents' care team, the resident is unable to manage his/her funds and the resident does not have a legal representative, the hospital or designee shall designate the MSW to manage the resident's funds. Any questions regarding an unreasonable request by a resident who needs guidance in managing his/her funds are to be discussed and resolved by the members of the resident's care team.

b. Steps for Authorizing Funds to the Medical Social Worker:

i. The MSW shall notify the A&E Financial Counselor of request for funds in writing indicating amount and reason for the request.

ii. The MSW shall submit receipts for purchases to the A&E Financial Counselor within one week.

~~iii. The MSW shall maintain a transaction record, which must be signed by the resident whenever money is distributed to the resident. The transaction record shall be forwarded to the A&E Financial Counselor, who shall place the form in the resident's file.~~

~~iv. MSW and MSW Management signature is required when requesting funds for residents or reimbursement P-Card or personal funds used for purchases or services~~

~~v. MSW signature is not require if:~~

- ~~Resident is able to sign bill payment~~
- ~~Funds sent to Medi-Cal Recovery Unit – California Department of Health Services~~
- ~~Funds returned to Social Security~~
- ~~Funds used for Burial Plans~~
- ~~Funds sent to Public Administrator~~
- ~~Funds sent to family/estate after death~~

~~vi. Refer to Steps for Authorization of Funds~~

~~21.~~18. **Monitoring Compliance**:

a. A&E: The A&E supervisor may conduct a random sample audit each month, reviewing and reconciling receipts against funds withdrawn and reimbursed to the authorized decision maker at any time. The A&E Manager is responsible for monitoring compliance.

b. Accounting Department performs monthly Trust Fund bank reconciliation. The Chief Financial Officer is responsible for reviewing this reconciliation.

Assurance of Financial Security

1. The facility will purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

2. The facility will not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts).

3. The facility may charge the resident for requested services that are more expensive than or in excess of covered services, as authorized by law.

ATTACHMENT:
~~None.~~
Resident Trust Fund Notification and Authorization

REFERENCE:
Nursing Department Policy for Handling Money Held on the Nursing Neighborhood

Revised: 98/11/16, 00/05/25, 04/12/02, 07/12/18, 10/04/27, 10/08/10, 11/03/24, 16/01/12, 18/03/13, 19/03/12, 21/09/14, 23/05/09 (Year/Month/Day)
~~18/03/13, 19/03/12, 21/09/14, 23/05/09 (Year/Month/Day)~~ Original adoption: 93/09/01

Deletion Medical Staff Policies and Procedures

ORGAN/TISSUE TRANSPLANT DONATION PROGRAM

PURPOSE:
The purpose of this policy is to facilitate tissue donation and to protect privacy and interests of the donors, recipients, and family members. Laguna Honda Hospital and Rehabilitation Center (LH) will use discretion and sensitivity appropriate to the circumstances, beliefs and desires of the family members.

This policy and procedure must be followed for Acute patients who die but may optionally be followed for Skilled Nursing residents who die.

POLICY:

A. LH, in compliance with PPHS 42 CFR Part 482-Conditions of Participation for Hospitals, California Assembly Bill 631, Section 7184, and Public Law 99509, Section 9138 – identifies potential tissue donors and cooperates in procurement of anatomical gifts. At this time, LH has been excused from organ donation due to no available intensive care services at the hospital.

B. All acute patients who die will be screened for potential tissue donation by California Transplant Donor Network (CTDN) within 1 hour of asystole.

C. All cases under the Medical Examiner's (ME) jurisdiction must be reported to the ME office prior to request to family members for tissue donation at LH and the CTDN staff shall contact the ME office and the family.

D. This referral shall be made within 1 hour of the time of asystole. The acute unit physician and/or the acute unit RN may make the initial referral call.
   1. Referrals to CTDN must be documented on the Tissue Donation request form, with the CTDN referral #.
   2. CTDN or designated tissue bank coordinator will evaluate the potential tissue donor to determine medical suitability.
   3. Medical and other hospital staff should refrain from discussing tissue donation with the family.

E. Medical suitability of potential donors for tissue donation
   1. Exclusion criteria
      a. History of serum or infectious hepatitis, extracranial malignancy, systemic sepsis, or active transmissible disease at time of death
      b. Jacob-Creutzfeldt disease or senile dementia of unknown etiology.
      c. Suspicion of exposure to HIV or at high risk for exposure to HIV
      d. Tissue irradiation or chronic steroid therapy
      e. Acute hospital residence of longer than 2 weeks may be an exclusion criteria.
      f. In jail or prison for greater than 72 hours.

F. Medical Examiner Cases:
   All cases under the Medical Examiner's jurisdiction must be reported to the Medical Examiner's Office prior to any request to family members. The jurisdiction of the Medical Examiner is defined in California Government Code Section 27491 and LHH Administrative Policy LHH 20-09.
   The telephone number for the ME's office is 415-553-1694.

PROCEDURE:

A. Identification and Referral of Potential Donors
   1. All deaths must be reported to the California Transplant Donor Network. 1 800 55 DONOR (1-800-553-6667)
   2. For tissue donation, the CTDN network must be notified within one hour of asystole.
   3. CTDN or the designate tissue bank coordinator will evaluate the potential tissue donor to determine medical suitability.

B. Tissue retrieval is approved on a case-by-case basis by calling the CTDN at 1 800 55 DONOR. THE CTDN then refers the call to the Musculoskeletal Transplant Foundation (tissue bank)
   1. The Tissue Bank Coordinator will perform a telephone evaluation of the potential tissue donor with the LH attending physician to determine medical suitability.
   2. LH attending physician will provide information including but not limited to:
      a. cause of death

b. lab results
c. IV fluids/blood products received
d. Next-of-kin information

C. Medical Examiner Cases – if after consultation with the donor's physician, it is determined that the case falls under the jurisdiction of the ME, the CTDN coordinator is responsible for contacting the ME's office for approval to procure tissue donation before approaching the family.

D. Consent and Release – the tissue bank coordinator will assess the family's readiness to be offered the option of tissue donation and obtain consent of the family members. A copy of the consent will be included in the patient's medical record.

E. Tissue Recovery Process
1. The Tissue Coordinator will schedule a time with the LH Administrator on Duty (AOD) or designee to determine where tissue recovery will take place (e.g. the morgue)
2. The Tissue Bank Coordinator will provide all needed staff, instrumentation and supplies used during the tissue recovery.
3. The Tissue Bank staff will ensure the appropriate disposition of the body and clean the facility when tissue recovery is completed.
4. The Tissue Bank Coordinator will assume responsibility for notifying all appropriate agencies regarding the donation (e.g. recovery team, funeral director, and ME if appropriate)
5. The Musculoskeletal Transplant Foundation (MTF) reimburses LH for all costs incurred for tissue recovery.

F. LH will work cooperatively with MTF and CTDN staff in educating acute care staff on donation issues and specified in the agreements.

G. LH Quality Management staff will collaborate with MTF and CTDN staff in performance improvement activities and monitor the effectiveness of facility protocols and policies (an example of a performance improvement activity is the review of death records of acute care patients to ensure that potential donors are identified).

CROSS REFERENCE
Deaths which must be Reported to the Medical Examiner-Coroner, MSP&P C01-04

Appendix…..Tissue Donation Referral Form, MSP&P F-C01-03a

MS Approved:
MS Revised: September 30, 2010

Revised Nursing Policies and Procedures

RESIDENT IDENTIFICATION, ~~AND~~ COLOR CODES, AND SAFETY ALERTS

POLICY:

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

   ~~Each resident is to wear a legible wrist identification band with resident name, hospital number and have a photograph on the Medication Administration Record (MAR). Any member of nursing staff may change wrist bands as needed.~~

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

~~1.~~

~~2.~~3. Residents requiring designated ongoing precautions and safety monitoring are assessed by the Resident Care Team (RCT) and identified using a consistent system of wristbands ~~with adhesive dots~~with ~~for~~ associated snap precautions and safety alerts.

~~3.~~1. ~~The nurse manager, charge nurse or nursing team leader will designate the use of color coding and safety alert interventions based on a thorough assessment of individual resident needs and risks.~~

PURPOSE:

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

PROCEDURE:

A. Resident Identification and designation of precautions and safety monitoring
~~**Color Coding Grid Table**~~

1. Upon admission, the resident will get their photograph taken and uploaded from the Admissions and Eligibility Department (A&E) for visual identification of the resident in the resident's electronic health record.

2. Nursing staff will print out the resident's wristband from the electronic health record and apply on the resident. Wristbands will be changed as needed when resident name, hospital number, barcode or QR code are not legible.

3. A&E will send the resident's nameplate card with the resident's first name and initial of last name to be placed by nursing staff at the bedside and hallway

when the resident arrives on the unit. A&E can reprint as needed or unit staff can write or print on paper as needed.

4. Residents who decline or are unable to tolerate a wristband, maybe offered an identification card (ID) that has same information as the wristband if they meet the following criteria below:

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

5. Nursing staff, the Resident Care Team (RCT) and other consulting departments (e.g. Speech Therapy) will identify safety precautions and monitoring based on the resident's resident conditions, needs and risks. Nursing leader (e.g., nurse manager, charge nurse, team leader) will ensure that precautionary and alert dot color coding, signage, wristband snaps are applied in the appropriate designated areas. Nursing staff and RCT will review this process ongoing on readmission, relocation, quarterly and as needed to ensure coding, signage and wristbands are updated.

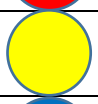
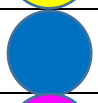
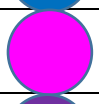
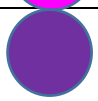
B. Safety Precautions or Alert Color Codes

1. Color coded stickers will be applied as below:

~~**A.**~~

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

~~COLOR OR SYMBOL~~	~~COLOR OR SYMBOL~~	~~HALLWAY, MOBILITY DEVICES, & BED CARD~~	~~Adhesive Sticker Placed on ID Wristband~~	~~Bed Card Stickers~~
	~~FALLING STAR~~	~~FALL RISK~~		
	~~RED~~	~~ALLERGIES~~		
	~~YELLOW~~	~~DIABETES~~		
	~~BLUE~~	~~SEIZURE RISK~~		
	~~PINK~~	~~ASPIRATION RISK~~		
	~~PURPLE~~	~~SPECIAL APPROACH~~		
~~Colors~~				
~~No Stickers~~			~~No Precautions~~	~~N/A~~

~~Red~~ 	~~Allergies~~	~~N/A~~
~~Yellow~~ 	~~Diabetic~~	~~Diabetic~~
~~Blue~~ 	~~Seizure~~	~~Seizure~~
~~Hot Pink~~ 	~~Aspiration~~	~~Aspiration~~
~~Purple~~ 	~~N/A~~	~~Unpredictable, aggressive behavior, uses special or cautious approach~~

~~B.~~C. Safety Precautions or Alert Signages~~s~~

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

~~1.~~a. Care Alert (Confidential Resident Information)

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

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

REQUIRES WIDE BED EVACUATION PROCESS

d. Residents with same or similar name as another resident on neighborhood may have "Name Alert" signage on hallway nameplate.

~~2.~~

~~3. Fall Risk (Star on Room Name Plate)~~

~~C.~~D. Safety Precautions or Alert Wristbands

1. Obtain wristbands from central supply and colored precaution ~~adhesive~~ snaps~~stickers~~.

2. ~~Apply~~ Snap on the ~~associated~~ associated ~~colored stickers~~ precaution or alerts onto the wristband [need copy of snap wristband, or EPIC wristband?]. ~~label that will be printed~~

~~3. To print wristbands:~~
~~Log onto LCR~~
~~Select Resident's name~~
~~On the left frame, scroll down then click "Clerical Fxns" link~~
~~Click "Print/Send Pt Info" link~~
~~Click "Print Patient Info" link~~
~~From the list of cases, click "Next Page" until you see the resident current Hospital Service Code with no Discharge Date.~~
~~Click "Resident Current Hospital Service Code"~~
~~Click "LHH Wristband Printing~~
~~2. "Wristband Generated" will be displayed~~

~~4. Use colored dot stickers for the following precautions (Refer to Procedure A: Color Coding Grid Table)~~

~~D.~~E. Documentation

~~Document~~ Document precautions in ~~precautions in~~ Electronic Health Record (EHR):

1.
   a. Physician can list precautions through an order
   b. ~~———————~~Care plan precautions and individualized interventions into appropriate care plan and update as needed when there are changes.
2. Review resident identification, precautions and alert signage during Readmission, Quarterly, Relocation, Change of Condition and as needed and document in Resident Care Team Conference and Progress Notes as needed.

CROSS REFERENCE:

LHHPP 26-02 Management of Dysphagia and Aspiration Risk

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

Reviewed: 2022/12/13

Approved: 2022/12/13

OBTAINING, HANDLING, AND STORAGE OF MEDICATIONS AND TREATMENTS

POLICY:

1. The charge nurse or team leader is responsible to have a continuous supply of prescribed medications available 24 hours a day, seven days a week through Department of Pharmacy Services or automated medication dispensing cabinets.

2. The medication room, medication cart, treatment cart, and medication refrigerator are to be locked when not in use or attended.

3. Complete an Unusual Occurrence if there is an error in the medication dispensed, or labeling error. Return any drug dispensed in error ~~the drug~~ to the Pharmacy immediately and obtain a replacement. If Pharmacy is closed, ~~give the medication to a nursing supervisor~~ notify the nursing supervisor who can return the medication to the pharmacy..

4. Licensed nurse adheres to relevant policies and procedures outlined by the Department of Pharmacy Services.

5. Unless otherwise stated in this policy, the licensed nurse does not need to date products with opened date.

PURPOSE:

Correct medications will be available and stored properly.

PROCEDURES:

A. Pharmacy Accessibility (Refer to Pharmacy Policy 01.01.01)

B. Obtaining medication from Pharmacy

1. New medication orders will be transmitted to pharmacy as an electronic prescription via the electronic health record. Medications will be available via automated dispensing cabinet or patient specific supply delivered by pharmacy. Medications needed prior to the next pharmacy delivery may be picked up at the pharmacy window by a licensed nurse or licensed psychiatric technician.

2. Maintenance Medications:

   a. Pharmacy will deliver a resident specific supply of maintenance medications to the neighborhood with scheduled oral medications.
   b. For new ordered medication, pharmacy will dispense the amount of medication up to the next cart fill exchange.

3. Short-term Medications:

   Pharmacy will dispense only the amount of medication that was specified in the order.

4. PRN or “As Needed” Medications (Refer to Pharmacy Policy 09.01.00).

5. Medication Refills

   If refill is needed before routine date of replacement put empty drug container or tubes in pharmacy pick up tray. Request the refill via the EHR.

6. Stock Items (Refer to Pharmacy Policy 09.01.00).

7. Controlled Substance Medications Pharmacy Policies 09.01.00 and 02.02.00).

C. Labeling Medications

1. The licensed nurse inspects the condition and legibility of labels. All prescription drugs that do not have a clearly legible label are to be returned to Pharmacy for replacement. If having difficulty scanning barcode of medication label, notify pharmacy of issue.

2. Label Changes:

   a. If label becomes soiled, illegible, or if change is made in dosage or frequency of an existing medication, the drug container is to be placed in a relabel zip lock bag and placed in the pharmacy pick up tray.
   b. In the event that the correct dose for the resident involves more than one strength of the medication to achieve the dose, multiple strengths of medication will be sent to achieve dose. It is the responsibility of the LN to confirm dose prescribed with amount to be administered.

D. Storage of Medications

1. Condition of Container and Contents

   a. Medications are to be kept in the containers received from Pharmacy. If containers become cracked, soiled, or do not have secure closures, return to Pharmacy for replacement.
   b. If drug contents become outdated, contaminated or show deterioration, return to Pharmacy for replacement.

2. Orderliness of Medication and Treatment Carts~~s~~

   a. Medication Cart:

      Medication cart stores the resident's supply of internal medication including injectables, ophthalmic preparations, otic preparations and inhalation preparations (nebulizer / aerosol).

   b. Treatment cart:
      i. Ointments and creams are labeled with resident's name and are legible. All medication tubes and bottles are to have covers.
      ii. Irrigating solutions are checked for expiration date labeling. Normal saline, ~~and~~ sterile water and isopropyl alcohol are ordered from Central Supply and are single use only, and after single use, remainder of solution is discarded..
      ~~ii.~~iii. Other irrigation solutions are ordered from Pharmacy and are labeled with expiration dates. ~~-~~Unlabeled or expired solutions are to be returned.
         ~~iii.~~i. When bottles of irrigation solution supplied by pharmacy are first opened, write the date, time and nurse's initials on the label. Refer to Pharmacy Policy 02.01.06 Appendix 1 for expiration policies and practice.
         ~~iv.~~ii. Irrigation solutions supplied by pharmacy are not to be used 24 hours after opening .

c. Medication Room

Licensed nurse checks expiration dates of medications before administering medication and on a weekly basis. All unlabeled and expired medications are to be discarded in the medication waste bin.

The following items are stored in locked medication room, locked carts or the automatic dispensing cabinet(s). Internal, external, and injectable items must be stored separately.
i. Approved ward stock supplies or medications.
ii. Emergency drug box, Emergency I.V. bag, I.V. solutions and tubing.
iii. Test reagents, Chemstrips, or hemoccult tests.

3. Medication refrigerator - is used only for drugs needing refrigeration.

a. Refrigerator temperature is monitored continuously via wireless refrigerator monitoring system. The temperature log is checked twice daily by nursing staff (Refer to LHHPP 31-01: Wireless Refrigerator and Freezer Temperature Monitoring System).
b. Store oral medications together in one area, refrigerated injectables together in a different area, and rectal suppositories together in another area inside the refrigerator.
c. No food or specimens are to be placed in the biological refrigerator.

4. Emergency Drug Box / Crash Cart

Emergency Box and Crash Cart stores medications that are used for emergency situations and during CODE BLUE. Locks are checked and documented in the Emergency Equipment / Refrigeration Monitoring Sheet.

a.DAY Shift licensed nurse checks lock of Crash Cart daily.
b.“Red lock” of the Emergency Drug Box is checked by licensed nurse every shift.

* For Wellness Center ONLY - Emergency Equipment such as AED & Crash Cart must be checked daily when Wellness Center is open, by Day Shift Licensed Nurses assigned to Pavilion – Mezzanine SNF.

E. Handling Medications

1. Oral Liquid Syringe Dispenser is used to accurately measure liquid medications such as Dilantin suspension. Shake the suspension medication well and be sure the syringe plunger is fully depressed before inverting the bottle to fill the syringe. Use the inside edge of the black measurement ring to read volume. The syringe may be attached to an enteric tube or put into the mouth between the teeth and cheek to administer medication. Discard dispenser after each individual dose.

2. Hazardous Medications (formerly known as antineoplastic / cytotoxic medications)

Special precaution needs to be applied when preparing and handling hazardous medication administration (Refer to LHHPP 25-05).

3. Controlled Substance Medications (Refer to Pharmacy Policy 02.02.00).

4. Multidose Injectables:

a. Multiple dose injectables shall be visually inspected prior to use and discarded if any of the following occur:
   i. There is a change in appearance of the solution.
   ii. There is damage or loss of integrity of the closure.
   iii. The drug has been improperly stored.
   iv. The vial is known or suspected to be contaminated
   v. The vial has met the expiration date

b. Expiration Dating (Refer to Pharmacy Policy 02.01.06 Appendix 1).

c. Injectables that do not contain preservative shall be used immediately and any remaining contents shall be discarded.

d. Insulin vials shall be:
   i. Dated upon initial entry.
   ii. Open vials may be kept in individual resident cassettes or in the refrigerator.
   iii. Open, in-use vials shall be discarded after 28 days. Pharmacy assigns expiration date.
   iv. Intact vials are to be kept in the refrigerator until the manufacturer's expiration date on the vial.

e. Injectables that contain preservatives shall be:
   i. Refrigerated for stability, if recommended by the manufacturer.
   ii. Discarded when empty or upon expiration (refer to Pharmacy 02.01.06 Appendix 1).

5. Resident Transfers:

a. When a resident is relocated within LHH, the nurse will send the resident's medication to the receiving neighborhood.
b. When a resident is transferred to or from an acute unit, the resident's medicines are *not* sent with the resident if the pharmacy is open. New orders must be placed. If the pharmacy is closed at the time of transfer to or from the acute care household, the nurse will send the medications to the receiving unit. The medications will be sent to the pharmacy for relabeling when the pharmacy opens.

6. Discontinued Medications:

a. Immediately after the medication is discontinued, print "DC" on the prescription label and place the medication in the pharmacy pick-up box. This also applies to the medications of residents who expire.

b. Resident Discharges:

   i. When a resident is discharged to any acute setting all medications must be returned to pharmacy.
   ii. When a resident is discharged to community. All in-house medications must be returned to pharmacy after resident is discharged.

F. Monthly Pharmacy Ward Survey

1. The pharmacist or pharmacy extern student may observe the nurse while doses of medication are being prepared and administered to the resident to ascertain that medications are given accurately and with acceptable infection control measures employed.

2. The pharmacist reviews the resident's drug regimen to monitor the suitability of drugs ordered for the resident.

CROSS REFERENCES:

Hospitalwide Policies & Procedures
- 25-01 High Risk - High Alert Medications
- 25-02 Safe Medication Orders
- 25-05 Hazardous Drugs Management
- 31-01 Wireless Refrigerator and Freezer Temperature Monitoring System

Pharmacy Policies & Procedures
- 01.01.01 Accessibility to Medications
- 01.02.02 Stop Orders
- 01.08.00 Extern Students
- 02.02.00 Controlled Substance
- 02.01.06 Expiration Dating of Pharmaceuticals
- 09.01.00 Automated Medication Dispensing Cabinets

Nursing Policies & Procedures
- B 6.0 Items Allowed at the Bedside

Emergency Equipment/Refrigeration Monitoring Sheet
Emergency Equipment Monitoring Sheet for Wellness Center Only

Adopted from NPP J 1.0 12/2006

New: 2010/04

Revised: 2011/03/17; 2015/07/14; 2017/01/10; 2019/05/14; 2020/05/19

Reviewed: 2020/05/19

Approved: 2020/05/19

Deletion Nursing Policies and Procedures

AEROSOL/NEBULIZER MEDICATIONS

POLICY:

1. Licensed Nurses are responsible for safely administering and monitoring aerosol and nebulizer treatments in the Skilled Nursing neighborhoods, but Respiratory Therapy may be consulted for complex needs.

2. Licensed Nurses or Respiratory Therapy are responsible for safely administering and monitoring aerosol and nebulizer treatments in Pavilion Acute.

PURPOSE:
To describe the process for the safe administration of aerosol/nebulizer treatments.

BACKGROUND:

1. Nebulizers are used for delivery of medication into the respiratory tract and/or moisturize airways and mobilize secretions.

2. Provision of relief for bronchospasm, wheezing, asthma and /or allergic reactions.

PROCEDURE:

A. Monitor resident

1. Before administering the initial treatment, monitor the resident's ability to participate in the medication administration process and to ascertain the most appropriate gas delivery device (e.g., mouthpiece, mask, etc.).

2. Whenever resident’s condition warrants and/or per physician's order, monitor heart rate and auscultate lung sounds before and after treatment administration, especially when giving a new medication or change in treatment.

3. Residents who are unable to self-manage the delivery system safely and effectively require frequent or continuous monitoring to ensure proper medication delivery.

B. Administration

1. Refer to Appendix 1, follow Manufacturer’s Instructions, and/or consult with Pharmacy or Nursing Education for clarification for appropriate use of inhaled medication devices.

2. When using multiple puffs of the same medication, allow at least 1 minute to elapse between each puff.

3. When using multiple inhaled medications, **wait 5 to 10 minutes between drugs** to get maximum benefit. **NOTE:** If both bronchodilator and a steroid inhaler are prescribed, **use the bronchodilator first**.

4. When using a steroid inhaler, rinse the mouth afterwards to help reduce dry mouth, hoarseness, and to prevent fungal growth.

5. Compressor/ Nebulizer

   a. Use with nebulizer face mask, which has medication cup and lid.
   b. For residents able to follow instructions, encourage resident to breathe as calmly, deeply, and evenly as tolerated until nebulizer stops producing mist.
   c. Never place machine on soft surfaces, such as beds.

C. Assessing Resident during treatment and for the effectiveness of treatment.

1. Briefly stop the treatment if rest is needed. Provide assisted coughing and expectoration as needed, and suction as clinically indicated.

2. Assess the resident's response to treatment.

D. Documentation for Inhaled Medications

1. When treatment or inhalation medication is given by the respiratory therapist, s/he will document on the Electronic Health Record (EHR).

2. Document any difficulties encountered during administration in the progress notes including interventions, outcomes and notifications.

3. Resident self-administration should be discussed with resident care team and ordered by the MD.

ATTACHMENTS/APPENDICES:

Appendix 1: Various Inhaler Instructions

REFERENCES:

AeroChamber Plus® Flow-Vu® Cleaning Instructions

DeWit, S., (2009). *Fundamental concepts and skills for nursing*, (3rd ed), St. Louis, MO: Elsevier

EBSCO - Nursing Reference Center - How to Use Your Metered Dose Inhaler (Adults)

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

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

CROSS REFERENCES:

Nursing Policies & Procedures
I 5.0 Oxygen Administration

Revised: 2005/12, 2006/04, 2008/05, 2016/03, 2019/03/12

Reviewed: 2019/03/12

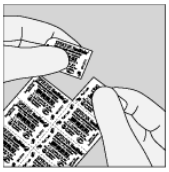
Approved: 2019/03/12

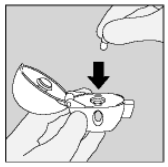
HandiHaler (Spiriva®)

10 Steps for Successful Inhaler Use:

1. Open dust cap by pulling dust cap upwards to expose mouthpiece. Open mouthpiece by pulling the mouthpiece ridge upwards.

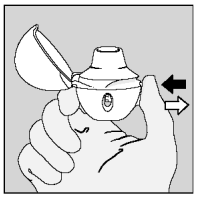

2. Tear along perforation to remove dose from blister card. Tip capsule out and insert in the center chamber of the HandiHaler device.



3. Close mouthpiece firmly until you hear a "click" and keep dust cap open.

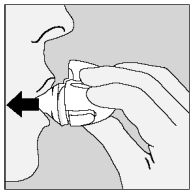
4. Hold inhaler device with mouthpiece upwards and press green piercing button until it is flush with the base and release button.



5. Hold device away from mouth and breathe out comfortably.

6. Keep head upright and bring inhaler to mouth horizontally and close lips around mouthpiece creating a seal.

7. Breathe in SLOWLY and DEEPLY through mouth. You should hear or feel the capsule vibrate (rattle).



8. Remove inhaler from mouth and hold breath for 10 seconds, then breathe out.

9. Repeat steps 7 – 10 if needed to get the full dose.

10. When finished, open mouthpiece and discard the used capsule. Close mouthpiece and dust cap.

HandiHaler (Spiriva®)

Common Errors with HandiHalers:

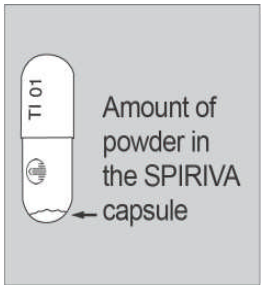
- Puncturing capsule more than one time. This can cause the capsule to break and shatter.
- Ingesting the capsule.
- Not breathing deeply enough. You should hear the capsule "whirl" inside the HandiHaler.

Important Notes for HandiHaler:

- Make sure patients understand that the capsule should not be ingested.

- Blister card can be difficult to open. Ensure patients are able to remove capsule and if not, offer assistance.

- Capsules are light sensitive. Do not remove the capsule from the blister card until you are ready to use the HandiHaler.



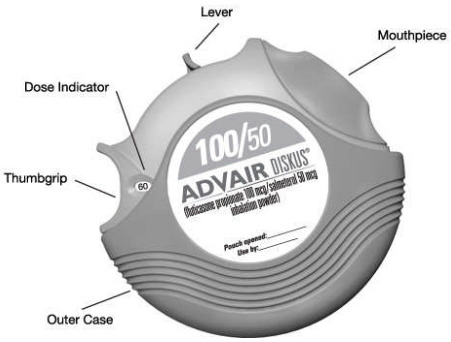
- Do not open the capsule before inserting into the HandiHaler device. Capsules contain medication in the form of a dry powder.

- Clean the HandiHaler as needed by rinsing under warm water. Do not use cleaning agents or detergents. Air-dry afterwards. Inhalers often take hours to dry, so choose an appropriate time for cleaning.

- Do not use the HandiHaler when it is wet.

Diskus

10 Steps for Successful Inhaler Use:



1. Open the diskus by holding it in the palm of your hand. Use the thumb of your other hand to push the thumb grip until the inhaler "clicks" into place.

2. Hold diskus in a level, <u>horizontal</u> position with mouthpiece towards the mouth.

3. Slide the dose release lever away as far as it will go until it clicks.

4. To avoid wasting medication
   - DO NOT close the diskus,
   - DO NOT tilt the diskus
   - DO NOT push lever more than once.

5. Before inhaling dose, turn head away from the inhaler. Breathe out as much as is comfortable. Remember: DO NOT breathe into the diskus mouthpiece.

6. Bring inhaler to mouth and close lips around the mouthpiece and over tongue, creating a seal.

7. Breathe in FORCEFULLY and DEEPLY through the mouth, not through the nose.

8. Hold breath and remove the inhaler from mouth. Continue to hold breathe for 10 seconds or for as long as is comfortable. Then breathe out slowly.

9. Close diskus by putting thumb on the thumb grip and slide the grip back as far as it will go until a "click" sound is heard.

10. Rinse mouth with water to avoid side effects after using steroidal powder (e.g. Advair).

Common Errors with Diskus:

- Not breathing forcefully and deeply enough.
- Breathing into the diskus.
- Using the diskus vertically.
- Taking extra doses because you do not feel or taste the medicine.

Diskus

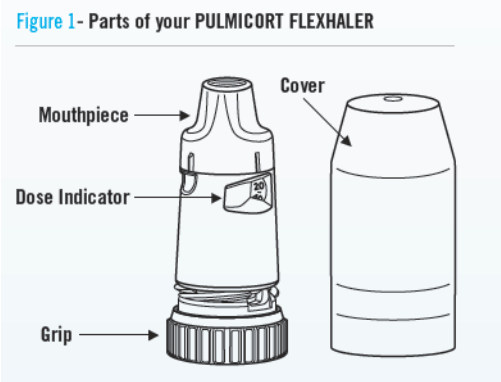
Important Notes for Diskus:

- The diskus is different than a pMDI. You do not have to shake or prime the diskus before using it.

- Helpful tip: Tell patients to position the inhaler as they would if they were biting into a hamburger. (Horizontally!)
- Never wash the diskus or any part of the diskus. Keep it DRY.
- Discard diskus 4 weeks after removal from the moisture-protective foil pouch or when the dose counter reads "0", whichever comes first.
- Never take the diskus apart.

Flexhaler (Pulmicort®)

10 Steps for Successful Inhaler Use:



1. Unscrew and lift off cap. If this is your first time using the inhaler, be sure to prime it.

2. Hold inhaler upright with mouthpiece up.

3. To "load" the Flexhaler, twist the colored turning grip on the bottom of the inhaler as far as it will go in one direction and then fully back again in the other direction until it stops. You will hear a “click” during one of the twisting movements.

4. Repeat step 3. The Flexhaler is now primed.

5. Turn head away from inhaler and breathe out comfortably. Bring inhaler to mouth and close lips around the mouthpiece and over the tongue, creating a seal.

6. Breathe in FORCEFULLY and DEEPLY through your mouth.

7. Remove inhaler from mouth and hold breathe for 10 seconds, then breathe out.

8. If additional puffs are needed, repeat steps 3-8.

9. Place cap back on inhaler and twist shut.

10. Rinse mouth with water. Do not swallow.

Flexhaler (Pulmicort®)

Important Notes for the Flexhaler:

- To prime the Flexhaler, twist the bottom grip as far as it will go in one direction, then fully back again in the other direction until it stops. It doesn't matter which way you turn it first. You will hear a "click" during one of the twisting movements. Repeat this once and your Flexhaler will be primed and ready to go.

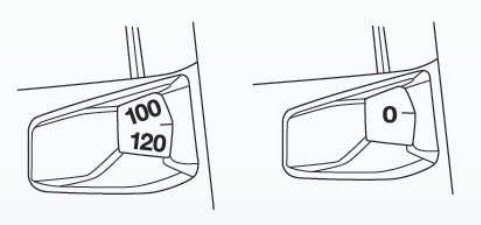
- You do not have to prime your Flexhaler again after this, even if you do not use it for a period of time.

- Do not bite or chew on the mouthpiece.

- Do not shake the Flexhaler after loading it.

- To clean your flexhaler, do not immerse it in water. Wipe the outside of the mouthpiece with a dry tissue.

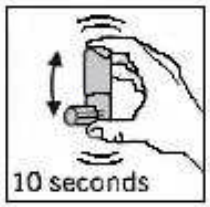
- Discard the inhaler when the dose indicator says 0. Markings are either with numbers or dashes, in intervals of 10.



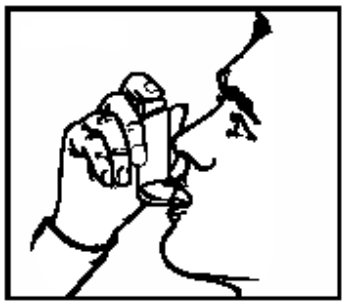
Instructions for Use of a Pressurized Metered Dose Inhaler (pMDI)

Using an Inhaler Without a Spacer

1. Sit up straight.
2. Shake the inhaler well before each dose.
3. Remove the protective cap.
4. **Exhale deeply.** Breathe out as completely as possible.

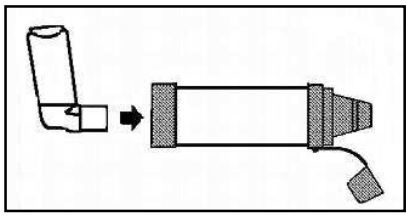


5. Place the open end of the mouthpiece into the mouth and close the lips tightly around it.

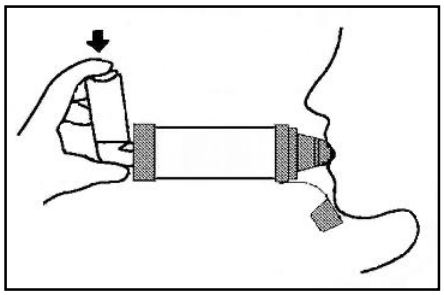


6. **Inhale slowly.** Take a **slow, deep breath** through the mouthpiece while pressing down on the inhaler. Be sure that the spray is not blocked by the teeth or tongue.
7. After taking a full, deep inhalation, remove inhaler from mouth and close mouth.
8. **Hold breath** as long as comfortable, up to 10 seconds, then breathe out slowly with pursed lips.
9. Replace the protective cap on the inhaler.

Using an Inhaler With a Spacer



1. Sit up straight.
2. Shake the inhaler well.
3. Remove the protective caps from inhaler and spacer, and **insert inhaler mouthpiece into the spacer.**
4. **Exhale deeply and fully away from mouthpiece.**
5. Place the spacer mouthpiece into mouth (between teeth) and close the lips tightly around it.
6. Press down on the inhaler to spray the medication into the spacer.



7. **Inhale slowly.** Take a **slow, deep breath** through the mouthpiece. A whistling sound should NOT be heard during inhalation. If a whistling sound is heard, inhale more slowly.
8. **Remove spacer from mouth and hold breath** as long as comfortable, up to 10 seconds, then breathe out slowly with pursed lips.
9. Remove the inhaler from the spacer and replace the protective caps on each.

Reminder:

- For 2 puffs of the same medication, wait 1 minute and shake the inhaler again before the second puff.
- For multiple different inhaled medications, wait 5 minutes between different inhalers.
- The mouth must be rinsed with water after using steroidal inhaler to prevent thrush.
- If 3 different types of inhalers are used, use bronchodilator first (e.g. albuterol), then anticholinergic (e.g. ipratropium) and steroidal inhaler last (e.g. Flovent).

Daily use of Respimat®—it's as easy as T.O.P.

TURN

- **Keep cap closed**
- **TURN** base in direction of the arrows on label until you hear a **click**

OPEN

- Flip cap **OPEN** until it clicks into open position

PRESS

- Close your lips around the mouthpiece end
- While taking in a slow, deep breath, **PRESS** dose release button; keep breathing in slowly
- Close cap
- Repeat **T**urn, **O**pen, **P**ress **(T.O.P.)** for a total of 2 puffs

TWO PUFFS ONCE DAILY

For a video tutorial, visit interactive.respimat.com.

References: 1. Placebo Respimat® inhaler package leaflet; instructions for demonstration. Boehringer Ingelheim International. September 2010. **2.** Hochrainer D, Hölz H, Kreher C, et al. Comparison of the aerosol velocity and spray duration of Respimat® Soft Mist™ Inhaler and pressurized metered dose inhalers. *J Aerosol Med.* 2005;18(3):273-282. **3.** Schürmann W, Barczok M, Timmer W, et al.

Preparing Respimat®: A soft mist for easy inhalation[1-3]

Only before first use

- **Keep cap closed**
- Press safety catch and pull off clear base

- **Keep cap closed**
- Insert narrow end of cartridge into inhaler and gently push against a firm surface to ensure that it has gone all the way in

- **Keep cap closed**
- Replace clear base

- **Keep cap closed**
- Turn base in direction of the arrows on label until you hear a **click**

- Flip cap open until it clicks into open position

- Point Respimat® inhaler toward ground and press dose release button
- Close cap
- **Repeat steps 4-6 until a cloud is visible**
- **Then repeat 3 more times before use**

RESPIMAT®

INSTILLATIONS OF THE EYE, EAR and NOSE

POLICY:

Medications instilled in the eyes, ears, or nose will be administered using the correct technique to maximize absorption and prevent cross contamination.

PURPOSE:

To guide the Licensed Nurse in the proper administration of eye, ear, and nasal medications.

PROCEDURE:

A. EYE INSTILLATIONS

1. General procedure during eye medication administration:

    a. Check orders designating which eye(s) requires medication:

O.D.	(Oculus dexter)	right eye
O.S.	(Oculus sinister)	left eye
O.U.	(Oculus uterque)	both eyes

    b. Perform hand hygiene.

    c. Position resident with head tilted slightly backward or lying in dorsal recumbent position.

    d. If a resident has an order for more than one eye medication, **wait about five minutes** between drugs to prevent one medication from washing the previous medication away.

    e. If residents are unable to cooperate adequately with administration of eye drops after reasonable coaching efforts, it is recommended that the Resident Care Team (RCT) review the necessity of the medication and/or discuss techniques to enlist the cooperation of the individual resident.

2. When using Eye Drops

    a. Using your finger, pull lower lid down gently to form a small pocket (cul-de-sac).

    b. Instruct the resident to tilt head back and look upward.

    c. Gently squeeze a drop into the center of the lower lid (cul-de-sac). If more than one drop is prescribed wait at least one minute between drops of the same medication.

    d. Do not touch the dropper tip to eye, or any surface, in order to avoid contamination of the solution.

    e. Apply pressure to the nasolacrimal duct (inner canthus) after each prescription eye medication for 30 seconds to prevent possible systemic effects.

    f. Do not wipe the dropper or rinse under water.

g. Instruct the resident to close both his eyes and to keep them closed for a full minute without squeezing.

h. To blot excess eye drops from the eyes, use a clean, separate tissue or gauze for each eye.

3. When using Eye Ointments

a. To administer eye ointments, apply a small strip of ointment into the cul-de-sac pocket. Avoid contacting the tube tip with the eye.

B. Ear Instillations

1. Have resident lie on side or sit with his/her head tilted and hand supporting the head on the unaffected side.

2. Use medication at room temperature.

3. Clean external orifice gently with cotton swab.

4. Gently pull the pinna upward and outward to straighten the auditory canal

5. Drop the prescribed amount of medication against the side of the ear canal and hold the ear in position for a moment to enable the drop to spread down the canal.

6. Have the resident maintain his position for a few moments.

7. Place a tissue or gauze loosely at canal opening to protect the canal and catch any outflow.

8. Document administration on the Medication Administration Record (MAR).

C. Nasal Instillations

1. Nose drops

a. Have resident lie flat with his head slightly lower than the shoulders.

b. Steady resident's head. Holding the dropper in a vertical position near the nasal opening, instill the number of drops ordered.

c. Keep the resident in position for at least two minutes. During this time, instruct the resident to sniff three or four times and not to blow his nose.

2. Nasal Spray

a. Resident may be in a sitting position during this procedure.

b. Place the tip of the bottle in resident's nostril.

c. Instruct resident to sniff up as you simultaneously squeeze the lower portion of the bottle.

d. Instruct resident to continue sniffing 3-4 times, and ask that he not blow his nose for at least two minutes.

CROSS REFERENCE:

NPP J 1.0 Medication Administration

REFERENCES:

Lexicomp - http://www.crlonline.com/lco/action/home/switch

National Institutes of Health (2008). Patient education: How to put in your eye drops. Accessed at http://www.cc.nih.gov/ccc/patient_education/pepubs/eyedrops.pdf

Revised: 12/2006, 07/22/2014

Reviewed: 07/22/2014

Approved: 07/22/2014

Revised Food and Nutrition Policies and Procedures

1.83 Resident Meal Service

~~Established and~~ Revised: 7/23

Policy: The nutritional needs of Laguna Honda Hospital Residents are met in accordance with the Recommended Daily Allowances of the National Research Council and in accordance with physician's orders. These will be accomplished through the operation of an efficient/effective meal delivery system to each resident neighborhood.

Purpose: To provide wholesome food to Laguna Honda Hospital Residents.

Procedure:

1. Three meals per day are served and in addition fruit juice and other nourishment are available for between meal snacks.
2. Resident's food preferences are adhered to as much as possible and substitutes are offered for food intolerance, dislikes and allergies.
3. If an individual is not eating a food (or foods) served, the staff will ask why and verbally offer a suitable food replacement. The individual will be encouraged to verbalize the choice of substitution. For individuals on therapeutic diets, the food replacements or any additional food requests should be appropriate for the therapeutic diet order and appealing to the individual.
4. If an individual agrees to eat the food replacement or requests for additional food, the substitution or request should be communicated with the diet office. This will typically be done through phone call. A food replacement will be prepared as soon as possible and delivered to the individual in a timely manner with the expectation to not exceed 30 minutes from the time of request.

~~2. These replacements will be provided with in 30 minuets after nursing contacts Nutrition Department with the request.~~

~~3.~~5. Food is prepared to conserve nutritive value, flavor, and appearance and is served attractively at appropriate temperatures. Variety, texture, color and cultural and religious background is considered when the cycle menus are planned.

~~4.~~6. Condiments are served according to the diet of the resident.

~~5.~~7. Foods are served with appropriate eating utensils, including straws, and in a form to meet individual needs.

~~6.~~8. For the safety of the North Mezzanine Residents, a plastic fork will be served with regular stainless-steel fork and spoon.

~~7.~~9. Temperatures are monitored every meal and food quality is checked production and tray service staff.

~~8.~~10. The department uses reusable Dinex Trays, Dinex Heated Base, Dinex Covers, China plates and bowls, beverage mugs, stainless steel flat ware, and diet kits. Some disposable dishes may be used in place of reusable plates and bowls.

~~9.~~11. The food is plated on a tray assembly line according to each resident's meal ticket and transported to each neighborhood according to estimated schedule time.

~~10.~~ Individualized or s~~S~~tandard aspiration precautions may be written at the bottom of the tray ticket including "pink lid." This is an indication for the checker ~~on the line comes across a tray ticket with "SFP" written it, the checker will~~ to place a mauve "pink" colored cover over the plate of hot food. This helps nursing easily identify

residents who have individualized or standard aspiration precautions. ~~to signify that the resident is on a *specialized feeding plan*.~~

~~11.~~12. Nursing will pass out food to the residents according to their meal ticket and diet in the Resident Dining Rooms or Resident Rooms as soon as possible or within 5-10 minutes of the delivery of the food cart.

~~12.~~13. Resident meals are served at the following times:
Breakfast 7:00 - 9:00 A.M. Lunch 11:15 A.M. - 1:15 P.M. Dinner 5:00 - 7:00 P.M.

~~13.~~14. After the meal service, Nursing will collect all soiled trays and place them back into the delivery carts.

~~14.~~15. Nursing will return soiled trays to the Galley or alcove to be picked up by a Food Service Worker.

~~15.~~16. Prior to all warewashing process, the Senior Food Service Worker or Supervisor will record the dishwasher machine temperatures to ensure that it is operating within standards.

~~16.~~17. The Food Service Workers will strip each soiled trays using the compost, recycle, garbage and the Salvajor waste collector.

~~17.~~18. The Food Service Workers washes and sanitizes all trays and dishware, mugs and silverware through a commercial dishwasher machine located in the main production kitchen.

~~18.~~19. Using the three-bucket cleaning procedure, the Food Service Workers washes and sanitizes the delivery carts. (1.164 General Cleaning and Sanitizing work Surfaces and Kitchen or Galley Equipment)

~~19.~~20. All cleaned and sanitized ware are brought back to the Tray Service Area by the Food Service Worker before the next meal service.

~~20.~~21. A Food Service Worker will sweep and mop dishroom floors at the end of each warewashing process.

~~21.~~22. A Food Service Worker will properly dispose all compost, recycle and garbage.

~~22.~~23. Food Service Supervisor and Team leaders will monitor the warewashing process in the dish room for compliance.